Executive Summary

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.

INTRODUCTION

Allina Health is a nonprofit health system dedicated to the prevention and treatment of illness and enhancing the greater health of individuals, families and communities throughout Minnesota and western Wisconsin. It cares for patients through more than 90 clinics, 11 hospitals, 13 retail pharmacies, and specialty care centers and medical services. Every three years, as part of its mission to serve communities, Allina Health and its hospitals conduct a federally-required Community Health Needs Assessment (CHNA) to examine health in the communities it serves, identify health priorities and develop strategies and action plans to address them. The hospitals conduct their CHNA in partnership with local public health departments, other hospitals and health systems, community organizations and residents.

Hospital and Community Description

Allina Health has more than 29,000 employees; each year, there are more than 6.5 million visits to its hospital and clinics. Though Allina Health serves patients from a wide geographic area, its primary service area (and the focus of this CHNA) are the counties surrounding its hospitals and clinics, including the seven-county Twin Cities Metro and suburban and rural communities in western Wisconsin, southern Minnesota and central Minnesota.

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

To respond to local needs and resources, each Allina Health hospital conducted its 2020–2022 CHNA independently. The hospitals worked closely with local public health. Some also collaborated with other health systems and community organizations. Where possible, the hospital aligned their process with assessments being conducted by local public health and other community agencies. In many cases, the hospitals conducted the CHNA jointly with partners, with shared leadership throughout.

The CHNA process occurred in three steps: data review and prioritization, community input and the development of a three-year implementation plan. Most hospitals used the Mobilizing for Action through Planning and Partnerships (MAPP) community-driven strategic planning process for improving community health. The official CHNA process began in June 2018 and was completed in August 2019.

Data Review and Local Prioritization

Each hospital’s CHNA team reviewed county-specific data related to demographics, social and economic factors, health behaviors, prevalence of health conditions and health care access. Sources
varied, but included the Minnesota Student Survey, health surveys conducted by local public health departments, local research studies on topics such as housing and secondary public health data available through the Minnesota Department of Health. Additionally, teams reviewed select county-specific Allina Health patient data. Many hospitals also collected feedback on perceived community health needs from local stakeholders through community dialogues, interviews and surveys.

Based on the data review and community feedback, local CHNA teams chose CHNA priorities for the 2020–2022 cycle. Hospital priorities include:

- Mental health and wellness, including substance use
- Obesity, physical activity and nutrition
- Access to care
- Social determinants of health
- Social isolation
- Violence
- Dental care
- Aging services

Specific prioritization criteria was determined locally, but size and seriousness of the problem, importance to the community and organizational capacity to address the need were all considered.

### Community Input

To increase their understanding of community members’ perspectives on identified health issues and ideas for addressing them, staff solicited input from individuals representing the broad interests of the community such as staff from social service and public health organizations and residents. Staff collected feedback through a range of methods, including focus groups and interviews. Focused outreach occurred to historically underserved communities who experience health disparities.

Community Input Results

Community members described mental and physical health as interrelated with broader challenges such as poverty and discrimination. These issues, along with housing shortages, transportation barriers and limited access to healthy food affect people's ability to maintain health, engage in healthy behaviors and access care.

Factors described as contributing to substance use and poor mental wellness included social isolation, stress and experiences with trauma. Stigma and limited service options, particularly for adolescents, were identified as barriers to mental health and substance use care. E-cigarette use, opioids and youth access to alcohol were common substance use concerns.

Community members shared many barriers related to being physically active and eating healthy. The easy availability, lower cost and advertising of fast food contribute to unhealthy diets while higher prices of healthy food are a barrier to eating nutritious food. A shortage of free or affordable exercise opportunities make it difficult for people to

### 2017–2019 CHNA IMPLEMENTATION HIGHLIGHTS

In its 2017–2019 Community Health Needs Assessment, Allina Health adopted obesity and mental health as systemwide priorities. With community partners, Allina Health implemented community health improvement initiatives, advocated for health-promoting policies and made grants and charitable contributions to community organizations. Highlights included:

- Equipping nearly 300 school and community professionals to engage with teens, parents and guardians around mental wellness through the [Change to Chill](#) train-the-trainer program.
- Reaching more than 10,000 high school students through the [Change to Chill School Partnership](#).
- Providing community education lessons and activities designed to help children ages three to 14 years to make healthier choices about eating, exercising, keeping clean and managing stress through the free [Health Powered Kids](#) program.
- Collecting 28,348 pounds of healthy food that was distributed to 250 local food shelves.
- Implementing the CMS Accountable Health Communities model at 75 clinics and 3 hospitals to screen patients for social needs such as housing and food instability.
be physically active. Seniors and cultural minorities expressed difficulty accessing appropriate physical activity opportunities.

