Community Health Needs Assessment
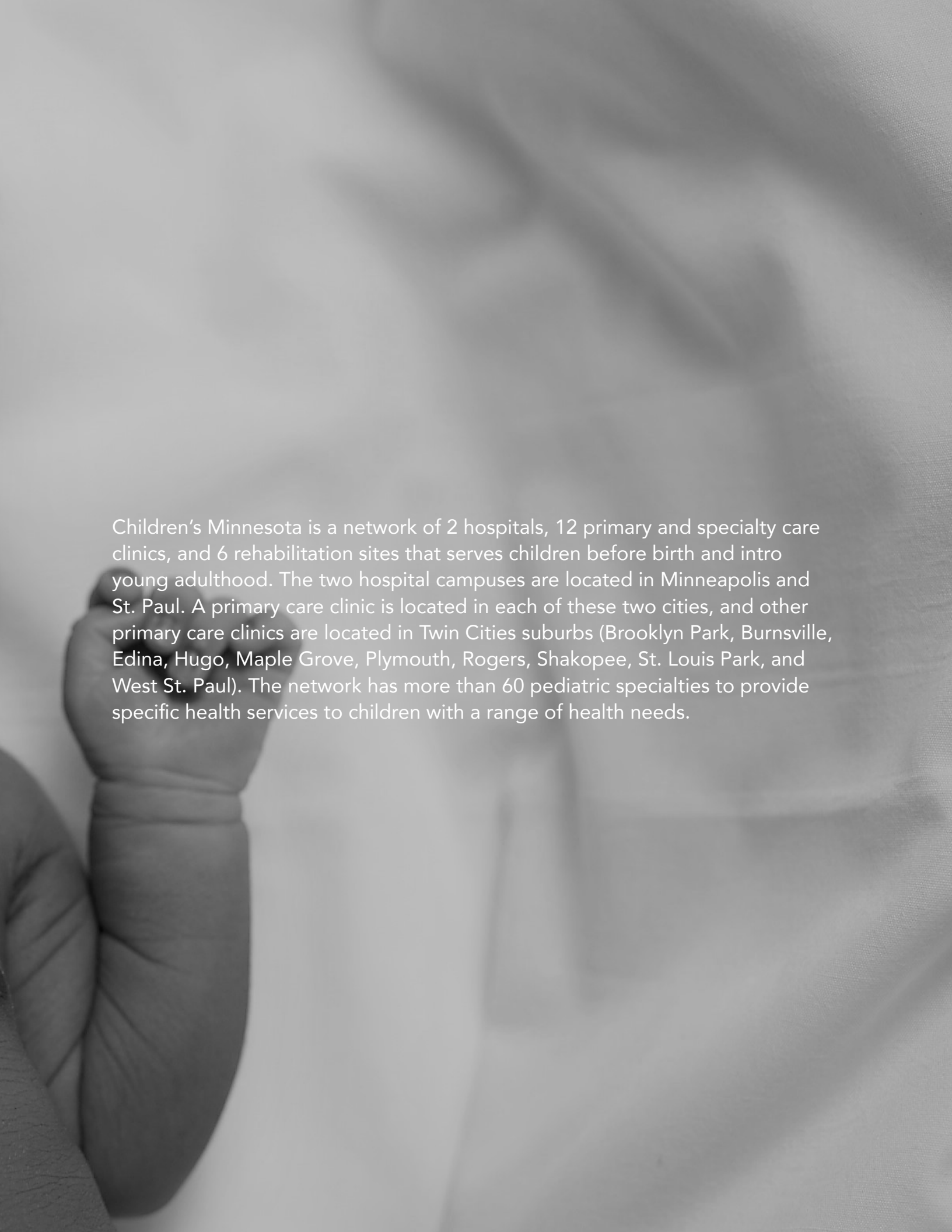Prepared by: Melanie Ferris and Katie Rojas-Jahn
December 2016

In partnership with:

Wilder Research
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Children's Minnesota is a network of 2 hospitals, 12 primary and specialty care clinics, and 6 rehabilitation sites that serves children before birth and intro young adulthood. The two hospital campuses are located in Minneapolis and St. Paul. A primary care clinic is located in each of these two cities, and other primary care clinics are located in Twin Cities suburbs (Brooklyn Park, Burnsville, Edina, Hugo, Maple Grove, Plymouth, Rogers, Shakopee, St. Louis Park, and West St. Paul). The network has more than 60 pediatric specialties to provide specific health services to children with a range of health needs.

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There are many people who gave of their time to help guide this assessment process, to share their experience and expertise, and to elevate the strengths, assets, concerns, and priorities of children and families living in the Twin Cities metro region. Wilder Research and Children's Minnesota appreciate the time and insight of the following individuals who served on the Community Advisory Committee (CAC):

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Sarah Berger	Neighborhood House
Stephanie Graves*	Minneapolis Health Department
Úrsula Reynoso*	Aquí Para Ti, HCMC

CAC members with an asterisk (*) by their name also participated in an interview about community health assets, needs, and priorities (see below).

This report was approved by the Executive Committee of Children's Minnesota's Board of Directors on December 13, 2016. Children's Minnesota and Wilder Research are responsible for the content and accuracy of this report.

