Allina Health

MERCY HOSPITAL

2023–2025

Community Health Needs Assessment and Implementation Plan

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Introduction

Mercy 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.

The CHNA process is completed in partnership with local public health, 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.

Mercy Hospital conducted a joint assessment with Anoka County Department of Health & Environmental Services. The purpose of this report is to share results from this assessment of health needs in the community served by Mercy 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.

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, Mercy Hospital will pursue the following priorities in 2023–2025:

Chronic disease and health habits includes issues related to diet, physical activity, and diseases that are closely tied to health habits.

Drugs and substance use refers to 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.

Mental health includes overall mental, social and emotional well-being, including social connectedness; resilience; and ability to access the full continuum of mental health care and supports.

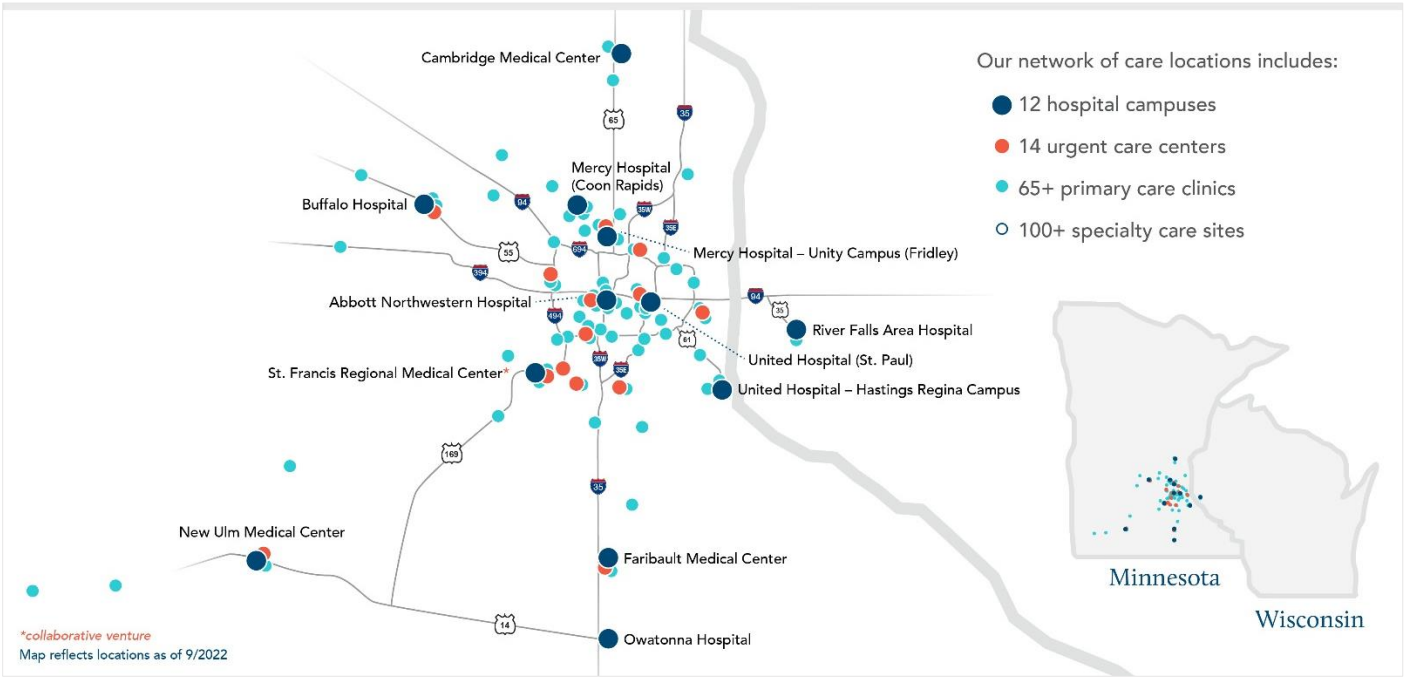
Relationship violence means issues related to a pattern of abusive behavior used by an intimate partner to maintain control over the other partner.

