Fairview

2024 Community Health Needs Assessment Report

M Health Fairview Woodwinds Hospital

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Fairview

Introduction

It takes the support and commitment of a community to conduct our triennial Community Health Needs Assessment (CHNA) process. Fairview is grateful for the essential insights from everyone who participated in an assessment activity, including taking a survey, joining a community virtual conversation, or attending our Community Health and Healing Summit. Our organization would also like to thank our community advisory committee members and our system community advisory council members for their ongoing involvement.

Fairview is proud to present this 2024 CHNA report. This narrative report shares our intentional focus on our needs assessment, including community engagement and process enhancement. Extensive appendices are available for readers to review additional data and areas of interest.

Our CHNA process is informed by the work of Fairview's Community Advancement team, in partnership with the M Health Fairview Center for Community Health Equity. The center extends the work our Community Advancement team is doing in community, creating space for Fairview and our community partners to work alongside one another toward a shared goal of improving health equity in the communities we serve and to which we belong.

Fairview's CHNA goes beyond the required guidelines and presents all the work our organization is leading. To find the specific requirements from the Section 501(r)(3) checklist, please see page 43.

Land acknowledgment

This acknowledgment was drafted by a group of employees across the healthcare system, inclusive of Native-identified team members, in consultation with American-Indian-led community organizations. The original acknowledgment was developed as part of the launch for the Center for Community Health Equity, based on the site of the first hospital in the State of Minnesota, to recognize the local history that importantly impacts our present-day conditions and context. The acknowledgment was an exercise in collectively understanding the place and circumstances where we find ourselves in order to intentionally build out the work of our Native Health Equity Initiative and take action to improve experiences and outcomes for our Native-identified patients, employees, and communities. It honors and recognizes the Indigenous communities who have stewarded the land since time immemorial and demonstrates our commitment to restorative action for all our marginalized neighbors. We use the terms Indigenous, Native, and American Indian interchangeably recognizing personal preference as well as governmental usage.

What is land acknowledgment?

According to the Native Governance Center, "Indigenous land acknowledgment is an effort to recognize the Indigenous past, present, and future of a particular location and to understand our own place within that relationship."[i] Land acknowledgments are verbal or written statements that are often shared at events, meetings, and community gatherings.

Why did we create a land acknowledgment?

Our history shapes so much of our present-day circumstances, systems, and outcomes. It is important to be honest about this history. Our work includes acknowledging how inequities have impacted the geographies and people we serve and have served. Educating team members and the larger health system about how this influences patient care and outcomes, and how history and the social

determinants of health are interconnected and have led to inequities in health care and beyond, is an essential component of our commitment and work to advance equity and inclusion.

Fairview's land acknowledgement

We acknowledge with respect and gratitude that the land on which we live is Indigenous land. Mni Sóta Makoce (Minnesota) is the homeland of the Dakota and Anishinaabe peoples and other Native nations, whose ancient relationships with the land continue to this day. We acknowledge that this sacred land does not belong to us. We are occupiers here who have also come to call this land where the water reflects the sky, home.

There is a complex history of genocide, broken treaties,[ii] including those of 1837 and 1851, and colonialism that has been concealed throughout history. We acknowledge the impacts of this history on the generations of the past and the generations of the future. While we cannot undo the wrongs and do not want to disguise the past, we must be forthright about the journey to today and thus take restorative action. We acknowledge that other communities have also been marginalized and exploited to generate the community's wealth over time. We commit to continued action and partnership with the community to address these injustices for all our relatives.

Our Native Health Equity Initiative works to support healing in four directions across our healthcare system through partnering with Indigenous organizations and Native Nations to drive health equity, co-hosting events to create connections and uplift Indigenous approaches, and advocating with and for local Native-led priorities. It is our aim to embrace the wisdom in Native traditions in planning for the next seven generations on this revered land. Toward this vision, we will continue to strengthen our relationships in our community as a health care provider, employer, academic institution, and corporate community member to collectively improve outcomes and experiences for Native patients, employees, and community members.

Impacts of history on our current conditions

We recognize the impact of history, power, and systems in shaping our present-day circumstances, including health outcomes and health disparities. As a part of our 2024 Community Health and Healing Summit, our partners came together to help us take a deep dive into the history of our communities, building a narrative that will help us acknowledge the challenges our neighbors have faced, grasp the resilience they've displayed in overcoming barriers to health and wellbeing, and learn from the ingenuity community has demonstrated in achieving connectedness and wellness.

This context is critical for our efforts to improve community health equity, develop healing connections, and foster trusted partnerships. We strive to do with and for – not to – our communities. Our community partners used these insights to help contextualize the needs identified in our 2024 CHNA. Fairview will work collaboratively with our local communities to create new, more positive, hopeful narratives.

Fairview

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.

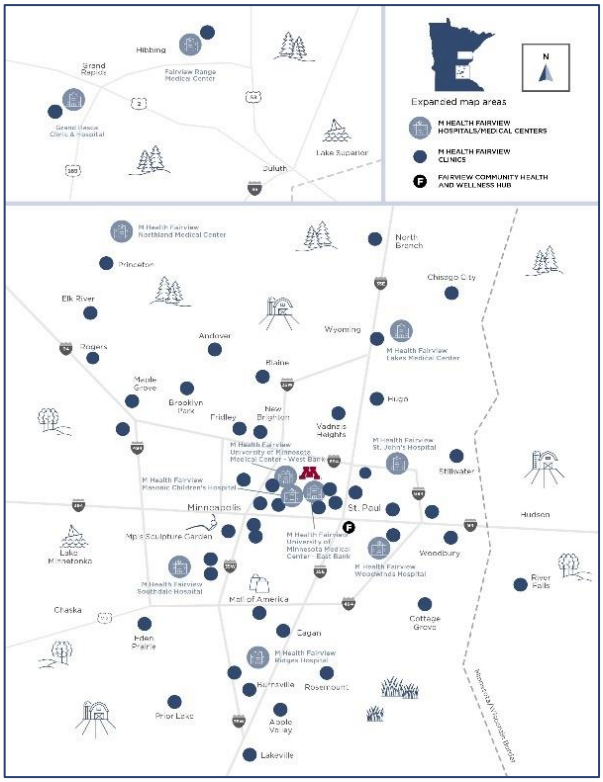
Values

Dignity - Integrity - Service
Compassion - Innovation

Fairview by the numbers:

- 34,000+ employees
- 100+ specialties
- 10 hospitals and medical centers
- 40+ primary care clinics
- 2.1+ million patients yearly

The names listed below reflect the Minnesota Department of Health licensed names. Through the remainder of this report, we will refer to all hospitals or medical centers by the names by which they are more commonly known in the community.



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

Fairview

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

About M Health Fairview Woodwinds Hospital

M Health Fairview Woodwinds Hospital, located in Woodbury, MN, opened in 2000 and is the only hospital in the southeast metro area. It features 86 beds and offers comprehensive services, including emergency care, specialty clinics, and outpatient services. Specialties include orthopedics, spine care, and women's care. The hospital employs approximately 1,100 staff members and records 7,200 admissions annually.

Woodwinds has a high patient satisfaction score, with a "Likelihood to Recommend" score of 76.7 and a 5-star rating from the Centers for Medicare and Medicaid Services. It was awarded the American Heart Association's Stroke Gold Award in 2023 and named one of the Best Hospitals for Maternity Care by U.S. News & World Report. It is ranked high performing in back surgery, hip and knee replacement, and pneumonia care.

The facility handles around 7,000 surgeries annually and has six operating rooms. Its emergency department, certified as stroke-ready and a level 4 trauma center, manages 36,500 visits yearly, with a low "left without being seen" rate. Woodwinds also provides comprehensive oncology services and delivers approximately 2,400 births each year.

The hospital serves a primarily older population, with 30% ages 65 and above. Its patient demographics are 77% Caucasian, with the remaining 23% comprising Asian, Pacific Islander, American Indian, and Black patients.

Key services		
Breast care/mammography	Heart care	Sleep services
Cancer care	Orthopedic surgery	The Birthplace
General surgery		

Framing and approach for 2024 assessment

Assessing and responding to community and patient needs is an important component of population health and an integral part of Fairview's community commitment, as Fairview has conducted triennial assessments to inform our community outreach since the mid-1990s. Fairview's 2024 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.

At Fairview, we are committed to those we serve – and as an anchor institution, our definition of those we serve stretches beyond our patients to embrace our entire community. As a result, this assessment process takes into consideration everyone our health system touches, including our community members, our patients, and our employees.

The assessment 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, Fairview 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 we serve by analyzing current demographics and social determinants of health indicators, as well as by collecting direct input from community members and organizations.
- Inform each hospital's CHNA implementation strategy and action plan development.

Our 2024 CHNA process continues to be grounded in the key principles that guide the way we work with community: focus on community voice and trust, commit to collaboration, and transform through action.

Guided by last assessment's implementation strategies, our 2024 CHNA represents an increased focus on the processes by which we engage with community, examining the foundations on which we are building our community engagement infrastructure for the future. This corresponds naturally to a focus on narrative about the assessment process in the report. Nevertheless, we are continuing to collect and analyze information about our priority populations and priority need areas. We have included extensive appendices with specific data, and we invite readers to refer to them.

Big problems require vision-driven solutions

As we have conducted multiple CHNAs, we have come to an inescapable conclusion: Our communities have faced the same challenges for more than a three-year CHNA cycle. Despite our efforts to address these issues, these problems are not relenting and can last a decade or more. Out of these intractable challenges, we have distilled three key lessons that have fundamentally shifted our approach:

- Despite best efforts, health needs and health inequities continue to grow and deepen.
- Collective action is critical.
- Transformational change requires sustained and focused commitment.

In 2021, in response to these lessons learned and guided by the key community outreach principles outlined above, we put forth a Fairview 10-year vision – **increased community health equity**. We

developed the first in a series of consecutive CHNA implementation strategies and plans that we will build and execute over the decade to bring that vision to fruition.

Getting stakeholder buy-in to execute a 10-year vision, and maintaining that interest and focus for a decade, takes vision and commitment: vision to imagine a better future and inspire others to work alongside us, and commitment to stay the course in pursuit of that vision. Although these two requirements are difficult to fulfill within the context of healthcare's dynamic landscape, we remain steadfast in our dedication and have developed processes to effectively support our work. These processes, and the progress they have enabled so far, are the subjects of this CHNA report.

2024 CHNA priorities

As part of our commitment to our 10-year vision and strategies, and in alignment with the Center for Community Health Equity, we are using consecutive CHNA cycles to build upon and deepen the work tied to the assessment. All the feedback, stakeholder input, and community voice we have gathered and heard since our last assessment confirms that the priority needs identified in our 2021 CHNA are still present, pressing issues in our communities. We remain committed to driving real, sustained change in those areas. We are using our 2024 CHNA cycle to gather further data and context about these priority needs to refine and deepen our understanding and to respond more impactfully.

The three priority needs are:

- **Accessing and navigating care and resources.** Individuals and communities struggle to access and navigate the resources they seek to support their unique health and well-being. System complexity, co-occurring health and mental health issues, and lack of coordination across entities make it difficult and cumbersome to access information and care. Provider shortages, lack of culturally responsive providers, and cost of care especially for under- or uninsured community members further exacerbate access challenges. Furthermore, many gaps in service exist, and services that are available are not always appropriate for or trusted by populations.
- **Addressing structural racism and barriers to equity.** Individuals and communities are experiencing differential access and assets due to historical and ongoing structural racism, discriminatory policies, and bias. The social determinants of health as well as individual risk factors contribute to disparate outcomes with care, resources, and opportunity, undermining the ability of all groups to achieve optimal health and wellbeing. Communities are calling for conditions that strengthen their capacity and center their priorities; institutions have a responsibility to share power and recognize marginalized voices in decision-making processes.
- **Cultivating trust, belonging, and healing.** Individuals and communities are experiencing an acute sense of polarization, breakdowns in trust of others as well as institutions, and increasing social isolation, especially post-pandemic and with distinct challenges across geographies. Historical trauma and discrimination further compounds these issues. This results in diminished social cohesion, increased anxiety or stressors, and lack of opportunities and spaces for connection and healing.

The priority populations include people across the lifespan, and span all geographies, from rural to urban, acknowledging barriers and approaches are unique for each community. Our priority populations are:

- **Racial or ethnic populations experiencing health disparities.** Racial or ethnic populations experiencing health disparities 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, Karenni, Kenyan, Korean, Lao, Liberian, Middle Eastern, Native American, Native Hawaiian, Nigerian, Oromo, Pacific Islander, Somali, and Vietnamese.

- **People experiencing poverty.** 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, Karenni, Kenyan, Korean, Lao, Liberian, Middle Eastern, Native American, Native Hawaiian, Nigerian, Oromo, Pacific Islander, Somali, Vietnamese, and white.

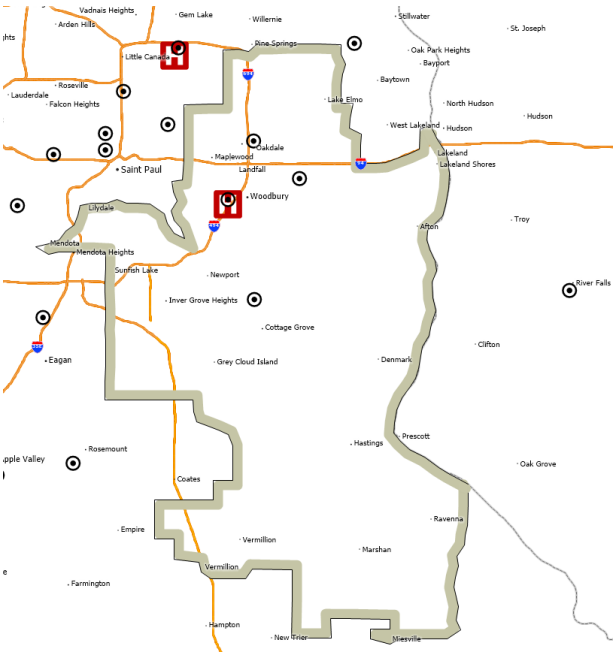
The identified priority populations are not mutually exclusive. Individuals may identify as either or both populations.

For an in-depth look at each of our priority need areas and priority populations, please see our 2021 CHNA report.

Defining community: Woodwinds Hospital CHNA community

In this definition of community, we include residents, patients, and employees. These categories are fluid: not only can individuals fall into more than one, but they can shift back and forth among these categories over time. For these reasons, the best definition of specific hospital communities considers all of these groups.

For the purposes of the CHNA, the Woodwinds Hospital community includes 18 zip codes. The hospital is in Washington County, and the hospital community also overlaps with Washington, Dakota, and Ramsey counties. The geography encompasses 345 square miles. The total population of this geographic community is 337,654 people. This makes up 5.6% of Minnesota's total population (5,760,091). This definition aligns with the hospital's primary service area, where a majority of its patients come from, that resides in state of Minnesota.



See Appendix A for a map of the community and Appendix B for list of zip codes and the corresponding cities and counties that fall within the Woodwinds Hospital CHNA community.

Description of community

Demographics

The Woodwinds Hospital community is more racially and ethnically diverse than the state, on average. Those who identify as members of racial or ethnic populations experiencing health disparities make up almost one-third (31.5%) of the Woodwinds Hospital community, compared to 24.2% of the state's total population. The diversity in the Woodwinds Hospital community is projected to grow. By 2029 the percentage of residents who identify as members of a racial or ethnic population experiencing health disparities is expected to increase from 31.5% to 36.4%. Notably, the percentage of the population in the Woodwinds community who identifies as Asian is 4.6% higher than the percentage of people across the state who identify as Asian. This community will continue to grow; those who identify as Asian will

increase from 10.1% in 2024 to 11.7% in 2029. By 2029, the Black/African American population in the Woodwinds Hospital community is projected to increase from 8.4% to 9.8%.

Those who identify as Hispanic/Latino make up 9.4% of the total Woodwinds Hospital community population. This is 2.7% greater than the percentage of those who identify as Hispanic/Latino across the state (6.7%). Additionally, the Hispanic/Latino population is projected to increase from 9.4% in 2024 to 10.4% by 2029.

This community is about the same age as the rest of the state. The median age for the Woodwinds Hospital community is 40.4 years, and Minnesota's median age is 40.3 years. In 2029, it is expected that the age 65 and older population will increase from 17.8% to 19.8%.

Go to Appendix C to see the Woodwinds Hospital community's full demographics data table.

Community characteristics

We selected the data points we reviewed, which we have shared on the community characteristics table (Appendix D), to provide a broad view of some of the factors that impact social needs and social determinants of health. We identified a few indicators from the community characteristics listed that are different in the Woodwinds Hospital community than they are across Minnesota, on average. Those are highlighted as indicators of interest.

- **Percentage of population with income below 50% Federal Poverty Level (FPL):** In the Woodwinds Hospital community, 2.5% of the population has an income below 50% of the FPL. This is 1.6% less than the percentage of Minnesota's overall population that has an income below 50% of the FPL (4.1%). For 2021, a family of four at 50% FPL has a combined household income of $13,250 or less.
- **Food security rate:** A higher percentage of the population in the Woodwinds Hospital community is food secure (95.7%) compared to the percentage of Minnesota's total population that is food secure (93.9%).
- **Households with no motor vehicle:** In the Woodwinds Hospital community, 5.2% of households do not have a motor vehicle. This is 1.3% lower than the overall percentage of Minnesota households with no motor vehicle (6.5%).

