grand itasca Clinic & Hospital | *Part of Fairview Health Services*

2024 Community Health Needs Assessment Report

Grand Itasca Clinic & Hospital

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Introduction

It takes the support and commitment of a community to conduct our triennial Community Health Needs Assessment (CHNA) process. Fairview is grateful for the essential insights from everyone who participated in an assessment activity, including taking a survey, joining a community virtual conversation, or attending our Community Health and Healing Summit. Our organization would also like to thank our community advisory committee members and our system community advisory council members for their ongoing involvement.

Fairview is proud to present this 2024 CHNA report. This narrative report shares our intentional focus on our needs assessment, including community engagement and process enhancement. Extensive appendices are available for readers to review additional data and areas of interest.

Our CHNA process is informed by the work of Fairview's Community Advancement team, in partnership with the M Health Fairview Center for Community Health Equity. The center extends the work our Community Advancement team is doing in community, creating space for Fairview and our community partners to work alongside one another toward a shared goal of improving health equity in the communities we serve and to which we belong.

Fairview's CHNA goes beyond the required guidelines and presents all the work our organization is leading. To find the specific requirements from the Section 501(r)(3) checklist, please see page 41.

Land acknowledgment

This acknowledgment was drafted by a group of employees across the healthcare system, inclusive of Native-identified team members, in consultation with American-Indian-led community organizations. The original acknowledgment was developed as part of the launch for the Center for Community Health Equity, based on the site of the first hospital in the State of Minnesota, to recognize the local history that importantly impacts our present-day conditions and context. The acknowledgment was an exercise in collectively understanding the place and circumstances where we find ourselves in order to intentionally build out the work of our Native Health Equity Initiative and take action to improve experiences and outcomes for our Native-identified patients, employees, and communities. It honors and recognizes the Indigenous communities who have stewarded the land since time immemorial and demonstrates our commitment to restorative action for all our marginalized neighbors. We use the terms Indigenous, Native, and American Indian interchangeably recognizing personal preference as well as governmental usage.

What is land acknowledgment?

According to the Native Governance Center, "Indigenous land acknowledgment is an effort to recognize the Indigenous past, present, and future of a particular location and to understand our own place within that relationship."[i] Land acknowledgments are verbal or written statements that are often shared at events, meetings, and community gatherings.

Why did we create a land acknowledgment?

Our history shapes so much of our present-day circumstances, systems, and outcomes. It is important to be honest about this history. Our work includes acknowledging how inequities have impacted the geographies and people we serve and have served. Educating team members and the larger health system about how this influences patient care and outcomes, and how history and the social

determinants of health are interconnected and have led to inequities in health care and beyond, is an essential component of our commitment and work to advance equity and inclusion.

Fairview's land acknowledgement

We acknowledge with respect and gratitude that the land on which we live is Indigenous land. Mni Sóta Makoce (Minnesota) is the homeland of the Dakota and Anishinaabe peoples and other Native nations, whose ancient relationships with the land continue to this day. We acknowledge that this sacred land does not belong to us. We are occupiers here who have also come to call this land where the water reflects the sky, home.

There is a complex history of genocide, broken treaties,[ii] including those of 1837 and 1851, and colonialism that has been concealed throughout history. We acknowledge the impacts of this history on the generations of the past and the generations of the future. While we cannot undo the wrongs and do not want to disguise the past, we must be forthright about the journey to today and thus take restorative action. We acknowledge that other communities have also been marginalized and exploited to generate the community's wealth over time. We commit to continued action and partnership with the community to address these injustices for all our relatives.

Our Native Health Equity Initiative works to support healing in four directions across our healthcare system through partnering with Indigenous organizations and Native Nations to drive health equity, co-hosting events to create connections and uplift Indigenous approaches, and advocating with and for local Native-led priorities. It is our aim to embrace the wisdom in Native traditions in planning for the next seven generations on this revered land. Toward this vision, we will continue to strengthen our relationships in our community as a health care provider, employer, academic institution, and corporate community member to collectively improve outcomes and experiences for Native patients, employees, and community members.

Impacts of history on our current conditions

We recognize the impact of history, power, and systems in shaping our present-day circumstances, including health outcomes and health disparities. As a part of our 2024 Community Health and Healing Summit, our partners came together to help us take a deep dive into the history of our communities, building a narrative that will help us acknowledge the challenges our neighbors have faced, grasp the resilience they've displayed in overcoming barriers to health and wellbeing, and learn from the ingenuity community has demonstrated in achieving connectedness and wellness.

This context is critical for our efforts to improve community health equity, develop healing connections, and foster trusted partnerships. We strive to do with and for – not to – our communities. Our community partners used these insights to help contextualize the needs identified in our 2024 CHNA. Fairview will work collaboratively with our local communities to create new, more positive, hopeful narratives.

grand itasca Clinic & Hospital | Part of Fairview Health Services

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. Fairview has enjoyed a long partnership with the University of Minnesota and University of Minnesota Physicians, now represented in the M Health Fairview brand. Together, we offer access to breakthrough medical research and specialty expertise as part of a continuum of care that reaches all ages and health needs.

Mission

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

Vision

Fairview is driving a healthier future.

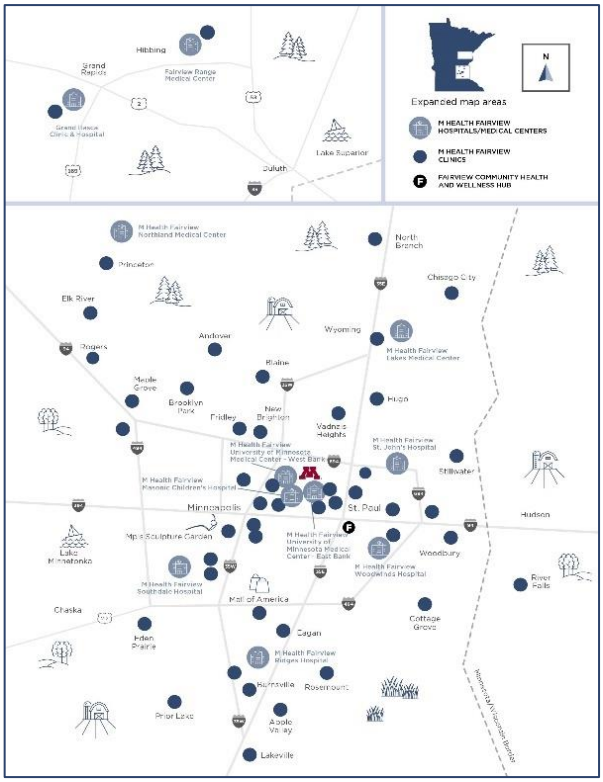
Values

Dignity - Integrity - Service
Compassion - Innovation

Fairview by the numbers:

- 34,000+ employees
- 100+ specialties
- 10 hospitals and medical centers
- 40+ primary care clinics
- 2.1+ million patients yearly

The names listed below reflect the Minnesota Department of Health licensed names. Through the remainder of this report, we will refer to all hospitals or medical centers by the names by which they are more commonly known in the community.



- Fairview Lakes Medical Center (referred to as Lakes Medical Center), Wyoming, MN
- Fairview Northland Regional Hospital (referred to as Northland Medical Center), Princeton, MN
- Fairview Ridges Hospital (referred to as Ridges Hospital), Burnsville, MN
- Fairview Southdale Hospital (referred to as Southdale Hospital), Edina, MN
- Fairview-University Medical Center (referred to as University of Minnesota Medical Center and Masonic Children's Hospital), Minneapolis, MN
- Grand Itasca Clinic and Hospital (referred to as Grand Itasca Clinic and Hospital), Grand Rapids, MN
- HealthEast Bethesda Hospital (referred to as Bethesda Hospital), St. Paul, MN
- HealthEast St. John's Hospital (referred to as St. John's Hospital), Maplewood, MN
- HealthEast Woodwinds Hospital (referred to as Woodwinds Hospital), Woodbury, MN
- St. Joseph's Hospital (referred to as St. Joseph's Hospital), St. Paul, MN
- University Medical Center Mesabi / Mesabi Clinics (referred to as Fairview Range), Hibbing, MN

Fairview is honored to care for a broad and diverse array of communities across Minnesota. While this report is specific to the populations served by the Grand Itasca, Fairview also serves urban, suburban and rural populations across its facilities. We acknowledge that the challenges the priority populations face, and the nuances of our priority need areas, look different across geographical context. We strive to provide programs and interventions at each facility that are responsive to the local community's specific needs.

About Grand Itasca Clinic & Hospital

Grand Itasca Clinic and Hospital, part of Fairview, is an integrated clinic and hospital in Grand Rapids, MN. Originally established in 1918 to bring care to the logging camps and paper mill in the area, today it serves as the leading employer and a powerful economic engine in greater Itasca County. Grand Itasca employs more than 700 people, including more than 70 providers, and partners with University of Minnesota Health specialists to bring advanced, high-quality care directly to the surrounding community. Grand Itasca is a Level III Trauma Center and an Acute Stroke Ready Hospital, designated by the Minnesota Department of Health. For two years in a row, Grand Itasca's women's health and birth team has been recognized as a Best Hospital for Maternity Care while delivering a record number of babies.

Key services

- Cancer care
- Chiropractic
- General surgery
- Heart care
- OB/GYN
- Occupational medicine
- Orthopedics
- Pharmacy
- Primary care
- Psychiatry
- Rehabilitation
- Sports medicine
- Urology

Framing and approach for 2024 assessment

Assessing and responding to community and patient needs is an important component of population health and an integral part of Fairview's community commitment, as Fairview has conducted triennial assessments to inform our community outreach since the mid-1990s. Fairview's 2024 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.

At Fairview, we are committed to those we serve – and as an anchor institution, our definition of those we serve stretches beyond our patients to embrace our entire community. As a result, this assessment process takes into consideration everyone our health system touches, including our community members, our patients, and our employees.

The assessment serves as a tool for guiding policy, advocacy, and program planning. It also fulfills Internal Revenue Service (IRS) requirements for CHNA 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 provide an annual evaluation of the previous implementation strategy's impact.

Through this process, Fairview aims to:

- Intentionally engage with community members and organizations, public health agencies, and other hospitals and health systems to identify and understand significant health needs in the community.
- Understand the needs of the community we serve by analyzing current demographics and social determinants of health indicators, as well as by collecting direct input from community members and organizations.
- Inform each hospital's CHNA implementation strategy and action plan development.

Our 2024 CHNA process continues to be grounded in the key principles that guide the way we work with community: focus on community voice and trust, commit to collaboration, and transform through action.

Guided by last assessment's implementation strategies, our 2024 CHNA represents an increased focus on the processes by which we engage with community, examining the foundations on which we are building our community engagement infrastructure for the future. This corresponds naturally to a focus on narrative about the assessment process in the report. Nevertheless, we are continuing to collect and analyze information about our priority populations and priority need areas. We have included extensive appendices with specific data, and we invite readers to refer to them.

