Hutchinson Health

Community Health Needs Assessment

December 2024

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Executive Summary

Through 2024, HealthPartners and Hutchinson Health partnered with the community to conduct a comprehensive Community Health Needs Assessment (CHNA). The CHNA process is designed to identify and prioritize the health needs of the community that the hospital serves as well as identify resources to address those needs. This process is an essential component in achieving the HealthPartners mission: to improve health and well-being in partnership with our members, patients, and community.

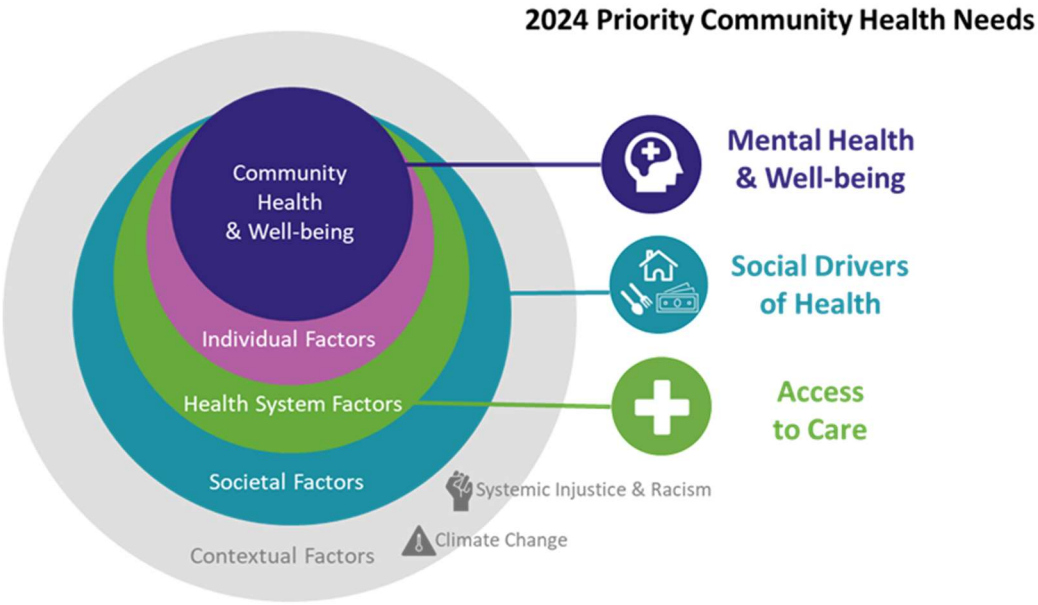
This CHNA report includes data describing the community that Hutchinson Health serves, defined as the entire population of McLeod County. While the hospital certainly serves individuals from outside of the county, the definition of a community as a single county simplifies and helps focus, helping ensure that the results can be presented clearly to the community.

Methodology

The IRS requires all nonprofit hospitals to conduct a CHNA every three years. For this CHNA cycle, HealthPartners and Hutchinson Health contracted with the Center for Evaluation and Survey Research (CESR), part of HealthPartners Institute, to complete the 2024 CHNA. Our CHNA is comprised of multiple data sources, some existing for other primary purposes, with more collected specifically for this purpose.

We convened a diverse, cross-hospital CHNA workgroup to collect and interpret information and seek health system consensus while centering local priorities and voice. Types of data we gathered include HealthPartners administrative data, patient and member-reported data collected primarily for evaluation of HealthPartners community initiatives or operational purposes, and publicly available data describing the population residing in McLeod County, county- and state-level factors, and health and well-being outcomes overall and for specific populations. We started our CHNA cycle with a prioritization process. Here, we reviewed publicly available data, facilitated internal and external stakeholder conversations, designed a community health needs prioritization survey and invited internal and external stakeholders to respond, and reviewed all inputs as a CHNA workgroup. This resulted in three prioritized community health needs we sought to understand more deeply in the second half of our CHNA year. Extensive quantitative data was gathered to describe each need and is complemented with rich qualitative data collected through numerous Community Conversations with internal stakeholders and community members.

All data were organized by our Needs Areas Framework, described below, and resulted in three identified Priority Needs for this CHNA cycle. The interrelated nature of these needs areas is depicted through the graphic here, which guides the organization of our CHNA. Throughout our CHNA, we seek to describe the ways in which systemic injustice and racism and climate change impact our community health and well-being. Informed by quantitative and qualitative data, our workgroup refined the definitions and described the status and impact of each prioritized community health need.



Prioritized Community Health Needs

Mental Health and Well-being Mental health refers to a person's emotional, psychological, and social well-being, affecting how they think, feel, and act. It influences overall health and how one manages stress, builds relationships, and copes with life's challenges. Mental health can vary across the life span, based on factors including social connectedness, emotional resiliency and mental health conditions, such as depression or anxiety, that disrupt thoughts, emotions, and behaviors.

Factors contributing to mental health or mental health conditions can include biological and environmental factors, trauma, medical conditions, social drivers of health, or substance misuse. Reducing stigma helps ensure everyone can access the care and support needed to lead fulfilling lives and manage life's challenges.

Social Drivers of Health Social drivers of health are the community and environmental conditions that affect health and well-being. They include adequate and secure income, housing, food and nutrition, employment and work, education, transportation, access to childcare and interpersonal safety. They also include a sense of belonging, the natural and built environment and climate impacts.

These social drivers of health do not exist in isolation and often interconnect, overlap, and contribute to other community health needs, including Mental Health and Well-being and Access to Care.

Access to Care Access to Care means having equitable access to convenient, affordable, safe, culturally responsive and high-quality health care. It includes a care experience where people feel like they are seen, heard, known and treated as a partner in the process, without bias. Access includes factors such as the cost of care and insurance coverage, medical transportation, care coordination, navigation and use of technology. It means simplifying the complex health care system to be more understandable and accessible for all.

Next Steps

Hutchinson Health, HealthPartners, and the community will continue to work together to address the needs of the community it services. An implementation strategy, a companion to this CHNA, will guide this work and will be created by May 2025. We will also evaluate progress towards goals throughout the CHNA cycle.

This Community Health Needs Assessment meets all of the federal requirements of the Patient Protection and Affordable Care Act (ACA) and the Internal Revenue Service final regulations. It was approved by the Hutchinson Health Board on 11/26/24. In accordance with federal and state requirements, this report is made widely available to the public on our website at https://www.healthpartners.com/care/hospitals/hutchinson/about/community-health-needs/.

Community Served

About HealthPartners & Hutchinson Health

HealthPartners is the largest consumer governed nonprofit health care organization in the nation, serving more than 1.2 million patients and 1.8 million medical and dental health plan members. Our mission is to improve health and well-being in partnership with our members, patients and community.

At HealthPartners, our values are excellence, compassion, partnership, and integrity. Our Partners for Better Health (PBH) goals aim to improve health, deliver a great patient experience, and make health care more affordable. In tandem with our Community Health Needs Assessment findings and implementation plans, we will work toward our vision of **health as it could be, affordability as it must be, through relationships built on trust.**

Hutchinson Health is part of HealthPartners. Hutchinson Health includes a 66-bed hospital, including 11 mental health beds, a Level 4 Trauma Center, and operates primary and specialty clinics. Our experienced team is comprised of the leading doctors, specialists and surgeons in the region. We've been named a Top 100 Rural & Community Hospital by the Chartis Group and have been recognized by the Minnesota Hospital Association for superior performance in quality and patient safety. We've also earned a four-star rating for the quality of patient care by the Centers for Medicare & Medicaid Services. Hutchinson Health has been caring for the Hutchinson community for more than a century. For more information, visit www.healthpartners.com/care/hospitals/hutchinson/

About the Community

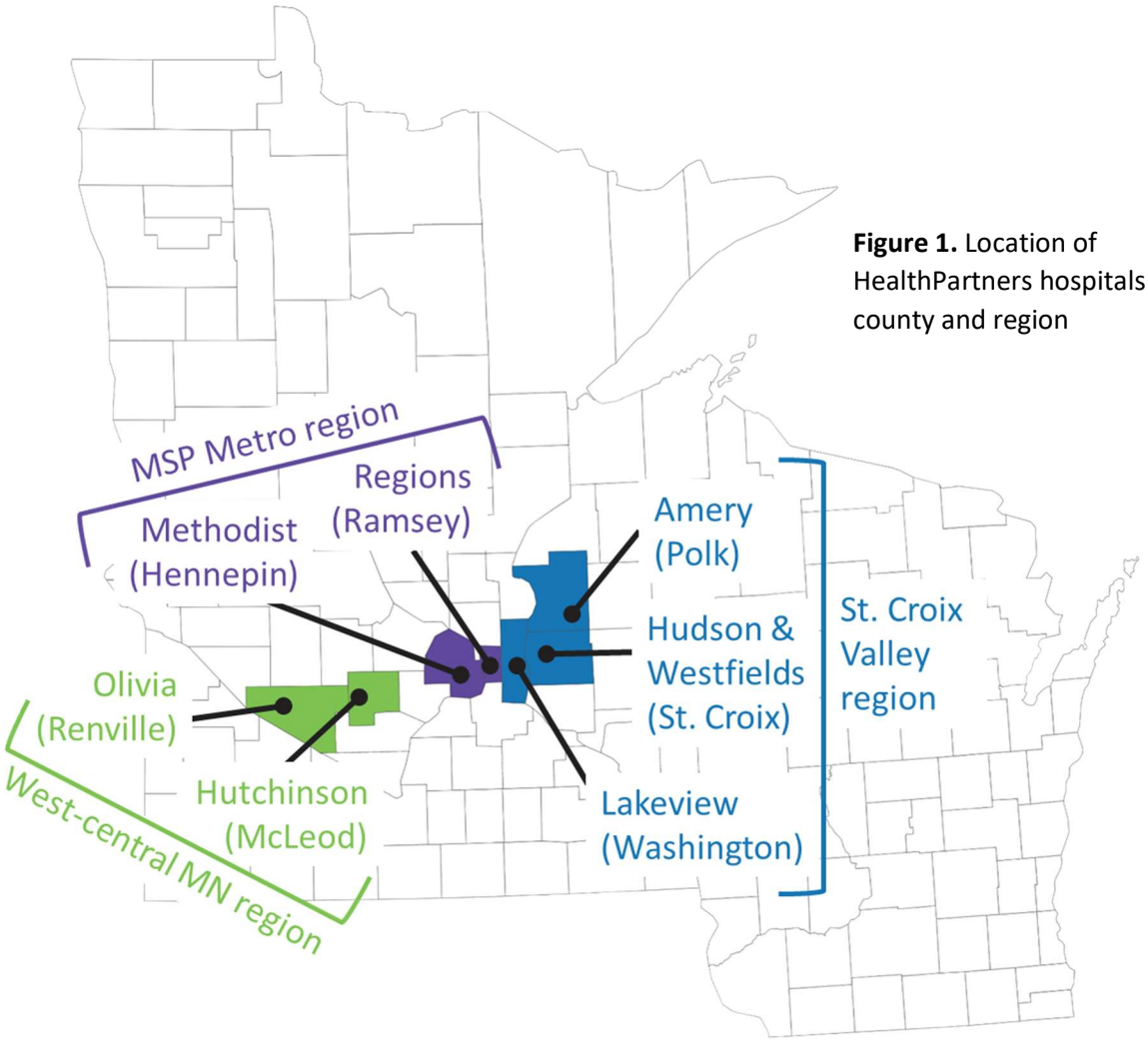


Figure 1. Location of HealthPartners hospitals by county and region

Hutchinson Health is located in the city of Hutchinson in McLeod County, Minnesota. For the purposes of this report, the "community served" by Hutchinson Health is people living in McLeod County and includes medically underserved, low-income, and minority populations.

Additionally, this definition includes all patients regardless of whether (or how much) they or their insurers pay for the care received or whether they are eligible for assistance under the hospital facility's financial assistance policy. While the hospital certainly serves individuals from outside of the county, the definition of a community as a single county simplifies and helps focus, ensuring that the results of this needs assessment can be presented clearly to the community.

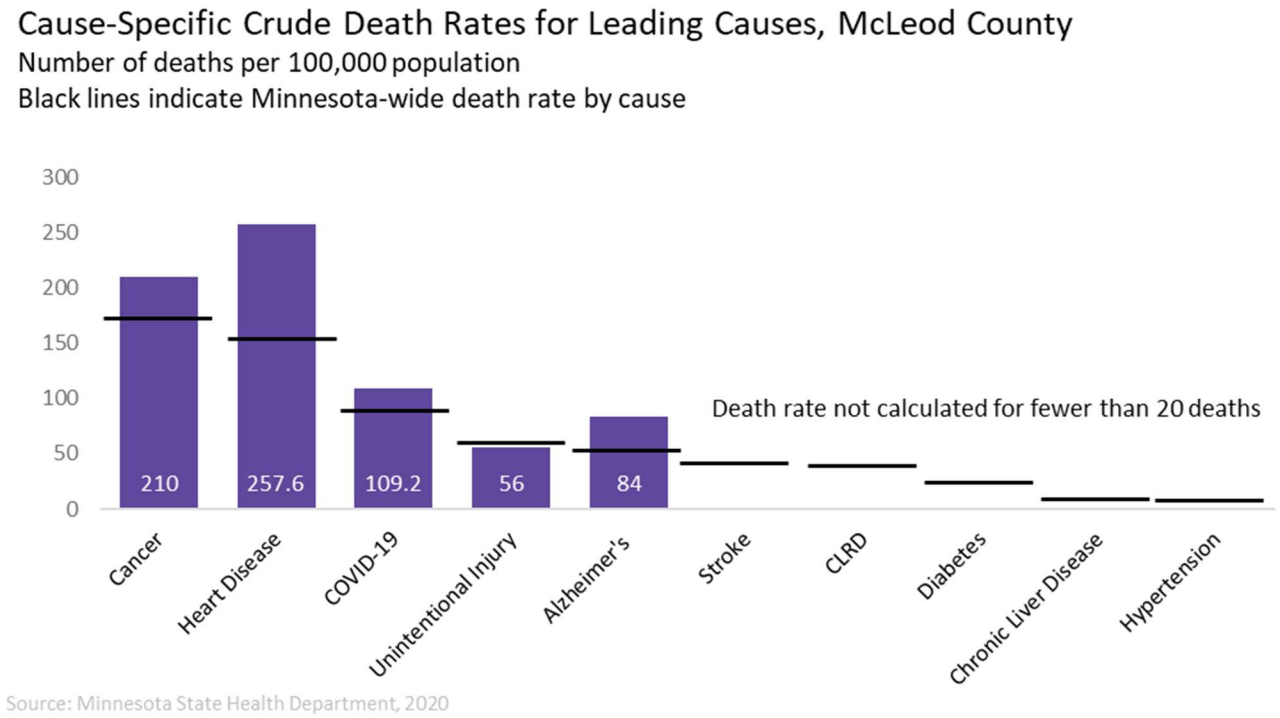
According to the 2022 American Community Survey 5-Year Estimates,[1] McLeod County has 36,727 residents, 49.8% of whom are female.

- The median age in this county is 41.3 years, with 19.4% of the population 65 years or older.
- More than nine in ten (92.2%) identify as **White**, with 0.6% identifying as **Black or African American**, 0.7% **Asian**, 0.3% **American Indian or Alaska native**, 0.0% **Native Hawaiian or other Pacific Islander**, and 2.5% as **more than one or some other race**.
- 6.9% identify as **Hispanic or Latino**.

There were 11,930 HealthPartners patients (age 18 and older who had an in-person or telemedicine visit with a HealthPartners provider in 2023) who lived in McLeod County in 2023.[2]

- Of these, 90% were over 25 years old and slightly over half (56%) were female.
- Nearly all were **White** (95%), with 1% identifying as **Black or African American**, fewer than 1% **Asian**, fewer than 1% **American Indian or Alaska Native**, fewer than 1% **Native Hawaiian or other Pacific Islander**, and fewer than 1% **some other race.**
- 1.6% reported a **Hispanic or Latino** ethnicity.
- Over 98% spoke English, with the second most common language being Spanish at 1%.
- Among HealthPartners patients in McLeod County, 52% use commercial insurance, 11% are covered by Medicare, and 34% are covered by Medicaid.

In the state of Minnesota in 2020, the three most common causes of death, in order, were cancer, heart disease and COVID-19.[3] In McLeod County in 2020, the three most common causes of death, in order, were heart disease, cancer and COVID-19.[3]



According to the Minnesota Department of Health, "chronic conditions are health conditions or diseases that can last a year or more and may require ongoing medical treatment" and can impact physical and mental health and well-being.[4] Across our service area, there was no decrease in prevalence of any chronic condition in any county since 2021 and many conditions became more common.

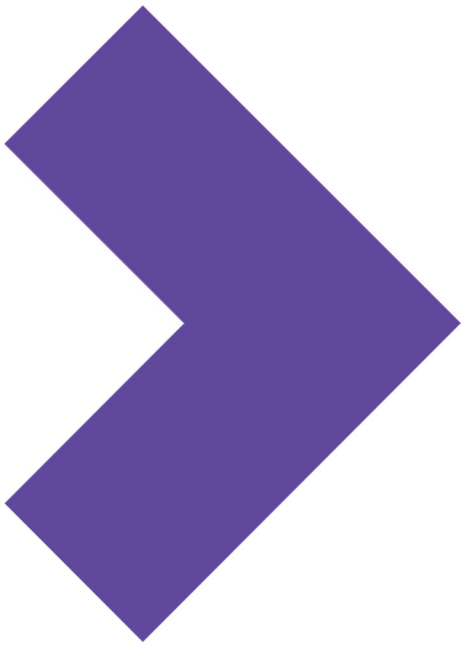
Here are common chronic conditions and their prevalence statewide and in McLeod County in 2023[5]:

- Hypertension: 19% of Minnesotans and 21% of McLeod County residents, up from 18% in 2022
- High cholesterol (hyperlipidemia): 18.5% of Minnesotans and 19% of McLeod County residents, up from 16% in 2022
- Diabetes, Type 2: 7.2% of Minnesotans and 8% of McLeod County residents, up from 7% in 2022
- Asthma: 6.6% of Minnesotans and 6% of McLeod County residents, up from 5% in 2022
- Heart disease: 4.4% of Minnesotans and 5% of McLeod County residents, up from 4% in 2022

Context

We know that **community health needs are complex and interconnected** – that where someone lives can impact how they can access and receive care, how they spend their time and how they feel. We acknowledge that the societal forms of racism – institutional, structural, and systemic – impact individual and community health.

Our assessment is structured in a way that seeks to understand the complex impacts of the societal factors, health system factors, and individual factors on health and well-being across the population and unique needs within special populations: by geography, by age, by race and/or ethnicity, gender, and other aspects of identity.



Systemic Injustice & Racism

Our CHNA framework is organized by a public health model that demonstrates how societal, health system, and individual factors are interconnected, and all influenced by context.[6] Systemic injustice and racism are contextual factors that shape these other factors and ultimately community health and well-being outcomes.

In April 2021, the Centers for Disease Control and Prevention (CDC) declared racism a serious public health threat.[7] But what exactly is racism? Racism refers to systems and policies, actions and attitudes that create unequal opportunities and outcomes for people based on race. It goes beyond individual prejudice, becoming more dangerous when combined with the power to discriminate, oppress or limit others' rights, whether on an individual or institutional level.

Institutions often have policies, practices and procedures that favor certain groups of people over others, which are collectively called systemic injustice. When certain racial or ethnic groups are favored or discriminated against, this is systemic racism. Unlike direct or overt discrimination, systemic injustice does not always involve intentional actions. It is a deeply rooted, complex issue where unjust systems are maintained and reinforced over time. Injustice is not a one-time event. It persists[8] because it is built into institutions and practices.

The harm caused by systemic injustice and racism is damaging for everyone. The CDC has long acknowledged that racism is a root cause of health disparities. Significant racial and ethnic health disparities are driven by factors both within and outside health care systems. For example, communities of color often face higher poverty rates, higher levels of pollution and crime, and limited access to green spaces — all of which contribute to health disparities and poor health outcomes.[9] In addition, a lack of affordable, quality health care makes it difficult to get timely treatment, which disproportionately affects people of color. Black, Hispanic, and Asian people are less likely to have health insurance, more likely to delay care because of costs, and more prone to medical debt.[10] They are also less likely to have a regular source of care or to receive timely preventive services, like vaccinations.[9]

Findings from Minnesota's African American Leadership Forum Community Harvest Report (2021)[11] highlight the interconnectedness of structural racism and the priority health needs identified in the CHNA. While the Black community viewed many health and well-being actions as within an individual's control, these actions are often made within the limiting context of systemic injustice, including traumatic and coercive environments. Community conversations held as a part of the HealthPartners CHNA further emphasized the impact of systemic injustice and racism on the priority health needs areas: Mental Health and Well-Being, Social Drivers of Health and Access to Care, especially in metro-area counties, including Hennepin and Ramsey. In rural areas, racism was less frequently or not acknowledged, with economic factors driving disparities in health being a more common topic.

HealthPartners has a long-standing commitment to health equity, focusing on reducing health care disparities, increasing workplace diversity and inclusion and addressing social factors like early childhood brain development, mental health stigma and access to food. We have the responsibility and opportunity to build stronger communities where racism -- and the inequity that results -- has no place. To advance this work, we established the Equity, Inclusion and Anti-Racism Cabinet, which provides

leadership and oversight to advance health equity and eliminate racism. The cabinet is made up of a diverse group of health equity leaders from across our organization.

The following principles at HealthPartners are foundational as we design for equity:
HealthPartners' strategic goal to advance health equity means a commitment to using a diverse, inclusive and equitable lens in the design of our work.

- We must be mindful of who is negatively impacted or left out, and,
- Consider changes to increase/improve equity and inclusion.

We have a commitment to making health care simple and affordable for everyone we serve. This will advance health equity and build trust with underserved communities. At the same time, we recognize that the most simple and affordable solution may not work for all patients, members and colleagues.

- We will simultaneously explore options for customization where it is needed to meet all needs from an equity perspective.
- Through rapid cycles of improvement, we will continue to adjust to meet the needs of all patients, members and colleagues.

