Hennepin Healthcare Community Health Needs Assessment 2019

Community Health Needs Assessment Implementation Plan – Health Services Plan 2020-2022

Hennepin Healthcare

Approved by Hennepin Healthcare System Board- 11/13/2019
Approved by Hennepin County Board of Commissioners - 12/12/2019

2019 Community Health Needs Assessment
2020–2022 Community Health Needs Implementation Plan and Health Services Plan

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Overview of Hennepin Healthcare

Hennepin Healthcare System (Hennepin Healthcare), a wholly owned subsidiary corporation of Hennepin County, is an integrated system of care. The system includes HCMC, a nationally recognized Level I Adult Trauma Center and Level I Pediatric Trauma Center and 484-bed academic medical center. The comprehensive healthcare system includes a large outpatient Clinic & Specialty Center as well as a network of clinics in Minneapolis and suburban communities of Brooklyn Park, Golden Valley, Richfield, and St. Anthony Village. Hennepin Healthcare has a large psychiatric program, home care and hospice, and operates a research institute and philanthropic foundation.

Hennepin Healthcare Mission

We partner with our community, our patients and their families to ensure access to outstanding care for everyone, while improving health and wellness through teaching, patient and community education, and research.

Values

- Patient & Family Centered
- Excellence
- Teamwork
- Respect
- Integrity
- Compassion

Hennepin Healthcare strives to provide the best possible care to every patient; to search for new ways to improve the care that will be provided tomorrow; to educate health care providers for the future; and to ensure access to healthcare for all.

Community health needs assessment process:

The purpose of the triennial community health needs assessment is to provide non-profit hospitals with opportunities to engage meaningfully with community to better understand current and emerging health needs and to develop strategies and actions to work in partnership to address identified priority needs.

The 2019 Hennepin Healthcare Community Health Needs Assessment process was planned and carried out by a team consisting of:

- Director of Population Health
- Community Health Program Liaison
- Community health intern
- Third-year University of Minnesota medical students
- University of Minnesota public heath intern
- Additional staff, including the American Indian Liaison and several staff interpreters who assisted with the qualitative interviews

The prioritization meeting was facilitated by a team from the Hennepin County Center for Innovation and Excellence.

Three Hennepin Healthcare committees provided input and guidance to the process:

- Hennepin Healthcare Board of Directors' Mission Effectiveness Committee
- Hennepin Healthcare Senior Strategy Team
- Hennepin Healthcare Community Advisory Board

The needs assessment process included the following steps:

1. Define the Hennepin Healthcare community

2. Review and analyze secondary quantitative data
    a. Data from external sources
    b. Data from internal (Hennepin Healthcare patients) sources
    c. Gaps in data

3. Develop Hennepin Healthcare Community profile (based on quantitative data)

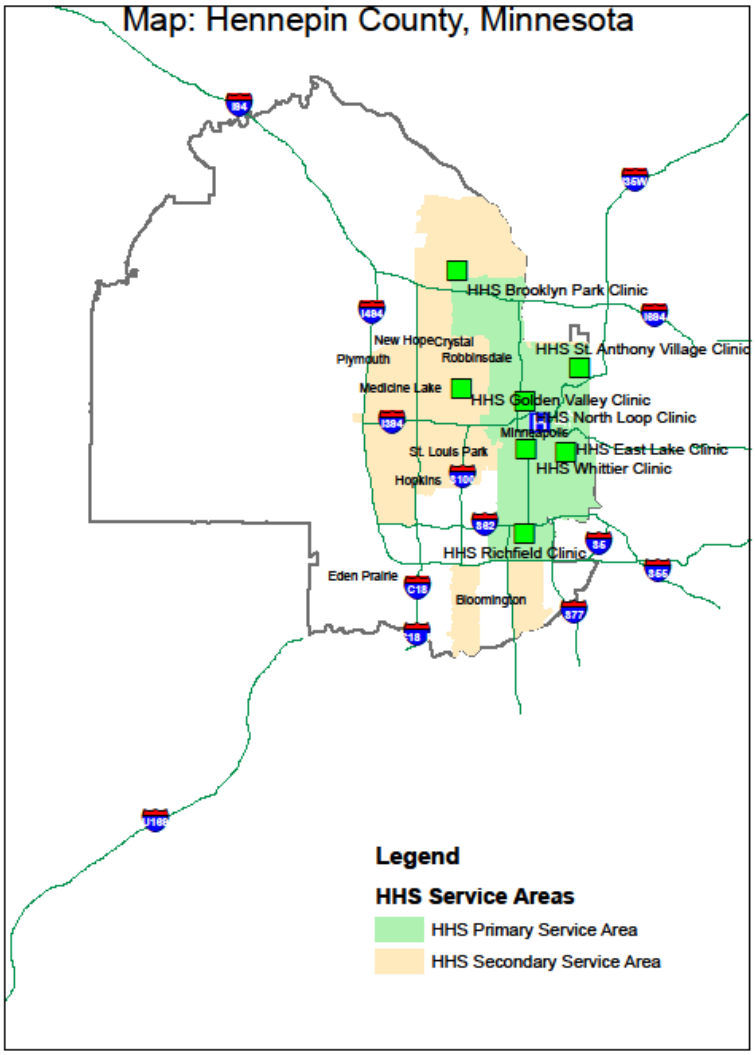
4. Collect and analyze primary qualitative data through key informant interviews
    a. Selection of interviewees
    b. Gaps in qualitative data
    c. Top themes emerging from key informant interviews

5. Execute structured process to prioritize community health needs

6. Select 2019 top priority health need

Step 1: Define the Hennepin Healthcare Community

Hennepin Healthcare provides care for patients from all 87 counties in Minnesota, with the majority of patients residing within Hennepin County. More specifically, most reside within the eastern half of the county. Based on the number of patients who receive care at HCMC (the hospital) and/or one of its community clinics, Hennepin Healthcare's primary and secondary service area includes 36 zip codes within the city of Minneapolis and the suburban communities of Brooklyn Center, Brooklyn Park, Crystal, Golden Valley, Richfield, and St. Anthony, and St. Louis Park. For the purposes of the Community Health Needs Assessment, Hennepin Healthcare has broadly defined its community as the primary and secondary service areas of the institution, noted on the shaded sections of the map:



Step 2a. Review and analyze existing external quantitative data

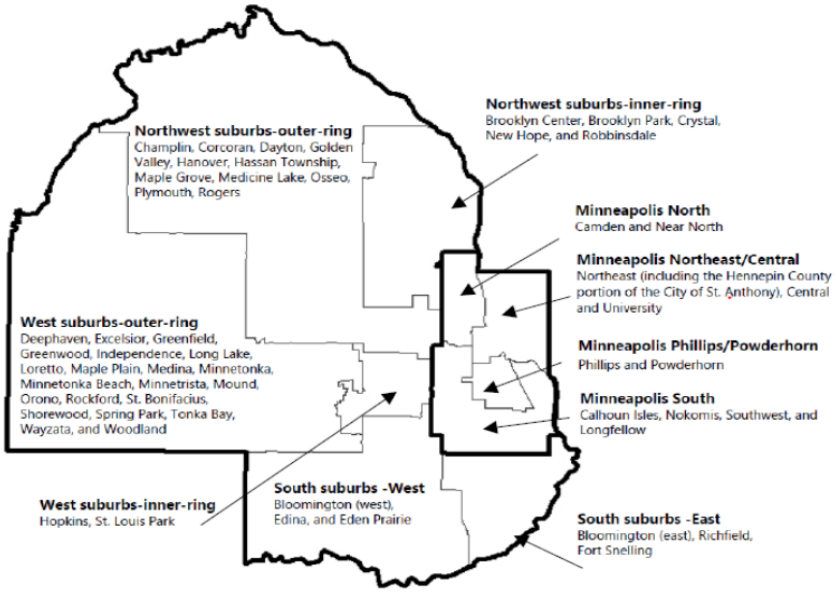
Because of the many diverse communities included in our defined community, the CHNA team chose to focus on data sources that highlighted differences and disparities within our community. The following external sources were reviewed as part of the assessment process:

1. Hennepin County SHAPE survey data (2018 Adult)[1], 40,000 randomly chosen adults living in Hennepin County. The survey is voluntary and is sent by mail. Data is broken down by geographic location (city vs. suburban, and by specific neighborhoods or areas), race, ethnicity, age, housing insecurity, education, poverty level (using the federal poverty level – PPL), disability status, LGBTQ status, and experiencing frequent mental distress (stress, depression, and/or emotional problems more than 14 days in one month).

[1] SHAPE. 40,000 randomly chosen adults complete a voluntary health survey called SHAPE. https://www.hennepin.us/your-government/research-data/shape-surveys

A Note about the SHAPE (mail) survey:
The Adult SHAPE survey (mailed) uses geographic reporting areas as seen in the map below:

Figure 1. Geographic reporting areas in Hennepin County for the SHAPE 2018 Adult Data Book



The arrows indicate the geographic reporting areas that are included the Hennepin Healthcare primary and secondary services areas, i.e. the Hennepin Healthcare "defined community".

2. Hennepin County SHAPE In-person survey (2018 Adult)[2], client-level data collected at NorthPoint Health & Wellness, the Office of Multicultural Services, and Hennepin County Human Service locations.with adults who receive one or more services through the county. The interviews were conducted by volunteers who represented the communities being surveyed. Surveys were translated into Spanish and Somali and interpreters were available at some sites. Participation incentives were provided. Approximately 3075 individuals participated. Data is broken down primarily by race/ethnicity.
3. The Center for Applied Research and Engagement Systems (CARES) at the University of Missouri[3], which complies data from many national sources. Those used in Hennepin Healthcare's report are:
    a. 2010 Census
    b. 2013–2017 American Community Survey (ACS) five-year estimates
    c. National Center for Education Statistics, NCES - Common Core of Data. 2015-16
    d. US Department of Education, EDFacts. Accessed via DATA.GOV.

