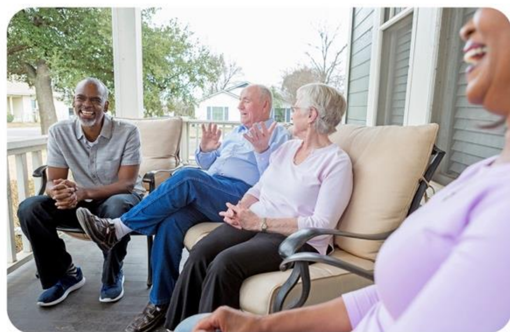
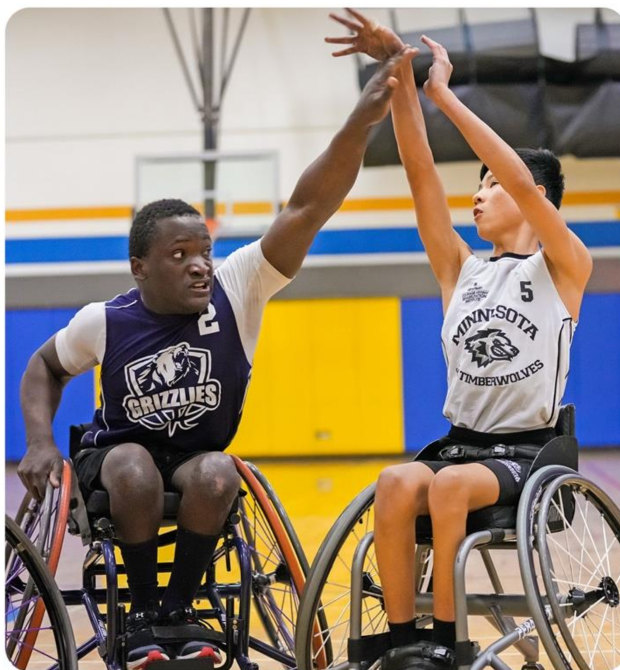
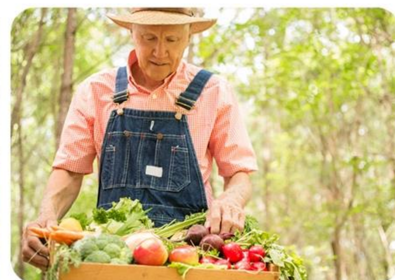
RIVER FALLS AREA HOSPITAL

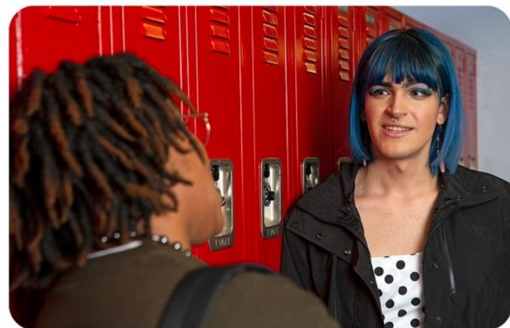
2023–2025

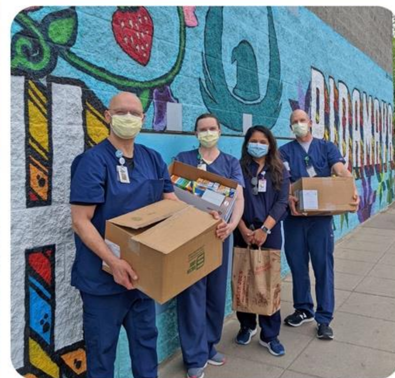
Community Health Needs Assessment and Implementation Plan











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Introduction

River Falls Area Hospital 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.

River Falls Area Hospital is part of the Healthier Together — Pierce & St. Croix County coalition (Healthier Together). The coalition was founded and is led, by representatives from Health Partners, Pierce County Public Health, River Falls Area Hospital, St. Croix County Public Health, United Way — St. Croix Valley and Western Wisconsin Health. Previously two separate coalitions, Healthier Together was reformed in 2015 to encompass both counties under one umbrella. The mission of Healthier Together is to create and maintain healthy communities. Healthier Together accomplishes its mission by providing a strategic and collaborative framework for evidenced-based/evidence-informed health improvement activities throughout the two-county region. The focus of the coalition's health improvement activities is determined by a community health needs assessment conducted every three years. River Falls Area Hospital's CHNA process is completed as part of Healthier Together's needs assessment work.

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 Healthier Together and River Falls Area Hospital 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.

For more information about Healthier Together, visit https://www.healthiertogetherpiercestcroix.org/about.

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, River Falls Area Hospital, in partnership with Healthier Together, will pursue the following priorities in 2023–2025:

Mental, social and emotional wellness

Mental wellness includes emotional, psychological, and social health. It impacts the ability to handle stress, relate to others, and make healthy choices. River Falls Area Hospital, in partnership with Healthier Together, is focused on creating policy, systems, and environmental changes that support the mental, social, and emotional wellness for all residents of Pierce and St. Croix Counties.

