Allina Health

NEW ULM MEDICAL CENTER

2023–2025

Community Health Needs Assessment and Implementation Plan

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Introduction

New Ulm Medical Center (NUMC) is 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 working with community members to systematically identify community health priorities and create a plan for addressing them. Each CHNA builds on the learnings from the previous cycle as well as ongoing community dialogues and assessment activities conducted by hospital staff.

The CHNA process is completed 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 health priorities and opportunities to increase health equity 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 Allina Health can partner with and support to improve health.
- Create an implementation plan outlining strategies and activities 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 community served by NUMC and the implementation plan to address those needs in 2023–2025. This report also highlights the hospital's 2020–2022 activities to address needs identified in the 2019 assessment.

ABOUT ALLINA HEALTH

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 not-for-profit health care system, Allina Health cares for patients from beginning to end-of-life through its 90+ clinics, 10 hospitals, 15 retail pharmacies, 52 rehabilitation locations, 2 ambulatory care centers, specialty care centers and specialty medical services that provide home care, hospice care and emergency medical transportation services.

MISSION

We serve our communities by providing exceptional care, as we prevent illness, restore health and provide comfort to all who entrust us with their care.

2023–2025 CHNA PRIORITIES

Based on the process described in this report, NUMC will pursue the following priorities in 2023–2025:

Mental health and wellness encompasses overall mental, social and emotional well-being including social support, sense of belonging in one's community, resilience and access to the full continuum of mental health care and supports.

Substance misuse, including tobacco use includes preventing, delaying or reducing harm associated with using substances such as alcohol, tobacco, e-cigarettes, marijuana, opioids and other drugs in a way that leads to physical, social or emotional harm.

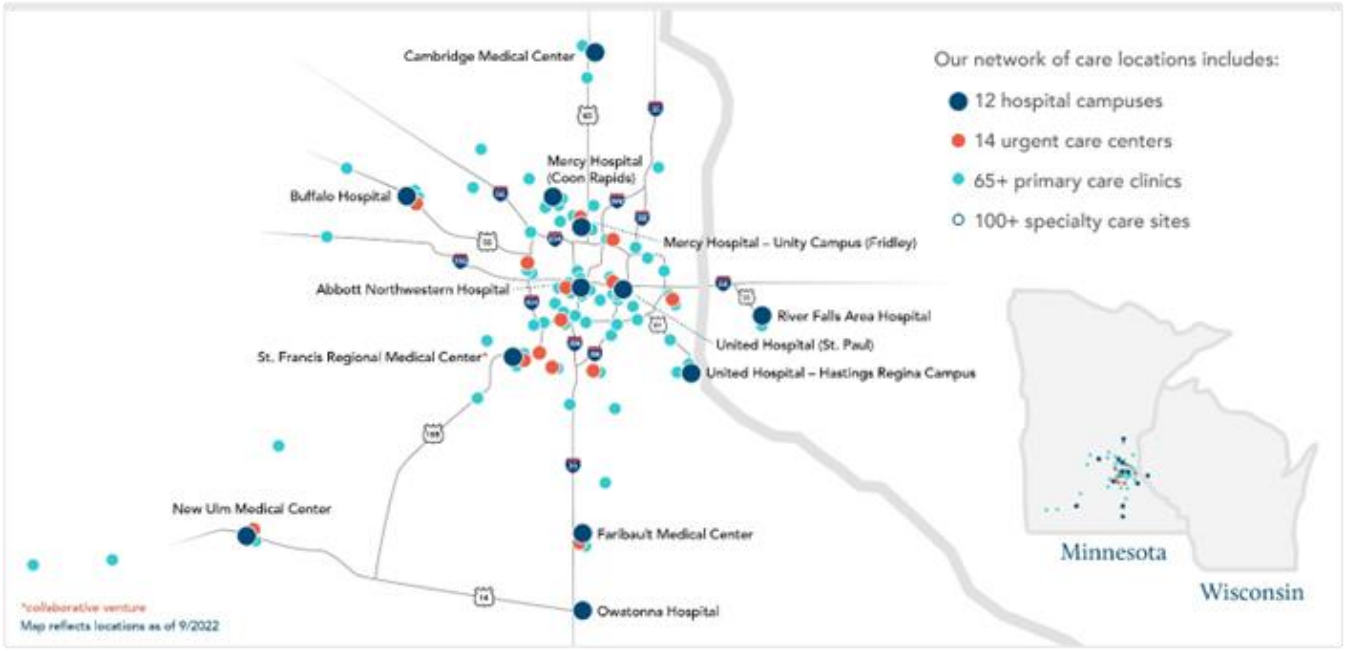
Obesity, including healthy eating and active living refers to issues related to diet and exercise including chronic diseases closely tied to health habits (e.g., heart disease, stroke), food insecurity and equitable access to opportunities for physical activity.

Additionally, NUMC prioritized the following communities for the 2023–2025 CHNA cycle:

- People living in or near poverty, including Brown County zip codes and neighborhoods with limited resources and/or high percentage of residents living in poverty (all three priorities)
- Specific age groups:
  - Obesity priority: ages 25–44
  - Mental Health priority: all ages — youth to senior citizens
  - Substance Use: youth and ages 25–44

Hospital and community description

ALLINA HEALTH SYSTEM MAP



HOSPITAL DESCRIPTION AND SERVICE AREA

NUMC is a nonprofit hospital with clinics in New Ulm, Springfield, Lamberton and Winthrop. Its primary service area (and focus of the CHNA) is Brown County, a rural community in southern central Minnesota. The hospital offers an extensive range of care options with more than 70 affiliated physicians and nurse practitioner (NP)/physician assistant (PA) providers and a full complement of visiting specialists. Among the many important services Allina Health offers to this rural region are obstetrics, surgery, mental health/addiction, home care, hospice and emergency medical services (EMS). In 2021, NUMC was named one of the Top 100 Critical Access Hospitals in the United States by the Chartis Center for Rural Health for the 10th time. NUMC is the only hospital in Minnesota and one of only three hospitals in the United States to make this list 10 times.