See Appendix D for the full community characteristics data table and Appendix E for a community characteristics snapshot for the Woodwinds Hospital community.

2024 CHNA process

During this cycle, we are taking a close look at our process – the "how" and "why" of our community engagement work. By conducting a structured examination of the methods we are using to engage with communities, we can identify strengths to build on as well as challenges to address. Correspondingly, this CHNA report focuses on an in-depth exploration of our current engagement processes. It represents an opportunity for us to respond to feedback from the community around the burden of engagement and to pursue ideas to improve the way we engage with communities.

As Fairview conducts our required CHNA process, led by Fairview's Community Advancement department, we are guided by the approaches and principles developed by **the Center for Community Health Equity,** which was launched in August 2022. As part of the center, we are building on our existing community engagement by creating an infrastructure that builds trusting partnerships and enables community voice to inform and influence our health system. For example:

- Fairview developed a Center for Community Health Equity Model of Community Engagement. The model articulates our approach to community engagement, community voice, and community partnerships as we work to advance community health equity.
- The center is developing a set of standard practices for collecting community voice to influence our social determinants of health initiatives without adding undue burden to the communities we seek to serve.
- The center's role as a convener and developer of community-informed best practices helps us keep equity at the center of our thinking as we study and evaluate our processes and engagement approaches.

To learn more, visit the Center for Community Health Equity website.

Our continued commitment to the priority needs and populations identified in our 2021 cycle embodies how we strive to show up – and *stay* – in the communities we serve. Continuing to work on these priority needs honors the knowledge and expertise that has already been shared with us through past assessment cycles and attempts to reduce the burden that repeated information collection places on communities. Moreover, these needs continue to disproportionately impact our priority populations, and these populations deserve to have the opportunity to achieve the best possible health outcomes.

Although approximately three-quarters of Minnesota's residents identify as non-Hispanic white, that statistic masks the reality that Minnesota is a highly diverse state. We have a large variety of languages and cultures here. Minnesota is home to among the United States' largest Hmong, Karen, and Somali populations, and there are also 11 federally recognized American Indian tribes with reservations in Minnesota[iii]

Our hospitals' service areas touch many populations that face health disparities, including Black/African American, Somali, Karen, Hmong, Latine, Vietnamese, American Indian, LGBTQIA2S+, and rural populations, among others. Minnesota has some of the largest health disparities in the nation – and with sustained commitment over time, we can change that reality.

The programs and partnerships we have built and co-developed to respond to these needs are deeply embedded in our local communities. Our current assessment and implementation cycle gives us the opportunity to:

- Continue to build momentum, expanding our networks and collaborations to better understand one another's needs and assets.
- More deeply integrate the voices of those who are disproportionately impacted by the social determinants of health and the voices of historically marginalized communities in articulating barriers and building solutions.
- Lean into our unique culturally and linguistically relevant programs and initiatives.

Strengthening partnerships and improving processes

As we conduct our 2024 CHNA, we are taking a series of steps to improve our assessment process, keeping in mind the impact of the data collection process itself on the communities we serve.

As we engage in bidirectional conversation and partnerships with community organizations that represent our priority populations and others, we are sensitive to the burden that incorporating the community's perspectives places on members of those communities and the organizations that serve them. In response, we are implementing several practices:

- We are offering grants to community-based organizations that are representing a priority population in our system community advisory council and stipends to the community-based organizations that are cohosting the system virtual community conversations with us.
- We are reviewing our outreach strategies, carefully planning, and partnering with others to avoid over surveying, over relying on the same voices or representatives, and asking the same questions assessment cycle after assessment cycle.

Fairview has **invested in subscriptions to tools, such as Spark Maps,** which enable our health system to utilize and respond more effectively to requests for community data. Spark Maps provides mapping and assessment tools that include a large database of indicators, data cleaning, benchmarking, and contextual information.[iv] For more information on Spark Maps see page 20.

Fairview has taken a leadership role in the **Center for Community Health (CCH),** a collaborative with health plans, hospitals, and public health agencies in Minnesota's seven-county metropolitan area. The CCH's member organizations will share data and processes to identify health needs and implement innovative approaches to advance community health, wellbeing, and equity. One result of this collaboration is Health Trends Across Communities, a dashboard that uses information from electronic health records to help fill gaps in the information available to health professionals, organizations, policymakers, and community members to promote health in Minnesota.

We are among the community partners supporting the **Minnesota Homeless Study**, a point-in-time study by Wilder Research that collects single-night counts of people experiencing homelessness across the state. For example, on the night of October 26, 2023, approximately 1,000 volunteers interviewed 4,600 people experiencing homelessness across Minnesota. Fairview also works with Wilder on the triennial **Minnesota Reservation Homelessness Study**. The study is conducted in partnership with six American Indian reservations in Minnesota: Bois Forte Band of Chippewa, Fond du Lac Band of Lake Superior Chippewa, Leech Lake Band of Ojibwe, Mille Lacs Band of Ojibwe, Red Lake Nation, and White Earth Nation and honors tribal ownership of their data.

Fairview has had representation on the planning team and provided financial sponsorship for **the Bridge to Health Survey**. The survey has been an important source of data on the health status of adults in northeastern Minnesota and Douglas County, Wisconsin, for more than two decades. The Bridge to Health collaborative met over the course of 2023 to develop an equity approach to guide future survey development. For more information on Bridge to Health Survey, see page 20.

We have been involved and **supported collaborations** particularly related to data and assessment in the Woodwinds Hospital community. For example, Fairview staff sits on CONNECT Washington County to help identify barriers and solutions to these topic-specific conversations.

Community engagement for the CHNA

Engagement approach

Our overall engagement approach is guided by four key considerations:

1. Fairview is focusing on **building and deepening our engagement infrastructure**, putting structures in place that will guide our long-term community engagement efforts.
2. We must implement tactics that gather both **breadth and depth of engagement**, bringing as many community members as possible into the conversation and yet also seeking to develop a deep understanding of nuances within each need.

3. Our priority needs are systemwide, and we approach our assessment process from a system level. However, each local community Fairview serves is unique, and we **recognize, honor, and prioritize local nuances** – in context, in populations, and in our understanding of both – so we can respond most appropriately within each locality. This dual system/local approach enables us to maximize our efforts' impact across the region we serve.
4. As we look to our local communities and seek to meet them where they are, we benefit from engaging with **multiple perspectives:** those of our community members, our patients, and our employees. To do this, we must take into consideration a variety of approaches, modes, and preferences to best fit the needs of these three groups.

Throughout our engagement efforts, we continue to deepen our understanding of community needs, including emerging needs as well as shifts in current needs.

1. It is essential that we have individuals within and across Fairview who are knowledgeable in collaborating with the community.
2. A key step in the process of effective community engagement is to develop an authentic relationship with a trusted agency or community organization to help build the role of the community in engagement or programming (including, but not limited to, community voice) that produces measurable changes in the community's health outcomes.

Community engagement spectrum

As we build our multiyear assessment engagement approach, having a single guiding model of community engagement helps us maintain alignment across the health system as we plan and conduct our work. The Center for Community Health Equity engagement spectrum, based on the International Association for Public Participation's Spectrum of Public Participation,[v] was collaboratively developed through interviews with local organizations, community members, Fairview employees, and other stakeholders.

Our engagement spectrum depicts five progressively more intensive levels of community engagement: inform, consult, involve, collaborate, and community led. The model includes examples of each level of community engagement, to clarify what each level could look like in practice. It is important to recognize that no level is inherently better than another level – a more intensive engagement is not appropriate in all situations. Rather, each level is equally valid and appropriate for certain activities and at certain times.

During our current assessment process, we used the Center for Community Health Equity engagement spectrum to help ensure that we are using strategies and tactics across the spectrum. Our intent is to build the capacity of stakeholders, community organizations, and other influencers to partner with our health system most effectively, enabling them to promote their community's interests to improve the broader community's health and wellbeing. Using the engagement spectrum as a model goes beyond merely incorporating community voice into Fairview's priority need areas. Its goal is to guide and frame co-development of community engagement activities and guide our implementation planning.

Please see Appendix F to view the Center for Community Health Equity engagement spectrum model.

Engagement infrastructure and community advisory groups

The phrase "engagement infrastructure" refers to the mechanisms through which we are sharing and receiving bidirectional feedback on an ongoing basis. Like our hospital's physical infrastructure, our engagement infrastructure is composed of enduring, permanent parts of our health system.

We are continuing to build a community engagement infrastructure that supports trusting partnerships and enables community voice to inform and influence the organization. The goal of the engagement infrastructure is to:

- Build and expand feedback systems for patients and community members.
- Embed process improvement in the health system's response to community voice.
- Create sustainable structures to convene and engage community voice around addressing social determinants of health.
- Hold space to pilot new and unique approaches to reach different populations and communities that may not otherwise be heard from.

Local Community Advisory Committee

Each hospital community has a **Local Community Advisory Committee**. We have been committed to and honored with a bidirectional, long-term commitment from our local community advisory committees, which have existed in various iterations for over 30 years.

The local community advisory committee's role is to:

- Advise and inform health improvement plans and collaborative programs.
- Guide local insight and voice for CHNAs and action plans.
- Monitor progress toward the goals outlined in the CHNA implementation strategy.
- Review the local CHNA report.

Each committee comprises members from, or representatives of, groups such as public health departments, medically underserved communities. communities experiencing poverty, populations experiencing health and/or racial disparities, community-based organizations, and schools.

Since our last assessment, membership is an area that we have purposefully identified gaps. We are continuing to work toward meeting the gold standard of committee membership

For a list of the Woodwinds Hospital Local Community Advisory Committee members, please see Appendix G.

System Community Advisory Council

Since our last assessment our **System Community Advisory Council** has adjusted the membership and focus to better fit the community and organizational needs. The system community advisory council spans the entire health system and incorporates the need for internal representation, local representation, and representation from organizations that represent our priority populations. It builds new, and deepens existing, relationships and partnerships that allow us to understand, respond to, and meet community and patient needs through collaboration.

The Fairview System Community Advisory Council's role is to:

- Advise the health system on the CHNA process and prioritization model from a systemwide perspective.
- Guide health system insight and ensure the voice of priority populations remains at the center of all discussions.
- Provide guidance and expertise in development of implementation strategy plans.

To view the Fairview System Community Advisory Council's roster, please see Appendix H.

Fairview's Employee Resource Groups (ERGs)

ERGs are voluntary, employee-led groups that aim to foster a diverse, inclusive workplace. They focus on impacting four important areas: community connection, organizational impact, meaningful change, and people development. ERGs supported the CHNA process by providing feedback and suggestions and supporting dissemination and recruitment of the data and engagement approaches. There are currently nine ERGs representing different affinities.

Patient Family Advisory Councils

Patient Family Advisory Councils bring together patient and family advisors along with staff to share insights and experiences to help Fairview improve. These committees help validate the current state, understand existing obstacles, and test ideas to overcome those barriers. During this CHNA cycle, our Patient Family Advisory Committees consulted on ways to approach community conversations, specifically our Town Halls.

Data components

The process of centering community voice enables us to use the CHNA process to bring the perspectives of the communities we serve back to the health system in an actionable format. By using the various data-gathering methodologies outlined below, we gain a better understanding of the top barriers and concerns among the people we serve. This process is also a crucial avenue for adding nuance, understanding how our communities' needs shift among different geographical areas, generations, and cultural communities.

Listening and learning sessions

Because listening to the perspectives of our community – a group that includes community members, patients, and Fairview employees – is crucial to our ability to achieve our 10-year vision of increasing community health equity, Fairview has held community listening and learning sessions through the HOPE Commission since 2020. These sessions hold a mirror to Fairview, assessing where we are today and helping us understand how we can make lasting change. Sessions were held in 2020 to hear from employees, in 2021 and 2022 to hear from patients, and in 2023 and 2024 to hear from community members.

In June 2022, after identifying a gap in participants from previous listening and learning sessions, we expanded these listening and learning sessions to include patients with limited English proficiency. Sessions were held in Somali, Spanish, Hmong, Karen, and American Sign Language. Prior to these sessions, there were limited mechanisms for patients with limited English proficiency to provide feedback about the care they were receiving. This series was an effort to bring more voices to the table and create inclusive opportunities for patients to express their needs and concerns.

Systemwide virtual conversations

We held a series of **systemwide virtual conversations** focused on the priority need healing, connectedness, and mental health and what that specifically looks like for youth (April 2024), aging adults (March 2024), and Indigenous populations (June 2024). These conversations were open to all, and their goal was to collect and share learnings and resources with participants. The conversations included presentations from community partners about their work, followed by small group discussions that provided valuable perspectives informing our understanding of population-specific needs, strengths, and future state visioning tied to healing, connectedness, and mental health.

See Appendix I to learn more about the presenters from each virtual conversation.

CHNA surveys

To gather input from a broad set of stakeholders on local strengths and the top needs of communities each of the respective stakeholders serves, we developed two aligned, but distinct, **surveys**. The surveys gathered feedback about:

- Patient and community members' top barriers to care, social determinants of health needs, and social needs.
- The unique barriers and assets for patients in one of our priority populations (racial or ethnic populations experiencing health disparities and people experiencing poverty).
- Barriers that providers and community partners face in responding to the social determinants of health-related needs of patients as well as existing assets and resources available.

The surveys were distributed to care team members[vi] and partner organizations, including faith leaders. Surveys were administered from mid-February to the end of March. We heard from 472 individuals across our hospital communities and our health system, with 296 responses from care team members and 176 responses from community organizations.

Of the community organizations that responded to the survey, over half offer their services in languages other than English. Over half reported that most of the community members they serve identify as Black/African American, and about one-third identified that most of the community members they serve identify as Black/African, Asian, Native American or Alaska Native, and/or Hispanic, Latine, or Spanish origin.

Most organizations also responded that they serve youth, older adults, families, low-income households, and women and children, with one-third offering services specifically to new immigrants.

Community Health and Healing Summit: Celebrating Culture, Building Connections, Guiding Action

The Community Health and Healing Summit, held in July 2024, aimed to propel our 10-year vision for a healthier Minnesota forward. The summit was a collaborative event bringing stakeholders together to work collectively on prioritizing needs and barriers to health in our communities. It blended the power of community and cultural healing with activities designed to collect participants' insights to not only shape our priorities but to actively drive positive change in our communities.

Participants engaged in several activities throughout the day to provide local context and nuance for each of the priority need areas and participated in a voting process designed to prioritize the highest-impact barriers within each of the priority needs. Attendees also participated in a health equity timeline activity to identify occurrences through history that impact the current state and contribute to or help to address health inequities.

Stakeholder interviews

For the past several years, we have engaged in in-depth discussions with key stakeholders to gain deeper insights into specific issues related to community health and health equity. The goal of conducting these conversations is to explore nuances, understand complexities, and gather stories that will help us understand unique local and cultural barriers to the care and health of patients. It also helps us understand the barriers that make it more difficult to respond to those needs, and potential solutions to those barriers, from a variety of care team members' perspectives. For this assessment cycle, we focused our efforts on conducting interviews with care team members across the health system.

In 2021, we conducted key stakeholder interviews with social workers and registered nurse care coordinators, two groups that work closely with cancer patients and are familiar with the barriers patients typically experience. We developed a protocol, and a social work intern and a public health intern conducted the interviews from August 2021 to March 2022.

From May to July 2024, we conducted stakeholder interviews with various Fairview care team members in both acute sites and clinics, including nurses, physicians, schedulers, social workers, care coordinators, and clinic managers. The interviews were guided by the results of our CHNA survey and aimed to gather more in-depth information and stories about the top barriers that had showed up most frequently during the survey.

Facilitated conversations

We conducted a variety of facilitated conversations across the health system, a few examples of which are summarized in this section. The goal of these activities is to gain a fuller, more nuanced picture of topic-specific or population-specific perspectives over time. By holding these conversations on an ongoing basis, we ensure that our assessment process and our aligned programmatic or initiative-related work is responding to and engaging with communities in real time.

Food is Medicine community conversations: As a part of our Food is Medicine initiative, we partnered with community-based organizations to host a community conversation in each hospital's service area. The goal was to learn more about the community's needs and strengths related to access to healthy food and the role of Fairview as a healthcare provider. In the fall 2023, we held eight Food is Medicine community conversations across different hospital geographies that were attended by 75 organizations representing sectors across the food scape including food shelves, farmers, social services organizations, schools, and municipalities.

Town halls: In November and December 2023, we hosted five town hall sessions that were open to the public and geared toward local government relations offices, the business community, community-based organizations, trade groups, civic groups, and rotaries. Each town hall provided an opportunity for community members to receive updates from Fairview, participate in a question-and-answer session with Fairview leaders, and engage in discussions regarding barriers to health and trust in healthcare organizations.

Ongoing program and partnership conversations: Through ongoing partnership and programmatic conversations, we are vetting and refining our understanding of the identified priorities and the responses that would best address them. As a foundational part of program planning and evaluation, Community Advancement staff members 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, driving insights into the needs of the communities we serve.

Primary data methods

Fairview staff developed standardized tools, processes, instructions, protocols, and training for facilitators, interviewers, and note takers. We compiled, cleaned, and analyzed all primary data. A note taker captured all community input, and when possible, conversations were also recorded.

Secondary community data

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 United States 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.

