

2015 COMMUNITY HEALTH NEEDS ASSESSMENT

University of Minnesota Medical Center



TABLE OF CONTENTS

Introduction	3
About University of Minnesota Medical Center.....	4
Community served	4
Community Health Needs Assessment process	6
Data sources.....	7
Processes and methods	9
Collaboration	10
Community input	10
Prioritization of needs	11
Potentially available resources	12
Evaluation of impact	13
Learnings	14
Conclusion	14

INTRODUCTION

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

This report represents months of work by many individuals throughout University of Minnesota Medical Center and our community. From Board members to pastors, physicians, nurses, educators, public health experts, social service leaders and others, this project benefited from the volunteered time, energy, insight and expertise of many community members.

In conducting our 2015 Community Health Needs Assessment, we were guided by the following objectives:

1. Identify the unmet health needs of community residents in each hospital's community.
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.

Assessing the unmet health needs of our community is critically important to carrying out Fairview's mission of healing, discovery and education for longer, healthier lives. The insight gathered through this process will inform University of Minnesota Medical Center's community benefit activities in the months and years ahead.

Our Mission

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

Our Vision

Fairview is driving a healthier future.

ABOUT UNIVERSITY OF MINNESOTA MEDICAL CENTER

Located in Minneapolis, University of Minnesota Medical Center (which includes University of Minnesota Masonic Children’s Hospital) is a 1,932-bed academic medical center offering a full spectrum of programs and services from delivery of thousands of babies each year to emergency care to organ transplant surgery. The medical center is a division of Fairview Health Services.

COMMUNITY SERVED

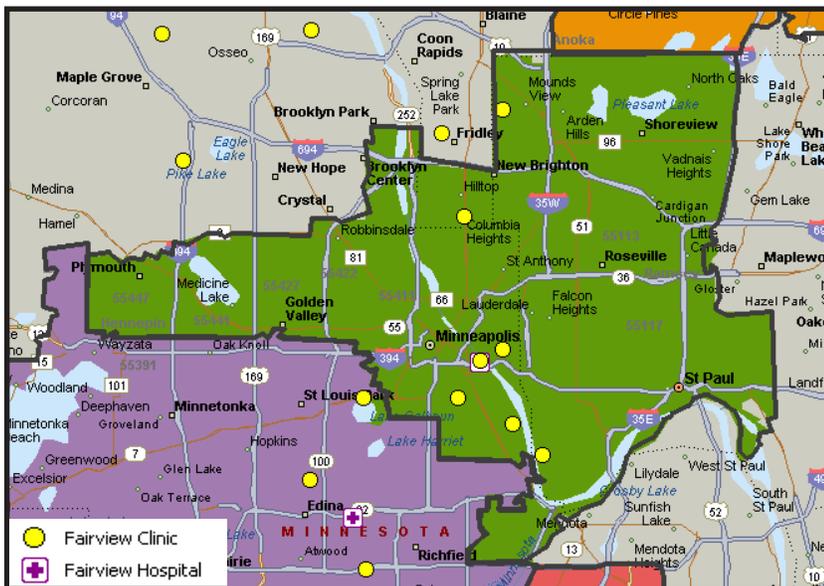
For the purposes of the Community Health Needs Assessment, community is defined as the population of the combined zip codes for University of Minnesota Medical Center’s primary service area, which are home to approximately 70 percent of the patients seen by the medical center, as well as the counties that include a zip

code in the primary service area. (See Appendix A for a full list of zip codes in this community.)

This definition of community was selected to:

1. Provide continuity of definition with previous community health needs assessments dating back to 2004;
2. Align with internal strategy and planning definitions of community (e.g., the combined zip codes that comprise the primary service area); and
3. Ensure alignment of priorities and existing relationships with county health departments that intersect with one or more zip codes that comprise the defined community.

University of Minnesota Medical Center: Community Served



A review of demographic data revealed the following:

