# Table of Contents

**2018 Community Health Needs Assessment Report** ................................................................. 3

Executive summary .................................................................................................................. 4
  - Process and methods ............................................................................................................. 4
  - Identification of priority health needs ................................................................................ 4

Acknowledgements .................................................................................................................. 6

Introduction and background ................................................................................................. 7

About Fairview Health Services ............................................................................................... 8
  - Fairview’s communities ......................................................................................................... 9
    - Key components of our community commitment ........................................................... 10
    - Organizational support .................................................................................................... 10

About Fairview Ridges Hospital .............................................................................................. 11
  - Fairview Ridges’ community .............................................................................................. 11

Community Health Needs Assessment .................................................................................. 12
  - Our process ......................................................................................................................... 13
  - Consultants ........................................................................................................................ 14
  - Data sources ....................................................................................................................... 14
  - Data methods and analysis ................................................................................................. 15
  - Data limitations .................................................................................................................. 15

Understanding the health needs of our community ............................................................. 16

Social determinants of health and health disparities .......................................................... 16

Leading causes of premature death, death, and contributing factors ............................... 22

Health disparities and priority populations ......................................................................... 23

Community voice .................................................................................................................... 24
  - Key findings: primary data collection ............................................................................... 25

Prioritization of health needs ............................................................................................... 26

Our 2018 priority health needs .............................................................................................. 28
  - Needs identified but not addressed ................................................................................... 28

Available resources to address priority health needs ......................................................... 29

Conclusion and next steps .................................................................................................... 29

Evaluation of impact, 2016-2018 CHNA Implementation Strategy ........................................... 30

**2019 – 2021 Implementation Strategy Report** ................................................................. 35

Community Health Improvement Plan 2019 – 2021 .......................................................... 36
  - Priority: Mental health and well-being .............................................................................. 36
  - Priority: Healthy lifestyles ................................................................................................. 38
  - Priority: Access to care and resources ............................................................................ 38

Adoption by Board of Directors and next steps ................................................................. 39

Citations ................................................................................................................................ 40

Appendices ............................................................................................................................. 41
Executive summary

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

Fairview Ridges has conducted a Community Health Needs Assessment (CHNA), every three years since 1992, to systematically identify, analyze, and prioritize the critical health needs of the community and to develop strategies to address those needs. The 2018 CHNA builds upon previous assessments and was developed in partnership with community members, organizations, and local public health agencies. In addition to fulfilling the IRS requirements for CHNA and Implementation Strategies pursuant to the Affordable Care Act of 2010, which requires 501(c)(3) nonprofit hospitals to conduct an assessment at least every three years, the CHNA will also serve to inform organizational strategies.

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 Fairview Ridges community. The report contains a description of the process used for the assessment, a discussion of the types of information collected and a summary of the results. The 2018 CHNA process took place between March 2018 and October 2018 and was led by the Fairview community benefit team.

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

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

Identification of priority health needs

The Fairview Ridges Community Hospital Advisory Council comprised of local public health, community partners, and local officials, met in June 2018 to lend their voices to help us better understand the health needs of the community. The hospital advisory council members met again in September 2018, to identify and prioritize emerging health issues affecting the community. The steering committee reviewed primary and secondary data collected and compiled, as part of this needs assessment. Additionally, the hospital advisory council reviewed the health priorities identified in the 2015 CHNA process, mental health and chronic disease prevention and management through healthy living.

The Fairview Ridges Community Hospital Advisory Council, in collaboration with the Fairview community benefit team, used the following weighted criteria to prioritize the significant health needs identified: 2015 CHNA priority needs, community priority, Fairview Ridges expertise/resources/feasibility, evidence of disparities, magnitude/scale of need, and need present in all 11 Fairview communities.

Through a voting process, the hospital advisory council recommended the following as Fairview Ridges’ 2018 CHNA priority needs:

- Mental health and well-being
- Healthy lifestyles
- Access to care and services
The priorities were intentionally chosen at broad level because they encompass much of what was heard from the community and found in the secondary data. Other significant needs identified in the process that will not be addressed in the next three-year Implementation Strategy include: chronic lower respiratory disease, costs associated with care, stroke, and transportation.

The 2018 CHNA report was posted on the Fairview website on December 31, 2018. Paper copies are available through the Fairview community benefit department.

Next steps
Beginning in late 2018, the Fairview Ridges team will develop a written Implementation Strategy to address the three priority health needs identified during the assessment process. This plan will be created in partnership with the Fairview Ridges Community Hospital Advisory Council, public health, and other community members, to be adopted by the Fairview Board of Directors by May 15, 2019, and executed during years 2019-2021.
Acknowledgements

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

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

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

Community Health Needs Assessment Team

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

Other Fairview Staff

- Alissa LeRoux Smith, Community Health & Well-being Strategist
- Amanda Knutson, Manager Community Health & Innovation
- Ann Ellison, Director Interfaith Community Health
- Bri Solem, Medical Staff Recruiter
- Cheryl Bisping, Community Health Outreach Coordinator
- Diane Tran, Senior Director Community Engagement
- Fatma Mohammed, Community Engagement Manager
- Francisco Ramirez, Community Engagement Manager
- James Janssen, Director Tax
- Jennifer Thurston, Senior Communication Specialist
- Joanie Aasen, Manager of Quality, Safety, and Process Improvement – Cancer Care Service Line, University of Minnesota Health Cancer Care
- John Swanholm, Vice President, Community Advancement and President, Foundation, Fairview
- Kara Rose, Senior Grant Writer
- Keith Allen, Manager Community Collaborations
- Laura Fangel, Multidisciplinary Coordinator, M Health Oncology Service Line, University of Minnesota Physicians
- Pa Chia Vue, Community Engagement Manager
- Pat Peterson, Faith Community Outreach Manager
Introduction and background

Fairview Ridges Hospital has conducted Community Health Needs Assessments (CHNA) since 1992 to systematically identify, analyze, and prioritize the critical needs of the community and address those needs. The 2018 CHNA builds upon previous assessments and was developed in partnership with community members and organizations, local public health agencies, and other hospitals and health systems. It serves as a tool for guiding policy, advocacy, and program planning. It also fulfills IRS requirements for CHNA and Implementation Strategies pursuant to the Affordable Care Act of 2010, which requires 501(c)(3) nonprofit hospitals to conduct an assessment at least every three years and provides an annual evaluation of impact of the previous Implementation Strategy. For additional detail, see section titled, Evaluation of impact, 2016-2018 CHNA Implementation Strategy.

Through this process, Fairview Ridges aims to:

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

Definition of health

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

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

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

Fairview Health Services (fairview.org) is a Minneapolis-based nonprofit health system driven to heal, discover, and educate for longer, healthier lives. Founded in 1906, Fairview provides exceptional care to patients and communities as one of the most comprehensive and geographically accessible systems in Minnesota, serving the greater Twin Cities metro area and north-central Minnesota. Through a close relationship with the University of Minnesota, Fairview offers access to breakthrough medical research and specialty expertise as part of a continuum of care that reaches all ages and health needs.

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

Our vision
Fairview is driving a healthier future.

Our values
Dignity
Integrity
Service
Compassion
Innovation

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

Fairview has the following hospitals and medical centers:
- Bethesda Hospital (St. Paul)
- Fairview Lakes Medical Center (Wyoming)
- Fairview Northland Medical Center (Princeton)
- Fairview Range Medical Center (Hibbing)
- Fairview Ridges Hospital (Burnsville)
- Fairview Southdale Hospital (Edina)
- Grand Itasca Clinic & Hospital (Grand Rapids)
- St. John’s Hospital (Maplewood)
- St. Joseph’s Hospital (St. Paul)
- University of Minnesota Medical Center and University of Minnesota Masonic Children’s Hospital (Minneapolis)
- Woodwinds Health Campus (Woodbury)
In addition to hospitals, clinics, and medical centers, Fairview provides services across our continuum including adult day programs, home care and hospice, home infusion, foundations, community health and well-being programs, medical transportation, sports and orthopedic care, and much more.

