

# 2018 Community Health Needs Assessment & 2019–2021 Implementation Strategy



St. John's Hospital



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# 2018 Community Health Needs Assessment Report

St. John's Hospital



## Executive summary

Assessing the health needs of our community is critically important to carrying out St. John's Hospital mission: driven to heal, discover, and educate for longer, healthier lives. In order to achieve optimal health for our community, we must reach beyond the walls of our hospitals and clinics to understand the health of our community where they live.

St. John's has conducted a Community Health Needs Assessment (CHNA), every three years since 1998, to systematically identify, analyze, and prioritize the critical health needs of the community and to develop strategies to address those needs. The 2018 CHNA builds upon previous assessments and was developed in partnership with community members, organizations, and local public health agencies. In addition to fulfilling the IRS requirements for CHNA and Implementation Strategies pursuant to the Affordable Care Act of 2010, which requires 501(c)(3) nonprofit hospitals to conduct an assessment at least every three years, the CHNA will also serve to inform organizational strategies.

In late 2017 St. John's Hospital participated in a multi-hospital Community Health Needs Assessment along with St. Joseph's Hospital, Bethesda Hospital, and Woodwinds Health Campus. The four hospitals also shared a common Community Advisory Council. After joining Fairview in 2018 the decision was made to conduct hospital specific assessment for these four hospitals using the shared HealthEast Community Advisory Council in the 2018 assessment process.

## Process and methods

The CHNA process was designed to gather current demographic and health data from a variety of sources in order to understand the needs of the St. John's community. The report contains a description of the process used for the assessment, a discussion of the types of information collected and a summary of the results. The 2018 CHNA process took place between March 2018 and October 2018 and was led by the Fairview community benefit team.

Secondary data describing the demographic, social, and economic characteristics of residents St. John's serves was obtained from a variety of sources, including the U.S. Census Bureau American Community Survey, Minnesota Department of Health, Minnesota Student Survey, Behavioral Risk Factor Surveillance System, State Cancer Profiles, and Community Need Index scores.

Primary data collection included a series of community conversations, facilitated discussions, focus groups, and key informant interviews on key issues impacting health and well-being. The data was collected and analyzed by Fairview's community benefit team.

## Identification of priority health needs

The HealthEast Community Advisory Council comprised of local public health, community partners, and local officials lent their voices to help us better understand the health needs of the community. Since the priority health needs and information gathered during the 2018 assessment built upon the 2017 board adopted Community Health Needs Assessment findings and priorities, this council was not asked to identify and prioritize health issues again in 2018. Instead, the council members met in September 2018 to provide community and priority population specific feedback on the primary data findings.

The Fairview community benefit team, used the following weighted criteria to prioritize the significant health needs identified: 2017 Plus CHNA priority needs, community priority, St. John's expertise/resources/feasibility, evidence of disparities, magnitude/scale of need, and need present in all 11 Fairview communities.

Through a voting process, the hospital advisory council recommended the following as St. John's 2018 CHNA priority needs:

- Mental health and well-being
- Healthy lifestyles
- Access to care and services



The priorities were intentionally chosen at broad level because they encompass much of what was heard from the community and found in the secondary data. Other significant needs identified in the process that will not be addressed in the next three-year Implementation Strategy include chronic lower respiratory disease, cost associated with care, quality and consistency of care, stroke, and transportation.

The 2018 CHNA report was posted on the Fairview Health Services website on December 31, 2018. Paper copies will be made available through Fairview community benefit department.

### **Next steps**

Beginning in late 2018, St. John's team will develop a written Implementation Strategy to address the three priority health needs identified during the assessment process. This plan will be created in partnership with the HealthEast Community Advisory Council, public health, and other community members, to be adopted by the Fairview Health Services Board of Directors on May 15, 2019, and executed during years 2019-2021.

## Acknowledgements

This report is the result of contributions from many individuals and organizations. We would first like to give special recognition to individuals who gave their time and experience working with and living in the local community.

- Angie Dixon, Community Conversation Facilitator
- Daniel Schriemer, Community Conversation Facilitator
- Kelly Chandler, Itasca County Public Health – Community Conversation Note-taker
- Linsey Savage, Itasca County Public Health – Community Conversation Note-taker
- Maggie Rothstein, Itasca County Public Health – Community Conversation Note-taker
- Murayo Nur, Community Conversation Note-taker
- Naesa Myers, Itasca County Public Health – Community Conversation Note-taker
- Roberta Morrow, Community Conversation Note-taker

We would also like to recognize the CHNA team who worked diligently to complete the community health needs assessment process for all 11 Fairview hospitals and medical centers. We also thank our Fairview Community Advancement leaders and other Fairview colleagues who played important roles in the process.

### **Community Health Needs Assessment Team**

- Jennifer Morman, Manager Community Benefit
- Joan Pennington, Senior Director Community Benefit & Measurement
- Kathy Bystrom, Community Partnerships Manager
- Mee Cheng, Data Analyst Associate
- Megan Chacon, Community Impact Manager
- Mohammed Selim, Community Benefit Analyst
- Paul Galchutt, Chaplain, University of Minnesota Medical Center
- Tiffany Hoffman, Community Benefit Analyst
- Yuko Ekyalongo, Community Conversation Note-taker, Key Stakeholder Interviewer

### **Other Fairview Staff**

- Alissa LeRoux Smith, Community Health & Well-being Strategist
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- John Swanholm, Vice President, Community Advancement and President, Foundation, Fairview
- Kara Rose, Senior Grant Writer
- Keith Allen, Manager Community Collaborations
- Laura Fangel, Multidisciplinary Coordinator, M Health Oncology Service Line, University of Minnesota Physicians
- Pa Chia Vue, Community Engagement Manager
- Pat Peterson, Faith Community Outreach Manager

## Introduction and background

St. John's Hospital has conducted Community Health Needs Assessments (CHNA) since 1998 to systematically identify, analyze, and prioritize the critical needs of the community and to address those needs. The 2018 CHNA builds upon previous assessments and was developed in partnership with community members and organizations, local public health agencies, and other hospitals and health systems. It serves as a tool for guiding policy, advocacy, and program planning. It also fulfills IRS requirements for CHNA and Implementation Strategies 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 impact of the previous Implementation Strategy. For additional detail, see section titled, Evaluation of impact, 2018 CHNA Implementation Strategy.

Through this process, St. John's aims to:

- Understand the health status and needs of the community it serves by analyzing current demographics, health data, and by collecting direct input from community members and organizations.
- Identify the strengths, assets, and resources available in the community to support health and well-being.
- Address significant health needs through partnerships with community members and organizations, public health agencies, and other hospitals and health systems.
- Create a Strategic Implementation Plan reflective of the data collected through the CHNA process.
- Inform St. John's community benefit activities.

### Definition of health

For the purposes of this assessment, health is not limited to traditional measures of physical health. It includes spiritual health, as well as social and economic factors relating to quality of life such as income, education, employment status, transportation, and housing.

St. John's Hospital believes that health and well-being starts where we live, learn, work, play, and pray. This philosophy is consistent with the dual definitions of health and social determinants of health, taken from the World Health Organization, which were enhanced and ultimately adopted by the HealthEast Community Advisory Council, which are:

- **Health** is a state of complete physical, mental, spiritual, and social well-being and not merely the absence of disease or infirmity.
- **Social determinants of health** are the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels.

## 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, serving the greater Twin Cities metro area and north-central Minnesota. Through a close relationship with the University of Minnesota, Fairview offers access to breakthrough medical research and specialty expertise as part of a continuum of care that reaches all ages and health needs.

### Our mission

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

### Our vision

Fairview is driving a healthier future.

### Our values

Dignity  
Integrity  
Service  
Compassion  
Innovation

### Fairview at a glance

33,000+ employees  
5,000+ system providers  
11 hospitals and medical centers  
2,177 staffed beds  
56+ primary care clinics  
55+ specialty clinics  
70+ senior housing locations  
40+ retail and specialty pharmacies

### Fairview has the following hospitals and medical centers

- Bethesda Hospital (St. Paul)
- Fairview Lakes Medical Center (Wyoming)
- Fairview Northland Medical Center (Princeton)
- Fairview Range Medical Center (Hibbing)
- Fairview Ridges Hospital (Burnsville)
- Fairview Southdale Hospital (Edina)
- Grand Itasca Clinic & Hospital (Grand Rapids)
- St. John's Hospital (Maplewood)
- St. Joseph's Hospital (St. Paul)
- University of Minnesota Medical Center and University of Minnesota Masonic Children's Hospital (Minneapolis)
- Woodwinds Health Campus (Woodbury)

In addition to hospitals, clinics, and medical centers, Fairview provides services across our continuum including adult day programs, home care and hospice, home infusion, foundations, community health and well-being programs, medical transportation, sports and orthopedic care, and much more.

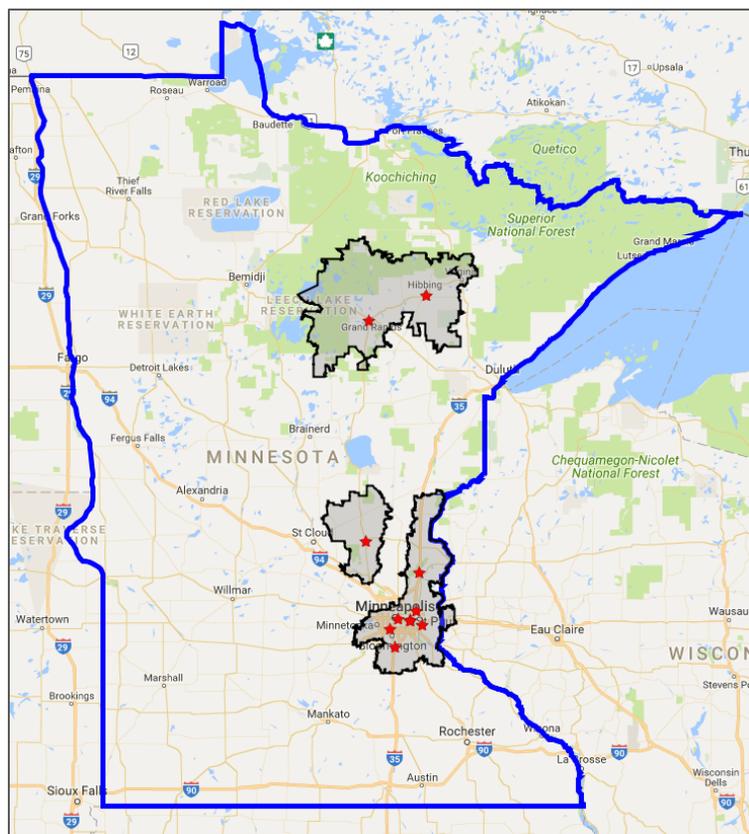
### Fairview's communities

For the purposes of the CHNA, Fairview's communities are defined as the population of the combined zip codes for Fairview's hospitals and medical center's primary service areas. These are comprised of 161 zip codes, nine Minnesota counties (Chisago, Dakota, Hennepin, Itasca, Mille Lacs, Ramsey, Sherburne, St. Louis and Washington) and an area of Wisconsin. All told, Fairview's communities represent a population of 2,645,690 people and covers 6,969 square miles. These zip codes are home to approximately 84 percent of Fairview's patients.

This definition of community was selected to:

- Provide continuity of definition with previous CHNAs.
- Provide balance between the micro view of community (e.g. zip code, neighborhood) and a macro view (e.g. county, state) in data collection and health need identification.
- Align with business development definitions of community (e.g. the combined zip codes that comprise the primary service areas).
- Ensure alignment of priorities and existing relationships with county public health departments that intersect with the defined community.

**2018 Fairview Health Services community**



■ Fairview community ★ Hospital □ State

## Key components of our community commitment

Each of Fairview's hospitals and medical centers are committed to improving the health and well-being of the communities we serve. We fulfill our responsibility through a variety of efforts including:

- A CHNA and Implementation Strategy that places community first and targets the most critical health needs in our communities.
- A sustainable funding structure that supports innovative and collaborative health projects that have measurably improved health outcomes and earned national recognition.
- Policies and billing practices that support appropriate financial assistance for those in need.