[2] file:///C:/Users/H63323/Downloads/InpersonTables_Ethrace5_20190702.pdf
[3] The Engagement Network is a national platform where you can find public and custom tools produced by the Center for Applied Research and Engagement Systems (CARES) at the University of Missouri. https://engagementnetwork.org/

4. Voices of Health 2018 report[4] from JustUs Health. Voices of Health is an annual community based survey on LGBTQ health in Minnesota.
5. Hunger Solutions Minnesota[5] and Supershelf[6]. Data was collected from individuals using the Hennepin County food shelves (19 food shelves, 442 individuals).
6. Minnesota Compass: https://www.mncompass.org/profiles/county/hennepin

Step 2b: Review and Analyze of Internal (Hennepin Healthcare Patient) Quantitative Data:

Hennepin Healthcare's electronic health record Epic, provides important insights about the individuals and populations who get care from Hennepin Healthcare. By looking at data from Epic and comparing it with other data sources, the CHNA team was able to understand the ways in which our patients are either similar to or different from the overall residents in our "defined community" and/or the county.

Step 2c: Identify Gaps in External and Hennepin Healthcare Patient Data

- Time frames varied from data source to data source.
- Region/location/neighborhood of data collection varied based on data source.
- Some data sources group racial and ethnic groups into larger categories (such as "black", "Hispanic", "Asian") and do not distinguish between those individuals who are U.S. born or born in another country. Since 25% of HCMC patients were born outside the U.S., this gap is notable.
- Due to small overall numbers in Hennepin County, American Indian residents were not included in the mail-in Adult SHAPE reports. Although the numbers are small, Hennepin Healthcare has seen significant disparities among American Indian patients and includes this population in analysis when possible.
    - Note: American Indian residents are represented in the in-person SHAPE survey and in the US Census Report, 2013 – 2017 American Community Survey.
- Data extracted from Hennepin Healthcare' electronic health record, Epic, only reflects those who seek services at Hennepin Healthcare.
- Quantitative data often captures a "moment in time" and presents one part of a larger narrative. It captures what has happened, but does not answer why or provide insight into contributing factors.

[4] JustUsHealth. Voices of Health 2018 Survey. https://www.justushealth.org/VOH, file:///C:/Users/H63323/Downloads/Voices%20of%20health-%20Just%20Us%20Health-2018%20Full%20Report.pdf. JustUSHealth (previously Minnesota AIDS Project and Rainbow Health Initiative) conducts an annual community-based survey on LGBTQ health in Minnesota.

[5] http://www.hungersolutions.org/

[6] https://www.supershelfmn.org/

Step 3: Develop Hennepin Healthcare Community Profile-quantitative data

The CHNA team reviewed a large quantity of external and internal data. Key selections from this data were used to create the following community profile.

Demographics:

The following tables compare:

- Hennepin Healthcare patients (2018).
- All residents living the Hennepin Healthcare "defined community", the 36 zip codes that comprise the primary and secondary service areas (2013 – 2017).
- All residents living within Hennepin County (2013 – 2017).
- NOTE: All values are rounded to the closest whole number (values may not add up to 100%).

Age:

Population	<18 years old	Age 18 to 64	Age 65+
Hennepin Healthcare patients (2018)	15%	75%	10%
Hennepin Healthcare "defined community" (zip codes in the Hennepin Healthcare service area)	22%	66%	12%
Hennepin County overall	22%	65%	13%

Data Sources: US Census Bureau, American Community Survey. 2013-17.
Hennepin Healthcare Epic data 2018.

Race/Ethnicity:

Population	Hispanic/ Latino (US and foreign born)	White	Black/ African American (US and foreign born)	Native American or Alaskan Native	Asian	Some Other Race	Multiple Races
Hennepin Healthcare patients (2018) (with known race/ethnicity)	19%	38%	34%	3%	4%	1%	n/a
Hennepin Healthcare "defined community"	9%	65%	18%	1%	7%	4%	4%
Hennepin County	7%	73%	13%	1%	7%	3%	4%

Data Sources: US Census Bureau, American Community Survey. 2013-17.
Hennepin Healthcare Epic data 2018.

Place of Birth:

Population	US Born	Foreign Born
Hennepin Healthcare patients (2018) with place of birth place identified	75%	25%
Hennepin County residents (2017)	86%	14%

Data Sources: Minnesota Compass data 2017.
Hennepin Healthcare Epic data 2018.

Among all Hennepin Healthcare patients born outside the U.S., the top five countries of birth were:

County of Birth	Percent of all foreign born Hennepin Healthcare patients
Mexico	30%
Somalia	14%
Ecuador	7%
Ethiopia	6%
Liberia	5%
All others	38%

Data Source: Hennepin Healthcare Epic data: 2018

Preferred Language:

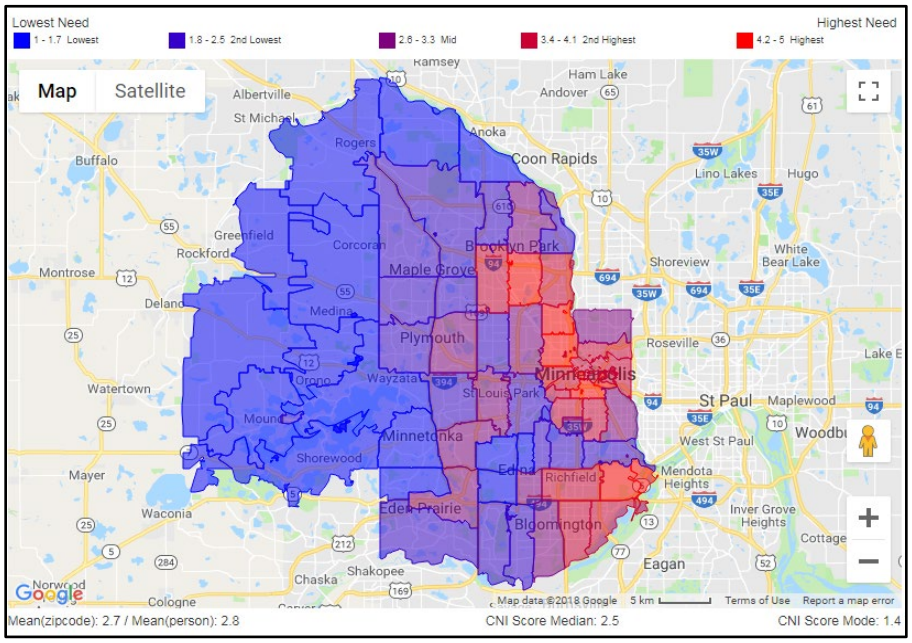
Population	English	Language other than English
Hennepin Healthcare patients (2018) with known language preference	79%	21%
Hennepin County residents (2017)	82%	18%

Data Sources: Minnesota Compass 2017.
Hennepin Healthcare Epic data 2018.

In 2018, of the patients with a preferred language other than English, 69% identified Spanish and 16% identified Somali as their preferred language. Hennepin Healthcare has a one of the largest hospital interpreter programs in the country. The department interpreters provide services in 21 languages and, through contracts, are able to provide services in an additional 50 languages.

Community Needs Index

Dignity Health created the Community Needs Index (CNI)[7] which assigns every populated ZIP code in the United States a barrier score of 1 to 5 depending upon the ZIP code national rank (quintile). The CNI score is an average of five different barrier scores that measure various socio-economic indicators of each community using the 2018 source data (income barrier, cultural barrier, education barrier, insurance barrier, and housing barrier). The following graphic depicts the disparities present in Hennepin County. Areas with the highest needs are depicted in red. The areas with the highest needs fall within the Hennepin Healthcare "defined community".



Overall Perception of Health Status:

Percent of Hennepin County residents who said their health was excellent, very good, or good:

Population (respondents)	Mail-in survey	In-person survey
All respondents	89%	72%
• Respondents from North Minneapolis	74%	n/a
Hispanic	82%	72%
American Indian	n/a	65%
Asian	86%	65%
Black (US and foreign born)	n/a	73%
Black US born	74%	n/a
Black foreign born	86%	n/a
White	90%	77%

Data sources: SHAPE mail-in survey 2018
SHAPE in-person survey 2018

[7] Truven Health Analytics. Dignity Health. Community Need Index. http://cni.chw-interactive.org/

Being Diagnosed with Diabetes:

Population (respondents)	Percent diagnosed with diabetes
All respondents	7%
• Respondents from North Minneapolis	13%
• Respondents from Northwest suburbs – inner ring	12%
• Respondent from Southeast suburbs	10%
Hispanic	11%
American Indian	n/a
Asian	7%
US born Black	11%
Foreign born Black	10%
White	6%

Data Source: SHAPE mail-in survey 2018

Other key disparities in diabetes diagnoses noted in the 2018 SHAPE mail-in survey:

- 13% of respondents living below the Federal Poverty Level (FPL) had been diagnosed (vs. 5% living above FPL).
- 17% of respondents with self-reported disabilities had been diagnosed (vs. 5% with no disabilities).
- 13% or respondents reporting housing insecurity have been diagnosed (vs. 7% who didn't report insecurity).
- 13% of respondents reporting frequent mental distress have been diagnosed (vs. 6% with/out frequent distress).

Lack of Access to Health Insurance: Uninsured

Population (data source)	Uninsured
Hennepin Healthcare patient (Finance Department) 2018	10%
SHAPE in-person survey (2018) of individuals using Hennepin County services	13%
Hennepin Healthcare "defined community" American Community Survey 2013- 2017	8%
Hennepin County American Community Survey 2013- 2017	6%

Of note, the 2018 SHAPE in-person survey data, which does not distinguish place of birth for Hispanic residents, indicates that 34% of Hispanics are uninsured.

Affordability of insurance:

The 2018 SHAPE mail-in survey asked a question regarding individual's difficulty paying for health insurance premiums, co-pays, and deductibles:

- Overall, 23% of Hennepin County residents said they had difficulty affording premiums, co-pays, and deductibles. Some key disparities included:
    - Residents living in North Minneapolis (39%) and in the NW suburbs – inner ring (32%).