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

- People living in or near poverty
- Black, Indigenous, and other people of color (BIPOC) communities
- People with disabilities
- Adolescents aged 12–17 (mental health & substance abuse focused)
- People who identify as Lesbian, Gay, Bi-sexual, Trans, Queer and/or Questioning, and other historically underserved sexual and gender identities (LGBTQ+) (mental health priority)

Hospital and community description

ALLINA HEALTH SYSTEM MAP



HOSPITAL DESCRIPTION AND SERVICE AREA

Mercy Hospital (Mercy), part of Allina Health, has provided exceptional care to North Metro communities for more than 50 years. The hospital has two campuses — the Mercy campus in Coon Rapids and Unity campus in Fridley. Though the hospital serves patients from a wide geographic area, its primary service area (and focus of the CHNA) is Anoka County—a suburban area in the Twin Cities' north metro.

Mercy offers a wide range of specialty services, including award-winning cancer care through the Virginia Piper Cancer Institute, women's and children's services through the Mother Baby Center, mental health care, emergency services, surgical services and top-rated cardiovascular care through the hospital's nationally known Heart & Vascular Center. Additionally, the hospital was named one of the nation's 100 Top Hospitals and 50 Top Cardiovascular Hospitals by Truven Health Analytics. Mercy Hospital has a long history of working to improve health in the communities it serves through charitable giving by Allina Health and the Mercy Hospital Foundation and programming that addresses health needs in the community.

Together, the two Mercy campuses operate 479 beds, and annually serve more than 100,000 patients and their families. Because Mercy is the only hospital within the Anoka County boundaries, it partnered with Anoka County Public Health and Environmental Services to complete a joint community health assessment and plan.

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

Mercy Hospital — Mercy Campus and Mercy Hospital — Unity Campus are both located in Anoka County which is ranked among the healthiest counties (15th) in Minnesota by County Health Rankings. According to the U.S. Census Bureau, a total of 363,887 residents live in the 423-square mile area occupied by Anoka County. About 24 percent of the total population in Anoka County is under the age of 18. In Anoka County, approximately 18 percent of residents are people of color — primarily Hispanic or Latino (5 percent), Asian (5 percent) or Black (7 percent). In 2020, almost 9 percent of residents were foreign-born, and 5 percent had limited English proficiency. Nearly 10 percent of county residents have a disability. The median household income in 2020 was $84,379, with almost 6 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, Anoka County residents report an average of almost four poor mental health days per month and 13 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, more than 4 percent of residents are uninsured. Further, Anoka County has a 540:1 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 19,000 people in Anoka County (approximately 5 percent) experienced food insecurity in 2020 and an estimated 23 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 almost 19 percent of all the housing in Anoka County, an estimated over 45 percent of those households are considered cost-burdened. Additional information about Anoka County can be found at Minnesota Compass.

Evaluation of 2020–2022 implementation plan

In its 2020–2022 Community Health Needs Assessment and Implementation Plan Mercy Hospital adopted chronic diseases and health habits, mental health and addiction and relationship violence 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. Mercy Hospital specifically supported four schools via continued partnership with Blaine, Coon Rapids, Fridley, and St. Francis High Schools. Mercy also supported three new partnerships with Andover, Centennial and Columbia Heights High Schools, along with Compass Programs (grades 6–12). In total, these efforts reached approximately 10,281 students and 230 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, we 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 $63,500 in Mercy'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 4-5 pounds 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 (Anoka County: 24 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 Anoka County specifically, more than 32 percent of equity patients identified a need compared to 26 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").

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 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, many of whom were non-white and non-English speaking patients. 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 who underutilize health care 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 MERCY HOSPITAL ACTIVITIES

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

In 2021, hospital staff became chair of the newly formed Community Resiliency Committee. This Committee is a subcommittee of Anoka County Children and Family Council, focused on addressing adverse childhood events (ACEs) affecting youth, families and the community. In 2022, this committee received funding from Minnesota Department of Health (MDH). Funds from this grant will be used to promote the Change to Chill program and offer Change to Chill activities in underserved communities in Anoka County. As a start to this work, the Community Resiliency Committee partnered with the Anoka County Children & Family Council (ACCFC) to conduct a Change to Chill workshop at the Oromo Resource Center. Twenty-seven youth ages 8–18 years old participated in the workshop to learn more about mental well-being and strategies to build resiliency and practice techniques with their peers. Participants were also given calm kits, containing stress balls, coloring pages and other tactile items to help them reduce anxiety, manage stress, and calm themselves. Interview and survey results indicate an interest in hosting more workshops from community leaders, community partners, youth participants and adult teachers/assistants.

