2012 Community Health Needs Assessment Report

Fairview Health Services

Fairview Health Services is comprised of:

- Fairview Lakes Medical Center
- Fairview Northland Medical Center
- Fairview Range Regional Health Services
- Fairview Ridges Hospital
- Fairview Southdale Hospital
- University of Minnesota Medical Center, Fairview / University of Minnesota Amplatz Children’s Hospital
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Community Health Needs Assessment Team Members

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- Cheryl Bisping, Fairview Range Regional Medical Center Team Lead
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- Ann Ellison, Process Owner/Director of Community Health Department
- Brian Grande Lemus, Quantitative Data Team Member
- Mark Hansberry, Champion/Sr VP Strategic Planning, Marketing and Communications, Fairview Health Services
- James Janssen, Tax Director, Fairview Health Services
- Beth Krehbiel, Fairview Ridges Hospital, Team Lead (shared role)
- Alissa LeRoux Smith, Fairview Southdale Hospital Team Member
- Marie Maslowski, Fairview Northland Medical Center Team Lead
- Paula McNabb, Qualitative Data Team Member
- Stacy Montgomery, Fairview Ridges Hospital Team Lead (shared role)
- Jennifer Morman, CHNA Project Manager
- Sahra Noor, University of Minnesota Medical Center/University of Minnesota Amplatz Children’s Hospital Team Lead
- Carla Norelius, Fairview Lakes Medical Center Team Lead
- Pat Peterson, Qualitative Data Team Lead
- Hiba Sharif, University of Minnesota Medical Center/University of Minnesota Amplatz Children’s Hospital Team Member
- Cathy Utne, Fairview Southdale Hospital Team Lead
- Amelia Vandarious, contracted graduate intern from University of Minnesota School of Public Health/Quantitative Data Team Lead
- Sue Winkel, Process Team Member

Contributors:

- Brady Atherton, Sr Planning and Market Analyst
- Cindy Fruitrail, Sr Director Communications and Public Affairs
- Cesar Garcia, Medical Interpreter and Community Health Coordinator
- Jon Howard, Planning Analyst

About Our Community Health Needs Assessment

Fairview’s hospitals have worked collaboratively with one another and in consultation with the broader community to conduct community health needs assessments (CHNA) since 1995. The results of these CHNAs have been used to inform community benefit efforts, ensuring that programs and services are serving those with the greatest needs.

In 2011, the Community Health Department was given the task of conducting an expanded CHNA to meet new federal requirements. The March 2010 passage of the Patient Protection and Affordable Care Act (PPACA) introduced new reporting requirements for private, not-for-profit
hospitals to maintain 501(c)(3) tax-exempt status. Effective for tax years beginning after March 2012, each hospital must:

- Conduct a CHNA at least once every three years on a facility-by-facility basis
- Identify action plans to address unmet community health needs
- Report the results of each CHNA publicly

Fairview’s six hospitals conducted the 2012 CHNA over a 10-month period spanning from February to December. All hospitals followed a standard methodology with the Community Health Department providing templates, tools and quantitative and qualitative data. Hospitals included in this report are:

- Fairview Lakes Medical Center
- Fairview Northland Medical Center
- Fairview Range Regional Health Services
- Fairview Ridges Hospital
- Fairview Southdale Hospital
- University of Minnesota Medical Center, Fairview / University of Minnesota Amplatz Children’s Hospital

Quantitative and qualitative data was gathered for Fairview Red Wing Medical Center’s PSA but its sale to Mayo Clinic mid-year halted the process before data analysis began. All gathered data was given to Mayo Clinic as part of the ownership transition.

The pages that follow present the results of the 2012 CHNA along with the methodology used for the assessment. As a companion to this report, hospital specific CHNA Implementation Plans with detailed information concerning all aspects of the hospital’s CHNA process are included in Appendix A.

**Overview and Background**

The 2012 CHNA examines the unmet health needs of populations living in Fairview’s primary service areas (PSA). The results of the CHNA will direct and focus community benefit efforts for these six not-for-profit hospitals as appropriate for their local communities.

**Objectives**

The objectives of the CHNA were to: 1) Identify the unmet health needs of community residents in each hospital’s PSA, 2) Understand the challenges these populations face when trying to maintain and/or improve their health, 3) Understand where underserved populations turn for services needed to maintain or improve their health and 4) Understand what is needed to help these populations maintain and/or improve their health.

