2020–2022

Community Health Needs Assessment and Implementation Plan

Allina Health
DISTRICT ONE HOSPITAL

Allina Health
OWATONNA HOSPITAL

TABLE OF CONTENTS

INTRODUCTION

District One Hospital and Owatonna Hospital are part of Allina Health, a nonprofit health system of clinics, hospitals and other health and wellness services, providing care throughout Minnesota and western Wisconsin. As part of its mission to serve communities, Allina Health and its hospitals conduct a Community Health Needs Assessment (CHNA) every three years. This process includes systematically identifying and analyzing community health priorities and creating a plan for addressing them through system-wide and hospital-specific strategies, resources and partnerships.

The CHNA process is conducted in partnership with local public health departments, other hospitals and health systems, community organizations and residents. The Patient Protection and Affordable Care Act of 2010 requires 501(c)(3) nonprofit hospitals to conduct an assessment at least every three years. The Internal Revenue Service provides guidelines for meeting this obligation.

Through the CHNA process, Allina Health aims to:

- Understand the health status and priorities of communities as defined by community members and the most recent health and demographic data.
- Elicit perspectives on factors that impede health and ideas for improving it from organizations, institutions and community members—especially people from historically underserved racial, ethnic and cultural communities and others who experience health inequity.
- Identify community resources and organizations that Allina Health can partner with and support to improve health in its communities.
- Create an implementation plan outlining strategies, activities and contributions that Allina Health and its hospitals will pursue to improve community health.

The purpose of this report is to share results from the current assessment of health needs in the communities served by District One Hospital and Owatonna Hospital and a combined implementation plan to address them in 2020–2022. This report also highlights the hospitals' 2017–2019 activities to address needs identified in the 2016 assessment.

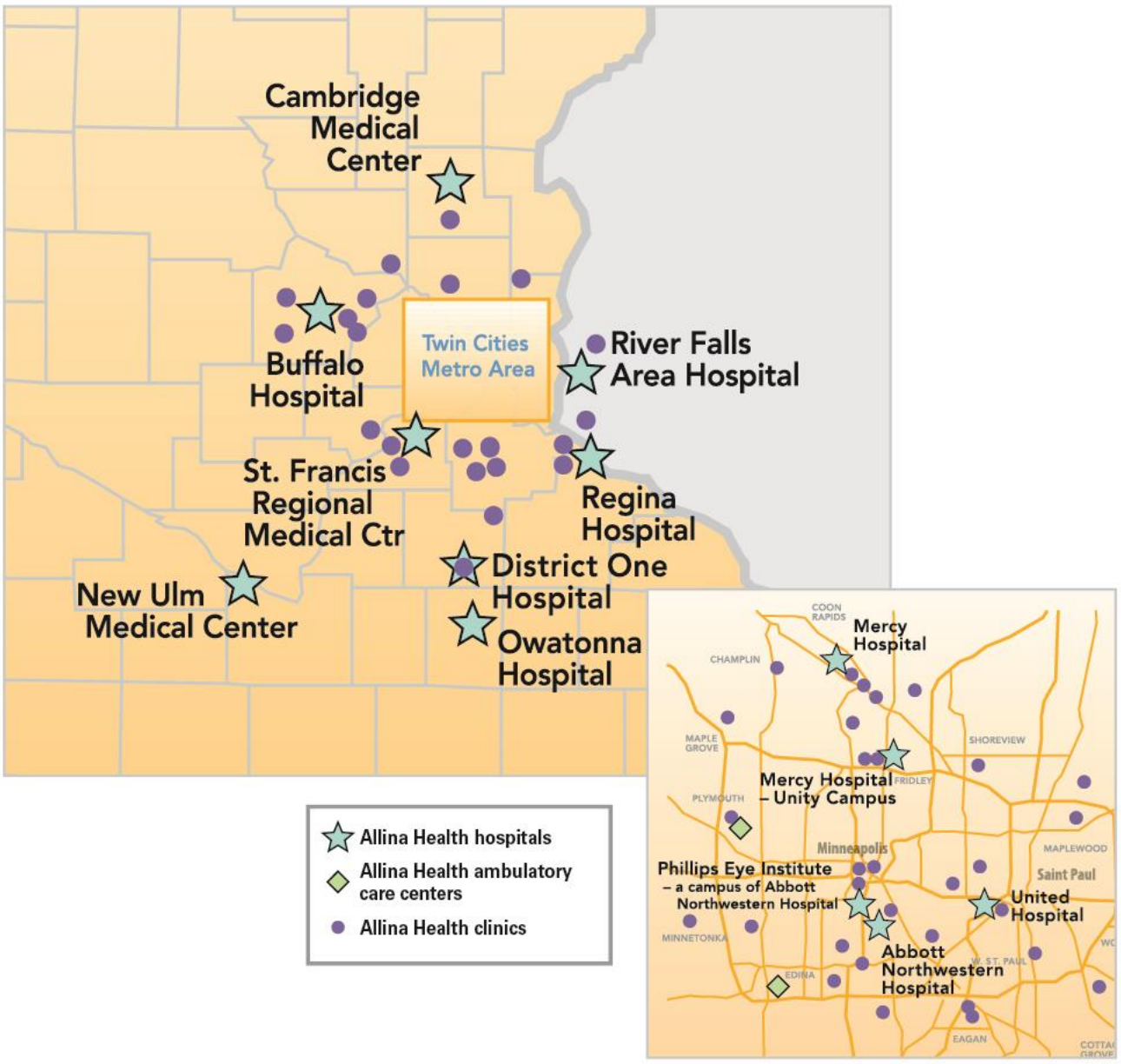
ALLINA HEALTH DESCRIPTION

Allina Health is dedicated to the prevention and treatment of illness and enhancing the greater health of individuals, families and communities throughout Minnesota and western Wisconsin. A nonprofit health care system, Allina Health cares for patients from beginning to end-of-life through its 90+ clinics, 11 hospitals, 13 retail pharmacies, specialty care centers and specialty medical services that provide home care, senior transitions, hospice care, home oxygen and medical equipment and emergency medical transportation services.