While Fairview's community health programs address the needs of the whole community, our efforts are focused on seniors, people experiencing poverty, persons of color, and indigenous people.

## Organizational support

Fairview is governed by a **Board of Directors** that come from a variety of professional backgrounds — including medicine, business, theology, government, and academia. Their expertise supports our commitment to improving the health of the communities we serve. The Fairview Board of Directors approves the CHNA and Implementation Strategies for nine Fairview hospitals and medical. See appendix A for roster. The local Board of Directors at the Fairview affiliate hospitals, Grand Itasca Clinic & Hospital and Fairview Range Medical Center, approve their local hospital assessments and strategies.

The **Fairview Patient Care and Experience Committee of the Corporate Board** provides direction, oversight, and counsel regarding quality and safety of care and the patient and family experience provided within the Fairview system. As a standing committee of the Fairview Board of Directors its membership is comprised of Fairview's Chief Executive Officer and others as appointed by the Board of Directors. See appendix B for roster. The Fairview Patient Care and Experience Committee of the Corporate Board formally recommend the nine medical center and hospital CHNAs and Implementation Strategies to the Fairview Health Services Board of Directors for adoption.

The **Community Advisory Council** is comprised of Fairview's President and Chief Executive Officer, staff from Ebenezer – Fairview's senior services division – and local community leaders from business, education, public health, philanthropy, faith communities, and nonprofit organizations. See appendix C for roster. These leaders select issues to study, to gain in-depth understanding, and collaborate in problem solving initiatives. This results in sustainable, effective community-based solutions to systemic health issues. The Community Advisory Council formally recommends the CHNAs and Implementation Strategies to the Fairview Patient Care and Experience Committee of the Corporate Board. Fairview's Community Advancement leadership team facilitates the system Community Advisory Council.

Fairview employs a team of **community benefit staff** dedicated to researching and assessing community health needs, as well as implementing strategies to improve them. Each fall, this team reports key strategies and outcomes to the Community Advisory Council and local community health steering committees. See appendix D for staff members.

**Community health steering committees and/or advisory councils** are the primary resources that Fairview uses to engage the community in better understanding local health needs and to develop plans for action. Each local committee has members who serve on the system Community Advisory Council. Fairview's community benefit team facilitates the committees all medical centers and hospitals.

Each committee is comprised of local community leaders from business, education, public health, faith communities, nonprofit organizations, and Fairview hospital leadership, staff, and physicians. See appendix E for roster. These members advise on the CHNA and Implementation Strategy processes providing in-depth understanding of needs, assets, and barriers, and collaborate in problem-solving initiatives. This results in sustainable, effective community-based solutions to systemic health issues.

Fairview providers and staff are integrated into a wide variety of these initiatives as appropriate.

## About St. John's Hospital

St. John's Hospital, part of Fairview Health Services, opened in Maplewood in 1985. St. John's Hospital provides a comprehensive range of medical care in the community, from the intensivist program (on-site critical care physician specialists) and 24-hour in-house obstetrics coverage to a wide variety of diagnostic and therapeutic services. Creating the best patient experience is a priority at St. John's: All patient rooms are private and specially designed to enhance recovery by providing dignity in a healing environment.

### Key services

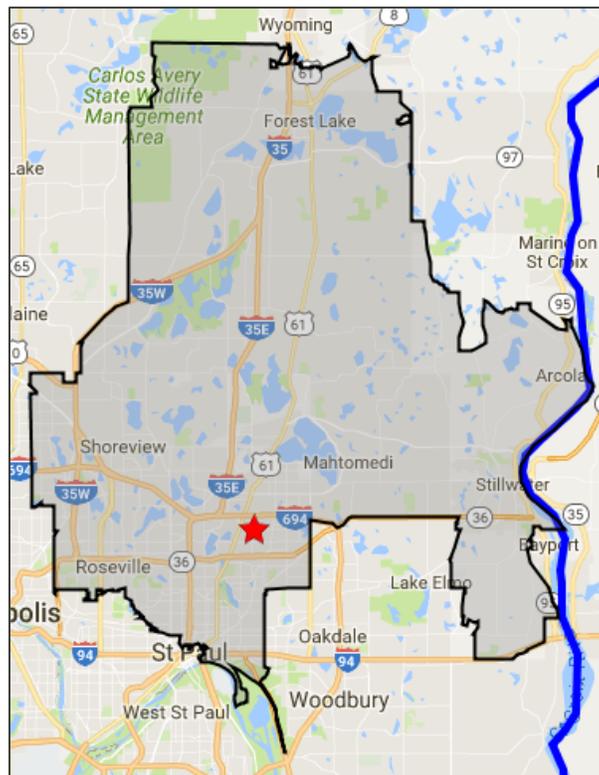
- Breast Center
- Cancer Care
- Maternity
- Orthopedics
- Sleep Center
- Robotic surgery

### St. John's community

St. John's Hospital defines its community as a sub-set of Fairview's defined communities. The community includes 15 zip codes where approximately 80 percent of its patients' live, the city where the hospital resides, Maplewood, MN, and the county where the hospital resides, Ramsey County. The total population of this geographic community is 452,106 people, it covers 382 square miles, and there is a median household income of \$73,577. See appendix F for list cities and zip codes.

For the remainder of this report when "community" is referred to it is defined according to the above paragraph.

**St. John's Hospital community**



■ St. John's Hospital community    ★ St. John's Hospital    □ State boarder

The proportion of St. John’s community residents age 65 and older is projected to increase by 2.2 percent, from 15.2 percent to 17.4 percent over the next five years. The population of residents ages 45-64 is projected to decrease by two percent.

St. John’s Hospital community – Age				
Year	2018		2023	
<b>Total Population</b>	<b>452,106</b>		<b>471,088</b>	
Ages 0 – 17	108,701	24.0%	113,277	24.0%
Ages 18 – 44	157,659	34.9%	163,305	34.7%
Ages 45 – 64	117,074	25.9%	112,524	23.9%
Ages 65 and older	68,672	15.2%	81,982	17.4%

Source: Claritas 2018

In 2018, 72 percent of the St. John’s community identified as white, with residents identifying as Asian making up the second largest group at 13.9 percent. Residents of color make up 28 percent of the overall population. Over the next five years, the number of residents of color is projected to increase to 31.1 percent of the overall population.

St. John’s Hospital community – Race				
Year	2018		2023	
<b>Total Population</b>	<b>452,106</b>		<b>471,088</b>	
White	325,538	72.0%	324,415	68.9%
Black / African American	34,357	7.6%	37,898	8.0%
American Indian / Alaskan Native	2,996	0.7%	3,038	0.6%
Asian	63,016	13.9%	76,338	16.2%
Native Hawaiian / Pacific Islander	226	0.0%	244	0.1%
Some Other Race Alone	11,093	2.5%	12,226	2.6%
Two or More Races	14,880	3.3%	16,929	3.6%

Source: Claritas 2018

Ethnicities, including Hispanic/Latino, can be any race and are included in the race categories above.

## Community Health Needs Assessment

Fairview Community Advancement used two key resources to frame its CHNAs and Implementation Strategies: The Catholic Health Association framework and the University of Wisconsin Population Health Institute model.

The Catholic Health Association framework describes the processes used to identify, prioritize, act on, and evaluate the health needs and assets of our communities in collaboration with community partners. The Fairview process is based on this model, and is as follows.

## Our process

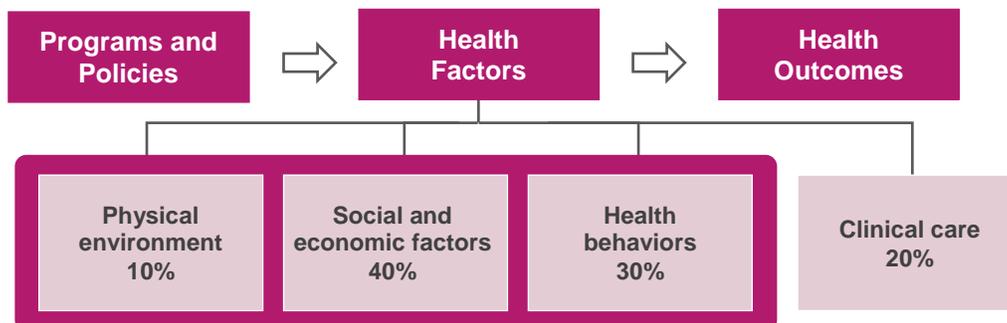
The CHNA process was designed to gather current demographic and health data from a variety of sources in order to understand the needs of the St. John's community. The report contains a description of the process used for the assessment, a description of the types of information collected and a summary of the results. The 2018 CHNA process took place between March 2018 and October 2018 led by the Fairview community benefit team.



Fairview used the University of Wisconsin Population Health Institute model below to understand the factors that influence health outcomes and to classify health needs and opportunities. According to this model, only about 20 percent of health is determined by clinical care. The CHNA helps to identify the other 80 percent of health influencers that occur outside of clinics and hospitals. These factors combined are called social determinants of health.

Social determinants of health are the conditions in which people are born, grow, work, live, and age, plus the wider set of forces and systems shaping the conditions of daily life.<sup>1</sup>

Inequitable social determinants of health often lead to health disparities — the unfair or avoidable differences in health status seen between groups of people. Social determinants, such as socioeconomic status, geography, and housing, affect opportunities for health and influence health behaviors and underlying conditions contributing to health.



Source: University of Wisconsin Population Health Institute

## Consultants

Wilder Research, a division of the Amherst H. Wilder Foundation in St. Paul, Minnesota, is one of the nation's largest nonprofit research and evaluation groups dedicated to the field of human services. Wilder Research conducts research for more than 100 nonprofit and government organizations whose sphere of influence ranges from the neighborhood to the national or international level.

## Data sources

The community benefit staff used a variety of data sources to gain a comprehensive understanding of the health needs of people throughout the community.

### Primary data

To ensure the CHNA had broad community representation, key populations — seniors, people experiencing poverty, persons of color, and indigenous people — were invited to participate in a series of community conversations, key stakeholder interviews and focus groups.

Questions were designed to help the team understand community identified top health needs, barriers to care, barriers to maintaining and improving health, and community assets. All primary data was collected between May and August of 2018.

### Secondary data

Secondary data were gathered from several online resources housing a variety of indicators that have been collected, analyzed, and displayed by governmental and other agencies through surveys and surveillance systems. Additional data was gathered through purchased data sources including Claritas and Wilder Research.

Wilder Research compiled and synthesized publicly available data and research studies to create issue briefs on the leading causes of death/premature death and the social determinants of health for Ramsey County. They reviewed multiple time-point indicators related to the following social determinants of health: socioeconomic status, education, employment, housing and transportation. The final issue briefs highlight disparities by race, ethnicity, age, gender, and other factors.

The following criteria were used to identify the quantitative data sources:

- Publicly available
- Availability of data by zip code, county, state, and U.S. levels
- Existence of benchmarks (e.g. Healthy People 2020)
- Ability to trend (e.g. updated on a regular basis)
- Informs understanding of health disparities

**Claritas** is a widely used national demographic estimate 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 data prepared for the current year, and projections are prepared for dates five years in the future based on U.S. Census, American Community Survey, and other data sources. This demographic data is used across various industries to understand population trend implications on business strategies and initiatives.

**Community Commons** provides a single location for a number of data sources available at the state, county, national, and often zip code level. It is managed by the Institute for People, Place and Possibility and the Center for Applied Research and Environmental Systems. Major funders and partners include the Centers for Disease Control & Prevention, Robert Wood Johnson Foundation, and the American Heart Association.

The **American Community Survey** is an ongoing survey by the U.S. Census Bureau designed to provide information about how communities are changing. It annually gathers information previously contained only in the long form of the decennial U.S. Census such as ancestry, educational attainment, income, language proficiency, and housing characteristics.

**Community Need Index scores** developed by Catholic Healthcare West and Truven Health Analytics combine publically available and proprietary data to create an objective measure of socio-economic barriers to health care access and their effect on inappropriate hospital re-admissions for ambulatory sensitive conditions.

## Data methods and analysis

### Primary data

Fairview's community benefit team developed standardized tools, processes, instructions, and facilitator, interviewer, and note-taker training. The team also gathered, cleaned, analyzed, and presented all primary data. Community conversations and focus groups lasted 90 minutes. Key stakeholder interviews were conducted over the phone and lasted 30 minutes or less.