**Definition of Community**

The CHNA definition of community included six PSAs. These areas are home to more than 1,887,000 people. To provide details of the differing health needs across the PSAs, data was collected and analyzed at the zip code level across these local communities. In all, 114 zip codes were included in this needs assessment. See Appendix B for a detailed list of zip codes by hospital PSA.
Roles
Fairview’s Community Health Department provided oversight, standardized tools and instructions and also did the gathering, cleaning, analyzing and presentation of quantitative and qualitative data. There were several teams leading specific pieces of the CHNA, including: a team for each hospital, a process team, a quantitative data team and a qualitative data team.

Each hospital created a Community Health Steering Committee (CHSC), following a standard charter, comprised of at least eight members and not exceeding twelve members. Each CHSC included the following roles:

- At least one hospital board member
- Director of Corporate Community Health
- Local Community Health Lead
- Physician
- Public Health Representative

Decisions on how to fill the remaining roles were made at the discretion of each hospital president and local Community Health Team Lead. A complete list of all CHSC members is provided in Appendix C.

The CHSC had many responsibilities ranging from helping in the identification of focus group participants to the review, prioritization and recommendation to the hospital board of prioritized community needs via hospital-specific CHNA Implementation Plans.

Hospital boards were periodically updated throughout the CHNA process and approved their hospital-specific priorities and CHNA Implementation Plans.

Community Descriptions by Hospital

For a map of each hospital’s PSA, see Appendix D.

The following community descriptions were sourced from: Minnesota Hospital Association, Jola, provider websites, Minneapolis/St. Paul directory, Minnesota Department of Health and Claritas.

Fairview Lakes Medical Center
The Fairview Lakes PSA is a mix of suburban and rural, and has a population of slightly under 150,000 people. The population is spread over a large geography, with only 167 people per square mile. The Lakes PSA is expected to experience strong population growth, with a 7.5% increase in population size expected over the next five years. Median household income of the Lakes PSA is around $62,500, which is comparable to the $63,000 of the residents of the 12-county metro area.

Fairview Lakes Medical Center is the only multispecialty hospital in the Fairview Lakes PSA, with Allina’s Unity Hospital and HealthEast’s St. John’s Hospital just outside the southern portion of the Lakes PSA. Lakeside Medical Center in Pine City is the other inpatient facility in this geography, but it only has 10 inpatient beds. Fairview Lakes Medical Center is the predominate primary care provider in the market, with Allina, HealthEast and HealthPartners/Park Nicollet each operating a primary clinic in the southern portion of the Lakes PSA.
**Fairview Northland Medical Center**
The Fairview Northland PSA is the smallest of the six PSAs, with a population of approximately 115,000 people. Due to its exurban and rural composition, it has a lower population density, with only 112 people per square mile. It also is not as wealthy as the 12-county metro, with a median household income of under $53,000, compared to $63,000 for the 12-county area. A good proportion of the Fairview Northland service area’s population is younger, with almost 29% of the population below the age of 17. This is the largest proportion of any of the Fairview service areas.

Fairview Northland Medical Center is the sole provider of inpatient care for this service area, with Allina’s Cambridge Medical Center being the next closest hospital directly to the east. Fairview Northland Medical Center is the main primary care provider in this area; with clinics along highway 169 from Milaca to Elk River. Allina, HealthPartners/Park Nicollet and North Memorial are the other health systems in the area, each operating a primary care clinic in Elk River.

**Fairview Range Regional Health Services**
Located in northeastern Minnesota, the Fairview Range PSA is a large, rural area with a population of just under 46,000 people. Residents tend to be much older, with almost 18% of the population above the age of 65. Over the next five years, this area is expected to age very quickly—with an 11.5% increase predicted for those over age 65 and a 3.7% decline in the population under age 17. The median household income of residents of Fairview Range PSA is around $42,500, which is slightly below the state median of $46,500.

There are three inpatient facilities in the Fairview Range PSA: University of Minnesota Medical Center - Mesabi, Virginia Regional Medical Center and the critical access Cook Hospital. Also, Duluth-based Essentia Health and St. Luke’s operate multiple primary care clinics in the area, and Fairview Range Regional Health Services has three primary care clinics in this PSA. Grand Rapids is just outside Hibbing to the southwest, and a portion of patients travel to the Grand Itasca Hospital and Clinic for care.