MISSION

The mission of Allina Health is to serve our communities by providing exceptional care as we prevent illness, restore health and provide comfort to all who entrust us with their care.

ALLINA HEALTH SERVICE AREA



DISTRICT ONE HOSPITAL DESCRIPTION AND SERVICE AREA

District One Hospital (District One), located in Faribault, Minnesota became part of Allina Health in the summer of 2015. It operates 42 beds, and serves over 30,000 patients and their families each year. For residents in Faribault and surrounding communities, the hospital provides a broad range of health care services, including orthopedic services, cardiac rehabilitation, cancer services in partnership with the Virginia Piper Cancer Institute® and Minnesota Oncology, a birth center and a sleep center. Emergency services in the hospital were expanded in 2015. Affiliated clinics include Allina Medical Clinic, Faribault, and Allina Medical Clinic, Northfield. The hospital also works to improve the health of the communities it serves through charitable giving and health improvement programming. Its primary service area (and the focus of the CHNA) is Rice County located in southern Minnesota.

COMMUNITY DEMOGRAPHICS

According to the U.S. Census Bureau, 65,251 residents live in the 516-square mile area occupied by Rice County. The area's population density, estimated at 126 persons per square mile, is greater than the national average. The median age in Rice County is 36.6 years, and approximately 22 percent of its total population is under age 18. In 2017, the median household income was $63,311 with 11.5 percent of residents living in households with income below the Federal Poverty Level.

Approximately 15 percent of area residents are people of color—primarily Hispanic or Latino (7.9 percent), Black (5.1 percent) or Asian (2.2 percent). The area also has a strong Native American community with an additional 0.4 percent of area residents identifying as American Indian or Alaska Native alone. Additionally, in 2017, 7.4 percent of residents were foreign-born, and approximately 4.4 percent of Rice County residents had limited English proficiency. Most Rice County residents born outside of the United States were born in Latin America (38.5 percent), Asia (22.2 percent) or Africa (32.9 percent) (U.S. Census Bureau, 2013–2017 American Community Survey 5-Year Estimates). The population of Rice County residents who emigrated from East Africa has increased substantially over the past few years, and is reflected in District One's patient population. For example, in 2018, one-third of babies born at the hospital were to born to Black or African American patients, primarily Somali residents.

Rice County residents face many of the same health concerns that are common across the United States. For example, Feeding America estimates 5,630 people in the county (9 percent) experienced food insecurity in 2017. Additionally, many residents struggle to access health care. Although more people are insured than in the past, at least 6 percent of residents are uninsured. Further, the region has a 1,080:1 ratio of residents to mental health providers compared with Minnesota's overall mental health provider ratio of 430:1. Approximately 30 percent of area adults are obese, and 12 percent report poor general health (County Health Rankings, 2019).

OWATONNA HOSPITAL DESCRIPTION AND SERVICE AREA

Owatonna Hospital (Owatonna) is located in Owatonna, Minnesota about 16 miles from District One. It serves over 20,000 patients and their families each year. Its primary service area (and focus of the CHNA) consists of Steele and Dodge counties—two rural areas located in southern Minnesota.

Owatonna has grown from a small city hospital that opened nearly 110 years ago to a comprehensive, high-quality regional medical facility that offers a full spectrum of services. The hospital has specialties in surgery and trauma care and a comprehensive array of outpatient rehabilitation services, including physical therapy, occupational therapy, speech therapy and cardiac rehabilitation through Courage Kenny Rehabilitation Institute-Owatonna. The two-story hospital is physically connected to Mayo Clinic Health System-Owatonna

Clinic and Koda Living Community, an 80-bed long- and short-term care facility. The Owatonna Health Care Campus bridges inpatient and outpatient services within the same medical disciplines to create a seamless approach to patient care. The hospital also has a long history of working to improve the health of the communities it serves through charitable giving and community health improvement programming.

COMMUNITY DEMOGRAPHICS

According to the U.S. Census Bureau, 57,097 residents live in the 872-square mile area occupied by Steele and Dodge counties. The area's population density, estimated at 65 persons per square mile, is less than the national average. The median age in Steele and Dodge counties is 39.3 years-old and 38 years-old, respectively. Approximately 26 percent of the total population is under age 18. Approximately 13 percent of area residents are people of color—primarily Hispanic or Latino (6.2 percent), Black (3 percent) or Asian (1 percent). In 2017, 2 percent of residents were foreign born, and 1.9 percent had limited English proficiency. The area's median household income was $64,980, with 7.8 percent of residents living in households with income below the Federal Poverty Level (U.S. Census Bureau, 2013–2017 American Community Survey 5-Year Estimates).

