2022

MINNESOTA COMMUNITY CARE

Community Health Needs and Assets Assessment

We're here. For you.

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CHAPTER 1: INTRODUCTION

Since 1969, Minnesota Community Care has been a safety-net health care provider for historically marginalized and underserved communities. Our mission "to strengthen the well-being of our community through health care for all" is inspired by a living history rooted in the push for health equity and the fight for the fundamental human right of access to health care for all. To impact health disparities, we focus on the incredibly complex and substantial barriers our communities face to leading health lives; we serve people throughout their lives and across generations; and we make our communities stronger in the process. We currently have 19 sites across St. Paul and the east metropolitan Twin Cities Area, including clinics in West Side St. Paul, in East Side St. Paul, in Farmington and co-located within 10 St. Paul Public High Schools, in McDonough Homes public housing, in the St. Paul Opportunity Center and United Gospel Mission for those experiencing homelessness, and in the Fairview Community Health and Wellness Hub.

The Community Health Needs and Assets Assessment (CHNAA) is an opportunity to hear from our patients and larger community about what they want to see in a community health center. It is not only a federal requirement for Federally Qualified Health Centers (FQHCs) such as ourselves, it is also the cornerstone on which we develop our strategic priorities as an organization.

In our last Community Health Needs and Assets Assessment in 2019, ***Community Collaborative Approach to Health Equity***, Minnesota Community Care partnered with SoLaHmo in a participatory process that centered and amplified the communities' voice. From that process emerged 24 key community recommendations, centered on 1) partnership and collaboration, 2) culture of equity, 3) structure for equity, 4) access to care and 5) high-quality care.

With these recommendations, Minnesota Community Care sought to improve the work we do and care we provide by the following:

1) Partnership and collaboration:

- MCC established a relationship with a local insurance navigation organization to provide patients with affordable, accessible healthcare, and connect eligible patients to insurance and public.
- MCC partnered with multiple community organizations, including Neighborhood House, UMN Mobile Health Initiatives, Catholic Charities, Ramsey County, to coordinate testing and vaccination for COVID 19.
- MCC's prenatal program for high-risk African-American mothers continued connection with the Minnesota Department of Human Services Integrated Care for High Risk Pregnancies (ICHRP) Initiative.
- MCC staff serve on the Minnesota council for HIV/AIDS Care and Prevention and work with Minnesota Department of Health (MDH) and Minnesota Department of Human Services (DHS) specifically work on the disparities elimination committee
- MCC further leveraged existing relationships with higher education and allied health institutions to increase certification and skills of MCC internal staff and students who are entering the healthcare workforce

2) Culture of Equity:

- MCC invested in diversifying the workforce at all levels of the organization, including increased ethnic diversity at the executive level
- The women's health team hired two women of African descent to meet the needs of the growing patient population of African descent.
- The organization has focused on more culturally inclusive artwork and murals in clinical hallways/building
- MCC has increased hiring of providers and leaders from historically intentional excluded populations, including but not limited to employees of diverse racial and ethnic backgrounds, employees in the LGBT+ community, and employees in recovery.
- So that more providers authentically represent the communities we serve, MCC redesigned student experiences to reflect the patient population at each clinic and co-located site.

3) Structure for equity:

- Improvements in the patient experience have been key: refocusing clinical/operational policies and workflows, decreasing wait times, improving telehealth access, simplifying appointment types to open access to patients and our communities.
- MCC strives to increase access for visits with family at one time (siblings, parents, etc.) to decrease barriers of accessing care.
- MCC seeks to be in the places where our community needs us to be. We are funded in the St. Paul Public Schools school-based clinics (SBCs) to achieve positive impact in battling Health Disparities with our EHDI (Eliminating Health Disparities Initiatives) in the schools where we provide services. Our efforts have been documented along with our success in reaching students of non- Euro dominant culture.

4) &5) Access to high quality care:

- We continue to offer our services by appointment and walk-ins and accommodate any evening/weekend needs
- MCC patient care teams meet regularly to better understand the needs of patients/community members that resulted in individualized and team training to eliminate barriers for our patients.
- Risk assessments changed to include psychosocial elements because of the Covid-19 pandemic. Now, MCC specifically assesses and ask patients to self-identify their mood, inquire about needed resources and make referrals when appropriate.
- In 2020 and 2021, the creativity of our staff increased to address the growing requests. Our HIV team offers home HIV testing kits, will send confidentially by mail, and make follow up phone calls.
- We have opened 2 new sites to better serve our communities, including our Farmington Clinic in November 2021 and the St. Paul Wellness Center in July 2022.
- Health Navigators (HN) and our scheduling team ensure patients have interpreters available or schedule the interpreter for the patient so their care is not negatively affected. The HN team helps the patient navigate the often-confusing healthcare system and get connected to care that may have been otherwise inaccessible because of cost, language barriers, or other barriers.

The CHNAA is instrumental in our clinics – it is the foundation for our strategic planning and goals and helps us shape priorities in the years ahead.

Scope of Project

As the last Community Health Needs and Assets Assessment (CHNAA) used secondary data to understand the needs of our larger community. This year, we wanted to hear directly from our key populations in their own words. The COVID19 pandemic has changed demands and priorities, and we want to better understand how we can walk that path with our communities.

With this focus, we specifically sought leadership, guidance, and feedback from the following 4 communities:

1. Those experiencing homelessness or housing insecurity
2. Those living in public housing
3. Those in school, particularly in St. Paul Public High Schools
4. Those living in the south metro, including Farmington, Burnsville and Apple Valley

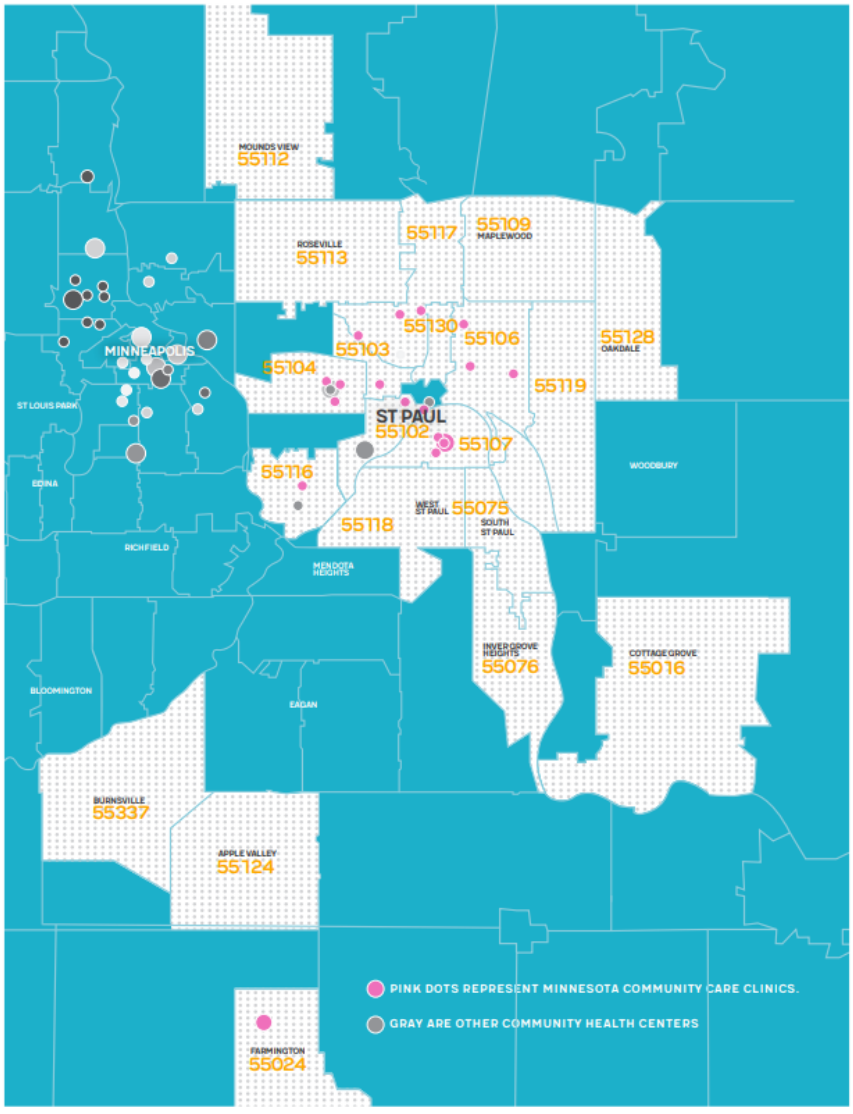
Minnesota Community Care identified these communities as they were not specifically examined in the last CHNAA, they have experienced some of the most instability during the COVID19 pandemic, and they are communities where we want to enhance our care.

While this approach gives more depth into the needs of these 4 key populations, it does not necessarily capture in totality the needs and assets of our larger service area. Additional secondary analysis using population health data sources were performed to give an overview of our larger service area and is including in the following section, "Population Health Snapshot."

POPULATION HEALTH SNAPSHOT

Per HRSA guidelines, the Minnesota Community Care Service Area is the geographic area where 75% of our patients live. In the last 3 years, our service area has grown to include an additional 4 zip codes, including Cottage Grove, Mounds View, Apple Valley and West 7th Street (Please see Figure A and Table A). This section seeks to better understand our service area and larger population with information collected from state and national surveys.

FIGURE A. MINNESOTA COMMUNITY CARE SERVICE AREA, 2022



UPDATED: JULY 2022

TABLE A. SERVICE AREA ZIP CODES AND NEIGHBORHOOD NAMES

Zip Code	Neighborhood Name
55016	Cottage Grove
55075	South Saint Paul

55076	Inver Grove Heights
55102	West 7th / Summit Hill
55103	Rondo / North End
55104	Midway / Frogtown
55106	East Side St. Paul
55107	West Side St. Paul
55109	Maplewood
55112	Mounds View
55113	Roseville
55116	Highland Park
55117	St. Paul / Little Canada
55118	West Saint Paul
55119	Greater Eastside / Highwood / Battle Creek
55124	Apple Valley
55128	Oakdale
55130	Payne-Phalen
55337	Burnsville

KEY DEMOGRAPHIC DATA:

INCOME.

Our service area covers a population of over 638,000 residents. Nearly 13% of residents in this geographic area live in poverty (less than 100% of the federal poverty limit) and nearly 30% are low income (less than 200% of the federal poverty limit), both numbers higher than the Minnesota state average[1] and higher than when we conducted our last CHNAA. The Payne Phalen neighborhood in the middle of St. Paul has the highest rate of poverty and low income (32.4% and 60.5% respectively). These rates are remarkably 3 times higher than in other parts of our service area and highlight the disparities and different communities served by our health centers. Low income rates are lowest in the south metro neighborhoods of Cottage Grove (10.3%) and Apple Valley (14.4%), lower than the Minnesota average of 23.7%. A third of our service area is unemployed (compared to 32.9% of the state of Minnesota, with highest rates in the Rondo/North End neighborhood (41.4%) and West St. Paul (38.2%). Despite such a high proportion of residents across our service area who are low-income, only about 25% of that population seek

[1] UDS Mapper, American Community Survey 2015-2019

health care at community health centers, meaning the vast majority of low income residents seek care with larger or private health systems.