**Fairview Ridges Hospital**
Fairview Ridges Hospital’s PSA, also known as Minnesota Valley, is a suburban area south of the Minnesota River, with a population of roughly 351,000 people. The area has been one of the fastest growing in the metro and this trend is expected to continue. In the next five years, the population is estimated to grow 6.4%, which is above the expected 4.1% growth of the 12-county metro area. Residents of the Minnesota Valley are relatively wealthy, boasting a median household income of just over $76,000, which is much higher than the $63,000 of the 12-county metro area. The Minnesota Valley also is a younger community, with only 7.2% of the population over age 65.

Fairview Ridges Hospital is the only inpatient facility in this PSA and it provides more than one-third of the inpatient care to the residents of the Minnesota Valley. Fairview Ridges Hospital and nearby Fairview clinics provide more than 50% of the care to the Minnesota Valley inpatient population. Fairview has eight primary care clinics in the Minnesota Valley, which is the most among the major metro health systems. Allina/Quello (5), HealthPartners/Park Nicollet (5) and HealthEast (1) are the other health systems with primary care clinics. Also, there are seven independent primary care clinics located in this PSA.
Fairview Southdale Hospital
With a population of roughly 509,000 people, the Fairview Southdale Hospital PSA is the second largest Fairview PSA and has a population density of 1,889 people per square mile. The residents of this PSA tend to be older, with almost 13% of the populace over the age of 65, compared to 10.5% in the 12-county metro area. By 2017, this age band is expected to grow by 12.1%, the fastest of any age group in the PSA. Not only is this PSA older than the broader 12-county metro, it is also more affluent. The residents of this PSA have a median household income around $69,000, which is well above the $63,000 median for the 12-county area.

Fairview Southdale Hospital and HealthPartners/Park Nicollet’s Methodist Hospital are the only inpatient facilities in the service area. Residents also travel to Abbott, Children’s, University of Minnesota Medical Center, Fairview/University of Minnesota Amplatz Children’s Hospital and Hennepin County Medical Center for inpatient care. There are more than 65 primary care clinics in this PSA. Over half are operated by HealthPartners/Park Nicollet, Allina, Fairview and Ridgeview, while the rest are independent.

The Fairview Southdale Hospital PSA has one Federally Qualified Health Center/Look-alikes include Southside Community Health Services and Universal Medical Services, Inc (d.b.a. AXIS Medical Center).

University of Minnesota Medical Center, Fairview/University of Minnesota Amplatz Children’s Hospital
The University of Minnesota Medical Center, Fairview/University of Minnesota Amplatz Children’s Hospital, also known as Central Metro PSA, has a 2012 population of roughly 716,000 people. It is one of the most urbanized of Fairview’s PSAs, with a population density of 4,793 people per square mile. Seventy percent of the population is white, with blacks and Asians representing 14% and 6% of the population, respectively. All other racial groups comprise 10% of the Central Metro’s population. The Central Metro PSA is relatively older and less affluent than the 12-county metro area. Residents over the age of 65 make up 11.9% of the service area, compared to only 10.5% of the 12-county area. Median household income of the residents is roughly $44,000, which is well below the $63,000 median income of the broader 12-county population.

Health care services in this PSA are arguably some of the best in the state, if not in the Midwest, and there is a full continuum of care for residents to potentially access. The spectrum runs from sophisticated, research-driven specialty care at University of Minnesota Medical Center, Fairview/University of Minnesota Amplatz Children’s Hospital to community health centers and clinics. Allina, Children’s, Gillette Children’s, Hennepin County Medical Center and Fairview have large hospitals in the Central Metro, with HealthPartners/Park Nicollet, North Memorial and HealthEast operating hospitals just outside the PSA boundaries. All the major metro health systems have primary care clinics and/or specialty clinics in the Central Metro, as well as a good mix of independent and community clinics.

Federally Qualified Health Centers/Look-alikes exist within the central metro area, including: Cedar Riverside People’s Center, Community University Health Care Center, Fremont Community Health Services, Hennepin County Care for the Homeless, Indian Health Board of Minneapolis, Native American Community Clinic and Northpoint Health & Wellness Center.
Data Types and Data Collection
The CHNA objectives, best practices (gleaned from review of national models) and data availability drove the selection of both the quantitative and qualitative data.