Big problems require vision-driven solutions

As we have conducted multiple CHNAs, we have come to an inescapable conclusion: Our communities have faced the same challenges for more than a three-year CHNA cycle. Despite our efforts to address these issues, these problems are not relenting and can last a decade or more. Out of these intractable challenges, we have distilled three key lessons that have fundamentally shifted our approach:

- Despite best efforts, health needs and health inequities continue to grow and deepen.
- Collective action is critical.
- Transformational change requires sustained and focused commitment.

In 2021, in response to these lessons learned and guided by the key community outreach principles outlined above, we put forth a Fairview 10-year vision – **increased community health equity**. We

developed the first in a series of consecutive CHNA implementation strategies and plans that we will build and execute over the decade to bring that vision to fruition.

Getting stakeholder buy-in to execute a 10-year vision, and maintaining that interest and focus for a decade, takes vision and commitment: vision to imagine a better future and inspire others to work alongside us, and commitment to stay the course in pursuit of that vision. Although these two requirements are difficult to fulfill within the context of healthcare's dynamic landscape, we remain steadfast in our dedication and have developed processes to effectively support our work. These processes, and the progress they have enabled so far, are the subjects of this CHNA report.

2024 CHNA priorities

As part of our commitment to our 10-year vision and strategies, and in alignment with the Center for Community Health Equity, we are using consecutive CHNA cycles to build upon and deepen the work tied to the assessment. All the feedback, stakeholder input, and community voice we have gathered and heard since our last assessment confirms that the priority needs identified in our 2021 CHNA are still present, pressing issues in our communities. We remain committed to driving real, sustained change in those areas. We are using our 2024 CHNA cycle to gather further data and context about these priority needs to refine and deepen our understanding and to respond more impactfully.

The three priority needs are:

- **Accessing and navigating care and resources.** Individuals and communities struggle to access and navigate the resources they seek to support their unique health and well-being. System complexity, co-occurring health and mental health issues, and lack of coordination across entities make it difficult and cumbersome to access information and care. Provider shortages, lack of culturally responsive providers, and cost of care especially for under- or uninsured community members further exacerbate access challenges. Furthermore, many gaps in service exist, and services that are available are not always appropriate for or trusted by populations.
- **Addressing structural racism and barriers to equity.** Individuals and communities are experiencing differential access and assets due to historical and ongoing structural racism, discriminatory policies, and bias. The social determinants of health as well as individual risk factors contribute to disparate outcomes with care, resources, and opportunity, undermining the ability of all groups to achieve optimal health and wellbeing. Communities are calling for conditions that strengthen their capacity and center their priorities; institutions have a responsibility to share power and recognize marginalized voices in decision-making processes.
- **Cultivating trust, belonging, and healing.** Individuals and communities are experiencing an acute sense of polarization, breakdowns in trust of others as well as institutions, and increasing social isolation, especially post-pandemic and with distinct challenges across geographies. Historical trauma and discrimination further compounds these issues. This results in diminished social cohesion, increased anxiety or stressors, and lack of opportunities and spaces for connection and healing.

The priority populations include people across the lifespan, and span all geographies, from rural to urban, acknowledging barriers and approaches are unique for each community. Our priority populations are:

- **Racial or ethnic populations experiencing health disparities.** Racial or ethnic populations experiencing health disparities include all minoritized communities, including but not limited to: African American, Alaska Native, Arab, Asian, Black, Cambodian (Khmer), Chinese, Ethiopian, Filipino, Hispanic/Latino, Hmong, Karen, Karenni, Kenyan, Korean, Lao, Liberian, Middle Eastern, Native American, Native Hawaiian, Nigerian, Oromo, Pacific Islander, Somali, and Vietnamese.

- **People experiencing poverty.** People experiencing poverty includes all race/ethnicities including, but not limited to: African American, Alaska Native, Arab, Asian, Black, Cambodian (Khmer), Chinese, Ethiopian, Filipino, Hispanic/Latino, Hmong, Karen, Karenni, Kenyan, Korean, Lao, Liberian, Middle Eastern, Native American, Native Hawaiian, Nigerian, Oromo, Pacific Islander, Somali, Vietnamese, and white.

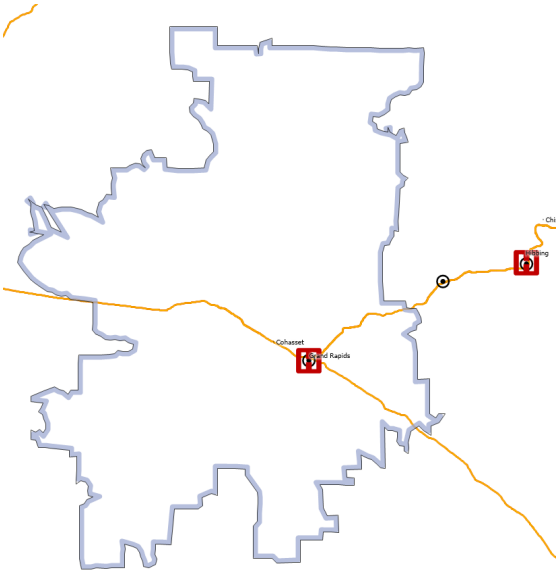
The identified priority populations are not mutually exclusive. Individuals may identify as either or both populations.

For an in-depth look at each of our priority need areas and priority populations, please see our 2021 CHNA report.

Defining community: Grand Itasca CHNA Community

In this definition of community, we include residents, patients, and employees. These categories are fluid: not only can individuals fall into more than one, but they can shift back and forth among these categories over time. For these reasons, the best definition of specific hospital communities considers all of these groups.

For the purposes of the CHNA, Grand Itasca's community includes 15 zip codes. Grand Itasca is located in Itasca County, and the Grand Itasca community also overlaps with Atkin and Cass counties. The geography encompasses 1,365 square miles. The total population of this geographic community is 41,312people. This makes up less than 1% of Minnesota's total population (5,760,091). This geographical definition of community is in alignment with the hospital primary service area, which is determined by where a majority of patients live.



See Appendix A for a map of the community as well as Appendix B for list of zip codes and the corresponding cities and counties that fall within Grand Itasca CHNA community.

Description of community

Demographics

Those who identify as members of racial or ethnic populations experiencing health disparities make up 10.6% in the Grand Itasca community compared to 24.2% of the state's population. By 2029, the percentage of those who identify as member of racial or ethnic populations experiencing health disparities is expected to make a 0.2% increase.

In the Grand Itasca community, the American Indian/Alaskan Native population (3.4%) is 2.2% higher than Minnesota's total American Indian/Alaskan Native population (1.2%). Those who identify as Black/African American and those who identify as Asian in the Grand Itasca community make up a significantly smaller percentage of the Grand Itasca population compared to the average percentage of these populations across Minnesota.

The percentage of the population who identify as Hispanic/Latino (1.5%) in the Grand Itasca community is 5.2% less than the percentage of Minnesota's population who identify as Hispanic/Latino (6.7%). By 2029, the Hispanic/Latino population is projected to have a small increase to 1.6%.

The Grand Itasca community is significantly older than the state. The median age in the Grand Itasca community is 6.8 years older than the median age of Minnesota's residents. In the Grand Itasca community, the percentage of the population between the ages of 18 and 44 years is 7.6% less than the percentage of that population in Minnesota as a whole. In the Grand Itasca community, the percentage of the population over 65 is 9.1% greater than the statewide percentage of residents who are 65 years or older. The Grand Itasca community will continue to get older over the next five years. By 2029, the ages 65 and older population is projected to increase by 2.8%.

Go to Appendix C to see the Grand Itasca community demographics data table.

Community characteristics

We selected the data points we reviewed, which we have shared on the community characteristics table (Appendix D), to provide a broad view of some of the factors that impact social needs and social determinants of health. We identified a few indicators from the community characteristics listed that are different in the Grand Itasca community than they are Minnesota-wide. Those are highlighted as indicators of interest.

- **Percentage of population with limited English proficiency:** Overall, 0.4% of Grand Itasca community's population (age 5+) has limited English proficiency, which is 4.6% less than the percentage of the Minnesota population with limited English proficiency (5%).
- **Unemployment percentage:** The Grand Itasca community has a significantly higher percentage of the population who is unemployed (6.8%), compared to the percentage of Minnesota's population who is unemployed (4.3%).
- **Food insecurity rate:** A higher percentage of the Grand Itasca community population is food insecure (8.6%), compared to the percentage of the statewide population who is food insecure (6.1%).
- **Percentage of population below 200% Federal Poverty Line (FPL):** Almost one-third (30.2%) of the Grand Itasca community population has an income below 200% of the FPL. This is 7.5% greater than the percentage of Minnesota's population with income below 200% of the FPL (22.7%). For 2021, a family of four at 200% of the FPL has a combined household income of $53,000 or less.
- **Percentage of population below 50% FPL:** In the Grand Itasca community, 5.6% of the population is at 50% of the FPL. This is 1.4% greater than the percentage of Minnesota's population with income below 50% of the FPL (4.1%). For 2021, a family of four at 50% of the FPL has a combined household income of $13,250 or less.

See Appendix D for the full community characteristics data table and Appendix E for a community characteristics snapshot for the Grand Itasca community.

2024 CHNA process

During this cycle, we are taking a close look at our process – the "how" and "why" of our community engagement work. By conducting a structured examination of the methods we are using to engage with communities, we can identify strengths to build on as well as challenges to address. Correspondingly, this CHNA report focuses on an in-depth exploration of our current engagement processes. It represents an

opportunity for us to respond to feedback from the community around the burden of engagement and to pursue ideas to improve the way we engage with communities.

As Fairview conducts our required CHNA process, led by Fairview's Community Advancement department, we are guided by the approaches and principles developed by **the Center for Community Health Equity,** which was launched in August 2022. As part of the center, we are building on our existing community engagement by creating an infrastructure that builds trusting partnerships and enables community voice to inform and influence our health system. For example:

- Fairview developed a Center for Community Health Equity Model of Community Engagement. The model articulates our approach to community engagement, community voice, and community partnerships as we work to advance community health equity.
- The center is developing a set of standard practices for collecting community voice to influence our social determinants of health initiatives without adding undue burden to the communities we seek to serve.
- The center's role as a convener and developer of community-informed best practices helps us keep equity at the center of our thinking as we study and evaluate our processes and engagement approaches.

To learn more, visit the Center for Community Health Equity website.

Our continued commitment to the priority needs and populations identified in our 2021 cycle embodies how we strive to show up – and *stay* – in the communities we serve. Continuing to work on these priority needs honors the knowledge and expertise that has already been shared with us through past assessment cycles and attempts to reduce the burden that repeated information collection places on communities. Moreover, these needs continue to disproportionately impact our priority populations, and these populations deserve to have the opportunity to achieve the best possible health outcomes.

Although approximately three-quarters of Minnesota's residents identify as non-Hispanic white, that statistic masks the reality that Minnesota is a highly diverse state. We have a large variety of languages and cultures here. Minnesota is home to among the United States' largest Hmong, Karen, and Somali populations, and there are also 11 federally recognized American Indian tribes with reservations in Minnesota[iii]

Our hospitals' service areas touch many populations that face health disparities, including Black/African American, Somali, Karen, Hmong, Latine, Vietnamese, American Indian, LGBTQIA2S+, and rural populations, among others. Minnesota has some of the largest health disparities in the nation – and with sustained commitment over time, we can change that reality.

