2012 - 2015

COMMUNITY HEALTH IMPROVEMENT PLAN

for Hennepin County Residents

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

COMMUNITY HEALTH IMPROVEMENT PARTNERSHIP

Convene ~ Catalyze ~ Collaborate

Hennepin

CITY OF BLOOMINGTON MINNESOTA

CITY OF EDINA, MINNESOTA

RICHFIELD

Minneapolis City of Lakes

To Our Community,

We are excited to share with you the culmination of six months of planning that has resulted in a shared vision and plan for improving health in our community. The Community Health Improvement Partnership (CHIP) was formed to foster strong alliances across public and private organizations to target important health issues – together - for greater impact. More than 100 diverse organizations involved in health-related work provided input and guidance in the development of the CHIP vision and plan. Partnerships have been forged and teams are preparing to move into action to address health issues important to our community.

Tackling tough issues is not new to us. Working on many fronts, multiple public and private partners took on different aspects of tobacco use – from policy work to individual education and interventions. We have made great strides in reducing the adult smoking rates in our community – from 21.2% in 1998 to 12.1% in 2010. What IS new is the building of a coalition of partners that includes public health, hospitals, health plans and systems, clinics and non-profits, community organizations and the faith community across the whole county to focus on ways to collaborate and align efforts to make greater progress more quickly.

The following CHIP Plan has the support of the five community health boards serving Hennepin County and their governing officials. The plan is built on health data and formed by the collective vision of multiple stakeholder organizations from the community. It has a strong Steering Committee of leaders from organizations involved in improving health. It also has the support of a wide range of community organizations willing to work together to achieve our common vision.

We know that together we can do more. That together we can build a synergy for collective impact – in ways none of us can do alone. That together, with a shared vision and aligned efforts, we can move our community forward to becoming healthier in the coming years. We hope that you will join us to support and create health for the residents of our county.

Mike Opat, Chair
Hennepin County Board of Commissioners and
Hennepin County Community Health Board

Gene Winstead
Mayor
City of Bloomington

James Hovland
Mayor
City of Edina

Debbie Goettel
Mayor
City of Richfield

Barbara Johnson, President
Minneapolis City Council / Board of Health

Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

Shared Vision of Characteristics of a Healthy Community

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

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CHIP ACKNOWLEDGEMENTS

The convening partners for this project were Hennepin County Human Services and Public Health (HSPHD), Minneapolis Department of Health and Family Support, and Bloomington Division of Public Health for the Community Health Boards of Bloomington, Edina and Richfield.

Support from so many people was critical to this process: the CHIP Leadership Group, staff of the public health agencies, the hospital advisors, and the ToP® facilitators. Many thanks to all of them for their time, enthusiasm, expertise and commitment to the CHIP planning! We have tried to include all individuals and organizations that assisted significantly to the CHIP initiative; our apologies for any omissions.

A special thank you belongs to the CHIP survey and forum participants for their contributions. Please see the Appendices for a listing. Acknowledgement is given to Hennepin County Human Services and Public Health for the financial support for the CHIP forums and the administrative support to this initiative.

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CHIP Plan Highlights

Introduction

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

- Develop a shared vision for improving health across public and private organizations.
- Establish common health-related priorities within and across multiple organizations.
- Identify actionable steps that could be executed collectively or collaboratively.
- Foster complementary action and alignment of efforts.
- Coordinate use of assets and resources to gain efficiencies and bridge gaps.

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

- Document the progress to-date.
- Be a guide for collaborative planning and action.
- Influence strategic planning efforts at the individual organizational level.

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

The CHIP assessment and planning work focused on two tracks:

1. Reviewing and compiling recent assessment data collected by the three partner public health departments and data drawn from other state and national sources.
2. Engaging community stakeholders through the CHIP Survey and the CHIP Forum Series - using the MAPP assessments as guides and the Technology of Participation (ToP®)[2 & 3] process to facilitate conversations.

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

The Partners

CHIP Conveners

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

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

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

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

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

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

CHIP Catalyzers

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

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

CHIP LEADERSHIP GROUP

February – June 2012

** Continuing onto CHIP Steering Committee*

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

CHIP Collaborators

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

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

What the Partnership Developed

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

- **The vision**: The partnership developed a vision for a healthy community that includes 10 characteristics they deemed important for community members to be healthy.
- **Guiding principles for action**: As the partners moved forward, they began to propose guidelines for collaborative action which are captured as principles for action.
- **Strategic health issues and goals**: Five strategic health issues have been selected for aligned and partnered efforts for which three targeted health improvement goals have been identified.

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

The Vision: Characteristics of a healthy community

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

SAFETY

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

ENVIRONMENTS THAT FOSTER HEALTH

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

COMMUNITY CONNECTEDNESS & ENGAGEMENT

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

EQUITABLY ACCESSIBLE HIGH QUALITY INFRASTRUCTURE

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

BASIC NEEDS ARE MET

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

ECONOMIC VITALITY

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

ACTIVE PARTICIPATION IN CREATING HEALTH

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

QUALITY EDUCATIONAL OPPORTUNITIES

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

MULTI-SECTOR LEADERS PROMOTE THE COMMON GOOD

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

GOOD PHYSICAL & MENTAL HEALTH

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

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

Guiding Principles for Action

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

Collaborative Guidance

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

Strategies Guidance

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

Strategic Health Issues and Goals

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

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

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

Moving into Action

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

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

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

COMMUNITY HEALTH IMPROVEMENT PARTNERSHIP

Convene ~ Catalyze ~ Collaborate

Characteristics of a Healthy Community

Safety

Environments that Foster Health

Community Connectedness & Engagement

Equitably Accessible High Quality Infrastructure

Basic Needs are Met

Economic Vitality

Quality Educational Opportunities

Multi-sector Leaders Promote the Common Good

Good Physical & Mental Health

Active Participation in Creating Health

Guiding Principles

Collaborative Guidance

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

Strategies Guidance

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

Strategic Health Issues & Targeted Health Improvement Goals 2012-2015

Maternal & Child Health

Increase childhood readiness for school

Nutrition, Obesity & Physical Activity

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

Social & Emotional Wellbeing

Increase community & social connectedness

Cross-cutting health issues:

- Health Care Access
- Social Conditions that Impact Health

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

Strategic Health Issues & Goals

Highlighted Data

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

Tables are provided for the following:

Maternal and Child Health

Increase childhood readiness for school

Nutrition, Obesity & Physical Activity

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

Social & Emotional Wellbeing

Increase community and social connectedness

Health Care Access

Social Conditions that Impact Health

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

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

Additionally, see the separate CHIP APPENDICES documents.

- Included is a PDF of data regarding 40 community health indicators for Hennepin County from which some of the data below has been extracted.
- There are also two documents with highlights from the SHAPE 2010 – Adult Survey and Child Survey that provides much more detail on many data topics.

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

Maternal & Child Health: Childhood Readiness for School

Target Goal 2012-2015:
Increase childhood readiness for school

Healthy beginnings

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

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

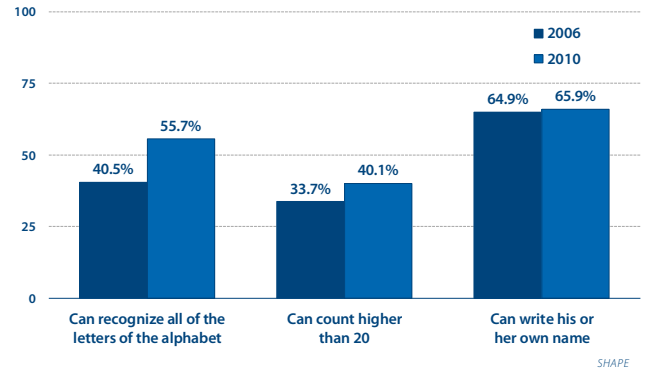
And healthy children become healthy adults who then help create healthy communities.

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

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

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

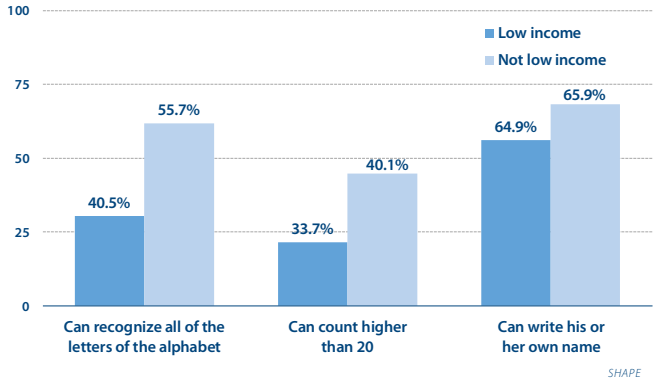
Percent of young childrenwho meet basic milestones for school readiness
Hennepin County Children Aged 3 to 5, 2006 & 2010



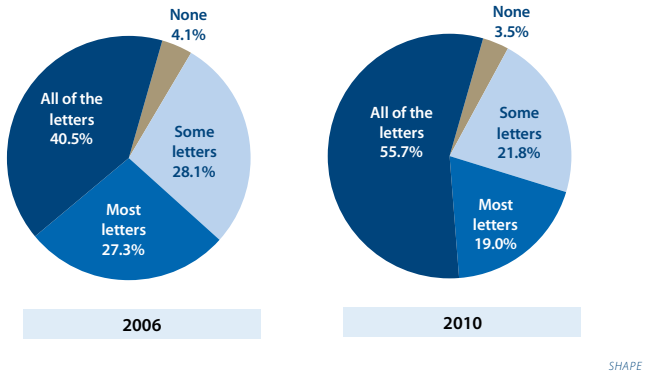
Why is this health issue important?

- Research shows that how a child develops in their first years has lifelong implications on physical, cognitive, and social-emotional health; learning; and overall wellbeing.
- During early childhood, children develop their language and motor skills as well as their abilities to attach with others and regulate their emotions. By age 3, the human brain has grown to 90 percent of its adult size.
- Healthy childhood development sets the stage for readiness for school - which influences success in life.
- A child's early and middle years are also foundational for health habits including: learning to make healthy choices, self-discipline, making good decisions about risky situations, and healthy eating habits.
- Environmental stressors and other negative risk factors can seriously compromise a child's ability to grow, play and learn – and affect physical, social-emotional, and cognitive growth and development.
- Research on a number of adult health and medical conditions suggest that they may have their beginnings in early and middle childhood.
- Unaddressed illnesses and conditions such as asthma, obesity, dental caries, child maltreatment, and developmental and behavioral issues all affect a child's ability to be healthy. It can delay their development, interfere with their education, and affect the health and wellbeing of the adolescents and adults they will become.

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



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



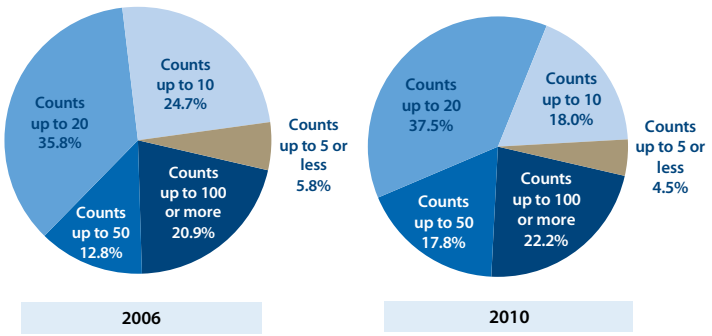
- Regular preventive care and developmental screenings play an important role in detecting and preventing significant health issues and provide opportunities to intervene early should a child show signs of growth or developmental delays or serious health conditions.