Bringing an equity lens to our work
One of the key components to growing our understanding of and the application of the concept of equity to our day-to-day work is to remain curious. **Incorporating the three questions below into commonly used tools and processes will help reflect and act upon inequities and integrate equity, inclusion, and anti-racism into decision-making.** Asking ourselves each of these questions challenges us to ensure the entire population is being considered and our decisions lead to simple and affordable health care for everyone.

1. For whom is this process/policy/change **simple and affordable**?
2. Is there any group or population **negatively impacted or left out** by this process/policy/change and how?
3. What potential changes could you make to increase/improve **equity and inclusion**?

Climate Change

A healthy environment is an important foundation for good health. **Access to clean air, water, and natural areas has positive effects on physical and mental health**, while exposure to pollution increases risk of various health problems.

In recent years, our facilities and communities have faced disruptions in our environment, including heat waves, droughts, and floods. The effects of climate disruptions are interconnected with each of the priority needs areas discussed in the CHNA. As greenhouse gas emissions in our atmosphere continue to rise, these disruptions are likely to become more frequent and more severe.

Extreme heat events are already taking place in Minnesota and Wisconsin, and are expected to become more common, more severe and longer lasting. Under a conservative "lower emissions" scenario, from 2015-2044, McLeod County is projected to see 7.7 days with a maximum temperature of over 95 degrees Fahrenheit each year, an increase of 5.6 days (267%) compared to the 1976-2005 historical average.[12]

Health effects of extreme heat events include heat-related illnesses and worsening of chronic conditions like heart disease, asthma, and chronic obstructive pulmonary disease (COPD). Extreme heat has also been associated with increases in irritability, aggression, alcohol and substance use, mental health related hospital visits, and suicide rates.[13] Lower income community members are more likely to live in areas with greater exposure to extreme temperatures,[14] and are more likely to experience income loss when extreme heat creates unsafe working conditions.[15]

Rainfall patterns are already changing, and scientists predict even more localized large storm events, which leave some areas flooded and others experiencing drought. Health impacts of flooding include physical injuries, mold exposure and waterborne disease. Emotional distress and mental disorders may also be exacerbated during flooding events.[16] Lower income and minority community members are more likely to experience these impacts, as they are more likely to live in flood-prone areas, are more likely to experience property damage, and are less likely to evacuate during a flood.[14]

Health impacts of drought include negative effects on food supply, potential concentration of groundwater contaminants and respiratory distress from dust, pollen, and wildfire smoke. Drought can also cause adverse mental health outcomes, particularly in rural or agriculture-dependent populations.[17]

HealthPartners is addressing climate change, from reducing our greenhouse gas emissions to increasing our ability to adapt to extreme weather events. As a signatory of the White House and U.S. Department of Health and Human Services Health Sector Climate Pledge, we have committed to reducing our Scope 1 and Scope 2 (organizational) emissions by 50% by 2030, and by 100% by 2050, from a 2018 baseline. As of 2023, we have reduced our organizational emissions by 24%.

HealthPartners climate resilience plan

In 2023, HealthPartners released a climate resilience plan[18] outlining the strategies and actions we will take as an organization to address and prepare for climate change and extreme weather. The plan is divided into three strategies: emergency preparedness and response, infrastructure resilience, and community health resilience. Actions in the emergency preparedness and response strategy include updating risk assessments and conducting trainings on extreme weather response, actions in the infrastructure resilience strategy include incorporating resilient design into buildings and landscapes,

and actions in the community health resilience strategy include conducting outreach to community members and partnering with community groups that are addressing climate change in at-risk populations. See the complete HealthPartners Climate Resilience Plan here: https://www.healthpartners.com/content/dam/corporate/sustainability/healthpartners-sustainability-climate-plan-report.pdf

Prioritization Process

The mission of HealthPartners is to improve health and well-being in partnership with our members, patients, and community. The Community Health Needs Assessment (CHNA) is an opportunity for our organization to identify the important health needs of the communities we serve, and to strategize and identify resources to help address those needs. This section describes our **process of gathering data and input to prioritize community health needs** across our health system.

Prioritization Approach

To identify priority community needs areas for the 2024-2026 CHNA cycle, the Center for Evaluation & Survey Research (CESR) designed and supported the HealthPartners CHNA workgroup through a consensus process.[19]

Selecting Key Informants. First, we convened a CHNA workgroup of **health system administrators** who work in one of HealthPartners eight hospitals (1-4 experts per hospital), as well as **subject matter experts** (SMEs) who work at the organizational level. These hospital workgroup members and SMEs have close connections to the community, work directly in the community, or work closely with those who provide direct care and are aware of health system priorities and opportunities. Taking a health equity approach, we also engaged **community stakeholders**, such as representatives from local nonprofit and public organizations, **hospital boards and advisory committees**, and **local public health** professionals in our methodological prioritization process. Each informant was selected due to their close connection with communities in the HealthPartners service area and their knowledge of public health and/or hospital priorities and opportunities.

Identifying Possible High-Priority Community Health Needs. Using a common public health framework[6], the CHNA workgroup brainstormed a list of *possible* community health needs, organized into three interconnected factors: societal factors, health system factors and individual factors, all of which affect community health and well-being outcomes. This framework and its accompanying image below were discussed, adapted and approved by the CHNA workgroup.

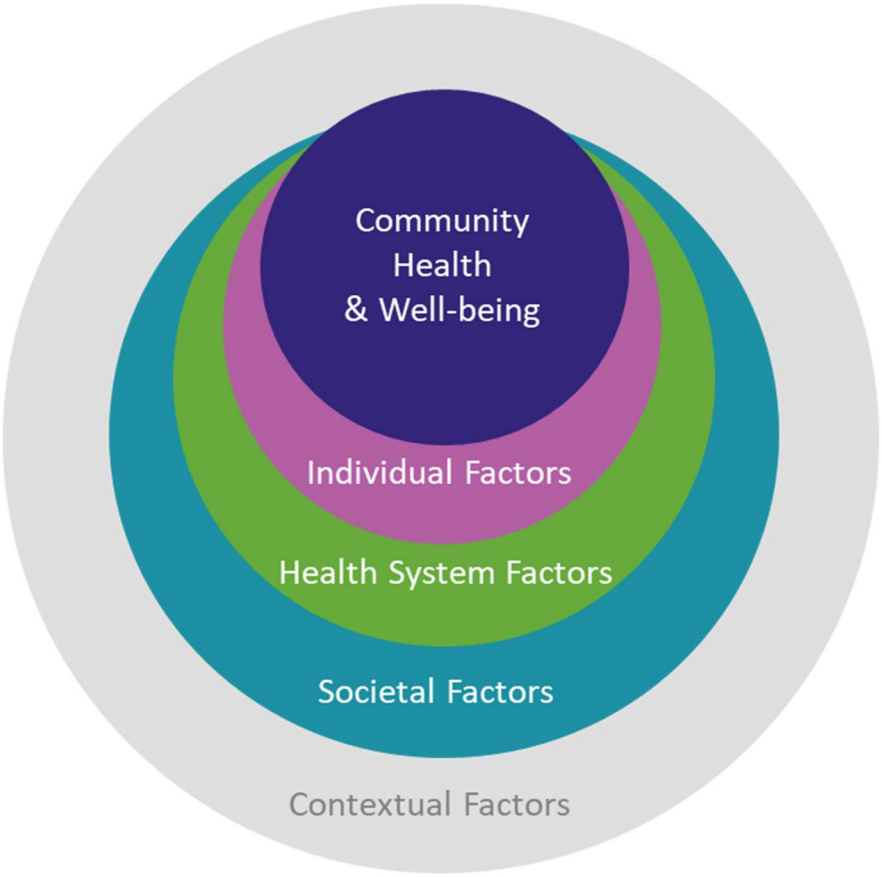


Figure 2. Framework for Organizing Community Health Needs (Adapted from McGovern 2014)[6]

Compiling a Regional Data Summary. Our team then identified six comprehensive, county-level data sources and described the current state of each brainstormed community health need:

- County Health Rankings, 2023[20]
- Minnesota Student Survey, 2022[21]
- Wisconsin Youth Risk Behavior Survey, 2021[22]
- KFF State Health Facts, 2022[23]
- Commonwealth Fund, 2022[24]
- Minnesota Community Measurement, 2022[25]

This information was compiled for each county and organized by hospital region: the Twin Cities metropolitan area, West Central Minnesota, and the St. Croix Valley (including eastern Minnesota and western Wisconsin). This regional data summary was shared with all key informants invited to participate in a qualitative discussion (described below). Participants were encouraged to review and reflect on this data prior to the discussion and were given an orientation to the data summary as well as time to review it during the discussion.

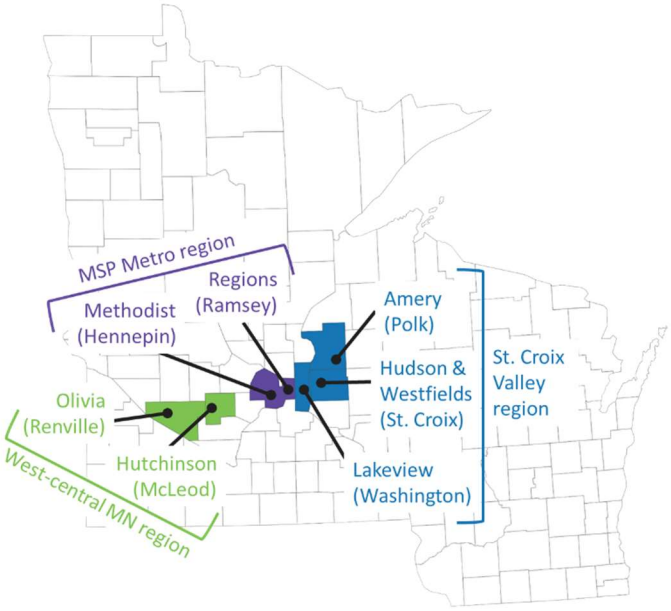


Figure 3. CHNA Communities by County and Region

Needs Area	Specific Needs
Societal Factors	• Economic Stability • Employment Stability • Housing Security • Food Security • Access to Healthy Food & Exercise Spaces • Social & Support Networks • Education & Childcare Quality & Access • Transportation Access • Public & Personal Safety • Environmental Health & Justice • Stigma • Political Climate & Civic Engagement
Health System Factors	• Just, Equitable & Trustworthy Care • Health Care Access & Availability • Health Care Workforce Availability • Health Care Quality • Health Care & Service Affordability • Health Insurance Coverage & Affordability • Emergency Preparedness • Interpretive Services & Health Communication • Long-Term Care Access & Affordability • Health System Community Engagement & Education
Individual Factors	• Use of Preventive Care Services • Eating Patterns • Physical Activity Patterns • Social Connectedness • Screen Time & Media Use • Sleep • Oral Hygiene Behaviors • Stress Management & Mindfulness • Substance Use • Sexual Health & Behaviors • Risk-Taking Behaviors
Community Health & Well-being Outcomes	• Mortality Rates • Physical Health, Chronic Disease, and/or Chronic Pain • Mental Health or Illness • Social-Emotional Health • Pregnancy & Birth Outcomes • Substance Use Disorder • Brain Health, Cognitive Impairment &/or Dementia • Infectious &/or Sexually Transmitted Diseases & Infections • Dental & Oral Health • Health Literacy
Contextual Factors	• Systemic Racism • Economic Disparities

Table 1. Table of Each Brainstormed Need, Organized by Needs Areas Framework

Engaging Subject Matter Experts and Community Stakeholders in Qualitative Discussions. The primary purpose of these conversations was to engage key informants' reflections and interpretations of the regional data summary prior to the prioritization survey (described below) so that responses were driven by available public health data. An additional purpose was to gather a more robust and nuanced understanding of prioritized health needs that emerged in the prioritization survey analysis.

A standard facilitation guide was created and used, including instructions for facilitators and notetakers for the discussion, along with guidance on how to use the regional data summary in the conversation. Specific discussion questions included:

1. Please introduce yourself and share – in ten words or less – what first comes to mind when I say, "community health needs."
2. Which of the data points **affirmed** what you hear or observe related to community health needs?
3. Which of the data points **surprised** you? In what way?
4. Were there any community health needs you know about that were **missing from the data summary**? Were any data points not describing the community health need?
5. Based on the data and your experience in the community, what community health needs seem the **most important** to address?
6. The following priority health needs have been named by a member of this group [review notes]. Are we missing any priority needs that you think are important to consider?

Attendees were then invited to complete the survey; it was explained to participants that the survey results would be the primary data source used to determine HealthPartners' priority health needs for this CHNA cycle and they were strongly encouraged to participate.

Identifying Priority Health Needs via Prioritization Survey. A community health needs prioritization survey was developed using survey design best practices.[26] This 10-minute web-based survey was emailed to health professionals through each hospital's communication channels, as well as to community stakeholders, including public health professionals. Survey responses were tied to county and hospital, which allowed for local survey summaries to be created.

The survey aimed to understand perspectives on priority community health needs, overall and by region. Respondents were informed that HealthPartners defines "community" as the people who live in the county where each of our eight hospitals is located. The survey asked which counties they work in and/or represent as well as what information informed their responses.

The survey asked participants to assess the importance of addressing or improving each of the possible community health needs. Respondents were then asked to identify their top five priorities (ranked #1 - #5) among the needs they identified as very important to address.

Determining Priority Community Health Needs. Analysis of survey responses resulted in a descriptive summary shared with the CHNA workgroup; results were presented overall and by hospital (with the exception of the four Valley hospitals, which were presented as a region). CESR calculated the average priority ranking of each community health need by assigning 100 points to each #1 priority, 80 points to each #2 priority, and so on, so that each #5 priority was assigned 20 points. Any community health need not ranked as a priority was assigned 0 points. Therefore, a higher score indicates a higher average ranking.

Table 2. Results from Prioritization Survey, Spring 2024.

	All n=589	HP System n=47	Hutchinson n=95	Methodist n=79	Olivia n=41	Regions n=63	Valley n=250
1	Mental health or illness (avg=24.75)	Housing Stability	Mental health or illness	Housing Stability	Childcare access and availability	Mental health or illness	Mental health or illness
2	Housing Stability (avg=19.08)	Healthcare access and availability	Healthcare access and availability	Food Stability	Food Stability	Housing Stability	Housing stability
3	Food Stability (avg=15.62)	Economic Stability	Childcare access and availability	Economic Stability	Mental health or illness	Food Stability	Health insurance coverage and affordability
4	Healthcare access and availability (avg=14.91)	Food Stability	Healthcare and service affordability	Mental health or illness	Employment Stability	Public and Personal Safety	Food Stability
5	Economic Stability (avg=13.21)	Public and Personal Safety	Healthcare workforce availability	Healthcare access and availability	Economic Stability	Healthcare access and availability	Healthcare access and availability

Mental health or illness was ranked #1 priority overall, on average, and was also ranked in the top 5 priority needs for all five geographic areas. Housing stability, food stability, and economic stability ranked #2, #3, and #5 overall, on average. These needs also ranked in the top 5 for four of the five geographic areas. Employment stability was a related societal factor need that was prioritized by respondents from Olivia. Finally, health care access and availability ranked #4 overall, on average, and ranked in the top 5 for four of the five geographic areas as well as respondents representing the HealthPartners system. Related health system factor needs of health care and service affordability and health care workforce availability also emerged in two geographic areas. No health system factor needs were prioritized in Olivia.

This analysis identified three *proposed* community health needs for the workgroup to review and approve. After workgroup member discussion, the following summary needs were developed:

1. Economic, employment, housing, food stability
2. Health care access, availability, affordability
3. Mental health or illness

The CHNA workgroup members met in three breakout groups representing our geographic areas: the Twin Cities metropolitan area, West Central Minnesota, and the St. Croix Valley (including eastern Minnesota and western Wisconsin) to interpret and discuss their local results. We then met as a full CHNA workgroup to reach consensus on priority health needs. Key insights from that discussion included:

- **Mental health or illness** is a large need area. Within this, the workgroup would like to explore substance use disorders, the relationship between societal and individual factors and mental illness, and how specific populations are impacted by mental health or illness. The workgroup would also like to better understand the work already happening to address mental health or illness in order to identify HealthPartners' role within this need area. The workgroup would like to call this **Mental Health & Well-being.** This was also the language used in the last CHNA cycle.

- **Economic, employment, housing, food stability** are all interconnected and the specific needs may vary by geographic region. The workgroup would like to group these needs as **Social Drivers of Health** until we better understand local needs through our CHNA process, but we will center the four needs prioritized by our communities in this phase. In addition, we will consider adding childcare to this need area as this emerged as a priority need in some of our geographic areas. Last cycle, this need area was called Access to Health, and workgroup members recalled needing to explain this language during community engagement.

- The need for **Health care access, availability, affordability** was confirmed by the CHNA workgroup members, but there was a proposal to call this need **Access to Care** to be clearer to the general public in the next phase of community engagement. This was also the language used in the last CHNA cycle.

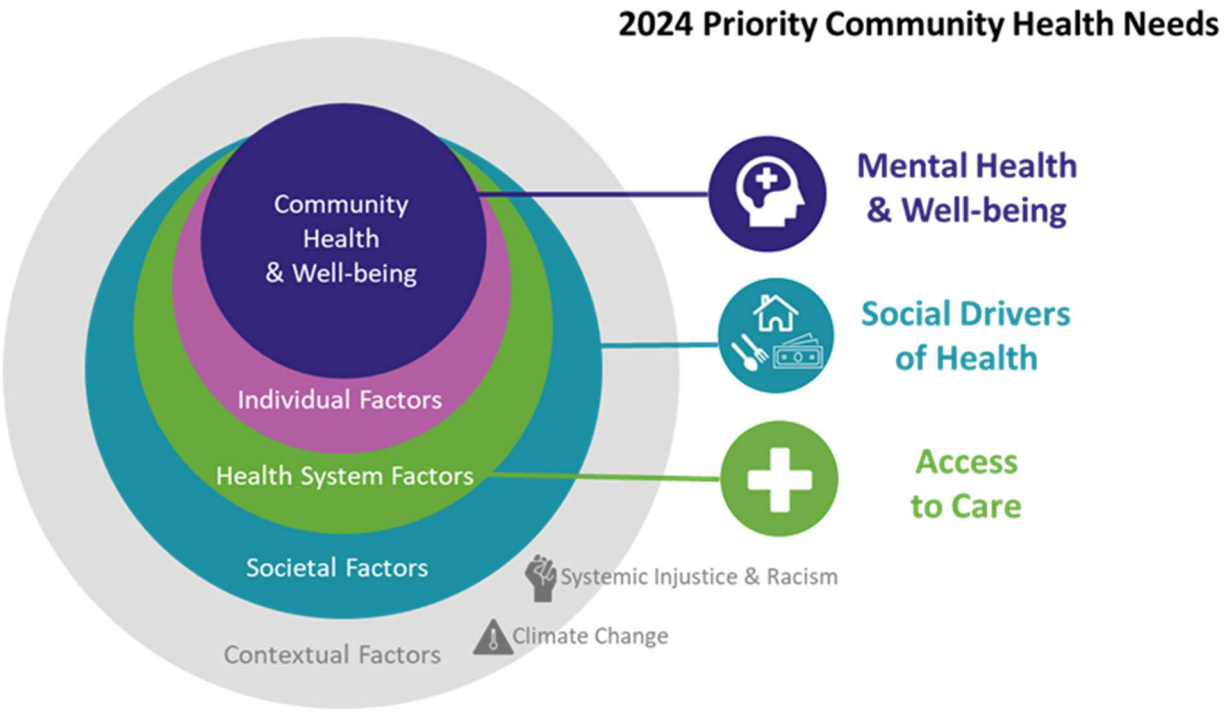


Figure 4. Approved Priority Community Health Needs, Spring 2024

CHNA Process

After identifying three shared HealthPartners priority health needs, we conducted our Community Health Needs Assessment for each hospital. Here, we describe the state of each prioritized need for the Hutchinson Health community, inclusive of all individuals who live in McLeod County:

- Mental Health & Well-being
- Social Drivers of Health
- Access to Care

To design an implementation plan that is responsive to the unique local needs, **we first must understand – both through existing quantitative data and the experiences and perspectives of those who live, work and play in the community – what's happening and how the community feels about it.**

Community Health Needs Assessment Approach

To conduct our CHNA, CESR developed a mixed-methods approach that gathered existing and new quantitative and qualitative data and interpreted data with local experts to ensure this report reflected the lived and professional expertise of the community. Much of this methodological approach mirrored the prioritization process and relied heavily on the meaningful contributions and partnership of the HealthPartners CHNA workgroup.

Quantitative Data. Throughout this section, you will find detailed quantitative data to describe each prioritized health need. Data includes county-level public health data that was available for each county served by our health system. This ensures our CHNA report captures the needs of those "medically underserved, low-income, or minority populations who live in the geographic areas from which it draws its patients," as required by the federal guidelines.[27] In addition, we include our own health system's patient data and survey data captured by the HealthPartners Institute to measure community initiatives. When possible, we also present the unique experiences or outcomes by subpopulations or identities, including race or ethnicity, gender, age group, and others. We also partnered with our CHNA workgroup members to identify local data sources that can help describe these community needs. Throughout the report, we seek to display data in ways that are meaningful and easy to interpret.

Qualitative Data. Our CHNA relies heavily on qualitative data gathered through Community and Internal Stakeholder Conversations and other engagement activities. Here, we sought to center local perspectives on a prioritized need, understand how the need impacts individuals residing in the county, and describe what work, if any, is being done at present to address this need. We also asked these stakeholders to inform our inclusion of quantitative data indicators and identify additional data sources to better describe the need with relevant data.

A common facilitation guide was created and used. The guide included instructions for facilitators and notetakers for the discussion. Facilitators could focus the conversation on one to three of the prioritized community needs, depending on the length of the meeting and the expertise and interests of the group gathered.

Specific discussion questions included:

1. Please introduce yourself and share in three words what first comes to mind when I say "[insert prioritized need]."
2. [After reviewing drafted definition of need] In your experience, what's **missing from this definition**?
3. Where do you go to learn more about this need? What **sources of information** do you know about?
4. What **current work** is happening to address this need? What is going well?
5. What are the **gaps** in resources that need to be addressed? What would make it better?

In addition, CHNA workgroup members attended other community meetings and took notes on a template designed to align with our CHNA priority questions. This data source allows our CHNA to include more local priorities and voice while minimizing the time and burden of contributing to other data collection strategies.

