Westfields Hospital & Clinic

Community Health Needs Assessment

December 2024

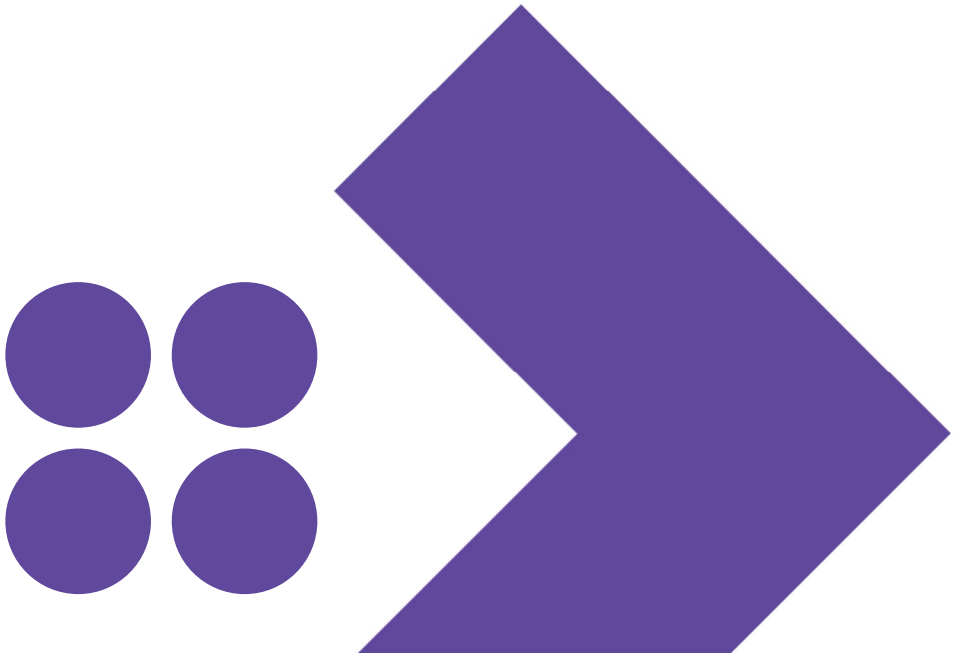


Table of Contents

Executive Summary

Through 2024, HealthPartners and Westfields Hospital & Clinic 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.

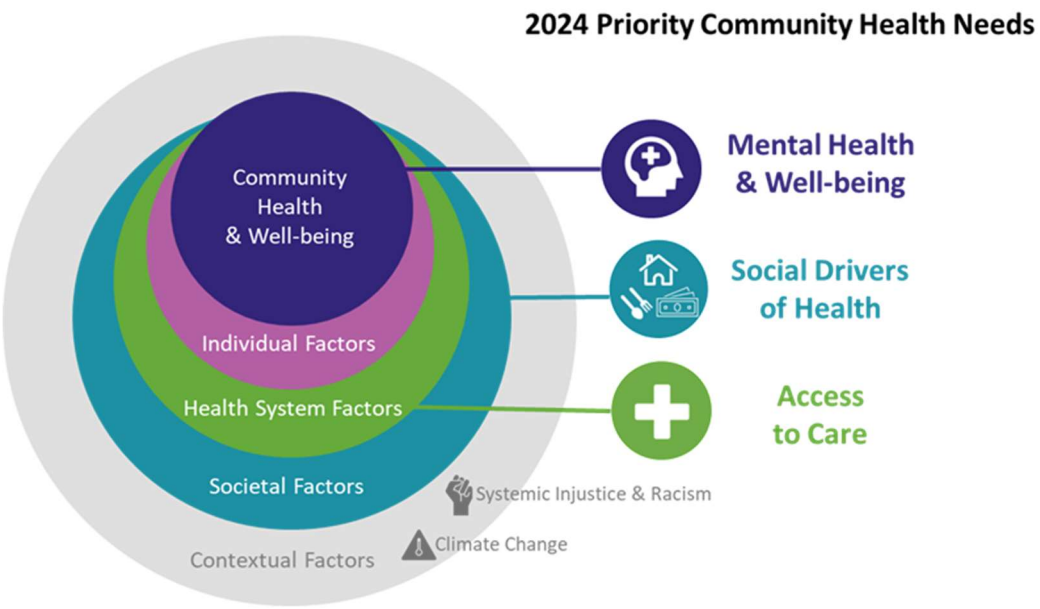
This CHNA report includes data describing the community that Westfields Hospital & Clinic serves, defined as the entire population of St. Croix County. While the hospital certainly serves individuals from outside of the county, the definition of a community as a single county simplifies and helps focus, 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 Westfields Hospital & Clinic 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 St. Croix 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 facilitated by our CHNA workgroup members to gather local perspectives.

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 definition 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

Westfields Hospital & Clinic, 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 HealthPartners Valley Joint Board on 12/18/24. In accordance with federal requirements, this report is made widely available to the public on our website at https://www.healthpartners.com/care/hospitals/westfields/about/community-health-needs/.

Community Served

About HealthPartners & Westfields Hospital & Clinic

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.**

Westfields Hospital & Clinic is part of HealthPartners. Westfields Hospital & Clinic serves patients across eastern Minnesota and western Wisconsin with primary, acute, emergency and outpatient health care services. For more information, visit www.healthpartners.com/care/hospitals/westfields/

About the Community

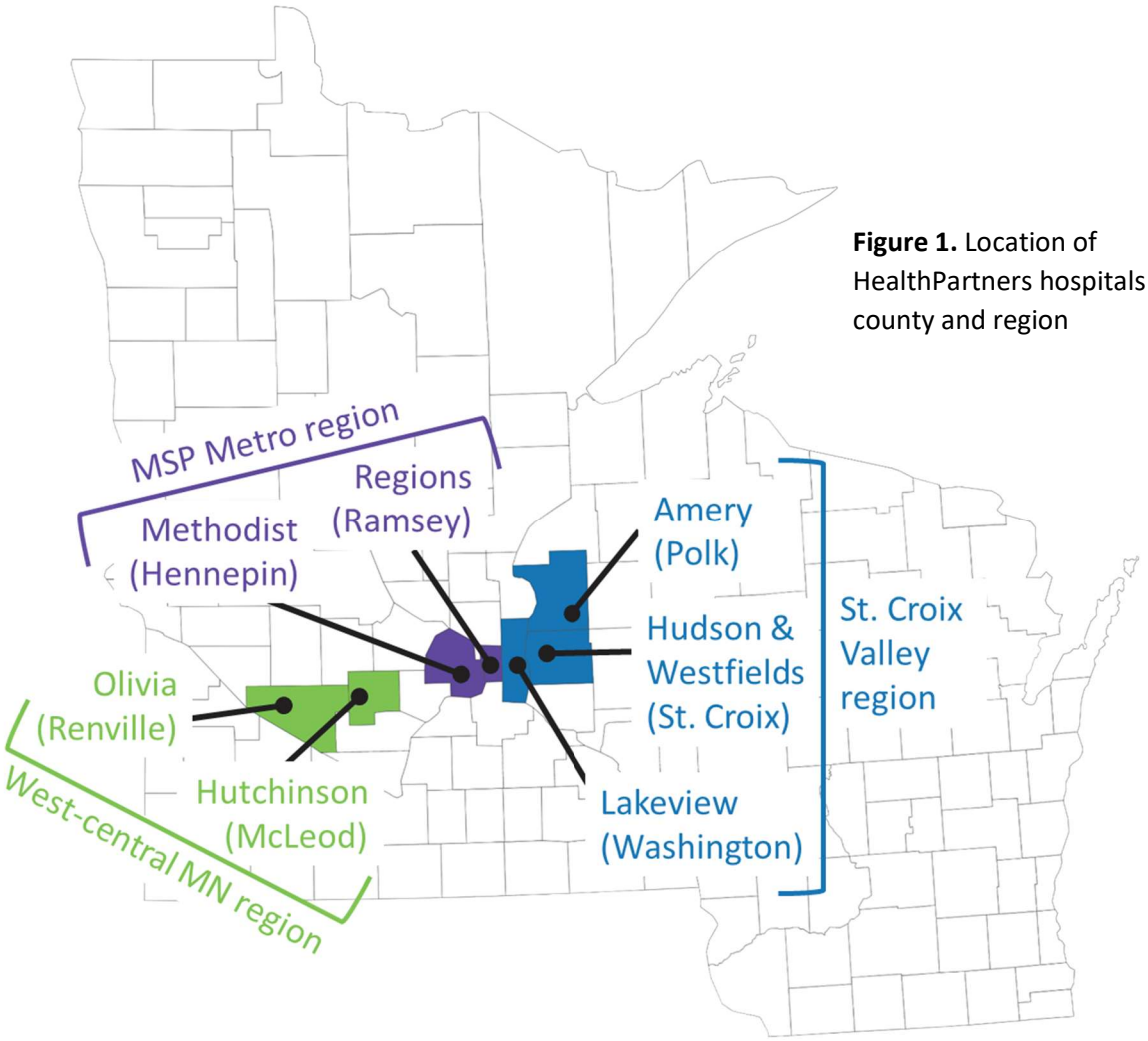


Figure 1. Location of HealthPartners hospitals by county and region

Westfields Hospital & Clinic is located in the city of New Richmond in St. Croix County, Wisconsin and the St. Croix Valley region. For the purposes of this report, the "community served" by Westfields Hospital & Clinic is people living in St. Croix 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, helping ensure that the results of this needs assessment can be presented clearly to the community.

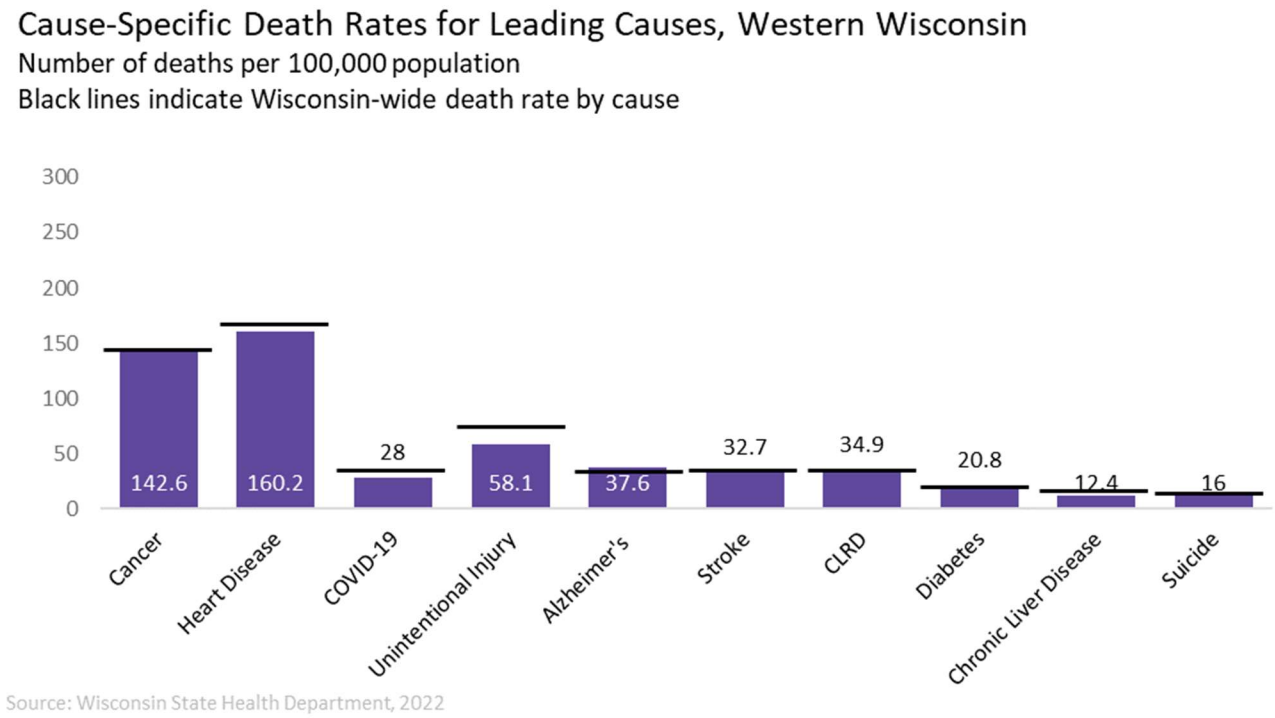
According to the 2022 American Community Survey 5-Year Estimates,[1] St. Croix County has 96,017 residents, 49.7% of whom are female.

