



Community Health Needs Assessment 2022

Approved by Hennepin Healthcare System Board: 11/16/2022
Approved by Hennepin County Board: 11/29/2022

Table of contents

Overview of Hennepin Healthcare	4
2022 Community Health Needs Assessment	5
2022 CHNA Process and Methods	5
Step 1: Defining the Hennepin Healthcare Community	5
• Geographic Definition.	5
• Defined Community Demographics	7
• Demographic Variation within the Defined Community	8
• Social Needs Variations within the Defined Community	11
Step 2: Process and Methods Used to Conduct the Assessment	15
• Data used in the Assessment	15
○ Existing quantitative data	15
○ Gaps in quantitative data	16
○ New qualitative data	16
○ Gaps in qualitative data	16
• Time Frame for Data Collection	16
• New Qualitative Data: Data Collection and Analysis Methods	17
○ Individual interviews	17
○ Small group conversations	18
• Parties Involved in the Needs Assessment Process	19
○ Hennepin Healthcare staff	19
○ Contractors	19
○ Collaborators	20
• Seeking Input from Individuals with Broad Interest of the Community	20
○ Public health officials	20
○ Government officials	20
○ Representatives from health insurance perspective	20
○ Community organizations representing medically underserved, Low income, and minority populations	20
○ Community members with personal, professional, and/or advocacy connections with medical underserved, low income, and/or minority populations	21
• Summary of Input from Individuals with Broad Interest of Community	22
• Input from Written Responses to 2019 CHNA Report	22
• Other Inputs into the CHNA	22

Step 3: Creating a Prioritized Description of Significant Health Needs	23
• List of preliminary themes	23
• Prioritization criteria	24
• Prioritization event	24
○ Event structure	25
▪ Opening presentation	25
▪ Phase One (small groups)	25
▪ Phase Two (large group)	25
• Naming and documenting top priority health needs	26
CHNA Results: Top Priority Community Health Needs 2022	27
• Number One: Accessibility to health and safety as a human right	27
• Number Two: Comprehensive, equitable education	27
• Number Three: Advocacy and cultural sensitivity	27
• Additional Needs:	28
○ Partnership to promote healthy communities	28
○ Building mutual trust	28
Next Steps: Implementation Planning	28
Potential Resources and Collaborative Partners	28
Evaluation of Impact of 2020 – 2022 CHNA Implementation Plan	30
Acknowledgements	40
Appendices	42
• Appendix A: 2022 CHNA Interview Guide	42
• Appendix B: CHNA Interviews: Method for data collection and analysis	45
• Appendix C: 2022 CHNA Interview Themes with Quotes	49
• Appendix D: 2022 CHNA Group Conversation Guide	61
• Appendix E: 2022 CHNA Prioritization Packet	63

Overview of Hennepin Healthcare

Hennepin Healthcare System (Hennepin Healthcare), a wholly owned subsidiary corporation of Hennepin County is an integrated system of care. HCMC is the flagship, 484-bed academic medical center, and a nationally recognized Level I Adult and Pediatric Trauma Center. The downtown Minneapolis campus includes a large outpatient Clinic & Specialty Center with more than 25 primary and specialty care clinics. A network of community clinics serves three Minneapolis neighborhoods and the suburban communities of Brooklyn Park, Golden Valley, Richfield, and St. Anthony Village.

The health care system includes a large psychiatric program, home care, Emergency Medical Services, and a research institute and philanthropic foundation. HCMC is the largest off-campus training affiliate of the University of Minnesota Medical School.

In 2020, Hennepin Healthcare played a pivotal role leading the regional response to COVID-19. In the early months, Hennepin had the highest volume of critical care COVID patients and was a leader in testing its patients and bringing testing to the community to address inequities in access. When the vaccine became available, Hennepin Healthcare focused on reaching underrepresented communities where there were glaring disparities in accessing the vaccine.

Hennepin Healthcare has made a commitment to addressing disparities in outcomes and inequities based on race a cornerstone of its strategic direction. As it works to become an anti-racist organization, all team members are participating in Courageous Conversations about racism and will take part in an immersive, yearlong learning program. The newly created Health Equity department established a Talent Garden to inspire and support historically excluded youth to pursue careers in health care. The Talent Garden initiates hands-on youth summits, mentorship, job shadowing, and paid internship opportunities for young people in the community to introduce them to health care careers.

Living up to its mission means Hennepin Healthcare partners with the community, patients, and families to ensure access to outstanding care for everyone, while improving health and wellness through teaching, patient and community education, and research.

2022 Community Health Needs Assessment (CHNA)

The purpose of the triennial Community Health Needs Assessment (CHNA) 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 2022 Hennepin Healthcare CHNA was conducted under the direction of the Hennepin Healthcare Director of Population Health. A CHNA Core Team, which was created and tasked with planning and executing the assessment, included:

- Hennepin Healthcare staff who led the overall process.
- Community consultants hired as fully active members of the Core Team.
- Members of the Hennepin Healthcare Research Institute who formed the Interview Analysis Team to guide the individual interview process.

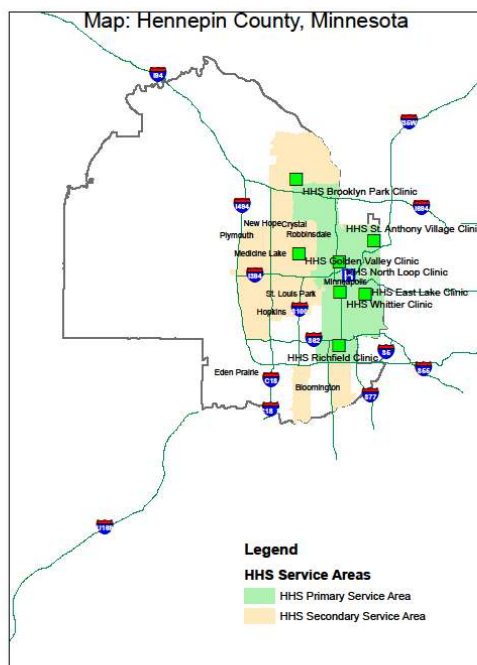
The 2022 CHNA Process and Methods

The needs assessment process included the following steps:

1. Defining the Hennepin Healthcare community.
2. Conducting the assessment, which included:
 - a. Identifying data sources.
 - b. Identifying time frame for data collection.
 - c. Establishing data collection and analysis methods.
 - d. Engaging parties involved in conducting the assessment, including collaborators and contractors.
 - e. Eliciting input from individuals representing broad interests of the community.
3. Prioritizing the significant health needs of the community identified through the CHNA.

Step 1: Defining the Hennepin Healthcare Community

Hennepin Healthcare provides care for patients from all 87 counties in Minnesota, with a significant majority of patients residing within Hennepin County. More specifically, most reside within the eastern half of the Hennepin 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, St. Anthony, and St. Louis Park. For the purposes of the CHNA, Hennepin Healthcare has broadly defined its geographic community as the primary and secondary service areas of the institution, noted on the shaded sections of the following map:



2022 Limitations in creating a current community profile:

Important Note: To create a profile of the defined community, the following two data sources provided the most useful information: MN Compass 2016 – 2020 and Hennepin County 2018 SHAPE data. Both sources enable capturing the geographic boundaries of the defined community. Unfortunately, updated data from both sources will not be available until either the end of 2022 or the summer of 2023. While the data provide an important lens to community need, the timing of the source data (2016 – 2020 and 2018) means the impact of the COVID-19 pandemic and other dynamics are not captured in these values. For example, a survey of Hennepin Healthcare primary care patients¹ in May 2020 found 35% of respondents were worried about food compared to the 6.1% of all Minneapolis residents (even lower for suburban communities) reported in the 2018 SHAPE data report. (Even with variation between communities, the highest percentage of frequent worry was 23%).

Policy changes during the pandemic created additional supports for food, time-limited protections against evictions, expanded unemployment benefit eligibility criteria, direct government payments to many individuals and families, and sustained Medicaid coverage. The pandemic also impacted the way individuals were able to access healthcare and receive preventive and chronic care services. These dynamic factors and their impact on the community are not reflected in the following defined community profile data.

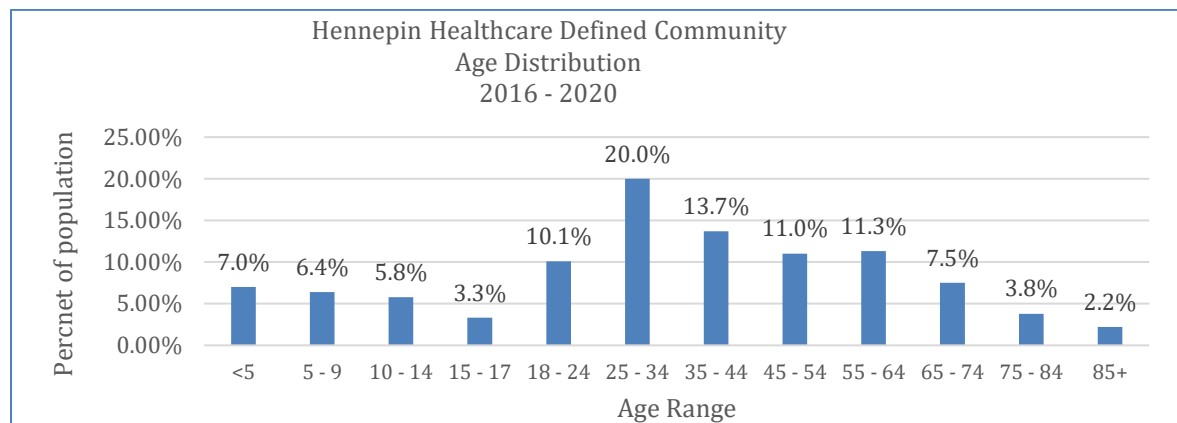
¹ *COVID-19 Impact and Basic Needs Survey Final Report*: a survey conducted for internal purposes: [COVID Results Packet R10 Final.pdf \(hennepinhealthcare.org\)](https://www.hennepinhealthcare.org/COVID-Results-Packet-R10-Final.pdf)

Defined Community Demographics

Data Source for the following demographic profile information is MN Compass Data 2016 – 2020 (<https://www.mncompass.org/profiles/county/hennepin>).

The MN Compass website has a tool that enabled the team to create the data map with boundaries identical to those of the defined community.

Age distribution:



Gender: (note: male and female are the only two options given)

- Male: 50.2%
- Female: 49.8%

Race/ethnicity:

Race/Ethnicity	Percent of Overall Defined Community Population
Black/African American alone	17.4%
American Indian/Alaska Native alone	0.7%
Asian or Pacific Islander alone	7.4%
Two or more races alone	4.1%
Other alone	0.6%
Hispanic of any race	8.7%
White alone	61.1%

Language:

Language	Percent of Overall Defined Community Population
English	79.1%
Language other than English	20.9%
(Limited English Proficiency)	8.2%

Place of birth:

- 85% born in the US
- 15% born outside the US

Disability status:

- 11.2 percent of the population within Hennepin Healthcare's defined community live with a disability.

Economic status:

- Median household income: \$71,829.00

Poverty status:

Poverty Status	Percent of Overall Defined Community Population
Below federal poverty level (FPL)	13.3%
100 – 149% of FPL	7.4%
150 – 199% of FPL	7.5%
200%+ of FPL	71.8%

Demographic Variation within the Defined Community

Using the Compass MN tool of creating custom zip code based areas, the team created data profiles for key geographic sub-communities within the overall defined community:

- Central (downtown) Minneapolis.
- North Minneapolis.
- Cedar Riverside (area just east of the hospital).
- Northeast Minneapolis.
- South Minneapolis, east of interstate 35W.
- South Minneapolis, west of Interstate 35W.

- North suburban city of Brooklyn Park.
- North suburban city of Brooklyn Center.
- South suburban city of Richfield.
- Northwestern suburbs (including Crystal and New Hope).
- Southwestern suburbs (including Saint Louis Park, Golden Valley, and Hopkins).

The following tables identify sub-communities with cultural diversity variation compared to the average for the entire Hennepin Healthcare defined community.

Race/ethnicity: Percent of population that identifies their race as other than White.

The table features sub-communities with higher percent of their population identifying race as other than White.

Community	Percent identifying race as other than White
Hennepin Healthcare's Defined Community	35.8%
North Minneapolis	71.1%
Cedar Riverside	70.0%
Brooklyn Center	59.1%
Brooklyn Park	54.3%

Language: Percent of population that identifies their preferred language as other than English.

The table identifies sub-communities with notably higher percentages of population with preferred language other than English.

Community	Percent with preferred language other than English
Hennepin Healthcare's Defined Community	20.9%
Cedar Riverside	54.8%
Central Minneapolis	27.1%
North Minneapolis	26%
Brooklyn Park	25.6%
Richfield	24.0%

Place of birth: Percent of population that was born somewhere outside the US. Sub-communities with notably higher percentages of population born outside the US.

Community	Percent born outside the US
Hennepin Healthcare's Defined Community	15.0%
Cedar Riverside	36.2%
Brooklyn Park	22.5%
Brooklyn Center	19.5%

Median income: Sub-communities with notably lower median income values.

Community	Median Income
Hennepin Healthcare's Defined Community	\$71,829
Cedar Riverside	\$20,358
North Minneapolis	\$46,317
Central Minneapolis	\$58,663

Poverty status: Percent of households with incomes below the Federal Poverty Level (FPL). Sub-communities with notably higher percentages of households below the FPL.