The programs and partnerships we have built and co-developed to respond to these needs are deeply embedded in our local communities. Our current assessment and implementation cycle gives us the opportunity to:

- Continue to build momentum, expanding our networks and collaborations to better understand one another's needs and assets.
- More deeply integrate the voices of those who are disproportionately impacted by the social determinants of health and the voices of historically marginalized communities in articulating barriers and building solutions.
- Lean into our unique culturally and linguistically relevant programs and initiatives.

Strengthening partnerships and improving processes

As we conduct our 2024 CHNA, we are taking a series of steps to improve our assessment process, keeping in mind the impact of the data collection process itself on the communities we serve.

As we engage in bidirectional conversation and partnerships with community organizations that represent our priority populations and others, we are sensitive to the burden that incorporating the community's perspectives places on members of those communities and the organizations that serve them. In response, we are implementing several practices:

- We are offering grants to community-based organizations that are representing a priority population in our system community advisory council and stipends to the community-based organizations that are cohosting the system virtual community conversations with us.
- We are reviewing our outreach strategies, carefully planning, and partnering with others to avoid over surveying, over relying on the same voices or representatives, and asking the same questions assessment cycle after assessment cycle.

Fairview has **invested in subscriptions to tools, such as Spark Maps,** which enable our health system to utilize and respond more effectively to requests for community data. Spark Maps provides mapping and assessment tools that include a large database of indicators, data cleaning, benchmarking, and contextual information.[iv] For more information on Spark Maps see page 20.

Fairview has taken a leadership role in the **Center for Community Health (CCH),** a collaborative with health plans, hospitals, and public health agencies in Minnesota's seven-county metropolitan area. The CCH's member organizations will share data and processes to identify health needs and implement innovative approaches to advance community health, wellbeing, and equity. One result of this collaboration is Health Trends Across Communities, a dashboard that uses information from electronic health records to help fill gaps in the information available to health professionals, organizations, policymakers, and community members to promote health in Minnesota.

We are among the community partners supporting the **Minnesota Homeless Study**, a point-in-time study by Wilder Research that collects single-night counts of people experiencing homelessness across the state. For example, on the night of October 26, 2023, approximately 1,000 volunteers interviewed 4,600 people experiencing homelessness across Minnesota. Fairview also works with Wilder on the triennial **Minnesota Reservation Homelessness Study**. The study is conducted in partnership with six American Indian reservations in Minnesota: Bois Forte Band of Chippewa, Fond du Lac Band of Lake Superior Chippewa, Leech Lake Band of Ojibwe, Mille Lacs Band of Ojibwe, Red Lake Nation, and White Earth Nation and honors tribal ownership of their data.

Fairview has had representation on the planning team and provided financial sponsorship for **the Bridge to Health Survey**. The survey has been an important source of data on the health status of adults in northeastern Minnesota and Douglas County, Wisconsin, for more than two decades. The Bridge to Health collaborative met over the course of 2023 to develop an equity approach to guide future survey development. For more information on Bridge to Health Survey, see page 20.

We have been involved and **supported collaborations** particularly related to data and assessment in the Grand Itasca community. For example, Grand Itasca Clinic & Hospital works alongside Essentia Health - Deer River to assess the Itasca County community. While each conducts their own CHNA, they also provide support by sitting on the local advisory committees for each organization. Through this collaboration, they work together to support their community.

Community engagement for the CHNA

Engagement approach

Our overall engagement approach is guided by four key considerations:

1. Fairview is focusing on **building and deepening our engagement infrastructure**, putting structures in place that will guide our long-term community engagement efforts.
2. We must implement tactics that gather both **breadth and depth of engagement**, bringing as many community members as possible into the conversation and yet also seeking to develop a deep understanding of nuances within each need.
3. Our priority needs are systemwide, and we approach our assessment process from a system level. However, each local community Fairview serves is unique, and we **recognize, honor, and prioritize local nuances** – in context, in populations, and in our understanding of both – so we can respond most appropriately within each locality. This dual system/local approach enables us to maximize our efforts' impact across the region we serve.
4. As we look to our local communities and seek to meet them where they are, we benefit from engaging with **multiple perspectives:** those of our community members, our patients, and our employees. To do this, we must take into consideration a variety of approaches, modes, and preferences to best fit the needs of these three groups.

Throughout our engagement efforts, we continue to deepen our understanding of community needs, including emerging needs as well as shifts in current needs.

1. It is essential that we have individuals within and across Fairview who are knowledgeable in collaborating with the community.
2. A key step in the process of effective community engagement is to develop an authentic relationship with a trusted agency or community organization to help build the role of the community in engagement or programming (including, but not limited to, community voice) that produces measurable changes in the community's health outcomes.

Community engagement spectrum

As we build our multiyear assessment engagement approach, having a single guiding model of community engagement helps us maintain alignment across the health system as we plan and conduct our work. The Center for Community Health Equity engagement spectrum, based on the International Association for Public Participation's Spectrum of Public Participation,[v] was collaboratively developed through interviews with local organizations, community members, Fairview employees, and other stakeholders.

Our engagement spectrum depicts five progressively more intensive levels of community engagement: inform, consult, involve, collaborate, and community led. The model includes examples of each level of community engagement, to clarify what each level could look like in practice. It is important to recognize that no level is inherently better than another level – a more intensive engagement is not appropriate in all situations. Rather, each level is equally valid and appropriate for certain activities and at certain times.

During our current assessment process, we used the Center for Community Health Equity engagement spectrum to help ensure that we are using strategies and tactics across the spectrum. Our intent is to build the capacity of stakeholders, community organizations, and other influencers to partner with our health system most effectively, enabling them to promote their community's interests to improve the broader community's health and wellbeing. Using the engagement spectrum as a model goes beyond

merely incorporating community voice into Fairview's priority need areas. Its goal is to guide and frame co-development of community engagement activities and guide our implementation planning.

Please see Appendix F to view the Center for Community Health Equity engagement spectrum model.

Engagement infrastructure and community advisory groups

The phrase "engagement infrastructure" refers to the mechanisms through which we are sharing and receiving bidirectional feedback on an ongoing basis. Like our hospital's physical infrastructure, our engagement infrastructure is composed of enduring, permanent parts of our health system.

We are continuing to build a community engagement infrastructure that supports trusting partnerships and enables community voice to inform and influence the organization. The goal of the engagement infrastructure is to:

- Build and expand feedback systems for patients and community members.
- Embed process improvement in the health system's response to community voice.
- Create sustainable structures to convene and engage community voice around addressing social determinants of health.
- Hold space to pilot new and unique approaches to reach different populations and communities that may not otherwise be heard from.

Local Community Advisory Committee

Each hospital community has a **Local Community Advisory Committee**. We have been committed to and honored with a bidirectional, long-term commitment from our local community advisory committees, which have existed in various iterations for over 30 years.

The local community advisory committee's role is to:

- Advise and inform health improvement plans and collaborative programs.
- Guide local insight and voice for CHNAs and action plans.
- Monitor progress toward the goals outlined in the CHNA implementation strategy.
- Review the local CHNA report.

Each committee comprises members from, or representatives of, groups such as public health departments, medically underserved communities. communities experiencing poverty, populations experiencing health and/or racial disparities, community-based organizations, and schools.

Since our last assessment, membership is an area that we have purposefully identified gaps. We are continuing to work toward meeting the gold standard of committee membership

For a list of the Grand Itasca Local Community Advisory Committee members, please see Appendix G.

System Community Advisory Council

Since our last assessment our **System Community Advisory Council** has adjusted the membership and focus to better fit the community and organizational needs. The system community advisory council spans the entire health system and incorporates the need for internal representation, local representation, and representation from organizations that represent our priority populations. It builds new, and deepens existing, relationships and partnerships that allow us to understand, respond to, and meet community and patient needs through collaboration.

The Fairview System Community Advisory Council's role is to:

- Advise the health system on the CHNA process and prioritization model from a systemwide perspective.
- Guide health system insight and ensure the voice of priority populations remains at the center of all discussions.
- Provide guidance and expertise in development of implementation strategy plans.

To view the Fairview System Community Advisory Council's roster, please see Appendix H.

Fairview's Employee Resource Groups (ERGs)

ERGs are voluntary, employee-led groups that aim to foster a diverse, inclusive workplace. They focus on impacting four important areas: community connection, organizational impact, meaningful change, and people development. ERGs supported the CHNA process by providing feedback and suggestions and supporting dissemination and recruitment of the data and engagement approaches. There are currently nine ERGs representing different affinities.

Patient Family Advisory Councils

Patient Family Advisory Councils bring together patient and family advisors along with staff to share insights and experiences to help Fairview improve. These committees help validate the current state, understand existing obstacles, and test ideas to overcome those barriers. During this CHNA cycle, our Patient Family Advisory Committees consulted on ways to approach community conversations, specifically our Town Halls.

Data components

The process of centering community voice enables us to use the CHNA process to bring the perspectives of the communities we serve back to the health system in an actionable format. By using the various data-gathering methodologies outlined below, we gain a better understanding of the top barriers and concerns among the people we serve. This process is also a crucial avenue for adding nuance, understanding how our communities' needs shift among different geographical areas, generations, and cultural communities.

Listening and learning sessions

Because listening to the perspectives of our community – a group that includes community members, patients, and Fairview employees – is crucial to our ability to achieve our 10-year vision of increasing community health equity, Fairview has held community listening and learning sessions through the HOPE Commission since 2020. These sessions hold a mirror to Fairview, assessing where we are today and helping us understand how we can make lasting change. Sessions were held in 2020 to hear from employees, in 2021 and 2022 to hear from patients, and in 2023 and 2024 to hear from community members.

In June 2022, after identifying a gap in participants from previous listening and learning sessions, we expanded these listening and learning sessions to include patients with limited English proficiency. Sessions were held in Somali, Spanish, Hmong, Karen, and American Sign Language. Prior to these sessions, there were limited mechanisms for patients with limited English proficiency to provide feedback about the care they were receiving. This series was an effort to bring more voices to the table and create inclusive opportunities for patients to express their needs and concerns.

Systemwide virtual conversations

We held a series of **systemwide virtual conversations** focused on the priority need healing, connectedness, and mental health and what that specifically looks like for youth (April 2024), aging adults (March 2024), and Indigenous populations (June 2024). These conversations were open to all, and their goal was to collect and share learnings and resources with participants. The conversations included presentations from community partners about their work, followed by small group discussions that provided valuable perspectives informing our understanding of population-specific needs, strengths, and future state visioning tied to healing, connectedness, and mental health.

See Appendix I to learn more about the presenters from each virtual conversation.

CHNA surveys

To gather input from a broad set of stakeholders on local strengths and the top needs of communities each of the respective stakeholders serves, we developed two aligned, but distinct, **surveys**. The surveys gathered feedback about:

- Patient and community members' top barriers to care, social determinants of health needs, and social needs.
- The unique barriers and assets for patients in one of our priority populations (racial or ethnic populations experiencing health disparities and people experiencing poverty).
- Barriers that providers and community partners face in responding to the social determinants of health-related needs of patients as well as existing assets and resources available.