Additionally, Mercy is partnering with Anoka Hennepin School District leadership to provide mental health education to Anoka-Hennepin School District staff. A $50,000 Anoka County Children & Family Council grant and a $50,000 Mercy Hospital Foundation Grant were provided to expand this support to additional school districts. In 2020, hospital staff presented Change to Chill to 15 student achievement advisors who work directly with students in Anoka-Hennepin School District and partnered with Indian Education Advisor to create culturally specific stress management kits for students. In January and March 2022, hospital staff worked with

the district to facilitate two middle and high school forums on a variety of Change to Chill topics, including mindfulness, gratitude and life balance.

Goal 2: Reduce barriers to mental health and substance use services for people in our communities.

Mercy staff serve as members of the North Metro Mental Health Roundtable, which is aimed at identifying strategies to assure access and coordination of services between community mental health providers, law enforcement, county and city representatives. The hospital is also actively engaged as a member of the Mental Health Roundtable Stigma Reduction Workgroup. In 2020, the group partnered with the Make it OK Campaign (MIO) to promote stigma reduction education in the community, including hosting a virtual public awareness event in December 2020 in partnership with Anoka County Library System. Thirty-five individuals attended this event.

Goal 3: Increase healthy eating and physical activity among Anoka County residents of all ages.

In addition to the charitable contributions to local food shelves described above, an additional $30,000 was provided to Alexandra House, Hope for Youth and Stepping Stone Homeless Shelter to promote healthy activities and care to people experiencing homelessness. Hospital staff also promoted opportunities for employees to volunteer annually at the above organizations and all local food shelves in 2020 and 2021. Mercy also referred patients to Alexandra House and Stepping Stone and assisted these organizations in addressing the physical, emotional, and mental issues that patients and community members are experiencing. Local food shelf and emergency services provider organization employees are active on our Mercy Hospital Community Health Advisory Council, which advises Mercy on community health issues and how to cooperatively assist community members and promote healthy communities.

Goal 4: Reduce violence, bullying and abuse among people living in Anoka County.

Mercy Hospital partnered with Anoka County to develop an Anoka County Violence Roundtable group to review data, identify gaps, set goals and plan for violence prevention and service improvement activities in the community. From 2020–2022, hospital representatives participated in monthly Roundtable committee meetings. In that period, the Roundtable hosted two focus groups, a community survey on interpersonal violence, and planned and implemented community education activities in partnership with Anoka County Public Health. Mercy Hospital's Forensic Nurse Program participated in community-wide efforts and coalitions to provide education on violence prevention. In addition, Mercy Hospital's Trauma Services Department has been active in promoting community education that addresses causes of trauma and increases community awareness. More information about Forensic Nurse Programs is available on Minnesota Forensic Nurses website. In addition, Mercy Hospital each year sponsored and participated in Alexandra House's annual Gala and HopeFest events.

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. The CHNA process included involvement from local public health, 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 Mercy Hospital were chronic diseases and health habits, mental health and addiction, and relationship violence. These priorities remain significant and are impacted by 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.

To efficiently conduct the CHNA and reduce community burden, Mercy Hospital partnered with Anoka County who is also required to conduct their own community health assessment. The two 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 plan.

Mercy Hospital Community Health Advisory Council and hospital 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	**REPORT WRITING** Coordinate report writing and share results and action plans with key stakeholders system wide.
September 2022	**DRAFT APPROVAL:** Mercy Community Health Advisory Council
December 2022	**FINAL APPROVAL** Present for final approval to the Allina Health Board of Directors.

Data review and issue prioritization

Mercy Hospital collaborated with Anoka County Public Health and Environmental Services to complete its CHNA. The group used a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) model and methodology, a community-driven strategic planning process for improving community health. The methodology informed the prioritization process, yet the working group did not move through all the stages of MAPP as most of those were completed during the previous assessment cycle. 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.

The collaborative steering committee (representatives from Mercy Hospital and Anoka County Public Health) met monthly starting in May of 2021 to develop a plan and strategies for conducting the CHNA process.

The steering committee then recruited 50 community representatives to form a Community Heath Assessment Team (CHAT). CHAT members include representatives from health plans, healthcare systems, local non-profits, the local faith community, local government, mental health providers, public health and community residents from a variety of cultural traditions. The purpose of CHAT is to provide input and review various data to conduct a thorough analysis and develop CHNA priorities. In addition to CHAT, advice and input was provided through two existing advisory groups: the Anoka County Community Health Advisory Committee and Mercy Hospital's Community Health Advisory Council. Based on broad input the decision was made to do a "refresh" of the 2020–2022 priorities unless other pressing priorities arose through the data review process. Specifically, the groups reviewed select Allina Health patient data and local public health data provided by Anoka 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 the patients seen at Allina facilities.

