

COMMUNITY HEALTH NEEDS ASSESSMENT

DECEMBER 2019



In partnership with:

**Wilder
Research**

Information. Insight. Impact.

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CHILDREN'S MINNESOTA STAFF

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Children's Minnesota and Wilder Research are responsible
for the content and accuracy of this report.



MISSION, VISION AND VALUES

At Children's Minnesota our mission is: We champion the health needs of children and families. We are committed to improving children's health by providing the highest-quality, family-centered care, advanced through research and education.

OUR VISION

Our vision is to be every family's essential partner in raising healthier children — not only during illnesses or injuries, but throughout childhood. As the health care industry faces a time of unprecedented change, we will continue our dedication to delivering an experience unlike any other, making access to health care easier and working with the community in innovative ways.

OUR VALUES

These values guide the way we engage with each other, our patients and our communities:

- **Kids first.** We're inspired by children — we channel their optimism, resiliency, courage and curiosity into everything we do.
- **Listen, really listen.** Each person has a story to tell. We listen with compassion, ask meaningful questions and build relationships with individuals and communities.
- **Own outcomes.** We are 200% accountable for providing extraordinary service. Tireless in our pursuit of excellence, we never stop learning or improving.
- **Join together.** We are all caregivers. And, we are stronger when teamed with our patients, families, community and one another. Super teams trump superheroes.
- **Be remarkable.** We are innovators, reimagining health care and going beyond what's expected. After all, kids are counting on us.



A NOTE TO OUR COMMUNITY

DEAR READER,

At Children's Minnesota, we have set our sights on a powerful vision: to be every family's essential partner in raising healthier children. This vision is reflected in our commitment to hearing from families and collaborating with community leaders and organizations as we work to provide high quality, holistic care to children and their families. As extensive as our expertise is, it will never equal the insight children, families and communities have about their own health and well-being.

Eighty percent of what impacts the health of children happens outside the clinic walls, which is why we continue to leverage this federally-required process to actively engage our partners across various social sectors to improve the health of the children and families we serve. The 2019 community health needs assessment (CHNA) focused on honoring what was learned in 2016 by engaging stakeholders in deeper discussions around the priority areas identified in the past assessment, while also creating space within those discussions to allow new priority areas to emerge.

Over the course of 2019, we have had the honor of listening to people within Children's Minnesota and in the surrounding communities as they shared their perspectives on health and well-being. We heard from:

- More than 640 people at neighborhood events and primary care clinics
- Community stakeholders via interviews
- Parents/caregivers within moderated focus groups
- Children's Minnesota employees and clinicians

What we have learned in this assessment continues to confirm what the community has known for generations: that health and well-being is directly impacted by the environments we live in, the educational and economic opportunities we have access to, our social connections and more. These factors continue to be influenced by inequities that exist within our social structures and institutions. These inequities must be addressed if we want the health of our communities to improve.

The 2019 CHNA has provided valuable information and insights that will influence our work, yet we understand that it cannot provide a complete understanding of the communities we serve. We view the present CHNA as one part of our commitment to engaging in a way that supports current and new pathways for partnership in support of better health for children.

Sincerely,



Maria Christu, JD

Chief Legal Officer & SVP, Advocacy and Health Policy
Children's Minnesota

WHAT IS HEALTH TO CHILDREN?

The children in our community are truly amazing and they have a wealth of knowledge when it comes to their health. To ensure that kids' voices were represented in this report, Children's Minnesota staff used discussion boards to ask children and families to finish the following sentence:

CHILDREN WHO ARE HEALTHY...



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



Center
Place
nacy

ABOUT THE ASSESSMENT

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

In 2016, Children's Minnesota began to emphasize health equity in the assessment process and broadened potential topic areas to include community conditions that contribute to health outcomes such as poverty, education and housing. The 2016 CHNA was a robust assessment that was led and informed by the community via the Community Advisory Council (CAC). The following health priorities were identified through the 2016 assessment and became the focus of new initiatives and expanded efforts: asthma, mental health and well-being, access to resources, income and employment, education and structural racism.

The 2019 CHNA process, similar to 2016, gathered input from the community and Children's Minnesota staff and reviewed existing data to identify critical needs. Given that most of the 2016 priorities were based on social determinants of health, it would be unrealistic to anticipate significant, measurable improvements to be achieved in three years. To that end, the 2019 assessment was designed to build upon key learnings from 2016 and address concerns through investments in services and community relationships. As a result, the goals of the 2019 CHNA were to:

- Confirm previously determined needs still exist and are significant in the community
- Refine Children's understanding of the existing health priority areas and how they present in the community
- Identify emerging needs that may not already be addressed through the existing health priority areas

Based on community input and existing data examined by Children's staff, the following health priorities were determined in the 2019 assessment: structural racism, health disparities, economic opportunity and income, mental health and developmental well-being and access to resources

THROUGH THIS PROCESS, CHILDREN'S WAS GUIDED BY THE FOLLOWING BELIEFS:

- Health is strongly influenced by the conditions in which people are born, live, learn, work, play, worship and age. These conditions, also called social determinants of health, have a greater influence on health than health care services.
- Social determinants of health are shaped by structures, decisions and policies that influence how money, power and resources are distributed. Inequities result when policies and systems that were designed to advantage affluent, and often white, residents negatively impact groups of people, often people of color, American Indians and lower-income residents. Policies that disproportionately impact people of color may not mention race explicitly. Inequities can also result when the full impact of policies is not considered and the people most likely to be affected by a proposed policy have limited influence — or are excluded from the decision-making process. To that end, Children's will continue to use a racial equity lens in its Community Health Needs Assessment (CHNA) process.

1 | Schroeder, S. (2007). We can do better – Improving the Health of the American People. *New England Journal of Medicine*, 357: 1221-1228.

ABOUT CHILDREN'S MINNESOTA

Children's Minnesota is a network of two hospitals, 12 primary and specialty care clinics and six rehabilitation sites that serve children from birth through young adulthood. Minneapolis and St. Paul are home to the two hospital campuses, along with a primary care clinic in each city. Additional primary care clinics are located in the Twin Cities suburbs of Brooklyn Park, Hugo, Maple Grove, Plymouth, Rogers, Calhoun and West St. Paul. Rehabilitation clinics are located in Minneapolis and St. Paul, as well as the suburbs of Maple Grove, Minnetonka, Roseville and Woodbury. The network has more than 60 pediatric specialties to provide health services to children with a range of health needs.

THE CHILDREN'S MINNESOTA COMMUNITY

Children's Minnesota serves a large geographic area and diverse patient population. In 2018, Children's cared for just over 135,000 patients through its hospitals, primary and specialty care clinics and in-home services. These patients represented all counties in Minnesota and 64% of the counties in the four neighboring states. At its hospital locations alone, there were more than 91,000 emergency department visits and nearly 15,000 hospitalizations in 2018.

Children's has a vision to leverage the CHNA process to advance ongoing efforts and community partnerships that will yield measurable health improvements. That means that while the CHNA is intended to help understand strengths, needs and priorities of all children in the region, it is also an opportunity to identify the specific neighborhoods and communities where the organization may be best able to support local efforts to improve health.

Most of the children served by Children's two hospitals and 12 primary care clinics live in the seven-county Twin Cities metro region (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington counties). Analysis of de-identified patient data show that the two hospitals serve a culturally, linguistically and socioeconomically diverse patient population. Similarly, county and statewide data show current and potential patients within the geographic communities served are becoming increasingly diverse. This assessment used the same definition of community that was developed through the 2016 CHNA process to understand community needs and inform action.

CHILDREN'S MINNESOTA COMMUNITY DEFINITION

For the purposes of this CHNA, the following definition of community has been adopted:

The community served includes the more than 700,000 children (0 – 17 years) who live in the seven-county Twin Cities region: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington counties.

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

- In Minneapolis: Phillips and Powderhorn neighborhoods
- In St. Paul: West Side, Frogtown/Thomas-Dale, and Dayton's Bluff neighborhoods

WHO RECEIVES CARE FROM CHILDREN'S MINNESOTA?

Children's serves children of all ages and from many cultures. English, Spanish and Somali are the most common languages spoken by patients. In 2018, interpreter services were provided for more than 100,000 visits in 70 different languages, most commonly Spanish, Somali and Hmong.

Patients receive care for a wide range of health concerns. The most common reasons for hospital visits in 2018 were treatment of acute respiratory illnesses (acute bronchiolitis and bacterial pneumonia), chemotherapy and care following a pre-term birth.