Qualitative Data
Qualitative data was collected through focus groups, stakeholder interviews and surveys. All qualitative data was gathered using a standardized set of questions and prompts. See Appendix E for the questions and tools used. Focus groups and stakeholder interviews were conducted in both English and Spanish. Surveys were conducted in English, Spanish and Somali, based on the populations within the PSAs.

There were a minimum of three focus groups conducted at each hospital – (1) moms with children, (2) seniors, and (3) vulnerable populations. The Hospital President, CHSC and Team Lead determined who to invite and extended the invitations for their hospital. Focus groups, stakeholder interviews and surveys were conducted by a core team that also had accountability for translations, transcription, analysis and reports.

Total qualitative data gathered, translated to English (when necessary) and analyzed:
- 27 focus groups, consisting of 230 people
- 72 stakeholder interviews
- 724 surveys (combined web and paper)

Quantitative Data
To identify the unmet health needs of community members, Community Need Index (CNI) Scores, mortality, hospitalization and ER utilization data were collected.

CNI scores were developed by Catholic Healthcare West and Thompson Reuters. The CNI Scores combine publicly available and proprietary data to create an objective measure of socio-economic barriers to health care access among populations and their effect on inappropriate hospital admissions. CNI scores range from a 5 (highest health disparity/highest community need) to a 1 (lowest health disparity/lowest community need).

The research completed by Catholic Healthcare West and Thompson Reuters shows a causal relationship between nine socio-economic barriers to health care and preventable hospital admissions. Their research found that residents of a zip code with a CNI Score of 5 are hospitalized 60% more than residents of a zip code with a CNI score of 1. Also, people with ambulatory sensitive conditions (ASC) such as pneumonia or ear infections were hospitalized 97% more when they resided in a zip code with a CNI score of 5 compared to people that live in a zip code with a CNI score of 1.
Variables included in the CNI

<table>
<thead>
<tr>
<th>Variable Description</th>
<th>Percentage Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of households below poverty line,</td>
<td></td>
</tr>
<tr>
<td>with the head of household age 65 or more</td>
<td></td>
</tr>
<tr>
<td>Percentage of families with children under 18</td>
<td></td>
</tr>
<tr>
<td>below poverty line</td>
<td></td>
</tr>
<tr>
<td>Percentage of single female-headed families with</td>
<td></td>
</tr>
<tr>
<td>children under 18 below poverty line</td>
<td></td>
</tr>
<tr>
<td>Percentage of population over 25 without a high</td>
<td></td>
</tr>
<tr>
<td>school diploma</td>
<td></td>
</tr>
<tr>
<td>Percentage of population that is minority</td>
<td></td>
</tr>
<tr>
<td>(including Hispanic ethnicity)</td>
<td></td>
</tr>
<tr>
<td>Percentage of population over age 5 that speaks English poorly or not at all</td>
<td></td>
</tr>
<tr>
<td>Percentage of population in the labor force, ages 16 or more, without employment</td>
<td></td>
</tr>
<tr>
<td>Percentage of population without health insurance</td>
<td></td>
</tr>
<tr>
<td>Percentage of households renting their home</td>
<td></td>
</tr>
</tbody>
</table>

Maps of each PSA with corresponding CNI scores are located in Appendix F.

Mortality data by zip code was obtained from the Minnesota Department of Health (MDH). Hospitalization and ER data (for which patient was not admitted to the hospital) at the zip code level was obtained from the Minnesota Hospital Association (MHA). All of the data was obtained for years 2008-2010 and by the following age ranges:

1. All Ages, 0 through time of death
2. Children, 0 to 18 years of age
3. Seniors, 65 years of age and older

Hospitalization and ER data was obtained at the ICD-9 code level. ICD-9 codes are the specific diagnosis which gives the reason that a patient was admitted to the hospital or visited the ER.

Mortality data was obtained at an ICD-10 category code level, a category code signifies that diagnoses are grouped into categories.

Substantial internal data was collected at the hospital level, but was not used for the analysis in this report due to HIPPA regulations. Internal data in conjunction with the qualitative data findings will be utilized over the next year as action plans are fully implemented.