DIVERSITY, EQUITY, INCLUSION AND BELONGING

Allina Health is committed to improving the health of all people in our communities by leveraging our collective organizational strength as a care provider, employer, purchaser and community partner to eliminate systemic inequities and racism. As a community partner, Allina Health collaborates with community members, organizations and policymakers to improve the health of all people in our communities and to focus our community health improvement initiatives and investments to improve health equity. These commitments serve as the guiding principles of our CHNA approach, including the assessment process, implementation of initiatives, partnerships and methods of evaluation directed at tracking and addressing health disparities in our community.

Allina Health Diversity, Equity, Inclusion and Belonging Definitions

- **Diversity:** Embracing and investing in our differences to create a better us.
- **Inclusion:** Cultivating a safe environment where you always bring your whole self, contribute, and thrive.
- **Equity:** Providing access to opportunities that support our communities' ability to reach its full potential. Creating solutions, informed by an understanding of unique needs that eliminate barriers to success and fill in opportunity gaps.
- **Health Equity**: "*Everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."* — Robert Wood Johnson Foundation
- **Belonging**: When individuals or groups feel supported and safe because there is a sense of acceptance, inclusion and respect for who they are.

COMMUNITY DEMOGRAPHICS

Brown County is ranked in the higher middle range of health among counties in Minnesota by County Health Rankings. However, these rankings do not account for differences within counties. There are significant socio-economic disparities among families living in Brown County.

According to the U.S. Census Bureau, 25,912 residents live in the 611.1-square mile area occupied by Brown County. About 22 percent of the total population in Brown County is under 18 years of age. Like Minnesota as a whole, Brown County is becoming increasingly diverse. Approximately 5 percent of residents are people of color — primarily Hispanic or Latine (4 percent). In 2020, more than 2 percent of residents were foreign-born, and 1 percent had limited English proficiency. Nearly 10 percent of county residents have a disability. The median household income in 2020 was $59,804, with 7 percent of residents living in households with income below the Federal Poverty Level (U.S. Census Bureau, 2016–2020 American Community Survey 5-Year Estimates).

Many residents face the same health concerns common across the United States. For example, residents report an average of four poor mental health days per month and 14 percent of residents report fair or poor health. Approximately 35 percent of area adults are obese, which is an increase over the last three years (County Health Rankings, 2022). Many residents also struggle to access health care. Although more people are insured than in the past, 5 percent of residents are uninsured. Furthermore, Brown County has a 480:1 ratio of residents to mental health providers compared with Minnesota's overall mental health provider ratio of 340:1 (County Health Rankings, 2022).

Most of a person's health is determined by factors outside of traditional medical care, such as race, income, ability and gender. As such, community health status is influenced by these factors. For example, Feeding America estimates 1,570 people in Brown County (approximately 6 percent) experienced food insecurity in 2020 and an estimated 18 percent of households are considered cost burdened (U.S. Census Bureau, 2016–2020 American Community Survey 5-Year Estimates). Additionally, though renter-occupied households account for nearly 21 percent of all the housing in Brown County, an estimated 40 percent of those households are considered cost burdened. Additional information about Brown County can be found at Minnesota Compass.

Evaluation of 2020–2022 implementation plan

In its 2020–2022 Community Health Needs Assessment and Implementation Plan, NUMC adopted obesity, including healthy eating and active living; substance use, including tobacco use; and mental health as its health priorities. It addressed these priorities between 2020 and 2022 through local and systemwide activities. Because mental health, including substance use, and obesity caused by physical inactivity and poor nutrition were identified as priorities for the entire service area, Allina Health also adopted them as 2020–2022 systemwide priorities. Additionally, social determinants of health, particularly access to healthy food and stable housing, were identified as key factors contributing to all elements of health.

The COVID-19 pandemic affected the scope and focus of work in 2020 and 2021 for all Allina Health hospitals and many activities were postponed or cancelled. While the pandemic hurt all communities, it did not do so equally. It is clear the disproportionate impact of COVID-19 on communities of color has been compounded by systemic inequities and the ongoing experiences of racial and community trauma. Many of the activities below reflect a focus on recovering from the effects brought forth in 2020 and 2021, along with a renewed commitment to reduce health disparities for every person in our community.

SYSTEMWIDE ACTIVITIES

Allina Health provided each of its hospitals with resources to address mental health and wellness, physical activity and active living and social determinants of health through the following activities:

Community health improvement programs

Allina Health's community health improvement programs offer free online resources to support community health and wellness at any stage of life.

Change to Chill

Change to Chill™ (CTC) supports teen mental health by partnering with schools and offering free online stress reduction tips, life balance techniques and health education services.

In 2020, COVID-19 provoked fear, stress and anxiety, with a large effect on youth and their mental wellness. The number of people visiting the Change to Chill website nearly doubled from approximately 25,000 to more than 58,000 people visiting the website that year. The program pivoted to meet the changing needs of community by offering a virtual care package for families to help them address mental health together. Change to Chill also transformed in-person trainings to virtual well-being classes for all, including more than 30 community presentations and trainings for school and staff. Change to Chill also began offering new online resources such as tools to help students sort out complicated feelings and cope with grief, loss and change and practice healthy communication during challenging times.

Additionally, in 2020 and 2021, Change to Chill partnered with Hennepin County Public Health to create and provide content on identity, discrimination and mental health. This work focused on providing culturally specific mental well-being resources for youth most impacted by COVID-19 including Black, Indigenous, Latine, and Lesbian, Gay, Bisexual, Transgender and/or Queer youth and their parents. Allina Health continued to build on these efforts in 2021 and launched Change to Chill in Spanish, which more than 2,000 people accessed in the first year. More resources tailored to the mental well-being of these youth and content on "Stress and Identity" will be launched in 2022.

To support a culture of well-being in local schools, the program has included the Change to Chill School Partnership (CTCSP) since 2018. Components of CTCSP include staff training on Change to Chill, a paid student internship and funding for a "Chill Zone" — a designated space in the school for students and staff to practice self-care. Evaluations of CTCSP have shown increases in confidence in ability to cope with stress among students who participate in program components. CTCSP has also received positive feedback from school staff regarding the highly effective nature of Chill Zones. From 2020–2022 Allina Health has partnered with 60 schools to deliver the program. NUMC specifically supported three schools via continued partnership with New Ulm, Red Rock Central, and Springfield High Schools. NUMC also supported one new partnership with New Ulm Middle School. In total, these efforts reached approximately 1805 students and 150 school staff completed a training with the program.

