

# Fairview



# 2021 Community Health Needs Assessment Report

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Bethesda Hospital



# Fairview

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### Community Advisory Council

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- Dr. Suzanne Burke-Lehman, Director of Nursing/Associate Professor of Nursing, St. Catherine's University
- Peggy Johnson, Community Relations Director, Dakota Electric Association
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- Dr. Mai Moua, Chief Operating Officer, Hmong American Partnership
- Mark Oleen, Branch Manager, Bremer State Bank
- Dave Oswald, Realtor, Dave Oswald Homes
- Steve Peacock, Director of Community Relations, Augsburg College
- Dr. Michael Raich, President, Northeast Higher Education District
- Jessalyn Sabin, Academic Dean, Hibbing Community College and Rainy River Community College; Chair, Fairview Range Board of Directors

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We would also like to recognize the Fairview community health needs assessment team, who worked diligently to complete the community health needs assessment process for all Fairview hospitals and medical centers. We thank Fairview's Community Advancement leaders and our other Fairview colleagues who played important roles in the process.

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## Letter from our President and CEO

Our triennial community health needs assessment process provides an important opportunity to engage with and understand our community, analyze what has changed—for better or worse—since the last assessment, and prioritize together with the community the issues we must urgently address in order to improve wellbeing and resilience. Recognizing that we have an outsized role in the process, it is humbling, as well as energizing, to have the opportunity to address health and health equity inside and outside of our hospital and clinic walls.

Since our last assessment, the pandemic and social unrest presented unanticipated challenges for our communities and our healthcare system. It pushed us to refocus our efforts and pull together with our healthcare workers, neighbors, and community partners to meet the urgent, emerging needs of the community.

In partnership with community, we swiftly adapted our plans and:

- Offered low-barrier testing and vaccinations in trusted spaces to community members disproportionately impacted by the pandemic.
- Distributed culturally appropriate meals and economic resources to individuals and families with transportation barriers or those who were at higher risk for COVID-19.
- Connected with those who were isolated, conducting wellness checks and outreach.
- Distributed grants directly to our community partner organizations serving our most vulnerable neighbors.

We used this opportunity to reevaluate our organizational efforts to improve health and wellbeing and provide equitable care during a time when inequities have been deeply exacerbated by COVID-19. By listening and engaging with our neighbors and collaborating with community-based organizations, local public health departments, and other health systems, we better understand the current local health needs and assets.

For the 2021-2024 reporting period, the priority needs that we will focus on are:

- Healing, connectedness, and mental health
- Addressing structural racism and barriers to achieving health equity
- Navigating and accessing care and resources

“We have the opportunity to think of healthcare as a more holistic concept, beyond our walls. Partnering with community organizations helps us have a better understanding of what the community needs and to be able to deliver, along with others who have different access points and different approaches, more effective care. Our commitment to the community is lasting, we’re in it for the long haul. We want to improve the lives of individuals and the communities that we are all a part of and that we serve.”

– James Hereford  
President and CEO,  
Fairview Health Services

We know that only 20 percent of our health is shaped by healthcare. The remaining 80 percent is impacted by the **social determinants of health** meaning our health behaviors (diet and exercise, substance use, and sexual activity), socioeconomic factors (education, job status, income, and family and social support), and our physical environment (housing, air quality, connection, and safety). When resources are limited, it can contribute to poor health outcomes, preventable diseases, increased chronic stress, and obesity rates.

As an **anchor institution** — an organization rooted in our community — we are committed to **addressing barriers to achieving health equity**, such as access to care and resources, transportation, cost, and cultural gaps, and the social determinants of health. In addition, as one of Minnesota’s largest employers, we are directly confronting **structural racism** (implicit biases in an organization’s policies, practices, and staff) by employing values-based hiring, bringing community voices into our institutional operations, and strategically providing services in conjunction with community.

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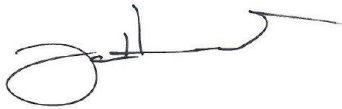
Our efforts will center on two priority populations across their lifespans and across geographies from rural to urban – all persons experiencing poverty and racial or ethnic populations experiencing health disparities.

There is work happening inside our walls as well. The COVID-19 pandemic changed ways of doing things across our health system, our community, and our state. Fairview rose to the challenge, by administering tens of thousands of free Covid-19 tests and vaccines and converting an entire hospital into a dedicated Covid-19 care facility. We swiftly made changes from that transformed patient care. We engaged in leading-edge research into the disease and its treatments, along with embracing innovative new ways to deliver care using telehealth and other technologies.

Further, we have joined leaders across the country in declaring racism a public health crisis. Our healthcare system formed the Healing, Opportunity, People, and Equity (HOPE) Commission, a multi-year transformational change effort to address structural racism and advance anti-racism and inclusion efforts. The goal is to drive more equitable outcomes and inclusive environments and experiences for our patients, employees, and communities. We have dedicated resources and workplans, including two newly created leadership roles, to help drive us forward.

Listening and Learning sessions were conducted to hear perspectives and ideas from the most impacted populations, including voices from staff and patients. We're seeing immediate impacts from our learnings. For example, work to improve the quality of demographic data of employees and patients is underway. It will help us better understand our patients and the people we serve so that we can identify gaps in healthcare access and make sure we address them with appropriate resources. In addition, we created culturally appropriate resources, such as videos and flyers, to educate and inform community members about COVID-19 and the importance of vaccination.

Our work is guided by and developed in partnership with the communities we serve. This process helps us, in alignment with our partners, direct our investments to make the biggest impact.



**James Hereford**

President and CEO

Fairview Health Services

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## About Fairview Health Services

Fairview Health Services (fairview.org) is a Minneapolis-based nonprofit health system driven to heal, discover, and educate for longer, healthier lives. Founded in 1906, Fairview provides exceptional care to patients and communities as one of the most comprehensive and geographically accessible systems in Minnesota. Fairview has enjoyed a long partnership with the University of Minnesota and University of Minnesota Physicians, now represented in the M Health Fairview brand. Together, we offer access to breakthrough medical research and specialty expertise as part of a continuum of care that reaches all ages and health needs.

### Mission

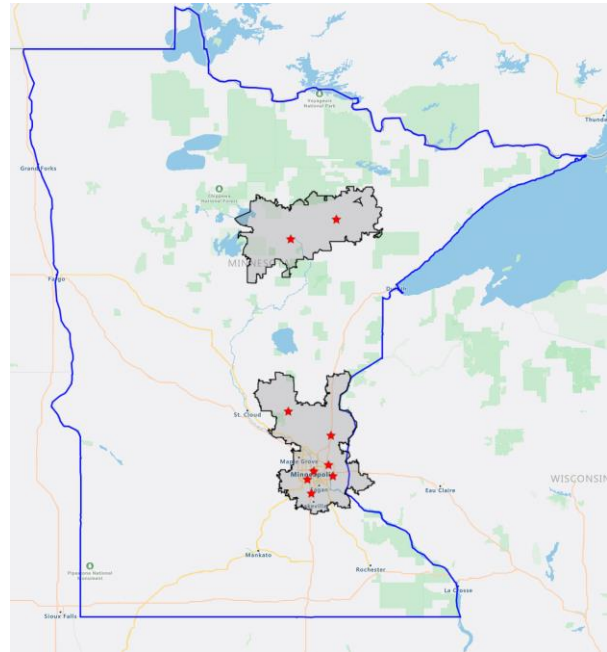
Fairview is driven to heal, discover, and educate for longer, healthier lives.

### Vision

Fairview is driving a healthier future.

### Values

Dignity • Integrity • Service  
Compassion • Innovation



★ Fairview Hospitals and Medical Centers

The names listed below reflect the Minnesota Department of Health licensed names. Through the remainder of this report all hospitals or medical centers will be referred to by the name they are more commonly referred to in the community.

- Fairview Lakes Medical Center (Lakes Medical Center), Wyoming, MN
- Fairview Northland Regional Hospital (Northland Medical Center), Princeton, MN
- Fairview Ridges Hospital (Ridges Hospital), Burnsville, MN
- Fairview Southdale Hospital (Southdale Hospital), Edina, MN
- Fairview-University Medical Center (University of Minnesota Medical Center and Masonic Children's Hospital), Minneapolis, MN
- Grand Itasca Clinic and Hospital (Grand Itasca Clinic and Hospital), Grand Rapids, MN
- HealthEast Bethesda Hospital (Bethesda Hospital), St. Paul, MN
- HealthEast St. John's Hospital (St. John's Hospital), Maplewood, MN
- HealthEast Woodwinds Hospital (Woodwinds Hospital), Woodbury, MN
- St. Joseph's Hospital (St. Joseph's Hospital), St. Paul, MN
- University Medical Center Mesabi / Mesaba Clinics (Fairview Range Medical Center), Hibbing, MN

Fairview is honored to care for a broad and diverse array of communities across Minnesota. While this report is specific to the urban and suburban populations served by the Bethesda Hospital, Fairview also serves rural populations at several of its facilities. We acknowledge that the challenges the priority populations face, and the nuances of our priority need areas, look different in a rural context. We strive to provide programs and interventions at each facility that are responsive to the local community's specific needs.

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## Our approach

Fairview's 2021 Community Health Needs Assessment (CHNA) builds upon previous assessments and was developed in partnership with community members and organizations, local public health agencies, and other hospitals and health systems. It serves as a tool for guiding policy, advocacy, and program planning. It also fulfills Internal Revenue Service (IRS) requirements for CHNA pursuant to the Affordable Care Act of 2010, which requires 501(c)(3) nonprofit hospitals to conduct an assessment at least every three years and provide an annual evaluation of the previous implementation strategy's impact.

Through this process, Bethesda Hospital aims to:

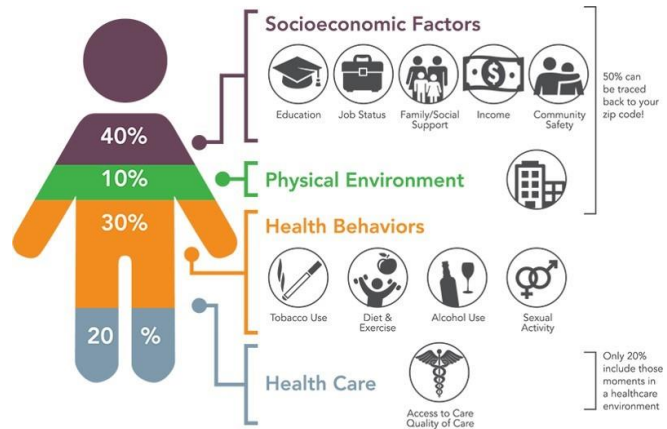
- Intentionally engage with community members and organizations, public health agencies, and other hospitals and health systems to identify and understand significant health needs in the community.
- Understand the needs of the community it serves by analyzing current demographics and social determinants of health indicators, as well as by collecting direct input from community members and organizations.
- Inform the Bethesda Hospital CHNA implementation strategy and action plan development.

As part of the 2021 CHNA process, we reexamined and built upon the extensive community insights shared during our 2018 CHNA, while also surveying the community for current and emerging needs. We have identified three system-wide priority need areas, and we will collaborate with our hospitals and shared services to address these priorities. Our specific response will vary by hospital based on the ways in which the priority needs manifest across a given community as well as the partnerships, both ongoing and new, that we have developed to address those needs.

## Social determinants of health

Social determinants of health are the conditions in which people are born, grow, live, work, play, pray, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. Social determinants of health include a range of socioeconomic factors, combined with factors related to an individual's physical environment, health behaviors, and healthcare quality and access.

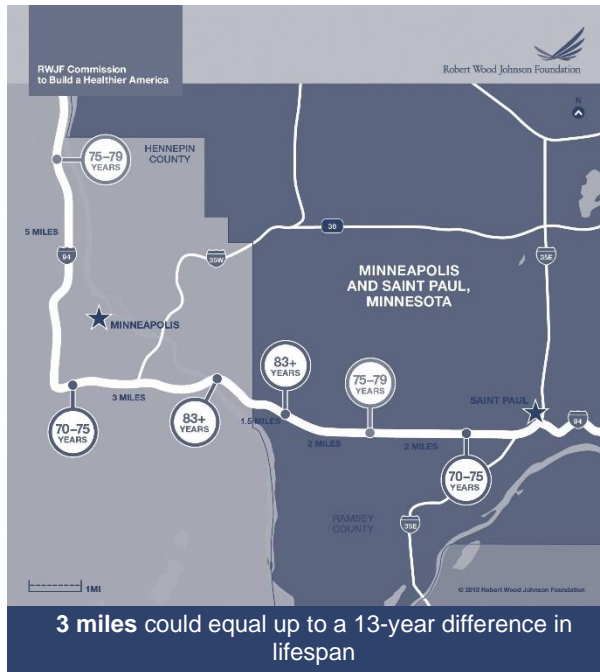
Our CHNA uses social determinants of health as a lens through which we frame our understanding of our community's most significant health needs. According to the Kaiser Family Foundation, interactions within a health care environment account for only 20 percent of a person's health outcomes.<sup>1</sup> That means that most of the factors that affect a person's health happen outside the doctor's office or hospital, in the person's day-to-day life. Based on this, health care institutions must look beyond their own walls and expand their understanding of the scope of care to improve health.



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)



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Social determinants of health also enable us to identify inequitable distribution of resources and access that negatively impacts health. Half of the factors that contribute to an individual's health depend on where that person lives, in both socioeconomic and physical terms.<sup>2</sup> Life expectancy can vary as much as 15 years between communities, sometimes within a few square miles.