**Fairview’s communities**

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

This definition of community was selected to:

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

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

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

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

Organizational support

Fairview is governed by a Board of Directors that come from a variety of professional backgrounds — including medicine, business, theology, government, and academia. See appendix A for roster. Their expertise supports our commitment to improving the health of the communities we serve. The Fairview Board of Directors approves the CHNA and Implementation Strategies for nine of Fairview hospitals and medical centers – Bethesda Hospital, Fairview Southdale Hospital, Fairview Ridges Hospital, Fairview Lakes Medical Center, Fairview Northland Medical Center, St. Joseph’s Hospital, St. John’s Hospital, and Woodwinds Health Campus. In addition, the Board of Directors for the University of Minnesota Medical Center, Grand Itasca Clinic & Hospital and Fairview Range Medical Center, approve their medical center or hospital assessments and strategies.

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

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

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

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

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

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

Fairview Ridges Hospital opened in 1985, in Burnsville, Minnesota providing comprehensive, specialized care to the southern Twin Cities community. Fairview Ridges Hospital provides care for the entire family, including pediatric emergency care and neonatal intensive care. The hospital offers onsite access to specialists in everything from heart and cancer care to midwifery and sports medicine. Fairview Ridges is a Blue Cross and Blue Shield Association Blue Distinction Center+ for Spine Surgery™.

Key services
- The Birthplace
- Heart Care
- Cancer Care
- Breast Center
- Orthopedic Surgery
- General Surgery
- Spine & Brain
- Pediatric Inpatient
- Sleep Services

Fairview Ridges’ community

Fairview Ridges Hospital defines its community as a sub-set of Fairview’s defined communities. The community includes 13 zip codes where approximately 80 percent of its patients live, the city where the hospital resides, Burnsville, MN and the county where the hospital resides, Dakota County. Seventy-two percent of Fairview Ridges’ employees live within the defined community. The total population of this geographic community is 368,374 people, covers 383 square miles, and there is a median household income of $93,739. See appendix F for list of cities and zip codes.

For the remainder of this report when “community” is referred to it is defined according to the above paragraph.
The proportion of Fairview Ridges' community residents age 65 and older is projected to increase by 2.8 percent, from 11.9 percent to 14.7 percent over the next five years. The population of residents' ages 0-17, 18-44, and 45-64 are projected to decrease.

<table>
<thead>
<tr>
<th>Fairview Ridges Hospital community – Age</th>
<th>2018</th>
<th>2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>368,374</td>
<td>383,681</td>
</tr>
<tr>
<td>Ages 0 – 17</td>
<td>92,861</td>
<td>91,847</td>
</tr>
<tr>
<td>Ages 18 – 44</td>
<td>127,081</td>
<td>129,840</td>
</tr>
<tr>
<td>Ages 45 – 64</td>
<td>104,477</td>
<td>105,538</td>
</tr>
<tr>
<td>Ages 65 and older</td>
<td>43,955</td>
<td>56,456</td>
</tr>
</tbody>
</table>

Source: Claritas 2018

In 2018, 81.8 percent of the Fairview Ridges community identified as white, with Black/African American residents making up the second largest group at 6.4 percent. Residents of color make up 18.2 percent of the overall population. Over the next five years, the number of residents of color is projected to increase to 20.2 percent of the overall population.

<table>
<thead>
<tr>
<th>Fairview Ridges Hospital community – Race</th>
<th>2018</th>
<th>2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>368,374</td>
<td>383,681</td>
</tr>
<tr>
<td>White</td>
<td>301,404</td>
<td>306,334</td>
</tr>
<tr>
<td>Black / African American</td>
<td>23,490</td>
<td>28,335</td>
</tr>
<tr>
<td>American Indian / Alaskan Native</td>
<td>1,733</td>
<td>1,843</td>
</tr>
<tr>
<td>Asian</td>
<td>22,036</td>
<td>24,657</td>
</tr>
<tr>
<td>Native Hawaiian / Pacific Islander</td>
<td>270</td>
<td>295</td>
</tr>
<tr>
<td>Some Other Race Alone</td>
<td>7,272</td>
<td>8,252</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>12,169</td>
<td>13,965</td>
</tr>
</tbody>
</table>

Source: Claritas 2018

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

**Community Health Needs Assessment**

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

The Catholic Health Association framework describes the processes used to identify, prioritize, act on, and evaluate the health needs and assets of our communities in collaboration with community partners. The Fairview process is based on this model, and is as follows.
Our process
The CHNA process was designed to gather current demographic and health data from a variety of
sources in order to understand the needs of the Fairview Ridges community. The report contains a
description of the process used for the assessment, a description of the types of information collected,
and a summary of the results. The 2018 CHNA process took place between March 2018 and October
2018 led by the Fairview community benefit team.

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

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

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

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

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

Primary data
To ensure the CHNA had broad community representation, key populations — seniors, people experiencing poverty, persons of color, and indigenous people — were invited to participate in a series of community conversations, key stakeholder interviews, and facilitated discussions. Bilingual facilitators and note-takers participated in community conversations held in languages other than English including Spanish. The note-takers provided real-time translation and captured the notes in English.

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

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

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

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

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

Claritas is a widely used national demographic estimate tool. Estimates and projections are provided at a zip code level including, but not limited to population based on age, sex, ethnicity, and income. Estimates are data prepared for the current year, and projections are prepared for dates five years in the future based on U.S. Census, American Community Survey, and other data sources. This demographic data is used across various industries to understand population trend implications on business strategies and initiatives.

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

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

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

**Data methods and analysis**

**Primary data**
Fairview's community benefit team developed standardized tools, processes, instructions, and facilitator, interviewer, and note-taker training. The team also gathered, cleaned, analyzed, and presented all primary data. Community conversations lasted 90 minutes. Some conversations were held in other languages (i.e. Spanish) which were conducted by facilitators and note-takers fluent in both English and the other language. All community input was translated by the note-taker and captured in English. Key stakeholder interviews were conducted over the phone and lasted 30 minutes or less.

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

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

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

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

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

**Secondary data**
Two key limitations are inherent in the collected secondary data:

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

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

Founded in 1849, Dakota County was one of the original nine counties created by the Minnesota Territory Legislature. It was established before Minnesota was considered a state. Situated in the southeast corner of the Twin Cities Metropolitan area, it is the third-most populous county in the state of Minnesota. Dakota County maintains a land use mixture of one-third urban, one-third suburban, and one-third rural. This combination of land use and the confluence of two major rivers (the Mississippi and Minnesota) that form the county’s northern and eastern borders make Dakota County a unique geographic area.

Dakota County demographics
Dakota County has become increasingly diverse. While Dakota County is still majority-white, white residents comprise a smaller percentage of the population today compared to in 2000 (79 percent compared to 90 percent, respectively). During the same timeframe, the percentage of black and Hispanic residents has more than doubled, as has the percentage of foreign-born residents.

The proportion of Dakota County residents age 65 and older has increased, however Dakota County still has a smaller percentage of older adults than the state overall. Currently, 14 percent of Dakota County residents are age 65 and older, compared to seven percent in 2000.

