Children's MINNESOTA

The Kid Experts™

COMMUNITY HEALTH NEEDS ASSESSMENT

December 2022

In partnership with:

Wilder Research

Information. Insight. Impact.

A NOTE TO OUR COMMUNITY

Dear community member,

Children born in America don't begin at the same starting line, with the same chances for a healthy life. So much of health depends on the social circumstances into which they are born. In fact, up to 80% of what impacts children's health happens outside the clinic walls.

At Children's Minnesota, we believe every child deserves a happy and healthy childhood. That's why we are working inside and outside our walls to improve the health of all children we serve.

Our vision is to be every family's essential partner in raising healthier children. Being that partner means asking our families what they and their children need most. It means really listening to their responses. It means collaborating with community leaders and organizations to fulfill those needs. Partnering, listening, collaborating. That's how we raise healthier children.

The Community Health Needs Assessment (CHNA) is a tool that helps us identify the health needs and priorities of our children, families and communities. The last assessment we conducted was in 2019. Just three years later, our world is a very different place.

The 2022 CHNA reflects those changes. It builds on the 2019 assessment and implementation strategy by engaging partners in conversations about our 2019 CHNA priorities, while also considering the impact of the COVID-19 pandemic, the social uprising in response to the murder of George Floyd that sparked a racial reckoning across the country, as well as other events that have significantly affected the communities we serve.

Throughout 2022, we have had the honor of listening to people within Children's Minnesota and in our surrounding communities as they shared their perspectives on community health and well-being. We heard from:

- Parents/caregivers and children in moderated focus groups.
- Children and families at neighborhood events and primary care clinics.
- Representatives from community-based organizations.
- Children's Minnesota employees and clinicians.

As you will see, the 2022 CHNA provides valuable insight that will continue to guide our work. At the same time, we acknowledge that no single assessment can provide a complete understanding of the communities we serve.

What we have learned in this assessment affirms our commitment to work in partnership with our children, families and communities. It's the best way, the only way, to improve social determinants of health, end structural racism in health care and eliminate health disparities so that all children can thrive.

Sincerely,

Marc Gorelick, MD
President and Chief Executive Officer
Children's Minnesota

CONTENTS

ACKNOWLEDGEMENTS

There are many people who gave their time to help guide this assessment process, to share their experience and expertise, and to elevate the strengths, assets, concerns and priorities of children and families living in the Twin Cities metro region.

COMMUNITY ADVISORY COMMITTEE

Wilder Research and Children's Minnesota appreciate the time and insight of the following individuals who served on the Community Advisory Committee (CAC):

Fayise Abrahim
Youthprise

Selena Davis
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Suzanne Guertin*
Southern Minnesota Regional Legal Services

Nadia Higgins*
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Mary Langworthy*
St. Paul Public Schools

Stella Nyakundi
PICA Head Start

Jihan Rashid
Pillsbury United Communities

Joan McDonough-Schlecht*
Neighborhood House

Sarah Shiele
Minneapolis Health Department

Betsy Sohn
Hope Community, Inc.

Amber Spaniol*
Minneapolis Public Schools

Meg Thell*
Hennepin County

*CAC members who also participated in an interview about community health assets, needs and priorities.

PARENTS/CAREGIVERS AND YOUTH

We extend our gratitude to the parents/caregivers and youth who gave their time to participate in focus groups, sharing their experiences and perspectives on the health needs, assets and priorities of the communities they identify with.

WILDER RESEARCH STAFF

We appreciate the Wilder Research team for their guidance and for contributing to this report by conducting a secondary data review, analyzing the primary data that was collected, facilitating interviews and focus group discussions and supporting the prioritization process.

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COMMUNITY-BASED ORGANIZATION REPRESENTATIVES

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Amanda Varley
Minnesota Department of Education

Colleen Wieck
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Antony Stately
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Queerspace collective

Cynthia Hassan
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Saint Paul Public Schools

Suzanne Guertin
Southern Minnesota Regional Legal Services

Anthony Drews
Tiwahe Foundation

Malik Rucker
V3 Sports

Jenny Britton
Washburn Center for Children

Karen Manikowski
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YWCA Minneapolis

CHILDREN'S MINNESOTA STAFF

We want to acknowledge the contributions of Children's Minnesota providers and staff who volunteered their time to share their perspectives on patient, family and community needs.

YOUTHPRISE STAFF

We would like to acknowledge the staff from Youthprise who worked with the Wilder and Children's Minnesota teams to conduct focus groups with youth, **Nadia Linoo** and **Essence Blakemore**. This team recruited focus group participants, managed logistics, facilitated the group discussions, and analyzed and presented results.

Prepared by Rebecca Sales, Carrie Au-Yeung, Megan Peterlinz and Lauren Gilchrist. This report was approved by the Children's Minnesota Board of Directors Executive Committee on December 21, 2022. 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 to 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.

HEARING FROM KIDS

The children in our community have a wealth of knowledge when it comes to their own health. To ensure that kids' voices were represented in this report, Children's Minnesota staff used discussion boards at community events and primary care clinics in Minneapolis and St. Paul to ask children and families to finish the follow sentence:

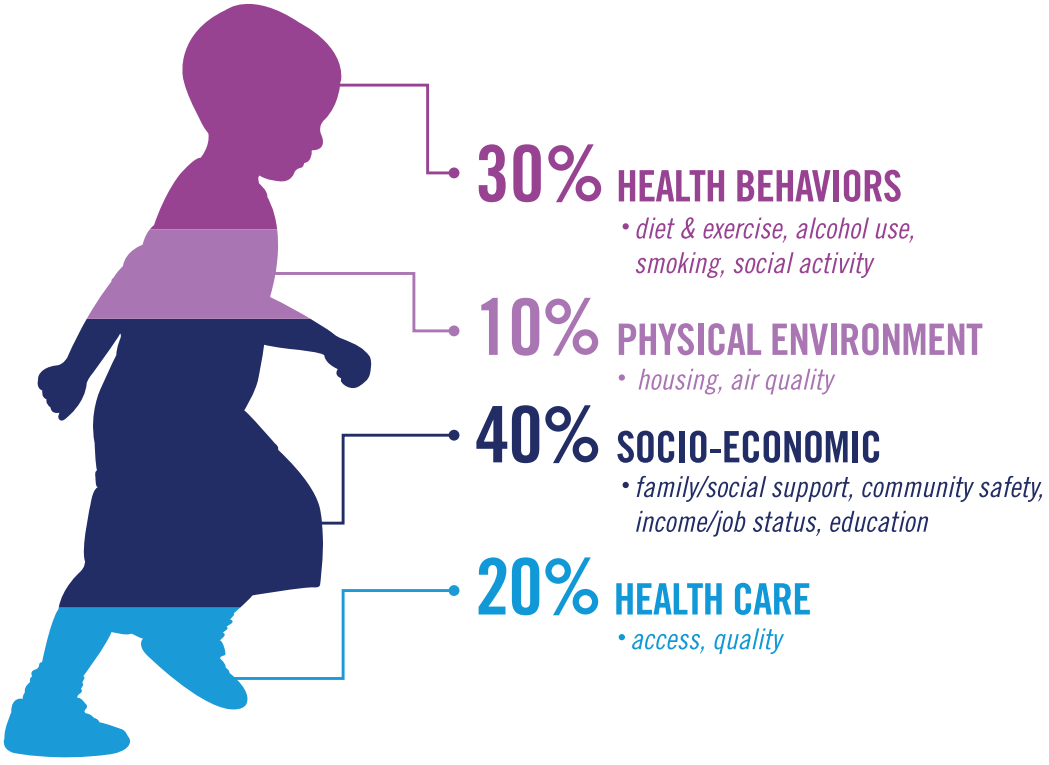
I FEEL HEALTHY WHEN I/I'M...

The written responses of children and families are shown in this figure. Respondents were invited to complete the sentence (written in English, Spanish, Somali and Hmong) in any language.

OVERVIEW OF THE ASSESSMENT PROCESS

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 the communities they serve as well as the steps that the hospital will take to address these health-related topics. This report describes the assessment process used to identify the priority health areas that community members believe are most critical for Children's Minnesota to address. A subsequent report will include an implementation strategy that describes specific actions Children's Minnesota will take during the next three years to address the priorities identified.

Children's Minnesota continues to take an expansive approach to identifying and understanding the needs of the community as they relate to health and racial equity and social conditions that contribute to health outcomes, shaping children and family's experiences both inside and outside of the walls of our hospitals and clinics.



Source: University of Wisconsin Population Health Institute (2022). "County Health Rankings Model." https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model

The 2022 CHNA 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.[1]
- Social determinants of health are shaped by structures, decisions, and policies that influence how money, power, and resources are distributed.
- Using a racial equity lens in the CHNA process is important, as 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 and lower-income residents. Policies that disproportionately impact people of color may not mention race explicitly. Inequities can also result when the full impacts of policies are not considered and if people most likely to be impacted by a proposed policy have limited influence or are excluded from decisions that impact health and well-being.

Children's Minnesota's previous CHNA, conducted in 2019, identified the following health priorities: *structural racism, health disparities, economic opportunity and income, mental health and developmental well-being, and access to resources.* Since then, Children's Minnesota has continued to build on existing initiatives and expand efforts to address those priorities.

The 2022 assessment was designed to build upon what was learned in the previous assessment, as the priorities identified are based upon deep-seated structural issues which Children's Minnesota is committed to addressing through investments in services and community relationships.

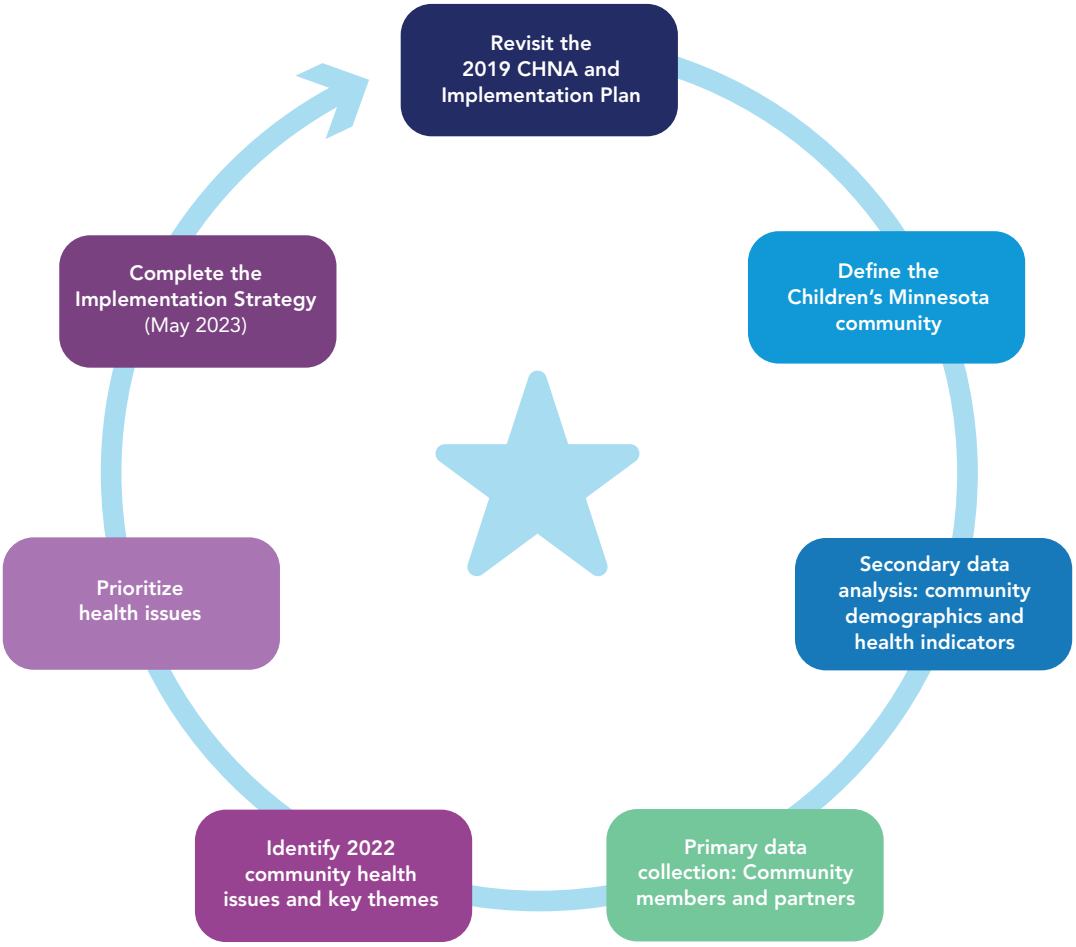
In May 2022, Children's Minnesota launched the Collective for Community Health which will both anchor and align community partnerships across the organization. The CHNA priorities and corresponding implementation strategy will guide both the work of the Collective for Community Health and the organization overall.