Summary of Community and Internal Stakeholder Engagement

CHNA workgroup members in McLeod County held three Community Conversations with approximately 40 individuals in total. These individuals represented various stakeholder groups, including the county health department, school board, parks and recreation department, emergency food shelf workers, the Hutchinson Health Patient and Family Advisory Council, and local residents.

A CHNA Liaison also engaged internal stakeholders and subject matter experts during twelve Community Conversations with more than 160 participants. These participants are part of several different groups, including advisory councils on community engagement and social drivers of health; colleague resource groups (LGBTQ+, Leaders of Color, Disability, and Black and African American); youth councils; health system leaders with insight on how mental well-being and access to care affect the HealthPartners' wider community.

Legend | Throughout this report we use different icons to highlight different topics and different types of data. Here is what they all mean:


Mental Health & Well-being (Priority 1)


Social Drivers of Health (Priority 2)


Access to Care (Priority 3)


This icon highlights data related to our Systemic Injustice & Racism contextual factor.


This icon highlights data related to our Climate Change contextual factor.


This icon calls out input collected from Community &/or Internal Stakeholder Conversations.


This icon calls out quantitative data from existing data sources.


This icon calls out HealthPartners Institute-administered survey results.


This icon highlights differences experienced by a specific subpopulation.

Mental Health and Well-being (Priority 1)

Mental health refers to a person's emotional, psychological, and social well-being, affecting how they think, feel, and act. It influences overall health and how one manages stress, builds relationships, and copes with life's challenges. Mental health can vary across the life span, based on factors including social connectedness, emotional resiliency and mental health conditions, such as depression or anxiety, that disrupt thoughts, emotions, and behaviors.

Factors contributing to mental health or mental health conditions can include biological and environmental factors, trauma, medical conditions, social drivers of health, or substance misuse. Reducing stigma helps ensure everyone can access the care and support needed to lead fulfilling lives and manage life's challenges.

Poor mental health may lead to poor quality of life, higher rates of chronic disease and a shorter lifespan. Communities[28] of color and low-income and rural communities experience disparities in mental health and well-being.[29-31] Underlying contextual factors such as systemic injustice, racism, and climate change also severely impact mental health and well-being through stigmatizing actions and discrimination and increasing stress and anxiety.[32,33]

Through the process described above, **Mental Health and Well-being was determined to be the highest priority community health need for the communities that HealthPartners serves**. This need is described in more detail below.

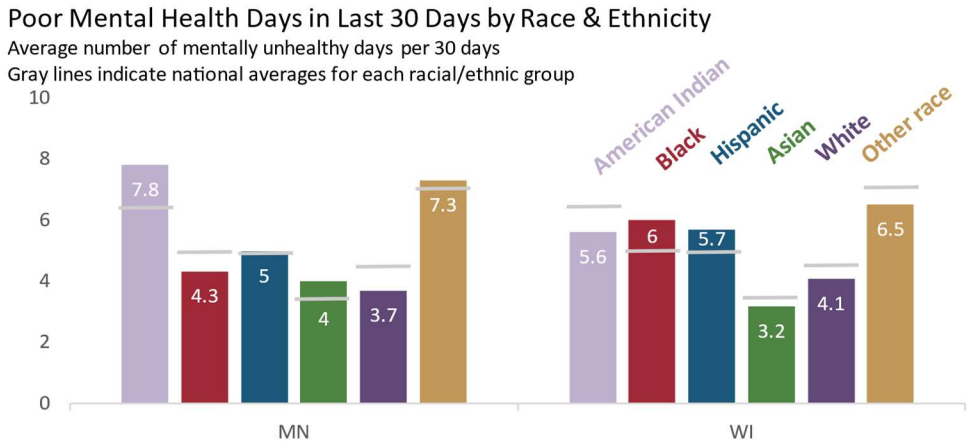
Factor 1: Social, emotional, spiritual, and physical well-being

Mental health and well-being should be broadly understood as inclusive of emotional and social health. According to the Centers for Disease Control, about one in three adults in the United States feels lonely, and one in four lacks social and emotional support.[34] Social and emotional connection supports mental and physical health.

Overall, through CHNA engagement, we heard that **social isolation, sense of belonging, stress and trauma, community, and a reliance on social media** (for both news and information as well as social connection) are challenges affecting social and emotional health within the HealthPartners communities. **Building resiliency, self-care and healthy coping skills are important efforts** to combat these challenges. Some community members look to improve partnerships with schools to better support students around mental health and wellness.

In McLeod County, community members echoed these same sentiments. They felt that technology is negatively impacting social skills and connection, along with a lack of consistent, community-gathering activities. It was also noted that young children are experiencing increased behavioral issues and teens are feeling stressed by high expectations.

Minnesota adults report an average of **4.1 mentally unhealthy days** in the last 30 days, fewer than the national average of 4.8 days (County Health Rankings).[35] Similarly, adults in McLeod County report an average of 4.4 mentally unhealthy days in the last 30 days.



Source: KFF, 2022

There are **notable differences in reported mentally unhealthy days by race or ethnicity**, especially among American Indian Minnesotans and Black, Hispanic, and American Indian adults living in Wisconsin.

There is limited local, county-level data on social connections or social isolation. One measure – the number of membership organizations per capita – shows **Minnesota and Wisconsin residents having slightly more opportunities for social connection than the national average** (County Health Rankings).[35] McLeod County had notably more social connection opportunities (16.5 per 10,000 population) than the state average (12.4) and the national average (9.1).

Factor 2: Depression, anxiety, other mental health conditions

Throughout our CHNA engagement, we heard concerns from stakeholders that poor mental health and mental illnesses are affecting our children and young people at high rates, especially teen girls. During a community discussion, **students reported not feeling comfortable talking about their mental health with their parents for fear they will not understand or will minimize the issue**. For those taking care of young people, either in schools, clinics or other settings, it is important to try and understand how social drivers of health, such as housing instability, hunger or an unsafe home life (e.g., addiction, abuse), impact mental health. In general, education is needed to teach parents and adults how to talk to young people about mental health. It's also important to remember that there are **mental illnesses beyond depression and anxiety that are impacting our communities:** bipolar disorder, obsessive-compulsive disorder, schizophrenia, eating disorders, etc., should also be prioritized.

> Our communities are concerned about the mental health of our youngest community members, especially
>
> **teen girls**

In McLeod County specifically, community members emphasized that mental health and illness encompasses a wide range of issues and experiences, and it affects people of all ages, though youth and seniors were called out as populations particularly struggling. They also feel that people do not always know where to get help for mental health issues.

In 2022, nearly **1 in 4 Minnesota (23.6%) and Wisconsin (23.0%) adults had a depression diagnosis. This rate has continued to rise over time** but is similar to the nationwide prevalence of adults with depression (21.7%, BRFSS).[36]

Among HealthPartners adult patients with a visit in 2023 living in McLeod County, 9.7% had a PHQ-9[37] (a common patient questionnaire to screen for depression) score above 9, which represents moderate to severe depression.

According to the Health Trends Across Communities (HTAC) Dashboard, **19% of Minnesotans have depression**. Females are more likely to have depression (19%) than males (10%).[5] In McLeod County, 14% of the population, 29% of American Indian residents, 16% of white residents, and 14% of Black residents have depression.

In addition, **19% of Minnesotans have anxiety**. Females are more likely to have anxiety (24%) than males (14%).[5] In McLeod County, 20% of residents have anxiety. This includes 38% of American Indian residents, 22% of white residents, and 19% of Black residents have anxiety.

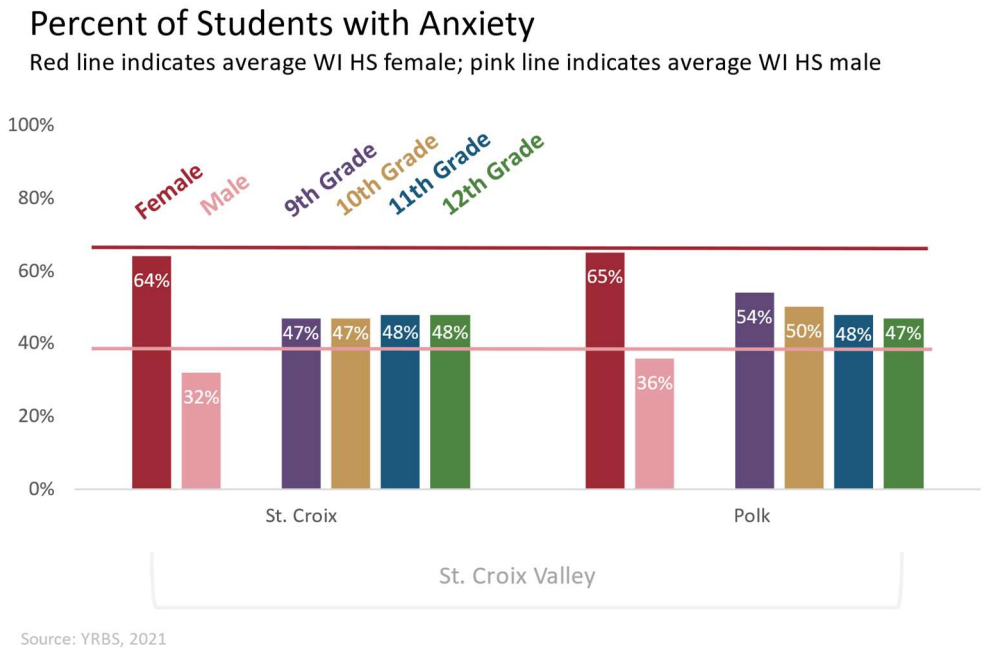
Finally, **1.5% of Minnesota adults have suicidal ideation**, including 4% of our American Indian community members. The rate ranges from 1% to 2% in each of our HealthPartners counties.[5]

This need deeply **impacts young people**. Across the Minnesota counties HealthPartners serves[21]:

- When asked if they had ever been treated for a mental, emotional, or behavioral problem, **11th grade female students** were most likely to say they have compared to other grades and genders.
- Between 8 and 50% of students reported long-term mental health problems, with females reporting more.
- Among surveyed students, 0 to 28% reported they seriously considered attempting suicide in the last year. This is similar to results of the 2019 survey (0 to 27% of students). [38]

This need deeply impacts young people. Across the Wisconsin counties HealthPartners serves (YRBS):

- Between 32 and 65% of students reported having anxiety, with **female students** more likely to say they have anxiety than male students.
- Among surveyed students, 11 to 22% reported they seriously considered attempting suicide in the last year, which is an increase from 2019, when 9 to 17% of students reported this.[39]

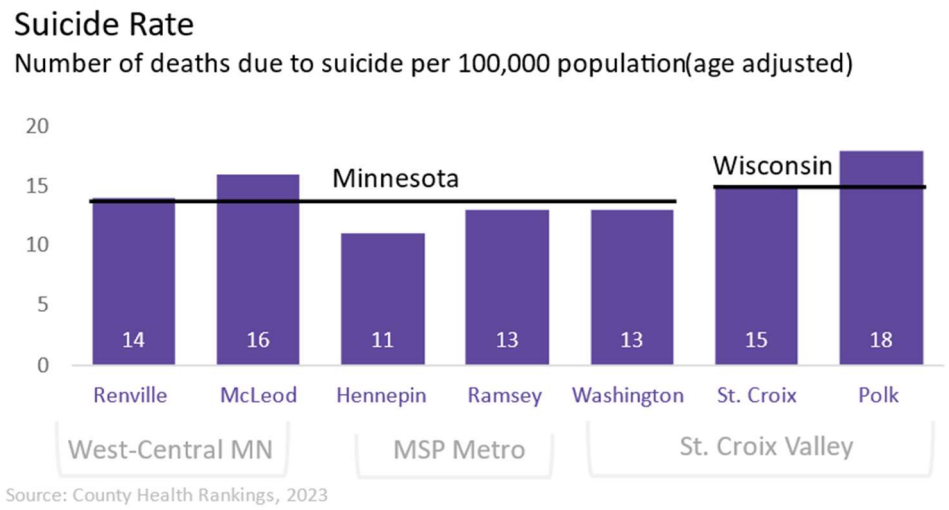


Source: YRBS, 2021

Direct exposure to a climate-related disaster, such as a drought or a flood, can lead to mental health conditions including anxiety, depression, and post-traumatic stress. Even people who have not been directly affected by a disaster are experiencing anxiety and dread related to climate change. Climate-related distress is particularly prevalent in young people.[40,41]

Nationwide, suicide rates have increased more than 35% since 2000.[42] According to the CDC, Americans with higher-than-average rates of suicide include American Indian and Alaska Native people, white people, veterans, people who live in rural areas, LGBTQ+ communities, and workers in certain occupations including mining and construction.

Across the HealthPartners service area, the **suicide rate** among adult residents ranges from 11 to 18 deaths per 100,000 population (County Health Rankings).[35] This is similar to the national average of 14.



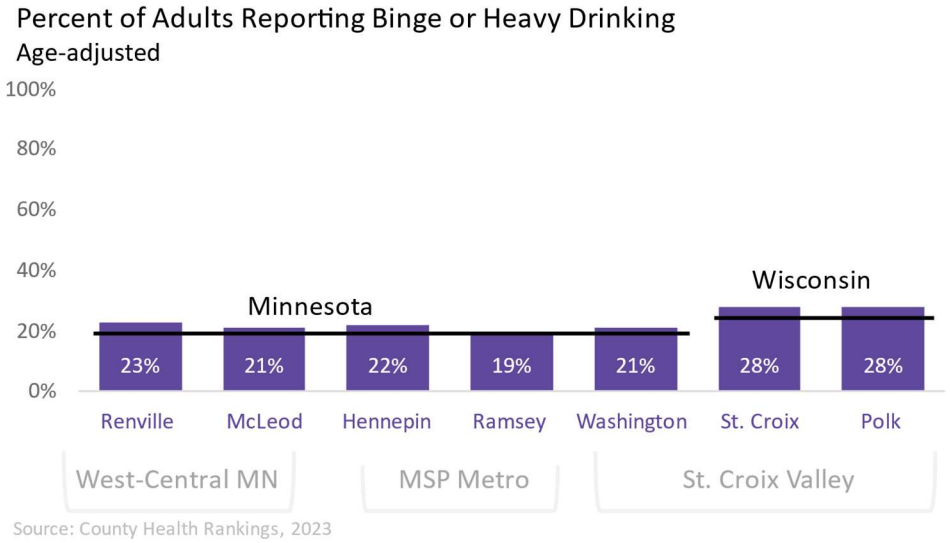
Factor 3: Substance misuse, substance use disorders

Alcohol and other substance misuse has well documented associations[43,44] with mental illness and alcohol is often used as a coping strategy among those with depression and/or anxiety. Communities of color, low-income, and rural communities are disproportionately impacted by aspects of substance misuse and substance use disorders.[45,46] Underlying contextual factors such as systemic injustice and climate change, as well as our other prioritized needs, Social Drivers of Health and Access to Care, have an impact on substance misuse and substance use disorders.

Stakeholders noted the increase in substance use during COVID-19 is still having effects on communities, and they are particularly concerned about rates of substance use among youth. During one conversation, teenagers discussed how substances are often used as a coping mechanism for other mental health problems. Other community members also called out the relationship between substance use and other mental health issues.

These themes are in line with what community members in McLeod County shared. Specifically, community members reported chemical dependency is a concern in McLeod schools, and the school board is considering alternative ways to address these concerns while keeping kids in school.

Across the counties HealthPartners serves, between 19 and 28% of adults report binge drinking, with Wisconsin counties being notably higher than Minnesota counties (County Health Rankings). Both states are above the national average of 18%.

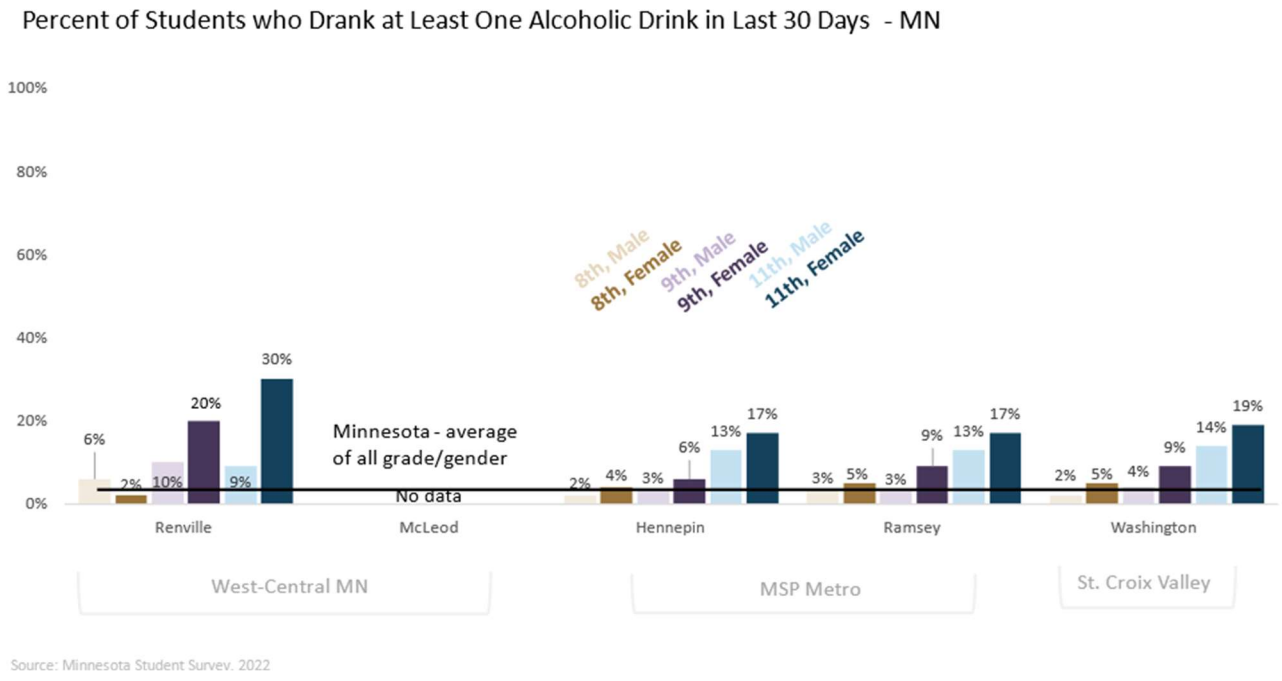


Source: County Health Rankings, 2023

Overall, 3% of Minnesotans have an alcohol use condition.[5] The American Indian community is disproportionately impacted, with **8% of American Indians living with an alcohol use condition statewide**. In McLeod County, 3% of adults have an alcohol use condition.

A study on the impacts of **structural racism on mental health and alcohol use** found that Hispanic/Latino participants used alcohol to cope with low mood due to structural barriers, experiences of discrimination, and stigma.[47] Another study on the connection between racism and substance use found that historical trauma and chronic race-based stress were contributing factors to substance misuse among American Indian people.[48]

In Minnesota, 10% of all students report using alcohol in the last 30 days, including 16% of 11th grade males and 19% of 11th grade females (Minnesota Student Survey).[49] This is a decrease from 2019, when 22% of 11th grade males and 24% of 11th grade females reported the same alcohol use.[38]



Source: Minnesota Student Survey, 2022

According to Health Trends Across Communities (HTAC),[5] 1% of all Minnesotans use **opioids** but there are notable disparities by race and geography. Six percent of the American Indian and Alaska Native population use opioids statewide, with 13% of American Indians living in Hennepin County and 8% in Ramsey County using opioids.

historical trauma and chronic race-based stress contribute to substance misuse among American Indian communities

According to the Minnesota Department of Health,[50] there were 4,349 opioid-involved emergency room visits in Minnesota in 2021. This includes seven visits in McLeod County. There were 978 opioid overdose deaths in Minnesota in 2021, and the **opioid crisis disproportionately impacts communities of color**. The opioid overdose death rate among American Indian residents was 192 per 100,000 residents in Minnesota, compared to 19 among white Minnesotans.

Extreme heat has been associated with increases in irritability, aggression, alcohol and substance use, mental health-related hospital visits, and suicide rates. Additionally, certain psychiatric medications can interfere with a person's ability to regulate heat, leading to an increased risk of heat-related illness.

Factor 4: Stigma experienced by people with mental illness

Stigma is a set of negative beliefs, often based on misinformation, that a society has about mental illness. Make It OK is a campaign supported by HealthPartners to reduce mental illness stigma in communities we serve. (MakeItOK.org).[51]

CHNA community engagement conversations about stigma varied based on the community. Overall, we heard that stigma is present, pervasive and that it can prevent people from reaching out for help. Teens feel comfortable talking with each other about their mental health but don't feel comfortable talking with their parents and believe their **parents would not feel comfortable with them seeking help from a therapist.** We also heard that **stigma can be experienced around mental health not just mental illness** and prejudice prevents people from seeking care.

Community members in McLeod County brought differing perspectives about how and where stigma shows up in their county during community conversations. Some community members working in public schools feel that young people talk openly about mental health and the stigma is diminishing, whereas participants working in other areas of the community see reluctance to reach out for mental health help for fear of being looked down on.

As part of the Make It OK evaluation, HealthPartners conducts the IMPACT survey, surveying members in selected communities about mental illness stigma. In 2021, 57% of surveyed community members agreed there are **negative impressions, stereotypes, or stigma about mental illness** in their community. This is a significant decrease from 63% in 2019.[52]

Thirty percent of IMPACT survey respondents reported they would be at least **somewhat reluctant to seek mental illness care**, with little variability between counties. Across all counties, **people of color** were more reluctant to seek mental illness care than those who identified as white. **Men** were also more reluctant to seek mental illness care than women. People who have never received mental health care were also more reluctant to seek care than those who have in the past. Those who perceived stigma in their community, however, were no more reluctant to seek mental illness care than those who did not perceive community stigma.[52]

Additional Factors: Mental Health and Well-being

There were a few additional themes we heard throughout our CHNA engagement that are important to include, as well as callouts to work being done to improve mental health and well-being throughout our service areas. The HealthPartners programs Little Moments Count and Make It OK are two initiatives working to improve mental health and well-being system wide. Little Moments Count works to build attachments between children ages 0-3 and caregivers and brings awareness to how family dynamics impact well-being. Make It OK works to reduce the stigma around mental illness and conducts trainings that have been very well attended.