We would also like to thank the following community stakeholders who took time to speak to the health assets, needs, and priorities of the communities they are part of or serve through their individual leadership or organization's services:

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Monica YellowBird
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Noya Woodrich
Minneapolis Council of Churches

Peter Eichten
Midtown Phillips Neighborhood Association

Rebeka Ndosi
Formerly at Nexus Community Partners

A NOTE TO OUR COMMUNITY

Dear Reader,

At Children's Minnesota, we have set our sights on a powerful vision: to be every family's essential partner in raising healthier children. Our vision demands that we push ourselves to reach all kids, and that we support the health of kids and families through collaborative effort and partnership. As extensive as our expertise is, it will never equal the knowledge children, families and communities have about how they define their own health and well-being.

It is in that spirit that we embarked on a new approach to understanding the health of our community. We wanted to leverage this federally required process to gain a broader view of health and through a process that actively engaged community partners. Why? It's simple – if we, as a pediatric health care organization, want to support the health of children in our community, we cannot afford to limit our scope to medical care alone and we must learn from and partner with the experts in our community.

Over the course of 2016, we have had the honor of hearing from people within and outside of Children's about their perspectives on health and well-being, including:

> › More than 800 people at community events and primary care clinics

> › 42 community stakeholders

> › 195 Children's Minnesota employees and clinicians

The body of scientific literature confirms what we and the community know intuitively through the experiences of raising children over generations: that health and well-being is deeply influenced by our environments, social connections, educational and economic opportunities, and more. These factors interact in complex ways with health behaviors and habits, as well as the accessibility and quality of medical care.

This work has brought us new insight and yet we know it is not an exhaustive understanding of our community. No assessment can be, and that's why we view the present CHNA as one part of a broader commitment to engaging with our community in a way that creates new pathways for partnership in support of better health for children in our community.

We know our communities offer so many strengths and they are home to amazing children. We look forward to working with you to support those children and their future.

Sincerely,

MARIA CHRISTU, JD
Vice President of Advocacy and Health Policy
Children's Minnesota

WHAT IS HEALTH FOR CHILDREN?

To ground our community health needs assessment (CHNA) in a discussion focused on assets and strengths, Children's Minnesota staff used discussion boards to ask children and families to finish the following sentence:

CHILDREN WHO ARE HEALTHY…

1   The written responses of children and families are shown in this figure. Respondents were invited to answer the question in any language

ABOUT THE ASSESSMENT APPROACH

Through the Affordable Care Act (ACA), all not-for-profit hospitals are federally required to conduct a community health needs assessment (CHNA) that identifies the health needs and priorities of community residents and the steps that the hospital will take to address these health-related topics. The report describes the assessment process used to identify and prioritize the community health topics that community stakeholders believe are most critical for Children's Minnesota to address. A subsequent report will include an implementation plan that describes the specific actions Children's Minnesota will take during the next three years to address these priority topics.

This assessment, while building from the 2013 assessment that relied heavily on secondary data, was designed to better reflect the strengths, needs, values, and priorities of the children and families it serves. Some of the key aspects of the approach used in this assessment process are described below:

› The entire assessment process has been guided by the Community Advisory Committee (CAC), a diverse group of community stakeholders, including local advocates and representatives of community organizations and systems serving children and families.

› The health topics considered through this assessment process were expanded to include community conditions and other factors that contribute to health, such as poverty, education, and housing.

› The assessment used a mixed-method approach to hear from multiple stakeholder groups, including Children's Minnesota staff in roles that connect patients to community resources (e.g., social workers, care navigators).

› The top health priorities were determined through criteria recommended by the CAC that valued quantitative and qualitative data and drew on the experience and expertise of committee members.

Children's Minnesota contracted with Wilder Research and Wilder Center for Communities to support the assessment process. The Wilder team worked closely with Children's Minnesota staff to plan meetings that engaged CAC members in discussion and decision-making and to conduct a comprehensive assessment process that met all federal requirements.

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2   Using a trauma-informed lens helps people, organizations, and systems understand the impact of trauma and potential paths for healing, recognize the signs and symptoms of trauma, and integrate this knowledge into policies, practices, and settings. A trauma-informed approach creates safe and supportive environments, avoids retraumatizing individuals, and builds on the strengths and resources of individuals in the context of their environmental and communities. A trauma-informed approach can be used in any setting. Adapted from:

COMMUNITY ADVISORY COMMITTEE

Children's Minnesota convened a Community Advisory Committee (referred to as the "CAC" in this report) to help guide the assessment process so that it is responsive to and supportive of community health. The goal was to convene a committee with members who collectively have varied perspectives about health, cultural and ethnic diversity, familiarity working with the challenges and opportunities of large systems, existing or interest in pursuing partnerships with Children's Minnesota, and ongoing relationships with residents of the communities in Minneapolis and Saint Paul that they work with or serve. The CAC developed a set of core principles that set the tone for the assessment. These include:

› Utilize a broad, open definition of health and well-being

› Keep equity at the center, ensuring it is considered in all decision-making

› Consider the impact of social determinants on our communities

› Use a trauma-informed lens to influence decision-making

› Be aware of Children's Minnesota's limitations and sphere of influence

The CAC was involved in the following specific tasks and provided additional insights and feedback throughout the assessment process:

› Developing the key questions to be answered through the assessment

› Recommending specific data collection strategies to ensure broad representation of community members in the assessment process

› Reviewing data gathered throughout the assessment process and suggesting changes to improve the way in which data are reported and shared

› Setting the prioritization criteria and participating in a process to identify the top health concerns that Children's Minnesota should work to address

This assessment process was intended to increase the involvement of community stakeholders in key decisions. However, Children's Minnesota also views the CHNA as one element of a broader community engagement commitment and ongoing partnership with community stakeholders.
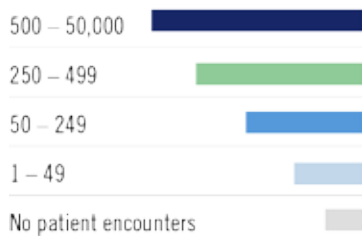
ABOUT CHILDREN'S MINNESOTA

Children's Minnesota is one of the largest pediatric health systems in the United States and the only health system in Minnesota to provide care exclusively to children, from before birth through young adulthood. An independent and not-for-profit system since 1924, Children's Minnesota serves children throughout the Upper Midwest at two free-standing hospitals (in Minneapolis and Saint Paul), 12 primary and specialty-care clinics, and six rehabilitation sites.