To develop the most holistic view of community needs, strengths and assets, Children's Minnesota and Wilder Research:

- Convened a community advisory committee to inform and guide the assessment process.
- Reviewed the 2019 CHNA report.
- Utilized secondary data from state and federal sources.
- Conducted primary data collection locally with parents and caregivers, youth, community-based organizations, and Children's Minnesota staff and providers.

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

2022 CHNA PROCESS OVERVIEW



In order to build upon previous CHNAs, the questions that guided the 2022 CHNA included:

- What does it look like when children and families in the community are healthy?
- To what extent are children and families in the Children's Minnesota community experiencing these health issues [2019 health issues] differently since 2019, considering local and global events?
- What health issues are newly emerging or are likely to emerge in the next couple years that will have a negative impact on the health of the community?
- What are the most important issues to address to improve the lives of children and families in the community?
- What resources, strengths, assets exist in the community today that have a positive impact on the health of the community?
- What do you believe are barriers to doing what needs to be done to improve the health of the community?
- What can Children's Minnesota do to advance the health of the community?

A full outline of study methods is included at the end of this report.

COMMUNITY CONTEXT

THE TWIN CITIES: GROWING AND DIVERSIFYING

Children's Minnesota hospitals and clinics are located within the seven-county Twin Cities metropolitan area. This area is Minnesota's economic, cultural and political center and it continues to grow in size and diversity. The communities that call the Twin Cities home have built a robust life here and continue to shape and contribute to the area's culture, economy and political landscape.

PERSPECTIVES ON HEALTH

In order to support a family's health, it is important to understand what it means to be healthy from a family's perspective, as well as from the perspectives of people who support families. As part of the CHNA caregivers, youth, Children's Minnesota staff and community-based organizations all shared what it looks like when families are healthy and what contributes to that health.

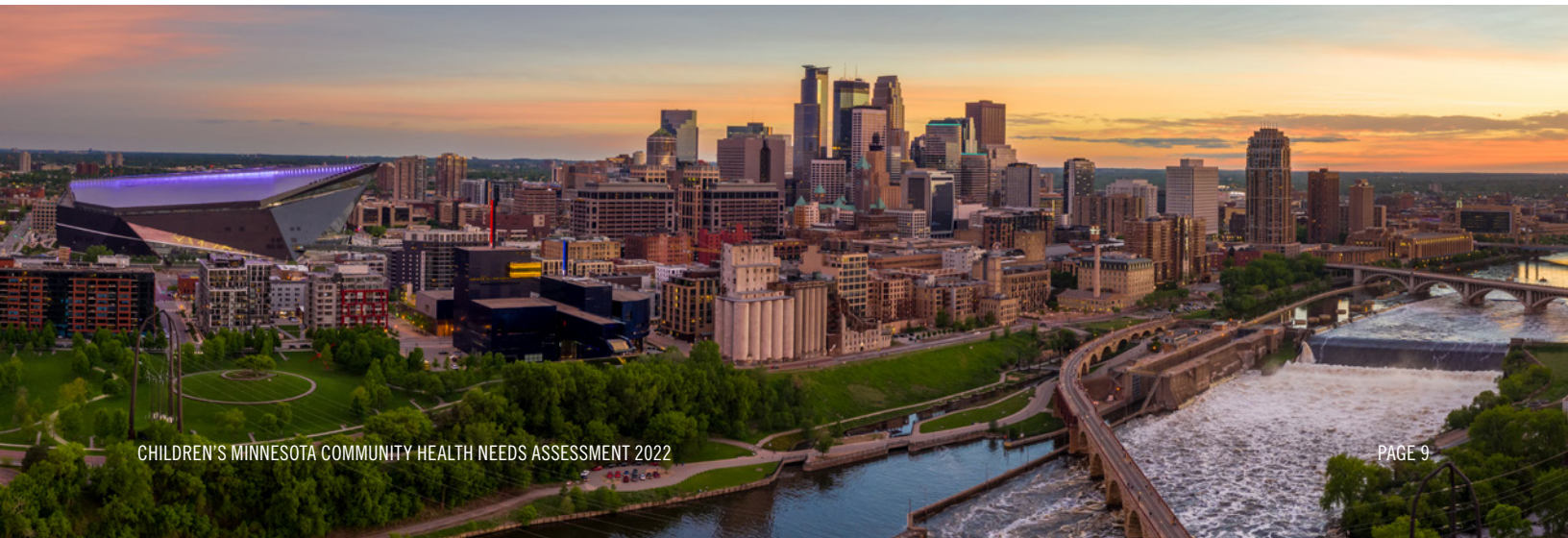
Caregivers emphasized access to affordable healthy food and recreation as well as the importance of socializing with family and friends, not being sick, having access to information about health and wellness, having good mental health and access to medications and providers.

CAREGIVERS:

"To me, my children and family looks heathy when we have access to healthy food and recreation and enrichment — things like museums, other than nature — stability and health... healthy food [is] affordable, healthy recreation... like biking trails, parks, lakes, equipment."

"Being healthy is when we are not doing the hospital or doctor visits all the time, having the literature that we need to care for our families in the proper way."

"I think about whole-person care. So, in our home, when everybody is mentally, physically and emotionally healthy, that means everybody's probably in good spirits. We're probably doing something together, and probably laughing or smiling."



Like caregivers, youth respondents emphasized access to basic resources — income, food, transportation — as prerequisites to being healthy. Youth also talked about the importance of being able to socialize and having places where they can be active.

YOUTH:

"...There's intersection, because if you have a mental health issue you need to be treated, right? Well, you need a stable financial account to be able to take care of things."

"One place I like to go and it is easier to go now [is] go to my friends' houses and go play basketball. But it's harder to do when you do not drive or have access to transportation."

"Having more options of places to go and things to do. My one friend who lives nearby and I would go around our neighborhood on bike rides, but it got repetitive."

Staff pointed to having a safe and supportive environment with access to resources as well as having access to healthcare and a primary care provider.

CHILDREN'S MINNESOTA STAFF:

"Access is huge for families. Everyone does better when we all do better. Having a community partner whether through primary care or through the ED... I think that is where families are able to shine."

Representatives from community-based organizations emphasized the importance of having access to resources and services and pointed especially to resources beyond the health system. They highlighted the importance of meeting basic needs, such as food, clothing, housing, safety and having the capacity to cope with challenges.

COMMUNITY-BASED ORGANIZATION:

"Being able to access services and supports needed to maintain that level of health."

THE IMPACT OF SIGNIFICANT LOCAL AND GLOBAL EVENTS

It is crucial to note that between the 2019 and 2022 CHNA there were several significant events that impacted the way people viewed and engaged with the world around them, both in Minnesota and around the globe.

- In early 2020, the world began to be impacted by the COVID-19 pandemic, which included mandatory shutdowns of businesses and schools, as well as social distancing. Schools were forced to move in-class learning to virtual "distance learning." In addition, unemployment skyrocketed to historically high levels, surpassing the Great Recession. While the rate of COVID-19 infections among children has been lower compared to other age groups, the ways in which COVID-19 disproportionally impacted certain adult populations created community instability that impacted families.[2]
- In May 2020, George Floyd was murdered by a Minneapolis police officer. This tragic event had a profound impact on the local community, exacerbating grief, trauma and anxiety resulting from generations of racial injustice. The community-led uprising in response to this tragedy called for an end to systemic racism in policing and other systems, garnering support for important antiracist work across the country and globally.

YOUTH:

"I feel with COVID and health issues it has created mental health issues."

"Homeless [students] took a huge hit during COVID and more so than others as they had nowhere to go or have resources they need such as not having a computer or access to distance learning and missed out on a whole year."

"We live right near the [uprisings] from George Floyd, and we saw people getting pushed out and not get stable housing and not being able to access resources and needs. Like what does it really mean to have safer streets when you move them or shove them into another corner?"

CHILDREN'S MINNESOTA PROVIDER:

"The murder of George Floyd, social injustice, abortion rights, anti-trans legislation, [...] COVID, have all adversely affected [multiple] populations at much higher rates, with worsening disparities."

In discussions with CHNA contributors on the health issues prioritized in this assessment (see page 20), it is clear that these and other events exacerbated existing challenges facing children and families in our communities, underscoring the critical need to pursue systemic change.

[2] Minnesota Department of Health. (2022). Health equity and COVID-19. health.state.mn.us/communities/equity/about/covid19

ABOUT CHILDREN'S MINNESOTA

Children's Minnesota is one of the largest pediatric health systems in the United States and the only health system in Minnesota to provide care exclusively to children, from before birth through young adulthood. An independent and not-for-profit system since 1924, Children's Minnesota is one system serving kids throughout the Upper Midwest at two freestanding hospitals, nine primary care clinics (Minneapolis, St. Paul, Brooklyn Park, Hugo, Maple Grove, Plymouth, Rogers, St. Louis Park and West St. Paul), multiple specialty clinics and seven rehabilitation sites. 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 2021, Children's Minnesota cared for over 166,000 patients through its hospitals, primary and specialty care clinics, and in-home services. These patients represented all counties in Minnesota and 57 percent of the counties in the four neighboring states. At its hospital locations alone, there were nearly 77,000 emergency department visits and approximately 16,500 hospitalizations in 2021.

Children's Minnesota is committed to having the CHNA process guide ongoing partnerships with communities to improve health. 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 specific neighborhoods and communities where the organization is best positioned to support local efforts to improve health.

Most of the children served by the two hospitals and nine primary care clinics live in the seven-county Twin Cities metro region. Analysis of de-identified patient data show that the two hospitals serve a culturally, linguistically and socioeconomically diverse patient population reflecting demographic trends across counties and the state. This assessment used the same definition of community* developed from the 2019 CHNA process to understand community needs and inform action.

*CHILDREN'S MINNESOTA DEFINITION OF COMMUNITY

Children's Minnesota has a broad reach; however, a majority of children served live in the seven-county Twin Cities metro region. Children's Minnesota will continue to use the following definition for the purposes for this CHNA:

> The community served includes more than 720,000 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) where children and families experience disproportionate burden of inequitable social, economic, and environmental conditions:

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

ABOUT THE CHILDREN'S MINNESOTA PATIENT POPULATION

Children's Minnesota serves children of all ages and from many cultures. While most of the patients served are infants to age 17, Children's Minnesota provides prenatal care and services to some young adults as they complete treatment for specific health issues. English, Spanish and Somali are the most common languages spoken by patients. In 2021, interpreter services were provided for more than 109,000 visits, in 73 different languages, but most commonly the languages of Spanish, Somali and Karen.