An issue brief from the American Action Forum further explains how social determinants of health interact with health care:

“While the health care delivery system impacts health during episodes of injury or illness, the social determinants interact with health much earlier, and on a day-to-day basis. They encompass the conditions in which people live, learn, work, and age, along with the broader social positions in which individuals find themselves that impact health. The social determinants can impact health directly but also can indirectly impact health by shaping how people behave. Poverty, unemployment, and

housing insecurity are all examples of social determinants that result in poor health outcomes. Of course, while the factors and conditions considered here are referred to as “social determinants,” they may be more aptly discussed as “influencers” or “predictors” rather than direct determinants of an individual's or community's health status. Most of these conditions are highly correlated with one's health but not necessarily causal; further, all social determinants of health (except race) can change throughout one's life.”<sup>3</sup>

## Indicator category descriptions

When considering data to analyze and include in our CHNA, we grouped indicators into broader categories as outlined below. The following information explains why we chose each indicator category and what the data helps us to understand about the community we serve.

### Demographics

Demographic data captures the characteristics and diversity of people in communities. Socioeconomic information such as age, race, and language spoken are used to analyze who lives in a community. This information leads to a better understanding of the needs of specific communities within the broader population of a given service area. Analyzing data from the perspective of different demographic categories can reveal a multiplicity of stories, rather than the single set of conclusions that is most often derived from monolithic, population-wide data. In this way, demographic data can help bring visibility to the needs of specific subgroups within a community.

Nevertheless, by its very nature, demographic data groups individuals, populations, and communities together, resulting in analysis that focuses on similarities within groups while flattening or obscuring unique differences among people. It is important to recognize that, as the Minnesota Department of Health notes in its 2017 Minnesota Statewide Health Assessment, “Although much of the data here are presented by race/ethnicity to reflect the diversity of the state's populations, the differences within each population group can be as great as the differences between different population groups... Data throughout the assessment should be understood as providing clues to the health of different populations, but not the whole story.”<sup>4</sup>

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## Physical environment

The physical environment in which an individual works or lives has a direct correlation with that individual's health. Certain aspects of the physical environment in which someone lives affects that person's ability to live a long and healthy life. To give just one example, a safe neighborhood may encourage more social interactions and connections and physical activity, while a neighborhood without those attributes can make those interactions and activities more difficult for the people who live there. Housing and transportation are important subsets of the physical environment. Whether a person has stable housing and reliable transportation are important factors that contribute to an individual's ability to secure and maintain employment as well as lead a long and healthy life.

- **Housing:** Having safe and affordable housing reduces the likelihood of homelessness and improves physical and mental health. According to research from the Robert Wood Johnson Foundation, housing stability, housing quality and safety, neighborhood characteristics, and affordability all affect health.<sup>5</sup>
- **Transportation:** Reliable transportation is fundamental to securing employment and being able to pay household expenses. It makes it easier and less time consuming to get to and from work and take children to and from daycare. It also enables other healthy behaviors such as, buying and bringing home fresh groceries, going to the doctor's office and filling prescriptions at their pharmacy.

## Socioeconomic factors

Socioeconomic factors influence health both directly and indirectly. They can have a direct positive or negative impact on a person's health and wellbeing, and they can also influence health in a wider range of ways by influencing that individual's behavior. Analyzing socioeconomic data, therefore, can help us better identify the causes and broader contributing factors helping to drive specific health needs among community members.

- **Community safety:** Feeling safe in the area in which a person lives and works is crucial to a person's health and wellbeing. Community safety can have an immediate impact on one's health and personal safety. Not feeling safe in one's surroundings can cause chronic stress, anxiety, and depression. It can influence the likelihood of connecting with neighbors, keep people from exercising or walking to necessities, and can even influence job availability. Community safety can have a direct and profound impact on a person's health and longevity.
- **Education:** Health and wellbeing are linked to the level of education a person has attained. More education means more opportunities: A higher level of educational attainment is correlated with securing good employment, increasing income, boosting wealth-building activities such as homeownership, and making it easier to increase other healthy behaviors. Life expectancy and other important health indicators improve with higher levels of educational attainment.
- **Employment:** Employment status is an important measure of health. Employment provides the financial resources individuals and families need to ensure that basic needs are met. From stable employment flows many other positive influences on health, such as food security, adequate housing, and health care access. Conversely, a lack of stable employment is a stressor in itself and also increases the risk of negative social determinants of health, including food insecurity, homelessness, and lack of access to health care. Unemployment and job loss are also linked to depression and anxiety, which can lead to stress-related illnesses such as heart disease, heart attack, and stroke.<sup>6</sup>

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- **Family and social support:** Humans are social creatures. As the COVID-19 pandemic has demonstrated so clearly, isolation can be devastating to a person's health and wellbeing. Individuals who are socially isolated are at a greater risk of dying early compared to those with strong family and social support systems.<sup>7</sup> Recent studies have concluded that loneliness can shorten a person's life by as much as 15 years – equivalent to smoking almost a pack of cigarettes a day or being obese.<sup>8</sup> Children who lack family support from a caring adult and those age 65+ and living alone are at risk of social isolation.<sup>9</sup> Family and social support are important to decrease likelihood of depression, anxiety, and suicide.
- **Income:** Poverty is defined as not having enough income to meet basic needs, including food, clothing, and housing. The federal poverty guidelines for 2021 established the "poverty line" in the United States as a household income of \$26,500 for a family of four.<sup>10</sup> Low-income status and poverty are correlated with a range of adverse health outcomes.<sup>11</sup> More generally, income affects a household's ability to buy food, afford adequate housing, secure childcare, and access health care.

## Health care

Clinical care refers to the medical treatment, screening, or vaccination of patients and is a critical part of reducing a person's risk of disease, disability, and death. The rate at which individuals in a specific community receive clinical care can give insight into the community's ability to access care and the barriers they may face.

- **Health insurance:** When people are uninsured or underinsured, they may forego preventive health care and may delay care for illnesses or injuries until they become emergencies. Having health insurance helps ensure access to care. Looking at the overall uninsured population, those age 65+ who are uninsured, and those who are on Medicaid allows us to better understand how these populations find care, receive preventive services, and pay for care. Improving access to care by improving health insurance access can help more people achieve the best health outcomes.

## Health outcomes

Our goal is for every member of our communities to thrive and live long and healthy lives. Studying the health outcomes of people in our community today, helps us to bring that goal closer by assessing the myriad factors that are currently influencing health outcomes to chart a path forward and track progress over time.

- **Length of life:** Length of life includes indicators that predict how many years an individual can expect to live. Leading causes of death, premature death, and suicide rates are also key indicators that reveal the major threats to life and health among the population.
- **Quality of life:** What makes life worth living? Quality of life is an outcome measured through self-assessed mental and physical health indicators. How individuals view their own emotional and physical quality of life affects their ability to enjoy life activities and have positive health-related outcomes. Quality of life is an important consideration in measuring unmet needs and designing interventions necessary for a specific population.

It is our hope and intention that by approaching our understanding of community needs through these multilayered indicators, we will be able to see our community more clearly and plan interventions that will have the greatest impact. For a full list of the core indicators used for the assessment, please see Appendix B.

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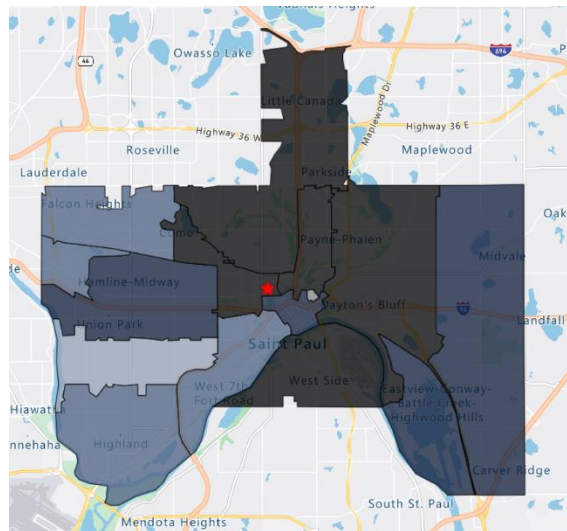
## Community Need Index for Bethesda Hospital

A Community Need Index score is a tool used to identify the severity of health disparities by zip code. Research has shown that zip codes with high Community Need Index scores show a strong correlation to high hospital use for both preventable and nonpreventable admissions.<sup>12</sup> Community Need Index scores are based upon five prominent socioeconomic barriers to healthcare access and range by zip code from a score of one (lowest need) to five (highest need).

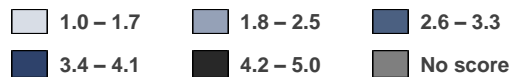
Socioeconomic barriers considered in the Community Need Index score are:

- Income barriers (percentage of elderly, children, and single mothers in poverty)
- Cultural/language barriers (percentage of Caucasian and non-Caucasian and percentage of adults over the age of 25 with limited English proficiency)
- Educational barriers (percentage without high school diploma)
- Insurance barriers (percentage uninsured and percentage unemployed)
- Housing barriers (percentage renting houses)

While Community Need Index scores do not provide information on specific health needs in the community, they do provide context and information about specific zip codes in which greater health disparities may be expected and where implementation strategies could be targeted.



Source: Truven Health Analytics



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## About Bethesda Hospital

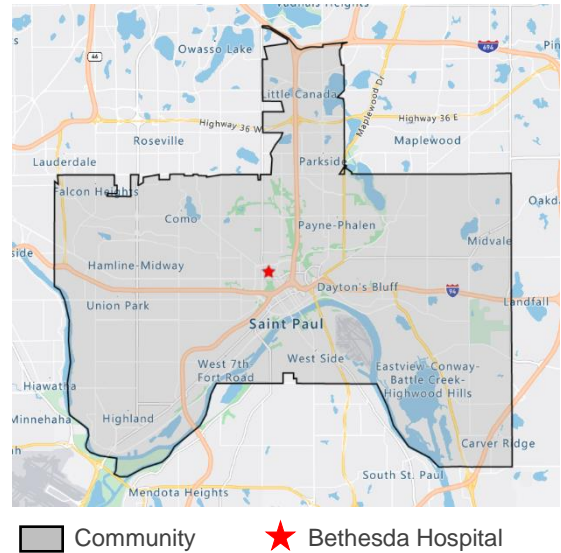
Bethesda Hospital, part of Fairview, opened in St. Paul in 1883. In 1989, it became a long-term acute care facility to serve patients with complex medical needs that required longer stays. When the pandemic hit in March 2020, Bethesda Hospital made history when it was converted almost overnight into one of the nation's first and only hospitals dedicated entirely to COVID-19 care. It treated some of Minnesota's most critically ill COVID-19 patients, with an intensive care unit patient survival rate that exceeded other hospitals around the world.

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## Bethesda Hospital CHNA community

For the purposes of the CHNA, Bethesda Hospital's community includes 14 zip codes. The total population of this geographic community is 345,400 people, and it covers 68 square miles.

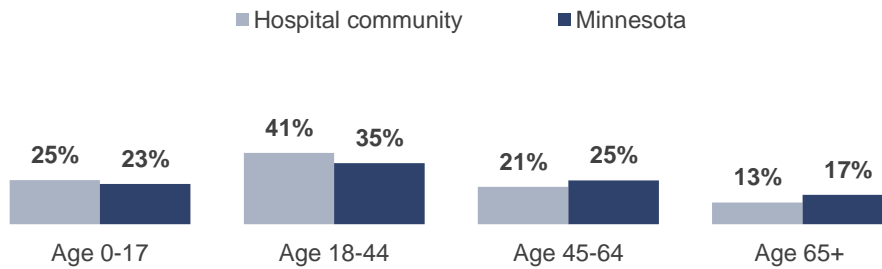
See Appendix C for a list of zip codes and the corresponding cities and counties that fall within the Bethesda Hospital CHNA community.



### Demographics

The Bethesda Hospital community is younger than the state in general with a higher percentage of people in the 0-17 age range (25 percent vs 23 percent) and the 18-44 age range (41 percent vs 35 percent). Over the next five years, the Bethesda Hospital community is projected to have a slight increase in the percentage of those ages 65 and older (from 13 percent to 14 percent).

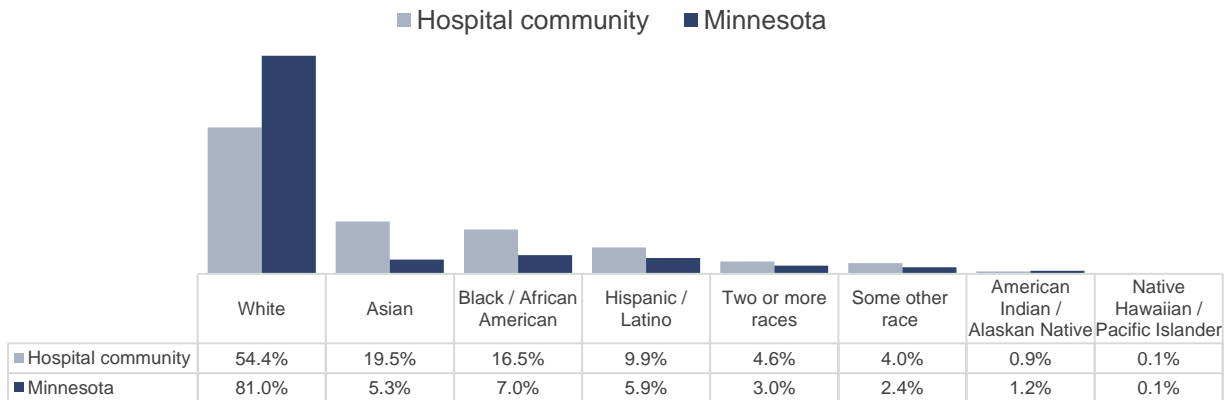
### Population by age



Source: Claritas, 2021

The Bethesda Hospital community is quite diverse. The percentage of the population who identify as Black/African American is twice as high as the statewide percentage. There is also a larger percentage who identify as Asian and Hispanic/Latino in the Bethesda Hospital community than in the state as a whole. In the next five years, there is projected to be an increase in the percentage of those who identify as Asian from 2021 (19.5 percent) to 2026 (21.6 percent).