Thriving and livable communities for all

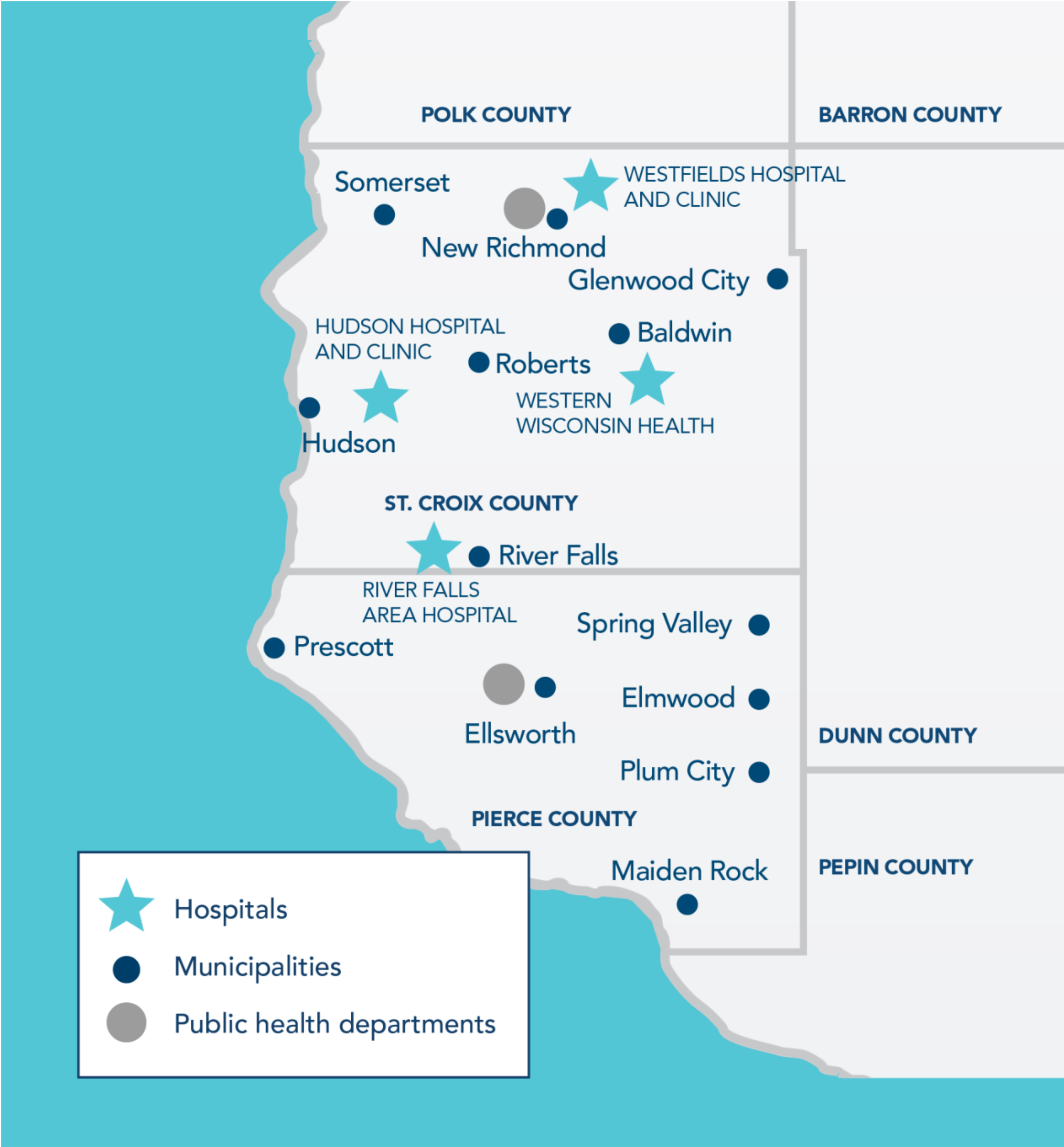
River Falls Area Hospital understands that the conditions in the environments where residents live, learn, work, play, and age affect a wide range of health outcomes. These conditions include factors such as economic stability, access to quality education, childcare, healthcare, affordable and healthy housing, transportation, safe air, water, food security, and safe and plentiful places for physical activity. River Falls Area Hospital, in partnership with Healthier Together, is committed to supporting social, physical, and economic environments that promote attaining the full potential of health and well-being for all.

Additionally, River Falls Area Hospital and Healthier Together, prioritized the following communities for the 2023–2025 CHNA cycle:

- People living in or near poverty
- People with disabilities
- 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+)
- Older adults

Healthier Together, hospital and community descriptions

HEALTHIER TOGETHER SERVICE AREA



HOSPITAL AND HEALTHIER TOGETHER DESCRIPTION

River Falls Area Hospital (River Falls), founded in 1939, is a part of Allina Health, a not-for-profit health system dedicated to the prevention and treatment of illness. The River Falls healthcare campus includes the River Falls Area Hospital, Allina Health River Falls Clinic, a number of specialty provider partners and the Kinnic Health & Rehab Facility. Its focus is to deliver exceptional health care, support services, and preventive care — putting the patient first in everything. The hospital also has a long history of working to improve health in the community it serves through programs and services that respond to the health needs of the community. The hospital's primary service area, and the subject of its 2022 CHNA, are Pierce and St. Croix Counties.

River Falls completed its 2022 CHNA as a member of Healthier Together — Pierce & St. Croix County (Healthier Together).

HISTORY OF THE LAND

A brief history of Pierce County

Native Americans were the first people to live in what is now Pierce County. Over time, Pierce County has been home to Ho-Chuck (Winnebago), Santee Dakota (Sioux), and Anishinaabeg (Ojibwe or Chippewa) peoples. Cultivation, building practices and looting destroyed much of what existed here before Euro-Americans arrived. The few artifacts that have been found indicate the region has been inhabited for 10,000 to 12,000 years. The Diamond Bluff area has many extensive burial mounds that mark the Native American settlement.

