Community Health Needs Assessment

Mayo Clinic – Saint Marys Hospital

September 30, 2013

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Executive Summary

Enterprise Overview:

Mayo Clinic is a not-for-profit, worldwide leader in patient care, research and education. Each year Mayo Clinic serves more than one million patients from communities throughout the world, offering a full spectrum of care from health information, preventive and primary care to the most complex medical care possible. Mayo Clinic provides these services through many campuses and facilities, including 23 hospitals located in communities throughout the United States, including Arizona, Florida, Georgia, Minnesota, Wisconsin and Iowa.

A significant benefit that Mayo Clinic provides to *all* communities, local to global, is through its education and research endeavors. Mayo Clinic reinvests its net operating income funds to advance breakthroughs in treatments and cures for all types of human disease, and bring this new knowledge to patient care quickly. Through its expertise and mission in integrated, multidisciplinary medicine and academic activities, Mayo Clinic is uniquely positioned to advance medicine and bring discovery to practice more efficiently and effectively.

In addition, through its Centers for the Science of Health Care Delivery and Population Health Management, Mayo Clinic explores and advances affordable, effective health care models to improve quality, efficiency and accessibility in health care delivery to people everywhere.

Entity Overview:

Mayo Clinic's Rochester, Minn., campus provides a complete spectrum of health care services, including leading-edge biomedical research and education programs to advance patient care. Mayo Clinic patients who need surgery and hospitalization are cared for in one of the two Mayo Clinic hospitals in Rochester, Saint Marys Hospital and Rochester Methodist Hospital, both owned and operated by Mayo Clinic. Clinical services in Rochester span primary and community care (provided at multiple facilities) to specialty care for the most complex medical needs.

Mayo Clinic's Saint Marys Hospital in Rochester serves patients from Olmsted County and other regional southeastern Minnesota counties, every state and approximately 135 countries throughout the world. Saint Marys Hospital has 1,265 beds and 55 operating rooms. Unique hospital services include a level-one trauma center, emergency department, neurosurgery, epilepsy monitoring, cardiac treatment, lung and heart transplants, robotic heart surgery, rehabilitation services, including for spinal cord and traumatic brain injury, intensive care, Eugenia Litta Children's Hospital and psychiatry and psychology inpatient treatment. Mayo Clinic is the only adult and pediatric level-one trauma center within a 120 mile-wide radius of Rochester, serving a population of approximately 1 million people in southeastern Minnesota.

Summary of Community Health Needs Assessment:

For this Community Health Needs Assessment (CHNA,) Mayo Clinic partnered with Olmsted County Health Department and Olmsted Medical Center to engage with and survey all available stakeholder community groups and public health-related data. The results of the assessment are being used to inform Mayo Clinic's strategies and partnerships to maximize community health and wellness, population health management and advance our mission of inspiring hope and contributing to health and well-being by providing the best care to every patient through integrated clinical practice, education and research.

Mayo Clinic is committed to studying and responding to health needs in Olmsted County through a community-wide approach. The Olmsted County CHNA project was conceived and developed by all participants with the intent of leveraging and strengthening existing relationships among health care providers, community services agencies, organizations and volunteers in Olmsted County in new ways to understand and respond to local health needs, as well as invite renewed awareness and engagement with the community at large.

A full copy of the Olmsted County Community Health Needs Assessment Report (OCCHNA) can be accessed at
http://www.co.olmsted.mn.us/OCPHS/reports/Pages/CommunityHealthNeedsAssessment.aspx.

The report describes in detail the process for identifying and prioritizing needs, including information sources, stakeholder engagement efforts and the collaborative and collective health needs assessment prioritization process.

The OCCHNA process identified the following top-five health needs for Olmsted County:

1. Obesity
2. Mental health
3. Vaccine-preventable diseases
4. Homelessness/financial stress
5. Diabetes

Our Community

Geographic area:

This CHNA covers the geographic area of Olmsted County, Minn., including the cities of Rochester (population 106,769), Byron (population 4,914), Chatfield (population 1,206), Dover (population 735), Eyota (population 1,977), Oronoco (population 1,300), Pine Island (population 703), and Stewartville (population 5,916).

Mayo Clinic in Rochester, including Saint Marys Hospital, provides critical and complex tertiary care to Mayo Clinic Health System (MCHS) patients, as well as patients referred from primary care providers throughout the U.S. and world. Through numerous outpatient facilities, Mayo Clinic in Rochester provides a complete spectrum of primary care to patients in Olmsted County. For those living outside the county, primary care is provided through MCHS. CHNAs from nearby MCHS hospitals in the rural areas of southern Minnesota, western Wisconsin and far northern Iowa collectively represent the regional reach and breadth of Mayo Clinic's primary and community health care.
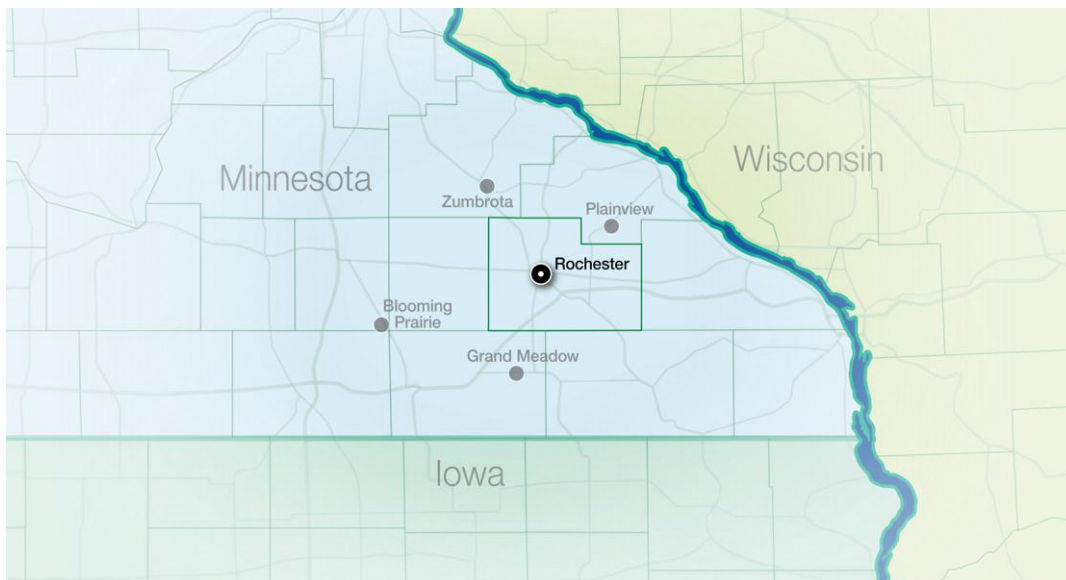
In 2012, Mayo Clinic Saint Marys Hospital provided care to 27,346 unique patients residing in Olmsted County; 32,117 unique patients within a 210-mile radius, including the southeast Minnesota region and Twin Cities metro area; 19,294 patients from throughout the U.S.; and 937 international patients.