Increasing cultural competence and being more welcoming of racial and ethnic minorities and LGBTQ communities has been identified as an opportunity for Allina Health in both metro and regional communities. Immigrant communities also described challenges interacting with health care because of language and insurance barriers.

Systemwide Prioritization
In February and April 2019, community engagement leaders from each of Allina Health’s hospitals discussed the results of each hospital’s data review, prioritization and community input processes. Priorities and common themes for action were identified across all geographies. Together, they identified mental health (including substance use) and obesity caused by physical inactivity and poor nutrition as priority needs in all Allina Health 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:

1. Mental health, including substance use
2. Social determinants of health
3. Healthy eating and active living

Implementation Plan
Based on community input, Allina Health hospitals developed a systemwide 2020–2022 implementation plan that outlines the strategies and activities it will pursue to address its health priorities. In addition to the systemwide plan, each hospital will pursue local strategies and activities. To make progress in achieving health equity among residents in its service area, Allina Health will prioritize partnerships and activities that engage historically-underserved populations.

2020–2022 IMPLEMENTATION PLAN

Mental Health and Wellness
Goal 1: Increase resilience and healthy coping. Strategies
• Increase resilience among school-age youth.
• Increase social connectedness and community-wide resilience efforts.

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.
• Increase support of policy and advocacy efforts aimed at improving access to mental health and substance use services.

Activities will include expanding Change to Chill™ and Health Powered Kids™ to more schools; supporting grassroots resilience and social-connectedness efforts; developing initiatives to address social isolation; enhancing stigma elimination content in Change to Chill; promoting stigma elimination messaging in community; and advocating for local and state policies aimed at increasing access to mental health and substance use services.

Social Determinants of Health
Goal: Reduce social barriers to health. Strategies
• Establish a sustainable, effective model to systematically identify and support patients in addressing health-related social needs.
• Establish a sustainable network of trusted community organizations that can support patients with these needs.
• Increase policy and advocacy efforts to improve social conditions related to health.
Activities will include supporting implementation and evaluation of the Accountable Health Communities model and transitioning to a modified version; identifying social service providers with which to collaborate on a two-way referral process to connect patients to them; and supporting coalitions aimed at improving access to transportation, housing and food.

**Healthy Eating and Active Living**

**Goal:** Increase physical activity and healthy eating.

**Strategies**

- Promote nutrition and physical activity.
- Improve access to healthy food.

Activities will include providing charitable contributions and volunteers to organizations that support access to healthy food and providing healthy eating and active living lessons to the community through Health Powered Kids.

**Community Partners**

Allina Health hospitals will collaborate closely with other agencies to pursue their identified strategies. Key community partners include health departments, schools, local government and law enforcement agencies, civic organizations, community-based mental health providers, social service agencies, local federally-qualified health centers, food shelves and faith-based organizations.

**Resources**

To fulfill the implementation plan, Allina Health will contribute financial and in-kind donations such as personnel, charitable donations and Allina Health’s systemwide programs. It will also encourage staff to volunteer with local organizations.

**Evaluation Plans**

Hospitals will monitor their progress on their implementation plans by tracking process measures, such as number of people served, staff time dedicated and dollars contributed. Allina Health will also evaluate systemwide programs to assess their effects on intermediate outcomes (e.g., physical activity), which evidence shows are likely to lead to improvement on population health measures. To assess long-term effects, Allina Health will monitor population-level indicators related to local and systemwide priorities.

**CONCLUSION**

Through the CHNA process, Allina Health hospitals used data and community input to identify health priorities it will pursue in 2020–2022.


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- Other staff at Allina Health and local hospitals who provided knowledge, skills and leadership.

For more information, please contact Christy Dechaine, manager, Community Benefit and Evaluation.