The surveys were distributed to care team members[vi] and partner organizations, including faith leaders. Surveys were administered from mid-February to the end of March. We heard from 472 individuals across our hospital communities and our health system, with 296 responses from care team members and 176 responses from community organizations.

Of the community organizations that responded to the survey, over half offer their services in languages other than English. Over half reported that most of the community members they serve identify as Black/African American, and about one-third identified that most of the community members they serve identify as Black/African, Asian, Native American or Alaska Native, and/or Hispanic, Latine, or Spanish origin.

Most organizations also responded that they serve youth, older adults, families, low-income households, and women and children, with one-third offering services specifically to new immigrants.

Community Health and Healing Summit: Celebrating Culture, Building Connections, Guiding Action

The Community Health and Healing Summit, held in July 2024, aimed to propel our 10-year vision for a healthier Minnesota forward. The summit was a collaborative event bringing stakeholders together to work collectively on prioritizing needs and barriers to health in our communities. It blended the power of community and cultural healing with activities designed to collect participants' insights to not only shape our priorities but to actively drive positive change in our communities.

Participants engaged in several activities throughout the day to provide local context and nuance for each of the priority need areas and participated in a voting process designed to prioritize the highest-impact barriers within each of the priority needs. Attendees also participated in a health equity timeline activity to identify occurrences through history that impact the current state and contribute to or help to address health inequities.

Stakeholder interviews

For the past several years, we have engaged in in-depth discussions with key stakeholders to gain deeper insights into specific issues related to community health and health equity. The goal of conducting these conversations is to explore nuances, understand complexities, and gather stories that will help us understand unique local and cultural barriers to the care and health of patients. It also helps us understand the barriers that make it more difficult to respond to those needs, and potential solutions to those barriers, from a variety of care team members' perspectives. For this assessment cycle, we focused our efforts on conducting interviews with care team members across the health system.

In 2021, we conducted key stakeholder interviews with social workers and registered nurse care coordinators, two groups that work closely with cancer patients and are familiar with the barriers patients typically experience. We developed a protocol, and a social work intern and a public health intern conducted the interviews from August 2021 to March 2022.

From May to July 2024, we conducted stakeholder interviews with various Fairview care team members in both acute sites and clinics, including nurses, physicians, schedulers, social workers, care coordinators, and clinic managers. The interviews were guided by the results of our CHNA survey and aimed to gather more in-depth information and stories about the top barriers that had showed up most frequently during the survey.

Facilitated conversations

We conducted a variety of facilitated conversations across the health system, a few examples of which are summarized in this section. The goal of these activities is to gain a fuller, more nuanced picture of topic-specific or population-specific perspectives over time. By holding these conversations on an ongoing basis, we ensure that our assessment process and our aligned programmatic or initiative-related work is responding to and engaging with communities in real time.

Food is Medicine community conversations: As a part of our Food is Medicine initiative, we partnered with community-based organizations to host a community conversation in each hospital's service area. The goal was to learn more about the community's needs and strengths related to access to healthy food and the role of Fairview as a healthcare provider. In the fall 2023, we held eight Food is Medicine community conversations across different hospital geographies that were attended by 75 organizations representing sectors across the food scape including food shelves, farmers, social services organizations, schools, and municipalities.

Town halls: In November and December 2023, we hosted five town hall sessions that were open to the public and geared toward local government relations offices, the business community, community-based organizations, trade groups, civic groups, and rotaries. Each town hall provided an opportunity for community members to receive updates from Fairview, participate in a question-and-answer session with Fairview leaders, and engage in discussions regarding barriers to health and trust in healthcare organizations.

Ongoing program and partnership conversations: Through ongoing partnership and programmatic conversations, we are vetting and refining our understanding of the identified priorities and the responses that would best address them. As a foundational part of program planning and evaluation, Community Advancement staff members are continuously soliciting feedback from community partners and program participants. We capture this information on an ongoing basis and use it to provide valuable context, driving insights into the needs of the communities we serve.

Primary data methods

Fairview staff developed standardized tools, processes, instructions, protocols, and training for facilitators, interviewers, and note takers. We compiled, cleaned, and analyzed all primary data. A note taker captured all community input, and when possible, conversations were also recorded.

Secondary community data

Claritas is a widely used national demographic estimation 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 based on data prepared for the current year, and projections are prepared for dates five years in the future based on the United States Census, the American Community Survey, and other data sources. This demographic data is used across various industries to understand population trends and their implications for business strategies and initiatives.

Spark Maps is a paid subscription that provides mapping and assessment tools that include a large database of indicators, data cleaning, benchmarking, and contextual information. Spark Maps is designed to support community organizations in tackling broad assessments of all aspects of communities, such as economy, environment, health, and housing, to gain insight and understanding into the communities they serve. It brings together publicly available data from over 100 sources, among them the American Community Survey, the United States Centers for Disease Control and Prevention, the Behavioral Risk Factor Surveillance System, and the United States Department of Agriculture Access Research Atlas. Spark Maps was developed by the University of Missouri Extension Center for Applied Research and Engagement Systems.

The **Bridge to Health Survey** has been an important source of data on the health status of adults in northeastern Minnesota and Douglas County, Wisconsin, for more than two decades. The survey is conducted every five years, with the last survey administered in 2020. The survey provides representative local information on key health indicators that allows for county and community-level analysis. The Bridge to Health Survey is a collaborative effort involving organizations across the region representing public health, hospitals, clinics, health systems, health plans, nonprofit organizations, government agencies, foundations, and higher education institutions.

The **Minnesota Student Survey** is one of the longest-running youth surveys in the nation. It is a triennial survey that began in 1989. The data used in this report is from 2019. The survey is an anonymous, statewide, school-based survey conducted to gain insights into the world of students and their experiences.

The **Area Deprivation Index** (ADI) is based on a measure created by the Health Resources and Services Administration over three decades ago, and has since been refined, adapted, and validated to the census block group neighborhood level by Amy Kind, MD, PhD, and her research team at the University of Wisconsin – Madison. It allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest (e.g., at the state or national level). It includes factors for the theoretical domains of income, education, employment, and housing quality. It can be used to inform health delivery and policy, especially for the most disadvantaged neighborhood groups. The ADI is publicly available on the Neighborhood Atlas website.

Health Trends Across Communities in Minnesota (HTAC) uses information from electronic health records to help fill gaps in the information available to health professionals, organizations, policymakers, and community members to promote health in Minnesota. HTAC is a collaboration among health systems, public health departments, health organizations, and health plans in Minnesota. HTAC uses

summary reports from electronic health records on a range of chronic, behavioral, and mental health conditions. The information comes from 11 health systems that make up the Minnesota Electronic Health Record Consortium (MNEHRC). Information from the MNEHRC represents approximately 90% of healthcare for Minnesotans, which makes HTAC a powerful tool to describe the health of many communities.

Minnesota Department of Health, County Health Tables were used to look at 2020 county-level top causes of death and premature death.

Secondary quantitative data methods

We conducted a broad examination of our quantitative data sources, focusing on indicators related to social needs and social determinants of health at a national, state, and community level. We determined where indicators at the community or county level differed from the state's averages. We also analyzed cause-specific death and premature death rates to inform our social determinants of health framing from a health condition perspective.

Prioritization process

As we are continuing our commitment to address the identified the priority need areas for our 10-year transformation efforts identified during our 2021 CHNA process, we next seek to better understand the factors that stand in the way of addressing these needs. To gain a clear picture of the problems and barriers that make these priority need areas so difficult to address, we turned to our community. We used the CHNA survey results and consulted with our local community advisory committees and system community advisory council, as well as our Community Advancement team members, to prioritize 10 barriers for which Fairview, in our role as a health system and anchor institution, could best show up in these need areas. To see a list of the top 10 barriers identified for prioritization in each priority need area, please go to Appendix J.

Next, we held the Community Health and Healing Summit in July 2024, during which community members from all our hospital and medical centers' service areas helped to narrow the list of barriers further:

- First, summit attendees voted for their top five most impactful barriers, noting their local area as well.
- Then, participants worked in small groups composed of people from different localities to form consensus on the top three barriers to addressing each priority need from a systemwide perspective.
- Small groups also provided additional context around the top barriers to understand the details and specifics of the nuances of the top barriers.

Finally, as a part of Fairview's prioritization process, as we transition into implementation strategy and action development, we will consider the health system's perspective as well as the community's perspective.

- Where do we already have effective programs that are generating momentum in these areas?
- Which areas best align with Fairview's existing priorities, including health equity?
- In which areas do we have the ability to contribute resources and expertise to address these barriers in priority need areas?

Defining our priority needs

We continue to believe that to have the greatest impact on our communities, we need to take a targeted approach. By focusing on specific issues and communities, we can understand and begin to address the root causes of health inequity in a more meaningful way. Our 2024 CHNA resulted in a reaffirmation, and better understanding, of the significant barriers that make our three priority need areas so difficult to address. We used these barriers to refine and better define the priority needs.

Based on our improved understanding of the needs and conversations with advisory groups, we have adjusted the title of one of our priority needs from 2021.

- Healing, connectedness, and mental health → Cultivating trust, belonging, and healing.

Although this change removed Mental Health from the title of this priority, we will lean into accessing mental health services as a part of the priority need "Navigating and accessing care and resources".

The tables below describe the primary barriers that stand in the way of improving priority needs across the health system. We identified these barriers through a deliberate listening, voting, and consensus-building processes with community and internal stakeholders. To develop each barrier's description, we synthesized the variety of unique concepts we heard around each barrier, captured in our qualitative data during this assessment process. Our more nuanced understanding of these barriers will help inform and guide our implementation planning and action plan development.

Priority need: Accessing and navigating care and resources

Individuals and communities struggle to access and navigate the resources they seek to support their unique health and well-being. System complexity, co-occurring health and mental health issues, and lack of coordination across entities make it difficult and cumbersome to access information and care. Provider shortages, lack of culturally responsive providers, and cost of care especially for under- or uninsured community members further exacerbate access challenges. Furthermore, many gaps in service exist, and services that are available are not always appropriate for or trusted by populations.