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 from over 100 sources, among them the American Community Survey, the United States Centers for Disease Control and Prevention, the Behavioral Risk Factor Surveillance System, and the United States Department of Agriculture Access Research Atlas. Spark Maps was developed by the University of Missouri Extension Center for Applied Research and Engagement Systems.

The **Bridge to Health Survey** has been an important source of data on the health status of adults in northeastern Minnesota and Douglas County, Wisconsin, for more than two decades. The survey is conducted every five years, with the last survey administered in 2020. The survey provides representative local information on key health indicators that allows for county and community-level analysis. The Bridge to Health Survey is a collaborative effort involving organizations across the region representing public health, hospitals, clinics, health systems, health plans, nonprofit organizations, government agencies, foundations, and higher education institutions.

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.

The **Area Deprivation Index** (ADI) is based on a measure created by the Health Resources and Services Administration over three decades ago, and has since been refined, adapted, and validated to the census block group neighborhood level by Amy Kind, MD, PhD, and her research team at the University of Wisconsin – Madison. It allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest (e.g., at the state or national level). It includes factors for the theoretical domains of income, education, employment, and housing quality. It can be used to inform health delivery and policy, especially for the most disadvantaged neighborhood groups. The ADI is publicly available on the Neighborhood Atlas website.

Health Trends Across Communities in Minnesota (HTAC) uses information from electronic health records to help fill gaps in the information available to health professionals, organizations, policymakers, and community members to promote health in Minnesota. HTAC is a collaboration among health systems, public health departments, health organizations, and health plans in Minnesota. HTAC uses summary reports from electronic health records on a range of chronic, behavioral, and mental health conditions. The information comes from 11 health systems that make up the Minnesota Electronic Health Record Consortium (MNEHRC). Information from the MNEHRC represents approximately 90% of healthcare for Minnesotans, which makes HTAC a powerful tool to describe the health of many communities.

Minnesota Department of Health, County Health Tables were used to look at 2020 county-level top causes of death and premature death.

Secondary quantitative data methods

We conducted a broad examination of our quantitative data sources, focusing on indicators related to social needs and social determinants of health at a national, state, and community level. We determined where indicators at the community or county level differed from the state's averages. We also analyzed cause-specific death and premature death rates to inform our social determinants of health framing from a health condition perspective.

Prioritization process

As we are continuing our commitment to address the identified the priority need areas for our 10-year transformation efforts identified during our 2021 CHNA process, we next seek to better understand the factors that stand in the way of addressing these needs. To gain a clear picture of the problems and barriers that make these priority need areas so difficult to address, we turned to our community. We used the CHNA survey results and consulted with our local community advisory committees and system community advisory council, as well as our Community Advancement team members, to prioritize 10 barriers for which Fairview, in our role as a health system and anchor institution, could best show up in these need areas. To see a list of the top 10 barriers identified for prioritization in each priority need area, please go to Appendix K.

Next, we held the Community Health and Healing Summit in July 2024, during which community members from all our hospitals' service areas helped to narrow the list of barriers further:

- First, summit attendees voted for their top five most impactful barriers, noting their local area as well.
- Then, participants worked in small groups composed of people from different localities to form consensus on the top three barriers to addressing each priority need from a systemwide perspective.
- Small groups also provided additional context around the top barriers to understand the details and specifics of the nuances of the top barriers.

Finally, as a part of Fairview's prioritization process, as we transition into implementation strategy and action development, we will consider the health system's perspective as well as the community's perspective.

- Where do we already have effective programs that are generating momentum in these areas?
- Which areas best align with Fairview's existing priorities, including health equity?
- In which areas do we have the ability to contribute resources and expertise to address these barriers in priority need areas?

Defining our priority needs

We continue to believe that to have the greatest impact on our communities, we need to take a targeted approach. 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. Our 2024 CHNA resulted in a reaffirmation, and better understanding, of the significant barriers that make our three priority need areas so difficult to address. We used these barriers to refine and better define the priority needs.

Based on our improved understanding of the needs and conversations with advisory groups, we have adjusted the title of one of our priority needs from 2021.

- Healing, connectedness, and mental health → Cultivating trust, belonging, and healing.

Although this change removed Mental Health from the title of this priority, we will lean into accessing mental health services as a part of the priority need “Navigating and accessing care and resources”.

The tables below describe the primary barriers that stand in the way of improving priority needs across the health system. We identified these barriers through a deliberate listening, voting, and consensus-building processes with community and internal stakeholders. To develop each barrier’s description, we synthesized the variety of unique concepts we heard around each barrier, captured in our qualitative data during this assessment process. Our more nuanced understanding of these barriers will help inform and guide our implementation planning and action plan development.

Priority need: Accessing and navigating care and resources

Individuals and communities struggle to access and navigate the resources they seek to support their unique health and well-being. System complexity, co-occurring health and mental health issues, and lack of coordination across entities make it difficult and cumbersome to access information and care. Provider shortages, lack of culturally responsive providers, and cost of care especially for under- or uninsured community members further exacerbate access challenges. Furthermore, many gaps in service exist, and services that are available are not always appropriate for or trusted by populations.

Barrier	Description
Access to care	refers to the significant obstacles that prevent timely and effective medical attention, such as long wait times, provider shortages, not enough time spent with providers, excessive paperwork, and scheduling difficulties.
Complexity of health systems and need for care coordination	refers to the challenges many patients, especially vulnerable adults, face as a result of the healthcare system's complexity, including inadequate follow-up care, difficulties in scheduling appointments, and confusion about insurance coverage. Healthcare’s fragmentation often results in a lack of clear communication among providers, few opportunities for patient advocacy, and insufficient navigation support, leaving patients uncertain about their care plans and where to seek assistance. It includes complicated documents, lack of information around navigating the basics, such as who to call, how to schedule an appointment, how to use electronic applications such as MyChart, and where care for specific issues is located.
Co-occurring or intersecting conditions and contexts	refers to the challenges that arise when multiple issues – health conditions, mental health, poverty, and historical trauma – are interconnected and exacerbate each other, making it difficult to seek support and effective treatment. The interconnectedness of these conditions highlights the need for stable housing and integrated care that addresses multiple unresolved issues, while recognizing the impact of historical trauma and external factors on individuals' willingness to seek help.
Cost of care and insurance	highlights the importance of having affordable healthcare solutions that enable individuals to receive necessary treatments and services without financial strain. It refers to issues such as cost transparency, insurance coverage, and the lack of availability of low-cost clinics.
Mental health care and services access challenges	refers to challenges in accessing timely and culturally relevant mental health care, including long wait times, high costs, and a shortage of diverse providers. It also includes a lack of consistent communication between mental health and primary care services, resulting in problematic transitions between levels of care. Patients may experience uncertainty about whom to contact and what mental health resources and supports are available, which can affect continuity of care and support after discharge from mental health facilities.

Transportation	refers to the difficulties individuals face in getting to medical appointments and services due to challenges such as the lack of reliable public transportation, high costs associated with travel and parking, and concerns about public transit safety and accessibility.

Priority need: Addressing structural racism and barriers to equity

Individuals and communities are experiencing differential access and assets due to historical and ongoing structural racism, discriminatory policies, and bias. The social determinants of health as well as individual risk factors contribute to disparate outcomes with care, resources, and opportunity, undermining the ability of all groups to achieve optimal health and wellbeing. Communities are calling for conditions that strengthen their capacity and center their priorities; institutions have a responsibility to share power and recognize marginalized voices in decision-making processes.

Barrier	Description
Community resources	refers to the difficulties individuals face in accessing support due to age restrictions, complex navigation and enrollment processes, stigma, and the lack of culturally relevant and trauma-informed services. Challenges in reaching marginalized individuals, language and cultural barriers, and the absence of centralized updated resource directories make these barriers worse, all of which contribute to a lack of awareness of available resources within the community.
Financial	refers to the challenges posed by economic inequality, generational poverty, and the high cost of living, which limit access to necessary services and contribute to ongoing financial instability. Stagnant wages, unlivable incomes, and the stress associated with managing basic needs exacerbate these barriers, affecting families' ability to make informed financial decisions and perpetuating a cycle of poverty that hinders equitable healthcare access and diminishes overall health.
Food access and food justice	refers to inconsistent access to affordable, healthy food and the limited availability of resources such as certified commercial kitchens and land for food production. Restricted hours for food shelves, poor communication among food networks, and insufficient funding compound these challenges, all of which limit the ability to address food-related health disparities and ensure equitable access to nutrition.
Housing	refers to the challenges individuals face in securing safe, stable, and affordable living conditions, which are foundational to overall health and wellbeing. Issues such as housing insecurity, homelessness, long wait lists for senior housing, and limited age-friendly options, combined with high living costs and a lack of transitional resources, significantly hinder access to necessary services and exacerbate disparities in health, especially for vulnerable populations like children, seniors, and unhoused individuals.
Marginalization and unheard voices	refers to the systemic exclusion and underrepresentation of Black, Indigenous, and People of Color, LGBTQIA2S+, and other minoritized communities, limiting their access to culturally relevant services and safe spaces. The lack of adequate community engagement, insufficient resources, and the perpetuation of information silos compound this marginalization, contributing to the invisibility of these groups and hindering their ability to express their voices and needs within society.

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Priority need: Cultivating trust, belonging, and healing

Individuals and communities are experiencing an acute sense of polarization, breakdowns in trust of others as well as institutions, and increasing social isolation, especially post-pandemic and with distinct challenges across geographies. Historical trauma and discrimination further compound these issues. This results in diminished social cohesion, increased anxiety or stressors, and lack of opportunities and spaces for connection and healing.

Barrier	Description
Connection	refers to the impact of social isolation, lack of safe communal spaces, and diminished social support, which hinders community engagement among community members and with the health system. The absence of intergenerational activities, cultural spaces and a need for connection between community organizations further deepens this feeling of community disconnection.
Culturally appropriate healing	refers to the need for respect and incorporation of diverse cultural practices and address the specific needs of communities. It also refers to the lack of affordable holistic wellness options, relevant spiritual resources, and safe spaces for historically marginalized communities to come together.
Fear and lack of trust	refers to patients' doubts about the healthcare system due to past negative experiences, discrimination, and inadequate communication. Inconsistent provider relationships, unmet expectations, and fears of being misunderstood or mistreated intensify these doubts, leading to decreased willingness to seek care. It also refers to broader historical and systemic distrust of government and institutions, particularly among undocumented populations who fear exposure and discrimination. The perception that systems prioritize financial outcomes over mission exacerbates this mistrust, making individuals hesitant to provide identifying information and uncertain about the safety of accessing essential resources.
Historical and generational trauma	refers to the enduring impact of past and ongoing systemic injustices, which perpetuate mistrust and stigma, creating significant barriers to accessing care and negatively impacting people's health.
Population-specific needs/considerations	refers to the challenges of addressing the unique needs of particular groups, such as seniors, veterans, children and youth, LGBTQIA2S+, rural area residents, and new immigrants. A lack of tailored resources and understanding of these groups' specific requirements can hinder effective communication, support, and services.

Priority populations

We have woven our current understanding of how priority needs manifest for our priority populations and other specific populations into the discussion and contextual details on barriers for each of our priority need areas and will continue to seek to deepen our understanding through ongoing assessment and partnership.

The priority populations are across the lifespan, from rural to urban:	
Racial and ethnic populations experiencing health disparities	People experiencing poverty

Additional local barriers for Woodwinds Hospital community

While Woodwinds Hospital is part of a larger health care system, it is unique in the populations it serves, its community assets, the built environment, and the social conditions locally. As such, we identified a few top barriers to effectively addressing priority needs that were specific to the Woodwinds hospital community, in addition to the barriers that apply system wide. We will use these local barriers as additional context to guide and inform our local responses to best meet the community's needs.

Accessing and navigating care and resources

Barrier	Description
Knowledge and education	refers to the challenges individuals face in understanding and managing their health due to gaps in knowledge, limited availability or awareness of health resources, health literacy levels, and difficulties in navigating complex medical information. It also refers to limited or disparate nature of educational resources that are often not culturally relevant or widely available which causes challenges in accessing information and understanding mental health services. These challenges can lead to confusion about when and how to seek care, misunderstandings about health insurance coverage, and a lack of access to crucial educational resources, impacting overall health outcomes and the ability to make informed health decisions.

Cultivating trust, belonging, and healing

Barrier	Description
Community social conditions	refers to societal factors, such as division, stigma, and lack of welcoming environments, that hinder individuals from seeking or receiving necessary opportunities for healing, connectedness, and mental health. Insufficient community spaces, gatherings, and programming, compound these barriers, exacerbating feelings of isolation and the perpetuation of mental health issues across all age groups.

Needs not addressed

During our assessment process, we worked to identify the most significant, most pressing barriers to increased community health equity focused on the three specific priority need areas outlined above. This does not mean, however, that our efforts will only move the needle in certain narrow areas. On the contrary, we anticipate that by focusing on three interconnected, upstream priority need areas, our work will generate a ripple effect that will improve community health and health equity across many domains.

For example, during our community voice, data collection, and review process, we learned that many community members regarded certain health conditions as priority needs. Responding to health conditions and providing clinical care in a healthcare setting is the role of our hospitals and clinics. Because, in this community assessment, we are focusing on the social determinants of health and health equity, specific health conditions were did not make the first round of prioritization of needs and thus, were not included. However, addressing upstream barriers to health equity will make it easier for every person to be happy, well, and access the care they need and deserve. This, in turn, will decrease health disparities and improve outcomes for all.

There are also barriers that arose tied to our priority needs that we will not be able to respond to in a targeted fashion during the current CHNA cycle. This list of barriers and health conditions, in alphabetical order, are:

- Alzheimer's disease
- Cancer
- Chronic liver disease
- Chronic lower respiratory disease
- COVID-19
- Diabetes
- Facilities/lack of space for community-based organizations
- Heart disease
- Hypertension
- Medication
- Organizational funding
- Physical environment
- Stroke
- Technology and internet
- Time
- Unintentional injury

Resources available to address

As Woodwinds Hospital develops its CHNA implementation strategy, we will look to both internal and external resources to address the significant health needs identified through the process described in this report. Internal and external resources include existing initiatives, programs, and relationships, which are the foundation that the implementation strategy will be built. For additional details on programs, initiatives, and our partners, see the most recent CHNA Action Plan.

Fairview provides staff and facilitation for the programs or lends staff time and expertise to partner-led programs. Fairview also acts as backbone support for the collaboratives. The partners listed are engaged and supportive, contributing both capacity and expertise. Fairview resources include Woodwinds Hospital, and the primary clinics that reside within its defined service area: M Health Fairview clinics – Cottage Grove, Oakdale, Tamarack, Woodwinds, River Falls.

Fairview is also honored with ongoing relationships with partner organizations that intersect with us in a variety of ways. All of these partner organizations are critical resources to their local communities and are committed to addressing community need. For a complete list of Local Community Advisory Committee member organizations please see Appendix G. For a list of System Community Advisory Council member organizations please see Appendix H. To see the partners that support us and our communities in our health system's programmatic, initiative, and collaborative work as a part of the annual community health needs assessment action plan please see Appendix K.

Contract support

The Fairview team contracted with Loren Blinde, PhD of Writing Power, a copywriter and content strategist, on the writing of the report.

Partners that presented at the system virtual conversations were offered stipends for their time. This included: Annex Teen Clinic, University of Minnesota's Earl E. Bakken Center for Spirituality & Healing, Ebenezer, Minneapolis Health Department, and University of Minnesota's internal medicine division.

We contracted with Kumbe Healing to guide summit attendees through healing activities at our 2024 Community Health and Healing Summit.

Adoption by Board of Directors

This report was adopted by the Fairview Health Services Board of Directors on December 4th, 2024.

Fairview

Evaluation of impact

To best evaluate our impact and track progress toward our anticipated impacts, we used a multitiered, tailored evaluation approach. We ground our work in understanding core information about our communities. This includes identifying and understanding the community need being addressed, the population or community being impacted, current and/or potential partners to work with to address the need, and the results we anticipate.

Community needs are determined in several ways. In addition to being determined through our formal CHNA process, we also respond to emerging needs brought to us by a community partner, by a public health agency, or through patient or community data showing significant health disparities. We have standardized several key measures to assess the degree to which we are meeting the needs of the CHNA priority populations, focusing our efforts on equity, and program quality. These measures are monitored and reviewed mid-year and end of year annually. A subset of established programs and initiatives are set up and supported for deeper evaluation. We are guided by the Centers for Disease Control and Prevention model for program evaluation to establish primary outcomes, process measures, and demographics.

We evaluate program impact and success from a variety of approaches using both qualitative and quantitative data. For many of the program outcomes shared below, we are reporting our reach or outputs. We offer a variety of programs that vary along a spectrum from low-touch/high-count to high-touch/lower count. In other words, the effort and impacts of the programs are not the same. This is a purposeful approach. We want to offer a variety of programs and to “right-size” programs to address the needs.

In the following evaluation of impact tables, we share the impacts that Woodwinds Hospital led and/or collaborated on locally, as well as the impacts that occurred across the health system that Woodwinds Hospital participated in partnership with other Fairview hospitals and medical centers.

Fairview

Woodwinds Hospital CHNA three-year evaluation of impact

Priority need	Navigating and accessing care and resources
Implementation strategy	Address the social determinants of health through the creation and expansion of programs; initiatives; collaborations; research; and policy, system, and environmental change work.
Anticipated impact	Remove barriers to care by providing community-placed care, co-located services, and navigation supports that address cultural and language barriers.