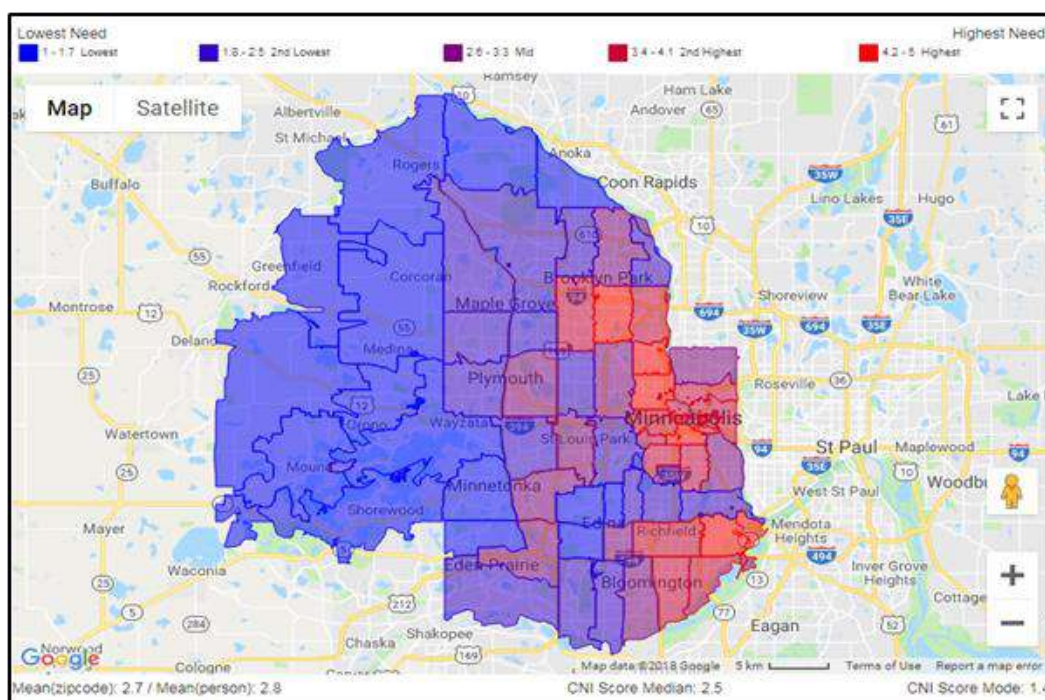
Community	Percent of households below the FPL
Hennepin Healthcare's Defined Community	13.3%
Cedar Riverside	49.9%
North Minneapolis	25.7%
Central Minneapolis	22.4%

Social Needs Variations within the Hennepin Healthcare Defined Community

2018 Community Needs Index:

Dignity Health created the Community Needs Index (CNI)² 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. Sub-communities within the defined community indicating the highest level of need include:

- Central Minneapolis
- North Minneapolis
- Cedar Riverside
- Northeast Minneapolis
- Brooklyn Park
- Parts of South Minneapolis (east of Interstate 35W)
- Richfield



² Truven Health Analytics. Dignity Health. Community Need Index. <http://cni.chw-interactive.org/>

2018 SHAPE Survey Data:

The following data from the 2018 Hennepin County SHAPE Survey (<https://www.hennepin.us/SHAPE>) captures social needs information for communities within Hennepin Healthcare's defined community including:

- Food insecurity.
- Housing insecurity.
- Transportation barriers.
- Frequent experience of discrimination (not feeling accepted).

Values for Minneapolis overall and suburban communities overall are reported along with those for sub-communities where residents reported notably higher percentages of concern.

Food insecurity: Percent of survey respondents that reported they often worried about food running out before having enough money to buy more.

Community	Percent who worry often about food
Minneapolis overall	6.1%
Suburban overall	3.3%
North Minneapolis	15.0%
Parts of South Minneapolis	8.5%
Self-identified LGBTQ	11.3%
Hispanic	11.4%
US Born Black	22.0%
Non-US Born Black	8.3%
SE Asian	13.7%
American Indian/Alaska Native	21.8%
Self-reported disability	11.4%
Experiencing housing insecurity	23.0%
< 100% of Federal PovertyLevel	20.5%

Housing insecurity: Percent of survey respondents who, in the previous year, reported missing or delaying a mortgage or rent payment due to lack of funds.

Community	Percent with missed/delayed payment
Minneapolis overall	9.7%
Suburbs overall	6.4%
North Minneapolis	21.4%
Parts of South Minneapolis	12.6%
NW Suburbs	12.9%
Self-identified Transgender	15.6%
Self-identified LGBTQ	14.2%
Hispanic	26.0%
Asian	13.3%
US Born Black	39.4%
Non-US Born Black	24.6%
< 100% of Federal Poverty Level	22.2%
Self-reported disability	14.4%

Transportation barriers: Percent of survey respondents who reported they were often not able to get to jobs, medical appointments, or shopping due to lack of transportation.

Community	Percent with frequent transportation barriers
Minneapolis overall	4.1%
Suburbs overall	1.8%
North Minneapolis	9.8%
Hispanic	21.6%
US Born Black	19.7%
Non-US Born Black	8.3%
< 100% of Federal Poverty Level	13.0%
Housing insecure	14.7%

Feeling not accepted due to race, religion, and immigration status:

Percent of survey respondents who frequently (at least once a month or more) feel they are not accepted because of their race, religion, or immigration status.

Community	Percent feeling not accepted
Minneapolis overall	7.3%
Suburbs overall	4.0%
North Minneapolis	13.5%
Self-identified Transgender	14.7%
Self-identified LGBTQ	12.2%
Hispanic	19.6%
American Indian/Alaska Native	22.5%
Asian	11.0%
US born Black	25.8%
Non-US born Black	10.5%
< 100% Federal Poverty Level	15.6%
Self-reported disability	10.1%

Feeling not accepted due to sexual orientation or gender identity:

Percent of survey respondents who frequently experience (at least once a month) not being accepted because of sexual orientation or gender identity.

Community	Percent feeling not accepted
Minneapolis overall	5.1%
Suburbs overall	1.5%
Self-identified Transgender	41.6%
Self-identified LGBTQ	21.6%
Hispanic	8.5%
American Indian/Alaska Native	9.5%
US born Black	8.9%
< 100% Federal Poverty Level	7.33%

Step 2: Process and Methods Used to Conduct the Assessment

Data Used in the Assessment:

Existing quantitative data:

- Hennepin County SHAPE Survey (<https://www.hennepin.us/SHAPE>): The currently available Hennepin County SHAPE data was collected in 2018. The county is on a four-year assessment cycle and is in the middle of collecting data for their 2022 assessment. The report on the newly collected created data will be available mid-year in 2023.

The SHAPE survey data has been particularly useful for Hennepin Healthcare's CHNAs because the data is looked at by geographic locations (e.g., by Minneapolis neighborhoods, by city versus suburbs, by race, ethnicity, age, housing insecurity, education, poverty level, disability status, LGBTQ identities, and impact of frequent mental distress.

Although the SHAPE survey data did not offer new insights, the team used some of the SHAPE findings to add social needs dimensions to the defined community profile.

- Minnesota Compass: <https://www.mncompass.org/profiles/county/hennepin>. The available data is newer (2016 – 2020) than that available in 2019 (2013 – 2017), However, it is still pre-pandemic and does not capture the impacts of COVID, the murder of George Floyd and subsequent uprising, and other factors that impacted community health and wellbeing.

The compass website allows users to build a custom map and data set using zip codes. The team put together a list of the 36 zip codes in our defined community and used their profile data to provide a snapshot of our defined community. Sources for the profile for our defined community include American Community Survey (ACS) 5-year estimates (2016 – 2020), and Longitudinal Employer-Household Dynamics (LEHD). (NOTE: The results of the 2020 Census are not yet available and are not reflected in the Compass data.)

The website includes a tool for creating custom data boundaries. Using this tool to pull data for the 36 zip codes included in our defined community, the team captured a demographic and economic profile of the defined community. Likewise, this tool enabled the team to create basic profiles for some of the key sub-communities within the defined community. Creating custom maps allowed us make comparisons based on key sub-communities.

- *COVID-19 Impact and Basic Needs Survey* Final Report: a survey conducted for internal purposes: [COVID Results Packet R10 Final.pdf \(hennepinhealthcare.org\)](#)

Gaps in quantitative data:

The biggest gap in quantitative data is the time frame when data was collected. SHAPE and MN Compass data was collected in 2018. The data represents a reflection of pre-pandemic realities. In addition, data provided through MN Compass does not distinguish between US born and non-US born Black/African American, Hispanic, and Asian populations which can often mask key disparities.

The *COVID-19 Impact, and Basic Needs Survey* captured initial impacts on patients during the first few months of the pandemic. It does not capture the impact of local, state, and national mitigation efforts on patients' needs over time.

New qualitative data:

Given the lack of timely community data, the primary input into the 2022 needs assessment was new qualitative data gathered through community engagement efforts including the completion of:

- A total of 49 individual interviews with a very diverse pool of public health officials, current and former elected officials, community leaders, representatives from community organizations, and community members.
- Seven small group conversations including a total of 34 community leaders and members.

Gaps in qualitative data:

Despite intentional efforts to include voices from a wide range of cultural and geographic communities within the boundaries of Hennepin Healthcare's defined community, the majority of voices come from the diverse cultural communities within Minneapolis. Although there is some representation from suburban communities, there is a gap in the balance between urban and suburban perspectives.

Time Frame for Data Collection

- Individual interviews:
 - Data collection in May and June 2022.
 - Data analysis from mid-June until late August 2022.
- Small group conversations:
 - Conversations held in late July through mid-August.
 - Data analysis from mid-August to mid-September.

New Qualitative Data: Data Collection and Analysis Methods

Individual interviews:

The qualitative interviews were guided by the CHNA Interview Analysis Team from Hennepin Healthcare Research Institute. The process included:

1. Developing the interview guide (see Appendix A):
 - a. Interview Analysis Team members and Core Team community consultants collaborated in developing the interview guide.
 - b. Specific questions were selected to elicit authentic views about priority community health and wellbeing needs.
2. Hiring community interviewers:
 - a. Ten community members representative of the cultural communities Hennepin Healthcare serves and who had prior interviewing experience were hired to conduct the interviews.
3. Selecting interviewees:
 - a. Community consultants and interviewers selected the list of interviewees, putting together a list of individuals likely to bring a wide range of perspectives as well as being inclusive of the diverse cultural communities within the Hennepin Healthcare defined community.
4. Training community interviewers:
 - a. The Interview Analysis Team provided a two-hour qualitative interviewing training focused on the goals of this specific interview.
5. Completing the 49 interviews and submitting audio tapes of the conversations for transcribing:
 - a. 22 interviews were conducted in person.
 - b. 27 were conducted remotely.
6. Analyzing interviews and identifying and developing key themes:
 - a. The Interview Analysis Team used the Framework Matrix Analysis (FWMA) approach, which involved:
 - i. Developing structured categories tied to the primary objective of the CHNA of identifying the top priority community health needs.
 - ii. Coding the 49 interviews.
 - iii. Identifying main themes and sub-categories.
 - iv. Reporting back and discussing themes with the CHNA Core Team.
 - v. Revising and finalizing themes based on community consultant feedback.
7. Determining initial themes, which were, in alphabetical order:
 - a. Accessible and affordable care.
 - b. Community centered care.
 - c. Culturally responsive care.
 - d. Fostering trust.
 - e. Meeting basic needs.
 - f. Neighborhood safety.

- g. Widespread access to mental health care.
8. See Appendix B for a more detailed description of the analysis process.
9. See Appendix C for the main themes, sub-categories, and relevant quotes.

Small group conversations:

At the completion of the individual interviews, the CHNA Core Team reviewed the demographics represented by the forty-nine interviewees. After careful review, the Core Team members decided to hold a series of small group conversations to bring in additional points of view and achieve a better balance in demographics. In particular, the group wanted to include more views from elders from different cultural communities, from individuals who identify as members of the LGBTQ community, and from more individuals who identify as men. The process included:

1. Developing small group conversations question guide (see Appendix D):
 - a. The Core Team community consultants chose to adapt the interview guide for group conversation, placing additional emphasis on the impacts of the pandemic and other factors on community health and wellbeing.
2. Organizing and holding small group community conversations:
 - a. Interested Core Team Community Consultants, Community Interviewers, and additional community members were hired to:
 - i. Organize groups.
 - ii. Recruit participants.
 - iii. Facilitate and record conversations.
3. Completing the seven community conversations and submitting the tapes for transcribing:
 - a. Four groups were held in person.
 - b. Three were held virtually.
4. Reviewing and analyzing the conversation transcripts and notes.
5. Identifying themes that aligned with the findings from the individual interviews.
6. Identifying new themes, unique to the conversations.
7. Reporting and discussing the full set of themes with the full CHNA Core Team.

Themes that emerged from the group conversations aligned well with all the interview themes, sometimes adding new sub-categories.

In addition, new themes emerged including, in alphabetical order:

- Need to address impacts of COVID-19 on communities.
- Importance of community members taking care of themselves and one another.
- Importance of holistic care.
- Need to address long-term impacts of systemic racism and white supremacy on BIPOC (Black, Indigenous, and People of Color) communities.

Parties Involved in the Needs Assessment Process

Hennepin Healthcare staff who led the overall process:

- Community Health Program Liaison (Population Health Department).
- Health Equity Community Engagement Program Manager (Health Equity Department).

Key contractors hired to assist with the assessment:

- Community consultants:
 - Eight CHNA Core Team Community Consultants, who either identified with or had strong ties to one of more cultural communities served by Hennepin Healthcare, were hired as key contributors/shared decision makers during all aspects of the assessment process.
- Community interviewers:
 - Ten community members were hired and trained to conduct the individual interviews (four were also Core Team community consultants; six were community members new to the assessment process).
 - The interviewers had ties to one or more of the cultural communities Hennepin Healthcare services.
 - Interviews were conducted in English, Spanish, and Somali.
- Community small group facilitators and notetakers were hired to conduct the small group conversations:
 - Six community members were hired to conduct seven small group conversations. All six were either Core Team Community Consultants or Community Interviewers.
 - Small groups were led in English, Somali, and Korean (with interpreter).
 - An additional two community members were hired to take notes during the conversations.