Data Analysis
During the planning phase of the CHNA, a review of national data collection and analysis methodologies was conducted. Best practices were implemented whenever possible.

Qualitative
Qualitative data was analyzed three ways – by hospital (PSA), by population (vulnerable, moms with children and seniors) and for the combined Fairview system. During analysis, the following key steps were followed:

- Review of hospital focus groups and stakeholder interview notes and reports
- Identification of trends
- Identification of overlaps with qualitative data
- Identification of outliers and removal or notation of them (dependent upon the outlier)
- Creation of hospital-specific reports
Quantitative
After mortality, hospitalization, ER and CNI data was gathered, it was cleaned and analyzed in a variety of ways and combinations.

Final analysis consisted of the following steps:
1. Identification of the top 20 conditions by mortality, hospital and ER utilization
2. The top 20 were narrowed to the top 10 conditions, both with and without birth data (birth data is defined as any pregnancy or birth related condition)
3. Comparison of top 10 conditions’ rate to the state’s rate for the same condition
4. Additional analysis, comparing each PSA to one another, looking for PSA specific outliers
5. Linkage of the quantitative data to the qualitative data
6. Presentation of the data to each hospital’s CHSC.

The above analysis was done for each hospital’s PSA, as well as for the Fairview system overall.

### Top Five Causes of Hospitalization, ER Visits and Mortality for the System, 2008-2010

<table>
<thead>
<tr>
<th>Rank</th>
<th>Hospitalization</th>
<th>ER Visits</th>
<th>Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pneumonia (nos)</td>
<td>Chest pain (nos)</td>
<td>Cancer</td>
</tr>
<tr>
<td>2</td>
<td>Hardening of the heart arteries</td>
<td>Abdominal pain</td>
<td>Heart diseases</td>
</tr>
<tr>
<td>3</td>
<td>Osteoarthritis, lower leg, localized (nos)</td>
<td>Headache</td>
<td>Mental disorders</td>
</tr>
<tr>
<td>4</td>
<td>Blood poisoning (nos)</td>
<td>Upper respiratory infection (nos)</td>
<td>Stroke</td>
</tr>
<tr>
<td>5</td>
<td>Irregular heart beat</td>
<td>Middle ear infection (nos)</td>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
</tr>
</tbody>
</table>

Hospitalization and ER Visits Source: Minnesota Hospital Association, 2008-2010  
Mortality Source: Minnesota Department of Health, 2008-2010  
^ designates a 0.5% or higher percentage of difference between combined PSA and state of MN  
↓ designates a 0.5% or lower percentage of difference between combined PSA and state of MN  
nos = not otherwise specified (unspecified diagnosis)  
nec = not elsewhere classified (diagnosis does not fit into a different category)

Pre-Prioritization
An early finding of little variation and primarily low CNI Scores within most Fairview hospital PSAs caused a mid-stream adjustment in overall analysis of need. Data findings for vulnerable populations will be utilized in numerous ways, both within the organization and externally with our community partners.

After data analysis was completed, quantitative and qualitative data were merged to create a hospital-specific presentation of top community needs. Each presentation included handouts of the top 10 mortality, ER visits and hospitalization data for all community members in the hospital’s PSA. See Appendix G for the top 10 lists by population and hospital.

The Quantitative Data Team Lead and/or CHNA Project Manager attended all of the CHSC data presentations to answer detailed data questions as they arose.
Prioritization Process
Each hospital’s CHSC members utilized a set of criteria to evaluate the health needs identified through the data analysis. The criteria included:

- The degree to which the issue was health related
- The degree to which the issue was tied to CNI score
- The magnitude of the need
- The seriousness of the need
- The feasibility of addressing the need
- The alignment with Fairview strengths and strategy

Each CHSC member used the criteria to rank the health needs. These results were shared with the committee for discussion. Team members were then given an opportunity to revise their rankings. These individual rankings were then summed to produce a composite ranking for each hospital. See Appendix H for the tool and criteria definitions used in the prioritization process.

Hospital Priorities

Below are the CHSC recommended and hospital approved priorities for years 2013-2015.