In 2018, more than 57,000 individual children received emergency department services and more than 13,000 were admitted to the hospital. Patient data from the two hospitals combined indicated that children who received emergency department services tended to be toddlers and school-age children, while infants were more likely to be admitted to the hospital (Figure 1). A more culturally and socioeconomically diverse patient population received emergency department services than those admitted for inpatient hospital care. Because measures of household income and poverty status are not routinely collected for all patients, this assessment used enrollment in Medicaid as a proxy measure for lower-income households. More than half of patients (57%) who received emergency department services, and 41% of patients who received inpatient hospital services, had Medicaid as their primary source of insurance.

1. CHARACTERISTICS OF NUMBER (N) OF PATIENTS SERVED IN 2018: HOSPITALS

| DEMOGRAPHICS | EMERGENCY DEPARTMENT (N=57,509) ^a | | INPATIENT HOSPITALIZATION (N=13,487) ^a | |
|--------------|----------------------------------------------|-----|---------------------------------------------------|-----|
| | N | % | N | % |
| <1 | 9,109 | 16% | 5,336 | 40% |
| 1-2 | 12,877 | 22% | 2,025 | 15% |
| 3-4 | 8,173 | 14% | 1,117 | 8% |
| 5-6 | 6,437 | 11% | 739 | 5% |
| 7-12 | 12,900 | 22% | 1,965 | 15% |
| 13-17 | 7,300 | 13% | 2,022 | 15% |
| 18+ | 713 | 1% | 283 | 2% |

Source: Children's Minnesota (2018).

Note: Due to rounding, totals may not equal 100%. Totals for race/ethnicity exceed 100%, as more than one category may be selected.

| DEMOGRAPHICS | N=62,129 | | N=13,456 | |
|----------------------------------|----------|-----|----------|-----|
| RACE/ETHNICITY | N | % | N | % |
| American Indian | 657 | 1% | 150 | 1% |
| Asian | 4,010 | 6% | 847 | 6% |
| Black/African American | 16,817 | 27% | 2,043 | 15% |
| Hispanic/Latino | 7,940 | 13% | 676 | 5% |
| Native Hawaiian/Pacific Islander | 114 | 0% | 19 | 0% |
| White/Caucasian | 23,358 | 38% | 7,627 | 57% |
| More than one race | 4,362 | 7% | 1,003 | 7% |
| Other | 710 | 1% | 126 | 1% |
| Unknown | 514 | 1% | 152 | 1% |
| Declined | 3,647 | 6% | 813 | 6% |

| DEMOGRAPHICS | N=62,413 | | N=13,487 | |
|-------------------------------------------|----------|-----|----------|-----|
| PREFERRED HOUSEHOLD LANGUAGE ^A | N | % | N | % |
| English | 49,990 | 80% | 12,225 | 91% |
| Spanish | 5,538 | 9% | 393 | 3% |
| Somali | 4,427 | 7% | 393 | 3% |
| Additional languages ^B | 2,458 | 4% | 476 | 4% |
| SOCIOECONOMIC STATUS | N | % | N | % |
| Proxy: Medicaid as primary insurance | 32,772 | 57% | 5,469 | 41% |

Children’s primary care clinics located on the Minneapolis and St. Paul campuses reach a more culturally diverse patient population than the hospitals or clinics located in other parts of the Twin Cities metro. At the Minneapolis clinic, 45% of children have a preferred household language other than English, while the same is true for 26% of children at the St. Paul clinic (Figure 2). Over half of the patients seen at the Minneapolis and St. Paul clinics live in lower-income households, as estimated by enrollment in Medicaid (67% and 56%, respectively). This is a much larger percentage of patients than at the other Children’s affiliated primary care clinics (15-49%) (Figure 3).

Source: Children’s Minnesota (2018).

Note: Due to rounding, totals may not equal 100%. Totals for race/ethnicity exceed 100%, as more than one category may be selected.

^AChildren’s Minnesota reports these as the total number of unique patients served. Due to differences in data systems used to gather and report patient information the N varies somewhat across the demographic categories.

^BAdditional languages identified (spoken by less than 1% of patients) included: Oromo, Karen, Amharic, Arabic, Nepali and Vietnamese.

2. CHARACTERISTICS OF NUMBER (N) OF PATIENTS SERVED IN 2018: MINNEAPOLIS AND ST. PAUL PRIMARY CARE CLINICS

| DEMOGRAPHICS | MINNEAPOLIS CAMPUS (N=11,762) ^a | | ST. PAUL CAMPUS (N=7,811) ^a | |
|--------------------------------------|--------------------------------------------|-----|----------------------------------------|-----|
| | N | % | N | % |
| AGE | | | | |
| <1 | 664 | 6% | 604 | 8% |
| 1–2 | 1,752 | 15% | 1,128 | 14% |
| 3–4 | 1,597 | 14% | 937 | 12% |
| 5–6 | 1,401 | 31% | 880 | 11% |
| 7–12 | 3,640 | 31% | 2,375 | 30% |
| 13–17 | 2,313 | 20% | 1,575 | 20% |
| 18+ | 395 | 3% | 312 | 4% |
| RACE/ETHNICITY | | | | |
| American Indian | 158 | 1% | 123 | 2% |
| Asian | 233 | 2% | 413 | 5% |
| Black/African American | 5,284 | 44% | 2,887 | 34% |
| Hispanic/Latino | 2,975 | 25% | 1,504 | 18% |
| Native Hawaiian/Pacific Islander | 54 | <1% | 27 | <1% |
| White/Caucasian | 2,392 | 20% | 2,829 | 33% |
| Other | 512 | 4% | 177 | 2% |
| Declined | 469 | 4% | 467 | 5% |
| Unknown | 18 | <1% | 20 | <1% |
| PREFERRED HOUSEHOLD LANGUAGE | | | | |
| English | 6,806 | 60% | 6,282 | 79% |
| Spanish | 2,502 | 22% | 920 | 15% |
| Somali | 2,431 | 21% | 533 | 8% |
| Additional languages ^b | 175 | 2% | 200 | 3% |
| Unknown | 25 | <1% | 36 | 1% |
| SOCIOECONOMIC STATUS | | | | |
| Proxy: Medicaid as primary insurance | 7,890 | 67% | 4,405 | 56% |

Source: Children's Minnesota (2018)

Note: Totals for race/ethnicity and language may exceed 100%, as more than one category may be selected. All race/ethnicity categories include foreign-born children.

^aChildren's Minnesota reports these as the total number of unique patients served. Due to differences in data systems used to gather and report patient information the N varies somewhat across the demographic categories.

^bAdditional languages identified (spoken by less than 1% of patients) included: Amharic, Arabic, French, Hmong, Karen and Oromo.

3. CHARACTERISTICS OF NUMBER (N) OF PATIENTS SERVED IN 2018: PRIMARY CARE CLINICS IN SUBURBAN TWIN CITIES LOCATIONS

| | CHILDREN'S | | PARTNERS IN PEDIATRICS | | | | |
|-----------------------------------------|---------------------------------------|---------------------------------------------------|--------------------------------------------|-----------------------------------|-------------------------------------------|------------------------------------|----------------------------------|
| | HUGO CLINIC (N=4,425) ^a | WEST ST. PAUL CLINIC (N=2,843) ^a | BROOKLYN PARK (N=7,768) ^a | CALHOUN (N=5,352) ^a | MAPLE GROVE (N=16,481) ^a | PLYMOUTH (N=7,093) ^a | ROGERS (N=8,262) ^a |
| AGE | N (%) | N (%) | N (%) | N (%) | N (%) | N (%) | N (%) |
| <1 | 233 (5%) | 112 (4%) | 460 (6%) | 337 (6%) | 1,054 (6%) | 304 (5%) | 468 (6%) |
| 1–2 | 529 (12%) | 289 (10%) | 975 (13%) | 799 (15%) | 2,575 (16%) | 750 (11%) | 1,023 (12%) |
| 3–4 | 549 (12%) | 266 (9%) | 910 (12%) | 674 (13%) | 2,130 (13%) | 719 (10%) | 1,047 (13%) |
| 5–6 | 519 (12%) | 292 (10%) | 825 (11%) | 614 (11%) | 1,943 (12%) | 703 (10%) | 983 (12%) |
| 7–12 | 1,265 (29%) | 804 (28%) | 2,318 (30%) | 1,516 (28%) | 4,563 (28%) | 1,919 (27%) | 2,491 (30%) |
| 13–17 | 957 (22%) | 655 (23%) | 1,578 (20%) | 971 (18%) | 2,931 (18%) | 2,100 (30%) | 1,649 (20%) |
| 18+ | 373 (8%) | 425 (15%) | 702 (9%) | 441 (8%) | 1,285 (8%) | 598 (8%) | 601 (7%) |
| RACE/ETHNICITY | | | | | | | |
| American Indian | ** | ** | 39 (1%) | ** | ** | ** | ** |
| Asian | 106 (3%) | 49 (2%) | 802 (11%) | 91 (2%) | 1,025 (7%) | 482 (8%) | 86 (1%) |
| Black/African American | 74 (2%) | 138 (6%) | 1,151 (16%) | 386 (8%) | 822 (5%) | 249 (4%) | 92 (1%) |
| Hispanic/Latino | 44 (1%) | 623 (26%) | | 68 (1%) | 280 (2%) | 88 (2%) | 89 (1%) |
| More than one race | 126 (3%) | 98 (4%) | 328 (5%) | 226 (5%) | 510 (3%) | 132 (2%) | 126 (2%) |
| Native Hawaiian/ Pacific Islander | ** | ** | ** | ** | ** | ** | ** |
| White/Caucasian | 3,531 (87%) | 1,370 (57%) | 3,957 (56%) | 3,634 (74%) | 11,474 (78%) | 4,479 (77%) | 6,847 (90%) |
| Other | 47 (1%) | 71 (3%) | 186 (3%) | 92 (2%) | 323 (2%) | 172 (3%) | 53 (1%) |
| Declined | 27 (1%) | 19 (1%) | 132 (3%) | 200 (4%) | 327 (2%) | 103 (2%) | 129 (2%) |
| Unknown | 78 (2%) | 39 (2%) | 235 (3%) | 188 (4%) | 352 (2%) | 116 (2%) | 213 (3%) |
| SOCIOECONOMIC STATUS | | | | | | | |
| Proxy: Medicaid as primary insurance | 657 (15%) | 1,380 (49%) | 3,161 (41%) | 1,363 (25%) | 3,604 (22%) | 1,113 (16%) | 1,286 (16%) |