### Secondary data

Fairview's community benefit team provided oversight, standardized tools, processes, and instructions for data gathering, cleaning, analysis and presentation of most secondary data. Wilder Research performed this role with data related to the social determinants of health and leading causes of death for Ramsey County.

## Data limitations

While the team made every effort to gather appropriate volume and variety of data to support the CHNA, they identified several information gaps and limitations.

### Primary data

Several limitations are inherent in the primary data collection. These include:

- Information gathered from key stakeholder interviews often represents the perspectives and biases of the organization, agencies, and groups with which the stakeholders are associated.
- Because few people can sense all the needs and concerns of their community, the perspectives of those who are less visible may be overlooked.
- Several key populations were not well represented in primary data collection. These include children and adolescents, men, young adults, and members of the LGBTQ community.

To minimize the above limitations, the team reviewed and analyzed all primary data within the context of the overall CHNA findings and secondary data sources.

### Secondary data

Two key limitations are inherent in the collected secondary data:

- The reporting of race and ethnicity data is often suppressed due to larger margins of error and/or small population sizes. Information for populations such as East African, Hmong, American Indian, and black are largely unavailable, or suppressed, especially at the local level.
- The majority of captured data is deficient-based thereby making the focus of the summary deficient within the community.

To minimize secondary data limitations, the team was intentional about speaking with seniors, persons experiencing poverty, people of color, and indigenous people.

## Understanding the health needs of our community

The city of Maplewood is a suburb of more than 36,000 people in the Twin Cities metropolitan area located about 15 minutes from downtown St. Paul. Maplewood has more than 30 parks and a great trail system. The City also has its own Department of Motor Vehicles as well as its own Police Department and Fire Department. Maplewood has strong schools and a variety of recreational opportunities that add to its quality of life. As a diverse and growing community, the City welcomes potential residents, business owners, and visitors.<sup>2</sup> Maplewood is located in Ramsey County.

Ramsey County was founded in 1849 and is named for Alexander Ramsey, the first governor of the Minnesota Territory. Ramsey County is included in the Minneapolis–St. Paul-Bloomington, MN-WI Metropolitan Statistical Area. It is the smallest and most densely populated county in Minnesota, as well as one of the most densely populated counties in the United States. St. Paul serves as the county seat of Ramsey County.<sup>3</sup>

### Ramsey County demographics

Ramsey County's population has become increasingly diverse. While white residents still account for the largest racial group in Ramsey County, white residents comprise a smaller percentage of the population today (62 percent) compared to 75 percent in 2000. Residents identifying as Asian make up the second largest group at 15 percent of the overall population. The proportion of Ramsey County residents age 65 and older has increased. Currently, 14 percent of Ramsey County residents are age 65 and older, compared to 12 percent in 2000.<sup>4</sup>

## Social determinants of health and health disparities

The World Health Organization defines social determinants of health as the conditions in which people are born, grow, work, live, and age, plus the wider set of forces and systems shaping the conditions of daily life.<sup>5</sup>

The Centers for Disease Control and Prevention on their Healthy People 2020 webpage explain that the social determinants of health have a greater influence on health outcomes than clinical care and that they are also largely responsible for health inequities – the unfair or unavoidable differences in health status seen between groups of people. Social determinants such as socioeconomic status, geography or housing, can limit or increase opportunities for health, which influences health behaviors and underlying social determinants.<sup>6</sup>

### Community need index scores

A Community Need Index score is a tool used to identify the severity of health disparities by zip code. Research has shown that zip codes with high Community Need Index scores show a strong correlation to inappropriate 30-day hospital readmissions.<sup>7</sup> Community Need Index scores are based upon five prominent socio-economic barriers to healthcare access and range by zip code from a score of one (lowest need) to five (highest need).

Socio-economic barriers considered in the Community Need Index score are:

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

### Community Need Index scoring

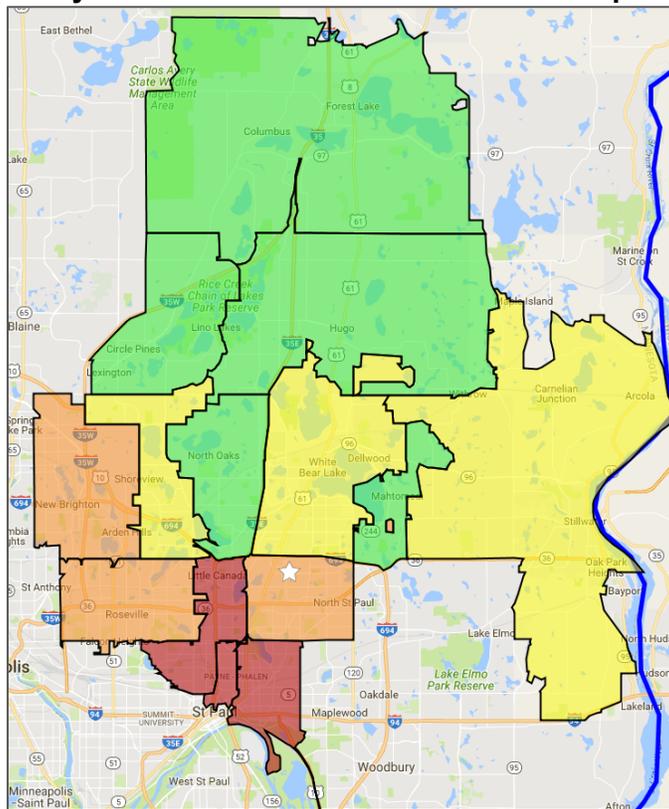
Highest Quintile	4.2 – 5.0
2 <sup>nd</sup> Highest Quintile	3.4 – 4.1
Mid Quintile	2.6 – 3.3
2 <sup>nd</sup> Lowest Quintile	1.8 – 2.5
Lowest Quintile	1.0 – 1.7

Between 2012 and 2016, 69 percent (9) of the zip codes in St. John’s community, for which there was a recorded score in both years, experienced an increase in their Community Need Index score. Thirty-one percent (4) of the zip codes remained the same, and none of the zip codes saw a decrease in their Community Need Index score.

In 2016, three of the zip codes located in the St. John’s community (55106, 55117, and 55130) were in the highest Community Need Index quintile 4.2 – 5.0. See appendix G for a list of Community Need Index scores for 2012 and 2016.

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

### 2016 Community Need Index scores for St. John’s Hospital community



Source: Truven Health Analytics

■ 1.0 – 1.7   
 ■ 1.8 – 2.5   
 ■ 2.6 – 3.3   
 ■ 3.4 – 4.1   
 ■ 4.2 – 5.0   
 ■ No Score

☆ St. John’s Hospital

## Socioeconomic factors

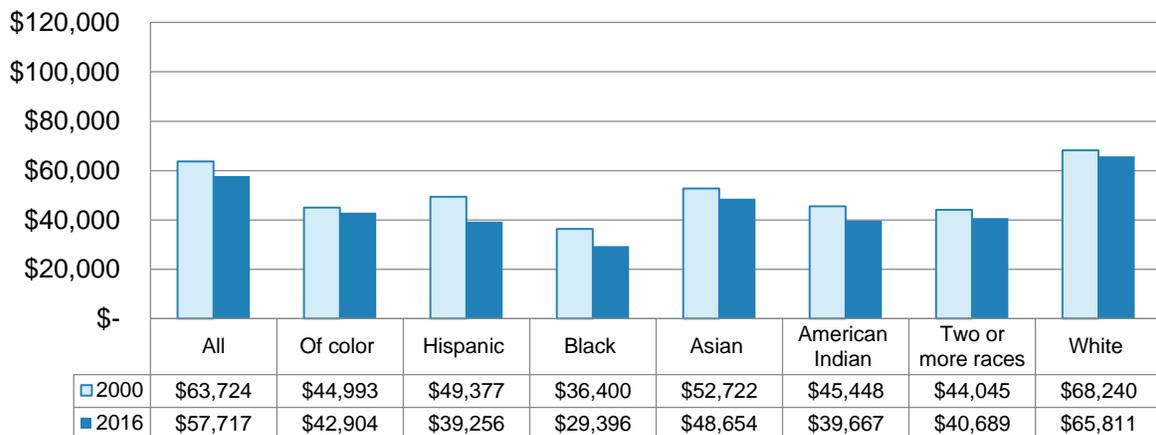
Fairview contracted with Wilder Research to research the social determinants of health for Ramsey County. The determinants reviewed were – socioeconomic status, education, employment, housing, and transportation. This summary includes data at multiple time points and highlights disparities by race, ethnicity, age, gender, and other factors when available.

Socioeconomic status, a person’s standing related to income, employment, and education, can impact health in many ways.<sup>8</sup> Residents with lower incomes may find it more difficult to purchase healthy food, pay for gym memberships, or cover the costs of health care visits or medication. In addition, financial instability or living in poverty can increase stress, impacting physical and mental health, as well as overall quality of life.

Median household income in Ramsey County has declined since 2000 and is lower than the state average<sup>9</sup> for all groups, but disparities exist by race, gender, and age. The current median household income in Ramsey County is \$57,717, which is a decrease from \$63,724 in 2000.

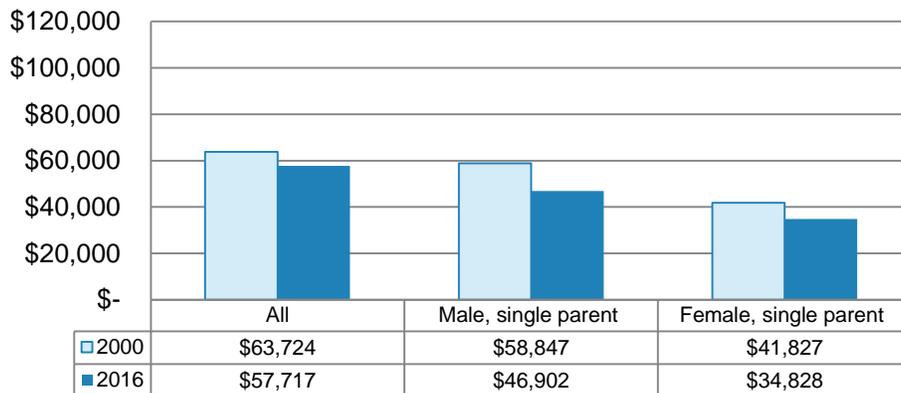
White residents have the highest income, while black residents have the lowest income. Although incomes for all residents declined, the biggest decreases were seen for Hispanic residents (20 percent), single male household with children (20 percent), black residents (19 percent), and single female households with children (17 percent). Additionally, single female households with children, on average, earn approximately \$12,000 less than single male households annually.

**Ramsey County - Median income by race/ethnicity**



Source: 2000 Decennial Census, 2012-2016 5-yr American Community Survey  
Data compiled by Wilder Research

**Ramsey County - Median income by gender**



Source: 2000 Decennial Census, 2012-2016 5-yr American Community Survey  
Data compiled by Wilder Research

## Poverty

There is a strong association between income and health. Across multiple indicators, people with lower incomes tend to have poorer health outcomes. Lower-income communities may lack the resources and amenities that support health.

Poverty guidelines are issued each year in the Office of the Federal Register by the Department of Health and Human Services. The guidelines are a simplification of the poverty thresholds for use for administrative purposes — for instance, determining financial eligibility for certain federal programs.

### 2016

<b>100% of the Federal Poverty Guidelines for the 48 Contiguous States and the District of Columbia</b>	
<b>Persons in family/household</b>	<b>Poverty guideline</b>
1	\$11,880
2	\$16,020
3	\$20,160
4	\$24,300

Source: Office of the Federal Register; <https://www.federalregister.gov/d/2016-01450/p-14>

The number of Ramsey County residents living in poverty increased for all groups of residents between 2000 and 2016, with significant disparities in rates by race and ethnicity exist. White residents and those age 65 and older had the lowest poverty rates with only eight percent living at or below 100 percent of the Federal Poverty Level (\$24,300 for a family of four), which is half the overall county rate. American Indian and black residents had the highest poverty rates at 36 percent living at or below 100 percent Federal Poverty Level. Additionally American Indians residents and children (ages 0-17) had the biggest changes in poverty with a seven percent increase between 2000 and 2016.