- Foreign born Black residents (32%), US born Black residents (33%), and Hispanic residents (40%).
- Residents who were housing insecure (61%).
- Residents who experienced frequent mental distress (40%).

Housing Insecurity:

Homeless at one or more times in 2018

Population (respondents)	SHAPE in-person survey Self-reported being homeless at least once in previous 12 months
White/Caucasian	19%
Hispanic	18%
Black (US born and foreign born)	33%
Asian	12%
American Indian	50%
OVERALL	29%

Data sources: SHAPE in-person survey 2018

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Ever been homeless

Population (respondents)	Hennepin Healthcare 2018 Patients who have ever been identified as homeless
White/Caucasian	8%
Hispanic	3%
Black (US born and foreign born)	21%
Asian	3%
American Indian	34%
OVERALL	*9%*

Data source: Hennepin Healthcare Epic data 2018 using a home address-based methodology

Homelessness among LGBTQ individuals: According to the Voices of Health 2018 survey of LGBTQ individuals in Minnesota, 29% of respondents had been homelessness one+ times in their lives.

Delayed rent or mortgage payment because of not having enough money?

Population (respondents)	**Percent who answered "yes" to delaying payment**
Hispanic	*33.6%*
American Indian	*43.0%*
Asian	*34.9%*
Black	*35.6%*
White	*34.3%*

Data Source: Shape In-person Survey 2018

Food Insecurity:

Frequency (during previous 12 months) of worry about food running out before you had money to buy more:

Population (respondents)	Often worried	Sometimes worried
Hispanic	18%	37%
American Indian	35%	35%
Asian	21%	36%
Black	23%	31%
White	*24%*	*32%*

Data Source: SHAPE in-person survey 2018

In 2017, Hunger Solution MN and SuperShelf conducted a survey of individuals who used one of 19 food shelves in Hennepin County. Some key findings:

- 63% said they got more than half their food from the food shelf.
- 65% said that, even with the food shelf support, they were still food insecure (worried food would run out before they had money to buy more).
- 69% report they have one or more health conditions.

Use of food shelves in Hennepin County by percent of visitors by race:

- White/Caucasian (46%)
- Black, African American (21%)
- More than one race (8%)
- Latino/Hispanic (7%)
- Native American (6%)
- Asian (2%)
- African (2%)

Economic Factors:

According to the Census Bureau, in 2019 the Federal Poverty Level (FPL) for a single individual is $12,490 and a family of four is $25,750.

From US Census Bureau, American Community Survey 2013 – 20137 data:

- 14% of individuals in the Hennepin Healthcare "defined community" (based on zip codes) live below the FPL compared to 12% of individuals in Hennepin County as a whole and 11% in the state of Minnesota.
- Populations disproportionally living below the FPL include:
  - American Indian individuals (34%)
  - Black or African American, US and foreign born, individuals (33%)
- 44% of individuals in the Hennepin Healthcare "defined community" rent their homes compared to 38% in Hennepin County as a whole and 28% in the state of Minnesota.

According to the National Center for Education Statistics, 2016 – 2017 data:

- 58% of children living in the Hennepin Healthcare "defined community" are eligible for free and reduced lunch compared with 42% for Hennepin County as a whole and 38% in the state of Minnesota.

Frequent Mental Distress: defined as experiencing stress, depression, and/or problems with emotions on 14+ days in the previous 30 days.

Population (respondents)	Percent reporting experiencing frequent mental distress
Hennepin County as a whole	12%
Minneapolis as a whole	15%
North Minneapolis	21%
Phillips/Powderhorn Minneapolis	19%
Us Born Black/African American	25%
Hispanic	18%
Respondents with self-reported disabilities	30%
Respondents who indicated they were housing in-secure	32%

Data source: SHAPE mail-in survey 2018

According to the 2018 Voices of Health survey, 75% of the respondents (LGBTQ) reported experiencing mental distress at the time of the survey.

Experiencing lack of acceptance based on race, culture, religion, immigration status or because of sexual orientation or gender identity:

The 2018 SHAPE in-person survey two questions related to lack of acceptance by others:

1. How often are you in a situation where you feel you are not accepted because of your race, culture, religion, or immigration status?

Population (respondents)	Often (1x/month or more)	Sometimes (a few time/years)
Hispanic	15%	29%
American Indian	32%	32%
Asian	16%	25%
Black	20%	29%
White	15%	19%

Data source: SHAPE in-person survey 2018

2. How often are you in a situation where you feel you are not accepted because of your sexual orientation or gender identity?

Population	Often (1x/month or more)	Sometimes (a few times a year
Hispanic	5%	7%
American Indian	11%	7%
Asian	*6%*	*10%*
Black	*10%*	*6%*
White	*4%*	*4%*

Data source: SHAPE in-person survey 2018

Being treated with respect by health care providers:

Both 2018 SHAPE mail-in and in-person surveys asked the question: How often in the last 12 months were you treated with respect by your provider?

Percent of participants who replied "always"

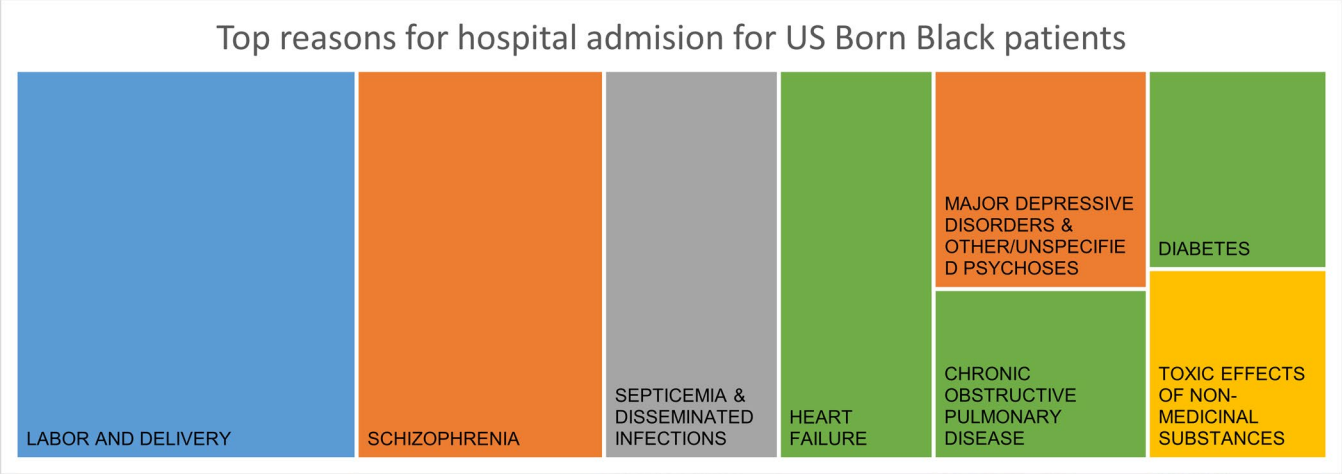
Population	In-person survey	Mail-in survey
Hispanic	69%	69%
American Indian	56%	n/a
Asian	56%	66%
Black	69%	72%
White	65%	80%

Data sources: SHAPE mail-in survey 2018
SHAPE in-person survey 2018

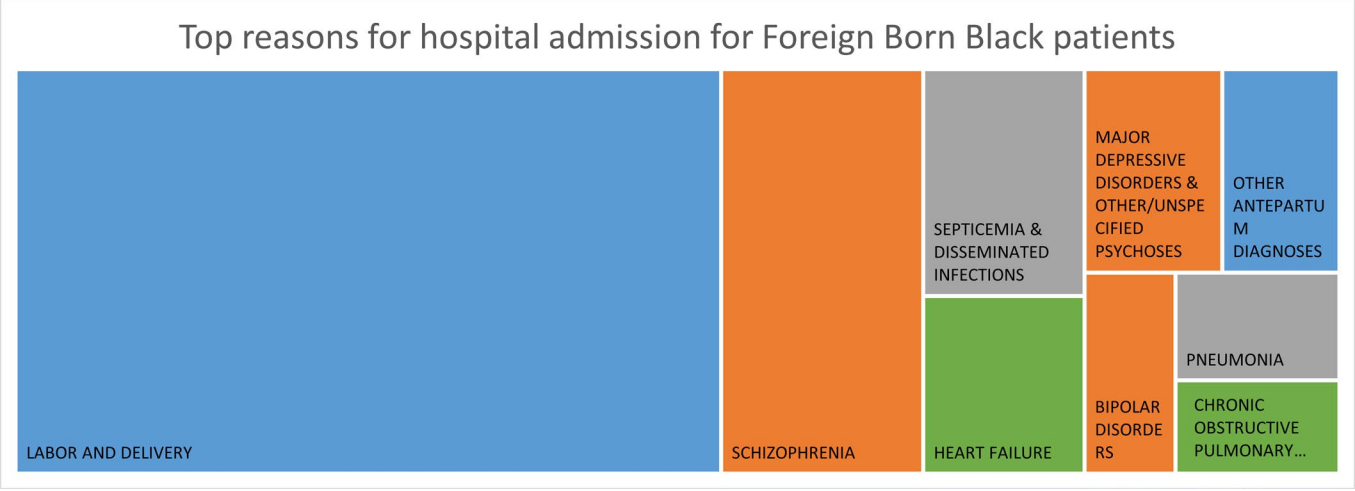
Hennepin Healthcare as a community resource: How different populations use the services offered at Hennepin Healthcare

To get a better understanding of how different populations in our community use the health care resources at Hennepin Healthcare, the CHNA team looked at the top reasons for admission to the hospital (HCMC) in 2018. Reasons for admission were categorized and color coded as follows:

mental health	substance use	labor and delivery	Chronic disease	infections and acute conditions	physical trauma