Barrier	Description
Access to care	refers to the significant obstacles that prevent timely and effective medical attention, such as long wait times, provider shortages, not enough time spent with providers, excessive paperwork, and scheduling difficulties.
Complexity of health systems and need for care coordination	refers to the challenges many patients, especially vulnerable adults, face as a result of the healthcare system's complexity, including inadequate follow-up care, difficulties in scheduling appointments, and confusion about insurance coverage. Healthcare's fragmentation often results in a lack of clear communication among providers, few opportunities for patient advocacy, and insufficient navigation support, leaving patients uncertain about their care plans and where to seek assistance. It includes complicated documents, lack of information around navigating the basics, such as who to call, how to schedule an appointment, how to use electronic applications such as MyChart, and where care for specific issues is located.
Co-occurring or intersecting conditions and contexts	refers to the challenges that arise when multiple issues – health conditions, mental health, poverty, and historical trauma – are interconnected and exacerbate each other, making it difficult to seek support and effective treatment. The interconnectedness of these conditions highlights the need for stable housing and integrated care that addresses multiple unresolved

	issues, while recognizing the impact of historical trauma and external factors on individuals' willingness to seek help.
Cost of care and insurance	highlights the importance of having affordable healthcare solutions that enable individuals to receive necessary treatments and services without financial strain. It refers to issues such as cost transparency, insurance coverage, and the lack of availability of low-cost clinics.
Mental health care and services access challenges	refers to challenges in accessing timely and culturally relevant mental health care, including long wait times, high costs, and a shortage of diverse providers. It also includes a lack of consistent communication between mental health and primary care services, resulting in problematic transitions between levels of care. Patients may experience uncertainty about whom to contact and what mental health resources and supports are available, which can affect continuity of care and support after discharge from mental health facilities.
Transportation	refers to the difficulties individuals face in getting to medical appointments and services due to challenges such as the lack of reliable public transportation, high costs associated with travel and parking, and concerns about public transit safety and accessibility.

Priority need: Addressing structural racism and barriers to equity

Individuals and communities are experiencing differential access and assets due to historical and ongoing structural racism, discriminatory policies, and bias. The social determinants of health as well as individual risk factors contribute to disparate outcomes with care, resources, and opportunity, undermining the ability of all groups to achieve optimal health and wellbeing. Communities are calling for conditions that strengthen their capacity and center their priorities; institutions have a responsibility to share power and recognize marginalized voices in decision-making processes.

Barrier	Description
Community resources	refers to the difficulties individuals face in accessing support due to age restrictions, complex navigation and enrollment processes, stigma, and the lack of culturally relevant and trauma-informed services. Challenges in reaching marginalized individuals, language and cultural barriers, and the absence of centralized updated resource directories make these barriers worse, all of which contribute to a lack of awareness of available resources within the community.
Financial	refers to the challenges posed by economic inequality, generational poverty, and the high cost of living, which limit access to necessary services and contribute to ongoing financial instability. Stagnant wages, unlivable incomes, and the stress associated with managing basic needs exacerbate these barriers, affecting families' ability to make informed financial decisions and perpetuating a cycle of poverty that hinders equitable healthcare access and diminishes overall health.
Food access and food justice	refers to inconsistent access to affordable, healthy food and the limited availability of resources such as certified commercial kitchens and land for food production. Restricted hours for food shelves, poor communication among food networks, and insufficient funding compound these challenges, all of which limit the ability to address food-related health disparities and ensure equitable access to nutrition.
Housing	refers to the challenges individuals face in securing safe, stable, and affordable living conditions, which are foundational to overall health and wellbeing. Issues such as housing insecurity, homelessness, long wait lists for

	senior housing, and limited age-friendly options, combined with high living costs and a lack of transitional resources, significantly hinder access to necessary services and exacerbate disparities in health, especially for vulnerable populations like children, seniors, and unhoused individuals.
Marginalization and unheard voices	refers to the systemic exclusion and underrepresentation of Black, Indigenous, and People of Color, LGBTQIA2S+, and other minoritized communities, limiting their access to culturally relevant services and safe spaces. The lack of adequate community engagement, insufficient resources, and the perpetuation of information silos compound this marginalization, contributing to the invisibility of these groups and hindering their ability to express their voices and needs within society.

Priority need: Cultivating trust, belonging, and healing

Individuals and communities are experiencing an acute sense of polarization, breakdowns in trust of others as well as institutions, and increasing social isolation, especially post-pandemic and with distinct challenges across geographies. Historical trauma and discrimination further compound these issues. This results in diminished social cohesion, increased anxiety or stressors, and lack of opportunities and spaces for connection and healing.

Barrier	Description
Connection	refers to the impact of social isolation, lack of safe communal spaces, and diminished social support, which hinders community engagement among community members and with the health system. The absence of intergenerational activities, cultural spaces and a need for connection between community organizations further deepens this feeling of community disconnection.
Culturally appropriate healing	refers to the need for respect and incorporation of diverse cultural practices and address the specific needs of communities. It also refers to the lack of affordable holistic wellness options, relevant spiritual resources, and safe spaces for historically marginalized communities to come together.
Fear and lack of trust	refers to patients' doubts about the healthcare system due to past negative experiences, discrimination, and inadequate communication. Inconsistent provider relationships, unmet expectations, and fears of being misunderstood or mistreated intensify these doubts, leading to decreased willingness to seek care. It also refers to broader historical and systemic distrust of government and institutions, particularly among undocumented populations who fear exposure and discrimination. The perception that systems prioritize financial outcomes over mission exacerbates this mistrust, making individuals hesitant to provide identifying information and uncertain about the safety of accessing essential resources.
Historical and generational trauma	refers to the enduring impact of past and ongoing systemic injustices, which perpetuate mistrust and stigma, creating significant barriers to accessing care and negatively impacting people's health.
Population-specific needs/considerations	refers to the challenges of addressing the unique needs of particular groups, such as seniors, veterans, children and youth, LGBTQIA2S+, rural area residents, and new immigrants. A lack of tailored resources and understanding of these groups' specific requirements can hinder effective communication, support, and services.

Priority populations

We have woven our current understanding of how priority needs manifest for our priority populations and other specific populations into the discussion and contextual details on barriers for each of our priority need areas and will continue to seek to deepen our understanding through ongoing assessment and partnership.

The priority populations are across the lifespan, from rural to urban:	
Racial and ethnic populations experiencing health disparities	People experiencing poverty

Additional local barriers for Grand Itasca Clinic and Hospital community

While Grand Itasca is part of a larger health care system, it is unique in the populations it serves, its community assets, the built environment, and the social conditions locally. As such, we identified a few top barriers to effectively addressing priority needs that were specific to the Grand Itasca community, in addition to the barriers that apply system wide. We will use these local barriers as additional context to guide and inform our local responses to best meet the community's needs.

Accessing and navigating care and resources

Barrier	Description
Substance use services	refers to the difficulties individuals encounter when attempting to access addiction treatment, including scarcity of programs, limited availability of substance abuse services, and a lack of diverse providers.
Specialty care access	refers to the challenges individuals face in accessing specific types of medical services, such as eye care, dental care, foot care, and pain management. These challenges are often due to limited availability of specialty providers, issues with insurance coverage, and other accessibility concerns, which can prevent patients from receiving the comprehensive care they need for managing their health effectively.
Knowledge and education	refers to the challenges individuals face in understanding and managing their health due to gaps in knowledge, limited availability or awareness of health resources, health literacy levels, and difficulties in navigating complex medical information. It also refers to limited or disparate nature of educational resources that are often not culturally relevant or widely available which causes challenges in accessing information and understanding mental health services. These challenges can lead to confusion about when and how to seek care, misunderstandings about health insurance coverage, and a lack of access to crucial educational resources, impacting overall health outcomes and the ability to make informed health decisions.

Addressing structural racism and barriers to equity

Barrier	Description
Transportation	refers to the challenges individuals face in accessing community resources, getting to and from work, and transportation to other basic needs such as

	grocery stores, social activities, and healthcare due to unreliable transportation options or limited access to bus lines. This also includes transportation barriers that keep volunteers from serving an important role in many nonprofit organizations' daily operations which strains the organizations' ability so serve community. Transportation issues are particularly problematic for older adults, persons in rural communities, and those without vehicles, making it difficult to reach necessary services and further exacerbating inequities in care.

Cultivating trust, belonging, and healing

Barrier	Description
Community social conditions	refers to societal factors, such as division, stigma, and lack of welcoming environments, that hinder individuals from seeking or receiving necessary opportunities for healing, connectedness, and mental health. Insufficient community spaces, gatherings, and programming, compound these barriers, exacerbating feelings of isolation and the perpetuation of mental health issues across all age groups.

Needs not addressed

During our assessment process, we worked to identify the most significant, most pressing barriers to increased community health equity focused on the three specific priority need areas outlined above. This does not mean, however, that our efforts will only move the needle in certain narrow areas. On the contrary, we anticipate that by focusing on three interconnected, upstream priority need areas, our work will generate a ripple effect that will improve community health and health equity across many domains.

For example, during our community voice, data collection, and review process, we learned that many community members regarded certain health conditions as priority needs. Responding to health conditions and providing clinical care in a healthcare setting is the role of our hospitals and clinics. Because, in this community assessment, we are focusing on the social determinants of health and health equity, specific health conditions did not make the first round of prioritization of needs and thus, were not included. However, addressing upstream barriers to health equity will make it easier for every person to be happy, well, and access the care they need and deserve. This, in turn, will decrease health disparities and improve outcomes for all.

There are also barriers that arose tied to our priority needs that we will not be able to respond to in a targeted fashion during the current CHNA cycle. This list of barriers and health conditions, in alphabetical order, are:

- Alzheimer's disease
- Cancer
- Chronic liver disease
- Chronic lower respiratory disease
- COVID-19
- Diabetes
- Facilities/lack of space for community-based organizations
- Heart disease
- Hypertension
- Medication
- Organizational funding
- Physical environment
- Stroke
- Technology and internet
- Time
- Unintentional injury

Resources available to address

As Grand Itasca develops its CHNA implementation strategy, we will look to both internal and external resources to address the significant health needs identified through the process described in this report. Internal and external resources include existing initiatives, programs, and relationships, which are the foundation that the implementation strategy will be built. For additional details on programs, initiatives, and our partners, see the most recent CHNA Action Plan.

Fairview provides staff and facilitation for the programs or lends staff time and expertise to partner-led programs. Fairview also acts as backbone support for the collaboratives. The partners listed are engaged and supportive, contributing both capacity and expertise. Fairview resources include Grand Itasca Clinic and Hospital.

Fairview is also honored with ongoing relationships with partner organizations that intersect with us in a variety of ways. All of these partner organizations are critical resources to their local communities and are committed to addressing community need. For a complete list of Local Community Advisory Committee member organizations please see Appendix G. For a list of System Community Advisory Council member organizations please see Appendix H. To see the partners that support us and our communities in our health system's programmatic, initiative, and collaborative work as a part of the annual community health needs assessment action plan please see Appendix K.

Contract support

The Fairview team contracted with Loren Blinde, PhD of Writing Power, a copywriter and content strategist, on the writing of the report.

Partners that presented at the system virtual conversations were offered stipends for their time. This included: Annex Teen Clinic, University of Minnesota's Earl E. Bakken Center for Spirituality & Healing, Ebenezer, Minneapolis Health Department, and University of Minnesota's internal medicine division.

We contracted with Kumbe Healing to guide summit attendees through healing activities at our 2024 Community Health and Healing Summit.

Adoption by Board of Directors

This report was adopted by the Grand Itasca Clinic & Hospital Board of Directors on December 17th, 2024.

Evaluation of impact

To best evaluate our impact and track progress toward our anticipated impacts, we used a multitiered, tailored evaluation approach. We ground our work in understanding core information about our communities. This includes identifying and understanding the community need being addressed, the population or community being impacted, current and/or potential partners to work with to address the need, and the results we anticipate.