TABLE B. PROPORTION OF LOW INCOME POPULATION IN SERVICE AREA BY ZIP CODE, 2019

Zip Code	Low-Income (#)	Low-Income (%)	Poverty (%)	Proportion of Low-Income Residents Seen at Community Health Centers
Total Service Area	186363	29.6%	12.9%	24.9%
55016	3721	10.3%	2.3%	15.3%
55075	5184	25.7%	11.0%	23.8%
55076	4816	22.0%	9.2%	17.5%
55102	5582	30.9%	12.2%	61.5%
55103	8008	57.6%	28.6%	22.5%
55104	15050	34.6%	19.6%	27.2%
55106	27663	47.3%	21.4%	35.7%
55107	6180	43.8%	20.9%	37.7%
55109	9303	27.7%	8.9%	15.4%
55112	9526	21.9%	9.7%	14.3%
55113	9028	22.4%	10.2%	15.0%
55116	6080	24.7%	11.1%	34.5%
55117	19404	42.9%	18.5%	21.7%
55118	6400	22.8%	11.1%	29.8%
55119	15495	35.8%	14.4%	25.2%
55124	7580	14.4%	5.4%	10.9%
55128	6087	21.2%	7.9%	16.5%
55130	10871	60.5%	32.4%	26.0%
55337	10385	23.2%	7.4%	12.0%

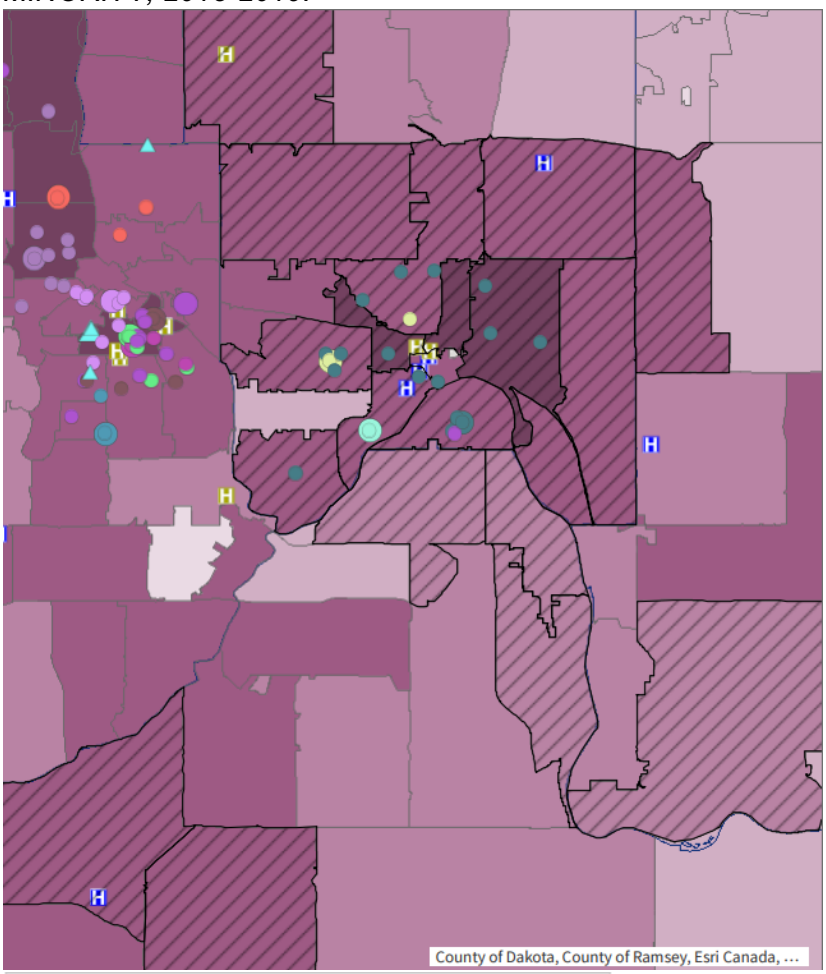
RACE & ETHNICITY.

Utilizing the definitions from the US Census Bureau and the American Community Survey from 2015-2019, 38.1% of Minnesota Community Care's service area identifies as a racial or ethnic

minority.[2] While zip codes in central St. Paul, including Payne Phalen, East Side St. Paul and Rondo/North End have over 68% of their population who self identify as a racial or ethnic minority, others such as Cottage Grove are much lower (19.3%) (See Figures B-F). In our service area, 67% of residents are white / European American, 13% Asian or Asian American, 12% Black or African American, 9% Latino/a/x or Hispanic and 0.6% Native American or American Indian,[2] which differs from our patient population that largely identifies as communities of color. Only 5% of our service area households have limited English proficiency, but this is over double the state average. Notably the neighborhoods of Payne Phalen (19%), Rondo/North End (14%), and East Side (13%) have the highest proportion of households with limited English proficiency. Westside St. Paul is slightly higher than our service area average at 7%.

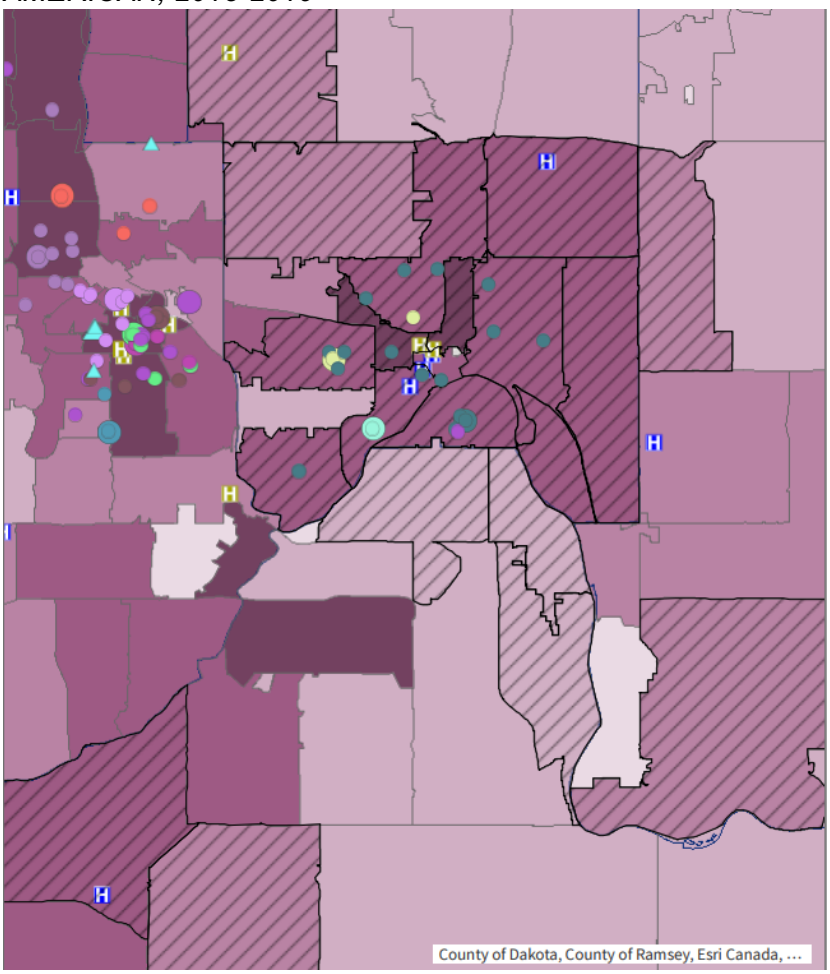
[2] American Community Survey (ACS) five-year estimates for counties or ZCTAs, 2015-2019 (U.S. Census Bureau)

FIGURE B. PERCENT OF POPULATION THAT SELF IDENTIFIES AS RACIAL OR ETHNIC MINORITY, 2015-2019.



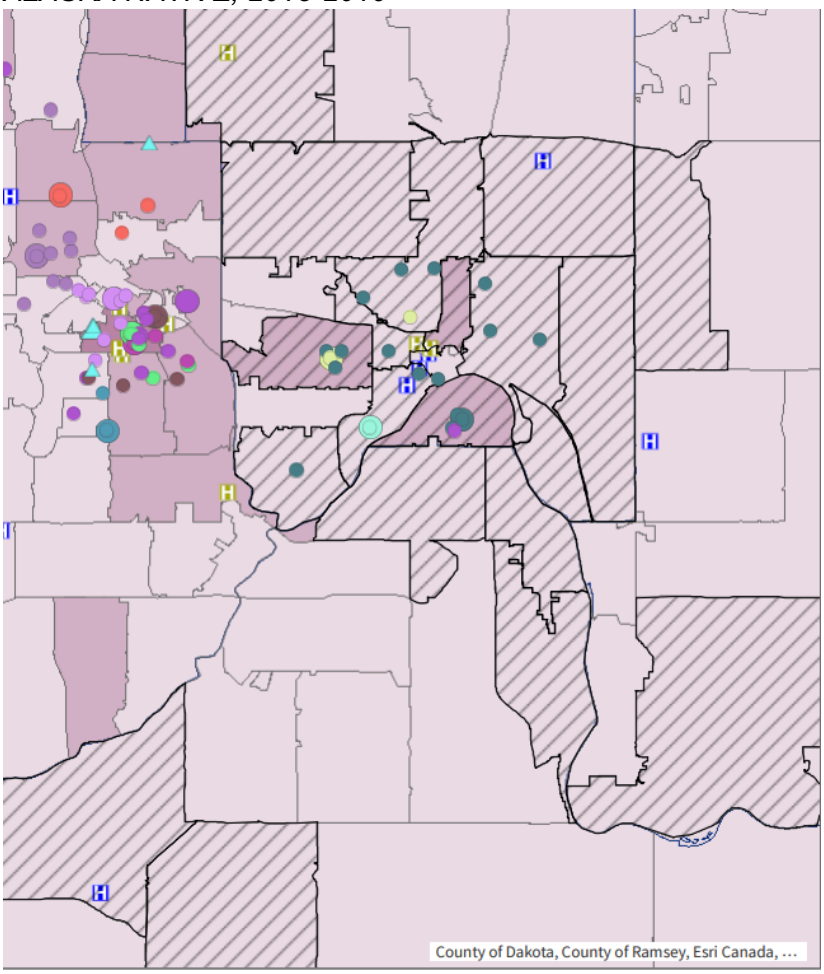
Pop: Racial/ Ethnic Minority (%) 2015-2019
<5%
5 - 10%
10 - 20%
20 - 50%
>50%

FIGURE C. PERCENT OF POPULATION THAT SELF IDENTIFIES AS BLACK / AFRICAN AMERICAN, 2015-2019



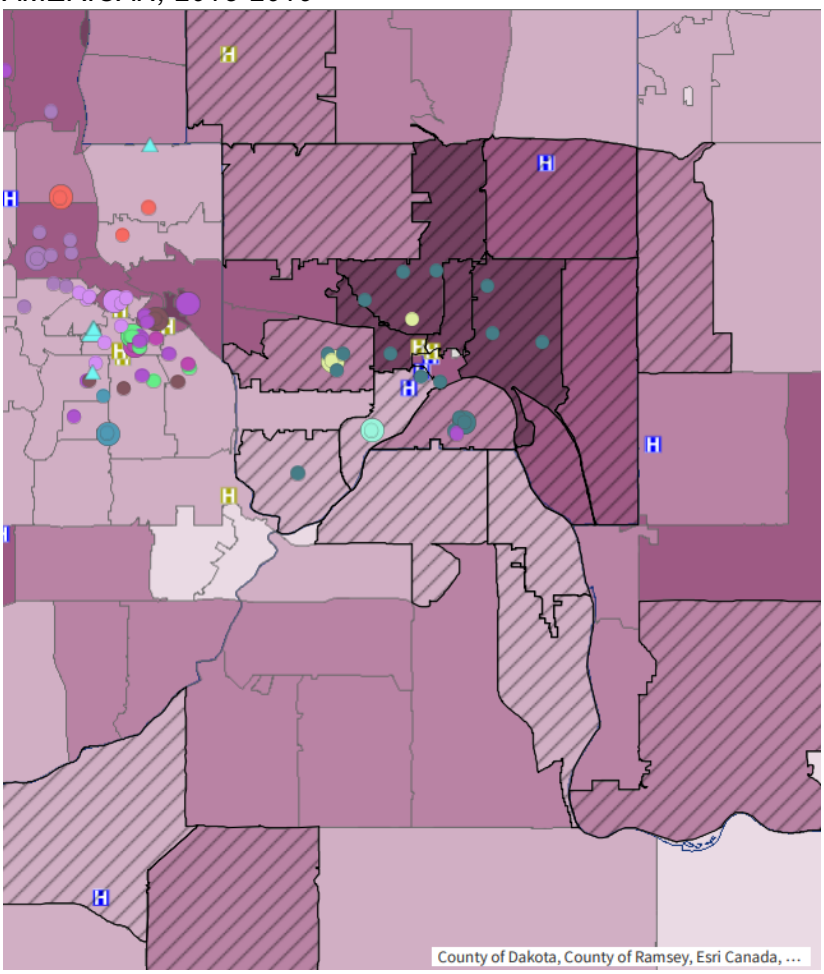
Pop: Black (%) 2015-2019
<1%
1 - 5%
5 - 10%
10 - 20%
>20%