In McLeod County, it was evident that mental health and well-being is an important priority for community members, and more knowledge of existing mental health resources, like support groups, is needed. We also heard that mental health, physical health, social health, and emotional health are all interconnected, and that it is hard to address one area without understanding the others.

Social Drivers of Health (Priority 2)

Social drivers of health are the community and environmental conditions that affect health and well-being. They include adequate and secure income, housing, food and nutrition, employment and work, education, transportation, access to childcare and interpersonal safety. They also include a sense of belonging, the natural and built environment and climate impacts.

These social drivers of health do not exist in isolation and often interconnect, overlap, and contribute to other community health needs, including Mental Health and Well-being and Access to Care.

Communities of color and low income and rural communities disproportionately experience more health-related social needs.[53-55] Poor health is due in part to structures and systems that create systematic biases against people of color. In addition, social drivers and social needs are connected to structural and systemic inequities that create and maintain poverty in communities of color. Through this CHNA, **Social Drivers of Health was determined to be the second highest priority community health need** for the communities that HealthPartners serves. This need varies by community and is described in much more detail in the following pages.[56]

Factor 1: Economic & financial security

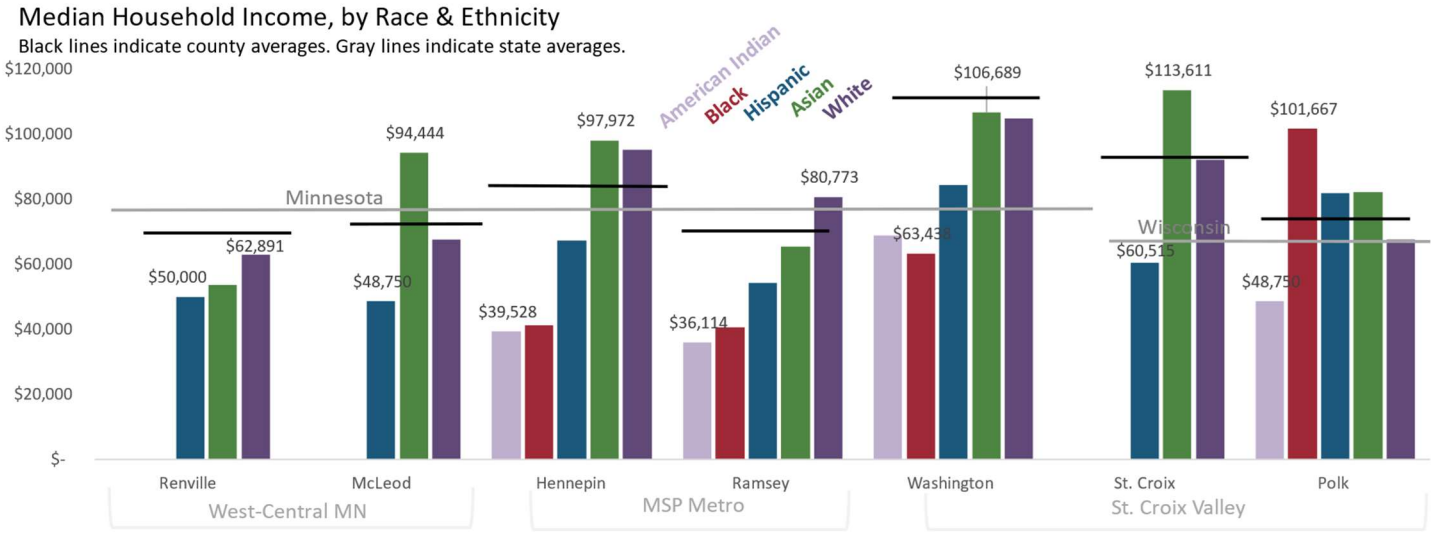
Financial insecurity is the inability of individuals or families to sustainably afford their essential needs. This can be observed in expenses exceeding income and can be experienced by anyone at or below federal poverty levels.[57]

Throughout our CHNA engagement, we heard that economic security goes beyond whether someone has a job, and it is important to have a holistic view of financial security. Economic security can also look different across geographic areas; for example, a rural community may be more dependent on a single employer, like a factory, than an urban community. The level of savings is a factor in financial security.

In McLeod County specifically, community members shared that inflation is exacerbating existing financial stress and affecting families' abilities to pay for food, school, housing, insurance, and other basic needs.

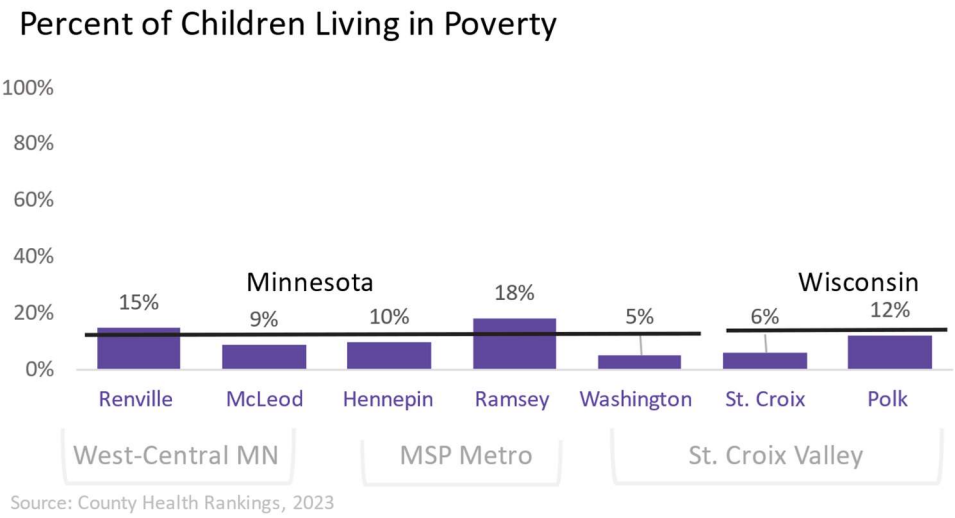
In 2022, the median household income in Minnesota ($82,338) was higher than the national average of $74,755.[58]

There are notable differences by geography and race or ethnicity. Among HealthPartners counties in Minnesota, the lowest median household income is in Renville County ($66,313) and the highest is in Washington County ($106,509).



The federal government calculates an income threshold by family size, adjusted for inflation, to determine if that family is considered in poverty and would qualify for various government support programs.[59] The counties served by HealthPartners are not immune from poverty. **Nearly one in ten adults in our service area live in poverty**.[58] Childhood poverty rates are even higher.

The adult poverty rate in McLeod County is 7.1%, lower than the Minnesota state average of 9.6%. The childhood poverty rate is 9%, lower than the state average of 11% and the national average of 16%. Of note, **61% of American Indian children** in McLeod County are living in poverty.[35]



Low-income community members are more likely to live in areas with greater exposure to climate disaster. Neighborhoods with higher poverty rates have greater concentrations of air pollutants like PM2.5[60] (particular matter measured 2.5 micrometers or smaller in diameter) and ozone, experience increased temperature mortality impacts, and are more likely to live in flood zones.

Additionally, climate disasters impose financial challenges for community members, particularly those with lower incomes and the farming community.[61] Examples include lost earnings due to business closures or unsafe working conditions, limited access to public benefits programs and childcare, property damage with delayed or incomplete repairs, and higher prices for energy and consumer goods.

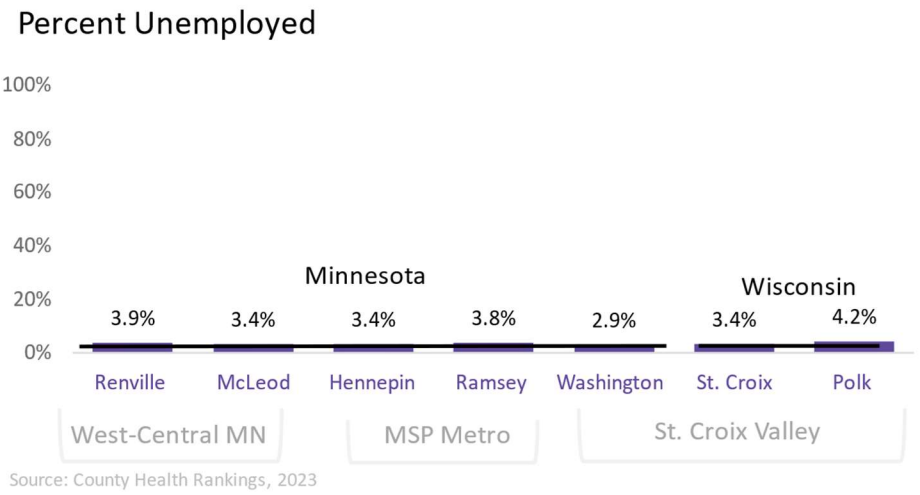
Factor 2: Employment security

Employment security can be defined as living without the fear of unemployment and the consequences of being unemployed, such as facing housing or food insecurity.[62] Employment, including *un*employment and *under*employment, impacts a community's health and well-being.

This was echoed during community and internal stakeholder engagement, where we heard that underemployment is an important indicator of employment security, along with unemployment, and should be prioritized when seeking to understand a community's employment security.

Community members in McLeod County are concerned that wages are not keeping up with inflation as it is increasingly difficult to make ends meet.

In 2023, unemployment was relatively low (under 5%) across all counties served by HealthPartners.[35] The national unemployment rate during the same time period was 3.7%.



Source: County Health Rankings, 2023

Community members can experience income loss when extreme weather causes businesses to close or creates unsafe conditions for workers. Outdoor workers, including those working in agriculture, are particularly susceptible to income loss due to extremes in weather and temperature.[63] Outdoor workers are more likely to be lower-income and people of color. Prolonged exposure to extreme weather conditions can affect workers' job performance, which can also result in a reduction in income.

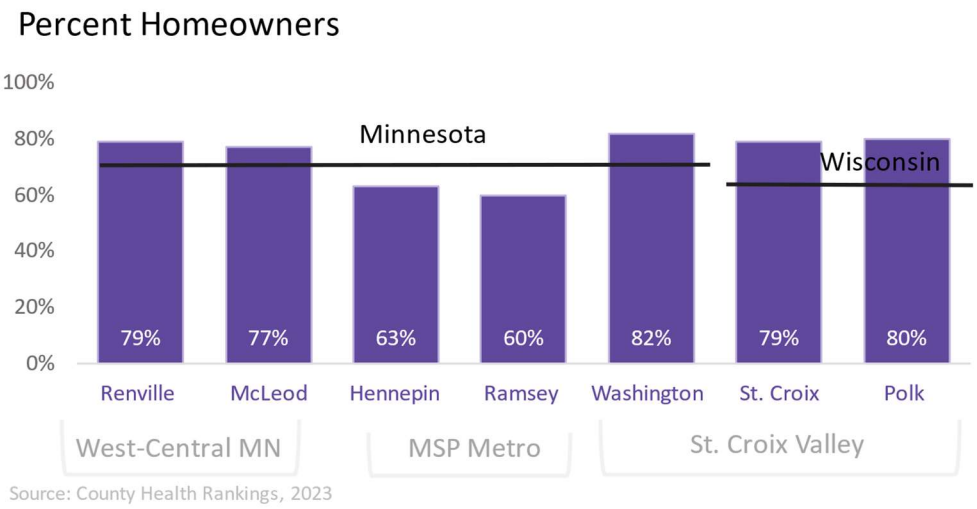
Factor 3: Housing security

Housing insecurity is when individuals and families lack the ability to access or maintain safe housing due to high housing costs relative to income, poor housing quality, unstable neighborhoods, or overcrowding.[64,65]

When discussing this topic with system wide stakeholders, we heard that it is important to consider people who are **unhoused, unstably housed, and renting** when thinking about housing security. The burden of housing expenses on a household is also a meaningful indicator.

In McLeod County, community members shared that housing security and homelessness affects people of all ages. They also feel that more affordable housing is needed to support people of lower incomes and that more services are needed to help them maintain and stay in their homes.

According to the 2023 County Health Rankings,[35] 65% of housing units were owner-occupied in the United States. In Minnesota, 72% of housing units were owner-occupied. Homeownership in McLeod County is 77%, higher than the statewide rate.

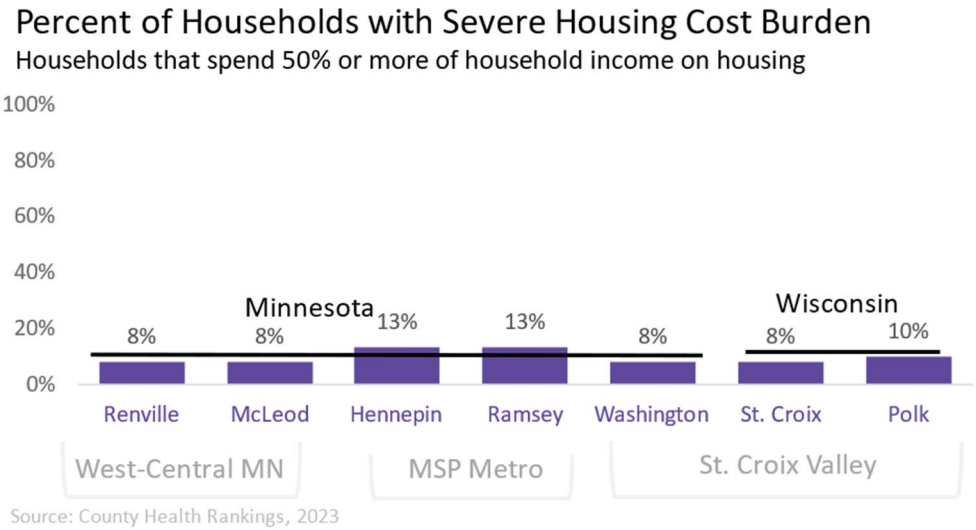


There are notable differences in home-ownership by race and ethnicity across Minnesota.[66]

- In 2022, 44% of American Indian Minnesotans owned their home.
- 64% of Asian Minnesotans
- 29% of Black Minnesotans
- 49% of Hispanic/Latine Minnesotans
- 77% of white Minnesotans

Nearly one in three American households (32.5%) spend **over 30% of their income on housing**, which makes them "cost burdened." In Minnesota, nearly one in four households (23.8%) are cost burdened.[66] In McLeod County, 23% of households are cost burdened.

Nationally, 14% of households spend **50% or more of their household income on housing**, which means they experience "severe housing cost burden" (County Health Rankings).[35] The rate is lower in both Minnesota and Wisconsin (11% of households for each state). Metropolitan counties of Hennepin and Ramsey have slightly higher severe housing cost burdens (13% in each county) than other counties in the HealthPartners service area.



County Health Rankings also reports the percentage of households that have severe housing issues.[35] In both Minnesota and Wisconsin, **13% of households meet this definition of having a severe housing issue**, which is lower than the national average of 17% of households. Fewer (9%) households in McLeod County have a severe housing issue.

13% of households face **severe housing issues** including overcrowding, high cost, lack of kitchen, or lack of plumbing

Lower-income families also struggle to pay rent. The median gross rent,[67] per month, for each county in our service area is:

- $652 in Renville County
- $724 in McLeod County
- $1,176 in Hennepin County
- $1,060 in Ramsey County
- $1,329 in Washington County
- $1,036 in St. Croix County
- $691 in Polk County

According to Housing Link's rental market data, rental vacancies in Hennepin County are not affordable for households earning less than half the median income.[68] For reference, the median household income in Hennepin County in 2023 was $93,668.[69]

In Central Minnesota, including Renville and McLeod counties, 97% of private market vacancies in 2022 were affordable. There were 5,603 publicly funded affordable rental units subsidized in this region, and 868 Section 8 housing choice vouchers available for regional residents.

In contrast, just 60% of these vacancies were affordable in the Twin Cities metropolitan area, including Hennepin, Ramsey, and Washington counties.[68] There were 87,796 publicly funded affordable rental units subsidized in this region, and 23,306 Section 8 housing choice vouchers available for regional residents.

Too many people in our community experience homelessness. According to the United States Interagency Council on Homelessness, affordable housing shortages, wages that do not keep up with the cost of living, failed social safety nets, and inequitable access to education, health care, and economic opportunity all contribute to homelessness.[70] In the State of Homelessness report by the National Alliance to End Homelessness, 8,393 Minnesotans (15 per 10,000 residents) and 4,861 Wisconsinites (8 per 10,000 residents) experienced homelessness on a given night in 2023.[71]

According to the 2023 Minnesota Homeless Study conducted by Wilder Research, even more people (10,522) were experiencing homelessness in Minnesota on a single night in 2023.[72] 191 people in Southwest Minnesota experienced homelessness last year.

People experiencing homelessness are more vulnerable to extreme heat events and poor air quality, due to increased exposure to the elements and higher rates of health conditions. Community members living in substandard housing, housing without air conditioning, or those who struggle to pay their electricity bills are also more vulnerable to extreme heat.

People living in substandard housing are also more vulnerable to flooding events. These homes are more likely to be located in flood-prone areas and are more susceptible to damage.

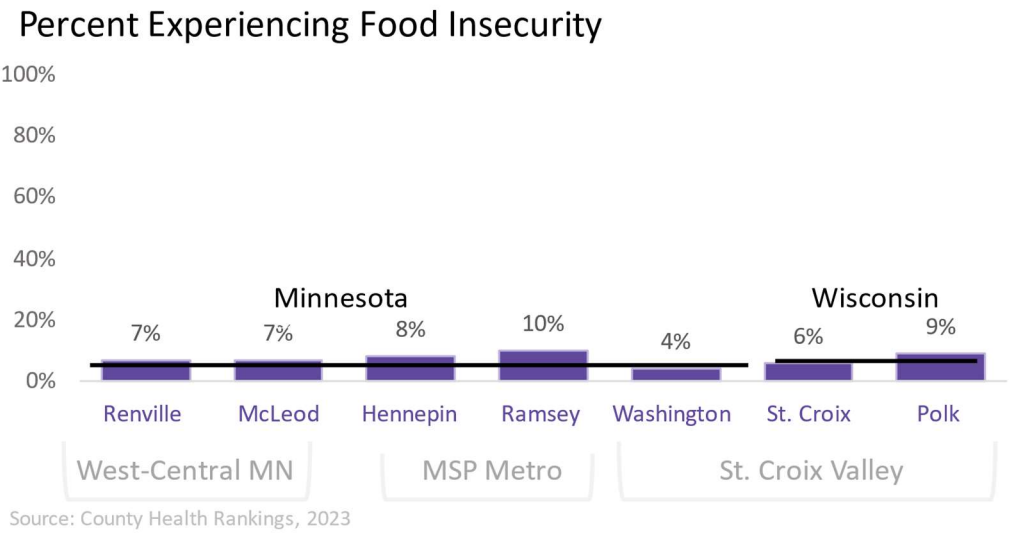
Factor 4: Food & nutrition security

Food and nutrition security is consistent access to enough food for an active, healthy life. This includes access to healthy foods and grocery stores. People living in food insecure households face a number of barriers to eating healthy that make them vulnerable to diet-related chronic diseases, including obesity, diabetes, hypertension, and heart disease. Food insecurity is influenced by factors including income, employment, race/ethnicity, and disability. Food insecurity is thought to play a role in poor health outcomes and rising health care costs.[73]

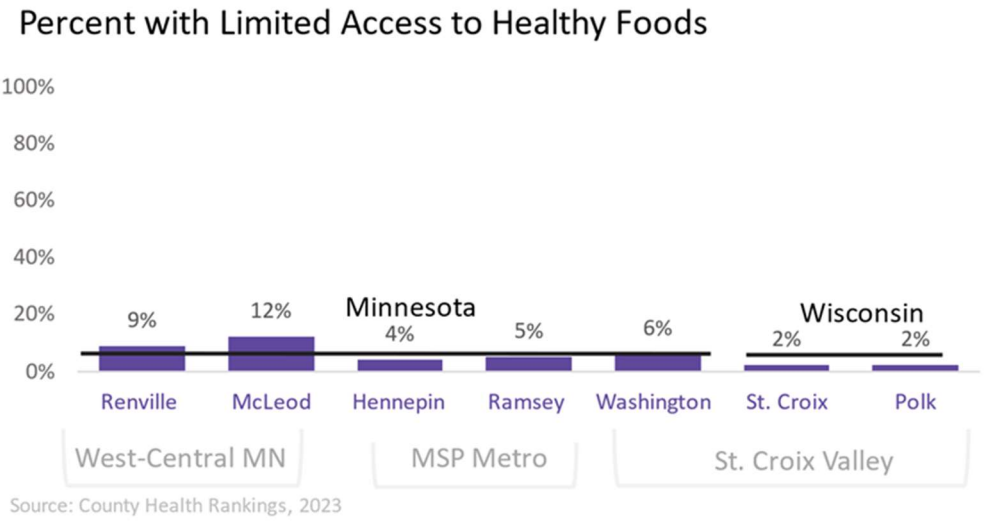
CHNA community engagement showed that access to nutritious food varies across HealthPartners communities, and food deserts are an issue in multiple areas. Stakeholders also felt that what it means to have adequate access to healthy foods needs to be better defined and understood.

Community members in McLeod County shared that some areas in McLeod are considered food deserts, with no access to fresh foods and limited transportation to food. They have seen a significant increase in the use of food shelves.

In 2023, 10% of Americans experienced food insecurity. **Between 4 and 10% of people in counties HealthPartners serves reported not having adequate access to food**, including 7% of Wisconsinites and 6% of Minnesotans (County Health Rankings).[35]



In addition, many of our community members have **limited access to healthy foods**. Rates in Minnesota (6%) and Wisconsin (5%) are similar to the nationwide average (6%). Among HealthPartners service areas, McLeod County faces the greatest limitations, with 12% of residents having limited access to healthy foods.[35]



In 2022, Minnesota middle and high school students were asked if they had to skip a meal in the last 30 days because their family did not have enough money to buy food.[21] Statewide, less than 4% said yes.

Climate change and extreme weather threaten nearly every component of food security. Potential impacts include decreases in food availability or quality, disruptions to food distribution, increases in food costs, limited access to culturally relevant food, and increases in risk to farmworkers' safety.

