Executive Summary

For St. Joseph's Hospital,
St. John's Hospital,
Woodwinds Health Campus and
Bethesda Hospital

2017 Plus
Community Health
Needs Assessment Report

HealthEast®

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Introduction/Background

HealthEast Care System—Bethesda Hospital, St. John's Hospital, St. Joseph's Hospital and Woodwinds Health Campus—hereafter referred to as "HealthEast", 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 organizational strategies, policy, and advocacy and fulfill the IRS requirements for Community Health Needs Assessments and Implementation Strategies pursuant to the Affordable Care Act of 2010. This Act requires 501(c)(3) nonprofit hospitals to conduct an assessment at least every three years.

Through this process, HealthEast 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 and 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."

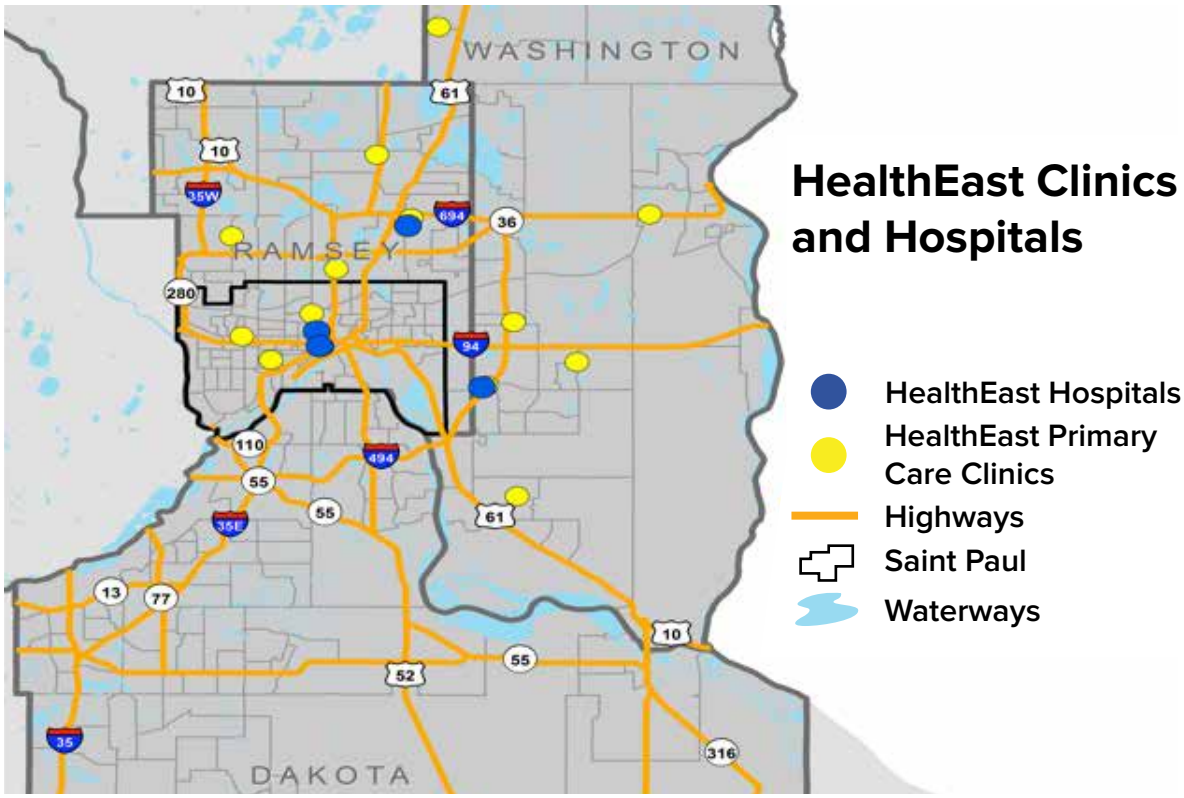
About HealthEast

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.

Community Served

Bethesda Hospital and St. Joseph's Hospital are located in the city of Saint Paul in Ramsey County, Minnesota. Both hospitals serve Dakota and Ramsey counties and the cities of Saint Paul, West Saint Paul, and Mendota Heights. St. John's Hospital is located in the city of Maplewood in Ramsey County, Minnesota. It serves the communities within Ramsey and Washington counties, as well as the cities of Maplewood, Hugo, North Saint Paul, Oakdale and White Bear Lake.

All three hospitals serve the culturally and ethnically diverse neighborhoods of Downtown, Frogtown/Thomas-Dale, Summit-University, Payne-Phalen, Dayton's Bluff, Greater East Side, Highland, North End, West Seventh, and West Side.