- The median age in this county is 40.5 years, with 16.1% of the population 65 years or older.
- More than nine in ten (92.7%) identify as **White**, with 1.0% **Asian**, 1.3% identifying as **Black or African American**, 0.1% **American Indian or Alaska native**, 0.0% **Native Hawaiian or other Pacific Islander**, and 4.6% as **more than one or some other race**.
- 2.8% identify as **Hispanic or Latino**.

There were 25,549 HealthPartners patients (age 18 and older who had an in-person or telemedicine visit with a HealthPartners provider in 2023) who lived in St. Croix County in 2023.[2]

- Of these, 91% were over 25 years old and over half (55%) were female.
- Nearly all were **White** (95%), with fewer than 1% identifying as **Asian**, fewer than 1% **Black or African American**, 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% reported a **Hispanic or Latino** ethnicity.
- Over 99% spoke English, with fewer than 1% of patients speaking Spanish.
- Among HealthPartners patients in St. Croix County, 63% use commercial insurance, 7% are covered by Medicare, and 27% are covered by Medicaid.

n 2022, the three most common causes of death in Wisconsin, as well as in Western Wisconsin, were, in order, heart disease, cancer, and unintentional injury. [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.

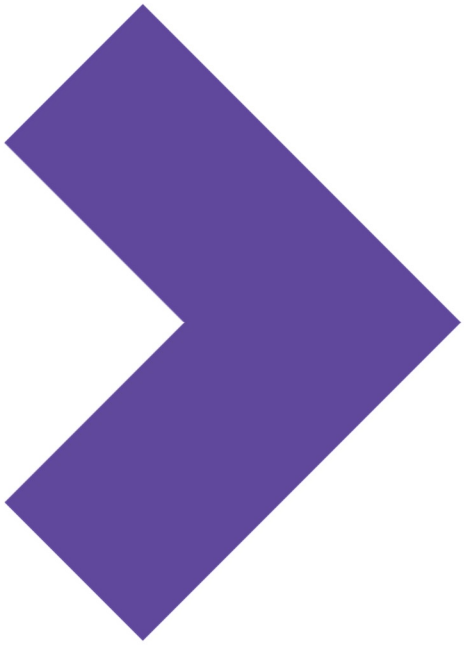
Here are common chronic conditions and their prevalence statewide and in St. Croix County in 2022[5]:

- Hypertension (adults who have been told they have high blood pressure): 31.5% of Wisconsinites, 25.1% of St. Croix County residents[6]
- High cholesterol (adults who have had their blood cholesterol checked and have been told it was high): 35.7% of Wisconsinites[7]
- Diabetes (including Type 1 or Type 2): 10.3% of Wisconsinites (up from 9.1% in 2022) and 4.9% of St. Croix County residents
- Asthma: 10.8% of Wisconsinites (up from 10.7% in 2021) and 14.6% of St. Croix County residents
- Heart disease: 4.6% of Wisconsin residents[7]

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.[8] 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.[9] 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[10] 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.[11] 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.[12] They are also less likely to have a regular source of care or to receive timely preventive services, like vaccinations.[11]

Findings from Minnesota's African American Leadership Forum Community Harvest Report (2021)[13] 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 to 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, St. Croix County is projected to see 5.3 days with a maximum temperature of over 95 degrees Fahrenheit each year, an increase of 4.3 days (430%) compared to the 1976-2005 historical average.[14]

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.[15] Lower income community members are more likely to live in areas with greater exposure to extreme temperatures,[16] and are more likely to experience income loss when extreme heat creates unsafe working conditions.[17]

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.[18] 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.[16]

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.[19]

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[20] 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.[21]

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 organization 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[8], 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.

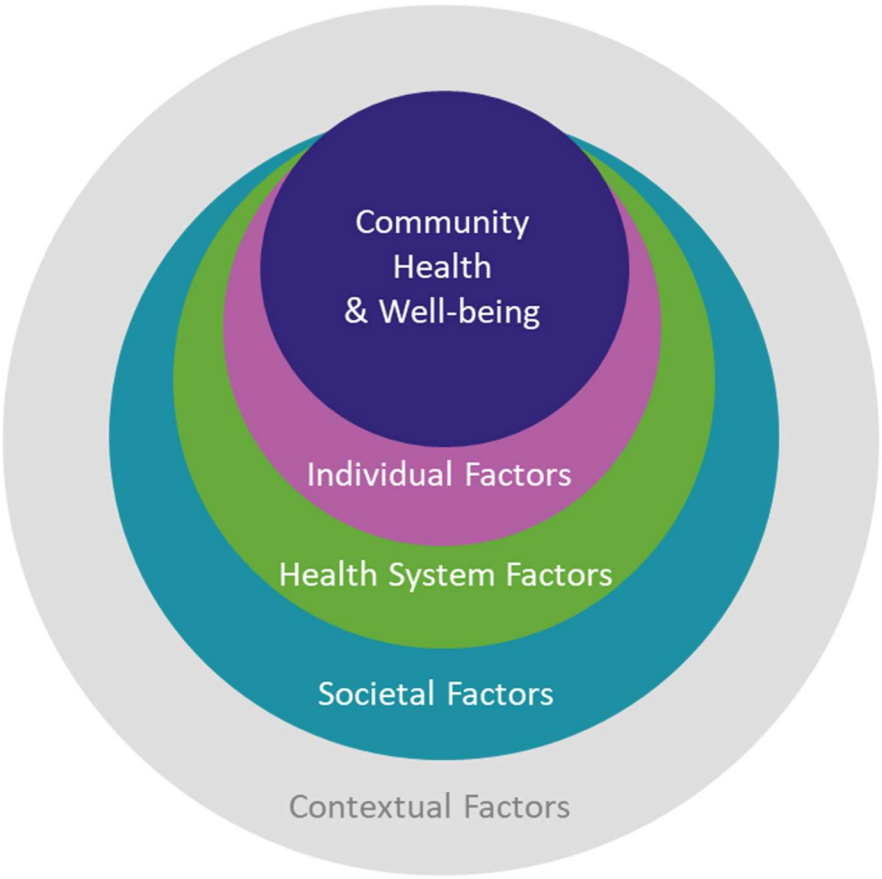


Figure 2. Framework for Organizing Community Health Needs (Adapted from McGovern 2014)[8]

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[22]
- Minnesota Student Survey, 2022[23]
- Wisconsin Youth Risk Behavior Survey, 2021[24]
- KFF State Health Facts, 2022[25]
- Commonwealth Fund, 2022[26]
- Minnesota Community Measurement, 2022[27]

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.

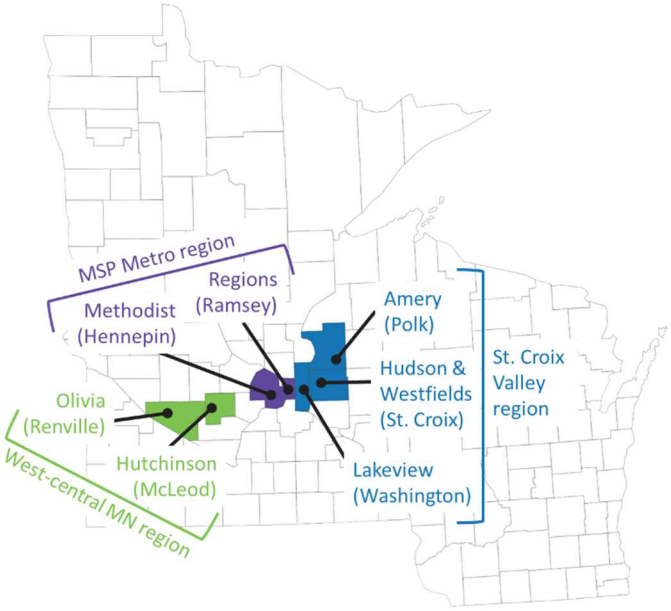


Figure 3. CHNA Communities by County and Region

Needs Area	Specific Needs
Societal Factors	• Economic Stability • Employment Stability • Housing Security • Food Security • Access to Healthy Food & Exercise Spaces • Social and 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, &/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 needs?
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.[28] 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, by the CHNA hospital workgroup members. 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 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 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 though 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.

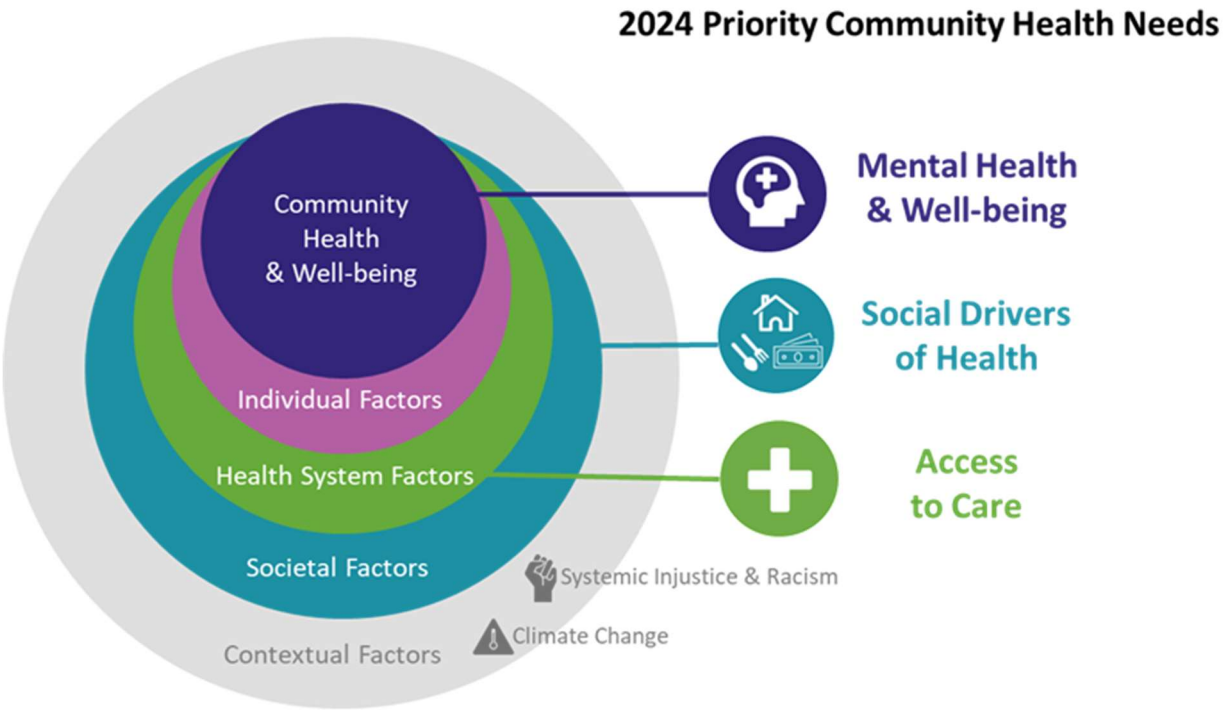


Figure 4. Approved Priority Community Health Needs, Spring 2024

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 Westfields Hospital & Clinic community, inclusive of all individuals who live in St. Croix 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 approached 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.[29] 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 St. Croix County held three Community Conversations with approximately 14 individuals. An additional five Community Conversations were held with another 40 participants from across the Valley region. Attendees represented various stakeholder groups, including local health care and public health, education, human services, nonprofit agencies, law enforcement, patient and family advisory councils, faith leaders, indigenous groups, and community members.