Demographics:

The 2012 U.S. Census data estimates that Olmsted County has a population of 147,066 residents. Residents make up the following ethnic groups: Caucasian (87 percent), Asian (5.6 percent), Black (5 percent), Latino (4.3 percent), American Indian and Alaska Native (.3 percent), and native Hawaiian and other Pacific Islander (.1 percent). (http://quickfacts.census.gov/qfd/states/27/27109.html)

Olmsted County residents living at or below the national poverty level between the years 2007-2011 was 8.1 percent. The median household income from 2007-2011 was $66,202. In Olmsted County, 7.3 percent of residents are under age 5, 25 percent are under age 18, and 12.9 percent are over age 65. According to state demographers, Olmsted County is expected to grow in population by 30 percent by 2030, and the proportion of Minnesota residents over the age of 65 years will increase 117 percent from 594,266 to 1,290,800. (http://www.co.olmsted.mn.us/yourgovernment/demographics/Documents/DemographicsWorkforce2011statewide.pdf)

Mayo Clinic in Rochester collaborates closely with the Salvation Army of Olmsted County to operate the Good Samaritan Dental and Health Clinics (SA GSHC and SA GSDC). These clinics are the primary provider of medical and dental services to underserved residents of Olmsted County. In 2012, the clinics provided care to 2,248 unique patients. In addition to staffing assistance and financial support for pharmaceutical aid to patients, the programs' 521 volunteers contributed 9,743 volunteer hours. The majority of volunteers are Mayo Clinic physicians and allied health professionals.

GSHC &GSDC Patient 2012 Demographic Data

	Good Samaritan Health Clinic	Good Samaritan Dental Clinic
Percentage minority	30	42
Percentage age younger than 25	11	24
Percentage age older than 34	74	76
Percentage new/repeat visits	14/86	47/53
Percentage with some insurance	0	50

Community health care providers
Additional health resources and providers for health and wellness services in Olmsted County include:

- Zumbro Valley Mental Health (http://zumbromhc.org/): Provides mental health care, pharmaceutical services, emergency housing services and a dental clinic to underinsured residents of Olmsted County

- Mayo Clinic Saint Marys Hospital emergency department and trauma center (http://www.mayoclinic.org/emergencymed-rst/): Serves all residents in Olmsted County, including uninsured and underinsured patients. In 2012, Saint Marys Hospital Emergency Department served a total of 73,006 patients.

- The Migrant Health Clinic (http://www.migranthealthservice.org/en/rochestermn): Serves patients in the community who are migrant farm workers, as well as their families. Mayo Clinic provides resources and refers patients to Migrant Health.

- Olmsted County Public Health Department (http://www.co.olmsted.mn.us/ocphs/Pages/default.aspx): Provides a broad spectrum of health and social services to residents of Olmsted County

- Olmsted Medical Center (http://www.olmmed.org/): Provides a full-spectrum health care to residents in Olmsted County. Mayo Clinic and Olmsted Medical Center frequently collaborate on community-wide efforts to advance health, health care access, biomedical research and education in the Rochester community and beyond.

- Hawthorne Education Center (http://www.mayo.edu/diversity/resources/community-outreach/hawthorne-health-initiative): Collaborates with Mayo Clinic, Rochester Public Schools and numerous community agencies and volunteers to improve health literacy and health care access to diverse communities in Rochester

Assessing the Needs of the Community

Overview:

The Olmsted County Community Health Assessment (OCCHNA) encompasses the partnership between the Olmsted County Public Health Department, Olmsted Medical Center and Mayo Clinic. In addition, the Olmsted County Planning Department and United Way of Olmsted County participated in planning and conducting the needs assessment research.

Member organizations of the Olmsted County Community Healthcare Access Collaborative [(CHAC)](#) dedicated a work group to provide CHNA input among their 23-member consortium. CHAC has existed since 2007 to identify and address health care and health care access issues for Olmsted County residents, with special focus on diverse and underserved populations.

The goal and approach of the assessment process was to ensure community ownership by incorporating strong stakeholder participation and engagement. This in turn helped to ensure accurate and actionable community health improvement priorities and assure ongoing collaborative community efforts to address identified needs through CHAC. This report is intended to be from and for the community and reflect all stakeholder perspectives, along with epidemiological evidence to verify qualitative input and analysis.

Community input

The OCCHNA team involved multiple layers of community input, including:

- Leaders of community human service and nonprofit organizations
- Randomly selected Olmsted County residents for a telephone survey
- Focus groups with local underserved and minority community population representatives

Process and Methods:

Planning structure and membership

The overall OCCHNA planning team convened bi-monthly over a period of 18 months to plan and facilitate stakeholder engagement, conduct and assemble research and prioritize health indicators. The core planning team included the director of Olmsted County Public Health, an Olmsted County epidemiologist, community primary care and clinical research physicians from Mayo Clinic, community and primary clinical research physicians from Olmsted Medical Center and other business and administrative representatives from all three organizations. In the core data-planning group, additional representatives included a planning specialist from United Way of Olmsted County and the planning director of Olmsted County.

Data and methods of collection

The OCCHNA team began its process by considering and referring to key local, regional and national examples of community and population health measures. Health indicators were grouped into the following categories: mortality, morbidity, health behaviors, clinical care, socio-economic factors and the physical environment.

A long-term goal of the community health improvement plan is to align new community health improvements efforts with existing ones across Olmsted County, and as possible, with proven models in other communities and regions for greatest potential collective impact and efficiency. These reference models included Healthy People 2020 (http://www.healthypeople.gov/2020/default.aspx) County Health Rankings (http://www.countyhealthrankings.org/about-project) the CDC (http://www.cdc.gov/) and others. For a complete listing of resources used in the assessment process, see the CHNA report (http://www.co.olmsted.mn.us/OCPHS/reports/Pages/CommunityHealthNeedsAssessment.aspx).

The OCCHNA team used four primary means of data collection:

1. A survey of local health-related and social-service organizations about health indicators relevant to their client populations, conducted in June 2012. (See Appendix A for a copy of the survey.) Forty-four indicators were identified and organized under the following areas: mortality, morbidity, health behaviors, clinical care, socio-economic climate and physical environment. (See Appendix D for a complete listing of the indicators)

2. A random telephone survey of 500 community members was conducted in January 2013; results were received in March 2013. (See Appendix B for a copy of the survey)

3. Seven listening sessions with representatives of diverse and underserved community groups were conducted in April and May 2013. Listening sessions were choses as an approach to reach community members who were not covered as successfully in the telephone survey or existing health assessments. Focus groups were facilitated by the Mayo Clinic Center for Translational Science Activities' Office of Community-Engaged Research, as well as OCCHNA team members. Facilitators were identified for their expertise in intercultural competency and communication, including language interpreters. (See Appendix C for a summary of these meetings, their make-up and findings)

4. Population health and clinical care experts within the core planning group then researched indicators with benchmark information from existing public data. (http://www.co.olmsted.mn.us/OCPHS/reports/Pages/CommunityHealthNeedsAssessment.aspx) They summarized each indicator by definition, relevant data sources, associated factors, trend and goal data, health inequities, current community perception, current level of community capacity and area of greatest opportunity. Work for this phase of the project began in April and ended in May 2013.

Prioritization method

Prioritization of health indicators was completed by the following groups in May and June 2013:

- Olmsted County Public Health Advisory Board
- Olmsted Medical Center
- Community Healthcare Access Collaborative
- Mayo Clinic Employee and Community Health Executive Leadership Team (ECH-ELT)
- United Way of Olmsted County Vision Council
- Olmsted County Community Health Needs Assessment Core and Data Groups

Each group graded the importance of the following aspects of each indicator and finding:

1. Proportion of population at risk
2. Proportion of population affected
3. Premature death attributable to problem/indicator
4. Perceived impact to quality of life
5. Perceived impact to economic impact
6. Community perception as a public threat
7. Ability to impact the indicator
8. Additional resources needed to make significant impact
9. Trend data in increasing or decreasing severity

Scores from each group were combined to create a final grading document. It's important to note that the findings of all groups separately concurred on the top five indicators that ultimately were prioritized highest by all in the final ranking.