European explorers began coming to the area in the mid-to-late 1600s. Government officials gave little consideration to the welfare of Native Americans already living in the Upper Mississippi region. Not only would the Dakota, Ho-Chunk, and Ojibwe face removal from traditional homelands, but their populations would be devastated by newly introduced diseases for which they had no immunity. They would lose thousands of members to undocumented epidemics before 1800, noted only by massive changes in numbers between one explorer or representative's visit and another.

In 1840, Saint Croix County was formed, covering a vast portion of northwest Wisconsin Territory. The state legislature split up Saint Croix County into Pierce, Polk, and Saint Croix counties in 1853. Pierce County was named after Franklin Pierce, the fourteenth president of the United States.

When Pierce County was developed, Prescott and River Falls were the largest communities in the county. Anthony Huddleston and his family had settled on the land near what would become Ellsworth in 1855.

In 1874, River Falls had the good fortune to have the state's fourth Normal School. Classes began in the fall of 1875 at the River Falls Normal School, known as the University of Wisconsin-River Falls today.

The eastern part of Pierce County was known initially for logging and mining. In the mid-1870s, high-quality iron ore was discovered, and by the early 1890s, Spring Valley had become a boom town. The city is also home to Crystal Cave, a popular tourist attraction.

A brief history of St. Croix County

St. Croix County once comprised most of northwestern Wisconsin and part of what is now northeastern Minnesota. Its Native American culture dates back thousands of years to the tribes of the Dakota and Ojibwa.

The peninsula formed by the St. Croix River and the Mississippi River was neutral territory between the Dakota and the Ojibwa, leaving it relatively open for settlement. European explorers began coming to the area in the mid to late 1600s. A trading post was established along the St Croix River in 1793. Trade with Native Americans continued for many years, dropping off in 1834 when farmers began moving into the area. White settlers' demand for land grew, and treaties pushed Native Americans from their land.

The lumber industry took hold in St. Croix County around 1840. In 1846, Stillwater and St. Paul were established as the election precincts for St. Croix County.

When Wisconsin was admitted to the Union as a full-fledged state in 1848, the western boundary of St. Croix County was then set as the St. Croix River. The borders of St. Croix County, as we know them today, were established in 1853. The Hudson and River Falls Railway connected the county to the line of Chicago, Milwaukee, St. Paul, and Omaha Railway. By the end of the 1800's, wheat was the staple crop in St. Croix County, and there were seven cheese factories, 14 creameries, and one brewery.

DIVERSITY, EQUITY, INCLUSION AND BELONGING

In 2022, Healthier Together formalized its commitment to health equity with a statement on the topic: *The Healthier Together coalition prioritizes advancing health equity. Health equity means that everyone has a fair and just opportunity to be as healthy as possible. We will do this by engaging impacted populations, building coalition competencies, and addressing root causes of poor health (social determinants of health).*

The coalition supports Allina Health's commitment 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.

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

The focus of inquiry for this CHNA was Pierce and St. Croix Counties — two rural communities located in western Wisconsin. According to the U.S. Census Bureau, a total of 137,631 (42,587 Pierce and 95,044 St. Croix) residents live in the 1,295.73 square mile area occupied by the two counties.

Population

Indicator	Pierce County	St. Croix County	Source
Median household income	$73,873	$84,985	US Census Bureau, Quick Facts, Population Estimates July 1, 2021 United States Census Bureau. 2020 American Community Survey 5-Year Estimates
Median age	37.3 years	39.2 years	
Population estimates	42,587	95,044	
Residents under age 18	20.6%	24.5%	
Residents age 65 or older	15.3%	14.7%	
Language other than English spoken at home	3.6%	3.4%	
Foreign born residents	1.9%	2.6%	

Race and Ethnicity

Indicator	Pierce County	St. Croix County	Source
White alone	95.7%	95.9%	US Census Bureau, Quick Facts, Population Estimates July 1, 2021
Black or African American alone	0.9%	0.9%	
Asian alone	1.2%	1.1%	
Hispanic or Latino	2.3%	2.6%	

Social and Economic Factors

Indicator	Pierce County	St. Croix County	Source
Persons in poverty	7.3%	4.9%	County Health Rankings, 2022 US Census Bureau, Quick Facts, Population Estimates July 1, 2021 United for Alice 2018
Children in poverty	6%	5%	
Percent of Population Asset Limited, Income Constrained, Employed (ALICE)	24%	22%	
Residents living in food insecurity	8%	7%	
Children eligible for free or reduced lunch	15.3%	13.6%	

Health Indicators

Indicator	Pierce County	St. Croix County	Source
Ratio of primary care physicians to residents	2,380:1	2,020:1	County Health Rankings, 2022
Ratio of mental health providers to residents	1,940:1	610:1	
Adults reporting binge or heavy drinking	26%	28%	
Adults who are obese	33%	33%	
Residents reporting poor or fair general health (age adjusted)	13%	12%	

Evaluation of 2020–2022 implementation plan

In its 2020–2022 Community Health Needs Assessment and Implementation Plan River Falls Area Hospital and Healthier Together adopted mental health and substance use disorders (SUD) 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. River Falls Area Hospital specifically supported five schools via continued partnership with St. Croix Central Middle School, Ellsworth High School, Hudson High School, and Plum City Middle and High Schools. In total, these efforts reached approximately 2,510 students. Additionally, 195 student peer mentors and 250 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