FIGURE D. PERCENT OF POPULATION THAT SELF IDENTIFIES AS AMERICAN INDIAN / ALASKA NATIVE, 2015-2019



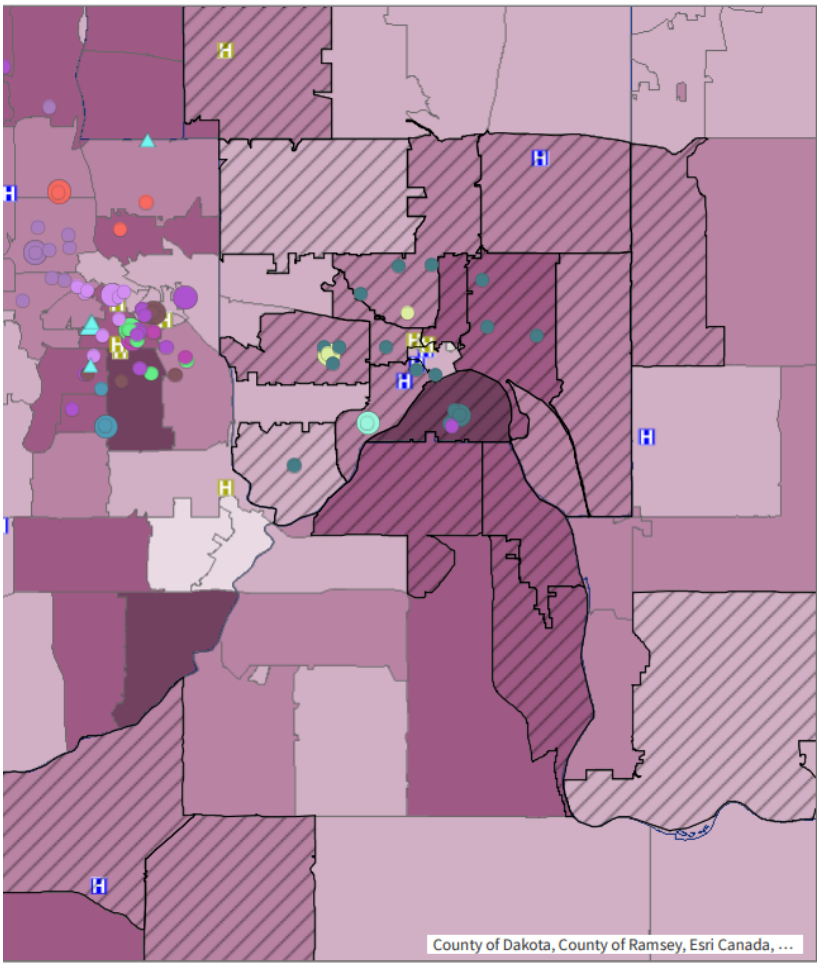
Pop: American Indian/ Alaska Native (%) 2015-2019
<1%
1 - 5%
5 - 10%
10 - 20%
>20%

FIGURE E. PERCENT OF POPULATION THAT SELF IDENTIFIES AS ASIAN / ASIAN AMERICAN, 2015-2019



Pop: Asian (%) 2015-2019	
<1%	
1 - 5%	
5 - 10%	
10 - 20%	
>20%	

FIGURE F. PERCENT OF POPULATION THAT SELF IDENTIFIES AS HISPANIC / LATINO, 2015-2019



Pop: Hispanic/Latino (%) 2015-2019
<1%
1 - 5%
5 - 10%
10 - 20%
>20%

TABLE C. PERCENT OF POPULATION WITH SELF-IDENTIFIED RACE OR ETHNICITY BY ZIP CODE, 2015-2019

Zip Code	American Indian / Alaska Native (%)	Asian / Asian American (%)	Black / African American (%)	Hispanic / Latino/a/x (%)	Racial / Ethnic Minority (%)	White / European American (%)
Service Area Summary:	0.6%	13%	12%	9%	38%	67%
55016	0.3%	7%	5%	5%	19%	84%
55075	0.8%	2%	3%	14%	25%	81%
55076	0.2%	4%	4%	13%	23%	83%
55102	0.6%	2%	10%	8%	25%	79%
55103	1.0%	25%	33%	7%	70%	34%
55104	1.2%	8%	19%	7%	39%	66%
55106	0.9%	37%	14%	12%	68%	40%
55107	1.7%	6%	14%	30%	56%	57%
55109	0.4%	14%	11%	7%	37%	67%
55112	0.3%	6%	8%	6%	25%	78%
55113	0.5%	9%	9%	3%	26%	76%
55116	0.3%	3%	16%	4%	26%	76%
55117	0.7%	25%	17%	9%	55%	51%
55118	0.2%	4%	4%	17%	27%	81%
55119	0.7%	19%	18%	10%	52%	54%
55124	0.2%	6%	9%	6%	25%	78%
55128	0.4%	9%	9%	6%	28%	76%
55130	2.0%	38%	23%	14%	80%	29%
55337	0.1%	5%	14%	6%	29%	74%

INSURANCE STATUS.

Similar to income, the Minnesota Community Care Service Area has higher rates of residents without insurance or who have Medicaid than the state average. These rates are higher in the central zip codes of St. Paul. Over 21% of residents in the MCC Service area have Medicaid, but only 14.7% of those residents receive care at health centers, indicating that they are seeking care elsewhere. While the zip codes in the south metro have fewer residents with Medicaid, there are

also fewer clinics that accept Medicaid insurance, limiting access to care in a different way. Notably, 73% of our service area has Medicare or private insurance and only 5.8% are uninsured, different than the proportion that is seen in our clinics.[3]

TABLE D. PERCENT OF POPULATION WITH OR WITHOUT INSURANCE BY TYPE AND ZIP CODE, 2019.

Zip Code	Uninsured (%)	Medicaid/ Public Ins (%)	Medicare/ Private Ins (%)	Proportion of Medicaid/ Public Ins. who go to Community Health Centers (%)
Service Area Summary:	5.8%	21.2%	73.0%	14.7%
55016	3.0%	9.0%	88.0%	5.1%
55075	7.0%	19.9%	73.1%	12.1%
55076	5.6%	16.2%	78.2%	7.6%
55102	6.7%	21.8%	71.5%	32.2%
55103	8.5%	29.6%	61.9%	26.3%
55104	5.7%	19.2%	75.1%	22.4%
55106	8.6%	38.0%	53.3%	19.8%
55107	7.7%	34.4%	57.9%	20.2%
55109	5.8%	18.1%	76.1%	9.5%
55112	4.7%	19.4%	75.8%	6.1%
55113	5.0%	14.5%	80.5%	8.3%
55116	4.2%	14.1%	81.7%	19.9%
55117	7.5%	24.7%	67.8%	20.0%
55118	5.8%	16.5%	77.7%	14.2%
55119	7.4%	27.7%	64.9%	13.4%
55124	3.0%	13.9%	83.1%	3.3%
55128	4.9%	14.8%	80.2%	8.5%
55130	9.1%	41.9%	49.0%	20.0%
55337	4.9%	19.5%	75.6%	3.8%

[3] American Community Survey (ACS) one-year estimates for PUMAs, 2019 (U.S. Census Bureau)

EMPLOYMENT & EDUCATION.

A third of the Minnesota Community Care service area is unemployed, with rates highest in the Rondo/North End zip code of 41.5%. Ten percent of our service area has less than high school education, much higher than the state average of 6.5%. Further disparities remain within our service area, as over 25% of the Payne-Phalen neighborhood has less than high school education, in comparison to less than 5% in Apple Valley and Cottage Grove.[2]

AGE.

Twenty-four percent of our service area is children less than the age of 18 and 17% are school-aged. Neighborhoods range in population of children with 16% in the West 7th neighborhood to 35% in Payne-Phalen. Fourteen percent of our population are elders ages 65 and older, with the lowest population living in Payne-Phalen (6%) and highest in West St. Paul (22%) and Roseville (21%). While the proportion of elders and children varies in zip codes, the proportion of adults ages 18 to 64 is similar, ranging between 58%-69% of the service area.[2]

FIGURE G. POPULATION UNDER AGE 18, 2015-2019

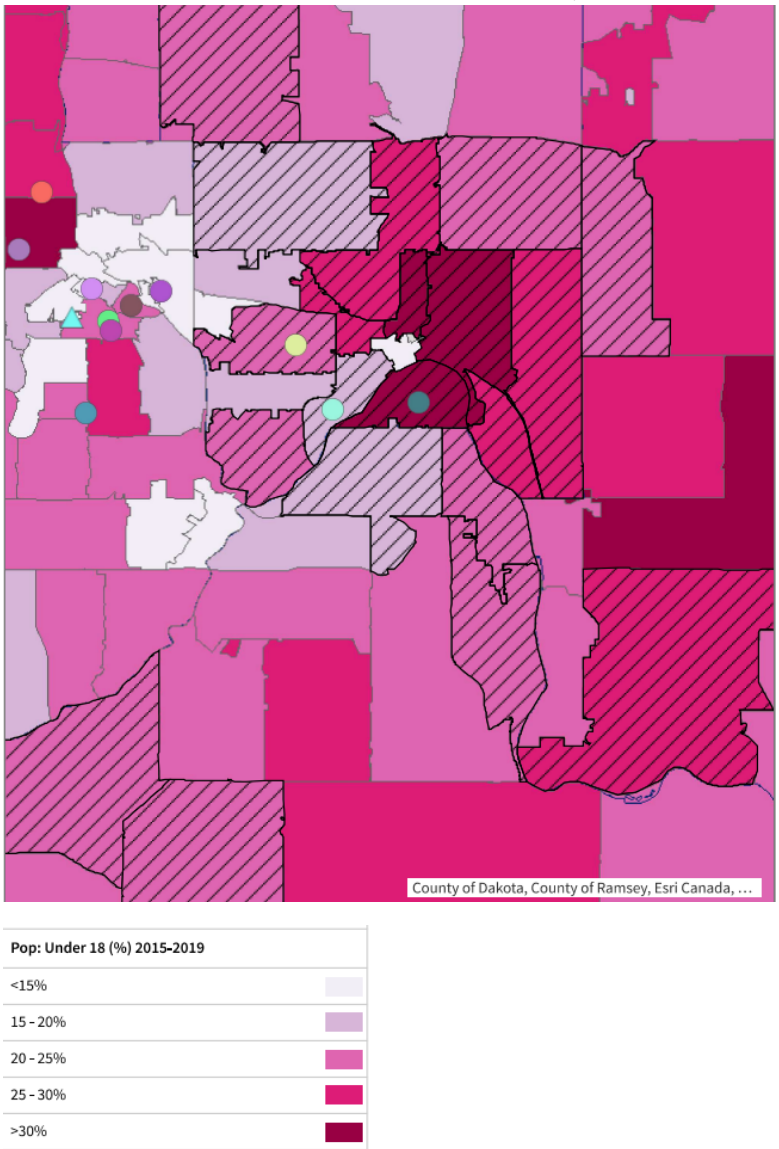
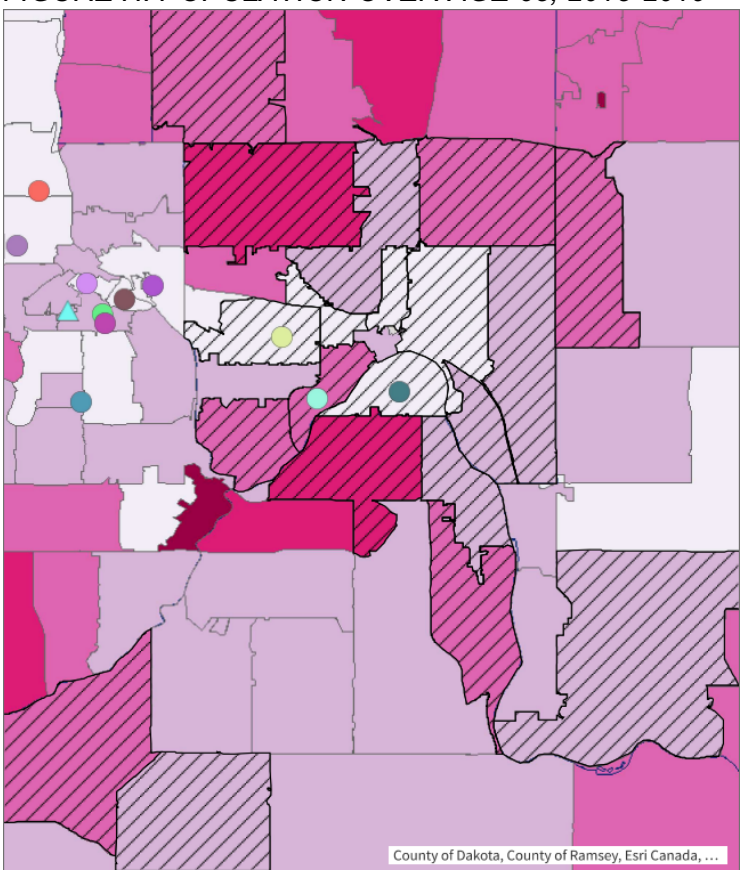


