# Community Health Needs Assessment and Implementation Plan 2020–2022

## Executive Summary

***The mission of Allina Health is to serve our communities by providing exceptional care as we prevent illness, restore health and provide comfort to all who entrust us with their care.***

### INTRODUCTION

District One Hospital (District One) and Owatonna Hospital (Owatonna) are part of Allina Health, a nonprofit health system of clinics, hospitals and other health and wellness services, providing care throughout Minnesota and western Wisconsin. Every three years, Allina Health's hospitals conduct a federally-required Community Health Needs Assessment (CHNA) to examine health in the communities they serve, identify health priorities and develop strategies and action plans to pursue them. The hospitals conduct their CHNA in partnership with local public health departments, other hospitals and health systems, community organizations and residents.

#### Hospital and Community Descriptions

District One, located in Faribault, Minnesota operates 42 beds and serves over 30,000 patients and their families each year. Its primary service area is Rice County located in southern Minnesota.

Owatonna, located in Owatonna, Minnesota serves over 20,000 patients and their families each year. Its primary service area consists of Steele and Dodge counties, also located in southern Minnesota.

Rice, Steele and Dodge counties were the focus of the hospitals' CHNA. According to the U.S. Census Bureau, 65,251 and 57,097 people live in Rice and Steele/Dodge counties, respectively. The median age is 38 years and about 24 percent of its total population is under age 18. Approximately 15 percent of residents in Rice County and 13 percent of Steele/Dodge county residents are people of color. The proportion of residents living in households with income below the Federal Poverty Level was 11.5 percent in Rice County and 7.8 percent in Steele/Dodge counties.

### COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

District One and Owatonna conducted a joint CHNA in collaboration with two required Community Health Improvement Plan (CHIP) processes: one conducted by Rice County Public Health and the other conducted jointly by health departments in Steele County and Dodge County. The groups used the Mobilizing for Action through Planning and Partnerships (MAPP) model, a community-driven strategic planning process for improving community health that has six phases: Organizing, Visioning, The Four Assessments, Identifying Strategic Issues, Formulating Goals and Strategies and the Action Cycle. For the purposes of this report, the phases are condensed to data review and prioritization, community input and implementation planning. The processes began in April 2018 and were completed in August 2019.

## EVALUATION OF 2017–2019 CHNA IMPLEMENTATION PLAN

Between 2017 and 2019, District One and Owatonna pursued heath priorities identified in their 2016 CHNAs. District One addressed mental health and access to care while Owatonna pursed strategies to address mental health (including addiction) and chronic disease self-management. The hospitals worked collectively on healthy aging for people over 50 years-old. Highlights include:

- Improving care for Somali residents by hiring a full-time Somali interpreter and adding Halal meal options to inpatient menus and prayer mats in the hospital's chapel space. (District One)
- Distributing Allina Health Bucks to patients and community members to redeem for fresh fruits and vegetables at local Farmers Markets. (Owatonna and District One)
- Reaching 120 Arcadia High School students and 40 staff with Change to Chill™ stress reduction programming.
- Awarding $86,800 in Neighborhood Health Connection™ grants to 24 local organizations in District One and Owatonna's regions. (Both)
- Launching Honoring Choices, an initiative focused on engaging older adults in completing their health care directives; conducting 75 outreach activities through 18 facilitators trained in advance care planning. (Both)

A complete description of 2017-2019 achievements is available online at https://www.allinahealth.org/about-us/community-involvement/need-assessments.

### Data Review and Prioritization

As part of their communities' respective CHIP processes, staff from District One and Owatonna reviewed Allina Health patient data and local data from sources such as the Minnesota Center for Health Statistics, Minnesota Student Survey, and local reports such as a housing and transportation analysis. Rice County CHIP Committee members also reviewed responses from 639 people on a community health survey conducted by Rice County Public Health. The Steele-Dodge CHNA Committee reviewed 27 responses to an online survey of key community partners' perspectives on priorities.

Both CHIP groups took several steps to engage community leaders and select top health priorities. The Rice County group selected mental health, housing, transportation and race relations as priorities. The Steele/Dodge group selected mental health, social determinants of health and obesity. To align activities and maximize resources, District One and Owatonna created three shared health priorities for 2020–2022:

- **Mental health and substance use**
- **Social determinants of health, including transportation, housing and cultural competency**
- **Obesity, including healthy eating and active living**

### Community Input

To gain residents' perspectives on these priorities and ideas for addressing them, the committees held two conversations with members of Faribault's Somali and Latinx communities. They also conducted focus groups with the Steele and Dodge counties' SHIP Community Leadership Teams, Mayo Clinic primary care providers, Owatonna High School students and Rice County social service providers. In addition, 80 residents participated in a community dialogue convened by Owatonna Hospital, United Way of Steele County and Mayo Clinic Health System.