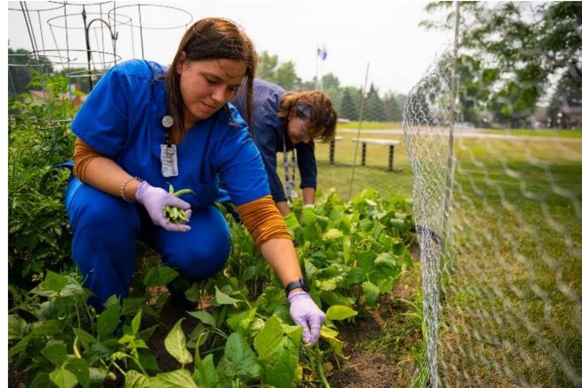
Hello4Health™ is a new online resource created in response to the 2019 CHNA which identified social isolation as a factor contributing to poor mental wellness among adults across all geographies. Allina Health developed the program in 2020 and launched it in April 2021 with a focus on older adults. Components 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 $12,450 in River Falls' 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

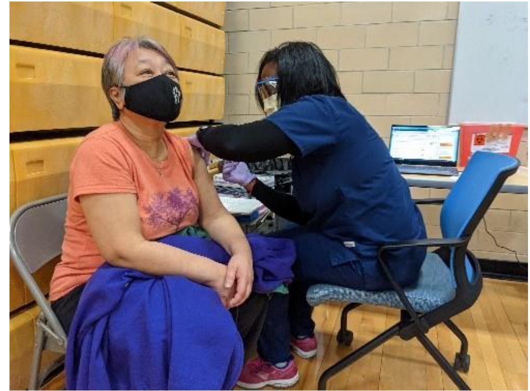
Accountable Health Communities model and Health Related Social Needs Program

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 (Pierce County: 30 percent; St. Croix County: 29 percent). 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. In Pierce County specifically, 44 percent of equity patients identified a need compared to 29 percent in the comparison population. 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"). There were not enough residents of St. Croix County screened to disaggregate data by race/ethnicity.

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 HEALTHIER TOGETHER ACTIVITIES

The COVID-19 pandemic required all of us to make changes to our lives and work. Many organizations leading Healthier Together were on the front lines of the COVID-19 response. In some cases, this prevented the completion of the envisioned 2019 Healthier Together implementation plan. However, despite the pandemic, Healthier Together members continued to work on improving our communities' mental health and preventing substance use disorders in creative and meaningful ways.

Healthier Together members gathered virtually in the Spring of 2022 to celebrate work accomplished in 2020–2022, despite the pandemic. Below is a summary of key accomplishments in the areas of Mental Health and Prevention of Substance Use Disorders:

Increased community capacity through training and awareness activities.

- Provided 11 Mental Health First Aid virtual trainings, resulting in 86 individuals becoming certified.
- Provided Make it OK presentations to River Falls middle schoolers and First Congregational Church in River Falls.
- Provided three Youth Mental Health First Aid trainings to staff in the Ellsworth school district.
- Completed Narcan overdose trainings for 73 individuals in Pierce County and 38 in St. Croix, including law enforcement and human services partners.
- Served as a panel member for the Anxiety in Children workshop at the Hudson Schools Mental Health Advisory Committee.
- Hosted a Make it OK table at Ellsworth High School.
- Secured additional grant funding to provide training to St. Croix County behavioral health staff.

- Coordinated School-Based Dialectical Behavior Therapy (DBT) Training for school mental health professionals to increase the capacity of group mental health and substance use services provided in schools.

Promoted self-care and resiliency among key populations.

- Completed two resiliency-building series (Taking Care of You and WeCOPE).
- Launched a free weekly self-care community of practice called Practicing the Pause.
- Hosted monthly self-care sessions for Hudson High School staff and parents.
- Successfully applied for a school-based mental health grant from the Department of Public Instruction.

Provided services in ever-changing pandemic environment.

- Secured American Rescue Plan Act funding to expand early intervention and community-based interventions involving individuals involved with law enforcement and criminal justice.
- Continued providing mental health and substance use services using virtual tools throughout the pandemic.
- Expanded mental health resources within River Falls High School through a partnership with St. Croix Valley Restorative Services by developing the Restorative Youth Leadership program for at-risk teens.

Reinforced community collaborations.

- Started the Healthier Together Health Equity workgroup.
- Hosted mental health provider meetings focused on networking and system improvement.
- Conducted meetings among school district mental health professionals to discuss collaboration opportunities for Youth Risk Behavior Survey data collection, mental health screening and mental health curriculum options.
- Strengthened communication between public health and city planning, with River Falls Planning Commission, to identify built environment effects on population health and well-being.

Supported mental health by connecting families to nature

- Secured funding for county park passes for the library park backpack program available at libraries in both counties to facilitate connecting children and families to nature in our local park system. Families in our counties checked out the park backpacks more than 130 times in 2021.

A full report of work accomplished by Healthier Together during 2020 and 2021 can be accessed here: https://www.healthiertogetherpiercestcroix.org/priorities.

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. As a member of the Healthier Together coalition, River Falls Area Hospital conducted a joint assessment in partnership with Hudson Hospital & Clinic, River Falls Area Hospital, Western Wisconsin Health, Westfields Hospital & Clinic, Pierce County Public Health, St. Croix County Public Health and the United Way of St. Croix Valley. This is the third community health needs assessment and plan developed by these partners under the auspices of Healthier Together. The CHNA process also included involvement from residents, community partners and stakeholders.

