Community Health Needs Assessment 2022

NORTH MEMORIAL HEALTH HOSPITAL

NORTH
MEMORIAL HEALTH

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Executive Summary

Assessing the health needs of the communities served by North Memorial Health Hospital (NMHH) is vitally important to our ability to live our mission—empowering our customers to achieve their best health. Health outcomes are determined by many factors, with clinical care being just one of them. Clinical care can diagnose, treat, and often cure diseases, but we recognize health is more than that. Social and economic factors like systemic racism, trauma, food security, housing, and jobs impact more than 50% of people's well-being. Because of this, it is our goal to understand health issues in our community, barriers to good health, community resources, and work towards creating healthier communities through a variety of targeted initiatives.

NMHH has conducted a Community Health Needs Assessment (CHNA) every three years since 2013. Throughout 2022, the hospital conducted a comprehensive Community Health Needs Assessment working collaboratively with numerous partners including our Community Engagement Advisory Team (CEAT), community members, community organizations and coalitions, and local public health agencies. The CHNA is designed to describe the health of people living in our consolidated service area, documents both health-related needs and strengths, and results in the identification of community health priorities for 2023-2025. Based on the CHNA, a three-year Community Health Implementation Plan (CHIP) will be developed highlighting key strategies, tactics, and partnerships to address the priority health issues in our region.

The 2022 CHNAs report on the health of our consolidated service area (CSA) that included 75% of the customers served by both NMHH and Maple Grove Hospital. The 2022 CSA includes 31 zip codes, 10 cities/towns, and seven school districts.

METHODOLOGY

The CHNA process gathered and analyzed current data and community input on a broad range of health issues using quantitative and qualitative data sources that focused on:

- The health of community members (demographic characteristics, births, deaths, chronic conditions, communicable diseases, mental health),
- Health behaviors (substance use, physical activity, nutrition),
- Accessible and affordable health care, including preventive health such as health care screenings, immunizations, and dental care,
- Healthy and safe environments, and
- Social and economic factors that influence health (education, employment, affordable housing, food security, and social support)

Data from quantitative sources included local health surveys that gather information on the health of youths and adults throughout the region. Key sources included the Hennepin County Survey of the Health of All the Population and the Environment (SHAPE), the Minnesota Student Survey, national health indexes, and data provided by Hennepin County Public Health and Minnesota Department of Health. Qualitative data was collected by intentionally engaging with community members and organizations to identify and understand significant health needs in the community and seek community member input on gaps, barriers, and resources they need to lead healthy lives. Primary qualitative data was collected from key health informant interviews, community engagement activities such as dinners and dialogues and surveying community members at community events, and use of an interactive digital website aimed at collecting information from North team members, providers, and community residents.

COMMUNITY HEALTH NEEDS PRIORITIZED

Quantitative data was scored by the NMHH Community Engagement Advisory Team (CEAT) on the basis of size, seriousness, effective interventions to address the issue, disparities, and whether population-based health goals were being met. There were a number of health issues that were identified as "critical" which are noted in the CHNA report under quantitative data findings.

Findings from data collected during community engagement events was shared by themes for the three types of qualitative research. Common themes that emerged from our qualitative research were:

- Need for increased access to health care and other resources, especially mental health
- Establish trusted care relationships within communities of color and immigrant communities
- Address the social determinants of health where gaps exist and where North Memorial Health can have the biggest impact
- Significant impact of Covid-19 and systemic racism on the community

In order to address many of the issues identified by the quantitative and qualitative data processes, two community health needs were prioritized for action with the belief that if they were addressed, health outcomes in a number of areas would be improved. The two areas that have been prioritized for action are ***Racial Disparities in Health*** and ***Life-Impacting Traumas***.

NEXT STEPS

NMHH will continue to work with community members to develop Community Health Implementation Plans (CHIPs) for the two prioritized heatlh issues. The CHIPs will be companion documents to the CHNA and will guide our work in 2023-2025. The plan will be created in partnership with the hospital CEAT, North Memorial Health hospital and clinical leaders, public health, and other community partners. It will include strategic actions, outcome and/or impact measures, hospital and community resources, and partners.

This Community Health Needs Assessment meets all the federal requirements of the Patient Protection and Affordable Care Act (ACA) and the Internal Revenue Service final requirements. It was approved by the NMHH Board of Trustees on August 8, 2022. In accordance with federal requirements, this report was made widely available to the public on our website. Paper copies are available through North Memorial Health's Diversity, Equity, and Inclusion and Community Health Department.

Additionally, findings from the Community Health Needs Assessment and our priority health issues will be shared with hospital leaders, decision-makers, community partners, and community residents through various presentations throughout the year.

Letter from the CEO

Dear North Memorial Health Community:

I am pleased to share the results of North Memorial Health's 2022 Community Health Needs Assessment (CHNA). The assessment is a deep dive into the health of the communities North Memorial Health serves and reports on both health-related needs and strengths in our region.

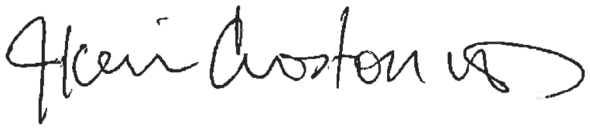
The CHNA will guide our work on the 2023-2025 Community Health Implementation Plan (CHIP). The CHIP will develop strategies and approaches to address select themes from our priority health issues of ***racial disparities in health*** and ***life-impacting traumas*** over the next three years. Addressing selected themes within our system and communities will require collaborative efforts with healthcare partners, community organizations such as schools, local governments, non-profit organizations, and community members. Development of the CHNA and CHIP are first steps in this long-term, systemic work. I look forward to working with you on these important and impactful efforts.

Certainly, the impacts of COVID-19 and systemic racism have challenged our communities and health system and have placed even greater importance on the need for robust, responsive, culturally sensitive healthcare systems. Ensuring that we are able to both reflect the communities we serve and meet our customers where they are at are critically important steps. By doing so, we can begin to address the inequities our community members are feeling and remain a trusted resource to all who are seeking care from North.

Finally, I want to thank our Community Engagement Advisory Teams, community partners, and consultants, for their work in reviewing and scoring health indicators and participating in community engagement activities. I also want to thank public health epidemiologists who devoted significant time providing data specific to our service area. This work would not have been possible without your efforts.

I am proud to advance this important work with urgency in the year ahead.

Sincerely,



J. Kevin Croston, MD, CEO
North Memorial Health

Acknowledgments

The CHNA is a result of contributions from many individuals and organizations. The 2022 CHNA was led by North Memorial Health's Carrie McLachlan, Senior Community Health Specialist, and Jessica Kingston, System Director, Diversity, Equity, and Inclusion. We would like to thank our Community Engagement Advisory Teams for reviewing and scoring key health indicators and selecting priority health issues for action. Thank you to the staff at Hennepin County Public Health who responded to a wide range of data requests specific to our consolidated service area, most notably Amy Leite-Bennett, Urban Landreman, Alissa Walden, Marie Maslowski, and Cameron Bright. Thank you also to Stefan Gingerich from the Minnesota Department of Health.

We could not have completed this assessment without the contributions of the North Memorial Health Hospital CEAT who reviewed and scored key health indicator data. Their participation in many conversations about the data, what it meant in terms of the health status of our communities, and shared stories about the clients and customers they served to help highlight the issues in our region.

CEAT TEAM

(Current as of the August CEAT Meeting)

- Amy Caron, Area Manager for Health Protection – Hennepin County Public Health
- Lauren Carter, Brand Engagement Program Manager – North Memorial Health
- Andy Cochrane, Chief Hospital Officer – North Memorial Health
- Telina Fleming, Care Coordinator – Broadway Family Medicine
- Samantha Hanson, Chief Administrative Officer – North Memorial Health
- Peter Hayden, PhD, President – Turning Point
- Mark Ihrke, Executive Director – New Hope and Ridgedale YMCAs
- Paul James, Marketing Strategist – North Memorial Health
- Shirley Kern, Clinical Nurse Specialist – North Memorial Health
- Hanmin Kim, Social Worker, Addiction Medicine – Broadway Family Medicine
- Jessi Kingston, System Director, Diversity, Equity and Inclusion – North Memorial Health
- Steve Knutson, Executive Director – Neighborhood HealthSource
- Carrie McLachlan, Senior Community Health Specialist – North Memorial Health
- Sheila Nesbitt, Coordinator, Outreach & Prevention, North Trauma Institute – North Memorial Health
- Jason Qualls, Communication & Engagement Coordinator – NorthPoint Health & Wellness Center
- Rosemary Robinson, Case Manager – Broadway Family Medicine
- Tim Sandvik, City Manager – City of Robbinsdale
- Molly Schlief, Clinic Social Worker – Broadway Family Medicine
- Margaret Schuster, Sr. Public Health Specialist – City of Minneapolis, Health Department
- Tsega Tamene, Director of Community Health – Pillsbury United Communities
- Filisha Thor, Hmong Interpreter/Care Coordinator – Broadway Family Medicine
- Latrese Van Buren, Community Health Worker – Broadway Family Medicine
- Ryan Van Wyk, Psy D, LP Specialty Lead – North Memorial Health

About North Memorial Health

North Memorial Health Hospital's (NMHH) roots lie in local, neighborhood-based health care. Founded as a community hospital in 1954 in Robbinsdale, Minnesota, the hospital is one of four Level I Trauma Centers in the state. It is a 353-bed tertiary hospital (518 licensed beds) and provides emergency and Level I trauma care, high-risk maternity services, a Level II neonatal ICU (NICU), cardiovascular services, acute psychiatric, and rehabilitation services. The NMHH campus also includes a state-of-the-art breast cancer center, a heart health and vascular center, and other specialty services. NMHH maintains strong connections with Minneapolis' North Side neighborhoods and northwestern suburbs, including Brooklyn Center, Brooklyn Park, Crystal, Golden Valley, New Hope, and Robbinsdale.

NMHH is an organization under the North Memorial Health (NMH) comprehensive healthcare system. Other entities in the system include Maple Grove Hospital (MGH), 27 owned or affiliated clinics, and one of the largest ground and air medical transportation services in the country. With 462 physicians on the medical staff and over 130 Advanced Practice Providers, NMH's 6000+ employees serve over 55,000 patients monthly.

Maple Grove Hospital was built in 2009. It is the #1 hospital for births in Minnesota. Its 130 beds include a 33-bed NICU, 12 labor and delivery beds, 29 post-partum beds, 29 general surgery, 26 ICU, and 2 pediatric beds. Services provided include a Level III NICU, urgent care, heart and vascular clinics, and a sleep center.

As a non-profit healthcare system, NMH's hospitals provide emergency care for all, regardless of insurance status or ability to pay. This means everyone who walks through the doors will receive the best healthcare the organization can provide. NMH's board-certified emergency physicians and nurses provide emergency and acute care to nearly 110,000 people every year. NMH's emergency departments are used as models nationwide. More than 75 locations in Minnesota and surrounding states refer trauma patients to NMHH for care and 100 percent of referring physicians have stated they would refer again.

In 2021, North Memorial Health served 31,617 hospital admissions and 358,243 outpatient clinic visits. The pharmacies dispensed 3,579,040 prescriptions; 5,603 babies were delivered; 22,049 surgeries were performed; 102,699 emergency services customers were treated; 94,879 ground ambulance runs and 2,693 helicopter transports were conducted; and 200,765 imaging procedures were performed.

North Memorial Health's mission is "empowering our customers to achieve their best health" towards the vision of "Together, health care the way it ought to be." The organization believes that everyone should have available the resources, knowledge, and tools necessary to make informed decisions regarding their own health. To this end, it strives to provide access to that information through education, support staff, and transparency in care. The values that we hold most dear are inventiveness, accountability, and relationships.

RECENT NMH RECOGNITION AND AWARDS

- **2022 Fortune/Merative 100 Top Hospitals®** honored NMH in the small health systems category and honored MGH for the fourth time as one of the top-performing medium community hospitals in the U.S.
- The Star Tribune named MGH as its "Gold Winner" in the "**Best Place to Have a Baby**" category.
- NMHH and MGH are designated "**LGBTQ+ Healthcare Equality Top Performer**" in the Human Rights Campaign Foundation's 15th anniversary edition of the Healthcare Equality Index (HEI).
- NMHH and MGH were named to the **2022 Women's Choice Award Best Hospitals** list in nine categories, including top performance designation for Obstetrics.
- Press Ganey named MGH a **2021 Guardian of Excellence Award®** winner for achieving the 95th percentile or above for performance in patient experience.

Community Health Needs Assessment

INTRODUCTION

The Patient Care and Affordable Care Act of 2010 requires that all 501(c)(3) hospitals conduct a community health needs assessment (CHNA) to meet the U.S. Department of Treasury and Internal Revenue Service (IRS) rules. The purpose of conducting community health needs assessments (CHNA) is to identify and analyze the health needs of the community and develop community health implementation plans (CHIP) to address priority health issues. NMHH conducted its first CHNA in 2012 and adopted their first community health implementation plan in 2013.

NMHH conducted a Community Health Needs Assessment in 2022. Over 90 quantitative key health indicator data elements were reviewed and scored in terms of size, seriousness, disparities, whether health goals are being met in the region, and if there exist effective community or clinical interventions that could be used to improve the health issue. Both quantitative and qualitative data were analyzed by hospital staff and members of NMHH Community Engagement Assessment Team (CEAT).

By examining social determinants and other community risk factors such as basic needs (housing, food, language barriers), the CHNA covers health in its broadest sense. It takes an in-depth look at upstream factors for early death or poor health. Efforts were made to identify health disparities and populations at greater risk of poor health. The CHNA is a key document leading to more in-depth analysis of the top issues. The work culminates in the development of community health implementation plans (CHIP) to address the hospital's health priority issues.

We do this work in partnership with numerous community partners. Our hope is that the CHNA will not only help identify top health issues in the hospital's service area but that the data can also assist civic leaders, community members, and non-profit organizations in their health improvement planning, as well.

PROCESS

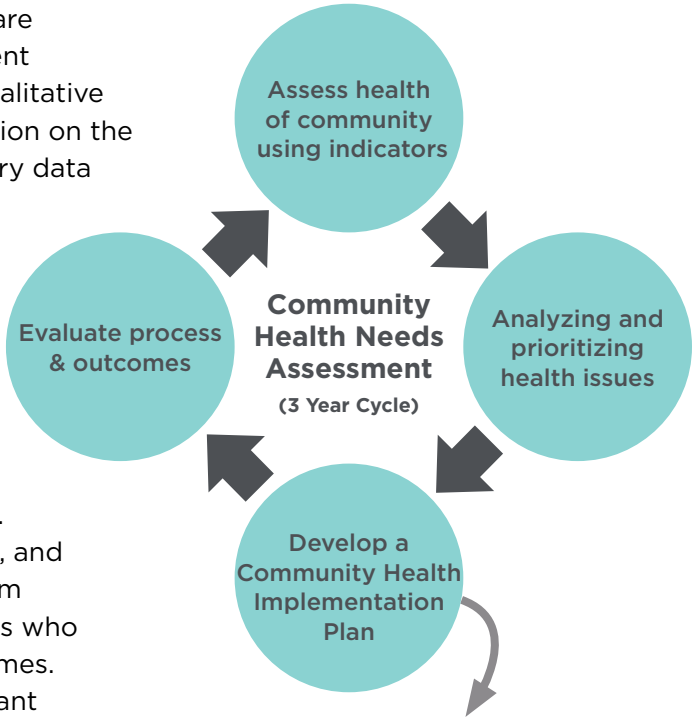
Community Health Needs Assessments gather data and community input on a wide range of health issues including:

- The health of community members (demographic characteristics, births, deaths, chronic conditions, communicable diseases, mental health),
- health behaviors (substance use, physical activity, nutrition),
- accessible and affordable health care, including preventive health such as health care screenings, immunizations, and dental care,
- healthy and safe environments, and
- social and economic factors that influence health (education and employment, affordable housing, social support)

We used a Community Health framework adapted from the Missouri Department of Health Community Health Assessment Resource Team (CHART) Model and the Institute of Medicine's CHIP Model (1997). The framework consists of four phases:

1. Assessing the health of the community using both quantitative and qualitative data
2. Analyzing and prioritizing health issues
3. Developing and implementing a community health improvement plan (CHIP), and
4. Evaluating the process and outcomes.

This cycle repeats every three years. The first two steps are accomplished in the Community Health Needs Assessment (CHNA). Data for CHNAs come from quantitative and qualitative data sources such as health surveys that gather information on the health of youths and adults in the community, and primary data collection by intentionally engaging with community members and organizations to identify and understand significant health needs in the community and seek input on addressing gaps and barriers so community members can lead healthy lives.



Community Health Implementation Plan (CHIP)

With community partners:

1. Explore subpopulation data; disparities
2. Identify gaps/barriers
3. Identify effective interventions
4. Inventory resources
5. Develop improvement strategies
6. Develop indicator set
7. Identify accountability

Partners for Qualitative Research

North Memorial Health contracted with several organizations to help with the qualitative data collection. Our goal was to seek input that reflects the racial, ethnic, and economic diversity of our communities, both directly from community members as well as from community partners who serve populations experiencing inequitable health outcomes. Susan DeSimone, Inc. led and conducted our Key Informant Interviews. With over 21 years of experience in qualitative research, Susan interviewed all CEAT members and a number of community partners representing various organizations including government, schools, non-profits, churches, and specific population-focused organizations.

Cultural Wellness Center (CWC) cooordinated and led our community engagement events including Dinners and Dialogues, Slow Rolls with Community Conversations, surveyed community members at community events such as Hmong Know Your Community Park, Lakeview Terrace and Maple Grove Farmers Markets, and Igbo Days. The Cultural Wellness Center brings deep and broad experience working closely with communities to help residents lead healthier lives by addressing multiple health issues,, and build community capacity. CWC has an established history of success in the Twin Cities and recognition as a knowledge-production organization offering culturally-based research and solutions to real-world health and well-being issues. Providing services that are all about people, from people, and for people, their People's Theory states that isolation/individualism, loss of culture, and loss of community makes one unwell, and engagement strategies must "Unleash the power of people to heal themselves and build community".

PRIMARY DATA SOURCES

Hospital data comes from the North Memorial Health system and is reported for the consolidated service area (CSA).

Maptitude

MAPTITUDE 2021 is a commercial GIS product from Caliper Inc. used by North Memorial Health to understand the population of the region they serve. Most Maptitude data is a blend of 1 year and five year American Community Survey (ACS) and U.S. Census data, and their own estimates. Five-year data estimates are often used in Maptitude, current through 2018 and 2019.

SHAPE

Much of the adult health data comes from the 2018 Hennepin County Adult Survey of the Health of All the Population and the Environment (SHAPE). We report data from three regions including Minneapolis North (Camden and Near North), Northwest suburbs-inner ring (Brooklyn Center, Brooklyn Park, Crystal, New Hope, and Robbinsdale) and Northwest suburbs-outer ring (Champlin, Corcoran, Dayton, Golden Valley, Hanover, Hassan Township, Maple Grove, Medicine Lake, Osseo, Plymouth, and Rogers).

Minnesota Student Survey (MSS)

Since 1989, the MSS is conducted every three years to all students in regular public elementary and secondary schools, charter schools, and tribal schools at 5th, 8th, 9th, and 11th grades. For the CHNA, we report 2019 MSS data for Anoka-Hennepin School District and Minneapolis School District (two of Minnesota's largest districts). Data from other school districts in the CSA has been combined and reported on as CSA student data. These districts included Brooklyn Center, Hopkins, Osseo, Robbinsdale, and Wayzata.

Social Vulnerability Index (SVI)

The SVI uses 15 U.S. Census variables to government and other non-profit agencies to identify communities that will most likely need support before, during, and after a hazardous events incluing natural disasters or disease outbreaks.

Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry/Geospatial Research, Analysis, and Services Program. CDC/ATSDR Social Vulnerability Index 2020 Database Minnesota. https://www.atsdr.cdc.gov/placeandhealth/svi/data_documentation_download.html.

Community Resiliency Estimate (CRE)

The CRE are estimates produced using information on individuals and households from the American Community Survey (ACS), the Census Bureau's Population Estimates Program (PEP), as well as publicly available health condition rates from the National Health Interview Survey (NHIS). The CRE for Equity dataset provides social vulnerability and equity information about the nation, states, counties, and census tracts.

U.S. Census, Community Resiliency Interactive Tool, 2019. https://www.census.gov/programs-surveys/community-resilience-estimates/data/tools.html

Child Opportunity Index

The Child Opportunity Index 2.0 (COI 2.0) is a composite index measured at the census tract level that captures neighborhood resources and conditions that matter for children's healthy development in a single metric. The COI focuses on contemporary features of neighborhoods that are affecting children. It is based on 29 indicators spanning 3 domains: education, health and environment, and social and economic. It can be accessed at: "Child Opportunity Index 2.0 database," https://data.diversitydatakids.org/dataset/coi20-child-opportunity-index-2-0-database?_external=True

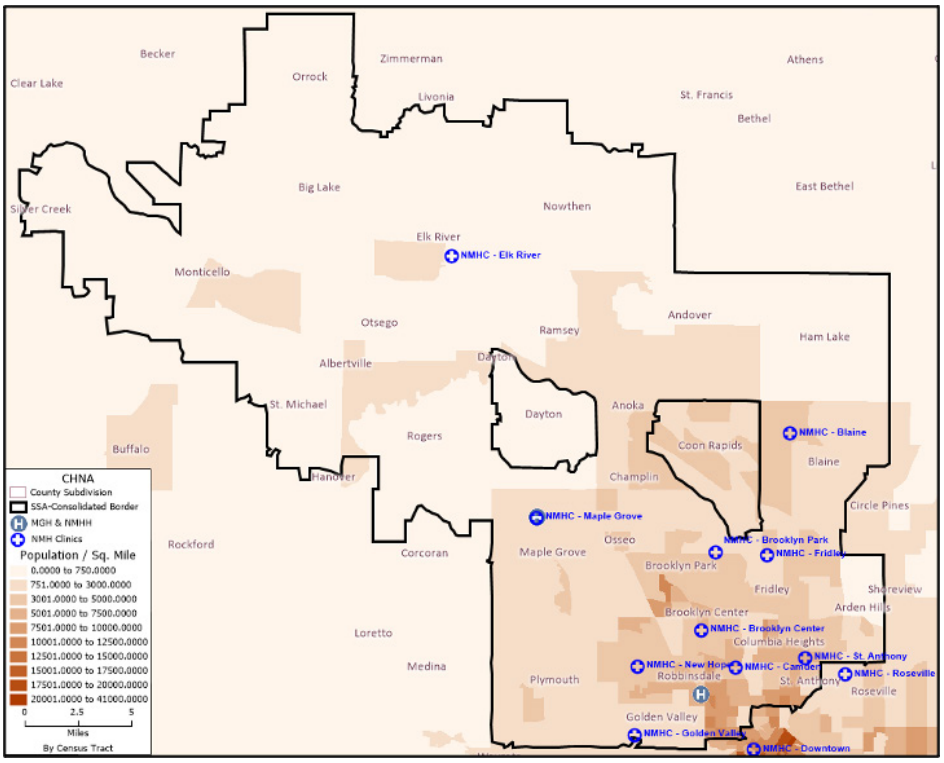
LIMITATIONS

This CHNA utilized a wide-range of data sources to develop a comprehensive picture about the health of the community we serve. As much as possible we explored health disparities within our population and sought input from diverse members of our community. There are, however, a number of limitations that impact various data sources which we would like to acknowledge here. They include:

- Time frames varied from data source to data source.
- Much of the ongoing population survey data (Hennepin County SHAPE (2018) and the Minnesota School Survey (2019)) were collected prior to COVID-19. Each of these surveys is being conducted in 2022 and will more accurately reflect the health of residents as impacted by both Covid-19 and the murder of George Floyd. It is critical to report on such data as a benchmark and monitor impact in upcoming years.
- The geographies (CSA, county, SHAPE geographic region, school districts) of data varied depending on the data source.
- Some data sources did not have racial/ethnic data available or group data into larger categories (such as "Black", "Hispanic", "Asian") which do not allow us to distinguish among ethnic groups or nationalities within categories. Many sources do not distinguish between those born in the United States or another country.
- Due to small numbers in either events and/or availability of race/ethnic data in varying geographies, it is difficult to assess some health disparities and variances in rates. In some cases, this CHNA uses number of events to describe the health issue being reported on (e.g. infant deaths, unintentional injuries).
- NMHH and Maple Grove Hospital data is based on Epic electronic health records, which only reflects the health of those seeking services from North Memorial Health facilities.
- Quantitative data is reflective of those participants and their individual experiences, but we recognize such stories and experiences are all part of the larger narrative about the health of our communities. Such data often does not reflect root causes and or provide insight into contributing factors, all important when assessing the health of communities.
- For some topics, we had incomplete or limited quantitative data and a lack of qualitative data to contextualize findings.

GEOGRAPHY/CONSOLIDATED SERVICE AREA

The CHNA reports on the health of people who live within the geographic boundaries of North Memorial Health's consolidated service area. The area selected for data analysis included 75% of all patients admitted to NMHH and Maple Grove Hospital in the year 2021. The service area included 31 zip codes, 10 cities and 7 school districts located partially or fully within the service area. Because the service area has changed from previous CHNAs, direct comparison to past CHNAs is not possible. Our goal is to report on baseline data for the entire consolidated service area as there is significant overlap of customers served by both hospitals. However, there is much variation between the zip codes included in the consolidated service area. When possible, community health staff reviewed data by zip codes and highlighted smaller geographies which seem to be facing more health issues and/or health disparities.



The ZIP CODES included in the service area include:

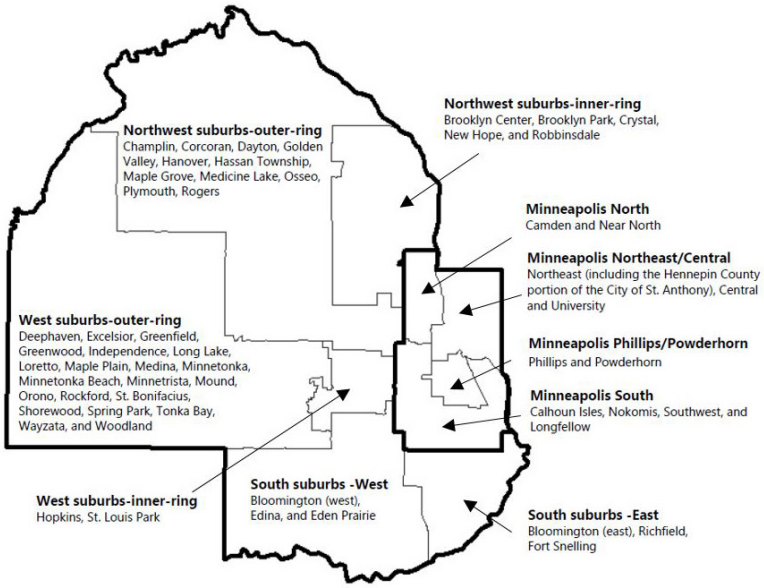
55418	Minneapolis	55441	Minneapolis	55316	Champlin
55411	Minneapolis	55447	Minneapolis	55304	Andover
55412	Minneapolis	55446	Minneapolis	55303	Anoka
55421	Minneapolis	55442	Minneapolis	55374	Rogers
55432	Minneapolis	55428	Minneapolis	55376	Saint Michael
55430	Minneapolis	55445	Minneapolis	55301	Albertville
55444	Minneapolis	55434	Minneapolis	55330	Elk River
55443	Minneapolis	55449	Minneapolis	55362	Monticello
55429	Minneapolis	55112	Saint Paul	55309	Big Lake
55422	Minneapolis	55369	Osseo		
55427	Minneapolis	55311	Maple Grove		

Regional Reporting Geographies

Throughout the CHNA we report on data from two regional surveys (Hennepin County SHAPE Survey and the Minnesota Student Survey). Adult data is reported for three geographic regions including Minneapolis-North, Northwest suburbs-inner ring, and Northwest suburbs-outer ring. Please see the map for the areas included in this assessment.

Data on youth health comes from the Minnesota Student Survey results and is reported on for the Minneapolis School District, Anoka-Hennepin School District, and a Consolidated School District (CSA) that includes data from Brooklyn Center, Hopkins, Osseo, Robbinsdale, and Wayzata School Districts.

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



KEY HEALTH INDICATORS SCORING TABLE

CEAT Members scored key health indicators on five criteria: Size, Seriousness, Effective Interventions, Disparities and Meeting a Health Goal.

Key Health Indicators

Size	Seriousness	Effective Interventions	Disparities	Meet Goal (HP2030, other)
Number of people affected by health condition/health issue in the NMHH/ MGH service area	Potential of a health condition and/or issue to result in serious disability or death	The availability of effective community-based or clinically-based health interventions/strategies	Differences in the health status of different groups of people, some groups of people have higher rates of disease, more deaths, and suffering, compared to others.	HP2030 establishes goals and objectives for many common health indicators; professional groups also establish goals for certain health indicators
0 = Do not know number affected by health condition/ heath issue	**0** = Do not know the impact of this issue on our communities	**0** = No known interventions to address this health issue/condition/ behavior	**0** = No known health disparities or health inequities	**0** = No goal available or inconsistently meeting a goal
1 = Relatively few people affected by health condition/ health issue	**1** = Not life threatening or resulting in disability	**1** = There are some strategies to address this issue but they have not been documented as promising or effective interventions	**1** = There are health disparities or health inequities in 1-2 subgroups	**1** = We are exceeding the HP20a30 goal or another gold standard goal
2 = Limited or moderate numbers affected in a particular subgroup	**2** = Not life threatening but sometimes results in disability			**2** = We are just barely meeting the HP2030 goal
3 = Moderate numbers affected across the population	**3** = Moderately life threatening with a strong chance of disability	**3** = There are promising practices or interventions to address this issue	**3** = There are health disparities or health inequities in 3-4 subgroups	**3** = We are not meeting the HP2030 goal, but we are close
4 = Large numbers affected in subgroups	**4** = Moderately life threatening with a strong chance of serious disability			**4** = We are not meeting the HP2030 and have significant work until we meet the goal
5 = Large numbers affected across the population	**5** = High likelihood of death or permanent disability	**5** = There are proven, effective community-based or clinically-based interventions to address this issue	**5** = There are disparities or health inequalities in many subgroups	**5** = We are a long way from meeting the HP2030 goal

Sociodemographic Data

INTRODUCTION

Sociodemographic data is used to describe the population within the consolidated service area. Such data includes demographic information about age, gender, race and ethnicity, income, unemployment, poverty, composition of households, and education levels. Data is reported on for the consolidated service area with several indicators at the hospital service area or school district levels.

Most of the sociodemographic data was not scored as it is descriptive of the population. That said, there are some key health indicators which can be changed and do have Healthy People 2030 goals, those were included in key health indicator scoring.