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

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

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

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

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

<table>
<thead>
<tr>
<th>Quintile</th>
<th>Score Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest Quintile</td>
<td>4.2 – 5.0</td>
</tr>
<tr>
<td>2nd Highest Quintile</td>
<td>3.4 – 4.1</td>
</tr>
<tr>
<td>Mid Quintile</td>
<td>2.6 – 3.3</td>
</tr>
<tr>
<td>2nd Lowest Quintile</td>
<td>1.8 – 2.5</td>
</tr>
<tr>
<td>Lowest Quintile</td>
<td>1.0 – 1.7</td>
</tr>
</tbody>
</table>

Between 2012 and 2016, 58 percent (7) of the zip codes in the Fairview Ridges community, for which there was a recorded score in both years, experienced an increase in their Community Need Index score. Twenty-five percent (3) of the zip codes remained the same, while 17 percent (3) of the zip codes saw a decrease in their Community Need Index score. See appendix G for a list of trended Community Need Index scores for years 2012 – 2016.

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

2016 Community Need Index scores for Fairview Ridges Hospital community

Socioeconomic factors
Fairview contracted with Wilder Research to research the social determinants of health for Dakota County. The determinants reviewed were – socioeconomic status, education, employment, housing, and transportation. This summary includes data at multiple time points and highlights disparities by race, ethnicity, age, gender, and other factors when available.
Socioeconomic status, a person’s standing related to income, employment, and education, can impact health in many ways. Residents with lower incomes may find it more difficult to purchase healthy food, pay for gym memberships, or cover the costs of health care visits or medication. In addition, financial instability or living in poverty can increase stress, impacting physical and mental health, as well as overall quality of life.

Although median household income in Dakota County is higher than the state average, there are disparities by race, gender, and age. The median household income in Dakota County is $73,321, fifth highest among all Minnesota counties and higher than the state average.

The median household income for black and Hispanic households saw the biggest declines and is currently below $50,000. Incomes for single-person households are also lower than the county average, with single female households with children, on average; earn approximately $13,000 less than single male households annually. Dakota county residents under age 25 and residents age 65 and older have much lower incomes ($42,289 and $48,851), while those age 25-44 and age 45-64 have incomes well above the county average ($82,681 and $94,932).
Poverty

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

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

<table>
<thead>
<tr>
<th>Persons in family/household</th>
<th>Poverty guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,880</td>
</tr>
<tr>
<td>2</td>
<td>$16,020</td>
</tr>
<tr>
<td>3</td>
<td>$20,160</td>
</tr>
<tr>
<td>4</td>
<td>$24,300</td>
</tr>
</tbody>
</table>


Nearly all populations in Dakota County saw an increase in poverty between 2000 and 2016, with notable disparities in rates by race and ethnicity. In 2016, white residents had the lowest poverty rates with only five percent living at or below 100 percent of the Federal Poverty Level ($24,300 for a family of four), while one-quarter black (23 percent) and Hispanic (21 percent) residents were living in poverty, an increase of 10 percentage points between 2000 and 2016.

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>355,904</td>
<td>421,751</td>
</tr>
</tbody>
</table>

Source: 2000 Decennial Census, 2012-2016 5-yr American Community Survey, Small Area Income and Poverty Estimates (SAIPE) Program 2000 and 2016. Data are suppressed, indicated by an asterisks (*), when it is unreliable due to small populations and high margins of error.

Note: All race/ethnicity, nativity, and age group poverty data are based upon the <100% Federal Poverty threshold. Data compiled by Wilder Research.

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>355,904</td>
<td>421,751</td>
</tr>
</tbody>
</table>

Housing affordability and transportation
Housing affordability impacts an individual’s or family’s economic stability. When a household is cost-burdened — paying more than 30 percent of their income on housing — there is less income to pay for basic needs, including health care costs. The number of cost-burdened households increased between 2000 and 2016, with renters being more likely to be cost-burdened than homeowners. The percentage of owner cost-burdened households increased by three percent between 2000 and 2016, while there was an 11 percent increase in renter cost-burdened households.

<table>
<thead>
<tr>
<th>Dakota County – Housing affordability</th>
<th>2000</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost burdened households</td>
<td>21%</td>
<td>26%</td>
</tr>
<tr>
<td>Owner cost-burdened households</td>
<td>17%</td>
<td>20%</td>
</tr>
<tr>
<td>Renter cost-burdened households</td>
<td>34%</td>
<td>45%</td>
</tr>
</tbody>
</table>

Source: 2000 Decennial Census, 2016 1-yr American Community Survey; Note: Cost-burdened households pay 30 percent or more of their gross income on housing Data compiled by Wilder Research.

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

<table>
<thead>
<tr>
<th>Dakota County – Transportation</th>
<th>2000</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household with no vehicle</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Used alternate transportation to get to work*</td>
<td>8%</td>
<td>10%</td>
</tr>
</tbody>
</table>


*This includes any worker over 16 years old in a household who did not commute by car/carpool.

Employment
Employment is an individual’s pathway to income and assets. Employment supports basic needs, and often provides access to affordable health insurance. Overall employment rates for Dakota County residents decreased between 2000 and 2016, however rates for most groups remain near or above the state rate of 78 percent. Hispanic residents and the broader group of residents identifying as persons of color had slight increases in income over time. While rates for key working age populations (25-34, 35-44, and 45-64) remained high despite slight declines, the rate for young adults decreased by nine percentage points.

<table>
<thead>
<tr>
<th>Dakota County – Employment by race / ethnicity</th>
<th>2000</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>355,904</td>
<td>421,751</td>
</tr>
<tr>
<td>American Indian</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Asian</td>
<td>73%</td>
<td>78%</td>
</tr>
<tr>
<td>Black</td>
<td>76%</td>
<td>73%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>70%</td>
<td>75%</td>
</tr>
<tr>
<td>Two or more races</td>
<td>76%</td>
<td>72%</td>
</tr>
<tr>
<td>White</td>
<td>84%</td>
<td>82%</td>
</tr>
<tr>
<td>Of color</td>
<td>73%</td>
<td>75%</td>
</tr>
</tbody>
</table>

Source: 2000 Decennial Census, 2012-2016 5-yr American Community Survey; Data are suppressed, indicated by an asterisks (*), when it is unreliable due to small populations and high margins of error. Data compiled by Wilder Research.
## Employment by age

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>355,904</td>
<td>421,751</td>
</tr>
<tr>
<td>Ages 16 – 64</td>
<td>83%</td>
<td>81%</td>
</tr>
<tr>
<td>Ages 16 – 24</td>
<td>73%</td>
<td>64%</td>
</tr>
<tr>
<td>Ages 25 – 34</td>
<td>87%</td>
<td>87%</td>
</tr>
<tr>
<td>Ages 35 – 44</td>
<td>88%</td>
<td>87%</td>
</tr>
<tr>
<td>Ages 45 – 64</td>
<td>85%</td>
<td>81%</td>
</tr>
<tr>
<td>Ages 65 and older</td>
<td>16%</td>
<td>20%</td>
</tr>
</tbody>
</table>

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

## Education

Addressing disparities in educational attainment is important because individuals who earn a bachelor’s degree or higher are more likely to secure full-time employment and higher earnings. A college education is a pathway to acquiring income, benefits, and assets, all of which are strongly associated with better health. Most people in Dakota County saw an increase in the completion of a bachelor’s degree or higher education, with overall higher rates than the state of Minnesota (35 percent).¹⁰

Black residents are the only group that saw a decline in the obtainment of a bachelor’s degree or higher between 2000 and 2016, however in addition to black residents, Hispanics and those identifying as two or more races also had rates below the county average.