Note: The ECH-ELT considered information for all 38 Olmsted County health indicators, but prioritized only those that related to clinical care and health outcomes (mortality and morbidity). It was felt this would ensure the greatest alignment for indicators where Mayo Clinic expertise and resources would have significant benefit. Mayo Clinic physicians considered the following criteria for each indicator: capacity for Mayo Clinic to act on the issue, readiness for Mayo Clinic to act, ability for Mayo Clinic to have a measurable impact on the issue, and alignment with Mayo Clinic priorities.

Collaborating organizations and third-party vendors

The OCCHNA team used the services of SNG Research (http://www.sngresearch.com/) to conduct the randomized community survey. The team also consulted with the Mayo Clinic Clinical Translational Science Activities (http://www.mayo.edu/ctsa/) team to conduct the community focus groups and summarize findings.

Addressing the Needs of the Community

Overview:

Through the process described in the preceding section ("Assessing the Needs of the Community") the OCCHNA team prioritized the following health needs:

1. Obesity
2. Mental health
3. Immunizations
4. Financial stress/homelessness
5. Diabetes

Obesity

Obesity is defined as having a body mass (one's body weight compared to height) that is significantly higher than normal. Obesity is a known contributor to higher levels of other chronic diseases that diminish wellness, lifespan and increase overall health care costs and disability.

According to OCCHNA research, Olmsted County Minnesota has both an actual and a perceived problem with obesity. According to 2011 data from the Minnesota Department of Health (http://www.health.state.mn.us/cdrr/obesity/facts.html), 23 percent of children, 71 percent of women and 53 percent of men in Minnesota are overweight or obese. The 2013 OCCHNA community survey found that 52 percent of respondents believe they are at "about the right weight." Forty-five percent of respondents believe they are "overweight," and three percent self-identify as "underweight." Also, in the community health need survey of 500 individuals in Olmsted County, obesity was the most-common health concern — 15 percent of all responses. Obesity also was mentioned frequently in community focus groups with ethnically diverse groups.

Mental health

Mental health is a significant health issue and concern in Olmsted County. It is defined broadly in this needs assessment and includes all ranges and aspects of mood and behavior disorders. For the purposes of this CHNA, addiction disorders were considered separately and did not rank as highly.

The OCCHNA explored mental health for children and adults separately. Data from the 2010 Minnesota School Survey reported that between 11 percent and 13.6 percent of all area students in the 6th, 9th, and 12th grades felt sad all or most of the time in the last 30 days. Also in 2012, Olmsted County experience two student suicides.

For adults, the OCCHNA community survey and focus groups indicated strong concern and prevalence for mental health. Thirty one percent of all respondents reported having one or more days of poor mental health in the last 30 days, and as many as 11 percent reporting having poor mental health for more than 14 days.

Immunizations

The OCCHNA defined vaccine-preventable diseases as those where a current immunization is available and recommended for the entire population to reduce and eliminate disease. It focused on early childhood immunization recommendations and influenza vaccination for adults and children.

The percentage of Olmsted County children and adults who get available vaccines is higher than both Minnesota and national rates. However it's still less than the goal of 80 percent, based on the national "Healthy People 2020" initiative's goals. Also, the OCCHNA report indicates strong community concern for vaccine-preventable diseases in Olmsted County. Survey respondents felt that vaccine and influenza health information would be very helpful to them and their family. The topic of immunizations and vaccine-preventable diseases also was considered important in the community focus groups.

The public perception and rates of immunization below national goals for residents of Olmsted County resulted in a high prioritization in the OCCHNA.

Financial stress/homelessness

The OCCHNA prioritized financial stress and homelessness highly among health needs. According to a 2011 study conducted in Olmsted County by homelessness experts and advocates, 107 families and 304 children were sheltered in Rochester due to domestic violence or homelessness due to economic difficulties. Also during the 2010-2011 school year, 314 children were reported homeless among all Olmsted County schools. The random OCCHNA survey asked community respondents about both homelessness and financial stress. Two percent (2,941 residents) of respondents reported having had a period of homelessness within the past year. Twenty six percent of survey respondents reported feeling worried and stressed about paying bills within the past year.

Financial stress and homelessness are linked to anxiety, depression, poor school attendance, crime and many other behaviors and health concerns.

Diabetes

The OCCHNA considered both type 1 and type 2 Diabetes Mellitus (DM), disorders in which the body cannot produce insulin, a necessary hormone for digestion and transfer of energy (glucose) to cells. The rate of DM type I in Minnesota isn't increasing, and the lifespan of those affected is lengthening.

Type II diabetes is closely related to obesity; the higher the rates of obesity, the greater incidence of diabetes among those who are overweight and obese. The rate of DM type 2 is increasing nationally (8.3 percent) and in Minnesota (6.5 percent). There is no available data for diabetes incidence among the population of Olmsted County.

Based on the significant association between DM type 2 and obesity and increasing rates for both health concerns, the OCCHNA process prioritized diabetes among the top health needs for Olmsted County.

Appendix A: Mailed Questionnaire

The following questionairre was mailed to all Olmsted County nonprofits and health-related service providers, June 2012.

Olmsted Medical Center, Olmsted County Public Health Services and Mayo Clinic are in the very early stages of developing a community health needs assessment, and we all agree that the emphasis should be on **community**. As such, we are asking for your help in framing the assessment. We would like to know what you think are *some of the major health conditions and factors influencing the health of our community and the clients you serve*. Please think of health in a very broad way. For example: the percentage of people who smoke, are obese, or live with diabetes; lack of places to walk; insufficient mental health services; higher prices for healthy foods; lack of access to health screenings, like mammograms; or resources for primary caregivers of elders.

Your input, along with input from many others, will be used to determine the main areas of focus for the assessment. As we are looking for areas where many agree there is greater need, we can't promise that every suggestion will be included in the final assessment tool. But we do plan for this to be an open, inclusive, and ongoing process for years to come, with an ability to assess the needs of many and to share the results with everyone in the community. We want this approach to hold value for your organization's and clients' needs, and we intend to use the final assessment intervention to identify areas where we can, as a community, work together to intervene on a wide variety of health related issues. Thank you for taking time and answering the questions below.

For questions one and two, please think about the health of the clients your organization serves.

1. What are the three **biggest health conditions** that influence **your clients'** overall well-being?
   (ex: obesity, mental illness, etc.)
   a. Health Condition #1
   b. Health Condition #2
   c. Health Condition #3

2. What are the three **biggest factors** affecting your **clients'** ability to have the **best possible health**?
   (ex: lack of recreational areas, transportation, insurance, etc.)
   a. Factor #1
   b. Factor #2
   c. Factor #3

For questions three and four, think now about the health of our community at large (Olmsted County).

3. What are the three **biggest health conditions** that influence **Olmsted County residents'** overall well-being?
   (ex: obesity, mental illness, etc.)
   a. Health Condition #1
   b. Health Condition #2
   c. Health Condition #3

4. What are the three **biggest factors** affecting Olmsted County residents' ability to have the **best possible health**?
   (ex: lack of recreational areas, transportation, insurance, etc.)
   a. Factor #1
   b. Factor #2
   c. Factor #3

5. Name at least one **program**, or **community change**, that has **positively impacted the health** of your clients or the population of Olmsted County in general over the past five years.
   a. Program/Community Change #1
   b. Program/Community Change #2
   c. Program/Community Change #3

6. Name 3-5 other **organizations** who should **receive this survey**.
   a. Organization #1
   b. Organization #2
   c. Organization #3
   d. Organization #4
   e. Organization #5

Please provide any additional comments that you would like to be considered regarding the Community Health Needs Assessment: _____

_____

_____

Appendix B: Public Survey Questionnaire

Following is the text for the 2012 Olmsted County Community Health Needs Assessment Public Survey Questionnaire.