POPULATION

The population of the consolidated service area is 847,500 people. The population consists of 416,379 males and 431,106 females. The total population consists of 27.7% children and youth ages 0-19, 59.4% adults ages 20-64, and 12.9% adults ages 65+. It is estimated that the population will grow to 928,592 people by 2025, growing by about 9.6%.

Population	MGH	NMHH	Consolidated
Male	49.0%	49.2%	49.1%
Male 18+	36.3%	36.9%	36.3%
Male 65+	5.7%	5.8%	5.7%
Female	51.0%	50.8%	50.9%
Female 18+	38.2%	38.6%	38.1%
Female 65+	7.3%	7.5%	7.3%

Age 0-19	27.4%	26.6%	27.7%
Age 20 to 24	5.1%	5.6%	5.2%
Age 25-34	27.6%	29.1%	28.1%
Age 45-64	26.9%	25.4%	26.0%
Age 65+	13.0%	13.4%	12.9%
2025 Population*	109.2%	112.1%	109.6%

*Projected

Median age ranged greatly by zip code with a low of 27.4 (55411) to a high of 47.4 (55442).

Source: Maptitude

RACE AND ETHNICITY

Even taking into account a larger service that includes more suburbs, the consolidated service area is more racially and ethnically diverse compared to previous CHNAs.

Race/Ethnicity	2012 NMHH CHNA	2022 NMHH CHNA	2022 MGH CHNA	2022 Consolidated Service Area
White	76.2	72.2	77.5	73.8
Black	9.6	14.0	10.2	12.6
Asian and/or Pacific Islander	5.9	7.1	7.0	7.2
All Other	3.3	6.7	5.4	6.3
Hispanic	5.1	5.9	4.9	5.7
Non-Hispanic	NA	94.1	95.1	94.3

HOUSEHOLD COMPOSITION

The consolidated service area has 313,018 households. These households include 109,475 with at least one child under age 18 living in the home and 76,521 households with at least one person over age 65 living in the home.

Household Income

The median household income in the service area was $78,873. Income levels vary widely in the service area from a low median income of $42,475 in north Minneapolis to a high median income of $134,200 in Plymouth. The median household income in Minnesota in 2020 was $75,489 with higher median incomes noted in Hennepin County ($81,772) (Source: Kids Count).

Unemployment

The latest unemployment data for the service area showed the unemployment rate to be 3.7% of civilians age 16+ who are in the labor force. There are disparities in unemployment rates by zip code with zip codes 55411 and 55412 (Minneapolis), 55429 (Brooklyn Center) and 55434 (Blaine) having unemployment rates above 5%.

We are meeting the HP2030 goal of 75% of working-age people, ages 16-64, to be employed.

Poverty

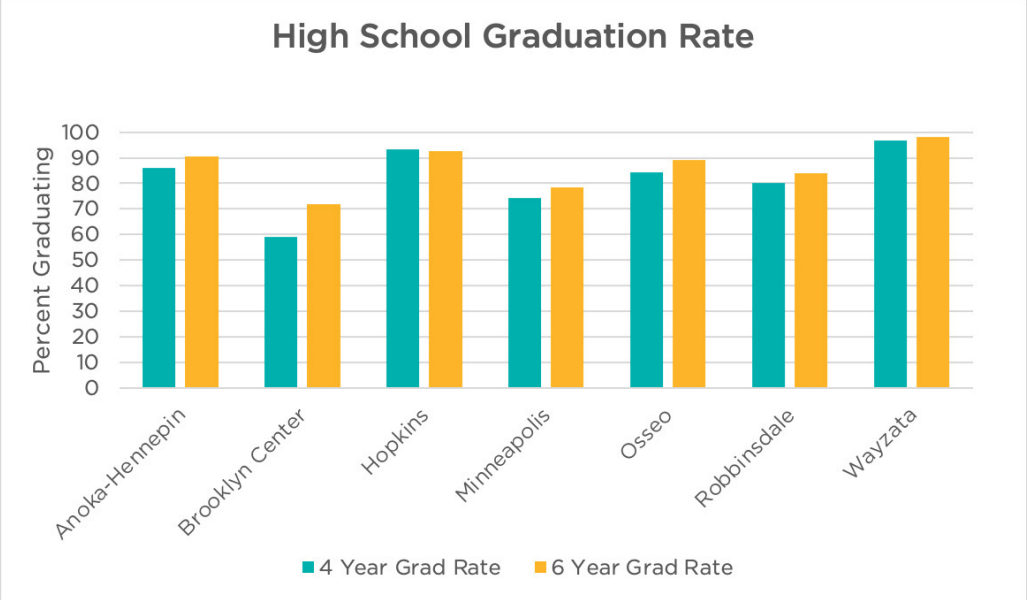
In the consolidated service area, 6.49% of all families are in poverty, with 8.06% of families with children under the age of 18. In the NMHH region, these numbers are 8.18% and 9.47% respectively, while in the Maple Grove Hospital region the percentages are 5.35% and 6.35% respectively. The U.S. Health and Human Services sets the federal poverty level (FPL) for all contiguous 48 states, Puerto Rico, the District of Columbia and all U.S. territories. In the lower 48 states the FPL was set at $12,760 for a household of 1, $17,240 for a household of 2, and $21,729 for a household of 3. The data shows that poverty is more common among certain groups, particularly female head-of-households with children. *Kids Count* reports that in 2019 there were 32,278 children in poverty in Hennepin County (11.9%), this number dropped to 28,282 (10.5%) in 2020.

The HP2030 goal is to reduce the portion of people living in poverty to 8.0%.

We are meeting this goal in the Maple Grove Hospital region but not in the North Memorial Health Hospital region.

Graduation Rates (4 and 6 years) by School District

Four-year graduation: The chart below shows both on-time (4 year) and 6-year graduation rate for public high schools in the service area. We defer to Hennepin County data for on-time graduation rates by race and gender. Minnesota Department of Education had an existing goal to reach a four-year adjusted cohort graduation rate of 90% with no student group below 85% (this was the goal they set for the year 2020).



The HP2030 goal is that 90.7% of students graduate on time.

Our rates vary but we are not meeting this goal in the Brooklyn Center, Minneapolis, Robbinsdale, Osseo and Anoka-Hennepin School Districts.

Adult Education Level

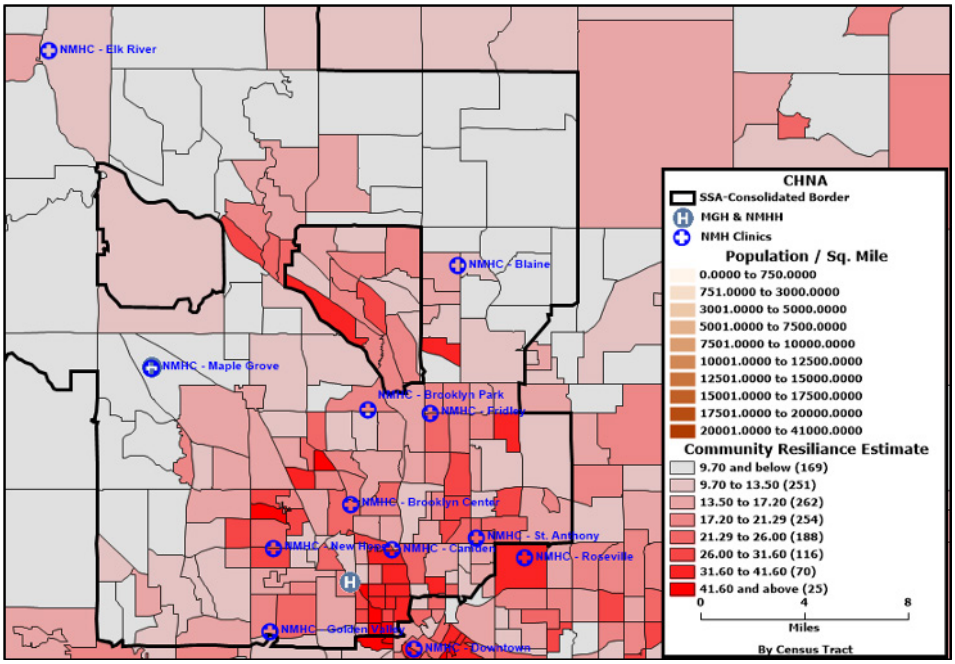
Most (94.1%) adults age 25 or over in the service area have graduated from high school or earned a high school graduation equivalency. Of these, 27.7% also have a bachelor's degree or higher. 6.6% of adults age 25 or older do not have a high school diploma.

COMMUNITY RESILIENCY ESTIMATES (CRE)

Community resilience is the capacity of individuals and households within a community to absorb, endure, and recover from the impacts of a disaster. The CRE are estimates produced using information on individuals and households from the American Community Survey (ACS), the Census Bureau's Population Estimates Program (PEP), as well as publicly available health condition rates from the National Health Interview Survey (NHIS). It creates an aggregate score from 10 social and economic risk factors at the census tract level (data from 2019 ACS). The U.S. Census uses this measure as a proxy to identify neighborhoods at higher risk of poor health outcomes and inequity to achieve an average standard of health. Risk Factors included in the CRE are:

- Income to Poverty Ratio
- Single or Zero Caregiver Household
- Crowding
- Communication Barrier
- Households Without Full-Time, Year-Round Employment
- Disability
- No Health Insurance
- Age 65+
- No Vehicle Access
- No Broadband Internet Access

Map notes CRE rates for the North Memorial Health Consolidated Service Area



The deeper the shade of red, the greater the rate of households with three or more risk factors.

SOCIAL VULNERABILITY INDEX (SVI)

The CDC/ATSDR's Social Vulnerability Index (SVI) uses 15 U.S. census variables to help government and other non-profit agencies identify communities that may need support before, during, or after disasters. Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health. Such stresses include natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss.

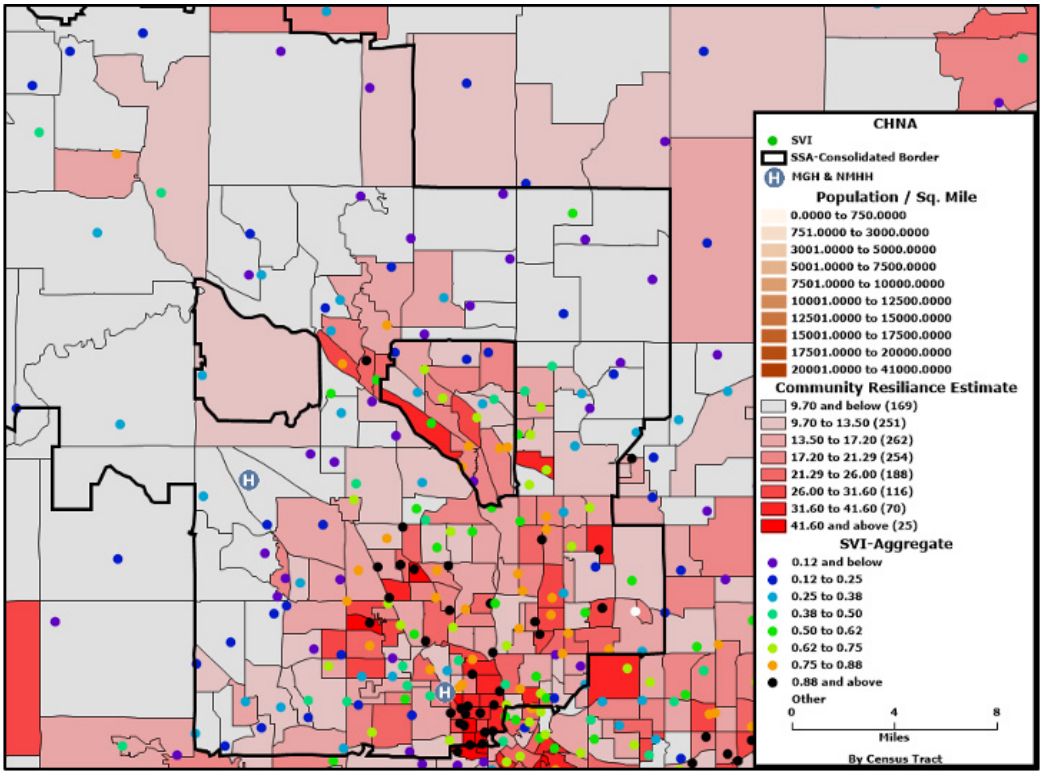
When SVI is added to the North Memorial Health consolidated service area map, it is easy to see the highest scores overlap the CRE on various census tracts.

The Social Vulnerability Index uses metrics in four areas to show percentile of rank of tract scores against one another. The four areas are socioeconomic status, household composition and disability, minority status and language, and housing type and transportation. The variables used in each of the four areas are shown in the Overall Vulnerability Chart.

Overall Vulnerability

Socioeconomic Status	Below poverty
	Unemployed
	Income
	No high school diploma
Household Composition & Disability	Age 65 or older
	Age 17 or younger
	Civilian with a disability
	Single-parent households
Minority Status & Language	Minority
	Speaks English "Less than well"
Housing Type & Transportation	Multi-Unit structures
	Mobile homes
	Crowding
	No vehicle
	Group quarters

North Memorial Health Service Area: Zoomed-in perspective of both CRE and SVI



FINDINGS: Within the North Memorial Health consolidated service area there seem to be three regions that are at risk in terms of social vulnerability and lack of community resilience factors — these three communities are parts of north Minneapolis, Brooklyn Center, and New Hope/Crystal.

Basic Needs

INTRODUCTION

This section focuses on the basic needs everyone needs to be healthy which includes access to affordable housing and food. Additional indicators in nutrition are examined in the Physical Activity and Nutrition section. We have also included the Child Opportunity Index (COI) in this section as it accounts for several variables at a zip code level that a child needs to thrive. Like the CRE and the SVI, the COI is a multi-variable index that ranks a child's opportunity by zip code. Additional child health and social indicators in the Maternal and Child Health section are included in the overall COI score as a metric of basic needs.

BURDEN OF HOUSING COSTS

One way to measure the burden of housing costs is to measure the gross rent as a percent of a household's income. The HP2030 goal is to reduce the proportion of families spending more than 30% of their income on housing to 25.5%. In the consolidated service area, 12.2% of the population is spending greater than 30% of their income on gross rent, with percentages varying from a low of 10.7% in the Maple Grove Hospital area to 14.8% in the NMHH Area. In Hennepin County from the years 2015-2019, there were 50,189 (22.4%) of households spending more than 30% of their income on housing. Of these, 8.4% (18,775) spent more than 50% of their income on housing (Source: Kids Count).

We are meeting the HP2030 goal of reducing the proportion of families spending greater than 30% of their income on housing to 25.5%.

CHILD OPPORTUNITY INDEX

The Child Opportunity Index (COI) is published by diversitydatakids.org housed at The Heller School for Social Policy and Management at Brandeis University. Developed in 2014, in collaboration with the Kirwan Institute for the Study of Race and Ethnicity at Ohio State University, the COI measures and maps the quality of resources and conditions that matter for children to develop in healthy ways in the neighborhoods where they live. The COI is also a tool intended to spark conversations about unequal access to opportunity and to spur actions to increase equity. The data is based on the diversitydatakids core question on whether all children—regardless of where they live or their race and ethnicity—have a fair chance of experiencing neighborhood conditions that help them thrive. The COI for the zip codes in the North Memorial Health service area vary greatly, however, most zip codes are rated to have high and very high overall COI scores. The zip codes with COI scores that are low or very low are 55411, 55412, 55428, and 55429.

FOOD SECURITY

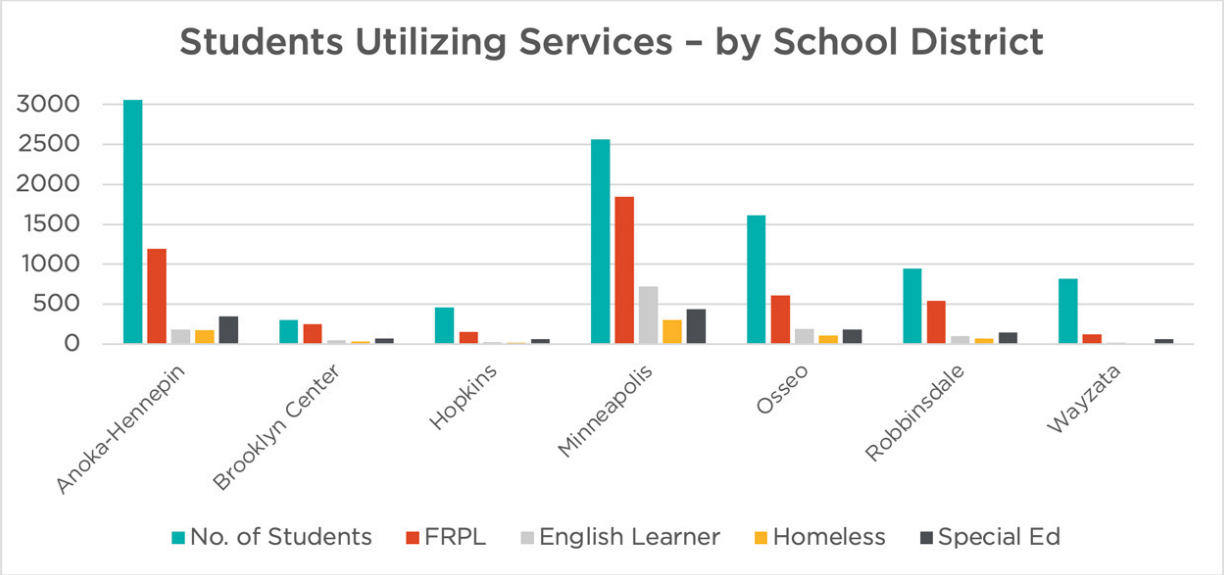
Adult

Having access to and the ability to purchase food is an important component to health and wellbeing. When asked if they worried in the past 12 months if food would run out before they had money to buy more, 39.7% of Camden/Near North residents reported they often or sometimes worried, 18.7% of Northwest suburbs-inner ring reported often or sometimes worried, and 5.9% of Northwest suburbs-outer ring reported worrying often or sometimes.

We are only meeting the HP2030 goal for food security in the outer region of the NW suburbs.

Youth

A little more than a quarter of students (27.8%) in the consolidated service area get free or reduced-price lunch (FRPL) at school. The Minneapolis School District has the most students utilizing the FRPL program, followed by Anoka-Hennepin with Osseo and Robbinsdale also having large percentages of students accessing the program. Students utilizing the FRPL program are often used as a proxy for students who experience food insecurity.



Kids Count also notes that in Hennepin County in 2019 there were 382,544 households that visited food shelves in 2019, this is a non-unique number, meaning that some households are counted more than once. This number increased to 431,460 in 2020. The number of children receiving supplemental nutrition assistance program (SNAP) benefits was 26,379 in 2019, 24,497 in 2020, and 27,730 in 2021. In 2021, this represented 11,385 households with children receiving SNAP benefits.

The HP2030 goal is that only 6% of households are food insecure.

We are not meeting this goal.

General Health

INTRODUCTION

The term "general health" refers to the health status of the population as a whole. It can be assessed by analyzing health outcomes of the population including birth, death, and disability rates; looking at cause of death in relation to years of potential life lost (YPLL); and the population's self-reported general health status.

BIRTHS

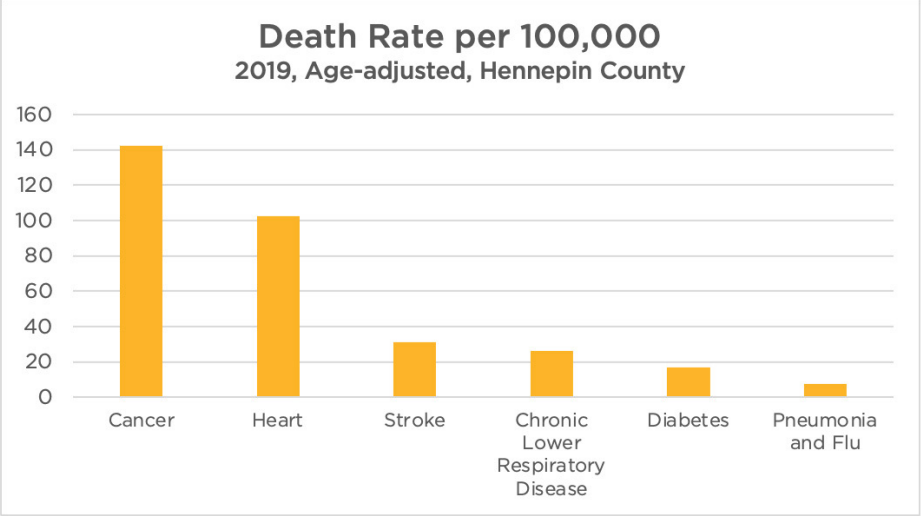
In 2020 there were 6420 births in the North Memorial Health consolidated service area. Almost 70% of births were to women who lived in ten zip codes: 55430, 55443, and 55429 (Brooklyn Center), 55412 (Minneapolis-Camden area), 55311 (Maple Grove), 55422 (Robbinsdale), 55418 (NE Minneapolis), 55369 (Osseo), 55428 (Crystal), and 55411 (Minneapolis-Near North).

DEATHS

By Age

In 2019 there were 8,987 deaths in the zip codes included in the consolidated service area.

Ages	# of deaths
0-4	93
5-14	15
15-24	84
25-34	203
35-44	248
45-54	479
55-64	1,024
65-74	1,581
75-84	1,918
85+	3,342
Total	**8,987**



We are not meeting the HP2030 goal for cancer deaths rates, which is 122.7 per 100,000
We are not meeting the HP2030 goal for heart disease death rates, which is 71.1 per 100,000
We are meeting the HP2030 goal for stroke death rates, which is 33.4 per 100,000

Cause of Death by Number and Years of Potential Life Lost (2019)

Years of potential life lost is a summary measure of premature mortality, providing an explicit way of weighting deaths occurring at younger ages, which may be preventable. The calculation of Potential Years of Life Lost (PYLL) involves summing up deaths occurring at each age and multiplying this with the number of remaining years to live up to a selected age limit (age 75 is used in OECD Health Statistics).

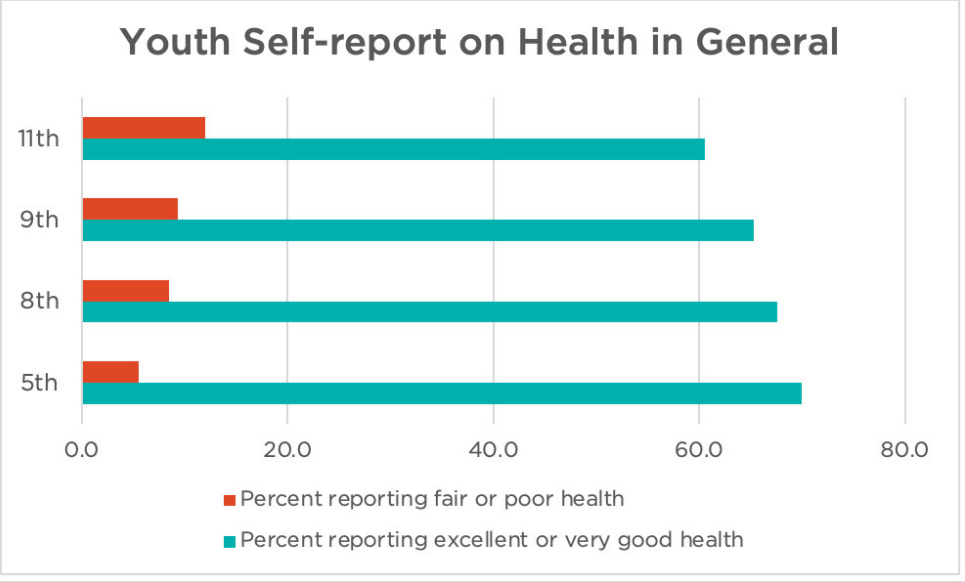
Cause of Death	# of deaths	Years Potential Life Lost
Other	2,449	12,465
Cancer	2,032	12,955
Heart Disease	1,488	7,205
Unintentional Injury	682	11,130
Alzheimer's Disease	481	310
Stroke (Cerebrovascular Disease)	449	1,870
Chronic Lower Respiratory Disease	370	1,525
Diabetes	248	1,635
Cirrhosis	176	2,915

Cause of Death	# of deaths	Years Potential Life Lost
Suicide	166	4,650
Pneumonia and Influenza	110	718
Nephritis	108	445
Septicemia	80	423
Homicide	51	1,983
Perinatal Conditions	40	2,828
Congenital Anomalies	40	2,008
AIDS/HIV	13	305
Atherosclerosis	4	25
SIDS	0	0

ADULT SELF-REPORT ON HEALTH

Adult General Health Indicators	Camden, Near North	Northwest Suburbs-Inner	Northwest Suburbs-Outer
Report Very Good or Excellent Health	40.8	50.1	62.7
Poor or Fair Health	25.7	13.4	9.4
Frequent Physical Health Distress	14.8	10.3	7.5
Frequent Mental Health Distress	20.8	13.7	11

YOUTH SELF-REPORT ON HEALTH



The SHAPE 2018 Survey reports disparities in general health with transgender, LGBT\self-identified, American Indian or Alaska Native, Asian or Asian American, and Black or African American.

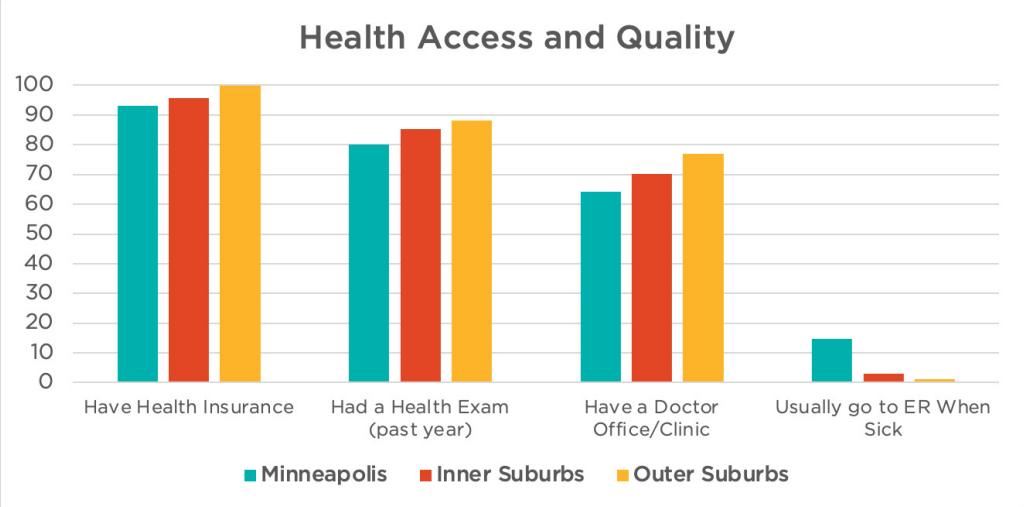
Health Access And Quality

INTRODUCTION

Access to comprehensive, quality health care services is key to achieving health equity and for increasing the quality of life for everyone. Insurance coverage and having access to care can influence an individual's overall physical, mental, and social health; prevention of disease and disability; identification and treatment of health conditions; preventable death; quality of life; and life expectancy.

Health Insurance Status

While the majority of respondents in our region have health insurance, there are differences by region from a high of 99% in the outer suburbs to a low of 93% in North Minneapolis. Maple Grove Hospital has higher percentages of residents who have health insurance and a primary care provider compared to North Memorial Health Hospital.



We are meeting the HP2030 goal of 92.1% of the population having health insurance.

Health Exam in the Past Year

Throughout the CSA, most adults (more than 80%) received a health exam in 2018. Ideally, all adults would have an exam on an annual basis. Such exams enable primary care providers (PCPs) to order age-appropriate health screenings and vaccinations, diagnose or track health conditions such as hypertension and diabetes, and offer prevention and wellness care advice. The data we are reporting on is pre-COVID-19. Due to COVID-19, many people put off their annual health exam. We have heard through CEAT and North Memorial Health team members that customers seen at hospitals and clinics are more sick, as they deferred regular healthcare due to COVID-19.

There were disparate populations who did not have a health exam in the year before the SHAPE survey. Those include adults who identify as Hispanic, American Indian/Alaska Native, and Black. In addition to those are individuals who are low-income, and/or do not have a high school education.

Have a Primary Care Provider

Having a PCP is important for maintaining health and preventing chronic diseases. PCPs can develop long-term relationships with patients and coordinate care across health care providers. When an individual has a PCP, they are more likely to receive recommended health screenings, vaccinations, and better manage chronic diseases.

According to SHAPE, the majority of adults in the region have a doctor's office or health clinic to go to when they need care. It varies by region, ranging from a high of 76.9% in the outer suburbs to a low of 64.3% in Minneapolis. For people who do not have a PCP, the emergency room is often where they go when sick, 14.7% of Minneapolis adults participating in SHAPE reported going to the ER when they are sick or need care. This compares to 1.1% of outer suburb adults who go to the ER when they are sick or need care.

HP2030 has a baseline goal that 84% of the population has a primary healthcare provider. In the CSA we are not reaching this goal.

Use of Emergency Rooms when Sick or Need Care

It is beneficial for people to establish a relationship with a PCP so when they do need care, that provider knows their medical history and status. Emergency rooms are vitally important for providing care in case of emergencies and when other care is not available. Individuals often use emergency rooms for care, especially if they lack insurance or do not have an established primary care provider. The chart above shows that a lower percentage of adults living in North Minneapolis adults have a PCP and have higher rates of utilization of emergency rooms.

Additionally, using the emergency room when sick or needing care was reported by higher percentages of persons who identify as American Indian/Alaska Native, Black, and/or have less than a high school education.

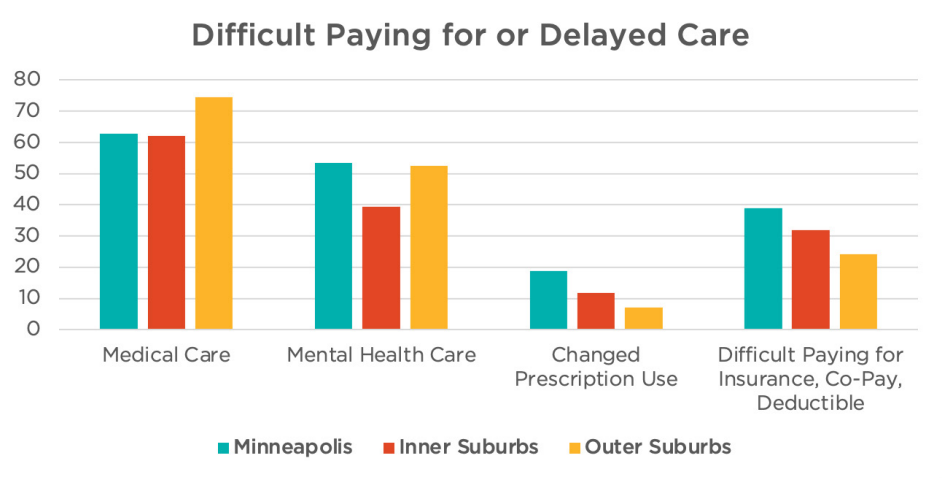
DELAYED CARE

This section includes data on persons who delayed care due to the cost of care and/or lack of health insurance. The chart below notes four key health indicators in which people delayed getting care or had trouble paying for healthcare or health insurance.