Data Sources: SHAPE[4] – Child Survey 2010 and Healthy People 2020[5].

How are we doing?

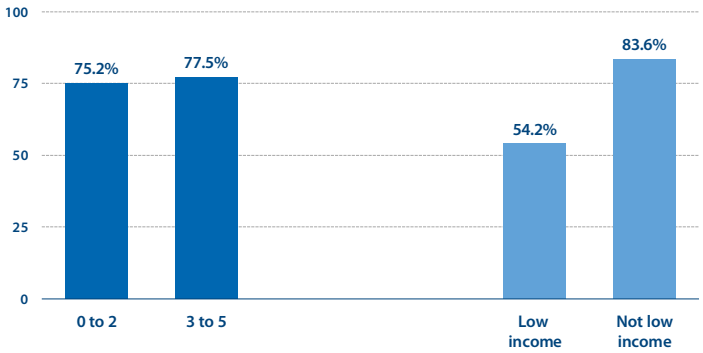
- There were over 90,000 children ages 0-5 in Hennepin County in 2010.
- A 2010 Minnesota Department of Education statewide sampling of approximately 5,800 kindergarteners found these rates of proficiency in the following performance areas (Defined as a score of 75% or greater):
  - 70% percent were considered proficient in physical development
  - 59% percent were considered proficient in personal and social development
  - 56% percent were proficient in language and literacy
  - 56% percent were proficient in mathematical thinking
  - 52% percent were proficient in the arts
- In Hennepin County in 2010, proficiency rates in three pre-school milestones ranged from a rate of 68% of students able to write their own names to a low rate of 21% of children able to count higher than 20.
- Within the county, overall improvements in alphabet recognition and basic counting skills have occurred since 2006. However, only four out of ten children aged 3 to 5 are currently able to count above 20.
- Nearly all parents report that they engaged in activities weekly that stimulate brain development and foster language and learning skills. However, some significant differences were noted in the number of times spent per week in these activities.
  - 54% of low-income households spent 4 or more times a week vs. 84% of households that were not low income.

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



SHAPE

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



SHAPE

- Three out of four children in Hennepin (76.1%) met the standard for preventive care visits. However, only 55.0% of infants and toddlers aged 0 to 2 years old were "on track" for receiving all of the recommended visits for their age group.
- Kindergartners from lower income families and those whose parents have lower educational levels are more likely to not be ready for kindergarten. The gap in performance between low-income and not-low income families is nearly double in some milestones.
- A 2009, Wilder[6] Research study found that the estimated cost burden to Minnesota's K-12 system due to children entering kindergarten unprepared for school success is about $113 million dollars annually.

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

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

Hennepin County Children Aged 0 to 17, 2010

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

SHAPE

Nutrition, Obesity & Physical Activity:
Nutrition*

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

Healthy eating

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

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

**See separate sheets for Obesity and Physical Activity*

Why is this health issue important?

Healthy growth and development

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

Healthy weight maintenance

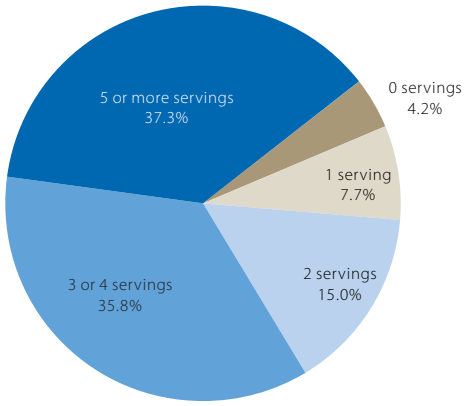
- Fruits and vegetables are important sources of vitamins and dietary fiber, essential for maintaining healthy weight.To maintain a healthy weight and avoid other health problems, it is strongly recommended that children avoid all sources of "empty calories" (non-nutritive foods or beverages). Drinks,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

How are we doing?

Fruit and vegetable consumption in adults

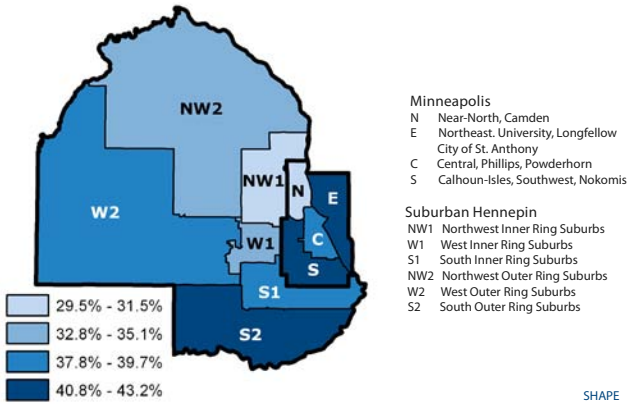
- Only 37% - just over one in three adults - consume five or more servings of fruits and vegetables daily.

Total servings of fruits and vegetables yesterday
Hennepin County adults 2010



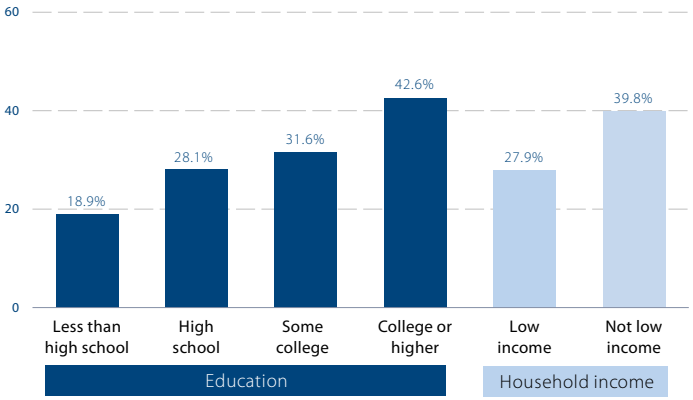
SHAPE

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



SHAPE

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

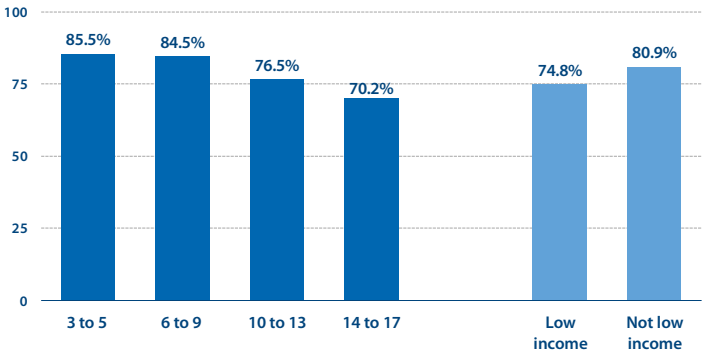


SHAPE

Fruit consumption among children

- Hennepin County's young children aged 3 to 9, are most likely to meet the recommended standard for fruit on a daily basis.
  - Most children ages 3 to 5 (85.5%) get two or more servings of fruit each day.
  - Four out of five children aged 3 to 17 (79%) are currently eating the recommended two servings.
  - Adolescents aged 14 to 17 are less likely to meet the daily recommended standard at 70.2%.
  - Only 3.8% of Hennepin County children overall had no (zero) servings of fruit the day prior to the survey.

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

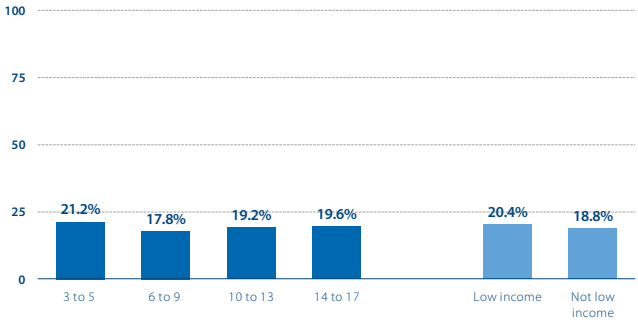


SHAPE

Vegetable consumption among children

- Only one in five children aged 3 to 17 (19%) is meeting the recommended guideline of eating three or more servings of vegetables each day.
  - One in seven Hennepin County children had no (zero) servings of vegetables the day prior to the survey (14.0%).Only one in four children aged 3 to 17 are meeting the daily recommended guideline for dairy products.
  - Children from low income households were significantly less likely to have met the recommended guidelines of four servings of dairy products per day.

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



SHAPE

Sugar-sweetened drinks among children

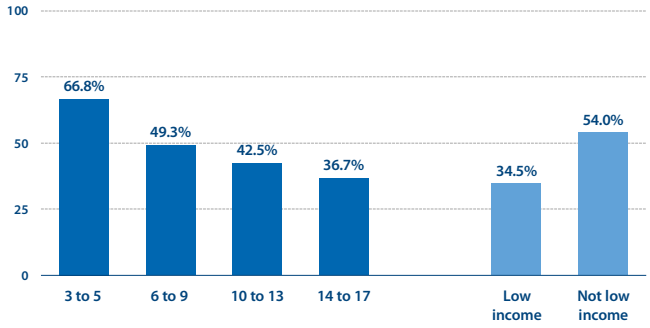
- Less than half of all Hennepin County children aged 3 to 17 met the recommended standard of avoiding sugar-sweetened drinks (48.1%).
  - Younger children, ages 3 to 5 years are doing well: 91.6% had zero or only one sugar-sweetened drink per day reported.
  - For youth 14 to 17, limiting sugar-sweetened drinks to zero or one per day drops to 68.4%.
  - Children from low income households were significantly more likely to have two or more sugar-sweetened drinks per day.

Understanding nutrition

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

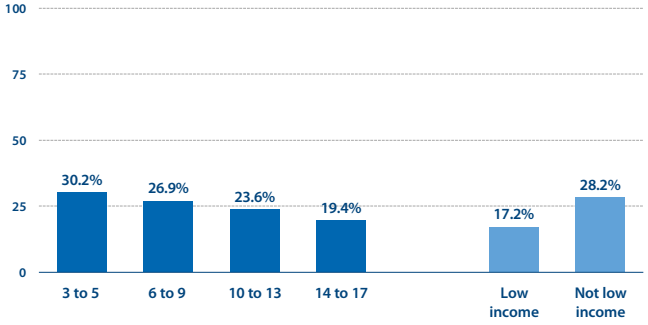
Data Source: SHAPE 2010 – Child Survey, Hennepin County.

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



SHAPE

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



SHAPE

Nutrition, Obesity & Physical Activity: Obesity

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

Healthy weight

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

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

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

Why is this health issue important?

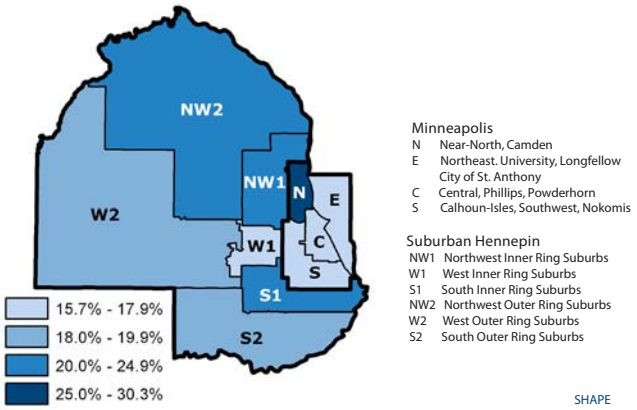
Adults

- Obesity and overweight are associated with increased risk of premature death and many chronic health conditions and diseases.
- It is one of the most common causes of diabetes and heart disease, which are more prevalent among low-income populations. These costly, preventable illnesses reduce quality of life and can cause disability and premature death.
- Over the past 30 years, the obesity rate among U.S. adults had increased dramatically and has reached an epidemic proportion.
- The overall medical cost related to obesity for U.S. adults in 2008 alone was estimated to be as high as $147 billion.