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[30] of color and low-income and rural communities experience disparities in mental health and well-being.[31-33] 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.[34,35]

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.

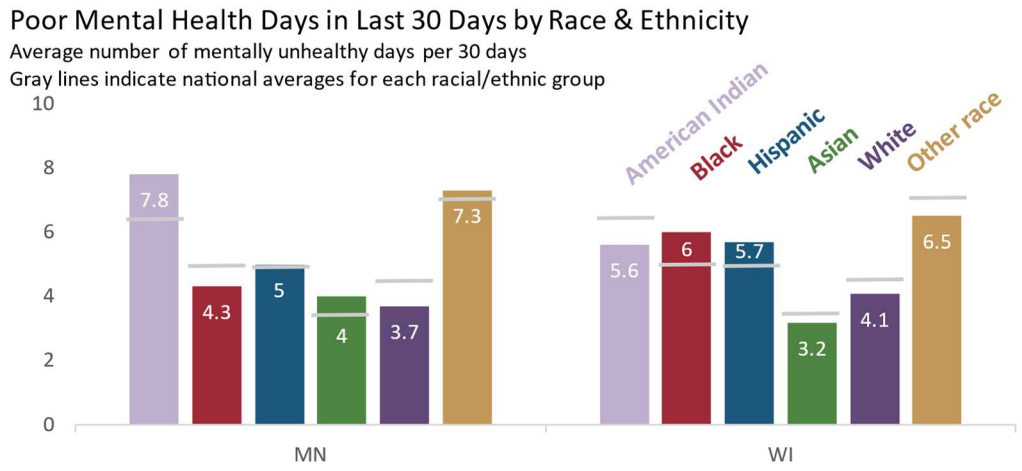
Factor 1: Social, emotional, spiritual, and physical well-being

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.[36] 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 St. Croix County, community members echoed these same sentiments. They shared that social isolation is an issue affecting all ages. To improve social connection, they feel that more organized community gatherings and stronger social networks (and spaces) should be pursued. They also noted that it is important to consider environmental and social stressors when evaluating social and emotional health.

Wisconsin adults report an average **of 4.4 mentally unhealthy days** in the last 30 days, fewer than the national average of 4.8 days (County Health Rankings). Similarly, adults in St. Croix County report an average of 4.1 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 Black, Hispanic, and American Indian adults living in Wisconsin, and among American Indian Minnesotans.

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).[37] St. Croix County had slightly fewer social connection opportunities (10.6 per 10,000 population) than the state average (11.2), though still higher than 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 St. Croix County specifically, community members emphasized the need to build resiliency and coping skills for people of all ages to better manage their mental health.

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).[7]

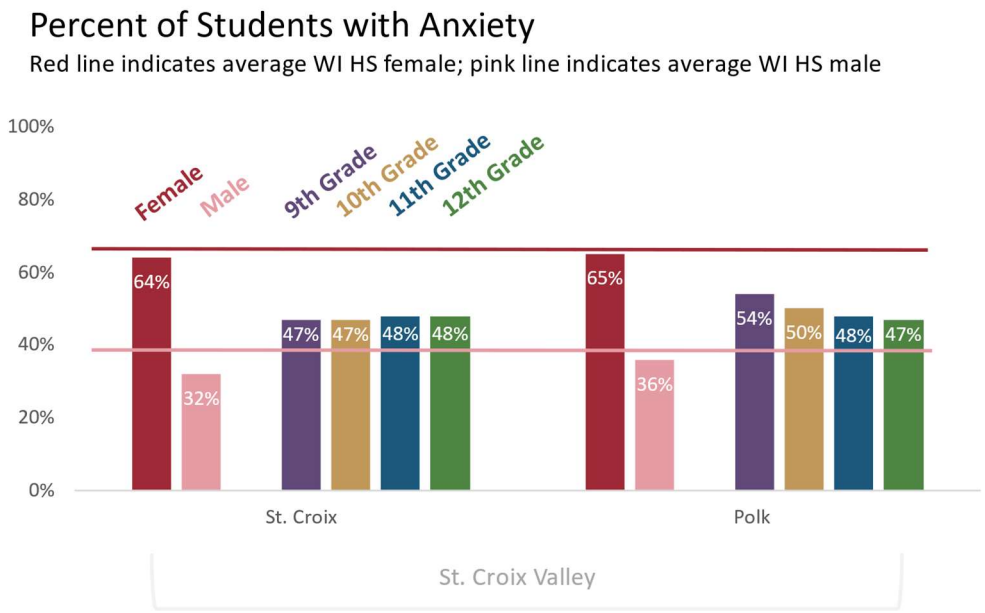
Among HealthPartners adult patients with a visit in 2023 living in St. Croix County, 8.1% had a PHQ-9 score above 9, which represents moderate to severe depression.

Across Wisconsin, 67,213 people received a mental health service in 2022, including more than half who received crisis services. There has been a slight decrease annually since service peaked in 2019.[38]

In St. Croix County, 1,221 people were served in 2022, and about half of these services were for crises. The number of people served annually, however, has remained fairly consistent over the last decade in the county,[38] with between 1,200 and 1,300 people served each year since 2016.

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

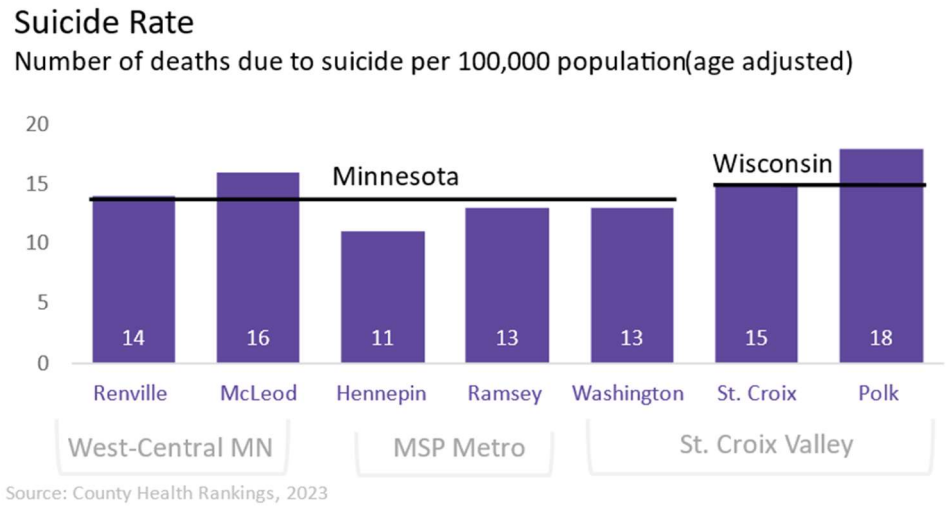
- Between 32 and 65% of students reported having anxiety, with **female students** more likely to say they have anxiety than male students.
- Among surveyed students, 11 to 22% reported they seriously considered attempting suicide in the last year, which is an increase from 2019, when 9 to 17% of students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



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).[37] This is similar to the national average of 14.



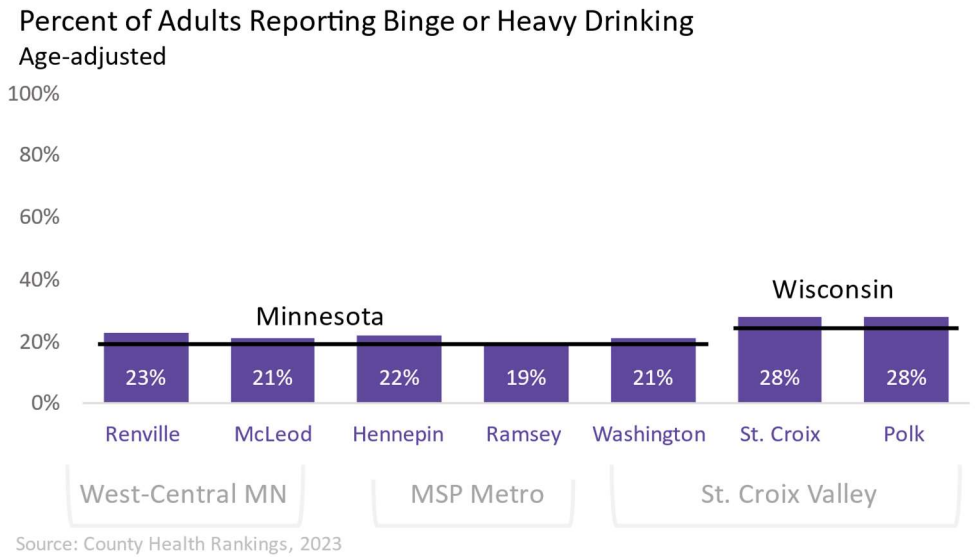
Factor 3: Substance misuse, substance use disorders

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 and 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 St. Croix County shared. Specifically, community members reported that substance use increased significantly during the COVID-19 pandemic. Opioid and methamphetamine use were mentioned, though alcohol remains the number one substance used. Community members also feel that a lack of social connection can impact substance use, along with other factors.