<b>Ramsey County – Population living at or below 100% Federal Poverty Level by race / ethnicity</b>		
<b>Year</b>	<b>2000</b>	<b>2016</b>
<b>Total Population</b>	<b>511,035</b>	<b>547,974</b>
<b>All Ramsey County Residents &lt;100% the Federal Poverty Level</b>	<b>11%</b>	<b>16%</b>
American Indian	23%	36%
Asian	27%	29%
Black	30%	36%
Hispanic	11%	21%
Two or more races	24%	26%
White	6%	8%
Of color	26%	30%

Source: 2000 Decennial Census, 2012-2016 5-yr American Community Survey, Small Area Income and Poverty Estimates (SAIPE) Program 2000 and 2016; Data are suppressed, indicated by an asterisks (\*), when it is unreliable due to small populations and high margins of error. Note: All race/ethnicity, nativity, and age group poverty data are based upon the <100% Federal Poverty threshold. Data compiled by Wilder Research.

<b>Ramsey County – Population living at or below 100% of the Federal Poverty Level by age</b>		
<b>Year</b>	<b>2000</b>	<b>2016</b>
<b>Total Population</b>	<b>511,035</b>	<b>547,974</b>
Children 0 – 17	13%	20%
Adults 65 and older	7%	8%

Source: 2000 Decennial Census, 2012-2016 5-yr American Community Survey, Small Area Income and Poverty Estimates (SAIPE) Program 2000 and 2016. U.S. Census Bureau 2017 Population Estimates Data compiled by Wilder Research.

## Housing affordability and transportation

Housing affordability impacts an individual's or family's economic stability. When a household is cost-burdened — paying more than 30 percent of their income on housing — there is less income to pay for basic needs, including health care costs. The proportion of cost-burdened households in Ramsey County increased between 2000 and 2016, with renters being more likely to be cost-burdened than home owners. The percentage of renter cost-burdened households was more than double the percentage of owner cost-burdened households. Renters also saw the biggest increase in cost-burdened housing (eight percent).

Ramsey County – Housing affordability		
Year	2000	2016
Cost burdened households	26%	30%
Owner cost-burdened households	17%	19%
Renter cost-burdened households	39%	47%

Source: 2000 Decennial Census, 2016 1-yr American Community Survey  
Data compiled by Wilder Research.

Access to reliable transportation, regardless of the mode, helps ensure residents can travel to work, purchase healthy foods, access health care services and other supports, and socialize with others, which all are necessary for health and a high quality of life. Fewer households in Ramsey County were without a vehicle in 2016. There was a slight increase in the use of alternate forms of transportation to get to work.

Ramsey County – Transportation		
Year	2000	2016
Household with no vehicle	12%	11%
Used alternate transportation to get to work*	14%	16%

Source: 2000 Decennial Census, 2016 1-yr American Community Survey  
\*This includes any worker over 16 years old in a household who did not commute by car/carpool.  
Data compiled by Wilder Research.

## Employment

Employment is an individual's pathway to income and assets. Employment supports basic needs, and often provides access to affordable health insurance. Overall employment rates for Ramsey County residents decreased between 2000 and 2016, and rates for most groups remain below the state rate of 78 percent.<sup>10</sup> There was a four percent decrease for residents identifying as having two or more races, a two percent decrease for white residents. There was a five percent increase for Asian residents, four percent increase for Hispanic residents and a three percent increase for the broader group of residents identifying as persons of color. Rates for key working age populations (25-34, 35-44, and 45-64) remained high, while rates for the age group 16-24 decreased by nine percent.

Ramsey County – Employment by race / ethnicity		
Year	2000	2016
<b>Total Population</b>	<b>511,035</b>	<b>547,974</b>
American Indian	63%	62%
Asian	58%	63%
Black	63%	64%
Hispanic	65%	69%
Two or more races	65%	61%
White	81%	79%
Of color	61%	64%

Source: 2000 Decennial Census, 2012-2016 5-yr American Community Survey  
Data compiled by Wilder Research.

Ramsey County – Employment by age		
Year	2000	2016
<b>Total Population</b>	<b>511,035</b>	<b>547,974</b>
<b>Ages 16 – 64</b>	<b>78%</b>	<b>74%</b>
Ages 16 – 24	67%	58%
Ages 25 – 34	81%	82%
Ages 35 – 44	82%	81%
Ages 45 – 64	79%	74%
Ages 65 and older	12%	16%

Source: 2000 Decennial Census, 2012-2016 5-yr American Community Survey  
Data compiled by Wilder Research.

### Education

Addressing disparities in educational attainment is important because individuals who earn a bachelor’s degree or higher are more likely to secure full-time employment and higher earnings. A college education is a pathway to acquiring income, benefits, and assets, all of which are strongly associated with better health. All Ramsey County residents saw an increase in the completion of a bachelor’s degree or higher education, with a higher county rate than the state of Minnesota (35 percent).<sup>11</sup>

White residents are most likely to have a bachelor’s degree or higher, while American Indian and Hispanic residents are least likely to have a bachelor’s degree. The biggest changes in educational attainment were for white residents (10 percent increase) and residents identifying as two or more races (11 percent increase).

Ramsey County – Educational attainment of a bachelor’s degree or higher by race / ethnicity		
Year	2000	2016
<b>Total Population</b>	<b>511,035</b>	<b>547,974</b>
American Indian	16%	19%
Asian	30%	31%
Black	33%	35%
Hispanic	16%	20%
Two or more races	28%	39%
White	37%	47%
Of color	22%	24%

Source: 2000 Decennial Census, 2012-2016 5-yr American Community Survey  
Data compiled by Wilder Research.

Ramsey County – Educational attainment of a bachelor’s degree or higher by age		
Year	2000	2016
<b>Total Population</b>	<b>511,035</b>	<b>547,974</b>
Ages 18 – 24	14%	16%
Ages 25 – 34	40%	44%
Ages 35 – 44	37%	44%
Ages 45 – 64	37%	41%
Ages 65 and older	18%	35%

Source: 2000 Decennial Census, 2012-2016 5-yr American Community Survey  
Data compiled by Wilder Research.

## Leading causes of premature death, death, and contributing factors

Fairview contracted with Wilder Research to research the leading causes of death, premature death, and their contributing factors. The table below shows the top five leading causes of death (all ages) and premature death (before age 75) for Ramsey County and Minnesota.

For all Minnesota counties, cancer is the leading cause of death, with breast cancer incidence and mortality the highest, followed by lung and colorectal cancers. Heart disease, while the leading cause of deaths in many states, is second in Minnesota and Ramsey County.

### 2016 Leading causes of death and premature death in Ramsey County and Minnesota

Rank	Ramsey County		Minnesota	
	Leading Causes of Death	Leading Causes of Premature Death	Leading Causes of Death	Leading Causes of Premature Death
1	Cancer	Cancer	Cancer	Cancer
2	Heart disease	Heart disease	Heart disease	Heart disease
3	Unintentional injury	Unintentional injury	Unintentional injury	Unintentional injury
4	Alzheimer's disease	Chronic lower respiratory disease	Chronic lower respiratory disease	Suicide
5	Stroke	Suicide	Alzheimer's disease	Chronic lower respiratory disease

Source: Minnesota Department of Health, Center for Vital Statistics, retrieved September 2018

Ramsey County has higher rates of death than the state and exceeds the national Healthy People 2020 goals for the leading causes noted below in red.

Ramsey County – Leading causes of death, 2012 – 2016 Mortality rates per 100,000 – Age-adjusted			
	Ramsey County	Minnesota	Healthy People 2020 goal
Cancer	155.0	153.1	161.4
Heart Disease	111.9	117.3	n/a
Unintentional injury	41.8	40.9	36.4
Alzheimer's disease	30.9	25.2	n/a
Stroke	40.1	33.0	34.8

Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16.

## Contributing factors of premature death

Although the leading causes of premature death are complex and there is no known single cause, certain risk factors can increase a person's chance of developing a disease or condition. Among the key risk factors for each leading cause, several are common across all and many are related to social determinants of health.

Below are examples of contributing factors of the leading causes of premature death in Ramsey County:

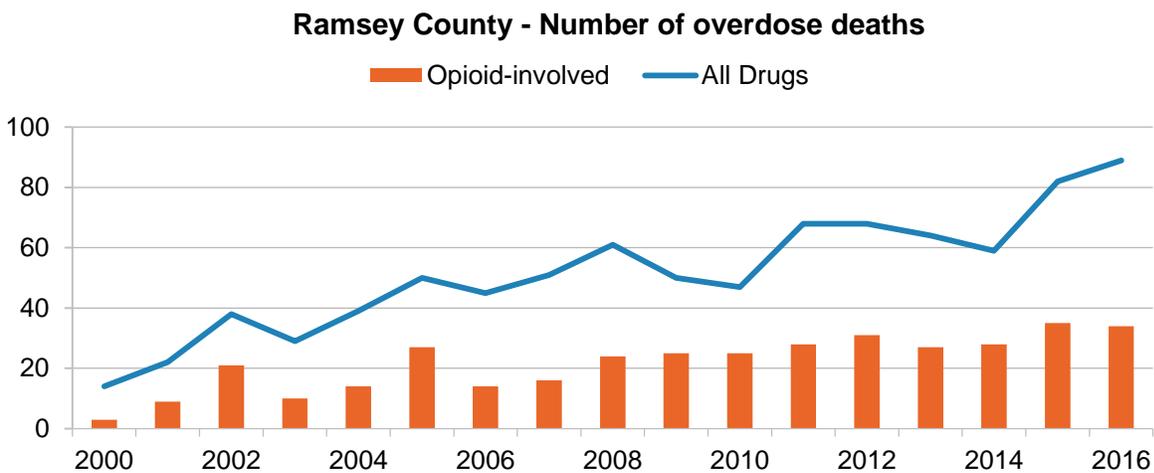
- **Cancer:** Poverty, limited access to care for screening, obesity, tobacco use, poor diet, physical inactivity, environmental exposure.
- **Heart disease:** Diabetes, obesity, poor diet, physical inactivity, smoking.
- **Unintentional injuries:** Falls, motor vehicle accidents, poisoning.
- **Chronic lower respiratory disease:** Lack of access to prevention and care, tobacco use, environmental exposure/air quality.

Many of the leading causes of death can be prevented by changes in health behavior. Residents who follow a healthy diet, maintain a healthy weight, exercise regularly, and avoid tobacco products are at a lower risk of many chronic health conditions.

### Other trends

Drug overdose deaths continue to increase in Minnesota. In 2016, death certificates indicated that 675 deaths were a result of drug overdose, compared to 538 in 2015. Drug overdose deaths include accidental poisoning by drugs, intentional self-poisoning by drugs, assault by drug poisoning, or drug poisoning of undetermined intent.<sup>12</sup>

Statewide opioid-involved deaths increased by 18 percent from 2015 to 2016. Deaths from overdose involving methadone and prescribed opioids, such as codeine, oxycodone, or hydrocodone remained stable; however, there was an increase in deaths involving heroin and other synthetic opioids. See below for Ramsey County specific numbers.



Source: Minnesota Department of Health, Injury and Violence Prevention Section. Wright, N. & Roesler, J. (2017)  
Data compiled by Wilder Research

## Health disparities and priority populations

Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.<sup>13</sup>

Each of the leading causes of death is related to unique health disparities, but also share several general similarities. For example, health disparities adversely affect people of color and indigenous people for cancer, heart disease, unintentional injury and chronic lower respiratory disease. Health disparities exist between those with the highest income levels and the lowest, as well as between the insured and

uninsured. Those in the lowest income level without insurance have the greatest health needs and are most challenged in gaining access to high-quality affordable healthcare.

As a result of the demographic findings during the CHNA process in addition to needs of the broader community there was an intentional focus on members of the following priority populations:

- Seniors
- People experiencing poverty
- Persons of color and indigenous people

These priority populations were also the primary focus when collecting primary data for the purposes of this CHNA. See the following section for additional details about the primary data collection process.

## Community voice

Primary data collection occurred between May and August of 2018 and included facilitated discussions, community conversations, focus groups, and key stakeholder interviews. These gave content experts, community members, local business, nonprofits, and government leaders’ voice around the health needs, barriers, resources, and assets in their community. See appendix H for a complete list of primary data sources.