## Educational attainment of a bachelor’s degree or higher by race / ethnicity

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>355,904</td>
<td>421,751</td>
</tr>
<tr>
<td>American Indian</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Asian</td>
<td>42%</td>
<td>48%</td>
</tr>
<tr>
<td>Black</td>
<td>31%</td>
<td>24%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>14%</td>
<td>19%</td>
</tr>
<tr>
<td>Two or more races</td>
<td>23%</td>
<td>32%</td>
</tr>
<tr>
<td>White</td>
<td>35%</td>
<td>43%</td>
</tr>
<tr>
<td>Of color</td>
<td>28%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Source: 2000 Decennial Census, 2012-2016 5-yr American Community Survey; Data are suppressed, indicated by an asterisks (*), when it is unreliable due to small populations and high margins of error. Data compiled by Wilder Research.

## Educational attainment of a bachelor’s degree or higher by age

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>355,904</td>
<td>421,751</td>
</tr>
<tr>
<td>Ages 18 – 24</td>
<td>7%</td>
<td>10%</td>
</tr>
<tr>
<td>Ages 25 – 34</td>
<td>26%</td>
<td>31%</td>
</tr>
<tr>
<td>Ages 35 – 44</td>
<td>22%</td>
<td>30%</td>
</tr>
<tr>
<td>Ages 45 – 64</td>
<td>25%</td>
<td>28%</td>
</tr>
<tr>
<td>Ages 65 and older</td>
<td>14%</td>
<td>23%</td>
</tr>
</tbody>
</table>

Source: 2000 Decennial Census, 2012-2016 5-yr American Community Survey; Data compiled by Wilder Research.
Leading causes of premature death, death, and contributing factors

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

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

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

<table>
<thead>
<tr>
<th>Rank</th>
<th>Dakota County</th>
<th>Minnesota</th>
<th>Dakota County</th>
<th>Minnesota</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cancer</td>
<td>Cancer</td>
<td>Cancer</td>
<td>Cancer</td>
</tr>
<tr>
<td>2</td>
<td>Heart disease</td>
<td>Heart disease</td>
<td>Heart disease</td>
<td>Heart disease</td>
</tr>
<tr>
<td>3</td>
<td>Unintentional injury</td>
<td>Unintentional injury</td>
<td>Unintentional injury</td>
<td>Unintentional injury</td>
</tr>
<tr>
<td>4</td>
<td>Chronic lower respiratory disease</td>
<td>Suicide</td>
<td>Chronic lower respiratory disease</td>
<td>Suicide</td>
</tr>
<tr>
<td>5</td>
<td>Stroke</td>
<td>Chronic lower respiratory disease</td>
<td>Alzheimer's disease</td>
<td>Chronic lower respiratory disease</td>
</tr>
</tbody>
</table>

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

Dakota County has higher rates of death than the national Healthy People 2020 goals for the leading cause of death noted below in red.

### Dakota County – Leading causes of death, 2012 – 2016

<table>
<thead>
<tr>
<th>Mortality rate per 100,000 – Age-adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dakota County</td>
</tr>
<tr>
<td>Cancer</td>
</tr>
<tr>
<td>Heart disease</td>
</tr>
<tr>
<td>Unintentional injury</td>
</tr>
<tr>
<td>Chronic lower respiratory disease</td>
</tr>
<tr>
<td>Stroke</td>
</tr>
</tbody>
</table>


Contributing factors of premature death

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

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

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

**Other trends**

Drug overdose deaths continue to increase in Minnesota. In 2016, death certificates indicated that 675 deaths were a result of drug overdose, compared to 538 in 2015. Drug overdose deaths include accidental poisoning by drugs, intentional self-poisoning by drugs, assault by drug poisoning, or drug poisoning of undetermined intent.\(^\text{11}\)

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

![Dakota County - Number of overdose deaths](image)

Data compiled by Wilder Research

**Health disparities and priority populations**

Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.\(^\text{12}\)
Each of the leading causes of death is related to unique health disparities, but also shares several general similarities. For example, health disparities adversely affect people of color and indigenous people for cancer, heart disease, unintentional injury and chronic lower respiratory disease. Health disparities exist between those with the highest income levels and the lowest, as well as between the insured and uninsured. Those in the lowest income level without insurance have the greatest health needs and are most challenged in gaining access to high-quality affordable healthcare.

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

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

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

**Community voice**

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

**Facilitated discussion**

The Fairview Ridges Community Hospital Advisory Council played a critical role in directing the focus of the hospital’s primary data collection. The hospital advisory council members are a diverse cross section of area community leaders and key internal staff.

![Table of Sectors and Organizations Represented](image-url)

The hospital advisory council held discussions to identify health needs in the community, determine gaps in the primary data collection, and provide feedback and guidance on need prioritization and local emerging health needs. See appendix I for questions asked during the facilitated discussion.

**Community conversations**

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

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

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

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

<table>
<thead>
<tr>
<th>Access to care and resources</th>
<th>Mental health and well-being</th>
<th>Healthy lifestyles</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Awareness and access to resources</td>
<td>• Adverse childhood experiences (ACES) / childhood trauma</td>
<td>• Lack of healthy food</td>
</tr>
<tr>
<td>• Affordable services</td>
<td>• Substance use</td>
<td>• Physical activity and exercise</td>
</tr>
<tr>
<td>• Discrimination</td>
<td>• Integration with physical health services</td>
<td>• Healthy eating</td>
</tr>
<tr>
<td>• Lack of healthy food</td>
<td>• Dual disorders (mental health and substance use)</td>
<td>• Chronic diseases</td>
</tr>
<tr>
<td>• Transportation</td>
<td>• Hopelessness</td>
<td>• Education of disease prevention and management</td>
</tr>
<tr>
<td>• Resources for uninsured and underinsured</td>
<td>• Suicide</td>
<td>• Root causes of leading causes of death including:</td>
</tr>
<tr>
<td>• Poverty</td>
<td>• Loneliness</td>
<td>• physical inactivity, obesity, poor nutrition, smoking, substance use and</td>
</tr>
<tr>
<td>• Lack of diversity in providers</td>
<td>• Depression</td>
<td>• environmental toxins</td>
</tr>
<tr>
<td>• Services for individuals who are undocumented</td>
<td>• Stress management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stigma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Social isolation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Discrimination</td>
<td></td>
</tr>
</tbody>
</table>

Everything included in the table above was mentioned more than once and was listed as voiced by the community. Throughout the key stakeholder interviews, the top needs identified fell within the mental health and well-being category, specifically the interconnection between mental health and substance use, suicide, and the stigma associated with accessing mental health services. The top needs identified during the community conversations fell within the healthy lifestyles category, including healthy eating and education, prevention, and management of chronic conditions.

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

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

- Identified needs tied to mental health, stigma, isolation, loneliness, and their interconnection with substance use
- The need for access to healthy and affordable food, transportation, low cost services, and services for individuals who are undocumented
- Help with chronic disease specifically in relation to - education, management, treatment, and caregiver support

Prioritization of health needs

In order to determine the top health needs in the community indicators from secondary data; data from Wilder Research on the leading causes of death and premature death, and the social determinants of health; and primary data that met two pieces of criteria: (1) a need and/or barrier that was said more than one time, and (2) a need and/or barrier that was repeated in at least two of the groups (e.g. both a stakeholder interview and a community conversation) were used. See graphic below for a description of this process.
The hospital’s Community Hospital Advisory Council reviewed and validated findings from the primary and secondary data and recommended three health needs to be adopted for the hospital. The three health needs are consistent across all 11 Fairview hospitals and medical centers and are intentionally broad to allow for local variation during the implementation planning process.

The following weighted criteria were used to prioritize health needs. A maximum of 20 points were possible. Highest weight was given to the two criterion deemed most important by the steering committee – continuing work in the 2015 CHNA priority areas and ensuring future priorities aligned with what the community identified as top needs.