Patients receive care for a wide range of health concerns. The most common diagnoses in 2021 were acute respiratory illnesses, Crohn's disease, appendicitis and suicidal ideation.

In 2021, over 53,000 individual children received emergency department services and over 13,500 were admitted to the hospital. Patient data from the two hospitals combined show that children who receive emergency department services tend to be toddlers and school-age children, while infants are 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 uses enrollment in Medicaid as a proxy measure for lower-income households. More than half of patients (56%) who received emergency department services, and 51% of patients who received inpatient hospital services had Medicaid as their primary source of insurance.

Children's Minnesota 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, 41% of children have a preferred household language other than English, and the same is true for 20% of children at the St. Paul clinic (Figure 2). Over three-fourths of the patients seen at the Minneapolis and St. Paul clinics live in lower-income households, as estimated by enrollment in Medicaid (75% and 66%, respectively). This is a much larger percentage of patients than at the other Children's Minnesota affiliated primary care clinics (13–48%) (Figure 3).

FIGURE 1. Characteristics of patients served in 2021: Hospitals

DEMOGRAPHICS	EMERGENCY DEPARTMENT[a]		INPATIENT HOSPITALIZATION[a]	
AGE	(N=53,425)		(N=13,519)	
	N	%	N	%
<1	9,251	17%	4,755	35%
1–2	7,657	14%	1,368	10%
3–4	9,660	17%	1,424	10%
5–6	6,386	11%	896	7%
7–12	11,752	21%	1,994	15%
13–18	9,606	17%	2,898	21%
19+	1,383	2%	343	3%
RACE/ETHNICITY	**N=53,527**		**N=13,519**	
	N	%	N	%
American Indian/ Alaska Native	513	1%	157	1%
African	362	1%	59	<1%
African American/Black	13,715	26%	2,189	16%
Asian	3,095	6%	726	5%
Hispanic/Latino	6,259	12%	862	6%
Middle Eastern	53	<1%	35	<1%
Native Hawaiian/ Pacific Islander	102	<1%	35	<1%
White/Caucasian	19,395	36%	7,219	53%
Other	564	1%	111	1%
More than one race	3,982	7%	1,042	8%
Unknown	1,777	3%	235	2%
Declined	3,702	7%	866	6%
PREFERRED HOUSEHOLD LANGUAGE	**N=11,673**		**N=7,204**	
	N	%	N	%
English	43,291	81%	12,228	91%
Spanish	4,170	8%	477	4%
Somali	3,338	6%	393	3%
Additional languages[b]	2,728	5%	421	3%
SOCIOECONOMIC STATUS	**N=53,528**		**N=13,519**	
	N	%	N	%
Proxy: Medicaid as primary insurance	30,322	56%	6,909	51%

Source: Children's Minnesota (2021)
Note: Due to rounding, totals may not equal 100%. Totals for race/ethnicity exceed 100%, as more than one category may be selected.
[a] Children's Minnesota reports these as the total number of unique patients served. Because of differences in data systems used to gather and report patient information the N varies somewhat across the demographic categories. [b] Additional languages identified (spoken by less than 1% of patients) included: Oromo, Karen, Amharic, Arabic, Nepali and Vietnamese.

FIGURE 2. Characteristics of patients served in 2021: Minneapolis and St. Paul primary care clinics

DEMOGRAPHICS	MINNEAPOLIS CAMPUS[a]		ST. PAUL CAMPUS[a]	
AGE	(N=12,739)		(N=7,780)	
	N	%	N	%
<1	1,407	11%	853	11%
1-2	1,174	9%	699	9%
3-4	1,690	13%	931	12%
5-6	1,561	12%	919	12%
7-12	3,584	28%	2,096	27%
13-18	2,864	22%	1,956	25%
19+	429	3%	416	5%
RACE/ETHNICITY	N=11,673		N=7,204	
	N	%	N	%
American Indian/ Alaska Native	89	1%	63	1%
African	78	1%	32	<1%
African American/Black	4,916	42%	2,419	34%
Asian	179	2%	290	4%
Hispanic/Latino	2,839	24%	1,134	16%
Middle Eastern	9	<1%	3	<1%
Native Hawaiian/ Pacific Islander	24	<1%	10	<1%
White	1,981	17%	2,115	29%
Other	324	3%	121	2%
More than one race	525	4%	485	7%
Unknown	210	2%	252	3%
Declined	499	4%	280	4%
PREFERRED HOUSEHOLD LANGUAGE	N=11,673		N=7,204	
	N	%	N	%
English	6,909	59%	5,740	80%
Spanish	2,319	20%	749	10%
Somali	2,259	19%	505	7%
Additional languages[b]	187	2%	210	3%
SOCIOECONOMIC STATUS	N=11,787		N=7265	
	N	%	N	%
Proxy: Medicaid as primary insurance	8,800	75%	4,779	66%

Source: Children's Minnesota (2021)
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.
[a] Children's Minnesota reports these as the total number of unique patients served. Because of differences in data systems used to gather and report patient information the N varies somewhat across the demographic categories. [b] Additional languages identified (spoken by less than 1% of patients) included: Amharic, Arabic, French, Hmong, Karen and Oromo.

FIGURE 3. Characteristics of patients served in 2021: Suburban Twin Cities primary care clinics

	CHILDREN'S MINNESOTA		CHILDREN'S MINNESOTA PARTNERS IN PEDIATRICS				
AGE	**HUGO** (N=5,174)[a] **N (%)**	**WEST ST. PAUL** (N=4,332)[a] **N (%)**	**BROOKLYN PARK** (N=8,176)[a] **N (%)**	**ST. LOUIS PARK** (N=5,663)[a] **N (%)**	**MAPLE GROVE** (N=18,430)[a] **N (%)**	**PLYMOUTH** (N=8,023)[a] **N (%)**	**ROGERS** (N=9,258)[a] **N (%)**
<1	398 (8%)	333 (8%)	744 (9%)	3,519 (9%)	1,821 (10%)	3,707 (9%)	832 (9%)
1–2	378 (9%)	378 (9%)	627 (8%)	446 (8%)	1,707 (9%)	586 (7%)	694 (7%)
3–4	637 (12%)	606 (14%)	935 (11%)	701 (12%)	2,555 (14%)	788 (10%)	1,111 (12%)
5–6	648 (13%)	515 (12%)	935 (11%)	739 (13%)	2,337 (13%)	846 (11%)	1,122 (12%)
7–12	1,493 (29%)	1,148 (27%)	2,215 (27%)	1,681 (30%)	5,052 (27%)	2,135 (27%)	2,688 (29%)
13–18	1,168 (23%)	1,003 (23%)	2,000 (24%)	1,148 (20%)	3,737 (20%)	2,182 (27%)	2,151 (23%)
19+	396 (8%)	349 (8%)	720 (9%)	429 (8%)	1,221 (7%)	779 (10%)	660 (7%)
American Indian	**	**	**	**	61 (<1%)	20 (<1)	**
Asian	128 (3%)	136 (3%)	892 (12%)	170 (3%)	1,176 (7%)	644 (9%)	171 (2%)
Black/African American	100 (2%)	349 (9%)	1,436 (19%)	508 (10%)	1,187 (7%)	411 (5%)	172 (2%)
Hispanic/ Latino	45 (1%)	609 (16%)	187 (3%)	49 (1%)	256 (2%)	100 (1%)	69 (1%)
Native Hawaiian/ Pacific Islander	**	**	**	**	**	**	**
White/ Caucasian	4,005 (88%)	2,027 (52%)	3,868 (52%)	3,801 (74%)	12,386 (74%)	5,603 (75%)	7,219 (86%)
Other	57 (1%)	128 (3%)	213 (3%)	108 (2%)	315 (2%)	159 (2%)	74 (1%)
Declined	101 (2%)	229 (6%)	278 (4%)	120 (2%)	610 (4%)	244 (3%)	313 (4%)
Unknown	71 (2%)	31 (2%)	175 (2%)	150 (3%)	219 (2%)	114 (2%)	194 (2%)

SOCIO-ECONOMIC STATUS	**HUGO** (N=5,174)[a] **N (%)**	**WEST ST. PAUL** (N=4,332)[a] **N (%)**	**BROOKLYN PARK** (N=8,176)[a] **N (%)**	**ST. LOUIS PARK** (N=5,663)[a] **N (%)**	**MAPLE GROVE** (N=18,430)[a] **N (%)**	**PLYMOUTH** (N=8,023)[a] **N (%)**	**ROGERS** (N=9,258)[a] **N (%)**
Proxy: Medicaid as primary insurance	662 (15%)	2,051 (52%)	2,740 (36%)	890 (17%)	2,968 (18%)	1,002 (13%)	1,127 (13%)

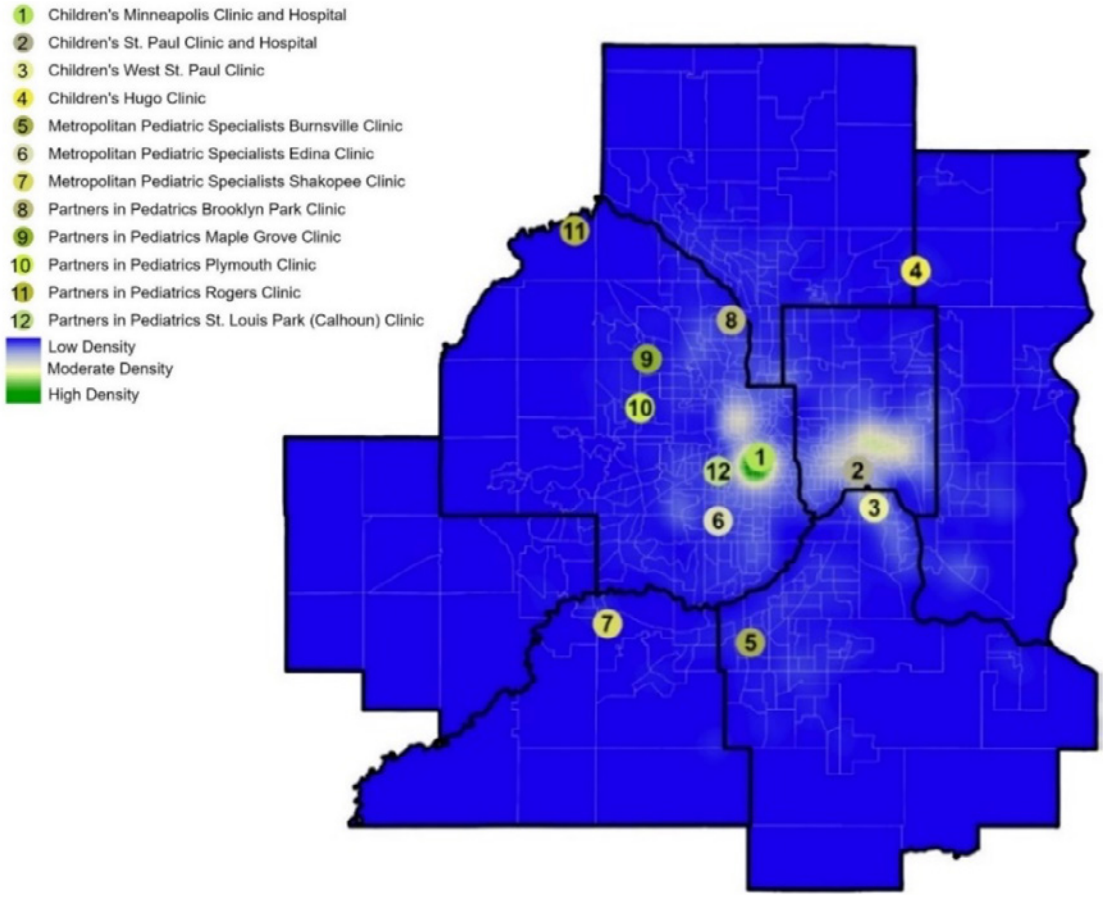
Source. Children's Minnesota (2021) .
[a] Children's Minnesota reports these as the total number of unique patients served. Because of differences in data systems used to gather and report patient information the N varies somewhat across the demographic categories.
** = Due to small numbers, reliable, 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 three million residents including more than 720,000 children age 17 and younger. Many of the children who received acute care services from the emergency department live in close proximity to the two hospital campuses in south Minneapolis and downtown St. Paul (Figure 4). The nine clinics affiliated with the Children's Minnesota system also provided preventive 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 5).

