Bethesda Hospital

2017 Plus
Community Health
Needs Assessment Report

HealthEast®

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Executive Summary

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) EFFORT

HealthEast Bethesda Hospital (part of the HealthEast Care System), hereafter referred to as "Bethesda Hospital", has conducted a community health needs assessment (CHNA) every three years since 2012 (tax year 2011) to systematically identify, analyze and prioritize the critical health needs of the community and develop strategies to address those needs. In partnership with community members and organizations, local public health agencies and other hospitals and health systems, the 2017 Plus CHNA (September 1, 2017-December 31, 2017) builds upon previous assessments. It is designed to serve as a tool for guiding policy, advocacy and program planning. For Bethesda Hospital, it will inform organizational strategies and fulfill the IRS requirements for Community Health Needs Assessments 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.

Through this process, Bethesda Hospital, in partnership with Wilder Research, collected primary and secondary data to identify and address significant community health needs. For the purpose of this assessment, the definition of health is not limited to traditional measures of physical health, but rather includes social and economic factors relating to quality of life, such as income, education, employment status, transportation and housing. As with prior CHNAs, this assessment also takes into consideration the strengths, assets, and resources available in the community.

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 communities Bethesda Hospital serves. This 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 2017 Plus CHNA took place over a seven-month period between May 2017 and December 2017.

Secondary data describing the demographic, social, and economic characteristics of residents Bethesda Hospital serves was obtained from a variety of sources, including the U.S. Census Bureau American Community Survey (ACS), 2011-2015, the Minnesota Department of Health, the Minnesota Student Survey (2016), and the Metro Adult Health Survey (2014).

Primary data collection included a series of community conversations and meetings with East Metro residents, community organizations and leaders, public health professionals, and health care providers focused on key issues impacting health and well-being. These data were collected and analyzed in 2016 and 2017.

IDENTIFICATION OF SIGNIFICANT HEALTH NEEDS

In fall of 2017, HealthEast hospitals convened a joint Community Advisory Committee (CAC) comprised of over 50 community partners, many from medically underserved areas, to lend their voices to help HealthEast better understand and respond to the health needs of the community. Committee members attended two forums to identify and prioritize emerging health issues affecting the communities served by HealthEast hospitals. The committee reviewed primary and secondary data collected by HealthEast and Wilder Research for this assessment, as well as the current health priorities identified in the 2015 (tax year 2014) CHNA

process, **unmet mental health needs, obesity, and access to health services**. Issue Briefs describing the current magnitude, impact, and seriousness of the identified health needs were also shared. CAC members were asked to consider the social and economic factors that influence health at a local level and to provide recommendations for how HealthEast can best address these issues in the future.

PRIORITIZATION OF HEALTH NEEDS

The CAC, in collaboration with the HealthEast Community Advancement Team, used the following criteria to prioritize the significant health needs identified:

- Level of need
- Evidence of disparities
- Potential impact
- Emerging trends
- Opportunities for collaboration

Through a dot-voting process, the group affirmed Bethesda Hospital's 2017 Plus health priorities to be:

- **Unmet mental health needs**
- **Access to health services**
- **Healthy eating and active living**

These issues met all five of the prioritization criteria. Recommendations were made to reframe the priority of obesity to emphasize the importance of positive lifestyle, such as healthy eating and active living, rather than focusing solely on reducing the number of people who are overweight. Other significant needs identified that did not meet all five of the prioritization criteria were: **chronic disease, transportation, crime, poverty, employment, lack of culturally appropriate services, and transportation.**

Many of these issues will be addressed indirectly through implementation strategies focused on healthy eating and active living, unmet mental health needs and access to health services.

NEXT STEPS

The 2017 Plus CHNA report will be published on the HealthEast website following Fairview Health Services Board approval in December 2017. Paper copies will be made available through the Fairview Health Services Community Advancement department. Beginning in 2018, Bethesda Hospital will develop a written implementation plan to address the three priority health needs-**healthy eating and active living, unmet mental health needs, and access to health services**-identified during the assessment process. This plan will be created in partnership with the Community Advisory Committee, public health, and other community members to be adopted by the Fairview Health Services Board of Directors by May 15, 2018, and executed during fiscal years 2018-2020.

Introduction/Background

HealthEast Bethesda Hospital has conducted a CHNA every three years since 2012, to systematically identify, analyze and prioritize the critical health needs of the community and to develop strategies to address those needs. In partnership with community members, organizations, local public health agencies and other hospitals and health systems, the 2017 Plus CHNA builds upon previous assessments. It is designed to serve as a tool for guiding policy, advocacy and program planning. For Bethesda Hospital, it will inform organizational strategies and fulfill the IRS requirements for Community Health Needs Assessments 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.

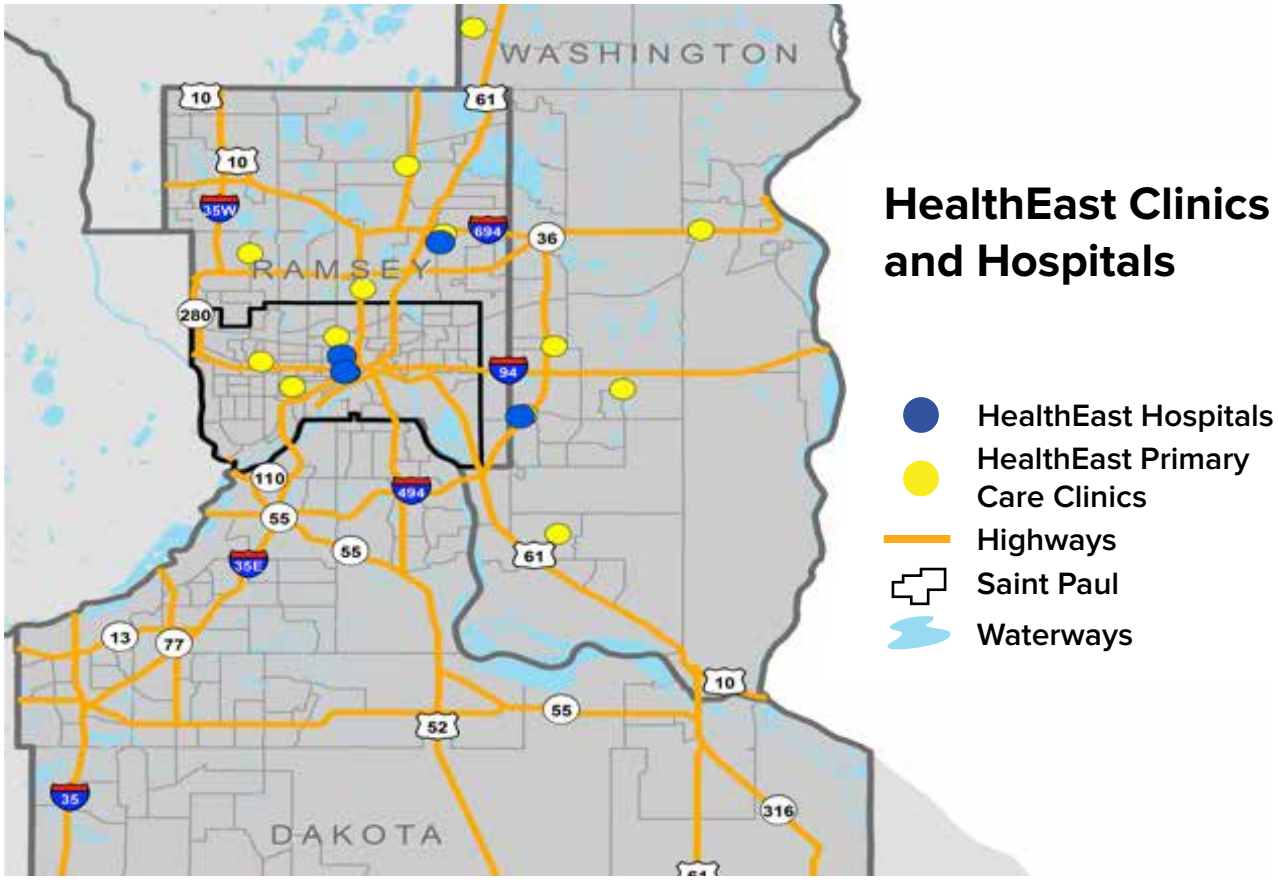
Through this process, Bethesda Hospital aims to:

- Better understand the health status and needs of the communities it serves by analyzing current demographic and 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, organizations, public health agencies and hospitals and health systems
- Create a strategic implementation plan reflective of the data collected through the CHNA process

For the purpose of this assessment, “community health” is not limited to traditional measures of physical health, but rather includes social and economic factors relating to quality of life, such as income, education, employment status, transportation and housing. HealthEast believes that health happens where we live, work, learn, play, and pray. This philosophy is consistent with the definition of health created by our Community Advisory Committee which states, “Health is the state of physical, mental, social, and economic well-being as defined by a person’s experience, culture, and preferences, and is not merely the absence of disease.”

About HealthEast

HealthEast (**healtheast.org**), part of **Fairview Health Services**, is the leading health care provider in the Twin Cities East Metro area. From prevention to cure, HealthEast meets the needs of the community with family health and specialty programs that span four hospitals—Bethesda Hospital, St. John's Hospital, St. Joseph's Hospital and Woodwinds Health Campus—plus primary care and specialty clinics, ambulatory services, home care, hospice and medical transportation. HealthEast has nearly 7,500 employees and nearly 800 employed and aligned providers. Our focus is optimal health and well-being for our patients, our communities and ourselves.