> **"Students are entering and using the [Chill Zone] to take a break in order to return to class with a better mindset.**
>
> –School staff person

Health Powered Kids

Health Powered Kids™, launched in 2012, is a free community education program featuring 60+ lessons and activities designed to empower children ages 3 to 14 years to make healthier choices about eating, exercise, keeping clean and managing stress. More than 100,000 people visit the Health Powered Kids website each year. In a 2021 survey, 84 percent of people "agreed" or "strongly agreed" the program increased their knowledge of youth and/or adolescent health and wellness, and 87 percent "agreed" or "strongly agreed" it increased knowledge of health and wellness among the young people using the program.

Hello4Health

Hello4Health™ is a new online resource created in response to the 2019 CHNA which identified social isolation as a factor contributing to poor mental wellness among adults across all geographies. Allina Health developed the program in 2020 and launched it in April 2021 with a focus on older adults. Components include education on the important role social connections play in positive health outcomes, suggested activities and skill-building tools for connecting with others. Because older adults and people with disabilities disproportionately experience feelings of social isolation, Allina Health partnered with Accessible 360 to take steps to enhance the accessibility of the website and conform to Web Content Accessibility Guidelines (WCAG) 2.0, Level AA guidelines. In 2021, 9,488 people living in Minnesota or Wisconsin visited the Hello4Health website. In 2022, Allina Health began to refer patients who self-identify as lonely or socially isolated to the website.

Be the Change

Be the Change was a campaign to eliminate stigma around mental health and addiction conditions at Allina Health and ensure all patients receive the same consistent, exceptional care. At the campaign's launch, 500 Allina Health employees volunteered to lead the effort. They became trained Be the Change Champions and helped educate and generate awareness among their colleagues about mental health and addiction conditions through presentations and education events. In 2020, Be the Change transitioned from a campaign to an Employee Resource Group (ERG). The purpose of this group is to create an inclusive, welcoming and supportive environment for people living with disabilities, mental health conditions and/or addiction and continue to work to eliminate stigma around mental health, addiction and disability conditions. In 2021, 129 individuals participated in the ERG. Key activities included: providing $1,250 ($416/each) in charitable contributions to three organizations: Survivor Resources, Division of Indian Work and the Disability Law Center; hosting quarterly member meetings with guest speakers; and hosting or co-hosting eight events to promote stigma reduction across the entire 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 $220,000 to healthy eating initiatives across its service area in 2020 and 2021, including $5,000 in NUMC's region. Allina Health launched a partnership with the non-profit organization Every Meal to connect patients with crisis food support. Through this partnership, Allina primary care clinics can provide free bags of nutritious, non-perishable food to patients who identify as food insecure. These meal bags are tailored for a variety of dietary preferences including East African, Latine and Southeast Asian preferences.

> **[My navigator] helped me a lot. [Working with them] made me aware, when we run out of food, and we don't have anything, I have access to resources that I didn't know I had access to.**
>
> –Allina Health patient

Accountable Health Communities model and Health Related Social Needs Program

Because social conditions such as food and housing inhibit access to care and contribute to chronic disease, in 2018 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 screened 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 identified needs, the care team provided a list of community resources. Some high-risk patients received assistance navigating to these resources.

From June 2018 through January 2022, more than 166,000 patients completed an AHC screening with 28 percent identifying at least one need. The most frequently identified needs were food insecurity and housing instability. Patients with needs were more likely to be female; report a race of Black/African American, Multi-racial, or Native American/Alaska Native; report Hispanic ethnicity; and be younger than those without needs. Patients who use both Medicare and Medicaid insurance ("dual-eligible") were the most likely to report a need (46 percent) while those with only Medicare were least likely to report a need (14 percent). Every county demonstrated racial and ethnic disparities in need rates. Allina Health defines its equity population as any patient who does not identify as white, non-Hispanic, U.S.-born, or note English as their preferred language (i.e., the "comparison population").

The AHC Cooperative Agreement ended in April 2022. At the end of 2021, Allina Health began developing an Allina Health-specific model for screening and addressing health-related social needs, the Health-Related Social Needs (HRSN) Program. In the first six months of implementing the HRSN Program, more than 85,000 patients were screened, 16 percent of whom identified a need. Additionally, more than 4,500 patients with need requested and received assistance navigating to these resources.

COVID-19 vaccine clinics

To promote equitable health care access, Allina Health partnered with community organizations from February through July 2021 to host free COVID-19 vaccine clinics. The clinics were in and aimed at serving communities who have been disproportionately impacted by COVID-19 and have historically experienced health disparities. Allina Health invested nearly $350,000 in clinical staff time, changes to infrastructure, supplies and other expenses to offer these clinics. Additionally, nearly 300 of our dedicated employees and friends volunteered more than 1,000 hours of their time over the five-month period to serve in non-clinical roles like greeting individuals upon arrival, guiding individuals through the vaccine clinic and other activities. Through these COVID-19 vaccine clinics, Allina Health was able to vaccinate more than 4,400 people. Non-white and non-English speaking patients were well-represented. For example, the percentage of event attendees who identified as Hispanic/Latine was double that of the total eligible community population (8 vs. 4 percent). Similarly, 81 percent more Asian residents and 32 percent more Black residents attended than make up the total eligible community population (6 percent and 9 percent of attendees, respectively). Patients underutilizing healthcare were particularly well represented, with 49 percent of attendees having no eligible healthcare visits in the two years before their first community event vaccination.

Impact Investment Portfolio and supplier diversity investments

In 2021, Allina Health allocated $30 million to create and fund the Allina Health Impact Portfolio, aimed at supporting local economic development opportunities. In the first year, $2 million of the portfolio was invested and the remaining funds are expected to be invested over a three-year period. Additionally, Allina Health spent more than $18 million in supplier diversity investments. By providing capital through investments to local organizations, Allina Health can improve the health of our communities, while ensuring investments are equitable and aligned to our guiding principles and values.

LOCAL NEW ULM MEDICAL CENTER ACTIVITIES

The Heart of New Ulm (HONU) started as a collaborative partnership between the community of New Ulm, Allina Health/New Ulm Medical Center and the Minneapolis Heart Institute Foundation. Since 2009, the entire community has been working together to reduce heart attacks and support a culture of wellness in New Ulm. HONU is now a community-owned initiative that includes a 12-member Community Leadership Team and more than 70 community volunteers who serve on seven action teams. NUMC implemented its 2020–2022 CHNA Implementation Plan in partnership with HONU.