Actual impact

Community clinical care initiative

The community clinical care initiative involves multiple community-based clinical programs, including Fairview's Minnesota Immunization Networking Initiative (detailed in the following section), blood pressure checks, and oral health services. All services are multisector community collaborations that provide care and education to the uninsured, underserved individuals, and communities facing health disparities in the greater Twin Cities area. The community clinical care team provides clinical care in trusted community settings at no cost and improves equitable access to vaccines and other services across various populations. The programs ensure a culturally and linguistically appropriate experience in a safe and trusted environment, in partnership with over 125 faith-based and grassroots community partners, serving clients at local churches, mosques, temples, schools, community centers, food pantries, and homeless shelters.

- From 2022 to 2024, across the system, the community clinical care team provided free blood pressure screenings and oral health services at 377 events.
- This includes 47 events in the Woodwinds Hospital community, during which the team provided 174 blood pressure checks and 61 dental fluoride applications.

Minnesota Immunization Networking Initiative (MINI)

MINI is a multisector community collaboration that initiated the community clinical care approach, which has since expanded. MINI provides free vaccinations and education to the uninsured, underserved individuals, and communities facing health disparities in the greater Twin Cities area.

- Across the system, the MINI team hosted 1,571 vaccination clinics from 2022 to 2024 at which 27,093 free COVID-19 vaccine doses,19,246 free flu shots, and 1,907 free mpox and MMR/Tdap shots were administered.
- From 2022 to 2024, in the Woodwinds Hospital community specifically, MINI held 55 clinics at which 1,338 free COVID-19 doses and 612 free flu shots were administered.

Fairview

- In 2023, MINI was invited to submit an article on its approach and successes, with a focus on partnerships with public health, to the New England Journal of Medicine. MINI's success continues to build the evidence base for community-placed and community-centered approaches.

Fairview Community Health and Wellness Hub

This first-of-its-kind center opened in August 2022 and addresses health disparities while providing a range of critical healthcare services. At the hub, Fairview works side by side with community partners to address food access, affordable healthcare services, and other socioeconomic factors affecting health. Hub partners include Minnesota Community Care, a federally qualified health center; M Health Fairview Mental Health and Addition Services; Fairview Frontiers research; a retail pharmacy; Ebenezer senior living; and M Health Fairview Bethesda Hospital, a long-term acute care hospital. Fairview initiated hub partnership meetings and provided ongoing coordination to ensure partnership, collaboration, and cross-programming among organizations located at the hub. For example, in 2023 Minnesota Community Care offered 20 slots of Fairview's Fresh Food Box program to their participants.

A few of the hub's successes in the first three years include commissioning a local artist to paint a mural at the hub to reflect the communities we serve, hosting four "Honoring St. Joseph's Hospital" reflection events, and holding a Winter Warming event that provided more than 150 of our unsheltered neighbors with winter coats, hand warmers, mittens, jackets, blankets, self-care items, and a warm meal. During the Winter Warming event, more than 50 community members participated in rapid HIV testing, and 24 attendees received foot and wound care. The hub also hosted Fairview system events such as a system Pride flag raising and the Beyond the Yellow Ribbon ceremony.

The events and education center at the hub provided free community gathering space to partners and local groups, and from 2022 to 2024 more than 110 events were hosted in the space. More than 1,000 community members were reached, 200 of whom were youth and young adults, through programming delivered in, or partnering with, the hub and the Center for Community Health Equity.

Priority need	Navigating and accessing care and resources
Implementation strategy	Address the social determinants of health through the creation and expansion of programs; initiatives; collaborations; research; and policy, system, and environmental change work.
Anticipated impact	Develop, grow, and sustain programs, educational offerings, partnerships, and initiatives; address barriers related to navigating and accessing care and resources.
Actual impact	
Healthcare education on "Inside Health Care"	

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Fairview partners with the leadership of Woodbury Thrives and The Woodbury Community Foundation to bring Fairview providers and community-based programs staff to the “Inside Health Care” talk show. This show has in-depth interviews with doctors, healthcare professionals, and the patients they care for. Some of the topics are disease prevention, chronic condition management, colon cancer, and emerging health needs and concerns.

- From 2022 to 2024, Fairview providers and experts participated in six episodes.

Dementia-Friendly Woodbury

Dementia-Friendly Woodbury is an initiative aimed at making sure that we are creating pathways to access care and resources for aging populations, those experiencing memory loss, and those having issues accessing the system. A key component of the work is increasing networking with other systems and community organizations actively working to support aging populations to increase synergies and opportunities for partnership.

- From 2022 to 2024, Fairview supported the Dementia-Friendly Woodbury advisory group by providing leadership, technical assistance, and three sponsorships.

Aging Well Infrastructure Support

Aging Well programming is dedicated to fostering healthy aging in Minnesota communities, focusing on underserved groups. The initiative offers a range of services and supports, promoting aging in place, safety, and end-of-life planning. Operating in trusted community settings, the organization aims to build a positive reputation. Through a continuum of aging support, Aging Well programming strives to make better health accessible to all community members.

- From 2022 to 2024, Fairview supported the Aging Well initiative by providing four training sessions focused on seniors or providers of senior services that were attended by 90 community members.

Educational offerings

Fairview developed and improved our educational offerings in response to community-identified needs and feedback. Programming included:

Health Across the Lifespan This nine-part virtual series addresses specific health and wellbeing issues experienced during the three stages of life (early years, early adult, and older adult), such as cancer, grief and loss, suicide prevention, and others.

- This series was held annually from 2022 to 2024, with 23 unique classes and 767 total attendees.

Living Well with Chronic Conditions In partnership with Trellis, this six-part evidence-based series supports those with chronic conditions. Two peer leaders guide participants through a prescribed curriculum.

- In 2023, two series were offered in Spanish, and 14 people completed the curriculum.

Community education forums These educational events were implemented virtually and were available to anyone. Topics included mental health and wellness, healthy habits through food, housing needs and programming, research participation 101, immunizations, and others.

Fairview

- From 2022 to 2024, Fairview held seven community education forums.

Opioid crisis response efforts

Naloxone training In response to the increase in drug overdose rates nationally and locally, including those caused by opioids, Fairview's community clinical care team partnered with the Steve Rummler Hope Network. The team trained several staff members to become naloxone educators and helped develop Spanish and Somali language curricula to address worsening racial disparities in overdose mortality rates.

- Across the system, there were 48 naloxone training sessions in 2023 and 2024, during which 971 individuals were trained to recognize and respond to an opioid overdose, including administering naloxone.
- Of those, one training session was held in the Woodwinds Hospital community, training nine individuals.
- In 2024, Fairview was awarded Steve Rummler's Champion of the Year award.

Naloxone access points Fairview hosts three low-barrier naloxone access points at locations across the health system.

Naloxone packing events Naloxone packing events are the volunteer-supported packing of naloxone kits for overdose prevention, which are then handed out for free at naloxone access points.

- From 2022 to 2024, Fairview hosted 34 naloxone packing events, where 17,910 naloxone kits were packed.

Priority need	Navigating and accessing care and resources
Implementation strategy	Create community engagement infrastructure that builds trusting partnerships and enables community voice to inform and influence the institution.
Anticipated impact	Build and expand feedback systems for patients and community members; embed process improvement in the health system's response to community voice.

Actual impact

Local and system community advisory groups

Local Community Advisory Committee Our Woodwinds Hospital Local Community Advisory Committee meets throughout the year to provide input, insight, and local expertise. We conducted an inventory of the current member organizations' focus areas and identified gaps in expertise and representation of our CHNA's priority populations. We continue to intentionally recruit participants to expand representation on the committees, focusing on these gap areas. In 2024, we developed a newsletter to communicate updates and opportunities to committee members more regularly.

Fairview

Fairview System Community Advisory Council The Fairview System Community Advisory Council supports development of the CHNA and the health system's community health strategies. By developing reciprocal relationships, building capacity, and strengthening trust, the council assists the health system in understanding, responding to, and meeting community and patient needs through collaboration. Throughout 2024, Fairview made a concerted effort to expand the membership of its System Community Advisory Council, resulting in increased representation from local Community Advisory Committees as well as organizations that work with racial and ethnic groups experiencing health disparities.

Patient and Family Advisory Councils (PFACs) These volunteer groups share insight into their experiences to influence our improvement work. These partnerships help validate the current state, understand existing obstacles, and test ideas to overcome those barriers.

- The number of patient and family advisors engaged in improvement work grew by 200%, from 190 in 2022 to nearly 600 in 2024.
- In the last three years, we added four new PFACs, including the Customer Experience PFAC, Scheduling and Billing PFAC, Comprehensive Gender Care PFAC and Youth Masonic Children's Hospital PFAC.
- The number of patient and family advisors serving on committees or workgroups has grown tremendously, from a handful involved in 2022 to over 12 individuals actively engaged in co-designing improvements in a variety of areas, including bedside rounding, patient education, restraint and seclusion, pediatric to adult transition, central line-associated bloodstream infections, and others.
- The number of digital advisors grew from 894 to 1,258. These advisors responded to surveys and provided insight on many projects including wayfinding, the use of iPads to improve overall care, customer experience standards, MyChart, depression care, preventive care, and others.

Healing, Opportunity, People, and Equity (HOPE) Commission listening and learning sessions

In 2022, as a part of the HOPE Commission, we hosted four listening and learning sessions for patients who speak primarily a language other than English. Sessions were hosted in Karen, Hmong, Spanish, and Somali. These sessions were the first of their kind for Fairview, and results included lessons about how to best connect with, listen to, and learn from our patents and community members who speak primarily a language other than English. In 2023, we expanded our patient listening and learning sessions to include a session for patients who use American Sign Language.

Priority need	Addressing structural racism and barriers to equity
Implementation strategy	Address the social determinants of health through the creation and expansion of programs; initiatives; collaborations; research; and policy, system, and environmental change work.
Anticipated impact	Develop, grow, and sustain programs, educational offerings, partnerships, and initiatives to address structural racism and barriers to equity.
Actual impact	

Fairview

Center for Community Health Equity

The M Health Fairview Center for Community Health Equity was launched in August 2022. As a part of the center, we launched and built three social determinants of health initiatives:

- Food is Medicine (see page 32)
- Housing is Health (see page 33)
- Connection is Cure (for details on this initiative, see page 40)

Additionally, the center is developing population health equity initiatives, the first of which is the Native Health Equity Initiative (see details under “Native Health Equity Initiative" on page 36 and page 41).

Social determinants of health policy agenda In close partnership with Fairview’s public policy team and partners from across the organization, the center is advocating for our patients and community members at the Minnesota State Capitol. The goal is to advance policies that address the social determinants of health, such as access to healthy food and safe, affordable housing. For the past two years, the center has been building and leading initiatives to address the social determinants of health: Food is Medicine, Housing is Health, and Connection is Cure. The center’s advocacy efforts are focused on these priority areas. Among its key accomplishments from 2023 to 2024, the center:

- Joined a coalition of health systems and community partners urging the Minnesota Department of Human Services to seek a federal waiver for Minnesota’s Medicaid program. Known as the 1115 Waiver for Health-Related Social Needs, this federal waiver would help fund further investment in upstream supports.
- Signed on again as part of the “Partners to End Hunger” coalition, led by Hunger Solutions.
- Attended Hunger Day on the Hill, Homeless Day on the Hill, and American Indian Day on the Hill at the Minnesota State Capitol each year to educate legislators about the importance of supporting hunger relief programs, advocate for legislators to support efforts to end homelessness, and work to address disparities impacting our local communities.

Clinical and operational improvements: social determinants of health screening

In September 2023, Fairview implemented social determinants of health screenings at all primary care clinics to better identify and respond to patients’ nonclinical needs. These screenings were extended to all acute care sites in August 2024.

Food is Medicine initiative

Food is Medicine’s approaches are framed to increase health equity through focused efforts to serve patients who have been historically marginalized by providing culturally appropriate food options and reducing food insecurity in a manner that upholds dignity and empowers the local food system. Clinically, Food is Medicine enables providers to serve patients experiencing food insecurity through a menu of distinct programs comprising an innovative wrap-around approach. One or more of the Food is Medicine programs, a selection of which are described below, is available to patients in 43+ clinics and nine acute sites across the health system.

Fairview

Fresh Food Prescription program Previously known as VeggieRx and FoodRx, the Fresh Food Prescription program distributes fresh, locally grown produce from four farm partners (Hmong American Farmers Association, Sin Fronteras, Naima's Farm, and Women's Environmental Institute) along with other locally sourced products. The program offers home delivery to address transportation barriers.

- In 2024, 28 clinics participated in the Fresh Produce Prescription program across Fairview hospital and medical center communities, four of which are in the Woodwinds Hospital community.
- From 2022 to 2024, the program reached 36 patients in the Woodwinds Hospital community.

Food resource navigator This new role was implemented in 2024 to offer individual support to patients who screen positive for food insecurity and have a corresponding medical condition that would improve with increased access to healthy food. The food resource navigator supports connection to community food programs, local and national food resources, and enrollment in appropriate Fairview clinical food programs.

Food voucher program Fairview's food voucher program, called MarketRx, provides patients with $80 per month to purchase groceries at either the Theo Food Group's Twin Cities Mobile Market or the Fare for All program. The program runs year-round and offers rolling enrollment. The program has grown significantly over the past three years.

- From 2022 to 2024, the program grew from 10 clinics enrolling patients to 48 clinics and in 2024, 950 patients redeemed vouchers.
- In the Woodwinds Hospital community from 2022 to 2024 the program grew from one clinic to six clinics. In 2024, 85 patients from the Woodwinds Hospital community redeemed vouchers

Shelf stable food resources Fairview provided shelf stable food resources for immediate needs. Shelf stable food options (MATTERBoxes and Every Meal bags) were available in the Woodwinds Hospital community, with each box containing enough food to feed a family of four for three days.

- From 2022 to 2024, we distributed 4,458 shelf stable food boxes at 43 sites across the system.
- During this time, we also distributed 496 food resource packets containing information about local food resources along with a grocery gift card to assist with immediate grocery needs.

Harvest at the Hub Fairview and local partners hosted an annual Harvest at the Hub event at the Fairview Community Health and Wellness Hub. The event consisted of a food giveaway with turkeys, fresh produce, and other holiday staples; a community resource fair; a vaccine clinic; and other health and wellbeing services.

- In 2022, there were 178 households served, which grew to 421 households (more than twice the number served in 2022) in 2023.

Housing is Health initiative

The Housing is Health initiative aims to use the protective power of housing to support patients' health and build thriving communities. We approach this initiative by providing clinically connected programs, supporting community partnerships, contributing time and expertise to collaboratives, and working to impact policy.

Fairview

Our Savior's Community Services partnership Fairview partners with Our Savior's Community Services to provide critical follow-up care and shelter for people who are unsheltered after a hospital stay. Patients are referred by Fairview's hospitals and medical centers and sheltered at Our Savior's. Additionally, a nurse provides care, and patients receive wrap-around services and social work support.

- From 2023 to 2024, 98 patients were supported through this program.

Housing and Health Equity Fellowship We are proud to have completed the inaugural Housing and Health Equity Fellowship, hosted by the Greater Minnesota Housing Fund, which aimed to expand community investment by health systems to address the housing crisis in Minnesota. As an outgrowth of the fellowship, our health system helped launch Healthcare for Housing (HC4H), a collaborative consisting of seven health providers and payers. Fairview is also strengthening its advocacy role related to housing. We currently chair the policy workgroup for HC4H, participated in Homeless Day on the Hill, and submitted letters of support for multiple housing efforts.

Twin Cities Habitat for Humanity Build In October 2022, 2023, and 2024, teams from across the health system participated in the annual build week with Twin Cities Habitat for Humanity, contributing a combined 1,000+ volunteer hours across the three years. Employees worked on a new construction, single-family house each year. In 2024, Fairview was also the healthcare sponsor for the Habitat for Humanity Jimmy & Rosalynn Carter Work Project. The 2024 Carter Work Project launched Habitat's construction efforts at The Heights on St. Paul's East Side, Twin Cities Habitat's largest-ever development.

Patient housing resources We administered a housing resource needs survey to Fairview care team staff to understand what housing needs they were seeing in their patients and what resources would be helpful in responding to patient needs. The survey resulted in recommendations for resource materials and training.

Reach Out and Read

Reach Out and Read is a national program designed to promote early childhood literacy. It has become the standard of care in pediatric primary care. At Fairview, the program is implemented at every routine pediatric checkup, from newborn through five years, with each child receiving a book at each checkup for their personal at-home library. Reach Out and Read books are tools providers can use to assess important developmental milestones. Books are currently available in English and 14 additional languages.

- From 2022 to 2024, 124,387 books were supplied across 42 clinics.

Priority need	Addressing structural racism and barriers to equity
Implementation strategy	Create community engagement infrastructure that builds trusting partnerships and enables community voice to inform and influence the institution.

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Anticipated impact	Create sustainable structures to convene and engage community voice around addressing social determinants of health.

Actual impact

Center for Community Health Equity

Launched in August 2022, the M Health Fairview Center for Community Health Equity guides our philosophy around how we gather community voice and who we talk with as we learn how to tie the information gathered back into the organization. We celebrated the center's one-year anniversary with a three-day event welcoming over 250 people, where we offered free vaccinations, free blood pressure checks, and the opportunity to connect, network, and learn more about the center's work. The center also leads the Center for Community Health Equity Work Group, the meetings of which focus on strategic discussions on issues relevant to the center. The work group was comprised of representatives from across the health system.