Data Source: Hennepin Healthcare Epic data 2018



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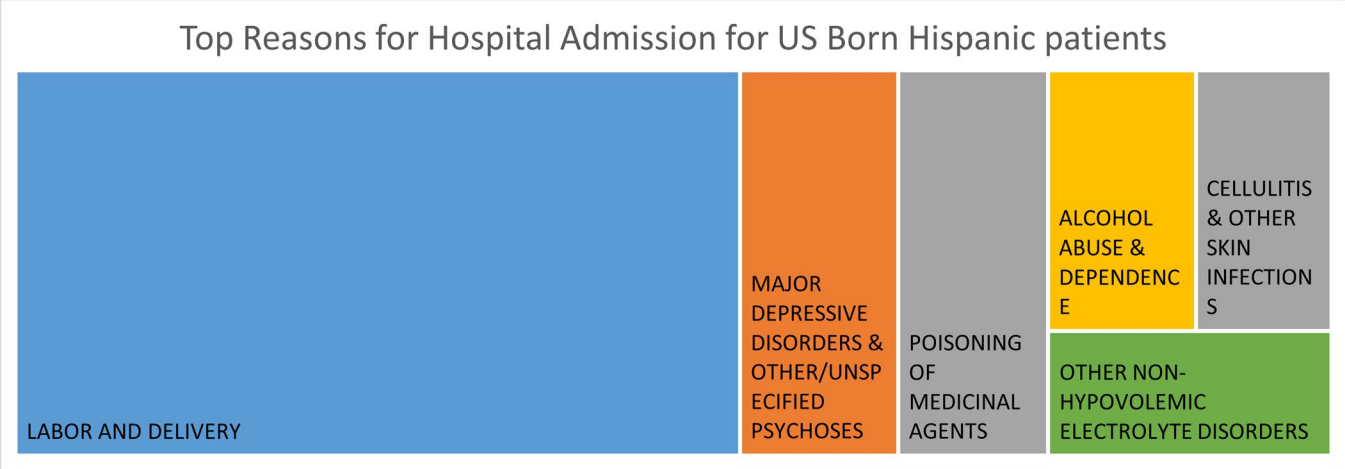

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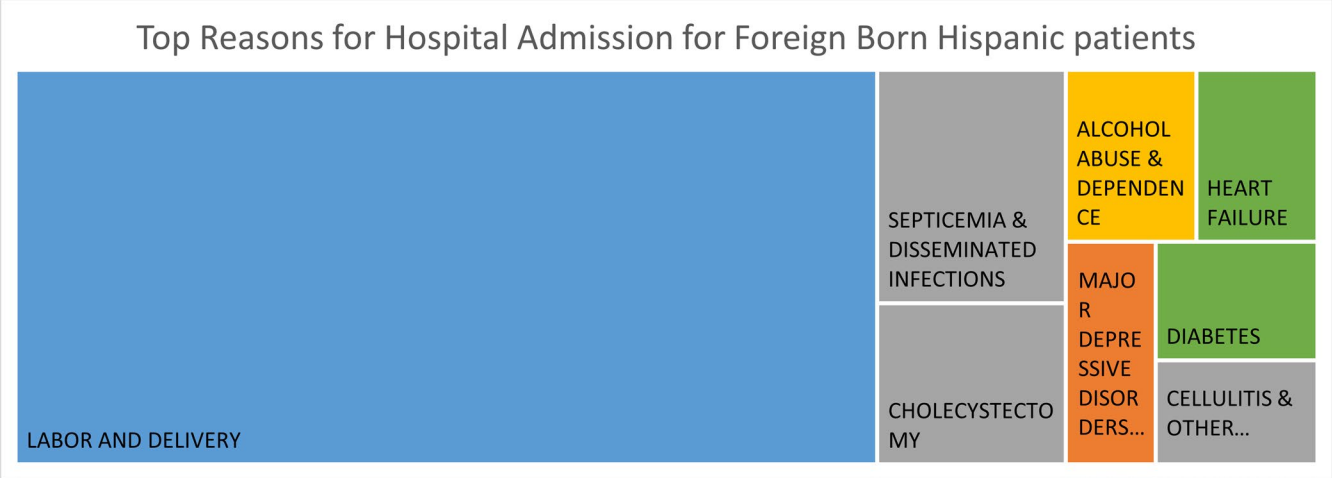

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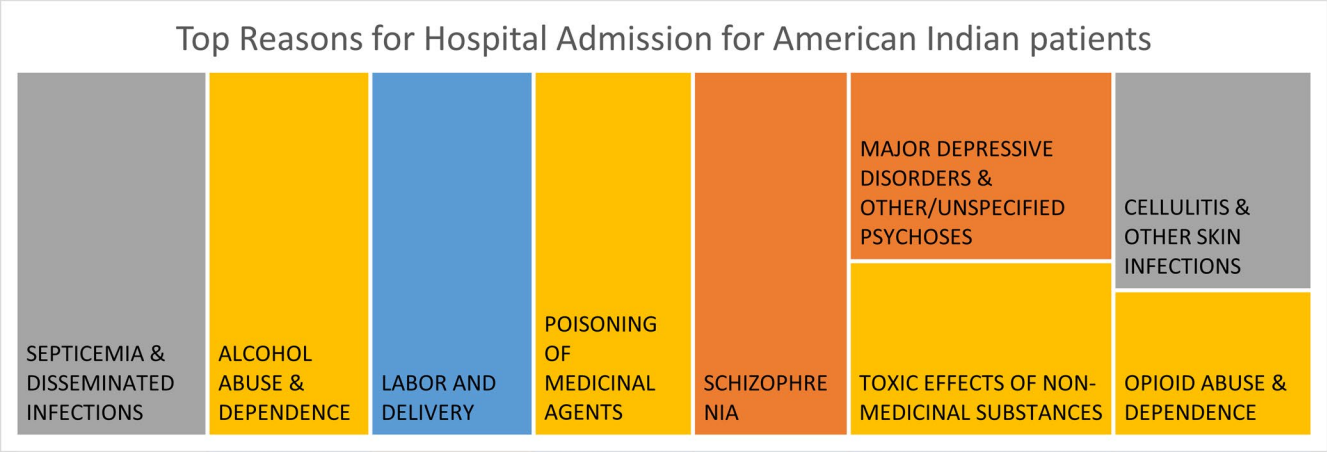

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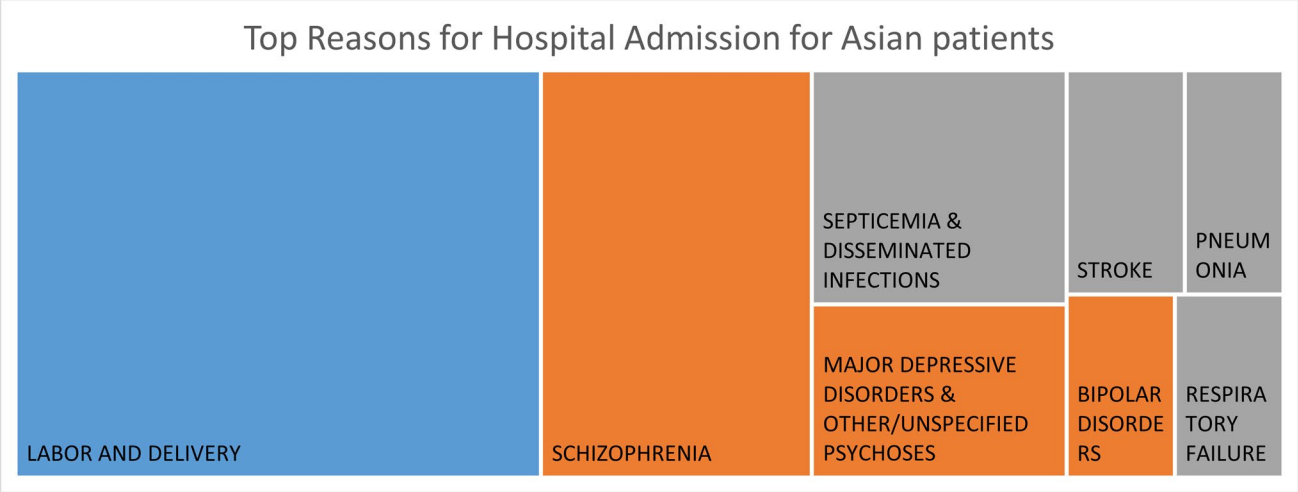

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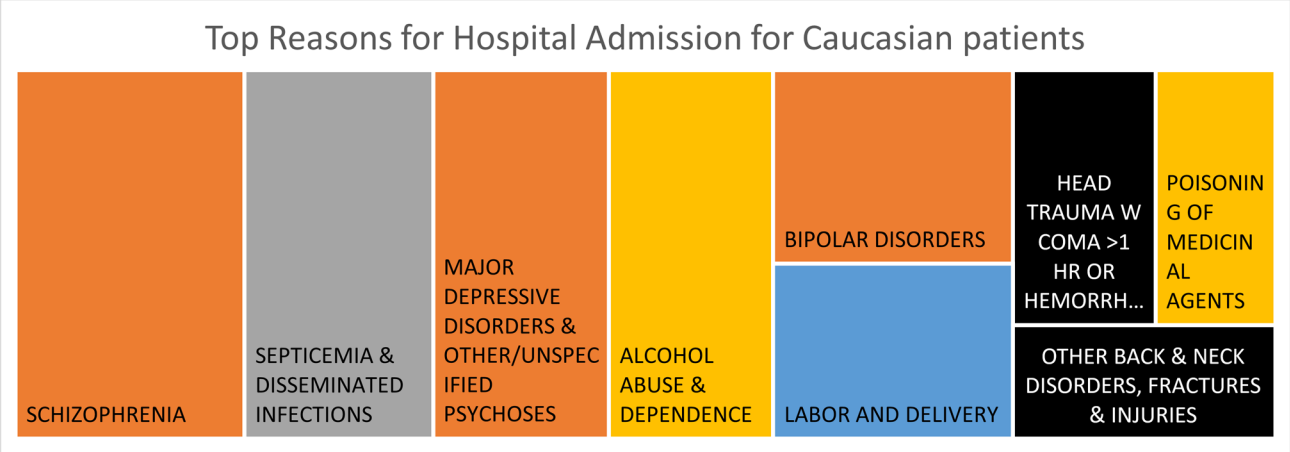


Data source: Hennepin Healthcare Epic data 2018

Step 4. Gathering Primary Qualitative Data

To better understand community perceptions of priority health needs and to gain insight into factors related to those needs, the CHNA team conducted 138 individual key informant interviews with stakeholders representing the communities we serve.