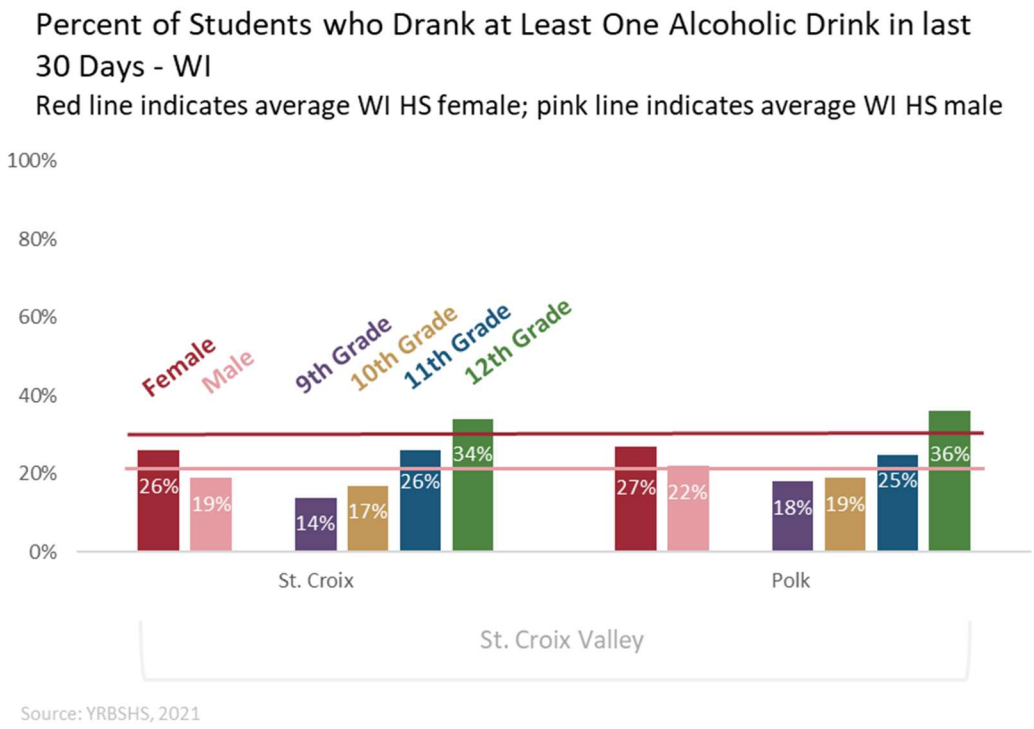
Across the counties HealthPartners serves, between 19 and 28% of adults report binge drinking, with Wisconsin counties being notably higher than Minnesota counties (County Health Rankings). Both states are above the national average of 18%.



Source: County Health Rankings, 2023

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 Wisconsin, more than 30% of all students report using alcohol in the last 30 days, including 22.3% of males and 29% of females (YRBS).[49] This is a decrease when compared to the 27% of males and 32% of females who reported the same behavior in 2019. [39]



According to the Wisconsin Department of Health[50], there were 2,575 opioid-involved emergency room visits in Wisconsin in 2023. This includes 14 visits in St. Croix County. There were 1,464 opioid overdose deaths in Wisconsin in 2022, and the **opioid crisis disproportionately impacts communities of color**. The opioid overdose death rate among American Indian residents was 98 per 100,000 residents in Wisconsin, compared to 20.5% among white Wisconsinites.

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

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 St. Croix County shared similar themes and reported that stigma prevents people from talking about their mental health concerns and from seeking mental health care.

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 St. Croix County, community members emphasized 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. There were several organizations in the Valley region named by community members that provide resources and support to those seeking substance use treatment and recovery services, including Programs for Change, the Family Resource Center St. Croix Valley, and more.

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 below.[56]

Factor 1: Economic & financial security

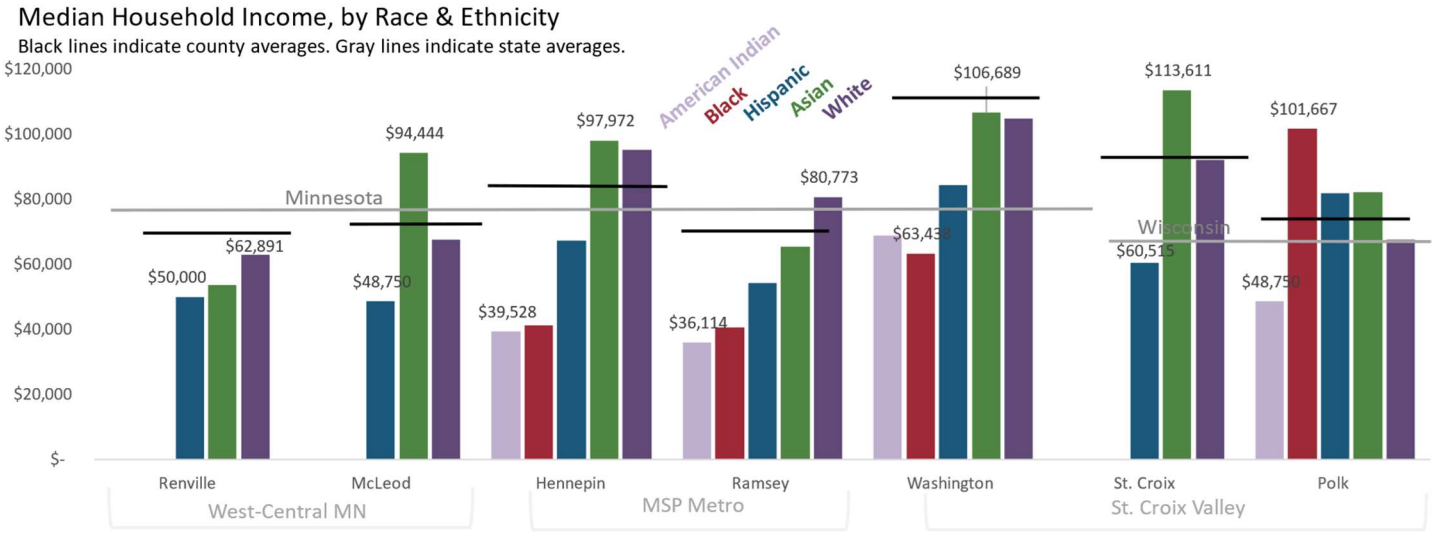
Financial insecurity is the inability of individuals or families to sustainably afford their essential needs. This can be observed in expenses exceeding income and can be experienced by anyone at or below federal poverty levels.[57]

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 St. Croix County specifically, community members shared that some people are making tough decisions about what needs to prioritize (food, housing, medication, gas, etc.). Access to childcare and transportation were called out as two important factors impacting a person's economic stability.

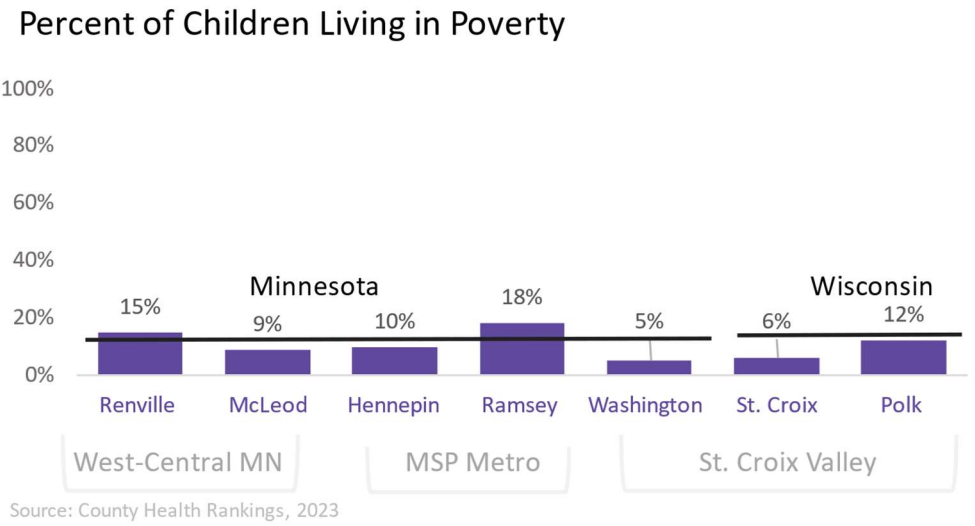
In 2022, the median household income in Wisconsin ($70,996) was slightly lower than the national average of $74,755.[58]

There are notable differences by geography and race or ethnicity. The median household income in Polk County ($74,142) is much lower than St. Croix County ($96,130).



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 St. Croix County is 5.6%, notably lower than the Wisconsin state average of 10.7%. The childhood poverty rate is 6%, also notably lower than the state average of 14% and the national average of 16%. Of note, **39% of Hispanic/Latine children** in St. Croix County are living in poverty.



United Way of Wisconsin provides data on ALICE (Asset Limited, Income Constrained, Employed), a designation for households that earn more than the federal poverty level but less than what is needed to make ends meet. While not officially classified as living in poverty, ALICE households often **struggle to afford essentials such as housing, food, childcare, and health care**. These households face financial instability and may not qualify for assistance programs[60], making it difficult for them to navigate economic challenges and unexpected expenses.

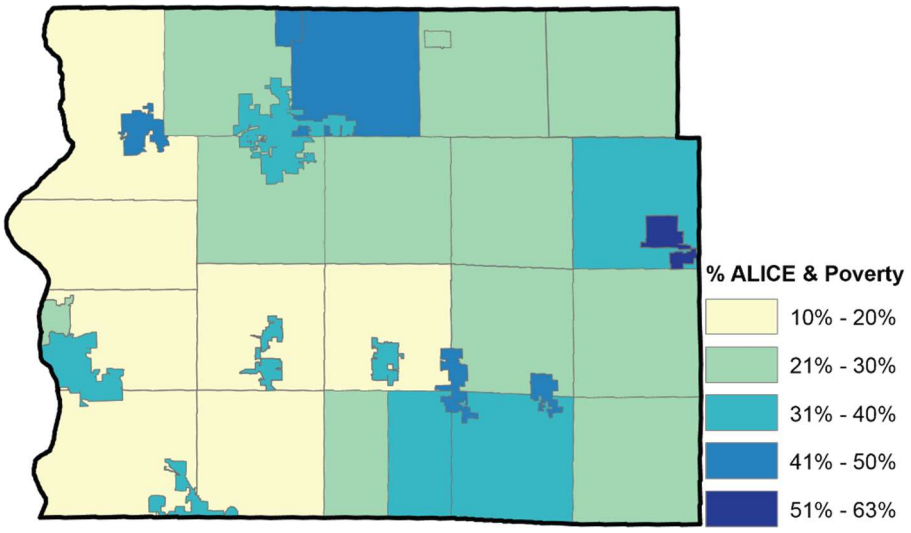
In St. Croix County, approximately 38% of households fall below the ALICE Threshold, which signifies they earn above the federal poverty level yet struggle to make ends meet. This group includes 28% classified as ALICE households[61] and 4% living in poverty, reflecting state trends where 35% of households face similar financial hardship.

Financial hardship varies in St. Croix County:

- Older adults (65+) face the highest rates: 53% below the ALICE Threshold (4% poverty, 41% ALICE).
- Single or cohabitating adults also experience significant hardship: 27% below the ALICE Threshold (19% ALICE, 8% poverty).
- Families with children: 18% below the ALICE Threshold (13% ALICE, 5% poverty).
- Financial hardship disproportionately affects Hispanic households, with 47% below the ALICE Threshold (41% ALICE, 6% poverty).

ALICE and poverty levels vary significantly across the county, with some areas facing higher levels of financial hardship than others. This map below provides a visual representation of each town's ALICE and poverty percentages, offering insight into geographic disparities.

Percent of Population in St. Croix County who are at or below the ALICE Threshold



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 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.[62] 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.