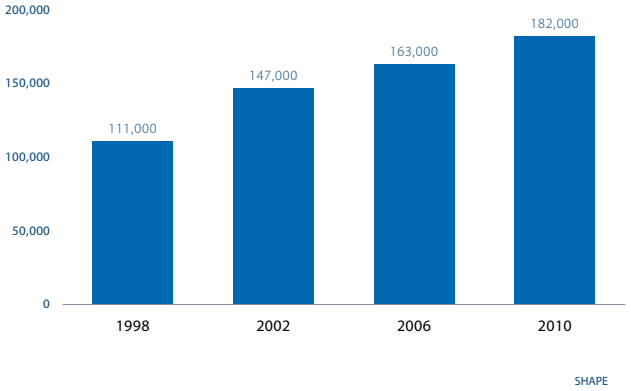
Children

- Obese children and teens have been found to be at increased risk for factors leading to cardiovascular diseases, including high cholesterol levels, high blood pressure, Type 2 diabetes, and abnormal glucose tolerance.
- Type 2 diabetes is increasingly being reported among children and adolescents who are overweight or obese.
- Asthma, hepatic steatosis (a liver enzyme disease) and sleep apnea are also health conditions associated with increased weight in childhood.
- Other consequences of being overweight or obese include social discrimination, psychological stress, low self-esteem, and social isolation.

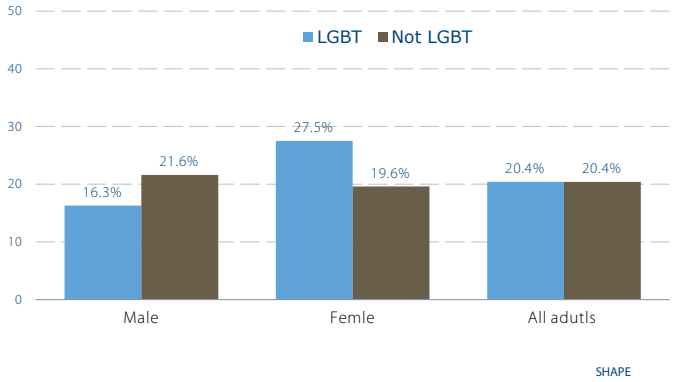
Percent of adults being obese by geographic areas
Hennepin County 2010



Number of adults who are obese
Hennepin County 1998-2010



Percent of adults being obese by sexual identity
Hennepin County 2010



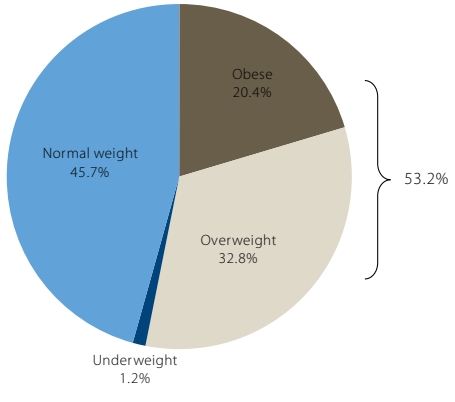
How are we doing?

Adults

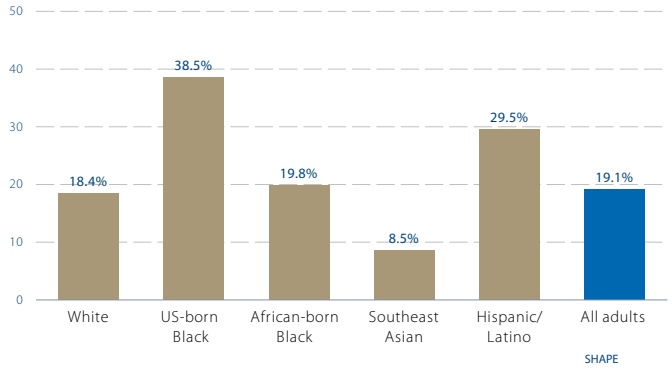
- In 2010, at least half (53%) of Hennepin County adults were either overweight (33%) or obese (20%).
- Approximately 71,000 more adults were obese in 2010 than in 1998. The rate of obesity rose from 14% in 1998 to 20% in 2010 (a 43% increase).
- The 20% obesity rate for county adults is significantly lower than the national average (28%), but far exceeds the 15% Healthy People 2020 Objective.
- Obesity disproportionately affects many population groups including: older adults, seniors, residents with low income or low education, U.S.-born Blacks, Hispanics or Latinos, older residents with disabilities, and residents experiencing frequent mental distress.
- Obesity rates among females who are Lesbian, Bisexual or Transgendered are significantly higher than the rate among females who are not (46% vs. 20%) – though the obesity rate for the full LGBT community is no higher than county adults overall.
- Obesity rates vary widely across the geographic areas of the county with north Minneapolis having the highest rate (30%).

Data Source: SHAPE 2010 – Adult Survey.

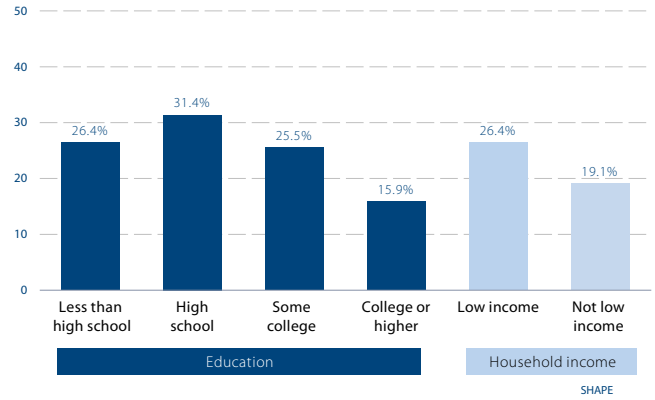
Adult weight status
Hennepin County adults 2010



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



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



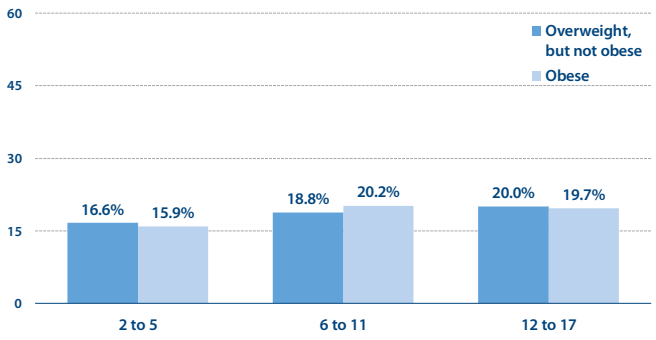
Children

- One out of five 9th and 12th graders in Hennepin County schools reported a weight and height that would place them in either the overweight or obese weight status group (19%).
- For 9th graders, the highest combined overweight and obesity rates were reported among African American and Hispanic/Latino students (28.4 and 31.5%) compared to 19.7% for all county 9th graders.
- Adolescents from low income households are more likely to be overweight or obese (29.0%) compared to those who are not low income (16%).

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

Percent of child patients who were overweight or obese by age group

Hennepin County Medical Center Patients, Aged 2 to 17, January to June 2011



HCMC - EPIC

Nutrition, Obesity & Physical Activity:
Physical Activity

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

Healthy bodies

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

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

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

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

Why is this health issue important?

Adults

- Physical activity can help control weight, reduce the risk of heart disease and some cancers, strengthen bones and muscles, and improve mental health.
- Being physically activity is one of the most important steps that Americans of all ages can take to improve their health.
- Physical inactivity can lead to obesity and Type 2 diabetes.
- Healthy People 2020 aims to reduce the proportion of adults who engage in no Leisure Time Physical Activity (LTPA) by 10%.

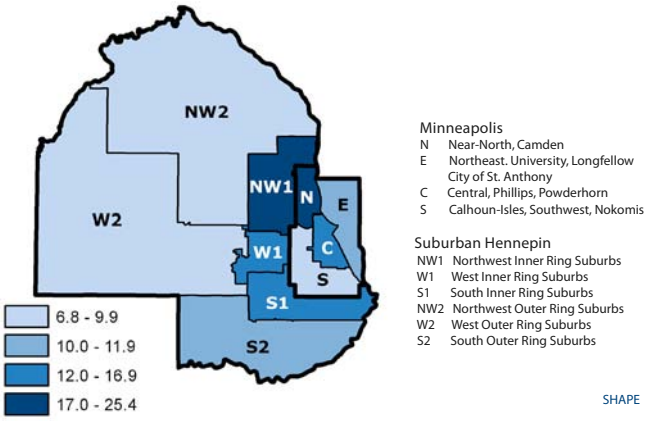
Children

- To maintain a healthy weight and avoid other health problems, it is strongly recommended that school-aged children grades 1-12 engage in regular physical activity every day for at least one hour or more.
- Increasing children's levels of physical activity is a modifiable health behavior that could lead to significant reductions in obesity and overweight among children.

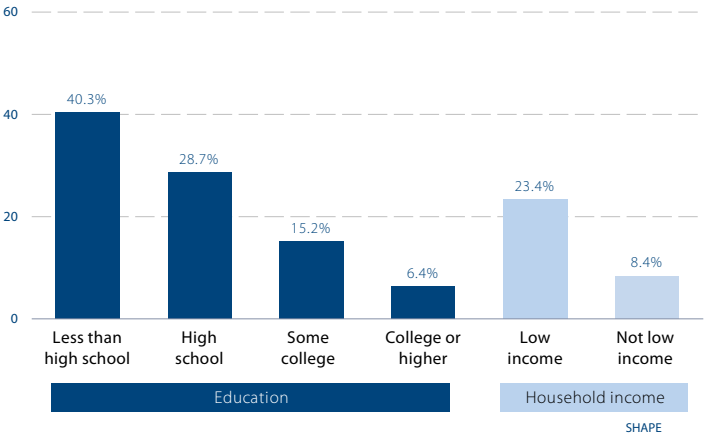
Adolescents

- To maintain a healthy weight and avoid other health problems, it is strongly recommended that adolescents regularly engage in moderate physical activities for at least 30 minutes on five or more days per week and vigorous activities for at least 20 minutes on three or more days each week.
- Inactivity in adolescence is associated with increased risk for factors leading to cardiovascular diseases, including high cholesterol levels and high blood pressure.
- Other consequences of inactivity include an increased risk of being overweight or obese which, in turn, can lead to systematic social discrimination. The psychological stress of social stigmatization can cause low self-esteem, and hinder academic performance and social functioning.