### Facilitated discussion

The HealthEast Community Advisory Council played a critical role by providing priority population and other pertinent feedback on the hospital’s primary data collection findings. The advisory council members are a diverse cross section of area community leaders, community members, and key internal staff.

Sectors	Organizations Represented
Cultural Organizations	American Indian Family Center
Education	Century College
Government	City of Maplewood
Healthcare	Community Dental Center
Local Public Health	Comunidades Unidas en Servicio (CLUES)
Social Services	Dakota County Public Health
	East Side Partnership for Healthy Aging
	Hearth Connection
	Hill-Murray High School
	Hmong American Partnership
	Karen Organization of Minnesota
	Lutheran Social Services Eastside Financial Center
	Maplewood, Oakdale North St Paul School District
	Metro State University
	Neighborhood House
	Portico Health Net
	St. Paul Public Schools
	St. Paul-Ramsey County Public Health
	Washington County Public Health
	Wilder Research – Twin Cities Mobile Market
	Woodbury Thrive Collaborative

### Community conversations

Community conversations increased understanding of health needs, barriers, and assets amongst specific community populations. The hospital advisory council helped to determine who should be included in these conversations.

Two community conversations were conducted in the St. John’s Hospital community. See appendix I for questions asked during the community conversations.

### Focus groups

Non-physician provider focus groups helped to inform the focus and guided the CHNA by increasing understanding of health needs, barriers, and assets among patients/populations served by the non-physician providers. Participants included care managers and care coordinators. See appendix J for questions asked during the focus groups.

### Key stakeholder interviews

Community input was supplemented by key stakeholder interviews with local officials, leaders of non-profit organizations, public health leaders, content experts, and others who understand the needs of the community, as well as the unique needs of seniors, people experiencing poverty, persons of color, and indigenous people in the community. See appendix K for questions asked during key stakeholder interviews.

### Key findings: primary data collection

In order to better understand the health needs of the community beyond the secondary data, the Fairview community benefit team gathered input from individuals representing the broad as well as unique interests of the community. These individuals included local public health departments, those who are medically underserved, people experiencing poverty, persons of color, indigenous people, and professionals whose organizations serve or represent the interests of these populations. The various methods used are described on pages 14 – 15. The results were compiled, analyzed, and synthesized.

Guided by direction from the hospital’s advisory council to build and expand upon the previous CHNA priority needs, findings from the primary data were first analyzed by previous Fairview and HealthEast system CHNA priority needs. See table below to see details provided by the community:

Primary data findings analyzed by previous CHNA priority needs		
Access to care and resources	Mental health and well-being	Healthy lifestyles
<ul style="list-style-type: none"><li>• Access to healthy food</li><li>• Culturally competent care</li><li>• Navigating the system</li><li>• Access to psychiatric care</li><li>• Culturally specific resources and services</li><li>• Access to affordable preventive care</li><li>• Cost of care</li><li>• Transportation – cost and availability</li><li>• Affordable housing</li></ul>	<ul style="list-style-type: none"><li>• Social connectedness</li><li>• Mental health and stress resilience</li><li>• Social isolation</li><li>• Dementia</li><li>• Connection to community</li><li>• Access to psychiatric care</li><li>• Depression</li><li>• Family counseling and parenting resources</li><li>• Youth drug use</li></ul>	<ul style="list-style-type: none"><li>• Diet and nutrition education</li><li>• Access to healthy food</li><li>• Prevention and management of chronic conditions</li><li>• Preventive care</li><li>• Culturally specific health education</li><li>• Root causes of leading causes of death including: physical inactivity, obesity, poor nutrition, smoking, substance use and environmental toxins</li></ul>

Everything included in the table above was mentioned more than once and was listed as voiced by the community. Throughout the key stakeholder interviews, the top needs identified fell within the access to care and resources category, specifically related to the social determinants of health and access to culturally specific resources. The top needs identified during the community conversations also fell within the access to care and resources category and focused on knowledge of services and how to access them, consistency and quality of care, and transportation.

Next, the primary data was further analyzed to determine if any new or emerging needs were identified by the community. See the table below for a summary of the types of needs and barriers expressed by the community.

### Primary data findings

Access to Care	Access to Resources	Healthy Lifestyles and Chronic Conditions	Mental Health
<ul style="list-style-type: none"> <li>• Access to dental care</li> <li>• Access to mental health services</li> <li>• Assistance in navigating the healthcare system</li> <li>• Awareness of how to access care</li> <li>• Awareness of how to access mental health services</li> <li>• Coordination of care - internal and external</li> <li>• Cultural advocates</li> <li>• Culturally informed care</li> <li>• Extended clinic hours</li> <li>• Follow-up care after care or hospitalization</li> <li>• Lack of trust in healthcare system</li> <li>• Language barriers and need for interpreters</li> <li>• Long wait times to appointments</li> <li>• Patient advocate/ navigator</li> <li>• Transportation <ul style="list-style-type: none"> <li>○ Distance to appointment</li> <li>○ Don't drive</li> <li>○ Don't qualify for Metro Mobility</li> <li>○ Limited bus system</li> <li>○ No vehicle</li> <li>○ Rides from friends/family</li> <li>○ Winter weather</li> </ul> </li> <li>• Trust and relationship with providers</li> </ul>	<ul style="list-style-type: none"> <li>• Access to healthy and affordable food</li> <li>• Access to services</li> <li>• Affordable community activities and gatherings</li> <li>• Awareness resources and services</li> <li>• Central place to access information on services and resources</li> <li>• Community gatherings, programs and activities for older adults</li> </ul>	<ul style="list-style-type: none"> <li>• Access to healthy and affordable food</li> <li>• Access to safe and affordable places to exercise</li> <li>• Chronic conditions</li> <li>• Chronic disease management</li> <li>• Diabetes</li> <li>• Education on healthy eating</li> <li>• Exercise and physical activity</li> <li>• Fear of falling</li> <li>• Health education</li> <li>• Health literacy</li> <li>• Maintaining independence while aging</li> <li>• Medication education and management</li> <li>• Nutrition education</li> <li>• Preventative care</li> </ul>	<ul style="list-style-type: none"> <li>• Access to mental health services <ul style="list-style-type: none"> <li>○ Psychiatrist</li> <li>○ Family counseling</li> </ul> </li> <li>• Awareness of how to access mental health services</li> <li>• Caregiver support</li> <li>• Connection to others</li> <li>• Depression</li> <li>• Historical trauma</li> <li>• Loneliness</li> <li>• Mental health</li> <li>• Racism</li> <li>• Sense of belonging</li> <li>• Social connection</li> <li>• Stigma</li> <li>• Stress</li> <li>• Support groups</li> <li>• Welcoming community</li> </ul>
	Cost of Care		Substance Use
	<ul style="list-style-type: none"> <li>• Access to and awareness of affordable insurance plans</li> <li>• Cost of care</li> <li>• Cost of insurance</li> <li>• Cost of medications</li> <li>• High cost for mental health care</li> <li>• High deductibles and co-pays</li> <li>• Inability to take time off work for illness or appointments</li> <li>• Insurance doesn't cover everything</li> <li>• Transportation <ul style="list-style-type: none"> <li>○ No vehicle</li> </ul> </li> </ul>	Social Determinants of Health	Other
		<ul style="list-style-type: none"> <li>• Access to healthy and affordable food</li> <li>• Employment opportunities</li> <li>• Fixed income</li> <li>• Housing <ul style="list-style-type: none"> <li>○ Affordable</li> <li>○ Stable</li> </ul> </li> <li>• Neighborhood crime and safety</li> <li>• Poverty</li> <li>• Transportation <ul style="list-style-type: none"> <li>○ No vehicle</li> <li>○ Reliable transportation</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Youth drug use</li> </ul>
			<ul style="list-style-type: none"> <li>• Dental care</li> <li>• Spiritual health</li> <li>• Traditional healers</li> </ul>

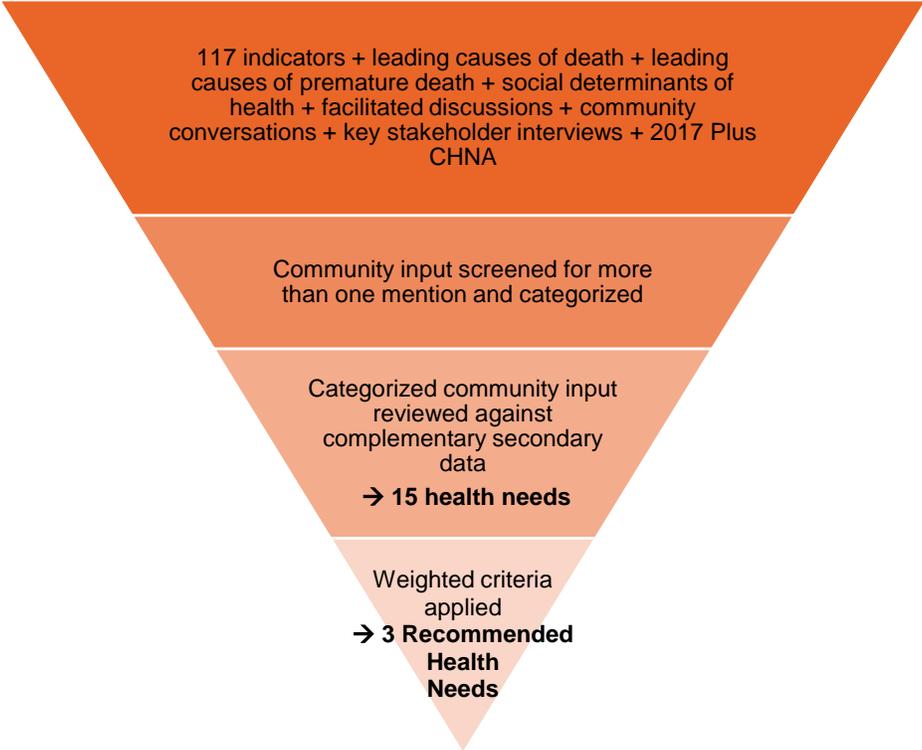
There were several findings from the primary data that were unique to the hospital's community, including:

- Access
  - Knowledge of services and information on how to access them
  - Barriers due to language and difficulty communicating
  - Lack of culturally appropriate resources
- Spiritual health
  - Spiritual health as a foundation, especially as a foundation to health
  - Body, mind, and spirit connections
- Mental health
  - Suicide was not mentioned

# Prioritization of health needs

In order to determine the top health needs in the community indicators from secondary data; data from Wilder Research on the leading causes of death and premature death, and the social determinants of health; and primary data that met two pieces of criteria: (1) a need and/or barrier that was said more than one time, and (2) a need and/or barrier that was repeated in at least two of the groups (e.g. both a stakeholder interview and a community conversation) were used. See graphic below for a description of this process.

## Prioritization process and need identification



The three health needs are consistent across all 11 Fairview hospitals and medical centers and are intentionally broad to allow for local variation during the implementation planning process.

The following weighted criteria were used to prioritize health needs. A maximum of 20 points were possible. Highest weight was given to the two criterion deemed most important by the hospital advisory council – continuing work in the 2017 Plus CHNA priority areas and ensuring future priorities aligned with what the community identified as top needs.

Weight	Criteria
6 points	2017 Plus CHNA priority need
5 points	Community priority
3 points	St. John’s expertise / resources / feasibility
3 points	Disparities exist
2 points	Magnitude / scale of need
1 point	Need is present in all 11 Fairview communities

The weighted criteria was applied to the top 15 health needs identified in the hospital community. The top 10 health needs include:

1. Mental health
2. Access to healthcare and resources
3. Healthy eating and active living
4. Suicide
5. Transportation
6. Quality and consistency of care
7. Cancer
8. Stroke
9. Care coordination
10. Cost associated with care

## Our 2018 priority health needs

- Mental health and well-being
- Healthy lifestyles
- Access to care and resources

These three priorities are consistent across all 11 Fairview hospitals and medical centers and are intentionally broad to allow for local variation during the implementation planning process.

### Needs identified but not addressed

Although the following health needs were not selected as priority needs, St. John's Hospital will continue to support work aligned with addressing these needs as appropriate particularly when doing so would address the social determinants of health and/or the leading causes of premature death.