Center for Community Health Equity Community Engagement Spectrum In partnership with the center, we developed a model of community engagement. The model defines how we approach community engagement, community voice, and community partnerships in our quest to advance community health equity. We will use this model to help guide the mechanisms through which we gather feedback, and the model has informed our 2024 CHNA.

Community voice

Fairview piloted a variety of community engagement approaches to determine best practices that lead to better, more authentic, community-centered experiences with bidirectional information sharing and learning:

- Fairview hosted eight Food is Medicine community conversations to inform our approach, during which we heard from 74 partner organizations. The conversations also served to convene food partners to increase opportunities for mutual awareness and collaboration.
- Fairview held a series of three population-specific (youth, older adults, Indigenous populations) virtual conversations focused on healing, connectedness, and mental health. In each conversation partners presented on the topic and population at hand, and attendees participated in facilitated discussions.
- In November and December 2023, we hosted town hall sessions that were open to the public but were geared toward local government relations, business community, community-based organizations, trade groups, civic groups, and rotaries. These town halls provided an opportunity for community members to receive updates from Fairview, participate in a question-and-answer session with Fairview leaders, and engage in a discussion regarding trust and barriers to health.

Backbone support for collaboratives

In the Woodwinds Hospital community, we participate in and have leadership roles in collaboratives such as the Minnesota Food Justice Network, Interfaith Health Collaborative, the Center for Community Health, CONNECT Washington County, and the Washington County

Fairview

Transportation Consortium. These are spaces where we do ongoing listening and relationship building with community partners and community members.

Community connection events

Fairview hosts an annual community summit that brings together over 50 community organizations, public health agencies, and other partners from across our service areas to share our impact, provide opportunities for discussion and networking, and identify areas of opportunity for collaboration as we respond to community members' social-determinants-of-health-related needs.

Priority need	Addressing structural racism and barriers to equity
Implementation strategy	Transform internal structures to create an antiracist and inclusive environment, and build community health by building wealth.
Anticipated impact	Using an antiracist approach, work to identify and eliminate racism by changing systems, organizational structures, policies, practices, and attitudes.
Actual impact	

HOPE Commission

The HOPE Commission is a multiyear transformational change effort to drive more equitable outcomes and inclusive environments and experiences for our patients, employees, and communities.

Key successes included:

- The development of the Equity Strategy Office along with the creation of new roles to further embed equity across daily work and operations.
- Increased capture of race, ethnicity, and language data to be able to better identify health disparities, which led to targeted interventions to reduce healthcare disparities.
- Ongoing capacity building across the system for individuals and teams to participate in the Intercultural Development Inventory.
- Language access work, with 18 improvement efforts happening across the system.
- Improvement in breast cancer screening rates among Karen, Hmong, and Somali patients through six mobile mammography events. The success of these events led to a commitment to hold 48 events in 2025.

Native Health Equity Initiative

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Building our engagement infrastructure involves engaging broadly with community but also increasing our capacity to engage with complex and intersectional groups. To that end, we are building a set of population health equity initiatives, one of which is the Native Health Equity Initiative.

- In September 2022, an Indigenous land acknowledgment ceremony honored the past, present, and future while recognizing the work our health system must continue to do to address the health equity issues affecting local communities. We also hosted the "Why Treaties Matter" exhibit from July to September 2022 at the Fairview Community Health and Wellness Hub.
- In 2023, a cohort of employees from across our system began work to advance health equity efforts in partnership with Native Americans and Indigenous communities. We facilitated six sessions to help our employees learn about the historical and current challenges faced by Native communities, connecting with key Native leaders and organizations about local priority issues, including healthcare. The sessions also engaged employees in working to improve experiences and outcomes for our Native patients, employees, and communities.
- We hosted a Native American and Indigenous-focused recruitment event at the Community Health and Wellness Hub.

Equity Strategy Office

Operational improvements from the Equity Strategy Office include dashboards and reporting on metrics across the areas of health equity; healthcare equity; and diversity, equity, and inclusion, which will inform the creation of action plans to reduce disparities found and create lines of sight for progress being made. Fairview is currently enhancing existing data collection and analytics across the institution to uncover and address health disparities. As part of this effort, Fairview successfully enhanced its analytics of Race, Ethnicity, and Language (REaL) data across the institution, enabling us to uncover and address health disparities more effectively. With the improved analysis of REaL data, we are now setting Fairview performance dimension goals specifically aimed at closing these disparities.

The Equity Strategy Office also supported strategic leadership within human resources and customer experience to incorporate restorative justice practices into their Just Culture and patient relations efforts. Additionally, in 2023, various units across the system operationalized systems to embed equity in project development and implementation across various parts of system decision making.

Priority need	Addressing structural racism and barriers to equity
Implementation strategy	Transform internal structures to create an antiracist and inclusive environment, and build community health by building wealth.
Anticipated impact	Leverage everyday business practices to build community wealth, promoting economic and racial equity and justice.
Actual impact	

Fairview

HOPE Commission, corporate citizen

As a corporate citizen, we aim to have trust with marginalized communities, who know that we are an attuned learning system that openly strives to achieve health equity and shares power to create healthy, resilient communities. Together, we will intentionally apply our long-term, place-based economic power, and human capital in partnership with the community to mutually benefit the long-term wellbeing of both.

Our anchor strategy which is part of our role as a corporate citizen, works to advance health equity by investing in the social and economic wellbeing of the communities we serve through our everyday business practices. The strategy focuses on local and diverse hiring, purchasing and investing, and serving and leading with trusted community partners.

- In 2022, Fairview signed on to the Healthcare Anchor Network's Impact Workforce Commitment as a demonstration of our commitment to workforce development and inclusive, local hiring.
- Fairview's workforce partnerships team is addressing the social determinants of health by helping people secure employment with family-sustaining wages and benefits, become successful in their jobs, and learn new skills. The team is also focused on inclusive, local hiring, resulting in a healthcare team that represents the communities we serve.
- Fairview built infrastructure for and launched a supplier diversity program. We engaged with a minority-led firm to assist in understanding our current spending with minority-/women-owned businesses and to implement the program in 2023.
- We increased the capture of our tier 2 spend (where existing contracts were purchasing from), which helped us understand how our current contracts are influencing diverse spending.

Fairview also has a robust social corporate responsibility program including employee volunteerism, memberships, affiliations, and sponsorships.

- Fairview employees reported over 19,000 volunteer hours between 2022 and 2024. Some key events that Fairview contributed to were Pride, Juneteenth, and Harvest at the Hub. We also supported partner organizations through volunteerism such as Habitat for Humanity build weeks.
- Fairview staff members sit on boards and/or are members of a diverse set of community organizations. These range from worldwide organizations to local nonprofit boards and chambers of commerce. Overall, Fairview supports over 100 organizations by providing staff leadership, expertise, and experience.
- Fairview underwent a review and update of our sponsorship program to better align with our commitment to advancing equity and our focus on diversity, equity, and inclusion. Aligned with our focus, Fairview awards sponsorships to support local community organizations in the needs and opportunities they have identified.

Research for health equity

In an effort to increase diversity and trust in clinical trials, the Center for Community Health Equity partnered with Fairview Frontiers to improve representation in a set of clinical trials. The partnership improved participants' diversity, increasing the percentage of those who identified as a race or ethnicity other than white from 15.5% to 33.8% in a set of clinical trials. A paper was published on the partnership and the methods that led to these successes.

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To grow interest among our younger community members, we hosted two educational events for youth to learn about the benefits of clinical research, how to participate in research, and careers in research.

In partnership with Fairview research teams, we hosted a research participant appreciation event in 2023 to increase trust and participation in clinical research. The event was attended by over 70 research participants.

Priority need	Healing, connectedness, and mental health
Implementation strategy	Address the social determinants of health through the creation and expansion of programs; initiatives; collaborations; research; and policy, system, and environmental change work.
Anticipated impact	Develop, grow, and sustain programs, educational offerings, partnerships, and initiatives; address barriers to healing, connectedness, and mental health.
Actual impact	

Mental health training sessions and educational offerings

Psychological First Aid (PFA) PFA is a two-hour, evidence-informed training for professionals as well as the broader community. Participants learn how to support individuals' healthy recovery following a traumatic event, public health emergency, natural disaster, or personal crisis. The curriculum integrates public health, community health, and individual psychology, drawing upon skills participants often already have.

- From 2022 to 2024, in the Woodwinds Hospital community, Fairview offered five PFA classes with 136 participants attending.

Mental Health First Aid (MHFA) Created and managed by the National Council for Mental Wellbeing, MHFA is an internationally recognized, eight-hour, evidence-based program that introduces participants to risk factors and warning signs of mental illnesses, builds an understanding of their impact, and summarizes common supports.

- In 2022 and 2023, two MHFA classes were held in the Woodwinds Hospital community, reaching 31 people. Fairview paused offering the program in 2024 due to overlap with existing offerings in the community.

Mental Health Forum Hosted, partnering with a community organization, this forum focuses on a cultural understanding of mental wellbeing and mental health issues.

- From 2022 to 2024 there were three virtual mental health forums attended by a total of 76 Participants

A Creative Look at Self-Care Previously called Refresh and Reset your Resiliency, this program promotes resiliency skills; offers wellness care tools for mind, body, and spirit; and encourages the development of a personal plan for self-care.

- From 2022 to 2024, in the Woodwinds Hospital community, three classes were offered with 51 attendees.

Feeding Hope This series of one-hour virtual learning sessions focuses on positive, hopeful topics that support wellbeing in the general community. It is offered in partnership with all Fairview hospitals and medical centers and is open to anyone across all of Fairview's communities.

- From 2022 to 2024, across the health system, eight sessions were held with a combined 1,795 attendees.

Connection is Cure initiative

Connection is Cure aims to build trust through strengthening social connections, centering linguistic and cultural diversity, and bridging silos across our hospital system and communities to transform medical practice.

- As part of Connection is Cure, we participated in the Institute for Healthcare Improvement's Trust Prototyping Network. We were one of eight healthcare organizations nationwide that were part of a 10-month project to test approaches for improving trust in healthcare systems. Our organization is focusing on a project to identify and remove system-level equity barriers for interpreters and patients with limited English proficiency. The goal is to improve patient outcomes, customer experience, and care team cohesion.

Priority need	Healing, connectedness, and mental health
Implementation strategy	Transform internal structures to create an antiracist and inclusive environment, and build community health by building wealth.
Anticipated impact	Build internal and external processes and structures to provide spaces that are safe and welcoming to all, responsive to community needs, and based on a culture of inclusion.

Actual impact

HOPE Commission

The HOPE Commission is a multiyear transformational change effort to drive more equitable outcomes and inclusive environments and experiences for our community members, patients, and employees.

Employee resource groups (ERG) continued to expand and foster a diverse, inclusive workplace while focusing on development, leadership, collaboration, and relationships. There are now nine ERGs:

- Pride Alliance Group for Equity (PAGE)
- Black Initiative Network (BIN)

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- Veterans Allies & Advocates (VAA)
- Facilitators of Unity & Strengtheners of Inclusivity of Nursing (FUSION)
- Asian Heritage Network (AHN)
- Cross-Cultural Leadership Network (CCLN)
- *Comunidades Latinas* for Engagement, Advancement, and Development (LEAD)
- Indigenous Healing Circle (IHC)
- Understanding Neurodiversity with Mentoring, Affirmation, Support, & Knowledge (UNMASK)

The HOPE Commission provided ongoing capacity building across the system for individuals and teams to participate in the Intercultural Development Inventory.

Fairview Health Services was named by Newsweek as one of "America's Greatest Workplaces for Diversity" for 2023.

Three of Fairview's hospitals were named high performers in providing equitable and inclusive care for LGBTQ+ patients and their families, according to Human Rights Campaign's 2024 Healthcare Equality Index.

Interfaith Health Collaborative

Interfaith Health Collaborative partners with more than 100 faith communities and faith-based organizations to provide health-focused work in their congregations and communities that improve community health and wellbeing.

- From 2022 to 2024, the collaborative worked to expand membership to diverse spiritual and faith-based organizations.
- In the Woodwinds Hospital community, membership grew by one organization over this time period.

Fairview Community Health and Wellness Hub healing events

In summer 2023, Fairview co-hosted a Heal the Healers Summit with Indigenous Roots Cultural Arts Center. The two-day summit welcomed more than 200 attendees for group learning sessions, rituals, seminars, and individual sessions with healers and professionals skilled in traditional healing modalities.

In summer 2024, we hosted a Community Health and Healing Summit. The day-long summit welcomed more than 100 attendees for group healing sessions, opportunities for networking and connection, and participation in developing a history and health equity timeline.

Native Health Equity Initiative

We reviewed and are working toward updating policies that impact patients' ability to participate in smudging and are promoting systemwide healing and spiritual policy conversations overall. We will be providing policy update training sessions at all acute care sites.

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Community Health Needs Assessment Section 501(r)(3) checklist

While we go above and beyond a checklist approach for our Community Health Needs Assessment, for readers who are looking for the areas where we speak to how we are meeting the specific requirements outlined in the Section 501(r)(3) checklist, we are identifying the pages where you can find that information below.

Documentation of CHNA written report requirements	Page number
A definition of the community and a description of how the community was determined.	9-10
A description of the process and methods used to conduct the CHNA.	10-19
Data and other information used in the assessment.	15-19
The methods of collecting and analyzing this data and information external source material in which case the hospital may simply cite the source material rather than describe the methods of collecting the data.	15-19
Any parties with whom the hospital facility collaborated or contracted for assistance in conducting the CHNA.	25
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.	13-17
In general terms, the input provided by such persons.	13-17
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).	13-17
The names of any organizations providing input and the nature and extent of the organization's input.	13-17, 50-57
The medically underserved, low-income, or minority populations being represented by organizations or individuals who provided input.	13-17, 50-57
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.	19-24, 58-60
A description of the resources potentially available to address the significant health needs identified through the CHNA.	25, 61-79
An evaluation of the impact of any actions that were taken to address the significant health needs identified in the immediately preceding CHNA.	26-41
Adoption for the hospital facility by an authorized body of the hospital facility.	25

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Appendices

Appendix A: Woodwinds Hospital community map

Appendix B: Woodwinds Hospital community zip codes, cities, and counties

Appendix C: Woodwinds Hospital community demographics

Appendix D: Woodwinds Hospital community characteristics table

Appendix E: Woodwinds Hospital community characteristics snapshot

Appendix F: Center for Community Health Equity Community engagement spectrum

Appendix G: Woodwinds Hospital Community Advisory Committee member organizations

Appendix H: Fairview Health Services System Community Advisory Council member organizations

Appendix I: CHNA Healing, connectedness, and mental health virtual conversation presenters

Appendix J: Top 10 barriers list for the priority needs

Appendix K: 2022 to 2024 Woodwinds Hospital CHNA Action Plan

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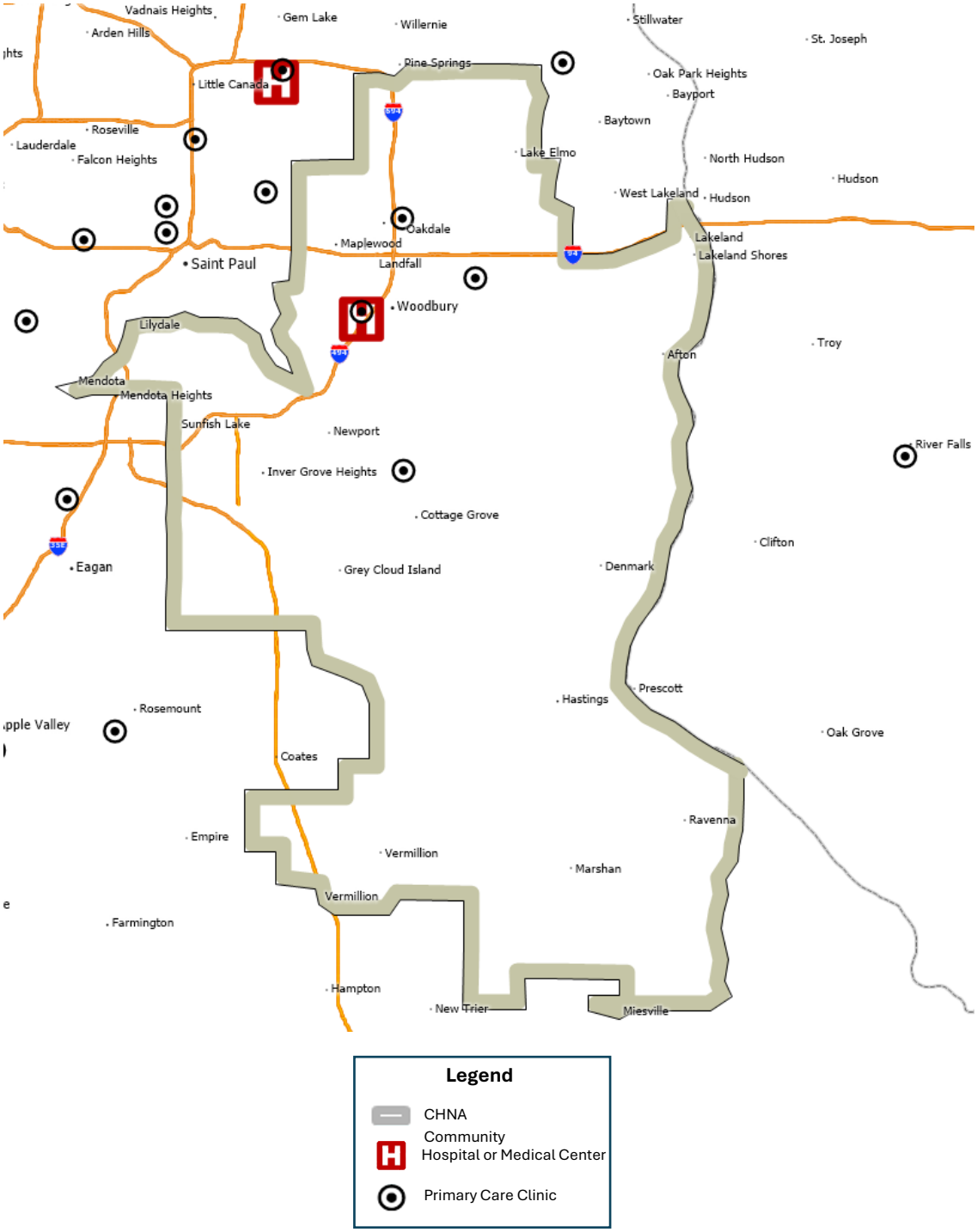
Appendix A: Woodwinds Hospital community map