Interviews were conducted from early April through the end of June 2019. In addition to the CHNA team members, a number of interpreters and other staff members conducted interviews. The team talked with community and Hennepin Healthcare leaders; front line and service level staff from community organizations and from Hennepin Healthcare; and Hennepin Healthcare patients and other members from the diverse communities.

Interview questions focused on the following key points:

- The individual's perception of top two to three health needs in his/her community (as defined by the participant).
- Key factors contributing to the health needs.
- Which group(s) in the community were disproportionally impacted by each of the health needs?

At the end of the interview, the interviewers asked each individual to name their number one need and to provide some thoughts on how to address this need.

In addition to soliciting the above information and insights, interviewers provided some basic information about the health needs that were identified during the 2016 CHNA and the actions taken and in progress to address those needs. The team asked interviewees for their thoughts about the work in progress. This question and content helped frame the need for a long-term vision for change and ongoing work beyond the 2017-2019 implementation time frame. (Appendix A includes the interview questions.)

4a. Selecting Key Stakeholders to Interview

The CHNA team was interested in hearing from stakeholders who could provide a wide variety of perspectives and insights and who represent the diverse communities we serve. We identified three stakeholder categories:

- Leadership Level: Individuals working in roles that, on a daily basis, do not involve direct interaction with community members served by their organization.
  - Examples:
    - Organizational and Government leaders
    - CEOs and Executive Directors
    - Policy makers
    - Program managers and directors
    - Foundation leaders and funders
  - Total number interviewed: 42

- Service Level: Individuals working in roles that involve regular, direct interaction with community members served by their organization.
  - Examples:
    - Providers (doctors, nurses, mental health providers, etc.)
    - Social workers
    - Community health workers
    - Advocates, navigators, community liaisons
    - Interpreters
  - Total number interviewed: 40

- Community members interviewed for their personal/family experiences rather than professional experiences.
  - Total number interviewed: 56

A total of 138 individuals were interviewed April-June 2019, and they were broadly representative of the Hennepin Healthcare "defined community".

Demographic information about interviewees

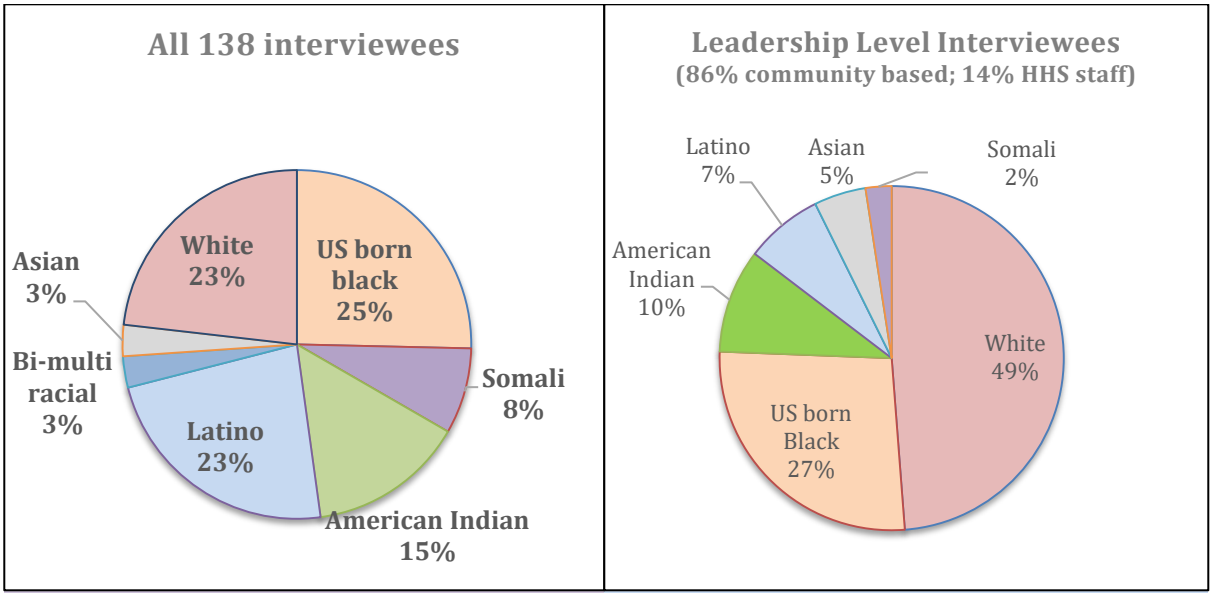
Gender of interviewees:

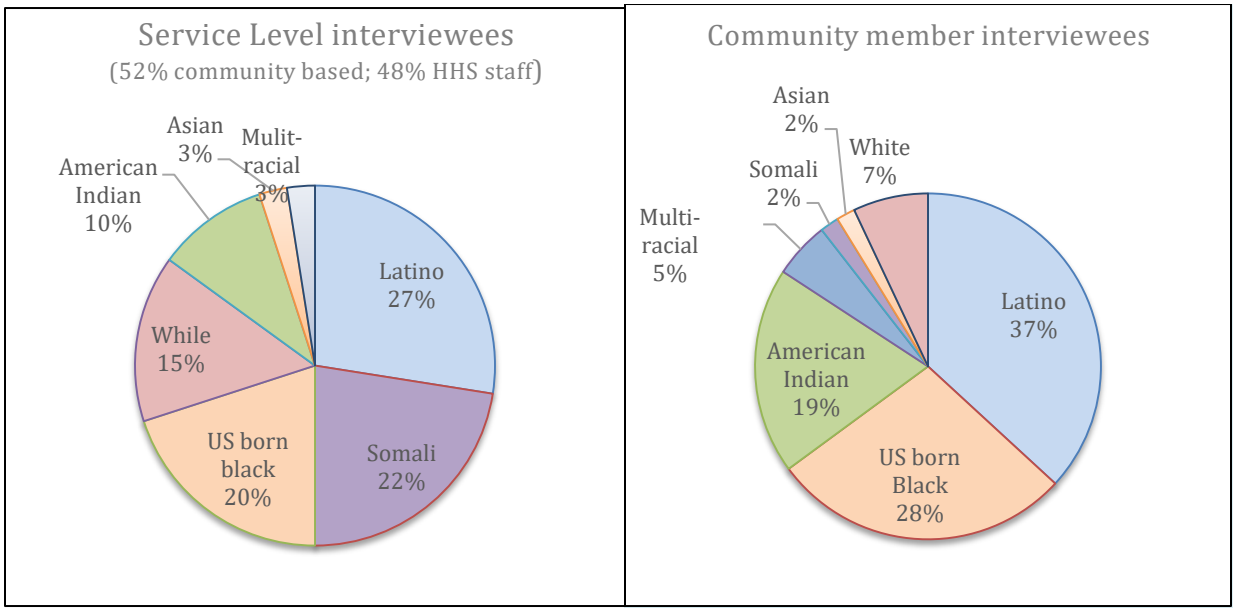
Male:	51
Female:	86
Non-binary	1

Age ranges of interviewees:

18-40	47
41-65	65
65+	12
Unknown	14

Race/ethnicity of interviewees





The community member interviewees—Hennepin Healthcare patients and other non-patient community members—represented a blend of residents from Minneapolis neighborhoods and most of the suburban communities in our “defined community”.

4b. **Gaps in Qualitative Data**

- Qualitative data results are reflective of the people who participate. The CHNA team reached out to a wide range of community stakeholders in hopes of including input and insight from as many populations within our “defined community”. While the interviewees represent a broad cross-section of our community, there are some notable gaps in representation. The following population groups are under-represented:
    - Hmong community
    - Other Asian and SE Asian communities
    - African Immigrant community other than the Somali community.
- Thanks to collaboration with the Hennepin Healthcare interpreter services department, we were able to conduct interviews with community members in Spanish.
- Interviewees frequently provided names and contact information for individuals who could provide additional insight and/or unique perspectives. The team was able to connect with some, but not all.

4c. **Top themes emerging from key informant interviews**

The 138 key informant interviews provided insights about current health needs in the community as well as about changes needed in healthcare access and delivery. The conversations were intentionally open-ended to allow interviewees the put health challenges into their own words. The team heard about what’s needed to improve health in the community and to improve levels of trust between different communities and the health care system (sometimes the system in general and other times Hennepin Healthcare specifically). Many of the conversations focused on issues of bias and racism in healthcare along with health equity and the need for more culturally responsive care and services. Even when people talked about chronic disease management, it was often discussed in terms of the need for more culturally specific education or services.

Using a structured process to analyze the interviews for themes and to quantify the frequency specific themes were identified in the conversations, the CHNA team was able to identify ten top priority needs that were representative of all categories (leadership, service level, and community perspectives) as well as being able to compare top identified needs by interviewee category and by race/ethnicity of the interviewee.

NOTE: Each interviewee was able to identify their top two or three community health needs as part of the conversation.