Community Need	Reasons Not Addressed
Chronic lower respiratory disease	This issue will be addressed as part of patient care but falls outside the scope of the community-based CHNA Implementation Strategy.
Cost associated with care	This issue will be addressed as part of patient care but falls outside the scope of the community-based CHNA Implementation Strategy.
Quality and consistency of care	This issue will be addressed as part of patient care but falls outside the scope of the community-based CHNA Implementation Strategy.
Stroke	This issue will be addressed as part of patient care but falls outside the scope of the community-based CHNA Implementation Strategy.
Transportation	This issue is beyond what St. John's hospital resources can support at this time.

## Available resources to address priority health needs

As the St. John's Hospital develops its CHNA Implementation Strategy, it will look to both internal and external resources to address the significant health needs identified through the CHNA process described in this report.

External resources include community initiatives in partnership with numerous community stakeholders including, but not limited to, Ramsey County Public Health, Hmong American Farmer's Association, and Karen Chemical Dependency Collaborative. These initiatives, programs and relationships are the foundation from which the Implementation Strategy will be built.

## Conclusion and next steps

### **Adoption by the Fairview Board of Directors**

The Fairview Board of Directors adopted St. John's Hospital's 2018 CHNA reports on December 6, 2018. This report is available on Fairview Health Services website, [www.fairview.org](http://www.fairview.org), on December 31, 2018.

### **Implementation Strategy**

In late 2018, the St. John's Hospital will conduct the final steps in the assessment process by developing a written CHNA Implementation Strategy to address the identified priority health needs – mental health and well-being, healthy lifestyles, and access to care and resources.

The Fairview Board of Directors will be asked to adopt the hospital's 2019-2021 CHNA Implementation Strategy in April 2019. The document will be publicly available on [www.fairview.org](http://www.fairview.org), by May 15, 2019 and executed during fiscal years 2019-2021.

## Evaluation of impact, 2018 CHNA Implementation Strategy

St. John's Hospital along with Bethesda Hospital, St. Joseph's Hospital, and Woodwinds Health Campus participated in a multi-hospital Community Health Improvement Plan in 2018. This improvement plan was written to measure shared impact of the four hospitals mentioned above.

<b>Priority Need: Healthy eating and active living</b> Goal: Promote healthy lifestyles by improving access to nutritious, culturally responsive food and physical activity in order to increase the percentage of people living at a healthy weight.	
<b>Strategy 1</b>	Increase participation in physical activity and nutrition education in targeted East Metro neighborhoods and/or with priority populations.
<b>Program 1: East Side Table</b>	<p>East Side Table is a pilot project that seeks to improve access to healthy food by improving food skills. Components of the project include recipe tastings, community meals, cooking demonstrations, other education and outreach activities, and free make-at-home meal kits.</p> <p>This strategy was measured through participation at community events.</p> <p>Outcomes:</p> <ul style="list-style-type: none"> <li>• 28 cooking classes and demonstrations were held.</li> <li>• 281 people attended a cooking class or demonstration.</li> <li>• 4,625 people were reached through healthy eating engagement efforts.</li> </ul>
<b>Program 2: Wellness and Prevention Programs</b>	<p>Wellness and Prevention Programs includes evidence-based falls prevention programs Tai Ji Quan and A Matter of Balance.</p> <p>This strategy was measured with participants surveys that were administered at the beginning of the first class (pre) and end of the last class (post).</p> <p>Outcomes:</p> <ul style="list-style-type: none"> <li>• 5 classes with 49 participants.</li> <li>• There was a 58% reduction in the number of falls among participants.</li> <li>• There was a 3% reduction in the fear of falling among participants.</li> </ul>
<b>Strategy 2</b>	Improve access to and consumption of healthy food and improve food skills in targeted neighborhoods and/or with priority populations.
<b>Program 1: East Side Table</b>	<p>East Side Table is a pilot project that seeks to improve access to healthy food by improving food skills. Components of the project include recipe tastings, community meals, cooking demonstrations, other education and outreach activities, and free make-at-home meal kits.</p> <p>This strategy was measured with participant surveys that were administered at the end of community events.</p> <p>Outcomes:</p> <ul style="list-style-type: none"> <li>• Over 10 weeks, 106 families received make-at-home meal kits</li> <li>• 75% of participants from the community meal with seniors felt the recipe introduced them to a new food skill or cooking tip.</li> </ul>

<p><b>Program 2:</b> Fruit and Veggie Rx</p>	<p>Fruit and Veggie Rx is a partnership between the Hmong American Farmers Association and three HealthEast clinics to provide weekly boxes of local fruits and vegetables to immigrants and refugees who are food insecure.</p> <p>This strategy was measured with participant surveys that were collected before the start of program (pre) and at the end of the program (post).</p> <p>Outcomes:</p> <ul style="list-style-type: none"> <li>Over 22 weeks, 97 families received community support agriculture (CSA) boxes filled with fresh fruits and vegetables.</li> </ul> <p>Note: Pre and post surveys were collected for participants. Post surveys were collected mid-December and are not included in this report.</p>
<p><b>Strategy 3</b></p>	<p>Increase social connectedness among aging and new immigrant populations through mealtime.</p>
<p><b>Program 1:</b> East Side Table</p>	<p>East Side Table is a pilot project that seeks to improve access to healthy food by improving food skills. Components of the project include recipe tastings, community meals, cooking demonstrations, other education and outreach activities, and free make-at-home meal kits.</p> <p>This strategy was measured through participation at community events and with participants surveys that were administered at the end of community events.</p> <p>Outcomes:</p> <ul style="list-style-type: none"> <li>755 guests shared a meal together at 13 community meals.</li> <li>97% of participants from the community meals with seniors stated that the event helped them feel more connected to others in their community.</li> </ul>
<p><b>Strategy 4</b></p>	<p>Leverage HealthEast leaders on community boards, committees and other initiatives.</p>
<p><b>Activity 1:</b> Participation on community boards, committees, and other initiatives</p>	<p>This strategy was measured through time spent participating in community boards, committees, and other initiatives.</p> <p>Outcomes:</p> <ul style="list-style-type: none"> <li>Staff contributed 1,234 hours to community boards, committees, initiatives, and collaborations to improve health and address the social determinants of health.</li> <li>Participated in local public health department community leadership committees, including St. Paul-Ramsey County Public Health and Washington County Public Health.</li> <li>Participated in Minnesota Department of Health – Healthy Minnesota Partnership.</li> <li>Participated in local collaborations, including The Center for Community Health, East Side Health and Well-Being Collaborative, Woodbury Thrives, Central Corridor Anchor Partnership, and African American Leadership Council.</li> <li>Participated in national organizations, including Root Cause Coalition and the Healthcare Anchor Network.</li> </ul>

<b>Strategy 5</b>	Influence policy and systems change priorities related to food systems and active living at local community, state and national levels.
No programs or activities tied to policy or systems change were conducted in 2018.	

**Priority Need: Mental health and stress resilience**

Goal: Improve access to and awareness of culturally responsive mental health resources and education.

<b>Strategy 1</b>	Reduce stressors and increase coping skills regarding basic needs to targeted minority and aging populations.
<b>Program 1: East Side Mental Health and Stress Resilience Partnership</b>	<p>East Side Mental Health and Stress Resilience Partnership is a pilot project that provides culturally responsive opportunities to foster mental health and holistic well-being. Components of the project include place-based cultural brokers, community and provider trainings on cultural aspects of mental health, culturally specific community dialogues, and the identification of safe and sacred places.</p> <p>This strategy was measured through interactions and referrals with cultural brokers.</p> <p>Outcomes:</p> <ul style="list-style-type: none"> <li>• Five cultural brokers worked with 643 individuals to build self-efficacy and resilience within the African American, American Indian, Hispanic/Latino, Hmong, and Karen communities.</li> </ul>
<b>Strategy 2</b>	Increase access to culturally responsive resources for East Metro residents with mental health needs.
<b>Program 1: East Side Mental Health and Stress Resilience Partnership</b>	<p>East Side Mental Health and Stress Resilience Partnership is a pilot project that provides culturally responsive opportunities to foster mental health and holistic well-being. Components of the project include place-based cultural brokers, community and provider trainings on cultural aspects of mental health, culturally specific community dialogues, and the identification of safe and sacred places.</p> <p>This strategy was measured through the placement of cultural brokers within community organizations, and through pre and post surveys that were administered to people who met with a cultural broker.</p> <p>Outcomes:</p> <ul style="list-style-type: none"> <li>• Five cultural brokers were embedded within community organizations to provide culturally responsive resources to members from the African American, American Indian, Hispanic/Latino, Hmong, and Karen communities.</li> <li>• 46% of individuals surveyed after an interaction with a cultural broker strongly agreed that they felt connected to their community.</li> </ul>
<b>Program 2: Karen Chemical Dependency Collaboration</b>	<p>Karen Chemical Dependency Collaboration (KCDC) is a multi-organization collaboration working together to address substance use in the Karen community through education, screenings, treatment, and community support programs using a culturally relevant and informed approach.</p> <p>This strategy was measured by the number of professionals trained.</p> <p>Outcomes:</p>

	<ul style="list-style-type: none"> <li>Education on the Karen community was provided to 150 mental health professionals and providers.</li> </ul>
<b>Strategy 3</b>	Promote mental health awareness in the community.
<b>Program 1:</b> East Side Mental Health and Stress Resilience Partnership	<p>East Side Mental Health and Stress Resilience Partnership is a pilot project that provides culturally responsive opportunities to foster mental health and holistic well-being. Components of the project include place-based cultural brokers, community and provider trainings on cultural aspects of mental health, culturally specific community dialogues, and the identification of safe and sacred places.</p> <p>This strategy was measured through community dialogues and listening sessions.</p> <p>Outcomes:</p> <ul style="list-style-type: none"> <li>Four community dialogues and one listening session about mental health and well-being, with 76 individuals, were held in partnership with members from the following communities: African American, American Indian, Hispanic/Latino, Hmong, and Karen.</li> </ul>
<b>Program 2:</b> Karen Chemical Dependency Collaboration	<p>Karen Chemical Dependency Collaboration (KCDC) is a multi-organization collaboration working together to address substance use in the Karen community through education, screenings, treatment, and community support programs using a culturally relevant and informed approach.</p> <p>This strategy was measured through number of individuals reached.</p> <p>Outcomes:</p> <ul style="list-style-type: none"> <li>40 people participated in treatment group and after care groups.</li> <li>40 people participated in Karen Alcoholics Anonymous (AA) community support meetings.</li> <li>80 people were referred to KCDC for addiction assessment and/or treatment.</li> <li>Community education was provided to 500 individuals within the Karen community.</li> </ul>
<b>Strategy 4</b>	Leverage HealthEast leaders on community boards, committees and other initiatives.
<b>Activity 1:</b> Participation on community boards, committees, and other initiatives	<p>This strategy was measured through time spent participating in community boards, committees, and other initiatives.</p> <p>Outcomes:</p> <ul style="list-style-type: none"> <li>Staff contributed 1,234 hours to community boards, committees, initiatives, and collaborations to improve health and address the social determinants of health.</li> <li>Participated in local public health department community leadership committees, including St. Paul-Ramsey County Public Health and Washington County Public Health.</li> <li>Participated in Minnesota Department of Health – Healthy Minnesota Partnership.</li> <li>Participated in local collaborations, including The Center for Community Health, East Side Health and Well-Being</li> </ul>

	<p>Collaborative, Woodbury Thrives, Central Corridor Anchor Partnership, and African American Leadership Council.</p> <ul style="list-style-type: none"> <li>Participated in national organizations, including Root Cause Coalition and the Healthcare Anchor Network.</li> </ul>
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**Priority Need: Access to services and resources**

Goal: Improve access to and understanding of resources that positively impact health and the social determinants of health.