Many factors influence how well and how long we live, from our access to affordable housing or well-paying jobs to opportunities for a good education for our kids. Acknowledging health is influenced by factors broader than clinical care, Healthier Together redesigned its assessment process to reframe its definition of health. To complete the 2022 CHNA, Healthier Together developed an assessment and planning process grounded in three key principles: a broad definition of health, health equity and cross-sector engagement. Through this process, Healthier Together engaged with community stakeholders to better understand the root causes of health issues in our communities, identified internal and external resources for health promotion, and created an implementation plan that leverages those resources to improve community health. The impact of these efforts will be tracked and evaluated over the three-year cycle. Innovation was required to complete this process while the COVID-19 pandemic raged, and partners were often pulled in many different directions to respond to urgent community needs.

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.

The Executive and Leadership Teams of Healthier Together, including River Falls Area Hospital leadership, received and approved the plan. Allina Health Board of Directors gave final approval.

2021–2022 CHNA timeline

TIMING	STEPS
June–August 2021	**COMMUNITY INPUT** Local survey distributed to residents of St. Croix and Pierce Counties. Began focus groups and key informant interviews.
September–November 2021	**DATA REVIEW** Gathered secondary quantitative data from diverse sources to understand health status of the community and identify inequities. Reviewed secondary and primary data. Developed analysis summaries.
February 2022	**STAKEHOLDER DATA REVIEW AND PRIORITIZATION** Hosted Zoom meetings with stakeholders to review data, affirm commitment to health equity, set a vision of the future, and decide on priority areas.
March–May 2022	**IMPLEMENTATION PLANNING** Hosted a series of meetings with coalition members to develop goal areas for each priority.
June–October 2022	**REPORT WRITING** Present plans to local boards/committees/leaders for approval. Coordinate report writing and share results and action plans with key stakeholders systemwide.
October 2022	**SEEK DRAFT APPROVAL:** River Falls Area Hospital Community Health Advisory Council
December 2022	**SEEK FINAL APPROVAL** Present for final approval to the Allina Health Board of Directors in December.

Community input

Healthier Together convened a group of community stakeholders to provide input, review data and prioritize issues as part of the 2022 CHNA process. These stakeholders represented the broad interests of the community and including representation from the following organizations:

- Allina Health EMS (Emergency Medical Services)
- Assistance Resource Center - River Falls
- Baldwin-Woodville School District
- C3 Church (Hudson and Ellsworth)
- Court Appointed Special Advocates (CASA) of St. Croix County (advocates for neglected or abused youth)
- Pierce County Board of Health
- University of Wisconsin-River Falls
- Citizen Review Panel/Foster Parent Community
- City of New Richmond
- City of River Falls
- City of Prescott
- City of Hudson
- Community Member, business owner
- Ellsworth School District
- Elmwood School District
- Family Resource Center St. Croix Valley
- First Lutheran Church
- Free Clinic of Pierce & St. Croix Counties
- Gethsemane Lutheran Church (Baldwin)
- Glenwood City School District
- Hudson Backpack Program
- Hudson School District
- Pierce County Judge, CJCC chair
- Our Neighbor's Place
- Pierce County Econ Development
- Pierce County Hunger Prevention Council
- Pediatrician at MHealth Fairview
- Pierce Aging and Disability Resource Center (ADRC)
- Pierce County Human Services
- Pierce County Land Management
- Pierce County Sheriff
- Pierce County WIC/Hunger Prevention Council Board
- Plum City School District
- Prescott School District
- River Falls School District
- Salvation Army — Grace Place (homeless shelter)
- St. Croix County Community Development
- St. Croix County Foster Care Coordinator
- School District of New Richmond
- School District of Somerset
- Spring Valley School District
- St. Croix Central School District
- St. Croix County Aging and Disability Resource Center (ADRC)
- St. Croix County Behavioral Health

- St. Croix County Medical Examiner
- St. Croix County Parks
- St. Croix County Sheriff's Office
- St. Croix County Health and Human Services (HHS) Board
- St. Croix Therapy
- St. Croix Valley Food Bank
- St. Croix Valley Foundation
- St. Croix Valley Restorative Services
- St. Croix Valley Sexual Assault Response Teams (SART)
- Turningpoint (serves survivors of domestic violence)
- University of Wisconsin — Madison Division of Extension
- United Way St. Croix Valley "Success by 6" Program (promotes health early childhood development)
- Veteran's Service — Pierce County
- West Community Action Program (CAP) (basic need provider)

Both qualitative and quantitative primary data were collected as part of the assessment process. First, quantitative data was collected through a community health survey conducted in the summer of 2021. The survey was collected virtually (using Survey Monkey) and via paper. Spanish versions were available. More than 1,000 responses were collected. Just over one-third of respondents (39 percent) were Pierce County residents, with the remaining respondents being St. Croix County residents. Respondents were overwhelmingly female (75.8 percent) and white (95.8 percent). Responses were received from residents in every zip code in Pierce and St. Croix Counties.

Next, after reviewing survey results, the Healthier Together coalition conducted 12 focus groups and key stakeholder interviews to better understand community health strengths and concerns. Focus groups were organized and led by coalition members, and a thematic analysis was conducted based on the notes. In addition to many of the stakeholders listed above, focus group participants included families on WIC (Women, Infants & Children), rural residents, community members experiencing homelessness, Hispanic community residents and area youth.

Participants were asked to think about what has changed in the community over the past year or two and about their fears and hopes for the future of the communities.

SURVEY RESULTS

Respondents were asked to select the top three community strengths. Results were compared to historical data from previous surveys. Responses did not change much from previous years, with "good place to raise children," "good schools" and "low crime/safe" rising to the top for community strengths. These top three were consistent across both counties.