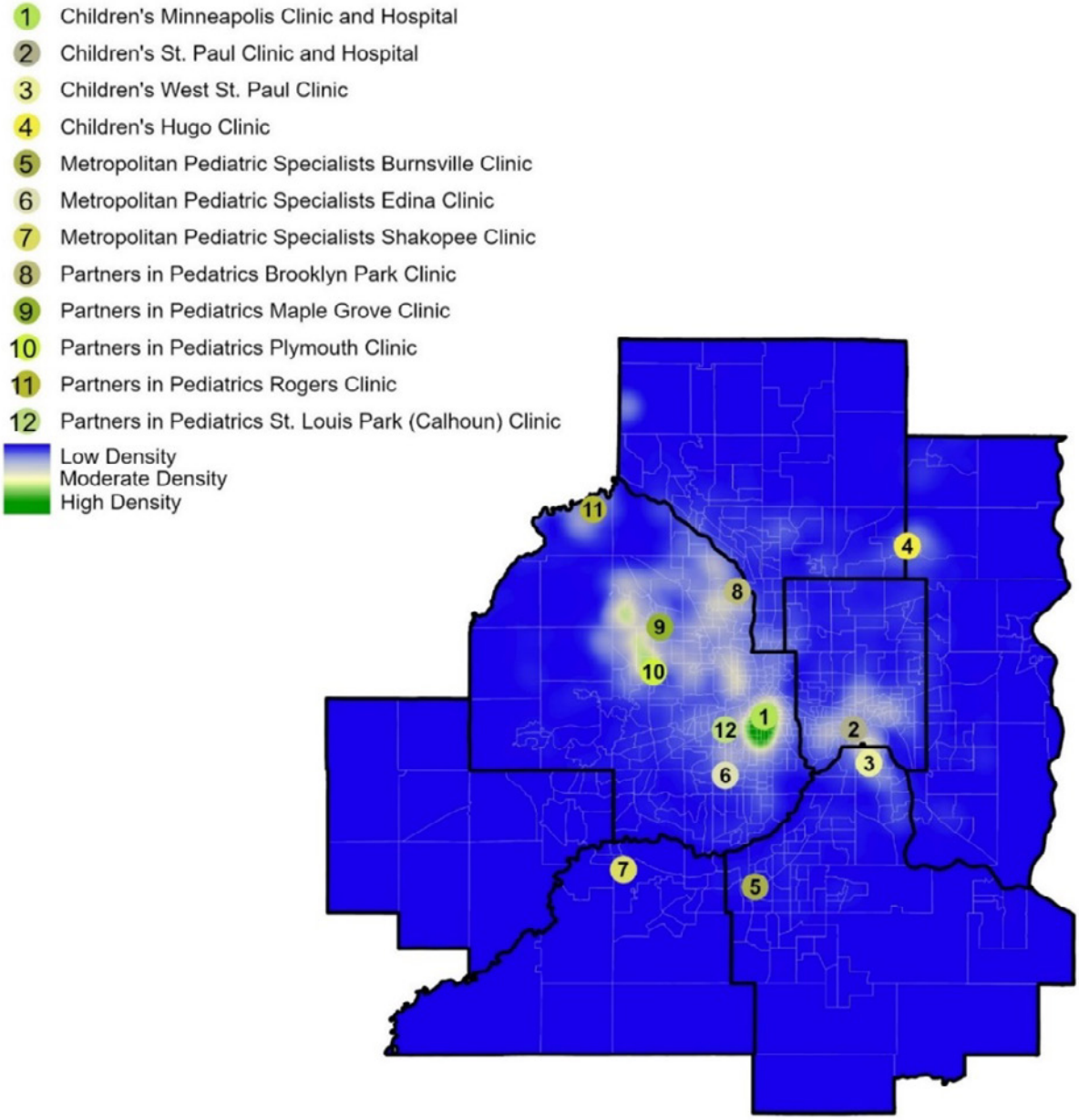
What is patient density?
Patient density is a relative measure of how close patients live to one another. In the following maps, areas of high patient density are shown using a color gradient with green indicating high-density areas and blue indicating low-density areas. This measurement helps identify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

FIGURE 4. Children served in Children's Minnesota emergency departments: Areas of high patient density (2021)



Source. Children's Minnesota (2021). 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 a Children's Minnesota emergency department between January 1, 2021 and December 31, 2021. 53,399 unique patients are represented in this map. Emergency departments are located at the Minneapolis and St. Paul hospital campuses (1 and 2 on the map).

FIGURE 5. Children served in Children's Minnesota primary care clinics: Areas of high patient density (2021)



Source: Children's Minnesota (2021). Mapping and analysis by Wilder Research using 2010 census tracts.
Note: The most recent residence was selected for each child who had at least one visit at a Children's Minnesota primary care clinic between January 1, 2021, and December 31, 2021. 62,281 unique patients are represented in this map. Children's Minnesota primary care clinics are located across the Twin Cities metro, and include clinics located at the Minneapolis and St. Paul hospital campuses (1 and 2 on the map). Patients who were seen only at one or more of the Metropolitan Pediatric Specialists clinics (located in Burnsville, Edina, and Shakopee) are not included in this map.

There are specific Minneapolis and St. Paul neighborhoods, particularly lower-income areas of the two cities, that have both a high density and overall number of children who receive services from Children's Minnesota.

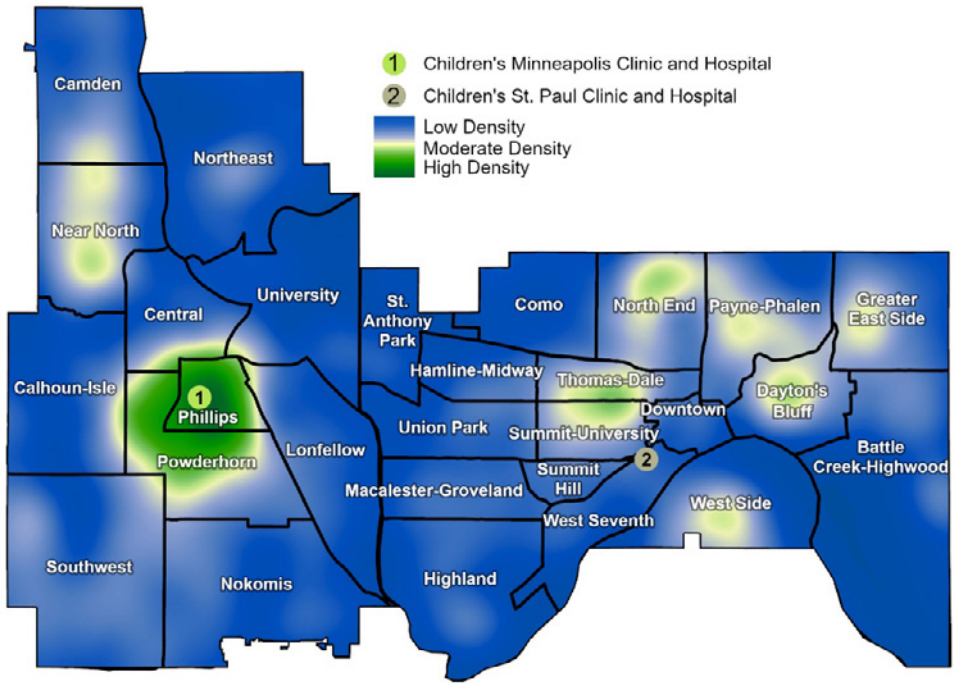
Almost 40% of children in the Phillips neighborhood in Minneapolis received some type of care from Children's Minnesota in 2021. In addition, more than one-third of children received services from Children's Minnesota in the Powderhorn (33%) and West Side (28%) neighborhoods of Minneapolis and St. Paul, respectively. About a quarter of children in St. Paul's Thomas-Dale and Dayton's Bluff neighborhoods received services from Children's Minnesota (Figures 6 and 7).

FIGURE 6. Percentage of children (age 0–17) reached in Minneapolis and St. Paul neighborhoods (2021)

NEIGHBORHOOD (CITY)	NUMBER OF CHILDREN IN THE NEIGHBORHOOD	NUMBER SERVED BY CHILDREN'S	PERCENTAGE
Phillips (Minneapolis)	6,367	2,467	39%
Powderhorn (Minneapolis)	11,876	3,978	34%
West Side (St. Paul)	4,599	1,460	32%
Thomas-Dale (St. Paul)	5,049	1,203	24%
Dayton's Bluff (St. Paul)	5,640	1,420	25%

Source: Decennial Census 2020 (P.L. 94-171 Redistricting data). Children's Minnesota. Wilder Research calculations.

FIGURE 7. Patient density within Minneapolis and St. Paul communities (2021)



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 January 1, 2021 and December 31, 2021 and live in focal Minneapolis or St. Paul neighborhoods. 31,718 unique patients are represented in this map.

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, but also the social and environmental factors that contribute to health and well-being. These efforts are consistent with overall trends in the health care industry to understand and respond to external factors that can drive 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.[3]

With input from parents and caregivers, youth, community-based organizations, and Children's Minnesota staff and providers (all referred to as contributors), as well as secondary data, six issues were identified as the most important to address to support the health and well-being of children and families. As Children's Minnesota develops implementation strategies to address these priorities, we will consider the intersectionality of these topics.

STRUCTURAL RACISM	HEALTH DISPARITIES	ECONOMIC OPPORTUNITY AND INCOME	MENTAL HEALTH	ACCESS TO RESOURCES	COMMUNITY SAFETY

The following summaries provide a working definition of each priority health issue, a description of who is impacted, and findings from the assessment process that describe the issue and its impact on the community.

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

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.[4]

Structural racism, rooted in the displacement of American Indians and the enslavement of Africans, is deeply entrenched into the United States' social, economic and political systems. It leads to disparities in opportunity and exclusion from power, as it relates to all aspects of community including employment, education, health, income, and housing. In 2016, Children's Minnesota was the first health system in the state to name structural racism as a priority health issue in a Community Health Needs Assessment. Because structural racism exacerbates and perpetuates all other health issues that may arise in a community, it is a fundamental challenge that we must address in order to make progress on the other topics prioritized in this and past assessments.

Who is impacted?