<table>
<thead>
<tr>
<th>Fairview Lakes Medical Center</th>
<th>Fairview Northland Medical Center</th>
<th>Fairview Range Regional Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Obesity</td>
<td>▪ Healthcare Information and Education</td>
<td>▪ Heart Disease</td>
</tr>
<tr>
<td>▪ Behavioral Health</td>
<td>▪ Access to Affordable Healthcare</td>
<td>▪ Substance Abuse</td>
</tr>
<tr>
<td></td>
<td>▪ Affordable Place to Exercise</td>
<td>▪ Depression</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fairview Ridges Hospital</th>
<th>Fairview Southdale Hospital</th>
<th>University of Minnesota Medical Center, Fairview/University of Minnesota Amplatz Children’s Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Mental Health</td>
<td>▪ Healthy Lifestyles</td>
<td>▪ Mental Health</td>
</tr>
<tr>
<td>▪ Obesity/Diabetes</td>
<td>▪ Social and Emotional Well-being</td>
<td>▪ Heart Disease</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fairview Southdale Hospital</th>
<th>University of Minnesota Medical Center, Fairview/University of Minnesota Amplatz Children’s Hospital</th>
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<tr>
<td></td>
<td>▪ Mental Health</td>
</tr>
<tr>
<td></td>
<td>▪ Heart Disease</td>
</tr>
</tbody>
</table>

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Limitations
Due to potential HIPPA violations, internal hospitalization, ER visit, mortality and clinic data was not used in analysis or prioritization of need. Internal data will be used to develop baselines and track priorities during the next three years.

The hospitalization and ER visit data provided by the Minnesota Hospital Association (MHA) was provided at the ICD-9 code level, while the mortality data provided by the Minnesota Department of Health was only available at the ICD-10 chapter code level.

This report was prepared for the December 13, 2012 meeting of the Fairview Board of Directors and was approved at that meeting.
Appendices

A. Hospital Implementation Plans
   (See individual hospital implementation plans)

B. Definition of Community – Zip Codes by Hospital PSA
   (See Appendix D in individual hospital implementation plans)

C. Community Health Steering Committee Members
   (See attached Appendix C for complete list; see individual hospital implementation plans for Steering Committee Members at each hospital)

D. Primary Service Area Maps by Hospital
   (See Appendix A in individual hospital implementation plans)

E. Qualitative Data Tools and Questions
   (See Appendix E in individual hospital implementation plans)

F. CNI Score Maps by Hospital
   (See Appendix B in individual hospital implementation plans)

G. Top Ten Health Conditions by Population and Hospital
   (See Appendix F in individual hospital implementation plans)

H. Prioritization Process Tool and Criteria Definition
   (See Appendix C in individual hospital implementation plans)
Complete list of Community Health Needs Assessment Steering Committee (CHSC) Members:

- Kevin Anderson, Pastor, Christ Our Light Catholic Parish
- Brad Beard, President, Fairview Southdale Hospital
- Officer Greg Benedict, School Liaison Police Officer, Hibbing Police Department
- Teresa Benge, R.N., Diabetes Educator
- Sheri Biondi, Director of Service Learning, Hibbing Community College
- Debra Boardman, President, Fairview Range Regional Health Services
- Jill Briggs, Chisago County Public Health
- Bonnie Brueshoff, Dakota County Public Health
- Kathy Bystrom, Community Health Outreach Assistant Manager, Fairview Lakes Medical Center
- Tom Clancy, University of Minnesota School of Nursing
- Kris Clementson, R.N., Patient Care Supervisor for Pine City, Rush City, North Branch and Job Care
- Roy Connaughton, CEO, Arrowhead Center Inc.
- Diane Cross, University of Minnesota Medical Center Board Member
- Connie Delaney, University of Minnesota Medical Center Board Member and University of Minnesota School of Nursing
- Jennifer Deschaine, Scott County Public Health
- Steve Devich, Manager, City of Richfield
- Doug Dirks, Fairview Ridges Hospital Board Member
- Therese Durkin, M.D.
- Sandra Eliason, M.D.
- Ann Ellison, Director, Fairview Community Health/Church Relations (sat on all CHSCs)
- Sue Erzar, R.N., Public Health Division Manager Itasca County Public Health
- Carrie Estey-Dix, Clinic Coordinator, Project Care Free Clinic
- Debby Feist, Community Member and former Fairview Lakes Medical Center Board Member
- Carie Fuhrman, Community Development Director, City of Princeton
- Harry Grinage, Range Respite
- Robb Gruman, Vice President Facilities and Support Services, Fairview Southdale Hospital
- Amy Gumestad, Director, Admissions and Marketing, Minnesota Life College
- Marni Gustafson, Executive Director, Sterling Point Senior Community
- James Hartert, M.D., Vice President and Medical Director, Range Regional Health Services
- Mohammed Hassan, M.D., University of Minnesota Physicians
- Sue Hedlund, Washington County Public Health and Environment
- John Herman, President, Fairview Northland Medical Center
- Sue Herm, Fairview Northland Board Member and Faculty, St. Cloud University
- Tammi Hoard, Medical Case Manager, Rural AIDS Action Network
- David Hohl, Vice President Business Development, Fairview Range Regional Health Services
- David Holm, retired Pastor and Fairview Southdale Board Member
- Rosemary Hoolihan, Fairview Lakes Medical Center Board Member
Appendix C: Fairview Health Services 2012 Community Health Needs Assessment Report