Source: Children's Minnesota (2018)

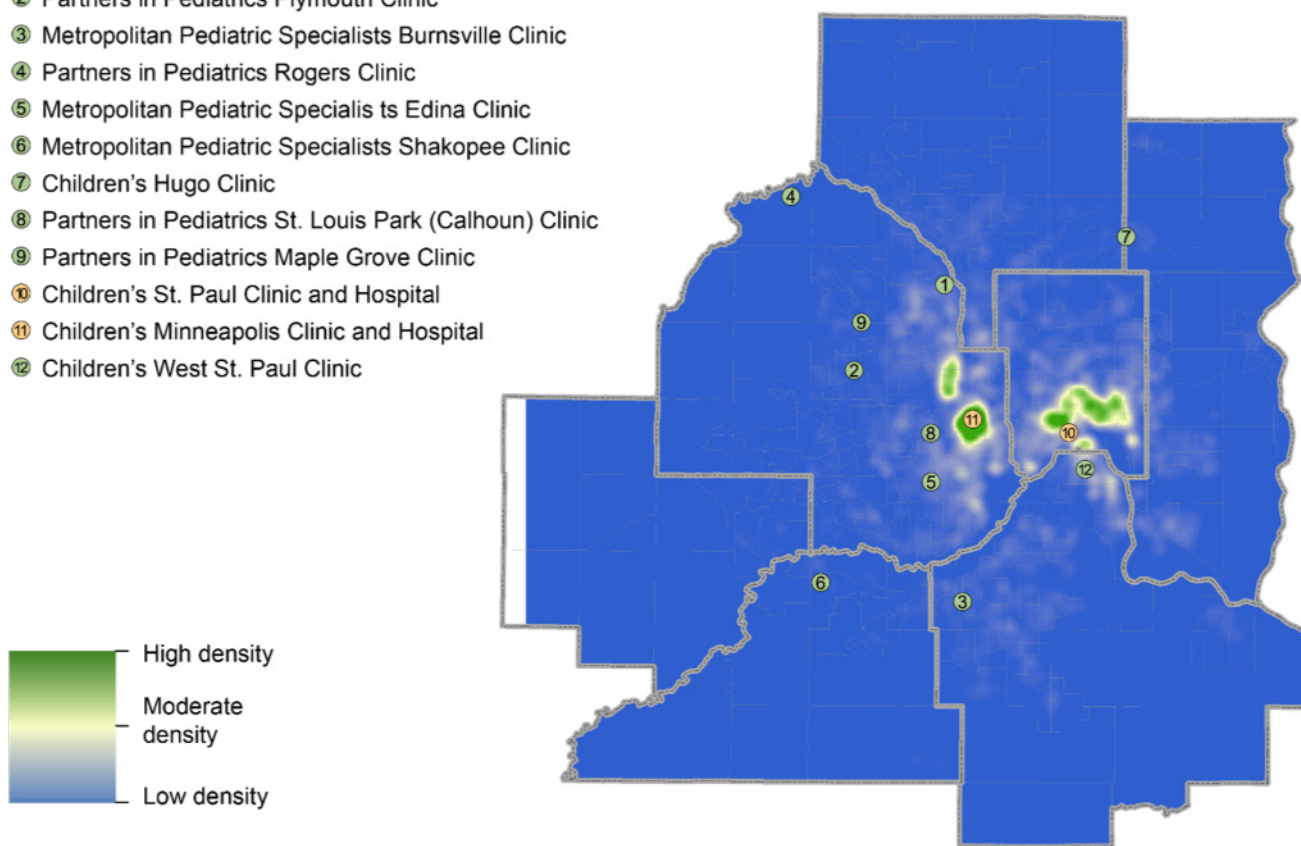
^aChildren's Minnesota reports these as the total number of unique patients served. Due to differences in data systems used to gather and report patient information the N varies somewhat across the demographic categories.

**Due to small numbers, reliable, unidentifiable numbers could not be provided.

Many emergency department and primary care clinic patients live in close proximity to the health care facilities that provide these services. The majority of patients live in the seven-county Twin Cities metro, a region of over 3 million residents including more than 700,000 children aged 17 and younger. Many of the children who received acute care services from the emergency department lived in close proximity to the two hospital campuses in south Minneapolis and downtown St. Paul. The 12 clinics affiliated with the Children’s Minnesota system also provided preventative and acute care services to children who live in Minneapolis and St. Paul, as well as suburban communities located near pediatric primary care clinics (Figure 4). Specific maps with emergency department visits and primary care clinic visits are located in the data summary.

4. CHILDREN SERVED IN CHILDREN’S EMERGENCY DEPARTMENTS, INPATIENT HOSPITAL UNITS AND PEDIATRIC PRIMARY CARE CLINICS: AREAS OF HIGH PATIENT DENSITY (2018)

- ① Partners in Pediatrics Brooklyn Park Clinic
- ② Partners in Pediatrics Plymouth Clinic
- ③ Metropolitan Pediatric Specialists Burnsville Clinic
- ④ Partners in Pediatrics Rogers Clinic
- ⑤ Metropolitan Pediatric Specialists Edina Clinic
- ⑥ Metropolitan Pediatric Specialists Shakopee Clinic
- ⑦ Children’s Hugo Clinic
- ⑧ Partners in Pediatrics St. Louis Park (Calhoun) Clinic
- ⑨ Partners in Pediatrics Maple Grove Clinic
- ⑩ Children’s St. Paul Clinic and Hospital
- ⑪ Children’s Minneapolis Clinic and Hospital
- ⑫ Children’s West St. Paul Clinic



Source: Children’s Minnesota. Analyzed by Wilder Research using 2010 census tracts.

Notes: The most recent residence was selected for each child who had at least one visit at Children’s Minnesota emergency departments or primary care clinics, or had an inpatient hospital stay between Jan. 1, 2018 and Dec. 31, 2018. This map represents 35,364 unique patients. Emergency departments are located at the Minneapolis and St. Paul hospital campuses (10 and 11 on the map).



WHAT IS “PATIENT DENSITY?”