Top Ten Identified Priority Community Health Needs (Based in the # of interviewees across all categories who identified the need as a priority)	# of interviewees
1. Access to care (includes physical and mental health care): o Rising costs of care and medication, even with insurance o Complexity of getting on and staying on Medical Assistance o Lack or limited knowledge of Western healthcare system	63
2. Culturally responsive care: o Current providers do not reflect the Hennepin Healthcare communities o Western medical and mental health care often exclude or ignore cultural and/or spiritual beliefs and practices. Need a bridge between.	51
3. Mental Health and Wellbeing: o Impact of stigma and fear in some cultures creates barrier to care. o Revolving door: hospital discharge, too long to get follow-up appointment, new crisis, the patient goes back to hospital. o Need more holistic, culturally responsive, options.	48
4. Health equity (includes bias, structural racism, disparities, inequities): o African American and American Indian patients (and other patients of color) perceive they receive inferior care. o Current governmental, health, and other systems are set up to privilege specific groups and create barriers for others.	47
5. Building Trust between Hennepin Healthcare and communities it serves: o Trust level between Hennepin Healthcare and the communities we serve is low/fragile. o Many opportunities to repair relationships and build trust.	46
6. Housing (availability, affordability, safety): o Shortage of truly affordable housing, safe housing. o Gentrification leading to displacements. o Access to shelters can be limited.	43
7. Chronic disease management and prevention: o Impact of social determinants of health on chronic disease. o Lack of culturally responsive education and care regarding disease.	26
8. Cultural competence (lack of): o Potential for re-traumatizing and/or misdiagnosing patients if providers don't know patients' historical and cultural context. o Cultural misunderstandings can lead to escalation, difficult situations.	25
9. Substance use and addiction: o Treatment models (28 days) are too short. It takes time to build trust. o In American Indian community: untreated grief and trauma, legacy of boarding schools/intergenerational trauma, spiritual disconnect.	24
10. Maternal child health: US born African American and American Indian birth outcome disparities o Negative experiences with prenatal care (not being listened to, being judged, no recognition or respect for culture) and implied "threat" of child protection involvement lead to decreased participation in prenatal care. o Shortage of African American and American Indian providers, doulas.	21

Top Three Identified Community Health Needs by Interviewee Category (# of individuals identifying each need in parentheses)		
Leadership Level (42 individuals total)	**Service Level (40 individuals total)**	**Community Members (57 individuals total)**
1. Health equity (24)	1. Access to care (26)	1. Access to care (21)
2. Mental health and wellbeing (19)	2. Culturally responsive care (24)	2. Housing (13)
3. Housing (18)	3. Building trust (20)	2. Chronic Disease (13)

Top Three Priority Community Health Needs by Race/Ethnicity of Interviewees (# of individuals identifying each need in parentheses)				
US born Black (35 individuals)	American Indian (20 individuals)	Latino (32 individuals)	Somali (11 individuals)	White (32 individuals)
1. Access to care (20)	1. Culturally responsive care (17)	1. Access to care (19)	1. Culturally responsive care (9)	1. Mental health and wellbeing (16)
2. Health equity (16)	2. Health equity (14)	2. Culturally responsive care (17)	2. Access to care (7)	2. Access to care (15)
3. Mental health and wellbeing (14)	2. Building Trust (14)	3. Housing (8)	3. Building Trust (6)	3. Housing (14)
3. Building Trust (14)		3. Chronic disease (8)		

Step 5: Structured Process to prioritize community health needs

The CHNA team worked with the Hennepin County Center for Innovation and Excellence to plan a half-day meeting to prioritize and determine the top community health needs for the 2019 CHNA.

The team from Hennepin County facilitated the prioritization meeting, using a modified consensus building model.

In preparation for the meeting, the CHNA team prepared documents highlighting key quantitative data and presenting the findings from the key informant interviews. These documents were shared in advance and used by participants at the prioritization meeting.

The prioritization meeting was held July 16, 2019 at the Hennepin County Regional Library in North Minneapolis. Invitations were sent to participants of the key informant interviews. Twenty five individuals participated in the meeting.

Meeting structure:

- Following a general welcome and introduction to the purpose of the meeting, participants were divided into five small groups that were facilitated by members of the Hennepin County team.
- Following introductions, group members reviewed the data documents. Each small group was given a sub-set of the quantitative data and the summary of the key informant interviews.
    - Group members individually reviewed the documents before discussing the information together.
    - Discussion focused on key ideas presented in the data.
    - Facilitators emphasized each data set was limited and that other groups were looking at different sets.
- Small group discussion about community needs and group determination of two to three top community health needs
    - Key ideas recorded to provide context.
    - Top needs recorded.
- Large group share out:
    - Each small group reported out:
        - Key discussion points.
        - Top two to three agreed upon top community health needs.
    - Following each group's report, members of the larger group were given an opportunity to ask questions and to write comments on note cards, which were then collected and added to presenting group's information.
- Gallery walk and individual voting.
    - Following the small group share outs, individual participants had time to walk around and review each small group's discussion points and top needs.
    - Each participant was given 3 sticker dots to use to vote for their top three health needs. They could select from any of the health needs identified by the small groups.
- Meeting ended after the voting.

Step 6. Selection of priority community health needs for 2019–2022

Immediately following the prioritization meeting, the CHNA team reviewed all of the information from the meeting including small group discussion points and all comments on notecards following each group's share out. The team tallied the votes:

- A total of 52 votes were cast. Each person was given three sticker dots, but may have chosen to cast fewer votes.

- Although the exact wording of each group's top needs varied, clear commonalities emerged. The concepts with similar themes were categorized together to facilitate a more meaningful vote tally. The health needs fell into one of three categories:
    - Culturally responsive care
    - Mental health and wellbeing
    - Housing

- Using these three categories, the vote tally was as follows:
    - Culturally responsive care: 40 votes
    - Mental health: 8 votes
    - Housing: 1 vote

- Culturally responsive care was the overwhelming vote getter. Multiple dimensions of culturally responsive care were identified throughout the key informant interviews and the prioritization meeting which could lead to a broad base of implementation actions, including:
        - Increasing the number of providers and other top staff who reflect the communities Hennepin Healthcare serves.
        - Providing cultural awareness trainings across the organization.
        - Implementing practices and policies that incorporate culture into care and services.

The CHNA team recommended to Hennepin Healthcare senior leadership, who agreed with and endorsed, developing the 2020–2022 CHNA implementation plan under the umbrella of one 2019 top priority health need:

Improving access to culturally responsive care and services.

Identified needs not being addressed by the implementation plan:

While Hennepin Healthcare is only adopting one priority health need for 2019, themes related to accessing culturally responsive care were embedded within many of the top ten community health needs identified through the key informant interviews. A cultural component was noted in comments related to access to care, mental health and wellbeing, chronic disease management and prevention, substance use and addiction, building trust, health equity, and maternal child health. As we take actions to improve access to culturally responsive care and services, we will be mindful of intersections with these other needs.

Additionally, the other health needs identified through community interviews and data review were not prioritized as high as Access to Culturally Responsive Care and Services by the community driven prioritization process. Limited resources also require Hennepin Healthcare to focus on the need of the greatest priority.

Input Representing the Broad Interests of the Community

Throughout the community health needs assessment process, the CHNA team sought input from wide range of perspectives including:

- Individuals and organizations with a high level view of and interest in community needs, including:
    - State, county, and local public health leaders
    - Government officials such as county commissioners, elected leaders, leaders from government departments with an interest in the wellbeing and needs of community residents.
    - Academic leaders and researchers with interest in community wellbeing.
    - Leaders from organizations with interest in the broad needs of the community.

- Individuals and organizations with specific experience and knowledge regarding the unique needs of one or more of the diverse populations Hennepin Healthcare serves. In particular, Hennepin Healthcare sought input from organizations engaged with indigenous communities, communities of color, and immigrant/refugee populations.

- Individuals with service roles that included day to day contact with community members in healthcare, educational, and social welfare settings, including:
    - Social workers
    - Community health workers
    - Case managers
    - Advocates
    - Navigators
    - Language interpreters

- Consumers and community members representing the diverse communities Hennepin Healthcare serves.

During the assessment process, the CHNA team sought input through individual interviews (see Appendix A for interview questions). A total of 138 interviews were conducted. See Appendix B for a complete lists of organizations involved in the assessment process.

The CHNA team was also interested in input from the 2016 Community Health Needs Assessment and the 2017–2019 CHNA Implementation Plan. These reports have been on the Hennepin Healthcare website since the documents were finalized and approved and the website includes information about who to contact for more information and/or to request a written copy. During the past three years, the team has received a handful of inquiries, mostly from public health students interested to learn more. The organization has received positive verbal comments on the implementation plan, particularly for specific aspects of the work.

To get more specific input and feedback on the previous assessment, during the key informant interviews conducted for the 2019 assessment, the CHNA team included time to share information about the previously identified needs and the work being done to address those needs. This was added, in part, because the current work is likely to continue beyond 2019. The great majority of interviewees provided positive feedback about the work and were happy to know that the efforts would continue beyond the implementation plan phase. Note: the discussion about the previous assessment was done after the interviewee shared his or her perception of current needs.

Evaluation of Impact of 2017 – 2019 CHNA Implementation Plan

In 2016, the 2017 – 2019 Hennepin Healthcare Priority Health Needs were identified as:

- Mental Health
- Social Determinants of Health
- Maternal Child Health

Mental Health

1. Identify and address barriers to mental health care in immigrant and refugee populations (narrowed from original list of barriers to increase focus and potential for meaningful action).
2. Adopt principles and practices of trauma-informed care – work towards becoming a trauma-informed institution.

Strategy One: Reduce barriers to mental health care in immigrant and refugee communities

2018

- Convened collaborative meetings with partner agencies/organizations with interest in improving mental health access for refugees/immigrants.
- Enhanced interpreter knowledge/skills related to mental health:
    - 61 interpreters participated in a self-care webinar *"Interpreting is not for the feeble".*
    - 44 interpreters registered for mental health online course designed for interpreters.
- The Hennepin Healthcare Psychiatry Family Resource Center Website updated, including resource listings specifically for refugees/immigrants.
- Conducted survey of interpreters to gain insight into their experiences working with mental health patients and providers and get recommendations for providing optimal care.