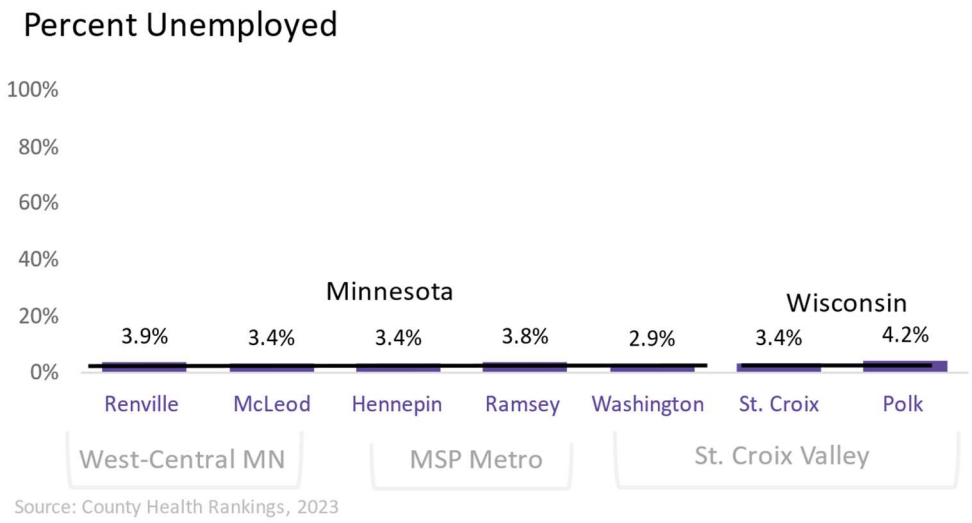
Factor 2: Employment security

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.[63] 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 St. Croix County specifically called out underemployment and staffing issues as challenges.

In 2023, unemployment was relatively low (under 5%) across all counties served by HealthPartners.[37] The national unemployment rate during the same time period was 3.7%.



We also know that being employed but receiving an hourly wage results in less household stability and that hourly workers are less likely to receive benefits from their employers. In St. Croix County, 38.6% of adults working full- or part-time receive hourly wages.

According to the Wisconsin Department of Workforce Development, labor force participation across the state in 2021 was 66.4% and has been trending downwards for the last two decades, with St. Croix County at 69.7% (compared to 72.8% in 2001) and Polk County at 67.9% (compared to 81.1% in 2001). This indicates an aging population.[64]

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.[65] These 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

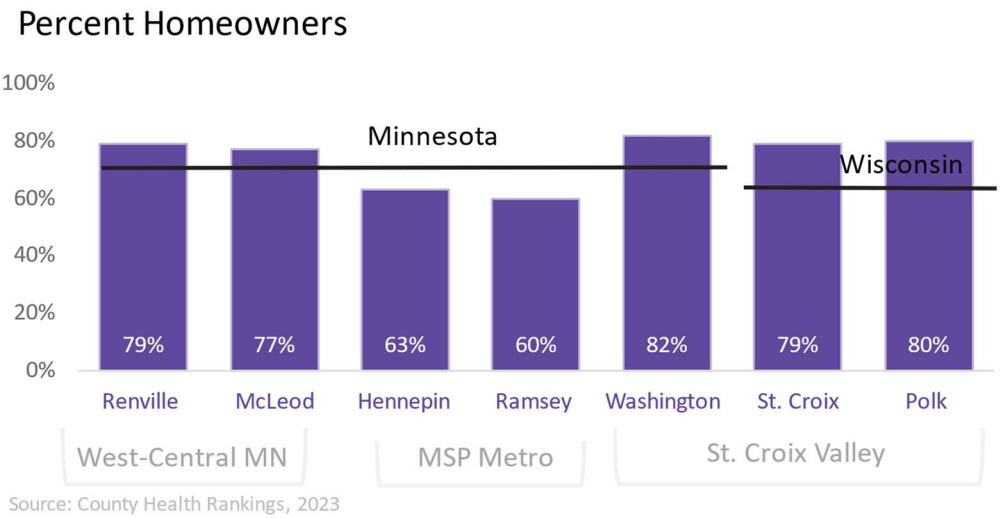
Housing insecurity is when individuals and families lack the ability to access or maintain safe housing due to high housing costs relative to income, poor housing quality, unstable neighborhoods, or overcrowding.[66,67]

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 St. Croix County, community members shared that there is a strong need for more affordable housing and homeless shelters across the Valley region.

According to the 2023 County Health Rankings,[37] 65% of housing units were owner-occupied in the United States.

In Wisconsin, 67% of housing units were owner-occupied. Homeownership in St. Croix County is 79%, higher than the statewide rate.

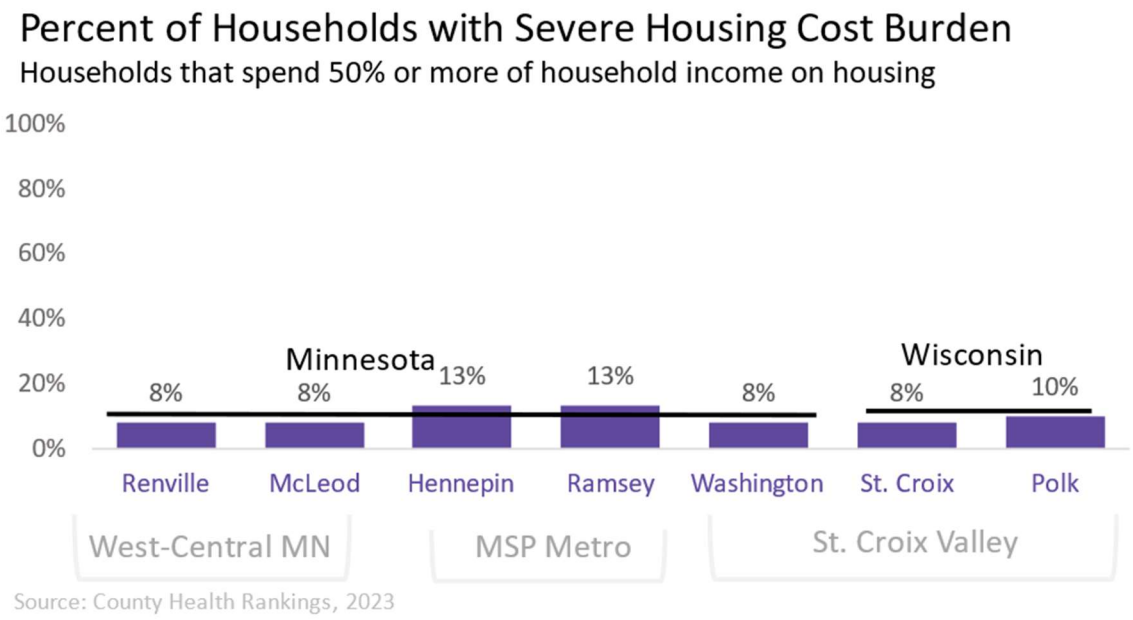


There are notable differences in home ownership by race and ethnicity across Wisconsin.[68]

- 0.5% of homeowners are American Indian or Alaska Native
- 1.5% of homeowners are Asian
- 2% of homeowners are Black or African American
- 3% of homeowners are Hispanic/Latine
- 90% of homeowners are white
- 2% of homeowners are multiracial

Nearly one in three American households (32.5%) spend **over 30% of their income on housing**, which makes them "cost burdened." In Wisconsin, just under half of renters (43%) and one quarter of homeowners (22%) are cost burdened.[64] In St. Croix County, 38% of renters and 22% of homeowners 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).[37] 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.



Source: County Health Rankings, 2023

County Health Rankings also reports the percentage of households that have severe housing issues.[37] 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 St. Croix County have a severe housing issue.

Lower-income families also struggle to pay rent. The median gross rent,[69] 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

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

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] During the most recent Point In Time count in Western Wisconsin, 41 people in St. Croix County were identified as experiencing homelessness.[72,73]

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.

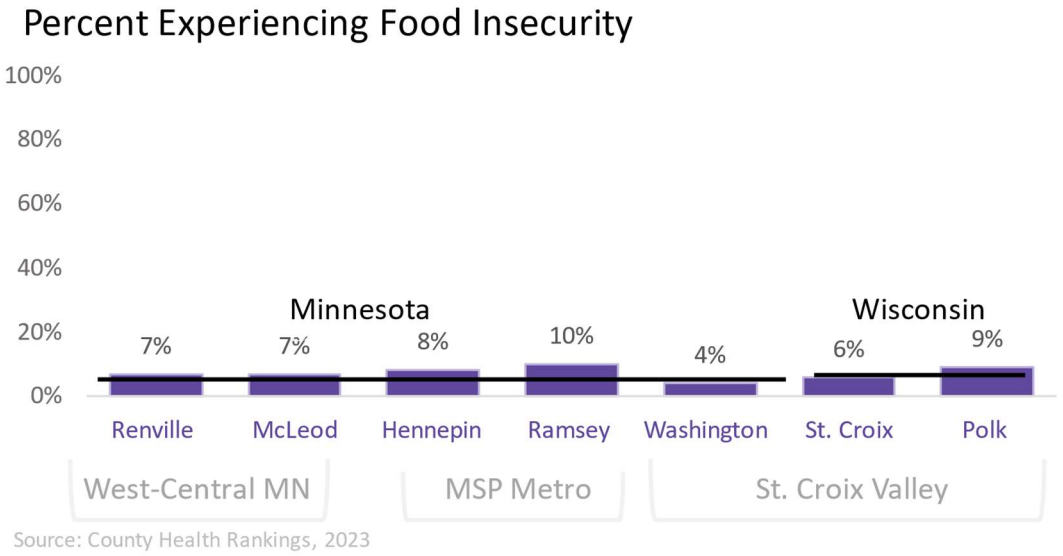
Factor 4: Food & nutrition security

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.[74]

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.

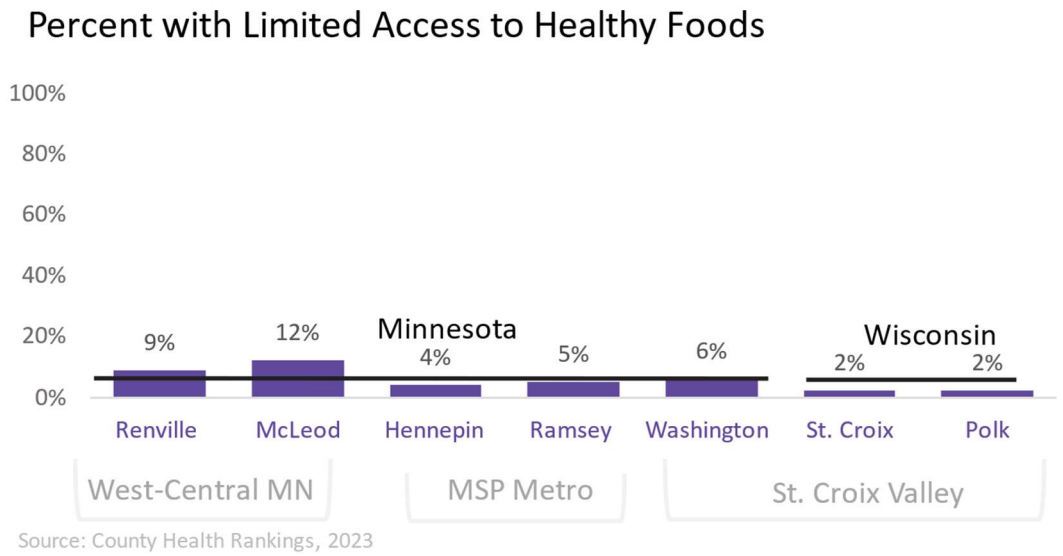
Community members in St. Croix County shared that people still feel stigmatized for going to a food pantry, which prevents some people from using this resource. To address this, they believe efforts should be made to make food pantries feel more like a community gathering space. Transportation is also a barrier that keeps people from utilizing food pantries. Community members commented on the difficulties of navigating food benefits and employment; some residents worry about losing their food benefits once employed, and others who are employed feel they still don't earn enough to support themselves or their family.