<b>Strategy 1</b>	Increase access to resources and services in the community.
<b>Program 1:</b> Faith Community Nurse Program	<p>Faith Community Nurse Program is a collaborative with faith-based settings and local congregations to provide basic health screenings, referrals to community resources, and opportunities for social connection in community-based settings.</p> <p>This strategy was measured through number of individuals reached.</p> <p>Outcomes:</p> <ul style="list-style-type: none"> <li>Faith community nurses reported 1,924 encounters with community members.</li> </ul>
<b>Program 2:</b> Minnesota Immunization Networking Initiative	<p>Minnesota Immunization Networking Initiative (MINI) is a community collaboration with the aim to increase influenza immunizations among minority and uninsured populations by utilizing the resources and trust of faith-based and grass-roots community organizations.</p> <p>This strategy was measured through number of individuals reached.</p> <p>Outcomes:</p> <ul style="list-style-type: none"> <li>21 MINI clinics were held and 2,118 individuals received a free flu shot.</li> </ul>
<b>Strategy 2</b>	Leverage organizational strengths and assets with those of the community by using upstream approaches to address social and economic factors that impact community health and well-being – our anchor mission
<b>Program 1:</b> Coming Home	<p>Coming Home is a partnership with Hearth Connection, Guild Incorporated, and Catholic Charities to improve the quality of life for homeless individuals with serious and persistent mental illness and to reduce unnecessary hospital admissions and emergency department visits by securing housing.</p> <p>This strategy was measured through number of individuals reached.</p> <p>Outcomes:</p> <ul style="list-style-type: none"> <li>13 individuals were permanently housed.</li> <li>Reduced emergency department visits by 65 visits.</li> </ul>
<b>Strategy 3</b>	Leverage HealthEast leaders on community boards, committees and other initiatives.
<b>Activity 1:</b> Participation on community boards, committees, and other initiatives	<p>This strategy was measured through time spent participating in community boards, committees, and other initiatives.</p> <p>Outcomes:</p> <ul style="list-style-type: none"> <li>Staff contributed 1,234 hours to community boards, committees,</li> </ul>

	<p>initiatives, and collaborations to improve health and address the social determinants of health.</p> <ul style="list-style-type: none"> <li>• Participated in local public health department community leadership committees, including St. Paul-Ramsey County Public Health and Washington County Public Health.</li> <li>• Participated in Minnesota Department of Health – Healthy Minnesota Partnership.</li> <li>• Participated in local collaborations, including The Center for Community Health, East Side Health and Well-Being Collaborative, Woodbury Thrives, Central Corridor Anchor Partnership, and African American Leadership Council.</li> <li>• Participated in national organizations, including Root Cause Coalition and the Healthcare Anchor Network.</li> </ul>
<b>Strategy 4</b>	Advocate for local community, state and national policy and systems change priorities and goals that broadly improve health and well-being.
No programs or activities tied to policy or systems change were conducted in 2018.	



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# 2019–2021 Implementation Strategy Report

St. John's Hospital



## St. John’s Hospital – Community Health Implementation Strategy

The following is the St. John’s Hospital Community Health Implementation Strategy to address the needs of the communities it serves for the years 2019-2021. This plan was developed with significant contributions from Fairview Health Services and St. John’s Hospital staff and providers, St. John’s Community Health Steering Committee members, and other community members and leaders.

The St. John’s steering committee reviewed and gave input to the Implementation Strategy, validated the development process, and recommended adoption of the Implementation Strategy and Community Health Improvement Plan by the Board of Directors.

Collaboration with community is the cornerstone of our work and Implementation Strategy process. While there are some elements of the strategy that are solely implemented by St. John’s Hospital, most will be executed in partnership with public health, businesses, nonprofits, faith organizations, educational institutions, health organizations, other community partners, and individuals to form sustainable solutions that go to the heart of local health assets, barriers, and needs.

## Community Health Improvement Plan 2019 – 2021

This plan will guide Fairview in bridging community and clinical care to improve health, address the root cause and contributing factors of health conditions, address priority populations, and catalyze Fairview’s anchor mission.

All programs and initiatives will focus on the identified priority needs of mental health and well-being, healthy lifestyles, and access to care and services, and will take into consideration our identified priority populations that include seniors, persons experiencing poverty, people of color and indigenous people.

### Priority: Mental health and well-being

Tactics	Hospital resources	Partners	Anticipated impacts
Offer Cultural Brokers	Community Engagement staff	American Indian Family Center Comunidades Latinas Unidas en Servicio (CLUES) Family Values for Life Hmong American Partnerships Karen Organization of Minnesota	Increase participants’ connectedness to others in the community
Offer evidence-based Mental Health First Aid training (adult and youth)	Behavioral Health staff Community Engagement staff Community Health and Innovation staff Interfaith Community Health staff Spiritual Health staff Youth Grief Services staff	Interfaith Health Collaborative Member Congregations StairStep Foundation	Increase in participants’ ability to recognize and correct misconceptions about mental health and mental illness

Tactics	Hospital resources	Partners	Anticipated impacts
Offer Mobile Substance Use Disorder Support Program	Fairview Mental Health & Addiction Fairview Ridges Medical Center St. John's Hospital St. Joseph's Hospital Woodwinds Health Campus	Bentson Foundation (through Regions Hospital Foundation) grant funding for two years East Metro Crisis Alliance Lakeview Hospital Minnesota Recovery Connection Ramsey County Detox Center Regina Hospital Regions Hospital United Hospital	Increase in the number of active participants in the recovery program
Offer Trauma Informed Congregations program	Interfaith Community Health staff	Hennepin Health StairStep Foundation	Increase in Clergy/Leader understanding of the impact of trauma on trauma survivors
Offer Youth Grief Services sessions and camps	Interfaith Community Health staff	Eluna (formerly The Moyer Foundation) New York Life	Increase in youth participants' knowledge of healthy coping strategies in response to grief
Tactics	Hospital resources	Anticipated impacts	
Collaborate in policy, systems and environmental (PSE) change around responding to trauma in settings such as schools and faith communities	Community Benefit & Measurement staff Community Engagement staff Community Health and Innovation staff Fairview Foundation Interfaith Community Health staff	Champions, partners and specific Primary Service Area (PSA) changes identified with implementation underway	

## Priority: Healthy lifestyles

Tactics	Hospital resources	Partners	Anticipated impacts
Offer East Side Table services	Community Engagement staff	American Indian Family Center Community Dental Care Comunidades Latinas Unidas en Servicio (CLUES) East Side Elders East Side Family Clinic Fairview (Legacy HealthEast) Kitchen on the Bluff & LEDC Local Crate Merrick Community Services Mississippi Market Neighborhood House The Sanneh Foundation / Conway Rec Center UMN Extension Urban Roots	Increase in participants' self-reported food skills
Offer evidence-based Falls Prevention Suite <ul style="list-style-type: none"> <li>Matter of Balance</li> <li>Tai Ji Quan</li> </ul>	Community Engagement staff Community Health and Innovation staff Interfaith Community Health staff Ways to Wellness	Arrowhead Agency on Aging Central Minnesota Council on Aging Juniper Local organizations serving seniors Metropolitan Agency on Aging	Decrease participants' fear of falling
Offer evidence-based Living Well Suite of programs <ul style="list-style-type: none"> <li>Chronic Disease Self-Management</li> <li>Chronic Pain Self-Management</li> <li>Diabetes Self-Management</li> </ul>	Community Engagement staff Community Health and Innovation staff	Arrowhead Agency on Aging Central Minnesota Council on Aging Juniper Metropolitan Agency on Aging	Increase participants' confidence to manage a chronic condition

Tactics	Hospital resources	Partners	Anticipated impacts
Offer Veggie Rx	Community Engagement staff Community Health & Innovation staff Integrated Primary Care Clinic Phalen Village Clinic Rice Street Clinic Roselawn Clinic	Hmong American Farmers Association (HAFA) Twin Cities Mobile Market	Increase vegetable consumption in food insecure patients

Tactics	Hospital resources	Anticipated impacts
Collaborate in policy, systems, and environmental (PSE) change around healthy food transformation addressing issues such as food insecurity, food access and changes to cafeteria menus	Community Benefit & Measurement staff Community Engagement staff Community Health and Innovation staff Fairview Foundation Interfaith Community Health staff	Champions, partners and specific PSA change identified with implementation underway

### Priority: Access to care and resources

Tactics	Hospital resources	Partners	Anticipated impacts
Conduct MINI Clinics	Interfaith Community Health staff	Homeland Health Specialists Portico Healthnet St. Catherine's University St. Mary's Health Clinics StairStep Foundation Additional site partners (more than 35)	Increase in the number of MINI clinics with culturally and/or linguistically appropriate materials around accessing care and resources
Offer Cultural Brokers	Community Engagement staff	American Indian Family Center Comunidades Latinas Unidas en Servicio (CLUES) Family Values for Life Hmong American Partnerships Karen Organization of Minnesota	Increase participants' confidence to access services themselves

Tactics	Hospital resources	Partners	Anticipated impacts
Offer evidence-based Falls Prevention Suite <ul style="list-style-type: none"> <li>• Matter of Balance</li> <li>• Tai Ji Quan</li> </ul>	Community Engagement staff Community Health and Innovation staff Interfaith Community Health staff Ways to Wellness	Arrowhead Agency on Aging Central Minnesota Council on Aging Juniper Local organizations serving seniors Metropolitan Agency on Aging	Increase in participants' comfort talking to their health care provider about medications and other possible risks of falling
Offer evidence-based Living Well Suite of programs <ul style="list-style-type: none"> <li>• Chronic Disease Self-Management</li> <li>• Chronic Pain Self-Management</li> <li>• Diabetes Self-Management</li> </ul>	Community Engagement staff Community Health and Innovation staff	Arrowhead Agency on Aging Central Minnesota Council on Aging Juniper Metropolitan Agency on Aging	Increase in participants who agree that the program helps them work with their health care providers
Offer evidence-based Mental Health First Aid training (adult and youth)	Behavioral Health staff Community Engagement staff Community Health and Innovation staff Interfaith Community Health staff Spiritual Health staff Youth Grief Services staff	Interfaith Health Collaborative Member Congregations StairStep Foundation	Increase participants' confidence in assisting someone to connect with professional resources
Offer Veggie Rx	Community Engagement staff Community Health & Innovation staff Integrated Primary Care Clinic Phalen Village Clinic Rice Street Clinic Roselawn Clinic	Hmong American Farmers Association (HAFA) Twin Cities Mobile Market	Increase participants' knowledge about where to buy locally grown produce



In addition to the tactics mentioned above, St. John's Hospital supports community efforts addressing needs identified during the CHNA process and/or by a public agency or community group that may extend beyond the three priority areas to create a positive environment through collaboration with external partners such as faith community nurses, the mental health and stress resilience partnership, and the East Side health and well-being collaborative. St. John's Hospital also supports community efforts through sponsorships and donations.

## **Adoption by Board of Directors and next steps**

The Fairview Board of Directors adopted the 2019-2021 Implementation Strategy on April 18, 2019. This report is available to the general public on the Fairview website, [www.fairview.org](http://www.fairview.org) on May 15, 2019.

Finally, program staff will conduct programming 2019 through 2021, measuring outcomes for each program. Over the three years, staff will conduct continuous improvement through weekly, monthly, and annual impact measurement and will continually seek new community partners and audiences for the programming. An evaluation of impact report will be given to the steering committee and the Board of Directors annually at the end of the year. At that time, changes or improvements to the plan will be made and approved.

## Citations

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<sup>1</sup> [http://www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/)

<sup>2</sup> <https://maplewoodmn.gov/523/Community>

<sup>3</sup> Insert citation "Ramsey County". Metro MSP. Minneapolis Regional Chamber Development Foundation. 2008. Retrieved July 30, 2008.

<sup>4</sup> 15% of all Minnesotans are 65 or older. <http://www.mncompass.org/trends/insights/2017-05-30-older-adults>

<sup>5</sup> [http://www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/)

<sup>6</sup> <https://www.healthpeople.gov/2020/about/foundation-health-measures/Disparities>

<sup>7</sup> <http://cni.chw-interactive.org/>

<sup>8</sup> American Psychological Association. <http://www.apa.org/topics/socioeconomic-status/>

<sup>9</sup> Minnesota's median household income was \$65,599 in 2016. <https://www.mncompass.org/economy/median-income#1-6799-g>

<sup>10</sup> Minnesota Compass. <http://www.mncompass.org/workforce/proportion-of-adults-working#1-6783-d>

<sup>11</sup> Minnesota Compass. <https://www.mncompass.org/workforce/educational-attainment#1-6803-g>

<sup>12</sup> Wright, N., & Roesler, J. (2017). Drug overdose deaths among Minnesota residents, 2000-2016. Saint Paul: Minnesota Department of Health.