Examples of indicators reviewed include, but are not limited to:

- Volume of Allina Health EMS ambulance runs by cities served in Anoka County
- Patient and public health data by county of residence (Anoka): 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
- Opioid and other drug-related deaths in Anoka County (2016–2020)
- Environmental health report

Secondary state and local data resources available to Anoka County were also reviewed such as:

- 2019 Minnesota Student Survey
- 2018 Anoka County Adult Health Survey
- Minnesota Housing Partnership (MHP) County Housing Profiles
- 211 dashboard
- Violence Prevention Community Survey (Anoka County Public Health)
- Minnesota 2020 Homicide Report
- Feeding America report: Impact of COVID on Food Insecurity 2020–2021

- Anoka County fact sheets, including: Anoka County Housing Profile, Relationship Violence Fact Sheet 2021, Environmental Health Fact Sheet 2021, Drug Use Fact Sheet 2021, Mental Health and Suicide Fact Sheet 2021
- Protecting Youth Mental Health: US Surgeon General Youth Mental Health Advisory

In total, data included more than 50 indicators related to demographics, social and economic factors, health behaviors, prevalence of health conditions, and health care access.

PRIORITIZATION PROCESS AND FINAL PRIORITIES

To identify priorities, the Mercy Hospital and Anoka County Public Health collaborative steering committee considered preexisting CHNA priorities and goals of Anoka 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, the following health topics were prioritized for 2023–2025:

- Chronic diseases and health habits
- Mental health and well-being
- Drugs and substance use
- Relationship violence

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

- People living in or near poverty
- Black, Indigenous, and other people of color (BIPOC) communities
- People with disabilities
- Adolescents aged 12–17 (mental health & substance abuse focused)
- People who identify as Lesbian, Gay, Bi-sexual, Trans, Queer and/or Questioning, and other historically underserved sexual and gender identities (LGBTQ+) (mental health priority)

NEEDS NOT ADDRESSED IN THE CHNA

The Steering Committee and CHAT Team decided to do a “refresh” of 2020-2022 priorities unless other pressing priorities arose through our data review process. At the end of the process, no new priorities emerged. However, the group identified the following issues to take into consideration during the implementation process:

- Health equity should be woven into community health plans, and programs should be tailored to meet cultural needs whenever possible.
- Cultural relevance and language should be taken into consideration; even for members of the community who are not typically underrepresented, communication and framing should be carefully developed.
- It is important to have providers that represent the community. There is a particular need for more BIPOC providers.
- Equity extends to the built environment, including zoning and regulations, transportation and public green spaces.
- Economically disadvantaged communities have less access to care or resources.

Community input

After selecting its 2023–2025 priorities, Mercy and Anoka County contracted with Wilder Research to collect additional feedback from CHAT members via a web survey and four focus groups.

Wilder analyzed the results of a web survey that was administered to CHAT members in October of 2021. Of 46 CHAT members, 30 completed the survey (65 percent response rate). The survey asked members about aspects of each of the health priority issues, including their perspectives of who was most impacted, and which community strengths were well-positioned to address the issue. Wilder developed data tables and charts based on the quantitative data and reviewed the open-ended responses for themes.

Following the web survey, CHAT members were invited to participate in one of four scheduled discussions. Each discussion followed the same protocol, and asked members about each of the priority health issues. The facilitation of these groups allowed for the development of a more nuanced understanding of how members viewed the issues and their ideas regarding solutions or approaches to each issue. The qualitative data gleaned from these discussions formed high-level themes, which are incorporated into each health priority issue below (Community Input Results).

In addition, Mercy Hospital worked closely with the Mercy Community Health Advisory Council to seek feedback on the issues, challenges and opportunities related to each chosen priority. Members of this council include representatives from:

- Alexandra House Domestic and Sexual Assault Center
- Allina Health Senior Leadership & Physician Services
- Allina Health EMS and Allina Health Community Clinics
- Anoka County Public Health & Environmental Services
- Anoka Hennepin School District
- ACBC Food Shelf
- Head Start of Anoka County
- Health Partners and Allina Health NW Alliance
- Liberian Health Initiative
- Neighborhood HealthSource Federally Qualified Health Clinic
- Trellis Area Agency on Aging for the Twin Cities

COMMUNITY INPUT RESULTS

Chronic diseases and health habits

Challenges, ideas and opportunities

Among survey respondents, food insecurity and lack of understanding of chronic disease management and prevention were the top-ranked priorities, and these issues were centered in focus groups. Nearly all survey respondents agreed that chronic diseases and health habits should be a high priority for community health. Of 29 respondents, only one person said they were not sure if this was a high priority.