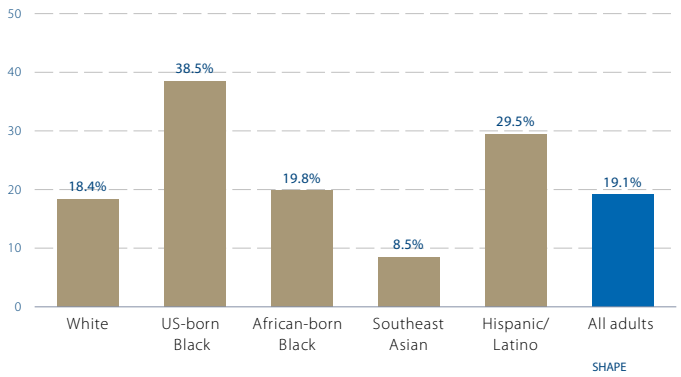
Percent of adults engaging in no leisure time physical activity by geographic area
Hennepin County 2010



Percent of adults engaging in no leisure time physical activity by education and household income
Hennepin County 2010



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

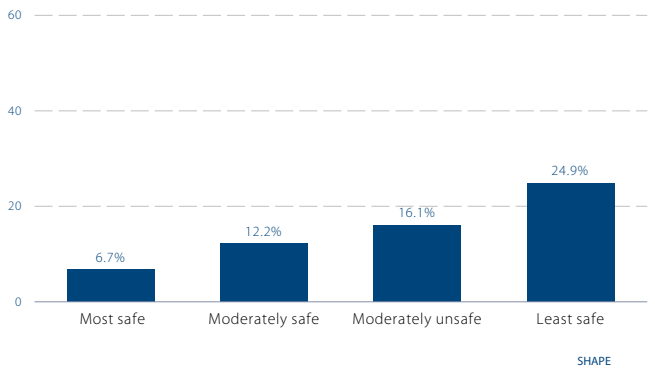


How are we doing?

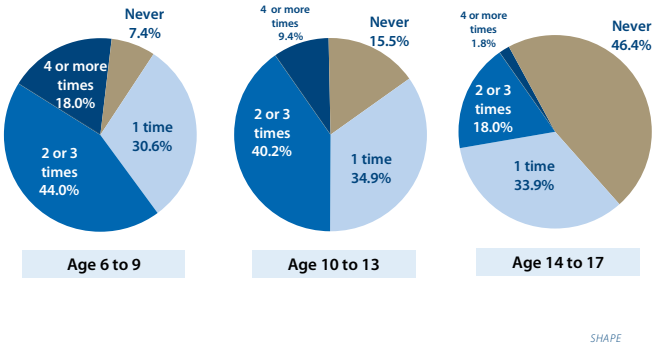
Adults

- In 2010, 12 % of Hennepin County adults engaged in no Leisure Time Physical Activity (LTPA), which is better than the state average (19%) and the national average (24%). It is also a significant decrease from what it was in 2006 (16%).
- The low rate of no LTPA among Hennepin County adults is not equally distributed across the county's populations. Significantly higher rates of no LTPA are found among senior residents, residents of racial and ethnic minorities, those who experience frequent mental distress and older residents with a disability.
- Geographic variation in the rates of no LTPA is evident, ranging from 7% in South Minneapolis to 25% in North Minneapolis.
- Social conditions matter: Residents with low household income are three times more likely to report no LTPA compared to those with higher household income. Residents with less than high school education are six times more likely to report no LTPA than compared to residents with college or higher education.
- Increased social connectedness, as measured by community involvement and getting together or talking to friends/neighbors, is found to be significantly related to increased rates of physical activity.
- The higher the perceived safety of a neighborhood, the lower the rate of no LTPA.

Percent of adults engaging in no leisure time physical activity by level of perceived community safety
Hennepin County 2010



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



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

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

MSS

Children

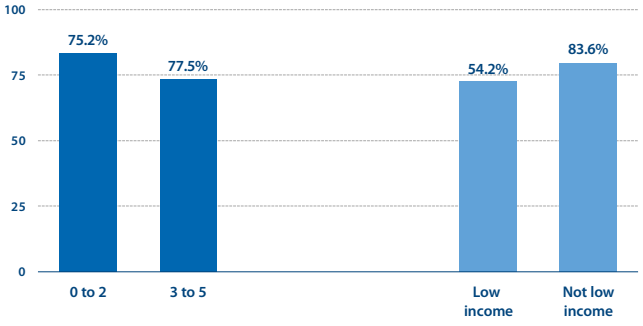
- Less than a quarter of all Hennepin children aged 6 to 17 met the recommended standard of weekly physical activity (24.1%). No significant differences were found by household income or geographic location.
- In 2010, only 28% of Hennepin children aged 6 to 13 were meeting the guideline of getting at least 60 minutes of daily physical activity. This drops even further to 15.7% for adolescents aged 14 to 17. No differences were observed by residence (urban vs. suburban).
- A large percentage of parents talk with their children about getting regular exercise (73% or more).
- Most parents play or engage in physical activities with their pre-schoolers four or more times per week (more than 73%). That percentage drops significantly by the time their children are teenagers (to 2%) - with nearly half of the parents spending no time in physical activities with their adolescent.

Adolescents

- Fewer girls are getting the recommended level of activity each day. In 2010, 31.2% of boys were meeting the guideline of getting at least 60 minutes ofdaily physical activity, as compared to only 16.8% of girls. Only one out of three 12th grade girls (34.4%) is currently meeting the recommended levels for moderate physical activity.
- Students of color are less likely to meet the recommended standards for moderate physical activity than others; their rates are 15% to 20% lower than their peers who are White.
- Three out of four 9th grade boys (76.6%) are meeting the recommended levels of vigorous physical activity. However, the percentages for each of the other grade/gender groups are notably lower.
- Trend data suggest that, there have been gradual increases in the physical activity levels for boys, but the rates for girls have remained relatively stable.

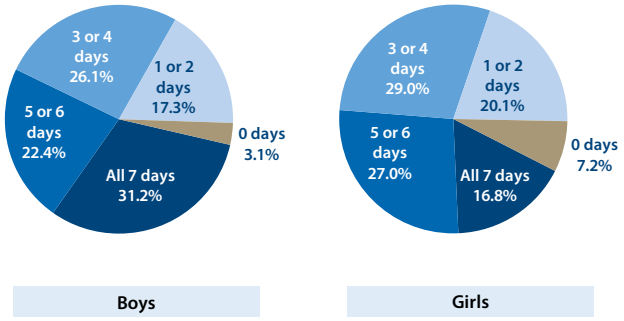
Data Source: SHAPE 2010 – Child Survey & Minnesota Student Survey - 2010, Minnesota Department of Health.

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



SHAPE

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



SHAPE

Social & Emotional Wellbeing: Community & Social Connectedness

Target Goal 2012-2015:
Increase community & social connectedness

Healthy connectedness

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

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

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

Why is this Issue Important?

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

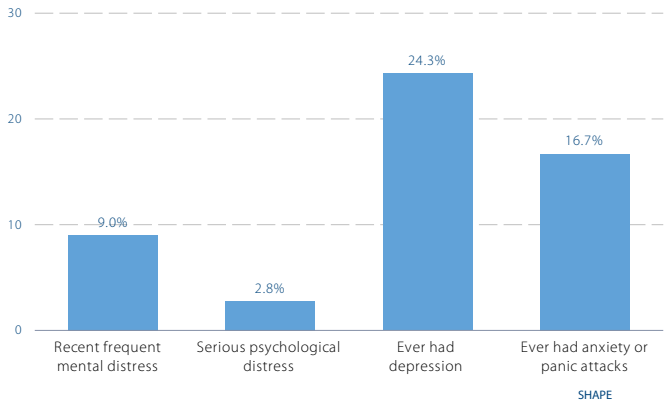
- Family networks and social interaction promote health.
- People are resilient despite great hardships.
- Health is viewed holistically.
- Access to physical activities is important to health.
- Cultural pride and maintaining cultural traditions are important to good health.
- Culturally-competent services are essential.
- Stigma surrounds mental illness.
- Residents need more help dealing with a range of emotions.
- More resources are available for mothers than fathers.
- Women and men both want group sessions for education, skill-building, and social support.

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

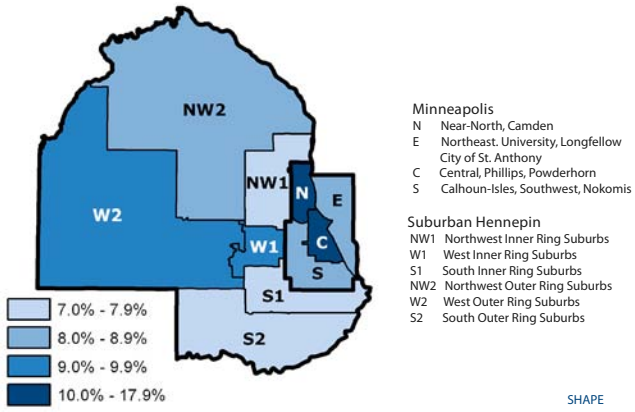
National and international studies have documented that people who have strong social connectedness and healthy relationships have higher quality lives and contribute to better functioning and vibrant communities.

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

Percent of adults with selected mental health conditions
Hennepin County 2010



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



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

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

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

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

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

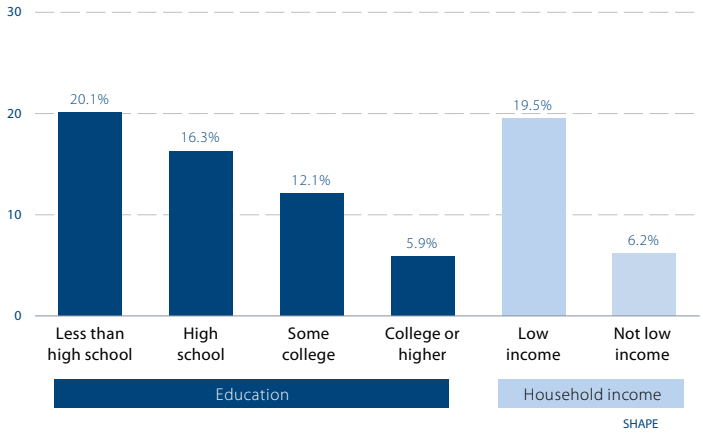
Burden of mental illness in the U.S. is among the highest of all diseases, and mental disorders are among the most common causes of disability.

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

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

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

Hennepin County 2010



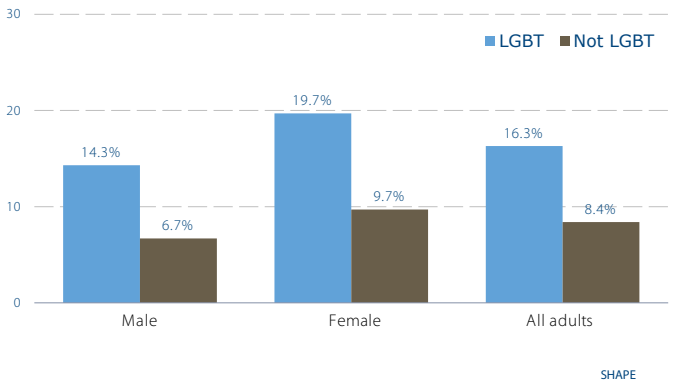
How are we doing?