IN 2015

› More than 130,000 children received care from Children's Minnesota; this included more than 96,000 emergency department visits and nearly 14,000 inpatient hospitalizations

› Children and families served by Children's Minnesota spoke 64 different languages and nearly 85,000 visits involved an interpreter

› Many children served lived in lower-income households; a majority of children who received care at Children's Minnesota hospitals or Minneapolis and Saint Paul clinics are insured through Medicaid

NUMBER OF CHILDREN'S PATIENTS IN 2015 BY COUNTY

500 – 50,000	
250 – 499	
50 – 249	
1 – 49	
No patient encounters	

Patients are counted once, even if they visited Children's multiple times at different facilities. Data includes all inpatient and outpatient encounters for all facilities.
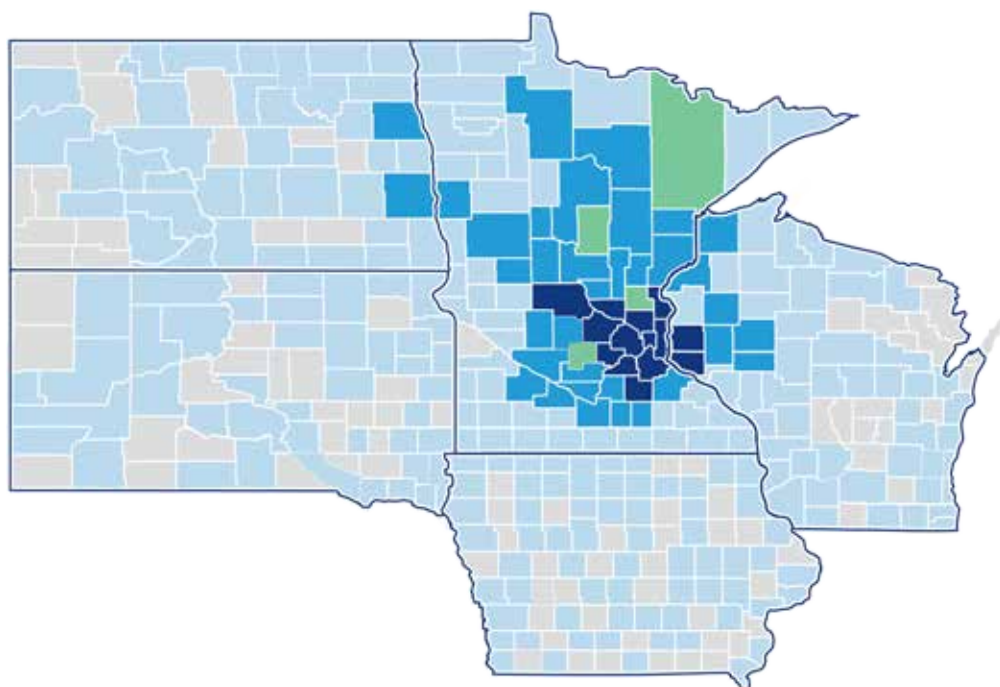
COMMUNITY DEFINITION

Children's Minnesota serves a large geographic area and diverse patient population. In 2015, Children's Minnesota cared for slightly more than 133,000 patients through its hospitals, primary and specialty care clinics, and in-home services. Children's Minnesota sees patients from all across Minnesota and more than 65 percent of the counties in the four neighboring states. At its hospital locations alone, there were more than 96,000 emergency department visits and 14,678 hospitalizations in 2015.

Although Children's Minnesota has a broad reach in the state and region, the definition of community used in this assessment focused on a smaller geographic area in order for this CHNA to be actionable. Mapping the addresses of children served by Children's Minnesota's two hospitals and 12 primary care clinics showed that most of the children who receive care from Children's Minnesota live in the seven-county Twin Cities metro region (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties) and that Children's Minnesota reaches large numbers of the child population in multiple Minneapolis and Saint Paul neighborhoods. (Additional details are included in a separate document, the Data Summary Packet.) Analysis of the demographic data collected by Children's Minnesota showed that the two hospitals serve a culturally, linguistically, and socioeconomically diverse patient population.

Based on these data, and with the input of the CAC, Children's Minnesota adopted the following definition of the community it serves.

CHILDREN'S MINNESOTA COMMUNITY DEFINITION

The community served by Children's Minnesota includes children of all ages (prenatal – age 17) who live in the seven-county Twin Cities region: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties.

The assessment also placed additional emphasis on learning about the health needs, assets, and priorities of children and families living in the following five neighborhoods where: a) high densities of Children's Minnesota patients live and b) where children and families experience disproportionate burden because of inequitable social, economic, and environmental conditions:

› In Minneapolis: Phillips and Powderhorn
› In Saint Paul: West Side, Frogtown/Thomas-Dale, and Dayton's Bluff

It should be noted that while Children's Minnesota has focused on these neighborhoods for the purpose of the CHNA, its work is not limited to these five geographic areas.