<table>
<thead>
<tr>
<th>Weight</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 points</td>
<td>2015 CHNA priority need</td>
</tr>
<tr>
<td>5 points</td>
<td>Community priority</td>
</tr>
<tr>
<td>3 points</td>
<td>Fairview Ridges expertise / resources / feasibility</td>
</tr>
<tr>
<td>3 points</td>
<td>Disparities exist</td>
</tr>
<tr>
<td>2 points</td>
<td>Magnitude / scale of need</td>
</tr>
<tr>
<td>1 point</td>
<td>Need is present in all 11 Fairview communities</td>
</tr>
</tbody>
</table>
The prioritization criteria was applied to the top 20 health needs identified in the Fairview Ridges community. The top 10 health needs include:

1. Mental health
2. Chronic disease
3. Cancer
4. Stress
5. Heart disease
6. Stroke
7. Stigma – mental health
8. Diabetes
9. Healthy eating
10. Tied for tenth (1) Chronic lower respiratory disease (2) Suicide (3) Alzheimer’s disease

Our 2018 priority health needs

Through a voting process, the Fairview Ridges Community Hospital Advisory Council validated the following priority health needs:

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

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

Needs identified but not addressed

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

<table>
<thead>
<tr>
<th>Community Need</th>
<th>Reasons Not Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic lower respiratory disease</td>
<td>This issue will be addressed as part of patient care but falls outside the scope of the community-based CHNA Implementation Strategy.</td>
</tr>
<tr>
<td>Cost associated with care</td>
<td>This issue will be addressed as part of patient care but falls outside the scope of the community-based CHNA Implementation Strategy.</td>
</tr>
<tr>
<td>Stroke</td>
<td>This issue will be addressed as part of patient care but falls outside the scope of the community-based CHNA Implementation Strategy.</td>
</tr>
<tr>
<td>Transportation</td>
<td>This issue is beyond what Fairview Ridges Hospital resources can support at this time.</td>
</tr>
</tbody>
</table>
Available resources to address priority health needs

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

External resources include community initiatives in partnership with numerous community stakeholders including, but not limited to Dakota County Public Health, 360 Communities, and Prince of Peace Lutheran Church. These initiatives, programs and relationships are the foundation from which the Implementation Strategy will be built.

Conclusion and next steps

Adoption by the Fairview Board of Directors
The Fairview Board of Directors adopted Fairview Ridges Hospital’s 2018 CHNA reports on December 6, 2018. This report is available on Fairview Health Services website, www.fairview.org, on December 31, 2018.

Implementation Strategy
In late 2018, Fairview Ridges Hospital will conduct the final steps in the assessment process by developing a written CHNA Implementation Strategy to address the identified priority health needs – mental health and well-being, healthy lifestyles, and access to care and resources. The Fairview Ridges Community Hospital Advisory Council and the Community Advisory Council will review the Implementation Strategies in early 2019.

The Fairview Board of Directors will be asked to adopt the hospital’s 2019-2021 CHNA Implementation Strategy in April 2019. The document will be publicly available on www.fairview.org, by May 15, 2019 and executed during fiscal years 2019-2021.
### Evaluation of impact, 2016-2018 CHNA Implementation Strategy

#### Priority area #1: Chronic disease prevention and management through healthy living

<table>
<thead>
<tr>
<th>Programs</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| **Program 1: Living Well** | The anticipated impacts for the Living Well program are to:  
1. Increase participant knowledge of techniques to deal with problems such as frustration, fatigue, pain and isolation  
2. Increase participant knowledge of appropriate exercise for maintaining and improving strength, flexibility, and endurance  
3. Increase participant knowledge of appropriate use of medications  
4. Increase participant ability to communicate effectively with family, friends and health professionals  
5. Increase participants' decision-making ability  
6. Increase participants' ability to evaluate new treatments |

*The Living Well: Chronic Disease Self-Management Program* is an evidence-based program developed by Stanford University's Patient Education Research Center. It is a workshop given 2.5 hours once a week, for six weeks. Fairview Ridges Hospital partnered with Prince of Peace Lutheran Church, Ebenezer, Risen Savior Church, Shepherd of the Valley Church and Juniper to offer the Living Well workshop in community settings in Fairview Ridges community. Workshops were offered in English, and Spanish by culturally relevant peer leaders.

The anticipated impacts were measured with participant surveys that were administered at the beginning of the first class (pre), at the end of the last class (post) and six months after the end of the workshop (6 month follow-up).

**2016:** 1 workshop; 16 participants
- 63% of participants reported the workshop helped them cope with feelings such as anger, sadness, frustration, and fear.
- 50% of participants reported the workshop helped them do more walking or other physical activities.
- There was a 67% increase in the percent of participants who stated they forget to take their medicine (pre to post).
- There was a 17% decrease in percent of participants who state they always or very often ask questions about the things they want to know and things they don't understand about their treatment when they visit their doctor (pre to post).
- 100% of participants reported the workshop helped them set and achieve goals and make action plans.
- Participant ability to make informed treatment decisions was not assessed in 2016.

**2017:** 3 workshops; 49 participants
- 84% of participants reported the workshop helped them cope with feelings such as anger, sadness, frustration, and fear.
- 81% of participants reported the workshop helped them do more walking or other physical activities.
- There was a 1% decrease in the percent of participants who stated they forget to take their medicine (pre to post).
- There was a 27% increase in percent of participants who state they always or very often ask questions about the things they want to know and things they don't understand about their treatment when they visit their doctor (pre to post).
- 92% of participants reported the workshop helped them make action
92% of participants reported the workshop helped them to make informed treatment decisions.

**2018: 1 workshop; 16 participants**
- 75% of participants reported the workshop helped them cope with feelings such as anger, sadness, frustration, and fear.
- 75% of participants reported the workshop helped them do more walking or other physical activities.
- There was a 53% decrease in the percent of participants who stated they forget to take their medicine (pre to post).
- There was a 22% decrease in percent of participants who state they always or very often ask questions about the things they want to know and things they don’t understand about their treatment when they visit their doctor (pre to post).
- 75% of participants reported the workshop helped them make action plans.
- 75% of participants reported the workshop helped them to make informed treatment decisions.

**Program 2: ReThink Your Drink**

The ReThink Your Drink campaign is an initiative that educates community residents, Fairview Ridges Hospital patients, patients’ families and employees on the health risks associated with drinking sugar-sweetened beverages. Activities conducted under the ReThink Your Drink campaign include raising awareness at community events and implementing policy change at the system level.

The anticipated impacts for the Rethink Your Drink campaign are to:
1. Increase awareness of the risks associated with drinking sugar-sweetened beverages amongst community residents, Fairview patients and employees
2. Review existing vending contracts to bring them in alignment with Partnership for Healthier America’s goal of less than 20 percent of vending beverages are sugar-sweetened

The anticipated impacts were measured through participation in an employee wellness campaign, vendor contract changes, participation at community events, and by participant surveys that were administered before and after presentations.

**2016**
- 47 employees participated in the Sugar Savvy Challenge.
- 90% of vending options were sugar-sweetened beverage free at the end of 2016.

**2017**
- 100% of vending options were sugar-sweetened beverage free as of April 3, 2017.

**2018**
- 1 presentations; 39 participants
- 11% increase in the percent of participants who were able to identify the risks associated with drinking sugar-sweetened beverages (pre to post).
Program 3: Colon Cancer Prevention Project

The Colon Cancer Prevention Project includes community education on colon cancer prevention, outreach, and recruitment of uninsured individuals to have a free colonoscopy procedure, all conducted by a Community Health Worker. The Community Health Worker assesses people who indicate interest in having colonoscopy procedure based on program criteria. Physicians volunteer time to conduct colonoscopy and all follow up care is provided free of charge.