Key contracted entities that enabled the assessment process and prioritization event to be linguistically inclusive:

- *Same Day Transcriptions* (<https://www.samedaytranscriptions.com/>) provided written transcripts for interviews and small group conversations, including transcripts translated from Spanish into English.
- *Language Line Solutions* (<https://www.languageline.com/>) provided written transcripts for interviews and small group conversations including transcripts translated from Somali into English.
- *University Language Center* (<https://ulanguage.com/>) provided written translations of prioritization packets into Somali and Spanish and provided both simultaneous and consecutive Somali and Spanish interpreters for the prioritization event.
- *Audio Logic Systems* (<http://www.audiologicsystems.com/>) provided simultaneous interpreting equipment and technical assistance for the prioritization event.

Key collaborators:

- Members of the Hennepin Healthcare Research Institute formed the Interview Analysis Team to guide the individual interview process. The members of this team included:
 - Co-director of the Health, Homelessness, and Criminal Justice Lab
 - Operations Director
 - Project Coordinator
 - Research partner from the University of Minnesota
- A three-person team from the Hennepin County Center for Innovation and Excellence led the prioritization process.

Seeking Input from Individuals with Broad Interest of the Community

In selecting individuals to participate in the individual interviews and the small group discussions, the community consultants, community interviewers, and small group conversation organizers were intentional in seeking out participants who not only brought unique perspectives but who, through their roles in the community and/or their professions would be able to represent the broad interests of Hennepin Healthcare's defined community and/or the broad interests of one or more of the culturally communities within the defined community. These individuals included:

- Public health officials:
 - Public health leader from Minneapolis Health Department.
 - Retired Epidemiologist from University of Minnesota.
- Government officials:
 - Current state senator.
 - Former Minneapolis city councilmember.
 - Former state representative.
- Representative from health insurance perspective:
 - Representative from United Healthcare.
- Community organizations representing the interests of medically underserved, low-income, and minority populations, including:
 - Hmong Healthcare Professionals Coalition: dedicated to serving the health needs of the Hmong community.
 - Korean Service Center: serving elders in Korean immigrant community.
 - Esperanza United: focused on ending gender-based violence in Latinx community.
 - Mujeres en Accion y poder: Women in Action and Power.
 - HACER: Hispanic Advocacy and Community Empowerment Through Research.
 - CLUES (Comunidades Latinas Unidas en Servicio): Focused on advancing social and economic equity and wellbeing for Latinos in Minnesota.
 - Native American Community Clinic: health care clinic in the heart of American Indian urban community in Minneapolis.
 - Minneapolis Public Schools.

- PICA: Parents in Community Action.
 - Seeds to Harvest: a collective of community leaders and organizations dedicated to bringing healing and joy to children in North Minneapolis.
 - Tubman Center: serving people who have experienced significant trauma, providing shelters, legal services, and other resources.
 - Northside Coalition: a group of organizations dedicated to the long-term economic prosperity of North Minneapolis.
 - Northside Achievement Zone: exists to permanently close the achievement gap and end generational poverty in North Minneapolis.
 - Urban Research and Outreach-Engagement Center: works to build thriving, innovative, and respectful collaborations, create new models of urban and community development, and strengthen the University as a vitally engaged 21st-century university serving the public good.
 - Hawthorne Neighborhood Council: seeks to improve the quality of life in the Hawthorne neighborhood through empowering the residents in order that they can address the physical, cultural, social and economic needs of the community.
 - Host, KMOJ Radio station, a community-oriented noncommercial radio station in Minneapolis.
- Community members with personal, professional, and/or advocacy connections with medically underserved, low income, and/or minority populations, including the following communities (descriptive words taken from those used by individuals to identify themselves):
 - Black/African American communities, including
 - Residents of North Minneapolis.
 - Male elders, ages 70+.
 - Members of churches active in meeting community needs.
 - Single parents.
 - Community doulas with focus on African American community.
 - Community activists and leaders.
 - Latinx Community, including:
 - Community leaders and activists.
 - LGBTQ Latino.
 - Heads of households.
 - Native American communities:
 - Red Lake Band of Ojibwe (Anishinaabe).
 - Leech Lake Nation (Anishinaabe).
 - Urban Native community.
 - Korean elders.
 - Somali community including:
 - Health care professionals serving the community.
 - Youth.
 - Mothers and Fathers.

- Grandparents.
- Community advocates.
- Among community, including:
 - Health professionals.
 - Mental health professionals.
 - First generation to go to college.
- Individuals identifying as LGBTQ including:
 - Mental health professional.
 - Single parent.
 - Gender non-binary.
 - Community activists.
- Parents of children living with disabilities.
- Community artists and musicians.

Summary of Input Provided by Individuals Representing Broad Interest of the Community

- All input was provided verbally either in person or virtually in the form of individual interviews or small group conversations.
- Interviewees and small group conversation participants answered questions related to individual and community health and well-being, including specific challenges and barriers as well as resiliencies, and their perceptions of current top priority needs.
- Input from the above individuals shaped the list of preliminary priority needs.
- All the above participants were invited to attend the day-long prioritization event where attendees engaged with the initial themes and, using a consensus approach, determined the top priority health needs.

Input from Written Responses to 2019 CHNA Report

Hennepin Healthcare has made the 2019 CHNA report widely available to the public. It is posted on the Hennepin Healthcare website along with the 2013 and 2016 CHNA reports. There are instructions for providing feedback and for requesting a written copy of the report. To date, Hennepin Healthcare has received no written comments about the report and/or the CHNA process.

Other Inputs into the CHNA

The following sources of input influenced Hennepin Healthcare's approach to the assessment process, the community leaders and members we engaged with, and the questions we asked.

- Hennepin Healthcare: *Our Future Insights Report: Learning Together/Engagement Insights*, October 2021: A community engaged assessment regarding the future of health care and the main Hennepin Healthcare campus. This report is for internal use and a public link is not available.

- Summaries from Hennepin Healthcare community specific listening sessions hosted by Hennepin Healthcare’s CEO (summaries for internal use only and a public link is not available):
 - Black/African American Community Conversation: August 2020.
 - Somali Community Conversation: September 2020.
 - American Indian Community Conversation: October 2020.
 - Latinx Community Conversation: December 2020.

Step 3: Creating a Prioritized Description of Significant Health Needs in Hennepin Healthcare’s Defined Community

The steps to create a prioritized description of significant health needs in the defined community included:

1. Creating a list of preliminary themes based on input from the community interviews and small group conversations.
2. Identifying prioritization criteria.
3. Holding a day-long prioritization event to determine the top priority needs.
4. Naming and documenting the top priority health needs.

Creating a list of preliminary themes

The themes from the interviews and group conversations were merged to create a list of preliminary needs to bring to the prioritization event. In alphabetical order, the ten themes were:

Access to Affordable Care: <ul style="list-style-type: none"> • Physical Health • Mental Health – widespread • Dental Care 	Address Impacts of COVID-19: <ul style="list-style-type: none"> • Isolation, loneliness, losses • Reduced access to care • Economic impacts
Building Trust: <ul style="list-style-type: none"> • HENNEPIN HEALTHCARE active in communities • Active partnerships 	Community Centered Care: <ul style="list-style-type: none"> • Community-driven solutions • Shared decision making
Communities Care of Themselves and One Another: <ul style="list-style-type: none"> • Support existing efforts • Collaborate 	Culturally Responsive Care: <ul style="list-style-type: none"> • Providers reflective of communities • Care honoring culture • Cultural navigators
Holistic Care: <ul style="list-style-type: none"> • Whole person – mind, body, spirit • Broader treatment options • Empowerment to care for self and others 	Long Term Impacts of Systemic Racism and White Supremacy on BIPOC (Black, Indigenous, and People of Color) Communities: <ul style="list-style-type: none"> • Education • Trauma Informed Care
Meeting Basic Needs <ul style="list-style-type: none"> • Healthy food • Affordable housing • Clean environments, air, and water 	Safety: <ul style="list-style-type: none"> • Emotional safety – can I be myself without judgement or harm? • Safety in neighborhoods

Prioritization Criteria

Throughout the needs assessment and prioritization process, participants with input into the CHNA were asked to identify the most important community health and wellness needs within the larger community as well as within the specific communities with which they were personally and/or professionally connected. They were asked to think about who was most impacted by the needs they identified and to consider the potential impact of addressing needs on the community at large as well as on specific cultural communities.

Using a consensus building approach to prioritize and determine which identified needs were selected as top priority in 2022, voices from across diverse communities were heard, considered, aligned with others, and, ultimately, combined in ways that met agreement by all involved. The resulting top identified needs for 2022 were determined with strong community support.

Prioritization Event

The CHNA team worked with the Hennepin County Center for Innovation and Excellence to hold a full-day community event to determine the top community health needs for the 2022 CHNA.

The Hennepin County team facilitated the prioritization event, using a consensus generating approach called Technology of Participation (ToP).

In preparation for the event, the CHNA team prepared a document highlighting the ten preliminary themes and sub-themes from the community interviews and conversations. The documents included relevant anonymous quotes from interviewees and group participants. This document was used by participants at the prioritization event as a starting point for further reflection and discussion. See Appendix E for the prioritization event document.

The prioritization event was held in-person on October 12, 2022, at the Minneapolis Central Library in downtown Minneapolis. All individuals who were involved in the assessment process including CHNA core team community consultants, community interviewers, small group facilitators, notetakers, all interviewees and small group participants were invited to participate. The invitation indicated that the purpose of the event was to determine the top priority community health needs in 2022.

Thirty-three individuals participated in the event, including public health leaders, health care professionals, community leaders, representatives from non-profit organizations serving one or more cultural communities, and community members representing the diverse cultural communities Hennepin Healthcare services.

Hennepin Healthcare provided both simultaneous and consecutive interpreters to support more inclusive participation for Spanish and Somali speaking participants.

Event structure:

Opening presentation:

- General welcome.
- Short presentation about the CHNA process and current status.
- Brief description of the preliminary ten needs identified through interviews and small group conversations.
- Charge for the day: prioritize needs and identify 2 – 3 top priority community health needs.

Phase One: Work done in small groups. During this phase, the small groups were facilitated by community facilitators trained by the Hennepin County team.

- Participants were divided into five small groups.
 - Three groups were facilitated in English.
 - One group was facilitated in Spanish.
 - One group was facilitated in Somali.
- The overriding question for this phase was: *“What community health needs are emerging for Hennepin Healthcare to focus on?”*

Phase One Steps:

1. Individual participants first reviewed the prioritization packet (see Appendix E) and individually brainstormed answers to the following questions:
 - a. What words or phrases stood out for you?
 - b. What excites you about what you heard?
 - i. Where do you see opportunities regarding what you heard?
 - ii. What worries you about what you heard?
 - c. What might be happening in the community to drive these issues?
 - i. What should we keep in mind as we prioritize?
2. Individuals shared their thoughts within their small group and the group then created a list of five to seven community health needs reflective of the ideas they shared.
3. Each group then ranked this list of needs (using three tier ranking) and selected a group reporter.

Phase Two: Large group with all five groups working together. During this phase, the discussion was facilitated by the team from Hennepin County.

- The five small groups combined to form one large group for the rest of the meeting.
- *Goal for Phase Two was to identify the top priority health needs in 2022 that Hennepin Healthcare should work to address:*

Phase Two Steps:

1. Small group report-outs:
 - a. Small group reporters read each need aloud and turned in the half sheet with the need in writing. These half sheets were put on the sticky board.
 - b. There were three rounds of small group report-outs to the larger group:
 - i. Two needs from tier one.
 - ii. Two needs from tier two.
 - iii. Two needs from tier three.
 - c. Following the third round, groups were invited to share any remaining ideas not already represented.
 - d. During the report-outs, the facilitator began informally clustering similar needs together.
2. Clustering and naming the needs:
 - a. Once all ideas were represented, the facilitator led the participants through a process to finalize the clustering of needs and determining an overarching name for each cluster.
 - b. This process continued until there was full group consensus about the clusters and names and that they represented the top priority community health needs.
 - c. At the end of this process, there were five named clusters.
3. Ranking and prioritization of needs:
 - a. As a final step, the facilitator asked each person to rank and identify their top two priority needs. Facilitators asked participants to consider the following two questions
 - i. What group of ideas demonstrates the biggest community health need?
 - ii. What will be different in your communities when these needs are addressed?
4. Naming and documenting the top priority needs.
 - a. At the end of prioritization event, the participants achieved full consensus regarding the 2022 top priority health needs that Hennepin Healthcare should focus efforts towards addressing. The final thing participants did was to rank the chosen needs.

CHNA Results: Top Three Priority Community Health Needs 2022

Number One: Accessibility to Health and Safety as a Human Right

Examples of specific needs:

- Access to affordable care for:
 - Working poor, especially seniors.
 - Children with special needs.
 - Individuals needing mental health care.
 - People who are homeless.
- Commitment to women's reproductive and comprehensive health care.
- (In partnership with other entities) address issues of people not feeling safe in their own neighborhoods (not feeling safe can lead to decline in health).