Community needs are determined in several ways. In addition to being determined through our formal CHNA process, we also respond to emerging needs brought to us by a community partner, by a public health agency, or through patient or community data showing significant health disparities. We have standardized several key measures to assess the degree to which we are meeting the needs of the CHNA priority populations, focusing our efforts on equity, and program quality. These measures are monitored and reviewed mid-year and end of year annually. A subset of established programs and initiatives are set up and supported for deeper evaluation. We are guided by the Centers for Disease Control and Prevention model for program evaluation to establish primary outcomes, process measures, and demographics.

We evaluate program impact and success from a variety of approaches using both qualitative and quantitative data. For many of the program outcomes shared below, we are reporting our reach or outputs. We offer a variety of programs that vary along a spectrum from low-touch/high-count to high-touch/lower count. In other words, the effort and impacts of the programs are not the same. This is a purposeful approach. We want to offer a variety of programs and to “right-size” programs to address the needs.

In the following evaluation of impact tables, we share the impacts that Grand Itasca led and/or collaborated on locally, as well as the impacts that occurred across the health system that Grand Itasca participated in partnership with other Fairview hospitals and medical centers.

grand itasca Clinic & Hospital | Part of Fairview Health Services

Grand Itasca Clinic & Hospital CHNA three-year evaluation of impact

Priority need	Navigating and accessing care and resources
Implementation strategy	Addressing the social determinants of health through the creation and expansion of programs; initiatives; collaborations; research; and policy, system, and environmental change work.
Anticipated impact	Remove barriers to care by providing community-placed care, co-located services, and navigation supports that address cultural and language barriers.

Actual impact

Community-based clinical services

Grand Itasca helps to provide community-based clinical programs. A partnership with the YMCA and the University of Minnesota – Duluth (UMD) School of Pharmacy brought a health fair to the community in 2022 and 2023, with plans to do so again in 2024. At the health fair, UMD pharmacy students provided free screenings for glucose, bone density, and blood pressure. Grand Itasca provided staff to assess grip strength and educate attendees about breast health. Other services at the health fair included memory tests, balance assessments, mental health resources, and programming for older adults.

- In 2022 and 2023, 78 community members participated in the free health screenings provided by the UMD pharmacy students.

Project Care Free Clinic partnership

Grand Itasca provides free lab and radiology services to patients of the Project Care Free Clinic. Many of the physicians and nursing volunteers at Project Care are part of the Grand Itasca staff.

- In 2022 and 2023, 50 Project Care patients had lab or imaging services done at Grand Itasca, with services valued at $34,906.

Bike helmet events

Grand Itasca participated in the Bike Rodeo hosted by the Forest History Center in 2023. Two members of our emergency department helped to fit bike helmets and handed out information about proper helmet fitting. Three bicycles were also donated as giveaway prizes.

The YMCA encourages families to get up, get out, and get moving at their Bike Rodeo and Family Picnic. This event allows families to enjoy the YMCA's bike fleet or bring their own bikes, with free bike inspections, a bike obstacle course, games, and bounce houses, along with a free hot dog dinner. In 2022 and 2023, Grand Itasca provided materials for proper helmet fittings and has given away bike helmets, as well as held drawings for bicycle giveaways.

- In 2023, 91 kids visited our table to learn about proper helmet fitting. This event has been hosted by the YMCA for several years but was discontinued in 2024 due to reduced funding.

Educational presentations to local organizations

Grand Itasca provides speakers to various events throughout the community. From infection control to how to lift clients properly, we can provide many topics to community organizations that request our expertise.

- In 2024 Grand Itasca provided five educational presentations to local organizations.

Growing Up Education

Grand Itasca partners with ISD 318 and provides education to its 5th graders about changes happening as they are going through puberty. A male provider speaks to the boys and a female provider speaks to the girls, offering them opportunity to ask questions.

- In 2022 Grand Itasca provided Growing Up Education to 251 students.

Minnesota Immunization Networking Initiative (MINI)

MINI is a multisector community collaboration that initiated the community clinical care approach, which has since expanded. MINI provides free vaccinations and education to the uninsured, underserved individuals, and communities facing health disparities in the greater Twin Cities area as well as Fairview's service areas in Grand Rapids and Hibbing.

- Across the system, the MINI team hosted 1,571 vaccination clinics from 2022 to 2024 at which 27,093 free COVID-19 vaccine doses,19,246 free flu shots, and 1,907 free mpox and MMR/Tdap shots were administered.

In 2023, MINI was invited to submit an article on its approach and successes, with a focus on partnerships with public health, to the New England Journal of Medicine. MINI's success continues to build the evidence base for community-placed and community-centered approaches.

Priority need	**Navigating and accessing care and resources**
Implementation strategy	Addressing the social determinants of health through the creation and expansion of programs; initiatives; collaborations; research; and policy, system, and environmental change work.
Anticipated impact	Develop, grow, and sustain programs, educational offerings, partnerships, and initiatives, address barriers related to navigating and accessing care and resources.

Actual impact

Walk with Ease

The Walk with Ease curriculum was developed by the Arthritis Foundation and is offered to encourage community members to encourage them to stay active.

- From 2022 to 2024, Grand Itasca hosted three Walk with Ease sessions, attended by 31 participants.

Living Well with Chronic Conditions

Grand Itasca also provides virtual Juniper classes for the community in partnership with ElderCircle. This program is offered at no cost. These are evidence-based, small group wellness classes that provide tools for managing chronic health conditions. The following classes are offered: Living Well with Chronic Conditions, Living Well with Chronic Pain, and Living Well with Diabetes.

- From 2022 to 2024, Grand Itasca offered six classes with 26 total program completers.

System virtual educational offerings

Fairview developed and adjusted educational offerings in response to community-identified needs and feedback. Programming included:

Health Across the Lifespan This nine-part virtual series addresses specific health and wellbeing issues experienced during the three stages of life (early years, early adult, and older adult), such as cancer, grief and loss, suicide prevention, and others.

- This series was held annually from 2022 to 2024, with 23 unique classes and 767 total attendees.

Free sports physicals

Grand Itasca offered free sports physicals for high school and college-age students. This service is promoted to organizations working with families that may experience barriers accessing healthcare before it is shared publicly, as there are a limited number of appointments available.

- From 2022 to 2024, 107 students obtained free sports physicals.

Foot care access

Due to a shortage of foot care services in the area, Grand Itasca began to provide this service at no cost to patients in fall 2023.

- In 2023 and 2024,152 people were served.

Memorial Blood Center

Grand Itasca supports blood donation from our employees through a partnership with Memorial Blood Center.

- From 2022 to 2024, there were 11 events where 129 employees donated blood.

Support groups

Diabetes support group Grand Itasca's diabetes educator facilitates a support group for those in our community with diabetes, along with their families. Meetings average five participants.

- From 2022 to 2024, there were approximately 150 community member interactions with a diabetes educator, at no cost to the patient.

Cancer support group Grand Itasca offers a cancer support group, in partnership with two local organizations, the Itasca County Breast Cancer Support Group and the Itasca County YMCA. The collaboration began in May 2023. Grand Itasca provides a monthly educational newsletter for the group. Meetings average five participants.

- In 2023 and 2024, there were approximately 75 community member interactions connected with the cancer support group.

Opioid response efforts

In September 2023, Grand Itasca Clinic & Hospital received a $1.5M Health Resources and Services Administration Rural Communities Opioid Response Program grant to use over three years to address the need in our community to support individuals struggling with opioid use disorder concerns, and more specifically infants, mothers, and their families impacted by Neonatal Abstinence Syndrome (NAS). The overall goal of the grant is to reduce the incidence and impact of NAS in our community by improving clinical care and social services as well as cultural and family supports. To help achieve this, our grant supports a consortium and working group composed of both community stakeholders and Grand Itasca staff. In addition, part of the grant funds will be used to start medications for opioid use disorder (MOUD) services at Grand Itasca with the support of a community health worker and a registered nurse substance use disorder care coordinator. Opioid response efforts supported by the grant include:

- MOUD/opioid use disorder trainings: 17 educational trainings offered in the first year.
- MOUD (suboxone) prescribers: There were zero MOUD prescribers prior to the start of the grant, and the number has grown to eight MOUD prescribers at Grand Itasca. Within five months of hiring a community health worker and a registered nurse substance use disorder care coordinator, we opened MOUD services to our community.

Priority need	Navigating and accessing care and resources

Implementation strategy	Creating community engagement infrastructure that builds trusting partnerships and enables community voice to inform and influence the institution.
Anticipated impact	Build and expand feedback systems for patients and community members; embed process improvement in the health system's response to community voice.

Actual impact

Local and system community advisory groups

Local Community Advisory Committee Grand Itasca's Local Community Advisory Committee meets throughout the year to provide input, insight, and local expertise. We conducted an inventory of the current member organizations' focus areas and identified gaps in expertise and representation of our CHNA's priority populations. We continue to intentionally recruit participants to expand representation on the committees, focusing on these gap areas. In 2024, we developed a newsletter to communicate updates and opportunities to committee members more regularly.

Fairview System Community Advisory Council The Fairview System Community Advisory Council supports development of the CHNA and the health system's community health strategies. By developing reciprocal relationships, building capacity, and strengthening trust, the council assists the health system in understanding, responding to, and meeting community and patient needs through collaboration. Throughout 2024, Fairview made a concerted effort to expand the membership of its System Community Advisory Council, resulting in increased representation from local community advisory committees as well as organizations that work with racial and ethnic groups experiencing health disparities.

Healing, Opportunity, People, and Equity (HOPE) Commission listening and learning sessions

In 2022, as a part of the HOPE Commission, we hosted four listening and learning sessions for patients who speak primarily a language other than English. Sessions were hosted in Karen, Hmong, Spanish, and Somali. These sessions were the first of their kind for Fairview, and results included lessons about how to best connect with, listen to, and learn from our patents and community members who speak primarily a language other than English. In 2023, we expanded our patient listening and learning sessions to include a session for patients who use American Sign Language.

Supporting local community-based organizations and collaboratives

Grand Itasca staff members collaborate regularly with community organizations such as Second Harvest Northland, Itasca County YMCA, ElderCircle, Kiesler Wellness Center, NAMI, ISD 318, the Pillars of Grand Rapids, and many others. These ongoing relationships strengthen and increase opportunities to improve resources and processes in our community.

Priority need	Healing, connectedness, and mental health
Implementation strategy	Addressing the social determinants of health through the creation and expansion of programs; initiatives; collaborations; research; and policy, system, and environmental change work.
Anticipated impact	Develop, grow, and sustain programs, educational offerings, partnerships, and initiatives, address barriers to healing, connectedness and mental health.

Actual impact

Welcoming Communities of Itasca County

Welcoming Communities of Itasca County was a transformational change effort to make Itasca County a more welcoming community. At training sessions for this effort, dedicated community members learned to drive more equitable outcomes, inclusive environments, and experiences for community members. Grand Itasca was part of the training held in both Grand Rapids and in Deer River.

Code Lavender

Code Lavender was offered to our employees starting in 2022. Our staff faces stress each day, with staff shortages and the day-to-day demands of their jobs. Grand Itasca wanted to show appreciation to employees and encourage self-care. We offer Code Lavender with *oshibori* (warm towels), essential oils, chair stretches, and M Tech hand massage. The employees take 10 minutes out of their workday to experience Code Lavender and learn techniques of self-care.