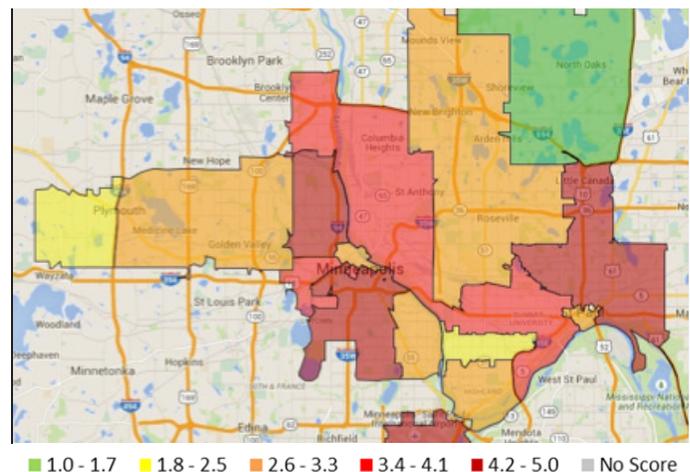
Community served: Demographics by Age, 2015 - 2020					
Age	2015		2020		'15-'20 Growth
	Numbers	% of Total	Numbers	% of Total	
Population Ages 0 - 17	190,534	35.8%	201,900	36.2%	6.0%
Population Ages 18 - 44	367,933	69.2%	369,653	66.4%	0.5%
Population Ages 45 - 64	201,130	37.8%	205,548	36.9%	2.2%
Population Ages 65+	102,609	19.3%	124,623	22.4%	21.5%
Total Population	862,206		901,724		4.6%
Population Density	4,106		4,294		4.6%
Service Area Square Miles	210		210		
Median Household Income	\$52,024				

Community served: Demographic Trends by Race, 2015 - 2020					
Race	2015		2020		'15-'20 Growth
	Volumes	% of Total	Volumes	% of Total	
White	560,918	65.1%	572,727	63.5%	2.1%
Black/African American	132,116	15.3%	139,678	15.5%	5.7%
American Indian/Alaskan Native	11,171	1.3%	11,298	1.3%	1.1%
Asian Alone	86,520	10.0%	99,334	11.0%	14.8%
Native Hawaiian/Pacific Islander	371	0.0%	404	0.0%	8.9%
Other	35,936	4.2%	39,097	4.3%	8.8%
Two or More Races	35,174	4.1%	39,186	4.3%	11.4%
Total Population		862,206		901,724	4.6%

A Community Need Index (CNI) “heat map” was created for the University of Minnesota Medical Center community, revealing areas of higher need in terms of socio-economic barriers to health care access in certain areas. CNI scores range from a 5 (highest health disparity/highest community need) to a 1 (lowest health disparity/lowest community need).

The University of Minnesota Medical Center community contains the highest CNI scores of all the communities served by the Fairview system. Thirteen zip codes were in the 4.2 to 5.0 range and close to half of these had a score of 5.0. (See Appendix A for a full list of CNI scores by zip code.)

University of Minnesota Medical Center: Community Need Indices



COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

University of Minnesota Medical Center followed Catholic Health Association's *2013 Assessing and Addressing Community Health Needs Guide* process recommendations in conducting the 2015 Community Health Needs Assessment and Needs Prioritization Process.

Throughout the assessment process, it was important to University of Minnesota Medical Center to work closely with community organizations and coalitions to ensure the final product was an accurate and representative assessment of community health needs, with a particular focus on persons who are uninsured and/or low-income. To this end, University of Minnesota Medical Center established a Community Health Steering Committee that followed a Fairview Health Services standard charter. (See Appendix B for a full list of members.)

University of Minnesota Medical Center's Community Health Steering Committee has 14 members including the following roles:

- Social service agency representative(s)
- Representative from underserved communities
- Public health representative(s)
- A hospital board member
- A hospital senior executive
- Fairview community health staff
- Physician or primary care representative

The Steering Committee at played many roles, including:

- Providing insight concerning community needs and assets
- Providing access to community stakeholders
- Working with the assessment team to use data and knowledge of the community in identifying and prioritizing community needs
- Providing insight on hospital assets and expertise
- Working with the assessment teams to develop action plans to address community needs

University of Minnesota Medical Center's Board was periodically updated throughout the assessment process and approved the final two priorities.

Process for gathering data

Secondary data were gathered from several online resources housing data that have been collected, analyzed and displayed by governmental and other agencies through surveys and surveillance systems. Community and hospital level patient utilization data were requested from the Minnesota State Hospital Association. The following criteria were used to identify the quantitative data sources used in the 2015 assessment:

- Publicly available
- Ability to compare data by county, state and U. S. level
- Availability of data at the zip code level
- Existing benchmarks (e.g., Healthy People 2020, Healthy Minnesota 2020, Minnesota Cancer Alliance)
- Ability to trend (e.g., updated on a regular basis, was included in earlier assessments)
- Ability to identify health disparities
- Contains utilization data at both the community and patient level

Fairview's Community Health Department provided oversight, standardized tools, processes and instructions and also did the gathering, cleaning, first level analysis and presentation of quantitative and qualitative data. University of Minnesota Medical Center's hospital team and Community Health Steering Committee Data Subcommittee also participated in limited data gathering for areas of need identified by the full Community Health Steering Committee (e.g., holding community listening sessions).