Across generations, African Americans, American Indians, and other communities of color, including immigrant and refugee communities, of all ages are impacted by structural racism. If efforts to address structural racism are not successful, the total number of children impacted will continue to grow, as children across the country, including the Twin Cities metro become more racially and ethnically diverse.

CAREGIVER:

"I am the one that finds resources and makes appointments because I speak English and it is almost all in English... It's hard for my family to feel supported..."

YOUTH:

"Racism makes me feel left out and I just had to accept it. It really does affect my mental health but I just learned to deal with it."

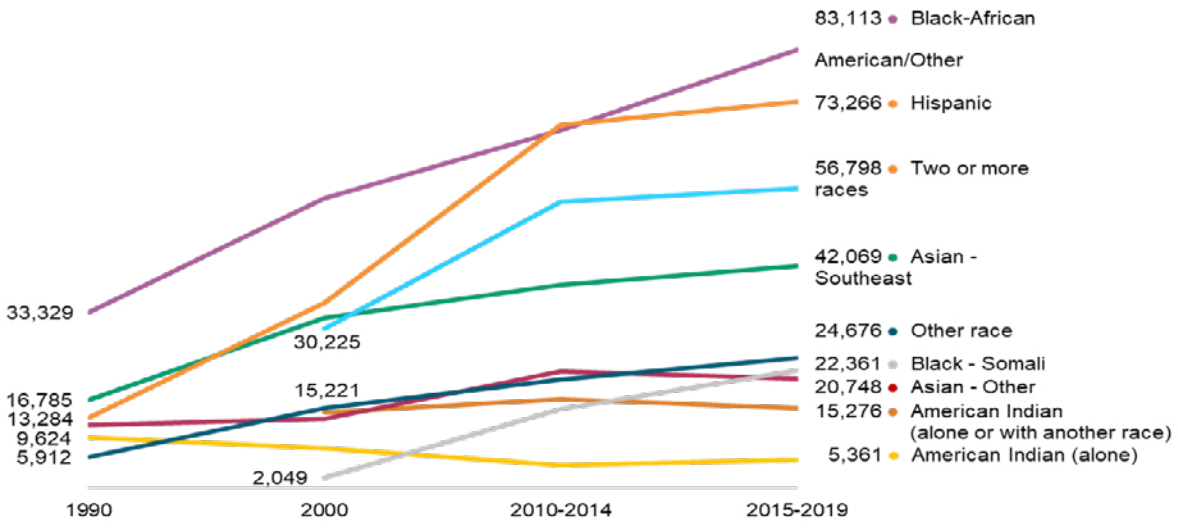
"The racism I have experienced during sports makes it so hard... I learned these spaces aren't safe at a really young age."

[4] 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

How structural racism impacts the community

- **All contributors felt structural racism is an issue that continues to impact the health and well-being of children and the community overall and should remain a priority,** whether discussed in name or through anecdotes.
- **Structural racism drives insufficient access to adequate medical services, implicit bias in health systems, and persistent health disparities by race/ethnicity.** For example, according to 2017 research, structural racism increases the risk of adverse birth outcomes for U.S.-born black Minnesotans compared to White Minnesotans, including pre-term birth, low birthweight, and small-for-gestational-age birth.[5] Children's Minnesota staff, providers, and parents and caregivers all acknowledged that there are still a lack of providers of color or linguistically appropriate resources (e.g., multilingual providers and staff, non-English print resources).
- **Structural racism drives disparities in social determinants of health.** For example, due to historical redlining policies combined with disparities in income, access to credit, and other forms of structural racism, there is a significant homeownership gap in Minnesota today. This gap has narrowed in recent years, but in 2021 just 26% of Black Minnesotans owned their home compared to 76% of white Minnesotans.[6]
- All contributors described how structural racism, as well as the explicit racism it upholds, shapes the environment in which people live and **negatively impacts health, especially mental health.**
- Youth contributors discussed the negative impacts of systemic racism and **shared pointed stories about how they are impacted on a regular basis by overt racism within their community.**

Children of color (age 0–17) in the Twin Cities metro



Source. Integrated Public Use Microdata Series (IPUMS) from the U.S. Census Bureau, Decennial Census and American Community Survey.
Note. Black/African American/other includes all Black or African American children who do not identify as Somali. The "two or more races" category was not used by the U.S. Census before 2000. The Southeast Asian category includes those who identified their race as Asian and reported belonging to any of the following ancestry groups: Burmese, Cambodian, Filipino, Hmong, Indonesian, Laotian, Malaysian, Taiwanese, Thai, or Vietnamese. The category Asian (other) includes those who identified their race as Asian but did not report belonging to the ancestry groups listed previously.

[5] Chantarat, T., Van Riper, D.C., & Hardeman. R.R. (April 2022). "Multidimensional structural racism predicts birth outcomes for Black and White Minnesotans." Health Services Research 57(3): 448-457.
[6] Homeownership rates are categorized by the racial/ethnic group of the householder. The data presented are from the U.S. Census Bureau, American Community Survey (2015-2019 five-year estimates) Retrieved from https://www.mncompass.org/topics/quality-of-life/housing?homeownership-gap#7-5600-g

Health Disparities

Health disparities are preventable differences in health outcomes caused by unequitable and unjust distribution of resources, opportunities and power.[7]

While Minnesota consistently ranks as one of the healthiest states in the country, health disparities are persistent and pervasive in Minnesota, meaning some community groups experience higher rates of disease or poorer health. Things that contribute to health disparities include, but are not limited to, inadequate access to health services (medical and non-medical), poverty, poor environmental conditions, educational inequities and often impact communities based on race, ethnicity, gender, sexual orientation, geography, and ability.

Also because a defining characteristic of health disparities is an "unequitable and unjust distribution of resources opportunities, and power" structural racism underpins many, if not all, health disparities.

Who is impacted?

The groups most often impacted by health disparities include people who identify as Black or African American, American Indian, Latino, Asian or other persons of color, immigrant and refugee populations, children from lower-income families and LGBTQ+ youth. These groups experience more barriers to health and worse health outcomes than other populations in Minnesota.

COMMUNITY-BASED ORGANIZATION:

"The disparities exist because of structural racism... look at the policies, systems and procedures that create barriers... they're embedded in racist ideologies."

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

How health disparities impact the community

- Most respondents felt health disparities are a critical area for Children's Minnesota to address. Contributors often talked about health disparities as an outcome of structural racism.
- Contributors most often identified **health disparities among racial groups and between LGBTQ+ and cisgender and heterosexual populations.**
- A number of parents, caregivers and youth readily described how **at times it is harder for them to be healthy in comparison to other people (i.e., health disparities) because of assumptions health systems make and community conditions** such as having enough money or knowing where to find services that meet their needs.
- **Asthma, a health issue of particular concern for children, disproportionately impacts some groups more than others based on race, ethnicity and language.** Rates of optimal asthma control are significantly lower for: Asian, Black, American Indian and Latino children (compared to rates for all children; children whose preferred language is Hmong, Karen, or Spanish (compared to the state average).[8]
- In 2019 8.8% of women in Minnesota received inadequate prenatal care, which can have a direct negative impact on birth outcomes. When the data was disaggregated by race, **American Indian (29%) and Black (18%) women were more likely to receive inadequate prenatal care** than other racial groups.[9]
- **Minnesota 9th graders who identify as gay, lesbian, or bi-sexual more often reported having long-term mental, behavioral or emotional health problems** (60%).[10] Eight percent of Minnesota 9th graders reported being bullied because they are gay lesbian, or bisexual or because someone thought they were.

YOUTH:

"Black women are especially dismissed when it comes to medical things. It's either a one and done, or a 'you don't have that, you'll be fine.' or a 'all you need to do is this.' When there's been stories and lots of cases where Black women was like, 'This is what the doctor told me, I did it, and it [made] me even worse."

[8] MN Community Measurement. (May 2021). "Minnesota Health Care Disparities by Race, Hispanic Ethnicity, Language and Country of Origin." Retrieved from https://mncmsecure.org/website/Reports/Community%20Reports/Disparities%20by%20RELC/2020%20Disparities%20by%20RELC%20Chartbook%20-%20FINAL.pdf

[9] Minnesota Department of Health. (2020). 2019 Minnesota health statistics annual summary. https://www.health.state.mn.us/data/mchs/genstats/annsum/AnnSum2019.pdf

Note. Adequacy is determined using the Adequacy of Prenatal Care Utilization (APNCU) Index, and is not comparable to GINDEX Index used in previous years.

[10] Minnesota Compass. (2019). Economy overview. Retrieved from https://www.mncompass.org/economy/overview.

Economic opportunity and income

Economic opportunity and income are the 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, with wealth and higher household income closely tied to better health outcomes. The major driver of household income is employment, but economic opportunities such as access to education and housing also support a family's ability to share and accumulate resources across generations. It is important to note that long-term effects of discriminatory policies and practices (e.g., housing policy discrimination, employment discrimination, racial discrimination in the criminal justice system, and unequal access to education opportunities) are major drivers of disparities in household wealth.

Who is impacted?

Nearly 200,000 children in the Twin Cities metro live in households with incomes at or near poverty levels ("lower-income households"). Despite recent decreases in the percentage of children living in lower-income households for most counties in Minnesota, poverty rates among children are still high in the Twin Cities metro area overall. While Minnesota has historically had a strong economy and one of the lowest poverty rates in the nation, significant income disparities exist among racial and ethnic groups, with Black and American Indian children in the Twin Cities metro area more likely to live in lower-income households and to experience poverty compared to white children.

YOUTH:

"Financial opportunity and income, I say, is the biggest barrier... because it plays into all the other topics. You need funds! There aren't too many charities for therapy."

How economic opportunity and income impact the community

The following specific concerns related to economic opportunity and income were identified through the assessment:

- Most contributors acknowledged that **lack of economic opportunity and income can pose the biggest challenge to a family's health**, as they impact the ability to meet basic needs.
- **Parents, caregivers and youth elevated the priority area** as they feel the day-to-day impacts of not having enough income to meet rising housing, food, and medical costs.
- The poverty rate for people of color in Minnesota has been falling since 2014, but **poverty rates were still twice as high for Minnesota's residents of color as for white residents in 2021.**[11]
- After more notable increases in the percentage of children living in lower-income households between 2000 and 2014, there has been a decrease since then for most counties. However, **poverty rates for children varied considerably amongst metro counties in 2021, from as few as 10% in Carver County to as many as 45% in Ramsey County.**[12]
- Between 2014 and 2019 there was a significant decrease in the percentage of children living below the federal poverty level for all racial and ethnic groups except American Indian. However, **Black (33%) and American Indian (35%) children more often lived in households at or below the federal poverty level in 2019** than did white children (4%).[13]
- **Unemployment and unemployment insurance claims skyrocketed to historically high levels during the Covid-19 pandemic.** In April 2020, the number of continuing unemployment insurance claims in Minnesota skyrocketed to 500,246 — a record high. Compared to April of the previous year, this represents a 978% increase in claims filed across the state and a 1,481% increase for the seven-county Twin Cities metro area.[14]

CAREGIVERS:

"[The biggest challenge] is financial opportunity and income, especially when it comes to the cost of health insurance, relating to the cost of health care and what health insurance does and doesn't take care of or help support."

"[Because of financial issues] families [do not have] enough basic needs, like food and transportation. [During the pandemic] one of the good things was the quick access to food."