BETHESDA HOSPITAL

Bethesda Hospital is a long-term acute care hospital that provides integrated programs for medically complex patients. Since being founded more than 125 years ago, Bethesda Hospital has grown from a small, community hospital to a comprehensive long-term acute care facility that specializes in treating brain injuries, respiratory illnesses, neurovascular conditions and complex medical problems. Bethesda Hospital offers integrated programs to patients with injuries and illnesses that have long-term effects—making it different from traditional, short-term acute care hospitals. Patients admitted to Bethesda Hospital stay an average of 20 days and need rehabilitative services, as well as daily hospital care.

COMMUNITY SERVED

Bethesda Hospital is located in the city of Saint Paul in Ramsey County, Minnesota. It borders the culturally diverse neighborhoods of Frogtown/Thomas-Dale, Summit-University, and Payne-Phalen. Both the Frogtown/Thomas-Dale and the Payne-Phalen neighborhoods are federally designated medically underserved areas; defined by the Health Resources and Services Administration as "geographic areas and populations that lack access to primary care services." Medically uninsured and/or underserved populations face economic, cultural and/or linguistic barriers to healthcare. Examples include, but are not limited to, those who are:

- Experiencing homelessness
- Low income
- Medicaid-eligible
- American Indians

For the purpose of this assessment, the community served by the hospital includes Ramsey County, the city of Saint Paul, and the Saint Paul neighborhoods of Frogtown/Thomas-Dale, Summit-University and Payne-Phalen.

Community Demographics

The following section provides a summary of demographic trends and key social and economic data available for the community served by Bethesda Hospital.

POPULATION CHARACTERISTICS

	Ramsey County	Saint Paul	Frogtown/ Thomas-Dale	Payne-Phalen	Summit University
Total population	536,071	300,353	15,504* (+/-5%)	31,121	18,296
White	65%	54%	21%	35%	49%
Black	12%	15%	28%	13%	34%
Asian	14%	17%	36%	34%	7%
Hispanic	7%	10%	8%	11%	6%
American Indian	1%	suppressed	2%	suppressed	suppressed
Of color	37%	46%	79%* (+/-5%)	65%* (+/-5%)	52%
Foreign-born	15%	19%	32%	27%	18%
Children, 0-17	23%	25%	33%	32%	23%
Working-age adults, 18-64	60%	66%	60%	62%	67%
Adults, 65+	13%	9%	7%	6%	10%

Source: U.S. Census Bureau, Population Estimates, 2015 and American Community Survey, 2011-2015
Notes: Margins of error are < +/-4% unless otherwise noted. Data are 'suppressed' when margins of error are 70% or more of the estimate. Persons of color include the population that self-identifies as American Indian, Asian, Black, some other race, multi-racial or Hispanic.

SOCIAL AND ECONOMIC CHARACTERISTICS

	Ramsey County	Saint Paul	Frogtown/ Thomas-Dale	Payne-Phalen	Summit/ University
Median household income	$41,993	$48,757	$35,126	$43,229	$47,306
Persons living at or below 200% of poverty	31%	31%	63%	57%	49%
Cost-burdened households[a]	32%	38%	46%* (+/-5%)	43%	39%
Proportion of adults working	75%	73%	63%* (+/-5%)	64%* (+/-5%)	74%
Adults age 25+ with college degree	40%	39%	19%	20%	45%
Households with no vehicle	4%	14%	23%	18%	20%

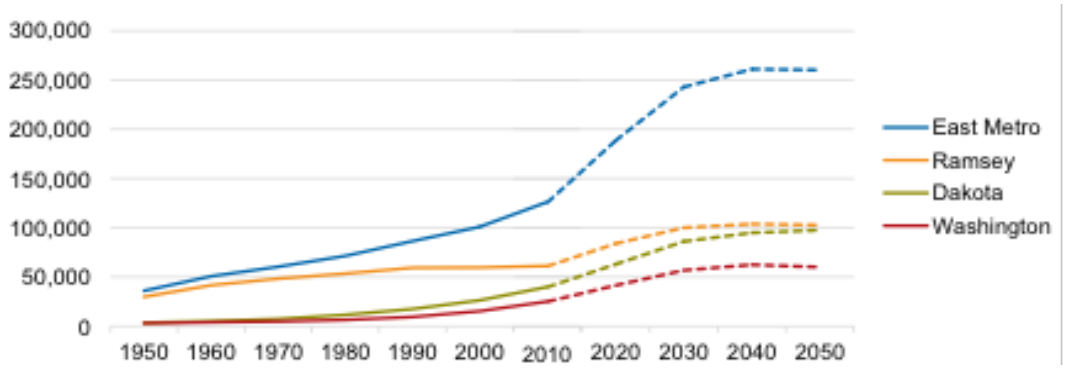
Source: American Community Survey, 2011-2015
Notes: Margins of error are < +/-4% unless otherwise noted. Data are 'suppressed' when margins of error are 70% or more of the estimate.
[a]Cost-burdened households pay 30 percent or more of their gross income on housing. The federal poverty threshold for a family of four living at or below 100% of poverty is $24,153 and $48,600 for a family of four living at or below 200% of poverty.

POPULATION CHARACTERISTICS

1. OLDER ADULTS

- East Metro populations are growing older and more racially and ethnically diverse, particularly in the communities surrounding Bethesda Hospital. The East Metro region continues to see increases in the number of residents of color and those who are foreign born.
- Large numbers of older adults will pose challenges and opportunities for communities. Older adults are least likely to live in poverty and more likely to have health insurance coverage. However, older adults are more likely than their younger counterparts to live alone and have disabilities.
- Older residents in the East Metro are more likely to be white; younger residents, age 0-17, are more likely to be of color.

Population age 65+ years in East Metro

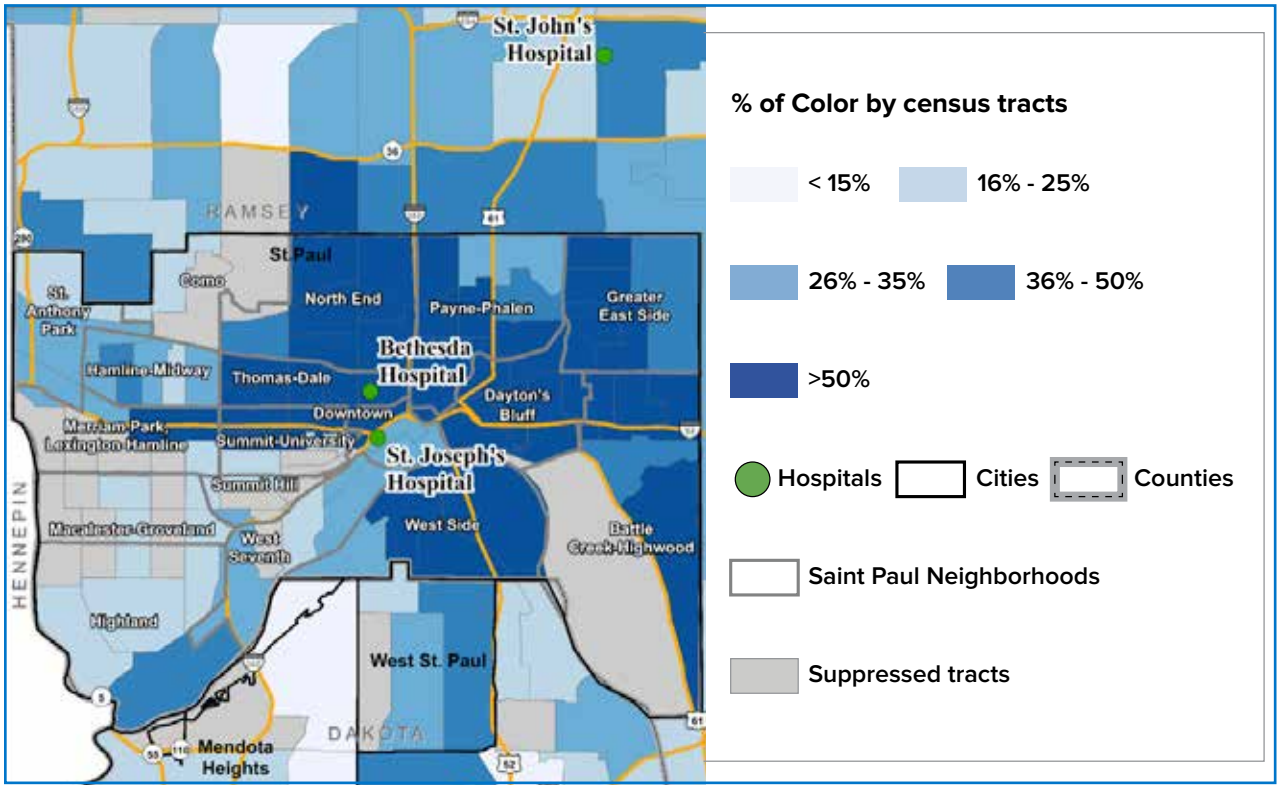


Source. Minnesota State Demographic Center and U.S. Census Bureau, Decennial Census and Population Estimates.

2. RACIAL AND ETHNIC DIVERSITY

Nearly 1 in 3 residents in Ramsey County are of color and just under half of residents in Saint Paul are of color. Saint Paul is home to the largest Asian population (17%) in the East Metro.

Percentage of residents of color living in the Bethesda Hospital service area by census tracts



Source: American Community Survey, 2011-2015
Note: Census tracts are suppressed when the margin of error is 70% or more of the estimate.