DATA SOURCES

Qualitative data

The following qualitative data sources were collected and/or reviewed:

A **Community Survey** was conducted, with 516 respondents. Of those who responded, only 29 percent were Caucasian, in contrast to the medical center's patient composition. Data were collected through a 17-question survey administered in September and October 2015. The survey was available in an online format and paper format in English, Spanish, Somali, Oromo, Russian and Hmong.

Community health staff worked with Steering Committee members, local nonprofit organizations, neighborhood universities (e.g., Saint Catherine University) and faith communities to distribute the survey electronically. The survey was promoted through Fairview's social media, news releases and distribution to Fairview employees.

A **Cedar-Riverside Outreach Survey** was conducted, with 279 respondents in the Cedar Riverside neighborhood of Minneapolis. Data were collected through a 10-question survey administered in person by University of Minnesota Medical Center staff and interns in the summer of 2015. The Cedar-Riverside neighborhood was targeted because this is comprised of a single zip code and has a very high percentage of new immigrants (98 percent of survey respondents were East African), high CNI scores and very high levels of poverty (over 98 percent of children are eligible for free/reduced price lunches).

A **Listening Session** was conducted in January of 2015 with nine Imams around mental health and wellness in the Somali immigrant community. The Imams responded to the following questions:

- What do you consider to be the main mental health problems in the Somali community in Minnesota?
- What do you think are factors that affect the mental health of the Somali community? (e.g., cultural, war, family)
- What do you think can be done to improve the mental health of the Somali community?
- Which groups in your communities are seeking help for mental health problems?

A second **Listening Session** was conducted in August 2015 with approximately 30 community attendees at the Health Commons at The Living Room, a drop-in community wellness center housed at Redeemer Center for Life in north Minneapolis. The sessions were facilitated by a staff nurse of the Health Commons program. Community members responded to the following questions:

- What does being healthy mean to you and your family?
- What roadblocks do you experience when you are working to maintain your health?
- How can the community work together to promote health?
- What are your thoughts and opinions on the questions?

Monthly Nurse Note Summaries from 2014 visits to the Health Commons at The Living Room were analyzed to understand the services that were of value to participants, with particular emphasis on the forms of health education deemed of most value.

2012 Focus Group and Stakeholder Interviews were reviewed from University of Minnesota Medical Center's 2012 Community Health Needs Assessment. In 2012, focus groups were held with vulnerable community members, including low-income and vulnerable populations, mothers and seniors. In addition, nine stakeholder interviews were conducted with leaders of the faith community and social service and nonprofit organizations serving community members. The focus groups and stakeholder interviews explored barrier to health and health care.

The Brooklyn Park/Brooklyn Center Community Listening Project was conducted from February to April 2015. The project included a series of ten listening sessions held with 177 community members from four minority groups: African born, African American, Hmong and Latino. It was conducted by Rainbow Research on behalf of Hennepin County Human Services and Public Health Department. The listening sessions focused on physical activities, healthy eating and tobacco awareness.

Quantitative data

Community Commons provides a single location for a comprehensive number of data sources available at the state, county, 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, Robert Wood Johnson Foundation and American Heart Association. Data are organized according to demographics, social and economic indicators, physical environment, clinical care indicators, health behaviors and health outcomes.

Community Need Index (CNI) scores were developed by Dignity Health and Truven and are updated annually. 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 are available at the zip code level for nearly all zip codes in the United States and provide an objective measure of socio-economic barriers to health care access among populations, and their effect on inappropriate hospital admissions for ambulatory sensitive conditions. CNI scores range from a 5 (highest health disparity/highest community need) to a 1 (lowest health disparity/lowest community need).

Variables included in the CNI include:

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

Minnesota Student Surveys are administered jointly by the Minnesota Departments of Education, Health, Human Services and Public Safety every three years. The survey asks questions about activities, experiences

and behaviors. County-level responses related to the following areas were analyzed:

- Demographics
- General health and health conditions
- Health care access
- Physical activity
- Nutrition and meals
- Emotional well-being and distress
- Suicidal thoughts and behavior
- Substance use
- Tobacco use

CommunityFocus is an application under development by Premier, a health care performance improvement alliance of approximately 3,600 U. S. hospitals and 120,000 other providers, in partnership with Fairview Health Services, Mercy Health and Wayne Memorial Hospital to manage the health of patient and community populations. Data available through CommunityFocus include:

- Event-level combined utilization data (hospital admission and Emergency Department visits) for all residents of Minnesota for the years 2012-2014. Utilization data are available by zip code, primary service area, county and state. It includes age, sex, diagnosis (up to 25 sub-diagnoses and procedures and up to 25 sub-procedures).
- Event-level mortality data for all residents of Minnesota for the years 2012-2014. These data, too, are available by zip code, primary service area, county and state-level as well.