Hunger Solutions Minnesota[74] supports food shelves throughout the state. In 2023, there were 7,551,147 visits to a food shelf in the state, which marks a 76% increase from 2022. McLeod County saw a 25% increase in food shelf visits between 2022 and 2023.

Additional Factors: Social Drivers of Health

Throughout CHNA engagement, we consistently heard that the social drivers of health are interconnected and affect our mental and physical health. We also heard some specific themes that did not fit into our priority needs factors, including how **transportation** and **childcare challenges impact community members.** Additionally, stakeholders described limited language assistance, geography, and stigma preventing some community members from accessing social support services.

McLeod County community members emphasized the need for improved access to transportation for residents of all ages, as this affects a person's ability to access many other resources. They named the organization Trailblazer Transit as a valuable resource working to meet this need, but more work needs to be done.

As a system, HealthPartners has several internal groups (Social Determinants of Health Advisory Council), programs (Little Moments Count, Make It OK, PowerUp), and external partnerships (Open Arms, Habitat for Humanity, American Red Cross) working to understand and improve the social drivers of health for our communities.

Childcare emerged as a priority theme through stakeholder engagement. **The cost and availability of childcare impacts young families throughout our service area**. The average monthly cost of childcare in Minnesota is $880 per child.[75] In Wisconsin, the average monthly cost for infant care is $769 and preschool care is $722.[76] Costs also vary widely within our service area. In McLeod County, the average monthly cost of childcare is $594.[75]

> "Lack of affordable childcare is driving people to not work and then they can't afford food."

Availability of childcare also varies throughout our communities. Minnesota has an average of 60 available childcare slots per 100 children aged five and under.[77] In Wisconsin, there are 14 available childcare slots per 100 children under 14.[76] In McLeod County, there are 68 available childcare slots per 100 children aged five and under.

Another community health need that emerged in community conversations was **access to transportation,** as that can result in missed care as well as limit access to opportunities for physical activity, healthy food, and/or social connection.[78] Across the United States, 8.2% of adults lack reliable transportation. [79] In McLeod County, 6.7% of adults lack reliable transportation.[79]

Access to Care (Priority 3)

Access to Care means having equitable access to convenient, affordable, safe, culturally responsive and high-quality health care. It includes a care experience where people feel like they are seen, heard, known and treated as a partner in the process, without bias. Access includes factors such as the cost of care and insurance coverage, medical transportation, care coordination, navigation, and use of technology. It means simplifying the complex health care system to be more understandable and accessible for all.

Communities of color, low income, and rural communities, and members of the LGBTQ+ community experience disproportionate barriers to accessing care.[80-82] Underlying contextual factors such as systemic injustice and racism impact access to care.

Access to Care is our third priority community health need and is described in much more detail in the following pages.

Factor 1: Coverage, health insurance, cost of care

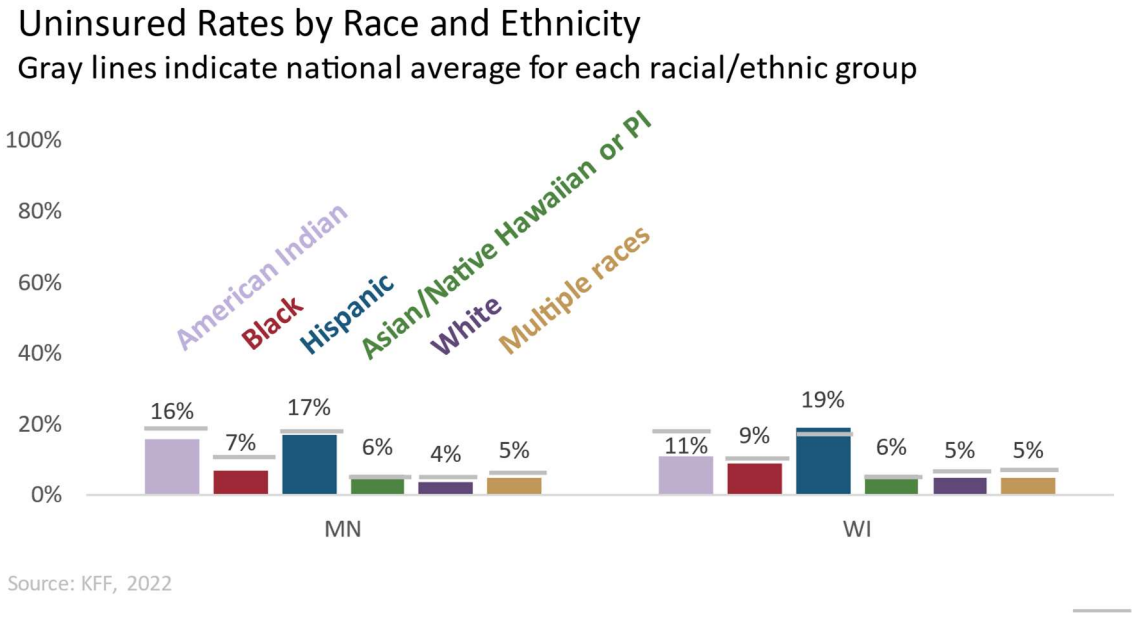
Both insurance coverage and cost of care can affect someone's ability to access health care services. Research suggests that **having insurance coverage is associated with reduced mortality**.[83]

Overall, through CHNA engagement, we heard that the cost of medical care is high, and patients do not always know or understand how they can access insurance or what their insurance covers. Even when patients have insurance, it does not always cover the care needed, or high deductible plans make getting care too expensive.

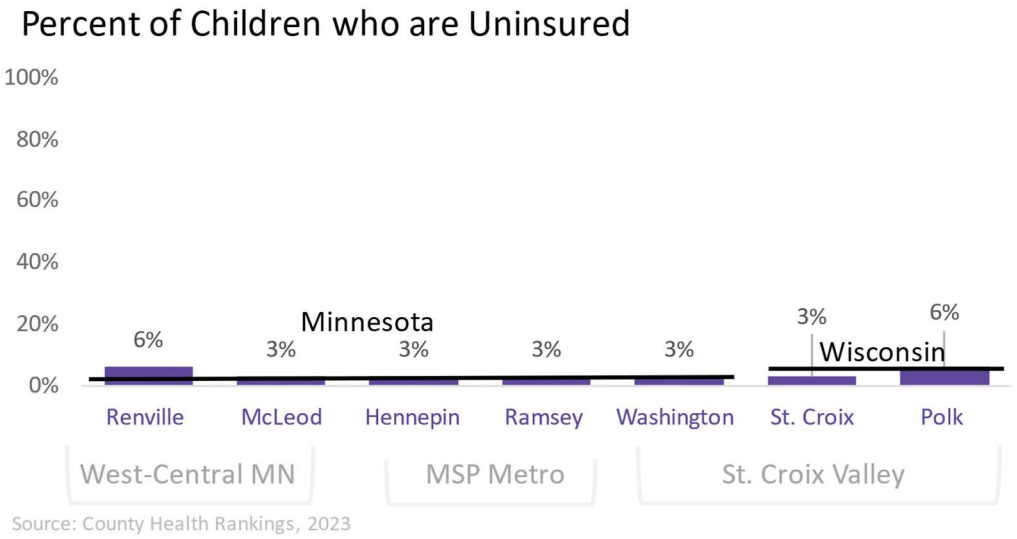
In McLeod County specifically, community members affirmed that health care in general, including specialty care, is expensive.

Across all counties HealthPartners serves, there were similar rates of uninsured adults and children compared to Minnesota and Wisconsin as a whole.[35] **All counties HealthPartners serves had adult uninsured rates lower than the national average of 12%.**

In Minnesota, data shows a large disparity for insurance coverage for Hispanic adults under age 65 (17% uninsured) and American Indian adults (16% uninsured) (KFF 2022).[84]

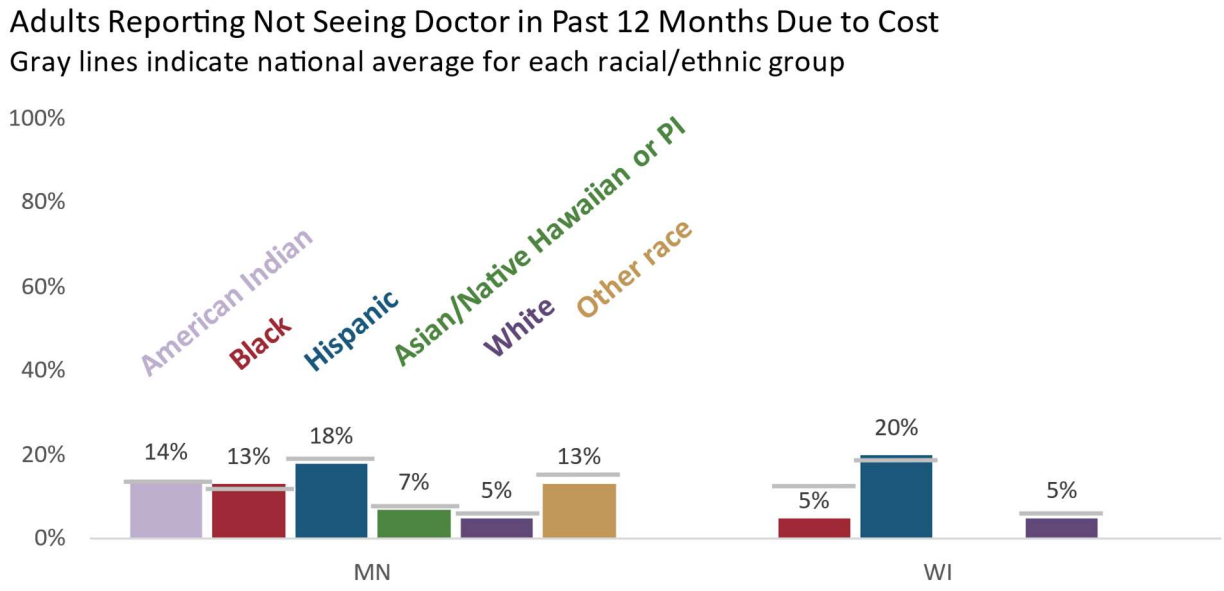


Across the country, 5% of children are uninsured. The rate is lower in both Minnesota (3%) and Wisconsin (4%).



Source: County Health Rankings, 2023

Many of our community members report choosing not to see a doctor in the past 12 months due to the cost of care. In Minnesota, 6% of all adults, including 18% of Hispanic adults and 14% of American Indian adults, did not see a provider due to cost.



Source: KFF, 2022

Blank = no data

In Minnesota, 9% of children are in families who had **trouble paying medical bills** in the past twelve months. This is the same as the national average (KFF 2022).[84]

Individuals without health insurance are more vulnerable to the potential health effects of heat exposure and experience higher rates of temperature-related mortality impacts.[14]

Factor 2: Availability and timeliness of care, services, workforce

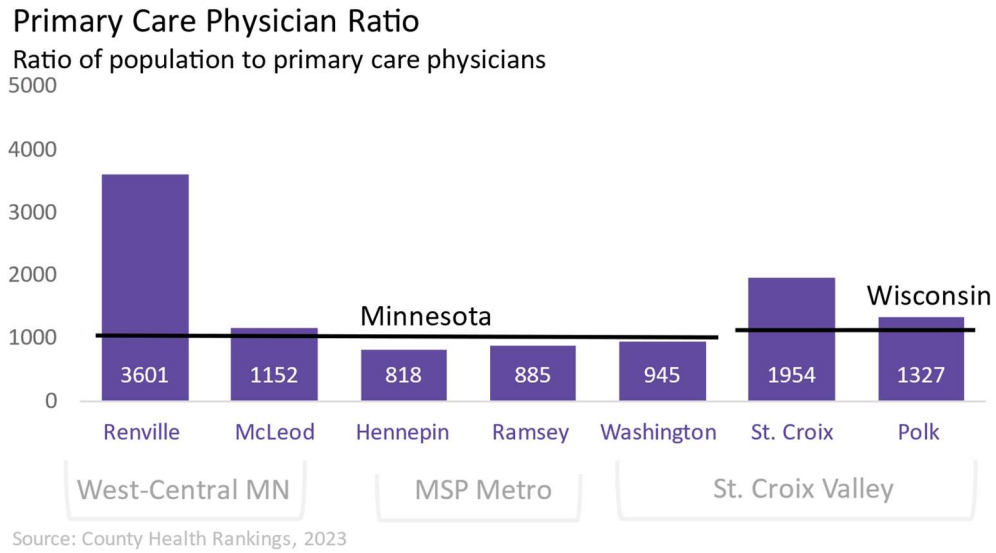
Availability of care includes availability of care providers, timeliness of appointment availability/care delays, availability of special services, availability of bilingual staff, interpreters and culturally appropriate care. Availability of care is impacted by workforce shortages, which vary by geography and by specialty.

Through CHNA engagement overall, we heard that more providers are needed across the HealthPartners service areas, and a broader representation of race, ethnicity, and physical abilities was called for among care providers. Health care systems are very difficult to navigate for many patients, so care coordination is a huge benefit when available. Finally, telehealth is seen as increasing access to health care, though this can still be improved.

> Health care is too hard for too many patients to navigate

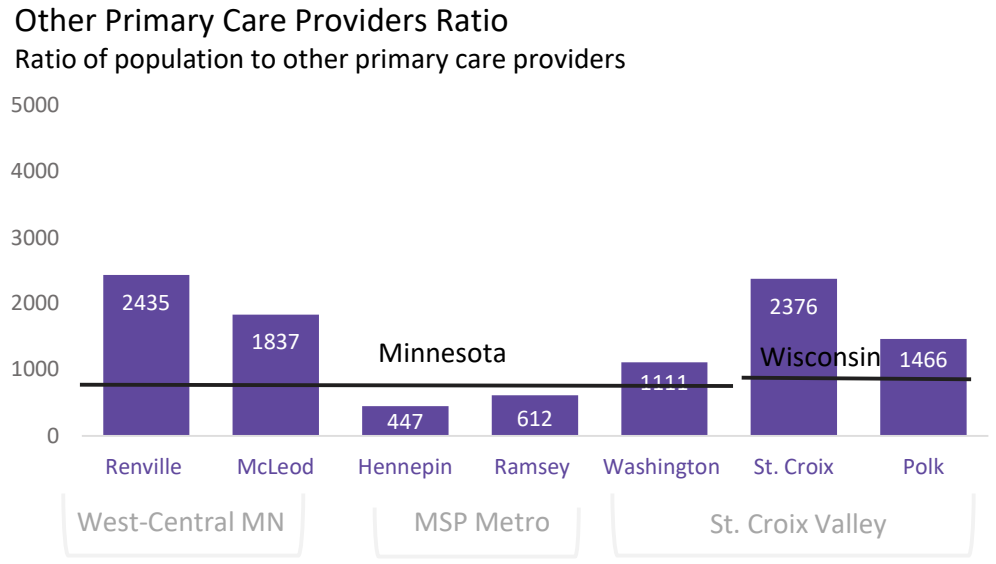
Community members in McLeod County shared that the area needs more mental health providers overall. Patients want an in-person connection with providers and to see the provider in a timely manner, especially when a patient may be in crisis. In general, they report long wait times for all types of care. Specialty care providers and interpreters are especially needed.

Primary care availability varied widely across counties HealthPartners serves, with some counties having **fewer primary care providers per capita** compared to their state ratio (1,110 people per 1 primary care physician in Minnesota and 1,242 per 1 primary care physician in Wisconsin) and the national average (1,330 per 1 primary care physician).[35]



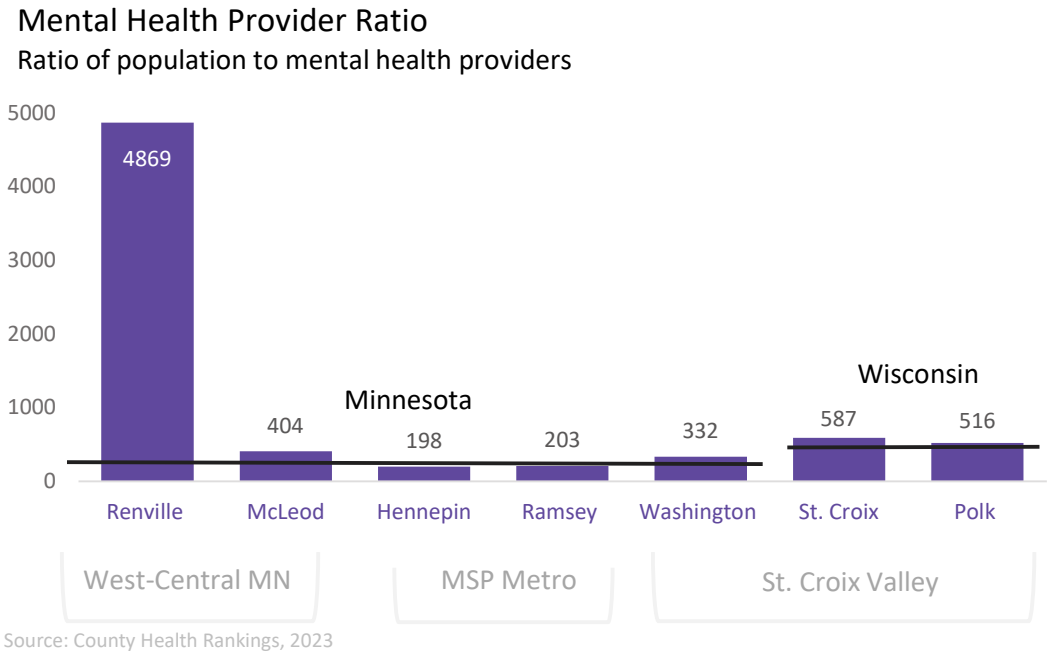
Source: County Health Rankings, 2023

Similar patterns exist for other primary care providers, including nurse practitioners, physician assistants, and clinical nurse specialists – all of whom can provide routine and preventive care in our service areas. This variation further contributes to **limited availability and timely access to care, especially in our more rural counties.**



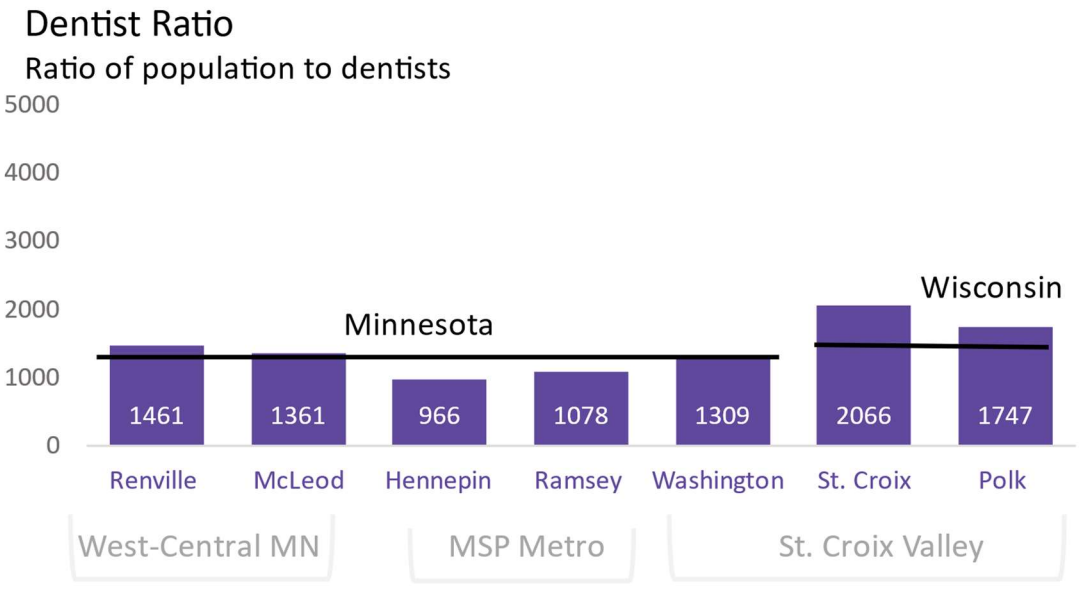
Source: County Health Rankings, 2023

Mental health provider availability varies by geography as well. In the United States, there is, on average, one mental health care provider per 320 residents. Across Minnesota, the ratio is similar with one provider per 322 residents. Not all counties have the same level of access, however. According to the Minnesota Department of Employment and Economic Development, the demand for therapists, counselors, and mental health social workers will grow by 11.1%, 16.8%, and 6.5% over the next ten years.[85]



Source: County Health Rankings, 2023

Availability of dental providers is more similar across counties in our service area and is similar to the national average of 1 per 1,360 residents.



Source: County Health Rankings, 2023

Across Minnesota, 13.8% of the population reports not having a personal health care provider, which is comparable to the national average of 14.5%. This percentage is significantly higher among Minnesotans who identify as Hispanic (37.2%) and Asian/Native Hawaiian or Pacific Islander (26.7%).[86]

Telehealth has changed how we all access health care, but access to telemedicine services requires access to the internet.[87] According to the Social Determinants of Health Database published by the Agency for Healthcare Research and Quality,[67]13.2% of households in McLeod County do not have internet access.

Availability is also determined by insurance coverage.[67] In McLeod County, there is only one substance misuse service facility accepting Medicaid and one facility that provides mental health services and accepts Medicaid.

Property damage, damage to critical infrastructure such as electricity and water, supply and staff shortages, and transportation disruptions resulting from extreme weather events can all affect the availability of regular health care services. In a best-case scenario, these challenges make operating conditions more difficult for a short period of time; in a worst-case scenario, facilities are forced to evacuate patients and suspend operations.[88]

HealthPartners is working hard to ensure continuity of care as our climate changes. Already, our emergency management teams are considering extreme weather projections in annual Hazard Vulnerability Assessments, updating continuity of operations plans related to weather events, and educating colleagues on extreme weather risk. Additionally, our facilities utilize thorough continuity of operations plans and are proactively pursuing opportunities to increase resilience for existing and new buildings.

Factor 3: Care experience, equitable and respectful care

Care experience in this section refers to how patients perceive their interactions with the health care system. This subtopic includes the ability to get **understandable health information**, as well as being **treated with respect** by health care providers. Race, ethnicity, socio-economic status, gender and sexual orientation can all impact care experiences.[89]

Stakeholders emphasized that patient comfort goes beyond physical needs and should also include how they are treated by their providers (cultural sensitivity, trauma responsiveness, etc.). Not all communities feel welcomed or safe in the health care system; cultivating trust and relationships with patients is critical. We also heard the need to make our care system easier to navigate for everyone, including ensuring language services and providing care coordination.