Respondents were also asked to select the top three concerns they had about their community. Affordable housing and COVID-19 were offered as new options compared to previous surveys. The top three community issues in 2021 were "mental health," "affordable housing," and "COVID-19-related concerns." Drug use, previously ranked second as a community concern, fell to fourth. Interestingly, when data was disaggregated by county, only 22 percent of Pierce County respondents ranked affordable housing as a top concern compared to 31 percent of St. Croix County residents. Pierce County residents also appeared more concerned with alcohol use, with 24 percent ranking it as a top concern compared to 18 percent of St. Croix residents.

When asked about barriers respondents experienced accessing health care or health resources for themselves or their household, one-third of respondents reported experiencing no barriers. Of those who did experience barriers, the most commonly reported barrier was cost of care.

Most respondents (64 percent) reported their household being impacted by social isolation/loneliness due to the COVID-19 pandemic.

A detailed review of Healthier Together' s 2021 community health needs assessment survey results can be found here: https://infogram.com/1p1rnwkq5yw0z1cmv00mzk0pg0a61w60r6p?live.

FOCUS GROUP RESULTS

Overall themes

Community members mentioned community division and increased mental health challenges as trends that arose over the course of the last few years. There was a noticeable change in how people access care, programs and do work compared to previous years. For example, residents are delaying medical care, and the community is dealing with more complex social situations. Focus group participants identified the need for more food resources and better access to healthcare.

Challenges

- Fear of continued political divide and inability to go back to civil discourse.
- Concern about use of social media platforms to propagate hate and misinformation.
- Lack of trust between residents and systems (i.e., public health, health systems, school district, etc.).
- Continued increased medical costs and lack of access
- Fear of overall price increases — housing, gas, cost of raising families.

The pandemic became much more than a health issue. It is a political issue that has divided communities. We will need to find a way to rebuild trust.

–Focus group participant from school district

COVID-19 impact on the community

- Increased social isolation and mental health issues.
- Increased alcohol consumption.
- Lack of civility and stress is impacting mental wellness
- Healthcare/school staff fatigued and stressed.
- Challenging to keep up with changing COVID-19 guidelines/restrictions and funding options related to COVID funding (specific to housing).

Concerns about inequities

- Many people experiencing inequities fly under the radar or people are not aware. There is a need to build systems to address barriers (i.e., language, transportation, etc.).
- Experiences of discrimination/racism have increased in the past two years.
- Some service providers feel they treat everyone the same regardless of culture or socioeconomic status but recognize they may have less awareness about some hidden inequities.
- There are challenges to accessing social services and meeting basic needs.
- Common materials need to be translated and distributed to locations in which people naturally gather.

Opportunities

Focus group participants and individuals interviewed stated Healthier Together, local area hospitals and community organizations can and should focus on building cohesion and a healthier community environment. The effort should focus on prevention of chronic diseases, creating healthier communities overall, promoting including and reducing stigma related to experiencing a mental illness.

ALLINA HEALTH SYSTEMWIDE COMMUNITY INPUT

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 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 amount 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 the 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.

Data review and issue prioritization

To supplement the feedback gathered directly from community members, Healthier Together reviewed select Allina Health patient data and local public health data. Due to the key principles of health equity, cross-sector engagement, and a more expansive view of health outcomes and factors that influence health, Healthier Together used the County Health Rankings model to organize the assessment data and focus on the factors that influence health rather than solely focusing on health outcomes. Indicators were chosen based on priorities defined by the Center for Community Health and Allina Health equity priorities.

Secondary data gathering and analysis occurred in the summer and fall of 2021. Secondary data focused on gathering quantitative data from various sources across diverse sectors, selecting the best indicators available, and visualizing that data using maps, graphs, or infographics. In total, data included more than 20 indicators related to demographics, social and economic factors, health behaviors, prevalence of health conditions and health care access. Where possible, the data were reviewed at the zip code data and disaggregated by race and ethnicity to better understand opportunities to increase health equity in the community and among the patients seen at Allina facilities. Meaningful geographic disparities in health outcomes were displayed on a map. Examples of indicators reviewed include, but are not limited to:

- Volume of Allina Health EMS ambulance runs by cities served in Pierce and St. Croix Counties
- Patient and public health data by county of residence (Pierce and St. Croix): demographic data (including race, ethnicity, language, age and insurance type), health-related social needs and select conditions
- Top three reasons for emergency room visits and suicide and self-inflicted injury encounters in the emergency department
- Tobacco use among adults and youth
- Rates of overweight and obesity
- Colorectal cancer screening rates
- Market analysis of how demand for mental health and addiction services will change

After compiling, Healthier Together convened a group of diverse stakeholders to review the secondary data in February 2022. Due to the ongoing COVID-19 pandemic, the stakeholder meeting was held virtually. Participants included those who participated in the community input sessions (listed above), as well as members of the LGBTQIA+ community, planning/zoning agencies, disability service providers and housing organizations not previously engaged. These additional participants were invited as a response to feedback and themes from the focus groups and community survey.

Meeting participants were provided with information ahead of time, including recorded data presentations. The meeting was facilitated by staff from the Wisconsin Department of Health Services (DHS) Office of Policy and Practice Alignment.

During the meeting, stakeholders participated in a multi-voting process to reach an agreement on top priority areas for focus during the next three years. The menu of priorities was based on the community health survey's top six needs identified. After two rounds of prioritization exercises, the top two priorities were identified.