Through these community input activities, Latinx and Somali participants described challenges interacting with health care because of language, cultural competency and insurance barriers. They also shared difficulties finding affordable housing that can accommodate bigger families. Lack of transportation emerged as a significant barrier to going to clinic appointments and English-learning classes. Related to obesity, some participants noted the cost of healthy food is a barrier to healthy eating. People in the Latinx group shared that mental health and physical health are intertwined with food insecurity contributing to stress and depression. Community members and health care providers also described a shortage of mental

health providers and substance abuse treatment options in their communities.

### Implementation Plan

Based on the community input, District One and Owatonna developed a joint 2020–2022 implementation plan that outlines the strategies and activities they will pursue to address the health priorities. To make progress in achieving health equity among residents, the hospitals will prioritize partnerships and activities that engage populations that have been historically underserved.

## 2020–2022 IMPLEMENTATION PLAN

### MENTAL HEALTH AND SUBSTANCE USE

**Goal 1:** Increase resilience and healthy coping skills.

**Strategies**

- Increase resilience among school-age youth.
- Increase social connectedness and community-wide resilience efforts.

Activities will include offering Change to Chill™ to high schools; enhancing the mental health and wellness components of Health Powered Kids™; providing charitable contributions to community organizations that increase resilience and social connectedness; providing financial support for a new regional multicultural resilience campaign and toolkit; participating in the Steele County Safe and Drug Free Coalition and Rice County Chemical and Mental Health Coalition; and supporting student-led activities that focus on assets and virtues.

**Goal 2:** Reduce barriers to mental health and substance use services.

**Strategies**

- Decrease stigma associated with seeking help for mental health and substance use conditions, with a particular focus on the experiences of racial and ethnic minorities and other historically underserved communities.
- Improve access to adolescent mental health and substance use services.
- Connect patients to Rice County Mobile Opiate Support Team (MOST) for rapid opioid abuse assessment and referral.

Activities will include enhancing the stigma elimination components of Change to Chill™; promoting stigma elimination messaging during mental health awareness months; participating in the MOST steering committee and advocating for local and state policies aimed at increasing mental health and substance use services.

### SOCIAL DETERMINANTS OF HEALTH—HOUSING, TRANSPORTATION AND CULTURAL COMPETENCY

**Goal:** Reduce social barriers to health.

**Strategies**

- Establish a sustainable, effective model to systematically identify and support patients in addressing their health-related social needs.
- Establish a sustainable network of trusted community organizations that can support patients in addressing their health-related social needs.
- Increase support of policy and advocacy efforts aimed at improving social conditions related to health.
- Increase staff awareness of Somali and Latinx cultural preferences.

Activities will include supporting implementation and evaluation of the Accountable Health Communities model and then transitioning to a modified version; identifying community partners and a tracked referral process that connects patients to them; educating staff on intercultural effectiveness and supporting community coalitions aimed at decreasing social barriers to health.

### OBESITY

**Goal:** Increase healthy eating and physical activity among community residents.

**Strategies**

- Increase access to vegetables and fruits for residents who experience food insecurity.
- Increase physical activity among people from historically-underserved communities, including seniors.

Activities will include providing grants and charitable contributions and connecting employee volunteers to food-related activities and organizations; participating in community coalitions related to healthy food and active living; providing Allina Health Bucks to patients and community members experiencing food insecurity; participating in healthy food drives; supporting physical activity opportunities for people from historically-underserved communities; advocating for transportation policies that support access to physical activity and recreational opportunities.

### Community Partners

Local govenerment, HealthFinders Collaborative, Free Clinic of Steele County, local Parks and Recreation departments, local food shelves, St. Vincent de Paul, Community Café, Fare for All, University of Minnesota-Extension, River Bend Nature Center, local public and private school districts, Northfield Healthy Community Initiative, United Ways of Rice and Steele Counties, local Chambers of Commerce, area businesses and area farmers markets.

### Resources

To fulfill the implementation plan, District One and Owatonna will contribute financial and in-kind donations such as personnel, charitable donations and Allina Health's systemwide programs. It will also encourage staff to volunteer with local organizations.

### Evaluation Plans

District One and Owatonna will monitor progress on their implementation plan by tracking process measures, such as number of programs delivered and people served, staff time dedicated and dollars contributed. Allina Health will evaluate systemwide programs to assess their effects on intermediate outcomes that evidence shows are likely to lead to improvement on health measures. To assess long-term effects, Allina Health will monitor population-level indicators related to the health priorities.

## CONCLUSION

Through the MAPP process, which included data review, prioritization and community input, District One and Owatonna identified the health priorities it will pursue in 2020–2022 with its own strategies and activities and Allina Health initiatives.

The full report for the District One and Owatonna 2020–2022 Community Health Needs Assessment is available on the Allina Health website: https://www.allinahealth.org/about-us/community-involvement/need-assessments.


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For more information, please contact Natalie Ginter, Community Engagement Lead for South Regional region or Christy Dechaine, Community Benefit and Evaluation Manager.

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