Steele and Dodge county residents face many of the same health concerns that are common across the United States. For example, Feeding America estimates 4,310 people in the counties (8 percent in Steele and 6 percent in Dodge) experienced food insecurity in 2017. Additionally, many residents struggle to access health care. Although more people are insured than in the past, 4 percent of people are uninsured. Further, the region has an average 2,300:1 ratio (Steele County 450:1/Dodge County 4,150:1) of residents to mental health providers compared with Minnesota's overall mental health provider ratio of 430:1. Approximately 29 percent of area adults are overweight or obese, and approximately 12 percent report poor general health (County Health Rankings, 2019).

Additional information about Rice, Steele County and Dodge counties can be found online at Minnesota Compass.

EVALUATION OF 2017–2019 IMPLEMENTATION PLAN

In its 2017–2019 Community Health Needs Assessment, District One adopted mental health and access to care as its health priorities. Owatonna adopted mental health, including addiction and chronic disease self-management in its 2017–2019 Community Health Needs Assessment. Each hospital addressed its priorities in 2017–2019 through Allina Health's systemwide activities and its own initiatives. They also worked collectively on a shared priority of healthy aging for people over 50 years-old. Because obesity and mental health were identified as priorities for the entire service area, Allina Health also adopted them as 2017–2019 systemwide priorities.

SYSTEMWIDE ACTIVITIES

Allina Health provided each of its hospitals with resources to address obesity and mental health through the following strategies:

Change to Chill

Change to Chill™ (CTC) is a free, online resource that provides stress reduction tips, life balance techniques and health education services for teens. More than 30,000 unique users, including teachers, teens and parents, visit the CTC website each year. In 2017 and 2018, Allina Health delivered an in-person model of CTC, reaching more than 2,300 students in high schools, middle schools and alternative learning centers across its service area. A pre/post participant survey showed an increase in students' knowledge of and ability to use healthy coping techniques. Additionally, nearly 300 school and community professionals, including seven from Northfield Public Schools, participated in a train-the-trainer model aimed at equipping community members to engage with teens, parents and guardians using the CTC program and materials.

To support a culture of mental well-being in local high schools, Allina Health launched the Change to Chill School Partnership (CTCSP) during the 2018–2019 school year. At nine high schools, CTCSP reached more than 10,000 students through focus groups, peer mentoring and a designated space called "Chill Zone" to practice self-care. Staff training and messages for parents were also provided. Owatonna and District One Hospitals supported Arcadia High School, reaching 120 students and providing training to 40 school staff. . Initial systemwide evaluation results demonstrate that students who participated in components of Change to Chill™ showed increased confidence in their ability to cope with stress. In the 2019–2020 school year, Allina Health will provide technical support and funding to 16 high schools and 34 CTC student interns, as well as ongoing financial support to its previous CTCSP schools.

Be the Change

In 2016, Allina Health launched Be the Change, a six-month, internal campaign to eliminate stigma around mental health conditions and addiction and to ensure that all patients receive consistent, exceptional care. More than 500 Allina Health employees volunteered to serve as Be the Change champions, providing presentations and events to 18,140 of their colleagues (approximately two-thirds of all Allina Health employees). Employee surveys reveal the campaign improved employees' perception of Allina Health's support of people with mental health or addiction conditions, their comfort interacting with people with mental health or addiction conditions and their knowledge of mental health resources. Between 2017 and 2019, Allina Health continued supporting Be the Change champions with ongoing communication and educational opportunities.

Neighborhood Health Connection

Neighborhood Health Connection™ (NHC) is a community grants program that aims to improve health by building social connections through healthy eating and physical activity. Each year, Allina Health awards over 50 Neighborhood Health Connection grants (ranging from $500 to $10,000) to local nonprofits and government agencies in Minnesota and western Wisconsin. Between 2017 and 2018, NHC-funded organizations reached 2,831

and 3,467 participants, respectively, with similar reach expected in 2019. Evaluations of the NHC program found most participants increased their social connections, made positive changes in physical activity and healthy eating and maintained these changes for at least six months. Owatonna and District One Hospitals awarded $86,800 in NHC grants to 24 local organizations from 2017–2019.

Health Powered Kids

Health Powered Kids™ (HPK) is a free community education program featuring 60+ lessons and activities designed to empower children ages three to 14 years to make healthier choices about eating, exercise, keeping clean and managing stress. Between 2017 and 2018, Allina Health added 16 lessons, mostly focused on mental well-being (e.g., Gratitude: Overlooked Blessings). More than 100,000 people visited the HPK website. In a 2017 user survey, 90 percent of respondents rated HPK as "helpful" to "essential" in improving health at their home, school or organization.

Healthy Food Initiative

To address food insecurity, Allina Health launched a healthy food initiative in 2017 to ensure all people in its communities have access to healthy, fresh and affordable food. Through charitable contributions, Allina Health contributed more than $400,000 to healthy eating initiatives across its service area between 2017 and 2018, including more than $6,000 in the region covered by Owatonna Hospital and District One Hospital. Additionally, through three annual "Give Healthy Food Drive" events, Allina Health employees collected 28,348 pounds of food that were distributed to 250 food shelves. In 2018 and 2019, Allina Health also offered coupons to Fare for All, a program of The Food Group, to community members at 52 clinics. Fare for All offers fresh produce and frozen meats at a low cost. Through this partnership, residents purchased nearly 1,200 boxes of healthy food—160 of which were purchased through support from Owatonna and District One's affiliated clinics. District One Hospital and Owatonna Hospital also partnered with six farmers markets and food cooperatives and three city Parks and Recreation Departments to accept Allina Health Bucks to help make fresh, local foods and opportunities for physical activity more affordable and accessible. Each year, $10,000 in Allina Health Bucks are distributed through local clinics and community partners.