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).[37]



Source: County Health Rankings, 2023

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.[37]



Source: County Health Rankings, 2023

In 2021, Wisconsin high school students were asked if they experienced hunger in the last 30 days due to a lack of food at home.[24] Statewide, 2.7% said yes, and in St. Croix County, 16% of students 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.

Through a survey of individuals visiting a food pantry in Pierce, Polk, and St. Croix counties in 2024 conducted by the University of Wisconsin Extension, we know that many residents have to choose between buying food and other essential expenses such as utilities, housing, transportation, and medication.[75] Nearly half of respondents (43%) live in a household with children. Another 41% live in a household with seniors. Of note, 44% of respondents said stigma or embarrassment is a barrier to accessing food pantries.

Between October 2023 and September 2024, the St. Croix Valley Food Bank reported serving 63,045 households in St. Croix County and 21,991 households in Polk County.[76]

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.

In St. Croix County specifically, community members shared that there is a lot of overlap and bidirectionality among the social determinants of health. In particular, they emphasized the need for affordable transit options and childcare facilities. Stakeholders reported that there is good work being done to increase access to housing, provide education and support to meet employment needs, and provide food to those who need it. Organizations like FamilyMeans, SeniorLinkage, Aging and Disability Resource Center, Interfaith Caregivers of Polk County and Family Resource Center St. Croix Valley are working to provide resources to families and/or older adults.

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**. In Wisconsin, the average monthly cost for infant care is $769 and preschool care is $722.[64] The average monthly cost of childcare in Minnesota is $880 per child.[77] Costs also vary widely within our service area. In St. Croix County, the average monthly cost of preschool-aged childcare is $789.[64]

> "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. In Wisconsin, there are 14 available childcare slots per 100 children under 14.[64] Minnesota has an average of 60 available childcare slots per 100 children aged five and under.[78] In St. Croix County, there are 13 available childcare slots per 100 children under 14.

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.[79] Across the United States, 8.2% of adults lack reliable transportation. [80] In St. Croix County, 5.1% of adults lack reliable transportation[80]

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.[81-83] 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

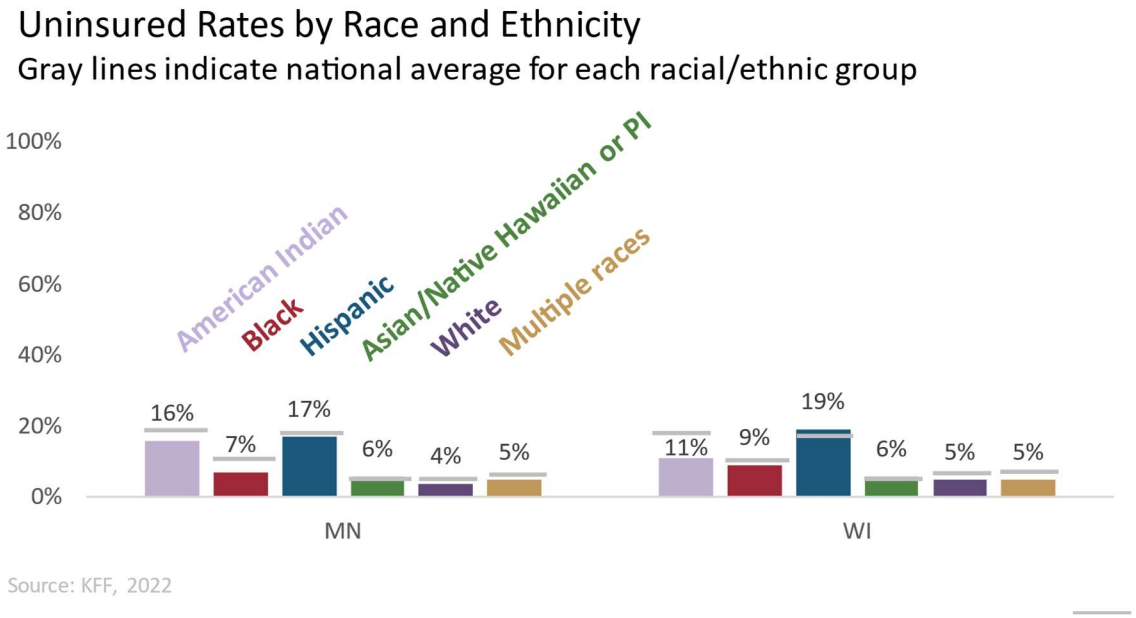
Both insurance coverage and cost of care can affect someone's ability to access health care services. Research suggests that **having insurance coverage is associated with reduced mortality**.[84]

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.

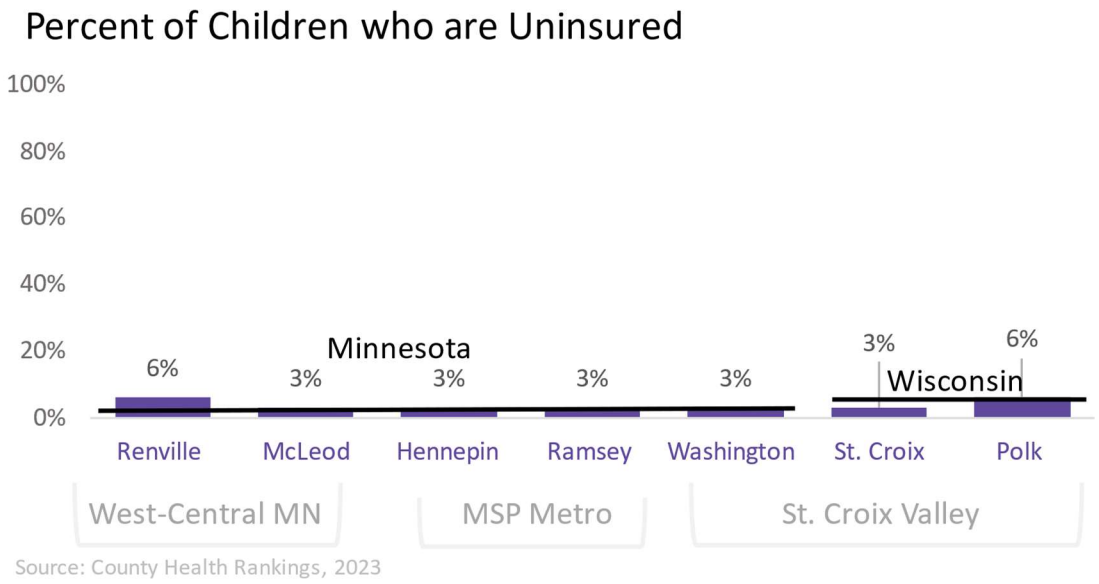
In St. Croix County specifically, community members shared that providers and health care systems have challenges working with certain insurance plans and spoke about the difficulties of seeking and providing care across the Minnesota-Wisconsin border. Community members also feel that insurance companies should provide more transparent billing, as it is sometimes unclear what services cost. In general, they affirmed that the cost of care can prevent people from seeking care.

Across all counties HealthPartners serves, there were similar rates of uninsured adults and children compared to Minnesota and Wisconsin as a whole.[37] **All counties HealthPartners serves had adult uninsured rates lower than the national average of 12%.**

In Wisconsin, data shows a large disparity for insurance coverage for Hispanic adults under age 65 (19% uninsured) and American Indian adults (11% uninsured) (KFF 2022).[85]

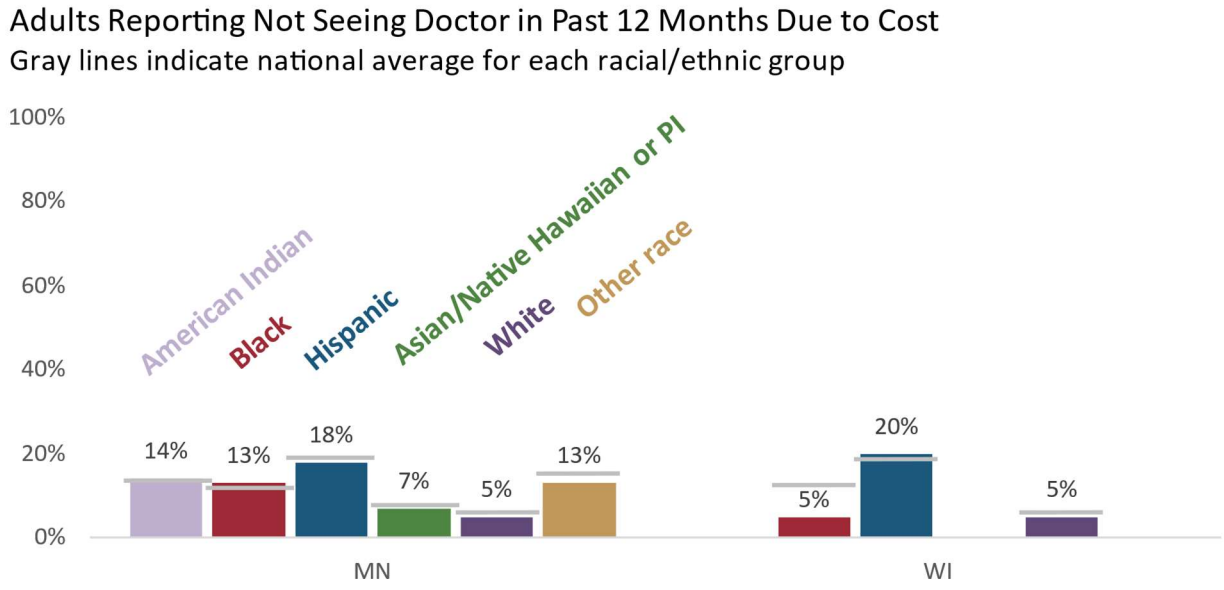


Across the country, 5% of children are uninsured. The rate is lower in both Minnesota (3%) and Wisconsin (4%). Of note, 6% of children in both Renville County and Polk County are uninsured.[37]



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 Wisconsin, 7% of all adults, including 20% of Hispanic adults, did not see a provider due to cost.[85]



Source: KFF, 2022

Blank = no data

In Wisconsin, 7% of children are in families who had **trouble paying medical bills** in the past twelve months. This is lower than the national average of 9% of children (KFF 2022).[85]

Individuals without health insurance experience higher rates of temperature-related mortality impacts.[16]