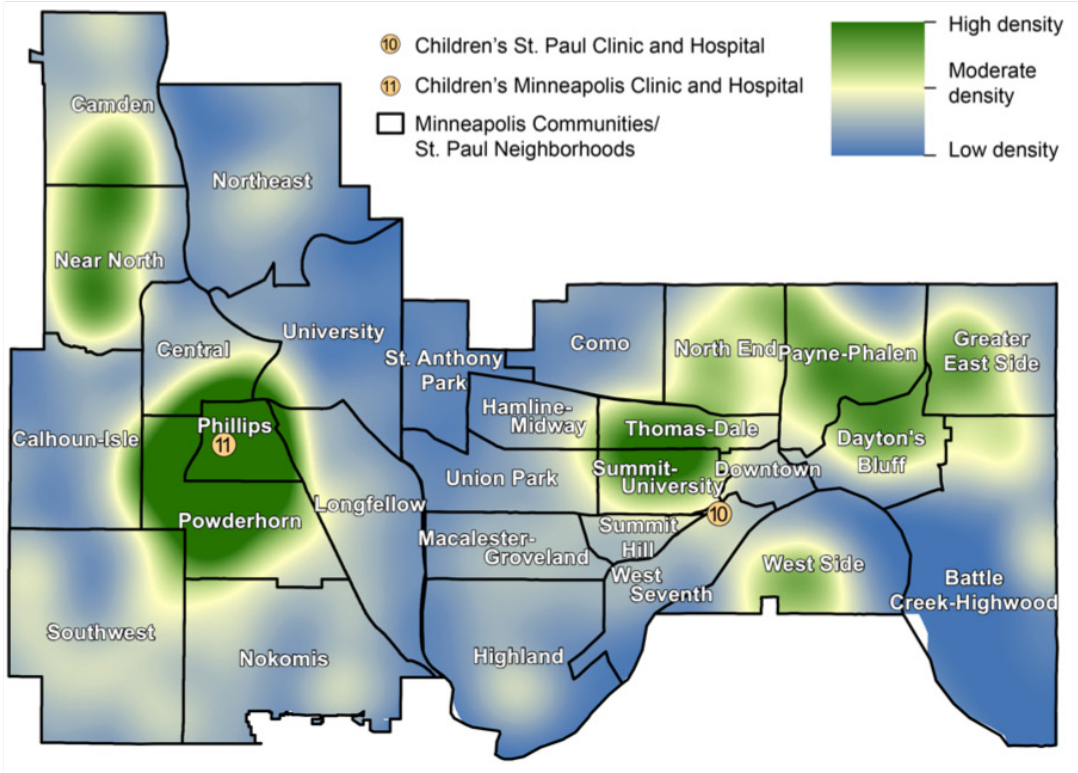
Patient density is a relative measure of how close patients live to one another. In the following maps, areas of high patient density are shown using a color gradient with green indicating high-density areas and blue indicating low-density areas. This measurement helps identify areas where Children’s serves a relatively large number of patients living in a small geographic area.

There are specific Minneapolis and St. Paul neighborhoods, particularly lower-income areas of the two cities, where there is a high density of children who receive services from Children’s. Four in 10 children in the Phillips neighborhood in Minneapolis received some type of care from Children’s in 2018. In addition, more than one-quarter of children received services from Children’s in the following neighborhoods: Powderhorn (33%), West Side (28%) and Thomas-Dale (26%). Of these focal neighborhoods, the smallest percentage of children receiving services were in Dayton’s Bluff (22%; Figure 5). Small areas in the Highland and Battle Creek neighborhoods in St. Paul stand out as areas of high patient density due to concentrated affordable housing options in those areas; however, Children’s serves relatively few children living in other parts of those neighborhoods (Figure 6). The data summary has more information about the population served.

5. PERCENTAGE OF CHILDREN REACHED IN MINNEAPOLIS AND ST. PAUL NEIGHBORHOODS (2018)

| NEIGHBORHOOD (CITY) | NUMBER IN NEIGHBORHOOD | NUMBER SERVED | PERCENTAGE OF POPULATION (AGE 0-17) SERVED (2018) | PERCENTAGE OF POPULATION (AGE 0-17) SERVED (2015) |
|---------------------------|------------------------|---------------|---------------------------------------------------|---------------------------------------------------|
| Phillips (Minneapolis) | 7,273 | 2,940 | 40% | 46% |
| Powderhorn (Minneapolis) | 12,832 | 4,220 | 33% | 35% |
| West Side (St. Paul) | 4,420 | 1,217 | 28% | 30% |
| Thomas-Dale (St. Paul) | 5,127 | 1,345 | 26% | 28% |
| Dayton's Bluff (St. Paul) | 5,588 | 1,232 | 22% | 26% |

6. PATIENT DENSITY WITHIN MINNEAPOLIS AND ST. PAUL COMMUNITIES (2018)



PRIORITY HEALTH ISSUES

The approach and process used for this assessment was intended to build upon previous assessment efforts to refine existing health priority areas and to identify new areas of concern for the community. A broad and holistic definition of health was used throughout the assessment process to consider not only diseases and health outcomes as potential priority areas, but also the social and environmental factors that contribute to health and well-being. These efforts are consistent with the overall movements in the health care industry to understand and respond to external factors in driving improved health outcomes. This includes a call from the American Academy of Pediatrics for greater understanding of how issues like racism and poverty impact child health.

Utilizing input from Children’s staff and providers, community stakeholders and parents, as well as secondary data, five issues were identified as the most important to address for the health and well-being of children and their families. As implementation strategies are developed to target these priorities, Children’s will consider the intersectionality of these topics. For instance, due to the profound influence early childhood experiences have on lifelong health and the high volume of patients Children’s serves who are under age six, special attention will be given to how these priorities impact children under five.

2019 PRIORITY HEALTH ISSUES

- Structural racism
- Health disparities
- Economic opportunity and income
- Mental health and developmental well-being
- Access to resources

The following summaries provide a working definition of each priority health issue, examples of the information gathered through the assessment describing the issue and its impact on health, relevant focal areas and a description of who is most affected.

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

STRUCTURAL RACISM

Structural racism refers to the ways in which the policies, practices and systems of organizations and institutions routinely advantage white residents while disadvantaging people of color and American Indians. Structural racism is deeply entrenched into our social, economic and political systems, leading to disparities in opportunity and exclusion from power. Structural racism exacerbates and perpetuates all other health issues that may arise in a community, including other issues prioritized by Children's.

WHO IS IMPACTED?

Structural racism contributes to disparities in areas such as employment, education, health, income and housing that disproportionately impact communities of color, including immigrant and refugee communities, and American Indians.

INSIGHTS FROM THE COMMUNITY AND CHILDREN'S MINNESOTA

All contributors felt structural racism needs to remain a priority, as it is a systemic issue of critical importance to the health of children and the community. Structural racism impacts every facet of people's lives including:

- Causing and perpetuating trauma and chronic stress, which exacerbates symptoms of poor mental health.
- Limiting opportunities for people of color to obtain income through good employment options, as well as homeownership, education and the intergenerational transfer of wealth.
- Making access to resources more difficult as a result of systems and services being designed primarily from a dominant, white culture perspective, with providers being unaware of their own implicit bias and/or lack of familiarity with the needs and cultural values of the communities they serve.

Children's has intentionally focused on creating more accountable and equitable systems, and remains committed to addressing structural racism within the organization as well as in the communities they serve. To address structural racism, Children's believes it is critical to ensure staff are representative of the communities they serve and that the organization provides culturally appropriate services for all.



Structural racism impacts so much, yet there is still a lack of understanding. It affects a person's ability to get an adequate education and quality employment, but it also causes trauma that can influence everything from mental health to birth outcomes."

— Community-based organization staff

3 | The Aspen Institute. (n.d.). Glossary for Understanding the Dismantling Structural Racism/ Promoting Racial Equity Analysis. Retrieved from <https://assets.aspeninstitute.org/content/uploads/files/content/docs/rcc/RCC-Structural-Racism-Glossary.pdf>

HEALTH DISPARITIES

Health disparities are persistent and pervasive in Minnesota, leading to some community groups experiencing higher rates of disease and poor health. Health disparities are preventable differences in health outcomes caused by an inequitable and unjust distribution of resources, opportunities, and power. Multiple communities are disproportionately impacted by health disparities, leading to differences in health by race or ethnicity, gender, education, income, disability, location (e.g., rural or urban) or sexual orientation. Health disparities are linked to structural racism in that they are often, at least in part, attributed to an uneven distribution of resources and power.

WHO IS IMPACTED?

The community groups most often impacted by health disparities include people who identify as persons of color or American Indian, immigrant and refugee populations, children from lower-income families, LGBTQ youth, and those living in the urban, densely populated and developed areas of the Children's community.

Health disparities for children may start before they are even born, with some women being more likely to receive inadequate prenatal care than others, which can lead to pregnancy complications, premature birth, and maternal and fetal mortality. In Minnesota, nearly 28% of American Indian women have inadequate prenatal care, while the same is true for only 6% of white women.

INSIGHTS FROM THE COMMUNITY AND CHILDREN'S MINNESOTA

All contributors identified health disparities within their communities as they discussed the needs that must be addressed. Children's feels it is critical to ensure that disparities are identified and that they recognize and address the unique health needs of the communities they serve, particularly communities that have historically been marginalized. Key areas of concern include:

- Continued gap in mental and behavioral health services for kids. While some community stakeholders and data suggest stigma around mental health may be declining among some youth, there are still disparities related to young people's abilities to acknowledge and access services. Young women are more likely to identify having a behavioral health concern than men, making it more likely for them to access services.
- Missed immunizations, vaccination hesitancy and targeted efforts to deter vaccination among community groups have been of particular concern for Children's staff. While inadequate resources may lead to missed immunizations, caregivers may also forgo vaccinating their children due to misinformation, religious practices or cultural values.
- Asthma-related hospitalizations remain higher in Minneapolis and St. Paul downtown areas and nearby neighborhoods than other areas in the Twin Cities metro region. Overall, emergency department visits due to asthma are also higher for children in the metro compared to children who live in greater Minnesota.