Accountable Health Communities model

Because social conditions, such as food and housing instability, inhibit access to care and contribute to mental health conditions, obesity and chronic diseases, Allina Health implemented the Accountable Health Communities (AHC) model through a cooperative agreement with the Centers for Medicare & Medicaid Services. In this model, care teams in 78 Allina Health sites screen patients with Medicare and/or Medicaid insurance for five health-related social needs: housing instability; food insecurity; transportation barriers; difficulty paying for heat, electricity or other utilities; and concerns about interpersonal violence. When patients identify needs, the care team provides a list of community resources tailored to their needs. Some high-risk patients receive assistance navigating the resources. From June 2018 through June 2019, more than 97,000 patients completed an AHC screening with 22 percent identifying at least one need. The most frequently identified needs were food insecurity and housing instability, identified by 60 percent and 47 percent of patients with needs, respectively.

In 2018, Allina Health also applied for and received grant funding from the UCare Foundation of Minnesota to develop and implement clinic-community connections to address health-related social needs of select patients of Allina Health clinics in Faribault and Northfield. From April through November 2019, the clinics piloted a two-way referral process with HealthFinders Collaborative, a local community-based organization. Clinic staff directly refer high-risk AHC patients to HealthFinders Collaborative, whose culturally-connected community health workers serve as an extension of the Allina Health primary care team and help patients navigate community services.

LOCAL DISTRICT ONE HOSPITAL ACTIVITIES

Goal 1: Improve access to quality, comprehensive mental health and addiction care and services and reduce social stigma.

The Allina Health-Faribault Campus Mental Health Action Team hosted a "Mental Health and Addiction Resource Fair" on the hospital's campus. Between 2017 and 2019, hundreds of community members, providers and hospital staff attended the fair where 15 vendors shared information about symptoms, treatments and resources for mental health conditions and addiction. This group also sponsored a Youth Mental Health First Aid workshop.

In fall 2017, District One and other community agencies launched "Project SHARE: Somali Health Artistic Renewal & Expression," which provides opportunities for Somali residents to use art for expressing feelings about traumatic events. To promote mental health among youth, District One participated on the Faribault Youth Investment (FYI) Advisory Council, which builds community connections for healthy youth development through the Faribault Youth Investment Activities Fair and youth listening sessions. It also offered Sip 'n Chill for Faribault Community School through Community Education.

To support community mental health services, District One provided charitable contributions, grants and in-kind contributions to Rice County Chemical and Mental Health Coalition, Steele County Safe and Drug Free Coalition and other nonprofit organizations working to address mental health and addiction.

Goal 2: Improve health care access and population health.

To improve care for Somali residents, District One hired a full-time Somali interpreter and added Halal meal options to its inpatient menus and prayer mats in the hospital's chapel space. It also integrated bottled water into seven hospital restrooms in support of Muslims' spiritual cleansing rituals.

District One staff also provided health screenings and health programs to students of Faribault Community School and charitable contributions and operational support to HealthFinders Collaborative.

To increase access to healthy food, District One employees volunteered at Basic Blessings and Community Café and contributed to annual healthy food drives.

LOCAL OWATONNA HOSPITAL ACTIVITIES

Goal 1: Increase knowledge of symptoms, treatments and resources for mental health and addiction conditions and reduce social stigma of mental health and addiction issues.

To increase access to mental health services, the hospital conducted a feasibility assessment of increasing beds in its mental health inpatient unit from 10 to 12. In partnership with Allina Health's Northfield Clinic, Owatonna's social workers provided e-visits to new patients of the Mental Health Hub, thereby reducing wait times for appointments. To better serve patients in its emergency department, the hospital added tele-psychiatry services. It also actively promoted a regional crisis response team at resource fairs and through groups such as the Homeless Prevention Team.

To improve care of LGBTQ community members, the hospital hosted a training in partnership with NAMI MN for staff and community partners on the unique mental health needs of these populations.

The hospital also began working on a regional community-based mental wellness initiative. The hospital supported evidence-based mental wellness programming, and participated in Steele County's Safe and Drug Free Communities Coalition. In partnership with HyVee Pharmacy, the hospital supported several community presentations on Narcan use and opiate overdose prevention.

Goal 2: Prevent and manage chronic disease.

Owatonna provided funding to several community organizations for cooking classes and community gardens. It hosted classes for people diagnosed with diabetes, and provided Living Well with Chronic Conditions and Matter of Balance classes to community members. To support physical activity, it supported activities at Owatonna Parks and Recreation sites.

Owatonna staff provided health education about preventive care to thousands of residents at the Steele County Fair and through 35 internal and external groups.

Through its participation in Steele County's Statewide Health Improvement Partnership Worksite Wellness Coalition, the hospital reached 15 local employers with information and resources on sleep, acupuncture and medical massage therapy, new mother and baby education and breastfeeding support and advance care planning.

SHARED ACTIVITIES

Goal 3: Healthy aging for adults over 50 years-old.

District One and Owatonna developed and launched Honoring Choices, an initiative focused on engaging older adults in completing their health care directives. They hired a program coordinator, and trained 18 facilitators in advance care planning. In partnership with churches, employers, senior centers and health care providers, the facilitators conducted more than 75 outreach activities, such as book groups, film viewings, Death Cafés classes and health fair booths to help community members plan their later-in-life health care wishes.