County Health Rankings is an online resource that measures the health of nearly all counties in the nation and ranks them within states. The rankings are compiled using county-level measures from a variety of national and state data sources. These measures are standardized and combined using scientifically-informed weights. The County Health Rankings and Roadmaps program is collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

County public health department community health assessments are completed every five years. Assessments—and when available, community health improvement plans—from Anoka, Hennepin and Ramsey counties were reviewed.

PROCESSES & METHODS

During the planning phase of the assessment, a review of national data collection and analysis methodologies was conducted.

Qualitative

After the *Community Survey* data were collected, they were analyzed in a variety of ways, including by community served, race/ethnicity and by respondent's age.

In addition to health needs identified through this survey, the survey also yielded learnings pertaining to the cultural competency of serving specific populations. These learnings will be shared internally to guide efforts to improve staff cultural competency.

Approximately two percent of survey responses included open-ended feedback that fell outside the parameters of the survey. This feedback was collated and shared with Fairview's senior leadership in the appropriate area for further review.

After the *Cedar-Riverside Outreach Survey* was conducted, it was analyzed in a variety of ways, including by respondents race/ethnicity, age, existing health conditions, and whether or not they were aware of and/or used the Health Commons Cedar Riverside community drop-in center.

After the *Imam Mental Health Listening Session* were conducted, the conversations were translated into English and responses separated into broad themes. These themes were used to help drive programming and health education content when working with East African Muslim populations.

After the *Health Commons at the Living Room Listening Session* was conducted, the conversations were analyzed and separated into broad themes. These themes were used to inform programming and health education and increase cultural competency in the delivery of programming.

Monthly Nurse Note Summaries from 2014 visits to the Health Commons at The Living Room were analyzed to understand the services that were of value to participants, with particular emphasis on the forms of health education deemed of most value.

2012 Focus Group and Stakeholder Interviews were reviewed from University of Minnesota Medical Center's 2012 Community Health Needs Assessment. In 2012, surveys and stakeholder interviews were taped,

transcribed (when they occurred in a language other than English), analyzed for themes and outliers around community member and stakeholder perceptions of unmet health needs, challenges and barriers to maintaining and improving health and where underserved populations turned for services needed in maintaining or improving their health.

The Brooklyn Park/Brooklyn Center Community Listening Project analysis was done by Rainbow Research on behalf of Hennepin County Human Services and Public Health Department. Data were analyzed and responses/themes reported by race and subject area (physical activity, healthy eating and tobacco use).

Quantitative

The data sources identified above provided data that had already been cleaned and analyzed with methodology limitations noted.

While substantial patient utilization data were collected at the hospital level, in many cases, it was not used for the analysis in this report due to HIPPA regulations. Internal data, in conjunction with other data findings, will be utilized over the next year as implementation strategies are fully implemented.

During the assessment process, team members established guidelines for the use of internal patient data. The team decided that any cohort consisting of fewer than 50 people would not be reported publicly, including to Steering Committees. Additionally, whenever feasible/practical, statistics are provided in the form of rates and percentages.

Information gaps & limitations

Several information gaps and limitations were identified through the assessment process:

- The reporting of race and ethnicity data in most data sources is not specific enough, nor does it have enough volume to yield meaningful information about many of the specific populations in our communities. Information about sub-populations, such as East African, Hmong and Oromo is largely unavailable, especially at the local level. One way we addressed this information gap was through the additional surveying and outreach described earlier in this report.
- Not all data sources are available at the zip code level.
- CommunityFocus mortality data only includes individuals whose death occurred at a hospital.

Due to HIPPA regulations, Fairview hospitalization, Emergency Department visit and mortality data were not used in analysis or prioritization of need, although clinic data measuring overweight/obese patients were used

due to the high numbers of people included. Additional internal data will be used to develop baselines and track priorities during the next three years.

COLLABORATION

Fairview Health Services collaborated with Premier to explore how CommunityFocus (an application used to manage the health of patient and community populations) could be utilized during a community health needs assessment. Work will continue with Premier during the development of Implementation Strategies.

Caroline Dunn-O'Brien, PhD, an epidemiologist who graduated from the University of Minnesota, served as a consultant in the data gathering, analysis and interpretation stages of the University of Minnesota Medical Center assessment.