Introduction:
Hello, I am… with…

Olmsted County Public Health Services, Olmsted Medical Center, and Mayo Clinic, along with community organizations, are conducting a community health needs assessment. By participating in this survey, you will be providing valuable input that will help us determine where time and resources should be spent on local health issues.

This survey is completely voluntary and confidential. The survey should take approximately 20 minutes to complete.

Do you have any questions before we begin?

I. Community Perception:
The first two questions deal with community perception surrounding important health issues.

1.1 What do you believe is the most pressing health issue impacting the community of Olmsted County?
　　　Answer (open-ended)

　　　Refused

1.2 What is the greatest health education service currently needed by you or your family?
　　　Answer (open-ended)

　　　Refused

II. Health behaviors:
The next several questions are about habits and behaviors you do regularly**.**

Think about the food you typically eat on a daily basis. Please think of all forms of food including cooked, raw, fresh, frozen, or canned. Also think about all meals, snacks and food consumed at home and away from home.

2.1 Not including French fries, a serving of vegetables is a cup of salad greens or a half cup of any vegetable. On average, how many servings of vegetables did you eat daily?

    None
    1 serving
    2 servings
    3 servings
    4 servings
    5 or more servings

    Refused

2.2 A serving of fruit is one medium-sized piece of fruit, a half-cup of chopped, cut or canned fruit or 6 ounces of 100% fruit juice. On average, how many servings of fruit did you eat daily?

    None
    1 serving
    2 servings
    3 servings
    4 servings
    5 or more servings

    Refused

The next few questions are about physical exercise, recreation or other activities.

2.3 During an average week, whether at work, at home or anywhere else, how many days do you get at least 30 minutes of moderate physical activity? Moderate activities cause only light sweating and a small increase in breathing or heart rate.

    Number of days (0-7)

    Refused

2.4 During an average week, whether at work, at home or anywhere else, how many days do you get at least 20 minutes of vigorous physical activity? Vigorous activities cause heavy sweating and a large increase in breathing or heart rate.

    Number of days (0-7)

    Refused

2.5 Do you consider yourself…? (Read)

    Overweight
    Underweight
    About right

    Refused

2.6 Have you smoked at least 100 cigarettes or 10 cigars in your entire life?
  Yes
  No

  Refused

2.7 If yes, do you now smoke cigarettes or cigars every day, some days or not at all?
  Every day
  Some days
  Not at all

  Refused

2.8 Do you currently use chewing tobacco, snuff, or snus every day, some days or not at all?
  Every day
  Some days
  Not at all

  Refused

III. Insurance and Clinical Care:
The next several questions are about…

3.1 Do you currently have any kind of health insurance, including private source through your employer or government plans such as Medicare and Medicaid?
  Yes
  No

  Refused

3.2 Do you currently have insurance that pays for all or part of your dental care?
  Yes
  No

  Refused

3.3 Do you currently have insurance that pays for all or part of your prescription medications?
  Yes
  No

  Refused

3.4 Was there a time in the past 12 months when you needed to see a health professional, but could not because of cost (i.e. health insurance premiums, co-pays, and deductibles)?

Yes
No

Refused

3.5 If yes, what health professional were you unable to see because of cost? Check all that apply (READ)

Doctor
Dentist
Mental health

Refused

3.6 Was there a time in the past 12 months when you needed to see a health professional, but could not because the location would not accept the form of your insurance?

Yes
No

Refused

3.7 If yes, what health professional were you unable to see because of the form of your insurance? Check all that apply (READ)

Doctor
Dentist
Mental health

Refused

3.8 About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition.

Within past year (anytime less than 12 months ago)
Within the past 2 years (1 year but less than 2 years ago)
Within the past 5 years (2 years but less than 5 years ago)
5 or more years ago
Never

Refused

3.9 About how long has it been since you last visited a dentist for a routine checkup?

Within past year (anytime less than 12 months ago)
Within the past 2 years (1 year but less than 2 years ago)
Within the past 5 years (2 years but less than 5 years ago)

5 or more years ago
Never

Refused

3.10 During the past year, have you seen a counselor, therapist, psychologist, psychiatrist or other mental health provider about your own health?
Yes
No

Refused

3.11 If no, during the past year, do you believe there was a time you should have seen a counselor, therapist, psychologist, psychiatrist or other mental health provider about your own health?
Yes
No

Refused

3.12 Have you ever had your blood cholesterol checked? Blood cholesterol is a fatty substance found in the blood.
Yes
No
Don't know / not sure

Refused

3.13 A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. Have you ever had this test using a home kit?
Yes
No
Don't know / not sure

Refused

3.13b If yes, has had a blood stool test: How long has it been since you had your last blood stool test using a home kit?
Within the past year (anytime less than 12 months ago)
Within the past 2 years (1 year but less than 2 years ago)
Within the past 3 years (2 years but less than 3 years ago)
Within the past 5 years (3 years but less than 5 years ago)
5 or more years ago

Refused

For those respondents that are 50 years of age and older, ask following question. If younger than 50, females go to question 3.15, for males go to section IV.

3.14 A colonoscopy is an exam in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. Have you ever had a colonoscopy?
> Yes
> No
> Don't know / not sure
>
> Refused

3.14b If yes: How long has it been since you had your last colonoscopy?
> Within the past 10 years
> 10 or more years ago
>
> Refused

3.15 Females only: A mammogram is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram?
> Yes
> No
> Don't know / not sure
> Refused

3.15b If yes, has had a mammogram: How long has it been since you had your last mammogram?
> Within the past year (anytime less than 12 months ago)
> Within the past 2 years (1 year but less than 2 years ago)
> Within the past 3 years (2 years but less than 3 years ago)
> Within the past 5 years (3 years but less than 5 years ago)
> 5 or more years ago
>
> Refused

3.16 Females only: A clinical breast exam is when a doctor, nurse, or other health professional feels the breast for lumps. Have you ever had a clinical breast exam?
> Yes
> No
> Don't know / not sure
>
> Refused

3.16b If yes, has had a clinical breast exam: How long has it been since you had your last breast exam?

    Within the past year (anytime less than 12 months ago)
    Within the past 2 years (1 year but less than 2 years ago)
    Within the past 3 years (2 years but less than 3 years ago)
    Within the past 5 years (3 years but less than 5 years ago)
    5 or more years ago

    Refused

3.17 Females only: A Pap test is a test for cancer of the cervix. Have you ever had Pap test?

    Yes
    No
    Don't know / not sure

    Refused

IV. Social and Economic Factors:
The next several questions are about…

4.1 Has there been a time in the past 12 months you would say you were worried or stressed about having enough money to pay your bills?