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

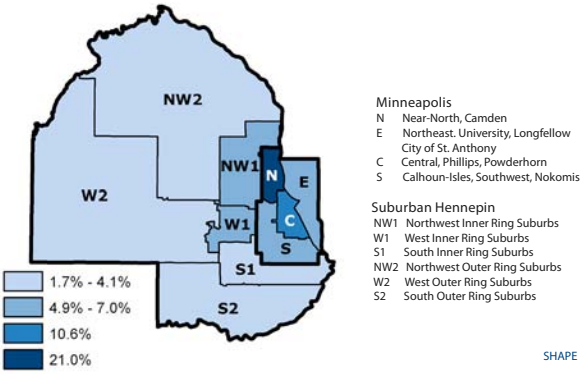
Adults

- In 2010, close to one in ten (9.0%) Hennepin County adults experienced Frequent Mental Distress (FMD).
- While the prevalence of FMD in 2010 (9.0%) is similar to the rate in 2006 (9.7%), it has significantly increased from the rate in 2002 (5.6%).
- FMD is more common among adult females (10.2%) than among adult males (7.6%) and less common among seniors (5.3%) than among younger adults.
- A large geographic variation in FMD rates is observed with the highest rates in North and Central Minneapolis (greater than 10%).
- Members of the Lesbian, Gay, Bisexual and Transgender (LGBT) community reported a rate of FMD twice as high as the rate reported by adults that are not (16.3% vs. 8.4%); the rate is highest for women in the LGBT community (19.3%).
- Obese adults have a significantly higher rate of FMD (13.9%) than adults that are not obese (7.7%).
- Adults with diabetes also have a significantly higher rate of FMD (13.2%) than adults without (8.8%).
- The rate of FMD is significantly higher among current smokers (19.8%) than among those who don't (7.3%).
- Adults who lack leisure time physical activity have significantly higher rates of FMD (13.8%).
- FMD is significantly higher among adults who are heavy alcohol users (11.5%) than those who aren't.
- The rate of FMD is significantly higher among adults with low income (19.5%), or low education (20.1% for less than high school education vs. college educated at 5.9%)
- FMD is also significantly higher among U.S.-born Blacks (20.7%) and Asians (13.9%). The most prominent disparities in FMD rates are found among older adults with disabilities (23.1%) and those with functional limitations (36.6%).

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



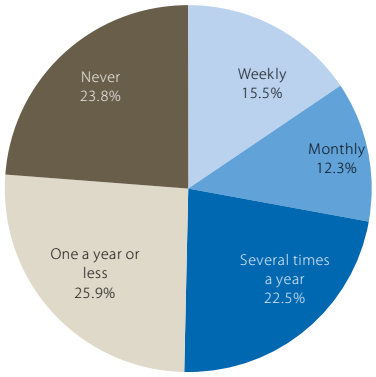
Percent of adults who frequently felt unaccepted due to race ethnicity or culture by geographic area
Hennepin County 2010



- In 2010, 2.8% of Hennepin County adults experienced Serious Psychological Distress (SPD); another 13% experienced mild to moderate psychological distress. Disparities for SPD mirror those for FMD.
- About half of all adults in the county are regularly involved in school, neighborhood or community activities.
- One in five adults is afraid to go out at night due to violence in their neighborhood.
- One in three residents experience situations at least once a year where they feel unaccepted due to their race, culture or ethnicity.

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

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

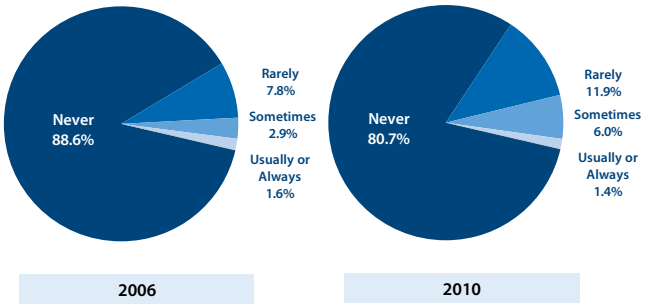


SHAPE

Children

- Nearly half of Hennepin County children have at least one meal with their families on all 7 days per week.
- About two thirds of parents talk with their school-aged children about their daily activities most days of the week.
- Approximately 10% of children spend more than one hour per week participating in leisure time activities such as fine arts, drama, dance or choir.
- Nearly half of school aged children spend one or more hours each day playing electronic games, watching TV or using computers for recreation.
- More than 50% of youth ages 10-17 volunteer some time each week; approximately one in four of those volunteer two or more hours per week.
- In 2010, 19.3% of school-aged child experienced fear of going to school at some point in the past year because of being picked on, teased or bullied by other children (compared to 11.4 % in 2006). That percentage is significantly higher for low-income children (27.2%) as compared to their non-low-income peers (15.4%).
- Nearly three quarters of 9th and 12th graders in Hennepin County schools report that their parents care about them very much. However, only one in four considered themselves to be strongly connected to both parents (26.1% and 26.6%).

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



SHAPE

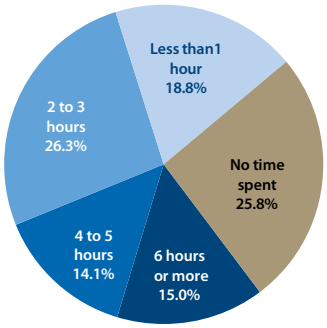
- One in three 9th or 12th graders in Hennepin County schools see themselves as not well connected to caring adults (33.8% and 38.4%). One in four see themselves as not well connected to their school.

Adolescents

- Mental health concerns were reported for one out of seven adolescents in Hennepin County.
- One out of ten 9th graders (9.9%) and nearly 12% of 12th graders report that they have a mental or emotional health problem that has lasted for one year or more.
- Chronic mental or emotional health problems were more likely to be reported by White students in 9th grade (10.5%) and in 12th grade (12.5%) than their non-White peers.
- Girls have notably higher rates for mental health problems than boys. 14.6% of girls in 9th grade reported self-harming behaviors (vs. 6% in boys) and 18.1% reported suicidal thoughts (vs. 11.2% for boys). By 12th grade the disparity remains but the rates drop. By12th grade the difference for chronic mental health problems for girls was 14.3% vs. 9.2% in their male peers.
- More than one in ten students of all racial and ethnic backgrounds report serious self-harming behaviors or suicidal thoughts.
- Students of color in both 9th and 12th grades report higher rates of serious self-harming behaviors and suicidal thoughts with rates dropping by 12th grade. By grade 12, the rates of these behaviors remain highest in Hispanic/Latino students (9.6% and 14.1% respectively) when compared to their peers.
- Nearly 40% of 9th graders and more than one third of 12th grade students report experiencing bullying behavior.
- Nearly three quarters of adolescents 10-17 spends time each week with an adult role model, tutor coach or mentor with approximately 55% spending 2 or more hours per week.
- More than 9 in 10 students report feeling safe in their neighborhood.

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

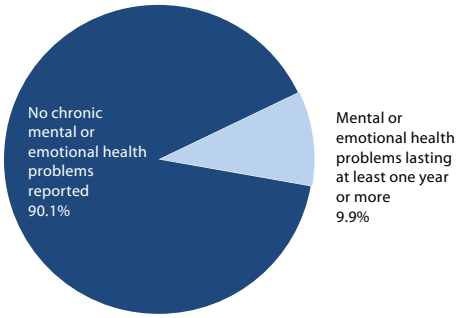
Percent of youths who spend time with an adult role model, tutor, coach or mentor, by amount of time per week
Hennepin County Children Aged 10 to 17, 2010



2010

SHAPE

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



2010

MSS

Health Care Access: Cross-cutting Health Issue

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

Access to health care

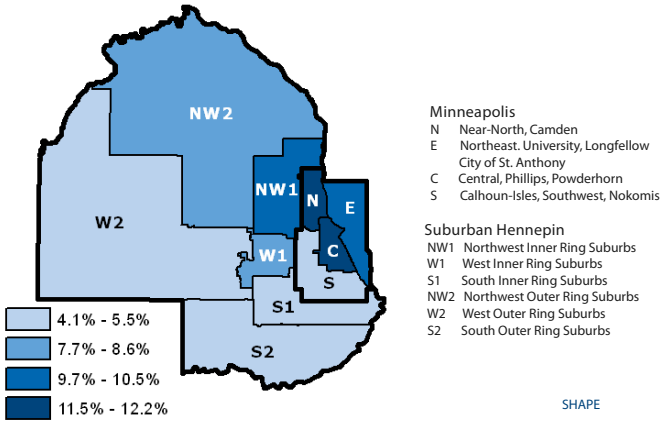
"Health care access" is NOT about the availability of quality local health care. Minnesota has plenty of first-rate hospitals, clinics and medical practitioners. Access is about barriers to getting needed care.There are still many people, including children, who lack adequate medical insurance to cover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

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

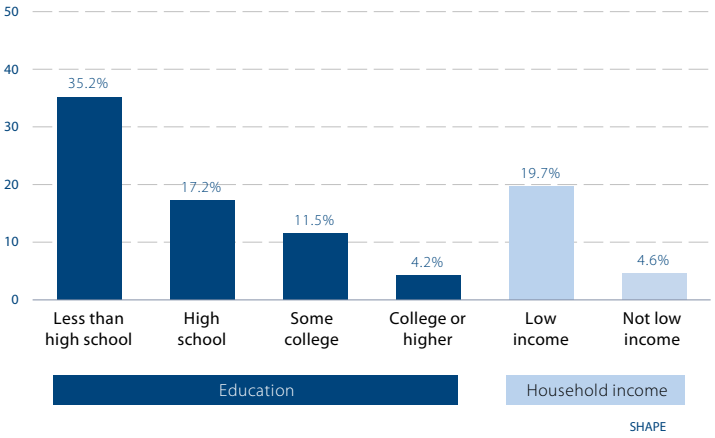
Why is this health issue important?

- A person's ability to access health services has a profound effect on every aspect of his or her health.
- Health insurance in one of the best known and most common means used to obtain access to health care.
  - People without medical insurance are more likely to lack usual sources of medical care, and more likely to skip routine medical care due to cost, thus increasing their risk for serious and disabling health conditions.
  - Health People 2020 set a goal of 100% coverage for Americans under age 65.
  - Coverage for health care increases the likelihood that a child is regularly seen by a doctor or health professional.
  - Regular health care visits are important for: monitoring healthy growth and development; accessing preventive screenings and immunizations; and, for diagnosing or treating serious health conditions.
  - The lack of adequate health care coverage is a considered a significant risk to a child's overall health and wellbeing.
- Usual place of care is an important measure for access to health care. A medical home is a doctor's office or clinic where a person usually goes when a person is sick or needs medical care.
  - Persons without a usual place of care are less likely to receive preventive care, more likely to have unmet health care needs, more hospitalizations, and higher costs of care.
  - It is important for children to have a consistent source of medical care, where their health concerns can be monitored by health professionals who know their conditions and where the child can receive any needed follow-up care.

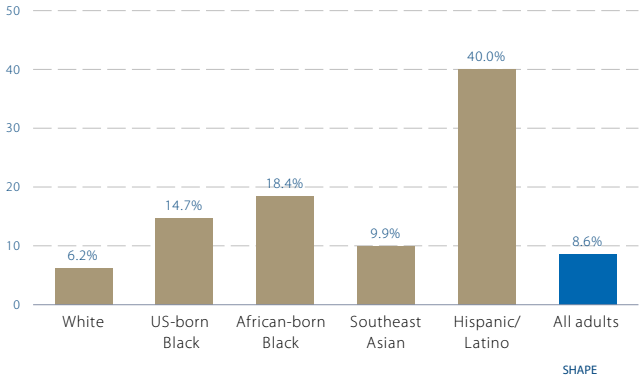
Percent of adults under age 65 currently uninsured by geographic area
Hennepin County 2010



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



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



How are we doing?