3. FOREIGN-BORN RESIDENTS

- The percentage of foreign-born residents in the East Metro region has been steadily increasing since 1990.
- Currently, about 1 in 5 Saint Paul residents are foreign born. Ramsey County and Saint Paul have the largest share of foreign-born residents who are recent arrivals, entering the US after 2010.
- Statewide, foreign-born headed households have a higher prevalence of renting, larger average household sizes, and less access to vehicles.
- In the Twin Cities seven county region, the number of U.S.-born children to foreign-born parents is highest among children under five.

SOCIAL AND ECONOMIC CHARACTERISTICS

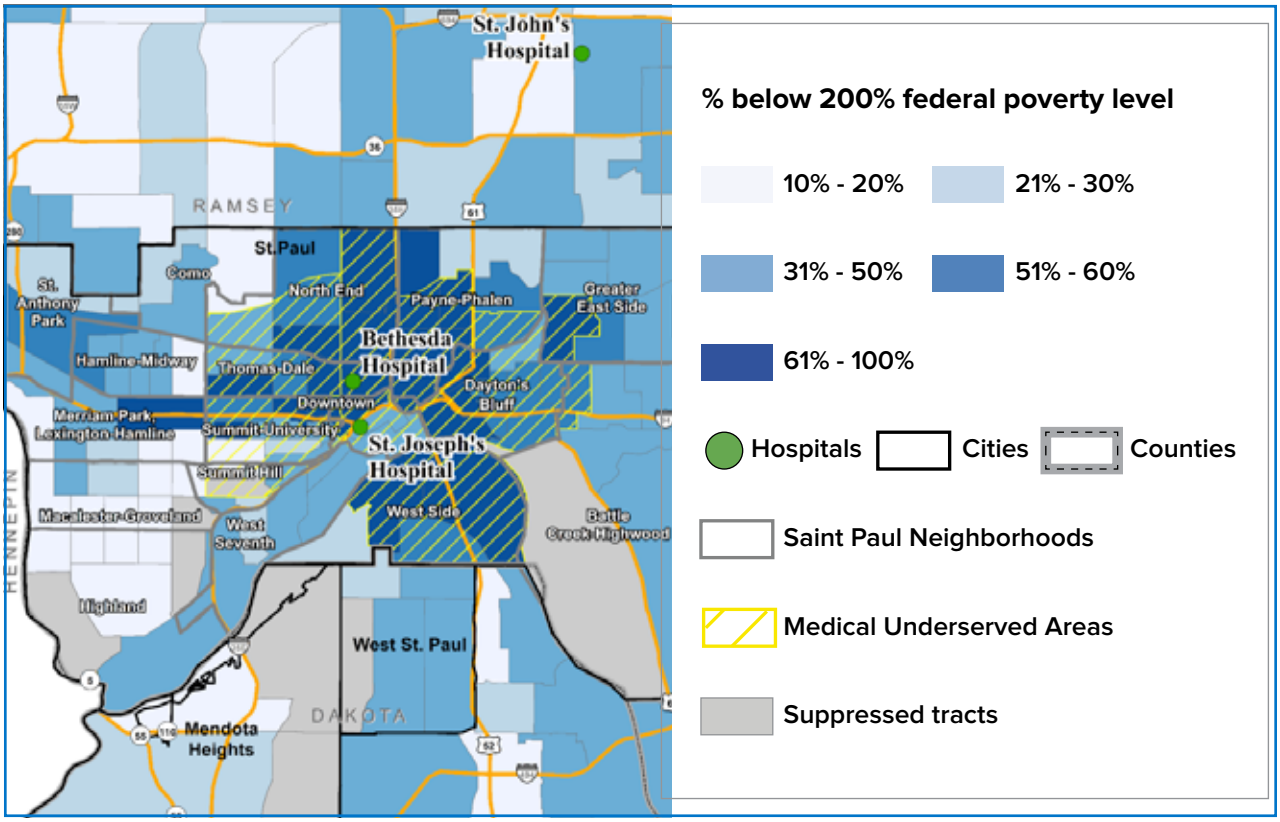
1. POVERTY

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

Magnitude. Ramsey County and Saint Paul have among the highest poverty rates in the East Metro region. One in four Saint Paul residents lives at or below the Federal Poverty Level and almost half live below 200 percent of poverty. Median household incomes within the communities that Bethesda Hospital serves fall between $40,000 and $50,000. Just under 40 percent of residents are cost-burdened— spending more than 30 percent of their income on housing.

Disparities. The burden of poverty is not equally distributed. Children, people of color, and foreign-born residents are more likely to live in poverty. In Ramsey County, residents of color are four times more likely to live in poverty than White residents and nearly half of all children live at or below 100 percent of the Federal Poverty Level. In Saint Paul, this percentage increases to almost two-thirds. Within Saint Paul, poverty is especially concentrated in the North End and Thomas-Dale neighborhoods.

Percentage of residents living at 200% poverty in the Bethesda Hospital service area by census tracts



2. EMPLOYMENT

Impact. There is a strong association between income and health. Employment is a pathway to individuals gaining income and assets, supporting their basic needs and accessing affordable health insurance.

Magnitude. Seventy-five percent of adults living in Ramsey County are employed. Pockets of disparities exist within specific neighborhoods—in particular, Saint Paul's Thomas-Dale and North End neighborhoods, where approximately 60 percent of adults are working.

Disparities. Residents in Ramsey County who identify as Black, Asian, Hispanic, Multiracial, or another race are less likely to be working than White residents.

3. EDUCATION

Impact. As with employment, a college education is a pathway to acquiring income, benefits, and assets, which are strongly associated with better health.

Magnitude. Forty percent of all residents age 25 or older in Ramsey County have a bachelor's degree or higher, which is on par with the Twin Cities region as a whole.

Disparities. Higher education disparities by geography and race exist among the communities served by Bethesda Hospital. Just 20 percent or less of residents in the Saint Paul neighborhoods of Frogtown and Payne-Phalen have a bachelor's degree or higher. In the East Metro region, 44 percent of White residents report having a bachelor's degree or higher, compared with 33 percent of residents of color. Ramsey County has the largest educational attainment gap by race in the state.

4. HOUSING AFFORDABILITY

Impact. 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—limited income remains to pay for basic needs, including health care costs.

Magnitude. About 30 percent of households are cost-burdened in Ramsey County. Rates are highest in the cities of Saint Paul and West Saint Paul.

Disparities. Renter households are also more likely to be cost-burdened than owner households. About half of renter households in Ramsey County are cost-burdened compared with 21-23 percent of residents who own homes

5. TRANSPORTATION

Impact. Reliable transportation helps ensure residents can purchase healthy foods, access health care services and other supports, and socialize with others, all of which are necessary for health and quality of life. Regardless of the mode of transportation chosen by residents, limited transportation options can make it difficult for residents to seek health care services and other community resources.

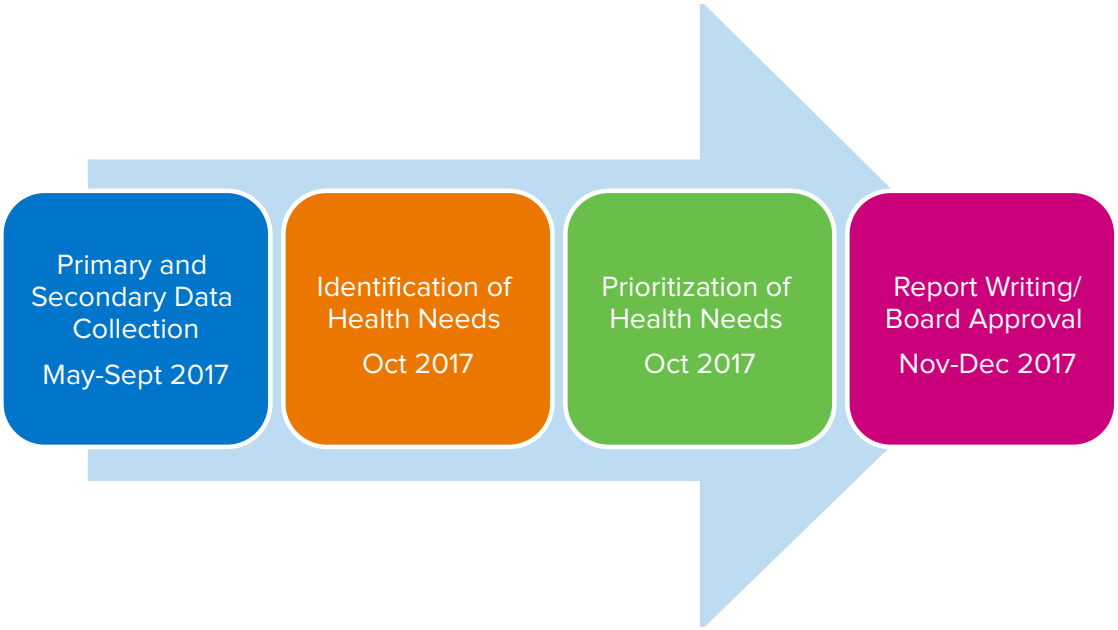
Magnitude. The majority of residents in Ramsey County have at least one vehicle and report using a vehicle to get to work.

Disparities. A higher proportion of residents in Saint Paul (14%) report having no vehicle and between 6 and 8 percent use public transportation to get to work.

2017 Plus CHNA Process & 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 East Metro residents. This 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 2017 Plus CHNA process took place over a seven-month period as illustrated below.