### Population by race and ethnicity



Source: Claritas, 2021

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## Premature death

The table below shows the top five leading causes of premature death (before age 75) for Ramsey County, Minnesota overall, and the Healthy People (HP) 2030 target. For all Minnesota counties, cancer is the leading cause of death, with breast cancer incidence and mortality the highest, followed by lung, prostate, and colon cancers, respectively.<sup>13</sup> Heart disease, while the leading cause of death in many states, is second in Minnesota generally and Ramsey County in particular.

**Top 5 leading causes of premature death in Ramsey County, 2015 – 2019**  
Rate per 100,000 people

Rank	Leading cause of premature death	Rate	MN rate	Above or below MN	HP 2030 target
1.	Cancer	73.6	72.8	↑	122.7
2.	Heart disease	35.7	34.8	↑	n/a
3.	Unintentional injury	30.0	26.6	↑	43.2
4.	Suicide	12.0	12.7	↓	12.8
5.	Chronic lower respiratory disease	11.6	11.0	↓	n/a

Source: Minnesota Department of Health, County Health Tables, 2015-2019

The leading causes of death do not impact all communities the same. Historically marginalized race and ethnicity groups not only have higher disease and mortality rates,<sup>14</sup> but higher rates of premature death as well. Across the U.S., counties that are majority non-Hispanic Black or majority American Indian/Alaska Native have higher rates of premature death than counties that are majority non-Hispanic white do.<sup>15</sup>

Premature death rates also vary by income level, with a disproportionate number of premature deaths occurring among people experiencing poverty. A study by the Minnesota Department of Health found that people experiencing poverty were more likely to die from diseases or conditions that are treatable, resulting in a high rate of avoidable deaths in this segment of the population.<sup>16</sup>

Among young people (ages one to 24), early death is both tragic and generally preventable. Significant disparities among marginalized race and ethnic groups lead to higher mortality rates for this group. One recent study's results "strongly suggest that eliminating socioeconomic gaps across groups is the key to enhanced survival for children and adolescents in racial/ethnic minority groups."<sup>17</sup>

Many of the leading causes of premature death can be prevented by changes in health behavior. Residents who follow a healthy diet, maintain a healthy weight, exercise regularly, and avoid tobacco products have a lower risk of developing many chronic health conditions. Changes in behavior like these are greatly influenced by the social determinants of health such as access to healthy food and safe spaces to exercise, reduced stressors as a result of job security, financial security, and stable and safe housing.



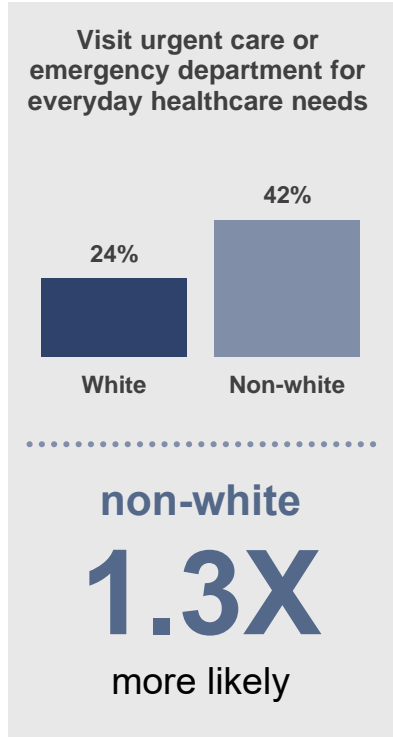
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## St. Paul survey results

To St. Paul residents, wellness means many things. Importantly, many view wellness as an active, ongoing endeavor to improve their whole health or achieve balance.

**Nearly one-third of community members said they go to an urgent care or emergency department to seek their everyday healthcare needs, and this number is even higher among non-white people.**

- People who say they face a barrier to staying healthy are significantly more likely to visit an ER or urgent care to meet their everyday health needs (47 percent) compared to those who do not face a barrier (20 percent).
- 32 percent of people said they have their everyday healthcare needs met in an urgent care or an ER; people identifying as non-white (including Black, Asian, Latino, or another race) were 1.3 times as likely (42 percent) to seek their everyday healthcare needs in an urgent care or ER compared to people who identified as white (24 percent).
- People who say they face a barrier to accessing the care they need when they are sick or have a medical need are significantly more likely to visit an urgent care clinic or ER for their healthcare.
- Of the people who said they visit a primary care or family doctor for their everyday healthcare needs, 15 percent said they access that care from a community, low-cost, or public health clinic. People identifying as non-white were more than twice as likely (23 percent) to seek care at a community, low-cost, or public health clinic compared to people who identified as white (11 percent).



**More than half of community members said they face barriers in getting care when they are sick or have a medical need.**

- 54 percent of survey respondents said they face barriers to getting healthcare when they are sick or have a medical need. The most common barriers relate to a lack of knowledge or understanding about how and where to get the right care (37 percent), closely followed by concerns over costs and the logistics of receiving their care (36 percent).

- I **don't know where** to go or who to go to
- I am **not sure the doctor will really help me** or answer all my questions
- I am **not sure I will be able to afford it**
- I **don't have transportation** to appointments
- I **don't have someone to watch my kids** while I see the doctor
- I **don't have the technology needed** for virtual or video appointments
- There **aren't choices or options** in my area

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- Non-white respondents are more likely to say they face a barrier to getting care they need when they are sick or have a medical need (61 percent) compared to white respondents (50 percent).
- 64 percent of 18- to 35-year-olds say they face a barrier in getting the care they need when they are sick or have a health need.
- Women are more likely to say they face a barrier to getting care when they are sick or have a medical need.

## Women compared to Men



## Even when not managing an illness or medical event, people are challenged to maintain their health.

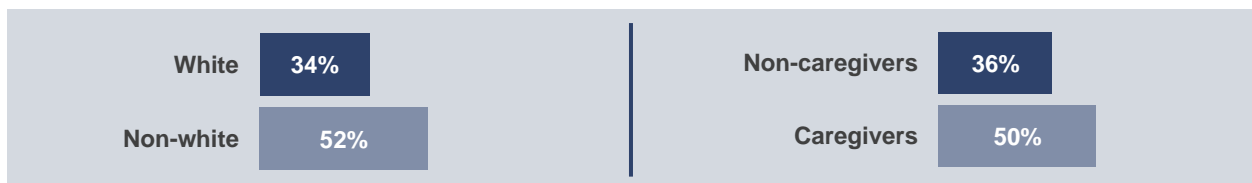
- Non-white people and those who identify as caregivers are significantly more likely to say they face a barrier to staying healthy compared to white people or people who are not caregivers.



## There is a demand among the community for more health and wellness services.

- Affordable healthcare centers that anyone can go to no matter financial or health insurance status; counseling, therapy, mental health and addiction treatment services; and affordable healthy and nutritious food options were the top-ranking options when respondents were asked to select what services the community needed more of.

## Desire for more counseling, therapy and other mental health and addiction treatment services is significantly higher among non-white people.





# Fairview

## Implications: Moving forward

This feedback from the community, as well as our patients, employees, and community partners, is vital in solidifying the path forward for the health and wellness hub. These insights have the following implications:

### 1. The survey results strengthened our resolve that a centralized hub of health and wellness can have a positive impact as a reimagined space.

- Half of people (50 percent) agree that existing healthcare services in downtown do not meet the health needs of surrounding communities, especially for low-income people, communities of color, and refugees.
- 61 percent of people are more aware of the unmet health needs in their community than they were before COVID-19.
- A majority of people familiar with plans to repurpose St. Joseph's believe it is a positive development for the community.

### 2. Community feedback affirmed that the community wants and will use these services, but we must remove barriers.

- People are likely to use services like affordable healthcare centers (59 percent); affordable vocational education and training opportunities (51 percent); counseling, therapy, mental health, and addiction treatment services (57 percent); affordable healthy or nutritious food options (63 percent); and options for pharmacy needs and filling prescriptions (60 percent) if they were located in a single location in downtown St. Paul.
- 71 percent of people agree that factors such as education, access to safe and affordable housing, racial inequality, and employment have just as much of an impact on health in their community as care in a hospital or clinic.
- A majority of people agree that access to preventative care like regular doctor visits and upstream mental health services like counseling and therapy are as important to maintaining their health as access to a hospital or acute mental health or addiction care programs.

### 3. We learned where we can work with community leaders and partners to meet unmet needs.

"We need **more places** for people to go to for **treatment and healthcare**. Most people don't even go to the doctor because they either know they're in a bad situation or have money problems."

"**Easily accessible nutrition and healthcare**. My community would benefit from **therapy services** as well as **addiction services**."

"Access to **affordable healthy foods** which need to be delivered or available for pickup in safe areas."

"I have what I need, but I **worry about people less fortunate than me**."

"**Education** as to why we need to be healthy."

"More affordable **fast healthy food** options."

"More **services for mental health** which can help people to get out of stress and anxiety."

"**Buena planificación y ejecución** para la salud pública."

"**Affordable exercise** programs, affordable medical **massage** and **chiropractor**."

"**Reliable transportation** to appointments and **shorter wait times**."

"**Dental services with short wait times to schedule an appointment**. It takes forever to get into local dentists these days."

"More **healthy food** and affordable **vocational training programs**."

# 65%

### of people surveyed

agree that repositioning the St. Joseph's campus as a hub for affordable and accessible health and wellness services will improve the health of low-income people and communities of color in St. Paul.

# 77%

Say they would be **likely to use at least one of these services**

**Non-white:**

**83%**

**Men:**

**83%**

**18- to 35-year-olds:**

**84%**

**Caregivers:**

**89%**

# Fairview

## Bethesda Hospital community social determinants of health snapshot

The percent of the population with **no high school diploma** in the Bethesda Hospital community is **almost twice** that than statewide.



**13%**  
Hospital community

**7%**  
Minnesota

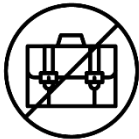
A higher percent of the Bethesda Hospital community is **uninsured** than statewide.



**7%**  
Hospital community

**5%**  
Minnesota

The **unemployed** rate in the Bethesda Hospital community is higher than the state's rate.



**5%**  
Hospital community

**4%**  
Minnesota

Almost one-third of the Bethesda Hospital community **speak a language other than English at home** which is much higher than statewide.

**29%**  
Hospital community



**12%**  
Minnesota

**One-third** of households in the Bethesda Hospital community are cost burdened (**spend a third or more of their income on housing**).



**33%**  
Hospital community

**25%**  
Minnesota

A **much higher** percent of households in the Bethesda Hospital community **receive SNAP benefits** than statewide.



**16%**  
Hospital community

**8%**  
Minnesota

The **median household income** in the Bethesda Hospital community is **much lower** than the state's.

  
**\$59,518**  
Hospital community

  
**\$80,714**  
Minnesota

The percent of individuals **living in households below the federal poverty level** is higher in the Bethesda Hospital community than statewide.



**18%**  
Hospital community

**10%**  
Minnesota

Family of four, annual income of \$25,750

Sources: Claritas, 2021; American Community Survey 2015-2019

# Fairview

## Our priorities

Fairview is committed to transparency and accountability in all we do, including our efforts to assess – and respond to – our community’s most pressing health needs. The community benefit work that we do across Fairview must reflect our community’s actual needs, not our assumptions about what those needs might or should be.

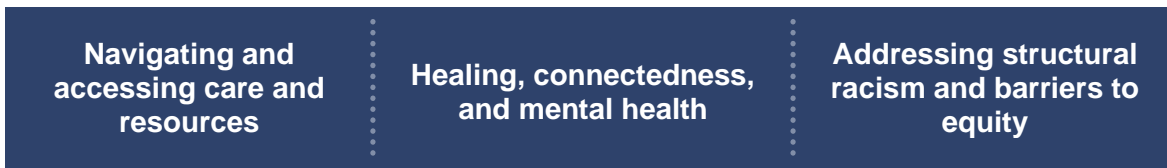
Because we understand that change cannot happen when we work in silos, and it cannot happen in a single year, we grounded our 2021 CHNA process in alignment with our 2018 CHNA needs, existing data, and the voices of our community members and community partners. Once we had collected, analyzed, and synthesized the information we received from both primary and secondary data sources, we established a prioritization process through which we could identify the community health needs that, if effectively addressed, would have the greatest positive impact on our communities and particularly on our priority populations. Having a consistent, defined process helps reduce the skewing effect of conscious and unconscious biases and enables us to define priority need areas that reflect our community’s top health needs rather than our perception of those needs.

We evaluated areas of need based on four broad criteria:

- Has this need been voiced by the community? Has this need been vetted by the community?
- Does this need align with Fairview’s strategies and priorities?
- Does this need align with existing public health strategies and community health assessments?
- Does this need build upon Fairview’s 2018 CHNA priority needs?

## Priority needs

Our process resulted in the identification of three priority need areas. They are:



For more details on our priority need areas, see the corresponding report section for each area below.

## Priority populations

In the course of our work with the communities we serve, we have come to the realization that to have the greatest impact, we must take a targeted approach. We have learned that by focusing on specific issues and communities, we can understand and begin to address the root causes of health inequity in a more meaningful way.

That is why, although not required for a CHNA, the process of defining and articulating specific priority populations is a key facet of Fairview’s approach to creating lasting, meaningful change for the better.

The priority populations are:



# Fairview

The priority populations span both geography and age, extending across the lifespan and across our service area. Social determinants of health can look different in urban and rural environments, but the systemic inequalities underpinning them are the same. The effect of social determinants of health on health disparities can begin before birth and follow an individual for a lifetime, forming an ever-widening gulf as individuals age. No matter where on the lifespan an individual is, we can respond with effective initiatives that will make a real difference.