Adults

- The rate of currently uninsured among county working age adults (7.8%) compares favorably to the rates among their peers in the state (10.5%) and in the nation (22.3%).
  - The great majority (92%) of Hennepin County working age adults (age 18-64) currently have health insurance coverage.
  - 11% of working adults are covered through public programs; 81% are covered through private health plans.
  - The current rate of uninsured adults (7.8%) is an equivalent to about 60,000 working age adults who lack health insurance coverage at any point of time.
  - Almost twice that many working age adults (110,000 persons, or 14.4%) lack health insurance at least some time during the past the year.
  - Social and economic status matters.
  - Those who reported a disproportionately higher rate of being currently uninsured include working age adults who were: male, low income, unmarried, lesbian or from a racial or ethnic minority group.
  - While the young adults (age 18-24) still reported the highest currently uninsured rate (11.8%) among all adults, this rate represents a 114% reduction from the rate in 2006 (25.3%). This reduction may largely be due to the new Minnesota Law that was effective in January 2008 to cover dependents under their parents' policy up to age 25.
  - Significant geographic variation in rates is also observed.

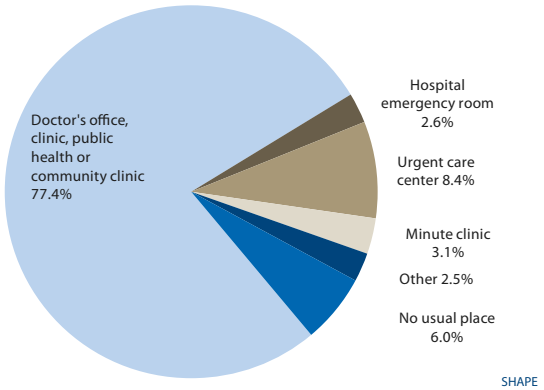
Unmet medical care needs by household income
Hennepin County adults 2010

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

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

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

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



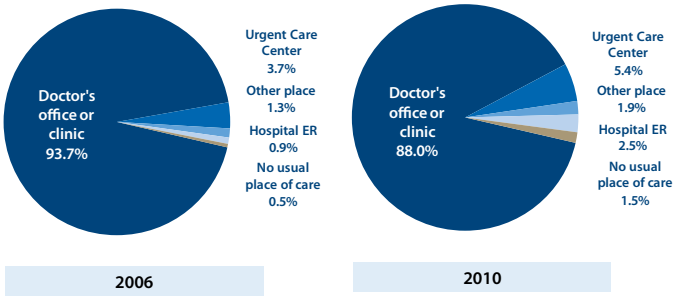
- Working age adults in North Minneapolis have a current uninsured rate almost three times as high as the rate for their counterparts in west and south suburb outer rings (11.5% vs. 4.1% or 4.2%).

- In 2010, a great majority (78%) of Hennepin County adults had a usual place of care.
  - However, over one-fifth of county adults (22%) have no usual source of care. This means when they are sick or need medical care, they either have no place to go, or use an emergency room, urgent care or minute clinic. This rate far exceeds Healthy People 2020 aims to reduce persons (all ages) without usual place of care to 5% or lower.
  - The rate of adults without usual place of care has increased from 14% in 2006 and in 1998 to 22% in 2010.
  - The rate of no usual source of care is 3.5 times higher among those currently uninsured than among those currently insured (64% vs. 19%).
  - Young adults and adult males have sizable higher rates of no usual place of care than older adults and adult females.
  - Adults with low income, low education, being U.S.-born Blacks, Hispanics or Latinos, experiencing recent frequent mental distress, or being lesbians, reported a higher rate of no usual place of care.
  - Wide variation in rates across geographic areas is also observed with the lowest rate (13%) in south suburban outer ring and the highest (29%) in North Minneapolis.

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

Percent of children by place the child usually receives his or her medical care

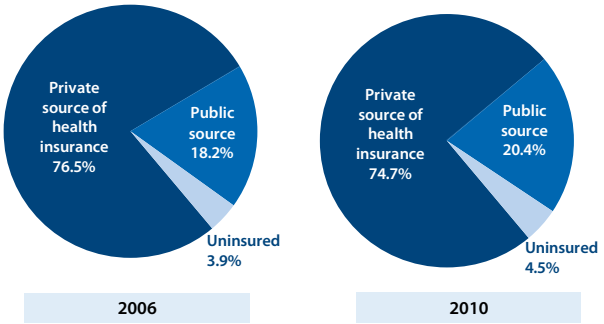
Hennepin County Children Aged 0 to 17, 2006 & 2010



SHAPE

Percent of children with health insurance coverage by source of coverage

Hennepin County Children Aged 0 to 17, 2006 & 2010



SHAPE

Children

- Most Hennepin County parents (95.1%) report that their child currently has insurance coverage that pays for his or her health care. Yet, nearly one out of twenty Hennepin County children (4.5%) is currently uninsured.
  - Three quarters (74.7%) of children were insured by a private source (down from 76.5% in 2006).
  - 20.4% were insured under a public program (compared to 18.2% in 2006).
  - 4.5% were uninsured (compared to 3.9% in 2006).
  - Hispanic/Latino children were significantly less likely to have access to health insurance coverage than Hennepin County children overall (29.2 % are currently uninsured).
  - Children from urban areas (Minneapolis) appeared to be somewhat more likely to be uninsured; however, the difference in the rates reported by location of residence is not statistically significant.
- Some children were experiencing gaps in their health coverage:
  - 7.2% did not have health coverage for at least part of the year (compared to 5.4% in 2006).
  - 2.7% were uninsured for the entire year (compared to 2.1% in 2006).
- Most Hennepin County parents report that their child has a regular medical home (88.8%), as compared to 93.7% in 2006, listing a doctor's office or clinic as their usual place to receive medical care.
  - The number of low income children who used emergency rooms or urgent care centers and had "no usual place of care" more than doubled (from 2.4% to 6.8%).
  - Children from low income households were significantly less likely to have a usual medical home as compared to the rate for all Hennepin County children overall (80.9% compared to 88.8%).
- A schedule of recommended preventive care visits, based on the child's age, provides a "standard" for determining if the child has received adequate preventive care in the past 12 months.
  - Three out of four children in Hennepin County (76.1%) met the standard for preventive care visits.
  - Infants and toddlers, aged 0 to 2 years old were likely to have had some preventive visits, but only 55.0% were "on track" for receiving all of the recommended visits for their age group.
  - There were no significant differences reported by income level or geographic location.

Data Source: SHAPE 2010 – Child Survey, Hennepin

Social Conditions that Impact Health: Cross-cutting Health Issue

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

Healthy communities

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

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

Why is this health issue important?

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

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

How are we doing?

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

CHIP Plan Development

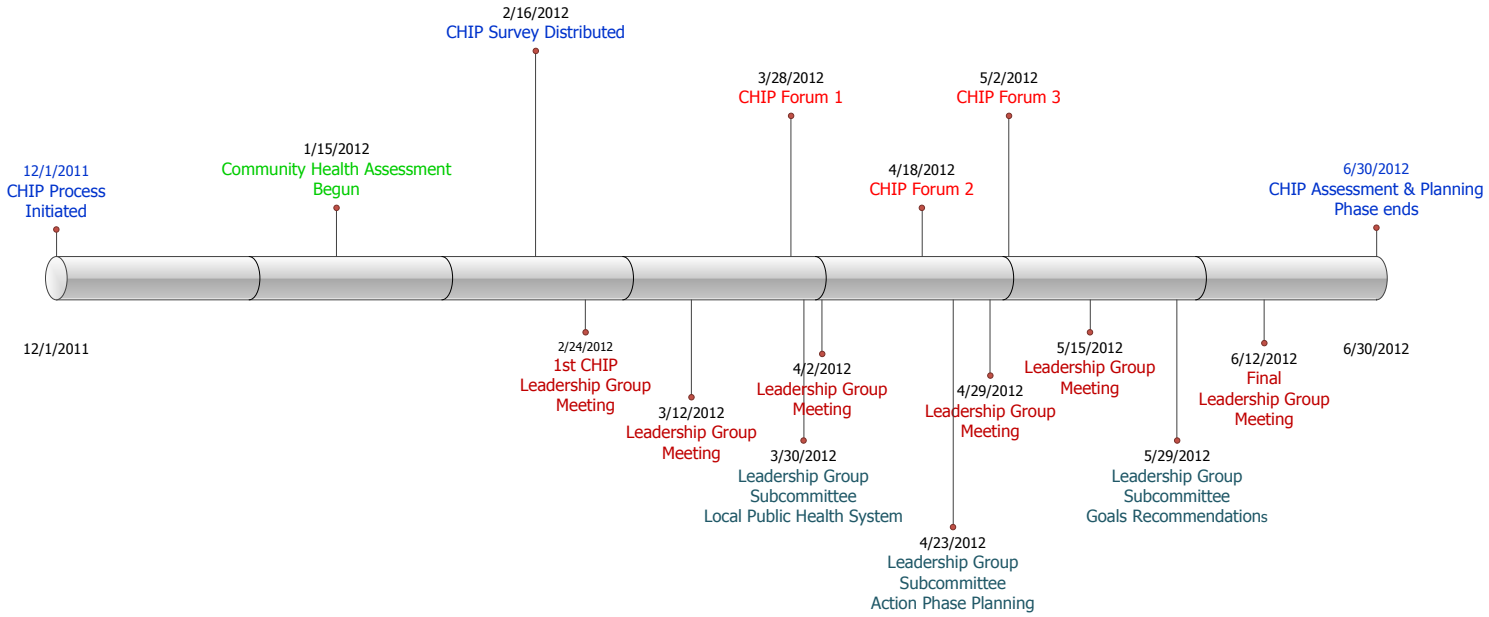
CHIP Process Overview

Timeline of Actions

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

Community Health Improvement Partnership

2012 Timeline



MAPP and ToP® Processes

Mobilizing for Action through Planning and Partnership (MAPP)

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

Technology of Participation (ToP®)

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

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

Building on Past Successes

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

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

Community Health Assessment: Data review

The CHIP assessment and planning work focused on two tracks:

- Compiling recent assessment data collected by the three partner public health departments and drawn from other state and national sources.
- Adding to these assessments from the stakeholder engagement work done through the CHIP Survey and the CHIP Forum Series.

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

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

- The Community Health Assessment Indicators (PDF file also in APPENDICES)
- *SHAPE - Survey on the Health of All the Population and the Environment*
- Minneapolis Department of Health and Family Support
- *Results Minneapolis*
- Bloomington Public Health
- Minnesota Department of Health's Data and Statistics
- *Minnesota Student Survey*
- *Healthy People 2020*
- MN Dept of Health Statistics & Data
- MN Dept of Education Data Center
- CDC Data & Statistics
- Census Bureau

Community Health Assessment

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

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

The CHIP Community Health Assessment

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

The three health departments jointly

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

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

Assessment and Data

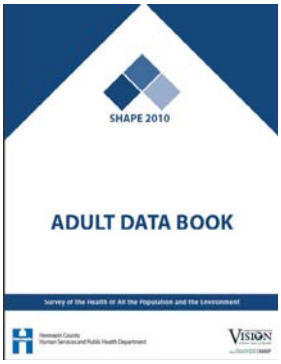
Staff from the data and assessment areas of the three health departments reviewed recently collected quantitative and qualitative health data from a variety of sources, including local, state and federal. They created, executed and analyzed a CHIP survey that was distributed to community organizations.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

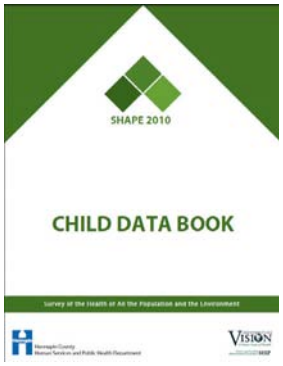
SHAPE

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

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

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





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

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

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

Community Health Assessment Indicators

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

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

Community health assessment data domains

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

Sample indicator summary

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

Indicator: ***Child regularly engages in Physical Activity***

Overview

Why Is This Indicator Important?