It is important to acknowledge that health disparities are primarily caused by differences in social determinants, defined as the conditions in which children and families live, work, age, learn and play. Without simultaneously acknowledging the stark racial disparities in critical areas such as high school graduation rates, employment, income, housing/homelessness rates and adverse childhood experiences, only incremental progress can be made toward specific health-related disparities. While Children's can take important steps to reduce health disparities through its work to address structural racism, the work of multiple child and family-serving systems is needed to address these deeply entrenched disparities.



It's no secret that families in communities of color don't have the same access to health care and that impacts people's lives. Particularly with children, when we talk about asthma and even preexisting conditions, children just do not have the same support and access in communities of color.

— Community-based organization staff

Centers for Disease Control and Prevention. (2008). Community Health and Program Services (CHAPS): Health disparities among racial/ethnic populations. Atlanta: U.S. Department of Health and Human Services.

Anxiety and Depression Association of America. (n.d.). Emerging adults see value of mental health care, but accessing care still a challenge for many. Retrieved from <https://adaa.org/college-aged-adults-face-less-mental-health-stigma>

Sum, L. H. (2017, August 21). Despite measles outbreak, anti-vaccine activists in Minnesota refuse to back down. The Washington Post. Retrieved from https://www.washingtonpost.com/national/health-science/despite-measles-outbreak-anti-vaccine-activists-in-minnesota-refuse-to-back-down/2017/08/21/886cca3e-820a-11e7-ab27-1a21a8e006ab_story.html?noredirect=on&utm_term=.199ab2ff70ce

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



ECONOMIC OPPORTUNITY AND INCOME

Economic opportunity and income are factors that ensure families can access and obtain financial resources that support the well-being of children and the community. There is a strong relationship between income and health, and employment is the major driver of household income. Wealth and higher household income are closely tied to better health outcomes. Economic opportunities, such as access to education and housing, also support a family's ability to share and accumulate resources across generations.

WHO IS IMPACTED?

Over 200,000 children in the Twin Cities metro live in households with incomes at or near poverty levels. Since 2000, the percentage of children living in lower-income households has more than doubled. Ramsey and Hennepin counties have the largest percentages of children living in poverty (47% and 32%); however, the neighborhoods of focus Children's identified are even more impacted, with 60-81% of children living in poverty.

Disparities, especially racial disparities, in poverty, income and employment are evident in Minnesota.

- Black and American Indian children are more likely to live in lower-income households and to experience poverty compared to white children.
- Only 54% of American Indian adults in the Twin Cities were working in 2017, compared to 80% of white adults.

INSIGHTS FROM THE COMMUNITY AND CHILDREN'S MINNESOTA

All contributors identified economic opportunity and income as key issues within their communities. Key concerns include:

- A lack of adequate employment opportunities, which prevents families from earning the income necessary for basic needs such as housing and transportation, healthy foods and health care. Low-wage jobs or those with few or no benefits do little to help employees accumulate the resources they need in the long-term.
- Intergenerational poverty, which prevents equitable access to resources that support the accumulation of wealth such as education, employment, housing and investment opportunities. Without these things, families will continue to live paycheck-to-paycheck, unable to withstand a crisis or invest in their children's future.
- Community investment: without it, there's limited commitment to the people served. Community stakeholders and Children's staff see an opportunity for the organization to further invest in the community by partnering with diverse, local organizations and vendors, and hiring staff from the community that reflects the race, ethnicity and culture of the children and families they serve.

"When you have an income that is sufficient to support your family, your margin of error on the things that can go wrong in your life gets bigger because you have the resources to mitigate them. There is not a lot of room for bad things to happen to some children and youth because their families are living so tight economically. When you look at asthma, birth weight and immunization rates, the children that have families who struggle with economic stability struggle with health, too."

— Community-based organization staff

MENTAL HEALTH AND DEVELOPMENTAL WELL-BEING

Mental health and developmental well-being refer to the wide-ranging topics that emerged through the assessment, from specific treatment and services available for children with a diagnosed mental illness, to efforts that address adverse childhood experiences (ACEs), trauma and chronic stress.

WHO IS IMPACTED?

Supporting mental health and developmental well-being for all children and families is important, but certain populations may be more likely to have unmet needs due to barriers to obtaining mental health services, lack of appropriate services, exposure to ACEs and other environmental conditions that contribute to or exacerbate mental health concerns. Stakeholders identified specific populations who have unmet mental health needs including young children under five, persons of color and American Indian communities, immigrant and refugee families, children living in poverty and adolescents in need of intensive mental health services. While systemic factors contribute to a child's exposure to ACEs, it is important to note that some children are more likely to report experiencing four or more ACEs including children who are: American Indian, African American, Hispanic/Latino, low-income or homeless.

INSIGHTS FROM THE COMMUNITY AND CHILDREN'S MINNESOTA

Community stakeholders and Children's staff saw mental health and developmental well-being as critical health issues that need continued focus. The following specific concerns were identified through the assessment:

- Overall, there is a lack of clinical and community services to address children's mental health. There are concerns that this leads to youth mental health issues going unaddressed until there is a crisis; youth not getting an appropriate level of services; and youth and parents using drugs and alcohol to self-medicate in the absence of appropriate mental health services.
- There are not enough culturally-appropriate mental health services or service providers, while providers not specializing in mental health do not have adequate information to proactively identify potential mental health issues early.
- Generational trauma among communities such as American Indians and African Americans contributes to chronic stress, which negatively impacts children's mental health and development.
- The current climate around immigration is exacerbating mental health issues and overall stress.

Adverse childhood experiences (ACEs) are potentially traumatic events that can have long-term impacts on the overall development, health and well-being of a child, such as separation from a caregiver through divorce, incarceration or death — or witnessing/experiencing abuse.

⁸ Sacks, et al. (2014). Adverse Childhood Experiences: National and State Level Prevalence. Child Trends Research Brief (Publication #2014-28). Retrieved from: https://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

⁹ Artiga and Ubri. (December 2017). Living in an Immigrant Family in America: How Fear and Toxic Stress are Affecting Daily Life, Well-Being, & Health. Kaiser Family Foundation. Retrieved from: <https://www.kff.org/disparities-policy/issue-brief/living-in-an-immigrant-family-in-america-how-fear-and-toxic-stress-are-affecting-daily-life-well-being-health/>



“

We see kids being diagnosed with developmental needs, but they are put on waitlists and that causes implications. Families may not get the support they need during a critical time, and the child could struggle to stay in school. There is a need for more therapeutic mental health services as we see more children suffering from the effects of trauma. We have a capacity issue.”

– Community-based organization staff

ACCESS TO RESOURCES

Access to resources is a term that has come to encompass the ability to not only access health care services, but also community resources, child-serving systems, public benefit programs and the basic resources all people need to survive and thrive, including food and housing. Children cannot gain the benefits of these resources without parents or caregivers who feel they have the support and knowledge to navigate the myriad of systems designed to help meet their needs.

WHO IS IMPACTED?

Accessing critical resources is often most challenging for lower-income families, immigrant and refugee families, and communities that have been intentionally excluded or not taken into consideration when service systems are designed.

In neighborhoods of concentrated poverty, resources that support health and wellness are often limited, making it more difficult for residents to make choices that promote health. All of the CHNA's focal neighborhoods within Minneapolis and St. Paul are areas of concentrated poverty; 60-81% of children experience poverty in these neighborhoods.

While a variety of programs exist to support families with children, not all children are receiving these benefits. For example, only 56% of eligible families in Hennepin County receive WIC.

INSIGHTS FROM THE COMMUNITY AND CHILDREN'S MINNESOTA

Community stakeholders and Children's providers and staff believe supporting family access to resources needs to remain a priority. It can be difficult for families to get services, even through referrals, due to a variety of barriers including time, unreliable transportation options, limited financial resources and a lack of knowledge or experience navigating service systems. The "access to resources" priority area is intentionally broad and requires Children's to use a holistic approach to understand and address the needs and concerns of youth and families, including the following health needs identified as emerging issues through the assessment process:

- The basic need for adequate housing was a significant concern identified by Children's providers and staff, community stakeholders and parents alike. There is currently a lack of affordable housing in the Twin Cities metro, leading to housing instability. Housing quality was also a concern, as issues including mold, pests, a lack of proper heating and cooling and neighborhood safety can be detrimental to a child's health. While Children's Healthcare Legal Partnership has some capacity to address these issues, staff felt more support is necessary.
- Food access remains a persistent issue among youth and families. While Children's already has some services available to address food insecurity, all contributors felt that hunger will be difficult to solve by providing short-term food resources alone. Additional education about nutrition, as well as addressing fundamental issues (e.g., income) are needed.