The anticipated impacts for the Colon Cancer Prevention Project are to:

1. Increase knowledge in the Latino community of ways to prevent and test for colon cancer
2. Provide up to 30 free colonoscopy procedures to uninsured Latinos per year
3. Provide a culturally responsive experience from community education to colonoscopy procedure

The anticipated impacts were measured with surveys that were administered at the beginning (pre) and end (post) of community presentations; through the number of colonoscopies completed; and with surveys that were administered to individuals after they received a colonoscopy procedure.

2016
- 28 free colonoscopy procedures were provided.
- 91% of participants indicated the doctors, nurses and other healthcare staff always explained things in a way they could understand.
- 100% of participants indicated the doctors, nurses and other healthcare staff always treated them with courtesy and respect.

2017
- 24 free colonoscopy procedures were provided.
- There was a 187% increase in percent of participants who reported they had good knowledge of ways to test for colon cancer (pre to post).
- There was a 266% increase in percent of participants who reported they had good knowledge of ways to prevent colon cancer (pre to post).
- 100% of participants indicated the doctors, nurses and other healthcare staff always explained things in a way they could understand.
- 100% of participants indicated the doctors, nurses and other healthcare staff always treated them with courtesy and respect.

2018
- 24 free colonoscopy procedures were provided.
- There was a 225% increase in the percent of participants who received a colonoscopy who had a lot of knowledge on colorectal cancer and colorectal cancer screening (pre to post).
- 100% of participants indicated the doctors, nurses and other healthcare staff always explained things in a way they could understand.
- 100% of participants indicated the doctors, nurses and other healthcare staff always treated them with courtesy and respect.
Program 4: Latino Community Health Education

Health education prepared and presented by Community Health Workers who come from the community they serve, to a group of people in a community setting or hospital facility. Presentation topics vary and are based on the needs of the community.

The anticipated impacts for the Latino Community Health Education program are to:
1. Increase participant knowledge on the impact of mental health problems and obesity on overall health
2. Increase participant awareness of behaviors that can positively impact mental health and/or obesity
3. Increase reach of community education to various subpopulations within the Latino community

The anticipated impacts were measured with participant surveys that were administered at the beginning (pre) and end (post) of community presentations and through participant report of meeting their action plan goal.

2016
- 10 presentations on the topic of obesity and mental health.

2017
- 20 people attended 1 presentation on the topic of obesity and mental health.
- 13 people participated Action Plan coaching
- 92% of Action Plan coaching participants either met or modified their action plan goal

2018
- 264 people attended 10 presentations and outreach activities on the topic of obesity and mental health.
- 13 people participated Action Plan coaching.
- There was a 14% increase in the percent of participants who stated obesity increases one’s risk of diabetes (pre to post).
- There was a 14% increase in the percent of participants who stated they learned new ways to prevent obesity (pre to post).
- There was a 163% increase in the percent of participants who stated they are aware of ways to reduce stress (pre to post).

Priority area #2: Mental health

Program 1: Mental Health First Aid

Mental Health First Aid is an internationally recognized evidence-based program that was created and is managed by the National Council for Behavioral Health. It is an eight-hour class that introduces participants to risk factors and warning signs of mental illnesses.

The anticipated impacts for the Mental Health First Aid programs are to:
1. Increase knowledge of the signs, symptoms and risk factors of mental illnesses
2. Increase knowledge of the impact of mental and substance use disorders in participants
3. Increase awareness of local resources and where to turn for help
4. Build capacity to assess a situation and help an individual in distress.

The anticipated impacts were measured with participant surveys that were collected at the beginning of the class (pre), at the end of the class (post) and six months after class (6 month follow-up).

2016: 3 adult classes with 51 participants; 1 youth class with 12 participants
builds understanding of their impact, and overviews common supports. There is also a Youth Mental Health First Aid that focuses on adults working with adolescents. Workshops were offered in English, Somali, and Spanish by culturally relevant instructors.

<table>
<thead>
<tr>
<th>2017: 3 adult classes with 45 participants; 1 youth class with 17 participants</th>
<th>2018: 1 adult class with 18 participants; No youth classes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 20% (adult) and 8% (youth) increase in the percent of participants between pre and post who recognize the signs that someone may be dealing with a mental health problem or crisis.</td>
<td>• 27% increase in the percent of participants between pre and post who recognize the signs that someone may be dealing with a mental health problem or crisis.</td>
</tr>
<tr>
<td>• 14% (adult) and 0% (youth) increase in the percent of participants between pre and post who are aware of their own views and feelings about mental health problems and disorders.</td>
<td>• 25% increase in the percent of participants between pre and post who are aware of their own views and feelings about mental health problems and disorders.</td>
</tr>
<tr>
<td>• 34% (adult) and 30% (youth) increase in the percent of participants between pre and post who could assist a person who may be dealing with a mental health problem or crisis to seek professional help.</td>
<td>• 6% increase in the percent of participants between pre and post who could assist a person who may be dealing with a mental health problem or crisis to seek professional help.</td>
</tr>
<tr>
<td>• 46% (adult) and 45% (youth) increase in the percent of participants between pre and post who could reach out to someone who may be dealing with a mental health problem or crisis.</td>
<td>• 54% increase in the percent of participants between pre and post who could reach out to someone who may be dealing with a mental health problem or crisis.</td>
</tr>
</tbody>
</table>
Fairview Ridges Hospital – Community Health Implementation Strategy

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

The Fairview Ridges Community Hospital Advisory Council reviewed and gave input to the Implementation Strategy, validated the development process, and recommended adoption of the Implementation Strategy and Community Health Improvement Plan by the Board of Directors. See appendix E for a list of hospital advisory council members.

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

Community Health Improvement Plan 2019 – 2021

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

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

Priority: Mental health and well-being

<table>
<thead>
<tr>
<th>Tactics</th>
<th>Hospital resources</th>
<th>Partners</th>
<th>Anticipated impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offer evidence-based Mental Health First Aid training (adult and youth)</td>
<td>Behavioral Health staff Community Engagement staff Community Health and Innovation staff Interfaith Community Health staff Spiritual Health staff Youth Grief Services staff</td>
<td>Interfaith Health Collaborative Member Congregations StairStep Foundation</td>
<td>Increase in participants’ ability to recognize and correct misconceptions about mental health and mental illness</td>
</tr>
<tr>
<td>Tactics</td>
<td>Hospital resources</td>
<td>Partners</td>
<td>Anticipated impacts</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Offer Mobile Substance Use Disorder Support Program | Fairview Mental Health & Addiction  
Fairview Ridges Medical Center  
St. John’s Hospital  
St. Joseph’s Hospital  
Woodwinds Health Campus | Bentson Foundation (through Regions Hospital Foundation) grant funding for two years  
East Metro Crisis Alliance  
Lakeview Hospital  
Minnesota Recovery Connection  
Ramsey County Detox Center  
Regina Hospital  
Regions Hospital  
United Hospital | Increase in the number of active participants in the recovery program |
| Offer Trauma Informed Congregations program         | Interfaith Community Health staff                                                 | Hennepin Health  
StairStep Foundation                                                          | Increase in Clergy/Leader understanding of the impact of trauma on trauma survivors |
| Offer Youth Grief Services sessions and camps       | Interfaith Community Health staff                                                 | Eluna (formerly The Moyer Foundation)  
New York Life                                                                   | Increase in youth participants’ knowledge of healthy coping strategies in response to grief |
| Tactics                                             | Hospital resources                                                                | Anticipated impacts                                                                 |
| Collaborate in policy, systems and environmental (PSE) change around responding to trauma in settings such as schools and faith communities | Community Benefit & Measurement staff  
Community Engagement staff  
Community Health and Innovation staff  
Fairview Foundation  
Interfaith Community Health staff | Champions, partners and specific Primary Service Area (PSA) changes identified with implementation underway |
### Priority: Healthy lifestyles