FIGURE H. POPULATION OVER AGE 65, 2015-2019



Pop: 65 and older (%) 2015-2019
<10%
10 - 15%
15 - 20%
20 - 25%
>25%

DISABILITY.
Fourteen percent of our service area reports to have a disability. This is highest in Rondo/ North End (21.9%), East Side (17.6%) and Maplewood (17.3%).[2]

TECHNOLOGY.
Access to broadband internet is a further indication about our communities' connection to care. Nearly 14% of the Minnesota Community Care service area does not have access to broadband internet in their homes, lower than the state average of 15%. Nonetheless, metro neighborhoods with higher than state average include Rondo / North End (27.2%), Payne-Phalen (22.2%), West St. Paul (17.8%), and St. Paul / Little Canada (16.7%).[2]

ACCESS TO CARE.

Due to multiple different pressures, many in our neighborhoods do not have access to the care they need. The most recent data available about our service area is from 2017, notably prior to the COVID19 pandemic where access to care became further strained. Twenty-seven percent of the adults in our service area have no usual source of care. This ranges from only 15% in Highland Park to 37% in South St. Paul.[4] More than half of the neighborhoods in our service area have higher than Minnesota state average lack of regular care (Figure G and Table E). The proportion of adults who have delayed care due to cost within our service area is notably higher than the Minnesota state average of 9.8%, but ranges from 7% in Highland Park to 14% in South St. Paul.[4]

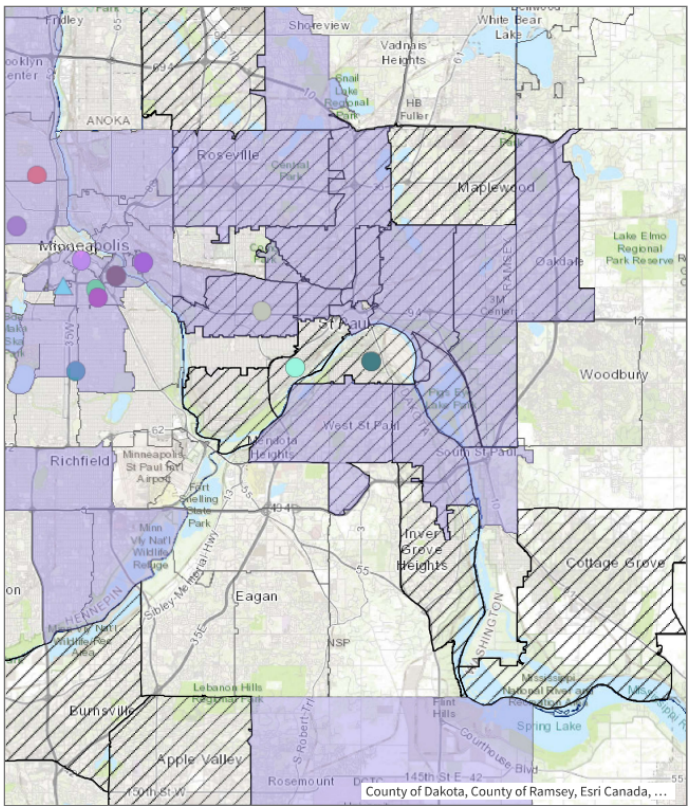
Access to dental care is a unique challenge for our service area, with 30% of adults reporting no dental visit in the last year. This jumps to 50% of the Payne Phalen neighborhood, 47% of Rondo / North End, 41% of East Side, and 38% of Westside St. Paul.[4]

Within the Minnesota Community Care Service area, there are 5 area hospitals. In the Minneapolis/ St. Paul Metro in 2019, there was a fairly low ratio of 304 people to 1 physician, reflecting improved access for patients than the more rural areas in Minnesota. However, access to primary care physicians is more limited, being 1001 people to 1 physician.[5] There are lower rates of general family medicine in the metro area (13.9% compared to 16.2%) and slightly higher rates of pediatricians (6.2% vs 4.9%). There are more psychiatrists in the metro area than the state average, but still only 2.6% of physicians.[5]

[4] Behavioral Risk Factor Surveillance System, 2017 (Centers for Disease Control and Prevention)

[5] Minnesota Board of Medical Practice, June 2019.
https://www.health.state.mn.us/data/workforce/phy/docs/cbphys.pdf

FIGURE I. PERCENT OF ADULTS WITH NO USUAL SOURCE OF CARE, 2017.[4]



Pop: Adults with No Usual Source of Care, Est. (%), 2017 — 26 to 61%

TABLE E. ACCESS TO CARE BY ZIP CODE, 2017.[4]

Zip Code	Adults with No Usual Source of Care, Est. (%) 2017	Adults Who Have Delayed/ Not Sought Care Due to Cost, Est. (%) 2017	Adults with No Dental Visit in Past Year, Est. (%) 2017
Service Area Summary	27%	12%	30%
55016	24%	11%	24%
55075	37%	14%	28%
55076	22%	9%	26%
55102	18%	14%	27%
55103	28%	13%	47%
55104	28%	14%	30%
55106	32%	13%	41%

55107	23%	12%	38%
55109	17%	10%	28%
55112	25%	13%	24%
55113	31%	14%	24%
55116	15%	7%	23%
55117	28%	12%	38%
55118	33%	13%	25%
55119	29%	13%	32%
55124	26%	11%	23%
55128	29%	11%	27%
55130	35%	13%	50%
55337	25%	12%	26%

HEALTH DISPARITIES IN OUR SERVICE AREA

Within the Minnesota Community Care service area, several key disparities deserve ongoing examination.

AGE ADJUSTED MORTALITY.

Remarkably, our service area has a lower total age-adjusted mortality rate than the Minnesota average (625/100,000 and 649/100,000 respectively).[6] Concerningly, however, there is great disparity between neighborhoods, where some neighbors have a rate 30% greater than others. Notably, neighborhoods farther out from the metro, including South St. Paul, West St. Paul, Inver Grove Heights, Oakdale, Burnsville, Apple Valley and Cottage Grove all have significantly lower age adjusted mortality rates.

LOW BIRTHWEIGHT.

Infants born weighing less than 2500 grams or 5.5 pounds are considered low birthweight and are more likely to have future health concerns as adults. The rate of low birthweight infants in Minnesota is 6.9 per 100 births, lower than the national average of 8.3 per 100 births. Within our service area, the rate is 7.3 per 100 births and nearly every neighborhood has a rate higher than the Minnesota state average. Rondo /North End, Payne Phalen, East Side, St. Paul/Little Canada, Maplewood, Midway, and Westside St. Paul all have the highest rates, over 7.5 per 100 births.[7]

[6] CDC Vital Statistics, 2017-2019 (Centers for Disease Control and Prevention)

[7] HRSA Area Resource File, 2017-2019 (2020-2021 data release)

DIABETES.
The proportion of adults in our service area with diabetes is similar to the state average 9.0% vs 8.9% respectively.[8] The neighborhoods of Rondo/North End (13.1%), Payne Phalen (12.7%), Westside St. Paul (10.8%), East Side (10.4%) and St. Paul-Little Canada (10.4%) have the highest burden.

HIGH BLOOD PRESSURE.
Adults report a history of high blood pressure are much more frequently, comprising a quarter of adults in our service area and with a narrower range of disease burden, ranging from 22% in Midway / Frogtown and 31% in West St. Paul.[8]

OBESITY.
Similar to those with high blood pressure, a high proportion of adults report a history of obesity, 32% of our service area.[8] Roseville has the lowest rates of obesity at 28% and Rondo / North End the highest at 36%.

EXCESSIVE DRINKING.
Interestingly the patterns of excessive alcohol use in our service area differ from that of other chronic disease. Twenty percent of the service area reports excessive drinking, consistent with the Minnesota state average. Rates are highest in Midway / Frogtown, West 7th, and Cottage Grove and lowest in Payne Phalen, West St. Paul, and Rondo/North End.[8]

TOBACCO USE.
Seventeen percent of the Minnesota Community Care service area smokes, but with rates nearly double in Payne Phalen (26%) and Rondo / North End (25%).[8]

DEPRESSION.
In St. Paul, the prevalence of depression in 2019 was 24% in those ages 18 and older, notably with higher rates in the neighborhoods of central St. Paul.[9] Among Ramsey County 9th graders in 2019, 45.9% report feelings of depression in the past 2 weeks. Over 16% of those same students had seriously considered attempting suicide.[10]

[8] PLACES Project, 2018 (2020 data release, Centers for Disease Control and Prevention)

[9] PLACES. Centers for Disease Control and Prevention, National Center for Chronic Disease and Health Promotion, Division of Population Health, Atlanta, GA, 2019

[10] Minnesota Student Survey Report, 2019. https://education.mn.gov/mde/dse/health/mss/