2019:

- Created and conducted a live webinar for 500 attendees across the country on "Interpreting for Mental Health Visits". This webinar is available on the Health Care Interpreter Network website: https://hcinlearn.org/
- Interpreter survey has been analyzed and plans are in the works to develop a provider trainer based on interpreter recommendations.
- Launched a community partnership program, funded by The Robert Wood Johnson Foundation, to engage with the Somali and Mexican immigrant communities to better understand barriers to mental health care in each community and to test community driven solutions.

Work beyond 2019:

- The community engagement work within the Somali and Mexican immigrant communities will continue into 2020.
- The focus on improved access to mental health services for specific populations with cultural and/or language barriers aligns with 2020–2022 CHNA implementation plan and should receive continued support.

Strategy Two: Adopt principles and practices of trauma-informed care, working towards becoming a trauma-informed institution.

2018:

- Convened a large and growing interdepartmental Trauma-informed Care Steering Team. This team meets monthly to promote and foster trauma-informed initiatives.
- Hennepin Healthcare collaborated with Collection Action Lab to provide Historical Trauma Sessions:
    - Total of 13, three-hour sessions held in 2018. Attended by 459 Hennepin Healthcare employees (60 Hennepin Healthcare leaders, 399 staff)

2019:

- After much research, Hennepin Healthcare adopted the East Bay Children's Agency Trauma-Informed System Model (from San Francisco, CA) to guide the work at Hennepin Healthcare.
    - Four Hennepin Healthcare staff members went to California to attend a train the trainer program
    - Current efforts are underway to train an additional 12 – 20 trauma-informed trainers.
- Continuation of Historical Trauma session:
    - Total of 12 sessions (six three hours sessions and six 90 minute sessions) held in 2019. Attended by 300 Hennepin Healthcare employees
- Hennepin Healthcare named a Director of Equity & Inclusion & Trauma-Informed Care.
- In fall 2019, Hennepin Healthcare launched Trauma-informed Care 101 training sessions.
    - By end of 2019, 75–100 employees are projected to attend.
- The four trauma-informed trainers frequently make local and national presentations about the trauma-informed care and the work Hennepin Healthcare is doing.
- Two Hennepin Healthcare employees participate on the Hennepin County Health Improvement Collaborative (CHIP), which is also doing focused work around trauma-informed services.

<u>Work beyond 2019:</u>

- Hennepin Healthcare will continue work launched during the 2017–2019 CHNA implementation phase with the long term goal of transforming the Hennepin Healthcare culture into one that is trauma-informed/trauma-responsive.

Social Determinants of Health:

1. Better understand patient/family social needs & connect to relevant resources.
2. Work in partnership with other community entities to positively impact SDOH

2018:

- Screened 21,000 patients for food insecurity across community clinics.
- More than 1,400 food insecure patients connected to Second Harvest for navigation to community food resources including SNAP.

- Homeless Consult Nurse, a collaboration between Hennepin Healthcare and Hennepin County Health Care for the Homeless, added to manage care transitions for homeless hospitalized patients.
- Social Service Navigator embedded in Medicine Clinic supporting high complexity patients of whom 100% had housing needs.
- Participated in a coalition against proposed changes to SNAP rules (state and federal level).

2019:

- Developed a new, coordinated service approach with Hennepin County colleagues to support patients at high risk of readmission due to housing status. Patients participating in the program had zero 30-day hospital readmissions, and 20% were housed. The population not participating in the program had a 24% readmission rate.
- Screened 25,852 individuals for food insecurity.
- In October, launched a new program, in partnership with community nonprofit, to source pre-packed food bags for patients needing immediate food support.
- Built a coalition and developed public policy pathway for possible Medicaid funding for medical respite coordination service bundle.
- Created an enhanced homeless housing indicator in Epic that draws from additional data sources.

<u>Work beyond 2019:</u>

- The SDOH steering team is an ongoing team with goals beyond the implementation plan phase.

Maternal Child Health

1. Increase participation and engagement of African American and American Indian pregnant women in early prenatal care and evidence based community programs designed to improve birth outcomes.

2018:

- Formed a Community Advisory Council comprised of women leaders from American Indian and African American communities.
- Held 10 focus groups with women to better understand prenatal care and delivery experiences.
    - 5 with American Indian women (total of 83)
    - 5 with African American women (total of 85)
- Focus group results summarized and shared. Results also included suggestions for action.
- MCH steering team members actively worked with OB/GYN department to develop solutions to reinstate doula services for HCMC patients.

2019:

- Received funding to develop, test, and pilot culturally responsible group prenatal care models for American Indian and African American women and their partners.
- Identified and contracted a development team for each cultural model, including project coordinator, curriculum developer, group facilitator, and clinical lead (OB/GYN and/or Certified Nurse Midwife).
    - All members of the African American team are African American.

    - With the exception of the clinical lead, all members of the American Indian team are American Indian.
- The curricula will be completed and the models designed by the end of 2019. The 10 session pilot group prenatal care programs are set to start in January 2020.
- Hennepin Healthcare contracted with an evaluator for the project.
- Hennepin Healthcare is collaborating with the Cultural Wellness Center to increase the number of African American doulas available to women in the community. By the end of 2019:
    - Up to 11 previously certified, but inactive, doulas will receive refresher training and be fully registered so they can bill for their services.
    - An additional 5 – 8 new African American doulas will be trained, certified and registered.

Work beyond 2019:

- The culturally responsible group prenatal care pilot project will continue through the end of August 2020.
    - Depending on the evaluation results, Hennepin Healthcare will incorporate the models into care options.
- The maternal child health work aligns very well with the goals of the 2020-2022 CHNA Implementation plan and is likely to get support for ongoing efforts to improve culturally responsive prenatal care and birth.

2020–2022 Implementation Plan Development

At the conclusion of the 2019 Community Health Needs Assessment process, Hennepin Healthcare chose to organize implementation work around a single community determined priority health need:

Improving access to culturally responsive care and services

Recognizing there are multiple dimensions to culturally responsive care, Hennepin Healthcare scheduled community listening sessions in order to:

- Gain a deeper understanding what being culturally responsive means to community members.
- Understand specific steps and actions community members would like Hennepin Healthcare to take to become more culturally responsive.

A total of five listening sessions were held between August 26 and 29. Hennepin Healthcare contracted with Data Solutions, LLC to facilitate and summarize the findings. The sessions were held at different community locations in North and South Minneapolis. A total of 50 community members participated in one of the conversations. Four of the sessions were facilitated in English; one was facilitated in Spanish.

Forty nine of the fifty participants completed a voluntary, anonymous demographic sheet:

Gender (as identified by participant)	Number of Participants	Percent of participants
Male	21	43%
Female	28	57%

Race/ethnicity (as identified by participant)	Number of Participants	Percent of participants
American Indian/Alaska Natives	21	38%
US born Black/African American	13	23%
Hispanic	10	18%
Foreign born Black	4	7%
Asian	2	4%
White	6	11%

Key themes that emerged from the listening sessions:

One of the central questions being addressed during the listening sessions was: "What can Hennepin Healthcare do to offer care and services that respects your culture?" Five themes emerged from the conversations. The direct quotations from attendees helped shape the contours of each theme.

1. Offer compassion and hospitality.

> "Why work in this field if don't care about people?"
>
> "They should be more considerate of low-income families who don't get the same care as rich people. Be more social, get to know their clients... Sometimes I feel like I am being a pest."
>
> We want "Nice, warm, welcoming and make you feel at home. More hospitality."
>
> "I watched how they treated me and watched to see if they are treating me the same as other patients. I recognize dealing with "public" can be challenging and people feel disrespected when they see they get different treatment from others. In the Emergency Room, I feel respected if the staff don't make "a thing" or see a problem with me showing up dirty. I always feel respected or I wouldn't come back."
>
> "I understand Hennepin Healthcare allows smudging. They need to make this more accessible so that nurses, intake, and scheduling staff know this available."

2. Listen to us. Don't treat us like stereotypes.

"I asked for my medical records. When I got them, I found a note for one visit that said I was probably using drugs and that my eyes were red and shining. That visit I was there to a check a concern with my pregnancy. I feel I was stereotyped; that it was racism. Made me upset and angry."

"I take my kids to a Native American clinic. The community treats me differently because I'm [not Native American]. They talk to my daughter and not me and I'm the parent/adult. I prefer to think of myself as a human."

"Sometimes staff/doctors don't believe what you're saying. They're not considerate of what you're going through."

We need more "conversations between patients and staff. Two-way communication to establish the humanity of both and find common ground."

"Avoid assuming based on stereotyping, they should ask you and respect if you want the information/communication in English or in Spanish."

"Providers do not engage and listen to me about what I know about my body and my lived experiences. It feels like they know what they need without engaging with me. It's very frustrating."

3. Be our allies and advocates.

"I need to deal with someone who has patience for whatever barriers I have such as communication, issues with insurance, staying touch when I am homeless and/or don't have a phone. They need to keep an open mind about scheduling."

We need "More communication. If they recommend that you see a specialist or have a test, there is no follow-up to you to make sure you go it. I take a lot of tests and I don't know what the results are, need better follow-up."

We need to "respect my time and don't make me late for work. With improved wait times, patients would make it on time too and there would be respect between doctors and patients."

"Sometimes doctor explain too much and they don't know if I understood. I'd like them to use simple words and pictures of the human body. If you're talking about the kidneys, show me a picture because I don't know where it is."

"Patients need more access to advocates who can help them navigate the system. Patients need to know how to access advocates."

"So many people don't have an advocate or access to service. Sometimes people just need help…translating medical literature. People don't want to feel dumb."

4. Hire more compassionate staff and providers of race/ethnicity backgrounds like us.

> "It was very important that I was able to see an African American therapist. He understood the situation I came from. Even if he didn't experience it all himself, could understand where I'm coming from. A white therapist might be caring, but would not understand, I felt more comfortable talking to an African American provider."
>
> We need "interpreters from different nationalities."
>
> "Having people that look like you. Hiring needs to be done at every level. They are fine with us being front line staff, but not supervisors or administrators."
>
> "Who they hire is important. Race doesn't matter if they're rude or disrespectful."