COMMUNITY INPUT

Community input was obtained through the following methods:

1. A community survey. The community survey was administered in September and October of 2015.
2. The Cedar-Riverside Outreach Survey. The survey was administered in summer 2015.
3. Listening session with Imams in January 2015
4. Listening session at the Health Commons at the Living Room in August 2015
5. Review of the Brooklyn Park/Brooklyn Center Community Listening Project
6. Broad community organization and public health involvement in the Community Health Steering Committee. Community organization and public health involvement on the committee occurred from July to December of 2015 and is expected to continue throughout the three-year assessment cycle. Community Health Steering Committee members represented the needs of their constituencies at Steering Committee meetings and were influential in the selection of final priorities.

The following organizations provided input via their role on the University of Minnesota Medical Center Community Health Needs Assessment Steering Committee and/or Data Subcommittee as well as in the distribution of community surveys:

- Hennepin County Human Services and Public Health Department

- People's Center Health Services
- Redeemer Center for Life
- St. Catherine University

Each of the above organizations serve or work closely with vulnerable populations. Below is a summary of these organizations and the population served:

- Hennepin County Human Services and Public Health Department serves the Hennepin County population, including medically underserved, low income and minority populations.
- People's Center Health Services is a Federally Qualified Health Center and certified Patient-Centered Health Care Home that offers three sliding-fee clinics in Minneapolis. The People's Center provides primary medical and behavioral health care serving community members with an emphasis on the East African immigrant community.
- Redeemer Center for Life is located in the Harrison neighborhood of North Minneapolis and serves medically underserved, low-income and minority populations, with a particular concentration on youth.
- St. Catherine University is a women's liberal arts college that provides significant scholarships to students from racial and ethnic minority populations.

PRIORITIZATION OF NEEDS

University of Minnesota Medical Center's priorities emerged following a multi-step prioritization process.

Initial prioritization by Community Health Department

An initial review of all data was completed by the assessment team, using the following criteria as recommended by the Internal Revenue Service:

- Scope/size of health need (e.g., how many individuals impacted)
- Severity of the health need
- The degree to which health disparities affect the need
- The burden to society if the need is not met

The overall process of prioritization and high-level focus areas aligned with local, state and national data sources were presented to the Community Health Steering Committee. The Committee evaluated the nine conditions identified as part of the high-level focus areas:

- Anxiety
- Arthritis
- Asthma
- Cancer
- Depression
- Diabetes
- Heart disease
- Obesity
- Stroke

The Community Health Steering Committee asked that additional qualitative data be gathered to ensure the community's voice was heard. The committee also requested that additional children's data be gathered, in light of University of Minnesota Medical Center's focus on children via University of Minnesota Masonic Children's Hospital. The Steering Committee elected to have a smaller Data Subcommittee meet to review, prioritize and bring final recommendations on top needs to the full committee for a vote.

Between steering committee meetings the full membership received a survey asking for their individual ranking of the nine health conditions as well as providing the opportunity to add and rank up to two additional needs they felt should be considered by the Data Subcommittee.

Secondary prioritization by Community Health Steering Committee Data Subcommittee

The Data Subcommittee, along with a paid consultant, met and considered the nine health conditions, the additional conditions identified by members of the Community Health Steering Committee, as well as extensive qualitative data, community and Fairview patient utilization data.

All data were examined using the following criteria:

- Scope/size of problem (# of individuals impacted)
- Severity/seriousness
- Health disparities/vulnerable populations
- Feasibility of interventions
- Ability to demonstrably impact health in three years
- Availability of existing resources (e.g., staff, time, money and equipment)

The following considerations were also taken into account:

- Ability to build upon existing programming and partners
- Degree of community readiness to address identified condition
- Community identified priority/need
- Outreach programming tied to hospital accreditation requirements (e.g., cancer center, trauma designation)
- Ability to impact vulnerable populations

The Data Subcommittee used a consensus voting process to identify five priority areas to bring forward to the full Community Health Steering Committee.

Final prioritization by Community Health Steering Committee

Members of the Data Subcommittee recommended five priority needs to the Steering Committee. The Steering Committee participated in a final prioritization process, which included discussing the assets, strengths and gaps of each priority area followed by a ranking of need and alignment by each Steering Committee member for each condition. Once the final ranking occurred, group discussion led to the identification of three areas of need, at which point a vote was taken to determine the final two priorities.

Steering Committee members decided that University of Minnesota Medical Center final priorities would be mental health and well-being and chronic disease prevention and management with a focus on healthy living.