Food insecurity was the focal point of group discussions, and this was also the top-ranked sub-issue on the survey. Participants in all four focus groups said that COVID has exacerbated food insecurity and that there are not enough resources to meet the high level of need. Key recommendations from three of the groups touched on the food available at food shelves. These participants discussed the importance of better matching up food offerings with what residents truly want to eat, especially fresh produce. They also noted that food shelves often do not carry culturally appropriate food.

Another key theme regarding food insecurity was barriers to access, especially transportation. Three of the groups mentioned transportation as a barrier to accessing food, and two also suggested partnering with the transportation system for food outreach. (One similar model is the Twin Cities Mobile Market.) During the pandemic, some residents were eligible to receive home deliveries of food due to recommended quarantine or isolation, and a few participants talked about the significant impact of having a low- or no-barrier option like this. Because of the burden on low-income households to seek out and apply for benefits, one group discussed the possibility co-locating support services at food shelves, including on-site social workers who could help with applications for SNAP (Supplemental Nutrition Assistance Program) or other programs.

While food insecurity was more deeply discussed than chronic diseases, two groups did note poverty is a key barrier to successful management of chronic health issues and providing disease management education is critical. In particular, they called out the need to combat misinformation, especially in immigrant communities.

When asked about the effect of the pandemic on chronic health issues, survey respondents described the overall decrease in regular health screenings and routine care (potentially because of disruption of some medical services); isolation and lack of socialization, especially among older adults; fewer adults getting adequate physical activity; and lack of equal access to health care among BIPOC communities.

Key takeaways:

- Food shelf offerings should better match preferences and dietary restrictions and have more fresh food available.
- Co-located services at food shelves could help residents access other needed supports.
- Transportation is a key barrier to accessing food shelves and affordable grocery stores.

Assets and populations experiencing disparities:
Percentages represent the number of CHAT members identifying this group or asset in the web survey.

- Populations of most concern: People living in or near poverty (86 percent); BIPOC communities (66 percent); People with disabilities (52 percent).
- Greatest community assets: Public health involvement (75 percent); Non-profit involvement (68 percent).

Drugs and substance use

Challenges, ideas and opportunities

Among survey respondents, use of opioids and other illicit drugs were the top-ranked priorities, and these issues were centered in focus groups. Nearly all respondents agreed that drugs and substance use should be a high priority for community health. Of 28 respondents, only one person said they were not sure if this was a high priority.

Participants in all four focus groups expressed awareness of and concern about the increase of opioid use and overdose deaths. Notably, three groups discussed the complicating factor presented by the presence of fentanyl circulating with substances. One participant suggested that access to more fentanyl test strips might help stem the issue. Other approaches included police department “takeback” programs (mentioned in one group) and harm reduction strategies, including use of Narcan (mentioned in two groups). Two groups talked about the importance of changing the narrative from a “you” problem to a community issue that should be collectively addressed.

A key issue noted by three of the groups was a lack of detox facilities and long-term care options for recovering users. These participants acknowledged that significant funding would be needed to build out appropriate programming and resources for this issue. They also expressed doubt about the feasibility of funding such

facilities or programs, given that funders are less keen to invest in something that will not see a payoff for several years.

When asked about the effect of the COVID-19 pandemic, survey respondents described isolation, stress, and lack of socialization as exacerbating addiction issues and an overall increase in mental health issues and need for coping mechanisms.

Key takeaways:

- Detox facilities and long-term care options are critically important, but currently lacking.
- Opioid use has increased significantly, and solutions should consider both harm reduction (e.g., fentanyl test strips, Narcan) and prevention (e.g., awareness building).

Assets and populations experiencing disparities:
Percentages represent the number of CHAT members identifying this group or asset in the web survey.

- Populations of most concern: Adults aged 18–64 (71 percent); Adolescents age 12–17 (61 percent); BIPOC communities (54 percent); People living in or near poverty (54 percent).
- Greatest community assets: Healthcare involvement (57 percent); Non-profit involvement (57 percent).