NEIGHBORHOOD REACH

Children's Minnesota reaches at least one-quarter of children who live in these five neighborhoods through its hospital and primary care clinic services alone; nearly half (46 percent) of children in the Phillips neighborhood of Minneapolis are served by Children's Minnesota. These five neighborhoods each have their own unique assets and share some common demographic characteristics. There are differences in the racial and ethnic composition of each neighborhood, and there is not a majority racial or ethnic group in any of the five neighborhoods. Compared to the Twin Cities metro region overall, children who live in these neighborhoods are more likely to experience financial instability, as measured by household income, the percentage of income spent on housing-related expenses, and adult employment rates. These neighborhood-level demographic characteristics underline the importance of the assessment process identifying racial and socioeconomic disparities that influence the health and well-being of children and families.
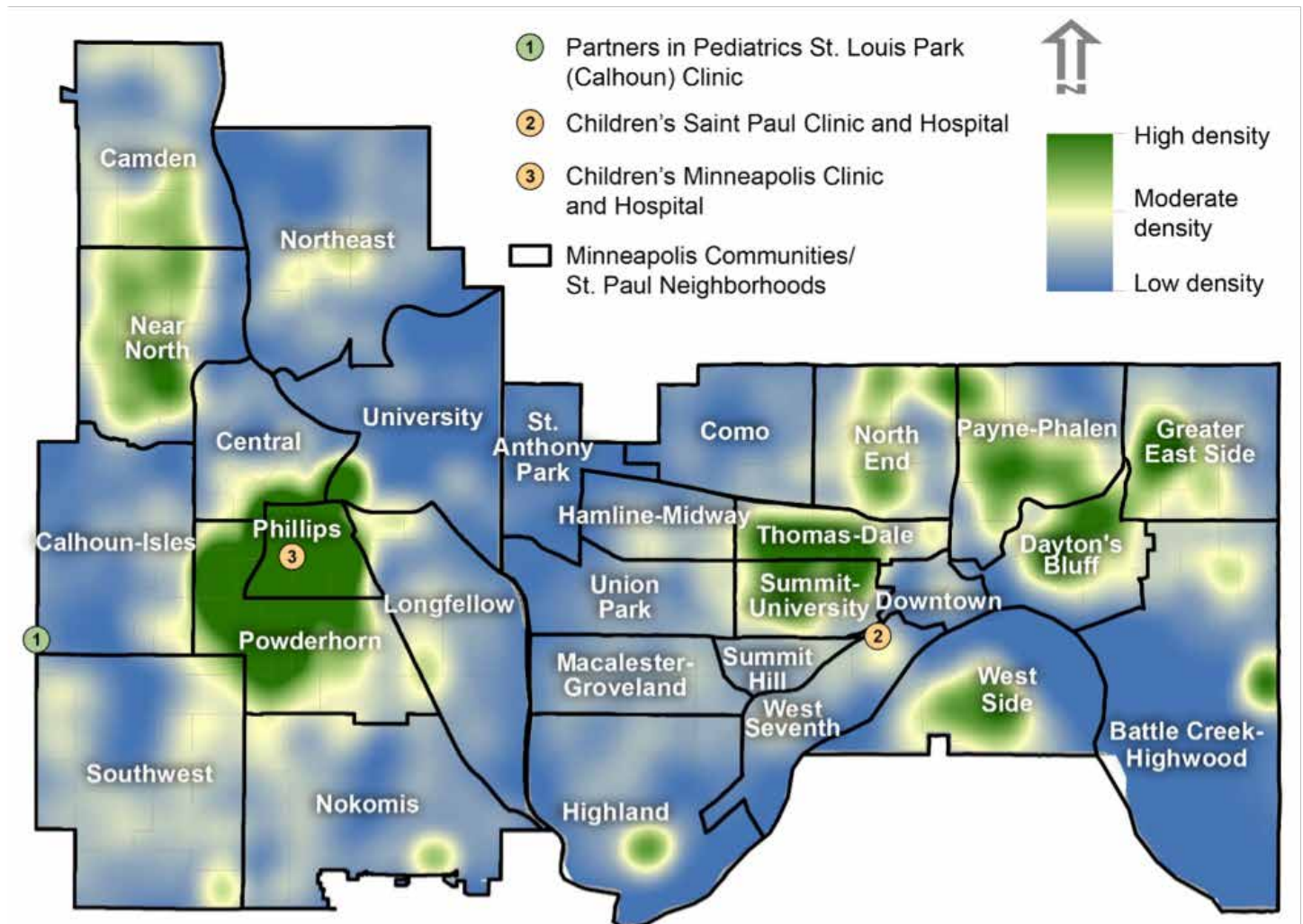
PRIORITY HEALTH ISSUES

The approach and process used for this assessment were designed to achieve a comprehensive view of health in the community served by Children's Minnesota. Through increased emphasis on primary data, layering that information with secondary data, an inclusive prioritization approach, and a shared decision-making process with community partners, this assessment revealed priorities that extend beyond the traditional definition of health. The consistency with which these issues emerged through secondary data, clinician and care provider perspectives, and community stakeholder input all support the multi-layered and comprehensive nature of health and well-being.