Number Two: Comprehensive, Equitable Education

Examples of specific needs:

- Address impact of trauma and systemic racism, for example by providing:
 - Mandatory classes, courses, and trainings for all Hennepin Healthcare providers, leaders, and staff on trauma informed care, historical trauma, and impact of racial trauma and discrimination on health and wellbeing.
- Provide more culturally tailored community education regarding:
 - Prevention.
 - Ways to support taking responsibility for one's own health.
 - Culturally responsive community resources available to support community health.
- Open more two-way communication between Hennepin Healthcare and community:
 - Hold meetings where community can sit down with hospital leaders and staff and participate in the shaping community solutions to existing issues.

Number Three: Advocacy and Cultural Sensitivity

Examples of specific needs:

- Hire more multilingual providers so communication between provider and patient can be in the patients' primary languages.
- Have community, cultural elders on staff.
- Improve navigation and coordination of care and access to information and resources.
- Cultural navigators to help patients navigate the system and help advocate for individual needs.

Additional Needs

In addition to the top three community health needs, participants put forward two other needs. The CHNA team decided to move them forward to the implementation planning process as they may help guide implementation frameworks and approaches.

Partnership to Promote Healthy Communities

Examples of specific needs:

- Support existing programs (with training and funding) such as neighbor health check networks and programs that promote intergenerational connections.
- Provide more casual points of contact within neighborhoods to build trust and begin to educate on healthy choices like nutrition and exercise:
 - Offer informal sessions with Q and A at convenient hours to accommodate everyone.
 - Create healthy hubs in communities as a source for outreach and for community to access information to improve health.
- Create culturally responsive, community specific patient advisory groups.

Building Mutual Trust

Examples of specific needs:

- Build trust by promoting and providing (culturally responsive) care before people are sick – care that creates sustainable wellness and healthy communities.
- Improve patient/provider relationships, reduce fear, and build trust through engagement and listening to whole patient needs without dismissing patient concerns.

Next Step: Implementation Planning

Implementation planning to address the identified needs will include convening internal stakeholders, representatives from potential community partners, and other community stakeholders to help shape the specific strategies and tactical approaches the hospital will use to address the identified needs.

Potential Resources and Collaborative Partnerships

The identified priority community health needs will require both an investment of Hennepin Healthcare resources (people and money) and meaningful partnerships with community entities. Hennepin Healthcare has some foundational pieces in place to address the needs including:

- Activities the hospital is already invested in such as hiring cultural navigators, providing trauma informed trainings, providing cultural trainings, partnering with community entities

to expand culturally responsive care. The results of the assessment push Hennepin Healthcare to expand and deepen these existing investments.

- Recently awarded Health Equity Plus accreditation from the National Committee for Quality Assurance (NCQA), which includes requirements around community partnerships that align well with the identified needs.
- A number of existing long-term partnerships with community entities that align well with the identified needs. The hospital will reach out to these and other relevant community entities to explore equitable partnerships to address the identified needs.

During the assessment process, many interviewees and community group conversation participants expressed interest in being involved beyond the needs assessment process. Hennepin Healthcare will maintain contact with all involved with the assessment and will continue the community engaged approach to ensure the implementation plan and ensuing work remains connected with community perceived and envisioned solutions.

Evaluation of Impact of 2020 – 2022 CHNA Implementation Plan

In 2019, the 2020 - 2022 Hennepin Healthcare Priority Health Needs were identified as: increase access to Culturally Responsive Care.

The overarching objective was to 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.

Four key strategies were identified for action:

- **Increasing 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.
 - Information on accessing care and services.
- **Developing Workforce:**
 - Increasing diverse representation across all levels of the organization (including providers, administration, and front-line staff).
 - Developing recruitment and retention initiatives.
- **Implementing Clinical Practices, Care Models, and Policies:**
 - Prioritize areas for action.
 - Change or create programs and services to enhance access to culturally responsive care.
- **Improving Environment and Navigation to Services:**
 - Enhancing physical environment at Hennepin Healthcare to be culturally inclusive, welcoming, and easy to navigate.
 - Building partnerships with community-based health care services to increase patient access to culturally appropriate services and resources that enable health.

Evaluation of Impact of 2020 – 2022 CHNA Implementation Plan		
Strategy	Key Tactics	Actions Taken
Increasing Knowledge through Education, Training, and other Communication options	Provide information on specific cultures	Since 2020, Hennepin Healthcare has provided department specific internal trainings related to: <ul style="list-style-type: none"> • Hmong culture (2020 and 2021). • Somali culture (2021 and 2022). • Black/African American culture (2022). • American Indian Culture. • White racial identity.

Evaluation of Impact of 2020 – 2022 CHNA Implementation Plan		
Strategy	Key Tactics	Actions Taken
Increasing Knowledge through Education, Training, and other Communication options	Provide information on techniques for talking about culture with patients	<p>Since 2020, Hennepin Healthcare has offered department specific trainings on topics such as:</p> <ul style="list-style-type: none"> • Providing culturally responsive care. • Implicit bias and the pursuit of health equity (2021 - 2022). • Navigating conversations about race (2021 – 2022). <p>Continued hospital wide trainings on the basics of providing trauma informed care (one element of providing culturally responsive care).</p>
Increasing Knowledge through Education, Training, and other Communication options	Provide information on adapting care and services for patient's cultural beliefs	<p>In January 2021, Hennepin Healthcare entered a partnership with a local non-profit (Open Path Resources) that serves as a bridge between Somali, East African Muslim community and institutions like health systems, school, etc.</p> <p>As part of this partnership, Open Path Resources has worked with various departments to increase their ability to adapt care and environments to better meet the cultural needs of Muslim patients.</p> <p>For example, in 2021, Open Path Resources donated Qibla stickers to the ED department to place in each patient room to indicate the direction of Mecca.</p>
Increasing Knowledge through Education, Training, and other Communication options	Information on accessing care and services	<p>In 2020, at the beginning of the pandemic, Hennepin Healthcare reached out to community partners from the various cultural communities it serves to find out:</p> <ul style="list-style-type: none"> • How different communities were receiving information about COVID and accessing care. • Specific concerns within each community. • How the health system could be more responsive to needs. <p>For example, Hennepin Healthcare initially directed patient to the hospital website for info and MyChart for accessing care. Hearing from community that many experienced access issues related to unreliable internet or lack of computers, a dedicated nurse line was established.</p>

Evaluation of Impact of 2020 – 2022 CHNA Implementation Plan		
Strategy	Key Tactics	Actions Taken
		<p>In 2020, Hennepin Healthcare’s CEO hosted community conversations with four of the cultural communities serviced by the health system: Black/African American, American Indian, Somali, and Latinx communities.</p> <p>In response to community request for more cultural support and help navigating to the care needed, Hennepin Healthcare is currently hiring three cultural navigators representing the various cultural communities served. Three are being hired in 2022 and additional navigators will be hired in 2023.</p>
Developing Workforce	Increasing diverse representations across all levels of the organization (including providers, administration, and front-line staff)	<p>Beginning in 2021, People and Culture and Health Equity Departments began a collaboration with the goal of investing the building a more diverse work force of the future by encouraging young people of Color to pursue medical and healthcare careers. They created what is called “The Talent Garden”. Activities to date:</p> <ul style="list-style-type: none"> • Daylong, hands-on youth summits designed to encourage youth of color to consider medical/ health careers: <ul style="list-style-type: none"> ○ December 2021: Black Men with Stethoscopes. ○ April and May 2022: Black Women with Stethoscopes. ○ Over 200 12 – 18 years olds attended one of these events. ○ Additional events planned in late 2022 and 2023. • 20 participants of the summits ages 16 - 17 were given paid internships during the summer of 2022. • Working in partnership with MVNA's Family Services unit, Hennepin Healthcare was able to provide an increased number of county, state and privately funded intern roles for 18- to 24-year-old single parents. Internship experiences included being trained and serving as phlebotomists, medical assistants, Next Step violence prevention responders,

Evaluation of Impact of 2020 – 2022 CHNA Implementation Plan		
Strategy	Key Tactics	Actions Taken
		patient nursing assistants, and Digital Equity Navigators.
Developing Workforce	Developing recruitment and retention initiatives	<p>The past three years - unpredictable due to the pandemic and the widespread, tight labor market - have created unique challenges for recruitment and retention.</p> <p>Recruitment:</p> <p>In July 2022, Hennepin Health care sponsored a People of Color Healthcare Career Fair.</p> <p>Retention and Recruitment:</p> <p>The Health Equity Department launched 14 employee run collectives with specific cultural or role-specific identities.</p> <ul style="list-style-type: none"> • The Collectives are designed to foster affirming social relationships, professional networks, development opportunities and a deeper sense of belonging by creating a space where diverse employees can be their authentic selves and take a collective breath and pause. • Some potential advocacy outcomes for the collectives include: <ul style="list-style-type: none"> ○ Advocating for more equitable policies, practices, and procedures. ○ Attracting and recruiting diverse candidates for open positions at all levels. ○ Increasing awareness of multicultural differences, understanding of cultural norms and celebrations of heritage. ○ Partnering with and increasing opportunities to conduct business with local BIPOC-owned businesses. (Black, Indigenous, People of Color). ○ Strengthening existing community partnerships and creating new community partnerships. ○ Strengthening existing community partnerships and creating new community partnerships.

Evaluation of Impact of 2020 – 2022 CHNA Implementation Plan		
Strategy	Key Tactics	Actions Taken
Implementing Clinical Practices, Care Models, and Policies	Prioritize areas for action	<p>Priority Area 1: Maternal Child Health – Addressing birth outcome disparities experience by Black/African American and American Indian families.</p> <p>Priority Area 2: Psychiatric Care outcome disparities for Somali, East African, and other Muslim patients.</p>
Implementing Clinical Practices, Care Models, and Policies	Change or create programs and services to enhance access to culturally responsive care	<p>Focus Area 1: Addressing birth outcome disparities experienced in Black/African American and American Indian families by creating culturally responsive options for Black/African American and American Indian prenatal patients:</p> <p>In March 2020, Hennepin Health care was set to launch two culturally responsive group prenatal care pilots: one with Black/African American pregnant patients; the other with American Indian pregnant patients.</p> <ul style="list-style-type: none"> • The development of these two program models was a continuation of 2017 – 2019 CHNA Implementation Plan work in response to the 2016 CHNA. The top priority health identified during the 2019 CHNA provided additional support to the continuation of this work. • One week before the launch, Hennepin Healthcare had to put a hold on the launch due to COVID 19. • The pandemic remained a factor preventing launching the pilot models until spring 2022. <p>Pivot to Culturally Congruent Virtual Doula Pilot:</p> <p>Thanks to support from Rotary Club of North Minneapolis and UCare health plan, Hennepin Healthcare was able to pivot to a culturally responsive doula care model:</p> <ul style="list-style-type: none"> • Interested Black prenatal patients living in North Minneapolis were matched with Black community doulas and a community health worker for virtual education, support, and connection to resources.

Evaluation of Impact of 2020 – 2022 CHNA Implementation Plan		
Strategy	Key Tactics	Actions Taken
		<ul style="list-style-type: none"> • This program was active between September 2020 and May of 2022. During that time 29 prenatal patients (41% of those who were eligible) were matched with a doula. • Evaluation findings indicated participants' appreciation for: <ul style="list-style-type: none"> ○ Extra support, especially at a time when people were isolated from family and friends due to the pandemic. ○ Assistance finding needed, culturally relevant resources. ○ Matches with Black doulas who were from the same cultural background, understood their situations, and helped them advocate for themselves. (66% of those matched with a doula indicated that cultural congruence was a very important factor in their decision to request a match. <p>Launching revised group prenatal models:</p> <p>By spring 2022, Hennepin Healthcare maternity care leaders determined that, with proper COVID precautions, the two group prenatal models could launch.</p> <p>Due to a variety of changes since the original launch date, the “prenatal care” aspect of the models was dropped, and the group focus shifted to prenatal education and cultural support. The models' key element of cultural congruence remained. Group facilitators and participants shared the same culture and the curriculum for each model remained culturally responsive.</p> <p>In May 2022, <i>Cherishing Future Generations</i>, culturally specific group prenatal education pilot for American Indian prenatal patients launched.</p> <ul style="list-style-type: none"> • This pilot program is a partnership between Hennepin Healthcare and Indian Health Board, located a few miles from the hospital. • The program was developed by and is being led by a team of Native American women.