Delayed medical care due to cost or lack of insurance

The majority of adults who delayed getting medical care reported it was due to cost or lack of insurance. In both Minneapolis and the inner suburbs it was about 62% while in the outer suburbs it was 74%.

The population reporting this most frequently were adults, ages 25-54.



Delayed access to care for a mental health concern (e.g. stress/depression/anxiety/troubling thoughts) due to cost or lack of insurance

SHAPE asks adults whether they had delayed seeking care for stress/depression/problem with emotions/ excessive worrying/troubling thoughts due to the cost of such care or lack of insurance. Even in 2018, over 50% (53.4% in Minneapolis and 52.6% in the outer suburbs) reported they had delayed or not received such care due to cost.

Delaying care for a mental health concern was reported by higher percentages of individuals who identify as females, adults ages 25-34, Hispanic, Black (foreign-born), and/or experience housing insecurity.

Adults who skipped doses, took smaller amounts or did not fill a prescription due to cost

Almost one in five adults (18.7%) in the Minneapolis region reported skipping doses of a prescription, taking smaller amounts or not filling a prescription due to cost. This compares to 11.7% in the inner suburbs and 7% in the outer suburbs.

Populations most at risk for not taking their prescriptions as prescribed include adults who identify as ages 18-24, transgender, LGBT, Hispanic, American Indian/Alaska Native, Black, low-income, do not have a high school degree, and/or experience housing insecurity.

Adults who stated it is very difficult or difficult for themselves or their family to pay for health insurance premiums, co-pays, and deductibles

There were regional differences in adults reporting they had difficulty paying for health insurance, co-pays, or deductibles. In the outer suburbs 24% of adults reported delaying care while 32% of adults in the inner suburbs and 39% of adults in Minneapolis reported difficulties paying for health care costs.

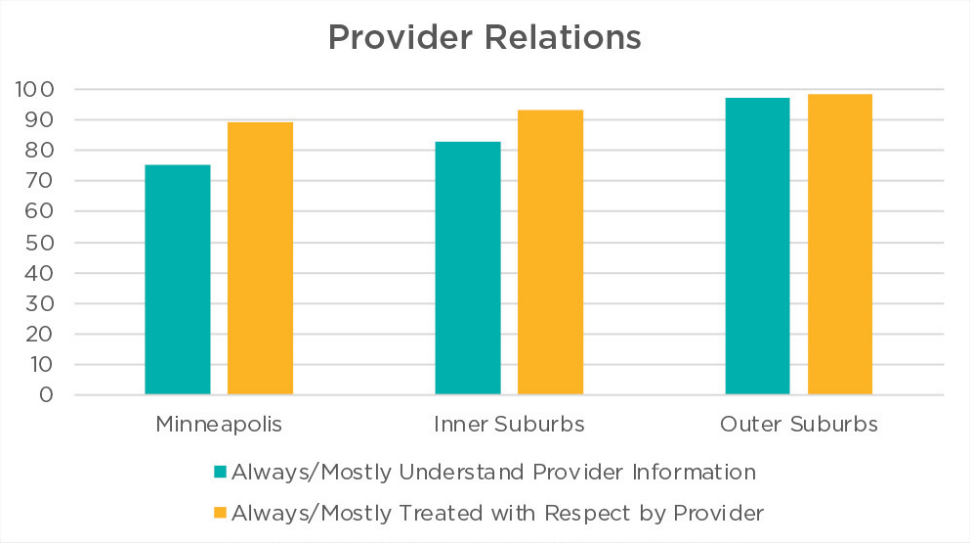
There are disparities in adults who identify as Hispanic, American Indian/Alaska Native, low-income, those with less than a college education, and/or persons with self-reported disabilities.

PROVIDER RELATIONS

In 2018, SHAPE asked a few questions focused on healthcare providers. These questions will not be included in upcoming SHAPE surveys but provide a snapshot of provider relations in 2018.

Most of the time or always understand health information from provider

There were regional differences in response to this question ranging from a high of 96.6% in the outer suburbs to a low of 75.1% in Minneapolis. Persons with higher percentages reporting "not always understanding the information their provider gave them" identify as Southeast Asian, Hispanic, Black (foreign-born), low-income, and/or experience housing insecurity.



Most of the time or always treated with respect by health care providers

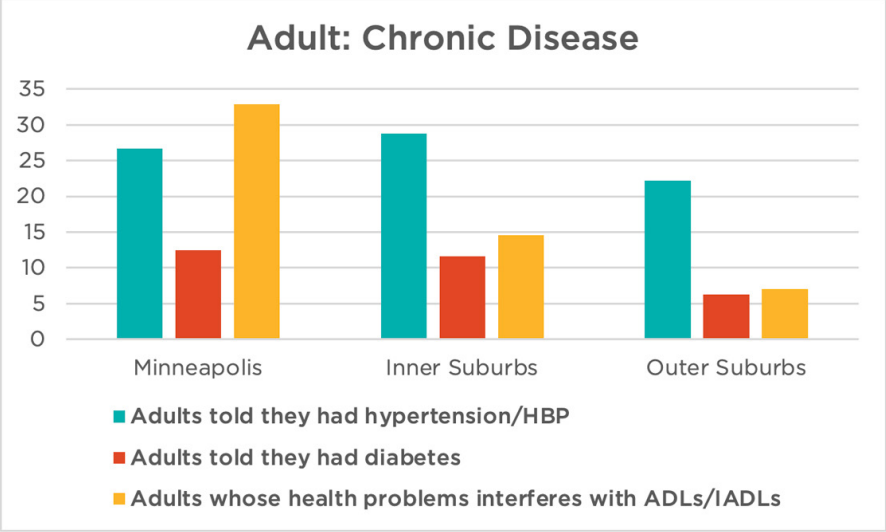
Most adults reported being treated with respect by healthcare providers (range of 89-98%). There were disparities noted by people who identify as transgender, Southeast Asian, and/or Black (foreign-born).

Chronic Disease

INTRODUCTION

Chronic diseases are conditions that can be controlled but not cured. These include conditions like asthma, diabetes, and heart disease. Lifestyle factors such as diet, physical activity levels and smoking can all impact chronic conditions. Cancer remains the number one cause of death in both NMHH and Maple Grove Hospital service areas. Early intervention is vital in treating cancer successfully. We are lacking data in cancer screening rates within our population. Timely colonoscopies, mammograms and pap tests are necessary to keep populations healthy and be able to address cancer at early stages. We have heard from CEAT and North Memorial Health team members that during the COVID-19 pandemic many people have put off routine screenings and annual exams.

CHRONIC DISEASE RATES AMONG ADULTS



The HP2030 goal for HBP is that less than 27.7% of adults have hypertension. They also have a goal that 60.8% of adults with hypertension have it under control. In Minneapolis and the outer suburbs we are meeting the HP2030 goal.

Adults who report the have been told they have hypertension or high blood pressure (HBP)

High blood pressure, or hypertension, is a fairly common disease, with 29.9% of U.S. residents reporting in 2017 that a doctor had, at some point in their lives, told them that they had high blood pressure. Our rates are similar ranging from 22.4% in the outer suburbs to 28.8% in the inner suburbs. There are disparities in hypertension rates in adults that identify as American Indian/Alaska Native, Black (US born), low-income, lower education levels, and/or persons with self-reported disabilities.

Adults who report they have been told they have diabetes.

Adults diagnosed with diabetes are at an increased risk of early death. Complications like heart disease and kidney disease are among the leading causes of death in people with diabetes. Improving diabetes treatments can help reduce the risk of these complications and lower the death rate in people with diabetes. Adult rates in our region range from low of 6.3% in the outer suburbs to 12.5% in Minneapolis.

The HP2030 goal is to reduce deaths from diabetes (per 100,000, age-adjusted) to 66.6. We are meeting the HP2030 goal.

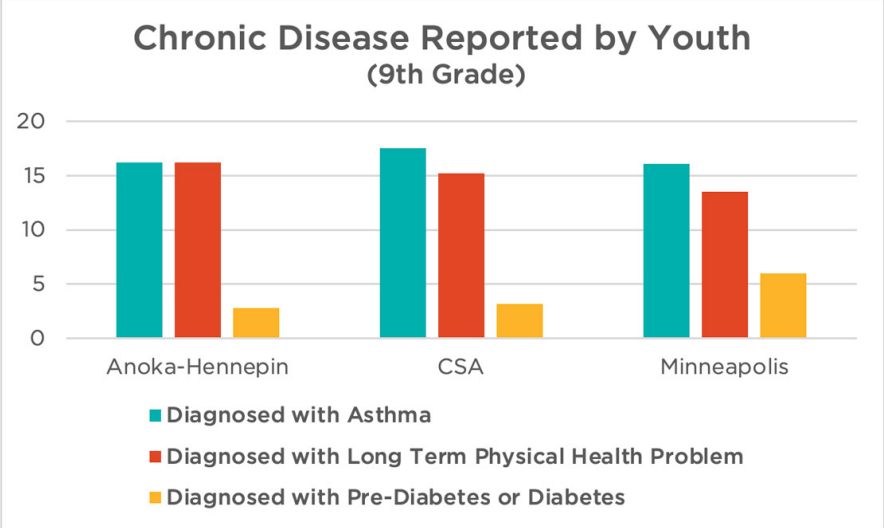
Disparities exist in adults who identify as male, Black, American Indian/Alaska Native, low-income, low education, and/or persons with self-reported disabilities.

Number of days poor health interfered with Activities of Daily Living (ADL) or Independent Activities of Daily Living (IADL), adults 55+

Activity limitation refers to a long-term reduction in a person's ability to perform their usual activities, including requiring the help of other people with personal care or routine needs, working, remembering, or any other activity that a person cannot participate in because of a physical, mental, or emotional problem. SHAPE asks adults whether an impairment or health problem interferes with their ADLs and IADLs.

There are disparities in persons who identify as female, Hispanic, Asian/Southeast Asian, Black, low-income, have less than a high school degree, experience housing insecurity, and/or with self-reported disabilities.

CHRONIC DISEASE RATES AMONG YOUTH



Youth with Chronic Health Conditions

Asthma is a leading chronic disease among children, accounting for many lost days at school and numerous visits to the hospital. It can be triggered by allergens (dust, pollen, mold), cigarette smoking, air pollution, weather changes, exercise, and infections, like a cold or flu. The percentages of youth who report they have been diagnosed with asthma are fairly similar in the schools districts ranging from 16.1% to 17.5%.

Between 15% and 16% of youth report they have a long-term physical health condition such as asthma, diabetes, or cancer. Youth who have been diagnosed with pre-diabetes or diabetes ranges from a low of 1.6% in the combined CSA area to a high of 6% in the Minneapolis School District.

Physical Activity and Nutrition

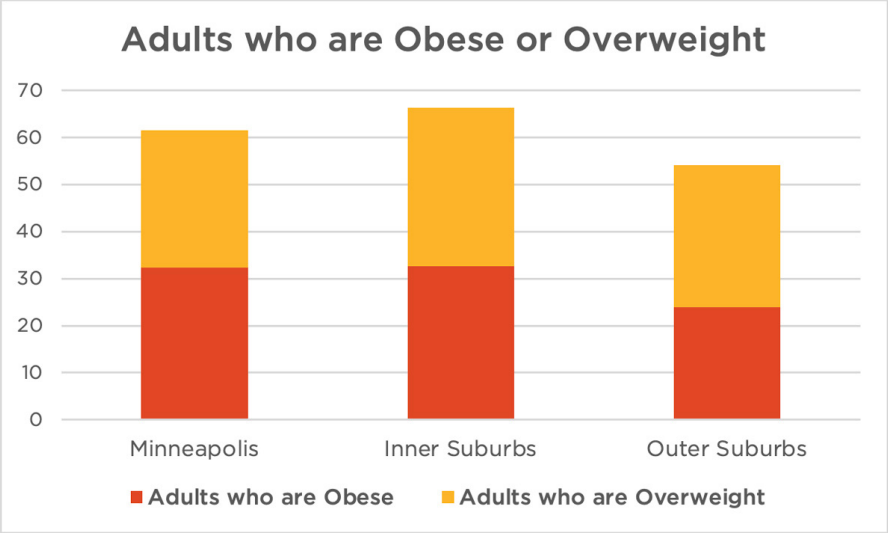
INTRODUCTION

Physical activity, combined with a diet rich in fruits and vegetables, are known to prevent chronic disease. Maintaining a healthy weight, promoting healthy habits and working with partners to create policies and communities that make healthy choices a way of life are key to community health improvement. It is the mission of North Memorial Health to empower our customers to achieve their best health. Encouraging healthy behaviors is one way to help accomplish that goal.

ADULT WEIGHT AND PHYSICAL ACTIVITY

Percent of Adult (18+) population who are obese or overweight by self-reported weight/height

The percentage of adults who are overweight or obese ranges from a low of 54.2% in the outer suburbs to a high of 66.4% in the inner suburbs. There are disparities in populations who are older, identify as Black, American Indian/Alaska Native, low-income, experience housing insecurity, and/or persons with self-reported disabilities. Individuals who identify as male are more overweight than those individuals who identify as female.



We are meeting the HP2030 goal which is for less than 36% of adults to be obese.

Percent of adults (18+) who did not participate any leisure time physical activity in past month

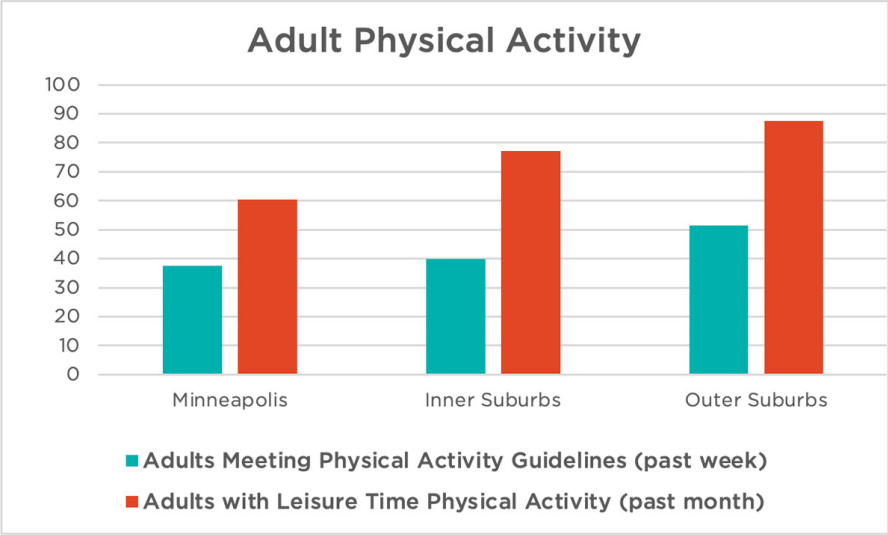
SHAPE asks adults whether they had participated in any physical activity or exercise in the past 30 days such as running, calisthenics, golf, gardening, or walking for exercise.

Adults report in SHAPE on whether they engaged in moderate leisure time physical activity (causes light sweating or a small increase in breathing or heart rate) on 0-7 days a week or engaged in vigorous leisure time activity (causes heavy sweating or a large increase in breathing or heart rate) for 0-7 days a week.

Percent of adults (18+) who reported they met either moderate or vigorous physical activity guidelines during the average week.

Adults need a mix of activities to stay healthy, with a goal of at least 150 minutes of moderate-intensity aerobic activity and muscle-strengthening activity at least 2 days a week. There are a number of strategies and policy approaches to support these behaviors.

There are disparities in levels of physical activity in adults who identify as transgender, Southeast Asian, low-income, less than a high school education, experience housing insecurity, and/or with self-reported disabilities.



While not an exact match, HP2030 has a goal of increasing the proportion of adults who do enough aerobic and muscle-strengthening activity to 28.4%. We are meeting this goal in all regions.

PHYSICAL ACTIVITY AMONG YOUTH

Percent of 9th graders who were classified as overweight or obese

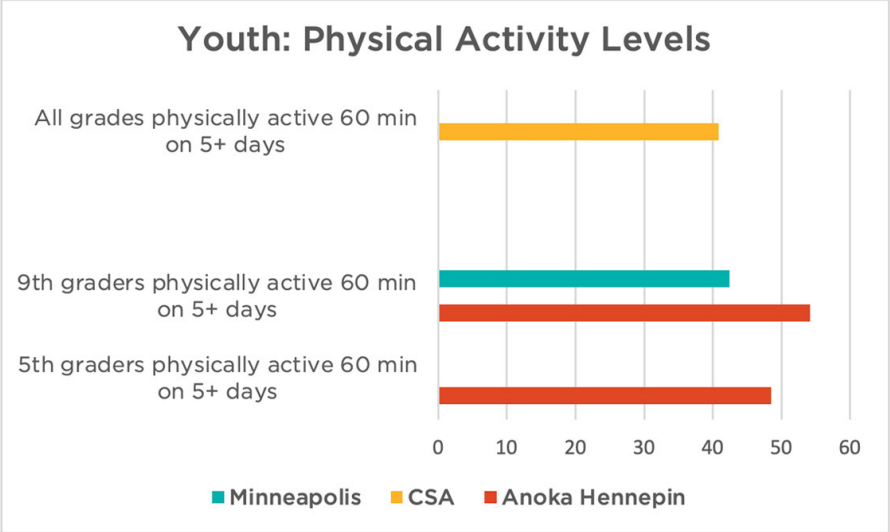
Between 22-26% of 9th grade youth were classified as overweight or obese. Both Anoka-Hennepin and Minneapolis School Districts, as well as Hennepin County as a whole, are meeting the HP2030 goal with obesity rates ranging from 9-11.4%.

We are meeting the HP2030 goal of reducing the proportion of children and adolescents with obesity to 15.5%

Youth: Physical Activity Levels

Children and youth need at least 60 minutes of physical activity a day. Physical activity improves heart, muscle, bone, and mental health in children. Strategies at the community and family level — and in schools and child care centers — can promote physical activity in children and youth.

Due to varying data, the Youth: Physical Activity Levels chart (page 31) notes the physical activity levels of 5th graders (Anoka-Hennepin) and 9th graders (Anoka-Hennepin and Minneapolis) and all grades combined (CSA). The data show youth who were physically active for 60 minutes or more on at least 5 days in the last week. The CSA data shows that persons who identify as male were more physically active than persons who identify as female (54.2% versus 42.4%).

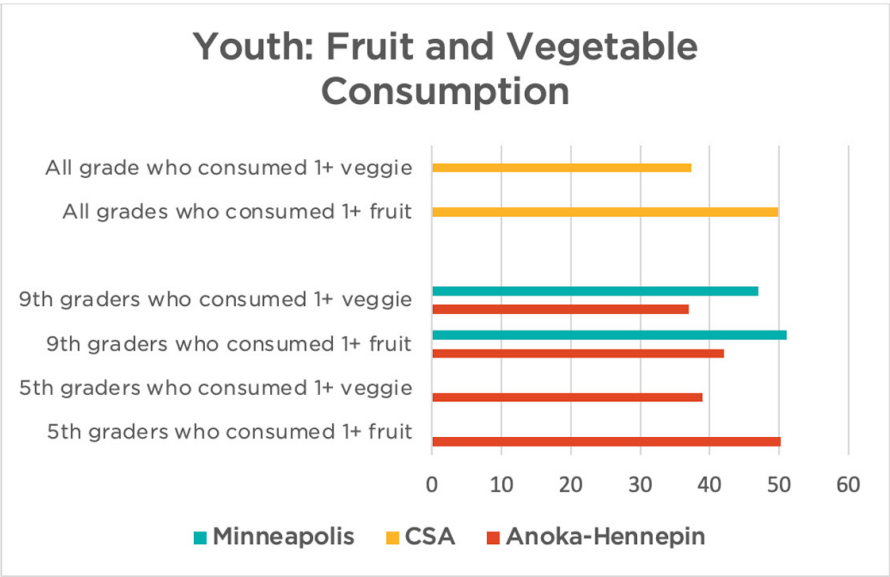


We are meeting the HP2030 goal of increasing the proportion of children who meet the current aerobic physical activity guidelines to 30.4%.

NUTRITION

Youth consumption of fruits and vegetables

Fruit and vegetable consumption are recommended as key parts of a healthy diet and are linked to lower risks for many diseases. Most people in the United States don't eat enough recommended servings of fruit or vegetables. Because of the way data is asked, the chart below shows youth who ate one piece of fruit or one serving of vegetables on the day before the MSS. Almost across the board, almost half of our youth are consuming only one serving of fruit or vegetables a day. Evidence suggests that nutrition counseling, school- and workplace-based programs that use more than 1 strategy, and school nutrition policies can help people eat more fruit and vegetables.



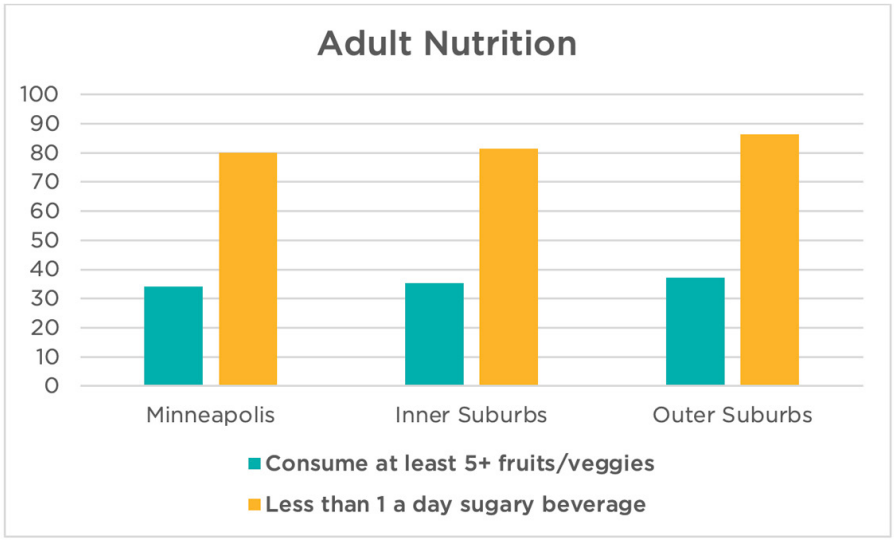
Adult consumption of fruits and vegetables

Adult consumption of 5 servings or more a day of fruit, fruit juice, and vegetables ranges from 34-37% of the adult population living in the CSA. Adults who identify as American-Indian/Alaska Native, Asian, and Black (US born) eat more fruits and vegetables. There are disparities in adults who identify as Black (foreign-born), persons with incomes between 100-199% of FPL, and/or persons with a high school education.

Adults and youth consumption of sugary beverages

Sugars added to foods and beverages can make it hard for people to get the nutrients they need without getting too many calories and puts people at higher risk for tooth decay and obesity. Many people in the United States consume too much added sugar. Pricing strategies and education interventions in schools may help people limit foods and drinks with added sugars.

We are pleased to report that both adults and youth in the CSA report low levels of sugary beverage consumption. Adult consumption of one sugary beverage or less is 86.3% in the outer suburbs, 81.4% in the inner suburbs and 80% in Minneapolis. Among our youth, in the CSA schools this percentage is 78%.



Communicable Disease

INTRODUCTION

Many people in the United States get sick and die from communicable diseases each year. A communicable disease is spread from one person (or other source) to another through a variety of ways that include: contact with blood and bodily fluids, breathing in an airborne virus, eating food or drinking water that is contaminated, or being bitten by an animal or insect. Some examples of communicable diseases include Influenza, measles, Hepatitis A, B and C, E-coli, salmonella, and other food-borne illnesses.

Minnesota law mandates that healthcare providers and laboratories report over 87 diseases or conditions to their local health department. Health departments can then rapidly deploy strategies to reduce the spread of the disease such as identifying the source of outbreaks, initiating interventions such as immunization clinics or quarantine programs, and alerting the public to seek medical care if they show symptoms of the disease so they can be diagnosed and treated quicker, increasing the likelihood of successful treatment.

Recent years have seen increases in various communicable diseases including COVID-19, infections like C. diff (Clostridioides difficile) and MRSA (Methicillin-resistant Staphylococcus aureus), and sexually transmitted infections. Many communicable diseases are preventable through vaccinations and other prevention strategies. Some diseases, such as hepatitis C, cannot be prevented by vaccines but early diagnosis and treatment can help improve health outcomes.

It is important that children and at-risk adults get vaccinated for diseases like measles, pertussis, flu, and hepatitis A. By increasing vaccination rates, communicable disease rates can be reduced. For example, adolescents need the HPV (human papillomavirus) vaccine, older adults need vaccines to help prevent pneumonia, and everyone age 6 months and older needs a yearly flu vaccine. Communication about the importance of vaccines, sending vaccination reminders, and making it easy to get vaccines all help increase immunization rates.

The COVID-19 pandemic has highlighted the threat communicable diseases are to human life, world economies, and disruptions to societal institutions. While we will always be under threat of emerging new viruses, it is important to prevent communicable diseases as much as possible through effective immunization and preventive health measures.

HP2030 has many objectives that pertain to vaccinations, with many either in development or the Centers for Disease Control (CDC) is collecting baseline data. These goals are high-priority public health issues that have evidence-based interventions to address them but do not have reliable baseline data. We do not have adequate data available for the CHNA to score HP2030 goals that focus on vaccinations, but here are some of the HP2030 objectives related to immunizations:

- Increase the percentage of children 24-35 months up to date with immunizations (vaccine series including DTaP, polio, MMR, Hib, Hep B, varicella, PCV, rotavirus, Hep A)
- Maintain the vaccination coverage level of 2 doses of the MMR vaccine for children in kindergarten
- Increase the coverage level of 4 doses of the DTaP vaccine in children by age 2 years to 90%
- Increase the proportion of adolescents who get recommended doses of the HPV vaccine to 80%
- Increase the proportion of adults age 19 years or older who get recommended age-appropriate vaccines to 95%
- Increase the proportion of people who get the flu vaccine every year to 70%
- Reduce hospitalizations for pneumonia in adults over age 65 to 642.5 per 100,000

COVID-19

COVID-19 Cases, Hospitalizations, ICU Admissions, and Deaths

Communicable diseases impact the health of our communities and can result in high rates of death and disability. As noted on the previous page, our nation and region have been impacted by the COVID-19 pandemic. Recently released national data from the National Center for Health Statistics noted an increase in the numbers of all deaths in 2020 with COVID-19 being the third leading cause of death, following cancer and heart disease. Influenza and pneumonia ranked as the ninth leading causes of death[1].

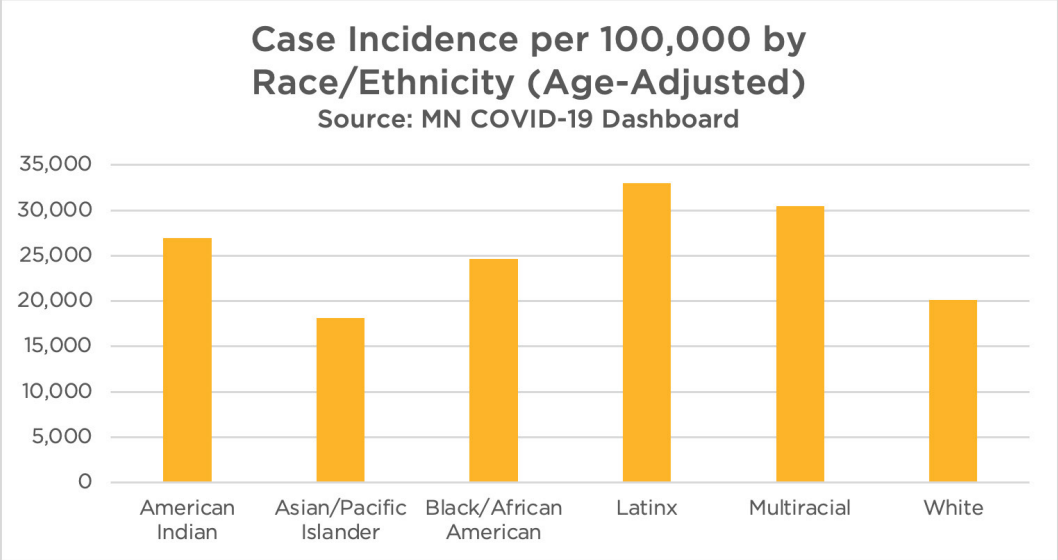
In examining data for the consolidated service area for the period 10/1/2020-9/30/21, the top three diagnoses noted in billing codes were COVID-19 related, accounting for 9.4% of total claims for this period.

The Minnesota Department of Health's COVID-19 Dashboard tracks COVID-19 cases, hospitalization, intensive care unit (ICU) admissions, and deaths by race/ethnicity. It notes:

> *As the result of systemic disparities, communities of color and indigenous communities have substantially higher rates of health disparities, including higher rates of chronic diseases and multiple health issues such as diabetes, heart disease, severe asthma, and obesity. This increases the susceptibility of communities of color and indigenous people to being infected with COVID-19 and puts them at higher risk for severe COVID-19 with higher rates of hospitalization, need for the ICU, and death.*

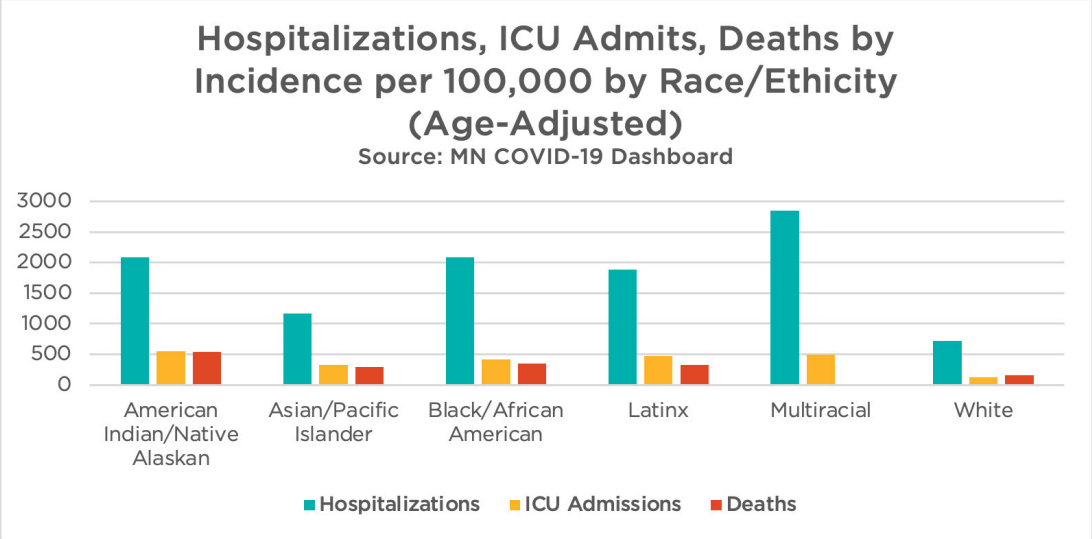
Communities of color and women also have increased exposure to COVID-19 because they often hold jobs that are considered essential such as childcare providers, grocers, service workers, and meat packers. Such jobs are often underpaid, lack health insurance, and lack worksite protections.