Another aim of identifying specific priority populations is to bring visibility to communities whose concerns and needs are often silenced and rendered invisible. Examining the data through the lens of specific communities is one way to develop a fuller understanding of community members' experiences. And because minoritized racial and ethnic groups and people experiencing poverty often do not have a formal voice in decision-making that affects them, we intend to take a collaborative approach as we move forward with our implementation plan that ensures these priority populations a seat at the table and elicits feedback at every stage.

Language is important. Because words have the power to reflect our intentions, we devoted significant energy to deciding how to frame the priority populations. Before deciding on the priority population terminology for this report, we had a series of conversations, specifically about language, with organizations that represent the priority populations, public health agencies, community committees, and internal staff. Guided by these conversations, and as a result of much thought and consideration, we have chosen to use the term "racial or ethnic populations experiencing health disparities" as the priority population. We will also use the term minoritized racial and ethnic groups.<sup>18</sup> Both of these terms include all minoritized communities, including but not limited to: African American, Alaska Native, Arab, Asian, Black, Cambodian (Khmer), Chinese, Ethiopian, Filipino, Hispanic/Latino, Hmong, Karen, Kenyan, Korean, Lao, Liberian, Middle Eastern, Native American, Native Hawaiian, Nigerian, Oromo, Pacific Islander, Somali, and Vietnamese.

Although this decision is the best one for this report at this time, we also recognize that language is fluid. While for now, "racial or ethnic populations experiencing health disparities" is most appropriate for this report, that may change with time.

You will also see the term Black, Indigenous, and people of color or (BIPOC) in some instances, as this term is currently used by many. This term was developed to highlight the unique relationship to whiteness that Black, Indigenous, and people of color experience. We also recognize these two groups (Black and Indigenous) are not always at the center of the issue being discussed at certain points within the report, and that the term BIPOC can further marginalize other communities of color, reinforcing their already low visibility.

People experiencing poverty includes all race/ethnicities including but not limited to: African American, Alaska Native, Arab, Asian, Black, Cambodian (Khmer), Chinese, Ethiopian, Filipino, Hispanic/Latino, Hmong, Karen, Kenyan, Korean, Lao, Liberian, Middle Eastern, Native American, Native Hawaiian, Nigerian, Oromo, Pacific Islander, Somali, Vietnamese, and White.

For more details on the priority populations, including the intersection between the priority populations and our priority needs areas, please see the following three sections below. The following three sections are designed to bring our priority needs areas, and their impact on the priority populations, into focus.

## Navigating and accessing care and resources

At Fairview, we offer exceptional care. Our world-renowned experts lead the way in breakthrough care and innovative research, with specialty programs among the nation's finest. None of that matters, though, if people can't access our care and resources. We must connect the dots between the care we offer and the people who need it, making it simpler and easier for more people to access our health system across the care continuum and in ways that work for them.

# Fairview

The communities we serve face barriers to accessing care at several levels. For the uninsured or underinsured, the cost of care can be prohibitive. Even if individuals do have insurance, navigating the complex world of preauthorization, deductibles, and fine print leaves many unsure about what they will have to pay for the care they need. That uncertainty can itself make people less likely to seek care.

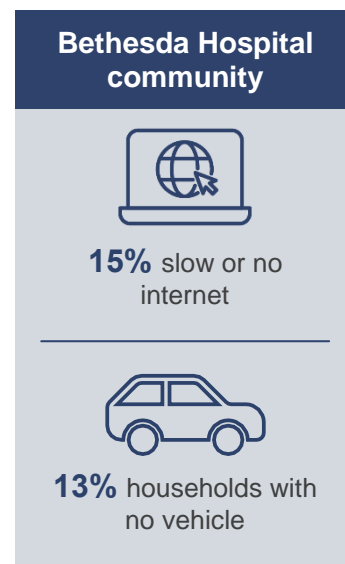
For those who do not speak English as a first language, health insurance may be more difficult to decipher, setting the bar for healthcare literacy – and the barrier to access – even higher. These language-related barriers might be compounded by worries about insurance or legal status, such that individuals might not trust local, state, or federal agencies with personal information.

Logistical and technological complexities present challenges as well. For those without a personal vehicle, simply getting to the clinic can require a long trip using public transportation. Others may work several jobs or have unpredictable work hours, making scheduling difficult. The increased use of telemedicine is seen by some as one silver lining of the COVID-19 pandemic. However, those with limited digital proficiency and people living in poverty may be in danger of being left behind without access to a computer with fast, reliable internet, as well as the technological savvy to manage appointments using email and videoconferencing.

## Bethesda Hospital community: Navigating and accessing care and resources

Within the Bethesda Hospital community, 13 percent of households do not have a motor vehicle to make it easier to get to doctor's appointments or the pharmacy. Telemedicine has the potential to improve access to care, but 15 percent of households within the Bethesda Hospital community either have no internet access in their home, use a dial-up connection for internet, or have access to the internet but don't pay for the service, putting virtual provider visits out of reach. Without fast, reliable internet access, individuals and families cannot take advantage of telehealth technology and are at risk of being left behind.

Access to care and resources can also be hampered by a lack of health insurance, which affects 6.5 percent of the Bethesda Hospital community's residents, a rate that is about the same as uninsured rates in Ramsey County (5.3 percent) and statewide (4.5 percent). Approximately 4.4 percent of children ages 0 to 17 are uninsured in the Bethesda Hospital community.



Source: American Community Survey 2015-2019

### Uninsured population by race and ethnicity Bethesda Hospital community

Race and ethnicity	Total	#	Percent
Asian	61,823	3,697	6.0%
Black or African American	51,547	4,165	8.1%
Hispanic or Latino	30,435	6,571	21.6%
Multiple race	16	1	8.7%
Native American or Alaska Native	2,654	401	15.1%
Native Hawaiian or Pacific Islander	94	7	7.5%
Some other race	8,272	1,881	22.7%
White	175,538	5,705	3.3%

Source: American Community Survey 2015-2019

# Fairview

Through a series of conversations with members of Bethesda Hospital community, we learned about a variety of needs and challenges facing the community. The table below summarizes what we heard related to navigating and accessing care and resources.

Navigating and accessing care and resources: Community voice summary		
Care and education are not culturally informed	Limited insurance coverage & education	Not enough preventative care
Complexity of care and not enough coordination/navigation support	Limited services & support for 65+ Population	Not enough resources and services in the neighborhood/community
Cost of care is prohibitive	Limited spiritual health resources	Not enough telehealth/virtual Classes
Dental care & insurance is inaccessible	Limited/ineffective translation services	Obesity
Inaccessible care (affordability, COVID-19, enough providers, don't know how to access)	Limiting clinic hours	Providers are not representative of community
Judgmental medical staff	Long wait times to appointments	Technology barriers (broadband, virtual interpretation, device access, virtual burn out)
Lack of follow-up care after hospitalization	Need for patient advocate/cultural advocate	Transportation (no vehicle, cost of gas, distance to appointment, reliable, bus challenges)
Lack of health literacy & education	Need more education on healthy eating	Uninsured population
Lack of trust in mainstream services	Need more medication education and management	

For more details on our community conversation process, please see the “Primary data collection and review” section of the report below.

## Priority populations: Navigating and accessing care and resources

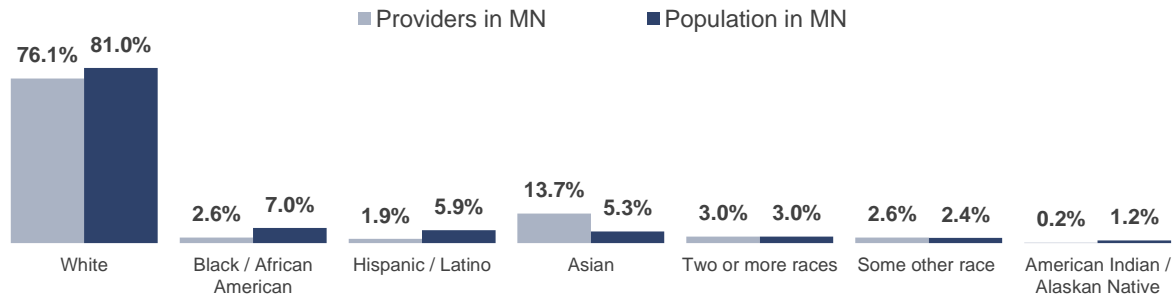
### Racial or ethnic populations experiencing health disparities

The U.S. healthcare system – a web of providers, facilities, insurers, private industry, and many other entities – can be difficult for anyone to navigate. Having a strong relationship with a trusted physician can make it easier for people to coordinate and manage their health care. Sharing a common cultural background is one way to establish a foundation of trust, yet for many racial or ethnic populations experiencing health disparities in Minnesota, that common ground is difficult to find. Of the 17,216 physicians surveyed in Minnesota in 2017, 24 percent identified as Asian, American Indian/Alaskan Native, Black/African American, Hispanic/Latinx, multiple races, or another race not listed. While this percentage is higher than the statewide average, for those who identify as Black/African American, American Indian/Alaskan Native or Hispanic/Latino, the percentage is much lower. More significantly, it means that many of the available doctors in our service area don't share their patients of color's racial, ethnic, or cultural background.



# Fairview

## Number of providers in MN compared to the population in MN by race and ethnicity



\*Providers in MN unavailable for Native Hawaiian/Pacific Islander

Source: Claritas, 2021; Minnesota Department of Health, Office of Rural Health and Primary Care, Physician Workforce Survey, 2019

Language barriers pose a big challenge for people seeking to access care, and they contribute significantly to healthcare disparities. According to a report from the Robert Wood Johnson Foundation, “Everyday experience is teaching hospitals that the quality of their medical care is closely linked to how well they meet the language needs of their patients – and language barriers are often complicated by cultural differences.”<sup>19</sup>

Many of the area’s residents face language barriers when accessing health care or resources. More than 29 percent of the Bethesda Hospital community speak a language other than English, and 15 percent of the population are limited English proficient, which means speak a language other than English at home and speak English less than “very well.” In contrast, only eight percent of Minnesota’s physicians communicate in Spanish in their practices, less than two percent speak French or Arabic, and less than one percent speak another language other than English.

**15%** of individuals are **limited English proficient** in the Bethesda Hospital community

Source: American Community Survey 2015-2019

### People experiencing poverty

Poverty is associated with poorer health outcomes. For example, socioeconomic inequalities in cancer mortality are widening, with the most notable gaps for the most preventable cancers.<sup>20</sup> Most adults experiencing homelessness in Minnesota (81 percent) have a chronic physical health condition (57 percent), serious mental illness (64 percent), or substance use disorder (24 percent). Half of Minnesota adults experiencing homelessness have more than one of these conditions.<sup>21</sup>

Since so many individuals and families access health insurance through their employers, unemployment increases result in higher poverty levels and greater barriers to health care access. Losing employment places significant financial strain on individuals and families as they may lose both income and benefits, including health insurance. Minoritized racial and ethnic groups experienced higher job losses during the COVID-19 pandemic, causing increased financial instability, which may lead to food and housing insecurity. The Minnesota Department of Employment and Economic Development reports that an estimated one in two Black workers in Minnesota have applied for unemployment between mid-March and July 2020, compared with one in four white workers.<sup>22</sup>

Medicaid is the nation’s public health insurance program for people with low income. One in five Americans are covered by Medicaid. Children account for more than four in ten (43 percent) of all Medicaid enrollees, and the elderly and people with disabilities account for about one in four enrollees.<sup>23</sup> In the Bethesda Hospital community, 33 percent of the population receive Medicaid.

**33%** of the Bethesda Hospital population is receiving **Medicaid**

Source: American Community Survey 2015-2019

# Fairview

## **COVID-19 and navigating and accessing care and resources**

Due to the rise of telehealth technology and its widespread adoption, the COVID-19 pandemic resulted in expanded modes of access to care for many people. However, a dependence on telehealth can prove to be a significant barrier for disadvantaged groups, including people experiencing poverty, people who speak a language other than English, and older adults who may have a lower comfort level with technological tools. In some communities, broadband internet may not even be available.

COVID-19 had a devastating impact on people without health insurance – and that number increased dramatically among the most vulnerable populations throughout the economic upheaval that COVID-19 caused.<sup>24</sup> Difficulty accessing health care makes it harder to get a COVID-19 test, undergo treatment for symptoms (including symptoms of “long COVID”), and receive a vaccine to protect against the disease. Vaccination rates among the priority populations are lower than statewide averages.

## **Healing, connectedness, and mental health**

Mental health challenges are a pervasive, and too often silent, threat to health. According to the U.S. Centers for Disease Control and Prevention, approximately one in five U.S. adults – that’s more than 51 million people – experience mental illness in a given year.<sup>25</sup> Therefore, it’s no surprise that the U.S. Department of Health and Human Services’ Healthy People 2030 initiative has defined mental health as one of its priority areas.<sup>26</sup>

Yet according to the National Institute of Mental Health, only about half of people experiencing mental illness get the treatment they need.<sup>27</sup> And although mental health challenges are experienced by people across every demographic group, the health disparities that disproportionately affect minoritized racial or ethnic populations and people experiencing poverty result in poorer mental health outcomes for those groups.

Social isolation can compound these issues. A recent national survey found that more than half of U.S. adults felt loneliness and isolation.<sup>28</sup> Social isolation is correlated with a range of negative health outcomes, including depression, sleep problems, cognitive decline, heart disease, and decreased immune system function.<sup>29</sup> Loneliness raises an individual’s risk of depression, anxiety, and suicide.<sup>30</sup>

Substance use is closely interrelated with other mental disorders. According to the National Institute of Mental Health, about half of individuals with substance use disorder also have another, co-occurring mental health issue, such as depression or anxiety. Mental health challenges also increase a person’s risk of developing a substance use disorder, partly stemming from an individual’s attempt to self-medicate with drugs or alcohol. Environmental stressors, including trauma, food insecurity, lack of safe housing, low income, and other social determinants of health, can also cause changes in the brain that may increase a person’s risk of developing a mental health disorder or substance use disorder.<sup>31</sup>



# Fairview

## Bethesda Hospital community: Healing, connectedness, and mental health

In the Bethesda Hospital community, 13 percent of people ages 18 and over reported 14 or more days a month of poor mental health. One in ten adults ages 65 and over within the Bethesda Hospital community live alone, increasing their risk of social isolation.