Mental health

Challenges, ideas and opportunities
Among survey respondents, stigma around mental health and lack of access to mental health services were the top-ranked priorities, and these issues were centered in focus groups. All respondents agreed that drugs and substance use should be a high priority for community health.

Focus group participants had a lot to say about mental health issues, and nearly all talked about the overall prevalence of such issues in the community. Three groups also linked the rise in drug use to mental health issues. While participants in two groups noticed a decrease in stigma around mental health, some noted it is still a taboo topic in certain cultural communities, which may worsen outcomes for those individuals. Two groups mentioned that BIPOC communities and those who speak English as a second language face added barriers to accessing mental health resources due to lack of language availability or cultural appropriateness.

Participants in two groups focused on mental health issues among adolescents, noting suicide rates have risen dramatically with the presence of social media, and the disruptions to social life caused by the pandemic. These groups talked about the potential benefit of working with schools but acknowledged that it can be difficult to work with schools or to obtain parental consent to provide therapy.

The lack of mental health providers came up in two groups, with those participants discussing the increased demand for services. This sometimes results in patients waiting months to see a mental health provider, which for some can be dangerous. The new Integrated Mental Health Center planned for Fridley was brought up as one community asset that should help significantly.

When asked about the effect of the COVID-19 pandemic, survey respondents described isolation as having exacerbated mental health issues, including depression and anxiety, and a lack of resources and facilities for treating mental health issues.

Key takeaways:

- There are not enough mental health providers who represent BIPOC communities.
- Partnerships with schools may be beneficial for adolescents experiencing mental health issues.
- Increased demand (in part due to the pandemic) for services has resulted in significant wait times to see a provider.

Assets and populations experiencing disparities:

Percentages represent the number of CHAT members identifying this group or asset in the web survey.

- Populations of most concern: Adolescents aged 12–17 (86 percent); People living in or near poverty (71 percent); People who identify as LGBTQ+ (71 percent).
- Greatest community assets: Non-profit involvement (64 percent); Education involvement (57 percent)

Relationship violence

Challenges, ideas and opportunities

Among survey respondents, stigma around relationship violence and lack of education about relationship violence were the top-ranked priorities, and these issues were centered in focus groups. Most respondents agreed that relationship violence should be a high priority for community health, though the strength of this response was lower than the previously mentioned issues.

All four groups expressed admiration for the work of Alexandra House, citing it as a fantastic resource for the community. However, more volunteers would help increase capacity.

Three groups talked about the need to identify solutions that solve the problem at its source. The most commonly suggested approach was to educate adolescents about healthy relationships early on (one group mentioned that it is discussed in tenth grade health classes, but that this is much too late), and that collaboration with schools could be beneficial. This education should focus on both physical and emotional abuse as well as halting generational or learned behaviors.

One interviewee noted that there is also a lack of services geared towards supporting LGBTQ people.
When asked about the effect of the COVID-19 pandemic, survey respondents described the following impacts:

- Increase in stress and mental health issues have led to an increase in relationship violence.
- Isolation has weakened support systems and caused relationship violence to become a "hidden" issue.

Key takeaways:

- Alexandra House is a great, well-respected community resource.
- Prevention is critical and should be approached by educating adolescents about healthy relationships.

Assets and populations experiencing disparities:

Percentages represent the number of CHAT members identifying this group or asset in the web survey.

- Populations of most concern: Adults aged 18–64 (81 percent); People living in or near poverty (58 percent).
- Greatest community assets: Non-profit involvement (93 percent); Law enforcement involvement (52 percent).

Overarching themes

Communication and messaging

Several groups agreed the key to successful messaging regarding public health issues is to engage people in "boots on the ground" roles, such as nurses, teachers, social workers, or community advocates. Participants felt successful outreach should include to following components:

- Deeper, more meaningful engagement with "boots on the ground" individuals, with a focus on building strong relationships.

- Cultural relevance and language should be taken into consideration; even for members of the community who are not typically underrepresented, communication and framing should be carefully developed.
- Partnerships with schools to provide education on priority health issues and key sub-issues.

Prioritize health equity

Participants in two groups and both interviewees said that health equity should be woven into any public health plans, and that programs should be tailored to meet cultural needs whenever possible. Aspects of health equity that were discussed include:

- The importance of having providers represent the community, and the need for more BIPOC providers.
- Equity extends to the built environment, including zoning and regulations, transportation, and public green spaces.
- Several survey respondents said that they have noticed inequities among BIPOC communities, especially those who are immigrants.
- Others reported inequities based on income or poverty status, noting that economically disadvantaged communities have less access to care or resources.