2017 Plus CHNA Process



QUALIFICATIONS OF CONSULTANTS

Wilder Research, a division of the Amherst H. Wilder Foundation in Saint Paul, Minnesota, is one of the nation's largest nonprofit research and evaluation groups dedicated to the field of human services. Wilder Research currently conducts research for more than 100 nonprofit and government organizations whose sphere of influence ranges from the neighborhood to the national or international level. Wilder Research staff has extensive experience conducting focus groups, key informant interviews, community surveys, local and statewide social service evaluations, demonstration projects, and community health needs assessments. More information about Wilder Research and links to recent reports can be found online at: **www.wilderresearch.org**

SECONDARY DATA COLLECTION

Secondary data were obtained from a variety of sources including the U.S. Census Bureau American Community Survey (ACS), 2011-2015 five-year estimates and 2015 one-year estimates. ACS estimates are produced annually and provide demographic, economic, and social characteristics of identified communities. Population health status and health behavior data were obtained from the Minnesota Department of Health (Minnesota County Health Tables 2015), the Minnesota Student Survey (2016), and the Metro Adult Health Survey (2014). Secondary data were analyzed by Wilder Research.

PRIMARY DATA COLLECTION

Primary data collection included a series of community conversations and meetings with East Metro residents, community organizations and leaders, public health professionals, and health care providers focused on key issues impacting health and well-being. These data were collected and analyzed by the HealthEast Community Advancement Team between 2016 and 2017.

The following is a description of the primary data collected:

- From February-July 2016, the East Side Health and Well-being Collaborative, of which HealthEast is a founding member, co-designed upstream interventions to improve health and well-being on Saint Paul's East Side. The East Side Health and Well-being Collaborative is made up of community partners from medically underserved areas at risk for not receiving adequate medical care. Seeking culturally responsive and transformational approaches, the collaborative co-designed two pilot programs: East Side Table and the East Side Mental Health and Stress Resilience Partnership. In May/June 2016, East Side Table partners surveyed 205 East Side residents regarding challenges to healthy cooking. The results mirrored those found by the Minnesota Food Charter and research conducted throughout the nation: **the top three barriers to cooking at home are time, motivation and expense**. Survey respondents indicated little interest in cooking classes, per se, but they did express an interest in improving their cooking skills. East Side Table partners developed make-at-home meal kits for 120 East Side households of varying size to help participants get healthy food on the table quickly and inexpensively while developing lifelong food skills.
- The East Side Mental Health and Stress Resilience Partnership comprises leading community organizations and clinics serving multiple low-income East Side communities including African-American, American Indian, Hmong, Karen, Latino, and Somali. The Partnership seeks to increase opportunities to build stress-resilience and holistic well-being within the community, which has often felt that mainstream healthcare marginalizes culturally based healing practices such as spiritual healers, community mediators, or family-based care. For many, mental health is often framed as a purely clinical issue and providers often turn to evidence-based practices even when the effectiveness of those practices has not been tested in different cultures. This combination of factors can lead to mistrust, misunderstandings about options, and inequitable access to care. In May-June 2016, the Partnership conducted interviews with 50+ East Side service providers and community members regarding current conditions and access to culturally responsive care, services, and support. Interviewees called for more culturally responsive services that contribute to holistic well-being; help meeting daily needs to reduce chronic stress; and places where they can feel safe.
- In fall of 2017, the Center for Community Health (CCH) hosted a dialogue for community leaders on the **Forces of Change Affecting Community Health**. CCH is a non-profit organization that is comprised of local public health departments, health systems, and health plans representing over 40 organizations across the seven-county metro Twin Cities area. The mission of CCH is to improve the health of our community by engaging across sectors and serving as a catalyst to align the community health assessment process and the development of action plans to better impact priority health issues and improve organizational effectiveness. Forces of Change (FoC) is one of the four assessments encouraged by the community health assessment framework, **Mobilizing for Action Through Planning**

and Partnerships (MAPP). The FoC process identifies factors that are or will be affecting the community and/or local public health system. The results of this assessment are used to identify strategic health priorities and action plans for addressing the priorities in partnership with local communities. During this dialogue, 60 participants contributed their insights and exchanged ideas regarding the local, regional, and national forces affecting community health. Issues such as the current political climate, immigration policy, racism, climate change, poverty, housing, mental health, and health insurance were discussed among numerous other existing and emerging trends. The results of this conversation will be used by CCH and other community organizations to inform their assessment activities and subsequent strategies to advance health in the Twin Cities.

COMMUNITY ADVISORY COMMITTEE

In fall of 2017, HealthEast convened a Community Advisory Committee (CAC) comprised of over 50 community partners, many from medically underserved areas, to lend their voices to help HealthEast better understand and respond to the health needs of the community. Committee members were asked to attend two forums to identify and prioritize emerging health issues affecting the communities served by HealthEast hospitals. Specifically, the CAC was asked to:

- Lend their unique community and organizational perspectives to discussions
- Help HealthEast understand the viability of current plans aimed to improve community health
- Provide input and critical feedback
- Inform HealthEast's decision-making and future planning processes
- Identify opportunities to work with HealthEast to co-create programming and other changes to support community health

The committee reviewed the primary and secondary data collected by HealthEast and Wilder Research for this assessment, as well as the current health priorities identified in the 2015 CHNA process, u**nmet mental health needs, obesity, and access to health services**. Issue Briefs describing the current magnitude, impact, and seriousness of the identified health needs were also shared. CAC members were asked to consider the social and economic factors that influence health at a local level and to provide recommendations for how HealthEast can best address these issues in the future (Appendix B & C).

Significant Health Needs Identified

LEADING CAUSES OF DEATH

The three leading causes of death in the East Metro are cancer, heart disease, and stroke. Tobacco use, obesity, physical inactivity, and poor nutrition are among the key risk factors that increase the likelihood of individuals acquiring these chronic conditions. Other leading causes of death include chronic lower respiratory disease, unintentional injury, diabetes, and Alzheimer's disease. In many of these areas, the overall trends suggest that the counties are meeting Healthy People 2020 goals for disease prevalence and/or mortality rates. However, a closer look shows that there are stark inequities where residents of color have poorer health outcomes. Suicide is among the top five leading causes of premature death among residents under the age of 75.

LEADING CAUSES OF DEATH IN DAKOTA, RAMSEY, AND WASHINGTON COUNTIES (RANKED)

Disease/condition	Dakota	Ramsey	Washington
Cancer	1	1	1
Heart disease	2	2	2
Stroke	3	3	3
Chronic lower respiratory disease (asthma, emphysema, chronic bronchitis)	5	4	4
Diabetes	6	5	6 (tie with Alzheimer's disease)
Unintentional injury	4	6	5

Source: American Community Survey, 2011-2015

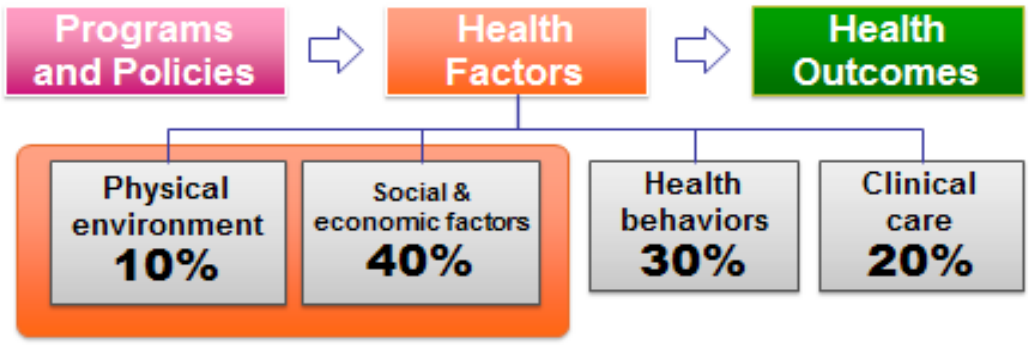
Mental illness, arthritis, asthma and chronic pain also result in disability, inability to work, and lower quality of life. Over 120,000 East Metro residents have one or more disabilities that limit daily activities. While individuals age 65 and older are most likely to have a disability, conditions like asthma and mental illness can limit activity and functioning for children, youth, and adults alike.

A RATIONALE FOR AN "UPSTREAM" FOCUS ON HEALTH

The Community Advisory Committee reviewed the primary and secondary data collected by HealthEast and Wilder Research for this assessment, as well as the current health priorities identified in the CHNA process, unmet mental health needs, obesity, and access to health services. Throughout this process, the group was purposeful in directing its attention to the "upstream" risk factors and social determinants that increase risk for premature death for the following reasons:

- While chronic disease management is a significant concern for some residents who have been diagnosed, or who care for someone with a chronic condition, issues that resonate with the broader population tend to focus on neighborhood conditions and resources that foster health, improve quality of life, and support healthy behaviors.
- Although clinical care is the primary focus of HealthEast, population health outcomes are more strongly influenced by social determinants of health (i.e., poverty, neighborhood conditions) than clinical care. This does not lessen the critical role of health care in improving health, but rather the CHNA process provides an opportunity for HealthEast to consider ways to work creatively "upstream" to reduce the burden of chronic disease among East Metro residents.

Factors that influence health



Source: University of Wisconsin Population Health Institute

PRIORITY 1: OBESITY

Rating criterion	Data highlights
Magnitude	Based on population estimates, over 225,000 East Metro adult residents (approximately one-quarter of the population) are obese.
Impact	Obesity rates are higher among lower-income residents and Minnesotans experiencing housing/food insecurity. Obesity rates by racial/ethnic group are not available through local data sources, but disparities are evident in state/national prevalence data.
Seriousness	Obesity is a risk factor for many chronic diseases including heart disease, type 2 diabetes, some types of cancer, and complications during pregnancy.
Trends	Obesity rates among adults have remained relatively stable since 2007. Among some age groups, there have been reductions in the rate of childhood obesity.