TABLE F. KEY HEALTH INDICATORS

Zip Codes	Low Birth Weight Rate per 100 births, 2017-2019	Age-Adjusted Mortality Rate (per 100,000), 2013-2016	Adults Ever Told Have Diabetes, (%) 2017	Adults Ever Told Have High Blood Pressure, (%) 2017	Adults Who Are Obese, (%) 2017	Adults Drink Alcohol Excessively, (%) 2017	Adults Who Smoke, (%) 2017
Service Area Summary:	7.3	624.9	9%	25%	32%	20%	17%
55016	6.5	566.4	7%	23%	29%	22%	15%
55075	6.9	535.8	9%	28%	35%	19%	18%
55076	6.7	551.3	9%	27%	35%	18%	17%
55102	7.3	665.0	8%	24%	31%	22%	15%
55103	8.4	694.8	13%	28%	36%	17%	25%
55104	7.6	676.3	8%	22%	31%	22%	16%
55106	7.8	658.6	10%	25%	33%	18%	22%
55107	7.5	629.7	11%	26%	35%	19%	20%
55109	7.3	656.9	9%	26%	30%	20%	16%
55112	7.2	660.2	8%	24%	29%	21%	14%
55113	7.2	661.4	8%	26%	28%	20%	13%
55116	7.4	679.3	8%	24%	29%	21%	13%
55117	7.8	680.6	10%	26%	33%	19%	21%
55118	6.9	545.8	10%	31%	34%	17%	15%
55119	7.7	667.6	9%	25%	32%	20%	19%
55124	6.8	559.5	8%	25%	33%	19%	15%
55128	6.7	554.3	9%	26%	30%	19%	17%
55130	8.2	674.2	13%	27%	35%	16%	26%
55337	6.9	556.0	9%	27%	34%	19%	16%

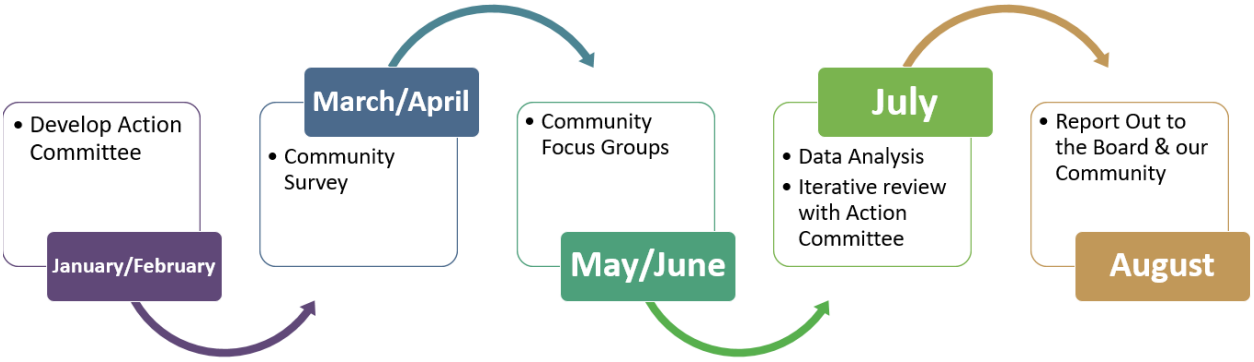
CHAPTER 2: METHODS

Where the findings from our Community Health Needs and Assets Assessment in 2019 came from extensive secondary analysis and iterative key prioritization exercises with community members, MCC had not previously attempted to collect feedback directly from our communities. The COVID pandemic drastically changed the healthcare system and had a global impact on the health and wellbeing of citizens. During this time, most of the data that we have about our community and service area reflects values prior to the pandemic. MCC agreed to center the community voice to better understand their needs, especially in the following key populations:

- Those experiencing homelessness or housing insecurity
- Those living in public housing
- Those who attend schools and receive school-based care
- Those who live in the southeast metro near Farmington, Burnsville and Apple Valley

To better understand the unique assets and needs of our communities, especially after the unique pervasive effects of COVID, MCC sought specifically more information from these key communities. MCC engaged in a 5-step process to collect and interpret the information from our communities, which is summarized in this report (see Figure B).

FIGURE G. METHODS: 5 STEP PROCESS



STEP 1: DEVELOPMENT OF A CHNAA ACTION COMMITTEE

The recruitment strategy including partnership with patients, staff, and community members who identified within the four populations. We used a grassroots approach (word of mouth, existing community and patient relationships) to identify 13 people to serve on the CHNAA Action Committee. Eight the people were from the community and five were staff. This group met monthly to identify the best methods to engage the communities to most authentically understand their unique needs and assets. The Action Committee was formed to obtain feedback, make recommendations and guide MCC in the needs assessment process.

Action Committee Members represented staff and community members from the four special populations-

- Adriene Thornton- Community Member
- Beverly Bushyhead- Community Member
- Cindy Kaigama- Health Equity Design Partner, MCC employee
- Der Moua- Clinic Manager, MCC employee
- Fabio Espinosa- Community Health Advocate, MCC employee

- Haylee Vang- Community Member
- Jasmine Bolden- Community Member
- Justice Nicholson- Community Member
- Katrina Smith- Community Member
- Lauren Graber- family physician and Senior Vice President of Population Health and Quality, MCC employee
- Mary Hernandez- Community Member
- Ruben Vazquez, Vice President of Equity People and Culture, MCC employee

STEP 2: SURVEY OUR COMMUNITIES

Our initial goal was to collect 100 surveys. As we moved along in the recruitment process, we increased the number to 200 surveys so we could understand more about each of the 4 key populations. We were successful and collected 247 surveys.

Survey participants were recruited through our CHNAA Action Committee, via personal connection and via social media. To further obtain more feedback, surveys were also conducted in person at:

- Union Gospel Mission, St. Paul MN
- Catholic Charities- St. Paul Opportunity Center, St. Paul MN
- Rambling River Community Center, Farmington, MN
- St. Paul Public Housing (two high-rise locations)

STEP 3: COMMUNITY BASED FOCUS GROUPS

The focus groups were designed to obtain more specific and nuanced information and community perspective on each of the four key populations. Four focus groups were completed with 20 people participated, each representing our 4 key populations:

- School based- four participants
- People experiencing homelessness- five participants
- Farmington- seven participants
- Public Housing- four participants

STEP 4: QUANTITATIVE AND QUALITATIVE DATA ANALYSIS

During the process of partnering with the Action Committee for data collection, one of the members submitted a letter of interest and was selected to provide quantitative data analysis of the surveys, qualitative thematic analysis of surveys, and focus group responses. The data collection closed in June 2022. An initial report of the data analysis was given to the CHNAA Action Committee in July, 2022. The analyst conducted qualitative analysis of the survey responses, created schematic categories/definitions, and identified counts. The analyst read the focus group summaries and created a qualitative coding scheme to also extract themes. This was to create a summary of the dataset in order to make inferences about the subset sample of the intended population for this assessment.

After the analysis was conducted, the action committee members reviewed the report and provided feedback. The committee appreciated that primary analysis was conducted on the four populations since there was no information from these groups in the past assessments.

STEP 5: REPORTING OUT TO MCC BOARD OF DIRECTORS AND OUR COMMUNITIES

The action committee and employees of MCC presented demographic data of the survey participants and summarized, the findings of the survey and focus groups, and offered recommendations to the board. The staff of MCC will contact the people who participated in the survey and focus groups who said they were interested in the outcomes of the assessment. Additionally, there will be a public report out and invitation of the public to hear the outcome of this CHNAA.

OVERVIEW OF SURVEY RESULTS

The results from the four priority populations identified by Minnesota Community Care are summarized in the following four sections: (1) definition of health/healthy, (2) needs, (3) barriers and (4) recommendations. Each of these sections includes the themes from the survey and focus groups that were recurrent, or comparatively strong.

DEMOGRAPHICS OF SURVEY PARTICIPANTS

This section includes information on the disaggregated and self-identified demographics of the survey respondents. 247 people completed the survey and 20 people participated in the focus groups. All questions were voluntary to answer and participants were allowed to skip the questions. This information is unavailable for the members of the focus group participants beyond their initials and identification within the following four priority groups since this information was not collected. All survey participants were over the age of 18.

TABLE G. RACIAL & ETHNICITY SELF IDENTIFIED BY SURVEY PARTICIPANTS

American Indian	5.67%
Asian	10.82%
Alaskan Native	0.00%
Middle Eastern	0.00%
Pacific Islander	0.00%
African American	15.46%
Hispanic	7.22%
Black	24.23%
African	5.67%
White / European American	43.30%
Latino/a/x	2.06%
Caribbean	1.03%
Prefer not to answer	4.12%
Please self-describe**	9.79%

**Of those who self-described: 7 identified as-Hmong, 3 identified as-Cambodian, 1 as-English, Irish and Cherokee, 1 as-Puerto Rican, 1 as-Red Lake Band of Ojibwa, 1 as-Mexican, German, Czech, Norwegian, 1 as- Igbo and 3 other responses were not clear (i.e. God's given, this is what I am born into, blank).

Women	43%
Men	28%
Non-binary	1 person = 0.01%
Agender	1 person =0.01%
Prefer not to answer	4%
Left blank	25%

TABLE H. AGE OF SURVEY PARTICIPANTS

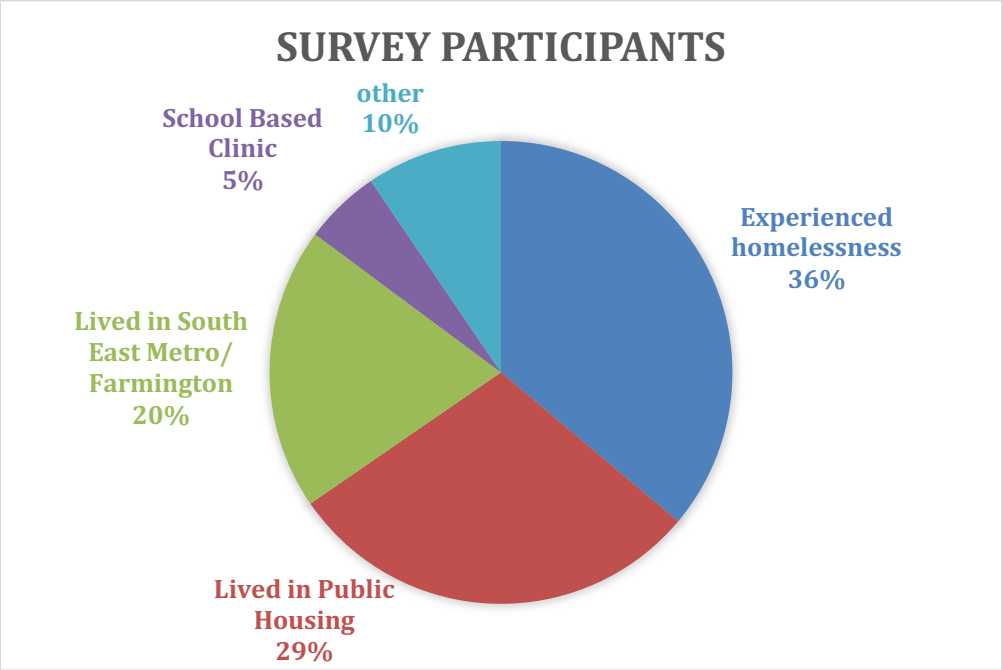
Prefer not to answer	1.05%	2
Under 18	0.53%	1
18-24	10.53%	20
25-34	14.74%	28
35-44	17.37%	33
45-54	16.84%	32
55-64	19.47%	37
65+	19.47%	37

TABLE I. KEY SOCIAL DETERMINANTS OF HEALTH

Which of these are important to you? Respondents checked as many as applied to them.

Housing	84.02%
Transportation	69.59%
Affordable healthcare	62.37%
Childcare	21.65%
Physical Activity	63.40%
Financial Stability	71.65%
Education	47.94%
Access to nutritious food	57.73%
Wellbeing	64.95%
Environmental (clean air, safe drinking water, pollution)	57.22%
Safe Neighborhood	70.62%
Health Insurance	53.61%
Other (please specify)	9.28%

FIGURE J. WHICH KEY POPULATIONS WERE SURVEYED?



CHAPTER 3: UNDERSTANDING OUR SCHOOL BASED POPULATION

This section includes information pulled from the responses of 5 participants who identified as people who are receiving care in school-based clinics and 3 participants who were part of the school-based clinic focus group. 3% of the survey participants were from this priority group.

WHAT DOES HEALTH/HEALTHY MEAN TO YOU?