The following charts show the age-adjusted incidence rates per 100,000 by race/ethnicity in Minnesota for COVID-19 cases, hospitalizations, ICU admissions, and deaths. Cases are those people that tested positive for COVID-19.



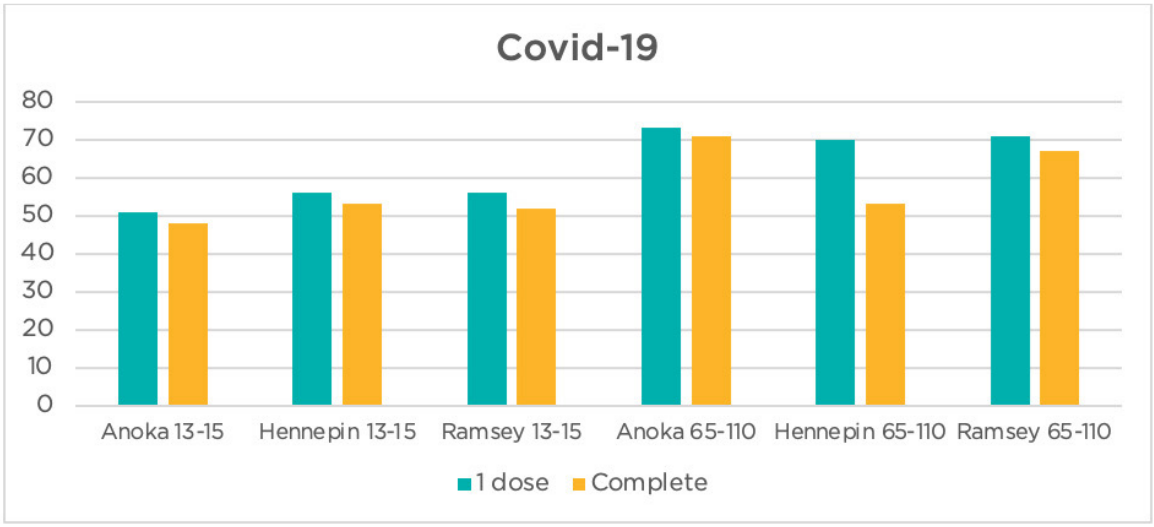
Minnesota Department of Health data shows that:

- Indigenous Minnesotans have the highest proportion of positive cases that have been hospitalized or admitted to the ICU
- Black, Latinx, and multiracial Minnesotans tested positive, hospitalized, and needed to be admitted to the ICU at higher rates compared to the overall population

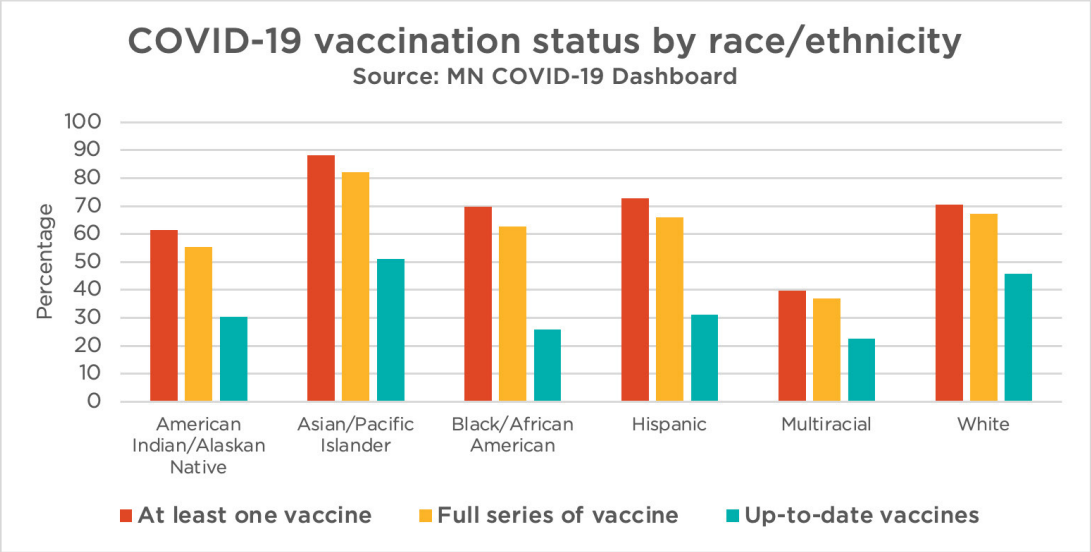


COVID-19 Immunization

Getting immunized against COVID-19 is a proven strategy known to reduce death, hospitalizations, and severe illness. North Memorial Health tracked the immunization status of adults in the service area and as of July 12, 2021, 59.3% of adults had one or more COVID-19 vaccinations and 56.5% had completed the vaccination series as recommended by the CDC.



The Minnesota Department of Health tracks vaccination status by race/ethnicity. The chart below shows populations by race/ethnicity and whether they have had one vaccination, completed a series of vaccinations (depending on manufacturer), and are up to date on COVID-19 vaccines – for persons ages 5-11 this means a complete primary series and for persons ages 12+ this includes at least one additional dose.



Nationally, a new report *The State of Black America and COVID-19: A Two Year Assessment*[2] was released by the Black Coalition Against COVID. The report was commissioned in response to data that showed that in January of 2022 rates of COVID-19 hospitalization for Black Americans were the highest they have been since the pandemic's start. A CNN analysis of CDC data states the hospitalization rate of Black people "...is double the overall weekly rate of hospitalizations for all races during the same time frame and nearly triple the rate of hospitalizations for White people at any point during the pandemic."[3]

Another 2022 CNN article states:

> *Since the start of the pandemic, the risk of dying from COVID-19 has been nearly twice as high for Black and Hispanic people in the United States than for White people. Black and Hispanic people also faced a higher risk of coronavirus infection and were more than twice as likely to be hospitalized. Even as COVID-19 cases, hospitalizations and deaths trend down in the United States, Black Americans recently experienced the "highest rate of hospitalization" for any racial and ethnic group since the inception of the pandemic.*[4]

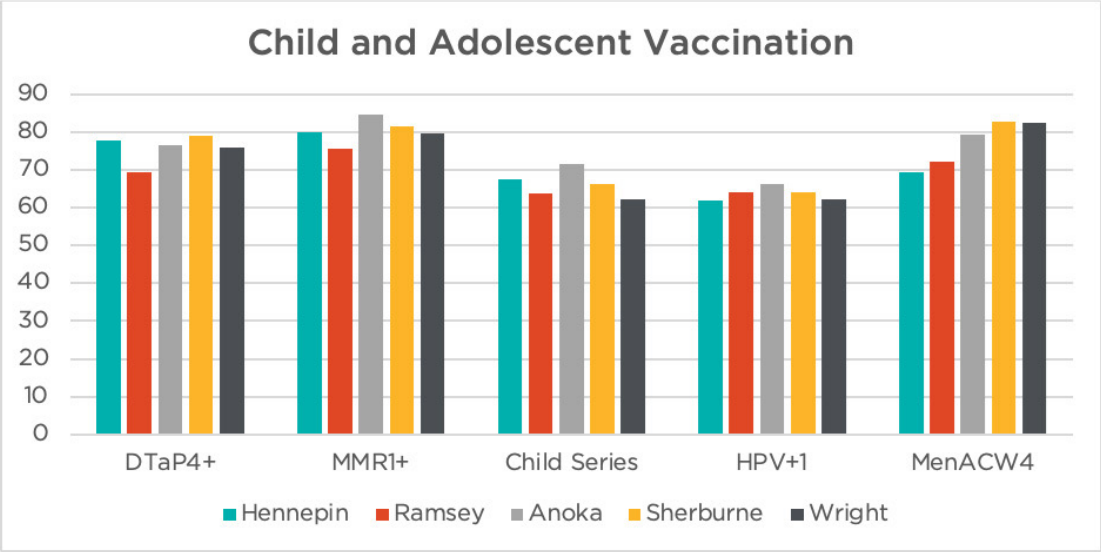
The State of Black America and COVID-19 focuses on both the disparities Black Americans experience because of COVID-19 but also the impacts of structural racism. The report states "Beyond the burden of infection, hospitalization, and death, Black Americans experienced significant economic, social, educational, and behavioral health crises. Black communities were disproportionately impacted by financial strain, loss of caregivers and elders, deficiencies in educational learning, and food insecurity."

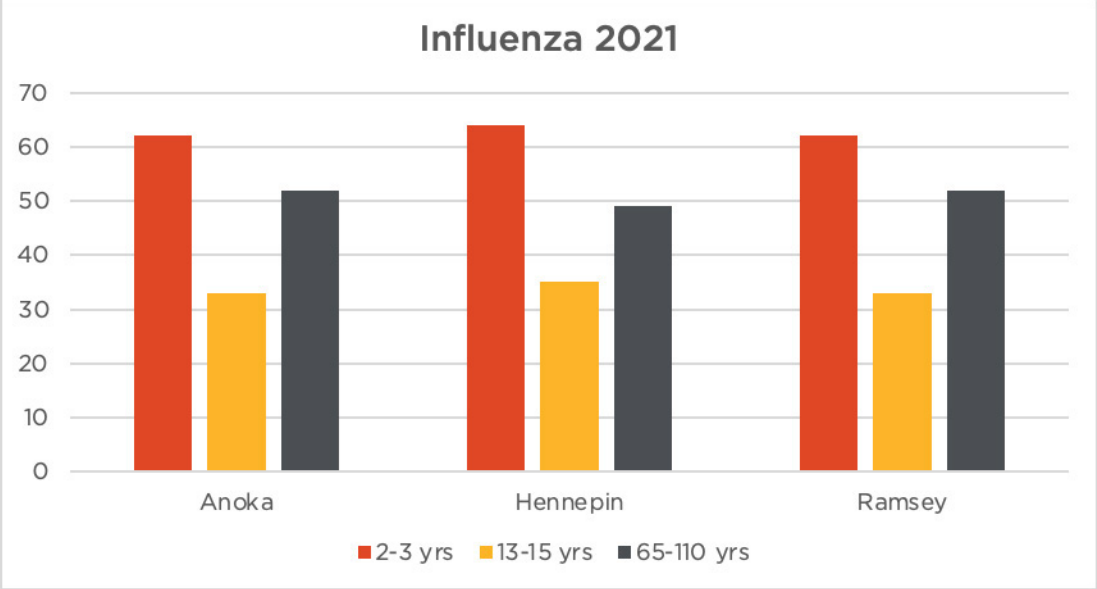
ADULT & CHILD IMMUNIZATIONS

This data was provided by Hennepin County Public Health staff on the immunization status of populations in the North Memorial Health consolidated service area.

The following charts note childhood and adolescent immunization status. The following key health indicators were selected to monitor, based on data availability, and use as a snapshot of the immunization status of North Memorial Health populations.

Data was pulled based on zip codes from county level data from our community members.





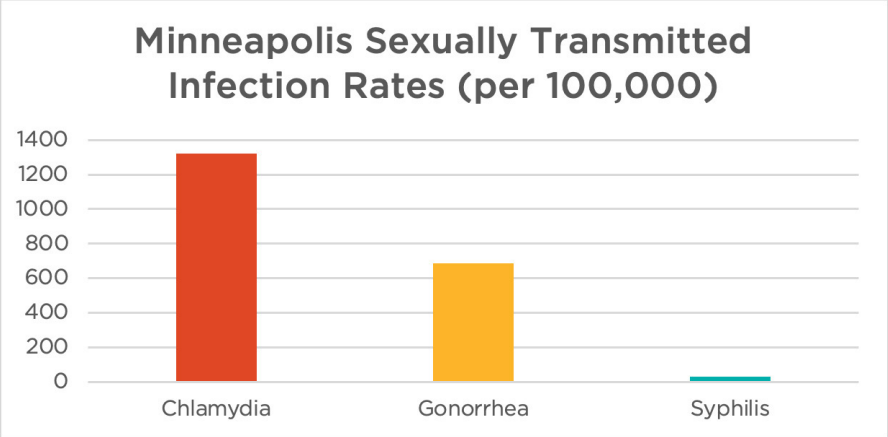
1. DTaP4+: Received 4 or more doses of DTaP
2. MMR1+: Received 1 or more doses of MMR
3. Childhood series of recommended vaccinations: Received 4+ DTaP (Diptheria, Tetanus, and Pertussis), 3+ Polio, 1+ MMR (Measles, Mumps, Rubella), complete Hib series (Haemophilus Influenza type b), 3+ Hep B, 1+ varicella, and complete PCV (Pnemonococcal Conjugate)
4. HPV1+: Human Papillomavirus
5. MenACW4: Meningococcal vaccination

SEXUALLY TRANSMITTED INFECTIONS

The Twin Cities metropolitan area had 23,018 cases of sexually transmitted infections (STIs) reported in 2019. These rates include 16,170 cases of chlamydia, 6055 cases of gonorrhea, 793 cases of syphilis (all kinds), and 267 cases of HIV/AIDS (diagnosed in 2018). Chlamydia, gonorrhea, and syphilis reached all-time highs in 2019.

Minnesota's rate of congenital syphilis (passed along from a pregnant person to a baby) also reached an all-time high in 2019 (n=21). Congenital syphilis can cause miscarriages and stillbirths and infants born with congenital syphilis may have severe health conditions including deformities, seizures, and/or anemia.

The chart below shows the rate per 100,000 for each of these STIs. There are many disparities in each of these STIs, which are noted for the state of Minnesota.



SEXUALLY TRANSMITTED INFECTION DISPARITIES PREVALENT IN MINNESOTA[5]

Chlamydia

The highest incidence rates of chlamydia are among adolescents, young adults, and communities of color. The rate among Black non-Hispanic individuals (2,092 per 100,000) is 9.7 times higher than the rate among white non-Hispanic individuals (216 per 100,000). Although Black, non-Hispanic people comprise approximately 5% of Minnesota's population, they account for 24% of reported chlamydia cases. Rates among individuals who identify as Asian/Pacific Islanders (420 per 100,000), Hispanic, any race (897 per 100,000), and American Indian/Alaska Native (1,025 per 100,000) are over 2 to 6 times higher than the rate among white, non-Hispanic persons.

Gonorrhea

Communities of color are disproportionately affected by gonorrhea. The incidence of gonorrhea among individuals who identify as Black, non-Hispanic (1042 per 100,000) is 18 times higher than the rate among individuals who identify as white, non-Hispanic (59 per 100,000). Rates among individuals who identify as Asian/Pacific Islanders (89 per 100,000), Hispanic, any race (194 per 100,000), and American Indian/Alaska Native (654 per 100,000) are up to 11 times higher than among individuals who identify as white, non-Hispanic persons.

HIV/AIDS

Despite relatively small numbers of cases, HIV/AIDS affects persons of color disproportionately in Minnesota. In 2019, men of color comprised approximately 17% of the male population in Minnesota and 58% of new HIV (Human Immunodeficiency Virus) diagnoses among men. Similarly, persons of color comprised approximately 13% of the female population in Minnesota and 68% of new HIV infections among women.

While we are not able to measure our data directly to HP2030 goals, HP2030 goals focused on sexually transmitted infections include:

- Increase the proportion of sexually active female adolescents and young women who get screened for chlamydia to 76.5%
- Reduce the number of new HIV infections to 3000 (U.S.)
- Reduce the syphilis rate in females to 4.6 per 100,000
- Reduce the syphilis rate in men who have sex with men to 392 per 100,000

[1]Ahmad FB; Anderson RN; The Leading Causes of Death in the US for 2020; JAMA. 2021;325(18):1829-1839. Accessed 4/5/22.

[2]The State of Black America and COVID-19: A Two-Year Assessment. The Black Coalition Against COVID, March 2022.

[3]Centers for Disease Control and Prevention. Risk for COVID-19 infection, hospitalization, and Death by Race/Ethnicity. 2022; https://www.cdc.gov/ coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.

[4]Jacqueline Howard, "It's been a year since CDC declared racism a public health threat. Now what?," CNN, April 8, 2022.

[5]Annual Summary of Communicable Diseases Reported to the Minnesota Department of Health, 2019, Volume 47, Number 1. Accessed 4/5/22 at https://www.health.state.mn.us/diseases/reportable/dcn/sum19/index.html

Oral Health

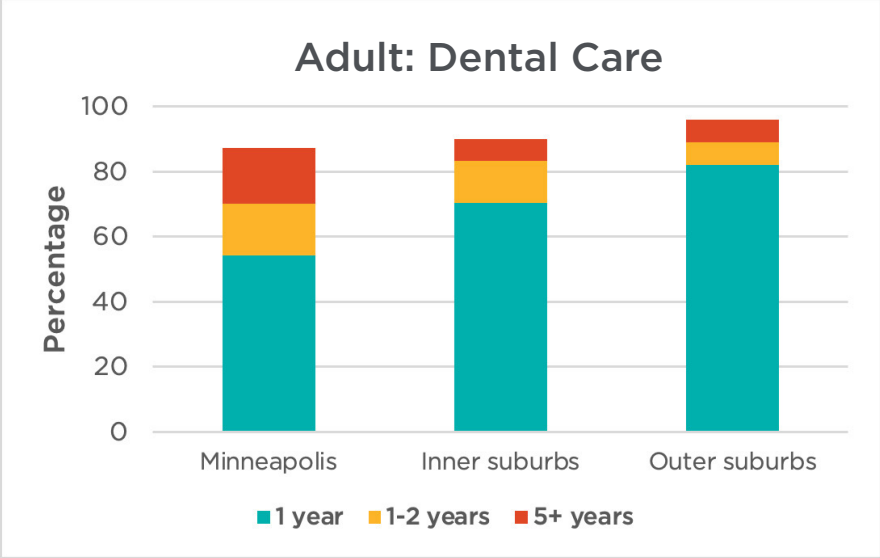
INTRODUCTION

Oral diseases cause pain and disability for millions of people in the United States, and some are linked to other diseases — like diabetes, heart disease, and stroke. Regular visits to the dentist can help prevent oral diseases and related problems.

Untreated tooth decay can lead to problems like pain and infections. Regular dental care can prevent these problems, but many people in the United States — especially in low-income families — do not get preventive dental care. Strategies to make it easier for people to get dental care are critical for better oral health and overall health outcomes. Training non-dental providers to do oral screenings, talk to caregivers about oral health, and referring patients to dental care can help more children, adolescents, as well as adults, get regular, preventive oral health care.

Adult Dental Care

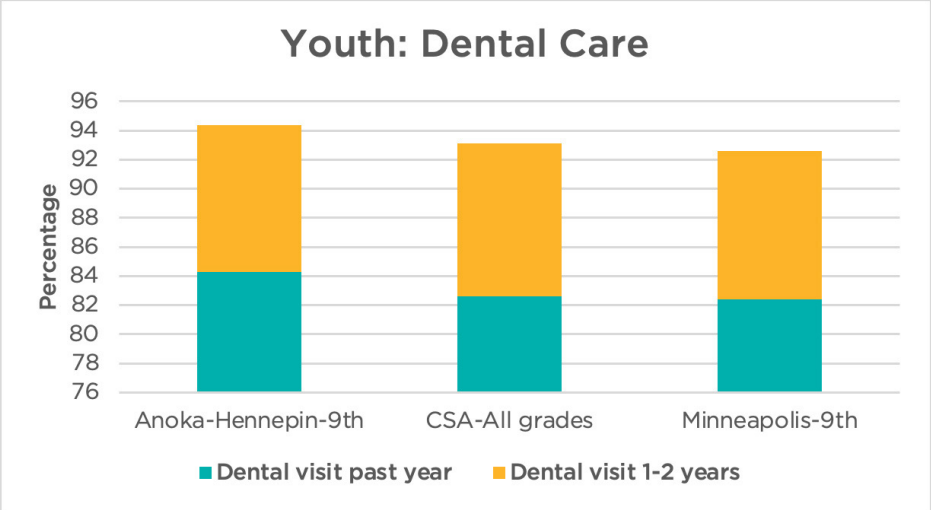
The chart below shows the percentage of adults who have visited the dentist or dental clinic for any reason within the past 2 years as well as those who have not been to a dentist in more than five years. There are disparities in Minneapolis, where 17.1% of Minneapolis adults had not been to a dentist in 5+ years There are also disparities among persons who identify as ages 18-24, transgender, LGBT, Hispanic, American Indian/ Alaska Native, Asian/SE Asian, Black (US and Foreign-born) and persons with lower incomes, less than a college degree, and/or who face housing insecurity.

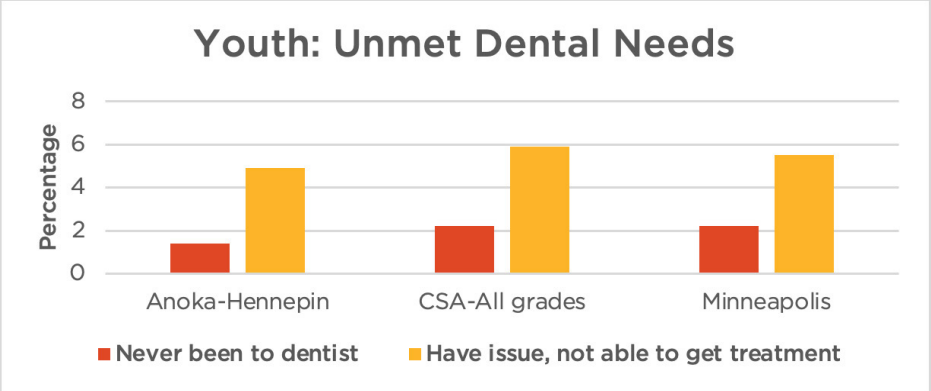


We are meeting the HP2030 Goal: Increase the proportion of children, adolescents, and adults who use the oral health care system to 45%.

Youth Dental Care

The *Youth: Dental Care* chart shows youth who had seen a dentist for a check-up, exam, teeth cleaning, or other dental work in the past two years. The *Youth: Unmet Dental Needs* chart shows youth with unmet dental needs – either they had never been to a dentist or had a dental problem but said they were unable to seek dental treatment.





We are meeting the two HP2030 goals for children and youth:

1. Increase the percentage of low-income youth who have a preventive dental visit to 82.7%;

2. Reduce to 10.2% children and adolescents with active and untreated dental decay.

Environmental Health

INTRODUCTION

Safe housing is vitally important for preventing exposures to toxic agents. While not in the scope of the CHNA, there are several indicators we will report on to raise awareness.

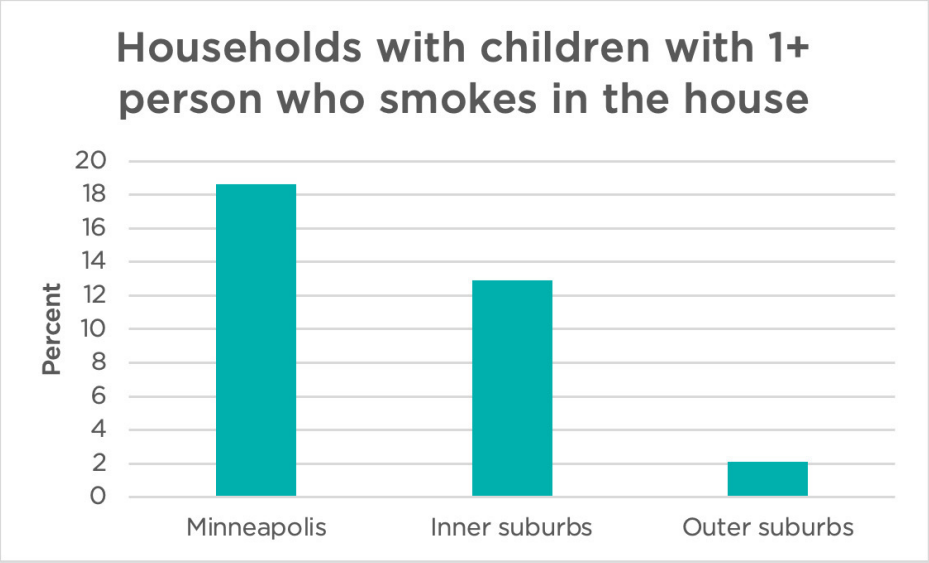
Reducing Children's Exposure to Lead: Highlighting a Local Resource

In 2018, more than 200 children tested for lead in Hennepin County had blood lead levels high enough to damage their health. Young children exposed to lead can suffer from brain and nervous system damage, slowed growth and development, learning and behavior problems, and hearing and speech problems.

Lead paint was banned by the federal government in 1978. Homes built before 1979 have the potential to increase a person's exposure to lead paint. The North Memorial Health consolidated service area has 163,702 housing units built before 1979. Hennepin County has received CDC funding to address childhood lead poisoning prevention and surveillance programmatic activities through September 29, 2022. The activities focus on community-based approaches for lead hazard elimination and emphasize population-based policy intervention. Under this program, homeowners and property owners may be eligible for help to detect and remove lead paint in homes built before 1979. Program participants get a free home test and up to $12,000 for work, including new windows.

Children/Youth in Smoke-Free Homes

Another environmental key health indicator of concern is households with children ages 0-17 where one or more persons regularly smoke in the house. Children exposed to tobacco smoke are more likely to develop severe health problems including sudden infant death syndrome, acute respiratory infections, ear problems, and severe asthma.



We are not meeting the HP2030 goal in Minneapolis or the inner NW suburbs, which is for 92.9% of homes with children to be smoke-free.

There are disparities among persons who identify as American Indian/Alaska Native, Black-US born, LGBT, have a self-reported disability, lower-income, and/or have less than a college degree.

Safe Food and Water

There are safe food handling and drinking water procedures that can reduce exposure to communicable diseases. In 2019, the metropolitan area had 506 cases of campylobacteriosis, 59 cases of Escherichia coli 0157 infection (E-coli), and 440 cases of Salmonellosis.

Climate Change Environmental Impacts

Climate change is an emerging issue that can affect a community's health. Indicators around exposure and/or unsafe conditions due to extreme heat or cold are being developed. HP2030 has an objective around heat exposure (reduce heat-related morbidity and mortality) in developmental status meaning it is a high-priority public health issue that has evidence-based interventions to address it but does not yet have reliable baseline data. Once baseline data are available, this objective may be considered to become a core Healthy People 2030 objective, as well as one of ours.

Another indicator that may be affected by climate change is the air quality in a region. Poor air quality both inside and outside can lead to asthma complications and respiratory issues. The Minnesota Pollution Control Agency reports on the number of days the Air Quality Index (AQI) exceeds 100. Air quality in the Twin Cities has been exceptionally good, with both the Minneapolis/St. Paul and North Metro areas reporting only one day in 2020 when air quality could impact persons with chronic health conditions or result in hospitalizations.

Maternal and Child Health

INTRODUCTION

Every year in the United States, thousands of infants die from causes like preterm birth, low birth weight, and sudden infant death syndrome. While we have seen great progress in decreasing the number of infant deaths, there are disparities by race/ethnicity, income, and geographic location. Ensuring access to equitable, high-quality care for moms and babies can help reduce the rate of infant deaths.

Pregnant women who receive ongoing prenatal care and follow a healthy lifestyle are more likely to give birth to a healthy baby. Women's health before, during, and after pregnancy can have a major impact on infants' health and well-being. It is important for women to practice healthy behaviors during their pregnancies and get recommended health care services before and during their pregnancy. Getting good medical care and avoiding risky behaviors — like smoking or drinking alcohol — can improve health outcomes for infants.

Reducing the rates of low or high birth weight helps babies get the healthiest start possible. Preterm births (infants born before 37 weeks of gestation) are more common in some racial/ethnic groups. Babies both preterm or at low birth weights have a higher risk of infections, developmental problems, breathing problems, and even death. There are clinical and community-based interventions that can help promote healthy pregnancies and healthy babies.

Births

In 2021 there were 5,755 babies born at Maple Grove Hospital and North Memorial Health Hospital. This compares to 5,556 born in 2020 and 5,467 born in 2019. Most (83.2%) pregnant women received prenatal care during their first trimester. Early prenatal care is important because screenings can identify babies or mothers at risk for health problems and healthcare providers can educate and prepare mothers for pregnancy and childbirth including advice about healthy nutrition and behaviors, such as smoking. Smoking during pregnancy is associated with adverse health effects including premature births, certain birth defects, and infant death. There have been significant declines in the proportion of women smoking during pregnancy with 4.4% of babies born in our CSA to women who smoked during their pregnancy.

Almost 10% (9.8%) of babies were premature (< 37 weeks) and 7.6% of babies were considered low birth weight (<2500 g). Almost a quarter (24.5%) of mothers participate in the Women, Infants and Children program which offers nutritional and breastfeeding support to new parents, 88.9% of mothers in the WIC program initiated breastfeeding in 2019. The teen birth rate (births rates among mothers ages 15-19 years per 1,000) in Hennepin County in 2019 was 10.5%, while in our consolidated service area it was 11.5%. In general, teen birth rates have been going down for the past ten years. The highest teen birth rates in the CSA were in Brooklyn Center and Brooklyn Park.