To support caregivers of adults with dementia, District One and Owatonna provided financial support to the Memory Café at the Northfield Senior Center and helped the Elder Care Collegium pursue the Dementia Friendly Community designation in Northfield. The hospitals also provided financial support to HealthFinders Collaborative and Growing Up Healthy, which regularly host community connections groups with diverse groups, including seniors.

As leaders in the Community Care Coordination Advisory Council in Steele County and the Health Care Summit in Rice County, the hospitals joined representatives from Mayo Clinic Health System, Northfield Hospital and Clinics, HealthFinders Collaborative, Rice County Public Health and other community partners to address inappropriate emergency department use and hospital readmission rates.

2018–2019 CHNA PROCESS AND TIMELINE

District One and Owatonna completed a joint CHNA process as part of a community collaborative facilitated by local public health. The group used the Mobilizing for Action through Planning and Partnerships (MAPP) model, a community-driven strategic planning process for improving community health. The model has six phases: Organizing, Visioning, The Four Assessments, Identifying Strategic Issues, Formulating Goals and Strategies and the Action Cycle. For the purposes of this report, the phases are condensed to data review and prioritization, community input and implementation plan. The process is cyclical with each phase informing the next and each assessment's results considered in light of the others. It is an interactive process that can improve the efficiency, effectiveness and performance of local public health systems, including health care institutions. Community members' participation is essential to the MAPP process.

The hospitals' leadership received and approved the plans. Allina Health Board of Directors gave final approval.

TIMING	STEPS
April–September 2018	**ORGANIZING and VISIONING** Staff establish initial assessment plans, compile learnings from local assessments, identify stakeholder groups for each hospital and share results from current implementation strategy, as appropriate.
October 2018–January 2019	**DATA REVIEW and PRIORITIZATION** Data review teams are convened, using locally available data and working closely with public health. Teams prioritize issues using locally-agreed upon criteria.
February 2019	**DESIGN COMMUNITY INPUT** Local teams identify specific methods and audiences for community input on the priorities and strategies for action.
February–June 2019	**GATHER COMMUNITY INPUT and DEVELOP IMPLEMENTATION PLAN** Dialogue with community stakeholders to solicit action and implementation ideas related to priority areas. Local teams develop action plan, metrics and resource inventory. Learnings are shared systemwide to identify commonalities and develop Allina Health systemwide action plan.
July–October 2019	**PREPARE REPORTS and SEEK INTERNAL SUPPORT/APPROVAL** Share results and action plans with key stakeholders systemwide. Present plan to local boards, committees and leaders for approval.
December 2019	**SEEK FINAL APPROVAL** Staff present plan to Allina Health Board of Directors for final approval.

DATA REVIEW AND ISSUE PRIORITIZATION

District One and Owatonna conducted a CHNA in collaboration with two required Community Health Improvement Plan (CHIP) processes—one conducted by Rice County Public Health and the other conducted jointly by Steele County and Dodge County. These hospitals' staff met several times with the Rice County and Steele-Dodge groups between April 2018–December 2018 to review data and prioritize needs. Other CHIP members included representatives from United Way of Steele County, HealthFinders Collaborative, Mayo Clinic Health System and Northfield Healthy Community Initiative.

Both groups reviewed state and local secondary data from sources such as the Minnesota Center for Health Statistics, a United Way assessment, the Steele County Safe and Drug Free Coalition, a housing and transportation analysis and county-specific responses on the Minnesota Student Survey. These data sources included demographics, social and economic factors, health behaviors, prevalence of health conditions and health care access.

Additionally, they reviewed select Allina Health patient data chosen based on priorities defined by the Center for Community Health and Allina Health equity priorities:

- Patient data by county of residence: demographic data (including race, ethnicity, language, age and insurance type), health-related social needs and select conditions.
- Top three reasons for emergency room visits.
- Tobacco use among adults and youth.
- Rates of overweight and obesity.
- Colorectal cancer screening rates.

The groups also collected primary data to understand health needs in these communities. Rice County Public Health conducted a 52-item community survey in fall 2016 that measured health behaviors and social needs (e.g., housing); 587 residents responded. Additionally, Rice County employees surveyed 36 Somali and 52 Latino community members. The Steele-Dodge CHNA Committee received 27 responses to an online survey of key community partners' perspectives on health priorities.

After collecting and reviewing data, the CHIP groups took several steps to select top health priorities. Steele and Dodge Statewide Health Improvement Partnership (SHIP) Community Leadership Teams reviewed online survey responses to identify the top 15 health priorities for the two counties and, through a dot survey, further narrowed the top 15 needs down to 10. Then, in January 2019, the Steele-Dodge CHNA Committee reviewed local data and the dot survey results, and used the Hanlon Method for Health Issue Prioritization to select their group's choice for the top three priorities. The Hanlon Method ranks health priorities based on: size of the problem and projection of future trends; seriousness of the problem, including disparate health burdens within the population; and effectiveness and feasibility of interventions. To further refine the list, community partner agencies voted on their top needs via an online survey. Through this process, mental health and substance use, obesity and social determinants of health were identified as the top three local priorities.

To prioritize needs in their community, HealthFinders Collaborative hosted a community input session in June 2018 in which community resource providers reviewed data about health needs, commented on how those needs affect the local community and completed a dot survey to prioritize their top three needs. Participants identified mental health, housing and transportation as the top needs in Rice County, with cultural bias as a key factor in all three.