5. Give us a seat at the table.

> "Need to have **(**American Indian) community members at table to develop [a cultural awareness training] curriculum."
>
> "Who are the decision makers and do they reflect the community?

Reviewing current practices at Hennepin Healthcare

After the listening sessions, the CHNA team recognized the need to better understand current adoption of culturally responsive practices at Hennepin Healthcare. In September, a team of providers and staff used the Cultural Competency Assessment Tool for Hospitals (CCATH) to evaluate the structure and processes at Hennepin for cultural competency. The CCATH measures an organization's adoption of Culturally and Linguistically Appropriate Services (CLAS) standards, which were developed by the U.S. Department of Health and Human Services.

The assessment, which is organized into 12 domains, gave the team a current view of strengths as well as areas for improvement. Overall, Hennepin Healthcare had 51% adoption of the CLAS standards.

Implementation Plan

The following CHNA community health needs assessment implementation plan reflects learnings from the needs assessment, prioritization meeting, listening sessions and organizational assessment:

<table>
<tr><th colspan="4">2020-2022 Community Health Needs Assessment Plan
and Health Services Plan:
Improve Access to Culturally Responsive Care and Services</th></tr>
<tr><td colspan="4">Increase community partnerships and voice
Work in partnership with community to improve access to culturally responsive care
Ensure community voice is central in determining strategies and actions</td></tr>
<tr>
<td>Increase Knowledge
Communication, education, and training on accessing and providing culturally responsive care
Information on specific cultures
Information on techniques for talking about culture with patients
Information on adapting care and services for patient’s cultural beliefs and practices
Information on accessing care and services</td>
<td>Develop Workforce
Increase diverse representations across all levels of the organization (including providers, administration and front-line staff)
Develop recruitment and retention initiatives</td>
<td>Implement Clinical Practices, Care Models and Policies
Prioritize areas for actions
Change or create programs and services to enhance access to culturally responsive care</td>
<td>Improve Environment and Navigation to Services
Enhance physical environment at Hennepin Healthcare to be culturally inclusive, welcoming and easy to navigate
Build partnerships with community based health care services to increase patient access to culturally appropriate services and resources that enable health</td>
</tr>
</table>

The anticipated impact of this work will be increased community participation, increased community partnerships, increased knowledge and changed practices. Initial evaluation efforts will focus on establishing specific process and outcome measures.

Potential Resources and Collaborative Partnerships

Hennepin Healthcare has adopted the results of the 2019 needs assessment and aligned the implementation plan with its strategic plan for 2020. Resources will be available for the work. In addition, Hennepin Healthcare has a long history of working in partnership with county and city agencies, community organizations, and community groups. All those who have been part of the

2017–2019 implementation work and/or part of the 2019 needs assessment process will be invited to participate in the 2020–2022 implementation work. New partnerships are also likely to emerge as the work unfolds. (See Appendix B for a complete list of community and Hennepin Healthcare organizations and departments represented in the 2019 needs assessment and/or the 2017–2019 implementation work.)

In addition to partnerships with specific organizations, Hennepin Healthcare will seek to partner more broadly with members from the communities. During the assessment interviews and listening sessions, community members and leaders expressed interest in being at the table to shape implementation work. To that end, Hennepin will actively seek community representation and voice to ensure the work is well grounded and leads to meaningful improvements.

Acknowledgements

This document serves as the Community Health Needs Assessment and Implementation Plan and is aligned with guidance from the Internal Revenue Service (IRS) for non-profit hospitals. This document also serves as the Health Services Plan as required by Minnesota Statute Section 383B.918.

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Appendix A

Key Informant Interview Questions

CHNA Key Informant Interview:
Date:
Info about interviewee:
Name:
Organization:
Position and/or Role:
Mission/focus of the Organization:
Community(s) Served by Organization:
Community(s) you are representing for this interview:

Background to provide either before interview or at the beginning of the interview. Key talking points:

- All non-profit hospitals are required by law to conduct a community health needs assessment every three years. The purpose of the assessment:
    - Identify priority health needs in the hospital's "community"
    - Develop and implement a plan to address the identified priority health needs.
- For the purpose of the assessment, Hennepin Healthcare defines its community as roughly the eastern half of Hennepin County. The great majority of the patients served by Hennepin Healthcare (HCMC and the Hennepin Healthcare community clinics) live in this part of the county.
- Within this broad definition of our community, we recognize there are many sub-communities and that there are disparities prevalent in many of these sub-communities on a range of health issues. Highlighting and elevating disparities is part of needs assessment process.
- "Health needs" can be defined in a variety a ways – from specific diagnoses or health conditions to a broader definition including conditions or other factors that impact individuals' and/or community health.
- We are interested in your observations, perceptions, beliefs, and opinions regarding health needs in the Hennepin Healthcare community – either as a whole or within one or more sub-communities.

Initial Questions:

1. Based on your professional and/or personal experience, what would you say are the top 2 or 3 health needs in the Hennepin Healthcare community?
2. For each of the needs you've identified:
    - Who (or what group(s) within the community) is/are most impacted?
    - What factors contribute to this health needs?
    - How has the need changed over the past 5 – 10 years (increased, decreased, stayed the same)?
    - What community assets/strengths are you aware of that help address this need?
    - What individuals and/or organizations (local or national) are you aware that are already working to address this need that we should be aware of?

Description of 2016 priority needs and work being done to address: Talking points:

- We would like to share the results of our last (2016) CHNA and the work that is being done to the address the identified priority needs. This work involves multi-year efforts to address systemic changes and we would like to hear your thoughts on the work to-date and where it might go in the future.

Background info on 2016 CHNA, needs identified, specific focus areas, implementation work in progress and future goals, etc. (will provide talking points).

Response to the current implementation work:

1. What thoughts do you have about the current work as just described? How does it resonate with your understanding and/or experience with the specific communities/populations identified in the work?
2. What thoughts do you have about future directions for this work – where could it go from these initial goals and actions?
3. What other groups/individuals in the community could be collaborators in this work?

Final questions:

1. Based on all you know and/or have heard about today, what do you think is the number 1 priority health need in the Hennepin Healthcare community and/or sub-community(s)?
2. Who else should we talk with to get their views on priority health needs? When we reach out to them, can we say that you recommended them to us?

Alternate beginning for community member interviews:

Today's Date:
Participant's Name:
Where the person lives – don't need specific address – Just city (example -Minneapolis, Brooklyn Center, Richfield, etc.)
Optional: How the participant identifies his/her community, race/ethnicity, sexual orientation, gender identity.

Appendix B

Community Organization and Hennepin Healthcare Departments involved with the 2017 – 2019 implementation work, the 2019 CHNA process, and/or are potential partners for 2020 – 2022 CHNA Implementation work			
Organization	**2017 - 2019 Implementation work**	**2019 CHNA**	**Potential partner for 2020 - 2022 Implementation work**
Abdi Ali, LLC (Somali community focus)	x	x	All organizations and individuals involved in 2017-2019 implementation work and the 2019 CHNA process will be invited to participate in 2020-2022 implementation activities.
African Community Services		x	
African-American Leadership Forum		x	
Ahavah BirthWorks (culturally congruent Doula agency)	x	x	
Amherst H Wilder Foundation		x	
Aqui Para Ti (Focus on Latino youth and family)	x	x	
City of Bloomington-Public Health		x	
Center for International Health	x		
CLUES (Comunidades Latinas Unidas en Servicio)	x	x	
First Covenant Church, Minneapolis		x	
Great Lakes Inter-tribal Council (Native American Focus)	x		
Head Start, Minneapolis		x	
Hennepin County- Administration		x	
Hennepin County- Office of Multi-Cultural Affairs	x	x	
Hennepin County- Opioid Strategy		x	

Hennepin Health Community Outreach	x	x	All organizations and individuals involved in 2017-2019 implementation work and the 2019 CHNA process will be invited to participate in 2020-2022 implementation activities.
Hennepin County-Public Health	x	x	
Hennepin Healthcare-Addiction Medicine		x	
Hennepin Healthcare-Clinics		x	
Hennepin Healthcare-Community Health Workers	x	x	
Hennepin Healthcare-Social Workers		x	
Hennepin Healthcare-Interpreter Services	x	x	
Hennepin Healthcare-Next Step Program (hospital-based violence intervention program)		x	
Hennepin Healthcare-Health Services Research		x	
Hennepin Healthcare-Patient Advocate	x	x	
Hennepin Healthcare-Community Advisory Board		x	
Hennepin Healthcare-Psychiatry		x	
Holy Rosary Church	x		
House of Charity		x	
City of Richfield		x	
Meridian Behavioral Health		x	
Mid Minnesota Legal Aid		x	
Minneapolis Department of Health-Infant Mortality	x	x	
Minnesota Department of Health-American Indian Health		x	
Minnesota Department of Human Services		x	
Minnesota Indian Women's Resource Center		x	

Minneapolis Public Health		x	All organizations and individuals involved in 2017-2019 implementation work and the 2019 CHNA process will be invited to participate in 2020-2022 implementation activities.
Minneapolis Police Department Community Liaison Program		x	
Minneapolis Public Schools	x	x	
MVNA Family Health	x	x	
NAMI MN-community outreach and engagement	x	x	
NAMI MN-multicultural outreach	x	x	
NorthPoint Health and Wellness Center		x	
Northside Achievement Zone (North Minneapolis focus)		x	
People Serving People (serving homeless families with children)		x	
PFund Foundation (LGBTQ focus)		x	
Ramsey County Public Health		x	
Second Harvest Heartland (Food access)	x	x	
Stairstep Foundation (African American focus)		x	
Street Voices of Change (homelessness advocacy)		x	
The Cultural Wellness Center	x	x	
The Food Group		x	
Turning Point (addiction treatment for African American men)		x	
University of MN Department of Family Medicine and Community Health		x	
Upstream Health Innovations	x	x	
Way to Grow (early childhood)		x	

Given the large number of individuals and organizations involved in 2017-19 implementation work, there may be names inadvertently left off this list.