<table>
<thead>
<tr>
<th>Tactics</th>
<th>Hospital resources</th>
<th>Partners</th>
<th>Anticipated impacts</th>
</tr>
</thead>
</table>
| Offer evidence-based Falls Prevention Suite  
  - Matter of Balance  
  - Tai Ji Quan | Community Engagement staff  
  Community Health and Innovation staff  
  Interfaith Community Health staff  
  Ways to Wellness | Arrowhead Agency on Aging  
  Central Minnesota Council on Aging  
  Juniper  
  Local organizations serving seniors  
  Metropolitan Agency on Aging | Decrease participants’ fear of falling |
| Offer evidence-based Living Well Suite of programs  
  - Chronic Disease Self-Management  
  - Chronic Pain Self-Management  
  - Diabetes Self-Management | Community Engagement staff  
  Community Health & Innovation staff | Arrowhead Agency on Aging  
  Central Minnesota Council on Aging  
  Juniper  
  Metropolitan Agency on Aging | Increase participants’ confidence to manage a chronic condition |

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

### Priority: Access to care and resources

<table>
<thead>
<tr>
<th>Tactics</th>
<th>Hospital resources</th>
<th>Partners</th>
<th>Anticipated impacts</th>
</tr>
</thead>
</table>
| Conduct MINI Clinics | Interfaith Community Health staff | Homeland Health Specialists  
  Portico HealthNet  
  St. Catherine’s University  
  St. Mary’s Health Clinics  
  StairStep Foundation  
  Additional site partners (more than 35) | Increase in the number of MINI clinics with culturally and/or linguistically appropriate materials around accessing care and resources |
<table>
<thead>
<tr>
<th>Tactics</th>
<th>Hospital resources</th>
<th>Partners</th>
<th>Anticipated impacts</th>
</tr>
</thead>
</table>
| Offer evidence-based Falls Prevention Suite  
  - Matter of Balance  
  - Tai Ji Quan | Community Engagement staff  
  Community Health and Innovation staff  
  Interfaith Community Health staff  
  Ways to Wellness | Arrowhead Agency on Aging  
  Central Minnesota Council on Aging  
  Juniper  
  Local organizations serving seniors  
  Metropolitan Agency on Aging | Increase in participants’ comfort talking to their health care provider about medications and other possible risks of falling |
| Offer evidence-based Living Well Suite of programs  
  - Chronic Disease Self-Management  
  - Chronic Pain Self-Management  
  - Diabetes Self-Management | Community Engagement staff  
  Community Health and Innovation staff | Arrowhead Agency on Aging  
  Central Minnesota Council on Aging  
  Juniper  
  Metropolitan Agency on Aging | Increase in participants who agree that the program helps them work with their health care providers |
| Offer evidence-based Mental Health First Aid training (adult and youth) | Behavioral Health staff  
  Community Engagement staff  
  Community Health and Innovation staff  
  Interfaith Community Health staff  
  Spiritual Health staff  
  Youth Grief Services staff | Interfaith Health Collaborative Member Congregations  
  StairStep Foundation | Increase participants’ confidence in assisting someone to connect with professional resources |

In addition to the tactics mentioned above, Fairview Ridges Hospital supports community efforts addressing needs identified during the CHNA process and/or by a public agency or community group that may extend beyond the three priority areas to create a positive environment through collaboration with external partners such as faith community nurses, the Latino colon cancer prevention program, and the Prince of Peace partnership. Fairview Ridges Hospital also supports community efforts through sponsorships and donations.

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


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

2. https://www.co.dakota.mn.us/
3. 15% of all Minnesotans are 65 or older. http://www.mncompass.org/trends/insights/2017-05-30-older-adults
8. Minnesota’s median household income was $65,599 in 2016. https://www.mncompass.org/economy/median-income#1-6799-g
10. Minnesota Compass. https://www.mncompass.org/workforce/educational-attainment#1-6803-g
Appendices

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

Fairview Board of Directors

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

Fairview Patient Care and Experience Committee of the Corporate Board

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

Community Advisory Council

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

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

Appendix E

Fairview Ridges Hospital Community Hospital Advisory Council
- Bonnie Brueshoff, RN, Dakota County Public Health
- Brian Knapp, Fairview Ridges Hospital
- Chuck Mathews, Zee Medical Service
- Dave Oswald, Coldwell Banker Burnet
- Dr. Douglas Bailey, Surgical Consultants PA
- Dr. Fady Chamoun, Fairview Ridges Hospital
- Janet Mohr, MN Department of Education (retired)
- Jeff Mortensen, 360 Communities
- Jeoff Will, Chief Operating Officer, Acute Care Hospitals, Ridges, Southdale, and Bethesda
- Dr. John Houghland, Emergency Physicians PA
- Julie Sethney, RN, Fairview Ridges Hospital
- Kurt Chroust, DDS, Chroust Family Dentistry
- Lisa Brodsky, MPH, Scott County Public Health
- Lynn Schomburg, Fairview Ridges Hospital
- Maria Hultman, Wells Fargo Corporate HR
- Dr. Melissa Clark, Metropolitan Pediatric Specialists PA
- Paul Kettler, Fairview Ridges Hospital
- Peggy Johnson, Dakota Electric Association
- Rev. Jeff Marian, Prince of Peace Lutheran Church
- Robert (Bob) Vogel, New Market Bank
Appendix F

Fairview Ridges Hospital cities and zip codes

<table>
<thead>
<tr>
<th>Zip</th>
<th>City</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>55020</td>
<td>Elko</td>
<td>Scott</td>
</tr>
<tr>
<td>55024</td>
<td>Farmington</td>
<td>Dakota</td>
</tr>
<tr>
<td>55044</td>
<td>Lakeville</td>
<td>Dakota</td>
</tr>
<tr>
<td>55054</td>
<td>New Market</td>
<td>Scott</td>
</tr>
<tr>
<td>55068</td>
<td>Rosemount</td>
<td>Dakota</td>
</tr>
<tr>
<td>55121</td>
<td>Eagan</td>
<td>Dakota</td>
</tr>
<tr>
<td>55122</td>
<td>Eagan</td>
<td>Dakota</td>
</tr>
<tr>
<td>55123</td>
<td>Eagan</td>
<td>Dakota</td>
</tr>
<tr>
<td>55124</td>
<td>Apple Valley</td>
<td>Dakota</td>
</tr>
<tr>
<td>55306</td>
<td>Burnsville</td>
<td>Dakota</td>
</tr>
<tr>
<td>55337</td>
<td>Burnsville</td>
<td>Dakota</td>
</tr>
<tr>
<td>55372</td>
<td>Prior Lake</td>
<td>Scott</td>
</tr>
<tr>
<td>55378</td>
<td>Savage</td>
<td>Scott</td>
</tr>
</tbody>
</table>
Appendix G