Through their respective processes, community engagement leadership at the two hospitals identified the following priorities:

Rice County Priorities:

- Mental health
- Housing and transportation
- Race relations: Cultural prejudice and language barriers

Steele and Dodge Counties Priorities:

- Mental health and substance abuse
- Obesity
- Social determinants of health

FINAL PRIORITIES

To align activities and maximize resources, District One and Owatonna created three shared health priorities they will pursue in 2020–2022:

- Mental health and substance use
- Social determinants of health with a focus on transportation, housing and cultural competency
- Obesity, including healthy eating and active living

NEEDS NOT ADDRESSED IN THE CHNA

Though recognized as emerging health issues in the community, the committee did not include vaping, texting while driving, video game addiction or cyberbullying as top priorities. Vaping will be partially addressed through the mental health and substance use priority. Participants believed other organizations, such as law enforcement, schools and chemical health coalitions, focus on these issues and Allina Health could support their efforts through charitable contributions, partnerships and advocacy.

COMMUNITY INPUT

After identifying priority issues, the committees hosted eight focus groups between February and July 2019 to solicit feedback from community members on the identified priorities and ideas for addressing them. In partnership with community organizations, they held two conversations with Faribault residents—one with nine Somali women and another one with Latinx adults. They also held focus groups with the Steele and Dodge counties' SHIP Community Leadership Teams, Mayo Clinic primary care providers, Owatonna High School students and Rice County social service providers.

In June 2019, United Way of Steele County in collaboration with Mayo Clinic Health Systems and Owatonna convened a group of 80 Steele County residents for a dialogue about community health. Approximately 35 percent of these participants identified as people of color; 23 percent were youth under the age of 24 years.

In these dialogues, the hospitals explored the following topics:

- Participants' vision for health and success related to each priority.
- Community and individual assets that support community health and effectively address the health priorities.
- Contributing factors to each health priority.
- Strategies for addressing the priorities.

Additionally, Latinx and Somali participants were asked how Allina Health providers, clinics and hospitals can change their services to be more welcoming and better meet the unique needs of their respective communities.

COMMUNITY INPUT RESULTS

Cultural bias and language barriers

Barriers and issues

Latinx and Somali residents both described challenges interacting with health care because of language, cultural competency and insurance barriers. They shared that some people need to seek help from a community organization to schedule appointments at Allina Health clinics and hospitals. They said there are too few live interpreters and bilingual staff at the clinics and the phone/online services do not work well. Participants also shared that cultural competency training with staff may lead to a better patient experience.

Community resources

Participants cited Somali Community Resettlement Services as a resource that helps them schedule appointments. HealthFinders Collaborative also assists patients with determining MNsure and Allina Health Partners Care eligibility.

Ideas and opportunities

Both the Latinx and Somali groups said they would like more interpreters and bilingual staff at clinics. The Latinx group shared that offering Spanish language options via phone and *My Allina* would be helpful for scheduling appointments. Community members also proposed that Allina Health hire South Central College graduates, which could address jobs and increase staff diversity in clinics. To be more welcoming, participants suggested Somali greeters, cultural competency training and increased compassion in patient care.

Housing and transportation

Challenges

Latinx and Somali residents both said their communities struggle to find affordable housing. Many Somali families cannot find rental properties for bigger families, citing examples of eviction after the birth of a new baby. Lack of transportation emerged as a significant barrier as many people struggle to get to clinics, especially specialists outside of the immediate area. Latinx and Somali residents also said it is hard to get to English learning classes, which they need so they can find jobs. Also mentioned was the policy for Faribault School District transportation that children within 2 miles of the High School are not provided bussing, which creates barriers to attending school, particularly in the winter months, or leads to students arriving late to school after assisting younger siblings with getting on the bus.

Transportation challenges also cause social isolation for new mothers. The Latinx group described overall safety concerns at a mobile home park where many people live, as well as inadequate and unsafe bussing from this location to schools.

Community resources
Focus group participants listed Somali Community Resettlement Services, Three Rivers Community Action, Faribault Education Center and the Minnesota CareerForce as agencies that help connect them to resources for housing, transportation and jobs.

Ideas and opportunities
Community members suggested improving transportation options. They also shared the need for bigger, affordable housing options, housing policy advocacy and financing options and more safety features, such as lighting, sidewalks, speed bumps and additional police patrols in some neighborhoods.

Mental health and substance abuse

Challenges
Community members and health care providers identified a significant lack of mental health providers and substance abuse treatment options in their community. There is also a lack of information about services that are available and their costs. Many people lack comprehensive health insurance that covers mental health or substance abuse treatment. Stigma exists around seeking treatment, and there is a tendency to reach out to faith communities before mental health providers. The teen group and health care provider group identified the negative effects of social media on youth mental health. Vaping, CBD use and peer pressure to engage in substance use were noted as rising concerns among teens. Health care providers also mentioned the correlation between marijuana use and anxiety.

Community resources
Focus group participants listed West Hills Social Commons, Mayo Clinic Health System's Discover Gratitude journaling program, Steele County Free Clinic, Healthy Seniors, school social workers and local Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) as community resources.