To maintain a healthy weight and avoid other health problems, it is strongly recommended that school-aged children engage in *regular physical activity every day for at least one hour or more*. The time does not need to be continuous, but should total at least 60 minutes per day.

How Are We Doing?

- Less than a quarter of all Hennepin County children aged 6 to 17 *met the recommended standard of physical activity during the week* (24.1%).
- Girls and adolescents aged 14 to17 years old were significantly less likely to *meet the daily recommended standard* (only 16.8% of girls and 15.7% of adolescents aged 14 to 17 met the recommended standard).
- No significant differences were found by household income or geographic location.

Data Source:

SHAPE 2010 – Child Survey, Hennepin County.

Population		Percent	C.I.
All Hennepin County children aged 6 to 17		24.1%	± 3.2
Age Groups	6 – 9 years	28.7%	± 5.7
	10 – 13 years	27.8%	± 6.3
	14 – 17 years*	15.7%	± 4.5
Gender	Male	31.2%	± 4.6
	Female*	16.8%	± 4.2
Geographic Location	Minneapolis	22.3%	± 4.9
	Suburban Areas	24.9%	± 4.1
Household Income**	Low income	23.3%	± 6.1
	Not low income	24.5%	± 3.8

*Denotes the difference in rates between this group and *all Hennepin County children* is statistically significant at $p<0.05$.
**See *Technical Notes* for information on data sources and chart notations.

Partnership for a Healthy Hennepin

Other Data Sources

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

Presentations to Community Stakeholders

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

Forum 1 Data Presentation

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

- Introduce the different types of health indicators – national and local.
- Share some foundational data about health status in the community.
- Inform participants about the types of data available - quantitative data vs. qualitative sources.
- Educate them on the many aspects of data to consider when attempting to set community health priorities.
- Provide resources to help them locate different types of data.

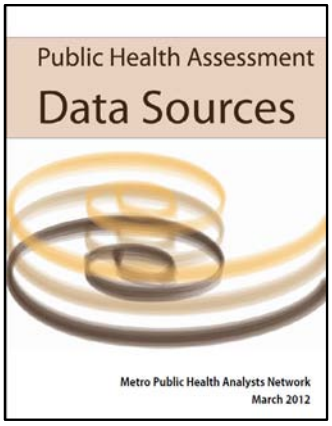
Data included trends, geographic distributions, racial and ethnic differences, and numbers of people affected. Copies of the slide presentation are included in the DATA APPENDIX.

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

- Community health assessment indicators
- *SHAPE*
- Minneapolis Department of Health and Family Support
- *Results Minneapolis*
- Bloomington Division of Public Health
- Minnesota Department of Health's Data and Statistics
- *Minnesota Student Survey*
- *Healthy People 2020*

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

Public Health Assessment Data Sources
MPHAN – March 2012



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

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

Forum 2 had no data presentation.

Forum 3 data presentation

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

Hennepin Profile

About the Jurisdiction

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

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

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

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

About the People

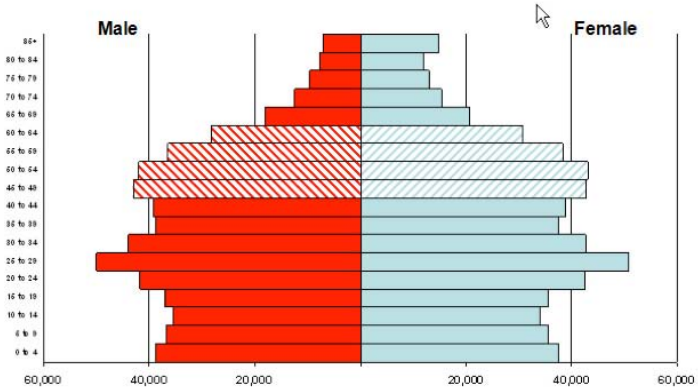
The citizenry in Hennepin is well educated: more than 88 percent of Hennepin County residents over age 25 are high school graduates – but not across all racial and ethnic groups.

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

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

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

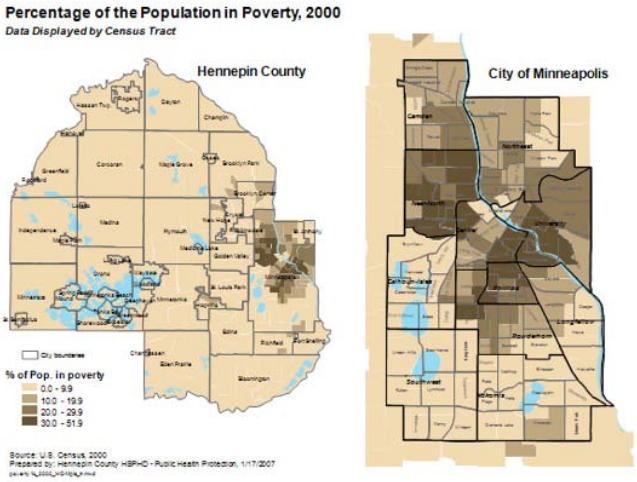
Hennepin County Population 2010



Hennepin County Population Change by Race/Ethnicity 2000-2010

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

Hennepin County Poverty Distribution

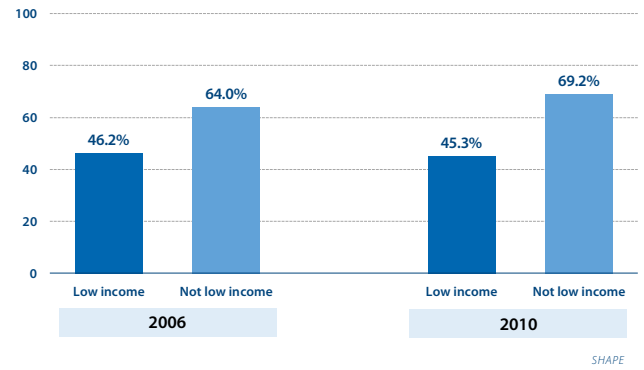


About Health in the Community

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

- County adults enjoy better health than adults nationwide, with 63% reporting excellent or very good health.
- The smoking rate continues to decline (from 21% in 1998 to 12% in 2010) and is lower than the national average.
- Like the rest of the country, our population is getting heavier.
  - More than half of county adults are either obese (20%) or overweight (33%).
  - The current obesity rate (20%) is as high as it was in 2006, and is notably higher than the rate in 1998 (14%) and the rate in 2002 (17%).

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



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

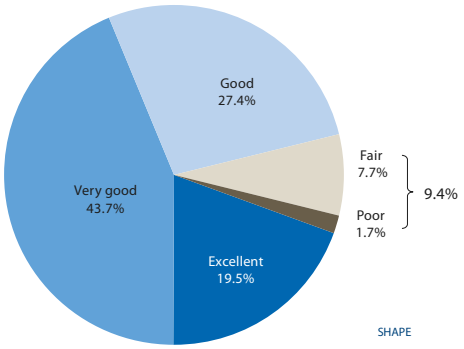
- Hennepin County infants, toddlers and children up to age 9 are doing very well.
- However, many of the key health indicators begin to "flatten out" or decline for youth aged 14 to 17.
- Serious health conditions affect about one in ten children in Hennepin.
- The incidence of asthma attacks has increased in children over the past few years.
- Mental health concerns were reported for one out of seven adolescents in Hennepin.
- Children from low-income families were significantly lower on many important measures of health and wellbeing than their peers.