Goal 1: Reduce barriers to active living and healthy eating.

NUMC provided charitable contributions and employee volunteer opportunities to healthy food-related activities and organizations, such as local community food shelves. In addition to the charitable contributions described above, the medical center promoted volunteer opportunities at United Way of Brown County Area and on local HONU action teams. The hospital staff led monthly Food Environment Action Team meetings and partnered with local vendors to offer a Power of Produce (POP) day at the community farmer's market. The event is aimed at providing an opportunity for children to engage in the local food system and learn about produce. It included opportunities for children to speak with farmers, educational games and demonstrations and exposure to new fruits and vegetables. Seventy-five families participated. In addition, NUMC started a "Wellness the NU Way" campaign. Messaging was focused on eating more fruits and vegetables, screen-free meals and healthy snacks. Through various printed and social media efforts, the campaign reached a large portion of the county; an estimated 38,367 people viewed the billboard weekly and the healthy eating website page averaged 600 monthly views. The HONU Worksite Wellness Action Team also provided quarterly workplace wellness trainings that focused on healthy eating/active living, to local businesses. In 2020 and 2021,

165 participants from 48 different worksites attended these programs. To increase walking, the HONU Coalition for Active Safe and Healthy Streets Team partnered with the Safe Routes to School program to create a traffic playground and a pedestrian crossing flag program to make intersections safer. The Traffic Safety Playground is a mini-street painted play space that provides children and families with a fun space to practice safe walking, bicycling and scooting skills away from traffic.

Goal 2: Decrease addiction rates and use of legal and illegal substances.

In 2020, NUMC assisted the city of New Ulm to update their tobacco policy, using best practices from Public Health Law Center. During the October 20, 2020, meeting, city council adopted a Tobacco Free Parks, Trails and Recreation Facilities policy which became effective January 1, 2021. The hospital is also an active participant in the Brown County Chemical Health Action Team (started July of 2020). This team offered naloxone training to 18 community members in 2021. In 2022, they created a responsible drinking marketing campaign which consisted of printed material, billboards and educational resources for community members. In addition, NUMC staff presented the dangers of vaping at the New Ulm High School health class in December and partnered with the school to promote the Escape the Vape campaign. Staff also created social media messages on vaping for community partners to use.

Goal 3: Increase resilience and healthy coping in communities.

NUMC hosted two Question, Persuade, Refer (QPR) trainings with 22 community participants during Suicide Prevention Awareness month in September and October 2021. People trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade and refer someone to help. In addition, throughout 2020–2022, NUMC staff continued to be active participants in the HONU Mental Health and Wellness Action Team. This team is comprised of NUMC staff and community experts and leaders. In 2020 the Mental Health and Wellness Action team obtained worksite commitments from five worksites to participate in The People Project, a five-month project that provides simple and effective tools to individuals, organizations and communities to promote health through happiness. From 2020–2022,14 worksites with a total of 1,508 employees have participated in the project. Evaluations have shown an increase in happiness measures among participating employees. Additionally, in 2022, the Mental Health and Wellness Action Team offered three workshops aimed at increasing individuals' resilience to the community. Two workshops were on Neuroscience, Epigenetics, Adverse Childhood Events and Resilience (NEAR) Science. The other workshop focused on trauma-informed care. In total, 113 community members attended.

Goal 4: Reduce barriers to mental health and substance use services.

In addition to promoting Change to Chill at local schools (described above), in 2020 NUMC created an online mental health resource directory, which transitioned onto the newly expanded HONU website in 2021. The directory lists local mental health resources available to community members, from those that are upstream/preventative to crisis based. Since the launch of the new website 96 people have downloaded the directory, making it the most downloaded document on the site.

2021–2022 CHNA process overview

To respond to local needs and resources, each Allina Health hospital conducted its 2023–2025 CHNA independently, with support and guidance from Allina Health System Office staff. NUMC conducted its CHNA in partnership with Brown County Public Health and the Heart of New Ulm (HONU). The CHNA process also included involvement from residents, community partners and stakeholders. It occurred in three steps: data review and prioritization, community input and the development of a three-year implementation plan which includes both local and systemwide activities. The impact of these efforts will be tracked and evaluated over the three-year cycle.

Allina Health serves communities that are geographically, culturally, racially and socio-economically diverse. We know systemic inequity and structural racism has led to variation in community health status by factors such as race, ethnicity, income, gender, current ability and more. To advance and improve health for all, Allina Health prioritizes investments to local populations facing the greatest need. To support these efforts, in 2022 Allina Health and each of its hospitals identified prioritized communities in addition to prioritized health topics.

Each CHNA builds on the learnings and changes from the previous cycle. The 2020–2022 CHNA priorities adopted by NUMC were obesity, including healthy eating and active living; substance use, including tobacco use; and mental health. These priorities are large and based on social determinants of health and ongoing experiences of community trauma. They require long-term effort to see significant, measurable improvement. Additionally, all these priorities were significantly exacerbated by the coronavirus pandemic, which emerged in 2020.

As a result, the goals of the 2022 CHNA were to:

- Confirm identified priorities remain relevant and significant to communities.
- Refine our understanding of these priorities, in particular, how the coronavirus pandemic, civil unrest and increased attention on systemic inequity change our understanding of these topics or approach to addressing them.
- Identify new or emerging community needs that may not be addressed through existing work.

NUMC, Brown County Public Health and HONU used a modified version of 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 planning. The MAPP process is cyclical with each phase and assessment informing the next. 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.

NUMC leadership received and approved the hospital plan. Allina Health Board of Directors gave final approval.