Evaluation of Impact of 2020 – 2022 CHNA Implementation Plan		
Strategy	Key Tactics	Actions Taken
		<ul style="list-style-type: none"> • The program incorporates Ojibwe and Dakota traditions into typical prenatal education content. • The initial cohort will finish prior to the end of 2022. • Evaluation results will be reviewed, and lessons applied. • A second cohort will begin in early 2023. <p>In October 2022, the <i>Black Families Childbirth Series</i> pilot launched.</p> <ul style="list-style-type: none"> • The series of classes is being held in the community and led by three Black community doulas with extensive childbirth and breastfeeding education experience. • The curriculum combines Evidence Based Birth® (https://evidencebasedbirth.com/) with topics culturally relevant to Black pregnant families seeking the positive experience and outcomes they deserve in systems that have built in biases in policies and practices. • The first series of classes will be completed by the end of 2022. • Evaluation results will be reviewed, and lessons applied. • A second series of classes will take place in early 2023. <p>Focus Area 2: Psychiatric Care outcome disparities for Somali, East African, and other Muslim patients.</p> <ul style="list-style-type: none"> • In 2020, Hennepin Healthcare completed a grant funded project to engage and partner with leaders and members of the Somali community to better understand and address cultural stigmas related to mental health/mental illness. <ul style="list-style-type: none"> ○ This project was part of the 2017 – 2019 CHNA implementation plan addressing the need for better access

Evaluation of Impact of 2020 – 2022 CHNA Implementation Plan		
Strategy	Key Tactics	Actions Taken
		<p>to mental health services in immigrant communities.</p> <ul style="list-style-type: none"> ○ The learnings from the project set the stage for further work. A Hennepin Healthcare psychiatrist participated in the project and was eager to do more to improve care for Muslim psychiatric patients. <ul style="list-style-type: none"> ● In January 2021, Hennepin Healthcare Spiritual Care Department began a partnership with a Open Path Resources (OPR) a community based non-profit with a mission of bridging the cultural gap between Somali, East African communities and large systems such as health care, schools, etc. As a result of this partnership, OPR was providing Muslim spiritual care leaders who were available to support Muslim inpatients throughout the hospital. ● In spring 2021, the founders of OPR and the interested psychiatrist along with other care team members from inpatient and outpatient psychiatry started meeting monthly to explore creating a culturally responsive care model for Muslim patients with the goals of: <ul style="list-style-type: none"> ○ Addressing cultural/spiritual stigmas. ○ Encouraging patients to see the benefits of following treatment plans and going for follow up visits post discharge. ○ Supporting providers and staff by providing cultural information and context. ○ Reducing preventable readmissions post discharge. ○ Increasing medication refills and maintaining appointments. <p>In the fall of 2021, the Population Health Department provided funding to support the building of the</p>

Evaluation of Impact of 2020 – 2022 CHNA Implementation Plan		
Strategy	Key Tactics	Actions Taken
		<p>proposed model that includes the presence of Muslim spiritual care leaders who are available to:</p> <ul style="list-style-type: none"> • support Muslim psychiatric inpatients and their families. • Support providers and staff. • Support the discharge process. • Continue patient and family support post discharge, especially in the gap between inpatient and the start of outpatient care. <p>A researcher from the University of Minnesota is providing evaluation support.</p> <p>In January 2022, OPR and team members from the departments of psychiatry and spiritual care launched the pilot model. The first evaluation results will be available in early 2023.</p>
Improving Environment and Navigation to Services	Enhancing physical environment at Hennepin Healthcare to be culturally inclusive, welcoming, and easy to navigate.	<p>The start of the COVID 19 pandemic in early 2020 meant significant efforts to make our environment more welcoming and culturally inclusive needed to be put on hold.</p> <p>Early COVID fears and restrictive policies created a less inclusive, welcoming, easy to navigate environment as entrances were closed, family and visitors were had to stay home, and public messaging encouraged sick people to care for themselves at home. This was happening across the country.</p> <p>Hennepin Healthcare staff did their best to make sure language services (in person or by phone) were readily available to address concerns of people arriving at the approved entry points. Additionally, iPads were available to facilitate patient/family conversations for those who still couldn't have visitors.</p> <p>In 2021, Hennepin Healthcare commissioned a large employee and community engagement study to look to the future of health care. This study was completed during a non-CHNA year. Employees and community leaders and members were asked to envision what the ideal healthcare of the future and</p>

Evaluation of Impact of 2020 – 2022 CHNA Implementation Plan		
Strategy	Key Tactics	Actions Taken
		what the main Hennepin Healthcare campus should look like. This input will shape future efforts to improve the hospital campus.
Improving Environment and Navigation to Services	Building partnerships with community-based health care services to increase patient access to culturally appropriate services and resources that enable health	<p>Increasing access to COVID 19 vaccines in culturally supportive spaces:</p> <p>In 2021, when the COVID vaccines became more available and eligibility criteria expanded, Hennepin Healthcare Health Equity Department and MVNA (Minnesota Visiting Nurse Association) developed and implemented a model for a COVID 19 Community Vaccination Program, bringing vaccines to areas of the metro with high Social Vulnerability Index scores. The hospital partnered with multiple trusted community organizations including schools and places of worship to hold vaccine clinics in spaces where community felt comfortable.</p> <p>Community Digital Navigators:</p> <p>In partnership with MVNA Family Services and the Health Informatics Team, the Health Equity department has been a part of forming a digital equity navigator team, who provide bedside assistance to patients learning how to access their medical records remotely. Digital proficiency has been shown to be a leading social determinant of health (SDOH). Along with the patient benefits, this has been a workforce development tool providing another path into healthcare for clients of the MVNA Teen HOPE / Pathways program (home visiting program for teen parents).</p>

Acknowledgements

This document serves as the Community Health Needs Assessment and is aligned with guidance from the Internal Revenue Service (IRS) for non-profit hospitals.

The Community Health Needs Assessment was made possible by the dedication and hard work from the following community members:

- Nimo Ahmed, community interviewer group facilitator
- Lynnea Atlas-Ingebretson, community consultant
- Trelawney Cernuto, community conversation notetaker
- Jennifer Bertram, community interviewer, conversation notetaker, and facilitator
- Brett Buckner, community consultant and facilitator
- Deanna Beaulieu, community consultant and interviewer
- Wali Dirie, community consultant and organizer
- Christine Hauschildt, community consultant, conversation notetaker, and facilitator
- Helen Jackson Lockett-El, community consultant, interviewer, and facilitator
- Adriana Jeffrey, community interviewer
- Sidney Johnson, community interviewer and staff member of Hennepin Healthcare Research Institute and Hennepin Health Care
- Clarence Jones, community interviewer and facilitator
- Silvio Kavistan, community consultant, interviewer, translator, and facilitator
- Fadumo Mohamed, community facilitator and notetaker
- Mohamed, community facilitator and notetaker
- Pakou Xiong, community interviewer and facilitator
- True Xiong, community consultant

The CHNA was conducted under direction from the Hennepin Healthcare Population Health Department:

- Amy Harris, Director of Population Health
- Danielle Robertshaw, M.D., Sr. Medical Director, Population Health

The process was facilitated and supported by the following staff and consultants from Hennepin Healthcare and Hennepin Healthcare Research Institute:

Hennepin Healthcare:

- Pat Schaffner, Community Health Programs Liaison, Population Health Department
- Aida Strom, Healthy Equity Community Engagement Program Manager, Health Equity Department

Hennepin Healthcare Research Institute:

- Kate Vickery, M.D., Co-director of the Health, Homelessness, and Criminal Justice Lab
- Becky Ford, Operations Director
- Sidney Johnson, Project Coordinator

- Sarah Manser, consultant and research partner
- Susan Gust, consultant

The prioritization event was designed and facilitated by team from Hennepin County's Center for Innovation and Excellence:

- Ge Lee
- Hangatu Omar
- Kay Adam

Finally, a special recognition and thank you to:

- The 83 individuals who took time to share their honest insights about community health and wellbeing during interviews or small group conversations.
- The 33 individuals who participated in the prioritization event and worked hard to achieve consensus in determining the top priority community health needs.

Appendices:

Appendix A: 2022 CHNA Interview Guide

1. Demographic/background questions

- a. How do you self-identify?
 - i. Can include race/ethnicity, language, generation, gender identity, immigration status, profession, role in the family, tribal status, sexual orientation, geographic location or origin, or any other factors the influences how the person identifies
 - i. Interviewer to write responses below:
 1. _____

- b. For this conversation, in addition to your own perspectives, what other community perspectives will you be sharing?
 - i. Can be based on personal or professional experience

 - ii. Are you here representing a particular organization? If yes, what is your role within that organization?

Identification of Community Health Needs

1. Through the rest of the interview, I'll ask you questions about health and wellbeing. We define health broadly to include physical, mental, emotional, and spiritual wellbeing. In this context, how do you define being healthy for yourself?
 - a. Probes:
 - i. When was the time in your life when you felt healthiest? What was going on in your life then that made you feel healthy?

2. Now we'd like you to think about the health of your community. You can answer in reference to a specific community you belong to or you can take a broader view of community. What does a healthy community look like to you?
 - a. Probes:
 - i. What's an example of a healthy community? What does it look like?
 - ii. What's a time in your life when your community felt healthy? What was going on then that made it feel healthy?
 - iii. Alternate wording: How would you describe a "healthy community"?
 - iv. What resources need to be available in a community for it be healthy?
 - v. As you look around you, in what ways are the communities you connect with healthy? In what ways are they struggling to be healthy?

Intro: Now we're interested in hearing what you think about current and past community health needs. I'm going start by asking for your ideas about what you see as your community's top needs and then ask you about how things have changed in recent years.

3. Thinking about the people you live and work with in your community, from your point of view, what does your community need most right now to achieve and maintain optimal health and wellbeing?
 - a. Probes:
 - i. What do members of your community need most to obtain health and wellness?
 - ii. What are the primary challenges people in your community face to achieving their health and wellbeing?
 - iii. In thinking about these priority health needs, how have these needs impacted your community?
 - iv. What communities are most affected by these needs?
4. The last community health needs assessment was conducted in 2019. How have health needs in your community changed in the last three years? Interviewers to have separate handout with 2019 themes
 - a. Probes:
 - i. What's missing from this from this list?
 - ii. Have you seen improvements in any of these areas?
 - iii. Have you seen things gets worse for any of these needs?
5. What are one or two changes the healthcare system could make that would have the greatest impact on your community's health and wellbeing?

Handout provided interviewees listing the top ten needs identified in the 2019 CHNA process.

<p>1. ACCESS TO CARE:</p> <ul style="list-style-type: none"> • Rising costs. • Getting on/staying on medical assistance. 	<p>2. CULTURALLY RESPONSIVE CARE:</p> <ul style="list-style-type: none"> • Need providers who reflect diverse communities. • Need bridge between medical approaches and cultural and spiritual beliefs and practices. 	<p>3. MENTAL HEALTH AND WELLBEING:</p> <ul style="list-style-type: none"> • Cultural stigmas. • More holistic, culturally responsive options. • Long delays between discharge and outpatient care.
<p>4. HEALTH EQUITY:</p> <ul style="list-style-type: none"> • Address biases, structural racism, long term disparities and inequities. 	<p>5. BUILDING TRUST:</p> <ul style="list-style-type: none"> • Trust between Hennepin Healthcare and communities it serves low and fragile – must repair. 	<p>6. HOUSING:</p> <ul style="list-style-type: none"> • Shortage of truly affordable. • Gentrification leads to displacement. • Limited access to shelters
<p>7. CHRONIC DISEASE:</p> <ul style="list-style-type: none"> • Management and Prevention. • Impact of social determinants (housing, access to healthy foods, etc.) • Need culturally responsive education & treatment options. 	<p>8. LACK OF CULTURAL COMPETENCE:</p> <ul style="list-style-type: none"> • Potential: re-traumatize. • Potential misdiagnosis. • Culturally misunderstanding can lead to escalation, difficult situations. 	<p>9. SUBSTANCE USE AND ADDICTION:</p> <ul style="list-style-type: none"> • Treatment too short. • Takes time to build trust. • (American Indian community: untreated grief, trauma, legacy of boarding schools leads to spiritual disconnect.)
<p>10. MATERNAL CHILD HEALTH:</p> <ul style="list-style-type: none"> • Birth outcome disparities in Black/African American and American Indian communities. • Negative experiences with prenatal care, birth: not being listened to, lack of cultural respect, implied threats of child protection, lack of Black/African American and American Indian providers and doulas. 		

Appendix B: CHNA Interviews: Method for data collection and analysis

Data collection

Development of the interview guide. The creation of the interview guide was a collaborative effort between the Core Planning Team members and the interview analysis team. First, the Core Planning Team identified and discussed ideas for the 2022 interview guide based on the interview guides from 2016 and 2019 CHNAs. Next, the analysis team generated a new guide, received feedback from the Core Planning Team, made revisions, and then received final approval from the Core Planning Team. Questions from the interview guide focused on general thoughts regarding a healthy community, perceptions of current priority health needs in the community, how priority health needs may have changed in the past three years, and identification of changes the health system could make to improve health and wellbeing in the community. The interview guide was designed for a semi-structured approach using open-ended questions with planned follow up probes to encourage reflection and open expression interview respondents. (see Appendix A for interview guide).

Interviewers and training. A group of ten interviewers was selected to complete CHNA interviews, and their demographic makeup closely resembled the demographic makeup of interviewees. Interviewers were chosen based on their connection to the community and previous experience conducting qualitative interviews. We also took care to have a diverse group of interviewers to ensure community members could have an interviewer with whom they felt comfortable. Interviewers attended a two-hour training session prior to conducting interviews. The training reviewed topics such as minimizing interview bias, active listening, note taking, post-interview memo completion, how to use the audio recorders, and reviewing the interview guide.

Interviewees. A diverse group of 50 interview respondents were selected based on recommendations for the Core Planning Team, interviewers, and representatives from local organizations. A total of 49 interviews were completed. Interviews took place in June of 2022, and were conducted both in-person and remotely in English, Spanish, and Somali languages. Interviewees received a \$50 gift card as compensation for their time. Interviews were audio recorded and transcribed into English for the purposes of analysis.

Analysis

Framework matrix analysis (FWMA)

Initial coding. The CHNA analysis team was made up of three analysts, two with graduate-level experience in qualitative research methods and one medical student with qualitative analysis experience. They conducted the analysis using the FWMA method, where data are coded into

highly structured categories derived directly from the project objectives, which in this case, was identifying priority community health needs, and from focus areas of the final interview guide. Analysts used line-by-line coding of the same interview to ensure agreement of application of the codebook. After establishing a consistent application of the codes, analysts coded the remaining interviews, coding each interview independently. Through the coding process, analysts abstracted and categorized interview responses to the framework matrix and, in each case, linked evidence for their categorization (either a direct quote or transcript line number reference).

Generating themes. After all interviews were coded, two analysts reviewed all coding to identify central themes. Analysis of interviewer post-interview memos were included in the summarization and identification of central themes. Through weekly analysis-team discussions and refinement of findings, priority health needs, central themes, and sub-themes were identified and categorized across all interviews. Emblematic quotes were linked to each theme to demonstrate how the data informed the theme, reflecting experiences and perceptions in the interview respondent's own words. In addition, the team identified when a theme was prevalent among a specific group of interview respondents.