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

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

Percent of adults by self - rated health status

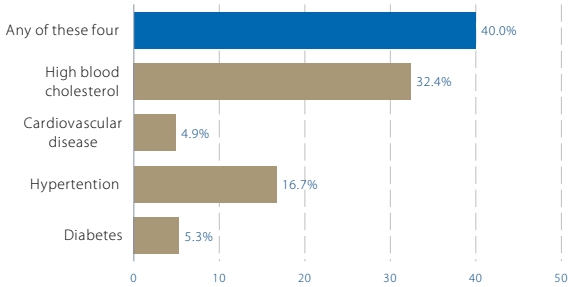
Hennepin County adults 2010



SHAPE

Percent of adults with selected chronic disease and conditions

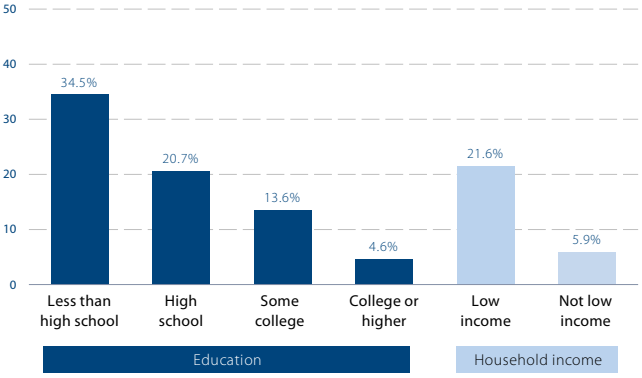
Hennepin County 2010



SHAPE

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

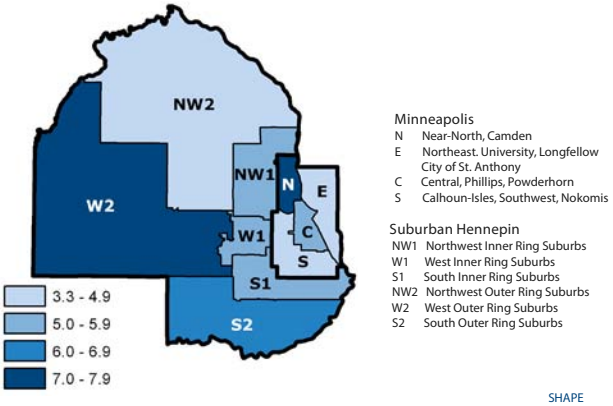
Hennepin County 2010



SHAPE

Percent of adults with diabetes by geographic area

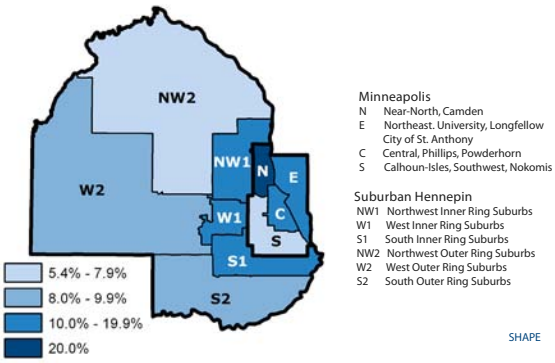
Hennepin County 2010



SHAPE

Percent of adults reporting poor or fair health by geographic area

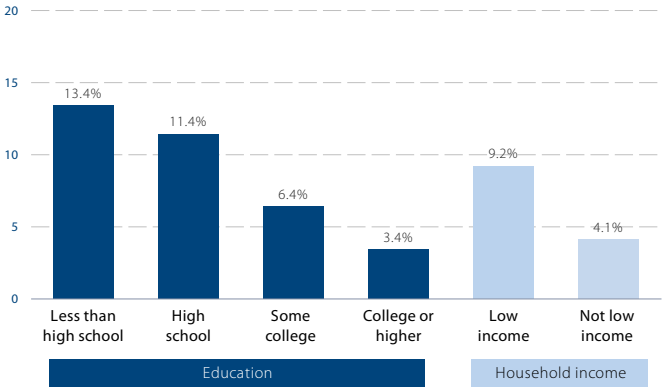
Hennepin County 2010



SHAPE

Percent of adults with diabetes by education and household income

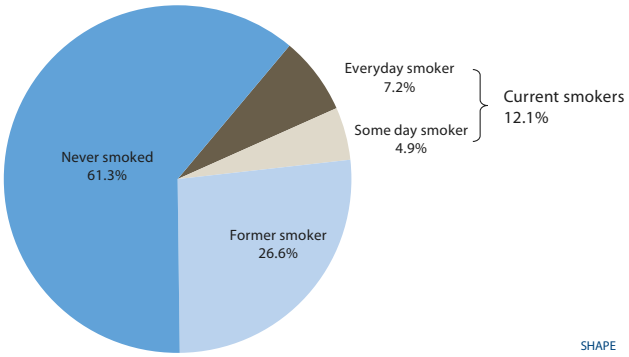
Hennepin County 2010



SHAPE

Current smoking status

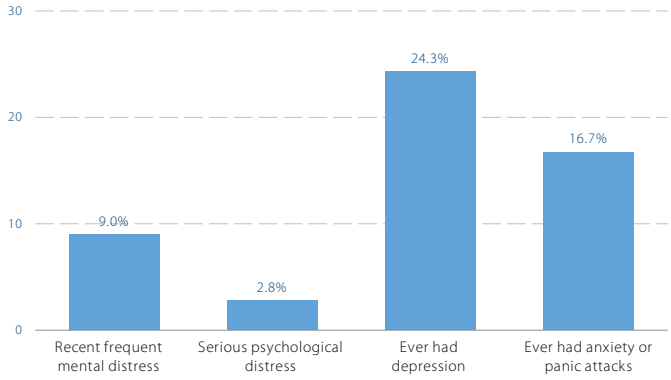
Hennepin County adults 2010



SHAPE

Percent of adults with selected mental health conditions

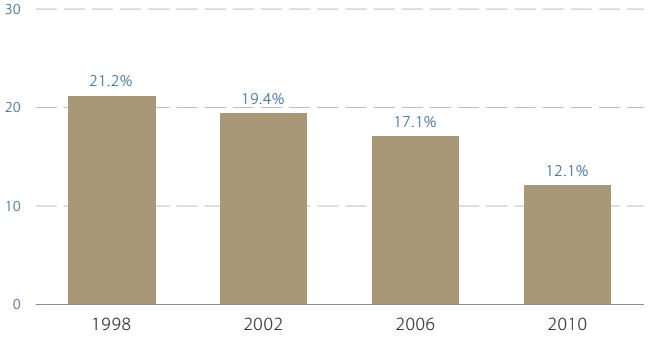
Hennepin County 2010



SHAPE

Percent of adults currently smoking

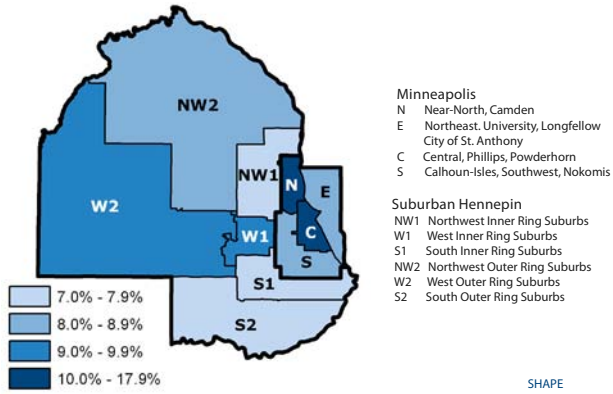
Time trend 1998-2010, Hennepin County adults



SHAPE

Percent of adults with frequent mental distress by geographic area

Hennepin County 2010



SHAPE

Community Health Assessment: Stakeholder engagement & planning

Overview

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

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

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

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

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

The CHIP Survey

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

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

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

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

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

They were followed closely by these three:

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

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

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

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

The Three CHIP Forums

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

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

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

Forum 1

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

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

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

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

Shared Vision of Characteristics of a Healthy Community

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

Forum 2

Forum 2 was focused on two areas of discussion:

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

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

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

Environmental scan

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

Contributors to Our Local Community Health System

Local community health system

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

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

Ideas for change

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

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

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

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

Forum 3

Forum 3 focused on the following topics:

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

Strategic health issue selection

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

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

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

Identifying priority goals for action

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

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

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

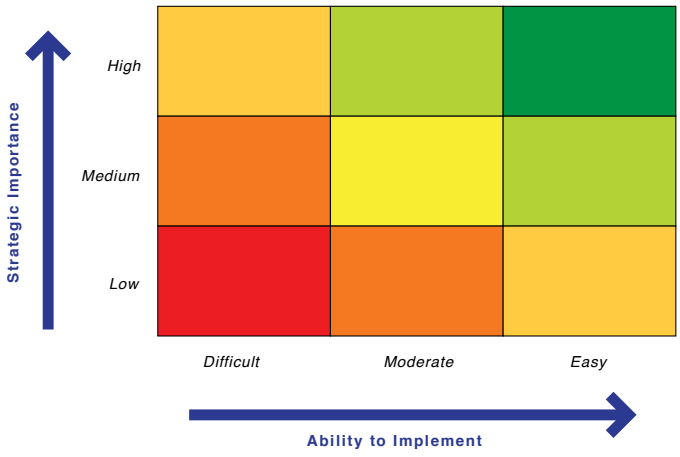
1. Increase childhood school readiness.

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

3. Increase community & social connectedness.

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

Community Health Improvement Partnership



Moving Into Action

Three action teams will begin meeting in early fall 2012:

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

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

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

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

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

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

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

Local Data

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

Data Source: SHAPE 2010 – Child Survey

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

Data Source: SHAPE 2010 – Adult Survey

Data from Bloomington, Edina and Richfield Health Boards

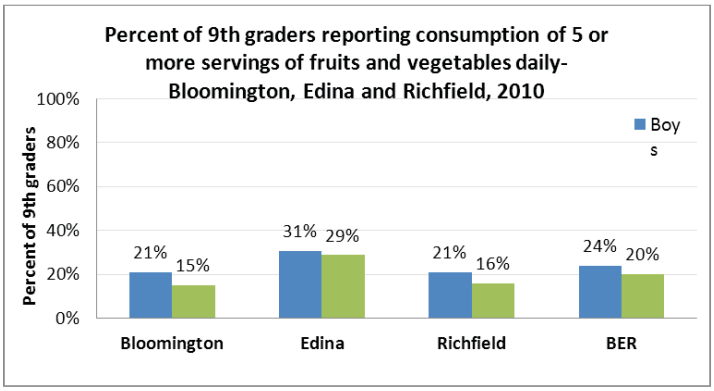
Nutrition, Obesity and Physical Activity

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

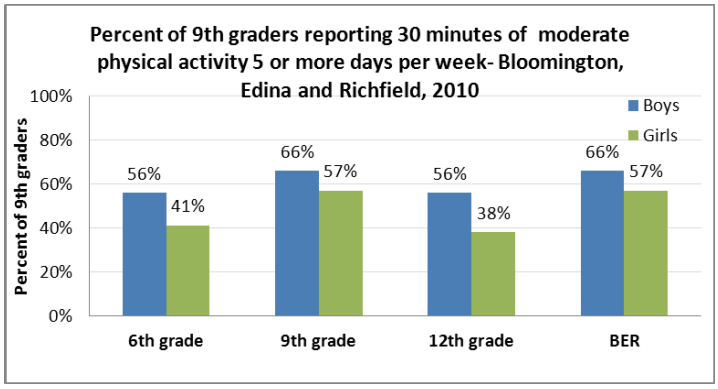
From Minnesota Student Survey data: Consumption of fruits and vegetables is still relatively low with less than one quarter of 9th graders consuming the recommended amount in BER. This percentage has been relatively stable in the last 10 years, not dramatically increasing or decreasing.

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

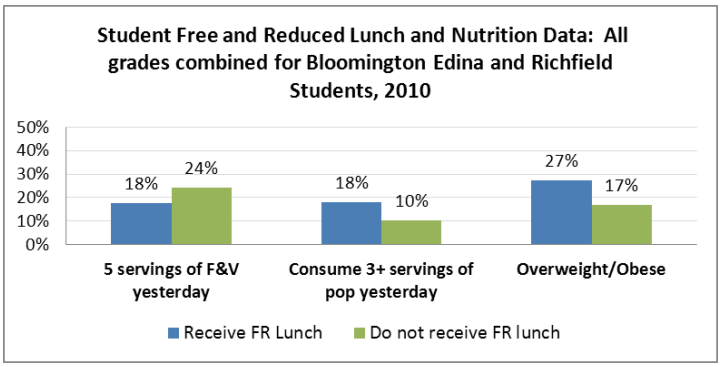
PER the Minnesota Student Survey, students that receive "free or reduced lunches" (per self-report on the survey) were less likely to report consuming 5 servings of fruits and vegetables, more likely to consume 3-plus servings of pop and more likely to be classified as overweight/obese.



Data Source: Minnesota Student Survey 2010



Data Source: Minnesota Student Survey 2010



Data Source: Minnesota Student Survey 2010

Social and Emotional Well-Being: Youth

- 42% of youth (6, 9th and 12th) in BER reported volunteering at least 1 hour per week.
- Nearly 1/3 (31.9%) of youth (6, 9th and 12th) in BER reported spending 11+ hours per week watching TV, playing video games or playing on the computer (screen time).
- 9% of 9th graders and 11% of 12th graders in BER reported that they have had a mental health or emotional health problem that has lasted for one year or more.
- 17% of 9th grade girls in BER reported suicidal thoughts in the past year compared to 11% of boys. For 12th graders these percentages are more similar with 13% of boys and 12% of girls reporting suicidal thoughts in the past year.
- Students that reported they were connected to their community, to a caring adult or to school were less likely to report using tobacco, alcohol or marijuana in the past 30 days (13% were using) compared to students who did not report they were connected to their community, to a caring adult or to school (25% were using).
- In 2010, 29% of Richfield 9th graders, 35% of Bloomington 9th graders and 41% of Edina 9th graders reported being bullied in the past 30 days.
- In 2010, 41% of Richfield 9th graders, 45% of Bloomington 9th graders and 42% of Edina 9th graders reported bullying others in the past 30 days.

Data Source: Minnesota Student Survey 2010

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

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CHIP APPENDICIES INFORMATION

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

APPENDIX 1: CHIP Participants

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

APPENDIX 2: The MAPP Process Details

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

APPENDIX 3 - PART A: Data Detail

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

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

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

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

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

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

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

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

SEE SEPARATE FILE.