2021–2022 CHNA timeline

TIMING	STEPS
March–July 2021	**INITIAL PLANNING** Local and System Office staff meet to develop local 2022 CHNA plans, including expected CHNA teams and support and data needs.
July–September 2021	**ESTABLISH PLANNING TEAMS and COLLECT DATA** Staff establish initial assessment plans, identify stakeholder groups for each hospital and share results from current implementation strategy, as appropriate
October 2021–January 2022	**DATA REVIEW and ISSUE PRIORITIZATION** Regional teams meet with data review teams, using locally available data and working closely with public health. Allina Health data provided by System Office. Teams prioritize issues using locally agreed upon criteria.
January–February 2022	**DRAFT CHNA PRIORITIES** Community Benefit & Engagement staff review prioritized issues to summarize themes for the system. Draft system-wide implementation strategies shared with communities.
	DESIGN COMMUNITY INPUT Identify specific methods and audiences for community input on strategies, including process and questions/topics. Work with local stakeholders to recruit participants.
March–May 2022	**DATA COLLECTION and ACTION PLANNING** Conduct community input sessions to solicit action and implementation ideas related to priority areas identified in the data review and prioritization process and summarize information from each process.
June–October 2022	**LOCAL APPROVAL and REPORT WRITING** Present plans to local boards/committees/leaders for approval. Coordinate report writing and share results and action plans with key stakeholders systemwide.
December 2022	**SEEK FINAL APPROVAL** Present for final approval to the Allina Health Board of Directors in December.

Data review and issue prioritization

NUMC collaborated with local public health to complete its CHNA. In partnership with Brown County Public Health, staff engaged the Mobilizing for Action through Planning and Partnerships (MAPP) Committee. This group, started in 2019, includes representatives from the following HONU Action Teams:

- HONU Leadership Team
- Downtown Action Team
- Safe Routes to School Team
- Coalition for Active Safe and Healthy Streets
- Chemical Health Action Team
- Food Environment Team
- Mental Health and Wellness Team

HONU is a community-owned project aimed at supporting a culture of wellness in New Ulm. It is led by a volunteer Leadership team and community residents and local business owners serve on seven action teams, representing more than 35 organizations. In addition to local public health and the medical center, MAPP Committee members include 66 community residents and representatives from local schools, government, law enforcement, social service agencies, professional groups and business owners.

From October 2021 through February 2022, each of the teams described above reviewed select Allina Health patient data and local public health data provided by Brown County Public Health staff. Indicators were chosen based on priorities defined by the Center for Community Health and Allina Health equity priorities. Where possible, the data was disaggregated by race and ethnicity to better understand opportunities to increase health equity in the community and among patients seen at Allina Health facilities. Examples of indicators reviewed include, but are not limited to:

- Volume of Allina Health EMS ambulance runs by cities served in Brown County
- Patient and public health data by county of residence (Brown): demographic data (including race, ethnicity, language, age and insurance type), health-related social needs and select conditions
- Emergency room data: top three reasons for emergency room visits; suicide and self-inflicted injury encounters; and opioid overdose encounters
- Tobacco, alcohol and other drug use among adults and youth
- Rates of overweight and obesity
- Colorectal cancer screening rates
- Market analysis regarding expected demand for mental health and addiction services over time
- Suicide and self-harm ideation and deaths by suicide among adults and youth
- Substance use disorder treatment admissions for alcohol

Secondary data resources available for Brown County were also reviewed such as the 2019 Minnesota Student Survey, Minnesota Housing Partnership (MHP) County Housing Profiles and the 211 dashboard. In total, data included more than 30 indicators related to demographics, social and economic factors, health behaviors, prevalence of health conditions and health care access.

PRIORITIZATION PROCESS AND FINAL PRIORITIES

The MAPP methodology informed the prioritization process, but the working group did not move through all the stages of MAPP as most of those were completed during the 2019 implementation cycle planning. MAPP Committee members made the decision to do a “refresh” of the 2020–2022 priorities unless other pressing priorities arose through the data review process.

Members considered preexisting CHNA priorities and goals of Brown County in light of the data. Special consideration was given to how COVID has impacted the health of the community and the importance of addressing health-related social needs.

Based on the data review and feedback from local public health, New Ulm Medical Center prioritized the following health topics for 2023–2025:

- Obesity, including healthy eating and active living
- Substance use, including tobacco use
- Mental health

Based on community demographics and the indicators and discussion described above, NUMC prioritized the following communities for the 2023–2025 CHNA cycle:

- People living in or near poverty, including Brown County zip codes and neighborhoods with limited resources and/or high percentage of residents living in poverty (all three priorities)
- Specific age groups:
  - Obesity priority: ages 25–44
  - Mental Health priority: all ages — youth to senior citizens
  - Substance Use: youth and ages 25–44

NEEDS NOT ADDRESSED IN THE CHNA

Many of the health issues not included among the top three priorities will be addressed at varying levels of specificity via the implementation plan. For example, student safety in schools and stress among youth will be addressed through strategies under the mental health priority. Due to correlation with healthy eating and active living, high rates of cancer will be partially addressed through strategies under the obesity priority. The group also identified unsafe driving practices, decreasing rates of prenatal care, increase in youth pregnancies and the cost of oral health as important issues, but agreed that other organizations would be more effective in addressing them.

Community input

To incorporate additional community feedback, staff from NUMC developed a Conversation in a Box guide used by HONU leadership and NUMC staff to facilitate community conversations. Each person was asked to facilitate two to three conversations using the Conversation in a Box guide. This guide focused on discussing strategies to pursue each health priority and ways in which HONU and NUMC can best address identified community needs. MAPP Committee members reviewed and discussed conversation results and identified common themes.

Five to 10 people participated per conversation, totaling approximately 100 people altogether. Prior to the conversation, the facilitator reviewed select county health data from the review described above. Each conversation was approximately one hour in length. Participants included representatives from the following organizations:

- New Ulm Medical Center
- New Ulm Public Schools
- Sleepy Eye Public Schools
- Brown County Public Health
- Brown County Human Services
- New Ulm Police Department
- Brown County Probation
- South Central Toward Zero Deaths (state traffic safety group)
- Southern MN Behavioral Health Center
- City of New Ulm
- New Ulm Chamber of Commerce
- United Way of Brown County
- Martin Luther College
- NUMC Foundation Board
- Firmenich (large manufacturing business)
- Oak Hills Living Center (senior living center)
- Bank Midwest
- KNUJ (local radio station)
- Bridging Brown County (local non-profit)
- Second Harvest (food shelf)
- University of Minnesota Extension
- Lutheran Social Services (human service non-profit serving people living in or near poverty)
- Guttes Essen — Oak Hills (assisted living)
- Sustainable Farming Association of Minnesota
- Springfield Clinic
- Wellness Collective (nonprofit offering community wellness services)
- Sioux Trails (Counseling & mental health services)
- Community residents and business leaders (e.g., neighborhood groups, local parents)

Through these conversations, NUMC, HONU and Brown County staff explored the following questions:

- What resources and activities currently exist to address this issue?
- Who supports this issue and what is missing?
- What are potential barriers to addressing this issue?
- What goals and strategies could be pursued for each issue?