In Ramsey County, suicide is the fourth leading cause of premature death at a rate of 12 per 100,000 people. Eight percent of ninth graders in Ramsey County reported having attempted suicide.<sup>32</sup> Each suicide is a tragedy, the damaging effects of which reverberate not only within families, but across entire communities.

Adverse childhood experiences (ACEs) are potentially traumatic events that occur in childhood (0 to 17 years of age). ACEs can have lasting, negative effects on health and wellbeing and can impact life opportunities such as education and job potential. The ACE score is a measure of cumulative exposure to adverse childhood conditions. Exposure to a single ACE condition is counted as one point. In Ramsey County, 14 percent of ninth graders reported an ACEs score of four or more.<sup>33</sup>

In Ramsey County's most recent Public Health Community Health Assessments, mental health was designated a priority area.


We heard a variety of community concerns related to healing, connectedness, and mental health during a series of conversations with the community. We have summarized the most common needs and challenges that we heard through our community conversation process in the table below.

**Bethesda Hospital community**



**10%** of the population **ages 65+ live alone**

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**13%** of those ages 18+ reported 14 or more days during the past 30 days during which their **mental health was not good**

Sources: American Community Survey 2015-2019; Minnesota Student Survey, 2019

Healing, connectedness, and mental health: Community voice summary		
Chemical dependency	• Inconsistent care among/between case managers and mental health providers	• No knowledge about financial assistance for mental care and prescriptions
Community not welcoming	• Inconsistent care with case managers and mental health providers	• Not enough cultural mental health providers
Depression	• Lack of youth mental health	• Social isolation (lack of connection/feeling of belonging)
Don't know how to access mental health services	• Need more mental health and addiction programming	• Stigma
Drug/addiction		• Stress
High cost for mental health care		
Historical trauma		

For more details on our community conversation process, please see the "Primary data collection and review" section of the report below.

# Fairview

## Priority populations: Healing, connectedness, and mental health

### Racial or ethnic populations experiencing health disparities

Race-related stressors – including overt discrimination as well as more insidious systemic racism woven through many aspects of American culture – can negatively affect the mental health of those who were discriminated against.<sup>34</sup> The U.S. Department of Health and Human Services Office of Minority Health has found that Black adults are more likely to report severe psychological distress than whites are. At the same time, Black adults have lower levels of mental health treatment.<sup>35</sup> In Minnesota specifically, adults who are Black, Indigenous/Native, multiracial, or Hispanic/Latino are less likely to receive optimal follow-up care for depression than average.<sup>36</sup>

We see similar inequities in Minnesota youth as, American Indian or Alaskan Native students reported higher rates of suicidal thoughts or attempted suicide and lower rates of feeling safe at home. Nearly three out of four (71 percent) of multiple race students reported feeling down, depressed, or hopeless or feeling nervous, anxious, or on edge on several days or more compared to 55 percent of Black, African or African American students, according to data from the 2019 Minnesota Student Survey.<sup>37</sup>

Although one contributing factor may be stigma associated with mental disorders and mental health treatment among some individuals in minoritized racial and ethnic populations, as an article in the National Council for Mental Wellbeing argues:

“It is arrogant to believe that we can decide to focus on communities that have gone underserved and be embraced and trusted, without earning that trust. We must start by listening and seeking to understand not only Black, Indigenous, and people of color but all underserved or inappropriately served communities, including the LGBTQ and socio-economically disadvantaged communities.”<sup>38</sup>

Untreated trauma and generational stressors can combine to form a high level of ambient background stress that affects both physical and mental wellbeing over time.

### People experiencing poverty

Low income is associated with higher rates of mental disorders and substance use disorders. The stressors associated with poverty – from lack of access to nutritious food and safe housing to toxic exposures – have also been shown to correlate with an increased risk of problems with cognitive development in children that may begin before birth and last throughout an individual’s life.<sup>39</sup>

People experiencing poverty are at a higher risk of homelessness. Homelessness can ravage mental health: the stress associated with housing instability is immense and makes it more difficult to seek gainful employment and care for personal health and wellbeing. To make matters worse, most adults experiencing homelessness in Minnesota (81 percent) have a chronic physical health condition (57 percent), serious mental illness (64 percent), or substance use disorder (24 percent). Half of Minnesota adults experiencing homelessness have more than one of these conditions.<sup>40</sup>

### COVID-19 and healing, connectedness, and mental health

COVID-19 exacerbated many of the factors that contribute to poor mental health, according to the CDC. In June 2020, 40 percent of U.S. adults reported struggling with mental health or substance use.

“During June 24–30, 2020, U.S. adults reported considerably elevated adverse mental health conditions associated with COVID-19. Younger adults, racial/ethnic minorities, essential workers, and unpaid adult caregivers reported having experienced disproportionately worse mental health outcomes, increased substance use, and elevated suicidal ideation.”<sup>41</sup>

As we look ahead, the worsened mental health and wellbeing that remain after the pandemic will continue to represent a significant community health need for both priority populations. During the COVID-19 pandemic, health disparities and psychosocial stressors for some racial and ethnic minority groups, especially Hispanic respondents, resulted in higher rates of mental health disorders, including substance use disorders.<sup>42</sup>

# Fairview

## Addressing structural racism and barriers to equity

We are dedicated to confronting the ways in which racial and ethnic inequalities intertwine with social determinants of health to result in health disparities. Providing excellent health care to everyone in an environment that values diversity, equity, and inclusion is foundational to the ongoing work of dismantling the structures and systems that have worked to secure and promote inequities that disadvantage racial or ethnic populations experiencing health disparities and other marginalized individuals and groups.

In many ways, the concerns and challenges outlined in our other priority needs categories are deeply intertwined with structural racism and the barriers that have been erected to withhold opportunities from racial or ethnic populations experiencing health disparities for generations. The lives of minoritized racial and ethnic groups have been devalued and undervalued for centuries in the U.S. It's not enough to see and understand what's happening now; it is our responsibility to honor those who came before us and heed history's lessons. This is the only way we can chart a path forward into a more just and equitable future for everyone.

Structural racism has resulted in a persistent wealth gap between white people and minoritized racial and ethnic groups, which in turn affects long-term health outcomes in minoritized racial and ethnic groups. According to the Robert Wood Johnson Foundation:

“A long history of discrimination and structural racism explains the wealth gap among people in America. Race-based unfair treatment built into institutions, policies, and practices — such as residential segregation in impoverished neighborhoods; discrimination in bank lending to residents of largely minority neighborhoods; and discriminatory policing and sentencing practices — continue to play a major role in wealth inequality between people of color and white people in the United States.”<sup>43</sup>

The Robert Wood Johnson Foundation concludes that building wealth within communities that have been afforded fewer opportunities is critically important to building health equity. The U.S. Department of Health and Human Services has connected wealth and health equity by focusing on the role of social determinants of health — including racism and discrimination as well as financial stability — in determining an individual's health.

Social determinants of health also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Simply promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.<sup>44</sup>

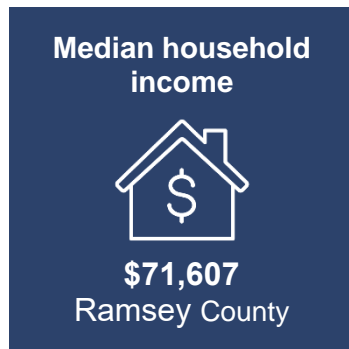
# Fairview

## Bethesda Hospital community: Structural racism and barriers to equity

Food insecurity occurs when an individual or a household does not have easy access to enough nutritious food to maintain a high-quality diet. Food insecurity can result in increased consumption of low-cost, unhealthy foods, which can have a harmful effect on household members' physical and mental health. According to Feeding America, many food insecure households do not qualify for federal nutrition benefits such as SNAP (Supplemental Nutrition Assistance Program), depending instead on community programs like local food banks.<sup>45</sup> In 2017, an estimated 12 percent of Ramsey County's population experienced food insecurity at some point during the year. Among children ages 0 to 17 in Ramsey County, an estimated 15 percent experienced food insecurity as well.<sup>46</sup>

Neighborhoods are a key component of the health and wellbeing of individuals and families. According to the Minnesota Department of Health, "A neighborhood's physical characteristics may promote health by providing safe places for children to play and for adults to exercise that are free from crime, violence, and pollution."<sup>47</sup> In the 2019 Minnesota Student Survey results for Ramsey County, seven percent of ninth graders disagreed or strongly disagreed with the statement, "I feel safe in my neighborhood."<sup>48</sup>

Housing is generally the line item that consumes the greatest share of a household's budget, followed by food and transportation. Yet in Minnesota, housing continues to get more expensive. According to the Minnesota Housing Partnership, "Housing costs continue to increase disproportionately to income. Between 2000 and 2019, the median renter income in Minnesota increased by just one percent, while median gross rent for the state increased by 14 percent. This has led to an increase in cost burdened households."<sup>49</sup>



Source: Claritas, 2021

There is a strong link between income and health. When groups of people are marginalized and kept from building wealth, it affects communities in not only financial terms, but in health terms as well. Study after study has shown "longitudinal associations between greater wealth and many favorable health outcomes, including lower mortality, higher life expectancy, and decreased risks of obesity, smoking, hypertension, and asthma."<sup>50</sup>

This link is intergenerational. It persists as a child's family status influences that child's access to education and opportunities that can shape the individual's future. Having fewer opportunities increases the chance that a child will make fewer economic gains over a lifetime, further perpetuating the cycle. While the median household income in Ramsey county (\$71,607) is similar to the state (\$80,714), we see large racial and ethnic disparities.



**12%** of the population in Ramsey County is **food insecure**



**33%** of households in the Bethesda Hospital community spend **one-third or more of their income on housing**

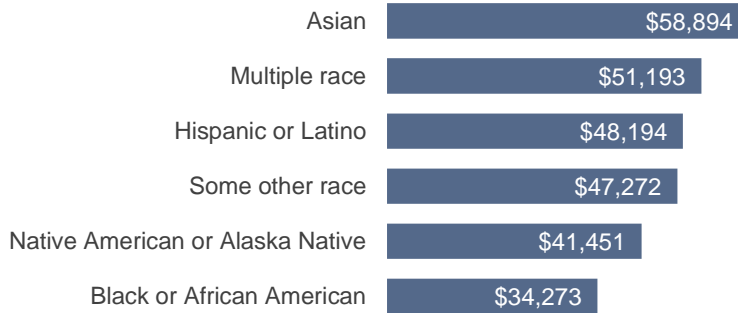


**7%** of 9th grade students in Ramsey County **do not feel safe in their neighborhood**

Sources: Feeding America, 2017; American Community Survey 2015-2019; Minnesota Student Survey, 2019

# Fairview

## Median household income by race and ethnicity Ramsey County



\*Unavailable for Native Hawaiian or Pacific Islander

Source: American Community Survey 2015-2019

Racial or ethnic populations experiencing health disparities and other marginalized individuals and groups need to have a leading voice in the decisions being made about their neighborhoods. As we have conducted listening sessions with community members, we have learned that among the top challenges in the Bethesda Hospital community related to structural racism and barriers to equity are:

### Structural racism and barriers to equity: Community voice summary

Barriers for immigrants and refugees	• Fixed income	• Need for small business repair and support
Barriers related to documentation status	• Homelessness	• Neighborhood crime and safety
Civil unrest	• Information silos	• Not enough housing that is affordable, healthy, safe, stable
COVID-19 disparities	• Lack of access to healthy and affordable food	• Poverty
Discrimination	• Limited/limiting employment opportunities	• Racism
Financial instability	• Need better way to figure out community need	• Safety

For more details on our community conversation process, please see the “Primary data collection and review” section of the report below.

## Priority populations: Structural racism and barriers to equity

### Racial or ethnic populations experiencing health disparities

Minnesota is one of the healthiest states in the nation,<sup>51</sup> but it is also among the states with the greatest health disparities between white people and minoritized racial and ethnic groups. Minoritized racial and ethnic groups in Minnesota face health disparities resulting from systemic racism and health inequities. A 2021 report of healthcare disparities in Minnesota concluded, “In general, Indigenous/Native, Black, and Hispanic/Latinx patients have significantly lower rates of optimal care compared to the statewide average in most of the reported measures,” including colorectal cancer screening, optimal diabetes care, optimal vascular care, optimal asthma control, and mental health screening.<sup>52</sup>

Inadequate access to supports for social determinants of health contribute to lower rates of preventive care, longer time to diagnosis, and more barriers to care. The ambient stressors of financial insecurity, food insecurity, lower wages, neighborhood violence, and a host of other factors also affect individuals’ ability to maintain and improve their health — and these social determinants of health factors disproportionately affect racial or ethnic populations experiencing health disparities.

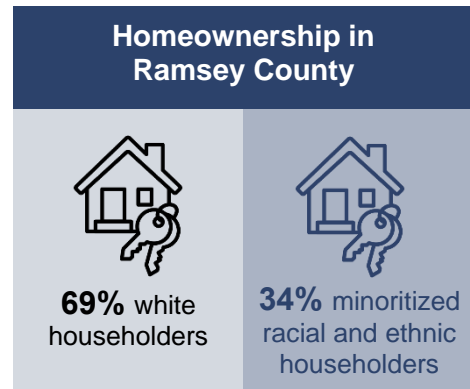
# Fairview

Systemic inequities such as zoning laws, have disproportionately driven down property values and driven out commercial investment in neighborhoods with high numbers of minoritized racial and ethnic groups. The effects of structural racism are revealed in the homeownership gap within the Bethesda Hospital community. In Ramsey County, 34 percent of minoritized racial and ethnic householders own their homes, compared to 67 percent of white, non-Hispanic or Latino householders.