Main themes and subcategories

Forty-nine key stakeholder interviews were conducted in which interview respondents' experiences, perceptions, and observations provided insight and rich description related to priority health needs in the respondents' communities. Interview respondents shared views on community health needs, existing assets, and improvements they would like to see in the future. Responses focused on the importance of community-driven care, removing discrimination from healthcare, fostering trust, and the provision of culturally congruent care. In addition, respondents delineated specific areas of health care where greater access is needed, particularly in the area of mental health care and access to other specialty care. Further, respondents raised concerns of highly related economic and social issues such as racism, health disparities, and challenges meeting basic needs. There was a high consistency of priority needs expressed across the interviews, however, the analysis team also noted patterns by groups of respondents, see Appendix B.

Six central themes were identified from the key stakeholder interviews: community centered care, fostering trust, culturally responsive care, meeting basic needs, neighborhood safety as a public health concern, widespread access to mental health care, and accessible and affordable care. Sub-themes were also identified for each theme to provide further description and specific health needs topics.

Priority Health Needs Central Themes and Sub-themes:

Community centered care: Needs driven by community and extended into community spaces	
Community representation in decision making and action planning	Access to primary and specialty care in the community
Community spaces to facilitate health	Outreach designed for targeted groups and communities
Fostering trust: Health system actively building trust with the communities it serves	
Trauma informed care that acknowledges past harms	Providers/staff communicating in a respectful and unbiased manner toward all patients
Stop delivering lower quality care to communities of color and patients who do not speak English	Transparency in how to navigate the healthcare system and what resources are available
Culturally responsive care: Access to care, services, and programs and that are honoring and appropriate	
Access to care and settings congruent with the cultural traditions of the patient	Services and resources provided by native speakers of patient's language
More providers who have a cultural connection to the patient population/look like the community they serve	Access to culturally congruent advocates, navigators, and CHWs
Meeting basic needs: Addressing basic needs as essential to health and wellness	
Integrate healthcare and other basic needs to facilitate ease of obtaining services	Neighborhood access to healthy food and outdoor exercise
Support for housing instability and affordability	Helping people initiate and maintain health insurance
Increased and targeted communication about available resources	Support people in making time to take care of their health and wellness
Neighborhood safety as a public health concern: Creating a safe environment for community members	
Violence prevention, including gun violence	Social isolation due to fear of going outside

Access to alcohol and other substances is too easy	Racism from police and others increases fear
Reestablish community policing and other community focused ways to protect the community	
Widespread access to mental healthcare: Easy and affordable access to mental and emotional support	
Reducing stigma of seeking out mental healthcare	Care focused on those who have experienced trauma, including personal and intergenerational trauma
Easier access to mental healthcare to prevent a crisis	Mental healthcare providers whose lived experience is congruent with the patients they serve
Accessible and affordable care: Ability to access affordable care for physical and mental health	
Identify barriers to attending appointments and provide services to support patients (e.g., transportation, childcare)	Decreased wait times for care
Easier and faster access to treatment for substance use	Provide affordable care and medications
Take action to prevent provider/staff burnout	

Appendix C: 2022 CHNA Interview Themes with quotes

Community centered care: Needs driven by community and extended into community spaces

Sub-theme	Group patterns (if present)	
Community representation in decision making and action planning		<p>"Like there's all these good ideas, but they don't ever go anywhere because we're still functioning in that same system of how we look at things because the community themselves know what's best for them, and what could work...And so, I think in a way, we're kind of caught in between the decisions—the people who can make the decisions and the people who know what's going to work for them. There's just this gap." -<i>Hmong woman and first-generation American citizen</i></p>
Access to primary and specialty care in the community		<p>"There is lack of access to providers, lack of access to actual healthcare, and then just the location. Depending on where you are, you might have access to a variety of different healthcare providers. Chiropractor, a massage therapist, and people that can do alternative health are going to be again concentrated in certain areas where you have more well-to-do people. Let us say you are a pregnant person, and you live in the inner city. You might not have a lot of doula providers there for your pregnancy. There may not be an OB clinic or midwife clinic right in your area, so you are going to have a travel a long distance." -<i>African American woman, parent and community member</i></p> <p>"I think the doctor is really only with them there in the visit so connecting them to their community is important and I think that idea of community health is something that medical providers can connect to more. So, if we have driving community organizations that are better at just taking care of their neighborhoods and are resourceful enough to provide neighborhood support, I think people will be healthier and if medical providers are partnering with these community organizations, and neighborhoods, I think that would be the perfect way to go." -<i>Southeast Asian woman</i></p>

Community spaces to facilitate health		<p>"It's hard to get the older folks a chance to either do physical activity. That's one of the things I think might be missing, at least from what I've seen in the city where I live. A lot of time I just see them sitting around, but if they had a chance to have-walk around, or at least somebody that's walking around with a group of older people, and just hanging out with them, and showing them how they can do better, I think that's one thing." -<i>Somali young adult</i></p> <p>"There's [preventative health] programming through temples and I think that is really important...I think temples are not being used as health hubs which I know one temple ...that does routine health checks at and they have vaccination clinics so I think that was pretty successful." -<i>South Asian woman</i></p>
Outreach designed for targeted groups and communities	Prominent among the Somali and Latinx respondents; younger people expressed desire for more outreach to older community members	<p>"I would suggest that the health sector to send many health-workers who can understand the local language of my community to conduct community health education and awareness programs so that I understand the importance of going to the hospital and seeking medical attention." -<i>Somali woman</i></p> <p>"If we could just see people as people needing help, if we could use more community health workers that had people that they visited on a 'how you doing' basis and not you have to be here because your health says so. I think we have to look at people as a whole unit. And so now people only come into the health department if they're sick or if they have something, but I think it should be a more social thing as well. How are you doing? Oh, you just had a baby, do you need any diapers? Do you need formula, which is a hard thing to find? think it's just self-identified community advocates, community health workers, people that go in that know the neighbors, and they're that extended voice." -<i>African American woman</i></p>

Fostering trust: Health system actively building trust with the communities it serves

Sub-theme	Group patterns	
Trauma informed care that acknowledges past harms	Prominent among African American respondents	<p>"So, and what I've said to the medical profession is, "Time alone is neutral. What you do in that time from the Tuskegee to today if you've done nothing because you've done nothing to rehabilitate or reestablish the notion of trust." -<i>African American man, government employee</i></p> <p>"Well, yes, I guess just becoming trauma-informed would change the landscape because it really asks us—asks me as a white bodied person—to examine who I am, how I think, how I got that thinking to sort of deconstruct that, you know, and really understand what those, you know, biases are and how I act in the world, in the space that I take up. And if every one of those systems undertook that same sort of internal as well as systematic review of how they act, I just am absolutely convinced that that would be a game changer for the people living in every community that has a touchpoint, you know, with any of those systems." - <i>White woman working in public health</i></p>
Providers/staff communicating in a respectful and unbiased manner toward all patients	Prominent among African American, Latino, and Somali respondents	<p>"Just historically black people have been denied humane services. We have been experimented on. Our concerns are just ignored... I have just had it where I am not taken seriously. I think too also being a woman, your pain and your concerns are just overlooked. They are really minimized." -<i>African American woman, parent and community member</i></p> <p>"If you do not present in the classical white woman way of being depressed and crying, you just get less sympathy because you are not as relatable... The things that you need in order to be healthy have been denied to people of color. Then when you are not healthy, they tend to blame it on individual choices. You are unhealthy because you eat too much. You are too inactive. You are too angry." -<i>African American woman, community member</i></p>

<p>Stop delivering lower quality care to communities of color and patients who do not speak English</p>		<p>"Long-term disparities, and inequities that have just become exacerbated, and exaggerated during the pandemic...So the issue of health equity, the issue of housing, chronic diseases seem to be exponentially growing." -<i>African American woman, community member and parent</i></p> <p>"When there are people who look like me that go to Hennepin County or other places to get services and we do not receive the same level of services and treatment--as other communities." -<i>Black man, government employee</i></p> <p>"I feel like as a [black] people, we go into spaces and they don't believe us as far as the pain. They don't believe us as far as what we know our bodies are going through." -<i>African American woman, community member and parent</i></p> <p>"We've had cases where someone goes to some place and they ask him for health insurance, and if he doesn't have health insurance, they sort of treat them differently. If they can't speak English, they would start treating them differently,"-<i>Afrolatina woman, community member</i></p>
<p>Transparency in how to navigate the healthcare system and what resources are available</p>	<p>Prominent among Latinx, Hmong, and Somali respondents. Of particular among respondents who are themselves undocumented or work with undocumented community members.</p>	<p>"If you know people need something and you hide it or you just make it a maze to get to it, I feel like that's just very counterproductive and it's actually borderline like cruel to withhold something that somebody could potentially be like a life-or-death thing." -<i>African American woman</i></p>

Culturally responsive care: Access to care, services, and programs and that are honoring and appropriate

Sub-theme	Group patterns	
Access to care and settings congruent with the cultural traditions of the patient	Prominent among Native American and Hmong respondents	<p>"I think a lot of the alternative health, spirituality included, ceremonies, traditional medicines, the things that we use, even energy healing, spirit healing, isn't paid for by hospitals. So, the people who need it the most, if they don't have the resources to do that, it's hard for them to get up north and find an elder and to give to them." - <i>Native American woman representing community organization</i></p> <p>"I've heard of places like you know hospitals just kind of also acknowledging that as well, which I think it's been great. Like if somebody needs a prayer or somebody needs like I said earlier just to feel spiritually connected, they actually ... doctors and nurses are also allowing that to happen within the community" -<i>Hmong woman, first generation American</i></p>
Services and resources provided by native speakers of patient's language	Pattern in those who did interviews in Spanish and Somali language	<p>"Because there are times that we really don't know if we are being translated -- if they are understanding us, actually, right? Because there's no one to translate at that moment, or sometimes you don't hear well when it's over the phone, or no - you don't know if - if I'm listening to you well, or things like that. I think the language is the - the - the main one." -<i>Latina woman</i></p>
More providers who have a cultural connection to the patient population/look like the community they serve		<p>"I think more healthcare providers of color. People from the communities that they actually serve....you are just treated very differently when you have a black healthcare provider or a healthcare provider of color. They are going to be more willing to listen to you and to take your concerns seriously. I just know again from my own experience and talking with others." -<i>African American woman, parent and community member</i></p>
Access to culturally congruent advocates, navigators, and CHWs		<p>"So if at most, to have advocates for your senior citizens, for your adolescents, for your middle-aged individuals, and also your pediatric patients. Have advocates for them, the same way that they do in the legal system, they have guardian ad litem for children." -<i>African American woman, longstanding community member</i></p>

Meeting basic needs: Addressing basic needs as essential to health and wellness

Sub-theme	Group patterns	
Integrate healthcare and other basic needs to facilitate ease of obtaining services		<p>"A healthy community to me means people are being able to afford their medicine. They're not starving. They're being able to have food to eat. Our youth are well educated, and our seniors are taken care of." - <i>African American woman representing community organization</i></p> <p>"If I had a really good relationship with my doctor and my doctor understands where I'm coming from--I can relate to my doctor—you bet I will be seeing you when I, you know, have concerns. I will be asking you for other things that could help me improve in my life that I'm dealing with. But if I don't have that, chances are I'm only going to come to you when I'm really sick, or when I really need that prescription refill, or when there's something that I just have to come do. But that's just not really going to be deepened. But this just doesn't help you or help me be healthier, right?" - <i>Hmong woman, Millennial</i></p>
Neighborhood access to healthy food and outdoor exercise	Pattern among respondents from North and South Minneapolis neighborhoods	<p>"The community offers a lot of support for [a healthy lifestyle]. So, there are mothers that go, like, on walks....They organize walks and they all go walk. Um, there might be a - a man that was a nutritionist in his country and he would provide healthy recipes, uh, that they could eat" -<i>Latina woman representing community organization</i></p>
Support for housing instability and affordability		<p>"But I also don't think anybody's basic needs are met, you know, the way they should be in America, you know. Like why are we having kids that can't eat, that don't have housing? That gets frustrating." -<i>White woman, parent and community member</i></p> <p>"We get a lot of [mental health] referrals and it's 'I can't focus on this right now because I'm homeless.' 'I can't focus on this right now because I'm getting evicted.' 'I can't meet with you because I work at a certain time frame and those are out of the hours that you're able to see me.'" -<i>Hmong woman, mental health provider</i></p>

Helping people initiate and maintain health insurance		"And I define access, you know, not only as access to, you know, insurance, you know, the insurance that covers, you know, health coverage, you know, to be able to seek a therapist" - <i>White women, government employee</i>
Increased and targeted communication about available resources	Prominent among services providers and representatives of community organizations	"The top thing is just, not just access, but knowledge of resources that are helpful that would help reduce some of the cost of them pursuing their health. I think access and knowledge. [When] people understand and go, 'Oh, this is available to me. Oh, okay.' I hear that so many times, 'Oh, I didn't know.' I do some work for an organization who has a clinic attached to it, and I've been surprised at the number of people that work for that organization that don't even know the resources of the clinic where they work." - <i>African American woman, community member</i>
Support people in making time to take care of their health and wellness	Prominent pattern among Latinx immigrant respondents	<p>"And so when [new immigrants] come here, they would talk a lot about the lifestyle changes, and there isn't any more time to socialize with your friends, you are working and sleeping.....working and sleeping, and that has created a lot of diseases, whether they're mental or physical" -<i>Afrolatina woman representing community organization serving Latinx immigrants</i></p> <p>"So, I think it's hard for people to try to help the community if they don't even have access to the insurance, or the knowledge, or the desire to want to stay on top of their health because there's just so many things taking their attention. And I feel like in our community in Hennepin County, there is just so many things going on that a lot of times help is of the least in the back of people's minds until something happens. It's always reacting to fires, right? So, which fire can I drive you to put out first?" - <i>Hmong woman, Millennial</i></p>