COMMUNITY INPUT RESULTS

Mental health

Challenges

Stakeholders described shortages of foster care homes, mental health providers, placement options for children needing mental health services and inpatient beds as challenges to meeting the community's mental health needs. In addition, they shared available resources are concentrated in New Ulm and transportation is a barrier for many people living in other parts of the county. Other access-related issues, such as cost and stigma, were also listed as barriers.

Participants also described an increase in anxiety and depression. Social isolation and related stress and depression affect mental health among all people, but particularly seniors and people with disabilities. Loneliness was identified as a particular concern among seniors.

School-age youth were described as experiencing high rates of stress, anxiety and depression due to current events.

Ideas and opportunities

Strategies for improving mental health services can be categorized into improving access and increasing education. Participants suggested increasing the availability of treatment centers and larger inpatient units for children and adults. They also recommended expanding community training and education on bullying, resiliency, adverse childhood events (ACEs) and Question, Persuade, Refer (QPR) training for suicide prevention. Participants also suggested addressing social isolation through partnerships with senior living facilities and strategies to help farmers manage stress.

Obesity, including healthy eating and active living

Challenges

Participants shared the COVID-19 pandemic, busy schedules, lack of childcare and transportation and cost are barriers to physical activity. These factors, the low cost and easy availability of fast food and lack of cooking skills negatively impact residents' ability to eat healthy. To increase healthy eating, participants suggested more education on nutrition and healthy cooking.

Ideas and opportunities

Participants suggested improving the built environment so physical activity and healthy eating become part of people's everyday life. Other healthy eating strategies included providing more education on nutrition, meal planning, healthy cooking and greater access to farmers markets and community gardens. Participants suggested the medical center support HONU to expand the existing restaurant recognition program by offering more healthy menu options at participating restaurants. They also suggested addressing the connection between stress and healthy behaviors.

To increase physical activity, participants suggested an exercise prescription program, offering affordable gym memberships and increasing education on the importance of exercise. They urged HONU to continue to prioritize and implement the objectives contained in the Safe Routes to School Plan and the Walkable Livable Communities Report. Other ideas centered around providing worksite networking and training opportunities to promote employee health and wellness.

Substance use, including tobacco use

Challenges

Participants stated there has been an increase in substance misuse due to COVID-19 pandemic, particularly alcohol. Participants were also alarmed that methamphetamine was the top primary substance of abuse for local patients in a chemical dependency treatment. Youth using alcohol and vape products at a younger age was also stated as a concern.

Ideas and opportunities

Community members stated the need to continue with resilience and community-building. They suggested NUMC continue working with the Brown County Mental Health Action Team and lead additional projects to raise awareness, education and provide tools to youth and parents. Participants also recommended supporting community organizations and programs who provide a sense of community for people experiencing a substance use disorder. One specific idea was to increase sober activities and peer recovery groups in the community. Increasing access to harm reduction resources such as naloxone was another recommendation.

SYSTEMWIDE COMMUNITY INPUT ACTIVITIES AND RESULTS

In addition to the local community engagement activities described above, Allina Health systemwide staff solicited feedback applicable to all Allina Health regions. This feedback focused on groups with which Allina Health has unique expertise regarding community needs and included conversations with Allina Health staff as well as patients/clients.

Based on their unique roles supporting patients, interviews were conducted with Allina Health staff from the following groups:

- Community Paramedics
- Language Services/Interpretation
- Spiritual Care

Additionally, community engagement staff partnered with staff from Courage Kenny Rehabilitation Institute (CKRI) to conduct three virtual community dialogues: two with individuals living with a disability and one with caregivers of people with a disability. Care was taken to recruit diverse participants in terms of geographic location, type of disability, gender and cultural group. Caregivers included those supporting family members with a disability as well as those working professionally in residential facilities (e.g., group homes).

In total, 12 interviews and focus groups took place between March and May 2022 with 27 people. The conversations were facilitated by Allina Health representatives. Each discussion lasted 60 minutes. Participants were asked to share their vision for health in the community, clarify aspects of the priority health areas that are most important to address, and discuss opportunities for Allina Health to support community health. The conversations included topics such as health equity, access to services and care, culturally appropriate care, and many others.

Key questions Allina Health sought to answer through the discussions were as follows:

- What factors in the community most affect health?
- Are there new or emerging health priorities in your community?
- How have you seen factors such as race, ethnicity and language impact the health of the patients you serve?
- How do you see Allina Health making it easier or more comfortable for ALL patients to access healthcare?

- In your opinion, what are the most important things Allina Health can do to help achieve health equity?
- By 2025, what is your vision of health for the community/patients you serve?

Community/stakeholder conversations' results

Overall themes

Community conversations identified mental health, substance use and social determinants of health as the most important priorities to address, with specific focus on housing and transportation needs. In general, social connectedness/isolation remains a key concern across all communities, along with the need for access to culturally responsive care and support navigating complex care systems. The participants identified an increased need for workforce education around stigma and diversifying clinical staff pool to be more representative of the communities served.

Vision for health

Community conversation participants envisioned a community where there is no stigma attached to those with mental health concerns and substance use or seeking help for both. There is an increased awareness within the community regarding mental health conditions, use/misuse of substances and the resources available in the community. Participants also described a health care system that allows doctors to have stronger personal connections with their patients and that involves more discussion, holistic care and fewer prescription medications. They also imagined a community that has an adequate number of providers who reflect the communities they serve, availability of culturally appropriate care and diversity of clinical staff serving the patients. Participants shared a vision of a community where all people are treated equally with respect for their cultural background, beliefs and values.

Existing strengths

Participants identified strengths in their local community that contribute to addressing health needs, such as existing coalitions and groups working on the social isolation, mental health and substance use priorities. Participants also felt there is a strong presence in the community services to help address health-related social needs (HRSN); however, service availability varies based on geography. The greatest asset mentioned in the conversations was Allina Health staff, their compassion and resiliency.