- 6 (75%) participants of focus group and survey identified health as having a strong mind and body.
  "*Keeping yourself physically strong. Proper vitamins. Exercises, stretches. Make sure you go outside, keeping yourself mentally awake. Grow your mind: puzzles, chess, word cross. Elevate your mind, you can forever grow. Emotional: take proper amount of time for yourself. Can get burnt out, be the best that you can – sometimes having to sacrifice."*

WHAT IS YOUR HEALTH NEED? WHAT IS YOUR COMMUNITY'S HEALTH NEEDS?

- 5 (63%) of participants primarily mention some form of mental health followed by weight management and sexual health.

WHAT ARE YOUR BARRIERS TO HEALTHCARE?

- 6 (75%) cited the availability of appointments and cost were as barriers.
  "One of the things I've seen is mental health is such a huge deal. When I worked in elementary, saw so many kids with poor dental health. Having ways to access dentists on a regular basis. Eyes, so many students cannot see or lost their glasses. It's so expensive. Not insured, or very little insurance coverage, love to see kids have access to that as well."

WHAT ARE SUGGESTIONS/RECOMMENDATIONS THAT YOU HAVE FOR US?

- Provide weight loss, nutrition and sexual health education and resources.
- Provide mental health support so students can have an outlet to express their emotions.
- Do more community engagement and convey care.

"I think there needs to be more providers available to support individuals and families with mental health needs and with niche needs. There are limited providers and people often have to wait quite a long time to receive services. We were lucky and only had to wait a couple of months for initial support. And our school system was able to provide support to bridge the gap between when we first began reaching out for help and when we were finally able to be seen."

- Have a live person respond to questions.
  "A personal relationship where we are known and feel cared for is really important. Patience when we have questions, and recommendations based on what is in our best interest. Compassion when we struggle. Support when the services needed are not covered by insurance (grant support, or reasonable alternatives)—and clarity/guidance so that is known up front and not something discovered later on. No judgement."

CHAPTER 4: LISTENING TO OUR COMMUNITY WITH HOUSING INSTABILITY AND LACK OF HOUSING

This section includes information pulled from the responses of 60 survey respondents who identified as people who are experiencing housing instability or have lack of housing and 4 of the people who participated in the people experiencing homelessness focus group. 26% of the survey participants were from this priority group.

WHAT DOES HEALTH/HEALTHY MEAN TO YOU?

- In the focus group, the majority of participants identified health as having purpose by sharing wisdom with younger people, physical and mental wellness and an environment conducive to good health.

  "I am working on my patience and that sometimes hinders my ability, trying to hear, listening to what people are saying. I want to be able to grow in wisdom, that plays a part in my health, I am okay physically. But to grow in wisdom and mentality to where I can be more of a help to the people that are coming up under me."

  "Health isn't only the physical thing, but what the environment looks like, the environment that is toxic and dangerous, what does that mean on the overall health of someone, their psyche. What is healthy? We can start by looking at ourselves, but we must consider, what is the outside environment and how is that stuff impacting the work we do and the care we give."

- 44 (71%) of this priority group who participated in the survey described health primarily as living a long life, being able to do what you want to do physically and "everything". Everything inferred participants meant health was all encompassing and part of their overall life-physical, mental, spiritual. There was also theme of responses that cited "body, mind and spirit" as health.
- 20 (33%) respondents of this priority group rated their health as fair/poor.

  "In western culture we see physical health more standardized but that might not be the same for everyone else. Someone might see something as good health that isn't necessarily what someone else thinks is good health."

WHAT IS YOUR HEALTH NEED? WHAT IS YOUR COMMUNITY'S HEALTH NEEDS?

- In the focus group, mental health and housing were discussed as needs.
- (90%) survey responses in this priority group, the most common needs identified were physical ailments (i.e. need for surgery, mobility, carpel tunnel, weight loss support).

"In my opinion, I think access to healthcare is a huge need. I have seen so many needs neglected because people don't have the money, don't have a way to get to and from the doctor, don't have the time because they have to work, speak languages other than English, don't have the time because they need to care for others, etc."

Mental health, access and choice of healthy food and chronic diseases (i.e. dialysis,

diabetes, cardiovascular/heart disease) were also listed as common barriers as well as need for specific healthcare and medication (i.e. tumor, pain control, diabetic meds, chemical dependency, etc.).

"If I didn't have someone who didn't understand my life history, I wouldn't be very trusting. If someone just read my chart without knowing me and my past, I don't believe I would receive the correct care".

WHAT ARE YOUR BARRIERS TO HEALTHCARE?

- 56 (92%) of survey responses cited affordability and navigating the payment process for health services, homelessness (instability), transportation and medical insurance as the most common barriers.

WHAT ARE SUGGESTIONS/RECOMMENDATIONS THAT YOU HAVE FOR US?

- Financial transparency and financial resources for payment assistance.
- Provision of transportation and assistance with childcare.
- Hours of operation that are flexible so patients don't have to utilize emergency and urgent care centers.

CHAPTER 5: UNDERSTANDING THE COMMUNITY IN FARMINGTON AND THE SOUTHEAST METRO AREA

This section includes information pulled from the responses of 48 survey respondents who identified as people who currently reside/previously resided in Farmington or the South Metro and 7 people participated in the Farmington focus group. A majority of the participants reside in zip code 55024 (Farmington/Lakeville). 22% of the survey participants were from this priority group.

WHAT DOES HEALTH/HEALTHY MEAN TO YOU?

- 38 (69%) survey participants described health as physical, mental well-being as well as "everything". Everything inferred participants meant health was all encompassing and part of their overall life (i.e. wellness, exercise, good life, feeling good, etc.).

  "I think that as simple as this question is, it is actually a very complex question, especially when you are weighing it as being a health care provider and seeing it through a patient lens. I think of it as the ability for individuals to function at an optimal level and a holistic level taking in a spiritual, emotional, physical and communal lens"

WHAT IS YOUR HEALTH NEED? WHAT IS YOUR COMMUNITY'S HEALTH NEEDS?

- In the focus group, mental health and housing were discussed as needs.

  "I have lived in Lakeville for 18-19 years and the demographics have changed significantly… going from a majority White community, now to a highly diverse community and more affordable housing. The issues that teachers are now facing in our schools are significant, and our teachers aren't prepared to manage those challenges in the classroom. I am on two school boards within the district and things are getting out of hand. I wish there was a way for us to intersect all of this new housing with the needs of this evolving community. Sadly, our schools are not able to meet the needs of the students with challenging behaviors and added to that is the fact that there is a lack of diversity within the teachers. While this is a health meeting, this transcends into other areas such as representation, diversity and inclusion training… the list goes on."

- From the survey results, the most common needs 16 (38%) respondents identified access to grocery stores, cost of healthcare and transportation.

  "There is not a grocery store in the South end of Farmington. The closest one is near Apple Valley. The closest place to my house is the gas station or the dollar store; outside of that it is a 15-minute drive. That directly impacts health, as my family likes fresh food and vegetables and they do not have that at the dollar store. I am lucky to have a car but there are elderly–who cannot drive– and people who do not have a car. Therefore, while there are food shelves, it is still hard for people to get healthy food."

WHAT ARE YOUR BARRIERS TO HEALTHCARE?

- 25 (45%) The most commonly cited barriers for survey respondents were time, money, appointment scheduling and transportation.
- In the focus group, barriers that emerged during the discussion included mental health resources, availability of grocery stores in the area and affordable housing, and representation of underserved community members (lack of diversity).

"***Affordable housing is difficult. I have seen many neighbors turn over as they were not allowed to be pushed out during covid and when covid protection ended they were evicted. Affordable housing is so difficult to find, when I can see million-dollar homes just down the corner. I have also noticed that in my area this is basically urban sprawl. You do get food deserts-my understanding is that we do have farmers markets starting shortly , but where I live it is hard to find real groceries as everything pretty much requires transportation."***

"Limited public transportation and affordable housing ."

WHAT ARE SUGGESTIONS/RECOMMENDATIONS THAT YOU HAVE FOR US?

- In the focus group discussion, the themes that emerged was quick access and availability to be seen without long wait times, the desire to have a provider who really demonstrates good listening, who demonstrates care for the patient, and to have the patient's concerns acknowledged instead of dismissed.
- Provision of transportation and assistance with childcare.
- Access to grocery stores/food and mental health providers/resources were also mentioned in the discussion.

"Very early in the pandemic I was practically unemployed therefore I was stuck going to the food shelves that we have talked about as my family was plagued with the question of "do we pay for a roof over our head or do we buy groceries?" I am very appreciative of the food shelters, I now volunteer at the food shelf at the local church. I will admit that growing up I had all of the things I had, and now I know how to work with things that I didn't know how to navigate–while I was younger– the experience opened my eyes to my privileges."

CHAPTER 6: LISTENING TO THE COMMUNITY LIVING IN PUBLIC HOUSING

This section includes information pulled from the responses of 61 survey respondents who identified as people who are currently living in public housing and 3 of the people who participated in the public housing focus group. 26% of the survey participants were from this priority group.

WHAT DOES HEALTH/HEALTHY MEAN TO YOU?

"Well in your body, mind, and spirit. Being able to go through your daily life in a way that is free from sickness and pain."

- 46 (75%) of this priority group survey participants described health primarily as living well, healthy and "everything". Everything inferred participants meant health was all encompassing and part of their overall life-physical, mental, spiritual.
- 23 (38%) respondents of this priority group rated their health as fair/poor.

WHAT IS YOUR HEALTH NEED? WHAT IS YOUR COMMUNITY'S HEALTH NEEDS?

- 13 (61%) of this priority group cited chronic diseases and physical ailments (i.e. nerve pain, arthritis, high blood pressure, hip/bone pain, etc.)
- 4 (7%) cited dental problems as a health need (i.e. teeth, dental care, etc.)
- 4 (7%) cited mental health problems as a need.

"Doing gatherings often so people are not so alone and feeling isolated. It would be nice to have people from clinics talk about mental health and talk about services available."

- In the focus group discussion, financial affordability was a big component of whether or not people had access. Mental health was another need that emerged in the discussion.

"I tried to reestablish a mental health relationship with a psychiatrist in behavioral health. Costed me $900, who had $900 to throw away? That was anxiety inducing and depressing. It made me spiral even worse, and very conscious. It was an unexpected cost and made me feel like my health care provider did not even know I am not covered under that. I felt ignorant that I did not know my insurance had two different parts. I could not make sense of it, and it made everything worse. I could not get into a mental health provider because the waiting list was so long. It took so long to get with someone in network."

WHAT ARE YOUR BARRIERS TO HEALTHCARE?

- The most commonly cited barriers for focus group participants were flexibility in location/hours and the affordability/cost.

"Have someone visit our community meetings where we have guest speakers because it's a good way to bring awareness to what the clinics have to offer. I think if they would come in to take vitals, blood pressure checks, that would help."

- 17 (28%) of survey respondents listed insurance cost, insurance issues and transportation as barriers.

WHAT ARE SUGGESTIONS/RECOMMENDATIONS THAT YOU HAVE FOR US?

- Provide affordable payment options (i.e. sliding scale)
- Make access-location and hours flexible.
- Build deeper relationships with patients and provide access to health information.

"Access is crucial. You could go to the clinic, walk in and just wait. I think a certain number of walk ins would be helpful. Making sure the people surrounding [your clinic] know that you're there. Making pop up [clinics] is a good idea [i.e. to check vitals]. We had one in the Cub Foods parking lot, and I did get my blood pressure tested because it was good. I found out I was borderline hypertensive."

CHAPTER 7: THE IMPACT OF COVID-19

The COVID19 pandemic greatly impacted our communities and changed how they sought and accessed health care, changed their own perceptions of their own health, and impacted their families emotionally and financially. As most of the population health data predates the pandemic and does not include the personal impact of the pandemic on our neighborhoods, we sought to more deeply understand how our communities were navigating.