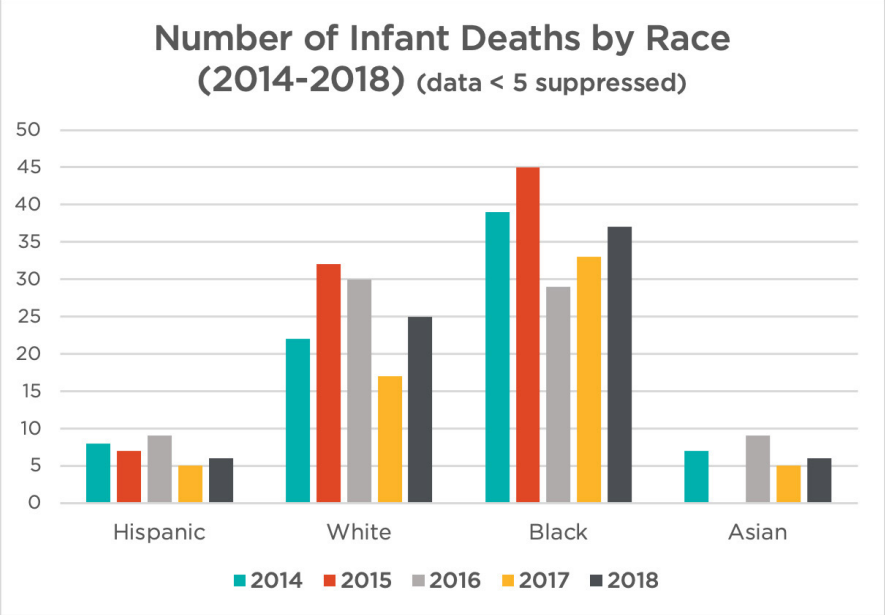
Childhood Immunizations

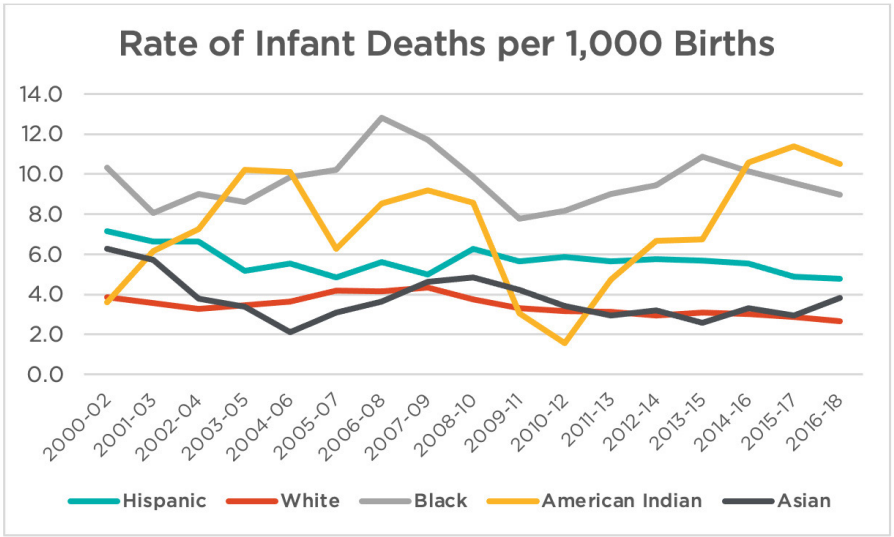
Once babies are born it is important for them to get immunizations to help protect them from communicable diseases. Minnesota Department of Health (MDH) reports on a seven vaccine series for children includes DTaP (diphtheria, tetanus, pertussis), hepatitis B, Hib (Haemophilus influenza type B), MMR (measles, mumps, rubella), PVC (pneumococcal conjugate vaccine), polio, and varicella (chicken pox). It does not include hepatitis A or rotavirus. In Hennepin County, 67.7% of all children ages 24-35 months were up-to-date on their immunizations in 2019.

Source: MDH, Minnesota Immunization Information, Connection (MIIC), accessed May 5, 2022.

Infant Deaths

Infant mortality is an important indicator of a population's health because it is associated with maternal health, quality and access to medical care, socioeconomic conditions, and public health practices. In 2019 there were 51 infant deaths in the North Memorial Health Consolidated Service Area. This is a rate of 4.45% and compares to a rate of 4.99% in Hennepin County. There are disparities in infant death rates by race and ethnicity with higher rates among Black, Hispanic, American Indian, and Asian populations when compared to white infant death rates. During the years 2014-2018, there were higher numbers of Black infant deaths compared to whites every year except in 2016.



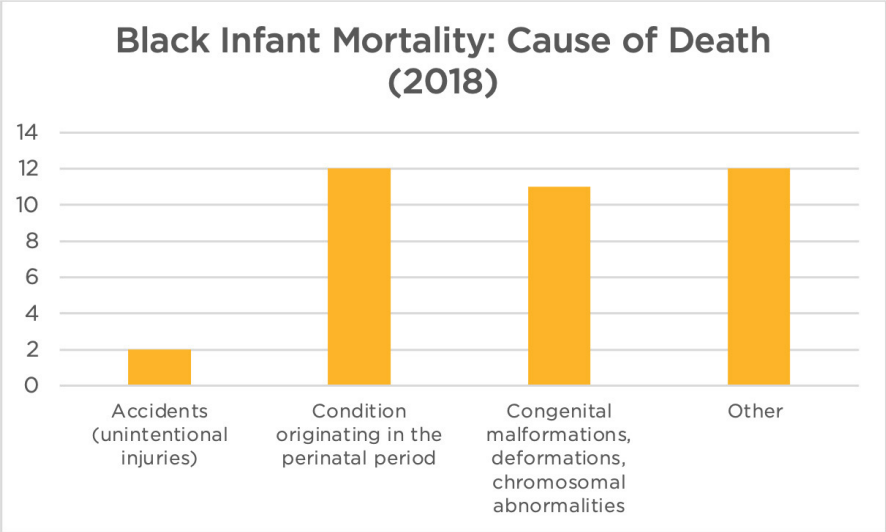


HP2030 has a goal to reduce pregnancies among adolescent females (aged 15-19) to 31.4 per 1,000. We are meeting that goal.

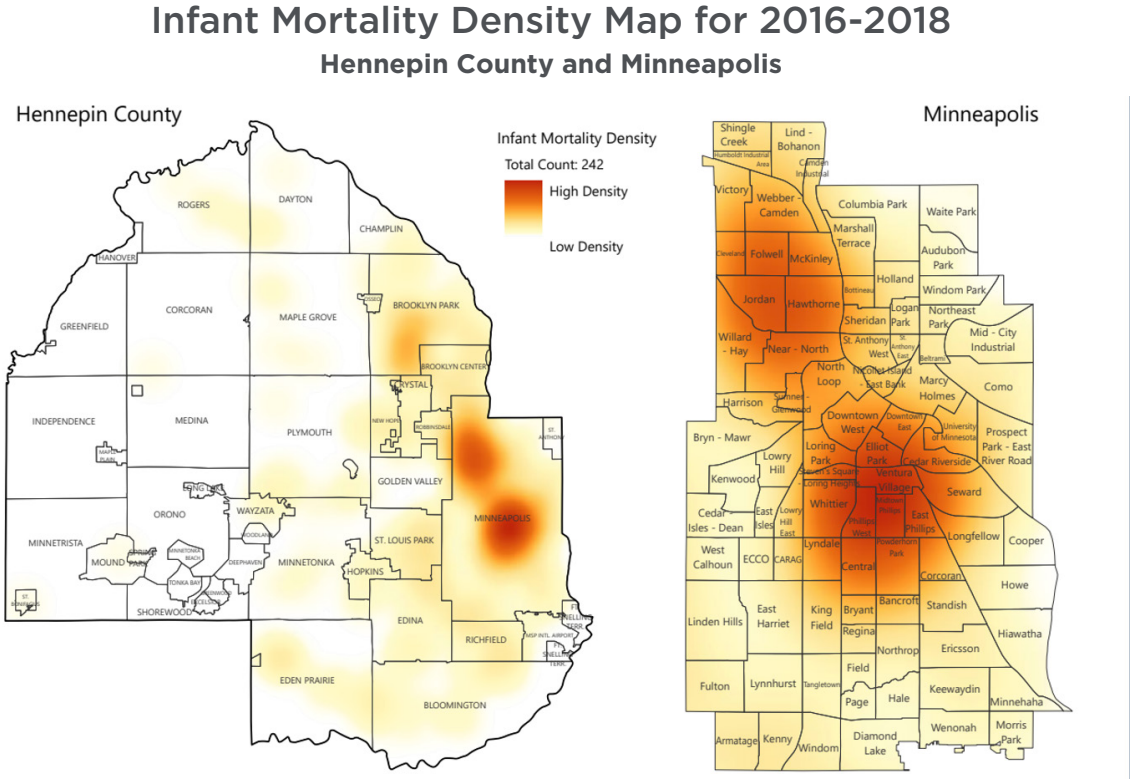
HP2030 has a goal to reduce the percentage of preterm births to 9.4%. We are not quite meeting this HP goal.

HP2030 has a goal to increase abstinence from smoking among pregnant women to 95.7%. We are very close to this goal.

The following chart shows the cause of death among Black infants, with the majority being conditions originating in the perinatal period, congenital malformations, deformations, and chromosomal abnormalities. Two deaths were due to accidents and twelve deaths were classified as “other”.



Here is a map of infant deaths in Hennepin County for the years 2016-2018. They note by density geographic regions with higher rates of infant mortalities.



Source: Hennepin County Health and Human Services

Injury, Violence, and Safety

INTRODUCTION

Injury includes injuries that are both unintentional as well as intentional. They can be both fatal and non-fatal. Injuries results in many visits to healthcare providers and hospitals. They include a wide range of types including burns, drownings, falls, firearm injuries (intentional and unintentional), motor vehicle crashes, and poisonings, to name a few. Injuries are often classified by intent of injury, such as unintentional (accidents, falls) or intentional injury, violence-related (homicide/assault, suicide, intentional self-harm) or by the mechanism (cause) of injury, such as fall, fire, firearm, motor vehicle crash, poisoning, or suffocation.

Injuries are the leading cause of death and disability for people ages 1-44 in the United States and in our consolidated service area. The Hennepin County Community Health Assessment (2018) reported that unintentional injury was the only top cause of death that increased compared to 2000, which was related to falls and poisonings (overdoses). Unintentional injuries are a leading cause of death and disability throughout the life span and a leading cause of premature death. Early death is both tragic and often preventable. There are many risk factors for injuries and there are many preventive health policies and practices that can be put into place to reduce the rate of injuries, especially unintentional ones.

UNINTENTIONAL INJURY

Lacking data specific to only North Memorial Health's consolidated service area, the following data shows the impact of unintentional injuries in Hennepin County. Falls, poisonings, and drug overdoses (mostly with opioids present) were the leading causes of unintentional injury deaths. There are health disparities in unintentional injury rates. Among African Americans who died of unintentional injuries, 70% were due to poisoning compared to 28% of white residents. Among American Indian populations who died of unintentional injuries almost all were due to poisonings as well.

Unintentional injuries (All ages)	
Falls	339
Poisoning	315
Drug overdose	294
Drug overdose – opioids present	237
Motor vehicle crash	60
Suffocation	38
Drowning	15
Fire/burn	6
All other causes	34

	Unintentional injuries (All)	Poisoning
Hispanic	31	12
American Indian	37	36
Asian	13	–
Black/African American	132	92
White	582	165
Multi-racial	11	6

Source: Provisional 2020 death records, Office of Vital Records, MDH. Analyzed by Hennepin County Public Health Assessment team, February 2022. Data is considered provisional and subject to change upon receipt of final 2020 death file from MDH Center for Health Statistics.

Falls

Falls are the leading cause of unintentional injury deaths in Minnesota and Hennepin County. In 2020, 339 Hennepin County residents died as a result of a fall. The majority of fall injury deaths were among White residents. People 65 years of older have a much higher rate of death caused by falls compared to all other ages. Falls are the leading chief complaint among customer seeking emergency care at North Memorial Health. Between the period 1/1/2019 and 5/2/2022 over 16,211 emergency encounters listed falls as the chief complaint.

There are community and hospital-based health interventions that can help prevent falls. Some community-based interventions include exercise programs that strengthen core strength and balance. One of these is Stepping On, a 7-week evidence-based program that reduces the risk of falls for people living at home who have experienced a fall or are concerned about falling. It has been proven to reduce falls in older people living in the community by 31%.

Another is home inspection programs offered to older home owners that can help them correct structural items around their homes that may lead to a fall, that ranges from as simple as reducing the use of throw rugs, minimizing clutter in hallways and walkways, to building ramps over curbs.

HP2030 Goal is to reduce fall-related deaths among older adults (age 65 and above) to 63.4 per 100,000. We are not meeting this goal.

Unintended poisoning mortality

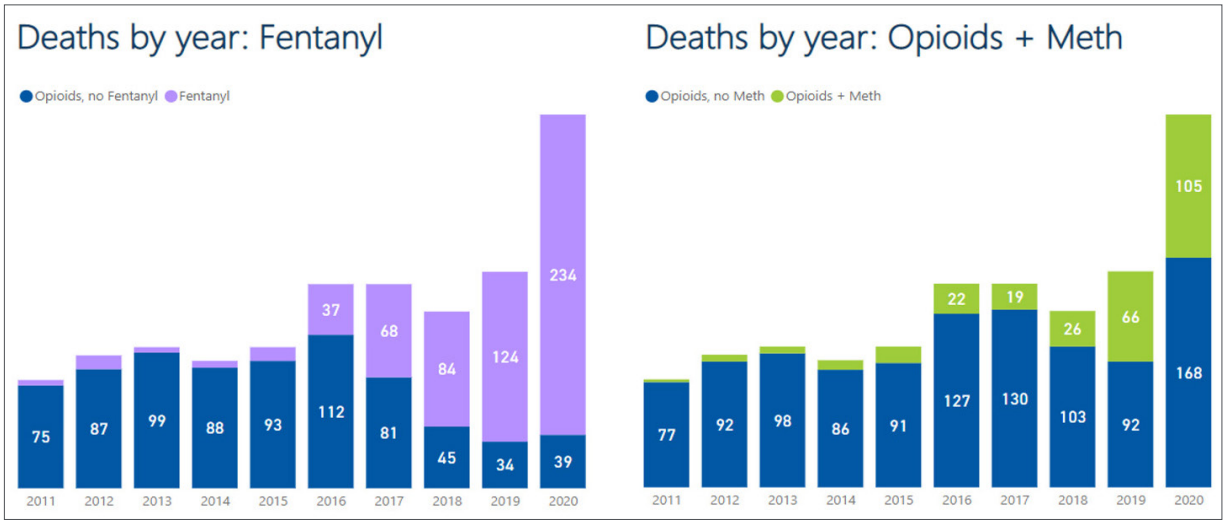
One of the leading, and growing, contributors to premature death is drug overdose deaths. The United States, including Minnesota, is experiencing an epidemic of drug overdose deaths. Since 2000, the rate of drug overdose deaths has increased by 137% nationwide. Opioids contribute largely to drug overdose deaths; since 2000, there has been a 200% increase in deaths involving opioids (opioid pain relievers and heroin). As noted above, about 1/3 (32%) of Hennepin County's unintentional deaths were due to poisoning. Of deaths due to poisoning, the vast majority are related to drug overdose (93%), and most often opioids were a contributing cause of death. Much of the increase in opioid overdose deaths is due to the presence of fentanyl or opioid and methamphetamines being used together. Fentanyl is a synthetic opioid that is about 50 times as potent as heroin. Fentanyl is cheap to manufacture, often is mixed with other opioid drugs, and a small amount goes a long way. Many people who use drugs are not aware of the exact composition of the substance they are using while others use fentanyl intentionally because of its potency.

Year
2020

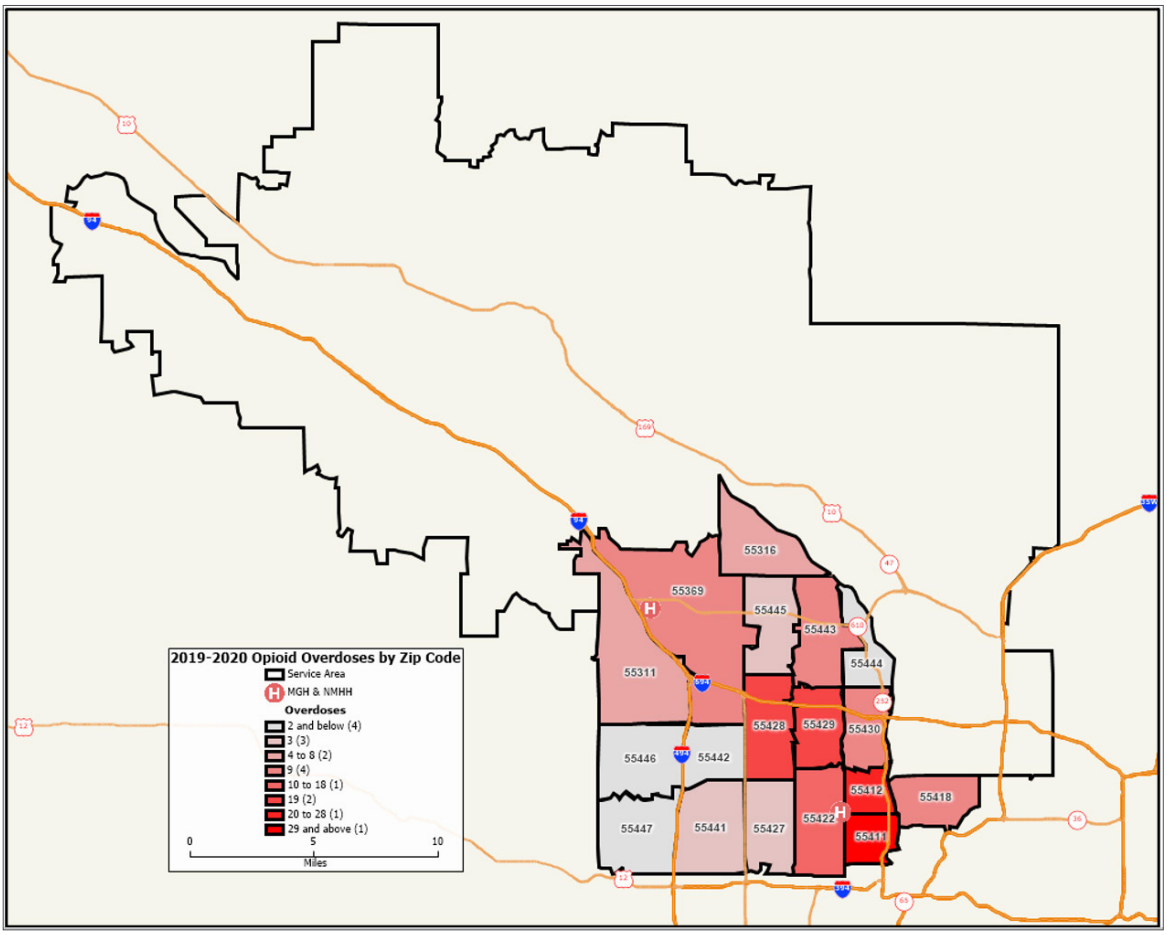
Opioid-related deaths
273

Percent with Fentanyl
86%

Percent with Meth
38%



In our consolidated service area we had 613 opioid overdose deaths in the years 2011-2020, with 167 (27.2%) occurring in 2019-2020. The highest concentration of deaths have occurred in our North Minneapolis region (55), followed by Brooklyn Park (28), Brooklyn Center (13), Maple Grove (12), Robbinsdale (12), and New Hope (10). See map below for more details.



There are interventions that can be used to stop drug overdoses. Some of them include interventions aimed at changing health providers' prescribing behaviors, distributing naloxone to reverse overdoses, increasing access to medication assisted treatment (MAT) for people with opioid use disorder, and encouraging safe disposal of opioid medications. Other evidence-based harm reduction strategies such as fentanyl test strips, safety planning, and access to safe supplies are vitally important in reducing opioid overdose deaths.

A number of these interventions have been put into place within North Memorial Health systems. One intervention we would like to showcase is the use of Deterra bags for safe medication disposal. In 2021 North Memorial Health purchased 4,200 Deterra medication bags to distribute to customers through the hospital pharmacies to increase safe disposal of household medications. The Deterra medication disposal pouch makes drugs safe for disposal in the household trash. It protects our environment and prevents accidental overdose by immediately and permanently deactivating and disposing of unneeded pills, patches, liquids, creams, and films.

Motor Vehicle Crashes

Over time, with increased safety features on cars, graduated licensure programs for new drivers, and safer roads and walkways, vehicle crash deaths from have been reduced. Motor vehicle crashes still remain a primary unintentional injury, however, resulting in much injury and pain. Between the period 1/1/2019 and 5/2/2022 there were 8805 emergency encounters with a motor vehicle crash as a chief complaint.

HP2030 has a goal to reduce deaths from motor vehicle crashes to 10.1 per 100,000

Drownings

Swimming, boating and other forms of water recreation are among Minnesota State residents' most popular pastimes. Sometimes, these activities can be dangerous or fatal. In 2020, Hennepin County had 15 residents die from drowning, including incidents related to boating. Preventing drowning requires multiple strategies. Isolation fencing of swimming pools is well-established as a method to reduce drowning in pools. Studies also show that wearing a life jacket and swimming lessons also reduce the risk of drowning.

INTENTIONAL INJURIES

Intentional injuries are where harm was intended, such as assaults, homicides, and suicides. Violence is a leading cause of injury and death, especially among youth and young adults. Violent crime rates vary throughout the Consolidated Service Area but have gone up during the pandemic. Most local police and sheriff's departments report the number of violent crimes to the Federal Bureau of Investigation's (FBI).

Even though suicide is considered an intentional injury, we will report on suicides in our Mental Health Data Briefing, along with other self-harm behaviors.

In 2020, there were 120 firearm related deaths in Hennepin County. Over half (54%) were homicides,

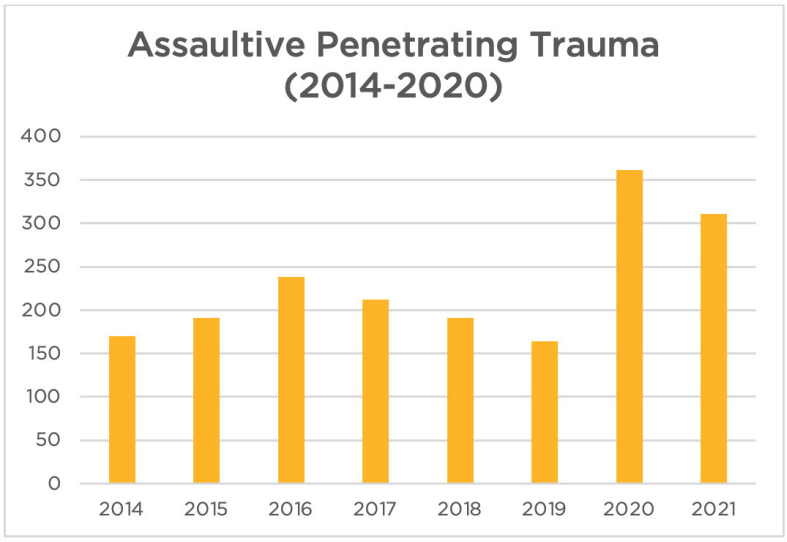
Highlight: Community Program Aimed at Ending Violence

In 2018, NMHH launched a program called **Next Step**. It was in response to the hospital seeing roughly 700 victims of violence related to physical assaults, stabbings, or gunshots each year. Next Step is a hospital-based violence intervention program that connects youth and young adult victims of violent assault injuries to resources and support. It provides both immediate and long-term support to young victims to help them break the cycle of recurrent violence that may be affecting them. Next Step's motto is "Change Your Story, Change Your Life" and aims to end the cycle of violence. The Next Step program is a hospital-based violence intervention program partnership between the City of Minneapolis, Hennepin Health, and NMHH.

Violence is preventable, and like with other communicable diseases, steps can be taken to prevent the spread of violence and help individuals heal and recover. Next Step provides immediate hospital and bedside support for young victims and their families, facilitates in-hospital interventions such as offering assistance with medical care and therapy, offers clothing and shoes for discharge, and continues support once participants are in the community. Such community support includes connecting them to a network of long-term services, guiding them through goal planning and assisting them in meeting goals such as obtaining a GED or getting trained in a trade, assistance with driver's licenses and state IDs, and getting referrals to mental health services and treatment. Next Step aims to interrupt the cycle of recurrent violence and help individuals avoid re-injury and further trauma.

and 43 percent were suicide. Almost all firearm deaths in Hennepin County were people identified as either White or Black/African American. The majority of homicide deaths by firearm were people who are Black while the majority of suicide deaths by firearm were people who were White. The remaining were accidental or undetermined intent.

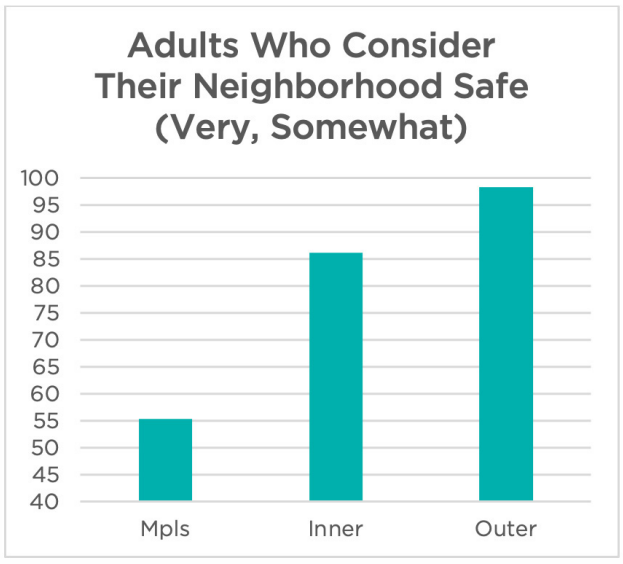
Penetrating Trauma

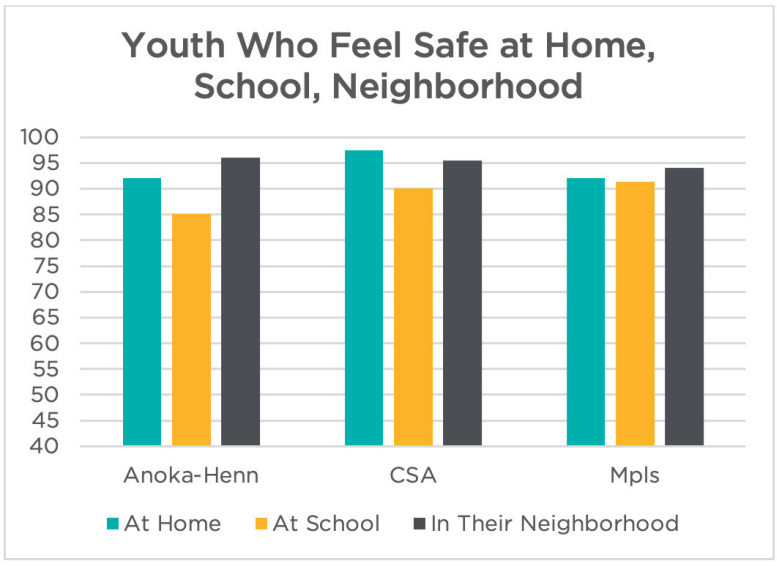


NMHH is a level 1 trauma center. Level 1 Trauma Centers are required to have immediately available all resources to stabilize and definitively treat even the most complex traumatic injuries. Penetrating trauma injuries are a broad category for trauma mechanism (blunt vs. penetrating). Assaultive penetrating trauma is what people might consider 'violent injury.' Assaultive penetrating trauma is an injury caused by something piercing or entering the victim that is intentionally caused by another person. This injury category includes gunshot wounds and stabbings, not physical assault with fists or a blunt object. It does not include unintentional injuries (falling on a sharp object) nor self-inflicted injuries. NMHH closely tracks penetrating trauma data and is working in partnership with other hospitals to try to reduce violence in our communities.

COMMUNITY SAFETY

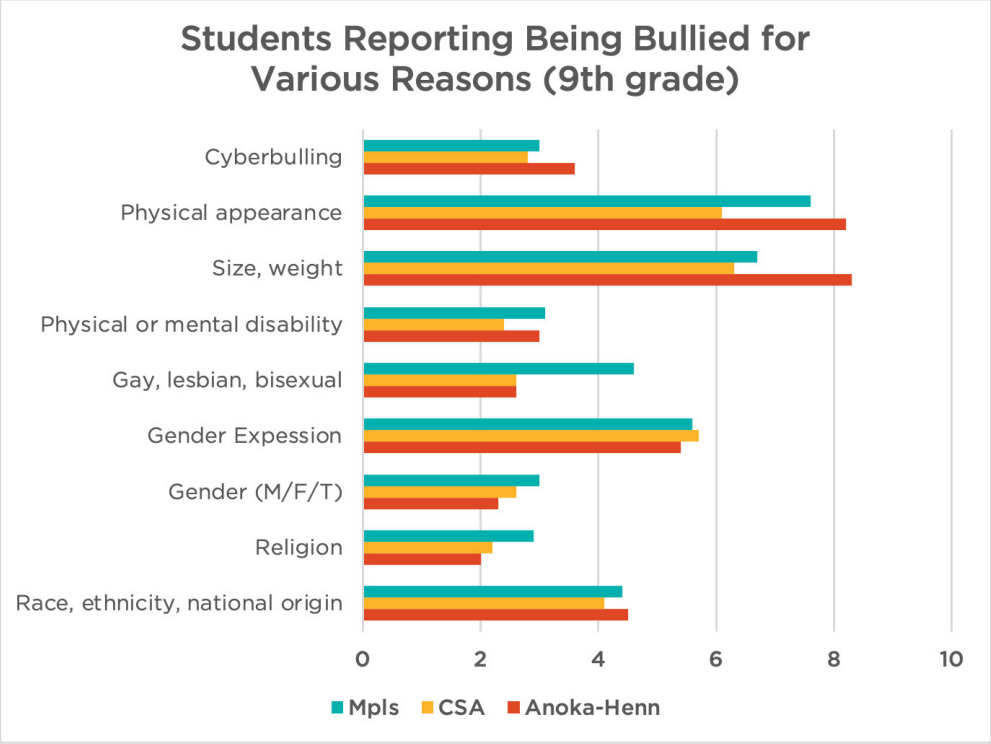
Most people desire to feel safe in their neighborhoods, places of employment, schools, and homes. Even though violent crime rates have gone up, the majority of residents in the consolidated service area feel safe in their neighborhoods, schools, and homes. The following data shows adults who consider their neighborhood as very or somewhat safe and youth who feel safe in their neighborhood, school, and home.





Bullying

While the majority of students attending schools in North Memorial Health service area report feeling safe at school, students often report feeling unsafe at school due to bullying behaviors. The Minnesota Student Survey asks many questions about bullying and the reasons for bullying. The following chart shows the percentages of students who report being bullied one time a week or more for a number of reasons. The primary reasons for bullying in all the school districts in the region are due to a person's physical appearance, their size, and/or obesity. Research shows that the establishment of strong anti-bullying policies and enforcement by school officials has the potential to prevent bullying.



Mental Health and Well-Being

INTRODUCTION

A person's psychological and emotional well-being has a direct correlation to overall health. Mental health and physical health are closely connected. Common mental health conditions such as depression and anxiety can affect a person's ability to eat healthy, be physically active, and take part in healthy behaviors. Mental illness is associated with greater occurrences of chronic disease, injury, and substance use. Conversely, people with chronic health conditions often find it harder to get treatment for mental disorders. About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime.[1]

Mental disorders affect people of all ages and racial/ethnic groups, but some populations are disproportionately affected. Estimates suggest that only half of all people with mental disorders get the treatment they need.[2] Screening for mental health conditions during other clinical appointments can help healthcare practitioners identify mental disorders and help their customers get the mental health care they need, along with care for their physical health.