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

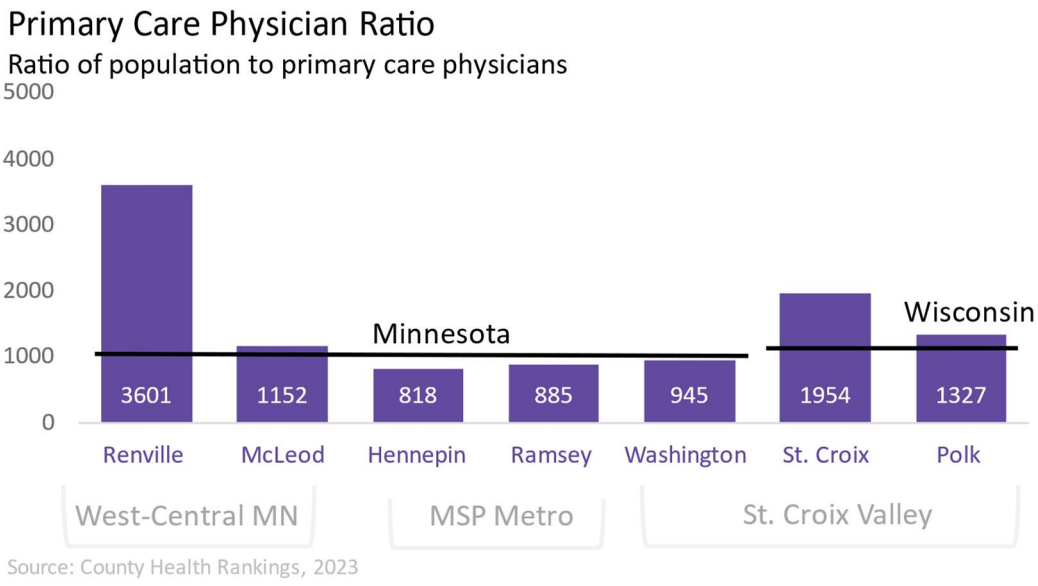
Availability of care includes availability of care providers, timeliness of appointment availability/care delays, availability of special services, availability of bilingual staff, interpreters and culturally appropriate care. Availability of care is impacted by workforce shortages, which vary by geography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

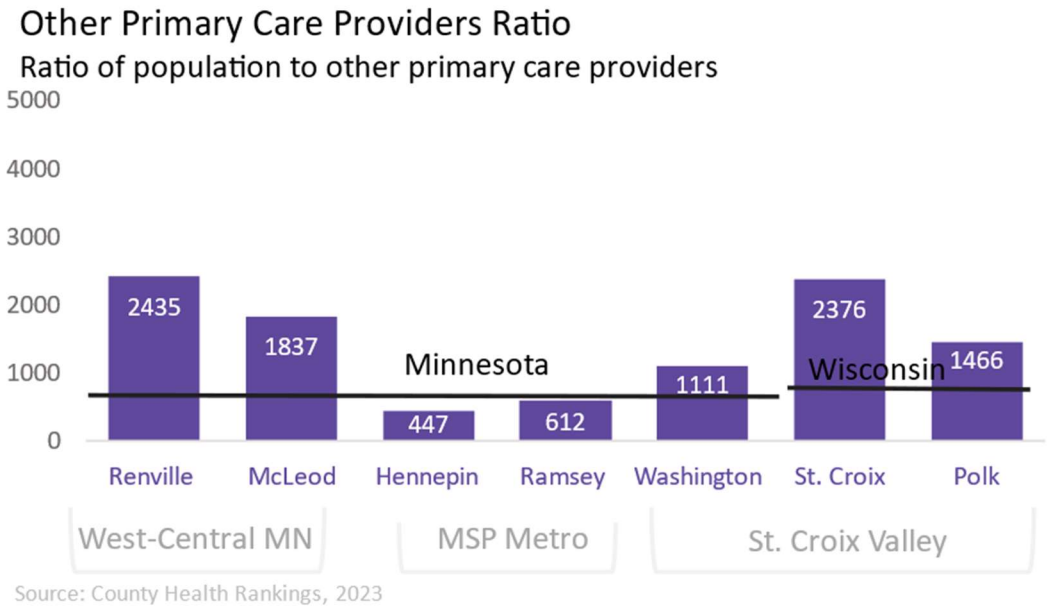
> Health care is too hard for too many patients to navigate

Community members in St. Croix County revealed several key factors affecting access to care. Better communication and education on navigating care systems and insurance plans are crucial, as effective care coordination helps patients access needed services. Workforce shortages, including health care providers and nursing home staff, limit care access and often lead to facility closures or reduced capacity. The community also needs more mental health providers and providers from diverse racial and ethnic backgrounds. Limited availability of specialized care, long waitlists for assisted living, and insufficient nursing home space create barriers, even for those with financial means. Additionally, improved access to emergency care, crisis stabilization, and detox programs is essential for addressing substance use disorders. Communication with patients must be timely, in their preferred language, and through appropriate modes like online portals for seniors. Finally, transportation remains a primary barrier to accessing care.

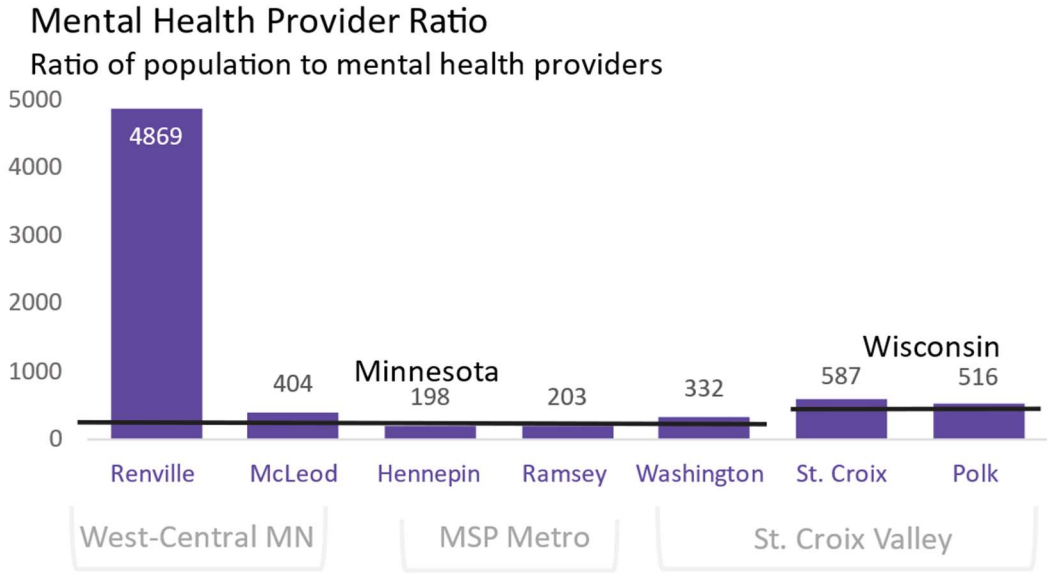
Primary care availability varied widely across counties HealthPartners serves, with some counties having **fewer primary care providers per capita** compared to their state ratio (1,110 people per 1 primary care physician in Minnesota and 1,242 per 1 primary care provider in Wisconsin) and the national average (1,330 per 1 primary care provider).[37]



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.**

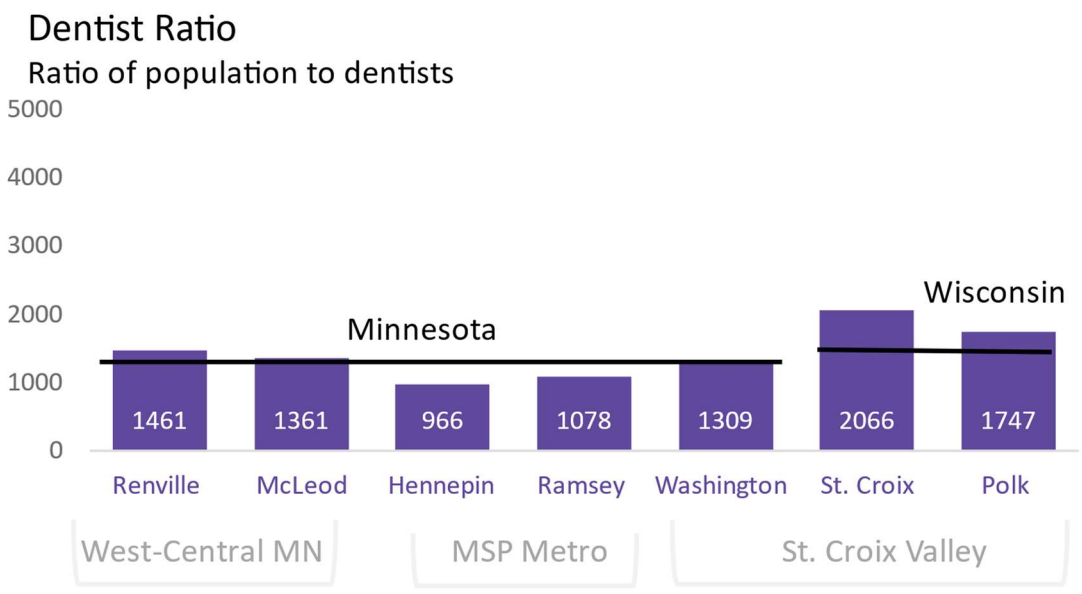


Mental health provider availability varies by geography as well. In the United States, there is, on average, one mental health care provider per 320 residents. Across Wisconsin, the ratio is similar with one provider per 423 residents. Not all counties have the same level of access, however.



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 Wisconsin, 11.4% of the population reports not having a personal health care provider, which is slightly below the national average of 14.5%. This percentage is significantly higher among Wisconsinites who identify as Asian/Native Hawaiian or Pacific Islander (27.7%) and Hispanic (24.9%).[86] The Wisconsin Department of Workforce Development estimates that health care practitioner jobs will grow by 2.5% over the next two years, which is just above the projected growth for all jobs.

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,[69] 9.7% of households in St. Croix County do not have internet access.

Availability is also determined by insurance coverage.[69] In St. Croix County, there are just three substance misuse service facilities accepting Medicaid and only three facilities that provide mental health services and accept 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 system. This subtopic includes the ability to get **understandable health information** from a health care provider, 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.

St. Croix County community members echoed these themes and shared that patients want stronger relationships with their care teams in an environment that is welcoming and culturally responsive. They feel it is also important to ensure that patients understand their health care (navigation and health literacy) and that their goals are being prioritized.

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, 88% of Westfields Hospital patients rated the hospital a 9 or 10, an increase from 87% in 2023 and 86% in 2022. Eighty-five percent of patients said they would definitely recommend Westfields Hospital in 2024, up from 84% in 2023 and 81% 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 St. Croix County, community members emphasized that access to care impacts all other areas of our lives. Since some of these issues exist on a large, systemic scale, it is important to think about our scope of influence and how we can affect change. They feel that HealthPartners could support communities' mental health by disseminating a list of resources people can access, hosting more community events connecting people to resources, and providing more education on how to access these resources. They also named the resource Know Your Cost, which compares the cost of medical care across different hospitals within HealthPartners.

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 below.