WHY IS OBESITY AN EAST METRO HEALTH CONCERN?

Obesity is a risk factor for a number of chronic diseases that contribute to premature disability and death. People who are at a healthy weight are less likely to experience premature death, develop chronic diseases, including type 2 diabetes, heart disease, and some types of cancer, and experience complications during pregnancy.[1]

WHO IS IMPACTED?

Approximately one-quarter of East Metro adult residents, over 225,000 adults, are obese. The obesity rate for the state and for all three East Metro counties has exceeded the national Healthy People 2020 goal (adult obesity rate of less than 30.5%). Among 9th grade students in the East Metro, rates of obesity are approximately twice as high among boys as girls (up to 16% for boys and 9% for girls).

[1] Healthy People 2020

A majority of HealthEast clinic patients are overweight or obese. Approximately 70 percent of HealthEast clinic patients are categorized as overweight or obese, based on body mass index (BMI). These totals are somewhat higher than the county-level estimates available through the Adult Metro Health Survey. Missing data may contribute to some of the differences between the two sources of data. However, it may also be that patients who use primary care clinic services are in poorer health and are more likely to be overweight or obese than the overall population.

Local data show higher rates of obesity among lower income residents. This disparity is most notable in Washington County, where 47 percent of lower-income residents are obese, compared to 24 percent of higher-income residents. Although local data are not available, national estimates suggest disparities in obesity by race/ethnicity. The obesity rate for whites in Minnesota is 27.3 percent, compared to 33.1 percent for Latino residents and 30.4 percent for black residents. (Estimates were not available for additional racial/ethnic groups.)

WHAT ARE THE CURRENT TRENDS?

In Minnesota and nationally, rates of obesity have remained stable or started to decrease in some age groups. Minnesota's obesity rate has remained stable since 2007, with only minor fluctuations year to year. Minnesota is one of 19 states that have reported significant reductions in childhood obesity. There was a 6 percent reduction in obesity among young children ages 2 to 4 in Minnesota between the years of 2008 and 2011. Nationally, obesity rates for youth ages 2 to 19 has not increased in recent years, but there has been a decline in obesity rates among young children (ages 2 to 5). More work is needed to determine whether these improvements are being experienced among residents of different cultural and socioeconomic groups.

PERCENT OF 9TH GRADE STUDENTS WHO ARE OVERWEIGHT OR OBESE, ACCORDING TO BMI

9th grade students	2007	2010	2013		2016	
			Male	Female	Male	Female
Dakota County						
Overweight	12%	12%	13%	10%	12%	6%
Obese	7%	7%	10%	6%	12%	6%
Ramsey County						
Overweight	14%	14%	15%	14%	13%	15%
Obese	11%	11%	14%	7%	16%	9%
Washington County						
Overweight	13%	11%	14%	12%	14%	11%
Obese	6%	9%	10%	5%	10%	5%

Source: Minnesota Student Survey

PRIORITY 2: UNMET MENTAL HEALTH NEEDS

Rating criterion	Data highlights
Magnitude	Approximately 194,000 East Metro adults (20% of the population) experience mental illness and nearly 50,000 experienced serious mental illness. In addition, nearly 30,000 children (ages 0-17) experience a mental health problem.
Impact	Mental illness can affect persons of any age and cultural group. However, traumatic experiences or life circumstances that result in chronic stress (e.g., homelessness, poverty) can exacerbate poor mental health symptoms and impede recovery.
Seriousness	Deaths due to suicide are the third leading cause of premature death in the East Metro. Poor mental health can contribute to a range of other issues that impact quality of life and overall health (i.e., less supportive social relationships, increased likelihood of criminal justice system involvement, greater likelihood of employment issues, and housing instability). There are associations between mental illness, poor physical health, and substance abuse. The number of residents experiencing dementia will increase with a growing aging population.

WHY ARE UNMET MENTAL HEALTH NEEDS AN EAST METRO HEALTH CONCERN?

Many East Metro residents experience poor mental health. According to the Substance Abuse and Mental Health Services Administration (SAMSHA) nearly 20 percent of adults experience a diagnosable mental illness, with approximately 5 percent of adults meeting the criteria for serious mental illness (SMI).[2,3]

In addition, between 14 and 20 percent of children, youth, and young adults experience some type of mental health or social-emotional disorder. Applying these estimates to adults living the East Metro region, approximately 194,000 adults and 30,000 children experience diagnosable mental health problems; nearly 50,000 adult residents experience serious mental illness.[4] Poor mental health, when considered along a continuum of well-being rather than meeting diagnostic criteria for mental illness, impacts even more individuals. More than one-third of East Metro adults report experiencing poor mental health at least one day in the past 30 days.

It is difficult to determine the severity of mental health problems among residents in the region and its impact on health and quality of life. A recent Minnesota Department of Health study found that the average life expectancy of adults with SMI is 58 years, compared to 82 years for the general population.[5] While some of this difference is the result of suicide, which took the lives of 144 East Metro residents in 2015, there are a number of ways mental illness can impact overall health and quality of life. Poor mental health is associated with a range of negative health and social outcomes, including unemployment, housing instability, criminal justice system involvement, social isolation, and poor physical health. However, good sources of local data are not available to determine the overall impact of untreated mental illness and poor mental health.

[2] National Survey on Drug Use and Health. (2012). State estimates of adult mental illness. Retrieved from: http://www.samhsa.gov/data/2k11/WEB_SR_078/SR110StateSMIAMI2012.htm

[3] Serious Mental Illness (SMI) is defined as mental illness that leads to significant impairment in one or more major life activities, such as employment or functioning in the home.

[4] Kessler, et al. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 62, 593-602.

[5] Minnesota Department of Human Services, Mental health. Retrieved from: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000085

WHO IS IMPACTED?

Mental illness can affect anyone, regardless of age, race/ethnicity, income, or education level. However, traumatic experiences or the chronic stress associated with living in poverty or having instability in the household can contribute to poor mental health in childhood and throughout adulthood.

Some populations may have difficulty seeking treatment to better manage and recover from their symptoms. People with lower incomes or high deductible/high co-pay health insurance plans may have difficulty affording and accessing mental health treatment service. New immigrant and refugee populations who have experienced war or other types of violence, displacement from their home and community, extreme poverty, may be experiencing symptoms of post-traumatic stress disorder (PTSD). Unfamiliarity with the mental health system, a lack of culturally specific mental health providers, and feelings of stigma can be significant barriers to seeking mental health services.

WHAT ARE THE CURRENT TRENDS?

Demographic trends will likely influence mental health needs in the East Metro. With the dramatic increase in the number and proportion of aging residents, the number of residents with dementia and other mental health problems will also grow. Culturally specific services are likely to be in greater demand as the region becomes more diverse.

PERCENTAGE OF EAST METRO ADULTS REPORTING THEIR MENTAL HEALTH WAS NOT GOOD FOR AT LEAST ONE DAY OUT OF THE PAST 30 DAYS

	Dakota County	Ramsey County	Washington County
All residents	45%	48%	39%
Lower-income	60%	57%	57%
Higher-income	43%	44%	44%

NOTE: "Lower-income" refers to residents with annual household income at or below 200% of the Federal Poverty Level (FPL), which is currently $24,600 for a family of 4). "Higher-income" refers to residents with annual household income greater than 200% FPL.
Source: Metro Adult Health Survey, 2014

PRIORITY 3: ACCESS TO HEALTH SERVICES

Rating criterion	Data highlights
Magnitude	Approximately 50,000 East Metro adult residents lack health insurance. Six percent of Ramsey County residents (under age 65) are without health insurance (6%), somewhat more than in Dakota or Washington counties (4% and 3%, respectively). Results from the 2014 Metro Adult Health Survey estimated that approximately 20 percent of East Metro residents reported they had not seen a health care professional during the past year.
Impact	Younger residents and lower-income residents are less likely to have health care coverage. Because of the high poverty rate in some Saint Paul neighborhoods, some geographic areas in the East Metro have been designated as "medically underserved areas."
Seriousness	Lack of access to health care services can result in late diagnoses or poor management of chronic health conditions, which can contribute to poorer health outcomes and reduced quality of life.

WHY IS ACCESS TO HEALTH SERVICES AN EAST METRO HEALTH CONCERN?

Residents need to be able to access both acute care services for illnesses and emergencies and preventative services to promote health and wellness. The percentage of residents without health insurance has been reduced by half since 2013. In 2016, six percent of Ramsey County residents lacked health insurance, somewhat more than in Dakota (4%) and Washington (3%) counties. Not all residents have health care plans with premiums that are affordable; in 2014, over 20 percent of East Metro residents found it "very" or "somewhat" difficult to pay for health insurance premiums, co-pays, and deductibles.

WHO IS IMPACTED?

In the East Metro, there are populations that experience difficulty accessing the health care services they need. In each of the three counties, approximately 80 percent of the population reported seeing a health care provider during the past year. Residents who did not see a health care provider were more likely to be male, younger (18-34 years old), and living in lower-income households. In addition, the neighborhoods of Dayton's Bluff, Thomas-Dale, Summit-Dale, and Payne-Phalen are all federally designated medically underserved areas because of the high concentration of poverty in these areas.

Although most East Metro residents have health insurance, high costs of care and difficulty accessing specialty services are still barriers to health. It is important to note that these rates do not describe the adequacy of insurance available. In the discussion groups with HealthEast staff and various patient and resident stakeholder groups, health care costs were described as a barrier to care.

Residents who speak languages other than English described difficulties finding culturally appropriate care and noted they did not always receive information in a way they could understand.