SCHOOL BASED-POPULATIONS

Although their were only a small number of respondents classified under this priority group, the responses were impactful, sharing the loss in educational time, social emotional development, and anger management. Survey respondents shared: “my job sucks, physically, mentally and emotionally,” and “I had it [Covid-19] before.”

“There’s a lot of anxiety. They [students] lost 2 years of learning. They lost all the stuff they needed to have, yet as a teacher I need to get them to a certain level. They have a hard time focusing. They cannot do things independently. Socially and emotionally, they are 2 years behind. 8th graders acting like 5th graders, they sometimes act violently with each other. They don’t know how to treat each other. There are so many violent outbursts. The lower grade levels regulate themselves better.”

“They didn’t have the time to learn what they needed to for online schooling. We tried to talk it though, parents disappeared. It was hard for kids to log on and find where things are. Overall, it was terrible for everyone. We had several grandparents who passed, kids were super depressed due to deaths from the pandemic. Kids are scared and prepared for the online schooling again. Higher percentage of kids dealing with anxiety than ever. We had to do things step-by-step. Kids are unsure of what to do next. They are not independent like they were before.”

COMMUNITY WITH HOUSING INSTABILITY OR HOUSING INSECURITY

Over half the survey respondents who had experienced homelessness cited the following as their experience of Covid-19: being homeless/finding housing, lost loved ones, lost job/finding a job, hard to pay rent/food, and getting sick from Covid-19.

“One aspect of the impact for me was in the emotional, social, and psychological space. We were in a pretty tight bubble because of vulnerable family members. Dark winters and not having the social aspect. Being an extrovert, I didn’t realize until maybe half way through the first year how low I was getting.”

“I was in California from December until May 5, I got Covid-19 and it was horrible. But mentally the pandemic took the most toll. My daughter is a nurse in LA, so the stress, I can’t emphasize it enough. The stress of losing people for medical workers, she lost some close friends and experienced it first hand and seeing the mental drain on healthcare workers, it is just scary. It is a scary thing for me. When I had Covid-19, it lasted a week and lucky for me I only had flu-like symptoms, no hospitalizations.”

“I was in Seattle before Covid-19 was announced and I got sick when I got back and that was the sickest I had probably ever been in years. This was before they announced Covid-19 had broken out so I think I had it in the very beginning and got over it after 3-4 days. But other than that, I have been blessed.”

COMMUNITY IN PUBLIC HOUSING

Over half the survey respondents of those living in public housing cited the following as their experience of Covid-19: social isolation, lost income, cough after Covid-19, friends dying, scared/fear of going out, and staying in.

"First of all, it [COVID-19] really impacted my mental health because my family did not take precautions. Got it in Nov 2020, got put on oxygen and lost access to a lot of services. Had to go to telehealth resources for my mental health. Did not work with me. Did not feel connection over video chat. Not as intimate. It was not enough. I am not in therapy right now because I have to find new therapist. I am on a restricted program where my doctor needs to send a referral. He has to review medications. My insurance restricted me. I got approved for SSI, I got approved during Covid-19 [pandemic]. The pandemic took things away from me but also showed me ---. This is my first time ever living on my own."

"Before the vaccine, the staying in was tough for me. I was not able to get out and do the normal stuff I would do. The middle of that, George Floyd was murdered. That caused me anxiety. I tried to reestablish a mental health relationship with a psychiatrist in behavioral health. Costed me $900, who had $900 to throw away? That was anxiety inducing and depressing. It made me spiral even worse, and very conscious. It was an unexpected cost and made me feel like my health care provider did not even know I am not covered under that. I felt ignorant that I did not know my insurance had two different parts. I could not make sense of it, and it made everything worse. I could not get into a mental health provider because the waiting list was so long. It took so long to get with someone in network. I was suffering medically from the vaccine. So, my whole left side was impacted. Had pain from my neck to my knee. The second injection harmed me. Now I am seeing a therapist, psychiatrist from trying to manage this Covid-19 pandemic. I only had two visits, and one of them was very helpful. The second visit was very helpful and compounded on my disappointment. Health care should be on a sliding scale, everyone should have access and should be based on your salary. Someone should be seen weekly, or twice a month for mental health."

COMMUNITY IN FARMINGTON AND SOUTH METRO

A majority of the respondents cited the following as their experience of Covid-19: taking away travel, sick family members, decline in mental health, disruption of work/daily activities, and social isolation.

"Actually, I got COVID in March of 2020 and I was sick for 2 months, really sick. I was isolated from my entire family. It was really a tough, tough time, I couldn't hug my babies, I think that was the beginning of me working on my mental health. It gave me the chance to not be around people, and it allowed me to slow down and quiet down my mind–from the stressful world at large–. It was hard, I still don't know how I dealt with everything. When you almost die from being alone, to now feeling like I am going to die if I go around people too much."

"Covid-19 has gone through our family 3 times. I now have asthma for life because of Covid-19, very early in the pandemic it was stressful figuring out how to manage."

“I contracted Covid-19 in April of 2020, at home healing from surgery, I had already climbed that mountain and I got Covid-19. Part of my decision to never receive care from Fairview again was the devastatingly poor way in which I was treated. I remember I ended up coming home and riding out Covid-19 and I decided I would rather die alone on my floor than in a hospital alone. I have asthma for life, so I have to use an inhaler. Before I contracted Covid-19I had been diagnosed with diabetes, I worked really hard to get rid of it. I wasn't even in the pre-diabetic range anymore, using diet to help myself get rid of it, and once I got Covid-19, something happened changing my body and diabetes came with a vengeance. Since April of 2020, I have literally been crawling my way back to health, it has been a long difficult road.”

“I don't feel like I get enough exercise especially during the first year of Covid-19, I used to walk getting 10-15,000 steps and then to working from home I would have days where I would get 900 steps, and in the middle of this I did get pneumonia and it was hard when I had to go into the hospital I would be treated like I had Covid-19.”

CHAPTER 8: RECOMMENDATIONS FROM OUR COMMUNITIES

While the shared experiences and themes from the four key populations are unique and provide a snapshot into how Minnesota Community Care can better meet their specific needs, four common themes across all groups also emerged.

OUR COMMUNITIES DEFINE HEALTH IN A HOLISTIC & COMPREHENSIVE WAY.

They incorporated their physical, mental, financial, environmental, and spiritual health and the support of those around them. This ranged from the appointments that they attend to their daily habits of self-care and meeting basic needs such as food and housing.

OUR COMMUNITIES WANT CONNECTIONS TO OTHER SERVICES IN THE COMMUNITY.

They want access to grocery stores, collaboration with schools, connection to affordable medications, options for housings and directions to community centers.

OUR COMMUNITIES WANT ENHANCED ACCESS TO BEHAVIORAL HEALTH SERVICES.

They want behavioral health care that is flexible, easy to access and where our communities live, learn, work and play. They want care that considers culture, ethnicity and lived experiences of the communities being served.

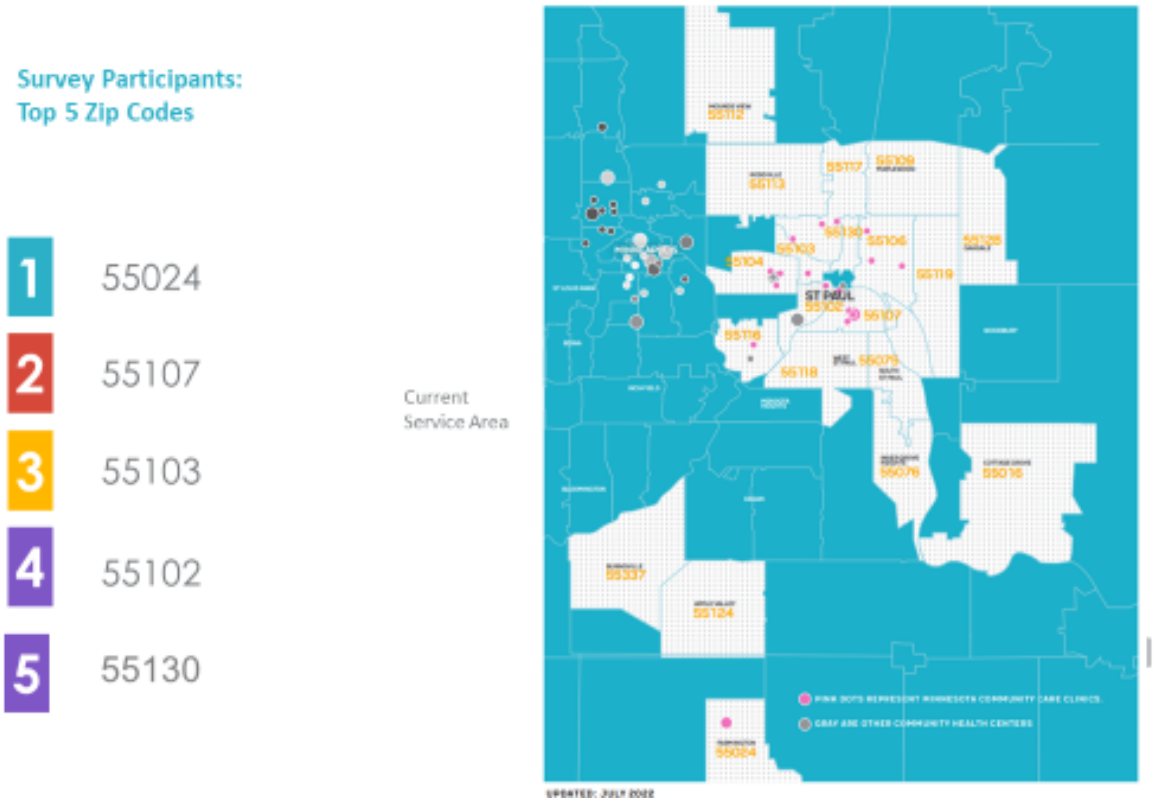
OUR COMMUNITIES WANT CARE PROVIDERS WHO LISTEN TO THEM AND UNDERSTAND THEIR UNIQUE EXPERIENCE.

They want care that sees them as the individual that they are and to receive services that is customized for their needs.