The following rationale was agreed upon in selecting the priority areas:

1. Mental health and well-being is important because:
 - a. The creation of a mental health category reflects the inclusion of depression, trauma/Post-Traumatic Stress Disorder, anxiety and suicide;
 - b. There are strong linkages between mental health (particularly depression and anxiety) and chronic disease conditions;
 - c. Language was chosen to both address stigma health on (e.g., mental health) and to allow community acceptance and investment in communities and populations in which mental illness of any kind is highly stigmatized (e.g., well-being);
 - d. This priority allows a wide range of potential interventions ranging from holistic health practices such as mindfulness and meditation to expressions through the arts (e.g., open mic nights);

- e. It is tied to public health priorities; and
 - f. It provides the ability to leverage resources.
2. Chronic disease prevention and management with a focus on healthy living is important because:
 - a. It is tied to public health priorities;
 - b. It provides the ability to leverage existing resources;
 - c. There are strong linkages between chronic disease conditions and mental health—poor mental health can reduce both treatment and medication adherence as well as lead to worse health outcomes;
 - d. Both the prevention of chronic disease and the management of existing chronic conditions impact the quality of life for individuals, families and communities;
 - e. The inclusion of a particular focus on healthy living was added to convey a positive tone, set the stage for community acceptance and investment and align with State Health Improvement Program priorities;
 - f. Strategies to prevent and manage chronic disease conditions overlap with strategies to prevent and address obesity;
 - g. High levels of health disparities exist in Minnesota for chronic disease mortality including heart disease, cancer and diabetes;
 - h. It is an area of local, state and national focus; and
 - i. It provides an opportunity for upstream/prevention (e.g., policy, systems, environmental strategies).

University of Minnesota Medical Center 2015-2018 priorities:

- Mental health and well-being
- Chronic disease prevention and management with a focus on healthy living

POTENTIALLY AVAILABLE RESOURCES

University of Minnesota Medical Center is involved in community initiatives in partnership with numerous sectors, including schools, area businesses, public health, law enforcement, religious groups, other health care organizations, substance abuse prevention initiatives, local government and other nonprofits. These initiatives,

programs and relationships are the foundation from which all community health outreach will be built.

Resources available to address identified health needs include existing community programming around mental health (e.g., Imams Training, Mental Health First Aid Training), existing programming around heart

health (e.g., Community Commons drop-in wellness centers in two locations), The People's Center (FQHC) and alignment and existing collaboration with Statewide

Health Improvement Programs (SHIP) focused on tobacco and physical activity.

EVALUATION OF IMPACT

University of Minnesota Medical Center's 2012-2015 priorities were mental health and heart disease. Below is an evaluation of the impact made in each of these areas.

Mental Health

- University of Minnesota Medical Center collaborated with a University of Minnesota Medical School's Department of Family Medicine and Community Health researcher on a UCare Foundation-funded project titled "Improving the Mental Health of Somali Women in Minnesota: Testing the Use of Evidence-Based Peer and Community Health Worker Delivered Train the Trainer Intervention." This project was a feasibility study of the use of cognitive behavioral therapy intervention for groups, as a "train-the-trainer" curriculum. Twelve Somali women from the Cedar-Riverside neighborhood completed the curriculum training.
- University of Minnesota Medical Center created and distributed approximately 300 mental health posters focused on promoting anti-stigma and awareness on Khat use and depression in the Somali community. Posters were distributed to approximately 25 organizations and businesses in the Somali community of Minneapolis.
- University of Minnesota Medical Center created a mental health work group to guide the projects such as Imam trainings and immigrant mental health mini-conferences. Members consisted of professionals who worked in mental health field from the University of Minnesota Medical School, University of Minnesota Powell Center, Fairview Behavioral Health, Summit Guidance, East Africa Health Project, UCare Foundation, Minnesota Department of Health, Barbara Schneider Foundation and the Minnesota Department of Human Services.
- Imam training was held to reduce the stigma of mental illness in the Somali community by engaging Imams in dialogue around mental health, increasing their knowledge of mental health symptoms and treatment options, and providing them with skills and resources needed to promote better access to mental health care. The project provided a total of

28 mental health trainings to a group of nine Somali Imams from four mosques in South Minneapolis. The trainings are held monthly and are facilitated by two mental health therapists. The project partners with East Africa Health Project Director Dr. Osman Ahmed Harare, who serves as liaison to the Imams.