Many people have both substance use disorders and mental health conditions (co-occurring disorders). Co-occurring disorders complicate diagnosis and treatment options. The health care system is complex and there is a shortage of mental health practitioners. When a person is not feeling healthy and competent, it is hard to negotiate for themselves and actively seek treatment.

Between the years 2000–2018 suicide rates had increased by 30% in the United States. Nationally rates declined in the years 2019 and 2020. Despite that, rates compared to other countries are still high and in January of 2021, the U.S. Surgeon General released a *Call to Action to Implement a National Strategy for Suicide Prevention*. The report notes "This Call to Action recognizes suicide as a complex issue that needs far-reaching solutions". The report advocates for a range of suicide prevention efforts such as:

- Promoting resilience and wellness
- Identifying and supporting at-risk individuals and groups
- Responding helpfully to crisis situations
- Caring for those at risk of suicide
- Supporting people affected by suicide

The report states "People with lived experience must guide this work, and it should be tailored for groups who are disproportionately affected by suicide, which include people who identify as military service members, veterans, indigenous, and ethnic, racial, sexual, and gender minorities."

Healthy People 2030 focuses on the prevention, screening, assessment, and treatment of mental disorders and behavioral conditions. The Mental Health and Mental Disorders objectives also aim to improve health and quality of life for people affected by these conditions.

[1]«Centers for Disease Control and Prevention. (2018). Mental Health: Data and Publications. Retrieved from https://www.cdc.gov/mentalhealth/data_publications/index.html

[2]National Institutes of Mental Health. (2018). Statistics. Retrieved from https://www.nimh.nih.gov/health/statistics/index.shtml

SOCIAL AND EMOTIONAL SUPPORT

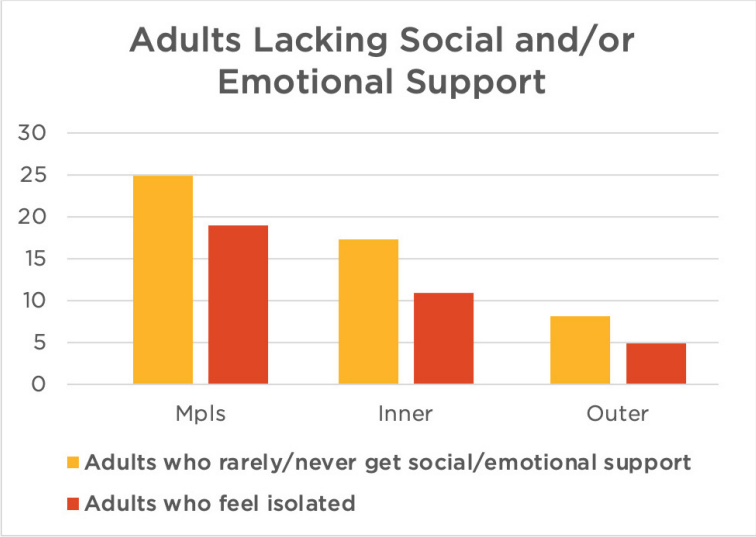
It is important to the mental health of both children and adults to have at least one person in their lives who can provide social and emotional support. People with inadequate social and emotional support are more likely to feel hopeless, alone, and isolated. They often turn to drugs and alcohol to help them cope with their emotions when they are feeling hopeless and unsupported.

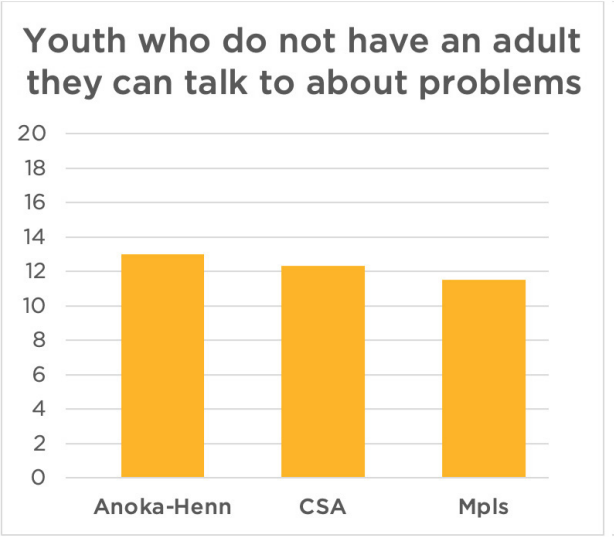
All people need someone they can talk to about their problems or health concerns or get emotionally supported. The SHAPE asks adults whether they have a person they can talk to for emotional support and whether they feel isolated. The chart below notes responses to these questions with North Minneapolis adults reporting less social and emotional support and feeling more isolated.

There were disparities among adults who rarely or never get social or emotional support when they need it among those who identify are ages 18-24, Hispanic, American Indian/Alaska Native, Black-foreign born, low income, have a high school degree or less, and/or are housing insecure.

There were also disparities among adults who report usually or always feeling isolated from others among those who are transgender, American Indian/Alaska Native (32.1%), Black-US born, have less than a high school degree, are housing insecure, or have self-reported disabilities.

It is important for youth to have at least one caring adult in their lives to talk to about problems. While most students in the school districts we are reporting on do have at least one caring adult in their life (87-88.5%), the 11-12% of students without a caring adult in their lives are a concern.

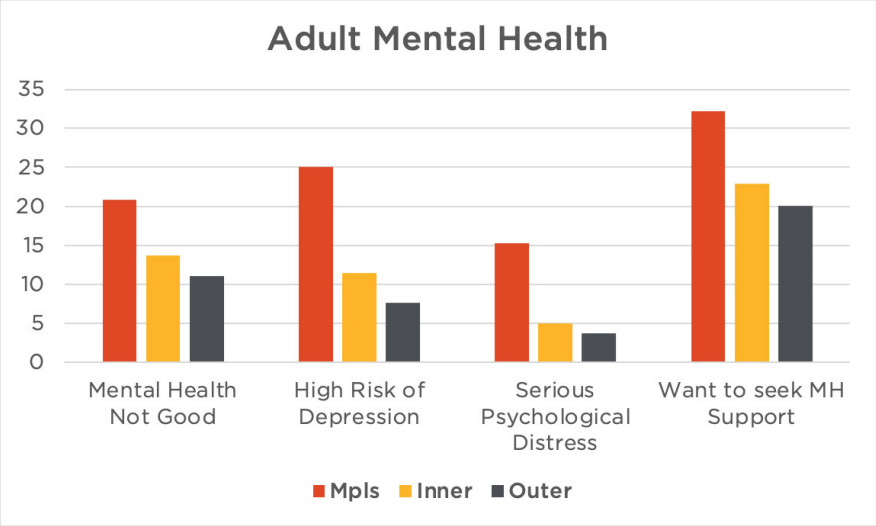




HP2030 has a goal to increase the proportion of adults who talk to friends or family about their health to 92.7%. We are only meeting this goal in the NW outer suburbs.

ADULT MENTAL HEALTH

The 2018 Adult SHAPE survey asks many questions about adult mental health. The following chart shows: 1) the percentage of adults who reported their mental health was not good for 14 or more days during the past 30 days; 2) adults who were at a high risk of depression based on their PHQ2 score; 3) the percentage of adults reporting feeling serious psychological distress/anxiety; and 4) adults who wanted to seek help for stress/depression/a problem with emotions/excessive worrying/troubling thoughts.



One in 5 adults

wanted to get help for a mental health issue such as stress, depression, a problem with their emotions, excessive worrying, and/or troubling thoughts.

There are disparities in adults who report their mental health is not good, which is higher in persons who identify as Black-US born, American Indian/Alaska Native, low-income, have less than a college degree, are housing insecure, and/or have self-reported disabilities.

There are disparities in adults at high risk for depression among those who identify as transgender, LGBT, American Indian/Alaska Native, SE Asian, Black-US born, low income, graduated from high school or less, are housing insecure, and/or have self-reported disabilities.

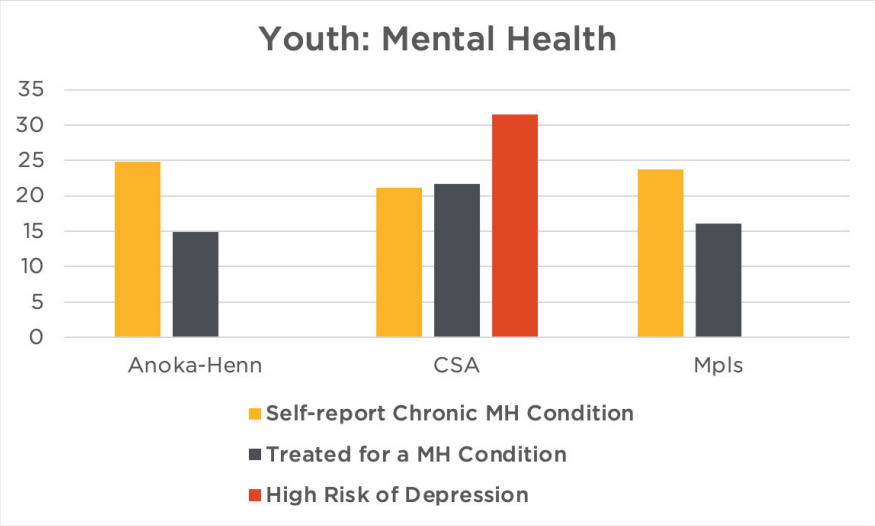
There are disparities in adults with serious psychological distress among adults who identify as transgender, LGBT, American Indian/Alaska Native, Black-US born, are <100% federal poverty level (FPL), have less than a high school degree, are housing insecure, and/or have self-reported disabilities.

There are disparities in adults who want to seek help for a mental health issue among those who identify as transgender (57.6%), LGBT, Hispanic, Black-US born, whose income is less than 100% FPL, are housing insecure, and/or have self-reported disabilities.

YOUTH MENTAL HEALTH

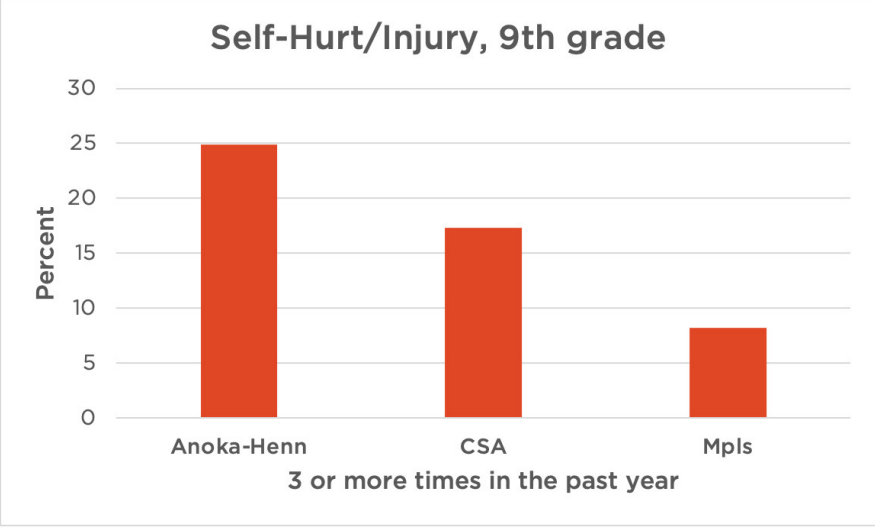
A young person who reports feeling sad or hopeless almost every day for two weeks or longer, to the point that they are not doing their usual activities meets the definition of youth depression in surveys like the Minnesota Student Survey (MSS) or the Youth Risk Behavior Survey. The following chart shows the percentage of ninth-graders who reported a chronic mental health condition in the past year, and those with a reported chronic mental health condition who received treatment for a mental health, emotional, or behavioral problem during the last year.

For school districts in the consolidated service area, other than Anoka-Hennepin or Minneapolis, the chart also shows those students who are at high risk for depression due to higher scores on a depression scale (PHQ2). This data was not available for Anoka-Hennepin or Minneapolis School Districts.



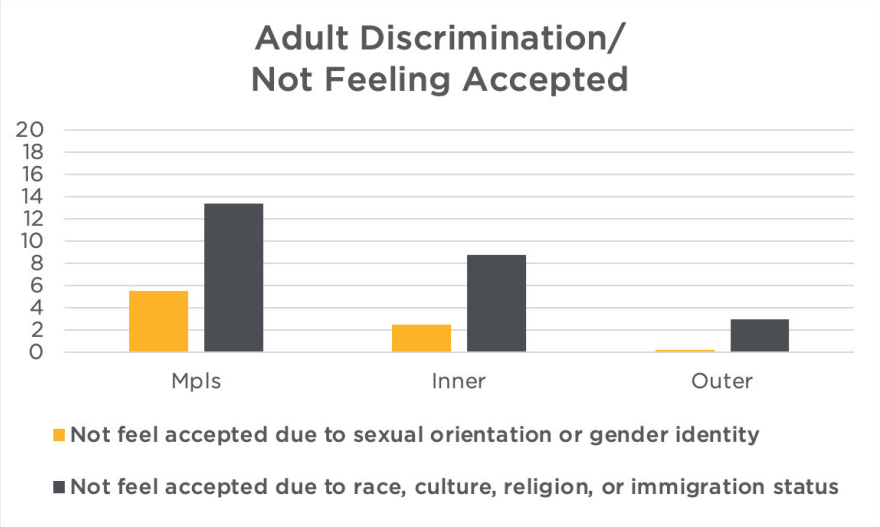
Youth Self-Hurt/Injury

The Minnesota Student Survey also asks students whether they have engaged in any self-harm behaviors in the past year. Non-suicidal self-harm includes behaviors include actions such as self-cutting, scratching, and burning, done without the conscious intent to take one's life. Self-harm/injury typically occurs between 14 and 24 years of age. The most common reasons for this type of harm are to reduce tension or relieve stress/ anxiety, but reasons may also include self-punishment, interpersonal reasons, and anti-dissociation mechanisms.



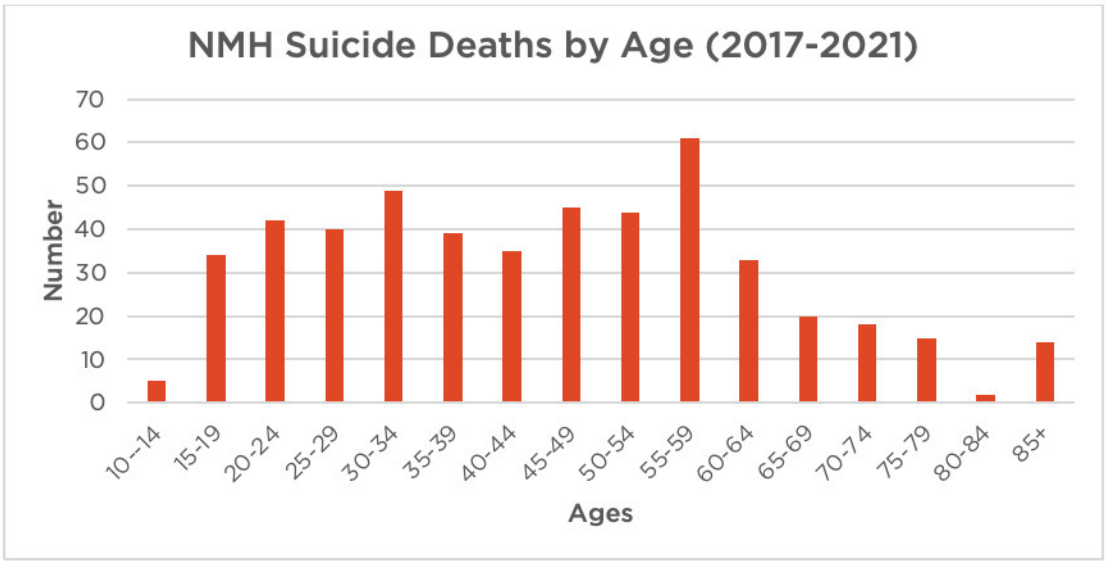
Discrimination and Acceptance

In the Injury and Violence section we shared data about youth being bullied. It is important to feel accepted in one's community. The SHAPE asks adults whether they have been discriminated against due to their to race/ethnicity, cultural background, religion, immigration status, or due to being LGBT, and/or their sexual orientation. Adults in the Minneapolis region have higher rates of discrimination and/or not feeling accepted.

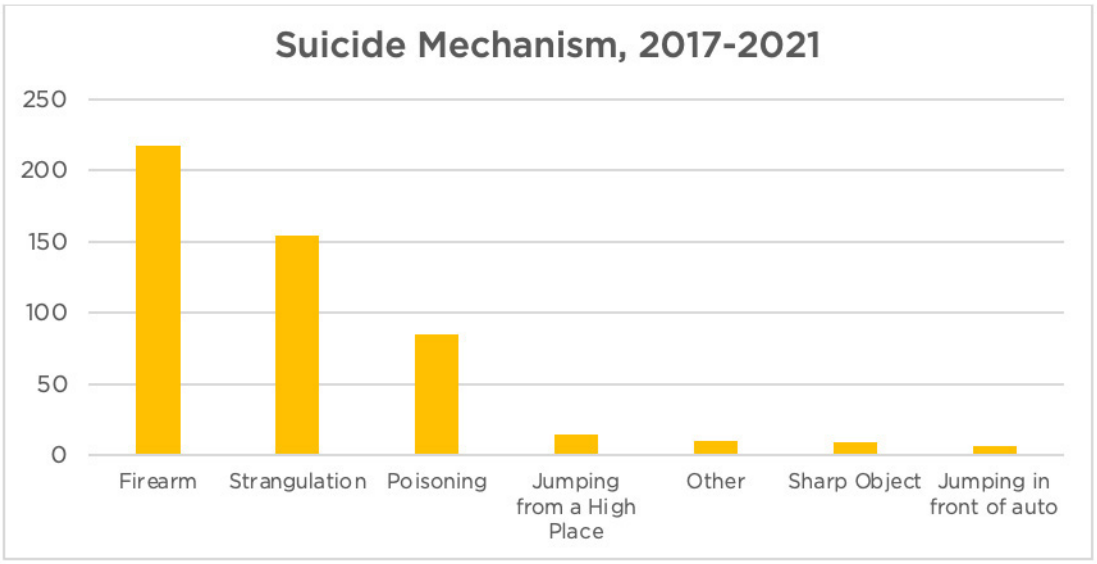


SUICIDE

We received suicide data from Minnesota Department of Health for the years 2017-2021. Data was shared about gender, age, and means. 244 people died by suicide in those years; more identified as male (81%) when compared to female (19%).

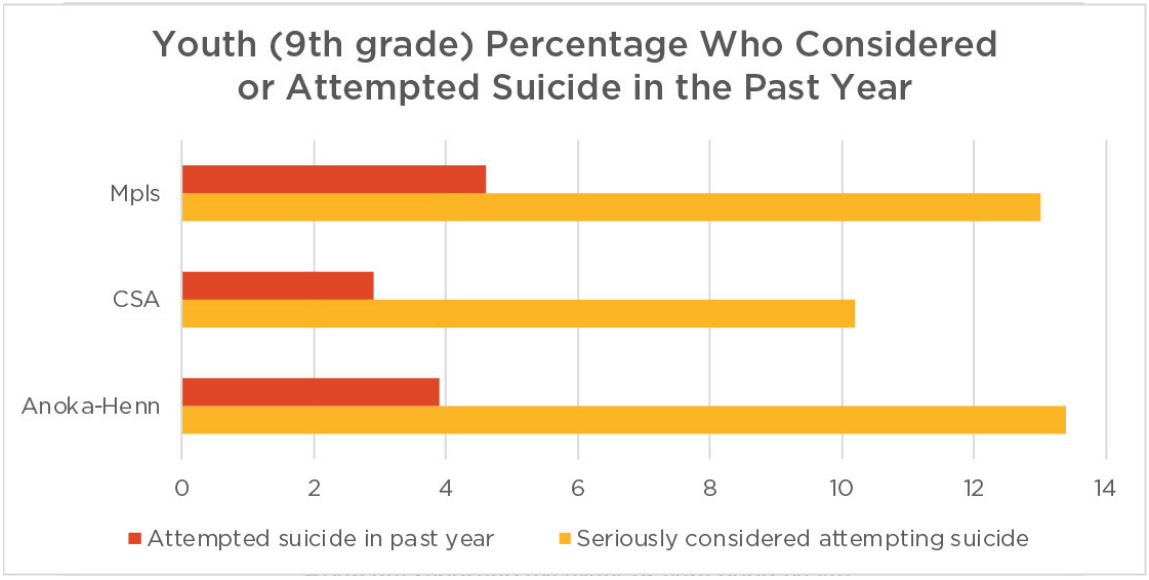


HP2030 has a goal to reduce suicide deaths to 12.8 per 100,000. Data is not currently available to measure the suicide death rate in the consolidated service area.



Youth Suicide Ideation and Attempts

A youth who is severely depressed might have thoughts about attempting suicide. The MSS asks students whether they had seriously considered attempting suicide during the past year or earlier and whether they had attempted suicide in the past year. Between 10-13% of youth in consolidated service area schools had considered attempting suicide and almost 3-5% reported they had attempted suicide in the past year.



NORTH MEMORIAL HEALTH MENTAL HEALTH DATA

Many NMHH and Maple Grove Hospital customers present for emergency services with their chief complaint being the need for treatment for a mental health condition or anxiety. Between 1/1/2019 and 5/2/2022, we had 6,472 Emergency Services encounters for these two chief complaints. Admissions at North Memorial Health hospitals for mental health conditions dropped during the COVID-19 pandemic. Most of the psychiatric admissions present at NMHH. Discharge data from the past three years show similar discharge rates for males and females. At the time of the CHNA, it was not possible to determine the ages of persons discharged and/or whether there were higher rates for different races/ethnicities.

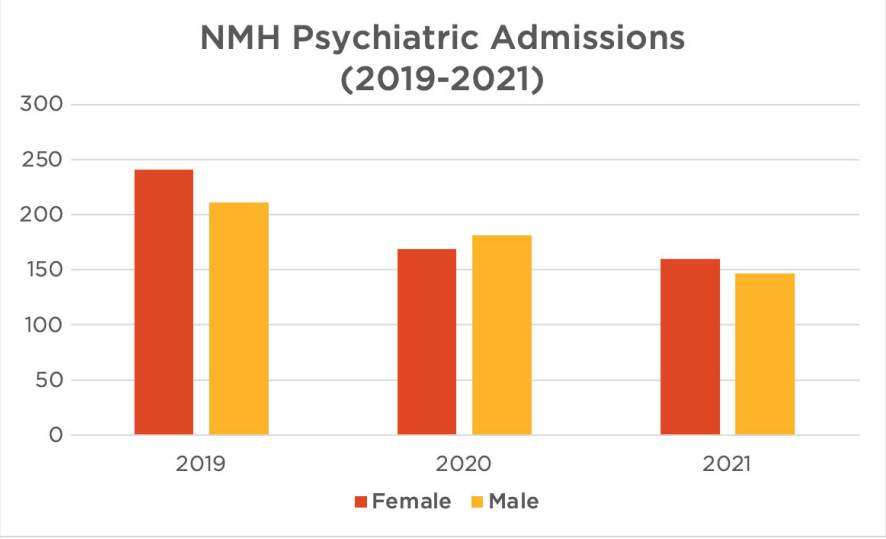
North Memorial Health Hospital: Suicide hospitalizations

North Memorial Health had 553 customers discharged with a primary ICD10 code for suicide ideation between 10/1/2020 and 9/30/2021 with 41 being ages 0-14, 69 being ages 15-17, 322 were ages 18-44, 100 were ages 45-64, and 21 were ages 65+. National data show that more persons die from suicide who identify as male, middle-aged adults, white, and American Indian.

North Memorial Health Hospital: Hospitalizations for Mental Health and/or Substance Use Conditions

There were 1,116 discharges from NMHH and Maple Grove Hospital between the months of 10/01/2020 and 9/31/21 for psychoses, alcohol/drug abuse or dependence, and/or poisoning and toxic effects of drugs. Most discharges for psychological conditions were at NMHH (Maple Grove Hospital had about 3 per year while NMHH had between 308-449 inpatient discharges during the years 2019-2021). Maple Grove Hospital averaged about 75 inpatient discharges for alcohol/drug abuse or dependence and NMHH averaged about 1,059 inpatient discharges each of the same three years. The rates for these discharges fell in 2020 but are tracking higher in 2021, especially for alcohol/drug abuse or dependence.

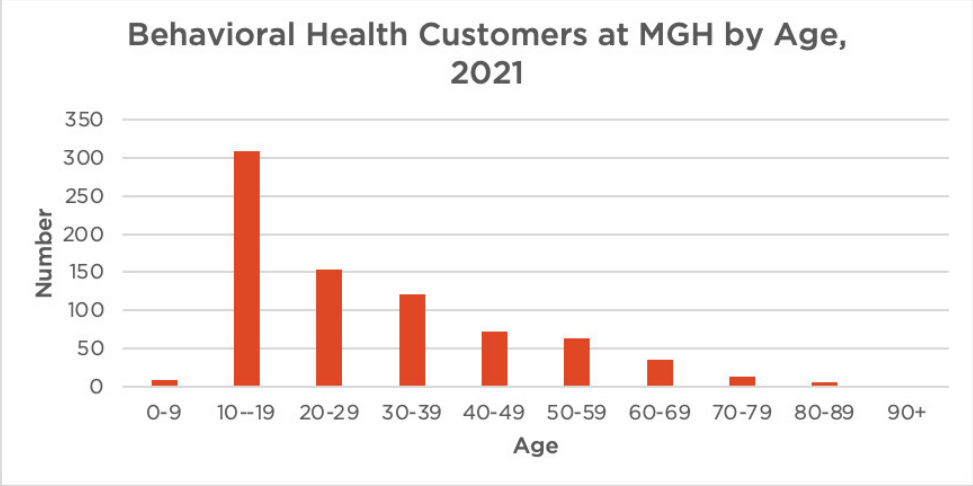
There were numerous health system encounters in the period 10/1/20 to 9/30/21 for mental health conditions (primarily depression, anxiety, post-traumatic stress disorder, suicide ideation, and other psychiatric diagnoses). Depression was one of the primary diagnoses for seeking care. At NMHH, psychoses, alcohol/drug abuse and dependence, and poisoning and toxic effects of drugs are three of the top DRGs among ages 18-64, not including birth-related DRGs.



Maple Grove Hospital Behavioral Health

Maple Grove Hospital provides behavioral health care. This care is provided in the Emergency Care Center and is also provided to customers with both medical and behavioral health needs. The goal is to stabilize and provide a safe discharge plan including an appropriate location based on individual needs. Maple Grove Hospital partners with contract organizations to provide behavior health consultations to Maple Grove Hospital customers needing a consult and follow-up care. In 2021, there were 782 customers in the Maple Grove Hospital ECC that received Behavioral Health Consultations. By May of 2022, there had been 298 Maple Grove Hospital customers that received a Behavioral Health Consultation. At times, there are customers admitted for a primary medical need and a secondary mental health issue becomes apparent. In 2021, 19 of these customers were identified and in 2022 YTD, there have been 7.

The table below shows the age ranges of Maple Grove Hospital customers who received a Behavioral Health Consultation in 2021. The most common age receiving a consultation was age 14.



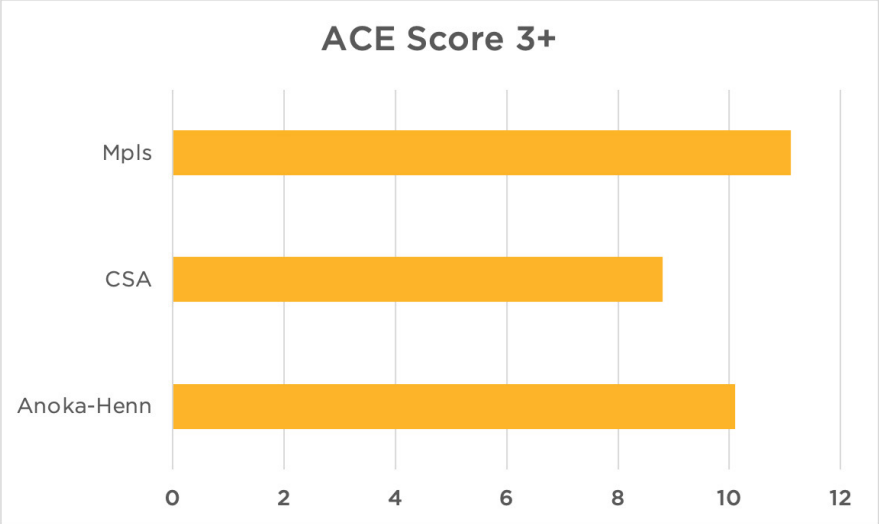
ADVERSE CHILDHOOD EXPERIENCES (ACES) AMONG YOUTH

In 1998, the Adverse Childhood Experiences (ACES) Study was conducted by Kaiser Permanente and reported on ten childhood experiences of more than 17,000 adults.[1] They collected data on abuse, neglect, and household stressors such as parental substance use and/or mental illness, domestic violence, divorce, and incarceration. The study team reported that more than one in five people had three or more ACES in their childhood. These childhood exposures are associated with a multitude of health and social problems. As the number of ACEs increases, the risk for health problems later in life increases. Since that time, a growing body of research has documented connections between traumatic experiences in childhood and a wide range of adverse outcomes across a person's lifespan. The following health problems have been linked to adverse childhood experiences: Alcoholism and alcohol abuse, obesity, depression, illicit drug use, ischemic heart disease (IHD), sexually transmitted infections (STIs), smoking, suicide attempts, and unintended pregnancies.

[1]Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V.,...Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14, 245-258.

[2]Zhang, X, and Monnat, SM. Racial/ethnic differences in clusters of adverse childhood experience and associations with adolescent mental health. SSM – Population Health, 16 December 2021, accessed May 2022.

A recent study by Zhang and Monnat (2021)[2] found that ACES prevalence was significantly higher among people who identify as Black or Hispanic. The authors recommend that "racially-tailored interventions to prevent and/or treat adolescents with a history of ACEs should also consider structural factors such as internalized racism, racial prejudice and discrimination, and the U.S.'s historical legacy of structural racism."