    Yes
    No (go to 2.3.2)

    Refused

4.1b If Yes: How often in the past 12 months would you say you were worried or stressed about having enough money to pay your bills? Would you say you were worried or stressed…? (Read)

    Every month
    Almost every month
    About half the months
    Only a few months this year

    Refused

4.2 Continue: Which of the following were you worried or stressed about not having enough money? Were you worried or stressed about… (Read, check all that apply)

    Rent/mortgage
    Groceries
    Daycare
    Utilities
    Medical bills
    Credit cards

Health/auto insurance
Other, specify:

Refused

4.3 During the past 12 months, have you stayed in a shelter, somewhere not intended as a place to live or someone else's home because you had no other place to stay?
Yes
No

Refused

For the next questions, please rate to which extent you agree or disagree with the following statements:

4.4 In my neighborhood, most residents can walk to grocery stores or markets. Do you…? (Read)
Strongly agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Strongly disagree

Refused

4.5 In my neighborhood, most residents can walk to community or recreation center, park, trails or playgrounds. Do you…? (Read)
Strongly agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Strongly disagree

Refused

4.6 In my neighborhood, most residents can walk to bus stops, public transit stops or stations. Do you…? (Read)
Strongly agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Strongly disagree

Refused

4.7 People in my neighborhood know each other. Do you…? (Read)
    Strongly agree
    Somewhat agree
    Neither agree nor disagree
    Somewhat disagree
    Strongly disagree

    Refused

4.8 People in my neighborhood are willing to help one another. Do you…? (Read)
    Strongly agree
    Somewhat agree
    Neither agree nor disagree
    Somewhat disagree
    Strongly disagree

    Refused

4.9 People in my neighborhood can be trusted. Do you…? (Read)
    Strongly agree
    Somewhat agree
    Neither agree nor disagree
    Somewhat disagree
    Strongly disagree

    Refused

4.10 People in my neighborhood are afraid to go out at night due to violence. Do you…? (Read)
    Strongly agree
    Somewhat agree
    Neither agree nor disagree
    Somewhat disagree
    Strongly disagree

    Refused

4.11 Community violence is a serious issue in my neighborhood. Do you…? (Read)
    Strongly agree
    Somewhat agree
    Neither agree nor disagree
    Somewhat disagree
    Strongly disagree

    Refused

4.12 Domestic violence is a serious issue in my neighborhood. Do you…? (Read)
    Strongly agree
    Somewhat agree
    Neither agree nor disagree
    Somewhat disagree
    Strongly disagree

    Refused

4.13 Children are safe in my neighborhood. Do you…? (Read)
    Strongly agree
    Somewhat agree
    Neither agree nor disagree
    Somewhat disagree
    Strongly disagree

    Refused

4.14 Do you feel safe in your home?
    Yes
    No

    Refused

V. Physical Environment:

5.1 How would you rate the overall condition of your home? By this we mean the physical condition of the house or building. Would you rate your home…? (Read)
    Excellent
    Good
    Fair
    Poor

    Refused

5.1a If any answer other than excellent… Why do you believe your home is not in excellent condition? Is it because your home has… (read, check all that apply)
    Dampness or water leaks
    Visible mold or musty smell
    Pests such as mice, cockroaches or other pests
    Risks for injury
    Harmful chemicals
    Other: Describe _____

    Refused

VI. Health, mood and feelings:

The next set of questions deal with health outcomes, specifically focusing on mental health.

6.1 During the past 30 days, for about how many days have you felt sad, blue or depressed?
Number of days (0-30)

Refused

6.2 During the past 30 days, for about how many days have you felt worried, tense or anxious?
Number of days (0-30)

Refused

6.3 Thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental health not good?
Number of days (0-30)

Refused

6.4 During the past 30 days, for about how many days did poor mental health keep you from doing your usual activities, such as self-care, work or recreation?
Number of days (0-30)

Refused

VII. Demographics:

These final questions are necessary to complete the full picture of health in Olmsted County, all relating to demographic characteristics.

7.1 What is your age?
Age in years

Refused

7.2 Are you Hispanic or Latino/a?
Yes
No
Don't know / not sure

Refused

7.3 Which one or more of the following would you say is your race? (Check all that apply)

White
Black or African American
Asian
Native Hawaiian or other Pacific Islander
American Indian or Alaska Native
OR Other (specify)_____

Don't know / not sure
Refused

7.3b For those that selected more than one response in question – Which one of these groups would you say best represents your race? (check all that apply)

White
Black or African American
Asian
Native Hawaiian or other Pacific Islander
American Indian or Alaska Native
OR Other (specify)_____

Don't know / not sure
Refused

7.4 Were you born in the United States?

Yes
No

Refused

7.4b If no: How long have you been here?

Number of years

Refused

7.5 Are you…? (Read)

Married
Divorced
Widowed
Separated
Never married
A member of an unmarried couple

Refused

7.6 Including yourself, how many people currently live in your household?

    Number of people

    Refused

7.7 How many children less than 18 years of age live in your household?

    Number of children

    Refused

7.8 What is the highest grade or year of school you completed? (Read only if necessary)

    Never attended school or only attended kindergarten
    Grades 1 through 8 (elementary)
    Grades 9 through 11 (some high school)
    Grade 12 or GED (high school graduate)
    College 1 year to 3 years (some college or technical school)
    College 4 years or more (college graduate)

    Refused

7.9 Are you currently…? (Read)

    Employed full-time
    Employed part-time, including seasonal work
    Self-employed
    Out of work for more than 1 year
    Out of work for less than 1 year
    A homemaker
    A student
    Retired
    Unable to work

    Refused

7.10 What is your annual household income from all sources?

    Less than $15,000
    $15,000 – $24,999
    $25,000 – $34,999
    $35,000 – $49,999
    $50,000 – $74,999
    $75,000 – $99,999
    $100,000 – $149,999
    $150,000 – $199,999
    $200,000 and over
    Refused

7.11 How many times have you moved in the past 2 years?
Never
1 time
2 times
3 or more times

Refused

7.12 Do you currently have internet access in your home?
Yes
No

Refused

7.13 About how much do you weigh?
Weight in pounds

Refused

7.14 About how tall are you without shoes?
Height in feet, inches

Refused

7.15 What is the ZIP Code where you live?
ZIP Code

Refused

7.16 Do you own or rent your home?
Own
Rent
Other arrangement

Refused

7.17 Indicate gender of respondent. (Ask only if necessary)
Male
Female

Refused

7.18 Do you have any other comments you would like to share?

    Answer (open-ended)

    Refused

That was my last question. Thank you very much for your time and cooperation. Everyone's answers will be combined to give us information about overall health and health practices of people living in Olmsted County. Please look to Olmsted County Public Health Services for the dissemination of the Community Health Needs Assessment in early Spring of 2013. If you have any questions, please contact X at (507) XXX-XXXX

Several groups provide free information and referral services including United Way 2-1-1, ?????????. Would you like any of these numbers?

Appendix C: Listening Sessions & Interviews

Double click on the icon below to read or download recap (PDF) of the CHNA listening sessions and interviews.

Olmsted County, Minnesota Community Health Needs
Assessment Listening Sessions & Interviews Summary Report

BACKGROUND

Olmsted County Public Health, Olmsted Medical Center, and Mayo Clinic combined efforts to conduct a community health needs assessment. The needs assessment process involved convening a team of community leaders, researchers, and health care providers to determine the health care needs of Olmsted County residents. A process was envisioned to help prioritize the community's health care needs. The team determined the leading health indicators and based on these indicators developed a survey. An independent research group was contacted to conduct the telephone survey of residents in Olmsted County. The survey obtained more detail on individual health concerns and service utilization. A total of 500 residents responded to the survey with 93% of the residents self-identifying as white. While the data yielded some useful information, the needs assessment team was concerned that the findings did not fully tell the story of the community's health concerns. Therefore, an additional process was sought to gather information in a systematic way that would allow for the voices of the residents to be heard. A systematic qualitative process was used to help inform and compliment the data that has been collected in the other process.