- University of Minnesota Medical Center organized three immigrant mental health half-day conferences for health professionals to provide a platform for networking, discussion and information and resource exchange on best practices with the hopes to collectively improve the mental health of the state's immigrant populations. The conferences were attended by approximately 240 healthcare professionals, including nurses and physicians, public health professionals, mental health therapists, social workers and teachers.

Heart Disease

- University of Minnesota Medical Center operated community-based drop-in wellness centers called "Health Commons" in two high need neighborhoods in Minneapolis: Cedar-Riverside and North Minneapolis. Services are free of charge and open to everyone. The program is based on the transcultural nursing model founded by Augsburg College where service is based on respect, relationship building, hospitality, collaboration, making connections and bringing hope to community members to live healthier lives. Services provided included: basic nursing care such as blood pressure checks and weight measurements, exercise classes such as strength training, aerobics, yoga, Sumba, swimming and basketball, chair massages and healing services, health education classes on healthy eating and physical activity, simple supplies needed for health, social services, and community and health-related resources and referrals.
 - o Cedar-Riverside Health Commons began in 2011 and is located in the Chase Building of the Riverside Plaza high rise buildings. The site provides an estimated 2,300 visits each year, including 750 encounters through a fitness program for girls. In 2014, there were an estimated 300 unique participant encounters.

- o North Minneapolis Health Commons began in 2014 and is located at The Living Room, a nonprofit center for Redeemer Lutheran Church. The site provides an estimated 1,300 visits each year. In 2014, there were an estimated 200 unique participant encounters.
- o Partners of Health Commons drop in centers included East Africa Health Project, Augsburg College, People’s Center Health Services and Redeemer Lutheran Church’s Center for Life.
- o Nutrition and physical activity programs were conducted in the Cedar-Riverside neighborhood in collaboration with partners including: University of Minnesota Extension, Fairview dietetics internship program, Cooke Clinic, Cedar Riverside Community School, Brian Coyle Center, UCare, Augsburg, Safety Center, Way to Grow, WellShare International, St. Catherine University interns.
- o Nutrition and physical activity programs were conducted North Minneapolis in collaboration with Redeemer Lutheran Church youth programs, University of Minnesota Extension, St. Catherine University interns, Fairview dietetics internship program, a nutrition diversity consultant, Appetite for Change, Zumba and yoga certified instructors from the community.

LEARNINGS

The Steering Committee concluded that staff should continue to provide community health programs that include a vision to empower the community and build community capacity, personal, and community involvement in health to improve the health of the communities we serve. Programs will involve community

collaborations and partnerships, continuing and new. University of Minnesota Medical Center will also create an evaluation plan and/or the use of evidence-based curriculum in programming to measure progress.

CONCLUSION

As a nonprofit health system, Fairview Health Services is driven to heal, discover and educate for longer, healthier lives. This report is one of many ways we partner with the communities we serve in carrying out our mission. The health needs identified in this report will be the

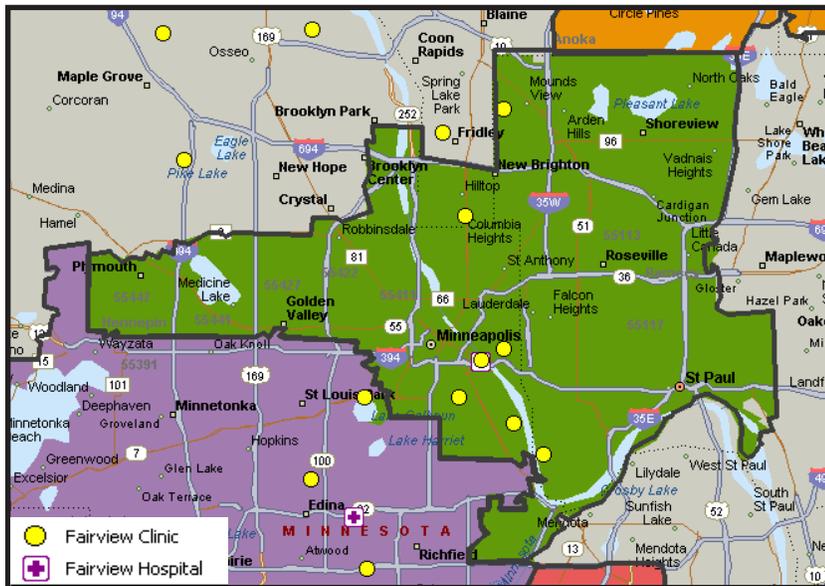
focus of University of Minnesota Medical Center’s community benefit work in 2016-2018 as detailed in a specific implementation plan to be finalized in the spring of 2016.