[11] Minnesota Compass. (2019). Economy overview. Retrieved from https://www.mncompass.org/economy/overview.
[12] U.S. Census Bureau. (2022). American Community Survey, including 5-year estimates (2000, 2010-14, 2015-19). [Data set]. https://www.census.gov/data/developers/data-sets/acs-5year.html
[13] U.S. Census Bureau. (2022). American Community Survey 5-year estimates (2015-2019) [Data set]. https://www.census.gov/data/developers/data-sets/acs-5year.html
[14] Minnesota Department of Employment and Economic Development (DEED). Unemployment Insurance Claims Statistics. Retrieved August 2021 from https://mn.gov/deed/data/data-tools/unemployment-insurance-statistics/uimonthly.jsp

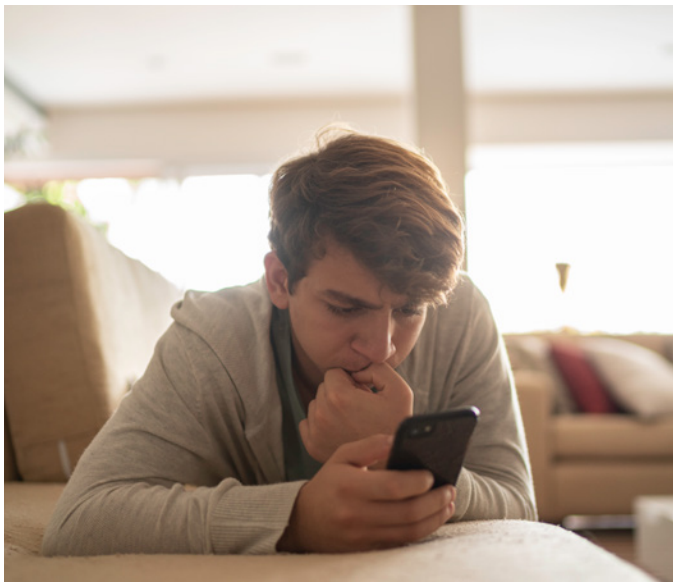
Mental health

Mental health refers to the critical need for children, youth, and families to have equitable access to a full spectrum of culturally responsive mental health services throughout their life, in both medical and community-based settings.

Mental health, our emotional, psychological and social well-being, affects how we think about and engage with ourselves and the world around us.[15] Mental health is just as important as physical health and is a key component of individual and community well-being. Mental health is also incredibly complex in that it is impacted by many, often interrelated factors, such as the physical environment, the people around us, and our genetics and family history, and its challenges can take the form of something more general such as poor mental health or something more specific such as a diagnosable mental health illness. Historically the discussion of mental health has been heavily stigmatized and it is only in recent decades that this stigma has lessened for many, although not for all communities.

Who is impacted?

Our mental health is a key element of our overall health and wellness and we all may experience mental health challenges at some point in our lives; however, some populations are disproportionately impacted. Higher proportions of the following groups experience mental, behavioral and/or emotional issues than average: female and non-binary youth, LGBTQ+ youth, homeless youth, and youth with 4+ adverse childhood experiences (ACEs).



YOUTH:

"I feel like mental health can consume all, meaning your physical health, your emotional health, everything. I know this from personal experience... I feel you can't be healthy in life in all aspects if you aren't working on your mental health. I suggest that above all."

[15] Centers for Disease Control and Prevention. (2021). About mental health. U.S. Department of Health and Human Services. https://www.cdc.gov/mentalhealth/learn/index.htm

CAREGIVER:

"My daughter has threatened to take her life. I have tried to get her to therapy and no places can take her."

How mental health impacts the community

- **All respondent groups saw mental health as a critical health issue that needs continued focus.**
- Overall, contributors felt **the lack of mental health services is negatively impacting the community**, especially at a time when there seems to be a greater need.
- A number of contributors felt **that non-urgent services (e.g., counseling, therapy, life coaching) and crisis services are unable to meet the current demand for children and adults** in the community.
- Equitable **access to appropriate mental health services that are delivered in a culturally responsive way was identified by as a key challenge** that many children and families in the Twin Cities area are grappling with. There is especially a lack of culturally responsive services and services for families who do not speak English.
- Youth contributors felt it **is difficult to focus on other areas of life when mental health is not in a good state.**
- Statewide and in the Twin Cities metro **the number of students reporting having mental health problems has increased over time**. This could be due to both an increase in the incidence of mental health problem and also more people seeking support due to reduced stigma.[16]
- **Acute, severe mental health issues (e.g., suicidal ideation, self-inflicted injury) appear to be impacting more children.** Contributors felt children are experiencing these mental health issues at younger ages than in the past. In the past several decades, suicide rates and non-fatal self-inflicted injuries have been increasing.
- While it seems that stigma around discussing mental health, particularly amongst youth, has declined, a number of community-based contributors **still see stigma impacting some of the families they work with.**

COMMUNITY-BASED ORGANIZATION:

"One of the biggest challenges [is that] there is no one system, and the way children find out about services [is not] a linear process. Everyone has their own journey and it is still stigmatized, and also some parents feel stigmatized for not knowing what to do."

[16] Minnesota Department of Health. (2018). Minnesota Student Survey, 2019 [Data set]. https://public.education.mn.gov/MDEAnalytics/DataTopic.jsp?TOPICID=242

Access to resources

Access to resources is the ability to have equitable access to culturally responsive health care services, as well as social supports that all people need to survive and thrive, including food, housing, transportation and education.

As people go about their daily lives they are constantly accessing resources, and navigating the systems that support them, in order to have what they need to survive and thrive — stopping at the store to purchase food, filling out paperwork to enroll a child in school, getting a referral for a specialty medical service. While accessing resources is a vital part of life, service delivery systems may be designed and operated in a way that can make it particularly difficult for families to use (e.g., offering services that do not match the needs of the families served, not promoting the services in a way that reaches those who need it), and creating burdensome requirements to obtain resources. Additionally, even if families are able to navigate systems to obtain resources, an overall lack of resources can further hinder families' well-being.

Who is impacted?

While all people access resources, specific groups experience the most significant access challenges, such as lower-income families, immigrant and refugee families, people with disabilities, 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.

CAREGIVER:

"I think the lack of child care is [a need]. It makes me stressed because I have to do everything by myself and if there isn't enough daycare I can't go to work or college."

YOUTH:

"I wish public transportation was free, so people can get to where they have to go without having to pay every time. It would be helping the public be more self-sufficient, getting to their jobs, appointments, etc."

"Access to resources is what I'd rank as the number one [need]. With access to the right resources, other problems could be sorted or kept in check."

While recognizing the need to increase access to resources in the Children's Minnesota community, contributors pointed to a range of existing assets that can be leveraged, including childcare and after-school programming; hospitals and clinics; dental services; the metro area transit system; interpretive programs; community and school clinics; the state health department; local nonprofits and advocacy groups; school-based services; nutrition programs (e.g., WIC); the state mental health assistance line; and cultural and religious centers.

How access to resources impacts the community

- **All contributors felt Children's Minnesota needs to keep access to resources as a priority area.** Parents, caregivers, and youth often talked about the importance of getting their basic needs met.
- **Contributors most often discussed access to resources in the context of describing "healthy families,"** when they mentioned access to basic needs like housing, food, transportation, health care, and education.
- **Families living in poverty have the greatest need for services and supports, but often experience the most difficulty** accessing resources.
- **The meaning of access can go beyond simple access to goods and services;** access can mean knowing where to go for help, understanding eligibility criteria, and having enough supports available — especially culturally responsive supports or supports for people who speak languages other than English, as needed.
- Disparities are also evident in access to social supports, with **people of color in Minnesota being more impacted by food scarcity during the pandemic** (18%) than White people (5%).[17]
- **Insurance coverage rates illustrate disparities in access to healthcare across demographic groups**. Uninsured rates have dropped for all racial and ethnic groups since the passage of the Affordable Care Act, but relative differences between groups remain. For example, the overall nationwide uninsured rate was about 8.6% in 2021, but the uninsured rate among subgroups ranged from a low of 5.7 percent among White, non-Hispanic people to a high of 18.8 percent among American Indians and Alaska Natives.[18]
- **Transportation is both a resource and something that facilitates access to other resources.** A number of contributors, especially parents and caregivers, often identified **transportation as a common challenge,** especially when it comes to having reliable transportation (public and private), the cost of parking, and the price of gas.
- Participants emphasized that **access to resources is critical for children *and* their caregivers.** Participants highlighted, for example, work-paid family leave, respite care, and support groups for specific health needs (e.g., Down syndrome).

COMMUNITY-BASED ORGANIZATION:

"Our systems also aren't designed for folks who don't have an understanding or knowledge of English, and they have to rely on interpreters or family members to get access."

[17] U.S. Census Bureau (2022). Household Pulse Survey. https://www.census.gov/data/experimental-data-products/household-pulse-survey.html
[18] U.S. Census Bureau (2022). Health Insurance Coverage by Race and Hispanic Origin: 2021. American Community Survey Briefs. https://www.census.gov/content/dam/Census/library/publications/2022/acs/acsbr-012.pdf

Community safety

Community safety is the opportunity for children and families to feel safe at home, at school, and in the broader community.

A lack of community safety, especially physical violence, affects health and quality of life in the short and long-term, both for those who are directly affected and those who are indirectly affected. Living in unsafe communities can impact health in a multitude of ways. For example, children in unsafe circumstances can suffer post-traumatic stress disorder and exhibit more aggressive behavior, alcohol and tobacco use, and sexual risk-taking than peers in safer environments. Living in unsafe neighborhoods can cause anxiety, depression, and stress, and unsafe neighborhoods are linked to higher rates of pre-term births and low birthweight babies. Additionally, fear of violence can keep people indoors, isolated from neighbors and away from opportunities to exercise and access healthy foods.[19, 20]

Trust between communities and the institutions responsible for public safety is essential. However, long-standing racial discrimination and inequities within current structures, such as police and child welfare systems, continue to undermine trust and community safety.

Who is impacted?

Rates of violent crime continue to be higher in lower-income, racially segregated communities with lower access to community resources.[21] Adolescents and young adults are also more likely than other groups to be impacted by violence.[22]

COMMUNITY-BASED ORGANIZATION:

"Gun violence is causing a lot of stress to families and their mental health and their sense of stability."

[19] Count Health Rankings & Roadmaps. "Community Safety: Why Is Community Safety Important to Health?" Accessed on October 25, 2022, at https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/social-and-economic-factors/community-safety
[20] Egerter S., Barclay C., Grossman-Kahn R., & Braveman P. (2011). Exploring the social determinants of health: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70452. Violence, social disadvantage and health (Issue Brief No. 10). Robert Wood Johnson Foundation (RWJF).
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The impact of community safety on families

Across all contributor groups, respondents discussed how various aspects of community safety, or lack thereof, have a significant impact on the health of children and families. The following specific concerns related to community safety were identified through the assessment:

- **Community safety concerns compound escalating mental health challenges** by adding to stress, anxiety and trauma.
- Concerns about community safety may **prevent children and families from seeking or using services in a certain geographic area or altogether.**

CAREGIVERS:

"Violence in the neighborhood [is a] hassle. [You] can't predict when things will happen, but it's an added stressor."

"Violence in the neighborhoods has a big impact. I take my kids to school in a different city because of the safety."

METHODOLOGY AND PRIORITIZATION PROCESS

ASSESSMENT METHODOLOGY

To develop the most holistic view of the community and the needs of the community, 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.

Primary data collection

Multiple stakeholder groups were asked to consider whether the health topic areas prioritized through the 2019 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.