The purpose of qualitative process was to determine the health concerns of the residents while taking into context access to health care, cultural beliefs, and perceived leading health concerns.[1] The process involved conducting listening sessions, similar to focus groups, with minority and underrepresented residents. The findings will help to determine not only priorities that the community feels are important but will inform and enhance services that are provided in the county, detail areas of potential improvement, and shed light on the expectations residents have on their health care providers. The qualitative assessment was led by Mayo Clinic Center for Translational Science Activity Office for Community Engaged Research and Olmsted County Public Health. The qualitative process involved the hosting several community listening sessions and conducting individual interviews with residents.

METHODS

The team consisted of a master's level public health nurse, an internal medicine physician, a community outreach expert, master's level trained public health practitioner, and a doctoral trained community engaged scientist. After initial conversations with the Core Planning Team for the community health assessment and initial meeting with the data management task force, the team three categories of interests: (1) determine the leading the health issues impacting the community; (2) determine the best way to disseminate information about health care and health care access to the community; and (3) describe any barriers and facilitators that impede or enhance access to health care services in Olmsted County, MN. The team identified five community groups that were not represented in the telephone survey that comprise

a large portion of residents. In addition to identifying the groups they also determined the appropriate community leaders to help recruit residents to the listening sessions. It was decided to conduct listening sessions with each group. Please note
that one group requested that sessions with males and females be conducted separate due to cultural concerns.

The sessions were conducted with 7 to 14 residents in locations that were easily accessible. Community leaders who were trained focus group facilitators assisted in the data collection process. Sessions were conducted with the Hispanic, Somali, Cambodian, South Sudanese, and unemployed and underemployed residents. Table 1 provides a description of the listening session locations and information on selected demographic characteristics of the participants.

A listening session guide was developed by the team based on the findings from the telephone survey and two open ended questions that were included on the survey. The questions were:

1. What do you believe is the most pressing health issue impacting the community of Olmsted County?
2. What do you believe is the most pressing health issue impacting your friends and family?
3. How is the best way to get information about health topics to your community and family?
4. What is the best way to get information about resources and services to your community and family?
5. Have you or your family encountered any barriers to receiving health services? If so, what?
6. What resources did you find in the community that will facilitate access to health services?

The listening sessions were conducted by trained focus group facilitators with at least two note takers in each session. When possible a member from each community facilitated the sessions. Participants were asked if they were willing for the sessions to be audio recorded (4 groups agreed). Notes were taken by note takers and newsprint was also used for note taking so participants would be able to see their responses. The notes and newsprint information was typed so that the information could be analyzed using traditional content analysis.

After the first five listening sessions were conducted, the team was afforded the opportunity to conduct interviews with residents. The interviews guide consisted of only four questions to help provide a bit more clarity. The questions were:

1. What do you believe is the most pressing health issue impacting the community, your friends and family?
2. Have you or family encountered any barriers to receiving health services? If so, what were they?
3. What did you find that facilitated or helped you access health services?
4. What is best way to get information about health topics or community resources to you and your family?

Traditional content analysis was used to systematically add rigor and categorize the information that was collected from the participants during the listening sessions and interviews.[2] This process involved reading the notes as a whole to understand the common themes that were presented in each session and interviews. Three members of the team conducted this process. Each member developed codes that summarized the main concepts found in the notes. After individually coding the notes the three coders met to gain consensus of their codes. This helped with systematically arranging the notes so that the main priority areas could be identified.

Table 1. Listening Sessions and Interview Description of Selected Participant Characteristics

Listening Session Sites	Description	Selected Demographic
Juntos Club – Hispanic Community	Juntos Club is a program in the Alliance for Chicano Hispanic and Latin Americans. The program offers English as a Second Language classes to adults and youth. The session was facilitated in Spanish and English.	n=8 Male=2 Females=6 Age M=46.9 years (Range 33-75)
Somali Coffee Shop with Somali Men	A traditional Somali male coffee shop. Arrangements were made to have a male Somali interpreter who is trained in focus group facilitation to be available to assist with information gathering. The session was facilitated in Somali and English.	n=7 Male 7 Female=0 Age M=all refused estimated range (50 and 65+)
Cambodian Leader's Home – Cambodian Community	A leader in the Cambodian community offered to host the listening session in his home. Arrangements were made for a Cambodian interpreter trained in focus group facilitation to be available to assist with information gathering. The session was facilitated in Cambodian	n=8 Male=5 Females=3 Age M=52.3 years (Range 28-67)
Mayo Clinic Siebens Building – Somali Women	A female leader in the Somali community arranged for the participants to attend the listening session. She is trained in focus group facilitation and facilitated the session in Somali and English.	n=14 Male=0 Females=14 Age M=42.2 years (Range 25-78)
Workforce Development, Inc.– Unemployed and underemployed	Workforce Development, Inc. provides career planning and pre-vocational skills training to community members who are having difficulties finding employment.	n=12 Male=2 Female=10 Age M=33 years (Range 21-58)
First Presbyterian Church – South Sudanese	First Presbyterian Church provided the opportunity to speak with members of their congregation.	n=12 Male=4 Female=8 Age M=29.4 years (Range 28-53)

Table 2. Description of Interview Location and Selected Demographic Characteristics of Interviewees

Interviews	Description	Selected Demographic
World Festival and Individual Interviews	Community event sponsored by Rochester International Association to bring awareness of cultural diversity in Rochester. Additional participants completed the interviews and returned the sheets to the listening session team after the World Festival.	n=42 Male=21 Female=20 Age M = 45 (Range=17-83)

RESULTS

After the data was coded, five main priority areas emerged from the notes: communication, access to care, preventive care and activities, cultural concerns, and major community health concerns. Table 3 shows the five priority areas along with the sub-categories that relates to each main area. The fishbone diagram (Figure 1) shows the relationship between the four main causes that the community mentioned (communication, access to care, preventive care and activities, and cultural concerns) and how they will lead to what they perceive are the major community health concerns. When we began examining the priority areas the notes between and within groups showed similar trends with little variation in the groups. There were a few areas that contrasting information was noted but this was infrequent in occurrence.