Educational inequality, and the generational wealth disparities that result from those inequities, affects the population we serve as well. Just 5.7 percent of the community’s white residents do not have a high school diploma. Compared to the state, a much higher percent of the Asian (35.3 percent compared to 19.2 percent in the state) and Native Hawaiian or Pacific Islander (28.7 percent compared to 18.2 percent in the state) population do not have a high school diploma in the Bethesda Hospital community. Higher levels of education unlock a wider range of opportunities for good-paying jobs with benefits. In turn, those higher incomes can lead to a range of positive health-related outcomes, from living in a safe neighborhood to having easy access to healthy food and medical care. Conversely, lower levels of education lock many people out of this positive trajectory.

## People experiencing poverty

Poverty correlates with increases in negative outcomes across the board, and it makes almost every aspect of life more difficult. Low income levels force individuals and families to make impossible choices – between buying food and buying medicine, for example. The health care system – like so many other social, economic, and cultural systems – are not designed with the needs of people experiencing poverty in mind.



Source: American Community Survey 2015-2019

## No high school diploma by race and ethnicity Bethesda Hospital community

Race and ethnicity	Total	#	Percent
Asian	656	232	35.3%
Black or African American	28,548	5,741	20.1%
Hispanic or Latino	30,545	5,157	16.9%
Multiple race	5,436	611	11.2%
Native American or Alaska Native	82,807	11,593	14.0%
Native Hawaiian or Pacific Islander	94	27	28.7%
Some other race	4,566	1,739	38.1%
White	143,545	8,139	5.7%

Source: American Community Survey 2015-2019

## Population below 100 percent federal poverty level by race and ethnicity, Bethesda Hospital community

Race and ethnicity	Total	#	Percent
Asian	61,058	15,173	24.9%
Black or African American	51,076	16,906	33.1%
Hispanic or Latino	29,973	6,714	22.4%
Multiple race	15,519	4,128	26.6%
Native American or Alaska Native	2,584	1,102	42.7%
Native Hawaiian or Pacific Islander	94	18	19.2%
Some other race	8,203	1,479	18.0%
White	189,150	20,031	10.6%

Source: American Community Survey 2015-2019



# Fairview

About eight percent of the Bethesda Hospital community is living in a household with income below 50 percent of the federal poverty level. That means for a family of four, the household annual income is around \$12,875.

Poverty and homelessness affect more people than ever in Minnesota. The Wilder Research study on homelessness in Minnesota found that homelessness increased 10 percent from 2015 to 2018 in Minnesota, with a 25 percent increase in homelessness among older adults (age 55+). A lack of affordable and subsidized housing in Minnesota is the primary barrier for getting out of homelessness.<sup>53</sup>

Homelessness presents significant challenges to succeeding at school, increasing the risk that a student will drop out before graduating from high school. Without a high school diploma, individuals face a narrower range of employment options, many of which are low-paying jobs without benefits. Jobs like these do not enable the upward mobility people experiencing poverty need to break out of their current situation and chart a brighter path forward. Approximately four percent of children and youth in the Bethesda Hospital community and three percent in Ramsey County are homeless compared to over two percent statewide.

## COVID-19 and structural racism and barriers to equity

COVID-19 is exposing what has always been true: racism is pervasive and persistent. This virus is exacerbating Minnesota's racial disparities on many fronts. The coronavirus pandemic disproportionately affected Hispanic or Latino, non-Hispanic Black or African American (Black), and non-Hispanic American Indian or Alaska Native populations — communities that have experienced higher infection rates and higher death rates throughout the pandemic<sup>54</sup> — as well as those experiencing poverty.<sup>55</sup>

Minoritized racial and ethnic groups have substantially higher rates of health inequities, making them more susceptible to getting infected and more susceptible to death from COVID-19. Indigenous Minnesotans have the highest proportion of positive cases that have resulted in hospitalization or spending time in the intensive care unit. Black and Latino Minnesotans are testing positive, getting hospitalized, and needing care in intensive care units at higher rates compared to the overall population.<sup>56</sup>

Minoritized racial and ethnic groups experienced higher job losses during the COVID-19 pandemic, causing increased financial instability and may also result in loss of health insurance, reduced access to health care, and food and housing insecurity.

## Assessment process and methods

This segment of the report details the methodology and processes we used to meet key Affordable Care Act regulatory requirements for the CHNA.

The assessment process and data collection methods we used during this CHNA cycle were different than ever before due to the COVID-19 pandemic. COVID-19 caused delays in data collection among local, state, and national organizations. As a result of these delays, the U.S. Census Bureau had not yet released finalized data from the 2020 U.S. Census by the time we began the CHNA process. As a result, we used 2015-2019 American Community Survey data. Local public health agencies also were not able to provide updated data as they have in the past. We acknowledge that, due to these setbacks, the data we used is less recent than desired.

Additionally, COVID-19 required us to add new safety precautions to our method of gathering community voice data. For example, all conversations and interviews, which had previously been in-person meetings, took place in a virtual format instead.



**8%** of individuals in the Bethesda Hospital community live in household with income below **50 percent of the federal poverty level**

For a **family of four**, the household annual income is around **\$12,875**

Sources: American Community Survey 2015-2019; Department of Health and Human Services, 2019.

# Fairview

## Secondary data review

Secondary data were gathered from five sources: American Community Survey, Claritas, Minnesota Student Survey, Spark Maps, and Truven Health Analytics.

**American Community Survey** is an ongoing survey by the U.S. Census Bureau designed to provide information about how communities are changing. It annually gathers information previously contained only in the long form of the decennial U.S. Census such as ancestry, educational attainment, income, language proficiency, and housing characteristics. While Spark Maps contains most of the data from American Community Survey that was used. There was some that were not included in Spark Maps that we used straight from American Community Survey.

**Claritas** is a widely used national demographic estimation tool. Estimates and projections are provided at a zip code level including, but not limited to, population based on age, sex, ethnicity, and income. Estimates are based on data prepared for the current year, and projections are prepared for dates five years in the future based on the U.S. Census, the American Community Survey, and other data sources. This demographic data is used across various industries to understand population trends and their implications for business strategies and initiatives.

The **Minnesota Student Survey** is one of the longest-running youth surveys in the nation. It is a triennial survey that began in 1989. The data used in this report is from 2019. The survey is an anonymous, statewide, school-based survey conducted to gain insights into the world of students and their experiences.

**Spark Maps** is a paid subscription that provides mapping and assessment tools that include a large database of indicators, data cleaning, benchmarking, and contextual information. Spark Maps is designed to support community organizations in tackling broad assessments of all aspects of communities, such as economy, environment, health, and housing, to gain insight and understanding into the communities they serve. It brings together publicly available data sources from over 100 sources, among them the American Community Survey, the U.S. Centers for Disease Control and Prevention, the Behavioral Risk Factor Surveillance System, and the USDA Access Research Atlas. Spark Maps was developed by the University of Missouri Extension Center for Applied Research and Engagement Systems.

**Truven Health Analytics**, together with Catholic Healthcare West, developed Community Need Index scores. Community Need Index scores combine publicly available and proprietary data to create an objective measure of socioeconomic barriers to health care access and their effect on hospital readmission rates for ambulatory sensitive conditions. The data used in this report is the index scores; the underlying data was not purchased.

- A **Community Need Index** score is a tool used to identify the severity of health disparities by zip code. Research has shown that zip codes with high Community Need Index scores show a strong correlation to inappropriately high 30-day hospital readmission rates.<sup>57</sup> Community Need Index scores are based on five prominent socioeconomic barriers to health care access and range by zip code from a score of one (lowest need) to five (highest need).

## Primary data collection and review

### Grounding in 2018 CHNA primary data

For this CHNA, we grounded ourselves in, and built outward from, the extensive qualitative data that we collected in 2018. During the summer of 2018, we talked with 515 individuals, across all Fairview communities, who represented a broad spectrum of views, experiences, and identities including, but not limited to, Black, Indigenous, and people of color; people experiencing poverty; and people ages 65 and older. We received a wealth of input from these conversations (please see our 2018 CHNA for more details).



# Fairview

Because we are building on and refining our priority needs from 2018 during this cycle, it was crucial for our work to be grounded in the conversations that we had conducted in 2018. Data collection in 2018 consisted of:

- **Facilitated discussion:** The 2018 HealthEast Community Advisory Council played a critical role by providing priority population and other pertinent feedback on the hospital's primary data collection findings. The advisory council members are a diverse cross section of area community leaders, community members, and key internal staff.
- **Internal focus groups:** Non-physician provider focus groups helped to inform the focus and guided the CHNA by increasing understanding of health needs, barriers, and assets among patients/populations served by the non-physician providers. Participants included care managers and care coordinators.
- **Community conversations:** Community conversations increased our understanding of health needs, barriers, and assets among specific community populations. The hospital community health steering committee helped to determine who should be included in these conversations.
- **Key stakeholder interviews:** We supplemented community input by conducting key stakeholder interviews with local officials, leaders of nonprofit organizations, public health leaders, content experts, and others who understand the needs of the community and the unique needs of seniors, people experiencing poverty, Black, Indigenous, and people of color in the community.

See Appendix D for a more detailed description of the sectors we included and the organizations that participated.

## Deepening our understanding

We collected additional community voice data by convening a broad array of stakeholders, with special focus on the priority populations. The process included discussions with community benefit and assessment committees, our community advisory council, the HOPE Commission listening and learning sessions, and key stakeholder interviews. Throughout this process, community members, local business leaders, government representatives, nonprofit and community organizations, and content experts shared their voices and perspectives about their community's health needs.

## St. Paul leader conversations

A series of conversations were had over an 18-month period from May 2020 to October 2021 with leaders from across sectors that represent or work with community members. During these meetings the results from the St. Paul survey were shared and the proposed priority needs. A discussion was had to vet the results of the St. Paul survey and the priority needs. Discussions covered if the priorities rang true, if any emerging needs were missing, and what within each priority need might be important to emphasize in this community.

For a detailed description of representation in these conversations, see Appendix E.

## Community Advisory Council

The Fairview Community Advisory Council, composed of key community leaders and staffed by Community Advancement, reviews the CHNA report and written implementation strategy and recommends it to the Patient Care and Experience Committee of the Fairview Board of Directors for review and adoption. Each member represents the member's respective community, and members represent a broad range of sectors, among them community organizations serving cultural communities, higher education organizations, banks, and a nonprofit electric company. The Community Advisory Council met from May through November 2021 to participate in the CHNA process, give feedback, and ultimately recommend the CHNA and implementation strategy for adoption.

For specific Community Advisory Council review dates, please see the "Next steps" section of this report.

# Fairview

## **HOPE listening and learning sessions and town halls**

The HOPE Commission is a multi-year transformational change effort of M Health Fairview to drive more equitable outcomes and inclusive environments and experiences for our patients, employees, and communities. The Commission conducted a series of listening and learning sessions in 2020 and 2021. The objective was to hold a mirror to Fairview to assess where we are now and how we can make lasting change. Part of being an anti-racist health system is developing a candid understanding of our shortcomings. We particularly sought to hear perspectives and ideas from the most impacted populations: BIPOC employees and patients, front-line workers who care for underserved and marginalized patients, and those patients themselves. A survey was also made available each year to gather insights and suggestions from employees and patients who could not directly participate in a listening and learning session.

In 2020, the commission convened 32 virtual listening and learning sessions and two town halls involving more than 1,500 participants across Fairview sites. The sessions focused on employees but included patients and community members as well. In September 2021, the HOPE Commission continued the listening and learning sessions following the same model. In this iteration, however, the focus was primarily on gathering input from patients (and employees as patients). In both 2020 and 2021's listening and learning sessions, the facilitators and note takers reflected the community represented by the session's group to the greatest degree possible.

## **Key stakeholder interviews**

In August and September 2021, Fairview's Community Advancement team conducted a series of interviews with staff members who work with communities. Each conversation followed a consistent interview protocol developed for this purpose, and each interview was captured by means of detailed notes. The goal of these interviews was to draw on staff expertise to gain a deeper understanding of our priority needs and to determine whether there are any emerging needs that we should be considering. Between Aug. 31 and Sept. 17, 2021, we conducted 17 interviews.

## **Focus groups**

In August 2021, we held two focus groups in partnership with other organizations. We convened the first focus group in partnership with HealthPartners and Allina Health, and the participants were faith community nurses. We convened the second focus group in partnership with the organizations that are a part of the East Side Health and Well-being Collaborative. This meeting's focus was on accessing care and resources for different cultural communities.

## **St. Paul survey**

Fairview also participated in two large surveys. KRC Research conducted a survey around health and health care needs in St. Paul between June 8 and July 7, 2021, and administered it to community members, Fairview employees, patients, and community partners. Responses were received from 294 residents, more than 1,000 employees, 221 patients, and 20 partners. The survey was offered online and by phone and in five languages: English, Spanish, Hmong, Somali, and Karen.

## **Ongoing feedback from Community Advancement program participants**

As a foundational part of program planning and evaluation, Community Advancement staff are continuously soliciting feedback from community partners and program participants. We capture this information on an ongoing basis and use it to provide valuable context and drive insights into the needs of the communities we serve.

## **Primary data methods**

Fairview staff developed standardized tools, processes, instructions, and facilitator, interviewer, and note-taker protocols and training. All primary data was compiled, cleaned, and analyzed. Community conversations lasted various lengths from 30-120 minutes. All community input was captured by note-taker.

# Fairview

## Significant needs and needs not addressed

Prioritizing needs that are the root causes of almost all health disparities allows us to develop upstream strategies that will have a large and lasting impact in our communities. All of the significant needs we have identified will ultimately be positively impacted by addressing the root causes we have identified as our priority needs.