Ideas and opportunities
Community members suggested adding more mental health professionals to the community and additional resources, such as a walk-in mental health clinic and a multi-lingual mental health hotline. Faith leaders should be trained on mental health and substance abuse awareness and resources. Existing resources such as AA, NA and Employee Assistance Programs should be advertised and enhanced to increase awareness and use. Participants mentioned school outreach to teach healthy coping skills and stress management to teens. Focus group members also requested a community center that would allow for relationship-building, connections to mental health services and collaboration between resources.

Obesity

Challenges
Participants expressed the need for community support to be healthy. One group noted that the cost of healthy food, particularly vegetables in the winter, is a barrier to healthy eating. People in the Latinx group shared that mental health and physical health are intertwined and that food insecurity can contribute to stress and depression. Food insecurity also limits healthy choices.

Community resources
Focus group participants listed local Parks and Recreation departments, Faribault Community Center, West Hills, River Bend Nature Center, St. Vincent de Paul, Senior Centers, Community Café, Fare for All and local farmers markets as community resources.

Ideas and opportunities
Participants suggested improving community design so physical activity and healthy eating become part of people's everyday life. Other healthy eating strategies included providing nutrition

education, cooking classes and greater access to farmers markets and community gardens. They also suggested addressing the connection between stress and healthy behaviors.

To increase physical activity, participants suggested promoting existing fitness activities and creating additional ones for families and seniors. Participants desired more physical activity opportunities, such as an affordable community bike program and a community wellness center like a YMCA. Other ideas centered around workplace wellness committees and establishing walking groups.

2020–2022 IMPLEMENTATION PLAN

After confirming their priorities with the community and gathering ideas for action, the hospitals' final phase of the CHNA process was to develop an implementation plan that includes goals, strategies, activities and indicators of progress.

As part of this final phase, hospital staff met in February and April 2019 with leaders from each of Allina Health's nine community engagement regions to discuss the results of each hospital's data review, prioritization and community input processes. Together, they identified mental health (including substance use) and obesity caused by physical inactivity and poor nutrition as priority needs in all or most geographies. They also identified social determinants of health, particularly access to healthy food and stable housing, as key factors contributing to health.

Based on this process, Allina Health will pursue the following systemwide priorities in 2020–2022:

- Mental health and substance use
- Social determinants of health
- Healthy eating and active living

By developing systemwide initiatives to address these priorities, Allina Health ensures efficient use of resources across its service area, and provides hospitals with programs they can adapt to meet their communities' unique needs.

The hospitals' final implementation plans incorporate Allina Health's systemwide strategies and activities and local ones. They integrate community input, evidence-based strategies (i.e., strategies whose effect has been proven) and promising ideas with potential for addressing the priorities. The plan reflects programs and services available through other organizations in the community, the hospitals' resources and Allina Health's systemwide contributions. To make progress in achieving health equity among residents in their service areas, the hospitals will prioritize partnerships and activities that will engage populations that have been historically underserved and experience health disparities.

PRIORITY 1: MENTAL HEALTH AND SUBSTANCE USE

Goal 1: Increase resilience and healthy coping skills.

Strategies

- Increase resilience among school-age youth.
- Increase social connectedness and community-wide resilience efforts.

Activities

- Offer Change to Chill™ programming in at least one additional high school every year, and continue to support the current Change to Chill™ schools, as requested.
- Enhance and promote Health Powered Kids™ mental health and wellness programming to schools in Dodge and Steele counties.
- Provide charitable contributions to community organizations and programs that increase resilience and social connectedness, especially among seniors and people from racial and ethnic minority communities and other historically underserved communities.
- Promote employee volunteer opportunities with food programming organizations to increase social connectedness for seniors.
- Support student-led activities that focus on assets and virtues.
- Participate in the Steele County Safe and Drug Free Coalition and Rice County Chemical and Mental Health Coalition focused on reducing adolescent substance use.

Goal 2: Reduce barriers to mental health and substance use services.

Strategies

- Decrease stigma associated with seeking help for mental health and substance use conditions, with a particular focus on the experiences of racial and ethnic minorities and other historically underserved communities.
- Improve access to adolescent mental health and substance use services.

Activities

- Enhance mental health and substance use stigma elimination components of Change to Chill™.
- Promote stigma elimination education and messaging, particularly in May and October mental health awareness months.
- Support and advocate for local and state policies aimed at increasing mental health and substance use services and improving access to them.

PRIORITY 2: SOCIAL DETERMINANTS OF HEALTH—HOUSING, TRANSPORTATION AND CULTURAL COMPETENCY

Goal: Reduce social barriers to health for Allina Health patients and communities.

Strategies

- Establish a sustainable, effective model to systematically identify and support patients in addressing their health-related social needs.
- Establish a sustainable network of trusted community organizations that can support patients in addressing their health-related social needs.
- Increase support of policy and advocacy efforts aimed at improving social conditions related to health.

Activities

- Support the successful implementation and evaluation of the Accountable Health Communities model at participating sites.
- Champion development of and support transition to an Allina Health systemwide strategy and care model to identify and address the health-related social needs of our patients.
- Implement a process to identify key community partners and support their sustainability through financial contributions, exploration of reimbursement models, employee volunteerism and policy advocacy.
- Design and implement a process with community organizations to facilitate tracked referrals that connect patients to community resources.
- Participate in and support community coalitions aimed at improving access to transportation, housing and food, including connecting Allina Health resources, expertise and data to these groups, as appropriate.
- Implement local customized "Intercultural Effectiveness" staff training specific to Somali and Latinx cultures, hosted in partnership with HealthFinders Collaborative

PRIORITY 3: OBESITY

Goal: Increase healthy eating and physical activity among community residents.