Allina Health's role and opportunities

Community conversation participants discussed ways Allina Health could help address the priority areas. Ideas included:

- Create better access to community-specific care and support navigating complex care systems.
- Create better access to culturally appropriate, language-specific care.
- Employ more multi-lingual, culturally and racially diverse providers and other clinical staff.
- Create and strengthen partnerships with culturally focused community organizations.
- Engage in community-healthcare partnership and integration work.
- Continue work on education and stigma reduction around disabilities, mental health conditions and substance use.

2023–2025 implementation plan

After the data review and community input phases, NUMC's 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 phase, NUMC staff met in March, April and July 2022 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 priority needs that occur in all Allina Health geographies.

Based on this process, Allina Health will pursue the following systemwide priorities in 2023–2025:

- Mental health and wellness
- Substance abuse prevention and recovery
- Social determinants of health and health-related social needs
- Access to culturally responsive care

The prioritized communities identified by each Allina Health hospital were also compared and the most common were identified for system action:

- People with disabilities
- People living at or near poverty
- People who identify as Black, Indigenous and/or People of Color (BIPOC)
- People who identify as Lesbian, Gay, Bi-sexual, Trans, Queer and/or Questioning, and other historically underserved sexual and gender identities (LGBTQ+)

Collectively and individually, these communities are not monolithic. They are large, diverse and intersect with one another. Specific activities will further refine intended audience based on disparities particular to the intended outcomes (e.g., social isolation, tobacco use) and factors such as community capacity to partner.

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 community's unique needs.

NUMC's final implementation plan incorporates Allina Health's systemwide strategies and activities, as well as local ones. It integrates 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, NUMC resources and Allina Health's systemwide contributions. To make progress in achieving health equity, Allina Health system resources will prioritize partnerships and activities that engage the four communities listed above. NUMC will prioritize hospital-specific activities that engage the local prioritized communities.

PRIORITY 1: OBESITY, INCLUDING HEALTHY EATING AND ACTIVE LIVING

Goal 1: Increase access to healthy foods and opportunities for physical activity.

Strategies

- Provide worksite networking and training opportunities to promote employee health and wellness.
- Improve the safety for walking and biking by making improvements to the built environment.
- Improve the availability and affordability of healthier food choices in a variety of different venues throughout New Ulm.

Activities

- Offer quarterly training for area worksite wellness and human resource leaders.
- Offer and support opportunities, resources and activities that promote wellness. i.e., holiday trimmings, community challenges, The People Project.
- Work with Minnesota Department of Transportation to create an active transportation plan.
- Continue to prioritize and implement the recommendations contained in the Walkable Livable Communities Report and the new Active Transportation plan when completed.
- Continue to prioritize and implement the objectives contained in the Safe Routes to School Plan
- Expand the restaurant recognition program by offering more healthy menu options at participating restaurants.
- Continue to expand farmers market events at New Ulm's Saturday market and Springfields market.
- Implement an edible garden in a low resourced neighborhood.

PRIORITY 2: MENTAL HEALTH AND WELL-BEING

Goal 1: Increase resilience and healthy coping skills in our communities.

Strategies

- Improve social connections and social cohesion in the Brown County area.
- Increase resilience and support the creation and maintenance of environments that contribute to positive mental well-being.
- Improve adults' confidence and skills around talking with youth about mental health, substance use and other issues affecting their mental well-being.

Activities

- Establish or strengthen partnerships with organizations who serve older adults to offer Hello4Health content/resources and opportunities for connection.
- Participate in the Brown County Mental Health and Wellness Action Team aimed at improving social connections, social cohesion and a sense of belonging.
- Offer and support opportunities, resources and activities that foster belonging and social cohesion among community residents.
- Provide schools in the Allina Health service area Change to Chill and/or Health Powered Kids content and tools; staff training; and financial support for creating a space for students and staff to relax, reflect and recharge.
- Provide worksites with education and resiliency tools which will contribute to a positive work environment for their staff.
- Offer community trauma-informed training to daycare providers, schools, worksites and other interested community members.

- Increase Change to Chill and Health Powered Kids content for adults who support school-age youth regarding how to practice resilience skills and connect with youth about issues affecting their mental well-being.
- Develop a process for providers to introduce guardians of school-age youth to Change to Chill and Health Powered Kids.
- Partner with local schools to have a section in the parent newsletter to provide content on key priorities.

Goal 2: Increase access to mental health services in the Brown County area.

Strategy

- Support public policy and advocacy efforts to improve access to mental health services.

Activities

- Lead and participate in community coalitions focused on improving access to mental health and addiction services.

PRIORITY 3: SUBSTANCE ABUSE PREVENTION AND RECOVERY

Goal 1: Decrease substance misuse in the Brown County area.

Strategies

- Improve environmental factors and individual knowledge and skills associated with decreased substance misuse, with a focus on youth, adolescents, and older adults.
- Decrease youth access to substances.

Activities

- Incorporate age-appropriate substance use education into Allina Health community health improvement program content and resources.
- Participate in and support the Brown County Chemical Health Action Team aimed at improving community protective factors associated with decreased substance misuse.
- Recruit and involve residents of all backgrounds and ages, including youth and seniors, to plan and implement strategies.
- Advance local, state and federal policies aimed at making it more difficult and/or less appealing to access alcohol, tobacco and other drugs.

Goal 2: Decrease harm and deaths related to substance misuse, with a focus on opioids.

Strategies

- Decrease access to opioids within community.
- Improve access to continuum of substance use disorder care.

Activities

- Provide and promote education, outreach and resources for proper disposal of prescription drugs.
- Provide planning, data and in-kind resources to support community planning efforts to deploy opioid settlement funds.
- Advance local, state and federal policies aimed at decreasing access to opioids in healthcare and community spaces.

- Strengthen internal and external education activities regarding when and how to access continuum of substance use and addiction care, including resources for secondary prevention, cessation and harm reduction.
- Offer and promote culturally responsive stigma elimination resources related to experiencing addiction and accessing substance use services.
- Lead and participate in community coalitions focused on improving access to mental health and addiction services.

ADDITIONAL ALLINA HEALTH SYSTEMWIDE ACTIVITIES

Additionally, while not explicitly identified as priorities by NUMC, social determinants of health, health-related social needs and access to culturally responsive care were identified as key factors in health across all Allina Health regions. The following activities will be pursued via systemwide efforts.