## Definition of community

The CHNA community of each hospital and medical center is defined as a subset of zip codes within the Fairview service area, where 90 percent of its patients live. Each of the hospitals and medical centers were attributed unique zip codes and geographies. The Bethesda Hospital community is comprised of 14 zip codes. Our definition of communities includes all community members, including those who are patients and employees who live, work, and play in our service areas.

See Appendix C for list of zip codes, cities, and counties included.

## Contract support

The Fairview team contracted with the following groups to support our assessment process:

- Loren Blinde, PhD of Writing Power, a copywriter and content strategist, on the writing of the report.
- Kristi Fordyce, an independent contractor, for analysis support.
- Weber Shandwick, for data collection and analysis of focus groups and stakeholder interviews focused on St. Paul.
- KRC Research for the administration and analysis of the St. Paul Community Survey.

## Available resources and assets

As the Bethesda Hospital develops its CHNA implementation strategy, we will look to both internal and external resources to address the significant health needs identified through the CHNA process described in this report.

External resources include existing initiatives, programs, and relationships, which are the foundation from which the implementation strategy will be built.

# Fairview

## Next steps

### **Review and adoption by the Patient Care and Experience Committee**

The Patient Care and Experience Committee of the Board oversees the processes related to patient care, clinical integration and outcomes, and quality of care as part of the integrated services provided at Fairview's hospitals and medical centers. The Committee reviewed adopted the Bethesda Hospital 2021 Community Health Needs Assessment report on December 1, 2021. This report is available on our website on December 31, 2021.

### **Formulating implementation strategies**

In late 2021, the Bethesda Hospital will conduct the final steps in the assessment process by developing a written CHNA implementation strategy to address the identified priority health needs — navigating access to care and resources; healing, connectedness, and mental health; and addressing structural racism and barriers to equity. Local committees and the health system's Community Advisory Council will review, and the Patient Care and Experience Committee of the Board will review and adopt the implementation strategies in early 2022. The document will be publicly available on our website by May 15, 2022 and executed during fiscal years 2022 to 2024.

# Fairview

## 2019-2021 Community Health Improvement Plan outcomes

Between 2019 and 2021, Fairview has implemented two broad types of programs that impact Community Health Improvement Plans (CHIP) outcomes. Some programs are centered at the local hospital or medical center level. Others are led at the system level, in close collaboration with the local hospital or medical center to optimize relevance and impact for the local community. Within system-wide collaborations, program leaders are recruited from the local community, and programs are executed in partnership with local organizations and agencies. Program instructors (if applicable) and staff are also drawn from the local community. Programs below are indicated as local or system programs. System programs are reported out at a system level.

Because local partners vary from location to location, specific programs may look slightly different in different locations. These programmatic variations are a strength, enabling us to address specific community needs in culturally appropriate and relevant ways. The program information we are sharing in this section is the tip of the proverbial iceberg — a great deal of other work is occurring, day in and day out, at each of our sites. None of this work is done in a silo — we’re engaging with a wide range of community partners to amplify our impact and engage in sustained, measurable, and meaningful change.

Finally, the COVID-19 pandemic brought with it many changes to the way we both executed our programs and measured their success. The data collection and measurement processes we had used to develop past CHNA reports needed to change to keep our staff and community safe. Our previous methods of measuring some of our programs’ impact no longer worked as effectively. For example, as food insecurity soared during the pandemic, we chose to prioritize helping in tangible ways, such as delivering food kits, over collecting questionnaire responses. In addition, because many of our programs shifted from in-person to virtual formats, participants engaged in those programs were not necessarily confined to our community. Overall, we made intentional choices to measure data in new ways that would minimize the impact of our data collection on the communities we were serving.

### Cultural Brokers

East Side Health and Wellbeing collaborative, led by M Health Fairview, co-designed the position of Cultural Broker Program serving Saint Paul’s East Side community to build stress resilience and holistic wellbeing among community members. The Cultural Broker co-navigates mainstream systems with clients and helps bridge those systems within culture, as well as locates resources and advocates for residents’ interests.

Priority area(s)	Anticipated impact	Anticipated impact response / results	Other program impacts
Access to care and resources	Increase participants' confidence to access services themselves.	18% increase (from 76% to 94%) of respondents strongly agree or agree, “I feel confident I can access the services I need.”	Number of clients: 121
Mental health and wellbeing	Increase participants' connectedness to others in the community.	3% increase (from 71% to 74%) of respondents strongly agree or agree, “I feel connected to others in the community.”	
<b>Partners</b>	American Indian Family Center, Comunidades Latinas Unidas en Servicio (CLUES), Family Values for Life, Hmong American Partnership, Karen Organization of MN		

# Fairview

## Falls Prevention suite of programs

Matter of Balance | Tai Ji Quan

Programs designed to reduce the fear of falling and increase activity levels among older adults. Led by a trained facilitator, participants learn to view falls and fear of falling as controllable, set realistic goals to increase activity, change their environment to reduce fall risk factors, and exercise to increase strength and balance.

Bethesda Hospital promoted the Falls Prevention suite of programs to local partners and the aging population.

Priority area(s)	Anticipated impact	Anticipated impact response / results	Other program impacts
Access to care and resources	Increase participants' comfort in talking to their health care provider about medications and other possible risks of falling.	88% of respondents strongly agree or agree, "I feel more comfortable talking to my healthcare provider about medications and other possible risks for falling."	Number of participants: 123 Number of classes: 17
Healthy lifestyles	Decrease participants' fear of falling.	6% decrease (from 86% to 80%) in participants fear of falling.	
<b>Partners</b>	Juniper, Ace Brain Fitness, Common Bonds		

## Living Well suite of programs

Chronic Disease Self-Management | Chronic Pain Self-Management | Diabetes Self-Management

These are evidence-based programs developed by Stanford University's Patient Education Research Center. Workshops are offered to individuals and their caregivers who are living with chronic conditions, pain, or diabetes. Subjects addressed include medication use, communication with doctors and caregivers, nutrition and fitness with practical exercises and advice designed to meet participants' needs.

Bethesda Hospital promoted the Living Well suite of programs to local partners and community members who have a chronic conditions, chronic pain, or diabetes.

Priority area(s)	Anticipated impact	Anticipated impact response / results	Other program impacts
Access to care and resources	Increase in participants who agree that the program helps them work with their health care providers.	76% of respondents strongly agree or agree, "I am confident I can work with healthcare professionals."	Number of participants: 210 Number of Chronic Disease Self-Management classes: 22 Number of Chronic Pain Self-Management classes: 6 Number of Diabetes Self-Management classes: 2
Healthy lifestyles	Increase participants' confidence to manage a chronic condition.	92% of respondents strongly agree or agree, "I am confident I can manage a chronic condition."	
<b>Partners</b>	Juniper, East Side Neighborhood Services, Faith Community Network		

# Fairview

## Mental Health First Aid

Mental Health First Aid is an internationally recognized evidence-based program that was created and is managed by the National Council for Behavioral Health. It is an eight-hour class that introduces participants to risk factors and warning signs of mental illnesses, builds understanding of their impact, and overviews common supports. There is a youth version that focuses on adults working with adolescents.

Bethesda Hospital promoted Mental Health First Aid to local partners and community members.

Priority area(s)	Anticipated impact	Anticipated impact response / results	Other program impacts
Access to care and resources	Increase participants' confidence in assisting someone to connect with professional resources.	34% increase (from 59% to 93%) of respondents strongly agree or agree, "I can assist someone who may be dealing with a mental health problem, substance use challenge or crisis in seeking professional help."	Number of participants: 1,060 Number of adult classes: 37 Number of youth classes: 16 Number of older adult classes: 11 Number of classes taught in Spanish: 2
Mental health and wellbeing	Increase participants' ability to recognize and correct misconceptions about mental health and mental illness.	39% increase (from 58% to 97%) of respondents strongly agree or agree, "I can recognize and correct misconceptions about mental health, substance use and mental illness as I encounter them."	Number of classes taught in Somali: 1 In October 2020, a class was held for Somali psychological practitioners working with the Somali community.
<b>Partners</b>	National Council for Behavioral Health		

# Fairview

## Minnesota Immunization Network Initiative (MINI) Clinics

Minnesota Immunization Networking Initiative (MINI) is a collaborative led by M Health Fairview and supported by over 125 community partners. MINI works to reduce barriers to influenza vaccinations for communities facing health disparities in the greater Twin Cities area. The success of the program is due to strong and lasting partnerships with multiple faith-based and grass-roots community organizations. MINI clinics are located in community-based settings such as local churches, mosques, schools, community centers, food pantries, and homeless shelters. Vaccinations are provided at no charge to participants.

Bethesda Hospital worked in partnership with local partners to host and promote MINI clinics to those facing health disparities in the community.

Priority area(s)	Anticipated impact	Anticipated impact response / results	Other program impacts
Access to care and resources	Increase in the number of MINI clinics with culturally and/or linguistically appropriate materials about accessing care and resource.	43% of new partner clinic sites had culturally and/or linguistically appropriate materials.	Number of people who received a flu vaccination: 2,106 Number of clinics: 49 Number of new partner clinics sites: 7 MINI partnered with MDH to provide Hepatitis A vaccinations in high-risk communities
<b>Partners</b>	Homeland Health Specialists, Karen Organization of Minnesota, Portico Healthnet, St. Mary's Health Clinics, Stairstep Foundation, and over 50 community organizations		

## Mobile Substance Use Disorder program

Serves adult residents (18+) in Ramsey, Dakota and Washington Counties who have substance use issues through Mobile SUDs team who are professional peer recovery specialists and clinical staff who collaborate to develop individual recovery plan.

*\*The program was discontinued in 2021. A similar program will be developed within the Mental Health & Addiction Transition Clinic for short-term treatment of patients after an emergency room visit.*

Priority area(s)	Anticipated impact	Anticipated impact response / results	Other program impacts
Mental health and wellbeing	Increase in the number of active participants in the recovery program.	Increase of 35 active participants	Number of referrals: 348
<b>Partners</b>	Allina Health, East Metro Crisis Alliance, HealthPartners, Minnesota Recovery Connection, Regions Hospital Foundation		



# Fairview

## Stress reduction suite of programs

Flourish | Tonic | Trauma and Resilience Program

These classes let participants experience a variety of mind-body practices designed to promote a sense of calm, joy, connection, and inner strength. Participants explore moving meditation, journaling, guided imagery and mindfulness. These programs are proven to reduce stress, increase self-esteem, and improve a person's overall quality of life.

Bethesda Hospital promoted the stress reduction suite of programs to local partners and community members.

Priority area(s)	Anticipated impact	Anticipated impact response / results	Other program impacts
Mental health and wellbeing	Decrease in participants' perceived stress.	On a 10-point scale, participants experienced an average of a 1.28-point decrease in perceived stress.	Number of participants: 105 Number of classes: 12
<b>Partners</b>	Firefly Yoga International, Ways to Wellness		

## Trauma Informed Congregations

The program, called Risking Connection in Faith Communities, is a curriculum designed to help clergy understand the nature of trauma, how it affects people and how faith leaders can help trauma survivors.

Bethesda Hospital worked in partnership with local faith community leaders to host and promote Trauma Informed Congregation trainings in the community.

Priority area(s)	Anticipated impact	Anticipated impact response / results	Other program impacts
Mental health and wellbeing	Increase in clergy/leader understanding of the impact of trauma on trauma survivors.	32% increase (from 68% to 100%) of respondents strongly agree or agree, "I understand the concepts of trauma and impact trauma can have on trauma survivors."	Number of people trained: 154 Number of classes 7 Five local faith leaders were trained to teach the program in the community.
<b>Partners</b>	Faith Community Nurse Network and Stairstep Foundation		

# Fairview

## Veggie Rx

A program in which food insecure patients receive Community Shared Agriculture (CSA) boxes each week at their clinics. The program is geared towards communities of color, immigrants, people in rural communities, and those with chronic health conditions that could be improved with a healthier diet.

Bethesda Hospital worked in partnership with local Fairview clinics to identify food insecure patients to provide them with fresh, local produce.

Priority area(s)	Anticipated impact	Anticipated impact response / results	Other program impacts
Access to care and resources	Increase participants' knowledge about where to buy locally grown produce.	13% increase (from 68% to 81%) to the question: "I know a lot or know some about where to buy locally grown produce."	Number of participants: 218 The program helps strengthen the local farming economy.
Healthy lifestyles	Increase vegetable consumption in food insecure patients.	14% increase (from 23% to 44%) to the question: "I consume three or more servings of vegetables per day."	
<b>Partners</b>	Hmong American Farmer Association, Sin Fronteras, Women's Environmental Institute (WEI)		

## Youth Grief Services

Youth Grief Services provides a safe and nurturing place where families can turn for help after a loved one dies. Youth Grief Services assists in the healing process through a network of programs and services that support, educate, and connect grieving families. Camp Erin, a free, weekend bereavement camp is available to youth who are grieving the death of a significant person in their lives.

Bethesda Hospital promoted the Youth Grief Services to local partners and to community members, primarily youth, who may have lost a loved one.

Priority area(s)	Anticipated impact	Anticipated impact response / results	Other program impacts
Mental health and wellbeing	Youth participants' knowledge of healthy coping strategies in response to grief.	66% of youth participants indicated that, "I have new tools to help me with my grief" after attending camp.	Number of Camp Erin participants: 174 Number of camps: 3 Number of series participants: 168 Number of series: 6 Ownership of Youth Grief Services transferred from Fairview to Brighter Days Grief Center in December 2020, providing a seamless transition of the program for participants.
<b>Partners</b>	Brighter Days Grief Center, Eluna, faith communities		

# Fairview

## Trauma – policy, system, and environmental change

Collaborate in policy, systems, and environmental (PSE) change around responding to trauma in settings, such as schools and faith communities.