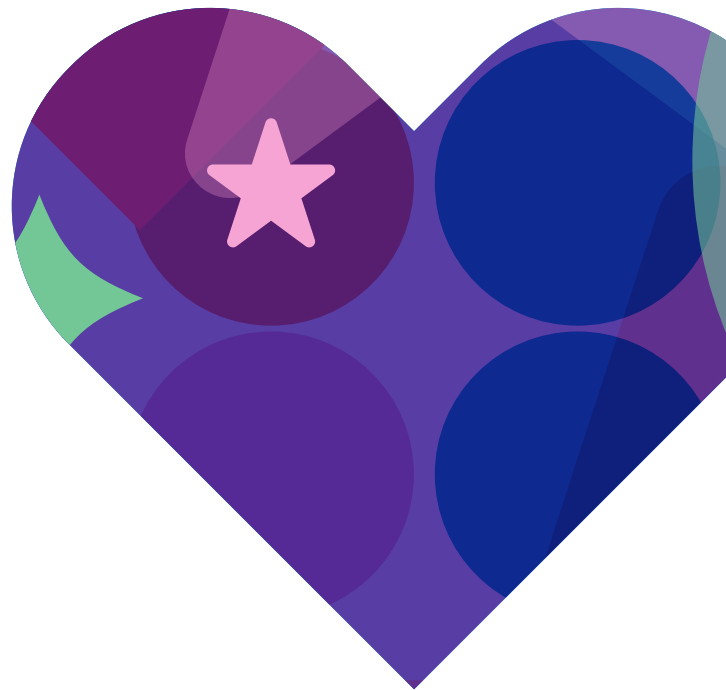
- Parent and caregiver education is of vital importance for kids and their families. For that reason, all contributors felt there is a need to provide more education for families so they are better able to make decisions for their children and access the services they need. Staff identified a number of topics where education could be improved including connections between environmental factors and health conditions (e.g. secondhand smoke and asthma), how to administer medications, obtaining and managing health insurance and a family's legal rights to access services and make decisions about their child's care.

Children's wants to ensure that insurance and health care costs are considered as part of this priority area. Families experience barriers to getting and keeping the affordable health care insurance necessary to guarantee they can access the medical services they need. Even with insurance, health care can be unaffordable for them due to costs from deductibles, co-pays and prescription medications.



There are a lot of barriers to accessing resources or accessing them equitably. This includes providing necessary resources in areas of the community that really need them, making it possible for families to receive these services and helping them use what they have to improve their family's condition."

— Public school staff



ASSESSMENT METHODS

To develop the most holistic view of the community and its needs, this CHNA utilized secondary data from state and federal sources, as well as primary data collected locally. More information about the following data is located in the supplemental data summary.

SECONDARY DATA REVIEW

Secondary data sources were used to describe the demographic characteristics of patients served by Children's Minnesota and to identify demographic trends as well as potential changes in health outcomes and emerging health concerns among youth who live in the Twin Cities metro region. This includes:

Children's Minnesota patient data: Patient data was used to describe the demographic characteristics of children served and to identify the neighborhoods where Children's serves large numbers of patients.

Demographic and health indicator data: The demographic data used to inform the 2019 CHNA is largely from the American Community Survey (ACS), the U.S. Census Bureau, Minnesota Student Survey, Minnesota Department of Health Public Health Data Access Portal and other state and federal sources.

PRIMARY DATA COLLECTION

Multiple stakeholder groups were asked to consider whether the health topic areas prioritized through the 2016 CHNA process continue to be community needs that should be addressed by Children's Minnesota. All groups, listed below, were also invited to identify additional emerging or unmet health needs within the community.

Community stakeholder interviews: Children's staff conducted semi-structured interviews with 41 community stakeholders or stakeholder groups who work closely with children and families. These stakeholders represented multiple sectors, including school districts, local not-for-profit organizations, faith communities and neighborhood associations.

Staff discussion groups: More than 25 staff in roles including social workers, interpreters, service coordinators, resource navigators and health equity specialists attended discussion groups (one in St. Paul and one in Minneapolis) to share their insights on the needs of children and families, as well as their experiences helping children and families improve their health and connect to community resources.

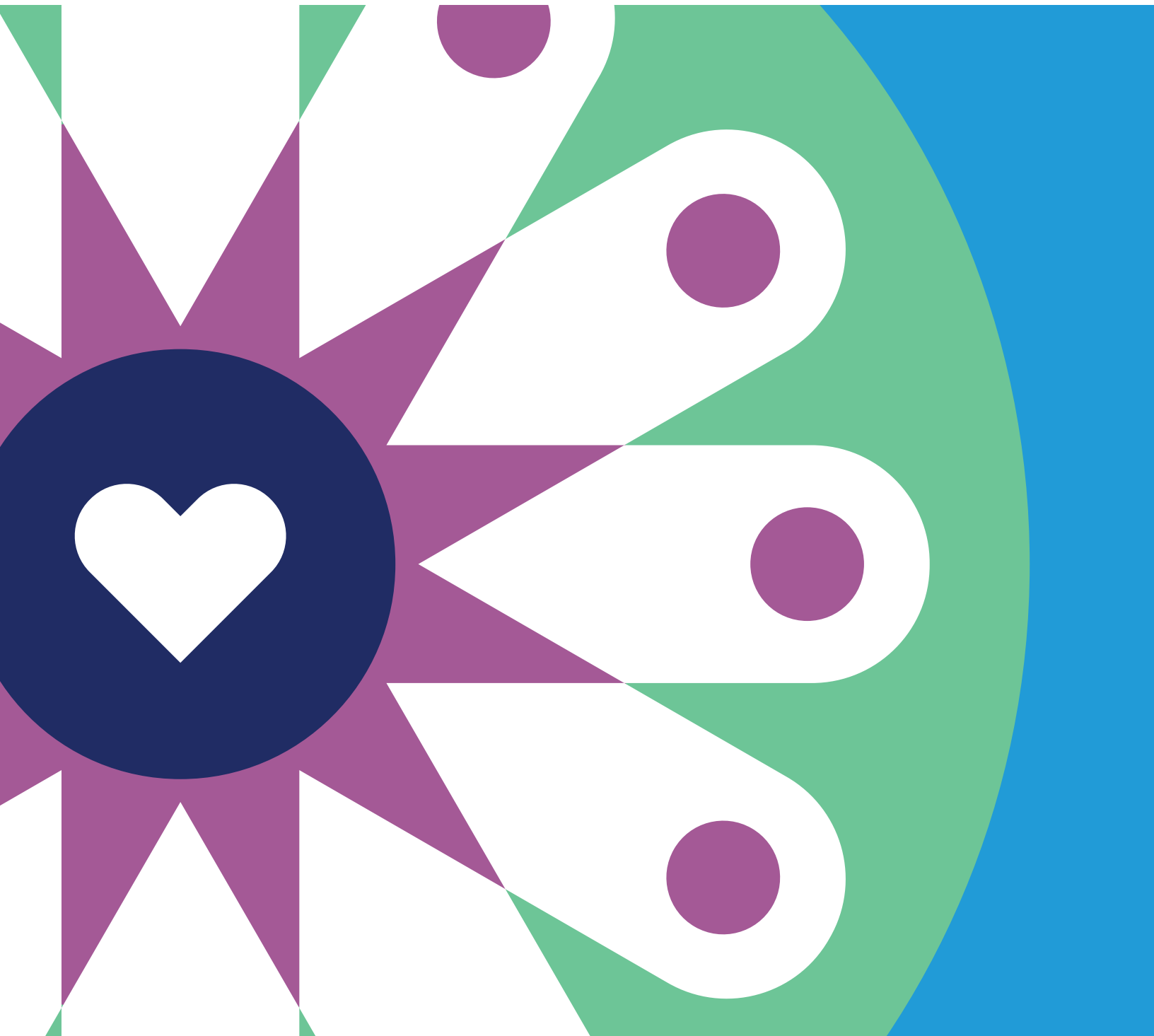
Provider survey: An online survey was used to gather information from providers who work at the two hospital locations, nine of its affiliated clinics and specialty care clinics in the Twin Cities metro region. The survey was sent to a group of Children's providers that included hospitalists, primary care clinicians, social workers, clinic managers and emergency department physicians. The survey was completed by 41 clinicians.