2024 Fairview Community Health Needs Assessment Woodwinds Hospital community

City: Woodbury, MN

County: Washington County



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Appendix B Woodwinds Hospital community zip codes, cities, and counties

Zip	City	County
55001	Afton	Washington
55016	Cottage Grove	Washington
55033	Hastings	Dakota
55042	Lake Elmo	Washington
55043	Lakeland	Washington
55055	Newport	Washington
55071	Saint Paul Park	Washington
55075	South St. Paul	Dakota
55076	Inver Grove Heights	Dakota

Zip	City	County
55077	Inver Grove Heights	Dakota
55085	Vermillion	Dakota
55118	Lilydale	Dakota
55119	Highwood	Ramsey
55125	Woodbury	Washington
55128	Oakdale	Washington
55129	Woodbury	Washington
55150	Mendota	Dakota

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Appendix C: Woodwinds Hospital community demographics table

	Woodwinds Hospital CHNA Community				Washington County				Minnesota			
Year	**2024**		**2029**		**2024**		**2029**		**2024**		**2029**	
Total population	**337,654**		**349,635**		**288,005**		**303,867**		**5,760,091**		**5,899,521**	
By race												
White	230,934	68.4%	223,987	64.1%	219,035	76.1%	217,645	71.6%	4,372,255	75.9%	4,347,825	73.7%
Black / African American	28,425	8.4%	34,135	9.8%	17,441	6.1%	22,313	7.3%	436,744	7.6%	496,453	8.4%
American Indian / Alaskan Native	2,205	0.7%	2,431	0.7%	1,464	0.5%	1,630	0.5%	70,489	1.2%	73,764	1.3%
Asian	34,209	10.1%	40,790	11.7%	23,693	8.2%	30,325	10.0%	313,942	5.5%	339,409	5.8%
Native Hawaiian / Pacific Islander	166	0.0%	182	0.1%	100	0.0%	126	0.0%	3,354	0.1%	4,005	0.1%
Some Other Race	14,260	4.2%	16,104	4.6%	5,783	2.0%	6,925	2.3%	183,847	3.2%	207,424	3.5%
Two or More Races	27,455	8.1%	32,006	9.2%	20,489	7.1%	24,903	8.2%	379,460	6.6%	430,641	7.3%
By ethnicity												
Hispanic / Latino	31,642	9.4%	36,370	10.4%	15,777	5.5%	19,438	6.4%	384,140	6.7%	442,333	7.5%
By age												
Median age	40.4	-	41.4	-	41.3	-	42.3	-	40.3	-	41.2	-
Age 0-17	78,157	23.1%	76,636	21.9%	66,177	23.0%	65,096	21.4%	1,282,646	22.3%	1,264,010	21.4%
Age 18-44	115,165	34.1%	117,922	33.7%	93,664	32.5%	99,256	32.7%	2,023,603	35.1%	2,040,717	34.6%
Age 45-64	85,641	25.4%	85,882	24.6%	76,933	26.7%	77,732	25.6%	1,390,700	24.1%	1,382,795	23.4%
Age 65+	58,691	17.4%	69,195	19.8%	51,231	17.8%	61,783	20.3%	1,063,142	18.5%	1,211,999	20.5%

Source: Claritas, 2024

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Appendix D: Woodwinds Hospital community characteristics table

	Woodwinds Hospital CHNA Community			Washington County			Minnesota		
	Total	#	%	Total	#	%	Total	#	%
Economic									
Below 200% federal poverty level[1] (total pop)	328,862	61,566	18.7%	261,262	34,367	13.2%	5,550,433	1,257,815	22.7%
Below 50% federal poverty level[1] (total pop)	328,862	10,068	3.1%	261,262	5,456	2.1%	5,550,433	229,643	4.1%
Median household income[4]	128,467	$100,754	-	107,216	$115,318	-	2,277,321	$88,864	-
Access to care									
Uninsured[3]	329,547	14,369	4.4%	262,019	8,967	3.4%	5,614,768	258,292	4.6%
Food, housing, and transportation									
Housing cost burden (30%) (total hh)	126,393	31,314	24.8%	98,647	21,865	22.2%	2,229,100	558,132	25.0%
Households with no vehicle (total hh)	126,393	6,625	5.2%	98,647	3,828	3.9%	2,229,100	144,942	6.5%
Food insecurity rate[2] (total pop)	329,581	14,156	4.3%	261,429	9,150	3.5%	5,650,048	342,640	6.1%
Civic engagement									
Voter participation rate (total pop 18+)	231,864	201,356	86.8%	187,071	166,786	89.2%	187,071	166,786	89.2%
Education									
Population with No High School Diploma (total pop 25+)	225,590	12,916	5.7%	179,100	6,702	3.7%	3,847,501	247,610	6.4%
Employment									
Unemployed[4] (total pop 16+)	188,114	7,852	4.2%	160,829	5,111	3.2%	3,174,444	137,941	4.3%
Language and culture									
Limited English Proficiency (total pop 5+)	313,248	16,694	5.3%	249,469	7,564	3.0%	5,322,004	239,624	5.0%
Foreign-born population	332,405	33,532	10.1%	264,818	19,854	7.5%	5,670,472	479,231	8.5%
Risk Factors									
4 or more ACEs[5] (total student respondents)	-	-	-	5,844	298	5.1%	82,650	5,729	6.9%

1. Data pulled from Spark Maps, source unless indicated: American Community Survey, 2017-2021
2. Total Population: For whom poverty status is determined (50% FPL: Family of 4, less than $13,250, 200% FPL: Family of 4, less than $53,000)
3. Source: Feeding America, 2021.
4. Total population: Civilian noninstitutionalized population
5. Source: Claritas, 2024
6. ACES: Adverse Childhood Experiences, Source: Minnesota Student Survey,2022

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Appendix E: Woodwinds Hospital community: social determinants of health snapshot

2024 Woodwinds Hospital community social determinants of health snapshot

The percentage of the population with **no high school diploma** is about the same in the Woodwinds Hospital community as statewide.

6% Hospital community

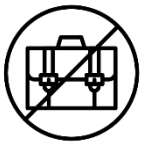
6% Minnesota

A slightly **lower** percentage of the Woodwinds Hospital community is **uninsured** compared to the state's rate.

4% Hospital community

5% Minnesota

The **unemployed** rate in the Woodwinds Hospital community is the slightly **lower** than the state's rate.



4% Hospital community

4% Minnesota

The percentage of the population who **speak a language other than English at home** is **higher** in the Woodwinds Hospital community than statewide.

16% Hospital community

12% Minnesota

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

25% Hospital community

25% Minnesota

A **slightly smaller** percentage of households in the Woodwinds Hospital community **receive SNAP benefits** than statewide.

6% Hospital community

8% Minnesota

The **median household income** in the Woodwinds Hospital community is **higher** than the state's.

$100,754
Hospital community

$88,864
Minnesota

The percentage of individuals **living in households below the federal poverty level** is lower in the Woodwinds Hospital community than statewide.

7% Hospital community

Family of four, annual income of $26,500

9% Minnesota

Sources: Claritas, 2024; American Community Survey 2017-2021

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Appendix F: CCHE community engagement spectrum

	Inform	Consult	Involve	Collaborate	Community Led
Community engagement goal	To provide the community with information to assist them in understanding the problem, alternatives, opportunities or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the community throughout a process to ensure that concerns and aspirations are consistently taken into consideration.	To partner with the community in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.	To respect community led decision making.
Promise to the community	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how community input influenced the decision.	We will work with you to ensure your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how community input influences the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decision to the maximum extent possible.	To support and/or align our actions with community led efforts.
CHNA examples	• CHNA Roadshow • CHNA Explainer Videos (5 languages)	• Surveys • Community Health and Healing Summit	• Community Advisory Groups • Patient and Family Advisory Groups	• Listening and Learning Sessions (Partner Grants)	

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Appendix G: Woodwinds Hospital Community Advisory Committee member organizations

Organization	Sector	Organization description
Woodwinds Hospital	Healthcare	Woodwinds Hospital is in Woodbury, MN and includes a full-service hospital and emergency department, doctors' offices, outpatient services, and auditorium.
Vital Aging Network	Social Services	The Vital Aging Network is a Minnesota-based nonprofit organization dedicated to empowering people over age 50 to be engaged contributors to their communities throughout their lives.
Washington County Public Health and Environment	Local Public Health	Washington County Public Health and Environment is a government organization which provides services to protect, promote and improve the Washington County community's health and environment.
Woodbury Thrives	Coalitions/Collaborators	Woodbury Thrives is a program of the Woodbury Community Foundation which works to connect the community of Woodbury to inspire health and wellbeing for all.
YMCA Woodbury	Social Services	The Woodbury Y features a fitness center, indoor pools and community programming facilities. It is a nonprofit organization that offers programs that build healthy spirit, mind and body for all.
SoWashCo CARES	Social Services	SoWashCo CARES acts as the central connection point between the schools and the community for needs and resources going both ways. They meet immediate needs in real time through social media. School staff will let us know if there is a student who is in need and coming to school without proper shoes or school supplies or whatever it is.
City of Woodbury, Community Engagement and Equity	Local Government	The City of Woodbury is committed to creating a sense of belonging and connectedness, building relationships, communicating openly, and creating opportunities for active participation with anyone who lives in, works in and visits Woodbury.

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Appendix H: Fairview Health Services System Community Advisory Council member organizations

Community Organization	Sector	Representing	Organization description
360 Communities	Social Services	Ridges LCAC	360 Communities is a non-profit organization based out of Burnsville, MN that provides holistic programming focused on violence prevention and intervention, school success, and providing community resources.
African Career Education and Resource (ACER)	Social services	Priority Population	African Career, Education, and Resource is a nonprofit organization serving African immigrants in the north and northwest suburbs through engagement, advocacy, and other programs which advance racial and economic equity.
American Indian Family Center	Social services	Priority Population	Serves approximately 700 American Indian families each year with mental health, recovery, employment, housing, family and youth services. We are a community gathering space for the American Indian community in St. Paul and the East Metro
Arrowhead Area Agency on Aging	Social services	Range LCAC	The Arrowhead Area Agency on Aging (AAAA) is the agency designated by the state to address the needs and concerns of all older adults at the regional and local levels in the Arrowhead Region of Minnesota.
Augsburg College	Higher Education	UMMC LCAC	Set in a vibrant neighborhood at the heart of the Twin Cities, Augsburg offers undergraduate and graduate degrees to students of diverse backgrounds.
Bloomington Public Health	Local Public Health	Ridges LCAC	City of Bloomington Public Health engages the community to promote, protect, and improve the health of all through services such as immunizations, family health home visits, and WIC services.
Bremer State Bank	Financial Institution	Northland LCAC	Bremer Bank offers mortgage, investment, wealth management, trust and insurance in Minnesota, North Dakota and Wisconsin.
Catholic Charities	Social services	Priority Population	With 25 programs in 21 sites across the Twin Cities, we work to prevent poverty before it starts, respond to immediate crises, and offer pathways to greater stability. Our programs for children, families and adults help nearly

Fairview

Community Organization	Sector	Representing	Organization description
			23,000 people every year — regardless of faith, background, or circumstance.
Central Minnesota Council on Aging	Social Services	Lakes LCAC	The Central Minnesota Council on Aging is a non-profit organization which works to help adults in the 14 county Central Minnesota region age successfully by building community capacity, advocating for aging issues, maximizing service effectiveness and linking people with information
Century College	Education	St. John's LCAC	Century College is a two-year community and technical college located in White Bear Lake, Minnesota.
Chisago County Public Health	Local Public Health	Lakes LCAC	Chisago County Public Health is a government organization which works to protect and enhance the health of Chisago County through data, education, evidence-based prevention strategies, partnerships and the promotion of health equity.
Dakota Electric Association	Utilities	Ridges LCAC	Dakota County Public Health is a government agency which provides programs and services that help improve the health of all Dakota County Residents.
Ebenezer Senior Living	Senior services	Priority Population	Ebenezer believes in creating environments for seniors where residents can continue to grow, develop new skills, and pursue longer, healthier, and more meaningful lives. We serve a number of different needs through our various housing and service programs.
Family Values for Life	Social services	Priority Population	Family Values for Life works with families to help them chart a path out of crisis through spiritual empowerment, mental alertness, physical fitness, and financial stability. Together we build capacities for families to network and leverage resources within their community. Strong healthy families cultivate secure communities.
Minnesota North College	Higher Education	Range and Grand Itasca LCAC	Created to make quality education accessible to all. Prepares lifelong learners and engaged citizens through inclusive, transformative experiences reflecting the character and natural environment of the region.

Fairview

Community Organization	Sector	Representing	Organization description
Hmong American Partnership	Social services	Priority Population	A nonprofit social service organization that addresses the needs of more than 25000 immigrants and refugees across the Twin Cities.
Itasca Economic Development Corporation (IEDC)	Economic development	Grand Itasca LCAC	Creates and retains quality jobs in Itasca County through education, research, and connections with businesses.
Karen Organization of MN	Social services	Priority Population	Builds on the strengths of refugee and immigrant communities and remove barriers to achieving economic, social, and cultural wellbeing. We provide multilingual services including job training, financial coaching, refugee new arrival services, MNsure navigation, elders and caregivers programming, preventive health education, youth case management, and after-school programs.
Minnesota Department of Health	Public health	Regional/Statewide	Protecting, maintaining and improving the health of all Minnesotans.
Minnesota Recovery Connection	Social services	UMMC LCAC	A grassroots recovery community organization. We offer peer-to-peer recovery support services, including telephone recovery support, recovery navigation services, and 1:1 recovery coaching for people seeking or sustaining long-term recovery from substance use disorder.
Open Path Resources	Social services	Priority Population	Open Path Resources is a Minnesota based nonprofit that serves East African immigrant families and community-led centers by building their capacity to have greater influence upon public policies that affect their current and future interests.
Project Care Free Clinic	Healthcare	Grand Itasca and Range LCAC	Project Care Free Clinic is a non-profit organization which provides basic healthcare services to people who are uninsured and underinsured in Minnesota's Iron Range communities at their clinics in Grand Rapids, Hibbing, and Virginia.
Saint Paul- Ramsey County Public Health	Local Public Health	St. John's LCAC	Saint Paul-Ramsey County Public Health is a government agency which provides a range of services to protect and

Fairview

Community Organization	Sector	Representing	Organization description
			improve the health of people and the environment in Saint Paul and all other cities in Ramsey County.
Second Harvest Heartland	Hunger relief	UMMC LCAC	One of the nation's largest food banks, distributing more than 100 million pounds of food to community food shelves, meal distribution sites, and emergency grocery pop-ups across 57 Minnesota and Western Wisconsin counties
Sherburne County Health and Human Services	Local Public Health	Northland LCAC	Sherburne County Health and Human Services is a government agency which works to promote the health, safety, wellbeing, and self-sufficiency of Sherburne County residents.
SoWashCo CARES	Social Services	Woodwinds LCAC	SoWashCo CARES acts as the central connection point between the schools and the community for needs and resources going both ways. They meet immediate needs in real time through social media. School staff will let us know if there is a student who is in need and coming to school without proper shoes or school supplies or whatever it is.
StairStep Foundation	Social services	Priority population	Stairstep's mission is to reignite and sustain a spirit of community among African Americans.
Washington County Public Health and Environment	Local Public Health	Woodwinds LCAC	Washington County Public Health and Environment is a government organization which provides services to protect, promote and improve the Washington County community's health and environment.
World Youth Connect	Youth development	Priority Population	A youth led organization based in Saint Paul that gives young people the opportunity to take on leadership roles and create change in the community. World Youth Connect builds communities across cultures and beyond borders. By creating and encouraging civic engagement opportunities, we help young people gain the skills and experience they need to be successful.
YMCA of the North	Social services	Regional/Statewide	By nurturing the potential of every child and teen, improving health and well-being, and supporting and serving our neighbors, the Y ensures that everyone has the opportunity to become healthier, more confident, connected and secure.