<sup>13</sup> U.S. Department of Health and Human Services. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020 [Internet]. Section IV: Advisory Committee findings and recommendations [cited 2010 January 6]. Available from: [http://www.healthypeople.gov/sites/default/files/PhaseI\\_0.pdf](http://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf).

## Appendices

- Appendix A: Fairview Board of Directors
- Appendix B: Fairview Patient Care and Experience Committee of the Corporate Board
- Appendix C: Community Advisory Council
- Appendix D: Fairview Community Benefit Staff
- Appendix E: HealthEast Community Advisory Council
- Appendix F: St. John's Hospital cities and zip codes
- Appendix G: Community Need Index scores for St. John's Hospital community
- Appendix H: List of primary data sources
- Appendix I: Community conversation questions
- Appendix J: Focus group questions
- Appendix K: Key stakeholder interview questions

## Appendix A

### Fairview Board of Directors

- Ann Hengel (Chair), Retired Executive Vice President and Chief Risk Officer, Bremer Financial Corporation
- Ann Lowry, MD (Second Vice Chair), Colon Rectal Surgery Associates, LTD
- Betsy L. Wergin, Former Minnesota Public Utilities Commissioner
- Brad Wallin, Business owner
- Brian Burnett, PhD, Senior Vice President, Finance and Operations, University of Minnesota
- Carol Ley, MD, Retired Vice President and Corporate Medical Director, 3M
- Jakub Tolar, MD, Dean of the Medical School, University of Minnesota
- James Hereford, President and Chief Executive Officer, Fairview
- John Heinmiller, Independent Investor and Consultant
- Julie S. Causey, Chairman Emeritus, Western Bank
- Karen Grabow (Secretary), Retired Senior Vice President, Human Resources, Land O'Lakes
- Kenneth Roering, Professor Emeritus, University of Minnesota
- Kevin Roberg, Founder and Principal, Kelsey Capital Management
- Michael Connly, Chief Information Officer, Optum
- Rich Ostlund (First Vice Chair), Partner, Anthony Ostlund Baer & Louwagie P.A.
- Rich Thompson, MD, Suburban Radiologic Consultants, Ltd.
- Sophia Vinogradov, Professor and Department Head, Department of Psychiatry, University of Minnesota
- Tim Marx, President and Chief Executive Officer, Catholic Charities

## Appendix B

### Fairview Patient Care and Experience Committee of the Corporate Board

- Ann Hengel, Retired Executive Vice President and Chief Risk Officer, Bremer Financial Corporation
- Ann Lowry, MD, Colon Rectal Surgery Associates, LTD
- Carol Ley, MD, Retired Vice President and Corporate Medical Director, 3M
- Jakub Tolar, MD, Dean of the Medical School, University of Minnesota
- James Hereford, President and Chief Executive Officer, Fairview
- Dr. Levi Downs Jr., MD, Professor, Department of Obstetrics, Gynecology and Women's Health, University of Minnesota
- Rich Thompson, MD, Suburban Radiologic Consultants, Ltd.
- Ruth Bachman, Author, Public Speaker and Founder, The Hourglass Project
- Sophia Vinogradov, Professor and Department Head, Department of Psychiatry, University of Minnesota
- Tim Marx, President and Chief Executive Officer, Catholic Charities

## Appendix C

### Community Advisory Council

- Alfred Babington-Johnson, Founder and Chief Executive Officer, Stairstep Foundation
- Bob Vogel, Banker, New Market Bank
- Dave Oswald, Realtor, Coldwell Banker
- Dave Purdy, Founder and Chief Executive Officer, Wealth Management Midwest
- David Holm, Director of Spiritual Services, Senior Care Communities
- Diane Tran, Senior Director Community Engagement, Fairview
- Ellen Grimsby, Owner, Premier Foods Brokerage
- James Hereford, President and Chief Executive Officer, Fairview
- Joanne Ploetz, Administrative, Recreational Supply Corporation
- John Swanholm, Vice President, Community Advancement and President, Foundation, Fairview
- Kathy Sterk, Educational Consultant
- Linda Madsen, Retired Superintendent, Forest Lake Area Schools
- Maggie Collins, Ebenezer Foundation
- Mai Moua, Chief Operating Officer, Hmong American Partnership
- Mark Oleen, Branch Manager, Bremer Bank
- Mary Kosak, Retired Program Officer, Blandin Foundation
- Michael Raich, Provost, Hibbing Community College
- Paul Pribbenow, President, Augsburg College
- Paul Mooty, Attorney
- Peggy Johnson, Community Relations Director, Dakota Electric Association
- Ruby Lee, President, Comunidades Latinas Unidas En Servicio (CLUES)
- Scott Berry, Attorney, Berry Law Offices
- Sondra Weinzierl, Faith Community Nurse, Peace Lutheran and Messiah United Methodist

## Appendix D

### Fairview Community Benefit Staff

- Jennifer Morman, Manager Community Benefit
- Joan Pennington, Senior Director Community Benefit and Measurement
- Mee Cheng, Data Analyst Associate
- Megan Chacon, Community Impact Manager
- Mohammed Selim, Community Benefit Analyst
- Tiffany Hoffman, Community Benefit Analyst

## Appendix E

### HealthEast Community Advisory Council

- Adam Crepeau, Fairview Health Services
- Alana Wright, East Side Partnership for Healthy Aging (Wilder)
- Amy Nelson-Forkner , Fairview Health Services
- Andriana Abariotes, Twin Cities LISC
- Ann Bailey, Dakota Area Resources and Transportation for Seniors (DARTS)
- Anna Greer, American Indian Family Center
- Anne Barry, St. Paul-Ramsey County Public Health
- Beth Hein, Century College
- Bonnie Brueschoff , Dakota County Public Health
- Courtney Troyer, St. Paul Eastside YMCA
- Crystal Yang, Community Dental Center
- Dean Neumann, Fairview Health Services
- Deb Rodahl, St. Joseph's Hospital
- DuWayne Konewko, City of Maplewood
- Eva Song Margolis, Lutheran Social Services Eastside Financial Center
- Jaeden Allen, Community Member
- Jessica Gourneau, American Indian Family Center
- Jodi Bantley, Metropolitan State University
- Jodi Ritacca, Woodbury Thrives
- Julia Wolfe, St. Paul-Ramsey County Public Health
- Julie Roles , Vital Aging Network
- Katherine Beecham, Lutheran Social Services Eastside Financial Center
- Kelby Grovender, Hearth Connection
- Keshawn Williams, Twin Cities Mobile Market
- Keven Blake, YMCA – Eastside Branch
- Kim Miles, Metropolitan State University
- Kristi Ball, Bethesda Hospital
- Kristin Reither, Maplewood Community Center – YMCA
- Laura Keithahn, St. John's Hospital
- Lisa Buesgens, Fairview Health Services
- Lowell Johnson, Washington County Public Health
- Mai Moua, Hmong American Partnership
- Mark Skeie, Vital Aging Network
- Melanie Countryman, Dakota County Public Health
- Michele Brin, Woodwinds Hospital
- Munira Salad, International Institute of Minnesota
- Nora Slawik, City of Maplewood
- Paige Bowen, West Side Community Health Services
- Pat Schoon, Metropolitan State University
- Rhys Williams, The Good Acre
- Roger Green, Woodbury Thrives
- Ruby Lee, Comunidades Latinas Unidas En Servicio (CLUES)
- Samuel Estes, Portico Healthnet
- Sara Barsel, Roseville Community Health Awareness Team
- Saw Baw, International Institute of Minnesota
- Sharon D'Agostino, Johnson & Johnson
- Tracy Berglund, Catholic Charities of St. Paul and Minneapolis
- Viva Yang, Lutheran Social Services Eastside Financial Center

## Appendix F

### St. John's Hospital cities and zip codes

St. John's Hospital		
Located in the city of Maplewood		
Located in Ramsey County		
Zip	City	County
55014	Circle Pines	Anoka
55025	Forest Lake	Washington
55038	Hugo	Washington
55082	Stillwater	Washington
55090	Willernie	Washington
55106	St. Paul	Ramsey
55109	Maplewood	Ramsey
55110	White Bear Lake	Ramsey
55112	New Brighton	Ramsey
55113	Roseville	Ramsey
55115	Mahtomedi	Washington
55117	Little Canada	Ramsey
55126	Shoreview	Ramsey
55127	Vadnais Heights	Ramsey
55130	St. Paul	Ramsey

## Appendix G

### Community Need Index scores for St. John's Hospital community

Zip	City	2012	2016
55014	Circle Pines	1.4	1.6
55025	Forest Lake	1.6	1.6
55038	Hugo	1.4	1.4
55082	Stillwater	1.4	1.8
55090	Willernie	*	2.6
55106	St. Paul	4.4	4.6
55109	Maplewood	2.4	3.2
55110	White Bear Lake	1.6	2.0
55112	New Brighton	2.2	2.8
55113	Roseville	2.6	2.8
55115	Mahtomedi	1.4	1.4
55117	Little Canada	3.8	4.6
55126	Shoreview	1.4	1.8
55127	Vadnais Heights	1.4	1.4
55130	St. Paul	*	5.0

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

## Appendix H: List of primary data sources

### Key stakeholder interviews

#	Organization	Role	Sector	Expertise	Date Consulted (2018)
1	City of Maplewood	Mayor	Government	Broad community	August 1
2	Karen Organization of Minnesota	Program Manager, Community Health & Youth Development	Coalitions / Collaborators	Karen community	August 15

### Community conversations and focus groups

#	Host Organization	Group Represented	Consultation Method	Date Consulted (2018)
1	Maplewood Professional Building	Care Managers	Focus Group	July 10
2	Maplewood Clinic (Group A)	Care Coordinators	Focus Group	July 25
3	Maplewood Clinic (Group B)	Care Coordinators	Focus Group	July 25
4	Maplewood Community Center (Group A)	Seniors	Community conversation	August 6
5	Maplewood Community Center (Group B)	Seniors	Community conversation	August 6

## Appendix I

### Community conversation questions

- What does “being healthy” mean to you and your family?
- What are the top health needs in your community?
- Whom do you turn to or where do you go when you need help with being healthy?
- What difficulties, barriers, or roadblocks do you experience when you are working to manage your physical or mental health?
- What difficulties, barriers, or roadblocks do you experience when seeking or receiving health services? By health services, we mean any care related to your health such as medical care, counseling, physical therapy, etc.
- What do you think is needed in the community to help you, your family and your community to be healthy?
- What do you see as the role of the clinic or hospital to help you, your family, and your community to be healthy?
- Let’s revisit the top health needs we identified at the beginning of our conversation. Should anything new be added to this list?

## Appendix J

### Focus group questions

- What does “being healthy” mean to you and the people/patients you serve?
- In thinking about the people/patients you serve, what are the top health needs?
- Where do the people/patients you serve turn to or where do they go when they need help with being healthy?
- What difficulties or barriers do the people/patients you serve experience when they are working to manage their physical or mental health?
- What difficulties or barriers do they experience when they are seeking or receiving health services? By health services, we mean any care related to health such as medical care, counseling, physical therapy, etc.
- What do you think is needed in the community to help the people/patients you serve to be healthy?
- What do you see as the role of the clinic or hospital to help people and communities to be healthy?
- Let’s revisit the top health needs we identified at the beginning of our conversation. Should anything new be added to this list?

## Appendix K

### Key stakeholder interview questions

- In thinking about the people and communities you serve, what are the top health needs?
- Which health needs do you believe are the most important to address among the people that you serve – the needs that are not being met very well right now?
- Are there any specific groups that have greater health needs, or special health needs?
- Where do the people you serve turn to or where do they go when they need help with being healthy?
- What difficulties or barriers do the people you serve experience when they are working to manage their physical or mental health?
- What difficulties or barriers do they experience when seeking or receiving health services? By health services, we mean any care related to health such as medical care, counseling, physical therapy, etc.
- What do you think is needed in the community to help the people you serve to be healthy?
- What are the strengths or assets in the community?



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