Community changes

Survey respondents described changes in Anoka County that may have an impact on public health issues. These changes included:

- An increase in crime.
- Challenges and barriers resulting from increasing polarization and the politicization of public health.
- Increasing diversity of the community, including more immigrants.

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 community-specific 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 that look like 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 are contributing 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 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, Mercy'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, Mercy 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.

Mercy'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, Mercy 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. Mercy will prioritize hospital-specific activities that engage the local prioritized communities.

PRIORITY 1: CHRONIC DISEASES AND HEALTH HABITS

Objective 1: Increase rate of Anoka County adults who have had a routine checkup with a doctor or health care professional in the past year from 75 percent (from the 2018 Anoka County Adult Health Survey) to 85 percent or higher by 2025, as measured by the Anoka County Adult Health Survey.

Objective 2: Reduce the "food insecurity" measure for Anoka County from 6 percent (2019) to 4 percent or less by 2025.

Objective 3: Decrease the rate of low-income (200% Federal Poverty Level or less) Anoka County adults who "often" or "sometimes" worried that food would run out before having money to buy more from 42 percent (from the 2018 Anoka County Adult Health Survey) to 30 percent or less by 2025, as measured by the Anoka County Adult Health Survey.

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

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 are 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 community 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 Allina Health 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.

Goal 3: Increase access to healthy foods for all community residents

Strategies

- Determine the most effective methods to address food insecurity in our community, and promote these methods to culturally diverse populations
- Establish partnerships and leverage existing resources to maximize the impact on food insecurity in our community.

Activities

- Complete a Food Security Solutions Prioritization Process to identify priorities for addressing food access in Anoka County by engaging with communities experiencing food insecurity and partners, such as food shelves and healthcare providers, to determine food access barriers (such as transportation) and needs and offer innovative ways to address food insecurity.
- Promote culturally appropriate resources for accessing healthy food in multiple languages to increase awareness and utilization of resources.
- Increase enrollment in WIC (Women, Infants & Children) and utilization of benefits for eligible families.
- Work with Anoka County Economic Assistance and others to co-locate services at local food shelves for enrollment in SNAP and other benefits.
- Work with SNAP/EBT to increase number of farmers markets that accept SNAP / EBT through community outreach and promotion.
- Promote community awareness of onsite school food resource programs, such as backpack programs and onsite food shelves.

Goal 4: Increase understanding of chronic disease prevention and increase access to health services and programs that are culturally specific, honoring and appropriate.

Strategies

- Increase access to care for all through utilization of consumer convenient accessibility methods and reduction of barriers for prevention and treatment.
- Support and promote health efforts aimed at preventative care and education.
- 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

- Increase healthcare access through utilization of telemedicine (increasing public readiness, knowledge, and use where appropriate), and work with seniors/others to increase access to in-person healthcare when telemedicine is not available / preferred.
- Engage with diverse and vulnerable communities to understand barriers to chronic disease management and prevention. Review communication and information systems (including individual biometrics) for accessibility for all audiences and educate providers about health literacy and information accessibility.
- Explore the development of an Anoka County healthcare provider network to increase access more broadly across the community.
- Promote Child & Teen Checkups and chronic disease prevention materials in partnership with public health and local health providers.

- 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 Allina Health's health related social needs 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.

PRIORITY 2: MENTAL HEALTH AND WELL-BEING

Objective 1: Reduce the 5-year suicide death rate in Anoka County from 13.2 deaths per 100,000 (2016 - 2020) to less than 10 deaths per 100,000 by 2025 (using 2021 - 2025 vital statistics data).

Objective 2: Decrease the rate of Anoka County adults who delayed or declined needed mental health care because they were "too nervous or afraid" from 33 percent (from the 2018 Adult Health Survey) to 20 percent or less by 2025, as measured by the Anoka County Adult Health Survey.

Objective 3: Reduce the rate of Anoka County adults going without or delaying needed mental health care from 20 percent in 2018 (from the 2018 Anoka County Adult Health Survey) to 15 percent or less by 2025, as measured by the Anoka County Adult Health Survey.

Goal 1: Reduce the stigma around mental health & increase resilience and healthy coping skills in our communities.