This view of health asks Children's Minnesota to consider the factors and conditions outside its clinical walls and expertise. It is also consistent with emerging and increasing calls within the health care industry to understand and respond to external factors in driving improved health outcomes. This includes a call from the American Academy of Pediatrics for greater understanding of how issues like racism and poverty impact child health.

CAC members and the Children's Minnesota team identified six issues as being the most important for Children's Minnesota to focus on in order to support the health and well-being of children and their families. As implementation strategies are developed to address these priorities, the CAC and Children's Minnesota will consider the intersectionality of these topics, as well as how they contribute to disparities. Because of the profound influence early childhood experiences have on lifelong health and well-being and the high volume of patients Children's Minnesota serves who are under age 6, special attention will be given to how these priorities impact young children age 0-5.

HEALTH STATUS

› Asthma

› Mental health and well-being

SOCIAL DETERMINANTS OF HEALTH

› Access to resources

› Income and employment

› Education

› Structural racism

The following summaries provide a working definition of each priority health issue, examples of the information gathered through the assessment describing the issue and its impact on health, and a description of who is most impacted. Additional information about each topic can be found in a separate document, the Data Summary Packet.

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3   American Academy of Pediatrics. (2010). Policy statement—Health equity and children's rights. Retrieved from American Academy of Pediatrics website: http://pediatrics.aappublications.org/content/pediatrics/early/2010/03/29/peds.2010-0235.full.pdf

ASTHMA

Asthma is a chronic lung disease that affects airways, making them more inflamed and sensitive to allergens, like mold and pollen, and irritants, like cigarette smoke. While asthma cannot be cured, it can be effectively controlled through treatment and by reducing exposure to triggers that lead to asthma attacks.

Throughout interviews, stakeholders discussed the persistence of inequity for conditions like asthma.

> **"** In Saint Paul schools, about 11 percent of students have asthma, but we do have schools where there are pockets of increased asthma, where the rates are as high as 20 to 22 percent in a building. **"**
>
> – Public school staff person

WHO IS IMPACTED?

Overall, 15 to 19 percent of ninth-grade students living in the Twin Cities metro region have been told by a health professional that they have asthma. Community stakeholders described how children living in densely-populated areas, old buildings, and areas near highways or other sources of pollution are more likely to experience asthma attacks. They described how children living in lower-income households and children of color are impacted. Asthma is a health concern for children, and also is the lead contributor to school absenteeism. The rate of asthma-related hospitalizations is higher in Minneapolis and Saint Paul than in other parts of the Twin Cities metro region, particularly in the downtown areas of each city and nearby neighborhoods.

WHAT DID WE LEARN THROUGH THE ASSESSMENT?

Community stakeholders and the CAC thought that asthma was an important health issue to address for many reasons, including: its impact on school absenteeism and its relationship to poor housing quality and air pollution. These influences are shaped by the environment, and one stakeholder noted that asthma rates among children can be twice as high in specific buildings compared to the overall population. Members of the CAC noted that better collaboration between schools, health care providers, and housing advocates could help families better manage asthma symptoms and improve the quality of housing.

4   Minnesota Student Survey, 2013
5   Minnesota Department of Health. Asthma hospitalizations (2009-2013) [Interactive map].
      Retrieved from MN Public Health Data Access: https://apps.health.state.mn.us/mndata/webmap/asthma.html`

MENTAL HEALTH AND WELL-BEING

Mental health and well-being is an intentionally broad category to give space to address the wide-ranging topics that emerged through the assessment, from specific treatment and services available for children with a diagnosed mental illness to preventive actions that support well-being for all children.

> **"** [There is] a broad trend of starting to [have] less stigma about mental health in general along with more acceptance and understanding that mental health really is part of health. **"**
>
> – Community service agency staff person

WHO IS IMPACTED?

By county, 10 to 13 percent of 9th grade students in the Twin Cities metro reported having a long-term mental health, behavioral, or emotional problem. This is in line with national estimates. In addition, suicide continues to be the second leading cause of death among adolescents and young adults. While mental illness does not differentiate by race or class, stigma around metal illness, difficulty accessing mental health treatment services and exposure to trauma can all lead to disparities in health and well-being. Stakeholders also identified specific populations who have unmet mental health needs, including: young children (age 0-5), immigrant and refugee families, and adolescents in need of intensive mental health services.

WHAT DID WE LEARN THROUGH THE ASSESSMENT?

Many of the community stakeholders interviewed for the assessment identified mental health as a major health concern, impacting how children interact with others at home, in school, and in the community. Many of these stakeholders described how traumatic experiences, including chronic poverty, homelessness, historical trauma, and experiencing or witnessing abuse, led to stress and contributed to poor mental health.

› A majority of Children's Minnesota providers indicated that mental health or social-emotional concerns are "frequently" identified by caregivers as a major health concern.

› Some Children's Minnesota staff thought that while stigma around mental health was decreasing, children were not able to receive the care they needed because of gaps in services. Community stakeholders also identified unmet mental health needs as a major health concern among children and families.

More specific concerns by stakeholders included: limited availability of intensive mental health services; a need for more mental health providers, particularly psychiatrists, and greater workforce diversity; a need for early identification and treatment of mental health concerns; and strategies to address barriers to services (e.g., transportation, cost of care/limited insurance options).

6   Minnesota Student Survey, 2013

ACCESS TO RESOURCES

In the assessment, access to resources was a broad term intended to include access to health care services, as well as community resources, child-serving systems, and public benefit programs.

In conversation after conversation, stakeholders pointed to the importance of envisioning resources that are readily available, relevant and navigable.