Parent and caregiver focus groups (August–September 2022). Wilder Research conducted two parent/caregiver virtual focus groups with a total of 15 participants. Participants were asked to provide their perspectives on the strengths of their communities, how they define health, challenges to having good health, and how Children's Minnesota can play a role in improving community health. Information from parent focus groups is used as a supplement to the other primary data collection and secondary data review. Because only two focus groups were conducted, responses may not be representative of all family experiences.

Youth focus groups (August 2022). Youthprise, a Minneapolis-based nonprofit youth development organization, conducted two virtual focus groups with a total of 15 participants. Participants were asked to provide their perspectives on the strengths of their communities, how they define health, challenges to having good health, and how Children's Minnesota can play a role in improving community health. Information from youth focus groups is used as a supplement to the other primary data collection and secondary data review. Because only two youth focus groups were conducted, responses may not be representative of all youth experiences.

Community-based organization interviews (June–August 2022). Wilder Research conducted 30 semi-structured interviews with representatives of community-based organizations who work closely with children and families. These stakeholders represented multiple sectors, including school districts, local not-for-profit organizations, social services, and heath care.

Children's Minnesota staff discussion groups (May 2022). Twenty-nine (29) staff in roles including social workers, interpreters, service coordinators, family resource managers, and family liaisons attended one of two virtual discussion groups (one focused on staff located St. Paul and one focused on staff located in Minneapolis). Staff were asked about their perceptions of families' needs related to Children's Minnesota's existing priority areas (developed in 2019), as well as what other needs are prominent among the children and families they work with.

Children's Minnesota provider interviews (May–June 2022). Wilder Research conducted semi-structured interviews with 12 Children's Minnesota health care providers. Participants included physicians, social workers, psychologists, and nurse practitioners who worked in multiple Children's Minnesota locations (Minneapolis and St. Paul) and settings (emergency departments, inpatient, primary care, and specialty care). Participants were asked to provide their perspectives on the importance of continuing 2019 community health priorities, perceptions of emerging health issues, and what barriers families experience to health and wellness.

Secondary data review

A review of secondary data sources was used to describe the demographic characteristics of patients served by Children's Minnesota and to describe demographic trends and identify potential changes in health outcomes or new emerging health concerns among youth who live in the Twin Cities metro region.

Children's Minnesota patient data. Patient data were used to describe the demographic characteristics of children served and to identify the neighborhoods where the organization 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, other state and federal sources, and standalone research reports from other organizations.

FIGURE 8. Overview of all health issues identified

2022 HEALTH ISSUES IDENTIFIED	2019 PRIORITY HEALTH ISSUE?	PRIORITIZATION STATUS IN 2022	2022 CHNA PRIORITY HEALTH ISSUES
Structural racism	X	Remain a priority →	Structural racism *Culturally responsive services*
Access to resources	X	Remain a priority →	Access to resources *Culturally responsive services*
Mental health and well-being	X	Remain a priority →	Mental health *Culturally responsive services*
Health disparities	X	Remain a priority →	Health disparities
Economic opportunity and income	X	Remain a priority →	Economic opportunity and income
Community safety		New priority →	Community safety
Culturally responsive services		Not prioritized *Use to address other priorities*	

PRIORITIZATION PROCESS

The health issues and key themes identified through the assessment process were presented to both Children's Minnesota CHNA Community Advisory Committee (CAC) and a cross-functional group of Children's Minnesota clinical and operational leaders. Both groups were asked to a) consider how key themes impact their views on the priority areas identified in 2019; b) determine if any of the 2019 priority areas should be changed; and c) suggest how emerging needs should be incorporated into the final 2022 priority areas. The final priorities were then approved by the Children's Minnesota Board of Directors.

The approach to prioritization included an emphasis on primary data collection findings, while also utilizing findings from the secondary data analysis and review to contextualize primary data collection findings. The prioritization process also assumed the 2022 CHNA would build on the work of the previous assessments, unless CHNA findings clearly indicated otherwise, recognizing ongoing strategies and investments that Children's Minnesota is making to address the priorities identified in the 2019 CHNA. As implementation strategies are developed to address the 2022 priorities, Children's Minnesota will continue to consider the intersectionality of these topics.

AVAILABLE RESOURCES

As we reflect on the events of the past three years, we recognize the responsibility of health care, the business community, public officials and others have to advance equity and racial justice by investing in community-led solutions that aim to address the priorities identified in this assessment.

At the individual, community and system levels we know that there are resources, strengths and assets that positively impact health and well-being. The following list reflects what we heard from contributors to this assessment and past assessments regarding community strengths and assets. This list is by no means exhaustive, but as Children's Minnesota considers its role in addressing assessment priorities, we want to ensure that our services, programming, partnerships and advocacy work build on these strengths.

- Physical and mental health providers, educators and social service providers with lived experiences reflective of the communities they serve.
- Supportive communities and environments where one's cultural identity can be expressed, celebrated and empowered.
- Organizations that provide supportive services designed for specific cultural communities.
- School systems and the supportive services they provide.
- Entrepreneurs and businesses that bring economic diversity and vitality to local neighborhoods and communities.
- Public benefit programs and social services that support families.
- Organizations and faith-based institutions that encourage culturally specific health practices and coping strategies.
- Support groups and community gathering spaces.
- Parks and safe play spaces.

The following table highlights some specific resources Children's Minnesota plans to draw on to support continued work to address each CHNA health priority both within our system and in partnership with others. Items listed reflect current Children's Minnesota services and initiatives further described in the "Progress since the 2019 CHNA" section of this report as well as notable collaborations and advocacy efforts.

Structural racism	• An equity and inclusion department focused on creating a diverse, equitable and inclusive culture at Children's Minnesota that reflects the rich backgrounds of the communities we serve. • Implementation and advancement of Respect and Dignity Safety Learning reports and tools for conducting root cause analyses using an equity lens. • Implicit bias training and intercultural development training for leaders and teams. • Day 2 of the Children's Minnesota New Employee Orientation program is focused on Equity and Inclusion and includes a self-study component. • Employee resource groups (ERGs) are established at Children's Minnesota and enhance inclusion and equity efforts and promote community enrichment and development for employees. • Children's Minnesota is a founding member of the Minnesota Business Coalition for Racial Equity and Groundbreak Coalition which are focused on building an equitable, inclusive and prosperous state with and for Black residents. • In 2020 Children's Minnesota President and CEO led an effort by more than 50 executive leaders from across the state expressing commitment to eliminating racial inequities and advancing social justice.

Health disparities	• Current measurement and operational initiatives to reduce disparities in asthma control, vaccination rates and patient experience. • A health equity team implementing community engagement strategies and clinical activities designed to reduce disparities. • A multidisciplinary gender health program that provides compassionate and comprehensive care for transgender and gender diverse youth. • Children's Minnesota recognized as a 2022 LGBTQ+ Healthcare Equality Leader by the Human Rights Campaign Foundation's (HRC) Healthcare Equality Index (HEI).
Economic opportunity and income	• Established relationships with local educational institutions and programs focused on equity and inclusion and creating a pipeline for health care careers. • Focused goals on increasing supplier diversity. • Partnerships with racially and ethnically diverse, local business to provide inclusive leadership coaching for senior leaders, board members and others within the organization. • Children's Minnesota's membership in the North Central Minority Supplier Development Council, the Women's Business Development Center and Quorum. • Prioritized work in the Minnesota Business Coalition for Racial Equity includes a focus on employment opportunities, Black business development and community well-being. • A financial counseling team that partners with patient families with concerns related to medical expenses and walks them through the entire process of applying for Medical Assistance (MA), TEFRA, Children's Minnesota financial assistance application for a discount, spend down, and Emergency Medical Assistance.
Access to resources	• Continued funding support for the Children's Minnesota Community Connect and Healthcare Legal Partnership programs to address health-related social needs and ongoing development of cross-sector referral partnerships. • Family resource centers in Minneapolis and St. Paul hospitals with information for families and food shelf access. • A Clinic in the Classroom webinar education series where clinic experts from Children's Minnesota provide ongoing continuing education programming for school nurses across the state. • Ongoing public awareness and advocacy efforts focused on ensuring that children have access to health care through Medicaid, CHIP and other public programs.
Community safety	• Established partnerships with local and state officials that allow for opportunities to collaborate to ensure that the communities where our hospitals and clinics are located in are safe for patients and families that live in those communities as well as employees. This includes an established, multidisciplinary internal safety and security advisory committee focused on supporting an equitable, safe and secure environment for patients, their families and employees. • The Midwest Children's Resource Center which is a child advocacy center (CAC) and clinic within Children's Minnesota that offers medical evaluations and case management in alleged child abuse cases, serious neglect and witness to violence. • A trauma and injury prevention department that works in the community to provide information and educational resources to support caregivers in their efforts to keep their children safe in their homes and other environments. • A large number of Minnesota health systems, including Children's Minnesota, have declared gun violence a public health crisis and commit to be partners in addressing it.
Mental health	• Integrated behavioral health specialists in all of our primary care clinics and inpatient specialty care areas. • A neurodevelopmental services department that has improved coordination and alignment with follow-up clinics. • Continued implementation of the HealthySteps program in Children's Minnesota primary care clinics. • Standard suicide screening tools for inpatient and outpatient mental health services. • Expansion of Children's Minnesota acute mental health services that includes a new inpatient mental health unit and will include a second partial hospitalization program. This expansion required advocating for new state legislation, which passed with unanimous bipartisan support in 2022. • Children's Minnesota is a member of the Mental Health Legislative Network and participates in meetings convened by the Minnesota Children's Cabinet focused on addressing and identifying gaps in the spectrum of care for children's mental health — including state leaders, county leaders, hospital staff and advocates.

PROGRESS SINCE THE 2019 CHNA

The 2019 CHNA identified five priorities that were the focus of the Children's Minnesota 2020–2022 CHNA Implementation Strategy. These priority areas and a brief summary of the impact of the work done to address each area is described below. In addition to the programmatic efforts listed below, these priorities and those of future assessments will guide the work of the Children's Minnesota Collective for Community Health. Launched in 2022, the Collective for Community Health will focus on improving the health of patients by strengthening community partnerships with the aim to improve social determinants of health, end structural racism in health care and eliminate health disparities.

It is important to note that the COVID-19 pandemic limited some of this work and/or shifted the focus of some initiatives.

PRIORITY HEALTH TOPIC:

Structural racism

Goal from 2020–2022 implementation strategy: Eliminate racism and resulting negative impacts on health by advancing health equity through changes in policies and practice, shifts in organizational culture and operations, and greater collaboration with community partners.

Objectives:

- Identify and address policies, practices and systemic issues within the organization that contribute to structural racism.
- Further implement a racial equity impact lens into organizational goal-setting, project planning and performance measures.
- Identify and address procedures, policies, and practices that influence clinical health outcomes and perpetuate disparities at the point of care.
- Partner with Human Resources in addressing departmental environments and behaviors that don't align with organization's goals of creating an inclusive and equitable organization.

Operationalizing racial equity as a measure of quality and clinical excellence

- In partnership with the Value and Clinical Excellence Department, the Equity and Inclusion team at Children's Minnesota continues to affirm equity and inclusion as a core value. Work has included re-sharing the organization's perspective on how and where to focus quality improvement efforts. Specific efforts include the implementation and advancement of Respect and Dignity Safety Learning reports and tools for conducting root cause analyses using an equity lens.
- The Equity and Inclusion team at Children's Minnesota consults on key components to service delivery within our care continuum including, but not limited to, the expansion of telehealth services and the utilization of the Children's Minnesota mobile clinic.