Strategies

- Increase access to healthy food, particularly access to vegetables and fruits for residents who experience food insecurity.
- Support an increase in physical activity, especially for people from diverse communities and seniors.

Activities

- Provide grants, charitable contributions and employee volunteer opportunities to healthy food-related activities and organizations.
- Actively contribute to and participate in community coalitions and partnerships related to healthy food and active living.
- Direct charitable contributions to food shelves and other community food partners.
- Direct Allina Health Bucks resources to programs serving residents and patients experiencing food insecurity.
- Recruit local Parks and Recreation departments, nature centers and nonprofit organizations to accept Allina Health Bucks and other forms of alternative payment.
- Participate in healthy food drive events that support area food shelves.
- Support physical activity opportunities, especially for people from diverse communities and seniors.
- Advocate for transportation policies that support access to physical activity and recreational opportunities.

COMMUNITY PARTNERS

Local public health SHIP, HealthFinders Collaborative, Free Clinic of Steele County, local Parks and Recreation departments, local food shelves, St. Vincent de Paul, Community Café, Fare for All, University of Minnesota-Extension, River Bend Nature Center, local public and private school districts, Northfield Healthy Community Initiative, United Ways of Rice and Steele Counties and area farmers markets.

RESOURCE COMMITMENTS

To effectively implement these strategies and activities, District One and Owatonna will commit financial and in-kind resources, such as specific programs and services, staff time to serve on community collaborations and volunteers for community organizations.

EVALUATION OF ACTIVITIES

District One, Owatonna and Allina Health will continue to engage in assessment and engagement activities throughout the implementation phase. The hospitals will develop specific work plans for implementing the strategies and activities outlined in the implementation plan. During the 2020–2022 CHNA period, the hospitals will monitor community-specific health indicators to adjust their activities as needed. They will also track process measures, such as people served and dollars contributed, to monitor progress on planned activities.

Where possible, Allina Health will assess outcome metrics to monitor the impact of its activities on health and related outcomes. It will establish or continue evaluation plans for specific programs and initiatives (e.g., Change to Chill™), and monitor population-level and community-specific indicators related to identified priorities (see Appendix).

CONCLUSION

Through the MAPP and CHNA processes, District One and Owatonna used data and community input to identify health priorities they will pursue in 2020–2022 with their own strategies and activities and Allina Health programs and initiatives.

For questions about this plan or implementation progress, please contact Natalie Ginter, Community Engagement Lead for South Regional region or Christy Dechaine, Community Benefit and Evaluation Manager.

Copies of this plan can be downloaded from Allina Health's website: https://www.allinahealth.org/about-us/community-involvement/need-assessments.

ACKNOWLEDGEMENTS

Staff at Allina Health would like to thank these partners for making this assessment and plan possible:

- The many community members who offered their time and valuable insights.
- Staff from organizations and local public health departments who met to review and prioritize data and develop implementation plans.
- Allina Health System Office staff and interns who supported the process throughout, particularly Emma Wolf, Leah Jesser and Bri Wagner.
- Other staff at Allina Health and District One and Owatonna who provided knowledge, skills and leadership to bring the assessment and plan to fruition.

APPENDIX: ALLINA HEALTH SYSTEMWIDE PERFORMANCE INDICATORS

Health Priority	Example program-specific, intermediate outcomes	Long-term population health outcomes
Mental health and substance use	• Increase in coping self-efficacy among students exposed to CTC messaging. • Changes to state and local policies aimed at improving access to mental health and substance use services successfully implemented.	• Increased percent of Rice, Dodge and Steele counties' adults reporting they receive the social and emotional support they need always or usually (Behavioral Risk Factor Surveillance System (BRFSS)). • Increased percent of Rice, Dodge and Steele counties' students reporting they "find good ways to deal with things that are hard in [their] life" (Minnesota Student Survey (MSS)). • Increased ratio of population to mental health providers (County Health Rankings).
Social determinants of health	• Reduced percent of patients screening positive for one or more health-related social needs (food, housing, transportation, utility payment and safety). • Increased staff confidence in ability to support patients in addressing their health-related social needs.	• Reduced percentage of Rice, Dodge and Steele counties' adults reporting they sometimes or often could not afford to eat balanced meals (BRFSS). • Reduced percentage of Rice, Dodge and Steele counties' households (renters and homeowners) using more than 30 percent of income on housing costs (MN Compass).
Healthy eating and active living	• Specific measures in development.	• Reduced percentage of Rice, Dodge and Steele counties' adults engaging in no leisure time physical activity (BRFSS). • Increased percentage of Rice, Dodge and Steele counties' ninth graders who were physically active for 60 minutes or more on at least five of the last seven days (MSS). • Reduced percentage of Rice, Dodge and Steele counties' adults eating less than five servings of fruit and vegetables daily (BRFSS). • Increased percentage of Rice, Dodge and Steele counties' ninth graders consuming at least one serving of fruit and one serving of vegetables daily (MSS).
Access to care	• Improved care utilization (e.g. reduced ED utilization, readmissions and no-show rates) among patients receiving support in addressing their health-related social needs via the Accountable Health Communities model.	• Reduced percentage of Rice, Dodge and Steele counties' adults who self-report that they do not have a primary care provider (BRFSS).

Allina Health
DISTRICT ONE HOSPITAL

Allina Health
OWATONNA HOSPITAL