> **"** By and large, the way we treat patients by having a structured setting where we invite people to come by appointment has been the same for a really long time…How can we design any of our systems to be more responsive to the evolving way that our families are living? **"**
>
> – Community service agency staff person

WHO IS IMPACTED?

Gaps in resources and barriers accessing resources can be particularly challenging for lower-income families, immigrant and refugee families, and communities that have been disenfranchised or excluded from systems responsible for supporting children and families.

WHAT DID WE LEARN THROUGH THE ASSESSMENT?

Gaps in services and difficulty accessing existing resources were themes that repeatedly emerged throughout the assessment process. The assessment did not focus on identifying which resources were most difficult for children and families to access. Instead, information gathered from multiple stakeholder groups highlighted the types of challenges that limit access to resources.

› Across multiple public benefit programs, there is a gap between the number of children and families eligible and the number that choose to enroll. Multiple issues contribute to this, including inadequate resources to serve all eligible families, inadequate outreach efforts, and decisions made by families not to receive services.

› Families can have difficulty accessing the resources that are in place to support health and wellness. Multiple stakeholders described the difficulties families faced in navigating education, financial, and health systems or enrolling in benefit programs like Medical Assistance.

› A study of emergency room use conducted by Children's Minnesota challenged some staff assumptions about reasons that families sought emergency department care, highlighting the importance of taking time to ask families about their experience accessing resources and barriers to care.

› Multiple stakeholder groups described ways that culture is a resource to children and families, while also recognizing that health care and other child-serving systems need to continually improve the ways that cultural strengths and assets are recognized and supported.

INCOME AND EMPLOYMENT

There is a strong relationship between income and health, and employment is the major driver of household income. Wealth and higher household income are closely tied to better health outcomes; health generally worsens as income levels decrease.

> **"** I am convinced that [racism and poverty] do absolutely have an effect on them physically, resulting in…a number of health related issues. **"**
>
> – Community service agency staff person

WHO IS IMPACTED?

More than 200,000 children in the Twin Cities metro currently live in lower-income households. The percentage of children living in lower-income households is considerably higher in neighborhoods Children's Minnesota identified as target neighborhoods than for the area overall. There are also racial inequities in the percentage of children who experience poverty. In the Twin Cities metro region, children of color are four to seven times more likely to experience poverty than children who are white. Children who are American Indian or black are more likely to experience extreme poverty.

WHAT DID WE LEARN THROUGH THE ASSESSMENT?

Community stakeholders described a number of ways that poverty and financial instability affected children and families. Unemployment and or living in low-income households can lead to housing and food instability, which contribute to stress and poor health.

› Multiple community stakeholders talked about ways that economic conditions impacted the types of resources available in neighborhoods, community safety, the availability of healthy food options, housing conditions, and opportunities for physical activity.

› Half of the providers in Children's Minnesota's primary and secondary care clinics and emergency departments saw poverty as a major barrier to health.

› The number of children living in lower-income households has increased significantly during the past decade. Multiple stakeholder groups identified poverty and income inequality as issues that increase stress and impact child health and wellness.

EDUCATION

Educational achievement, such as graduating from high school, is closely associated with employment and income level in adulthood. In addition, literacy is important in order to understand information about health and to access resources that support health and well-being.

> **"** Children's ability to participate in school – there are so many aspects of health and wellness that can impact that. While we've known trauma has been around for centuries... [It's] the idea that there is a trauma-informed approach included in our lens of how we work with young people. **"**
>
> – Community service agency staff person

WHO IS IMPACTED?

Children of color have lower high school graduation rates than children who are white. Graduation rates for American Indian and black students are some of the worst in the nation.

WHAT DID WE LEARN THROUGH THE ASSESSMENT?

The importance of education came up in multiple ways throughout the assessment process. Overall, educational disparities stood out to multiple stakeholders as a key issue that negatively impacts health. Some stakeholders also highlighted the need for more culturally appropriate and accessible health education resources.

› Minnesota has some of the worst disparities in graduation rates in the country. Statewide, less than two-thirds of American Indian, Latino, and black students graduate from high school. The assessment focused only on a few key measures of educational attainment; however, education outcomes and graduation rates reflect multiple interconnected issues that impact opportunities for learning, the school environment, and student academic success.

› The assessment did not explore access to resources and supports to reduce educational disparities and improve academic outcomes. However, some stakeholder groups did identify Head Start and other early learning/preschool settings as important for child health and wellness.

› CAC members also stressed the importance of education as a strategy for addressing disparities and noted that increased partnerships between schools and health care settings could offer opportunities to better support children and families.

STRUCTURAL RACISM

Structural racism refers to the ways in which the policies, practices, and systems of organizations and institutions routinely advantage white residents while disadvantaging people of color and American Indians. Structural racism is deeply entrenched into our social, economic, and political systems, leading to disparities in opportunity and exclusion from power.

> **"** It's so systemic, it's everywhere. It's in the schools they go to, in their case workers…The racism is everywhere, institutional racism is the best way to describe it…They are treated different, they are dehumanized, their needs aren't met. That's why we need our advocates and we need the culture and we need all these different things because our people are treated poorly. **"**
>
> – Community-based organization staff person

> **"** There is an assault on black bodies in that the stress on black folk in this neighborhood is so deep, and [there is] cyclical, generational issues and disinvestment in the black community… The degree and the magnitude of crisis manifest very visibly. **"**
>
> – Community-based organization staff person

WHAT DID WE LEARN THROUGH THE ASSESSMENT?