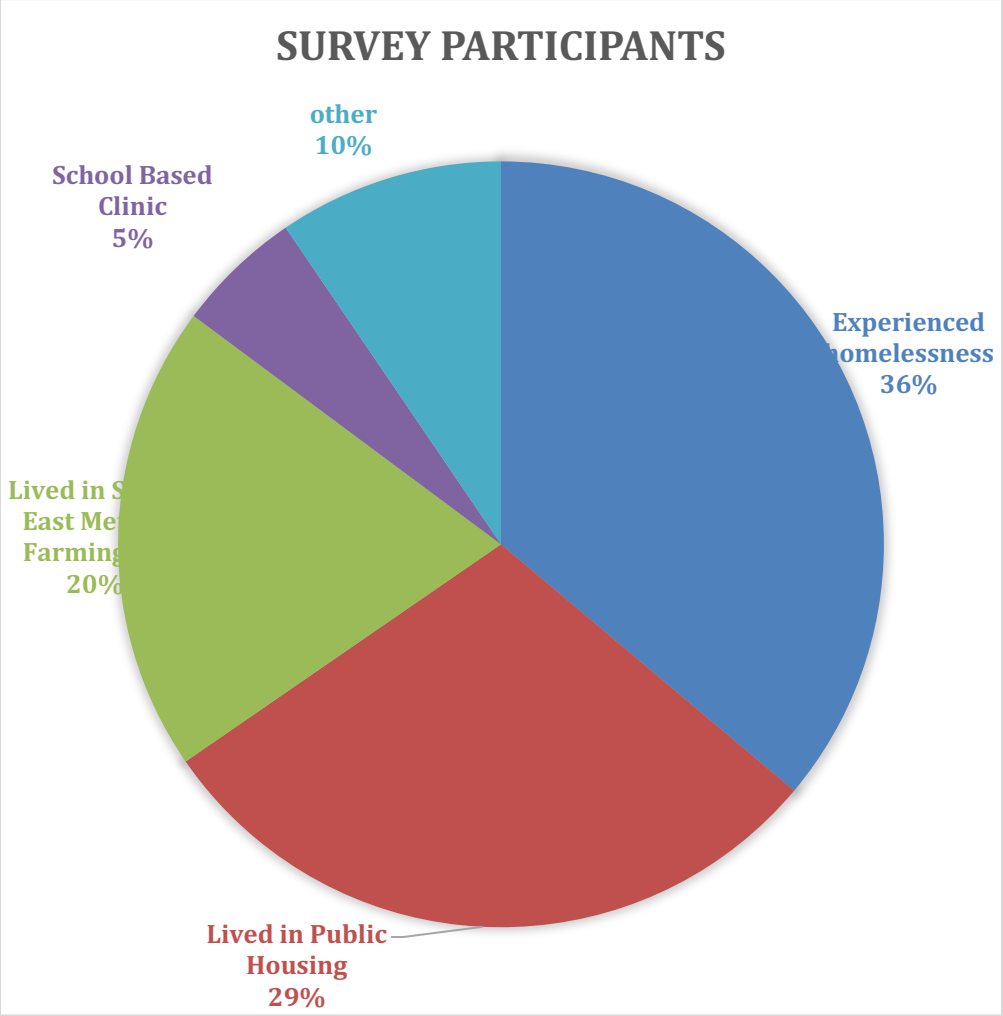
APPENDIX. ADDITIONAL FINDINGS FROM THE SURVEYS & FOCUS GROUPS

TOTAL SURVEY RESPONSES AND WORD CLOUDS FOR ALL PARTICIPANTS

Top 5 Zip Codes of Survey Participants

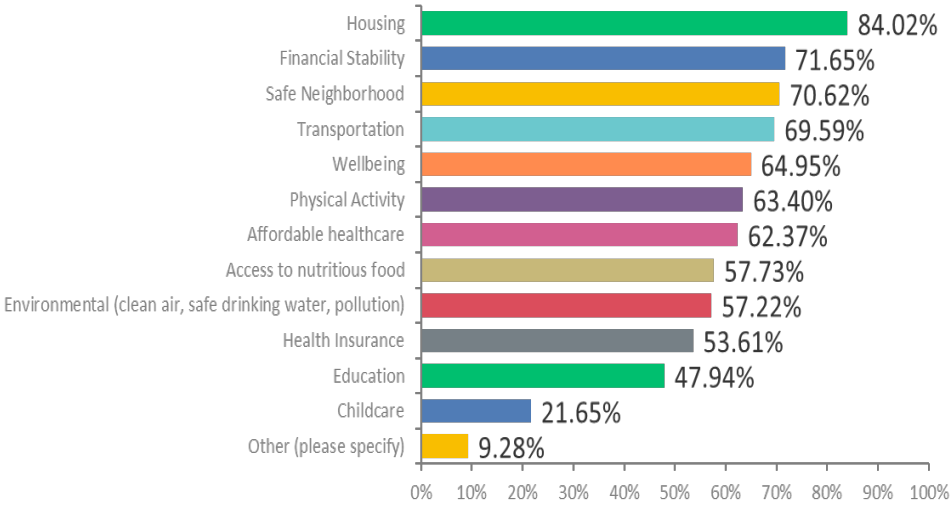


Which of the following have you experienced?



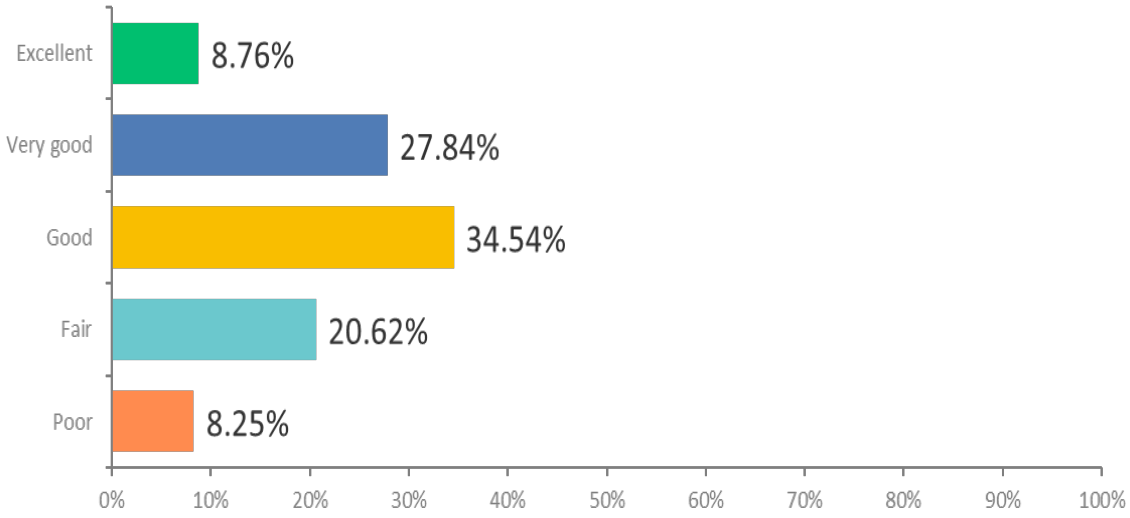
*Other responses: Live with parents, employment loss caused homeless, managing pain; mental health

Which of the following are important to you? Check all that apply.

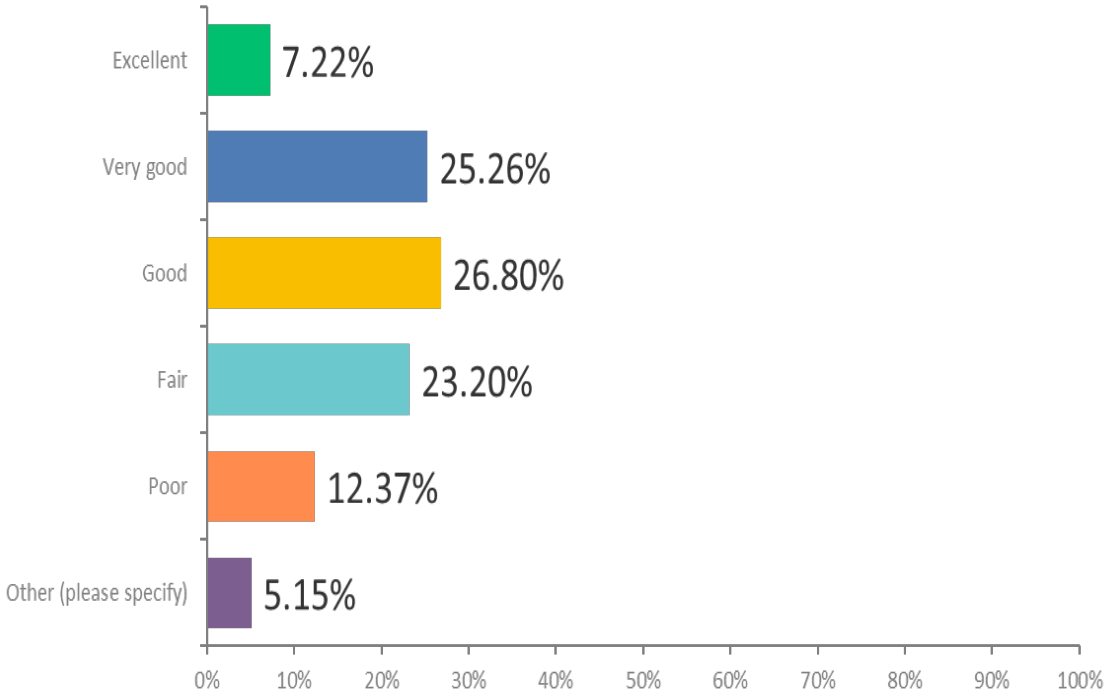


*Other responses :pharmacy access all week and recycle for used medicines, mental health illness, don't get me started, Obgyn, privacy, honest- non-corrupt people, culturally based healing

Based on what health means to you, how would you rate your overall health?



Overall, how would you rate your oral/dental health?



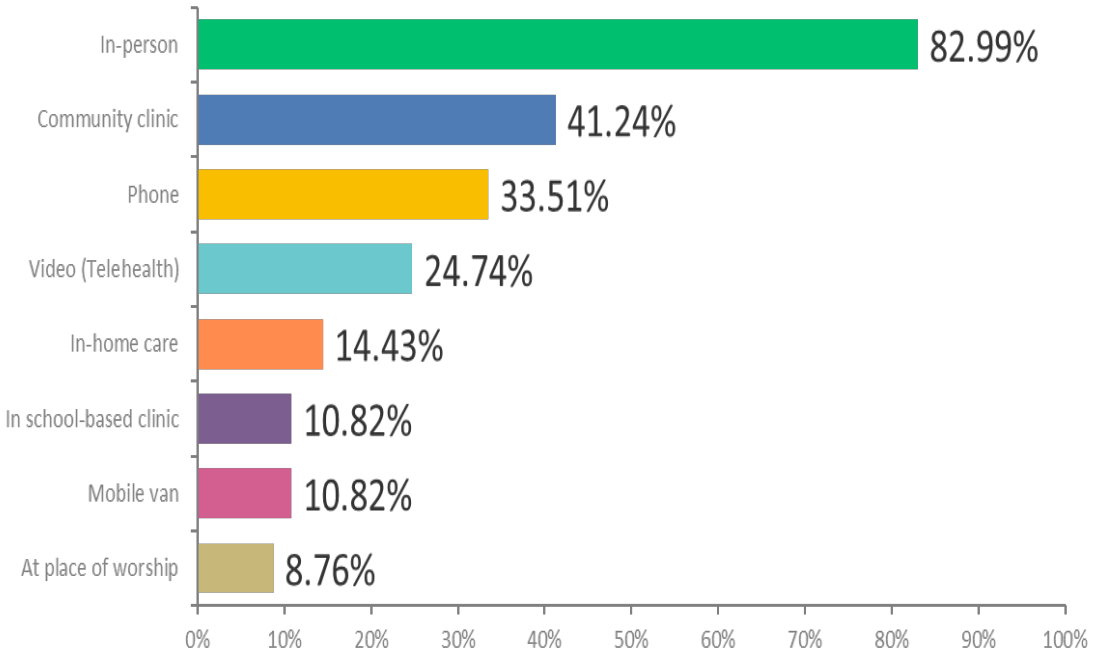
*Other responses: Need for dentures, need new dentist, need teeth repaired

In your opinion, what is the largest health need of the community you live at this time?

"We need universal healthcare and good preventative testing and care. Please have pharmacy at West Side open all week long. Let's have more screening for disease such as cancer."

"I believe in this community. the largest health need is therapeutic mental health."
"More honest physicians in a patient's care and reliable social workers to one's own needs."

Which of the following ways are you interested in receiving healthcare?



What is your largest health need at this time?

"Taking more naps!"

"I need help with everything."

"Shorter wait times for psychiatry and therapy appointments. The huge burden of healthcare costs, even with insurance."

What barriers are keeping you from getting the healthcare you need?

I can't afford medical insurance."

"Not getting on the phone to talk to a dentist."

"Working daytime hours significantly limits the ability to go attend medical appointments. It is very difficult to make appointments and take children to the dentist and well-child appointments when you are expected to work every day or face financial consequences for missing work."

In your opinion, what is the largest health need of the community you live in now?

Strengthening the well-being of our community through health for all.

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