McLeod County community members echoed these themes and shared that navigating health care and insurance systems are hard, and work can be done to make access easier for all.

HealthPartners administers the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey from National Research Corporation (NRC) Health to patients who receive care at any of our hospitals. Patients are asked to rate the hospital during their stay on a scale from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible. NRC standard (known as “top box”) is to present the percent of patients who rated the hospital a 9 or 10.[90] Additionally, the survey

asks respondents if they would recommend the hospital to their friends and family. Here, we present the percent who said, “definitely yes.”

In 2024, 78% of Hutchinson Hospital patients rated the hospital a 9 or 10, an increase from 76% in 2023 and 75% in 2022. Sixty-five percent of patients said they would definitely recommend Hutchinson Hospital in 2024, a decline from 71% of patients in 2023 and 72% of patients in 2022.

Additional Factors: Access to Care

Throughout engagement, we heard the importance of **creating partnerships to improve access to care for our communities**. At a system level, HealthPartners is working to make care more convenient and accessible for patients in various ways, including increasing the number of same-day appointments, incorporating care navigators into certain departments, offering more online care options, and recruiting providers to work in rural areas.

In McLeod County, community members had a positive attitude about Hutchinson Health and their genuine desire to partner with others to meet their community's needs. They reported that McLeod County Public Health is good at coordinating referrals and provider relationships and named Hutchinson Health's Health Care Home program as an important asset for coordinating patient resources and services.

Evaluation

of 2022-2024 Community Health Implementation Plan

The Community Health Needs Assessment conducted in 2021 identified the following five priorities in our community:

- Mental health and well-being
- Access to health
- Access to care
- Nutrition and physical activity
- Substance use

Each hospital developed a Community Health Implementation Plan with specific objectives and activities to address these priority Needs Areas and to serve as the implementation roadmap for 2022, 2023 and 2024. We engaged and partnered with the community to address these needs, seen through the strategies and progress shown in the following pages.

Mental Health & Well-being

Goal: *Improve mental health and well-being.*

Strategies:

- Since 2022, the Make It OK campaign has engaged 1,113 people through virtual and in-person presentations and trained 542 Ambassadors through virtual and in-person sessions about reducing stigma of mental health and illnesses. The campaign also reached 15,000+ people through community events and 855 Ambassador subscribers through quarterly e-newsletters. In 2023, the Make It OK campaign celebrated a decade of progress with the release of the Make It OK 10-Year Report and an event attended by over 150 people. Make It OK launched a transformed website in 2024.
- Between 2022 and 2023, Little Moments Count welcomed 30 new partners and five new health care system partners to the collaborative early childhood brain development movement. Over 150,000 families were reached, more than 214,000 books were distributed and over 30,000 Think Small Parent Powered parent education text conversations occurred each year. More than 26 million media impressions occurred through Minnesota Public Radio, as well as 2.6 million digital impressions. Partnerships with cultural media outlets continued, reaching Latine, Hmong, Somali, African American and Indigenous communities. New resource pages in five languages were accessed from five countries and 24 states. A new NAZ Early Childhood & Family Toolkit, and a Successful Learner Toolkit project were launched. In 2022, the Little Moments Count Family Birth Center pilot launched, reaching over 5,000 families. In 2023, more than 7,000 families were reached during the second year of the Little Moments Count Birth Center pilot. In 2023, Little Moments Count hosted a successful hybrid 8th annual conference with more than 1,000 attendees. The fourth season of the Early Risers podcast launched in 2023.
- Behavioral Health Services completed the initial pilot of the Behavioral Health Consultant (BHC) model, continues to utilize rapid process improvement strategies and the model is scoped to all primary care regions. To-date, seven BHCs have been hired across HealthPartners, with the goal to hire at least one BHC for each region within the HealthPartners system. Results to-date indicate significantly increased numbers of patients receiving Behavioral Health Care with average access to Behavioral Health Care in fewer than five days, and very high patient satisfaction. There is also a new single scheduling phone number for outpatient behavioral health care services.
- Be Well employee well-being programs continued to offer mental health, well-being and resiliency programs and services. New additions to the Be Well offerings included 11 training series of a Mental Fitness and Psychological Safety workshop, a new Restore and Recharge program focusing on stress management and adaptability and expanded group coaching to allow for more coaching topics.
- The Children's Health Council (renamed from Children's Health Initiative) implemented an automatic referral to behavioral health when a postpartum depression screening is positive. This was implemented after observing a gap in support -- Behavioral Health leaders are also creating an organization-wide postpartum program to support new mothers and ensure they are followed up with in a timely manner following a positive postpartum depression screening. In addition, a Quality Academy focused on bridging the gap between behavioral health and pediatric care and is working on implementing suggestions that came from this assessment.
- Sponsored Mental Health First Aid (MHFA) at Hutchinson High School and provided information about coping skills for teens during Mental Health Month.

- Participated in Dassel-Cokato School District Career & Health Fair with information on affirmations and teen mental health.
- Participated in Ridgewater College Community Health Fair with information on mental health stigma.
- Participated in A to Z Mental Health Wellness fair with information on mental health stigma.
- Mental health and well-being community collaborations remain key to advancing community health.
- Collaborated with 2B CONTINUED, McLeod County Public Health and NAMI of McLeod County to provide Together for Mental Health, Hutchinson Mental Health Awareness Event and Go Green Day.

Access to Health

Goal: *Improve access to health*

Strategies:

- An Advisory Council for Social Drivers of Health screening and referral was convened within HealthPartners to make recommendations on an approach to screening and referral for the health care system. The Advisory Council adopted a framework for an approach and completed an inventory of Social Drivers of Health activities in care, coverage and the community.
- The SuperShelf partnerships continues to transform food shelves with appealing, healthy food throughout Minnesota. This increases food access for patients and members.
- Community partnerships and participation in community collaborations remain key to advancing community health.
- The Children's Health Council (renamed from Children's Health Initiative) added Social Drivers of Health questions to the questionnaire parents receive during the Healthy Beginnings program.
- Hutchinson Hospital continued its sustainability efforts, restarting the Green Team, purchasing a trash compactor and exploring composting of kitchen waste. In 2023, Hutchinson Hospital was awarded a Practice Greenhealth Partner for Change award.
- Promoted Fare for All, healthy and local foods at a discounted price.
- Partnered with local farmers market to help fund Power of Produce program for kids to receive a weekly token for free produce at the market. Power of Produce expanded to include seniors.
- Began the Veggie Rx program, providing a $5 voucher to patients for produce at the farmer's market. In 2024, vouchers were increased to two $5 vouchers.
- Funded freezers for local food shelf to broaden food options offered.

Access to Care

Goal: *Improve Access to Care*

Strategies:

- HealthPartners is committed to building an anti-racist culture. As part of this work and commitment, a clinician Unconscious Bias training was launched, and 30 facilitators have been trained to deliver the training. More than 130 Unconscious Bias training sessions have been facilitated and attended by HealthPartners colleagues, and the training has been transitioned to an eLearning platform. This training has a 98% completion rate. An Inclusive Leader Workshop was developed and launched, as well as a new Equity Framework that will guide our system's

work around diversity, equity, inclusion and belonging. Colleague Resource Groups continue to meet around shared identities and affirm diversity and inclusion throughout the organization.

- The Children's Health Council (renamed from Children's Health Initiative) created workgroups to address concerns about obstetric care brought up by Black patients. From these workgroups, Community Circles and Expecting Together were implemented. Community Circles are a support group for Black women at any point in their pregnancy or postpartum journey. Expecting Together, a monthly education series with Dr. Corinne Brown-Robinson, focuses on what Black mothers can expect during their pregnancy and the care they should receive.
- The Children's Health Council has also implemented a Black Perinatal Partner program, where two dedicated staff partner with U.S. born Black patients, families, care providers and clinic teams to help patients achieve optimal health goals by providing support, education and resources with cultural understanding in a compassionate, non-judgmental way. Patients have provided feedback on the Black Perinatal Partner program, and our system is now working to expand it and partner with local community health workers.
- The Children's Health Council hosted a refresh training for providers around changes made to the teen questionnaire used during well-child visits, including how to talk to teens about health topics.
- As part of the Community Senior Care program, in partnership with the patient's primary care provider and/or the hospital, clinicians see patients in their homes during transitional times. Providers can address social determinants of health as well as co-morbidities. The program ensures that patients have a hand-off from discharge to their location of choice based on the patient's needs and complexity of care. The program works very closely with the care coordination and social worker teams to give patients resources and instructions that will help them have a successful transition to one of the programs. Our Community Senior Care program is successfully delivering on health outcomes and safe transitions of care for our patients. We continue to build partnerships with our community partners to assure collaborative approach to care. The program continues to monitor measures of success including patient satisfaction scores, readmission rates and hospitalization rates.
- Telemedicine for psychiatry was increased.
- HealthPartners Cancer Center at Hutchinson Health increased access to oncology providers and the addition of a nurse practitioner.
- New partnership with TRIA to provide orthopedic care.
- Increased options for online scheduling and mobile check-in.
- Health education classes continue to be held, including topics such as pre-diabetes, childbirth, breastfeeding and advanced directives.

Nutrition & Physical Activity

Goal: *Improve nutrition and physical activity*

Strategies:

- PowerUp reached 40,000+ kids and families annually with the PowerUp Press Family Newsletter, distributed to families, schools and community. The initiative has also reached 12,600+ elementary students through the School Challenge program and has reached 45,568 kids and families at community events. In addition, new family resources have been developed including a family magazine and eight new video resources focused on eating better, moving more and

feeling good. PowerUp with Plants, a new web resource with plant-based protein information, was developed and engaged nearly 200 participants in pilot activities.

- Nutrition and physical activity community collaborations remain key to advancing community health.
- The HealthPartners Teen Leadership Council (TLC) impacted 84,969 people through volunteerism in the community. The teens on the council also offer consultations for community organizations, to lend youth voice to programs or projects in the community. The council has impacted 714,145 people through consultations for HealthPartners and community organizations such as the Minnesota Department of Health, BeReal, and Washington County Public Health & Environment. The Teen Leadership Council participates in Youth Day at the Capitol each year, an opportunity for teens to meet with representatives about issues important to them. More than 250 people attended the TLC's annual meeting the last few years to learn about the teens' work and impact.
- The Children's Health Council (renamed from Children's Health Initiative) created an internal centralized lactation page for staff, making it easier to find information about lactation education and community resources. Following this implementation, lactation consultants have been added to clinics where free lactation cafes are held weekly. Lactation cafes continue to reach 5-12 people each week, at each clinic. In 2024, a virtual lactation partner, Nest Collaborative, was added to lactation offerings for patients to help support an easier transition for parents once baby arrives. To date, Nest Collaborative sees 5-8 patients each month, with numbers continuing to increase.
- Partnered with Hutchinson Farm to School program to fund kitchen equipment for summer school.
- Partnered with the Hutchinson Farm to School staff to do fruit/veggie tasting for 9 kindergarten classes.
- Participated in Bike/Walk to School Day twice annually.
- Joined Hutchinson's Bike and Pedestrian committee to focus on accessibility and safety for bikers and walkers.
- Sponsored free family swim nights in summer, free community swim nights in winter and youth and family open gym nights.
- Funded St. Anastasia School's playground upgrade.

Substance Use

Goal: *Reduce Substance Use*

Strategies:

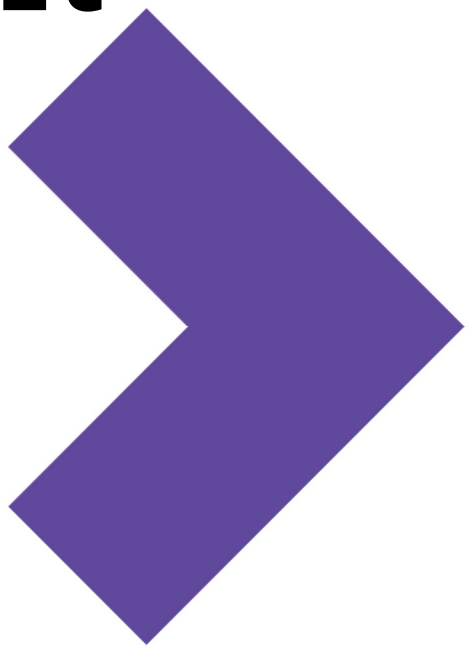
- Created a new Make It OK to Talk About Substance Use Disorder presentation, in partnership with the Programs for Change substance use recovery team. Since the presentation's launch, nine presentations have been offered to the public and 141 people have attended to learn more about substance use disorder.
- A system-wide Opioid Steering Committee meets quarterly to review prescribing patterns and trends. The committee reviewed ambulatory prescribing guidelines and identified care model gaps and opportunities with a defined work plan to support services in 2024.
- Opioid prescribing data for hospital and ambulatory services was reviewed and shared regularly throughout 2023. Data reviewed helped identify an opportunity to adjust the defaults in the prescription for Tramadol to reduce prescription MME and the number of

pills prescribed. Prescription data reviewed indicated stable numbers from 2022 of patients who received or were prescribed a new or chronic opioid.

- Partnered to promote and increase awareness of McLeod County Medication Safety Program and National Take Back Day for prescriptions.
- Hutchinson Health has representation on Methamphetamine Education, Alcohol and Drug Awareness (MEADA) of McLeod County.
- Hutchinson Health Chemical Dependency Counselors provide substance use disorder services for students attending Hutchinson High School.

What's Next

Throughout the 2024 Community Health Needs Assessment process, Hutchinson Health, in partnership with community and internal stakeholders, identified three priority community health needs for the community we serve: **Mental Health and Well-being, Social Drivers of Health**, and **Access to Care.** We know these needs look different within our community and across the HealthPartners service area and we will continue to seek partnerships to determine, implement, and measure strategies to address them.



Resources Available

HealthPartners has key resources available to help address the community needs identified through the CHNA process. Specifically, HealthPartners has a number of programs that work closely with the community on important issues (mental health, child development, and nutrition and physical activity, respectively) that align well with CHNA Needs Areas, including Make It OK, Little Moments Count, PowerUp, PowerUp with Plants and Faith Community Nursing. Similar initiatives such as the Teen Leadership Council, Social Drivers of Health Advisory Council, Children's Health Council and ChooseYourFish also focus on and provide resources surrounding CHNA Needs Areas. Internally, HealthPartners has an Equity, Inclusion and Anti-Racism Cabinet that provides leadership and direction to increase health equity and eliminate racism. Our comprehensive, award-winning sustainability program is taking action to reduce our impact and provide a healthier, cleaner, and more livable environment for patients, members, and the community.

As an integrated health system, HealthPartners also has close external partnerships to drive forward this important work. Additional partnership examples include SuperShelf, Reach Out and Read, Healthy Beginnings, which promotes drug, alcohol and tobacco free pregnancies, East-Metro Mental Health Roundtable, Mental Health Drug Assistance Program, food insecurity referral to Hunger Solutions, Minnesota Science Museum Sportsology exhibit and more. Finally, HealthPartners has long-standing relationships with community organizations and members of the community. Some of these include Hmong Community Stroke Education and Awareness Initiative, Minnesota Department of Health Healthy Minnesota Partnership, Early Brain Development Leadership Council, SuperShelf Leadership Team, and Center for Community Health (CCH). For a comprehensive list of partnerships, see Appendix.

CHNA Strengths, Limitations and Opportunities

The CHNA process brought together many existing data sources to identify and confirm the needs of our community. Using publicly available data is beneficial because it is efficient, drawing from validated sources that can be compared to other communities. However, where there were gaps in the data, HealthPartners' own data complemented these public datasets. Not surprisingly, many of these unique data sources are aligned with areas already established as organizational priorities, due to the existing community need. These data, along with robust community engagement facilitated during the prioritization process and the community health needs assessment process, determined and described the complexity of these community health needs.

Opportunities to further understand the specific needs of our community where gaps in existing data – whether quantitative or qualitative – remain. This can be especially true for our communities that proportionally contribute a smaller amount to the whole and may not be reliably included in many publicly available data sources. There are always additional perspectives to consider and Community Conversations to be held. As we move forward through implementation, we continue to solicit and welcome these important voices to the conversation. Throughout this CHNA process, our stakeholders emphasized the importance of building long-term, sustainable partnerships to make the biggest impact in a community. We look forward to this continued work.

Dissemination

This report has been posted on the Hutchinson Health website: https://www.healthpartners.com/care/hospitals/hutchinson/about/community-health-need

Additionally, details from the report have been and will be presented to hospital leaders, decision-makers, and the community in various presentations throughout the year.

Next Steps

What we present here is a single point in time snapshot of the needs of the community that Hutchinson Health serves. This interrelated framework will be used by Hutchinson Health and HealthPartners to continue to work collaboratively with the community to address the needs identified in the CHNA, which will be presented in our implementation strategy.

While Hutchinson Health and other HealthPartners hospitals worked together to prioritize system needs, data and inputs were tailored to the individual hospital as required by IRS guidelines. Moreover, the CHNA and the implementation strategy that follows will be presented for approval to each hospital board.

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Appendix

Table 1. Data sources used in 2024 CHNA

Data source name	Year(s)	Availability
Agency for Healthcare Research and Quality – Social Determinants of Health Database	Through 2022	Public
American Community Survey (ACS)	2022	Public
Behavioral Risk Factor Surveillance Survey (BRFSS)	Through 2022	Public
CDC WONDER	Varies	Public
Commonwealth Fund – State Health Data Center	Through 2023	Public
County Health Rankings	Through 2024	Public
HealthPartners electronic medical records	2020, 2023	Internal data only
IMPACT survey	2019, 2021	Internal data, public summary
KFF	2022	Public
Metro SHAPE	2018	Public
Minnesota Compass	Varies	Public
MN Community Measurement	Through 2023	Public
Minnesota Department of Employment and Economic Development – Occupations in Demand	Ongoing	Public
Minnesota Department of Health – Cardiovascular Health and Diabetes Prevalence	2021	Public
Minnesota Department of Health – 2020 County Health Tables	2020	Public
Minnesota Department of Health - Data Access Portal	Varies	Public
Minnesota Department of Health – Drug Overdose Dashboard	Through 2022	Public
Minnesota EHR Consortium – Health Trends Across Communities	Through 2023	Public
Minnesota Homeless Study – Wilder Research	2023	Public
Minnesota Student Survey	2019, 2022	Public
National Center for Health Statistics	Varies	Public
National Alliance to End Homelessness	2023-2024	Public
National Vital Statistics System	Varies	Public
SHAPE survey	2022	Public
Supershelf	2019	Public
Twin Cities Rental Revue – HousingLink	Through 2024	Public
United for ALICE – Wisconsin County Reports	2022	Public
US Census Bureau - Profiles	2020 - 2022	Public
Wisconsin Department of Health Services	Varies	Public
Wisconsin Department of Health Services – Chronic Disease Prevention Program	2018	Public
Wisconsin Department of Health Services – Leading Causes of Death Dashboard	2022	Public
Wisconsin Department of Health Services – Opioids Data	Through 2023	Public
Wisconsin Department of Health Services – WISH Query: Behavioral Risk Factor Survey Trend Data	Through 2024	Public
Wisconsin Department of Workforce Development	2023	Public
Wisconsin Youth Risk Behavior Survey (YRBS)	2019, 2021	Public

Table 2. 2024 Hutchinson Community Engagement

Hutchinson Hospital
Community Conversation
McLeod County Stakeholder Meeting
Hutchinson Farmer's Market
Community Needs Assessment Meeting

Table 3. 2024 Stakeholder Conversations

HealthPartners System Internal Stakeholder Conversations
Community Advisory Council
Advisory Council on Social Drivers of health
Community and Advocacy Cornerstone
Social Drivers of Health Internal Stakeholders
HealthPartners Disability Colleague Resource Group
Make It OK Steering Committee
Mental Health & Well-being Internal Stakeholders
Access to Care Internal Stakeholders
Black and African American Colleague Resource Group
HealthPartners Teen Leadership Council
HealthPartners Leaders of Color Colleague Resource Group

HealthPartners System Other Stakeholder Conversations
MN Youth Council CHNA Committee

References

1. U.S. Census Bureau. Explore Census Data. Accessed Sep 10, 2024. https://data.census.gov/
2. HealthPartners Electronic Health Records (EHR) provided by Health Informatics.
3. Minnesota Department of Health (MDH), Minnesota Center for Health Statistics (MCHS). *2020 Minnesota County Health Tables: 2020 Data by State, County, and Community Health Board*. 2023. https://www.health.state.mn.us/data/mchs/genstats/countytables/index.html
4. Minnesota Department of Health (MDH). Cardiovascular Health and Diabetes Prevalence in Minnesota. Updated July 22, 2024. Accessed Sep 4, 2024. https://www.health.state.mn.us/diseases/chronic/cdprevdata.html
5. Minnesota EHR Consortium. Health Trends Across Communities in Minnesota Dashboard. Updated Aug 8, 2024. Accessed Sep 4, 2024. https://mnehrconsortium.org/health-trends-across-communities-minnesota-dashboard
6. McGovern L. The Relative Contribution of Multiple Determinants to Health. *Health Affairs Health Policy Brief*. 2014;doi:10.1377/hpb20140821.404487
7. Centers for Disease Control and Prevention (CDC), Minority Health. Racism and Health. Accessed Sep 11, 2024. https://www.cdc.gov/minority-health/racism-health/index.html
8. Haslanger S. Systemic and structural injustice: is there a difference? *Philosophy*. 2023;98(1):1-27. doi:10.1017/S0031819122000353
9. Radley DC, Shah A, Collins SR, Powe NR, Zephyrin LC. Advancing Racial Equity in U.S. Health Care: The Commonwealth Fund 2024 State Health Disparities Report. The Commonwealth Fund. Accessed Sep 12, 2024. https://www.commonwealthfund.org/publications/fund-reports/2024/apr/advancing-racial-equity-us-health-care
10. Mahajan S, Caraballo C, Lu Y, et al. Trends in differences in health status and health care access and affordability by race and ethnicity in the United States, 1999-2018. *JAMA*. Aug 17 2021;326(7):637-648. doi:10.1001/jama.2021.9907
11. African American Leadership Forum. Annual Report 2021. Accessed Sep 12, 2024. https://aalftc.org/wp-content/uploads/2022/04/AALF-2021-Annual-Report-new.pdf
12. U.S. Climate Resilience Toolkit. Climate Mapping For Resilience and Adaptation (CMRA). Accessed Aug 30, 2024. https://livingatlas.arcgis.com/assessment-tool/search
13. American Psychiatric Association. Extreme Heat Can Take a Toll on Mental Health. Accessed Sep 10, 2024. https://www.psychiatry.org/news-room/apa-blogs/extreme-heat-can-take-a-toll-on-mental-health
14. Environmental Protection Agency. Climate Change and Social Vulnerability in the United States: A Focus on Six Impacts. Accessed Sep 10, 2024. https://www.epa.gov/system/files/documents/2021-09/climate-vulnerability_september-2021_508.pdf
15. U.S. Department of the Treasury. The Impact of Climate Change on American Household Finances. Accessed Sep 10, 2024. https://home.treasury.gov/system/files/136/Climate_Change_Household_Finances.pdf
16. Stanke C, Murray V, Amlot R, Nurse J, Williams R. The effects of flooding on mental health: Outcomes and recommendations from a review of the literature. *PLoS Curr*. May 30 2012;4:e4f9f1fa9c3cae. doi:10.1371/4f9f1fa9c3cae
17. Vins H, Bell J, Saha S, Hess JJ. The mental health outcomes of drought: a systematic review and causal process diagram. *Int J Environ Res Public Health*. Oct 22 2015;12(10):13251-75. doi:10.3390/ijerph121013251
18. HealthPartners. Climate resilience plan. Updated 2023. Accessed Sep 10, 2024. https://www.healthpartners.com/content/dam/corporate/sustainability/healthpartners-sustainability-climate-plan-report.pdf