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.
- Participation in mental health coalitions continue, including the Make It OK Steering Committee, Healthier Together, and more.
- 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. Additionally, in our Wisconsin clinics we utilize the Integrated Behavioral Health Therapy model to also offer rapid access for Primary Care patients. Results to-date indicate significantly increased numbers of patients receiving Behavioral Health Care with average access to Behavioral Health Care in fewer than 5 days, and very high patient satisfaction. There is also a new single scheduling phone number for outpatient behavioral health care services.
- In 2022, the Crisis Immediate Access program facilitated tele-video assessments for 116 patients seeking urgent mental health and crisis support. Of these, 90 patients were referred from Valley HealthPartners hospitals, with 25 referrals coming specifically from Westfields Hospital. In 2023, the Crisis Immediate Access program provided tele-video assessments for 174 patients in need of urgent mental health and crisis support.
- In 2022, the Emergency Behavioral Health Tele-video program provided behavioral health assessment and referral for 223 Emergency Department patients, including 113 from the St. Croix Valley region (Polk, St. Croix, Pierce, and Washington counties), with 101 of those patients residing in St. Croix County, WI. In 2023, the program saw increased use among patients accessing emergency department care during mental health crisis. A total of 481 patients utilized the program, with 229 residing in St. Croix County, WI.

- The St. Croix Valley Grief Coalition was founded with over 70 members offering support, education and advocacy for grief.
- 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.
- Growing Through Grief is a no-fee, school-based grief counseling and crisis support program for K-12 students who have lost a loved one. Offered in two school districts within the Westfields Hospital service area, the program supports eight grief groups across eight schools, supporting 65 students. In 2023, Grief Counselors facilitated nine grief groups across the same eight schools, reaching 71 students. Additionally, the program provided support to 1,174 students and school staff during one death-related crisis event.

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.
- Westfields Hospital continued its sustainability efforts by installing bee hives, which have produced over 160 jars of honey, and enhancing the community garden with a new irrigation system. Additional efforts included setting up a bike repair station, installing two Level 2 EV charging stations, seeding and planting trees in the area, and reintroducing the farmers market on campus. These accomplishments earned the hospital several recognitions, including the PGH Emerald Award, Arbor Day Tree Campus Healthcare designation, Audubon Cooperative Sanctuary recognition, and the WSBC Green Master Award.

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.
- Efforts were focused to reduce and eliminate disparities in chronic conditions, preventive screenings, maternal and infant care, and childhood immunizations. With an emphasis on health equity, this involves identifying disparities related to race, socioeconomics, gender, and other factors. Some highlights of this work include:
    - Breast Cancer Preventative Screening: Interventions to reduce disparities included culturally humble scripting on preventive services, same-day mammograms, and telephone outreach to women of color and those in government programs, ages 50 to 75, who were overdue for a mammogram. Focused interventions were implemented at clinics with the greatest needs, with consultant support.
    - Colorectal Cancer Preventative Screening: Interventions to increase colorectal cancer screening rates focused on culturally sensitive outreach, improving access to screenings, and expanding initiatives to close gaps. A care model was developed to effectively initiate screenings, enhance patient education (available in seven languages), and address transportation barriers. Clinician training also targeted reducing bias and understanding patients' beliefs, concerns, and fears around screening. As a result, colorectal screening rates for patients of color at HealthPartners Medical Group improved from 43% in 2009 to 60.2% by the end of 2023, nearing the goal of 70%.
    - Immunizations: Interventions to close gaps included a focus on discussing immunizations with parents, direct outreach and extended Saturday hours at some

sites. There were improvements in completion rates for Combo 10 by 60 months and Combo 2 by 15 years.
    - Neonatal Virtual Care: In collaboration with Children's Minnesota, 24/7 neonatal virtual care is provided at Westfields Hospital. This technology enables critical audio/video consultations during newborn stabilization, ensuring timely access to pediatric and neonatal specialists.
    - Outpatient Lactation Programs: Westfields Hospital birthing center provides inpatient and outpatient lactation services to support breastfeeding success. These programs offer education, community connection, and resources for improved maternal and infant health outcomes.
- The Faith Community Nursing program began expansion efforts in New Richmond, with an overwhelmingly positive partner response. New partnerships continue to develop.
- Expanded technology use to engage patients and promote healthy behaviors, including: enhanced and increased mobile check-in and text communications; increased account creation, patient arrival, and online scheduling; advanced virtual care services in primary care; refined and spread virtualist with APH models; increased outreach via MyChart for preventive and chronic disease management.
- Care Coordination in 2023 focused on transition care management and patients needing more focused attention due to high risk for readmission to hospital or Emergency Department. This model uses registered nurses to outreach and coordinate care. There are dedicated hospital follow-up visits held on schedules so patients are able to get into primary care to see clinicians within 1-2 weeks of discharge.
- Clinic and services expansion has continued, making progress in the following areas:
    - Advance Practice Clinicians have been added, who complete virtual visits.
    - Twelve new primary care clinicians have joined the Valley Clinics, significantly expanding access.
    - Telemedicine is offered to reach patients in rural locations.
    - Advance Practice Clinicians have been added to several specialties including Urology, Neurology and Otolaryngology to reduce wait times and improve continuity of care.
- The Patient Family Advisory Committee meets quarterly to provide insights and improve the care experience, working toward enhanced patient satisfaction and service improvements. At Westfields Hospital, the committee made notable contributions by offering feedback on preferred methods for receiving chemotherapy medication information to the director of the Cancer Center of Western Wisconsin, who presented two different approaches for their input. Additionally, the OB nurse manager introduced the new Teledoc program, which provides 24/7 on-demand audio/visual consultations with neonatologists at Children's Hospital in Minneapolis for neonatal patients requiring acute stabilization. This presentation aimed to inform the committee about this new service, which enhances Westfields' capabilities as a critical access hospital.
- High quality diabetes education programs are offered for patients and families. A new 10-week weight-loss class, Healthy Weight Matters, began. Additional monthly classes, Stomp Out Diabetes and Food for Life, continue to be offered, as do podcasts and community education classes around diabetes education. Outpatient nutrition education sessions have increased from 44 per month in 2021 to 134 per month in 2022, 142 per month in 2023 and 75 per month the first quarter of 2024. The total number of patients seen in diabetes education at Westfields Hospital was 422 in 2022 and 414 in 2023. Diabetes education continues to work with patients

to develop affordable payment plans, and Westfields Hospital offers an insulin assistance program to help patients afford insulin.

- Community health education classes and podcasts were offered to community members in 2022. A total of 265 community members attended classes and 2,010 people listened to one or more health education podcast. Classes and podcasts have paused, as the colleague managing them has retired.
- Westfields Hospital conducts community outreach and education focused on injury prevention. Since 2022, the hospital has carried out 10 car seat inspections, distributed 30 bicycle helmets at bike rodeos in collaboration with the New Richmond Police Department, and hosted Stop the Bleed classes, engaging 40 participants.
- Focused work on increasing awareness and engagement in health care employment continues. Partnerships with high schools continue, and partnerships with post-secondary schools to create customized cohorts are also being explored. A three-pronged approach in partnership with local high schools includes:
    - Career exploration activities
    - Applied learning, including embedding health care topics into curriculum in partnership with high school teachers to provide real-world application to state curriculum
    - Professional mentorship and career opportunities
- Community Paramedicine provides follow-up home visits for patients after discharge from the hospital for congestive heart failure. In 2022, the Community Paramedicine program served 576 patients, preventing 96 future hospital admissions. In 2023, the program served 444 patients with a total of 1,196 home visits.
- Homecare, Palliative Care & Hospice provides in-home care to seriously ill patients and supports them and their caregivers. Since 2022, 1,655 patients were served.
- 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 ensure patients have resources and instructions that will help the patients 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.

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 in 2023 and 2024 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.

Substance Use

Goal: *Reduce Substance Use*

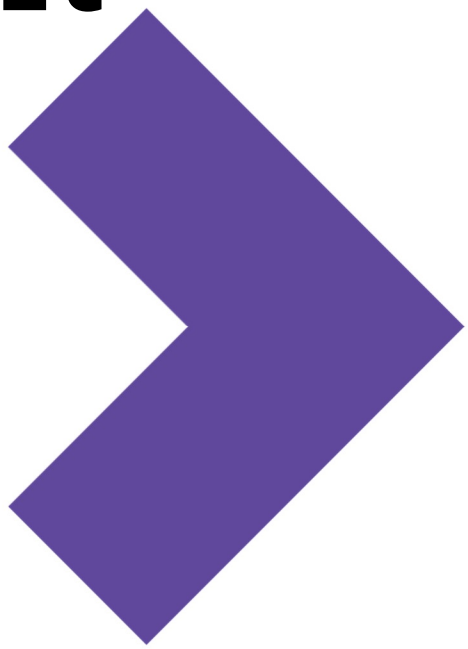
Strategies:

- 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.
- HealthPartners hospitals in the St. Croix Valley have continued to re-examine and monitor prescribing patterns and have adjusted the quantity and strengths of opioids prescribed. In 2022, the number of patients receiving a new opioid prescription decreased 9%, and the number of pills prescribed reduced by 13%. In 2023, new patient opioid prescriptions reduced by 5% and the number of pills prescribed reduced by .2%. Medically complex patients or patients using opioids have been invited to participate in medication therapy management (MTM).

- Drop boxes are located at the hospital to collect prescription medication and opioids in a secure manner. Since 2022, more than 1,389 pounds of medication have been collected at Westfields Hospital.
- Programs for Change is a compassionate, non-judgmental intensive outpatient substance use disorder treatment and recovery program using evidence-based models. In 2022, the program at Westfields Hospital completed 87 assessments.
- Substance use community collaborations remain key to advancing community health.

What's Next

Throughout the 2024 Community Health Needs Assessment process, Westfields Hospital & Clinic, 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.



Community Strengths

Each HealthPartners hospital in the St. Croix Valley area has a longstanding tradition of collaboration and community partnership.

- Lakeview Hospital has closely collaborated with Washington County Public Health & Environment for more than 25 years with shared leadership of a Community Health Action Team that still collaborates today.
- Hudson Hospital & Clinic and Westfields Hospital & Clinic has closely collaborated with St. Croix County Public Health, Pierce County Public Health, Western Wisconsin Health and River Falls Hospital for many years.
- Amery Hospital & Clinic has closely collaborated with Polk County Public Health, Osceola Medical Center and St. Croix Health for many years.

In addition to this thorough CHNA process, our hospitals are engaging with, listening to and partnering with community on an ongoing basis. Valley communities have a strong sense of community identity, which fosters involvement and collaboration of citizens in this work. This is a strength as we develop our implementation plans with and for community. HealthPartners' current programs have a high level of community engagement and partnership with schools, public libraries, park systems, local nonprofits and others.

Broad strengths in the St. Croix Valley that are often mentioned by community members include: many recreational opportunities, beautiful natural surroundings, excellent schools, many ways to be involved in community and a desire to give back and help out others.

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 Westfields Hospital & Clinic website: https://www.healthpartners.com/care/hospitals/westfields/about/community-health-needs/

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 Westfields Hospital & Clinic serves. This interrelated framework will be used by Westfields Hospital & Clinic 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 Westfields Hospital & Clinic 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 Hudson, Westfields, and Valley Community Engagement

Hudson and Westfields Hospitals
Community Conversation
Westfields Patient & Family Advisory Council
Hudson Hospital Patient and Family Advisory Council
New Richmond Ministerium

Valley Region
Community Conversation
Valley CHNA Committee
Valley Health Equity Committee
Polk and St. Croix Counties Emergency Food Systems Meeting
WI Community Health Action Committee
Valley Social Workers, Care Management, Faith Community Nurses

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

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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 Relations
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
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

HealthPartners St. Croix Valley Hospitals **CHNA Steering Committee Members**

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Deb Rudquist
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Marna Canterbury
Katy Ellefson
Andrea Anderson
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