PRIORITIZATION PROCESS AND FINAL PRIORITIES

Based on the data review and feedback, the coalition chose to continue to pursue the topics selected in 2019 as its 2023–2025 priorities:

- Mental, Social and Emotional Wellness
- Thriving and Livable Communities for All

In 2019, Healthier Together used the Hanlon method to select the final priorities. This method includes ranking health priorities based on three primary criteria: size of the problem and projection of future trends; seriousness of the problem including health burdens within the population; and effectiveness and feasibility of interventions. In 2022, the coalition also considered issues community members emphasized as most important, the effectiveness of interventions and staff capacity to address each need.

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

- 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+)
  People living at or near poverty

NEEDS NOT ADDRESSED IN THE CHNA

The needs highlighted by the community members are addressed in this plan, with varying specificity. The mental, social, and emotional wellness priority encompasses alcohol and substance use, as community members articulated it was important to continue the work in those areas. Objectives also include bringing new services or providers to the community, which can be explored but not guaranteed. The thriving and livable communities priority addresses community concerns around affordable and accessible housing and transportation which are recurring challenges, however, not all proposed activities will be implemented.

2023–2025 implementation plan

After the data review and community input phases, River Falls' final phase of the CHNA process was to develop an implementation plan that includes goals, strategies, activities and indicators of progress. To ensure each objective was developed with a lens of health equity, the Healthier Together Health Equity Team assisted in revising the planning template and identifying opportunities to further infuse health equity into the plan during the final objective review process.

Additionally, as part of developing its implementation plan, River Falls 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.

River Falls' final implementation plan incorporates Allina Health's systemwide strategies and activities, as well as local ones co-owned by the Healthier Together coalition. 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, River Falls and Healthier Together 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. River Falls and Healthier Together will prioritize hospital-specific activities that engage the local prioritized communities.

LOCAL HEALTHIER TOGETHER IMPLEMENTATION PLAN

PRIORITY 1: MENTAL, SOCIAL, EMOTIONAL WELLNESS

Goal 1: Enhance workforce resiliency and well-being.

Objectives

- By July 2023, engage at least 15 community members in arts-based focus groups to better understand their experience of the pandemic, while also supporting community recovery through artistic expression.
- By May of 2023, develop and promote a menu of mental health and emotional wellness training and assistance programs throughout St. Croix and Pierce counties.
- Expand Youth and Adult Mental Health First Aid training opportunities through strategic collaboration with YMCA in Hudson, United Way St. Croix Valley and other community partners in St. Croix and Pierce County, resulting in 250 new individuals trained as Mental Health First Aiders by December of 2023.
- By December 2023, address the short and long-term mental health impacts that COVID-19 had on healthcare workers (direct and non-direct patient care) and other caregivers by offering 4 resiliency training and employee engagement opportunities per year to promote well-being, teamwork, and employee retention.

Goal 2: Build healthy coping skills and stress reduction strategies for youth and their caregivers.

Objectives

- By July 2023, engage at least 10 youth in the photo contest to express their experience during the pandemic and their hopes for the future.
- By June 2023, conduct checks of 34 facilities in Pierce County and 71 facilities in St. Croix County to see if they will sell tobacco or vaping products to minors. Take an education-based approach for retailers who do sell.
- By December 2025, increase awareness of mental health, mental illness, substance use disorders and their associated stigma through community awareness, education and support opportunities by establishing 4 new community partners.
- By December 2023, increase youth mental health collaboration among school, county, medical, and non-profit partners to support mental health screening, support, and coordination of care for youth to bimonthly meetings with at least 92 percent of Pierce and St. Croix County school districts participating.
- By December 2023, increase access to the Library Parks Backpack Program with multilingual materials in every backpack.
- By Spring 2025, the Mental, Social and Emotional Wellness group will meet with St. Croix and Pierce County community foundations (St. Croix Valley Foundation, Hudson Community Foundation, New Richmond Community Foundation, Somerset Community Foundation, River Falls Community Foundation, Prescott Community Foundation) to inform grantmaking that supports programs that build healthy coping skills and stress reduction strategies for youth and their caregivers.

Goal 3: Improve local access to meet the needs of residents seeking mental health care.

Objectives

- Maintain behavioral health crisis telemedicine in 4 hospital EDs (Emergency Department) and increase behavioral health telemedicine in 2 satellite sites by 2025.
- By 2025, increase amount of prescription medications and opioids collected in a secure manner at drop box locations at hospitals by 5 percent.
- By December 31, 2023, increase participation by 10% for two community symposium events that inform, and/or educate the public on issues related to mental health and/or substance use disorders.

PRIORITY 2: THRIVING AND LIVABLE COMMUNITIES FOR ALL

Goal 1: Improve social, environmental, and economic conditions that influence health.