Implicit bias training and intercultural development

- The Children's Minnesota simulation team travels throughout the Midwest to train staff from hospitals in best practices when responding to pediatric or neonatal emergencies. Since the 2019 CHNA the work of the simulation team has expanded to include providing implicit bias training and de-escalation strategies with Children's Minnesota nursing staff.
- All new employees at Children's Minnesota are now required to complete an equity and inclusion self-study as a part of the New Employee Orientation program. The Equity and Inclusion department also consults with both clinical and non-clinical departments to guide employees in their completion of an Intercultural Development Inventory.

Education on equitable and inclusive health care

- The Children's Minnesota interprofessional education team has dedicated time and effort to making sure that 20% of all interprofessional education has a health equity focus. Health equity topics are consistently discussed at Grand Rounds and the education team continues to partner with Employee Resource Groups on content development opportunities.
- In 2020, Children's Minnesota started producing the Talking Pediatrics podcast that features a regular Equity Actions segment which is hosted by our Chief Equity and Inclusion Officer and Health Equity Manager.

Inclusive leadership cohort training

- The Equity and Inclusion team is working with Children's Minnesota leaders to conduct Inclusive Leadership training. This will enable leaders to further develop and strengthen skills relative to advancing an inclusive and equitable organization as per the Annual Operating Plan. The training has been implemented in 2022 and will continue on into the first quarter of 2023.

PRIORITY HEALTH TOPIC:

Health disparities

Goal from 2020–2022 implementation strategy: Build internal capacity and work in partnership with the community to establish goals and implement strategies to significantly reduce targeted health disparities.

Objectives:

- Share available and reliable disaggregated data with the community, including health disparities in vaccination rates and asthma condition support and management.
- Work with the community to co-create strategies to address health disparities.
- Engage the community regularly to share progress, refine strategies, and prioritize additional health disparities to address.

Expanding the Children's Minnesota health equity team

- In order to improve visibility and enable community collaboration, Children's Minnesota has continued to make investments in this work by expanding the health equity team.

Health equity measurement and data collection

- The Children's Minnesota health equity team continues to utilize a patient equity index to measure health disparities. The index currently reflects three priority metrics including: vaccination rates, asthma control and patient experience.
- The health equity team is also working collaboratively with other departments to identify ways to improve capturing race, ethnicity and language (REaL) data. This will allow us to use disaggregated race and ethnicity data to better address disparities in health outcomes and patient experience.
- In 2020 Children's Minnesota joined together with the African American Leadership Forum, Insight News, Northpoint Health & Wellness, Minnesota Community Care and the Minnesota Spokesman Recorder to create a virtual townhall series that considered the impact of COVID-19 on Black Minnesotans while also addressing other current events and issues impacting the community.

Health equity and the COVID-19 pandemic

- A member of Children's Minnesota's infection prevention team appeared regularly in town hall meetings to provide COVID-19 updates and information.
- Children's Minnesota played a key role in providing information and expertise about COVID-19 and kids through virtual events and podcasts while also working to address vaccine hesitancy and collaborating with community partners to offer COVID-19 vaccines.

American Indian community partnership programs

- The Twin Cities metro area is home to a large urban American Indian population and that population experiences some of the highest health disparities. While programs have been paused during the pandemic, Children's Minnesota is actively working to build relationships and drive better outcomes with the American Indian community including:
  - "The First Gift" — a partnership between Children's Minnesota and the Minnesota Indian Women's Resource Center — is a program that connects traditional knowledge, community healing and positive storytelling/ narratives, to promote healthy American Indian babies. Traditionally, "The First Gift" is a pair of moccasins given to a newborn baby. As a part of "The First Gift" program at Children's Minnesota, American Indian community members gather for a meal and to make moccasins that can be distributed to American Indian newborn babies at Children's Minnesota and other health care institutions.
  - The Children's Minnesota American Indian volunteer cohort specifically aims to recruit American Indian community members to come to Children's Minnesota to deliver "The First Gift" moccasins, hold babies in the Special Care Nursery (SCN) and support American Indian families. This cohort was designed to create a more inclusive, representative, and culturally aware environment for Children's Minnesota patients and families.

Providing gender affirming care

- In 2019 Children's Minnesota launched a first of its kind pediatric, multidisciplinary gender health program that provides compassionate and comprehensive care for transgender and gender diverse youth. The clinic was opened in response to the growing need for gender informed and gender affirming care. The LGBTQ population, particularly transgender and gender diverse patients, experience health disparities relative to access to care, insurance coverage, and several other health outcomes. This program is part of an ongoing effort to reduce health disparities by ensuring that Children's Minnesota provides care in an environment that is inclusive and gender affirming.
- In 2020 Children's Minnesota was recognized as a Top Performer by the Human Rights Campaign Foundation's (HRC) Healthcare Equality Index (HEI). This recognition gave us the opportunity to continue to make strategic structural and policy changes that led to receiving the highest recognition from the HRC as a LGBTQ+ Healthcare Equality Leader in 2022.

PRIORITY HEALTH TOPIC:

Economic opportunity and income

Goal from 2020–2022 implementation strategy: Invest in economic and employment opportunities for all of the communities Children's Minnesota serves

Objectives:

- Increase investment of resources into local community businesses through supplier contracts and sponsorships.
- Increase employment opportunities for the community Children's Minnesota serves, including patients and families themselves.
- Implement training, recruitment, and retention strategies to achieve organizational work force diversity, equity and inclusion goals.
- Expand programs and supports that help families access available benefits.

Investing in community businesses

- Children's Minnesota is committed to increasing the number of diverse vendors we work with in the community. Current focus areas include subcontractors for construction projects.
- Children's Minnesota also partners with racially and ethnically diverse, local businesses to provide inclusive leadership coaching for senior leaders, board members and others within the organization.

Pipeline for health care careers

- Children's Minnesota has partnered with the People of Color Career Fair platform and it is utilized weekly by recruiters.
- Children's Minnesota continues to invest in the workforce of the future through the equity and inclusion internship program. Established in 2019, the program provides opportunities for diverse high school and college students to learn and engage in areas that they potentially see as a future career opportunity. Nearly 40 students have completed the program since its launch.

Minnesota Business Coalition for Racial Equity

- The Children's Minnesota chief equity and inclusion officer and senior vice president of government and community relations was one of the founding members of the Minnesota Business Coalition for Racial Equity. The coalition brings together Minnesota's leading businesses and organizations and is focused on building an equitable, inclusive and prosperous state with and for Black residents. Current work of the coalition is prioritized into three pillars that include: employment opportunity, Black business development and community well-being.

Patient family access to public programs

- In 2021, 17 percent of referrals made to the Children's Minnesota Healthcare Legal Partnership (HLP) involved public program benefit cases. Cases included denial of benefits, petitioning for an increase in benefits and providing key information to patient families about overall eligibility. More information about the Children's Minnesota HLP is available under "Access to Resources".
- Children's Minnesota continues to advocate for improved access to state programs like Medicaid.

PRIORITY HEALTH TOPIC:

Mental health and developmental well-being

Goal from 2020–2022 implementation strategy: Identify opportunities for enhanced and more coordinated mental health support for children with an emphasis on early childhood services, early intervention and culturally informed care.

Objectives:

- Identify and develop specific services in follow-up clinics for at-risk early childhood patient populations.
- Improve access by expanding Integrated Behavioral Health into primary care clinics.
- Implement suicide screening across behavioral health and primary care programs.

A new neurodevelopmental services clinic

- The Neurodevelopmental Services Clinic is a team consisting of neuropsychology, developmental pediatrics and psychology with a focus on providing care for children with developmental differences. This includes children with medical complexities that have an impact on development as well as developmental conditions like autism. Children's Minnesota provides detailed developmental and neuropsychological assessments, ongoing developmental care, and assistance coordinating care and services.

HealthySteps

- HealthySteps is an interdisciplinary program that promotes the healthy development of babies and toddlers by focusing on positive parenting, supportive resources and parent well-being. The program connects specialists with parents during well-child visits and is continuing to be implemented in Children's Minnesota primary care clinics.

Standard suicide screening

- Children's Minnesota now uses standard suicide screening tools for inpatient and outpatient mental health services. Risk assessments are conducted for all new clinic patients 11 years of age or older.

Expanding our continuum of mental health services

- In response to the growing mental health crisis among children and youth, Children's Minnesota is expanding our continuum of mental health services. In 2021, Children's Minnesota opened our first mental health partial hospitalization program and in 2022 Children's Minnesota opened our first inpatient mental health unit. Plans to open a second partial hospitalization program in early 2023 are also underway. In addition to this work, Children's Minnesota has successfully embedded integrated behavioral health into all of our primary care clinics.
- At the policy level, Children's Minnesota continues to participate in conversations focused on improving the kids' mental health system considering inpatient mental health services, day treatment services, community placements and home health supports.

PRIORITY HEALTH TOPIC:

Access to resources

Goal from 2020–2022 implementation plan: Expand programming and partnerships that connect patients and families to essential resources to positively impact overall health, development and well-being.

Objectives:

- Extend Community Connect model to serve additional patient populations.
- Promote continued organization awareness and utilization of Children's Healthcare Legal Partnership.
- Build upon existing relationships and explore new partnerships to foster mutually beneficial collaborations with community-based organizations, schools, and other key entities to streamline communication, service delivery and information sharing.

Community Connect

- The Children's Minnesota Community Connect program was launched in 2017 in our Minneapolis and St. Paul primary care clinics. In 2022 the program expanded and now also serves patient families in our West St. Paul and Brooklyn Park clinics.
- The program continues to screen families for unmet social needs and connects them with Resource Navigators. Navigators work with families by finding responsive resources and providing supportive follow-up services. Given the stressful nature of the ongoing pandemic, Resource Navigators have been making a conscious effort to assist families in prioritizing immediate needs with a focus on action planning and goal setting to increase success in ensuring families can access what they need.
- Community partnerships are the key to ensuring seamless referrals and access to resources. Between January and October of 2022, Community Connect sent a total of 1,113 closed-loop referrals, which enables the program to track outcomes.

Healthcare Legal Partnership

- Launched in 2017, the Children's Minnesota Healthcare Legal Partnership (HLP) continues to support two attorneys based in our St. Paul and Minneapolis hospital campuses. These dedicated lawyers collaborate with healthcare teams to identify, prevent and remedy health-harming factors that are rooted in legal problems. The majority of cases involve family law, housing, benefits and immigration.
- At the height of the COVID-19 pandemic, the HLP developed extensive materials summarizing COVID-19 related rights, resources and benefits to keep stakeholders informed of key changes against a quickly shifting landscape.

Clinic in the Classroom

- In response to schools' requests for information in the midst of the COVID-19 pandemic, Children's Minnesota hosted a number of webinars specific to school health professionals. The success of these webinars, along with expressed interest from schools in receiving more information on a number of topics, led to the development of the Children's Minnesota Clinic in the Classroom webinar series. School health professionals from across the state now have the opportunity to access continuing education provided by Children's Minnesota clinicians on a monthly basis. An advisory council that includes school health professional staff from local districts and the state continues to provide guidance on content that will best meet the practical needs of school health staff.

NEXT STEPS

During the next few months Children's Minnesota will take a number of steps to develop an implementation strategy that aligns with the 2022 CHNA.

To accomplish this, Children's Minnesota staff will:

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

Children's Minnesota plans to continue our efforts to engage community members in our broader work and to maintain and develop new partnerships.

For more information about the 2022 Community Health Needs Assessment, visit childrensMN.org/chna.

Questions? Contact Children's Minnesota at **community@childrensMN.org.**

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