- From 2022 to 2024, more than 250 employees participated in a Code Lavender event.

Mental health educational events

Grand Itasca works closely with the National Alliance on Mental Illness (NAMI). Grand Itasca's community health coordinator is part of NAMI's education committee, and NAMI staff has brought several educational presentations to our community. In 2023, NAMI facilitated a community discussion to increase awareness about the mental health crises that can escalate when someone is kept waiting in the emergency department, due to a shortage of beds in mental health facilities across the state. An emergency department provider was part of the discussion panel, as well as members from several other relevant community organizations. Also contributing to the discussion were Grand Itasca's emergency department director and manager. There were 42 in-person attendees and eight community members who joined the event virtually. Participants developed important connections and understanding through this event.

Following this event, Grand Itasca partnered with NAMI to renovate a patient room in the emergency department that is designated for patients in a mental health crisis. Partnering with a local artist, the room was transformed to create a more inviting, less chaotic, and calming atmosphere.

Grand Itasca also participated in The Good Life: A Mental Wellness Conference, hosted by Minnesota North College – Itasca in 2024. In addition to hosting a table, a Grand Itasca emergency physician participated in the panel discussion, "What do you do if someone is not ok?"f Grand Itasca continues to work with local organizations, finding ways to improve mental health access and processes in our community.

Safe Routes to School

Safe Routes to School is an initiative that encourages physical activity for school-aged children. Grand Itasca partnered with the organization twice by sending a team that walks kids to a designated pickup spot after school. Bikes have also been an option at some of the events. Grant funding for this program ended in June 2024.

- From 2022 to 2024, 13 students participated.

Support Within Reach "Chalk Walk"

Chalk Walk was a family-friendly event designed to share community resources. Information from participating community organizations was provided, and kids did a chalk drawing at each booth as their parents or guardians learned about the available resources. Those who completed all the drawings were entered into a raffle for fun prizes. Grand Itasca supported and attended this event, which was hosted by Support Within Reach, but the organization did not continue the event in 2024.

Community Connect

Community Connect is a community event hosted by Itasca County Health and Human Services, area churches, and nonprofit agencies with the goal of connecting people with community resources. Grand Itasca's diabetes educator was on site for the event, providing blood sugar checks and offering diabetes education. Grand Itasca supports and attends the event annually.

Mental health training and educational offerings

Psychological First Aid (PFA) PFA is a two-hour, evidence-informed training for professionals as well as the broader community. Participants learn how to support individuals' healthy recovery following a traumatic event, public health emergency, natural disaster, or personal crisis. The curriculum integrates public health, community health, and individual psychology, drawing upon skills participants often already have.

- From 2022 to 2024, in the Grand Itasca community, there were five classes offered with 100 participants attending.

Connection is Cure initiative

Connection is Cure aims to build trust through strengthening social connections, centering linguistic and cultural diversity, and bridging silos across our hospital system and communities to transform medical practice.

As part of Connection is Cure, we participated in the Institute for Healthcare Improvement's Trust Prototyping Network. We were one of eight healthcare organizations nationwide that were part of a 10-month project to test approaches for improving trust in healthcare systems. Our organization is focusing on a project to identify and remove system-level equity barriers for interpreters and patients with limited English proficiency. The goal is to improve patient outcomes, customer experience, and care team cohesion.

Priority need	**Healing, connectedness, and mental health**
Implementation strategy	Transforming internal structures to create an antiracist and inclusive environment and to build community health by building wealth.
Anticipated impact	Build internal and external processes and structures to provide spaces that are safe and welcoming to all, responsive to community needs, and based on a culture of inclusion.
Actual impact	

HOPE Commission

The HOPE Commission is a multiyear transformational change effort to drive more equitable outcomes and inclusive environments and experiences for our community members, patients, and employees.

Employee resource groups (ERG) continued to expand and foster a diverse, inclusive workplace while focusing on development, leadership, collaboration, and relationships. There are now nine ERGs:

- Pride Alliance Group for Equity (PAGE)
- Black Initiative Network (BIN)
- Veterans Allies & Advocates (VAA)
- Facilitators of Unity & Strengtheners of Inclusivity of Nursing (FUSION)
- Asian Heritage Network (AHN)
- Cross-Cultural Leadership Network (CCLN)
- *Comunidades Latinas* for Engagement, Advancement, and Development (LEAD)
- Indigenous Healing Circle (IHC)
- Understanding Neurodiversity with Mentoring, Affirmation, Support, & Knowledge (UNMASK)

The HOPE Commission provided ongoing capacity building across the system for individuals and teams to participate in the Intercultural Development Inventory.

Fairview Health Services was named by Newsweek as one of “America’s Greatest Workplaces for Diversity” for 2023.

Three of Fairview’s hospitals were named high performers in providing equitable and inclusive care for LGBTQ+ patients and their families, according to Human Rights Campaign’s 2024 Healthcare Equality Index.

Fairview Community Health and Wellness Hub healing events

In summer 2023, Fairview co-hosted a Heal the Healers Summit with Indigenous Roots Cultural Arts Center. The two-day summit welcomed more than 200 attendees for group learning sessions, rituals, seminars, and individual sessions with healers and professionals skilled in traditional healing modalities.

In summer 2024, we hosted a Community Health and Healing Summit. The day-long summit welcomed more than 100 attendees for group healing sessions, opportunities for networking and connection, and participation in developing a history and health equity timeline.

Native Health Equity Initiative

We reviewed and are working toward updating policies that impact patients' ability to participate in smudging and are promoting systemwide healing and spiritual policy conversations overall. We will be providing policy update training sessions at all acute care sites.

Priority need	**Addressing structural racism and barriers to equity**
Implementation strategy	Addressing the social determinants of health through the creation and expansion of programs; initiatives; collaborations; research; and policy, system, and environmental change work.
Anticipated impact	Develop, grow, and sustain programs, educational offerings, partnerships, and initiatives, to address structural racism and barriers to equity.

Actual impact

Center for Community Health Equity

The M Health Fairview Center for Community Health Equity was launched in August 2022. As a part of the center, we launched and built three social determinants of health initiatives:

- Food is Medicine (see page 36)
- Housing is Health (see page 37)
- Connection is Cure (for details on this initiative, see page 33)

Additionally, the center is developing population health equity initiatives, the first of which is the Native Health Equity Initiative (see details under "Native Health Equity Initiative" on page 34 and page 40).

Social determinants of health policy agenda In close partnership with Fairview's public policy team and partners from across the

organization, the center is advocating for our patients and community members at the Minnesota State Capitol. The goal is to advance policies that address the social determinants of health, such as access to healthy food and safe, affordable housing. For the past two years, the center has been building and leading initiatives to address the social determinants of health: Food is Medicine, Housing is Health, and Connection is Cure. The center's advocacy efforts are focused on these priority areas. Among its key accomplishments from 2023 to 2024, the center:

- Joined a coalition of health systems and community partners urging the Minnesota Department of Human Services to seek a federal waiver for Minnesota's Medicaid program. Known as the 1115 Waiver for Health-Related Social Needs, this federal waiver would help fund further investment in upstream supports.
- Signed on again as part of the "Partners to End Hunger" coalition, led by Hunger Solutions.
- Attended Hunger Day on the Hill, Homeless Day on the Hill, and American Indian Day on the Hill at the Minnesota State Capitol each year to educate legislators about the importance of supporting hunger relief programs, advocate for legislators to support efforts to end homelessness, and work to address disparities impacting our local communities.

Clinical and operational improvements: social determinants of health screening

In September 2023, Fairview implemented social determinants of health screenings at all primary care clinics to better identify and respond to patients' nonclinical needs. These screenings were extended to all acute care sites in August 2024.

Food is Medicine initiative

Food is Medicine's approaches are framed to increase health equity through focused efforts to serve patients who have been historically marginalized by providing culturally appropriate food options and reducing food insecurity in a manner that upholds dignity and empowers the local food system. Clinically, Food is Medicine enables providers to serve patients experiencing food insecurity through a menu of distinct programs comprising an innovative wrap-around approach. One or more of the Food is Medicine programs, a selection of which are described below, is available to patients in 43+ clinics and nine acute sites across the health system.

Shelf Stable Food Bags Several food-related projects at Grand Itasca made an impact for community members experiencing food insecurity. Second Harvest North Central Food Bank, now part of Second Harvest Northland (SHN), provides a consistent supply of food bags to patients seen in the clinic who meet criteria for food insecurity. The program started in September 2022.

- From 2022 to 2024, 354 bags were given to patients. A supply of food is stored securely onsite, through the generous funding of a Statewide Health Improvement Partnership grant, which was used to purchase a cabinet to store the food bags from SHN.

Supporting Second Harvest Northland Food Bank Grand Itasca also continues to send a team each month to volunteer at Second Harvest to help package food. Most foods come in bulk and need to be individually packaged.

- From 2022 to 2024, 338 volunteer hours were provided. A Grand Itasca director sits on the local board of directors for Second Harvest. Additionally, Grand Itasca is a sponsor of the annual Chef's Gala fundraiser for Second Harvest.

Healthy eating education Grand Itasca also offered a class in 2023 to educate community members about healthy eating. The class was done in partnership with the Grand Rapids Farmer's Market. Participants received weekly vouchers for free produce, along with weekly emails

containing healthy eating tips, recipes, and reminders. There was a midpoint in-person meeting featuring a cooking demonstration with a Grand Itasca physician. There were 13 participants, all of whom indicated they would participate again and/or share with friends and family.

Housing is Health initiative

The Housing is Health initiative aims to use the protective power of housing to support patients' health and build thriving communities. We approach this initiative by providing clinically connected programs, supporting community partnerships, contributing time and expertise to collaboratives, and working to impact policy.

Housing and Health Equity Fellowship We are proud to have completed the inaugural Housing and Health Equity Fellowship, hosted by the Greater Minnesota Housing Fund, which aimed to expand community investment by health systems to address the housing crisis in Minnesota. As an outgrowth of the fellowship, our health system helped launch Healthcare for Housing (HC4H), a collaborative consisting of seven health providers and payers. Fairview is also strengthening its advocacy role related to housing. We currently chair the policy workgroup for HC4H, participated in Homeless Day on the Hill, and submitted letters of support for multiple housing efforts.

Habitat for Humanity partnership Starting in 2022, Grand Itasca partnered with Itasca County Habitat for Humanity to find ways to support their work. Grand Itasca provided lunches for the week when workers were building a new Habitat home. The partnership went so well that Grand Itasca assembled their own work team and assisted with builds in 2023 and in 2024.

Childcare access in partnership with YMCA

Grand Itasca partnered with the Itasca County YMCA to address the shortage of childcare in our community. The YMCA has historically been one of the largest childcare providers in Itasca County, with 70 childcare spots available. In 2023, the YMCA sought to expand childcare services, in the hope of providing an additional 58 childcare spots. Grand Itasca chose to sponsor this expansion with a donation of $16,000, as adequate childcare is not only necessary for Grand Itasca employees, but also imperative to grow the workforce in our community. Families coming to the area need to know they will have the support they need.