Structural racism was raised as a key issue impacting health throughout the CHNA process and as a root cause of disparities across multiple areas, including income, homeownership, employment, and education. The CAC elevated this topic by identifying it explicitly and naming it as a community health priority.

Throughout the assessment, multiple stakeholders described ways in which oppression and discrimination in their communities have led to trauma, stress, anxiety, and poor health. Some community stakeholders provided examples of ways that service-delivery approaches designed by and for a dominant culture create barriers for children and families, limiting access to services and negatively impacting interactions between community members and services providers and institutions.

Whether looking at health outcomes, educational attainment, socioeconomic status, or other health-related topics, the data gathered through the assessment routinely showed differences by race and ethnicity. The assessment did not aim to review and assess the impacts of current and historical systems, policies, and practices. However, comparing the boundaries of historically redlined districts , which served to restrict homeownership among people of color, with lower-income neighborhoods today was one way to visualize the long-lasting impacts of historical policies. Structural racism directly impacts communities of color and American Indians, making it difficult for all children to reach their full potential and achieve optimal health.

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7   The CAC utilized the following definition of structural racism for this assessment: "Structural Racism: A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing, ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with "whiteness" and disadvantages associated with "color" to endure and adapt over time…It has been a feature of the social, economic and political systems in which we all exist." (From the Aspen Institute Structural Racism Glossary)

8   Redlining is a discriminatory practice in which lenders refuse or limit loans within specific geographic areas deemed to be a poor financial risk. The Fair Housing Act of 1968 made this practice illegal.

PRIORITIZATION PROCESS

ASSESSMENT METHODS

CHNAs bring information together across multiple sources to help stakeholders understand the health needs, strengths, and priorities of communities. In this assessment, the CAC played a key role in shaping the assessment questions and refining the data collection approaches used to hear from community stakeholders. CAC members also had opportunities to review and offer suggestions to improve the data summaries prepared to report the assessment results.

CHNA GUIDING QUESTIONS

› What is the health status of children in the metro region?

› How do children and families describe what it means to be healthy?

› What are key barriers to child health and wellness?

› What strengths, resources, and assets support the well-being of children in our community?

› In what ways is culture used as a resource to support health and wellness?

› What are the emerging issues or trends impacting the health and well-being of children?

› How do social determinants and experiences of trauma impact the health and well-being of children in our community?

REVIEW OF SECONDARY DATA SOURCES

As described earlier, Children's Minnesota patient data were used to describe the demographic characteristics of children served and to identify the neighborhoods where Children's Minnesota served large numbers of patients. This assessment drew from multiple sources of existing (or secondary) data to describe the demographic characteristics and health and well-being of children and families living in the Twin Cities metro. Additional sources of existing data, including other CHNAs and community-generated reports, were also reviewed. Information from these sources can be found in the Data Summary Packet.

PRIMARY DATA COLLECTION STRATEGIES

A mixed-method primary data collection approach was used to gather new information, or primary data, from multiple stakeholder groups. More information about each method and key results is available in a separate document, the Data Summary Packet. The CAC identified the questions they wanted the CHNA to answer and also helped refine the following data collection strategies used in the assessment:

› **PROVIDER SURVEY**

An online survey was used to gather information from providers who work at the two hospital locations, nine of its affiliated clinics, and specialty care clinics in the Twin Cities metro region. The survey was sent to 384 individuals and completed by 161, a response rate of 42 percent.

› **STAFF DISCUSSION GROUPS**

A total of 34 staff in roles including social workers, interpreters, service coordinators, and community health workers attended a group discussion to share their insights and experiences helping children and families improve their health and connect to community resources.

› **COMMUNITY STAKEHOLDER INTERVIEWS**

Children's Minnesota staff conducted semi-structured interviews with 36 community stakeholders or stakeholder groups who work closely with children and families. These stakeholders represented multiple sectors, including school districts, local not-for-profit organizations, faith communities, and neighborhood associations.

› **DISCUSSION BOARDS**

Children and caregivers were invited to write their response to the prompt, "Children who are healthy: _____" on large posters, called discussion boards. These discussion boards were posted at Children's Minnesota Minneapolis and Saint Paul primary clinic locations and available at six community events attended by Children's Minnesota staff. Word clouds, visually displaying the responses collected, are included in the Data Summary Packet.

LOCAL PARTNERSHIPS

Children's Minnesota also explored opportunities to partner with local organizations to host community conversations with youth and caregivers. In recognition that community members and organizations are often overburdened and under-resourced with such requests, Children's Minnesota is instead exploring opportunities to support conversations on health through established community partnerships, both in support of long-term community engagement efforts and to inform the implementation strategies (forthcoming in 2017).

PRIORITIZATION PROCESS

The prioritization process was the culmination of months of work to gather, synthesize, and report information gathered from secondary data sources and community stakeholders. A two-step process was used to determine the health priorities that Children's Minnesota will work to address. First, CAC members rated each health topic on criteria that they believed were most important to consider: evidence of disparities, likely impacts, and access. Through this process, the CAC identified the health priorities described in this summary. Second, the Children's Minnesota's Advocacy and Health Policy team considered organizational readiness to respond to each health topic. The decoupling of discussions of community need and organizational readiness was done intentionally as a way to ensure the priorities identified through the CHNA reflected the needs of the community.