Fairview

Community Organization	Sector	Representing	Organization description
Youthprise	Youth development	Priority Population	Leverages its financial, political, and relational capital and expertise in youth development to increase funding for Minnesota youth programming and promote innovation in how our communities work with youth. As a philanthropic intermediary, Youthprise is designed to invest more than just money. Youthprise partners with youth and youth service organizations to share knowledge, capture lessons learned, and spread best practices to advance outcomes for young people throughout Minnesota.

Fairview organizational roles represented
Chief of Primary Care / Assoc Chief Medical Officer
Vice President & Treasurer
Chief Operating Officer, Acute Care community Hospitals and Periop Domain
Chief Quality Officer
Family Medicine Physician, Roselawn Clinic
System Director Equity Initiatives
Fairview Foundation
Executive Vice President & Chief Public Affairs Officer
Lead Chief Nursing Officer - Fairview Nursing Services; Vice President/Chief Nursing Officer, University of Minnesota Medical Center and Masonic Children's Hospital
Director, Tax
Vice President, Community Advancement
Vice President, People Experience and Inclusion
Vice President, Clinical Integration

Fairview

Fairview organizational roles represented
System Director, Customer Experience
System Executive Director, Community Health Equity and Engagement
Regional Director Foundation, Community Relations, Interfaith Health

Fairview

Appendix I: Healing, connectedness, and mental health virtual conversation presentation partners

Virtual Conversation	Partner	Presentation topic
Healing, connectedness, and mental health: Youth	Annex Teen clinic	Programs & Services & How We Do It!
Healing, connectedness, and mental health: Youth	University of Minnesota, School of Nursing	Protecting and Promoting Adolescent Mental Health
Healing, connectedness, and mental health: Older Adults	Ebenezer	Older adults, spiritualty, and mental health
Healing, connectedness, and mental health: Older Adults	University of Minnesota's Earl E. Bakken Center for Spirituality & Healing	Cultivating awareness and focusing on a virtuous mind during traumatic experiences (Ethnographic research, 2016-2017)
Native approaches to healing, connectedness, and mental health	Minneapolis Health Department	Community conversation – American Indian approaches to healing, connectedness, and mental health
Native approaches to healing, connectedness, and mental health	University of Minnesota Internal Medicine	Connection for Indigenous health

Fairview

Appendix J: Top ten barriers for priority needs

Top 10 barriers to navigate and access care and resources

Health insurance and cost of care

- Lack of insurance.
- Lack of cost transparency.
- Cost of medications, mental health services, etc.
- Lack of awareness of affordable insurance plans.

System complexity and need for care coordination

- Lack of coordination with external agencies.
- Limited follow-up after care or hospitalization.

Transportation

- Public transport doesn't connect with services.
- Cost of parking and gas.
- Lack of access to a vehicle.
- Reliability and availability of public transit.
- Unable to drive.

Trust

- Lack of trust in providers and healthcare system.
- Patient feels their symptoms are not being taken seriously.
- Fear of experiencing racism.
- Fear of being deported.
- Perception of system putting profits before patients.

Inaccessible care

- Appointment barriers.
- Wait times and difficulty scheduling.
- Excessive paperwork.
- Long wait time at emergency room.
- Inability to take time off work for illness or appointments.

Specialty care

- Access issues for eye care.
- Insurance doesn't cover dental care.
- Foot care.
- Pain management barriers and needs.
- Limited specialty care

Population-specific barriers (Youth, older adults, new immigrants, LGBTQIA2S+, veterans, etc.)

- Respect for patient's gender identity.
- Lack of post-discharge resources for veterans.

Language and interpretation

- Limited/ineffective translation services.
- Lack of translation services in multiple languages.

Health education

- Lack of education on nutrition, diabetes, first aid, how to navigate insurance, etc.
- Need for medication education and management.

Cultural competency & responsiveness

- Need for cultural advocates and traditional healers.
- Availability/respect of use of alternative medicine.
- Lack of culturally competent care.

Fairview

Top 10 barriers to healing, connectedness, and mental health

Connection

- Loneliness/social isolation.
- Lack of safe spaces for Native Americans to encourage them to be proud of their culture and heritage.
- Need for safe spaces to come together.

Connect with healthcare

- Lack of continuity of care.
- Disconnection between mental health and primary care.
- Insufficient follow-up after mental health inpatient discharge.

Compounding conditions

- Tie between mental health and substance use.
- Self-esteem and its effect on cycle of poverty.
- Stigma.
- Mental health is a barrier to physical health.

Mental health providers

- Psychiatrist shortage.
- Limited availability of mental health providers.
- Limited diversity of providers/limited culturally representative mental health providers.

Mental health services

- Availability.
- Awareness of how to access mental health services.
- High cost.
- Lack of mental health programming.

Community social conditions

- Community divide.
- Community not welcoming.
- Lack of community spaces and events.

Culturally appropriate healing

- Historical trauma.
- Lack of culturally competent mental health care.
- Limited spiritual and holistic health resources.

Substance use services

- Lack of addiction programming.
- Lack of access to help or treatment for substance use.
- Need more chemical health services.

Knowledge and Education

- Lack of coping skills.
- Lack of knowledge of mental health medication side effects.
- Need more community education on drug tendencies.

Population-specific barriers & needs

(Youth, older adults, new immigrants, LGBTQIA2S+, veterans, etc.)

- Lack of community activities for older adults.
- Lack of community programming for youth and families.
- Lack of post-discharge follow-up with veterans.

Fairview

Top 10 barriers to structural racism and barriers to equity

Financial

- Economic inequality.
- Poverty (generational, fixed income, non-livable wages, cycle of poverty).
- Stress of poverty.
- Children living in poverty.
- Income inequities.

Community resources

- Lack of youth resources in rural and suburban areas.
- Eligibility criteria (age and geographic limitations).
- Lack of culturally relevant resources.

Stigma

- Youth and students worry about privacy; they prefer discreet distribution of food.
- Stigma specifically connected to federal nutrition programs.

Transportation

- Lack of transportation for clients (access to bus lines, lack of vehicle, etc.).
- Lack of transportation support for volunteers.
- Home delivery services are distance-constrained.
- Some older adults cannot drive.

Housing

- Accessing safe, stable, and affordable housing.
- Long wait lists for housing for seniors.
- Lack of safe and stable housing for children.
- Lack of transitional housing or care resources.
- Limited support for unhoused individuals.

Trust

- Distrust of government.
- Fear of being undocumented.
- Distrust in systems.
- Clients are hesitant to provide identifying information.

Discrimination

- Islamophobia.
- Racism.
- Lack of inclusive spaces.
- Ableism.

Access to Food

- Limited food shelves hours.
- Stigma of being food insecure.
- Lack of access to cooking spaces for homeless individuals.
- Access to affordable, culturally relevant, healthy food is inconsistent.

Historical trauma

- Generational poverty
- Historical distrust in systems.
- Lack of culturally relevant and trauma-informed services.
- Racism.

Marginalization/ unheard voices

- Lack of safe spaces for BIPOC communities.
- Invisibility of minoritized racial and ethnic populations.
- Invisibility of LGBTQIA2S+ community.

Appendix K: 2022-2024 Woodwinds Hospital CHNA Action Plan

Policy, System, and Environmental Change Initiatives

Fairview's mission and vision extend beyond traditional healthcare settings, driving a healthier future for the communities we serve. Policy, System, and Environmental Change Initiatives (PSE) initiatives are implemented across the system (hospitals, clinics, etc.) to create sustainable and lasting change to advance health equity and community wellbeing.

 **=** Priority need being addressed

 **=** Both priority populations are being served

Initiative	Objectives
Healing Opportunity People Equity (H.O.P.E.) Commission  ***Addressing Structural Racism and Barriers to Equity***  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 work of the HOPE Commission has been to identify foundational and transformational opportunities for our organizations to advance health equity (HE) and promote diversity, equity, and inclusion (DEI). This work will be operationalized through our critical roles as an **employer, healthcare provider, academic institution, and corporate citizen** and require broad engagement not only from leadership but also from employees throughout the organization.	**Employers:** • All three M Health Fairview employers will review job descriptions, qualifications, and postings for bias and inclusivity. • All three M Health Fairview employers will have completed pay equity audits and address any needed changes. • All three M Health Fairview employers will continue to set goals and strategies to close gaps in areas of underrepresentation. **Healthcare Provider:** • We will focus on specific equity issues within colon cancer screening and pediatric immunizations. **Academics:** • Complete three panel discussions with broad and diverse expert and stakeholder participation to outline best practices in using race/ethnicity in research and guide the next steps. • Establish a formal, long-term process for the witness signature for non-English speaking research consent conversations. **Corporate Citizen:**

Initiative	Objectives
The framework for the HOPE Commission's efforts seeks to engage the enterprise's core strengths. This two-fold approach centers and elevates the perspectives and insights of those who are often marginalized and most impacted by inequity issues and applies the enterprise's platform and resources to demonstrate commitment and action toward achieving transformational, sustainable change. **Anchor Institution** Through the work of the HOPE Commission, Fairview is committed to impacting the socioeconomic factors that contribute to the overall wellbeing of our communities. One way is leveraging Fairview's everyday business practices to create economic impacts. As a health system and an anchor institution, we employ people, spend money on goods and services, invest locally and regionally, and engage with our communities. Contact: HopeCommission@email.fairview.org	• We will co-develop a Community Health Needs Assessment implementation plan with our Community Advisory Committees to address prioritized community needs, including key community health equity impact metrics. • Minnesota Immunization Networking Initiative (MINI) will provide over 5,000 free flu immunizations in the community and will continue to contract with state and local public health to offer low-barrier COVID-19 vaccinations. • As Board seats open, we will continue to seek racial, ethnic, gender, and LGBTQIA+ diversity. • Identify sourcing opportunities that will include Minority and Women-owned Business Enterprises and local suppliers and service providers.
M Health Fairview Center for Community Health Equity: ***Addressing Structural Racism and Barriers to Equity*** **Purpose.** The M Health Fairview Center for Community Health Equity (center) aims to advance health equity and reduce racial and other disparities in community health outcomes in the State of Minnesota through our role as a health system. **Approach.** The center convenes stakeholders and catalyzes action to address the social determinants of health, particularly for racial and ethnic groups experiencing health disparities. The center is the catalyst of the health system's extensive region-wide work to support health equity and engagement in the communities it serves. It aims to expand and formalize the system's efforts to innovate and work with the community to reduce racial and other disparities in community health outcomes. Together with the community, we can apply	The center aims to advance racial and health equity and improve community health outcomes in Minnesota through our role as a health system. To fulfill this purpose, we developed our 10-year vision through listening and engaging with the community. **Our 2032 vision:** Increased community health equity Our strategies: **Community Incubator.** Addressing the social determinants of health as well as individual and social factors influencing patient health through the creation and expansion of programs; initiatives; research; and policy, system, and environmental work. **Engagement Infrastructure.** Strengthening an engagement infrastructure that builds trusting partnerships and enables community voices to inform and influence both inside and outside of our health system.

Initiative	Objectives
equity-centered, culturally responsive approaches as we identify challenges and opportunities, create, or expand programs and partnerships, and then scale or deepen learnings and successes across our system and the communities we serve. Contact: Diane Tran Diane.Tran@Fairview.org	**Inclusive Institution.** Transforming internal structures to create an antiracist and inclusive environment and to build community health by building wealth, knowledge, and capacity.
Fairview Community Health and Wellness Hub  ***Addressing Structural Racism and Barriers to Equity***  The M Health Fairview Center for Community Health Equity offers free community meeting spaces aligned with social determinants of health to promote wellbeing. Embracing its role as an anchor institution, the center provides these spaces at no cost to community partners, fostering trust and sharing a valuable resource. This initiative aims to enhance community access to health and wellness resources, strengthening public offerings and emphasizing collaboration for improved overall community health. The M Health Fairview Center for Community Health Equity is located within the Fairview Community Health and Wellness Hub, which is home to the 24-bed Bethesda Long-Term Acute Care Facility (LTAC), serving patients recovering from serious injury or illness, and several hub partner organizations who collaborate to bring place-based health and wellness services. Contact: Christina McCoy Christina.McCoy@fairview.org	Fairview Community Health and Wellness Hub priorities: • Providing care in trusted spaces by bringing our clinical services into neighborhoods to expand access. • Investing in our neighborhoods through advancing our anchor mission's local initiatives – hiring, purchasing, investing, and leading and serving. • Addressing social risk factors through food access and community education and outreach.
Food is Medicine  ***Addressing structural racism and barriers to equity***  Using the healing power of food to nourish our patients, enrich our communities, and transform our systems. Contact: communityengagement@fairview.org	"Food is Medicine" (FiM) is a Center for Community Health Equity initiative to address food insecurity and hunger for Fairview patients and community members. • Nourish our patients: Advance food security to reduce health disparities and diet-related health conditions. • Enrich our communities: Cultivate trusting and engaged partnerships to build and share resources, assets, and capacity. • Transform our systems: Nurture just and equitable food systems to ensure health equity.

Initiative	Objectives
Housing is Health  ***Addressing Structural Racism and Barriers to Equity***  Using the protective power of housing to support patient health and build thriving communities. Contact: communityengagement@fairview.org	Our Housing is Health approach: • Develop an investment strategy through Greater Minnesota Housing Fund's Minnesota Housing & Health Equity Fellowship that will increase the availability of affordable housing units. • Respond to immediate patient needs through programming and resource connection. This includes the Our Savior's Community Services respite program which provides shelter for patients being discharged from the Emergency Department (ED). • Develop programmatic and policy responses that focus on supporting those experiencing housing instability. Early initiatives will focus on our employees as well as our neighbors. • Partner with local and national housing organizations to co-develop solutions and drive collective impact. Lend our voice and expertise as a health system to advocate for policies that increase accessibility to safe, stable, appealing housing.
Connection is Cure  ***Healing, connectedness, and mental health***  Building trust through social connections, centering linguistic and cultural diversity, and bridging silos across our hospital system and communities to transform medical practice. Contact: communityengagement@fairview.org	• Deepen our presence and engagement in our local communities as a health care provider and anchor institution. • Provide ongoing training and development as well as opportunities for civic engagement to advance civic health. • Develop and engage a system-wide Roster of Health Equity Champions • Building trust by centering cultural and linguistic diversity. • Advancing and amplifying community and cultural efforts. • Providing opportunities for connection and learning among community, patient, and employees. • Driving more culturally competent and responsive medical care.
Transforming our organization  ***Addressing structural racism and barriers to equity*** 	Build lasting infrastructure and support for the following within and across the entire health system. • Culturally appropriate patient care • Equitable and inclusive organizational policies • Collection and use of equity data to drive action

Initiative	Objectives
Internally facing systemwide efforts to embed equity within core functions. Contact: Maria Regan Gonzalez Maria.ReganGonzalez@fairview.org	• Community collaboration for solutions • Systemic and shared accountability for equity • Diverse representation in leadership & guidance

Programs, Collaboratives and Local Partnerships

Fairview implements programming, activities and initiatives applying an equity-centered, culturally responsive approaches as we identify challenges and opportunities, create or expand programs and partnerships, and then scale or deepen learning and successes across out system and the communities we serve.