Parent and caregiver focus groups: In partnership with two community organizations and Wilder Research, two parent focus groups with a total of 19 participants were conducted. Parents were asked to discuss what issues most impact their community and family. Information from the parent focus groups was used as a supplement to the other primary data and secondary data. Because only two focus groups were conducted and participants came from specific cultural communities, responses may not be representative of all family experiences.

PRIORITIZATION PROCESS

The health issues identified through the assessment process were presented to a cross-functional group of Children's clinical and executive leaders charged with determining the organization's 2019 priorities. The group was asked to: a) determine whether each of the health areas identified in the 2016 assessment should continue to be priorities; b) consider whether health topics identified through the current assessment should be elevated as priorities; and c) recommend the final priorities, to be approved by the Children's Minnesota Board of Directors.

This group was intentional about discussing the needs identified by the community, as well as existing community resources and Children's organizational capacity and readiness to address stated needs.



7. OVERVIEW OF ALL HEALTH ISSUES IDENTIFIED

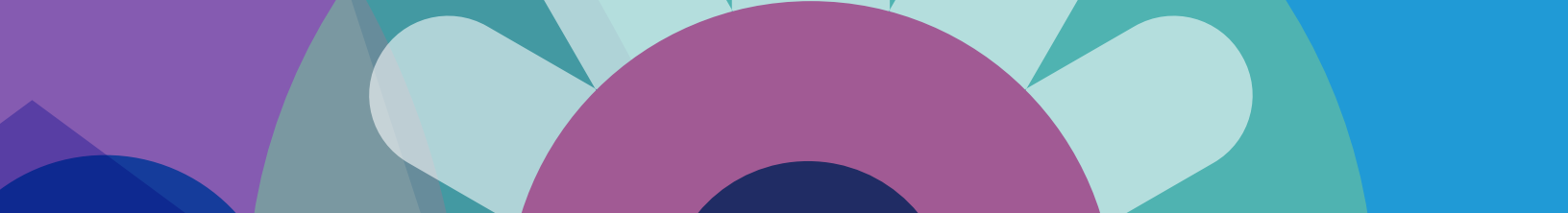
| | Health Issue | Status in 2019 | 2019 CHNA Priority Health Issues |
|--------------------------------|--------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| 2016 Priority Health Issues | Structural racism | Remains a priority | Structural racism <i>Culturally responsive services</i> |
| | Education | Still a concern, but lesser <i>Address with existing efforts and community partners</i> | |
| | Access to resources | Remains a priority | Access to resources <i>Housing</i> <i>Food</i> <i>Parent education</i> |
| | Mental health and well-being | Remains a priority | Mental health and developmental well-being <i>Chronic stress</i> |
| | Asthma | Still a concern, but lesser <i>Address via other priority</i> | |
| | Income and employment | Remains a priority | Economic opportunity and income |
| 2019 Emerging Areas of Concern | Parent education and support | Strategy to use <i>Address via other priority</i> | |
| | Culturally responsive services | Strategy to use <i>Address via other priority</i> | Health disparities <i>Asthma</i> <i>Vaccinations</i> |
| | Housing | <i>Address via other priority</i> | |
| | Food | <i>Address via other priority</i> | |
| | Chronic Stress | <i>Address via other priority</i> | |



AVAILABLE RESOURCES

The following table highlights resources Children’s Minnesota can draw on to address each health priority. While these resources are valuable, Children’s Minnesota recognizes that this work must be done in partnership with the communities we serve. Culturally relevant programming, strong community leadership, social connections, traditional healing practices and places of worship are important assets within the multiple cultural communities that call the Twin Cities metro area home. Addressing these priorities in a significant way is contingent upon our ability to maintain and develop new partnerships with community leaders, organizations and other vital stakeholders.

| PRIORITY | CHILDREN'S MINNESOTA RESOURCES |
|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Structural Racism | <p>A health equity and inclusion team focused on creating a diverse, equitable and inclusive culture of the backgrounds of the communities we serve</p> <p>The Children’s Health Equity Council which addresses and promotes health equity within the Children’s Minnesota system, identifies and addresses policies, practices and behaviors that maintain or exacerbate inequities and employees</p> |
| Health Disparities | <p>A social needs screening process implemented in Children’s asthma clinic and referral services through the Community Connect program</p> <p>Increased efforts to reduce asthma disparities and increase access to care at Children’s</p> <p>Experienced providers working to implement community engagement strategies and activities designed to increase vaccination rates</p> |
| Economic Opportunity and Income | <p>Established relationships with local educational institutions and programs focused on equity and creating a pipeline for health care careers</p> <p>Membership in the North Central Minority Supplier Development Council, the Women’s Business Center and Quorum</p> |
| Mental Health and Developmental Well-being | <p>Integrated behavioral health specialists in all of our primary care clinics and inpatient specialty clinics</p> <p>Implementation of the HealthySteps program in Children’s primary care clinics</p> <p>Participation in the Harvard Center for the Developing Child’s Pediatric Innovation Cluster (Child Health Research National Practice Sites)</p> <p>Expertise in brain science and impacts of adverse childhood experiences on health shared with external partners and advocates through presentations</p> |
| Access to Resources | <p>Continued funding support for Children’s Community Connect and Healthcare Legal Partnership</p> <p>Ongoing development of cross-sector patient referral partnerships</p> <p>Family resource centers in Minneapolis and St. Paul hospitals with information for families and for providers</p> <p>Participation on the Hennepin County Community Health Improvement Partnership (CHIP) Housing and Stability cross-sector group focused on improving housing access and stability</p> <p>Ongoing public awareness and advocacy efforts focused on increasing access to high quality early childhood development and educational opportunities as well as increased funding for school nutrition programs</p> <p>Advocacy partnership between Children’s Minnesota, Hennepin County and the City of Minneapolis focused on finding funding for programs that help families address the environmental factors associated with childhood lead exposure</p> |



| COMMUNITY RESOURCES | |
|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| that reflects the rich | Resilience, hope and a sense of cultural identity held within families and communities |
| Children's system and for patients, families | Multiple community organizations and institutions recognizing and bringing attention to how structural racism and trauma impact children and families |
| | Programs that foster the development of a positive cultural identity |
| through Children's | State and county public health initiatives and community partnerships focused on addressing health disparities and promoting health equity |
| designed to improve | |
| inclusion and | Social services (e.g., food shelves, supportive housing programs, employment training programs) to help lower-income families afford safe housing, healthy food and access to employment opportunities |
| s Development | |
| are areas | Culturally-competent social workers and mental health providers |
| | Organizations and faith-based institutions that encourage culturally-specific healing practices and coping strategies |
| ren's is one of eight | Trauma-informed training programs for providers, teachers and others who work with children and youth in the community |
| educators and | |
| programs | Community centers, community-based organizations and faith centers that connect residents to resources |
| | Technology designed to link residents to key resources (e.g., computers and smart phones) |
| od shelf access | Mobile services that bring resources and support directly to residents |
| ng Action Team – a | |
| ly childhood programs | |
| opolis focused on n asthma | |



PROGRESS SINCE THE 2016 CHNA

The 2016 CHNA identified six priorities that were the focus of Children's efforts through 2019. These priority areas and a brief summary of the impact of the work done to address each priority area is described below. In addition to the programmatic efforts listed below, Children's policy and advocacy agenda was also informed by these priorities.

PRIORITY HEALTH TOPIC: ASTHMA

Goal from 2017-2019 implementation plan: Develop improved asthma condition support and management with attention to disparities in health care outcomes, environmental factors and community-informed approaches to care.

DESCRIPTION OF EFFORTS AND THEIR IMPACT:

Social Support Needs Screening

- All patients who are seen in a Children's asthma clinic participate in a screening that helps identify areas where families may need social support resources. The screening tool was developed by Children's Community Connect program (see page 35 for more information).
- Families reporting one or more social needs like housing or food insecurity are referred to multi-lingual, multi-cultural resource navigators that connect families to targeted resources.

Reducing Asthma Disparities

- Children's is addressing barriers to accessing asthma care, including increasing the availability of walk-in appointments and extending clinic hours. Disparities are also tracked monthly in all primary care clinics so that providers can reach out to families proactively to ensure they have what is needed to manage their child's asthma.

Asthma Care in Schools

- Thanks to a generous grant from Kohl's, Children's was able to partner with the Minneapolis and St. Paul public school districts and a few public charter schools to enhance asthma management in children aged kindergarten through eighth grade. More than 300 school nurses and teachers were trained at the "Kohl's Cares: Partnering to Optimize Asthma Care in Schools" professional development seminars, led by Children's staff in 2018 and 2019. Children's continues to pilot new ways to provide school health professionals and asthmatic students with clinical support.
- In addition to the "Kohl's Cares: Partnering to Optimize Asthma Care in Schools" program, Children's has created a process for Minneapolis and St. Paul school nurses to receive assistance from Children's clinicians when they work with children who have poor asthma control. Processes have been put in place to improve communication and information sharing between Children's clinics and local schools.