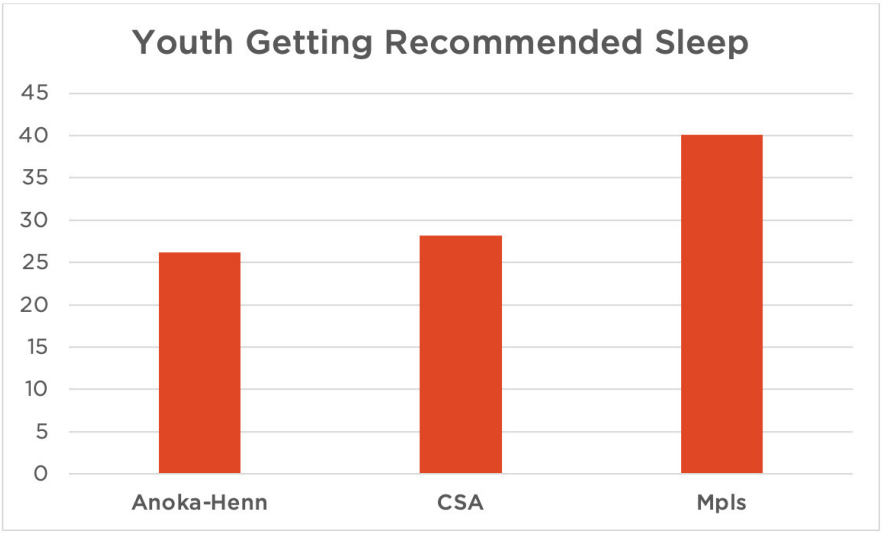


SLEEP

Many people in the United States don't get enough sleep. Not getting adequate sleep is linked to an increased risk of obesity, diabetes, heart disease, cancer, and death. Adults who don't get enough sleep are also at higher risk for problems related to the brain, like stroke or dementia. Many youth also don't get enough sleep. Inadequate sleep is linked to an increased risk of physical and mental health problems, alcohol and drug use, motor vehicle crashes, and sports-related injuries. Children and youth who don't get enough sleep may also do worse in school.

Youth Sleep

The American Academy of Sleep Medicine and the American Academy of Pediatricians have new recommendations that teens get 8-10 hours of sleep a night. HP2030 notes the issue of youth getting adequate sleep is getting worse, their goal is to increase the proportion of high school students who get enough sleep to 27.4%. Students in the Anoka-Hennepin School District are not meeting that goal and those in the CSA districts are barely meeting that goal (28.2%).



The HP2030 goal is to increase the proportion of adults who get enough sleep (7+ hours) to 68.6% but we do not have data on the sleep patterns of adults in the CSA.

Substance Use

INTRODUCTION

A wide range of drugs are classified under substance use disorder including alcohol, cannabis, phencyclidine, and other hallucinogens, inhalants, opioids, sedatives, stimulants, tobacco, and other or unknown substances. Using prescription drugs outside the scope of healthcare provider directions or for conditions they are not prescribed for is considered substance misuse. Substance misuse is a contributing factor to many leading causes of death including cancer, heart disease, and stroke, and increases a person's risk for both intentional and unintentional injury. Substance misuse often impacts a person's education, employment, family, and social relationships.

A substance use disorder (SUD) is a health disorder that affects a person's brain and behavior, leading to a person's inability to control the use of substances such as legal or illegal drugs, alcohol, or medications. Substance use disorder is the persistent use of drugs despite substantial harm and adverse consequences. The misuse of substances can result in a wide range of mental/emotional, physical, and behavioral problems. It can include impacts such as chronic guilt; an inability to reduce or stop consuming the substance(s) despite repeated attempts; driving while intoxicated; and physiological withdrawal symptoms. Symptoms can range from moderate to severe, with addiction being the most severe form of SUDs.

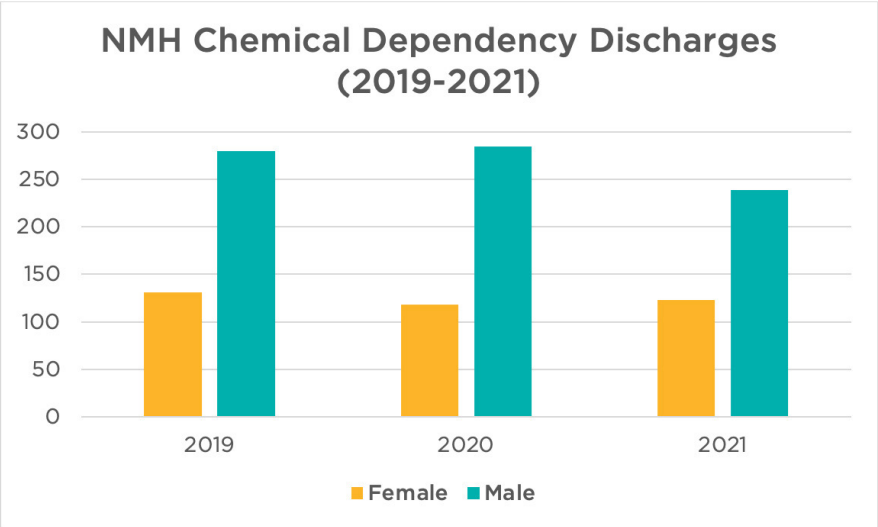
More than 20 million people in the United States have a substance use disorder, and most of them don't get the treatment they need[1]. Substance use disorders are linked to many health problems and can lead to overdose and death. Deaths from opioid use disorder have increased dramatically in recent years.

Research has found that about half of individuals who experience a substance use disorder (SUD) during their lives will also experience a co-occurring mental disorder and vice versa. Co-occurring disorders can include anxiety disorders, depression, attention-deficit hyperactivity disorder (ADHD), bipolar disorder, personality disorders, and schizophrenia, among others.

Strategies to prevent drug and alcohol use at the school, family, and community level are key to reducing substance use disorders. Increasing non-opioid pain management may also help prevent opioid use disorder and deaths. And interventions to help people with substance use disorders get treatment can help reduce related health problems and deaths.

North Memorial Health Data: Chemical Dependency Discharges

The *NMH Chemical Dependency Discharges* chart documents the number of chemical dependency discharges that occurred in 2019-2021. The numbers dropped in 2021, particularly for males. Customers who identify as male are a higher percentage of customers who are treated for chemical dependency health conditions.



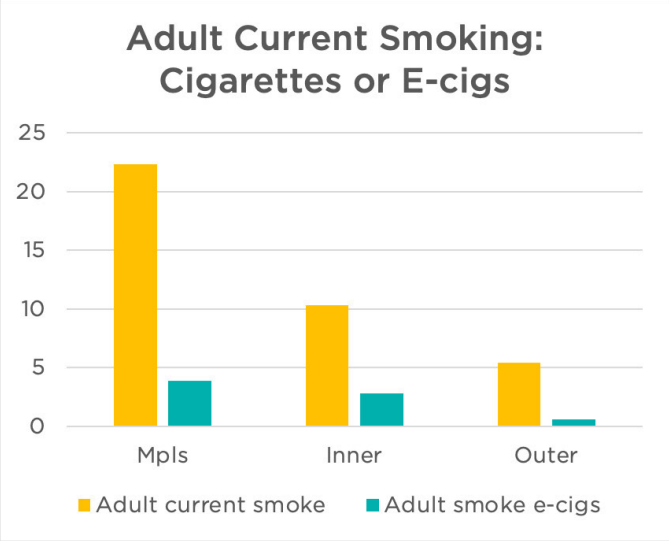
[1] Substance Abuse and Mental Health Services Administration. (2014). Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings. Retrieved from https://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf.

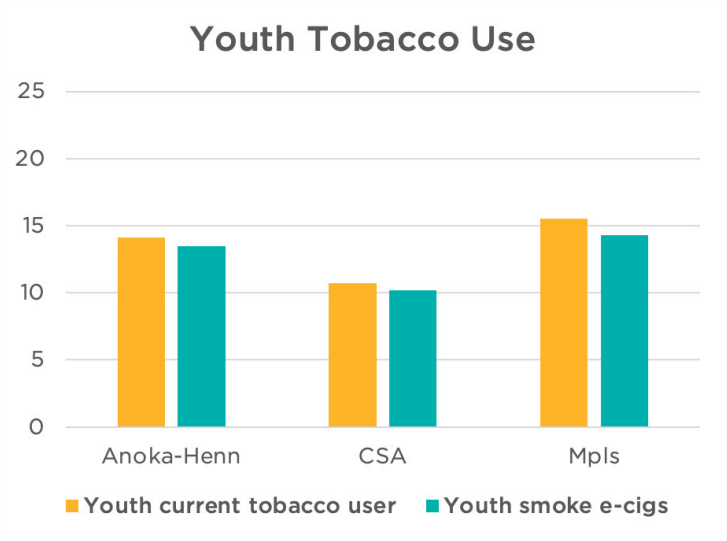
TOBACCO USE: ADULTS AND YOUTH

Regular tobacco use can result in increased rates of lung cancer and other chronic respiratory and chronic diseases. Both adult and youth cigarette use has declined over time. In youth, however, although cigarette use has declined, the drop in cigarette use is offset by using other tobacco products, such as e-cigarettes, and marijuana. The use of nicotine and marijuana can impact a youth's developing brain—having been shown to impact both IQ and healthy brain function.

HP2030 has a baseline goal to reduce current e-cigarette use among youth to 10.5%. We are not meeting that goal in the Anoka-Hennepin or Minneapolis School Districts but are meeting that goal in the other CSA school districts.

The charts below show the percent of adults (18+) who reported they currently smoke cigarettes and/or e-cigarettes and the percent of 9th-grade youth reporting the use of any tobacco products or e-cigarettes in the past 30 days.





ALCOHOL USE

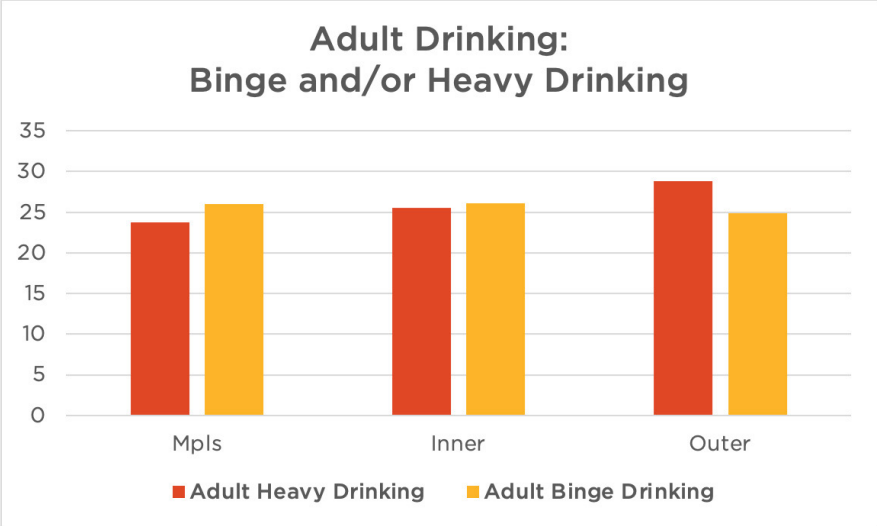
Alcohol is the most frequently misused substance nationally. Drinking too much alcohol can cause serious health problems including stroke, cancer, and cirrhosis. People with alcohol use disorder are also more likely to get sick and less able to fight off infections. Prevention strategies include programs at the school, family, and community level — and behavioral therapies and medications can help treat alcohol use disorder.

Adult Alcohol Use

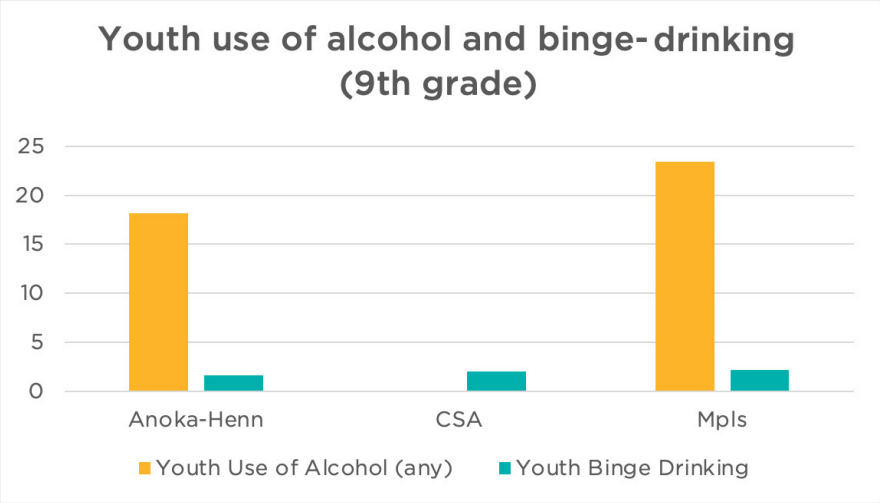
The SHAPE asks respondents about their use of alcohol in the past 30 days. Alcohol misuse can be classified as binge drinking which is 4 drinks on a single occasion, generally within two hours for women, and 5 drinks on a single occasion, within two hours, for men. A respondent's use of alcohol might also be classified as heavy drinking which is drinking 1 or more drinks on average per day for women or two or more drinks per day for men. The chart below notes that about 25% of the adult population in all three regions are either heavy drinking or binge drinking with slightly higher heavy drinking in the outer suburbs.

There are disparities in adults who are heavy drinkers with higher rates in adults ages 18-54, identify as female, Hispanic, Black-US born, have an income of greater than 200% FPL, and some college or a college degree.

There are disparities in adult binge drinking among adults who are ages 18-44 (32-44%), Hispanic, Black-US born, White, and have a high school degree or above.



Youth Alcohol Use

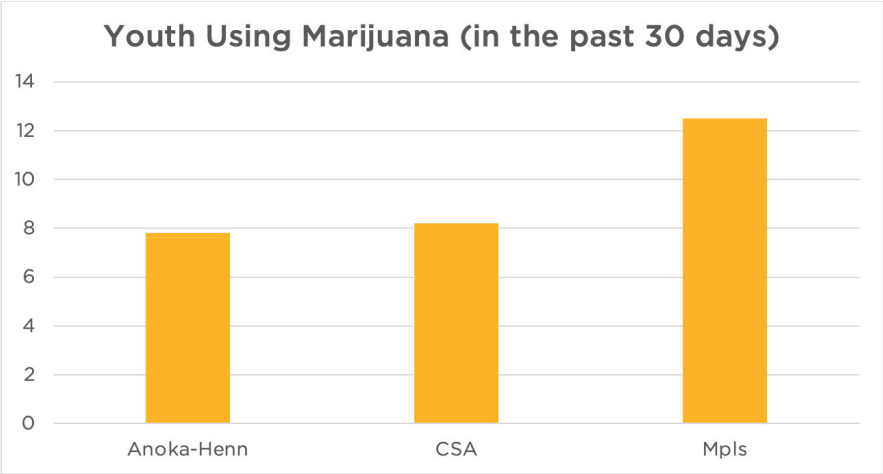


HP2030 has a goal to reduce the proportion of people under 21 years who engaged in binge drinking in the past month to 8.4%, we are meeting that goal among our youth.

MARIJUANA USE

Marijuana is the most commonly used illegal substance in the U.S. and its use is growing among adults of all ages, genders, and pregnant women. The perception of how harmful marijuana use can be is declining especially with marijuana getting legalized in many states. Increasing numbers of adults and young people do not consider marijuana use a risky behavior. There are, however, real risks for people who use marijuana, especially youth and young adults, and women who are pregnant or nursing. The marijuana available today

is stronger than ever before. People can become addicted to marijuana and approximately 1 in 10 people who use marijuana will become addicted. When they start before age 18, the rate of addiction rises to 1 in 6.[1]

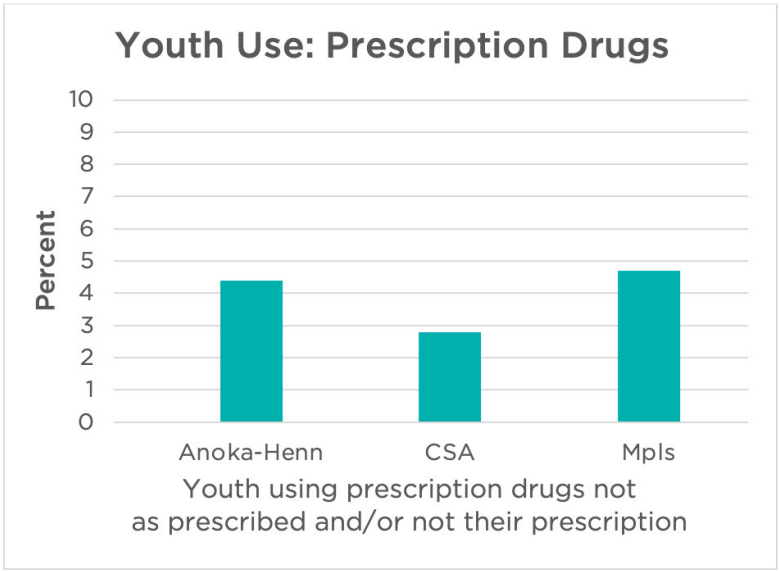


HP2030 has a baseline goal to reduce the proportion of adolescents who used marijuana in the past month to 6.8%. We are not meeting that goal in any school district.

YOUTH USING PRESCRIPTION DRUGS

The Minnesota Student Survey asks students whether they had used prescription drugs in the past 30 days not as they were prescribed to them or were another person's prescription.

Less than 5% of 9th grade youth report using prescription drugs in either of these ways. HP2030 does not have a goal for this substance misuse.



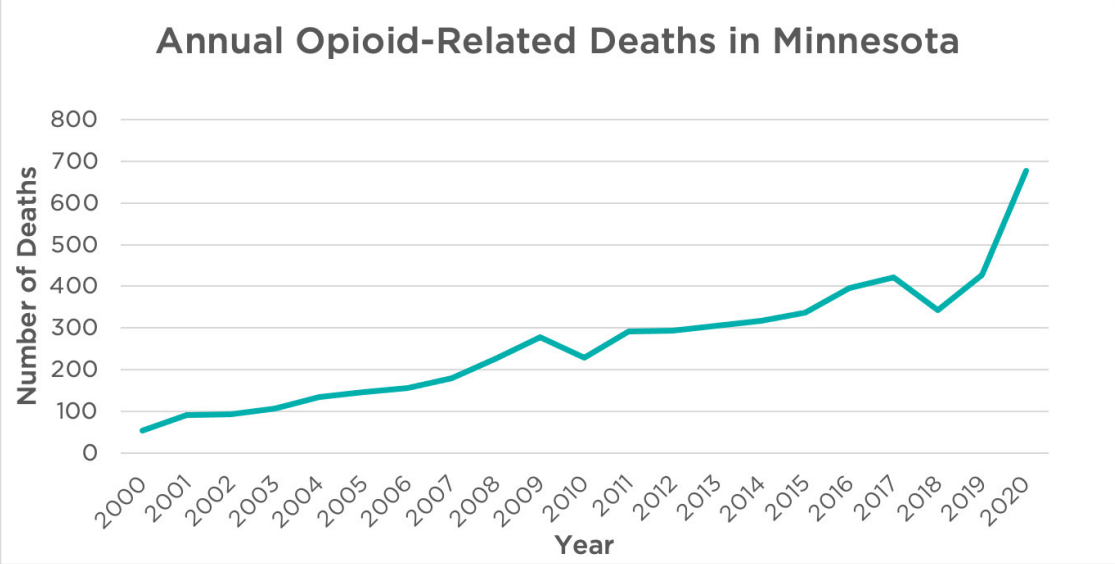
[1]SAMHSA Fact Sheet "Learn About Marijuana Risks" Know the Risks of Marijuana | SAMHSA, accessed May 16, 2022.

Opioid Overdose Deaths

Opioid overdose deaths have risen sharply in recent years and reducing opioid use disorder is key to preventing overdose deaths. Less than half the people who need treatment for opioid use disorder get it. Improving opioid prescribing practices and increasing access to and use of medications for addiction treatment can help reduce opioid use disorder.

HP2030 has a baseline goal to reduce emergency department visits for harms from nonmedical use of prescription opioids to 3.5 per 10,000 population. They also have a goal to reduce the age-adjusted overdose death rates to less than or equal to 20.7 per 100,000 by 2030.

Many medication-related emergency department visits involved nonmedical use of prescription opioids. Prescribing the lowest possible dose of opioids and treating pain with non-opioid treatments can help reduce nonmedical use of prescription opioids. In addition, increasing treatment of opioid use disorder and making naloxone widely available to treat acute overdoses can help reduce emergency department visits for nonmedical use of prescription opioids.



Quantitative Data

REVIEW OF FINDINGS

Quantitative data about the health of youths and adults in the community was obtained from population-based health surveys, clinical and hospital data, and local and national public sources. CEAT members examined key health indicator (KHI) data from many sources, ninety-one KHI were shared for the North Memorial Health Consolidated Service Area including twenty sociodemographic characteristics of the population. Seventy-one KHI were scored in terms of size, seriousness, availability of effective interventions, disparities, and whether a health goal (often HP2030) was being met. The scoring table used by CEAT members can be found on page 14.

The number of CEAT members who scored the key health indicators ranged but in general we had ten members from the NMHH score the KHIs, with 3 members scoring all the KHIs.

When looking at the range of scores we noted that a number of KHIs did not have a health goal. Thus, scores were looked at both including the health goal score and not including the health goal score. It was determined that health issues would be categorized as a Critical Health Issue if they had a score of 15+ when health goal* scores were included or a score of 13+ when health goal* scores were not included.

We also wanted to share the Key Health Indicators where we were doing well. We decided that "Doing Well Health Issues" were those items that had a score of up to 10, with and without health goal* scores.

While the indicators vary some by hospital, the following are common at both North Memorial Health Hospital and Maple Grove Hospital.

Doing Well

- Adult and youth consumption of sugary beverages
- Adult fruit and vegetable consumption
- Adults age 25+ who have graduated high school or earned a high school graduation equivalency
- Adults getting adequate sleep
- Adults with a health exam in the past year
- Birth rates among mothers ages 15-19
- Number of days the Air Quality Index (AQI) exceeded 100
- Percent of women smoking during their pregnancy
- Unemployment
- Youth feel safe at school
- Youth feel safe in their home
- Youth fruit and vegetable consumption
- Youth marijuana use
- Youth misusing prescription drugs
- Youth getting adequate sleep
- Youth reporting very good or excellent health
- Youth who have been to the dentist in the past 1-2 years
- Youth with untreated dental issues

Additional indicators the NMHH CEAT scored as Doing Well

- Adults who have been to the dentist in 1-2 years
- Adults reporting very good or excellent heath
- Youth not bullied at school

Critical Health Issues

- Adult mental health
- Adults delaying care for a mental health concern due to cost or lack of insurance
- Cause of death: Cancer
- Cause of death: Heart Disease
- Falls mortality rate
- Hospitalizations due to COVID
- Rate of infant deaths per 1,000 live births

- Percentage of births to mothers who received prenatal care during the first trimester
- Sexually transmitted infection rates
- Suicide mortality
- Youth mental health

Additional indicators the NMHH CEAT scored as Critical

- Adult obesity and overweight
- Adult physical activity
- Adult tobacco use
- Adults delaying medical care due to cost or lack of insurance
- Adults not taking their prescriptions as directed due to cost
- Adults whose poor health interferes with daily living
- Adults with diabetes
- Adults with hypertension/high blood pressure
- Cause of death: Stroke
- COVID-19 vaccination
- Families finding it difficult to pay for health insurance premiums, co-pays, and deductibles
- Food security (Adult)
- Food security (Youth)
- Percent of persons in households with children 0-17 where one person smokes
- Poverty
- Understand health information from provider
- Unintentional poisoning mortality
- Youth obesity and overweight
- Youth tobacco use
- Youth: alcohol use and binge-drinking
- Adult alcohol use: binge or heavy drinking

Qualitative Research

REVIEW OF FINDINGS

Background on Community Engagement

For our 2022 CHNAs we engaged with the community in three ways:

1. We conducted 50 key health interview surveys of Community Engagement Advisory Team (CEAT) members, North Team members, and leaders of non-profits, government, and education organizations in our service area.
2. We held a number of community engagement events resulting in more than 400 local residents sharing about their vision of health, the impact of Covid-19 and systemic racism on their health, barriers to good health, and suggestions for improving the health services offered by North Memorial Health.
3. Finally, we engaged with Team members, providers, and community members through digital dialogues that ask the same questions asked our key informants and community members. The site, **communityhealthchat.com** aimed at gathering input from North Team members, providers, their family and friends living in the North service area, and the other people living throughout North communities.

All three forms of community engagement focused on the same five questions. The questions were:

1. What is your vision of health? How does your culture influence your vision and approach to health?
2. Over the past couple of years, how has Covid-19, systemic racism, and traumatic experiences impacted your, your family's, and our communities' (either live and/or work in) ability to live that vision of a healthy community? What support and resources did you need over the past couple of years?
3. Who do you turn to when you have health questions or concerns? What are your trusted healthcare relationships?
4. As we reimagine healthcare, what does it look like, and how does it improve the health of our community, your family, and yourself?
5. How can North Memorial Health help achieve the vision of a healthy community you just described over the next three years? What gaps and challenges exist, and what meaningful changes should be made?

Topline Findings

Across all the interviews, these were the key needs that rose to the top most consistently.

The need for more access to mental health care – in many ways/forms – was one of the most consistent and universal priorities identified in these conversations.

Causes	• COVID-related anxiety and isolation creating high demand • The increased impacts of trauma within the community (e.g., systemic racism, exposure to violence, family dysfunction, etc.) • Unprecedented rates of youth anxiety/depression • Growing awareness/understanding of mental health issues and efforts to destigmatize also creating increased demand
Barriers	• Demand eclipses supply across the board – not enough providers, not enough hours in the day to see patients, waitlists, provider burnout, etc. • Providers of color and/or culturally-sensitive/trauma-informed providers are even more rare • Lack of inpatient beds overall, but particularly for youth – creating long-term ER stays with limited resources or people turned out on the street in desperate need • Insurance coverage/ability to afford the cost of care • Those in need don't know how to begin/how to seek trusted care, may put off care until a mental health crisis emerges
Specific Needs to Address	• More providers/more timely access to therapy/treatment • Investing in more providers of color (now and over time) to serve BIPOC patients and/or trauma-informed/culturally-sensitive therapy shorter-term to address BIPOC needs (a similar need exists for the LGBTQIA community) • Greater inpatient capacity/beds, particularly for youth • Increased insurance access, sliding scales, changes in reimbursement rates to make mental health care a business priority • More guidance around how/where to seek help, pathways in to care, outreach to communities in need

Establishing more trusted care relationships was often identified as a much-needed pathway to improved health within the BIPOC and immigrant communities.

Causes & Barriers	• Lack of trust in the heath care system • Lack of experience/knowledge around how to navigate the healthcare system • Lack of in-language care/lack of translation/lack of connection with providers who don't understand language/culture • Lack of culturally-sensitive and/or trauma-informed care • Lack of health education • Lack of insurance/lack of funds to pay for care out of pocket • Providers who rush patients, ignore or minimize their concerns, pre-judge them based on race, culture, cultural differences, etc.
Imacts on the Community	• Delayed care leads to larger issues prior to seeking treatment, becomes a health crisis/ER visit vs. proactive care • Costs associated with overuse/abuse of EDs/ambulance services/911 resources for more minor needs • Lack of health education that, with access, might lead to healthier lifestyle choices (e.g., fitness, nutrition, stress relief/self-care, etc.)
Specific Needs to Address	• Establishing trusted primary care relationships close to home – with North Memorial or with community clinics that can feed into specialty care when/where needed • More providers of color (short and long-term) and/or trauma-informed or cultural sensitivity training for providers (short-term) • More in-language options, increased ability to communicate in first-language for both clarity and comfort level

Related to that, there was continued desire to address the social determinants of health where gaps may exist

Causes & Barriers	• Lack of transportation/safe public transit/limited access to physical clinics or locations • Lack of safe/secure housing (particular emphasis on those experiencing homelessness and aging apartment complexes with toxic living conditions in communities like Brooklyn Park/Brooklyn Center) • Lack of access to healthy foods, both broadly and with particular emphasis on culturally-appropriate foods that are also medically recommended (e.g., diabetes-friendly nutrition that reflects cultural/religious criteria) • Lack of funds for care – both for the insured who may be challenged to pay out-of-pocket costs like co-pays, deductibles, prescriptions, etc. and for the uninsured and/or undocumented who may struggle with accessing care out-of-pocket. (Also, lack of time/inability to take time off work to seek care without losing critical income.) • Lack of [safe] access to parks/green spaces, recreational activities, fitness centers, etc. • Lack of understanding of the healthcare system/how to navigate/how to enter
Imacts on the Community	• Delayed care leads to larger issues prior to seeking treatment, becomes a health crisis/ER visit vs. proactive care • Unhealthy living conditions and lifestyles lead to more heart disease, diabetes, respiratory issues, etc. • Costs associated with overuse/abuse of EDs/ambulance services/911 resources for more minor needs
Specific Needs to Address	• Mobile health units/bringing healthcare screenings and services directly to the community • Creation of healthcare ”guides” – people who can help patients enter and navigate the system • Partnerships with clinics providing no or low-cost care to help • More telehealth or affordable after-hours care for those who have limited capacity to leave work • Ensuring patients have access to the nutrition and support they need to live with/manage health needs (e.g., at discharge from ER or inpatient stay, at clinic appointments, etc.)

In addition to those broad and far-reaching community health needs, we heard other specific health needs.

Substance Use Disorder	LGBTQIA Health Needs	Senior/Elderly Health Needs	Pre-Natal/ Post-Natal Care
This was considered a community health issue, but often seen as adjacent to mental health needs (e.g., a symptom of a greater need vs. the issue in and of itself). Proper treatment of and care for those suffering from substance use disorder overlaps with mental health.	There was a desire among some respondents to see a greater level of attention and support for patients who may identify as LGBTQIA, particularly transgender patients and those who feel most marginalized and misunderstood by the healthcare community.	In communities around Maple Grove Hospital and communities with a larger base of aging-in-place adults, there was desire to see more support for aging adults, whether that be ensuring they have a proper home environment, transportation to appointments, opportunities to get out of the house, increased access to safe social activities post-COVID.	Given the size and importance of the birth center at Maple Grove Hospital, we also heard a desire to ensure greater support for mothers needing pre-natal and post-natal care, especially regarding nutrition, culturally-sensitive and in-language resources and practices, etc.

The impact of COVID-19 on the health of the community has been both direct and indirect.