 **=** Priority need being addressed

 **=** Community Benefit program

 **=** Both priority populations are being served

Program	Partners
Clinical Food Programs  ***Addressing structural racism and barriers to equity***  A set of programs designed to increase culturally appropriate food access, food security, healthy eating, food as medicine, community connectedness, local food system support, and local procurement. • Fresh food prescription program: A fresh food box program intended to decrease food insecurity by distributing fresh, locally sourced foods to populations of color and those experiencing poverty who are food insecure, have diet-related chronic disease, and would benefit from increased access to nutritious food. Boxes contain fresh produce, proteins, and pantry staples with food skills and nutrition information. Home delivery available. • MarketRx: Fairview's MarketRx program provides patients with $80 per month to purchase groceries from our partner, The Food Group, at either their Twin Cities Mobile Market or Fare for All program. The program runs year-round and offers rolling enrollment. • Shelf stable, on-site food bags: contain shelf-stable, staple items and available at hospitals and clinics for immediate, low barrier distribution. • Food Resource Packets – contain information about local food resources, along with a grocery store gift card and connection to Fairview's MarketRx program.	East Side Table Every Meal Street Fleet The Food Group – Twin Cities Mobile Market, Fare for All The Hmong American Farmers Association (HAFA) The Sanneh Foundation Women's Environmental Institute (WEI) Naima's Farm LLC Appetite For Change The Good Acre

Program	Partners
• Food Resource Navigator: pilot program offering individual support to patients who screen positive for food insecurity and have a corresponding medical condition that would improve with increased access to healthy food. Supports connection to community food programs and enrollment in appropriate Fairview clinical food program. Contact: Terese Hill Terese.Hill@fairview.org	
Community Clinical Programs  ***Navigating and accessing care and resources***  The community clinical care team, part of the Community Advancement Department, oversees multiple community-based clinical programs and initiatives. Programs include the community oral health outreach program, the Minnesota Immunization Networking Initiative (MINI) clinics, cardiovascular health education, and an opioid overdose prevention program. Collectively, these programs address the healthcare needs of uninsured and underserved populations across the Twin Cities and surrounding communities. The clinics ensure a culturally and linguistically appropriate experience at no cost to improve equitable access to preventive oral health care and other services across various populations. Operating alongside the MINI clinics, the community oral health outreach program started in 2016 and offers free preventive fluoride varnish applications, oral health education, and referral resources to individuals of all ages. Since then, over 3,900 free fluoride varnish applications have been provided to community members of all ages. Participants also receive essential dental hygiene products such as toothbrushes, toothpaste, and dental floss. In 2022, the community clinical care team launched a program to strengthen and increase knowledge regarding the importance of blood pressure monitoring and its relation to cardiovascular health. The program provides free readings and connects community members to tools and resources to promote the prevention of hypertension-related chronic conditions. Contact: Mohammed Selim (Oral Health) Mohammed.Selim@fairview.org	African Immigrants Community Services Brian Coyle Center CAPI USA Comunidades Latinas Unidas en Servicio Comunidades Organizando el Poder y la Acción Latina Fairview Foundation Islamic Association of North America, Inc. Karen Organization of Minnesota MORE Community Services Pillsbury United Communities Saint Catherine University Department of Nursing St. Mary's Health Clinics Stairstep Foundation Tserha Aryam Kidist Selassie Church University of Minnesota School of Dentistry Vietnamese Social Services . . . and many more community and faith-based organizations

Program	Partners
Darcey Mccampbell (Blood Pressure) Darcey.Mccampbell@fairview.org	
Faith Community Nursing  ***Healing, connectedness, and mental health***  Programs and services available to Faith Community Nurses to hold in their congregation, $750 mini-grants, health education materials and resources, and networking opportunities. Contact: Ann Ellison Ann.Ellison@fairview.org	Faith Community Nurse Network
Minnesota Immunization Network Initiative (MINI)  ***Navigating and accessing care and resources***  The Minnesota Immunization Networking Initiative (MINI) program is a multi-cultural collaborative established and led by Fairview and supported by nearly 200 community partners through its different programs. MINI provides free vaccines to uninsured, underserved populations in community settings throughout Minneapolis and St. Paul, Minnesota, and surrounding communities. Community Advancement's community clinical care team leads the MINI program and oversees other community-based clinical programs and initiatives, such as the community oral health outreach program, cardiovascular health education, and an opioid overdose prevention program. The MINI program started in 2006 to reduce barriers to seasonal influenza vaccinations for communities facing health disparities. Since its inception, MINI has distributed over 125,000 free influenza vaccinations to people six months and older. Using a similar approach to the influenza clinics, MINI has collaborated with over 50 local community partners, the Minnesota Department of Health, Saint Paul – Ramsey County Public	African Immigrants Community Services Brian Coyle Center CAPI USA Community Action Partnership of Hennepin County Comunidades Latinas Unidas en Servicio Comunidades Organizando el Poder y la Acción Latina Fairview Foundation Hmong American Partnership Hmong Health Care Professionals Coalition Homeland Health Specialists, Inc. Interfaith Action Islamic Association of North America, Inc. Karen Organization of Minnesota Minneapolis Health Department Minneapolis Mpox Taskforce

Program	Partners
Health, Minneapolis Health Department, and many others, to ensure that underserved populations have equal access to the COVID-19 vaccine since January 2021. Between January 2021 and December 2023, MINI provided more than 62,000 COVID-19 vaccinations at over 1,420 events. MINI also expanded vaccines offered in response to a national public health emergency and partnered with multiple organizations to provide 1,013 mpox vaccines to individuals with the highest infection risk at 60 mobile vaccination events. Contact: Ingrid Johansen Ingrid.Johansen@fairview.org	Minneapolis Public Housing Authority Minnesota Assistance Council for Veterans Minnesota Department of Health Minnesota Vaccines for Children Program & Uninsured and Underinsured Adult Vaccine Program MORE Community Services Pillsbury United Communities Portico Healthnet Saint Catherine University Department of Nursing Saint Paul – Ramsey County Public Health St. Mary's Health Clinics Stairstep Foundation Tserha Aryam Kidist Selassie Church Vietnamese Social Services . . . and many more community and faith-based organizations
Children's Literacy **Reach Out and Read** (ROR) Reach Out and Read is a national program to promote early childhood literacy and has become the standard of care in pediatric primary care. Reach Out and Read is implemented at every routine pediatric checkup, from newborn through five years, with Each child receiving a book for their personal at home library. Reach Out and Read books are a tool providers can use to assess important developmental milestones. Books are currently available in English and 14 bilingual languages. **NICU Reach Out and Read (NICU)** Reach Out and Read is also available in the Neonatal Intensive Care Unit (NICU) at M Health Fairview Masonic Children's Hospital.	National Reach Out and Read Minnesota Reach Out and Read

Program	Partners
Take 15 Minute to Read (15 min) Take 15 books are new books available for children ages 0-18. They are for any child to take home. They are available for use in lobbies waiting areas, lab, patient rooms, and Specialty Clinics, urgent care and special events. **One World, Many Stories (OWMS)** This program was developed with the mission to promote diversity and inclusion by distributing diverse children's books to patients during their visit to the Radiology Department at the hospital. Contact: Julie Nalezny Julie.Nalezny@fairview.org	

Collaboratives:

To partner with the community in different aspects of the decision-making process, including the development of alternatives and the identification and delivery of the solution. When describing working with the community in this way, it is sometimes called co-design, co-build, or co-implement.

Collaboratives	Partners
Interfaith Health Collaborative ***Healing, connectedness, and mental health*** Interfaith Health Collaborative partners with more than 100 faith communities and faith-based organizations to provide health-focused work in their congregations and communities that improve community health and wellbeing. Contact: Ann Ellison Ann.Ellison@fairview.org	Jewish Family and Children's Service of Minneapolis Jewish Family Service of St Paul Mental Health Connect Normandale Center for Healing and Wholeness St Mary's Health Clinics-University of Minnesota Medical Center Stairstep Foundation TRUST, Inc 102 faith communities and Faith Based Organizations
Metro Food Justice Network ***Addressing structural racism and barriers to equity***	Backbone Organizations • Appetite for Change • The Good Acre • Hunger Solutions • Pillsbury United

Collaboratives	Partners
Food justice is crucial to our communities. Many collective efforts to improve our food system in the Twin Cities Metro Area have been successful in the past, but more work is needed. The table is set for a different kind of collective action. The Metro Food Justice Network brings together many organizations, community members, and institutions who are ready to work together more collaboratively and equitably. We need all of us to join together and do what none of us can do alone. Our food system and future generations' wellbeing require that we work together. Contact: Terese Hill Terese.Hill@fairview.org	Food is Medicine Action Team • Transforming the Table • Luv Micros • Minnesota Community Cares • Scott County • St. Paul Public Schools • St. Catherine's University • Healthy Roots Institute • Holistic Health Farms • Community member consultant
Center for Community Health ***Navigating and accessing care and resources*** The Center for Community Health (CCH) is a collaborative with health plans, hospitals, and public health agencies in the seven-county metropolitan area in Minnesota. The CCH mission is that the collaborative of health plans, hospitals, and public health agencies will share data and processes to identify health needs and implement innovative approaches to advance community health, well-being, and equity. Contact: Jenny Morman, Jennifer.Morman@fairview.org	Public Health Agencies • Anoka County Community Health & Environmental Services • Carver County Public Health & Environment • City of Bloomington, Division of Health • City of Edina Community Health • City of Richfield Public Safety • Dakota County Public Health • Hennepin County Public Health • Minneapolis Health Department • St. Paul-Ramsey County Public Health • Scott County Public Health • Washington County Public Health & Environment Non-Profit Health Plans • Blue Cross Blue Shield/Blue Plus of Minnesota • HealthPartners • Medica • Hennepin Health • PreferredOne • UCare • Minnesota Council of Health Plans Not-For-Profit Hospitals/Health Systems • Allina Health • Children's Hospitals and Clinics, Ridgeview Medical Center • M Health Fairview

Collaboratives	Partners
	• HealthPartners Family of Care: Methodist, Regions Hospital, Lakeview Hospital, HealthPartners & Park Nicollet Medical Clinics • Hennepin Health Care • Maple Grove Hospital • North Memorial Medical Center • Minnesota Hospital Association

Local Partnerships

Fairview partners with community members to support activities related to community health and wellbeing. We invest and engage in mutual projects and initiatives by sharing resources and actively exchanging information.

Local partnerships activities	Partners
Aging Well Programming ***Healing, connectedness, and mental health*** Aging Well programming is dedicated to fostering healthy aging in Minnesota communities, focusing on underserved groups. The initiative offers a range of services and supports, promoting aging in place, safety, and end-of-life planning. Operating in trusted community settings, the organization aims to build a positive reputation. By delivering classes, community education, and other resources, it empowers aging Minnesotans to proactively manage their health. This approach reduces reliance on emergency services, fostering independence and overall well-being. Through a continuum of aging support, Aging Well Programming strives to make better health accessible to all community members. Contact: Christina McCoy Christina.McCoy@fairview.org	Vital Aging Network Ramsey and Washington County Wellness 50+ Groups Age-Friendly and Equity Alliance for Ramsey County
Dementia-Friendly Woodbury Advisory Group ***Navigating and accessing care and resources***	Woodbury Thrives The Woodbury Community Foundation Family Means

Local partnerships activities	Partners
Our health system actively contributes to the Dementia-Friendly Woodbury Initiative, in collaboration with Woodbury Thrives and The Woodbury Community Foundation. Dedicated to enhancing the lives of individuals and caregivers dealing with memory loss, our health system offers vital connections to healthcare resources, specialized expertise, and technical support. We play a pivotal role as an engaged member of the Dementia-Friendly Woodbury Advisory Committee, contributing valuable insights and actively participating in the initiative's mission to create a more supportive environment for those affected by dementia. Contact: Christina McCoy Christina.McCoy@fairview.org	
Healthcare education on "Inside Health Care" ***Navigating and accessing care and resources*** Fairview partners with the leadership of Woodbury Thrives and The Woodbury Community Foundation to bring Fairview providers and community-based programs staff to the "Inside Health Care" talk show. This show has in-depth interviews with doctors, healthcare professionals, and the patients they care for. Some of the topics are disease prevention, chronic condition management, colon cancer, and emerging health needs and concerns. Contact: Christina McCoy Christina.McCoy@fairview.org	Woodbury Thrives Woodbury Community Foundation

Fairview

Education, Training, and Outreach Events

Fairview is committed to providing education to improve the health and wellbeing of our patients and community members.

= Priority need being addressed

= Community Benefit program

Education, Training, and Outreach Events	Partners
Bike Helmet Events ***Navigating and accessing care and resources*** Fairview participates in community events to provide education on traumatic brain injury prevention and free bike helmets to kids. During the events, children learn bike safety tips and receive a free bike helmet and fitting. Contact: Francisco Ramirez Fancisco.Ramirez@fairview.org	Local partners are to be determined for each event. Internal departments at Fairview (Trauma Department and Emergency Medical Services). Woodbury Thrives White Bear Lake P.D. Lakes Area P.D. Hope Church Forest Lake P.D. Mission Outpost Rice St./Larpenteur Alliance Health Commons Riverside Princeton Schools Wyoming P.D.

Education, Training, and Outreach Events	Partners
Community Education Forums  ***Navigating and accessing care and resources***  Virtual Zoom webinars to provide education and have a community conversation about current and relevant health topics. Contact: Emily Carpenter Emily.Carpenter@fairview.org Christina McCoy Christina.McCoy@fairview.org Andrea Martinez Andrea.Martinez@fairview.org	Internal departments at Fairview
Feeding Hope  ***Healing, Connectedness, and Mental Health***  Virtual 1-hour learning sessions focused on positive, hopeful topics that support wellbeing in the general community. Contact: Ann Ellison Ann.Ellison@fairview.org	Ebenezer Accent Care Fairview
Health Across the Lifespan  ***Navigating and accessing care and resources***  A nine-part virtual series that addresses specific health and wellbeing issues experienced during the three stages of life (early years, early adult, and older adult), such as: cancer, grief and loss, suicide prevention, etc.)	External and internal partners are speakers.

Education, Training, and Outreach Events	Partners
Contact: Kate Taylor Kathryn.Taylor@Fairview.org	
Living Well with Chronic Conditions  ***Navigating and accessing care and resources***  In partnership with Trellis, this evidence-based 6-part series supports those with chronic conditions. Two peer leaders take the participants through a prescribed curriculum. Contact: Kate Taylor Kathryn.Taylor@Fairview.org	Trellis Local partners COPAL
Mental Health First Aid  ***Healing, Connectedness, and Mental Health***  Mental Health First Aid is an internationally recognized evidence-based program that was created and is managed by the National Council for Mental Wellbeing. It is an eight-hour class that introduces participants to risk factors and warning signs of mental illnesses, builds an understanding of their impact, and overviews common supports. Contact: Kate Taylor Kathryn.Taylor@Fairview.org	We will be pausing this program in 2024
Psychological First Aid  ***Healing, Connectedness, and Mental Health*** 	Conservation Corps MN and Iowa

Education, Training, and Outreach Events	Partners
Psychological First Aid (PFA) is an evidence-informed training for all community members and professionals. Trainees will learn how to support healthy recovery in individuals following a traumatic event, public health emergency, natural disaster, or personal crisis. The curriculum integrates public health, community health, and individual psychology by drawing upon skills the trainees probably already have. PFA is a two-hour training. Contact: Kate Taylor Kathryn.Taylor@Fairview.org	
A Creative Look at Self-Care  ***Healing, Connectedness, and Mental Health***  This program promotes resiliency skills, offers wellness-care tools for mind, body, and spirit, and encourages the development of a personal plan for self-care. Contact: Kate Taylor Kathryn.Taylor@Fairview.org	Soulnami
Mental Health Forum  ***Healing, Connectedness, and Mental Health***  Partnering with a community organization, this forum will focus on a cultural understanding of mental wellbeing and mental health issues. Contact: Kate Taylor Kathryn.Taylor@Fairview.org	Faith Community Nurse Network

Community Engagement

Community Engagement: It is a continuous process of developing relationships with community members and partners to identify action steps to improve health equity and promote wellbeing. This intentional practice includes diverse community perspectives, addresses power dynamics, fosters long-term trusting relationships, and leads to action. Our community engagement approaches span across all our service areas and focus on all three priority areas and the two priority populations and are also responsive to emerging needs.

Approach	Objectives
Community Listening and Learning  Contact: communityengagement@fairview.org	Ensure program alignment and the implementation of equitable practices to ensure the involvement of key stakeholders. To develop a model that incubates community-based solutions based on the local context and on each communities' characteristics and needs. To strengthen the inclusion of underrepresented members in the Community Health Needs Assessment process. To strengthen our relationships and communication strategies with community partners.
Sponsorships  Contact: Emily Carpenter Emily.Carpenter@fairview.org	All sponsorships to be in alignment with Fairview's commitment to advancing equity and Fairview's focus on diversity, equity, and inclusion.
Memberships  Contact: Emily Carpenter Emily.Carpenter@fairview.org	• Fairview staff are active and engaged in national, regional, state and/or local organizations. • Support partner organizations by providing time and expertise. • Work collaboratively to build community capacity through those investments.

Approach	Objectives
Employee Volunteerism Program Contact: Emily Carpenter Emily.Carpenter@fairview.org	We aim to deliver high-quality opportunities for employee volunteerism and engagement within a healthy and positive work environment that includes high morale, equitable policies and processes, and the promotion of wellness. • Focus on the development of strengths and assets that are inherent in our employees. • Being culturally responsive and relevant, with services, programs, and opportunities recognizing and valuing cultural identity. communities we serve.
Community Health Needs Assessment Under the 2010 Affordable Care Act all nonprofit hospitals are required to conduct triennial community health needs assessments with community involvement to prioritize community informed priority needs and develop implementation strategies and action plans to address those needs. Assessing and responding to community and patient needs is an important component of population health and integral part of Fairview. Fairview has conducted triennial assessments to inform our community outreach since the mid-1990s. During our last CHNA Fairview made a bold decision to commit to a 10-year vision of increased community health equity and supporting strategies. You can find the 2021 community health needs assessment reports which outline the prioritized needs, along with the CHNA Implementation strategy reports and the details of our commitment to forwarding community health equity found on our website. Contact: Jennifer Morman Jennifer.Morman@Fairview.org	Conduct a community health needs assessment process centered on deep, authentic community and organizational engagement which builds trust and capacity while increasing operational alignments and strengthening mechanisms for community feedback. Reach a large set of diverse stakeholders through CHNA engagement events and activities that inform needs and tactics. Stakeholders actively participate and provide guidance and partner with Fairview on assessment activities. Complete a CHNA report for each hospital that is approved by the community advisory council and board adopted.

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Citations

[i] Native Governance Center. Beyond Land Acknowledgement: A Guide. Published September 21, 2021. Retrieved from https://nativegov.org/news/beyond-land-acknowledgment-guide/. Accessed August 20, 2024.
[ii] Minnesota Treaty Interactive. The U.S.-Dakota War of 1862. Retrieved from http://usdakotawar.org. Accessed October 16, 2024.
[iii] Office of the Minnesota Secretary of State. Tribal Government. Retrieved from https://www.sos.state.mn.us/about-minnesota/minnesota-government/tribal-government/. Accessed August 20, 2024.
[iv] Spark Maps' data sources include 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.
[v] International Association for Public Participation. Retrieved from https://www.iap2.org/mpage/Home. Accessed July 2, 2024.
[vi] Including, but not limited to, doctors, nurses, nurse practitioners, care coordinators, social workers, dietitians, behavioral health providers, peer support specialists, and emergency medical services team members.