19. James D, Warren-Forward H. Research methods for formal consensus development. *Nurse Res*. Jan 2015;22(3):35-40. doi:10.7748/nr.22.3.35.e1297
20. University of Wisconsin, Population Health Institute, School of Medicine and Public Health. County Health Rankings: Data and Documentation. Accessed Aug 27, 2024. https://www.countyhealthrankings.org/health-data/methodology-and-sources/data-documentation
21. Minnesota Student Survey (MSS) Interagency Team, Minnesota Department of Health (MDH). 2022 Minnesota Student Survey Statewide Tables. Accessed Aug 27, 2024. https://www.health.state.mn.us/data/mchs/surveys/mss/docs/statewidetables/Heterosexual22.pdf
22. Wisconsin Department of Public Instruction. Wisconsin Youth Risk Behavior Survey [YRBS 2021]. Accessed Aug 27, 2024. https://dpi.wi.gov/sspw/yrbs
23. KFF. Health State Facts. Accessed Aug 27, 2024. https://www.kff.org/statedata/
24. The Commonwealth Fund. State Health Data Center. Accessed Aug 27, 2024. https://www.commonwealthfund.org/datacenter
25. MN Community Measurement. Reports. Accessed Aug 27, 2024. https://mncm.org/reports/
26. Fowler FJ, Jr. *Survey Research Methods*. SAGE Publications; 2013.
27. Internal Revenue Services (IRS). Community health needs assessment for charitable hospital organizations - Section 501(r)(3). Updated Aug 20, 2024. Accessed Aug 27, 2024. https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3
28. Minnesota Department of Health (MDH). Mental Health Promotion: Mental Health and Well-Being Narrative. Updated Mar 22, 2023. Accessed Aug 26, 2024. https://www.health.state.mn.us/communities/mentalhealth
29. Ka'apu K, Burnette CE. A culturally informed systematic review of mental health disparities among adult Indigenous men and women of the USA: what is known? *Br J Soc Work*. Jun 2019;49(4):880-898. doi:10.1093/bjsw/bcz009
30. Reiss F. Socioeconomic inequalities and mental health problems in children and adolescents: a systematic review. *Soc Sci Med*. Aug 2013;90:24-31. doi:10.1016/j.socscimed.2013.04.026
31. Valentine SE, Shipherd JC. A systematic review of social stress and mental health among transgender and gender non-conforming people in the United States. *Clin Psychol Rev*. Dec 2018;66:24-38. doi:10.1016/j.cpr.2018.03.003
32. Kalin NH. Impacts of structural racism, socioeconomic deprivation, and stigmatization on mental health. *Am J Psychiatry*. Jul 2021;178(7):575-578. doi:10.1176/appi.ajp.2021.21050524
33. Schwartz SEO, Benoit L, Clayton S, Parnes MF, Swenson L, Lowe SR. Climate change anxiety and mental health: environmental activism as buffer. *Curr Psychol*. Feb 28 2022:1-14. doi:10.1007/s12144-022-02735-6
34. Centers for Disease Control and Prevention (CDC). Social Connection: Health Effects of Social Isolation and Loneliness. Accessed Aug 28, 2024. https://www.cdc.gov/social-connectedness/risk-factors/index.html
35. University of Wisconsin, Population Health Institute, School of Medicine and Public Health. County Health Rankings: Health Data. Accessed Aug 26, 2024. https://www.countyhealthrankings.org/health-data
36. Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. Accessed Sep 10, 2024. https://www.cdc.gov/brfss/brfssprevalence/
37. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med*. Sep 2001;16(9):606-13. doi:10.1046/j.1525-1497.2001.016009606.x

38. Minnesota Student Survey (MSS) Interagency Team, Minnesota Department of Health (MDH). 2019 Minnesota Student Survey Statewide Tables. Accessed Sep 11, 2024. https://public.education.mn.gov/MDEAnalytics/DataTopic.jsp?TOPICID=11
39. Wisconsin Department of Public Instruction. 2019 Youth Risk Behavior Survey Results. Accessed Sep 11, 2024. https://dpi.wi.gov/sites/default/files/imce/sspw/pdf/2019WIH_Summary_Tables.pdf
40. American Psychiatric Association. How Extreme Weather Events Affect Mental Health. Accessed Sep 11, 2024. https://www.psychiatry.org/patients-families/climate-change-and-mental-health-connections/affects-on-mental-health
41. Hickman C, Marks E, Pihkala P, et al. Climate anxiety in children and young people and their beliefs about government responses to climate change: a global survey. *Lancet Planet Health*. 2021;5(12):e863-e873. doi:10.1016/S2542-5196(21)00278-3
42. Centers for Disease Control and Prevention (CDC). Facts About Suicide. Accessed Sep 11, 2024. https://www.cdc.gov/suicide/facts/index.html
43. Boden JM, Fergusson DM. Alcohol and depression. *Addiction*. May 2011;106(5):906-14. doi:10.1111/j.1360-0443.2010.03351.x
44. Grant VV, Stewart SH, Mohr CD. Coping-anxiety and coping-depression motives predict different daily mood-drinking relationships. *Psychol Addict Behav*. Jun 2009;23(2):226-37. doi:10.1037/a0015006
45. Delker E, Brown Q, Hasin DS. Alcohol Consumption in Demographic Subpopulations: An Epidemiologic Overview. *Alcohol Res*. 2016;38(1):7-15.
46. Rural Health Information Hub. Substance Use and Misuse in Rural Areas. Updated Aug 2, 2024. Accessed Aug 27, 2024. https://www.ruralhealthinfo.org/topics/substance-use
47. Lee CS, O'Connor BM, Todorova I, Nicholls ME, Colby SM. Structural racism and reflections from Latinx heavy drinkers: Impact on mental health and alcohol use. *J Subst Abuse Treat*. Aug 2021;127:108352. doi:10.1016/j.jsat.2021.108352
48. Skewes MC, Blume AW. Understanding the link between racial trauma and substance use among American Indians. *Am Psychol*. Jan 2019;74(1):88-100. doi:10.1037/amp0000331
49. Minnesota Department of Health (MDH). Minnesota Student Survey Reports 2013-2022. Accessed Aug 26, 2024. https://public.education.mn.gov/MDEAnalytics/DataTopic.jsp?TOPICID=242
50. Minnesota Department of Health (MDH). Drug Overdose Dashboard. Updated May 14, 2024. Accessed Aug 27, 2024. https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html
51. HealthPartners. Make it OK: stop mental illness stigma. Accessed Nov 13, 2022. https://makeitok.org/
52. Center for Evaluation and Survey Research, Ziegenfuss JY, JaKa MM, Dinh JM, Andersen JA, Rivard RL. Make It OK Evaluation: IMPACT Survey Results. Bloomington, MN: HealthPartners Institute; 2022 May.
53. Blankenship KM, Rosenberg A, Schlesinger P, Groves AK, Keene DE. Structural racism, the social determination of health, and health inequities: the intersecting impacts of housing and mass incarceration. *Am J Public Health*. Jan 2023;113(S1):S58-S64. doi:10.2105/AJPH.2022.307116
54. Harris JK, Beatty K, Leider JP, Knudson A, Anderson BL, Meit M. The double disparity facing rural local health departments. *Annu Rev Public Health*. 2016;37:167-84. doi:10.1146/annurev-publhealth-031914-122755
55. Marmot M, Bell R. Fair society, healthy lives. *Public Health*. Sep 2012;126 Suppl 1:S4-S10. doi:10.1016/j.puhe.2012.05.014
56. Minnesota Department of Health (MDH). *Minnesota Statewide Health Assessment*. 2024. https://www.health.state.mn.us/communities/practice/healthymnpartnership/sha.pdf

57. International Labour Organization (ILO). Definitions: What we mean when we say “economic security”. Accessed Aug 26, 2024. https://webapps.ilo.org/public/english/protection/ses/download/docs/definition.pdf
58. U.S. Census Bureau. Profile: United States. Accessed Aug 26, 2024. https://data.census.gov/profile
59. U.S. Census Bureau. How the Census Bureau Measures Poverty. Updated June 15, 2023. Accessed Sep 24, 2024. https://www.census.gov/topics/income-poverty/poverty/guidance/poverty-measures.html
60. United States Environmental Protection Agency (EPA). Particulate Matter (PM) Basics. Updated June 20, 2024. Accessed Nov 1, 2024. https://www.epa.gov/pm-pollution/particulate-matter-pm-basics
61. Our Minnesota Climate. Farmers face new challenges for crops, livestock. Accessed Sep 24, 2024. https://climate.state.mn.us/farmers-face-new-challenges-crops-livestock
62. Dasgupta S. Employment Security: Conceptual and Statistical Issues. International Labour Office. Accessed Aug 28, 2024. http://oit.org/public/english/protection/ses/download/docs/employ.pdf
63. Tigchelaar M, Battisti DS, Spector JT. Work adaptations insufficient to address growing heat risk for U.S. agricultural workers. *Environ Res Lett*. Sep 2020;15(9)doi:10.1088/1748-9326/ab86f4
64. Riva A, Rebecchi A, Capolongo S, Gola M. Can homes affect well-being? A scoping review among housing conditions, indoor environmental quality, and mental health outcomes. *Int J Environ Res Public Health*. Nov 30 2022;19(23)doi:10.3390/ijerph192315975
65. Rohe WM, Han HS. Housing and health: time for renewed collaboration. *N C Med J*. Sep-Oct 2012;73(5):374-80.
66. Minnesota Compass. Quality of Life: Housing. Accessed Aug 28, 2024. https://www.mncompass.org/topics/quality-of-life/housing
67. Agency for Healthcare Research and Quality (AHRQ). Social Determinants of Health Database. Updated June 2023. Accessed Sep 6, 2024. https://www.ahrq.gov/sdoh/data-analytics/sdoh-data.html
68. HousingLink. Twin Cities Rental Revue - Shadow & Apartment Market Data. Accessed Aug 28, 2024. https://www.housinglink.org/Research/TCRentalRevue
69. U.S. Census Bureau. Hennepin County, MN. https://data.census.gov/profile/Hennepin_County,_Minnesota?g=050XX00US27053
70. United States Interagency Council on Homelessness. Data & Trends. Accessed Sep 23, 2024. https://www.usich.gov/guidance-reports-data/data-trends
71. Soucy D, Janes M, Hall A, National Alliance to End Homelessness. State of Homelessness: 2024 Edition. Accessed Sep 11, 2024. https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness/
72. Wilder Research. Minnesota Homeless Study: 2023 Study Results. Accessed Aug 26, 2024. https://www.wilder.org/mnhomeless/results
73. Gundersen C, Ziliak JP. Food insecurity research in the United States: where we have been and where we need to go. *Appl Econ Perspect Policy*. 2018;40(1):119-135. doi:https://doi.org/10.1093/aepp/ppx058
74. Hunger Solutions Minnesota. Hunger Data. Accessed Aug 26, 2024. https://www.hungersolutions.org/hunger-data/
75. Minnesota Employment and Economic Development. Reports and Resources: Child Care Access. Accessed Sep 11, 2024. https://mn.gov/deed/programs-services/child-care/reports/
76. Job Center of Wisconsin, State of Wisconsin Department of Workforce Development (DWD). Wisconomy: Wisconsin Country Profiles. Accessed Sep 10, 2024. https://jobcenterofwisconsin.com/wisconomy/pub/profiles
77. Child Care Accesss. Mapping Access to Child Care for Minnesota Families. Accessed Sep 11, 2024. https://childcareaccess.org/

78. American Hospital Association. Social Determinants of Health Series: Transportation and the Role of Hospitals. Accessed Sep 11, 2024. https://www.aha.org/ahahret-guides/2017-11-15-social-determinants-health-series-transportation-and-role-hospitals
79. Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. PLACES: Local Data for Better Health [online]. Accessed Sep 11, 2024. https://www.cdc.gov/PLACES
80. Elster A, Jarosik J, VanGeest J, Fleming M. Racial and ethnic disparities in health care for adolescents: a systematic review of the literature. *Arch Pediatr Adolesc Med*. Sep 2003;157(9):867-74. doi:10.1001/archpedi.157.9.867
81. Hsieh N, Ruther M. Despite increased insurance coverage, nonwhite sexual minorities still experience disparities in access to care. *Health Aff (Millwood)*. Oct 1 2017;36(10):1786-1794. doi:10.1377/hlthaff.2017.0455
82. Silberholz EA, Brodie N, Spector ND, Pattishall AE. Disparities in access to care in marginalized populations. *Curr Opin Pediatr*. Dec 2017;29(6):718-727. doi:10.1097/MOP.0000000000000549
83. Hadley J. Sicker and poorer--the consequences of being uninsured: a review of the research on the relationship between health insurance, medical care use, health, work, and income. *Med Care Res Rev*. Jun 2003;60(2 Suppl):3S-75S; discussion 76S-112S. doi:10.1177/1077558703254101
84. KFF. The independent source for health policy research, polling, and news. Accessed Aug 28, 2024. https://www.kff.org/
85. Minnesota Employment and Economic Development. Occupations in Demand. Accessed Sep 6, 2024. https://mn.gov/deed/data/data-tools/oid/
86. KFF. State Health Facts: Adults Who Report Not Having a Personal Doctor/Health Care Provider by Race/Ethnicity. Accessed Sep 6, 2024. https://www.kff.org/statedata/
87. Jerjes W, Harding D. Telemedicine in the post-COVID era: balancing accessibility, equity, and sustainability in primary healthcare. *Front Digit Health*. 2024;6:1432871. doi:10.3389/fdgth.2024.1432871
88. Health Care Without Harm. Safe haven in the storm: Protecting lives and margins with climate-smart health care. Accessed Aug 30, 2024. https://us.noharm.org/media/4297/download?inline=1
89. Batbaatar E, Dorjdagva J, Luvsannyam A, Savino MM, Amenta P. Determinants of patient satisfaction: a systematic review. *Perspect Public Health*. Mar 2017;137(2):89-101. doi:10.1177/1757913916634136
90. National Research Association (NRC). Making the most of CAHPS for effective compliance. Accessed Sep 23, 2024. https://nrchealth.com/solutions/cahps/

Table 4. Committee Participation

Committee or Community Meeting Name	Purpose	Frequency
African American Breast Cancer Alliance	AABC strategy, education and discussion sessions to create collective action on BIPOC maternal and child health equity topics.	Bi-annually
AHIP Health Equity Leadership Committee	A committee of AHIP, a national trade association for health plans, of which HealthPartners is a member and Andrea Walsh, HealthPartners' President & CEO, is on the board.	
ARCH	Discuss quality metrics and how we can improve on them. For example: getting patients in for their mammogram, diabetic labs etc.	
Belonging/Welcome Week - Hutchinson Community	Planning welcome week event that focuses on welcoming and including others.	Monthly
Better Together Hennepin - Community Advisory group	Better Together Hennepin - Community Advisory Group.	Quarterly
Birth Justice Collaborative	A Hennepin County-led initiative to engage communities to co-design strategies to improve birth outcomes for the Black and American Indian communities.	
BLHS Community Education Board	Planning and facilitation and organization of community education opportunities for all age groups.	Quarterly
BOLD Community Education Board	Planning and facilitation and organization of community education opportunities for all age groups.	Quarterly
Brooklyn Center Health Resource Center Advisory Committee	Guide/advise operations and partner services for BCCS Health Resource Center.	Monthly
Brooklyn Center Health Resource Center Advisory Council	Brooklyn Center Health Resource Center Advisory Group.	Monthly
Building Bridges for Breastfeeding	Meeting with WIC, MDH and care systems and clinicians working in breastfeeding across MN.	1x/year
Burnsville Diamondhead Clinic Advisory Board	Guide/advise operations and partner services for Diamondhead Community Clinic.	Quarterly
C&TC Metro Action Group	Metro area C&TC	Quarterly
CAD Minnesota	Coalition of critical access dental providers working to advance policies that help expand access to dental care for Minnesotans served by public programs.	Bi-monthly
CDC National Hypertension Control Roundtable	Multisector action coalition to improve hypertension control nationally.	Quarterly
Center for Community Health (CCH)	A collaborative between public health agencies, non-profit health plans, and not-for-profit hospital/health systems in the seven-county metropolitan area in Minnesota. The mission is to	3x/year

	advance community health, well-being, and equity through collective understanding of needs and innovative approaches to foster community strengths.	
Center for Community Health (CCH) Assessment and Alignment Workgroup	This subgroup of CCH services as a catalyst to align the community health assessment process.	Monthly
Central C&TC	Central area C&TC	Quarterly
Central Clinic Advisory Council - SLP	Guidance and input for operations of Central Clinic – St. Louis Park Public Schools	Monthly
Child Passenger Safety Liaison, State Meeting	As a recipient of the Child Passenger Safety Hospital Liaison grant, this group has a higher level of statewide leadership responsibilities supporting child passenger safety initiatives - supporting all trained technicians and instructors within the state.	
Child Passenger Safety State Task Force	State approved individuals to serve on a child passenger safety task force to support the state occupant protection coordinator/child passenger safety initiatives and serve as a panel of experts. This task force will also oversee initiatives as well as the statewide CPS educational track at the MN TZD Annual Meeting.	
Children First Saint Louis Park Mental Wellness Committee	Convening of community leaders and Children First for directional guidance for their Youth for Change Coalition (Y4CC)	10x/year
City of Bloomington 5-year Economic Development Plan Steering Committee	HealthPartners' Vice President of Government and Community Relations was invited to participate given 8170 HP headquarters location.	
City of Hutchinson Bike & Pedestrian Committee	Collaboration to support bike and pedestrian safety.	Quarterly
Community Health Action Team (CHAT), New Richmond	CHAT meets monthly to discuss and address unmet community health needs in the area through action, networking and educational opportunities. CHAT members represent health care, human and social services, education, nonprofits, and faith communities.	Monthly
Community Health Action Team (CHAT), Stillwater	CHAT meets monthly to discuss and address unmet community health needs in the area through action, networking and educational opportunities. CHAT members represent health care, human and social services, education, nonprofits, and faith communities. CHAT's service area is Stillwater Area School District, and also extends into other areas within Washington County.	Monthly
Crow River Area Breastfeeding Coalition	Collaboration with local health departments, WIC, healthcare, business, and community members to protect, support and promote breastfeeding.	Quarterly
CONNECT-Leadership Team	Washington County Collaboration around Chemical and Mental Health.	Monthly
Dakota County Healthy Communities Collaborative	The Dakota County Healthy Communities Collaborative (DCHCC) is a resource sharing and networking collaborative. It brings together health care providers, county staff, school representatives, faith communities, law enforcement, nonprofits and other organizations to support health and well-being of Dakota County residents. Members plan the annual South of the River Mental Health Summit and other educational events across the county.	Quarterly

Dakota County Oral Task Force	Focuses on improving dental access and dental programs/services within Dakota County.	Quarterly
DHS Behavioral Health Division & MCO Monthly Meeting	For DHS to share updates on behavioral health services with MCOs.	
DHS Dental Services Advisory Committee	A subcommittee of the HSAC provides clinical guidance on the dental care benefits and coverage policies for MN Health Care Programs. Uses evidence-based research to inform recommendations used to advise the Minnesota Department of Human Services commissioner on pertinent dental policy topics.	Monthly
DHS Health Services Advisory Committee (HSAC)	Provide leadership in designing health care benefit and coverage policies for MN public health care programs. A particular focus of HSAC is evidence-based coverage policy, in which decisions regarding health care services paid for by public programs are made using the best available research on their effectiveness.	Monthly
DHS MN Medicaid 2024 Equity Partnership	Discusses DHS plans to improve health equity and how organizations can support.	Monthly
Diamondhead Clinic Advisory Board	Diamondhead Clinic Advisory Board – Burnsville	Monthly
Early Brain Development Cultural Consultant Team	A subset of the Early Brain Development Leadership Council representing leaders from key cultural communities including African American, Somali, Hmong and Latin American.	3x/year
Early Brain Development Leadership Council	Regular meetings with leaders from key community, public health and private organizations to discuss collective action on the topic of early brain development.	6x/year
East Metro Mental Health Roundtable	Accelerate improvements in the Twin Cities east metro mental health system through partnerships that deliver high quality mental health services.	
Feeding Renville County	Working alongside SHIP to meet with a variety of individuals that help feed Renville County. Looking for ways to educate our community and work better together helping our communities.	Quarterly
Governor's Workforce Development Board	The GWDB's mission is to analyze and recommend workforce development policies to the governor and legislature toward talent development, resource alignment and system effectiveness to ensure a globally competitive workforce for MN.	
Greater MSP Board	Serves as a key resource for businesses and individuals looking to relocate, invest, partner and grow in the greater Minneapolis-St. Paul region. The partnership helps by coordinating community connections and share relevant information. The partnership brings together individuals and organizations to strengthen our region's competitiveness and inclusive economic growth.	Quarterly
Growing Through Grief Advisory Board	Guidance and input into the Growing Through Grief school-based grief counseling program for K-12 students in 16 districts. Park Nicollet Foundation/Park Nicollet Hospice	Quarterly
Health and Wellbeing Advisory Committee	Advisory committee for Lakeview/Valley Health and Wellbeing with representation from multiple sectors.	