DIRECT IMPACTS OF COVID-19 ON THE COMMUNITY:

- The rate of COVID infections, serious cases, and deaths in the community overall
- Long COVID health impacts for some patients, old and young
- COVID disproportionately impacting communities of color, both in infection rates and deaths, particularly:
  - Communities with higher rates of comorbidities such as diabetes, heart disease, obesity, etc.
  - Those who had to keep working (e.g., non-salaried, non-work-from-home roles)/increasing exposure during the pandemic
- Lower vaccination rates amongst communities of color and immigrant households

INDIRECT IMPACTS OF COVID-19 ON THE COMMUNITY:

The indirect impact has been felt on many levels:

- Loss of work/income during the shutdown, affecting insurance coverage and disposable income for food, shelter, healthcare, etc. – particularly the households who could least afford it
- Fear of seeking healthcare during the pandemic (e.g., putting off routine care, delaying procedures, etc.)
- Note that there is a sense that this issue has begun to normalize, although some may have higher needs now due to the delay in receiving care during the height of the pandemic
- Social isolation and anxiety as well as loss of traditional coping mechanisms which affected mental health
- Loss of and/or lack of trust in the health care system – not sure who to believe/what information to trust
- Family or household dysfunction including domestic violence rates higher and/or more hidden

- Polarization – feeling increasingly distanced from each other/neighbors/co-workers politically and/or with regard to beliefs around COVID (e.g., masking, vaccinations, etc.), increased hostility/aggression
- Online school and the multiple impacts on children's development, education, socialization, physical activity as well as parents' stress levels in trying to maintain school at home while working

The impact of systemic racism has also been broad and far-reaching – with some noting both potential positive and negative impacts during this time period

CLEAR NEGATIVE IMPACTS

- Emotional and physical trauma within communities of color – leading to re-injury, fatigue, stress, anger, fear, anxiety, etc.
- Increased and/or validated lack of trust in institutions and systems – including healthcare/healthcare providers
- Volatility and unrest, including increased rates of violence/gun violence (i.e., neighborhoods/ people within them feel less safe, less able to access community resources)

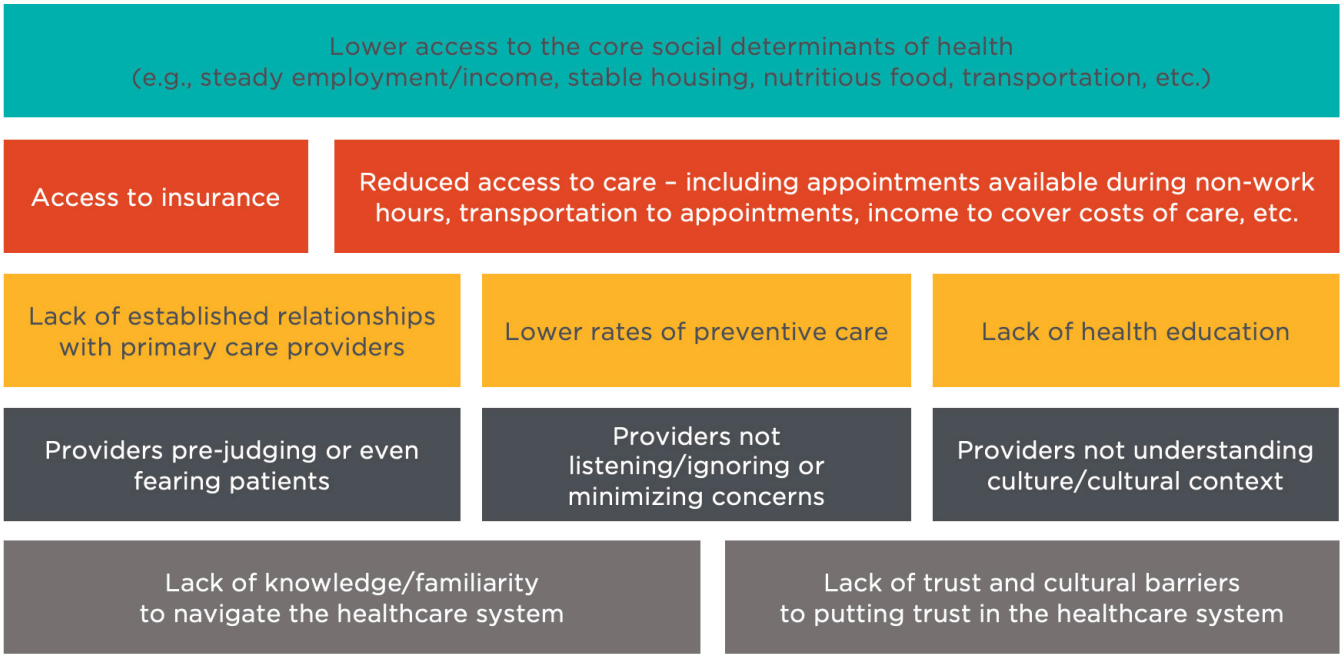
POTENTIAL POSITIVE IMPACTS

- An awakening among the non-BIPOC community
- A growing awareness or willingness to recognize long-standing inequities and begin to address them
- The ability to begin to have conversations and actually listen to communities and people who have been marginalized

Note that perceptions – or the perspective taken – around systemic racism varied across different geographies and respondents.

- When we spoke to respondents who were less directly affected – for example, less likely to be working with patients/clients who were BIPOC, not personally of color, working with a more suburban or white clientele – we often heard a perspective that was more about the levels of "social unrest" and increased rates of violence in the community that might create fear/anxiety and lead community members to avoid going out as much, or avoid using the parks for fitness, or avoid being out at night, etc.
- When we spoke to law enforcement, we often heard the direct impact of this time period on crime rates and gun violence and the need to create community dialogue and partnership.
- But when we spoke to BIPOC respondents or those who work closely with communities of color, we were far more likely to hear about the importance of exposing and addressing the long-standing inequities created by systemic racism.

Those inequities and their causes/factors included:



COMMUNITY CONVERSATIONS

Cultural Wellness Center coordinated and led community conversations throughout our consolidated service area. From mid-June to mid-August we held community engagement events that include several participation options. Participants had the option to participate in a Slow Roll bike ride and a conversation about community health and/or participate in a Dinner and Dialogue. The events were fun and include wonderful food, music, and a healthy activity (either the Slow Roll or a short health-instructor lead stretching/moving activity). Participants heard about the Blue Zones health findings and broke into facilitated small groups to discuss the five key questions.

These events enabled us to capture some deep dialogues from diverse participants ranging in age from 18-92!

Outreach

To promote our community conversation activities, we engaged in much community outreach at Farmers Markets and other local activities. We attended the Lakeview Terrace Farmers Market, the North Market Health Fair, the Maple Grove Farmers Market, the Hmong Community Know Your Park event, and a number of other local Farmers Markets and events. As part of our outreach we collected demographic data about attendees and asked them to respond to the five questions as well. While not as rich as the community conversations, it allowed us to connect and engage with community residents who might not attend a longer in-person event.

Vision of Health Conversation Findings

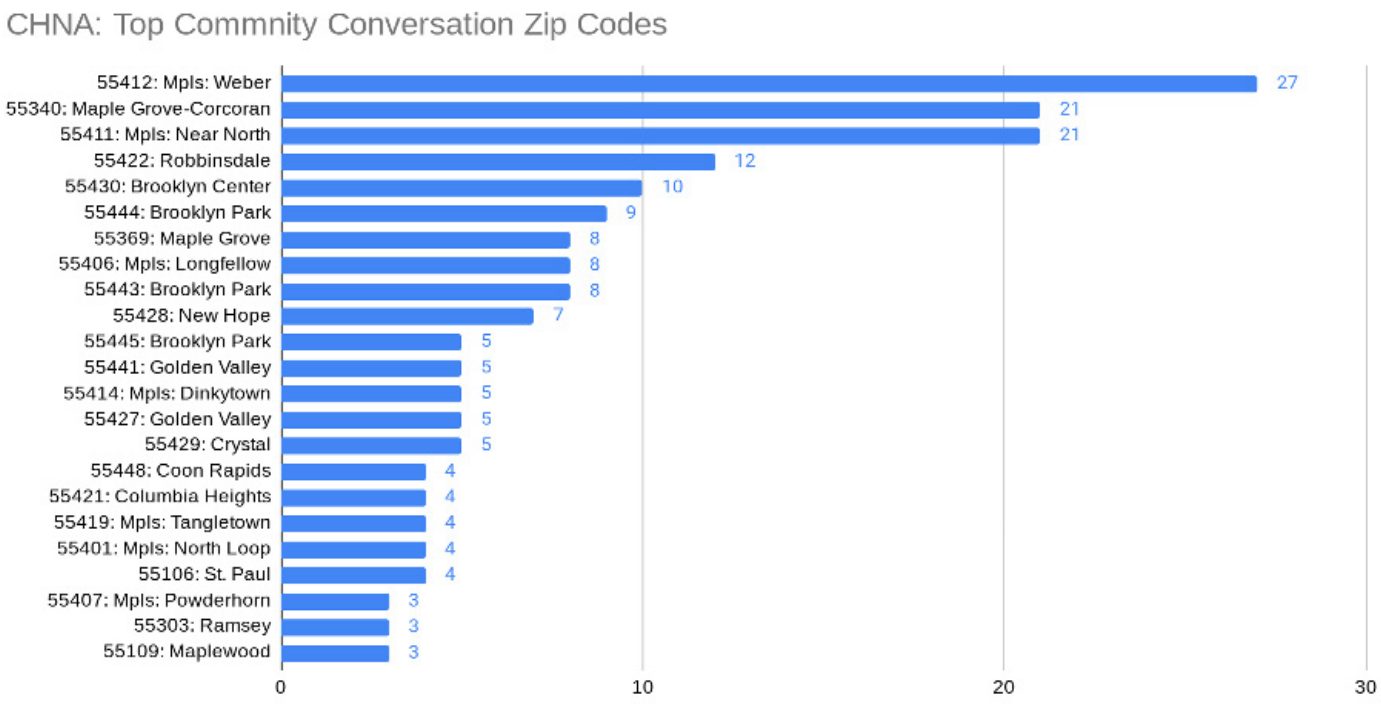
As noted above, a number of community engagement activities took place in shared spaces and diverse sites across the CSA aimed at engaging a wide range of community members across cultures and from many

communities and neighborhoods. The focus of the activities was to both build bridges in the community while asking community members about their dreams for their health and that of their community, identify issues particularly taking into account the effects of systemic racism and Covid-19, gather opinions on how North Memorial Health could shape the health of communities they provide care to, and set priorities.

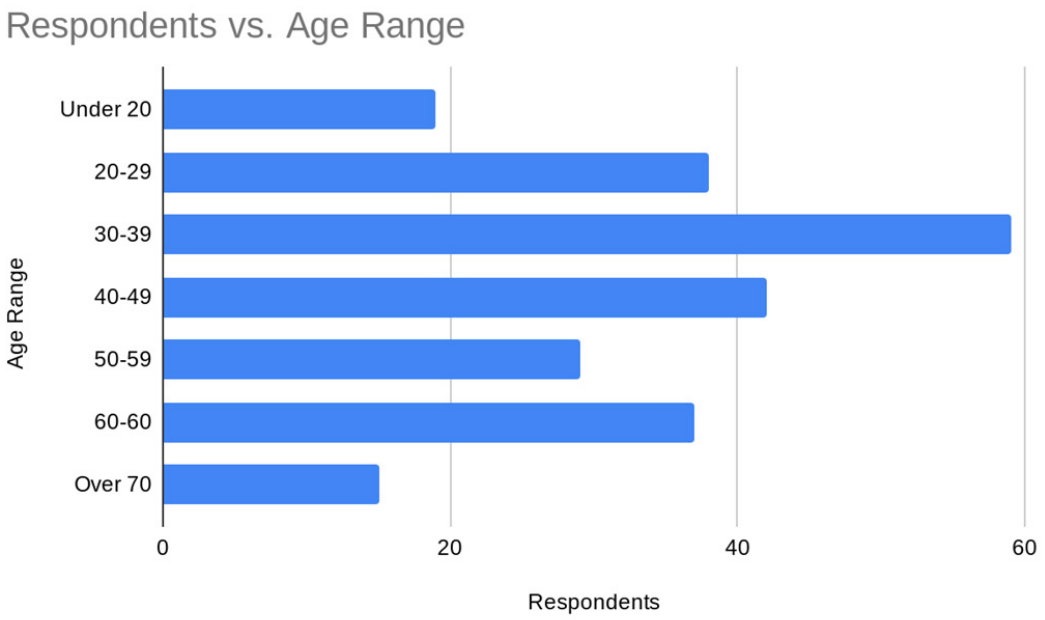
The activities included health-focused listening sessions, in-depth discussions, and targeted surveys which collected both sociodemographic data and responses to the five questions. Such activities also included a number of informal conversations with community members about their health, barriers to leading healthy lives, and opportunities to improve health.

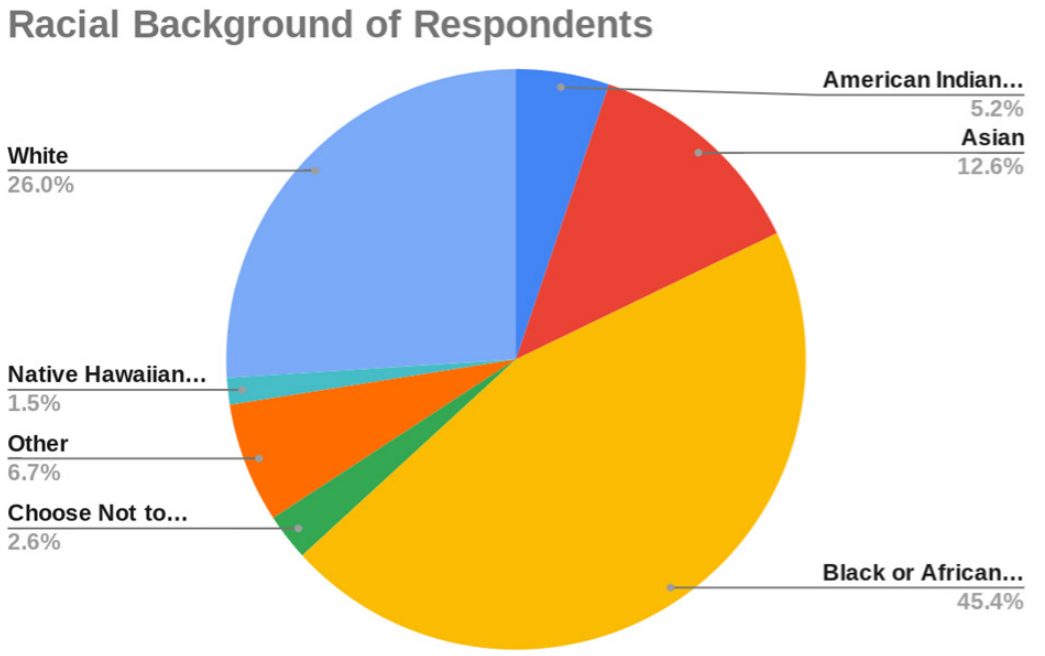
The scope of our community engagement activities included:

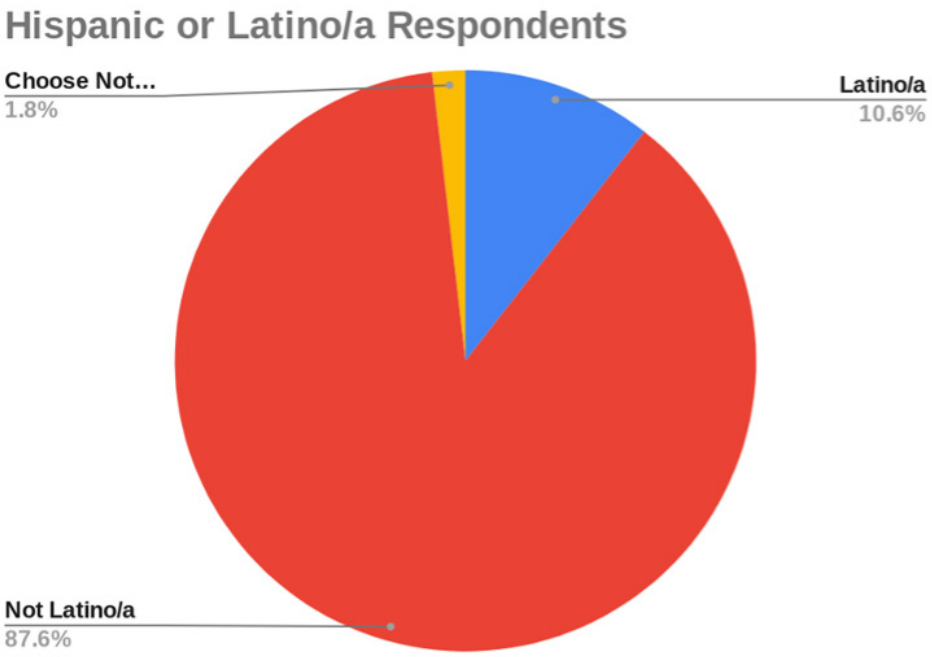
683 people participated in activities	**8 dinners and dialogues**	**17 community gathering event sites**	**3 Slow Roll bike rides**



Participants included a wide range of ages, racial backgrounds, and languages spoken. More people who identify as females (66%) participated compared to people who identify as males (32.4%) or other (1.6%). Most participants identified as heterosexual (87.2%) with smaller percentages of the participants identifying as bisexual (2.1%), gay or lesbian (1.6%), or pansexual (1.2%) and 4.9% chose not to reply.







While the majority of participants spoke English, participants spoke many other languages as well, as noted in the graphic to the right.

Similarly, the majority of participants noted their religion to be Christian, with some specifying denominations such as Lutheran, Catholic, and Baptist. There were a wide range of other religions as well including Buddhism, Islam, Shamanism, and Animisan.

Responses to Questions

The following are themed responses to the five questions that were asked during the dialogues and on the surveys:

Vision of Health/Definition of Health

- Ability to move freely, be active and rest w/o worry
- Interconnected to wellness across body, mind, soul, and spirit
- Best and longest lasting experiences were connected to groups (social, family or community)
- Desire for greater awareness of linkages between community health, family (health in the home) and personal health

Influence of culture on vision of health and approach

- Culture often viewed as a resource
- Cultural practices modeled the integration of health into everyday living and staying connected to community

- Loss of practices linked to loss of parents/grandparents, move from traditional/familial home-area and modernity
- Desire for greater awareness of linkages between community health, family (health in the home) and personal health

Impact of Covid-19, systemic racism and trauma on health

- Direct loss and grief, sickness, depression and isolation tied to covid
- More difficulty "trusting" government, systems and institutions
- Severely strained social, family and community ties and connections
- Ongoing stressors for BIPOC respondents tied to community violence and systemic racism led to greater levels of burnout and exhaustion

Resources that are utilized to sustain participants' vision of healthy communities

- Integrated community-based services were invaluable
- Government and institution support often hit or miss (rent, housing, health, employment)
- Community leaders and elders key to social fabric and sustaining connectedness

Sources of knowledge participants turn to for health questions or concerns

- Significant number of respondents stated a close family member, friend, or longstanding doctor as their key advisor/sounding board
- Some "brand" loyalty expressed to key healthcare providers and healthcare systems
- Significant subset of respondents turn to online/social media sources

Who are participants trusted healthcare relationships?

- Respondents desired trusted relationships, but often do not find them via PCP or are not fully satisfied with their current PCP relationship
- Specifically cited not being heard, concerns about being understood, and their perspective and cultural background not being valued
- Desire for equitable care and more culturally-trained providers

If participants reimagine healthcare what would it look like?

- Stronger relationships between healthcare providers, systems, and community organizations
- Greater focus on supporting preventive care, cultural practices, and holistic/alternative approaches
- Invest resources in training, educating, and employing more BIPOC providers and staff; make culturally-competent healthcare the standard
- Support efforts to increase universal access, sliding fees, and other approaches to lowering the cost burden
- Explore how culture and community may be leveraged as assets in providing care, sustaining wellbeing, and improving health

How North Memorial Health care help make meaningful improvements to the health of communities

- Improve staffing to lower wait times for care
- Establish pathways and set aside funds to increase employment from residents in under-resourced communities

- Be an advocate for the community: promote and raise awareness of program and resources outside of healthcare
- Develop integrated approaches to care that leverage family and community support networks (especially for mental health)
- Sponsor healing and listening circles, sustain community health conversations as a continuous open exchange
- Make patients feel like they are always heard, valued and accepted in every interaction (i.e. respect everyone)

VIRTUAL COMMUNITY CONVERSATIONS

We launched a "Community Health Chat" site, a virtual site that asks participants for their ideas/responses to the five key questions by posting ideas on digital bulletin boards. Our target audiences for this engagement option were North Memorial Team member, providers, and community members. It took longer than anticipated to get the virtual conversation tool launched and as a result we had less response to this community engagement method of providing feedback to the questions. Still, despite the short timeline, we had 581 site visits, 34 site registrations, and 32 activated participants who responded to the questions or noted they agreed with previously posted ideas. We also had participants visiting the pages, downloading documents, and following the project. We plan to use this tool and other tools in the Community Health Implementation Planning phase of the project.

Answers to the questions are similar to those noted in other forms of community engagement. For Question 1 (vision of health and cultural influence) participants noted they would like to know health costs upfront, they would like access to specialists all in one place, desired healthcare for all, and integrated health records where all providers post consultations and results. Responses to Question 2 (impact of Covid-19 and systemic racism) were that participants were finding it hard to re-emerge in a post-covid world, and wanted more mental health resources, especially for children and youth. In response to Question 3 (who they turn to for health advice) participants noted MyChart and family members. Responses to Question 4 (re-imagining health) included pro-active patient/family health, not having healthcare determined by insurance companies, a desire for naturopathic MDs and other holistic providers to be covered under insurance and able to order labs and procedures, and a healthcare system that integrates proven alternative therapies. Finally, to Question 5 (advice for North Memorial Health) respondents noted the need for more mental health, including pediatric mental health, and chemical dependency resources that are able to be accessed in a timely manner, and respect for patient healthcare directives.

2023-2025 Community Health Priorities

The 2022 CHNA took a comprehensive view of the health of our community throughout both the quantitative and qualitative data collection and analysis process. Several community-wide challenges and needs were discussed extensively.

> *"Ideally, I want a team of providers that are Black or from a POC community as I feel they see me fully. I wish all providers are culturally competent and have engaged in sensitivity training"*
>
> – Community engagement participant

We recognize that health is influenced by many factors outside the healthcare system. A wide range of issues arose based on the scoring of key health indicators and the themes from our community engagement activities. ***Racial disparities in health*** and ***life-impacting traumas*** have had significant impact on our community and were selected as priorities for our work beginning in 2023. North Memorial Health has committed to working on these two priorities, believing if we focus on them, the health of our community will improve over time.

RACIAL DISPARITIES IN HEALTH

Racial disparities were evident throughout the assessment process and have a severe impact on health and quality of life. As a result, people experienced a lack of access to healthcare; did not have a primary care provider; delayed care, especially for mental health; and reported higher use of emergency departments for sickness.

> *From 2014-2018, the number of Black infant deaths was consistently higher than all other races and ethnicities, except in 2016.*
> – Hennepin County Public Health

Some examples of racial disparities in health in our community are:

- Chronic diseases such as hypertension, diabetes, and cancer are more prevalent in BIPOC (Black, Indigenous and People of Color) community members
- Infant mortality rates are higher in Black, Hispanic, and American Indian populations
- Communicable diseases impact BIPOC communities more severely, as shown by higher COVID-19 death rates and hospitalizations, as well as higher rates of sexually transmitted infections
- Unintentional injury rates among African Americans, American Indians, and Alaska Natives are higher than those of white residents.

LIFE-IMPACTING TRAUMAS

The effects of COVID-19 and systemic racism have resulted in large numbers of our population feeling depressed, anxious, and isolated. In addition, traumas such as community violence, opioid overdoses, and suicides have left many people grieving and in need of support to help them heal. Our needs assessment found that many youth and adults feel a lack of social support.

> *"Unfortunately, my father passed away in December 2021 due to COVID. With him not knowing English and being alone at the hospital, it was very traumatic."*
>
> – Community engagement participant

Other drivers of life-impacting trauma in our community are from triple "ACEs":

- Adverse Childhood Experiences (ACEs) are traumatic events that occur in childhood and can include violence, abuse, and neglect as well as growing up in a family with mental health issues, substance use, domestic violence, and/or parental divorce or separation. People who report experiencing ACEs from ages 0-17 have more health problems, including depression, heart disease, sexually transmitted infections, substance use, and suicide attempts.
- Adverse Community Experiences (ACEs) such as crime, social unrest and violence all impact the health of our community. Community members reported not feeling safe in their neighborhoods or being impacted by acts of community violence, which leads to higher levels of anxiety, depression, and loneliness.
- Adverse Community Environments are those natural or human-caused disasters (earthquakes, tornadoes, wildfires, floods, terrorist acts) and threats such as disease outbreaks, like the COVID-19 pandemic, that impact many lives, straining local resources aimed at response and recovery to such disasters or threats.

Intersection of the top two priority issues

Certainly both of the top issues are intersectional in nature. The concept of intersectionality describes the ways in which systems of inequality based on class, disability, ethnicity, gender, gender identity, race, sexual orientation, and other forms of discrimination "intersect" to create unique dynamics and effects. Recent studies, for example, have documented that BIPOC youth have higher ACEs scores when compared to white peers. BIPOC youth also experience more acts of discrimination and life-impacting traumas.

> *"Exploring the marginalization of people along multiple identities can also create space for taking an intersectional approach to the work, recognizing that those holding multiple identities (e.g. women of color) are often worse off than others".*
>
> Reference: Kania J, Williams J, Schmitz P, Brady S, Kramer M, & Splansky Juster J. "Centering Equity in Collective Impact", Stanford Social Innovation Review, Winter 2022.

Throughout the fall of 2022, North Memorial Health and Cultural Wellness Center continued to engage with community members through community conversations and other outreach activities to dig deep into the two health priorities. Our goal was to identify populations most at risk, explore gaps in community resources, barriers to addressing key health issues noted under these two topics, root causes of the health issues, and community-driven strategies that community members believe will make a difference in addressing the issues. Community Health Implementation Plans (CHIPs) will be developed to address these issues over the next three years. They will be publicly available on North Memorial Health's Community Health webpage in Spring 2023.

COMMUNITY HEALTH IMPROVEMENT PLANNING

Ongoing power dynamics and historical events between communities and health entities foster distrust, lack of relationship with healthcare providers, and oppressive practices and structures that do not center equity or community health. North Memorial Health is committed to ongoing and meaningful community engagement which can significantly improve the hospital/health system's efforts to address community health and social outcomes, in addition to improving patient experiences. North Memorial Health will continue to deepen

dialogues with our community, increase opportunities for community members to have a voice in the services within the North Memorial Health system, and make recommendations for program and organizational improvements, and enhance data collection and the disaggregation of data by race and other characteristics. We believe these efforts will help us better understand and respond to life-impacting traumas and racial disparities in health as we live our mission of helping all community members live their best and healthiest lives.

UPDATE ON PREVIOUS CHNA PRIORITY HEALTH ISSUES

In the previously conducted CHNA and CHIP (2019), NMHH focused on the three areas of Mental Health, Substance Use Disorders, and Culturally Competent Care. Maple Grove Hospital focused on the three areas of Mental Health, Substance Use Disorders, and Healthy Aging. Due to the Covid-19 pandemic, many planned interventions had to be changed in order to protect the safety and health of our populations. It is also very hard to compare metrics for our previous priority health issues due to effects of the pandemic in areas of mental health, substance use, and the increase in feeling isolated and lacking support. The 2022 CHNA made a concerted effort to gather information about the impacts of Covid-19 and systemic racism in all thirteen health topics and during qualitative data gathering.

Key highlights from activities in 2022 include efforts to distribute Deterra bags for drug disposal, educating the public on the use of Narcan, mental health communications across a wide range of topics, and work within North Memorial Health focused on resilience and promoting a healthy workforce during very trying times. Hospital employees continued to engage and collaborate with a wide range of community partners on these health issues and participated in a number of community events with key messages around safe medicine disposal, fall prevention, mental health awareness, and resiliency. It is important to acknowledge that some community needs were deprioritized by more pressing needs that arose during the pandemic. It is also realized that some community needs were compounded due to the pandemic, such as mental health concerns and the increase in youth and adults feeling more isolated and alone. Despite this, North Memorial Health's sponsorship program also aligned their support of community organizations to those that aligned with the CHIP priorities from 2019. A full list of actions and sponsorship support is available upon request from North Memorial Health's Community Health program.

Appendix

KEY INFORMANT DISCUSSION GUIDE (30-45 MINUTES)

Moderator welcome and introductions

Purpose of conversation/CHNA

Susan's background and role

How the information will be used/shared (permission to record for note-taking)

Participant introduction (role, organization, location, proximity to either NMHH or Maple Grove Hospital or both, etc.)

Participant Questions

- Can you tell me a little bit about the population your organization serves?
- What is your vision of – or how would you define – "health" for our community overall or for the population you serve specifically? What would that look like or feel like?
- What part does the culture of the community play in influencing that vision and approach to health?
- What have you and/or your organization observed about the health of our community?
- In recent years, what if anything has changed to affect the health of our community for the better or worse?
- Probe for specificity and range – "and how has that affected the health of the community – in what ways?" and "what else has changed?"
- Show on-screen and probe around major themes like COVID-19 and systemic racism, as well as specific topics like racism, violence, grief, healing, childhood or relationship trauma, etc.
- What are their unmet needs directly related to health? How do these unmet needs differ for specific populations?
- What barriers do your clients experience in accessing healthcare?
- If you were to reimagine "health care" in the community, what would that look like for you? For example, that could mean a variety of things – from more access to mental health resources to more culturally-appropriate training and interactions, etc. These are just a couple of examples from what could be a list of many – and may or may not be the ones on your mind. What might that look like for you?
- What are the gaps and challenges that exist in bringing that vision to life?
- How can North Memorial Health Hospital and/or Maple Grove Hospital help achieve that vision of a healthy community you just described over the next three years?
- What role do you see your organization playing in creating this healthy community?
- What community resources or assets are already in place that can help your city or neighborhood achieve this vision of a health community?
- What other programs and resources need to be brought into the community to improve the health of the community?
- The CEAT team has had a few presentations around the issues/challenges affecting community health. As you think about those issues, what would you consider to be your top three at this point?
- Are there other organizations and/or people we should speak with to better understand the barriers to being healthy in our community? Like whom?
- [If not mentioned previously] I wanted to come back and ask you about a few specific things.
- What is your sense of what might be driving racial disparities in health and healthcare? What is your feeling about that issue?

- What needs to be done to address those disparities?
- Are there other disparities that are of concern – for example, LGBTQ+ or the disability community – that are of concern for you/your population?
- What needs to be done to address those disparities?
- There has been a high level of community trauma over the past two years in particular. What impact has that had on community health? How can North Memorial Health Hospital/Maple Grove Hospital contribute to community healing?
- The COVID-19 pandemic has also had significant impact on our communities– from a direct health perspective from those who have become ill, of course, but also in how we think about pre-existing conditions and risk factors to serious illness, the impacts of social isolation, job losses, etc. What impact has that had on community health? How can North Memorial Health Hospital/Maple Grove Hospital contribute recovery from the pandemic or its impact on community health?