Neighborhood safety as a public health concern: Creating a safe environment for community members

Sub-theme	Group patterns	
Violence prevention, including gun violence		"Safety is what we need right now. That's - that's a priority because it's - it's - we used to have a quiet and relaxed city, and now? You go out and you don't know what - what you are going to get." <i>-Latino Spanish speaking man from South Minneapolis</i>
Social isolation due to fear of going outside		"Once the gun violence stops, we'll be healthier. People won't be scared to come out of their house. And then they'll be able to come out and exercise again. They will be able to take walks." <i>-African American woman representing community organization</i>
Access to alcohol and other substances is too easy	Prominent theme among respondents living in/representing North Minneapolis neighborhoods	"See, things like substance use, addiction, and abuse, you can get a liquor license for every single community in the world, but you can't get any other, kind of, a small business license in a residential area." <i>-African American woman, community member</i>
Racism from police and others increases fear	Pattern among African American and Hmong respondents	"It is traumatizing to constantly see people of color be killed by the police, subjected to police brutality, or whatever the case is...It is like you have to navigate everyday life while also dealing with wounds that can never heal." <i>-African American community member and mother</i>
Reestablish community policing and other community focused ways to protect the community		"There was a time when [community policing/CCP Safe] was really important, and then it just changed around. And I remember talking to the police department, I said, 'I remember when you guys used to have on your cars To Serve and Protect. Then that disappeared.' I said, 'When that disappeared, that's when all the sudden all the crime went up.' I said, 'No, it looked like to me that's when your focus on the community changed.'" <i>-African American woman, community member</i>

Widespread access to mental healthcare: Easy and affordable access to mental and emotional support

Sub-theme	Group patterns	
Reducing stigma of seeking out mental healthcare	Prominent among immigrant respondents, with particular concern about youth and older generations seeking care	<p>"The older people, it's harder for them to express what they're dealing with mentally because it's the culture is different, whereas the younger people, they're willing to be open about it." -<i>Somali young adult</i></p> <p>"So I think like sometimes someone would come forward with a mental health issue and people wouldn't acknowledge that it is an actual issue and they would say oh something is just going on with them but we'll get married and it'll go away. So I think, when I'm saying acknowledgment I think from within the community, acknowledgment that mental health is real and that oh when someone is maybe feeling sad for an extended period of time, maybe that is depression. Maybe that's something that they can actually diagnosed and get help with." -<i>Southeast Asian woman</i></p>
Care focused on those who have experienced trauma, including personal and intergenerational trauma		<p>"I went to [a clinic], and I wanted to see a therapist. There were no American Indian therapists, and by the time I educated my therapist on historical trauma and this and that, she had left the clinic. And I thought, gosh. I got another therapist and I kind of had to start all over because none of them knew what historical trauma was." -<i>American Indian woman representing self and community organization</i></p> <p>"And I see a lot of people struggling because they're caught up in this society where they're self-medicating themselves to feel better, and I think that with the historical trauma that I mentioned earlier, whenever you have racial disparities and things like that, the PTS starts. It's trauma on trauma on trauma. There's healing happening, but I think we need more healing." -<i>American Indian woman representing self and community organization</i></p>
Easier access to mental healthcare to prevent a crisis		<p>"So, you know, they go through a window of getting sick, and once they're sick, that's when they want to go to [substance use] treatment. But by the time that, you know, they get a referral to treatment, then they're back using again." -<i>Native American woman, community member</i></p>

<p>Mental healthcare providers whose lived experience is congruent with the patients they serve</p>		<p>“I think more healthcare providers of color [are needed in our community]. People from the communities that they actually serve. Just based on my own experience in the healthcare system, you are just treated very differently when you have a black healthcare provider or a healthcare provider of color. They are going to be more willing to listen to you and to take your concerns seriously.” - <i>African American woman</i></p> <p>“I’ve had families struggle with ‘I went to HCMC and then I met with the psychiatrist who I couldn’t really – I felt like they didn’t understand where I was coming from and we weren’t the same culture.’” - <i>Hmong woman, mental health provider</i></p> <p>“Because I have been receiving treatment with a psychologist, but it’s never the same with someone translating as me personally venting things with a psychologist where she can speak the same language, she can understand me. Uh, not having to have another person there to be looking at me or hearing what I’m talking about with my psychologist.” - <i>Latina Spanish speaking woman</i></p>
-----------------------------------------------------------------------------------------------------	--	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Accessible and affordable care: Ability to access affordable care for physical and mental health

Sub-theme	Group patterns	
Identify barriers to attending appointments and provide services to support patients (e.g., transportation, childcare)		"And it cannot be that you have to take an entire day off of work and travel to Woodbury without a car to get a doctor's appointment. Like all of these things are insurmountable for so many people and it's the only way to get it for so many people." <i>-White woman, parent</i>
Decreased wait times for care	Prominent in discussions of specialty care	"For the population that I work with, it feels to me that preventative mental health, having access to consistent therapy or psychiatric services or that kind of thing, are often not available or affordable for people. And so, by the time they're getting intervention services, it's often a mental health crisis. That can be incredibly disruptive." <i>-Social services provider</i>
Easier and faster access to treatment for substance use disorders	Prominent theme among American Indian and Somali respondents	<p>"I think direct access to treatment, kind of a health treatment for substance use disorders. I know there's probably about two places that do direct access where you're able to walk in for your chemical health assessment and get into treatment right away. It's a lengthy process to like get somebody into a Rule 25 and then wait for the referral and wait for all of this to happen. By that time, you've waited days to weeks, and you're done. You don't want to go back. You don't want to go to treatment now. That ship has sailed." <i>-American Indian woman representing community organization</i></p> <p>"If you overdose and you go the hospital, they let you out within a couple hours. So it's like this revolving door. There's no like intervention or like intervention happening." <i>-American Indian woman, community member</i></p>

Provide affordable care and medications		<p>"I think that at least, like my mom, she has diabetes. But it costs her so much money to pay for it every month. So, then she'll have to like save some [medicine] to get through in the end, you know, when you're not supposed to." -<i>White woman, parent and community member</i></p> <p>"[People] don't have health insurance and they don't go [to the doctor] because they're afraid of the high bills they will get...when you go to the doctor too late, that's when there's no longer a remedy for the illness. Like, you know, there's a time when cancers develop in women...These are diseases that develop quickly." <i>Latina woman, community member</i></p>
Take action to prevent provider/staff burnout		<p>"In terms of professionals that there's been a lot of burnout too in terms of mental health professionals and practitioners and being that – what's the word – the frontline workers that had to work during the pandemic to hold space and to create safe spaces for the community." -<i>Hmong woman</i></p>

Appendix D: 2022 CHNA Group Conversation Guide

1. Starting with yourself: from your own experiences, **what does “being healthy” or having a sense of “wellbeing” mean to you?**
 - a. What do you need to feel your best, most healthy self?
2. Now, think about your family, friends, neighbors, members of various communities you either identify with or are aware of: Based on what you have experienced or witnessed, finish the following sentence:
A “healthy community” is _____. (Facilitator – give an example.)
 - a. What resources do communities need to support the health and wellbeing of their members?
 - b. What impact does lack and/or shortage of those resources have on the health and wellbeing of community members?
3. Now, Think about all we individually and as a community experienced in the past couple of years. Based on your experience or what you have witnessed: **what do you think has been the biggest impact of the past couple of years on individual and community health and wellbeing?**
 - a. Who has been most impacted?
 - b. In what ways have people/communities been impacted? What does that impact look like?
 - c. What efforts have you observed/are you aware of to address these impacts.
 - d. What are some barriers (if any) to addressing these impacts?
 - e. Who could have the greatest impact on improving health and wellbeing?
 - i. Health systems?
 - ii. Community support systems?
 - iii. Schools?
 - iv. Faith communities?
 - v. Government assistance?
 - vi. Combination (be specific)?
4. From your own experience and observations, **when people are sick or concerned about their health:**
 - a. **What encourages them or makes it easier for them to get the care they need?**
 - b. **What are some barriers they might face trying to get needed care?**

5. Finally, thinking about impacts on health and wellbeing from recent years as well as long-standing concerns and needs: **what do you think is right now the number one health and wellness need in the communities you connect with?**

Appendix E:
Hennepin Health Care Community Health Needs Assessment
Prioritization Event:
What We Heard in Interviews and Group Conversations
Ten Key Themes
In alphabetical order

Access to Affordable Care

Physical health care:

1. Decrease wait times.

"I think direct access to treatment, kind of a health treatment for substance use disorders. I know there's probably about two places that do direct access where you're able to walk in for your chemical health assessment and get into treatment right away. It's a lengthy process to like get somebody into a Rule 25... By that time, you've waited days to weeks, and you're done. You don't want to go back."
- American Indian woman representing community organization (interview)

2. Identify barriers to attending appointments.

"I think once we start feeling sick, it's when we often go to the doctor. And I wouldn't say that we're all neglectful, but I feel like it's also like this belief of not having that medical access that prevents us from actually seeking help or seeking any support before we have the diseases...it's a challenge for many people who don't have money or the financial means to pay for medical care." -Latina woman representing community organization (interview)

"[People] don't have health insurance and they don't go [to the doctor] because they're afraid of the high bills they will get...when you go to the doctor too late, that's when there's no longer a remedy for the illness. Like, you know, there's a time when cancers develop in women...These are diseases that develop quickly." -Latina woman, community member (interview)

3. Provide more supports (transportation, childcare).

"And then for me, I think in terms of resources that I've seen being helpful is actually free transportation. Free transportation to wherever they need to go to for treatment and making it easy. Sorry, I'm not sure if they have it in like the Hmong language because there's a lot of hesitancy if the person doesn't speak Hmong and they have to call to get their own ride. The ones that do though...they did do well, much better with their health." – Hmong Health Care Professional (group conversation)

Widespread mental health care:

1. Reducing stigma related to seeking mental health care.

"So I think like sometimes someone would come forward with a mental health issue and people wouldn't acknowledge that it is an actual issue and they would say oh something is just going on with them but we'll get married and it'll go away...I think from within the community, acknowledgment that mental health is real and that oh when someone is maybe feeling sad for an extended period of time, maybe that is depression. Maybe that's something that they can actually diagnosed and get help with." - Southeast Asian woman (interview)

"The older people, it's harder for them to express what they're dealing with mentally because it's the culture different, whereas the younger people, they're willing to be open about it." - Somali young adult (interview)

2. Easier access to mental health care to prevent crises.

“Just generally in healthcare we do not do a very good job with just providing easy access to care. It is especially mental health. If you have a problem with mental health, say yes. I will get you in in nine months.” - African American community leader (group conversation)

“For the population that I work with, it feels to me that preventative mental health, having access to consistent therapy or psychiatric services or that kind of thing, are often not available or affordable for people. And so, by the time they’re getting intervention services, it’s often a mental health crisis. That can be incredibly disruptive.” - Social services provider (interview)

3. Trauma-informed mental health care.

“I went to [a clinic], and I wanted to see a therapist. There were no American Indian therapists, and by the time I educated my therapist on historical trauma and this and that, she had left the clinic. And I thought, gosh. I got another therapist and I kind of had to start all over because none of them knew what historical trauma was.” - American Indian woman representing self and community organization (interview)

Dental care: Need for better access.

“There is a shortage in dental health. A lot of people have a lot of illnesses, I am one of them, that is attributed to dental services. It is so expensive. Even when you have insurance that covers it, you still end up in debt.” - African American woman (group conversation)

Health care and care systems that are easy to navigate.

“A lot of times people just do not know where to go. They do not know where to go and do not know what to do in situations.” - African American woman (group conversation)

“And then care coordination is a huge issue as well. There’s a lack of navigation and that’s one of the biggest problems that I see.” – Hmong Health Care Professional (group conversation)

Address Impacts of COVID-19

1. Isolation, Loneliness, and losses.

“Because of COVID, people weren’t going out. My parents have not gone to church or other meetings or social relationships with others. They have lost language and mental capacity, possibly dementia (they’re in their 80’s).” - Korean community member (group conversation)

“I will speak to the Covid where loneliness and the inability to have contact...I remember I had expressed to my brother who lives in California. I would talk with him on the phone, but I could not see him. You know? It is how important it is to be visual. You know, you can hear a person’s voice sometimes. You cannot see them. It was just important. We hooked up with Zoom – not Zoom, Google Duo. We were able to see each other, and that helped. It is the loneliness.” - African American woman (group conversation)

“The community needs to come together, after all we’ve been through. I spent 27 days in the hospital with Covid and I even lost a lot of friends to it. I have experienced and suffered the covid virus and seeing people I know dying to it. It’s important we look out for each other, reminding and warning ourselves to be careful. We need to speak and discuss as to what being healthy looks like as a community. This includes holding these kinds of meetings regularly.” – Somali community member (group conversation)

2. Reduced access to health care.

“There are two things that I feel affected a lot of people during Covid. One was having access to medical care. You could not get doctor or service doctor appointments unless you went to emergency. That impacted a lot of people who did not have the insurance to go to emergency because that cost more... it looks like the doctors cut their hours or are working from home. They are doing video calls. Sometimes you just need to see a doctor. You know? They cannot diagnose you over the telephone.” - African American woman (group conversation)

3. Continuing or worsening disparities.

“A lot of times our systems are so disjointed that they do not really meet the needs of the people that are engaging them. The medical field is one that is, especially for the African American community, just so disjointed. When we look at what happened in the pandemic and how long it took for us to get vaccines to the community, where other communities were almost given preference. Can you imagine? They were given preference to get vaccines.” - African American man (group conversation)

4. Economic impacts.

“These past years we’ve been hit with inflating, rising costs and finances going down. People are not able to help each other. You’re more liable and likely to get sick when your finances are down.” - Somali community member (group conversation)

Building Trust

1. Build active, authentic community partnerships.

"I think the doctor is really only with them there in the visit so connecting them to their community is important and I think that idea of community health is something that medical providers can connect to more. So, if we have thriving community organizations that are better at just taking care of their neighborhoods and are resourceful enough to provide neighborhood support, I think people will be healthier and if medical providers are partnering with these community organizations, and neighborhoods, I think that would be the perfect way to go." -Southeast Asian woman (interview)

"What I will say that I have learned from being a part of UROC, why we do research and outreach, the main thing that we do to me is be a good neighbor. You show up the way people want you to show up. When people ask you to do something, you do that. You do not come in telling folks what needs to happen. Sometimes people will look to you, and then you have to say hey. No, I am waiting until you think about how you really want me to show up. Hennepin County can do that and be a good neighbor. People and the community have said how they would like Hennepin County to show up a number of times, so it needs to listen." – African American woman (group conversation)

2. More frequent community conversations plus actions.

"I find these kinds of programs and discussions important but especially this one because it shows us that Hennepin County cares." - Somali community member (group conversations)

3. Providers/staff interact with all patients in respectful, unbiased way, listening and responding to patients concerns without preconceived notions based on race, ethnicity or religion, sexual orientation, or gender identity.