SOCIAL DETERMINANTS OF HEALTH AND HEALTH-RELATED SOCIAL NEEDS

Goal 1: Improve access to community resources that provide food, housing, transportation and loneliness/social isolation support to Allina Health patients and communities.

Strategies

- Continue to build a sustainable network of trusted community partners who can support patients and community members in addressing their health-related social needs, with a focus on housing, food, transportation and loneliness/social-isolation.
- Reduce community resource gaps in the communities served by Allina Health.

Activities

- Increase number and type of social service agencies we refer patients to via HRSN Program, including those listed on patients' community resource summaries and those partnering in two-way referrals.
- Establish a model to increase community-based organizations' capacity to respond to patient and community needs through financial contributions, exploration of reimbursement and financing models, data-sharing, employee volunteerism and policy advocacy.
- Partner with community-based organizations to address select patient needs at point of care and connect qualifying patients to community programs or resources that support ongoing need.
- Establish a model to reduce resource gaps in the communities served by Allina Health. Elements to include but not limited to: (1) strategic financial contributions, (2) coalition participation and policy advocacy, and (3) exploration of opportunities to provide services to patients for which there are currently no or limited resources available.

Goal 2: Improve the long-term social, physical and economic conditions in the communities served by Allina Health, to improve health and reduce the presence of health-related social needs.

Strategies

- Operate as an anchor institution by using the collective strength of Allina Health as a care provider, employer, purchaser and community partner to eliminate systemic inequities and racism.

Activities

- Direct charitable contribution dollars to organizations that improve the physical, social and economic vitality of communities served by Allina Health.
- Lead and participate in coalitions, policy and advocacy efforts to improve social conditions related to health equity and social justice.
- Invest Allina Health Impact Portfolio dollars in opportunities that support economic vitality in Allina Health service areas.
- Prioritize the inclusion of businesses owned by Black, Indigenous, people of color and other underrepresented and underserved people when purchasing goods or services.

ACCESS TO CULTURALLY RESPONSIVE CARE

Goal: Increase access to care, services and programs that are culturally specific, honoring and appropriate.

Strategies

- Improve cultural responsiveness of Allina Health programs and services.
- Improve access to community resources who specialize in meeting the unique needs of prioritized communities.
- Increase diversity of Allina Health workforce, with a focus on leadership to ensure we reflect the communities in which we live and serve.

Activities

- Develop and strengthen community partnerships to co-create, implement, and evaluate culturally responsive community health improvement programming and resources.
- Provide a greater percentage of Allina Health community health improvement content compliant with ADA standards and in languages other than English.
- Increase staff training and education opportunities regarding the provision of culturally responsive, inclusive care to patients in the prioritized communities.
- Direct Allina Health resources to organizations that provide care tailored to meeting the needs of the prioritized communities.
- Improve processes and tools for referring to community-tailored social service agencies via HRSN Program, including those listed on patients' community resource summaries and those partnering in two-way referrals.
- Implement initiatives aimed at recruitment, retention, and promotion of diverse staff.

RESOURCE COMMITMENTS

To effectively implement these strategies and activities, Allina Health and NUMC will commit financial and in-kind resources, such as specific programs and services and staff time to serve on community collaborations. The hospital will also encourage staff to volunteer with local organizations.

EVALUATION OF ACTIVITIES

NUMC and Allina Health will continue to engage in assessment and engagement activities throughout the implementation phase. NUMC will develop specific work plans for implementing the strategies and activities outlined in the implementation plan, including further refining intended audiences for each activity.

Additionally, the hospital will establish or continue evaluation plans for specific programs and initiatives (e.g., HRSN Program). Evaluation plans will include process measures, such as participant or partner satisfaction, goal completion, people served and dollars contributed, to monitor reach and progress on planned activities. Where possible, Allina Health will also assess outcome metrics to evaluate the effects of its initiatives on health and related outcomes (see Appendix for examples).

Conclusion

NUMC and Allina Health will work diligently to address the identified needs prioritized in this process by acting on the strategies and activities outlined in this plan.

For questions about this plan or implementation progress, please contact: Jen Maurer, Community Engagement Lead for Southwest 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.

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- Allina Health System Office staff and interns who supported the process;
- Heart of New Ulm Leadership Team.

Appendix: Example Allina Health systemwide performance indicators

Health Priority	CHNA Goals	Example progress indicators	Example program-specific, intermediate outcomes
Mental health and wellness	Increase resilience and healthy coping skills.	• Progress on workplan to implement process for providers to introduce patients to community health programs. • Number of middle and high schools with a Chill Zone • Participant satisfaction with community health programming	• Increase in coping self-efficacy among youth exposed to CTC content • Increased sense of social support among Hello4Health program participants
	Increase access to mental health services across the Allina Health services area.	• Changes to Allina Health, state and local policies aimed at improving access to mental health and substance use services successfully implemented	• Improved access to mental health services amongst Allina Health patients (specific indicator TBD)
Substance abuse prevention and recovery	Decrease substance misuse in the communities served by Allina Health.	• Number of people reached via CTC, HPK and/or Hello4Health substance use content	• Increase in confidence discussing substance use with school-age youth among adults exposed to CTC and HPK content
	Decrease harm and deaths related to substance misuse, with a focus on opioids.	• Pounds of prescription medication collected via Allina Health drug disposal boxes • Changes to Allina Health, state and local policies aimed at decreasing access to opioids and/or improving access to substance use care successfully implemented	• Improved access to addiction services amongst Allina Health patients (specific indicator TBD)
Social determinants of health and health-related social needs	Improve access to community resources that provide food, housing, transportation and loneliness/social isolation support to Allina Health patients and communities.	• Number of patients served via tracked referral partnerships • Qualitative feedback from key community partners • Estimated resource saturation in CHNA counties	• Reduced HRSN rate among Allina Health patients
	Improve the long-term social, physical and economic conditions in the communities served by Allina Health.	• Percent Impact Portfolio dollars invested	
Access to culturally responsive care	Increase access to care, services and programs that are culturally specific, honoring and appropriate.	• Percent CTC, HPK and/or Hello4Health content provided in languages other than English • Percent Allina Health managers and above who identify as people of color	• Outcome measure to be determined