Priority area(s)	Anticipated impact	Results
Mental health and wellbeing	Champions, partners and specific PSE changes identified with implementation underway.	<ul style="list-style-type: none"> <li>• Opened Minnesota’s first EmPATH unit– or Emergency Psychiatric Assessment, Treatment, and Healing– a pioneering approach to emergency mental health that offers rapid, comprehensive care in a calming environment. Planning underway for opening a second unit at University of Minnesota Medical Center.</li> <li>• Planning for Virtual Health Hubs that will break down barriers and allow people to access care despite the physical location.</li> <li>• Partnering with Princeton High School to offer Teen Mental Health First Aid.</li> <li>• As a member of the Center for Community Health, planning an event to discuss social isolation needs, strategies, and opportunities for collective impact.</li> <li>• In partnership with Ebenezer, developed a new quarterly speaking series called HOPE, that addresses topics such as Adverse Childhood Experiences (ACEs), trauma, and pandemic fatigue.</li> <li>• Member of both the Ramsey County Mental Health and Wellness Action Team and Mental Wellbeing Task Force for the Hennepin County.</li> </ul>

## Food – policy, system, and environmental change

Collaborate on policy, systems, and environmental (PSE) change around healthy food transformation addressing issues such as food insecurity, food access, and changes to cafeteria menus.

Priority area(s)	Anticipated impact	Results
Healthy lifestyles	Champions, partners, and specific PSE change identified with implementation underway.	<ul style="list-style-type: none"> <li>• “Food Transformation” system champions were identified and a food philosophy was adopted.. Cafeteria and food service transformations, including nutrition guidelines, were implemented at various sites across the system.</li> <li>• Joined the Food Justice Network as a backbone partner.</li> <li>• Expanded the reach and partners of established food programs; East Side Table and Veggie Rx. New partners include Women’s Environmental Institute, Sin Fronteras Farm and Food, and Appetite for Change.</li> <li>• Signed contract for Now Pow which will screen for social determinants such as food security.</li> <li>• Provided \$10,000 grants to community organizations responding to increased food support needs due to COVID-19.</li> <li>• Developed process and infrastructure for Matter Box distribution at cancer center clinics.</li> </ul>

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## Appendices

- Appendix A: Community Health Needs Assessment Section 501(r)(3) checklist
- Appendix B: CHNA core data indicator list
- Appendix C: Bethesda Hospital cities, zip codes, and CNI scores
- Appendix D: 2018 Bethesda Hospital community voice summary
- Appendix E: St. Paul Leadership Conversations



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## Appendix A: Community Health Needs Assessment Section 501(r)(3) checklist

Documentation of CHNA written report requirements	Page number
A definition of the community and a description of how the community was determined	13, 35
A description of the process and methods used to conduct the CHNA	31-34
Describes the data and other information used in the assessment	31-34
Describes the methods of collecting and analyzing this data and information (may rely on and describe in report) external source material in which case the hospital may simply cite the source material rather than describe the methods of collecting the data	31-34
Identifies any parties with whom the hospital facility collaborated or contracted for assistance in conducting the CHNA	35
A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves	32-34
Summarize, in general terms, the input provided by such persons	22, 25, 29, 32-34
Describe how and over what time period such input was provided (for example, whether through meetings, focus groups, interviews, surveys, or written comments and between what approximate dates)	32-34
Provide the names of any organizations providing input and summarize the nature and extent of the organization's input	32-34, 54,55
Describe the medically underserved, low-income, or minority populations being represented by organizations or individual's that provided input	54,55
A prioritized description of the significant health needs of the community identified through the CHNA. This includes a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant needs	19
A description of the resources potentially available to address the significant health needs identified through the CHNA	35
An evaluation of the impact of any actions that were taken to address the significant health needs identified in the immediately preceding CHNA	37-43
Adopted for the hospital facility by an authorized body of the hospital facility	36

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## Appendix B: CHNA core data indicators

Category	Indicators	Data source	Year
Access to Care	Addiction/Substance Abuse Providers	Centers for Medicare and Medicaid Services, CMS Geographic Variation Public Use File	May 2021
Access to Care	BIPOC Providers	Minnesota Department of Health; MDH ORHPC Physician Workforce Survey	2019
Access to Care	Dentists	U.S. Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File	2015
Access to Care	Lack of Prenatal Care	Centers for Disease Control and Prevention, National Vital Statistics System.	2019
Access to Care	Mental Health Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES)	2020
Access to Care	Physicians who Communicate in a Language Other than English, in Their Practice	Minnesota Department of Health; MDH ORHPC Physician Workforce Survey	2019
Access to Care	Population Receiving Medicaid	U.S. Census Bureau, American Community Survey	2015-2019
Access to Care	Primary Care Physicians	US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File	2017
Access to Care	Uninsured Population	U.S. Census Bureau, American Community Survey	2015-2019
Access to Care	Age 65+ Uninsured	U.S. Census Bureau, American Community Survey	2015-2019
Clinical Care	Colorectal Cancer Screening	Minnesota Community Measures	2020
Clinical Care	Flu Vaccinations	Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases (NCIRD)	2019-2020
Clinical Care	Optimal Diabetes Care	Minnesota Community Measures	2020
Clinical Care	Optimal Vascular Care	Minnesota Community Measures	2020
Community Safety	ACEs Score-Short	Minnesota Student Survey	2019
Community Safety	I feel safe in my neighborhood	Minnesota Student Survey	2019
Demographics	Age 0-17	Claritas	2021, 2026

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Category	Indicators	Data source	Year
Demographics	Age 18-44	Claritas	2021, 2026
Demographics	Age 45-64	Claritas	2021, 2026
Demographics	Age 65+	Claritas	2021, 2026
Demographics	Median Age	Claritas	2021, 2026
Demographics	American Indian/Alaskan Native	Claritas	2021, 2026
Demographics	Asian	Claritas	2021, 2026
Demographics	Black/African American	Claritas	2021, 2026
Demographics	Native Hawaiian/Pacific Islander	Claritas	2021, 2026
Demographics	Some Other Race	Claritas	2021, 2026
Demographics	Two or More Races	Claritas	2021, 2026
Demographics	White	Claritas	2021, 2026
Demographics	Ethnicity: Hispanic/Latino	Claritas	2021, 2026
Demographics	Foreign-Born	U.S. Census Bureau, American Community Survey	2015-2019
Demographics	Language Other than English	U.S. Census Bureau, American Community Survey	2015-2019
Demographics	Population with Disability	U.S. Census Bureau, American Community Survey	2015-2019
Demographics	Population with Limited English Proficiency	U.S. Census Bureau, American Community Survey	2015-2019
Demographics	Veteran Population	U.S. Census Bureau, American Community Survey	2015-2019
Education	Bachelor's Degree or Higher	U.S. Census Bureau, American Community Survey	2015-2019
Education	High School Graduate or Higher	U.S. Census Bureau, American Community Survey	2015-2019
Education	No High School Diploma	U.S. Census Bureau, American Community Survey	2015-2019
Employment	Unemployed Population	Claritas	2021, 2026
Family & Social Support	Age 65+ Living Alone	U.S. Census Bureau, American Community Survey	2015-2019
Family & Social Support	Connection with Caring Adult	Minnesota Student Survey	2019
Housing & Transit	BIPOC Homeowners	U.S. Census Bureau, American Community Survey	2015-2019
Housing & Transit	Homeless Children and Youth	U.S. Department of Education, EDFacts	2018-2019
Housing & Transit	Households Renting	U.S. Census Bureau, American Community Survey	2015-2019

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Category	Indicators	Data source	Year
Housing & Transit	Households with No Vehicle	U.S. Census Bureau, American Community Survey	2015-2019
Housing & Transit	Housing Cost Burden (30%)	U.S. Census Bureau, American Community Survey	2015-2019
Housing & Transit	Substandard Housing	U.S. Census Bureau, American Community Survey	2015-2019
Housing & Transit	White Alone, not Hispanic or Latino Homeowners	U.S. Census Bureau, American Community Survey	2015-2019
Income	Children Eligible for Free/Reduced Price Lunch	National Center for Education Statistics, NCES - Common Core of Data	2018-2019
Income	Food Insecurity	Feeding America	2017
Income	Households Receiving SNAP Benefits	U.S. Census Bureau, American Community Survey	2015-2019
Income	Low Food Access	U.S. Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas	2015
Income	Median Household Income	Claritas	2021, 2026
Income	Poverty – Below 100% Federal Poverty Level	U.S. Census Bureau, American Community Survey	2015-2019
Income	Poverty – Below 200% Federal Poverty Level	U.S. Census Bureau, American Community Survey	2015-2019
Income	Poverty – Below 50% Federal Poverty Level	U.S. Census Bureau, American Community Survey	2015-2019
Income	Ages 65+ – Below 100% Federal Poverty Level	U.S. Census Bureau, American Community Survey	2015-2019
Income	Children – Below 100% Federal Poverty Level	U.S. Census Bureau, American Community Survey	2015-2019
Length of Life	Leading Causes of Death	Minnesota Department of Health, County Health Tables	2019
Length of Life	Leading Causes of Premature Death	Minnesota Department of Health, County Health Tables	2019
Length of Life	Life Expectancy	Centers for Disease Control and Prevention and the National Center for Health Statistics, U.S. Small-Area Life Expectancy Estimates Project	2010-2015
Length of Life	Mortality, Suicide	Centers for Disease Control and Prevention, National Vital Statistics System	2015-2019
Length of Life	Suicidal Consideration	Minnesota Student Survey	2019

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Category	Indicators	Data source	Year
Other	Community Need Index (CNI) Score	Truven Health Analytics	2019
Physical Environment	Households with No or Slow Internet	U.S. Census Bureau, American Community Survey	2015-2019
Physical Environment	Park Access	U.S. Census Bureau, Decennial Census, Environmental Systems Research Institute (ESRI) Map Gallery	2013
Quality of Life	Poor Mental Health (14+ days per month)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System	2020
Quality of Life	Poor Physical Health (14+ days per month)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System	2020

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## Appendix C: Bethesda Hospital cities, zip codes, and CNI scores

Zip code	City	County	2019 CNI score
55101	St. Paul	Ramsey	3.6
55102	St. Paul	Ramsey	3.2
55103	St. Paul	Ramsey	4.8
55104	Midway	Ramsey	3.6
55105	Mac-Groveland	Ramsey	2.4
55106	St. Paul	Ramsey	4.6
55107	St. Paul	Ramsey	4.2
55108	Falcon Heights	Ramsey	2.6
55114	Hwy 280-Como	Ramsey	3.0
55116	Highland	Ramsey	2.8
55117	Little Canada	Ramsey	4.2
55119	Highwood	Ramsey	3.4
55130	St. Paul	Ramsey	4.6
55155	St. Paul	Ramsey	*

\*Community Need Index score not available due to low population

# Fairview

## Appendix D: 2018 Community voice summary

	Sectors	Organizations represented
<b>Key stakeholder Interviews</b>	Coalitions/collaborators Education Government Healthcare Local public health Social services	American Indian Family Center City of Maplewood Hmong American Farmers Association Karen Organization of Minnesota South Washington County School District St. Paul – Ramsey County Public Health St. Paul Technical College Washington County Services
<b>Facilitated discussions</b>	Cultural organizations Education Government Healthcare Local public health Social services	American Indian Family Center Century College City of Maplewood Community Dental Center Comunidades Unidas en Servicio (CLUES) Dakota County Public Health East Side Partnership for Healthy Aging Hearth Connection Hill-Murray High School Hmong American Partnership Karen Organization of Minnesota Lutheran Social Services Eastside Financial Center Maplewood, Oakdale North St Paul School District Metro State University Neighborhood House Portico Health Net St. Paul Public Schools
	Roles	
<b>Internal focus groups</b>	Clinic care guide, clinical financial resource guide, registered nurse, social worker	
	Populations	Collaborators
<b>Community conversations</b>	Aging population Broader community	Dakota Area Resources & Transportation for Seniors (DARTS) South Washington County School District YMCA – Maplewood Community Center



# Fairview

## Appendix E: St. Paul Leadership Conversations

Organization	Sector	Organization description
Hearth Connection	Coalitions/Collaborators	Hearth Connection uses innovation, research and best practices to end long-term homelessness.
Minnesota Community Care	Healthcare	Minnesota Community Care is a community health center serving more than 30,000 patients each year in the Twin Cities. It is also Minnesota’s largest federally qualified health center (FQHC). Minnesota Community Care specializes in delivering high quality primary and preventative health care for all by removing common barriers like income and language while partnering in communities to impact systemic barriers to health access.
Outpatient Mental Health Services	Healthcare	The space will be designed to deliver integrated, high-quality mental health and addiction outpatient services based on individual patient needs through a combination of in-person, telephone and video visits, and provider recommendations to best serve patients’ full care experience. In the expanded outpatient clinic, Fairview will continue providing services currently located in St. Paul, like psychotherapy, psychiatry, addiction medicine and transition care services, while introducing expanded and flexible scheduling, including access to onsite nurse practitioners.
Saint Paul- Ramsey County Public Health	Local Public Health	Saint Paul - Ramsey County Public Health is a government agency which provides a range of services to protect and improve the health of people and the environment in Ramsey County.
Second Harvest Heartland	Social Services	Fairview and Second Harvest Heartland are building upon their longtime partnership and “Food as Medicine” programming across the state by establishing a new effort at the Fairview Community Health and Wellness Hub where they can immediately address the needs of the community by operating food storage and distribution activities.
Sisters of St. Joseph’s of Carondelet/St. Mary’s Health Clinics	Coalitions/Collaborators	For more than 170 years, the Sisters of St. Joseph have been serving in Minnesota where the need is greatest. From the founding of St. Joseph’s Hospital in response to the cholera epidemic to the 1918 Spanish Flu to both World Wars, the Great Depression and now COVID— and everything in between—the Sisters have always responded nimbly with dignity and compassion to those in need. They advance opportunities for others.