Table 3. Combined Priority Areas

- **Communication**
  Language (translation, interpretation, and health literacy)
  - Health and resource communication (individualized or family in a one-on-one setting)
  - Health education (pamphlets, brochures, websites and community presentations)
  - Location (places of worship, schools, stores, homes, community centers and groups)
  - Family and friends
- **Access to Care**
  - Insurance and cost
  - Transportation
  - Knowing where to go to address health concerns
  - Service providers and community based resources
  - Health care service providers (physicians, physician assistants, nurses, community health workers, patient navigators, social workers)
  - Wait time
  - Consistency of care
  - Paperwork and documentation
  - Care for seniors
- **Cultural Concerns**
  - Trust and respect
  - Patient adherence
  - Lack of attention to patient's concerns
  - Different treatments offered
  - Cultural awareness and competency (providers and patients)
  - Social isolation (gender, age, and race or ethnicity)
- **Diseases and Health Issues**
  - Mental health (stress, autism, addiction, depression, ADD/ADHD)
  - Chronic disease (obesity, cancer, cardiovascular disease, diabetes, hypertension, osteoporosis, stroke, arthritis,
      autoimmune, GI issues like GERD)
  - Infectious disease (STI, viral infections, TB, hepatitis)
  - Vision and hearing
  - Dental
- **Preventive Care and Activities**
  - Diet and nutrition
  - Vaccination
  - Physical activity
  - Prenatal care
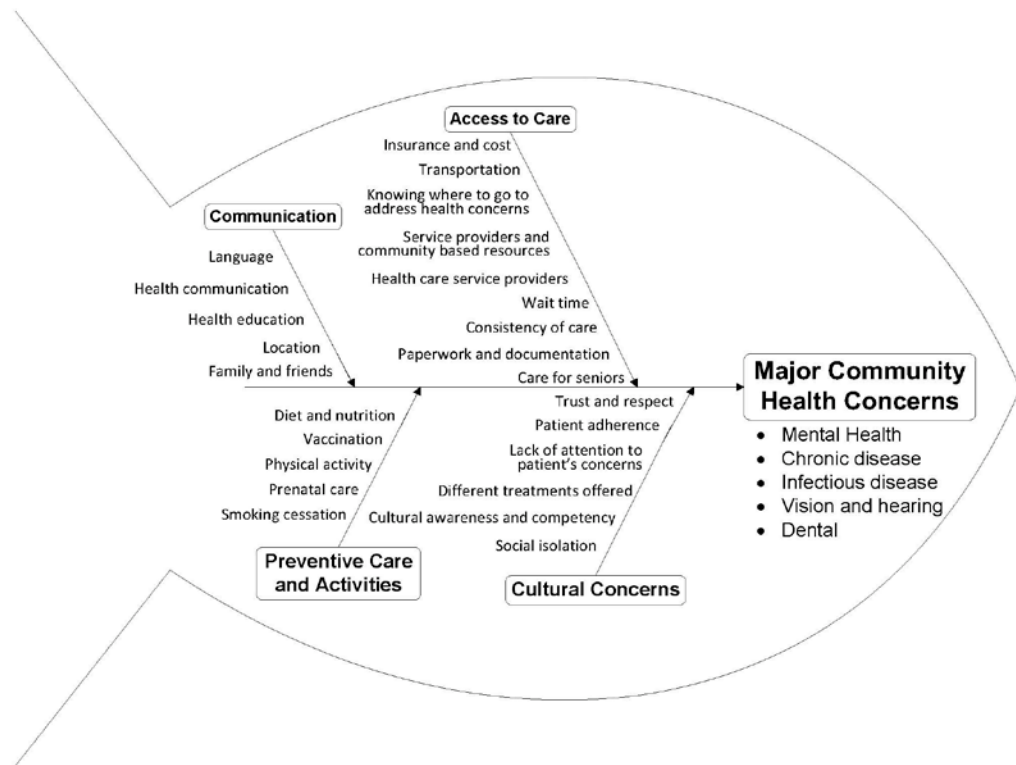 - Smoking cessation

Figure 1. Fishbone Diagram of Causes of Major Health Concerns

Communication

Communication was a priority area that was identified in each listening session as well as the interviews. Residents mentioned issues related to language such as translation service, use interpreters, and health literacy. It was maintained that the use of live interpreters were preferred over online services. It was also mentioned that it was unacceptable to have only one or few live interpreters available to assist an entire community group with health related appointments. For instance, in two of the listening sessions residents mentioned:

> *Interpreter issues lead to miscommunication and mistrust. The phone interpreters are often rude, yell, won't translate everything. Even healthcare physicians can sense the issue and how upset the patient is.*

> *If I didn't speak English then my family would not receive health care.*

> *[I]Prefer not to use interpreting service online. Much prefer in-person interpreters.*

Residents found that more needed to be done for health resources for individuals and families in a one-on-one setting. Plus the use of health education materials and intake forms needed to be written in a way that was appropriate and culturally sensitive to the communities being served. Several residents mentioned using community leaders as well as having community health workers to assist with providing health education, bringing awareness of health resources, and helping with the navigation of the health care system.

> *Have someone from the community ("no offense to you people") to provide information (to reduce stigma that they [whites] aren't giving us all the information we want or is right for us) and provide information.*

> *Community leaders who help people who don't speak English and help them.*

> *Our community [health] workers, [mentioned two community members by name] brought health update to us.*

The use of community health workers and culturally appropriate materials would assist with helping to reach a diversity of residents and increase health equity in our community.

> *Sometimes people will hear about information but if it isn't available in Spanish they will not go (to an event).*

When asked about paperwork that is needed to receive services the residents felt that many of the agencies did not have material written in their languages. This was disappointing to many because when they would arrive for services that they would not receive care until they completed paperwork. Many mentioned they did not understand the forms and that follow-up appointments resulted in them having to complete the forms again.

> *Will tell you that you don't qualify for services and need more information (give notice right away on things needed to qualify for health services then 30-day wait. Keep asking for information).*

> *Making patients sign paperwork prior to receiving care in emergency room. Possibly do after the health care providers have determined the [patient's] reason for visit.*

Residents maintained that it was important to go where they meet and gather to provide health education information and even health screenings. This means places of worship, schools, locally owned businesses, and community centers.

Access to Care

Access to care was a priority area that was present in each session. Residents were concerned about the cost of health care and insurance. Transportation and knowing where to access health services was pointed out as a barrier in the community. In consistency of care, care for seniors, long waiting time, inability to complete paperwork and culturally inappropriate paperwork were listed as barriers to access to care.

> *When family members go to hospital, doctors ask about money for care rather than addressing the patient health concerns (want to make sure they are going to get paid). [It] happened in Mexico and now here [in Rochester].*

> *When [women] go to the doctor – the doctor refuses certain medicine and/or treatment because it is too expensive and the patient can't pay. So, why go to the doctor if they are only going to tell me to take Advil.*

> *[I] went to doctor. They gave over 400 pills and told to take several at night without significant communication. The doctor made them more confused. They feel the doctor is responsible because he did not explain when issued the medications. Asked for clarity on why to her regular health care provider? They didn't tell me what was wrong with me and just told me to take the pills. Doesn't know why this happens. I didn't want to so I went back to another doctor who explained things to me. Told doctor she didn't take them.*

In one of the listening sessions, access to care for persons with disabilities was mentioned as a priority.

> *[The] care for disabled people – patients are not aware of their rights for care. Sometimes they miss appointments because of lack of transportation or no reliable transportation and the doctor thinks that they are not showing.*

Access to care related to type of health care providers that were available to address residents' health care concerns.

> *See[ing] more Somali nurses at the hospital. It helps to break the barriers [to care].*

> *Having more diversity in the staff in the hospital. Now you see nurses who are Somali and therapists who are Somali, and this decreased the barrier.*

Cultural Concerns

Cultural concerns were an area of interest mentioned in every listening session. Issues relating to trust, respect, fear and even a lack of a patient's concerns were pivotal. Patient adherence and the perception that they are receiving different treatments impact health care. Health care providers should be aware that many of the population experience social isolation. Therefore, cultural awareness and competency of the providers and even patients will help to increase overall wellness in our community.

Fear was a common area of concern:

> *Sometimes patients are afraid to admit to social services that they cannot take care of themselves with the fear of having their children removed from their home.*

> *Because of culture, disease is kept secret. Hidden shame, shy personal confidentiality. There is shame and often even the immediate family does not know. Treatment is not sought and premature death occurs.*

Recognizing that the community has a variety of people that are new to the area this includes recent immigrants. For instance:

> *There are 2 groups [in our community] – those who have been here awhile and those who are recent immigrants. The recent immigrants often lack health insurance and won't spend money on unneeded appointments (like general check-ups/screenings).*

Being mindful of learning about the cultures that are being cared for as well as being willing to provide information about how to navigate the health care system will impact wellness.