PERCENTAGE OF EAST METRO ADULTS REPORTING THEY HAVE SEEN A DOCTOR, NURSE, OR OTHER PROFESSIONAL ABOUT THEIR OWN HEALTH IN THE PAST 12 MONTHS, BY GENDER, POVERTY STATUS

	Dakota County	Ramsey County	Washington County
Percentage of residents without health insurance	4%	6%	3%
Percentage of residents who find it "very difficult" or "somewhat difficult" to pay for health insurance premiums, co-pays, and deductibles	24%	22%	18%*
Percentage of residents who have seen a health care provider in the past 12 months	85%	82%	82%

* The estimate is potentially unreliable and should be used with caution.
Source: Metro Adult Health Survey, 2014

WHAT ARE THE CURRENT TRENDS?

There are a number of service delivery models (e.g., accountable care organizations, accountable communities for health, health care homes) that emphasize the roles of care coordinators and other similar positions to help patients access health care services and manage their health. Community Health Workers, for example, often share the same cultural background as the patients and community residents they work with, helping individuals seek resources that support their health and serving as a cultural bridge between health care providers and patients. The impact of any proposed federal health care reform on health insurance rates, the affordability of health care services, and access is unclear.

Prioritization of Health Needs

Based on the review of the data summarized above, the Community Advisory Committee, in collaboration with the HealthEast Community Advancement Team used the following criteria to prioritize the significant health needs identified:

- Level of need
- Evidence of disparities
- Potential impact
- Emerging trends
- Opportunities for collaboration

Through a dot-voting process, the group affirmed Bethesda Hospital's 2017 Plus health priorities to be:

- **Unmet mental health needs**
- **Access to health services**
- **Healthy eating and active living**

These issues met all five of the prioritization criteria. Recommendations were made to reframe the issue of obesity to emphasize the importance of positive lifestyle, such as healthy eating and active living, rather than focusing solely on reducing the number of people who are overweight. Other significant needs identified that did not meet all 5 of the prioritization criteria were: **chronic disease, transportation, crime, poverty, employment, lack of culturally appropriate services, and transportation.**

Many of these issues will be addressed indirectly through implementation strategies focused on healthy eating and active living, unmet mental health needs and access to health services.

Intersection of HealthEast Healthcare Priorities, Health Issues, and Emerging Health Trends Identified by the Advisory Committee

ACCESS TO HEALTH SERVICES

- Lack of culturally appropriate services
- Language barriers
- Limited service and provider availability (primary care, dental, drug/alcohol treatment)
- Understanding and navigating healthcare and insurance
- Affordability of health services
- Language barrier
- Cost
- Insurance status
- Lack of healthcare facilities
- Chronic diseases

MENTAL HEALTH

- Lack of culturally appropriate services
- Youth mental health - addressing it early
- Drug abuse and addiction
- Need for social support
- Isolation
- Toxic stress
- Chronic diseases
- Lack of medication management
- Shame
- Need for community connections

OBESITY

- Lack of culturally appropriate services
- Lack of knowledge about health eating and physical activity
- Need for social support
- Availability and affordability of healthy foods
- Availability and affordability of healthy activities
- Air quality
- Toxic stress
- Asthma
- Sedentary lifestyle
- Automobile dependence
- Chronic diseases
- Lack of medication management
- Shame

FACTORS UNDERLYING ALL PRIORITY AREAS

Poverty - Homelessness - Crime - Neighborhood safety - Lack of affordable and safe housing - aging population - Daycare availability - Need for Living wages - Economic instability - Poor access to transportation - Immigration status and policies - Negative experience with service systems (government, health, social service) - Family instability - Legal difficulties - Inequality - Achievement gap - Access to employment - Family caregiving - Need for financial wellness

Resources to Address Health Needs

As Bethesda Hospital develops its community health improvement plan, it will look to both internal and external resources to address the significant health needs identified through the CHNA process. To begin, Bethesda Hospital will evaluate existing strategies to determine which initiatives can be modified or expanded to better address the priority needs. Through the Community Advisory Committee and East Side Health and Well-being Collaborative, Bethesda Hospital will continue to work closely with local public health departments and community service providers to co-create programs designed to meet the needs of East Metro residents in a way that best leverages organizational resources.

The Center for Community Health will continue to serve as a significant resource to HealthEast hospitals and clinics. Data from the **Forces of Change** event will be used for health improvement planning and strategy development.

In addition, Bethesda Hospital will leverage existing relationships with community organizations already working in East Metro neighborhoods to address unmet health needs. These organizations include, but are not limited to, the YMCA, Wilder Foundation, City of Saint Paul Parks & Recreation, police departments, fire departments, school districts and state universities, Hearth Connection, Catholic Charities, Karen Organization of Minnesota, Hmong American Partnership, Merrick Community Services, and the Metropolitan Area Agency on Aging.

Finally, Bethesda Hospital will work with Saint Paul-Ramsey County Public Health department to identify resources and opportunities to coordinate efforts through their Statewide Health Improvement Plans (SHIP) and Community Health Improvement Plans (CHIP).

Needs Identified but Not Included in the CHNA

Significant needs identified through the 2017 Plus assessment process that will not be addressed in the three year Community Health Implementation Plan are listed below.

Community Need	Reasons Not Addressed
Affordable Housing and Housing Supports	This issue will be addressed through our access to health services priority.
Chronic Diseases	This issue will be addressed through our unmet mental health needs, healthy eating and physical activity, and access to health services priorities.
Transportation	This issue will be addressed through our access to health services priority.
Crime	This issue is beyond what our resources can support at this time.
Poverty	This issue will be addressed through our access to health services priority.
Employment	This issue will be addressed through our access to health services priority.
Lack of culturally appropriate services	This issue will be addressed through our access to health services priority.
Social Insolation	This issue will be addressed through our unmet mental health needs and access to health services priorities.

Next Steps in the CHNA Process

ADOPTION BY THE FAIRVIEW HEALTH SERVICES BOARD OF DIRECTORS; POSTING FOR THE COMMUNITY

The Fairview Board of Directors will be asked to review and adopt the 2017 Plus CHNA report on December 7, 2017. This report will be made available to the general public on the HealthEast website, **www.healtheast.org**, on or before December 31, 2017. Paper copies will be available through the Fairview Health Services Community Advancement department.

IMPLEMENTATION STRATEGIES TO ADDRESS PRIORITY HEALTH NEEDS

Beginning in 2018, HealthEast will conduct the final steps in the assessment process by developing a written implementation plan to address the identified priority health needs-**healthy eating and active living, unmet mental health needs, and access to health services**. This plan will be created in partnership with community members and public health professionals to be adopted by the Fairview Health Services Board of Directors by May 15, 2018, and executed during fiscal years 2018-2021.

2015 CHNA Results and Impact

In pursuit of our vision of **optimal health and well-being for our patients, our communities and ourselves**, HealthEast conducted its second CHNA in 2015 (tax year 2014) to identify significant community health needs. The HealthEast Board of Directors approved the report in August 2015 and an advisory committee and other key stakeholders reviewed and prioritized the many significant health needs that would be addressed over the next three years. The three priority needs identified were: **obesity, mental health and access to resources**. The stakeholders developed the Community Health Implementation Plan with supporting goals, objectives and strategies to address these priority needs and to serve as the implementation roadmap for fiscal years 2016-2018. Through the lens of health equity, the implementation plan focused on addressing the issues of obesity, mental health and access to resources within three priority populations: aging residents, residents in poverty and populations of color. The HealthEast Board of Directors adopted the plan in December 2015.

2016-2018 COMMUNITY HEALTH IMPLEMENTATION PLAN

The following describes the significant actions taken by HealthEast as part of its Community Health Implementation Plan:

PRIORITY: OBESITY

Goal: Promote healthy lifestyles and improve access to nutritious food and physical activity in order to increase the percentage of people living at a healthy weight.

FRUIT AND VEGGIE RX

Food insecurity, defined as lacking access to a safe, consistent and culturally appropriate source of food, is strongly associated with an increased risk of developing chronic diet-related diseases. It is also a fact of life for many in our community. In partnership with the Hmong American Farmers Association (HAFA) and

HealthEast Roselawn and Rice Street clinics, HealthEast seeks to ease food insecurity by providing culturally specific nutrition information and distributing fresh fruit and vegetables to those at risk of hunger. The goal is increased access to nutritious foods and to help combat chronic disease. In the Fruit and Veggie Rx program, which is targeted at immigrants and refugees, 37 food-insecure individuals with chronic diet-related disease are working with a dietician to learn about nutrition and set healthy eating goals for their family. For a period of 21 weeks in the summer and fall of 2017, HAFA provided participants with weekly Community Supported Agriculture (CSA) boxes filled with fresh fruits and vegetables chosen to appeal to cultural preferences. Physicians measured recipients' food security, body mass index, and healthy eating behavior at the beginning and at the end of the program.

EAST SIDE TABLE

In a unique collaboration on Saint Paul's East Side, HealthEast is working with community organizations and residents to counteract the effects of poverty, racism and other social determinants of health on individuals' well-being. The East Side Health and Well-being Collaborative, comprising of more than 20 community partners, co-designed and co-implemented an 18-month pilot program designed to provide opportunities for East Side residents to overcome barriers to healthy eating, such as expense and preference for high-fat, high-sugar foods. Focused on food skill development, the program includes make-at-home meal kits, dozens of large and small tasting events, a five-language website and access to healthy, quick and tasty recipes. The program currently provides weekly meal kits to 120 East Side families.