The Frogtown/Thomas-Dale, Payne-Phalen, and Dayton's Bluff 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

The community served by Woodwinds Health Campus includes: Washington and Dakota counties, and the cities of Woodbury, Cottage Grove, Newport, Saint Paul Park, South Saint Paul, Inver Grove Heights and Stillwater.

Community Demographics

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

POPULATION CHARACTERISTICS

1. OLDER ADULTS

- East Metro populations are growing older and more racially and ethnically diverse, particularly in the communities surrounding Bethesda, St. Joseph's, and St. John's Hospitals. The East Metro region continues to see increases in the number of residents of color and those who are foreign-born.
- Fewer than 15 percent of residents in Dakota, Ramsey, and Washington counties are older than 65. By 2030, around 20 percent of residents will be age 65 and older.
- 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.

2. RACIAL AND ETHNIC DIVERSITY

- Nearly 1 in 3 residents in Ramsey County and 1 in 5 residents in Dakota County are of color. Just under half of residents in Saint Paul and a third of residents in West Saint Paul are of color. Of the East Metro cities, Saint Paul has the largest Asian population (17%) and West Saint Paul has the largest Latino population (20%).
- In the Saint Paul neighborhoods served by St. John's, St. Joseph's, and Bethesda hospitals, the majority of residents are of color.
- About 1 in 5 residents in Dakota County and 1 in 6 residents in Washington County are people of color.
- Of the cities that Woodwinds Health Campus serves, Woodbury and Inver Grove Heights are home to the largest share of people of color.
- In Woodbury, the largest racial and ethnic group other than White is Asian (9%), and in Inver Grove Heights, Hispanic residents make up 11 percent of the population.

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.
- Aside from Saint Paul, the city of Maplewood has the highest percentage of foreign-born residents at 13%, followed by Woodbury at 12% and Inver Grove Heights at 11%.

- 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 age 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 live at or below the Federal Poverty Level and almost half live below 200 percent of poverty. Median household incomes within the communities that Bethesda and St. Joseph's hospitals serve 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. In Washington County, the poverty rate for residents of color is more than double that of White residents. South Saint Paul and Newport have the highest poverty rate among the communities surrounding Woodwinds Health Campus.

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. A higher proportion of adults are employed in Dakota County (82%) than Washington (81%) or Ramsey County (75%). 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. Geographic and racial employment disparities exist within the communities that HealthEast serves. In Ramsey and Washington counties, white residents are more likely to report working than residents of color. Large employment gaps by race and ethnicity exist in all three counties—the greatest gaps are among multiracial and White residents (60% vs 78%), Asian and White residents (62% vs 78%), and Black and White residents (63% vs 78%).

3. EDUCATION

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

Magnitude. At least forty percent of all residents age 25 or older in Ramsey, Dakota and Washington counties have a bachelor's degree or higher.

Disparities. Higher education disparities by geography and race exist among the communities served by HealthEast. 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 (16%) 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. Approximately 30 percent of households are cost-burdened in Dakota and Ramsey counties. Rates are highest in the cities of Saint Paul and West Saint Paul. In Washington County, 1 in 4 residents are cost-burdened.

Disparities. Renter households are also more likely to be cost-burdened than owner households. About half of renter households in Ramsey, Dakota and Washington counties are cost-burdened compared with 21-23 percent of residents who own homes. Higher rates of cost-burdened households are concentrated in and near Saint Paul, North Saint Paul, South Saint Paul, Inver Grove Heights and Stillwater.

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.