Trended Community Need Index scores for Fairview Ridges Hospital community

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>55020</td>
<td>Elko</td>
<td>1.0</td>
<td>1.2</td>
<td>1.6</td>
<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>55024</td>
<td>Farmington</td>
<td>1.6</td>
<td>1.4</td>
<td>1.4</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>55044</td>
<td>Lakeville</td>
<td>1.4</td>
<td>1.4</td>
<td>1.4</td>
<td>1.6</td>
<td>1.6</td>
</tr>
<tr>
<td>55054</td>
<td>New Market</td>
<td>*</td>
<td>1.4</td>
<td>1.8</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>55068</td>
<td>Rosemount</td>
<td>1.6</td>
<td>1.4</td>
<td>1.4</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>55121</td>
<td>Eagan</td>
<td>2.4</td>
<td>3.4</td>
<td>3.2</td>
<td>3.0</td>
<td>2.6</td>
</tr>
<tr>
<td>55122</td>
<td>Eagan</td>
<td>2.0</td>
<td>2.2</td>
<td>2.4</td>
<td>2.4</td>
<td>2.4</td>
</tr>
<tr>
<td>55123</td>
<td>Eagan</td>
<td>1.8</td>
<td>1.6</td>
<td>1.6</td>
<td>1.8</td>
<td>1.8</td>
</tr>
<tr>
<td>55124</td>
<td>Apple Valley</td>
<td>1.4</td>
<td>1.8</td>
<td>2.0</td>
<td>1.8</td>
<td>1.8</td>
</tr>
<tr>
<td>55306</td>
<td>Burnsville</td>
<td>2.4</td>
<td>3.2</td>
<td>2.8</td>
<td>3.4</td>
<td>3.2</td>
</tr>
<tr>
<td>55337</td>
<td>Burnsville</td>
<td>2.6</td>
<td>2.6</td>
<td>2.6</td>
<td>2.8</td>
<td>2.8</td>
</tr>
<tr>
<td>55372</td>
<td>Prior Lake</td>
<td>1.4</td>
<td>1.4</td>
<td>1.4</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>55378</td>
<td>Savage</td>
<td>1.8</td>
<td>1.6</td>
<td>1.6</td>
<td>1.8</td>
<td>1.8</td>
</tr>
</tbody>
</table>

*Community Need Index score not available due to low population
Appendix H: List of primary data sources

Key stakeholder interviews

<table>
<thead>
<tr>
<th>#</th>
<th>Organization</th>
<th>Role</th>
<th>Sector</th>
<th>Expertise</th>
<th>Date Consulted (2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Fairview Ridges Hospital</td>
<td>Nutritionist</td>
<td>Healthcare</td>
<td>Patient and family</td>
<td>July 5</td>
</tr>
<tr>
<td>2</td>
<td>University of Minnesota Health Clinics and</td>
<td>Psychologist</td>
<td>Healthcare</td>
<td>Patient and family</td>
<td>July 5</td>
</tr>
<tr>
<td></td>
<td>Surgery Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Fairview Ridges Hospital</td>
<td>Nurse Manager</td>
<td>Healthcare</td>
<td>Patient and family</td>
<td>July 6</td>
</tr>
<tr>
<td>4</td>
<td>Fairview Ridges Cancer Clinic</td>
<td>Billing</td>
<td>Healthcare</td>
<td>Patient and family</td>
<td>July 9</td>
</tr>
<tr>
<td>5</td>
<td>Fairview Ridges Hospital</td>
<td>Nutritionist</td>
<td>Healthcare</td>
<td>Patient and family</td>
<td>July 10</td>
</tr>
<tr>
<td>6</td>
<td>Fairview Ridges Hospital</td>
<td>Social Worker</td>
<td>Healthcare</td>
<td>Patient and family</td>
<td>July 11</td>
</tr>
<tr>
<td>7</td>
<td>Fairview Ridges Hospital</td>
<td>Practice Nurse Leads</td>
<td>Healthcare</td>
<td>Patient and family</td>
<td>July 11</td>
</tr>
<tr>
<td>8</td>
<td>Fairview Ridges Hospital</td>
<td>Care Coordinator</td>
<td>Healthcare</td>
<td>Patient and family</td>
<td>July 11</td>
</tr>
<tr>
<td>9</td>
<td>Fairview Ridges Specialty Center</td>
<td>Pharmacist</td>
<td>Healthcare</td>
<td>Patient and family</td>
<td>July 16</td>
</tr>
<tr>
<td>10</td>
<td>Fairview Ridges Hospital</td>
<td>Nutritionist</td>
<td>Healthcare</td>
<td>Patient and family</td>
<td>July 17</td>
</tr>
<tr>
<td>11</td>
<td>Fairview Ridges Hospital</td>
<td>Social Worker</td>
<td>Healthcare</td>
<td>Patient and family</td>
<td>July 17</td>
</tr>
<tr>
<td>12</td>
<td>Fairview Ridges Hospital</td>
<td>Chaplain</td>
<td>Healthcare</td>
<td>Spiritual health</td>
<td>July 18</td>
</tr>
<tr>
<td>13</td>
<td>Dakota County Public Health</td>
<td>Community Health Worker</td>
<td>Local Public Health</td>
<td>Local health needs</td>
<td>July 20</td>
</tr>
<tr>
<td>14</td>
<td>FACTS: Family Adolescent &amp; Child Therapy</td>
<td>Clinical Director, MSW, LICSW</td>
<td>Social Services</td>
<td>Mental Health</td>
<td>July 20</td>
</tr>
<tr>
<td></td>
<td>Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Fairview Ridges Hospital</td>
<td>Chaplain</td>
<td>Healthcare</td>
<td>Patient and family</td>
<td>July 23</td>
</tr>
<tr>
<td>16</td>
<td>Fairview Ridges Cancer Clinic</td>
<td>Clinic Supervisor</td>
<td>Healthcare</td>
<td>Patient and family</td>
<td>July 24</td>
</tr>
<tr>
<td>17</td>
<td>Dakota County Public Health</td>
<td>Community Health Worker</td>
<td>Local Public Health</td>
<td>Somali Community</td>
<td>July 25</td>
</tr>
<tr>
<td>18</td>
<td>Fairview Ridges Hospital</td>
<td>Director Patient Relations</td>
<td>Healthcare</td>
<td>Patient and family</td>
<td>July 27</td>
</tr>
<tr>
<td>19</td>
<td>Fairview Ridges Hospital</td>
<td>Social Worker</td>
<td>Healthcare</td>
<td>Patient and family</td>
<td>July 27</td>
</tr>
<tr>
<td>20</td>
<td>City of Burnsville</td>
<td>Mayor</td>
<td>Government</td>
<td>Broad community</td>
<td>July 31</td>
</tr>
<tr>
<td>21</td>
<td>Fairview Ridges Cancer Clinic</td>
<td>Care Coordinator</td>
<td>Healthcare</td>
<td>Patient and family</td>
<td>August 1</td>
</tr>
<tr>
<td>22</td>
<td>Lakeville Area Learning Center</td>
<td>Secondary Personalized Learning Coordinator</td>
<td>Education</td>
<td>Grades 8 - 12</td>
<td>August 7</td>
</tr>
<tr>
<td>23</td>
<td>City of Burnsville</td>
<td>Police Chief</td>
<td>First Responder</td>
<td>Public Safety</td>
<td>August 8</td>
</tr>
<tr>
<td>24</td>
<td>City of Lakeville</td>
<td>Police Chief</td>
<td>First Responder</td>
<td>Public Safety</td>
<td>August 15</td>
</tr>
</tbody>
</table>

Community conversations and facilitated discussions

<table>
<thead>
<tr>
<th>#</th>
<th>Host Organization</th>
<th>Group Represented</th>
<th>Consultation Method</th>
<th>Date Consulted (2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Fairview Ridges Hospital</td>
<td>Community Hospital Advisory Committee</td>
<td>Facilitated discussion</td>
<td>June 1</td>
</tr>
<tr>
<td>2</td>
<td>CommonBond</td>
<td>Seniors</td>
<td>Community conversation</td>
<td>August 8</td>
</tr>
<tr>
<td>3</td>
<td>Oasis De Amor Church</td>
<td>Latino Community</td>
<td>Community conversation</td>
<td>August 8</td>
</tr>
</tbody>
</table>

Fairview Ridges Hospital | 48
Appendix I

Facilitated discussion questions

- What are the most important issues impacting the health and well-being of residents in your community?
- What key health trends or emerging health concerns are impacting your community?
- In your experience who (populations, communities, groups or individuals) should be brought into the conversations?
- How should we prioritize community conversations and interviews?

Appendix J

Community conversation questions

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

Key stakeholder interview questions

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