AVAILABLE RESOURCES

While this CHNA was conducted to guide Children's Minnesota's work to support the health and well-being of children and families, an effective response to these health priorities is contingent on coordinated partnerships with external organizations. Fortunately, the Twin Cities metro region, including Minneapolis and Saint Paul, has many resources available to support health and well-being. The following table highlights both resources that Children's Minnesota can draw on to support work to address each health priority and examples of existing community resources and assets that were identified by community stakeholders.

AREA	PRIORITY	CHILDREN'S MN RESOURCES
HEALTH STATUS	ASTHMA	› Asthma care management available through primary care and Asthma specialty clinic
	MENTAL HEALTH AND WELL-BEING	› Onsite psychology and social work services, available on a sliding fee scale › Current pilot projects underway to integrate behavioral health into primary care
SOCIAL DETERMINANTS OF HEALTH	ACCESS TO RESOURCES	› Family resource centers in Minneapolis and Saint Paul hospitals with information for families and food shelf access › Development of Resource Hub to connect patients and families with community support › Public policy advocacy, including membership on the Governor's Early Learning Council, MinneMinds and Minneapolis Cradle to K Cabinet › Collaborative efforts with American Indian community-based organizations and agencies on maternal health and birth outcomes › Involved in efforts to support early learning (e.g., Talking is Teaching, Reach Out and Read) › Expertise in brain science and impacts of adverse childhood experiences on health shared with educators and advocates through presentations
	EDUCATION	› Active member of district wellness team with Saint Paul Public Schools › Ongoing efforts to explore partnerships with schools/school districts › Provide influenza vaccine clinics in schools, focused on reaching uninsured/underinsured children and adults (opportunity to build on connections)
	INCOME AND EMPLOYMENT	› Financial support to Project for Pride in Living for health care career training efforts › Host employer to students in the Step Up program
	STRUCTURAL RACISM	› Internal expertise and presentations on the intersection of structural racism and health care › An active and experienced Advocacy and Health Policy Team working to align existing internal efforts and work in the community › Growing capacity of staff participating in the Community Engagement Learning Series

Across all areas: Culturally-specific programming, strong community leaders, social connections, traditional healing practices, and places of worship are also important assets within multiple cultural communities that are relevant across a number of the priority health topics.

COMMUNITY RESOURCES
› Multiple community clinics and targeted care management efforts in schools
› Culturally-specific social workers, mental health providers › Culturally-specific coping strategies › Trauma-informed training for teachers that includes youth sharing their own experiences
› Community centers, community-based organizations,and faith centers that connect residents to resources › Technology (e.g., computers, smart phones) that links residents to key resources › Mobile services that bring resources and support directly to residents
› Public libraries and community learning opportunities › School-based programs aimed to reduce truancy or improve graduation rates
› Services (e.g., food shelves, supportive housing programs, community garden initiatives) to help lower-income families afford safe housing, healthy food, and other basic needs
› Resilience, hope, and sense of cultural identity held within families and cultural communities › Multiple organizations and institutions recognizing and bringing attention to how structural racism and trauma impact children and families › Programs that foster development of a positive cultural identity

PROGRESS SINCE THE 2013 CHNA

The CHNA conducted in 2013 identified five broad health priorities that were the focus of Children's Minnesota's efforts through 2016. These topics and a brief summary of the impact of the work done to address each priority area is described below.

ACCESS TO CARE

› In 2015, Children's Minnesota financial counselors worked with 3,974 people that applied for Medical Assistance and other public programs, an increase from just under 3,000 people the year before.

› In 2014 and 2015, Children's Minnesota absorbed $158.5 million to cover the difference between Medicaid reimbursement rates and the cost of providing care to help ensure all children have access to quality health care.

› A total of more than 15,000 flu vaccines were administered at vaccination clinics done in partnership with Kohl's Cares in 2014 and 2015.

MATERNAL AND CHILD HEALTH

› In 2014 and 2015, a total of 240 patients received HIV-related care during pregnancy and childbirth.

› First Gift, a space for the American Indian community to come together to make baby moccasins that are donated to American Indian families whose babies are receiving intensive care services, has continued to support families during stressful times.

MENTAL HEALTH

› In both Minneapolis and Saint Paul primary care clinics, an integrated behavioral health support program was developed and piloted. The change in practice allows psychologists and social workers to be available for on-site consultation and support at primary care clinics.

MORBIDITY AND MORTALITY: OBESITY AND ASTHMA

› More than 600 individuals participated in Vida Sana, a program done in partnership with Pillsbury United Communities that provides nutrition education and fitness classes for Latino families in Minneapolis.

SOCIAL AND ECONOMIC FACTORS

› Family Resource Centers at both hospital locations provide a variety of supports to families. In 2015, the centers provided 8,318 meals through an on-site food pantry.

NEXT STEPS

During the next few months, Children's Minnesota will take a number of steps to finalize the CHNA report and develop an aligned implementation plan. Children's Minnesota staff will:

› Work closely with the CAC and additional community stakeholders to identify the specific implementation strategies that they will use to address the priority health topics identified through this assessment.

› Develop an evaluation plan to monitor the status of the implementation plan and its impact.

› Gather input from the CAC to reflect on the process used and how it can be improved.

› Establish communication strategies to regularly update CAC members and community partners on its progress and to encourage feedback that will improve its work.

› Present the final implementation plan to the Children's Minnesota Board of Directors and make the documents available to community stakeholders and the public.

Children's Minnesota also plans to continue its ongoing efforts to engage community residents in their broader work and to foster the partnerships that formed or strengthened during this assessment process.