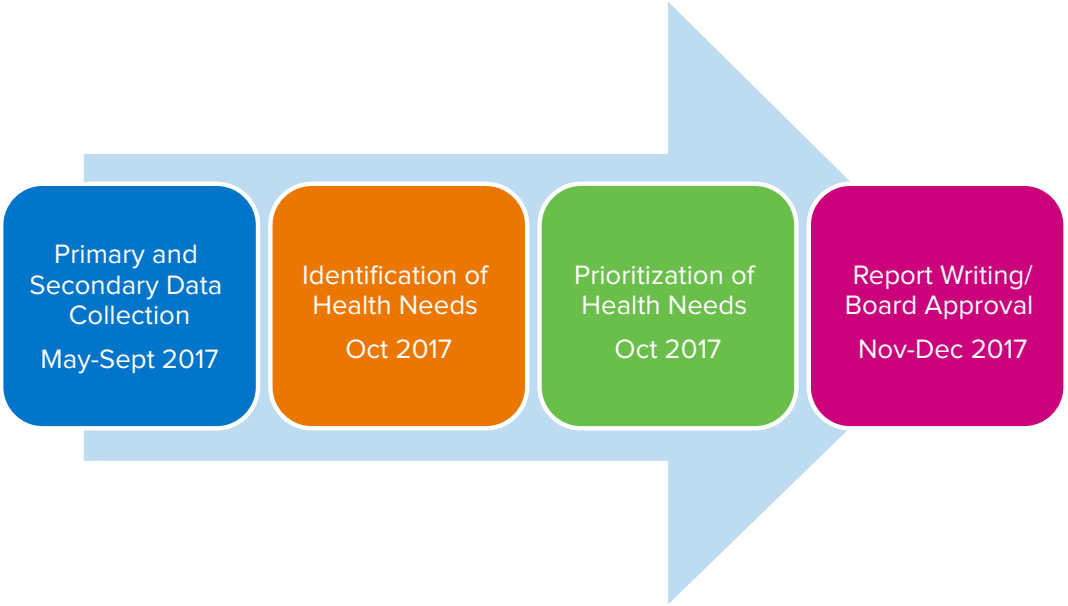
Magnitude. The majority of residents in all three counties have at least one vehicle and report using a vehicle to get to work.

Disparities. A higher proportion of residents in Saint Paul (14%) and West Saint Paul (12%) 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 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.
- Between May 2016 and October 2016, members of **Woodbury THRIVES**, a grassroots community effort led by Woodbury residents and local organizations to create a healthy community, hosted a series of community conversations about the challenges to good health residents face. More than 350 community members participated in a series of dialogues about what was important to them, and demographic and other descriptive data were used to highlight the population's assets and challenges. The results suggest that "good health" encompasses physical, mental, emotional, spiritual, and financial well-being and the main obstacles to health are physical inactivity, unmet mental health and relationship issues, and access to services. **Woodbury THRIVES** responded by creating opportunities

for community members to engage in activities that promote **Healthy Lifestyles, Social Connectedness and Inclusivity, and Mental Health Well-being**.

- 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 help 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 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 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 personal and professional perspectives to the assessment process
- Help HealthEast to better understand the viability of current plans aimed to improve community health
- Provide input and critical feedback regarding emerging health trends and strategies to address these trends
- Inform HealthEast's decision-making and future planning processes regarding community health and well-being
- Identify opportunities to work with HealthEast to co-create community health programming and other services designed to meet the needs of residents

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, **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.

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 often 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: Minnesota Department of Health, County Health Tables (2016)

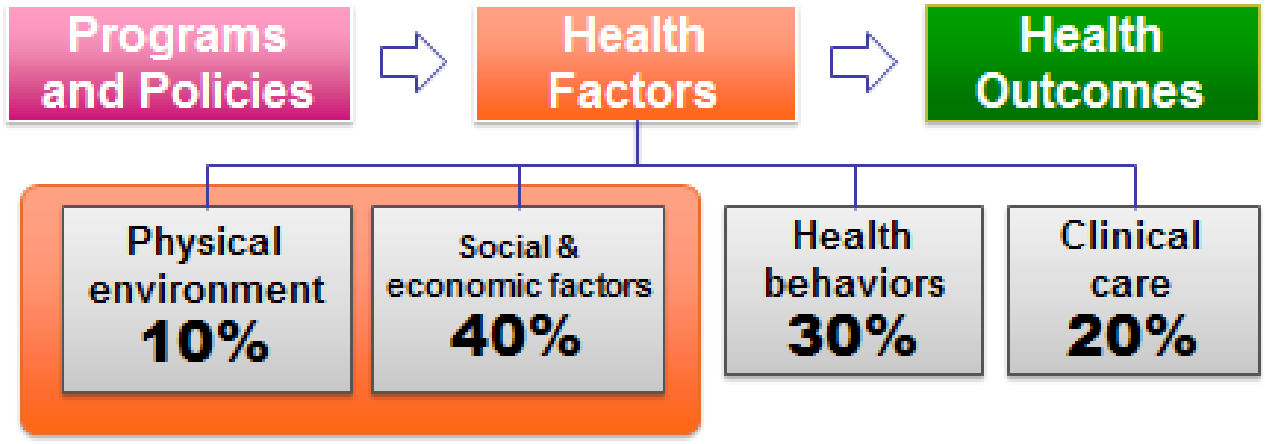
Mental illness, arthritis, asthma and chronic pain also result in disability, inability to work, and lower quality of life. Over 120,000 East Metro residents have one or more disabilities that limit daily activities. While individuals age 65 and older are most likely to have a disability, conditions 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 diagnosed 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 (Figure 2). This does not lessen the critical role of health care in improving health. Instead, 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 and to improve and maintain health.