FREE OR REDUCED COST WELLNESS AND PREVENTION PROGRAMS

HealthEast partnered with the Metropolitan Area Agency on Aging, All Saints Lutheran Church, Gladstone Community Center, Keystone Merriam Park Community Center, Washington County Public Health and the Centers for Disease Control and Prevention to offer free or reduced cost diabetes prevention and Tai Ji Quan and Matter of Balance falls prevention programming in the community. A total of 106 individuals completed the programs which resulted in an increase in self-reported physical activity, weight loss and a decrease in falls and the fear of falling.

PRIORITY: UNMET MENTAL HEALTH NEEDS

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

EAST SIDE MENTAL HEALTH AND STRESS RESILIENCE PARTNERSHIP

A second pilot program born out of the East Side Health and Well-being Collaborative is the East Side Mental Health and Stress Resilience Partnership. This program is designed to assist residents' efforts to access culturally-based and mainstream health and social services supporting stress-resilience and holistic well-being on the East Side. The Partnership aims to increase cultural responsiveness and understanding of the mental health system, and provide support for those living in social isolation through the employment of bicultural and bilingual cultural brokers— serving our African American, Karen, American Indian, Latino and Hmong communities. It also provides culturally responsive Mental Health First Aid trainings and hosts community dialogues which focus on reducing the stigma associated with mental illness.

KAREN CHEMICAL DEPENDENCY COLLABORATION PROGRAMS

In collaboration with the Karen Organization of Minnesota (KOM), and funding support from the Bush Foundation, F.R. Bigelow Foundation, The Saint Paul Foundation and Medica Foundation, HealthEast has provided culturally responsive substance use treatment and addiction resources to the Karen community through the Karen Chemical Dependency Collaboration (KCDC). KCDC is a multidisciplinary group that includes Karen community and faith leaders, healthcare providers, interpreters, social workers, mental health specialists, and local law enforcement. The group recognizes that the "status quo" approach to substance use treatment is often inaccessible, inadequate, and ineffective for non-English speaking individuals who lack basic health literacy. Most existing treatment programs do not address acculturation, pre-migration trauma, resettlement stress, or extreme poverty, all of which impact substance use for refugees. Karen community leaders and health and social service providers have identified harmful substance use and lack of accessible, culturally relevant prevention/education, screening, treatment, and community support programs as the most important concern facing the Karen community. In response to this, KCDC has developed culturally specific substance use treatment curriculum, held the first Karen-language Alcoholics Anonymous recovery meeting in the United States, and has established a staff position with KOM that bridges the HealthEast Roselawn Clinic with KCDC to work in partnership to address the harmful effects of drugs and alcohol in the Karen community.

MENTAL HEALTH DRUG ASSISTANCE PROGRAM

The Mental Health Drug Assistance Program (MHDAP) is a collaboration that began in 2008 between United, St. Joseph's, and Regions hospitals in Saint Paul; the crisis services of Ramsey, Dakota, and Washington counties, and the Mental Health Crisis Alliance to financially assist community members with medication management needs. MHDAP provides 24/7 access to stop-gap medications to low-income people who experience severe mental illness. Contributions pay for the cost of prescriptions and co-pays for needy patients within the Twin Cities East Metro. The program helps patients avoid mental health emergencies that can result from a loss of medication access. In 2017, MHDAP provided stop-gap insurance to help 298 individuals obtain needed prescriptions.

PRIORITY: ACCESS TO SERVICES AND RESOURCES

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

COMING HOME

The Coming Home project is a partnership between Hearth Connection, Guild Incorporated, Catholic Charities and HealthEast. The goal of the program is 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.

HealthEast St. Joseph's Hospital in downtown Saint Paul serves approximately 500 homeless patients in its emergency department and inpatient facilities each year. Many of these patients suffer from serious and persistent mental illness and leave the hospital without a clear path toward permanent housing. Coming Home offers a seamless transition from hospital to temporary housing to permanent supportive housing. The process starts at St. Joseph's Hospital where care providers and staff from Guild Inc. identify and screen eligible candidates. At discharge, staff walk participants next door to Catholic Charities' Higher Ground facility, which provides temporary housing and works with Guild and Hearth staff to help participants access state-funded intensive case management services and housing subsidies. If the participant qualifies for services other than supportive housing, Guild and Catholic Charities will work to obtain these services. The goal of this program is to transition participants to permanent housing in the community in 120 days or less. Case manager involvement may last 18 months or longer, depending on participant need. In the first five months of the pilot, two individuals were permanently housed and several more have transitioned to temporary housing.

HEALTH INSURANCE LIAISON PILOT PROJECT

In partnership with Portico Healthnet, this project aimed to enhance access to health care services through insurance coverage. Embedded in the HealthEast Roselawn Clinic, which cares for a large number of immigrants and refugees who do not have health insurance, a health insurance liaison helped patients navigate and gain access to health coverage programs including Medicaid, Minnesota Care, Portico and other employer-based health insurance plans. As of May 2017, 355 previously uninsured individuals gained access to insurance through this project.

FAITH COMMUNITY NURSING

In partnership with City Passport, Shobi's Table, Fairmount Avenue United Methodist Church, Woodbury Baptist Church, Church of the Blessed Sacrament and Lyngblomsten, the HealthEast Faith Community Nurse program provides basic health screenings, referrals to community resources and opportunities for social connection in community-based settings. In fiscal year 2016, Faith Community Nurses reported more than 2,300 encounters with community members.

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Community Member, Jaeden Allen

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HealthEast Executive Leadership Team

Cathy Barr, East Region President

Kevin Garrett, East Region Medical Executive

Dawn Ksepka, Interim Vice President and Controller, Finance

Don Moschkau, System Executive, Human Resources

Joanne Sunquist, Chief Information Officer

HealthEast Foundation Board of Directors

Gregory G. Freitag, AxoGen Inc.

Litton E. S. Field, Jr., Bearence Management Group

Taqee Khaled, Blue Cross and Blue Shield of MN

Betty A. Brost, Brost Enterprises

Dennis P. Todora, CareAparent

Timothy A. Becken, Cemstone Products Co.

Josephine (Jo) Bailey, Community Volunteer

Kathryn Correia, CAO, Fairview Health Services

Mai Moua, Hmong American Partnership

Scott A. Mueller, Mueller Memorial

Rev. Roland Hayes (Retired), St. Michael's Lutheran Church

Thomas G. Fee, Vector Wealth Management LLC.

HealthEast Community Advancement Staff

Keith Allen, Neighborhood Integration Manager

Tiffany Blank, Senior Director of Philanthropy and Operations

Jesus Calzas-Millan, Cultural Broker – Latino/ Hispanic Community

Mee Cheng, Community Benefit Specialist

Amy Fehrer, Community Assessment and Measurement Manager

Terese Hill, East Side Table Coordinator

Foua Choua Khang, East Side Mental Health and Stress Resilience Partnership Manager

Joan Pennington, Senior Director Community Health, Policy & Measurement

John Swanholm, Vice President of Community Advancement & Executive Director of HealthEast Foundation

Diane Tran, Director of Neighborhood Integration and Community Engagement

Wilder Research

Melanie Ferris, MPH, Research Manager

Rebecca Sales, MPH, Research Associate

Ellen Wolter, MPH, MPA, Research Scientist

Steven Aviles, Research Associate

Marilyn Conrad, Administrative Manager

Jennifer Bohlke, Communications Specialist

Center for Community Health

Anoka County Community Health and Environmental Services

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City of Edina Community Health

City of Richfield Public Safety

Dakota County Public Health

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Minneapolis Health Department

Saint Paul-Ramsey County Public Health

Scott County Public Health

Washington County Public Health and Environment

Blue Cross and Blue Shield/Blue Plus of Minnesota

HealthPartners

Medica

Metropolitan Health Plan

Preferred One

UCare

Minnesota Council of Health Plans

Allina Health

Children's Hospitals and Clinics

Fairview Health Services

HealthEast

HealthPartners Family of Care

Hennepin County Medical Center

Maple Grove Hospital

North Memorial Medical Center

Minnesota Hospital Association

North Memorial Medical Center

Minnesota Hospital Association

Appendix A

DISCUSSION RESPONSE THEMES

HEALTHEAST ADVISORY COMMITTEE #1

What perspectives and experiences are you bringing to this conversation and the CHNA process?

- Educating the community about health/healthcare
- Developing, managing, maintaining partnerships in the community
- Local government and represent constituents
- Community engagement
- Specific demographic perspective (personally or clients) – American Indian, youth, Spanish-speaking, undocumented, underserved populations, older adults, homeless
- Lead initiatives aimed at improving health and wellbeing including health assessments and direct programming
- Work in areas that are or impact social determinants: housing, employment, education (school board, birth-3), food access
- Work in a health field (Mental health, chemical health)

What are the most important issues impact health and wellbeing for residents in the community? Are there key health trends or emerging health concerns?

- Lack of access to healthcare, social services, and other support services
  - Specifically mentioned dental, primary care, chemical health, mental health
  - Unaffordability of health services
  - Understanding/navigating insurance
- Culturally appropriate services and providers; language barriers
- Lack of housing/Lack of affordable housing/homelessness
- Lack of access to healthy and affordable foods
- Poverty
- Growing aging population
- Crime
- Addiction
- Transportation
- Chronic stress
- Chronic health conditions

What is the role of health care organizations, including HealthEast, can play in address these issues and improve community health and wellbeing?