Thank you to members of Fairview Community Health 2015 Assessment Team for their contributions to this report:

- Cheryl Bisping, Fairview Range Medical Center Hospital Lead
- Erin Burns, Director of Communications, Fairview Health Services
- Kathy Bystrom, Fairview Northland Medical Center and Fairview Lakes Medical Center Hospital Lead
- Ann Ellison, Director of Community Health, Fairview Health Services
- Brian Grande, Data Analyst Associate, Fairview Health Services
- James Janssen, Tax Director, Fairview Health Services
- Alissa LeRoux Smith, Fairview Southdale Hospital Lead
- Stacy Montgomery, Fairview Ridges Hospital Lead
- Jennifer Morman, Community Benefit Program Manager, Fairview Health Services
- Jenifer Turner, Sr. Business Analyst, Fairview Health Services
- Tiffany Utke, Community Health Coordinator, Fairview Health Services
- Pa Chia Vue, University of Minnesota Medical Center Lead

Appendix A:

University of Minnesota Medical Center Community Served



Zip Code	City	2014 CNI Scores	County	Zip Code	City	2014 CNI Scores	County
55430	Brooklyn Center	4.0	Hennepin	55408	Mpls-LynLake	4.2	Hennepin
55421	Columbia Heights	3.4	Anoka	55411	Mpls-Near North	5.0	Hennepin
55108	Falcon Heights	2.8	Ramsey	55407	Mpls-Phillips	4.4	Hennepin
55111	Fort Snelling	4.6	Hennepin	55454	Mpls-Riverside	5.0	Hennepin
55427	Golden Valley	2.8	Hennepin	55414	Mpls-SE	3.6	Hennepin
55116	Highland	2.6	Ramsey	55455	Mpls-University	4.0	Hennepin
55114	Hwy 280-Como	3.0	Ramsey	55401	Mpls-Warehouse	3.2	Hennepin
55117	Little Canada	4.2	Ramsey	55112	New Brighton	2.6	Ramsey
55105	Mac-Groveland	2.4	Ramsey	55441	Plymouth	2.6	Hennepin
55104	Midway	3.8	Ramsey	55447	Plymouth	2.0	Hennepin
55450	Minneapolis	4.2	Hennepin	55422	Robbinsdale	2.8	Hennepin
55418	Mpls-Broadway NE	3.4	Hennepin	55113	Roseville	2.6	Ramsey
55412	Mpls-Camden	4.2	Hennepin	55126	Shoreview	1.6	Ramsey
55405	Mpls-Cedar/Hwy 55	3.8	Hennepin	55102	St. Paul-West 7th Fort Rd	3.6	Ramsey
55413	Mpls-Central NE	4.0	Hennepin	55103	St. Paul-North End	5.0	Ramsey
55402	Mpls-Downtown	4.0	Hennepin	55130	St. Paul-Payne-Phalen	5.0	Ramsey
55415	Mpls-Downtown	4.2	Hennepin	55101	St. Paul-Downtown	3.0	Ramsey
55406	Mpls-East Lake	3.2	Hennepin	55106	St. Paul-East	4.4	Ramsey
55404	Mpls-Franklin	5.0	Hennepin	55127	Vadnais Heights	1.4	Ramsey
55406	Mpls-Loring	3.8	Hennepin				

Source: Dignity Health

Appendix B: University of Minnesota Medical Center Community Health Steering Committee

Suzanne Burke-Lehman, RN, Department of Nursing, Saint Catherine University

Debra Cathcart, Chief Nursing Executive, University of Minnesota Medical Center

Dustin Chapman, Behavioral Services Liaison, University of Minnesota Medical Center

Kelly Chatman, Senior Pastor, Redeemer Lutheran Church

Diane Cross, Board Chair, University of Minnesota Medical Center

Caroline Dunn O'Brien, PhD, Public Health Epidemiologist, Independent Consultant

Ann Ellison, Director of Community Health and Church Relations, Fairview Health Services

Zahra Hassan, Community Health Outreach Coordinator, University of Minnesota Medical Center

Lauren Johnson, Director of Patient and Family Support Services, University of Minnesota Masonic Children's Hospital

Sharif Mohamed, Imam and Chaplain, University of Minnesota Medical Center

Jennifer Morman, Community Benefit Program Manager, Fairview Health Services

Liliana Tobon-Gomez, Principal Health Promotion Specialist, Hennepin County Human Services and Public Health Department

Dr. Steve Vincent, Physician, People's Center Health Services

Pa Chia Vue, Community Health Project Manager, University of Minnesota Medical Center