- Steve Housh, President, Fairview Lakes Medical Center
- Pete Jensen, M.D.
- Kellie Kershisnik, M.D. and Fairview Lakes Medical Center Board Member
- Martin Kirsch, former Mayor of Richfield and Fairview Southdale Hospital Board Member
- Cyndi Klobuchar, RN, Patient Care Medical-Surgical Supervisor, Fairview Range Regional Health Services
- Beth Krehbiel, President, Fairview Ridges Hospital
- Heidi Lahti, Manager, Diagnostic Imaging, Fairview Range Regional Health Services
- BJ Larson, Director of Spiritual Health, Fairview Southdale and Fairview Ridges hospitals
- Alissa LeRoux Smith, Manager, Community Health and Volunteer Services, Fairview Southdale Hospital
- Charles Li, M.D.
- Carrie Link, M.D., University of Minnesota Department of Family Medicine and Community Health
- Rev. Jeff Marian, Pastor, Prince of Peace Lutheran Church
- Marie Maslowski, Community Outreach Manager Fairview Northland Medical Center
- Donna McAlpine, University of Minnesota School of Public Health
- Allison Miller, Patient Education, Rum River Health Services
- Janet Mohr, Fairview Ridges Hospital Board Member and Community Member
- Stacy Montgomery, Director, Patient Relations, Fairview Ridges Hospital
- Gretchen Musicant, Commissioner of Health, City of Minneapolis
- Sahra Noor, Director of Language Services and Community Health, University of Minnesota Medical Center, Fairview
- Carla Norelius, Community Health Outreach Manager, Fairview Lakes Medical Center
- Marge Page, Vice President, University of Minnesota Medical Center, Fairview
- Brian Payne, Chief of Police, City of Princeton
- Shari Prest, Fairview Ridges Hospital Board Member
- Pam Pringle, Director of Patient Care Practice, Fairview Northland Medical Center and Community Member
- Anita Provinzino, Director, Housing and Development Authority
- Shelley Robinson, Executive Director, Range Center Inc.
- Sgt. Jeff Ronchetti, Community Liaison Officer Hibbing Police Department
- Deb Rudquist, Fairview Health Services Cardiovascular Service Line Executive and Fairview Range Regional Health Services Board Member
- Janelle Schroeder, Community Health Supervisor, Mille Lacs County
- Jessica Schuster, Marketing Specialist, Fairview Range Regional Health Services
- Hiba Sharif, Community Health Coordinator, University of Minnesota Medical Center, Fairview
- Murt Sherek, Fairview Ridges Hospital Board Member
- Dawn Sievert, District Nurse, Princeton Schools
- Sue Soroko, R.N., St. Louis County Public Health
- Richard Sturgeon, M.D., Interim Vice President of Medical Affairs, Fairview Southdale Hospital
- Lori Syverson, President, Edina Chamber of Commerce
- Peter Toensing, M.D., Chief of Staff elect Fairview Ridges Hospital
- Cathy Utne, Director, Patient and Guest Services, Fairview Southdale Hospital
Shelly Valentini, Executive Director, United Way of Northeastern Minnesota and Fairview Range Regional Health Services Board Member
Carolyn Wilson, President, University of Minnesota Medical Center, Fairview
Raymond Yu, Principal, Oakgrove Elementary School
Karen Zeleznak, Public Health Administrator, Bloomington Health Division