"... we're trained about culture sensitivity, the respect. We come from a point that the provider or institution has to have that, and which makes sense. But I think it has to be the other way around as well...there needs to be a middle ground so that we can practice the proper context. And that's also where kind of trust comes from is the understanding of each other because there are some people who don't trust the given recommendation or treatment and then there are some institutions or providers who don't trust that their patient is being compliant. And with that there might be underlying subconscious biases or discrimination even from same group. And it needs to be made conscious and adjusted to reflect the reality."- Hmong Health Care Professional (group conversation)

"Just historically black people have been denied humane services. We have been experimented on. Our concerns are just ignored... I have just had it where I am not taken seriously. I think too also being a woman, your pain and your concerns are just overlooked. They are really minimized." -African American woman, parent and community member (interview)

"I like to have people understand when I'm seeking out healthcare, people listen to me and listen to what I'm telling them and not try to tell me what I'm feeling without listening to the information that I'm giving them, forcing something on me instead of deciding what the symptoms I'm giving them mean." – Community member who identifies as LGBTQ (group conversation)

4. Be transparent about how to navigate the system and what resources you have available to patients and families.

“... you know new immigrants or refugees do not understand the health system. So I think if there are opportunities for health systems to create kind of like going to the see the doctor 101 or how does your insurance work or things like that, I think that would be very impactful. I think even for people who’ve lived here for a long time or do speak English, even the healthcare system is still very hard to navigate.” - Hmong Health Care Professional (group conversation)

Community Centered Care

1. Community-driven solutions

“You know, whenever we have these types of situations going on, people really do not listen to what the constituents are saying. It is like, we better hurry up and do something. In hurrying up and doing something, you do not even know what the problem is because you are not listening. You already made up in your mind, this is what you want to achieve.” – African American woman and community leader (group conversation)

“We need to be more aware that people want to be part of the solution, not part of the problem” – African American woman and community leaders (group conversation)

2. Shared decision making. Community representation in decision making and action planning.

“Like there’s all these good ideas, but they don’t ever go anywhere because we’re still functioning in that same system of how we look at things because the community themselves know what’s best for them, and what could work...And so, I think in a way, we’re kind of caught in between the decisions—the people who can make the decisions and the people who know what’s going to work for them. There’s just this gap.” – Hmong woman and first-generation American citizen (interview)

3. Access to primary and specialty in the community.

“...more clinics in the neighborhood that you can get to. Say if you go Downtown to Hennepin County, you’ve got to find parking, you’ve got to do all this, the A building, the blue building. That’s complicated. But when it’s in your community, you have to go. That’s what I’m saying. I think with healthcare in your community and getting the information out...this is where you go for this, go for this...people are more apt to come. But when you’ve got to go elsewhere, to the suburb or wherever, and it’s not in your community, people are not going to go, if they’ve got to get on the bus or whatever. But if it’s right at home, you’re more apt to get more participation, I think.” – African American man and community elder (group conversation)

4. Community spaces to facilitate health.

“For me having a healthy mind includes having spaces in our community that are spiritual. Having access to mosques to rest, read and calm down spiritually. A restaurant to eat some food good. Having a reason to leave the house because staying at home can make you sick. The three most important things are Spiritual, Health and Safety. Being able to go out and have conversations with people in your community and seeing them in person.” - Somali community member (group conversation)

Communities Taking Care of Themselves and One Another

“We each have to be responsible for our neighbor. You know? We have to be wanting to outreach. We cannot just say we are going to have the government do it or we are going to have this. We have to initiate it. Be a part of that helping system and not just sitting around on your rump. Be active. Be proactive about it. It starts with your individuality.” – African American woman – (group conversation)

“Taking a look at how other communities manage and learning from the different people. We need to come together beware of the concerns we share and show up for each other. We gotta have a sense of togetherness and a strong community involvement.” -Somali community member (group conversation)

“Helping our youth because they are the future. We need to help them and create rehabilitation programs for them to get off the streets. If they don’t receive health, help, and encouragement there is going to be violence and death.” - Somali community member (community conversation)

“The purpose of a family, of a man, is to show your kids how to get along without you. The purpose of us right now is to show the young community how to get along without us.” African American man, age 70+ (group conversation)

Culturally Responsive Care:

1. Hire more providers who are reflective of the communities Hennepin Healthcare serves.

"For me, I look for black providers, people of color to provide for me clinicians. Then if I cannot get somebody black, I prefer somebody who is not from this country. Why? It is because they have not been indoctrinated in white supremacy in the same way this country pushes it." African American woman/community leaders (group conversation)

"I think more healthcare providers of color. People from the communities that they actually serve....you are just treated very differently when you have a black healthcare provider or a healthcare provider of color. They are going to be more willing to listen to you and to take your concerns seriously. I just know again from my own experience and talking with others." -African American woman, parent and community member

2. Provide care and setting congruent with the cultural traditions of patients.

"I think a lot of the alternative health, spirituality included, ceremonies, traditional medicines, the things that we use, even energy healing, spirit healing, isn't paid for by hospitals. So, the people who need it the most, if they don't have the resources to do that, it's hard for them to get up north and find an elder and to give to them." -Native American woman representing community organization (interview)

3. Care provided by native speakers of patients' language:

"Because there are times that we really don't know if we are being translated -- if they are understanding us, actually, right? Because there's no one to translate at that moment, or sometimes you don't hear well when it's over the phone, or no - you don't know if - if I'm listening to you well, or things like that. I think the language is the - the - the main one." -Latina woman (interview)

4. Increased access to culturally congruent advocate, navigators, and community health workers.

"So if at most, to have advocates for your senior citizens, for your adolescents, for your middle-aged individuals, and also your pediatric patients. Have advocates for them, the same way that they do in the legal system, they have guardian ad litem for children." -African American woman, longstanding community member (interview)

5. Outreach designed for specific cultural groups and communities.

"I mean, in terms of the queer community, there are a lot of autistic people who are in the queer community and trans community, and so making sure there are different ways of getting information, not just going to a place and having a lot of verbal stuff thrown at you but having visual things. And having people who facilitate those things who are also part of the community as opposed to them having to go to a cis person who is facilitating something who has no idea what those people's experiences actually are." – Community member who identifies as LGBTQ (group conversation)

"I would suggest that the health sector to send many health-workers who can understand the local language of my community to conduct community health education and awareness programs so that I understand the importance of going to the hospital and seeking medical attention." -Somali woman (Interview)

Holistic Care

1. Care that addresses the needs of the whole-person: mind-body-spirit:

“To me, physically healthy is one thing. You have to really be mentally and emotionally healthy also. All of that plays a part in your viability as a functioning individual. You could be in the best of health according to the matrix of the doctors and nurses. If you are having apprehensions about your security, about your finances, those things have a significant impact on being healthy. I was glad to hear you speak of a holistic approach, because all of this is important.” – African American woman (group conversation)

“...good environment: peaceful mind is very important; if you are too greedy, it can cause mental harm; be happy with what you have.” - Korean elder (group conversation)

2. Broader treatment options available and covered by insurance.

Naturopathic practitioners are not covered by insurance and people who need them cannot go – chiropractor or acupuncture. I wish those services could be covered by insurance. More variety of insurance providers for needs; Access to information - how do you know where to go or what is available? - Korean elder (group conversation)

3. Empower individuals and communities to care for themselves and others.

“To have knowledge and being able to read and follow directions. Having basic understanding and literacy is important to be aware of what’s going on in the community. Opening your eyes and ears when it’s associated with health and being connected with community health. God is the giver of health and so starting with faith and being connected with community awareness of your own health.” - Somali community member (group conversation)

Long-term Impacts of Systemic Racism and White Supremacy on Black, Indigenous, and other Communities of Color

1. Education for providers and staff.

"I think that some of the folks that our decision makers could benefit from some education of how white supremacy and institutional racism have shaped this community. I think it will help them have a better view of why situations are the way they are. I do think that at times when we show up, there is a thought that we are just not trying. You know? There is something wrong with us that we are not where we need to be. It is not that there is something wrong." – African American woman, community leader (group conversation)

"I think it's systemic. You understand? And it seeps down to us, to our community. We keep getting pushed back on all the programs, all of the everything. Going to jail, the sentences are longer. The expectations of us are different from other nationalities. You know what I mean? Every nationality has its problem, and we've got a systemic problem. We're addressing the way we were raised, but there are so many obstacles that are throwing the kids away, social media, the drugs. These kids can't afford no cocaine. How is that much cocaine in the neighborhood? How is this many guns in the neighborhood? It's systemic. Somebody is making sure that we don't succeed. You know what I'm saying?" – African American man, age 70 (group conversation)*

2. Trauma-informed care.

"So, and what I've said to the medical profession is, "Time alone is neutral. What you do in that time from the Tuskegee to today if you've done nothing because you've done nothing to rehabilitate or reestablish the notion of trust." - African American man, government employee (interview)

"Well, yes, I guess just becoming trauma-informed would change the landscape because it really asks us—asks me as a white bodied person—to examine who I am, how I think, how I got that thinking to sort of deconstruct that, you know, and really understand what those, you know, biases are and how I act in the world, in the space that I take up. And if every one of those systems undertook that same sort of internal as well as systematic review of how they act, I just am absolutely committed that that would be a game changer for the people living in every community that has a touchpoint, you know, with any of those systems." -White woman, public health leader (interview)

Meeting Basic Needs

1. Access to healthy food.

“Quite a few years ago there was instituted a health initiative in our church. That has really been a blessing. It is eye-opening of the foods that I should eat and the foods that I should not eat... You know, I am learning in the last few years what really health food is and what it can do or cannot do... I have friends that certainly we support each other in our eating... We do support each other with veggies and really healthy eating.” - African American woman (group conversation)

“In Somalia we had a great diet because of the natural food that was readily available here there’s a lot of process food to watch out for. We have to be aware and be educated about what we consume and when it comes to food.” - Somali community member (group conversation)

“...would like to see more healthy foods being sold; there is a lot of very junky food being sold now; when you go out to eat, food is not healthy - too salty, sweet, too much fat. We need more fresh produce; “healthy” means no stale foods, reduced or no fats, less salty and sweet too; limit fried foods.” - Korean elder (group conversation)

2. Affordable housing.

*“We get a lot of [mental health] referrals and it’s ‘I can’t focus on this right now because I’m homeless.’ ‘I can’t focus on this right now because I’m getting evicted.’ ‘I can’t meet with you because I work at a certain time frame and those are out of the hours that you’re able to see me.’”
-Hmong woman, mental health provider (interview)*

“But I also don’t think anybody’s basic needs are met, you know, the way they should be in America, you know. Like why are we having kids that can’t eat, that don’t have housing? That gets frustrating.” -White woman, parent and community member

3. Clean environments, public transportation, air and water.

“Really basic needs are like clean air...I need to be able to breathe. I want to have clean air... clean air, clean water.” - White woman, physician (group conversation)

4. Green spaces for all ages.

“For me, especially from a mental health perspective, I really feel like it is so important to have access to green spaces. You know? Being around nature. For kids it is so important. They need green time. They need to be in a park. They need to be seeing some trees and grass.” – White woman physician (group conversation)

Safety

1. Emotional safety: can I be myself without judgement or harm?

"I was also going to say safe because I think that's something that queer people often, we don't feel. We don't feel like we're being listened to, or we don't feel like we're safe because there are certain things that happen, specifically health-wise, in our community that are not really acknowledged." – Community Member who identifies as LGBTQ (group conversation)

"It is traumatizing to constantly see people of color be killed by the police, subjected to police brutality, or whatever the case is...It is like you have to navigate everyday life while also dealing with wounds that can never heal." -African American community member and mother (interview)

2. Safety in Neighborhoods.

"Safety is the most important because you have that then you're healthy. If you're constantly worried or scared for your safety then there's no way to have a healthy mindset and that is an obstacle people face. We need safety when your worry is high your health goes down." - Somali community member (community conversation)

"Safety is what we need right now. That's - that's a priority because it's - we used to have a quiet and relaxed city, and now? You go out and you don't know what - what you are going to get." -Latino Spanish speaking man from South Minneapolis (interview)