- Support and fund innovation and evidence-based programs in the community
- Address social determinants and advocate for other efforts to address them (Specifically mentioned: housing, food access)
- Educate patients and the community
  - Develop resources/classes to help people navigate healthcare and address specific health issues (e.g. obesity)
  - Community involvement/health challenges
- Increase availability of culturally appropriate services and more diverse providers
  - Advocate for reimbursement of holistic healers, healers from different cultures
- Partner with community organizations and other allied health professionals

- Connect patients to appropriate community services and supports
- Provider person-centered care
- Share data and/or assessment findings

What would make your participation in the Committee and/or the CHNA valuable to you? What will make this work most valuable to your organization and the community?

- Gaining a better understanding of health needs in the community via discussion and data sharing
- Having input on solutions to address health needs in the community
- Having a safe place to share ideas and come up with solutions
- Build on past work and the experience of those involved
- Sharing data and measurement to develop cross-sector partnerships
- Commitment to address cultural concerns (e.g. culturally specific services, serving the undocumented community)
- Commitment to follow through and bring about results in the community
- Learn about and utilize all the resources participants and their organizations have to offer

Who else should be asked to participate on the community advisory committee?

- More diverse perspectives (e.g. race, ethnicity, language, age, those with disabilities)
- Community members
- Additional school partners
- Insurers
- Elected officials
- Funders
- Policy makers
- Specific organizations mentioned: Cultural Wellness Center, Atum Azzher; MAAA, Dawn Monson; United Way, Megan Barp; MN Chamber of Commerce
- City planners
- Faith community
- Primary care providers
- Workforce development

What is one thing you appreciated?

- Meeting others from the community and learning about their work
- Learning about the community work and CHNA HE is already doing or has done
- The engagement, knowledge, and openness of attendees

What is one thing that could be improved?

NOTE: Most attendees had no suggestions. Below are the suggestions of 7-8 participants

- Include a wider diversity of attendees
- Consider a daytime meeting if possible
- Have a committee member host
- More time to get to know those at the table
- What is Fairview's participation and partnership in this work?

Appendix B

HEALTHEAST CHNA COMMUNITY ADVISORY FORUM: SUMMARY AND NEXT STEPS

Forum date: September 19, 2017

During the first Community Health Needs Assessment (CHNA) Community Advisory Forum, attendees provided a number of suggestions that will inform future meetings and next steps in the CHNA process.

The table below briefly summarizes this feedback and how it will be used:

Feedback/suggestions from attendees	How it will inform the CHNA process
Suggestions were made to the proposed "definition of health" so it is more inclusive and holistic	A revised definition of health will be shared back at the second community advisory forum
Attendees identified multiple roles that health care organizations can play to improve community health and well-being, including: - partnering with and supporting community organizations to advance innovation, advocate for changes, and improve access to services - providing person-centered, culturally appropriate services and resources	The issue briefs prepared for the second community forum describe some of the work HealthEast has done to date to address community health needs. HealthEast will consider this feedback and clarify the roles it can play to improve health during implementation and strategy development (2018)
Attendees hoped the CHNA process would help them gain knowledge about community health needs, available resources/services, and potential partners Attendees appreciated that the first forum provided a safe place to share ideas and information, offer input on solutions, and to hear information that can be brought back to their community	Future forums and meetings will provide opportunities for discussion; meeting materials (ex. slides, handouts) will be made available to attendees The CHNA planning team will continue to host meetings in ways that encourage open discussion and sharing of ideas
Attendees appreciated the diverse perspectives and multiple sectors represented during the forum and also identified people and organizations missing from the room	HealthEast will continue to invite a diverse group of people to future forums; particularly as the work moves into developing implementation strategies

Appendix C

SOCIAL DETERMINANTS AT A LOCAL LEVEL

HealthEast Community Health Needs Assessment

A. Population Characteristics: Aging, race/ethnicity, immigration

1. 1) What stands out to you? 2) How does this information align with or differ from your experience?
2. 3) What new insights or questions did this raise for you? 4) What are the implications for HealthEast?

B. Social Determinants of Health: Poverty, employment, education, housing affordability, transportation

3. 1) What stands out to you? 2) How does this information align with or differ from your experience?
4. 3) What new insights or questions did this raise for you? 4) How do these factors influence the three
5. health priority areas (mental health, obesity, and access to health services)?

C. Suggestions for HealthEast

Using this information and drawing on your own experience, how can HealthEast use this information to address the health priority areas (mental health, obesity, and access to health services) in this community?

ST. JOHNS

Recommendations

- Use strength base language to discuss social determinants of health and focus on utilizing community assets
- Diversifying the healthcare workforce; ensure representation of the communities surrounding the hospital
- Partner with the educational system for opportunities (pre-k to post education)
- Lower the cost of healthcare
- Build trust with and involve people of color and immigrants by hosting community conversations in the community
- Identifying/understanding cultural differences of health especially related to mental/behavioral health
- Talk to people living with mental health issues; mental health is also emotional/behavioral health.

What stood out in the data, Thoughts, Observations, Questions

- Data does not fully represent the communities and the issues within the communities. Data can provide some insight on gaps, but community voice is needed to challenge and/or validate data.
- Population living in poverty have access to post-secondary education
- Growth of Latino aging population 65+ and youth
- Trust issues on the eastside Saint Paul; Having honest conversations about systems that have not changed over 40 years.

- How data is measured and labeled: using Indigenous People category of “race”; how ethnicity is “named” = people of color; data for students who are in-between HS and college – 2 year education data; Elders living alone, do we know who has dementia; measuring access to education;
- Food is food; what is “unhealthy” vs what is seen healthy culturally; the importance of healthy right now vs. long-term health outcomes
- Partnerships moving upstream
- Under-employment: People with a college degree not being able to find a job, lives in poverty, discriminated against; families are working 2-3 jobs and living in poverty
- Single parent household, household size, generational household

Affirming Health Priority Areas

- Mental Health – All attendees voted for mental health to remain a priority area.
- Access to Health Services – All attendees voted for access to health services to remain a priority area.
- Obesity – 9 attendees felt obesity should remain a health priority area, while 3 were unsure.
- Other Areas to Consider – employment (3 people), education opportunities (2), Housing (1), collaboration among health services (mental, dental, medical) (1), ecosystem of local community (1)

ST. JOSEPHS & BETHESDA

Recommendations

- Broaden pilot programs to larger population
- Consider the importance of where service is provided: mobile, moving, bring into the community where people are comfortable, such as providing service in their social spaces
- Make time to build trust and be consistent with maintaining relationships
- Contribute to what’s already happening in the community as opposed to developing new programs and figuring out how to scale it. Do an environmental scan to determine what’s in place.
- Bring STEM/healthcare education to elementary/middle schools
- Integration of the community health worker into the care model. Advocate for CHW/lay person and services to be billable.
- Providers and staff should reflect/represent cultures of community, providing understanding and culturally appropriate care; keep preferences in mind when working/providing care.

What stood out in the data, Thoughts, Observations, Questions

- Affordability of healthcare and insurance is an issue even for those with insurance (copys/medications, etc.)
- Adults are white, while children are people of color
- Immigration = larger family size = hard to find housing (city codes that pose challenges)
- For elders, transportation is a huge issue

- The Coming Home project was important in housing individuals with health needs; need to look deeper at layers of complexity/trauma experienced by homeless
- Policy and legislation reform – advocate for changes to what activities are fundable
- Food availability in urban areas (deserts) is an issue; how can we leverage mobile food, keeping it culturally relevant
- MH/obesity/access looks so different for so many people
- Create a system where we can train, educate and foster the next generation of providers from within the community

Affirming Health Priority Areas

- Mental Health – All attendees voted for mental health to remain a priority area, but provided the following comments "If mental health includes stress/trauma non-traditional. More inclusion around spiritual practices that are within the respective culture."
- Access to Health Services – All attendees voted for access to health services to remain a priority area, but provided the following comments "Embed services within community both access for uninsured and help using insurance effectively."
- Obesity – 8 attendees felt obesity should remain a health priority area, while 3 were unsure. The group felt the obesity priority should be "reframed around healthy lifestyles (active living and eating)."
- Other Areas to Consider – Safe and affordable housing

WOODWINDS

Recommendations

- Consider where services are provided; transportation is an issue, so bring services into the home or into community places.
- Identify and utilize the communities strengths to improve the issues that negatively impact the communities health
- Focus on collaboration between system, other service providers, public and private, etc. to provide better care and make resources more available.
- Healthcare providers need to have a greater understanding of the environment our patients and community members live in. Utilize Community Health workers or similar staff to get the community and hospital connection.
- Provide culturally appropriate education to the community so people are more aware of health issues and they have more information/are empowered to make healthy decisions (personal responsibility)

What stood out in the data, Thoughts, Observations, Questions

- Woodbury lacks cultural resources in the community to support the needs of new immigrants (cultural centers, grocery/markets, worship centers, etc.).
- This area is becoming more diverse, so now is the time to address various community health issues (even small ones) before they grow larger.
- There are no clinics in this area
- Elderly poor – this is in conflict with what we have experienced/seen
- Language issue biggest issue for elderly of foreign born,
- Don't let the optimist overview of the Woodbury area take away from the fact that not everyone is doing as well: there are still 6,000+ people in poverty in Woodbury, it is hard to maintain affordable housing, and many the work (retail, restaurants, hotels) and play in the community are less well-off than those living there.
- Embed community liaison within the hospital systems (parish R.N.)
- Number of foreign born entering the community more recently

Affirming Health Priority Areas

- Mental Health – All attendees voted for mental health to remain a priority area.
- Access to Health Services – All attendees voted for access to health services to remain a priority area.
- Obesity – All attendees voted for obesity to remain a priority area.

HealthEast®

OPTIMAL HEALTH *and* WELL-BEING

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