Health Care Climate Council	A leadership body of U.S.-based health systems committed to protecting their patients and employees from the health impacts of climate change and becoming anchors for resilient communities. As a group of diverse health systems from across the country committed to addressing climate change, the Climate Council uses its unified voice to set and track climate goals, share best practices with one another and the broader sector, and collectively advocate for policies that accelerate progress toward achieving climate-smart health care.	Monthly
Health Care Home MN Cares Study	Care Coordination participating with the MN Department of Health. We would be sharing information to judge the effectiveness of Care Coordination/Health Care Home for our patients.	
Health Services Advisory Committee for CAPRW HeadStart	This committee reviews initiatives to support and improve the health, well-being and safety of the Ramsey and Washington County HeadStart children and their families. This advisory committee provides expertise and resources to CAPRW (Community Action Partnership of Ramsey and Washington Counties).	
Health Trends Across Communities (HTAC) project	HTAC uses electronic health record (EHR) data to track health conditions and disparities and enhance the information available to improve community health in Minnesota.	
Healthcare Environmental Awareness and Resource Reduction Team (HEARRT Midwest)	Networking with other Minnesota based health care sustainability leaders on best practices and challenges.	Quarterly
Healthier Together Leadership team + workgroups	County-wide collaboration with representation from public health, health systems and multiple sectors in St. Croix and Pierce Counties, WI.	Monthly
Healthy Beverages Statewide Convenings	Organized and convened by Healthy Beverages Steering Group - healthy beverage advocates are convened to discuss the topic, policy options, and collective action.	3x/year
Healthy Beverages Statewide Sugary Beverage Action Steering Group	Steering group representing leaders from public health, health plans and care systems, interested in reducing consumption and health impacts of sugary drinks. Group also provided technical assistance and support of an MDH policy modeling grant related to sugary drinks and Safe Routes to School.	Monthly
Healthy Polk County	Advisory council for Polk County with representation from multiple communities.	
Hennepin Community Mental Wellbeing Action Team	Workgroup focused on physical, social, cultural, and mental wellbeing in Hennepin County.	Monthly
Hennepin County Health Improvement Program (CHIP) Community Mental Well-being Action Subgroup	Collection action subgroup working together on Hennepin County projects related to housing access, affordability and support.	6x/year
Hennepin County Health Improvement Program (CHIP) Housing Action Subgroup	Collection action subgroup working together on Hennepin County projects related to community mental well-being and trauma-informed organizations and practices.	6x/year
Hennepin County Child and Family Health Connection	Regular meetings with director of the Children and Family Health at Hennepin County to discuss topics related to children's health.	3-4x/year
Highrise Health Alliance	Highrise Health Alliance, Minneapolis Public Housing Authority (MPHA) and the Minneapolis Health Department (MHD) launched the Highrise Health Alliance (HHA) in June 2020 to build	Quarterly

	community-clinic linkages that better serve high-rise residents. The HHA is focusing on 1) access to primary care; 2) medication management and 3) mental health access as priorities.	
Hutchinson Bicycle & Pedestrian Advisory Committee	Provides advice on issues related to bicycling and pedestrian needs in Hutchinson, advocates for pedestrian and bicycling infrastructure improvements, and promotes recreational walking and bicycling in Hutchinson.	Monthly
Hutchinson Connect	Connect individuals in the Hutchinson community.	
Hutchinson Health Foundation	Facilitates community and financial support to improve the health and well-being of patients, families and community.	6x/year
ICSI Expert Panel on Social Determinants of Health	Focus on shared strategies to address social determinants of health through the care system.	TBD (on hold due to COVID 19)
Jeremiah Conference	Convening with presentations on 2nd generation learning concept and discussion on how we translate this work in the community.	1x/year
Lakeview Foundation Health & Wellbeing Advisory Committee (HWA)	Serves as the eyes and ears for Lakeview Health and provide resources and services to meet the health and wellbeing needs of the community. Members include representatives from the Community Health Action Team (CHAT), Washington County Public Health, St. Croix County Public Health, Lakeview Health, Lakeview Foundation Board and HealthPartners.	Quarterly
Little Moments County Steering Committee	In partnership with other health care systems and community organizations, build awareness and change behavior around early brain development in the first 1,000 days of life.	
Make It OK Steering Committee	Advisory committee for Make It Ok with representation from multiple communities.	
MCHP-Health Equity Committee	Newly formed group with focus on health plans, health equity.	TBD
McLeod Alliance for Victims of Domestic Violence	Support for victims of domestic violence in McLeod County.	Monthly
McLeod County Mental Health Local Advisory Council	A place for people to share their first-hand experiences with mental health challenges with county and state policymakers for the purpose of improving mental health care in their communities.	Monthly
McLeod County NAMI	Raise mental health awareness through education, support and advocacy.	Varies
MDH Equitable Health Care Task Force	The task force's charge is to examine inequities in how people experience health care based on race, religion, culture, sexual orientation, gender identity, age and disability. It will identify strategies for ensuring that all Minnesotans can receive care and coverage that is respectful and ensures optimal health outcomes.	Quarterly
MDH Health Care Homes Advisory Committee	Health Care Homes Advisory Committee to advise Commissioners on the ongoing statewide implementation of the Health Care Homes (HCH) program.	Quarterly
MDH Health Care Workforce & Education Committee	The committee was established in 1993 by the Minnesota Legislature to examine the financing of medical education and research in Minnesota's changing health care market.	Quarterly

MDH Healthy Brain Initiative – Data Action Workgroup Together	Define needs and identify solutions for the collection and dissemination of ADRD data for the next five years. Inform the dementia dashboard.	Monthly
MDH Healthy Minnesota Partnership	The Healthy Minnesota Partnership brings community partners and the Minnesota Department of Health together to improve the health and quality of life for individuals, families, and communities in Minnesota. The Partnership has been charged with developing a statewide health improvement plan around strategic initiatives that ensure the opportunity for healthy living for all Minnesotans, and that engages multiple sectors and communities across the state to implement the plan.	5x/year
MDH Maternal Mortality Review Committee	Review pregnancy associated deaths. Make recommendation for improvement for care.	
MDH Mental Well-Being & Resilience Learning Community	The purpose is to expand understanding about a public health approach to mental health by profiling current community initiatives across a continuum of public health aligned strategies.	Monthly
MDH Minnesota Health Equity Networks	The network works to connect, strengthen and amplify health equity efforts.	Quarterly
MDH Parenting Educator Forum	Statewide training and discussion forum convened by MDE to discuss current evidence, changes, issues and the field of early childhood and parent education.	Annually
MEADA of McLeod County	Education and drug awareness to educate youth, families and citizens on the dangers of drugs with a focus on methamphetamines.	Bi-monthly
Medi-Sota Board of Directors	A health care consortium currently comprised of 35 rural health care facilities in Minnesota.	
Metro Breastfeeding Networking Meetings	Convenings of public health nurses, WIC county staff across MN, and health care, plan, and other community representatives involved in breastfeeding and birth work.	3x/year
Metro TZD Steering Committee	This is a regional group of leaders from the various TZD county advisory groups. This forum discusses and shares the county initiatives, what is happening on a regional level and how we fit into the larger statewide initiative of reducing roadway fatalities to zero.	
Minneapolis Community Health Leadership Team	CLT advises, consults and makes recommendations on use of City of Minneapolis public health grants and designated budgets.	6x/year
Minnesota Breastfeeding Coalition Governance and Equity Subcommittees	Statewide coalition representing leaders and advocates collectively working together to optimize practice and support of breastfeeding.	6x/year
Minnesota Breastfeeding Coalition Steering Committee	Statewide coalition steering group representing leaders and advocates collectively working together to optimize practice and support of breastfeeding.	6x/year
Minnesota Cancer Alliance	A broad partnership dedicated to reducing the burden of cancer across the continuum from prevention and detection to survivorship and end of life care.	
Minnesota Council of Health Plans	Trade association for nonprofit health plans.	
Minnesota Council of Health Plans - Behavioral Health Workgroup	A subgroup to the Council of Health Plans Govt. Programs meeting that focuses on specific behavioral health topics and provides input and also raises awareness on issues/concerns around BH services or trends. MCOs participate in this workgroup alongside MCHP reps.	

Minnesota Electronic Health Record Consortium	Partnership between MN health systems and public health; uses data to inform health policy and practice.	Weekly
Minnesota Healthy Kids Coalition	Statewide organizational leaders in public health and private sectors engaged in collective and policy action related to physical activity and better eating for families in MN.	2-4x/year
Minnesota Healthy Kids Policy Subgroup	Policy subgroup at the State Capitol to strategize outreach and communication on issues to legislators.	2-4x/month during session
Minnesota Healthy Kids Steering Committee	Steering group of statewide stakeholders in public health and private sectors engaged in collective and policy action related to physical activity and better eating for families in MN.	Quarterly
Minnesota Hospital Association - Behavioral Health Committee	Focuses on issues related to mental health and substance use disorder treatment in Minnesota. Advocates for improved access to behavioral health services, promoting policy reforms, and addressing workforce challenges in the mental health sector.	Bi-monthly
Minnesota Hospital Association - Finance Committee	Provides guidance on financial strategies, regulations, and policies that affect health care organizations, helping them navigate economic challenges and ensure long-term sustainability.	Bi-monthly
Minnesota Hospital Association - In House Counsel Committee	Provides MHA with education, resources, and guidance on a wide range of health law issues, including regulatory compliance, hospital bylaws, and political lobbying.	Quarterly
Minnesota Hospital Association - Policy & Advocacy Committee	Advises on legislative and regulatory priorities, ensuring that hospitals can provide high-quality care while navigating evolving and complex health care regulations.	Bi-monthly
Minnesota Hospital Association - Quality and Patient Safety Committee	Provides expert guidance and oversight on quality and safety initiatives within Minnesota hospitals. It helps develop resources, strategies, and roadmaps for improving patient care.	Bi-monthly
Minnesota Hospital Association - Workforce Committee	Focuses on addressing the ongoing health care workforce challenges in Minnesota. Advises on strategies for recruitment, retention, and workforce development, including efforts to increase diversity among health care staff and enhance the workforce pipeline.	Quarterly
Minnesota Hospital Association - Board of Directors	Provides strategic direction, leadership, and governance for the MHA, guiding its advocacy efforts and initiatives aimed at improving health care quality, access, and outcomes in the state.	Quarterly
Minnesotans for a Smoke-Free Generation	A coalition of Minnesota organizations that share a common goal of saving Minnesota youth from a lifetime of addiction to tobacco, often through public policy initiatives.	Weekly during session
MN Action for Healthy Kids/MN School Nutrition Network	Statewide collaborative around student health.	Monthly
MN Children's Cabinet Connection	Regular meetings with manager of the Governor's Children's Cabinet to discuss topics related to children's health.	3-4x/year
MN Climate Action Framework - Goal 5 Team	Revising and implementing Goal 5: Healthy Lives and Communities of the MN Climate Action Framework. MDH's Climate & Health Program team leads meetings.	Quarterly
MN Community Measurement Board of Directors	MN Community Measurement Board of Directors, Executive Committee and Measurement and Reporting Committee.	Quarterly
MSP Wellness	A partnership between the Minneapolis Regional Chamber, Hennepin County Public Health, Minneapolis Health Department, and HealthPartners. These four entities work together to help	

	businesses of all sizes create healthier work environments by providing resources, technical assistance and programming.	
NAMI Local Chapter	Raise awareness and provide support and education on mental illness.	
Nancy Latimer Annual Convening	Annual Convening recognizing excellence and innovation in early learning and brain development efforts in Minnesota.	Annually
NCQA Cardiovascular Measurement Advisory Panel	Advises NCQA on cardiovascular quality measures used to evaluate health plans.	Quarterly
PACT 4	PACT 4 is a family services and children's mental health collaborative.	Quarterly
Patient & Family Advisory Committee	Helps evaluate all aspects of patient care.	
Polk & St. Croix Counties Community Health Action Team CHAT	Collaboration on community health needs in New Richmond with representation from multiple sectors.	
Polk County Healthy Minds	Advisory Committee for mental health in Polk County, WI with representation from multiple sectors.	
PowerUp Steering Committee	Advisory committee for PowerUp with representation from multiple sectors.	
Premier Environmentally Preferred Purchasing Advisory Council	The Council works with Premier to research and discuss EPP with a focus on providing members with best practices and resources to achieve measurable success in environmentally preferable purchasing.	
Prenatal to Three Policy Forums	Bipartisan convening to examine how to use collective action and policy as a tool for change to support children, ages 0-3.	Quarterly
Promise Neighborhood Early Childhood Development Coalition	St. Paul group of Promise Neighborhood and other advocates for culturally grounded early brain development and early education.	6x/year
Ramsey County Birth Equity Community Council (BECC)	Cross of cross-sector county, state, coalition, health care and other sector leaders working together to improve birth equity in Ramsey County.	Monthly
Ramsey County Healthy Families Communities Council	Ramsey County Family Health home visiting community advisory committee.	
Ramsey County Toward Zero Deaths Advisory Board	This group includes representatives from engineering, enforcement, education and EMS/Trauma to review roadway injuries and fatalities within Ramsey County, review current initiatives around reducing roadway deaths to zero and implement new initiatives within the county.	
RAPAD	Join the meetings when time allows. The RAPAD Coalition engages Renville County members in reducing underage substance use through awareness, policy, enforcement, education and training.	Quarterly
Renville County Back-the-Pack	A 501(c)3 Non-Profit that provides weekend meals to students facing food insecurities in Preschool through Grade 8 in Renville County Public Schools. Working toward alleviating hunger in our communities.	Quarterly

Renville County Housing Committee	Facilitates partnerships in the areas of housing and health equity in order to create a thriving community for our neighbors to live, learn, work and play.	Monthly
Renville County Rural Child Care Innovation Program	The long-term goal of the RCCIP program is to build a cohesive stakeholder group who will continue, after the two-year planning cycle, with First Children Finance and begin to adapt and implement the recommendations.	Quarterly
Richfield Health Resource Center Advisory Council	Guide/advise operations and partner services for Richfield Health Resource Center.	Monthly
Rural Health Community Collaboration	In conjunction with MN Department of Health employees, and Straits Health employees to develop strategies in our area to improve population health in our community.	
Safe Kids Greater East Metro/St. Croix Valley Coalition	A team of vested partners who engage in childhood injury prevention initiatives. Members represent a wide array of professionals who work with children and implement prevention programming as part of their regular business model, utilizing Safe Kids resources as well as their Level I trauma and burn centers for expertise and resource support.	
St. Paul Business Review Board	Advisory body to mayor and City Council of St. Paul to review and recommend improvements to regulations affecting businesses, simplify unnecessary rules while ensuring public health, safety, and fiscal responsibility, enhance coordination between city regulatory agencies, and advise on proposed legislative and procedural changes impacting business and the broader community.	Monthly
SAMHSA National Guidelines for Behavioral Health Crisis Care	Help define national standards for mental health crisis care (mobile crisis, emergency services, freestanding crisis centers, mental health urgent care, etc.).	
Science Museum of Minnesota Capital Campaign Steering Committee	Campaign to reimage the SMM building to expand transformative STEM-equity programs, make science exciting and relevant, support our teachers, change the face of future scientists, motivate all Minnesotans to participate in solving our most pressing challenges while celebrate the history of innovation and excellence	Quarterly
SDOH Community Convening StratisHealth	Convening/collaboration with a goal to develop a shared approach to social needs screening and referral between health systems and community partners.	
St. Louis Park Mental Health Collaborative	Builds awareness and aligns action to support mental health and well-being in our community.	Monthly
St. Paul Downtown Alliance	Nonprofit organization that represents downtown businesses, nonprofits, government entities, residents, and entrepreneurs. Together, we work to build a strong and vibrant downtown, creating a positive downtown experience for all.	Quarterly
St. Paul Ramsey County Public Health Statewide Health Improvement Program Community Leadership Team Meetings	The Minnesota Department of Health provides funding to Saint Paul – Ramsey County Public Health through the Statewide Health Improvement Partnership (SHIP) to work with a variety of partners to improve the health of our community. Saint Paul - Ramsey County Public Health is in its fourth cycle of SHIP funding. Three goals: increasing physical activity; improving access to healthy foods; reducing the use of and exposure to tobacco.	Quarterly

St. Paul Ramsey County Community Health Services Advisory Committee	The board advises, consults with or makes recommendations to the Saint Paul City Council and the Ramsey County Board of Health on matters relating to policy development, legislation, maintenance, funding, and evaluation of community health services.	Monthly
Stearns/Benton Dental Workgroup	Focuses on improving dental access and dental programs/services available in the central region.	Quarterly
Stillwater Circulator Bus Loop Advisory Committee	Guide circulator bus route and policies to best serve isolated elders.	Quarterly
Stillwater Community Health Action Team (CHAT)	Stillwater/Washington County convened by Lakeview to collaborate around community health priorities.	
Suburban Metro Area Continuum of Care Affordable Housing Workgroup	A workgroup that supports SMAC goals by discussing how to increase affordable housing.	Varies
SuperShelf Leadership Team	Collaboration with public health, nonprofits, University of MN and HealthPartners to transform food shelves to provide good food for all.	Monthly
Twin Cities Habitat for Humanity	Engages a broad network of supporters and community members to create, preserve, and promote affordable homeownership in the seven-country metro area of Minneapolis and St. Paul.	
Twin Cities Refugee Consortium	A collaboration to discuss how to continue to assist refugees resettling in MN.	Quarterly
Twin Cities Regional Breastfeeding Coalition	Coalition representing leaders and advocates collectively working together to reduce rates of disparities in breastfeeding across the metro counties.	Quarterly
Twin Cities Regional Breastfeeding Coalition School Change Subgroup	Subgroup of TCRBC working to manage a Ramsey County grant supporting site and cultural changes to support lactation in metro schools.	6x/year
U of M Duluth Labovitz School of Business Health Care Advisory Board	U of MN Duluth Labovitz School of Business Health Care Advisory Board.	Bi-annually
Valley Outreach Board of Directors	Food shelf and basic needs organization, Stillwater and East Metro.	Monthly
Washington County Breastfeeding Coalition	Coalition representing leaders and advocates collectively working together to optimize support of breastfeeding in Washington County.	6x/year
Washington County Community Leadership Team	Advisory committee for Washington County SHIP.	Monthly
Washington County CONNECT Leadership Team	Youth Mental Health Collaborative Washington County.	
Washington County Transportation Steering Committee	Address transportation needs in Washington County.	Quarterly
Well-Spring Leadership Team	Washington County Collaboration around mental well-being	
Wilder Board of Directors	Oversee organizational strategy and fiscal stewardship of Wilder.	Bi-monthly
Wilder Program Committee	Understanding of Wilder programs and connection to strategic plan and communities.	Bi-monthly

Wisconsin Hospital Association (WHA) Public Policy Council	Advisory group within WHA that helps shape and guide the association's advocacy efforts on behalf of Wisconsin hospitals and health systems, and the communities they serve.	Bi-monthly
Wisconsin Hospital Association (WHA) Board of Directors	Advocacy, education, and convening organization to collectively enhance hospital and health systems ability to provide high-quality, affordable, accessible health care for Wisconsin families and communities.	Quarterly
Workforce Innovation Board of Ramsey County	One of 16 legislatively mandated Workforce Boards in Minnesota, the WIB harnesses the collaborative power of business, government, economic development, education and the community to develop strategic solutions for workforce challenges in Ramsey County.	Monthly
YMCA of the North Board	Engage communities in MN by nurturing the potential of every child and teen, improving health and well-being, and supporting and serving our neighbors. The Y ensures everyone has the opportunity to become healthier, more confident, connected and secure.	Quarterly

HealthPartners CHNA Workgroup Members

HealthPartners' Center for Evaluation & Survey Research was contracted to complete the 2024 Community Health Needs Assessment for all 8 HealthPartners hospitals. Housed in HealthPartners Institute, grounded in public health and health care content knowledge, and driven by a continuous learning health system culture, CESR comprises of experts in evaluation methods, survey and qualitative methods, community engagement, health communications, data visualization, and statistical analysis. Led by Jeanette Ziegenfuss, PhD, Director of Survey and Evaluation Science, with expertise from Senior Evaluation Scientist Meghan JaKa, PhD and Evaluation Scientist Maren Henderson, MPP, and project management from Evaluation & Survey Project Manager Jennifer Dinh, MPH, and Project Coordinator Laura Zibley, MPH.

Role	Name, Affiliation
CHNA Evaluators	Jeanette Ziegenfuss, CESR Director Meghan JaKa, CESR Evaluator Maren Henderson, CESR Evaluator Jen Dinh, CESR Project Manager Laura Zibley, CESR Project Coordinator
CHNA Liaisons	Marna Canterbury, Community Health DeDee Varner, Community Relations Andrea Anderson, Community Health
Hospital Partners	Katy Ellefson, Amery Hospital Tracy Marquardt, Hutchinson Health Anna Jepson, Hutchinson Health Andrea Anderson, Valley Hospitals (Hudson, Westfields, Lakeview) Jackie Edwards, Olivia Hospital & Clinic Pat Croal, Park Nicollet Foundation Paul Danicic, Park Nicollet Foundation Heather Walters, Regions Hospital Danielle Hermes, Regions Hospital Tony Grundhauser, Regions Hospital Foundation
Internal Consultants	Allison Egan, HealthPartners Sustainability Tom Kottke, Medical Director, Well-being Shaun Frost, Medical Director, Health Plan Tamika Jeune, Attorney, Legal Pahoua Hoffman, SVP of Government and Community Relations Sidney Van Dyke, Director, Health Equity and Language Access