Strategies

- Improve social connections and social cohesion in our community.
- Address stigma and the issues of suicide and self-harm through existing community collaborations.
- 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.
- Participate in existing community coalitions that are working to identify risk and protective factors associated with self-harm and suicide in the community, including opportunities to mitigate trauma.
- Promote mental health stigma-reduction resources such as Change to Chill, Make it OK, social emotional learning, and other programs and resources in schools, businesses and other community settings.

- 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.
- 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 our community.

Strategies

- Support public policy and advocacy efforts to improve access to mental health services.
- Address the issue of homelessness and its impact on individuals in crisis or with mental illness.

Activities

- Lead and participate in community coalitions focused on improving access to mental health and addiction services, inclusive of supporting the development of a new integrated mental health facility to serve the community.
- Support and advocate for local, state and federal policies aimed at increasing access to mental health services.
- Participate in community collaborations aimed at reducing incarceration and homelessness among individuals in crisis and/or living with a mental health or addiction condition.

PRIORITY 3: SUBSTANCE ABUSE PREVENTION AND RECOVERY

Objective: Reduce the 5-year opioid overdose death rate in Anoka County from 45.5 deaths per 100,000 population (2016-2020) to less than 30 deaths per 100,000 population by 2025 (using 2021-2025 vital statistics data).

Goal 1: Decrease substance misuse in our communities.

Strategies

- Improve environmental factors and individual knowledge and skills associated with decreased substance misuse.
- 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 aimed at improving community protective factors associated with decreased substance misuse.
- Identify opportunities to improve navigation of substance use disorder resources and access to timely treatment by eliciting feedback from the Substance Use Disorder Provider Network and other partners.
- 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.

- 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.
- Advance local, state and federal policies aimed at making it more difficult and/or less appealing to access alcohol, tobacco and other drugs.
- Promote drug use prevention education in the community, including through schools. Work with community partners, including local elected offices and others, to advocate for public health education in schools and other settings.

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, drug take-back programs, as well as supporting and promoting drug awareness events in the community.
- Increase harm reduction resources in the community, which may include fentanyl testing, Naloxone availability, training on the signs of overdose and how to administer Naloxone, and promoting community resources like the Naloxone Finder website, in partnership with pharmacies and other partners.
- 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 4: RELATIONSHIP VIOLENCE

Objective 1: Decrease the rate of 11th grade Anoka County public school students reporting experiencing relationship violence from 19 percent in 2019 (2019 Minnesota Student Survey) to 15 percent or less by 2025 as measured by the Minnesota Student Survey.

Objective 2: Decrease the rate of Anoka County residents reporting ever or currently being in an abusive relationship from 6 percent (from 2018 Anoka County Adult Health Survey) to 4 percent or less by 2025, as measured by the Anoka County Adult Health Survey.

Goal 1: Decrease the number of people experiencing violence in Anoka County

Strategies

- Reduce stigma around relationship violence

- Increase knowledge about healthy relationships, relationship violence resources, and the importance of addressing relationship violence
- Reduce barriers to accessing relationship violence services and fill resource gaps

Activities

- Engage local leaders, community members, and other subject matter experts such as Violence Free Minnesota to identify cultural and access needs regarding relationship violence prevention such as cultural considerations with relationship violence stigma.
- Support funding for Alexandra House and other critical resources by: A) Collaboratively engaging in grant applications and advocating for funding to continue / expand with critical partners, and B) Support awareness-raising events, such as HopeFest, and invite community organizations to participate, including businesses, libraries, parks, and others.
- Raise awareness of relationship violence in the community and provide healthy relationship education to the community through a variety of settings and partnerships.
- Work with local schools and partners such as Alexandra House to expand education on healthy relationships early in adolescence and to better educate parents and school staff about healthy relationships.
- Complete a series of survivor focus groups and community dialogues with individuals with lived experience with relationship violence and broader community members to identify local barriers to accessing relationship violence services.
- Work with community organizations, such as the Alexandra House and community care providers to assess the potential impact of the development of a comprehensive resource guide to promote services and connect community members to resources.
- Increase awareness of community service and care providers with the Lethality Assessment Project and their efforts to quickly connect victims of relationship violence to local resources.

RESOURCE COMMITMENTS

To effectively implement these strategies and activities, Allina Health and Mercy 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

Mercy Hospital and Allina Health will continue to engage in assessment and engagement activities throughout the implementation phase. Mercy Hospital 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

Mercy Hospital 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: Craig Malm, Community Engagement Lead for North Metro 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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- Other staff at Allina Health and Mercy 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