Objectives

- By December 2023, present Having a Healthy Home at 5 community events or meetings.
- Through the state funded Project Growth: DREAM UP! grant opportunity, the established grant Core Team Members will participate in a strategic Planning Process for the purpose of improving and expanding the childcare capacity within a specified region of St Croix and Polk Counties. By 9/2023, core team members will have met 6 times to establish an agreed to goal for improvement.
- By December 2023, provide grassroots advocacy training to at least 15 Healthier Together members.
- By January 2024, begin a monthly distribution of a free diapers to low-income Pierce County residents.
- By December 2023, complete the final housing assessment process and report to include at least three potential next steps related to housing policy, systems, or environmental changes.
- By December 2024, six community-lead projects to increase equitable opportunities for physical activity will be funded and completed.
- In 2023–2025, Pierce and St Croix Counties will partner to complete 6 screening events to increase the number of private wells screened for Nitrate for all, increase access to lab certified Nitrate testing of drinking water for all, and evaluate results to identify townships with elevated nitrate levels to plan future activities.
- By 2023, establish a health equity page on Pierce/St. Croix Healthier Together's website. This page will provide vetted resources that have been previously explored or implemented by workgroup members. These resources can then support the work of Healthier Together as well as the public around the subject of health equity and the social determinants of health. Once established it will be improved and maintained throughout the 2023-2025 Community Health Improvement Plan.
- By December 2023, implement a system-wide approach to address Social Determinants of Health (SDoH) in 4 medical centers in Pierce and St. Croix counties through screening, systems, community partnerships, and referrals.
- By July 2023, 50 percent of food pantries in Pierce and St. Croix Counties will implement a new Diversity, Equity, and Inclusion practice into their pantry operations.
- By December 2023, at least 20 Pierce County community members will participate in a seed library to empower families to grow vegetables and fruits at home.

Goal 2: Increase equitable access to health care.

Objectives

- By May 2023, complete an access to care assessment through qualitative research on 30 individuals or families experiencing homelessness or in transitional housing in St. Croix County.
- Increase communication and communication strategies with the public on immunizations to increase the rates of vaccination in children 0–18y by 10 percent as documented in WIR by the end of 2025.
- Identify and address barriers to care to ensure health equity for all we serve in the 4 medical centers in Pierce and St. Croix Counties by 2025.
- By December 2025, establish at least 2 new dental partnerships to increase access to dental care for Pierce and St. Croix County residents.

ALLINA HEALTH SYSTEMWIDE IMPLEMENTATION PLAN

In addition to the work conducted as Healthier Together, River Falls Area Hospital will implement Allina Health's systemwide strategies and activities. 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.

PRIORITY 1: MENTAL HEALTH AND WELLNESS

Goal 1: Increase resilience and healthy coping skills in Pierce and St. Croix Counties.

Strategies

- Improve social connections and social cohesion in the communities served by Allina Health.
- Increase resilience and support the creation and maintenance of environments that contribute to positive mental well-being among youth.
- 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 in the prioritized communities to offer Hello4Health content/resources and opportunities for connection.
- Participate in community coalitions in Allina Health's service area 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.
- Connect patients who screen positive for loneliness or social isolation with community resources that provide opportunities for social connection.
- 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.
- Co-create efforts to build healthy coping skills and community protective factors with schools, community organizations, and other groups in which youth and families in the prioritized communities gather and feel belonging (shared with substance abuse prevention and recovery priority).
- Increase Change to Chill and Health Powered Kids content for adults who support school-age youth.
- Develop a process for providers to introduce guardians of school-age youth to Change to Chill and Health Powered Kids.

Goal 2: Increase access to mental health services in Pierce and St. Croix Counties.

Strategies

- 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.
- Support and advocate for local, state and federal policies aimed at increasing access to mental health services.

PRIORITY 2: SUBSTANCE ABUSE PREVENTION AND RECOVERY

Goal 1: Decrease substance misuse in the communities served by Allina Health.

Strategies

- Improve environmental factors and individual knowledge and skills associated with decreased substance misuse, with a focus on youth, adolescents, and older adults.
- Improve adults' confidence and skills around talking with youth about mental health, substance use and other issues affecting their mental well-being.
- 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 expansion of community coalitions in Allina Health's service area aimed at improving community protective factors associated with decreased substance misuse.
- Co-create efforts to build healthy coping skills and community protective factors with schools, community organizations, and other groups in which youth and families in the prioritized communities gather and feel a sense of belonging.
- Increase Change to Chill and Health Powered Kids content for adults who support school-age youth.
- 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.
- Decrease youth access to substances.

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.
- Advance local, state and federal policies aimed at increasing access to substance use care such as removing barriers to community and telephonic/virtual provision of care and other evidence-based treatment programs (e.g., Medically Assisted Treatment (MAT)).
- 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.

PRIORITY 3: 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.

PRIORITY 4: 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 River Falls Area Hospital 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

River Falls Area Hospital and Allina Health will continue to engage in assessment and engagement activities throughout the implementation phase. River Falls Area Hospital in conjunction with Healthier Together will develop specific work plans for implementing the strategies and activities outlined in the implementation plan, including further refining intended audience 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

River Falls Area Hospital, part of Allina Health in partnership with Healthier Together 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: Brandi Poellinger, Community Engagement Lead for East 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;
- Healthier Together Coalition and its' partners whose leaders worked diligently to perform a joint assessment and plan in partnership with River Falls Area Hospital;
- Partners from organizations who met to review and prioritize data and develop implementation plans, and the individuals who contributed their expertise and experience to ensure a thorough and effective outcome, especially staff from local public health agencies;
- Allina Health System Office staff and interns who supported the process;
- Other staff at Allina Health and River Falls Area Hospital who provided knowledge, skills and leadership to bring the assessment and plan to fruition.

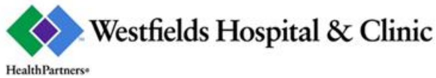
Appendix: Example Allina Health systemwide performance indicators

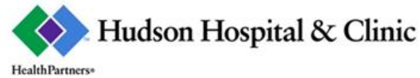
Health Priority	CHNA Goals	Example progress indicators	Example program-specific, intermediate outcomes
Mental health and wellness	Increase resilience and healthy coping skills.	• Progress on workplan to implement process for providers to introduce patients to community health programs. • Number of middle 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

Healthier Together

Pierce County

St. Croix County





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