> *Educate clinicians about cultural awareness*

> *Sometimes [we] carry culture too much, are strict with their beliefs. Wife is often shy, won't tell husband of issues. Sometimes family keeps quiet, doesn't want to admit issues to people outside of the family.*

> *Training in cultural awareness. Train young people in [our community] so they can teach the others in this community.*

Many of the resident mentioned that they use complementary and alternative medicines (CAM) as a way to care for their health concerns. This is sometimes a cultural, religious, and spiritual decision and should be valued.

> *Our family utilizes CAM therapies and it's challenging for healthcare providers to work with patients utilizing CAM therapies.*

> *I don't believe in doctors. I go with herbs. I work a lot with my mind to try to do what is good for myself. Doctor makes me feel that I'm the doctor not the patient.*

Diseases and Health Issues

Mental health issues, chronic disease, infectious disease, tobacco cessation, vision, hearing, and dental were major concerns. Dental health care was mentioned as a concern due to the lack of health care providers in the area that take public insurance. This results in potential patients having to go to another community for dental care.

Mental illness was discussed in the context of children being diagnosed with autism and ADD/ADHD. Several residents discussed the issues of addiction, depression, and stress management.

Mental health – understanding of mental health issues, fear and lack of trust within the health care providers, percentage in the community of mental illness has been increasing.

Obesity, gastrointestinal problems, and hypertension are only a few of the chronic health concerns that were mentioned.

Patients do not know how to lose weight. They do not have access to facilities to exercise.

Various types of cancer were mentioned during the qualitative process.

Cancer – there is a fear of finding out about cancer because every time someone in the community finds out about it, they die. They would rather not know than fear impending death.

This is an issue [liver disease and liver cancer] because people don't get the treatment they need right away and by the time they go to the doctor it went from Hepatitis into full blown liver cancer. Hepatitis and cancer back home has not been properly taken care of.

Sexually transmitted infection, hepatitis, and tuberculosis were the most frequently mentioned infectious diseases.

TB & tetanus checks are important – [our] community has recently lost 2 lives because of late diagnosis.

Preventive Care and Activities

Lifestyle modification and prevention care were two areas of discussion for the residents. From diet and nutrition, each session group had in-depth conversations about the need for more preventive care and services to reduce preventable disease. There was also the discussion that more education is needed about different types of prevention like vaccines, that some communities prefer separate educational sessions and classes for men and women, and that sometimes they feel that they are receiving inappropriate treatments.

Sometimes kids are immunized without reason why and will have parents sign permission with no explanation and fear that if for something not healthful. Parents aren't notified if there's gelatin in the vaccine and things like that.

The residents maintained that it is important to remember the growing diversity in our community. That with the changes in our community's demographics that some new residents and immigrants may have a different perspective when it comes to even going to the doctor. This could mean using the emergency room (ER) instead of going to a primary care facility for care or not receiving care.

Overuse of ER instead of primary care [may occur].

Newcomers don't believe in screening or general check-ups, but from the community's perspective it is important to find TB, especially when it's in hiding with no symptoms.

Residents were asked about things that would increase the health of our community. . Residents mentioned that the weather and other environmental issues impacted community members ability to exercise outside. Aside from the weather the issue of safety was mentioned:
Safe walking and biking in all areas.

DISCUSSION/ CONCLUSION

There were several lessons learned from these sessions. First, it is clear that more works needs to be done to increase the communication between patients and the health care providers. This does is not limited to cultural awareness just on the part of the health care provider but the front desk staff and others that play a role in providing care. Communication is even linked to the patient being willing to learn more about their new community which may help with navigating the health care system. The fact that several groups mentioned the value of community health workers efforts should be in place to increase training opportunities to increase the pool of community health workers. Secondly, access to care was directly linked to insurance, transportation, and even knowing where to receive services. Without health insurance or the ability to determine other ways to pay for care we will continue to have residents who are unable to obtain the preventive care they need. Third and one of the most pivotal concerns is cultural awareness and competency. The feelings of fear, distrust, and lack of respect that was mentioned during several the sessions indicated that more work needs to be done so that we are not missing people that need care. The value that is placed on care of our diverse community should go beyond just them completing paperwork but should match the value that they bring as fellow humans.

The data collection process was quick and we did have some limitations. Due to the timeframe we were not able to reach a variety of communities that would have helped to inform this process. Moreover, the identification of primary focus areas may be subjective to the team performing the analysis. We recognize that this format does not allow for the use of every quote that was given during the listening sessions and interviews. Moreover, we did not have the needed time to transcribe the sessions that were recorded and we did not use qualitative data analysis software instead we used a systematic
approach to identify the primary areas. Traditional content analysis provided the best approach to examine the data in quick and systematic way. This also provided the opportunity to ensure that we had an understanding of the information
that we were provided.

In summary, this quote really brings home the purpose of this qualitative assessment that our community members want "to be healthy" and know [their] "family [medical] history". It can be said that Olmsted County, MN has "good health care providers" that are willing to do more to make sure that the needs of the residents are addressed.

REFEENCES

1.   KL Pieh-Holder, C Callahan, P Young. Qualitative needs assessment: healthcare experiences of underserved populations in Montgomery County, Virginia, USA. *Rural and Remote Health* 2012; 12: 2045.

2.   HF Hsieh and SE Shannon. Three Approaches to Qualitative Content Analysis. *Qualitative Health Research* 2005; 15 (9): 1277-1288.

Appendix D: Health Indicators

Below is a complete list of the identified health indicators for the CHNA.

Theme	Indicator
Health Outcomes - MORTALITY	
Infant/Maternal	
	Infant Mortality
Overall	
	Overall Mortality (including leading COD)
Life Expectancy & Premature Death	
	Life Expectancy at Birth
Health Outcomes - MORBIDITY	
Infectious Diseases	
	Vaccine Preventable Diseases
Disease Prevalence	
	Obesity (adult and childhood)
	Diabetes
	Individuals diagnosed with Multiple Chronic Conditions
	Dental Disease
Mental/Chemical	
	Mental Illness (adult and childhood)
Health Factors - HEALTH BEHAVIORS	
Alcohol/Drug	
	Tobacco Smoking Rate (adult and adolescent)
	Alcohol Use - Adolescent

Nutrition/Physical Activity

     Vegetables and Fruit Guidelines Met (adults & school-aged youth)

     School Lunches

     Physical Activity Guidelines Met (adults & school-aged youth)

Health Factors - CLINICAL CARE

Insurance

     Level of Insurance (combined uninsured and underinsured)

Providers

     Geographic Access (dental and mental health providers)

Care

     Seen Dentist in last 12 months

     Seen Primary Care Physician

     Prenatal Care

Health Screenings

     Mammogram

     Diabetes

     Colorectal Cancer Screening (i.e. colonoscopy)

     Hypertension

     Cholesterol

     Mental Health

     Developmental (0-5 years of age)

Health Factors - SOCIAL AND ECONOMIC FACTORS

Education

     Education Level (i.e. 25+ with HS diploma or GED)

Income/Employment

     Poverty

     Median Household Income (housing stress)

     Unemployment

Households

     Homelessness

Miscellaneous

(Neighborhood) Safety (violent crime rate; domestic/child abuse)

Public Transportation (mobility deprivation)

Health Factors - PHYSICAL ENVIRONMENT

*NOTE: The Environmental Management Team is currently administering a key informant survey to help generate a potential list of additional indicators - some may already be on the following list.

Environmental Hospitalizations

Asthma

COPD

Built Environment

Healthy Food Access

Environmental Quality

Air Quality

Miscellaneous

Housing Conditions and Quality (cost/value per sq foot)