PRIORITY HEALTH TOPIC: MENTAL HEALTH AND WELL-BEING

Goal from 2017-2019 implementation plan: Identify opportunities for enhanced or more coordinated mental health support for children.

DESCRIPTION OF EFFORTS AND THEIR IMPACT:

Integrated Behavioral Health Services

- Children's is now embedding integrated behavioral health workers into primary care clinics and inpatient specialty care areas. This helps connect families to providers that can address and identify mental health concerns in the short term while also connecting families to long term mental health resources if needed.

HealthySteps

- Healthy Steps is an interdisciplinary pediatric program which Children's is taking efforts to implement in our primary clinics. The program connects specialists with parents during well-child visits, and focuses on positive parenting, supportive resources and parent well-being with the ultimate goal of promoting healthy development for babies and toddlers.

Pediatric Innovation Cluster

- Children's Minnesota is one of eight national practice sites participating in the Harvard Center for the Developing Child's Pediatric Innovation Cluster (PIC) which is focused on testing new measures of resilience and the effects of stress in early childhood. As a result of our participation in the PIC, Children's tests patients for toxic stress, screens for adverse childhood experiences (ACEs) and connects parents and families to supportive community resources.

Depression Screening Services

- In addition to training providers to screen patients for symptoms of depression and/or suicide at all well-child visits, Children's also conducts postpartum depression screenings with new mothers, connecting them to supportive services as needed.

Expanding Access to Pediatric Behavioral Health Care

- To address the shortage of practicing pediatric behavioral health care providers in Minnesota, Children's is training pediatric behavioral health residents and fellows at Children's behavioral health clinic sites.

- To meet needs in rural Minnesota, Children's is implementing telehealth services within its psychiatry and eating disorder clinics.

Community Partnerships

- Children's continues to work with the following community partners to enhance behavioral health care services. Children's continues to partner with Fraser, one of Minnesota's largest providers of services for children with autism. This partnership has helped create a seamless approach to autism care for Children's patients and families.
- Children's works closely with the Minnesota Autism Center to implement the use of autism tool kits to create a more supportive clinic environment for children with autism.
- Children's eating disorder clinic works with the Emily Program to conduct research on strategies that can be used to support the improved health of eating disorder patients.

PRIORITY HEALTH TOPIC: ACCESS TO RESOURCES

Goal from 2017-2019 implementation plan: Implement programs that identify and connect patients and their families to referral and resource support that can positively impact the social determinants of health.

DESCRIPTION OF EFFORTS AND THEIR IMPACT:

Community Connect

- In 2017, Children's Minnesota launched the Community Connect program, which improves access to social support resources, empowers family decision making, and aims to deliver more equitable care while respecting cultural traditions. A total of 3,754 families have been enrolled in the program since its inception, and 1,671 families were enrolled from January–October 2019. Families are screened for social needs including food, employment/income, education, housing, transportation, household goods and legal services. Children's navigators connect qualifying families with community-based organizations and resources and provide ongoing follow up.

Healthcare Legal Partnership

- Children's Minnesota launched the Healthcare Legal Partnership (HLP) in September 2017. The program supports two attorneys based in our St. Paul and Minneapolis hospital campuses. These dedicated lawyers collaborate with health care teams to identify, prevent and remedy health-harming factors that are rooted in legal problems. Since the program's inception, the HLP has provided legal services for 472 closed cases across multiple legal issues including housing, benefits, family law and immigration. From January–September 2019, the HLP closed 197 cases.

PRIORITY HEALTH TOPIC: INCOME AND EMPLOYMENT

Goal from 2017-2019 implementation plan: Support health care career education opportunities and hiring initiatives to attract and maintain a diverse workforce.

DESCRIPTION OF EFFORTS AND THEIR IMPACT:

Pipeline for Health Care Careers

Children's Minnesota has established relationships with local programs and colleges that have an acute focus on equity and inclusion, and work with us to offer opportunities for internships in various departments at Children's.

- Children's has partnered with Achieve Minneapolis' Step-Up program and the Dougherty Family College of the University of St. Thomas, as well as colleges of nursing, like St. Catherine University, to engage and recruit nurses of color.

Career Development and Networking

- Employee Resource Groups (ERGs) have been established at Children's to promote recruiting, retention and professional development for Children's employees. Children's has also partnered with leading Minnesota companies to create networks of ERG leaders to enhance inclusion and equity efforts, and promote community enrichment and development throughout the metro area.

Equity and Inclusion Scorecard

- In an effort to build a workforce that reflects the communities we serve and help us cultivate a more inclusive and equitable environment, we have implemented scorecards that allow leaders to review, analyze and track overall performance on specific equity and inclusion metrics. Metrics focus on the representation of our staff, retention and turnover rates, as well as supplier diversity and health equity metrics.

Equity Action

- Children's CEO joined more than 750 CEOs from across the country to advance diversity and inclusion in the workplace and share best practices as part of the CEO Action Network. Children's Minnesota also created a new equity and inclusion department.

PRIORITY HEALTH TOPIC: EDUCATION

Goal from 2017-2019 implementation plan: Build active partnerships with schools focused on mutually-beneficial programs/initiatives that support improved health and, in turn, stability and opportunity in the educational system.

DESCRIPTION OF EFFORTS AND THEIR IMPACT:

School Partnerships

- Children's continues to work with the St. Paul and Minneapolis school districts to identify intervention opportunities based on health conditions, geography, absenteeism and improved information sharing. Since 2016 this work has been focused on improving care and reducing absenteeism related to asthma (see page 34 for more information).

PRIORITY HEALTH TOPIC: STRUCTURAL RACISM

Goal from 2017-2019 implementation plan: Integrate and standardize a racial equity impact lens into organizational goal-setting and project planning efforts.

DESCRIPTION OF EFFORTS AND THEIR IMPACT:

Health Equity Council

- In order to address and promote health equity within the Children's system, Children's staff and executives worked to pull together a cross-disciplinary, cross-hierarchical a Health Equity Council, focused on building equity practices into the culture of Children's and identifying and addressing policies, practices and behavior that maintain or exacerbate inequities for patients, families and employees.

Equity Measurement & Data Collection

- Children's equity and inclusion staff are developing tools to analyze the patient experience through an equity lens and identify the various impacts of structural racism. Staff have created a patient equity index that addresses racial disparities; respect and dignity safety learning reports related to emotional harm events to help us identify themes and bias while creating equitable solutions; and a racial equity impact assessment to examine Children's policies for structural racism.
- Children's is in the process of enhancing our race, ethnicity and language data collection which will include tribal affiliation for American Indian patients. This will allow us to use disaggregated race and ethnicity data to better address disparities in patient experience.

American Indian Community Collaborative

- The urban American Indian population living in the Twin Cities metro area is one of the largest in the country and experiences some of the highest health disparities. Launched in 2014, Children's American Indian Community Collaborative seeks to build relationships and drive better outcomes with the American Indian community, including:

- American Indian advisory committee – providing guidance to Children's equity and American Indian patient focused efforts.
- American Indian volunteer cohort – enhancing the experience of Children's American Indian families.
- First gift – hand-crafting moccasins for American Indian babies at Children's.
- Partnership with the Midwest Regional Children's Advocacy Center (MRCAC).

Operationalizing Equity in Social Work

- Children's equity and inclusion department has partnered with the social work department to operationalize equity and set goals. Social workers have taken an inventory and created individual action plans, helping the department address the impact of structural racism on their work. Social workers have also partnered with Children's American Indian collaborative and American Indian social workers from the community to identify racial inequities and structural racism in Children's processes, policies and procedures, and to expose how individual bias might impact subjective decision making.

NEXT STEPS

During the next few months Children's Minnesota will develop an implementation plan aligned with this assessment. Areas of focus will include:

- Working with community stakeholders and internal staff to identify implementation strategies that will be used to address the priority health topics identified in this assessment.
- Developing an evaluation plan to monitor the status of the implementation plan and its impact.
- Gathering input from community stakeholders and internal staff to reflect on the CHNA process and how it can be improved.
- Establishing a communications strategy to update community partners, Children's staff and the public on what was learned in this assessment.
- Presenting the final implementation plan to the Children's Minnesota Board of Directors and making the documents available to community stakeholders and the public.

Children's Minnesota plans to continue ongoing efforts to engage community members in their broader work and to maintain and develop new partnerships that were formed as a result of this assessment process.

For more information about the contents of the 2019 Community Health Needs Assessment, visit www.childrensmn.org/CHNA.

Questions? Contact the Community Affairs & Advocacy Specialist at community@childrensmn.org.



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