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. Minnesota has the 16th lowest adult obesity rate in the United States.[2] 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).

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 (or 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 lowerincome 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.)

[1] Healthy People 2020
[2] The State of Obesity: Healthier Policies for a Healthier America (2014). Retrieved from: http://stateofobesity.org/files/stateofobesity2014.pdf

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.

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).[3,4] 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.[5] 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.

[3] 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

[4] 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.

[5] 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.

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.[6] 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.

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.

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, somewhat more than in Dakota or Washington counties (4% and 3%, respectively). In the 2014 Metro Adult Health Survey, 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.

[6] 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

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 don't 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.

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 HealthEast'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 five of the prioritization criteria were: chronic disease, transportation, crime, poverty, employment issues, lack of culturally appropriate services and social isolation.

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

Resources to Address Health Needs

As HealthEast 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, HealthEast will evaluate existing strategies to determine which initiatives can be modified or expanded to better address the priority needs. Through the Community Advisory Committee, East Side Health and Well-being Collaborative, and Woodbury THRIVES, HealthEast 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, HealthEast will leverage its 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, the Cities of Saint Paul, Maplewood, and Woodbury, school districts and state universities, Hearth Connection, Guild Incorporated, Portico, Catholic Charities, Karen Organization

of Minnesota, Hmong American Partnership, Hmong American Farmers Association, Merrick Community Services, and the Metropolitan Area Agency on Aging.

Finally, HealthEast will work with Saint Paul-Ramsey County Public Health, Dakota County Public Health, and Washington County Public Health 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 Health Services 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 to be adopted by the Fairview Health Services Board of Directors by May 15, 2018, and executed during fiscal years 2018-2020.

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 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 health 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 in the Twin Cities East Metro area, 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.

Acknowledgments

This report is the result of contributions from many individuals and organizations:

HealthEast Community Advisory Committee

American Indian Family Center, Jessica Gourneau & June Blue

Catholic Charities of St. Paul and Minneapolis, Diana Vance-Bryan & Tracy Berglund

Century College, Beth Hein

City of Maplewood, Nora Slawik & DuWayne Konewko

CLUES (Comunidades Latinas Unidas En Servicio), Ruby Lee

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Community Dental Center, Crystal Yang

Dakota County Public Health, Bonnie Brueschoff & Melanie Countryman

DARTS, Ann Bailey

Fairview Health Services, James Janssen & Jennifer Thurston

Genesys Works, Karen Marben

HealthEast Bethesda Hospital, Kristi Ball

HealthEast St. John's Hospital, Laura Keithahn

HealthEast St. Joseph's Hospital, Deb Rodahl

HealthEast Woodwinds Health Campus, Michele Brin

HealthEast, Lisa Buesgens, Adam Crepeau, Amy Nelson-Forkner & Dean Neumann

Hearth Connection, Kelby Grovender

Hmong American Partnership, Mai Moua

International Institute of Minnesota, Saw Baw & Munira Salad

Johnson & Johnson, Sharon D'Agostino

LSS Eastside Financial Center, Katherine Beecham, Eva Song Margolis & Viva Yang

Maplewood Community Center - YMCA, Kristin Reither

Metropolitan State University, Judith Graziano & Frank Schweigert

Minnesota Leadership Council on Aging, Alana Wright

North St. Paul-Maplewood-Oakdale ISD 622, Tricia Hughes & Alecia Salo

Portico Healthnet, Samuel Estes

Roseville Community Health Awareness Team, Sara Barsel

St. Paul Eastside YMCA, Kevin Blake & Courtney Troyer

St. Paul Fire Department, Matt Simpson

St. Paul Midway YMCA, Cassie Rood

St. Paul-Ramsey County Public Health, Anne Barry & Jamie Cha

The Good Acre, Rhys Williams

Twin Cities LISC, Andriana Abariotes

Twin Cities Mobile Market, Keshawn Williams

Vital Aging Network, Julie Roles & Mark Skeie

Washington County Public Health, Lowell Johnson

West Side Community Health Services, Paige Bowen

Woodbury Thrives, Roger Green & Jodi Ritacca

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Anoka County Community Health and Environmental Services

Carver County Public Health and Environment

City of Bloomington, Division of Health

City of Edina Community Health

City of Richfield Public Safety

Dakota County Public Health

Hennepin County Human Services and Public Health

Minneapolis Health Department

St. 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

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Minnesota Council of Health Plans

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