Workforce development

High school career development Grand Itasca continues to look at ways to develop our local workforce by partnering with area schools. We partnered in high school career development programs/events, including Grand Rapids High School (GRHS) Career Day, GRHS Student Pathway program, Minnesota North – Itasca mock interviews, Greenway mock interviews, a summer internship, Iron Range SCRUBS camp, Greenway career expo, and Discover Health.

- From 2022 to 2024, we were involved with 30 career development programs.

Lake Superior college partnership Grand Itasca donated surgical instrument sets to Lake Superior College's surgical technologist program. Our surgical director is a member of Lake Superior's Surgical Technician Advisory Board.

Priority need	Addressing structural racism and barriers to equity
Implementation strategy	Creating community engagement infrastructure that builds trusting partnerships and enables community voice to inform and influence the institution.
Anticipated impact	Create sustainable structures to convene and engage community voice around addressing social determinants of health.

Actual impact

Center for Community Health Equity

Launched in August 2022, the M Health Fairview Center for Community Health Equity guides our philosophy around how we gather community voice and who we talk with as we learn how to tie the information gathered back into the organization. We celebrated the center's one-year anniversary with a three-day event welcoming over 250 people, where we offered free vaccinations, free blood pressure checks, and the opportunity to connect, network, and learn more about the center's work. The center also leads the Center for Community Health Equity Work Group, the meetings of which focus on strategic discussions on issues relevant to the center. The work group was comprised of representatives from across the health system.

Center for Community Health Equity Community Engagement Spectrum In partnership with the center, we developed a model of community engagement. The model defines how we approach community engagement, community voice, and community partnerships in our quest to advance community health equity. We will use this model to help guide the mechanisms through which we gather feedback, and the model has informed our 2024 CHNA.

Community voice

Fairview piloted a variety of community engagement approaches to determine best practices that lead to better, more authentic, community-centered experiences with bidirectional information sharing and learning:

- Fairview hosted eight Food is Medicine community conversations to help inform our approach, including one by Grand Itasca, during which we heard from 74 partner organizations. The conversations also served to convene food partners to increase opportunities for mutual awareness and collaboration.
- A series of three population-specific (youth, older adults, indigenous populations) virtual conversations focused on healing, connectedness, and mental health.
- In November 2023, we hosted a coffee and conversation session that was geared toward local government relations, business community, community-based organizations, trade groups, civic groups, and rotaries. The coffee and conversation session provided an opportunity for community members to receive updates from Grand Itasca, participate in a question-and-answer session with our leaders, and engage in a discussion regarding trust and barriers to health.

Backbone support for collaboratives

Staff from Grand Itasca provided leadership and collaboration to several organizations in the community. Staff members sit on boards for the Boys and Girls Clubs of Grand Rapids and Green Way, Second Harvest Northland, Itasca County YMCA, ElderCircle, and Lake Superior College. Staff members also collaborate regularly with organizations such as the Kiesler Wellness Center, NAMI, ISD 318, the Pillars of Grand Rapids, and many others.

Priority need	**Addressing structural racism and barriers to equity**
Implementation strategy	Transforming internal structures to create an antiracist and inclusive environment and to build community health by building wealth.
Anticipated impact	Using an antiracist approach, work to identify and eliminate racism by changing systems, organizational structures, policies, practices, and attitudes.

Actual impact

Twin Cities Gay Men's Chorus

Grand Itasca was a sponsor to bring the Twin Cities Gay Men's Chorus to Grand Rapids in January 2024. This event not only brought incredible musical talent to our community, but also brought awareness of and support for the LGBTQ+ community. Our support for all people, regardless of race, ethnicity, gender, age, ability, religion, or sexual orientation, extends beyond our walls into the community.

HOPE Commission

The HOPE Commission is a multiyear transformational change effort to drive more equitable outcomes and inclusive environments and experiences for our patients, employees, and communities.

Key successes included:

- The development of the Equity Strategy Office along with the creation of new roles to further embed equity across daily work and operations.
- Increased capture of race, ethnicity, and language data to be able to better identify health disparities, which led to targeted interventions to reduce healthcare disparities.
- Ongoing capacity building across the system for individuals and teams to participate in the Intercultural Development Inventory.

- Language access work, with 18 improvement efforts happening across the system.
- Improvement in breast cancer screening rates among Karen, Hmong, and Somali patients through six mobile mammography events. The success of these events led to a commitment to hold 48 events in 2025.

Native Health Equity Initiative

Building our engagement infrastructure involves engaging broadly with community but also increasing our capacity to engage with complex and intersectional groups. To that end, we are building a set of population health equity initiatives, one of which is the Native Health Equity Initiative.

- In September 2022, an Indigenous land acknowledgment ceremony honored the past, present, and future while recognizing the work our health system must continue to do to address the health equity issues affecting local communities. We also hosted the “Why Treaties Matter” exhibit from July to September 2022 at the Fairview Community Health and Wellness Hub.
- In 2023, a cohort of employees from across our system began work to advance health equity efforts in partnership with Native Americans and Indigenous communities. We facilitated six sessions to help our employees learn about the historical and current challenges faced by Native communities, connecting with key Native leaders and organizations about local priority issues, including healthcare. The sessions also engaged employees in working to improve experiences and outcomes for our Native patients, employees, and communities.
- We hosted a Native American and Indigenous-focused recruitment event at the Community Health and Wellness Hub.

Community Health Needs Assessment Section 501(r)(3) checklist

While we go above and beyond a checklist approach for our Community Health Needs Assessment, for readers who are looking for the areas where we speak to how we are meeting the specific requirements outlined in the Section 501(r)(3) checklist, we are identifying the pages where you can find that information below.

Documentation of CHNA written report requirements	Page number
A definition of the community and a description of how the community was determined.	9-10
A description of the process and methods used to conduct the CHNA.	10-19
Data and other information used in the assessment.	15-19
The methods of collecting and analyzing this data and information external source material in which case the hospital may simply cite the source material rather than describe the methods of collecting the data.	15-19
Any parties with whom the hospital facility collaborated or contracted for assistance in conducting the CHNA.	25
A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves.	14-17
In general terms, the input provided by such persons.	14-17
How and over what time period such input was provided (for example, whether through meetings, focus groups, interviews, surveys, or written comments and between what approximate dates).	14-17
The names of any organizations providing input and the nature and extent of the organization's input.	14-17, 49-58
The medically underserved, low-income, or minority populations being represented by organizations or individuals who provided input.	14-17, 49-58
A prioritized description of the significant health needs of the community identified through the CHNA. This includes a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant needs.	19-24, 59-61
A description of the resources potentially available to address the significant health needs identified through the CHNA.	25, 62-74
An evaluation of the impact of any actions that were taken to address the significant health needs identified in the immediately preceding CHNA.	26-40
Adoption for the hospital facility by an authorized body of the hospital facility.	25

Appendices

Appendix A: Grand Itasca community map

Appendix B: Grand Itasca community zip codes, cities, and counties

Appendix C: Grand Itasca community demographics

Appendix D: Grand Itasca community characteristics table

Appendix E: Grand Itasca community characteristics snapshot

Appendix F: Center for Community Health Equity Community engagement spectrum

Appendix G: Grand Itasca Community Advisory Committee member organizations

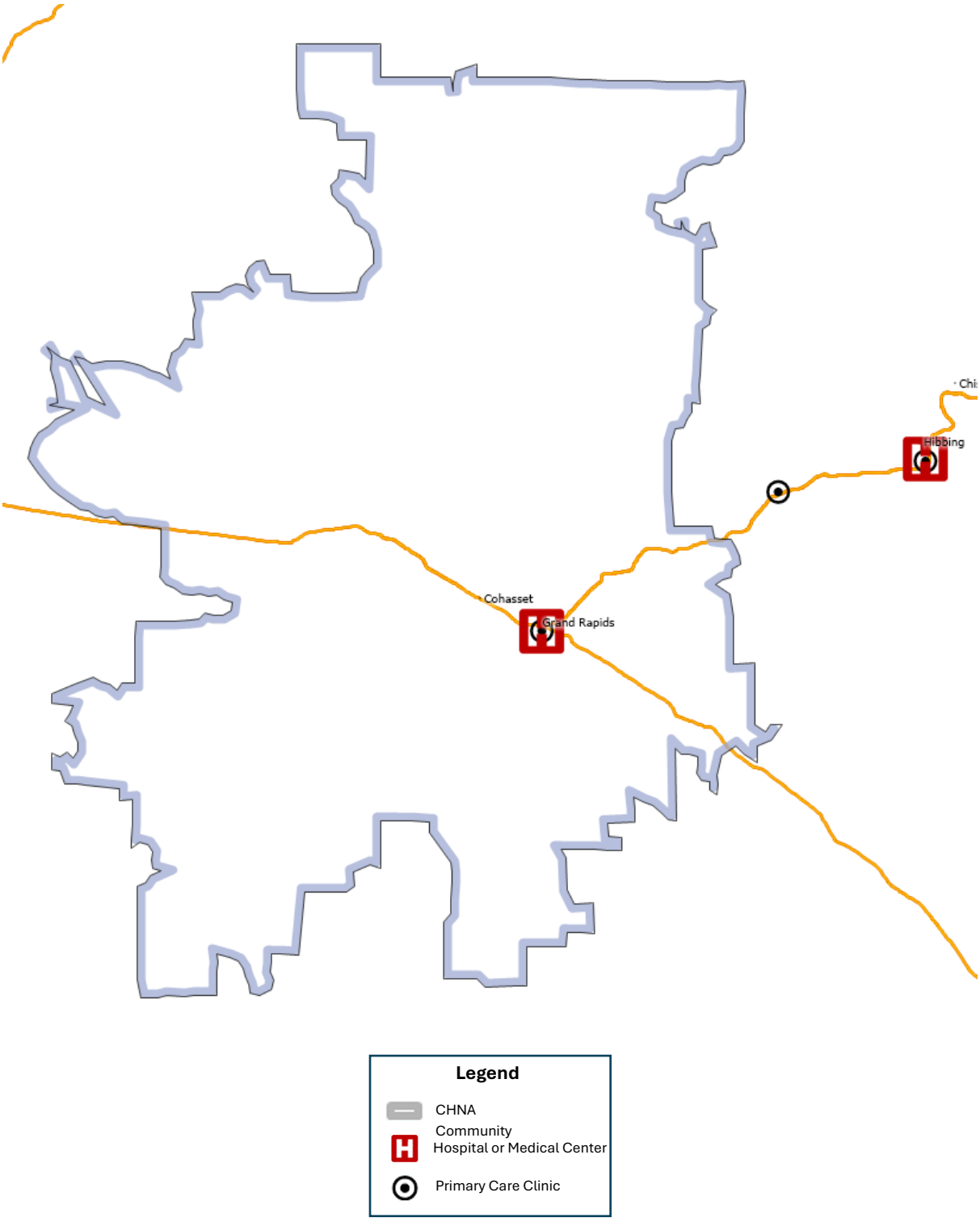
Appendix H: Fairview Health Services System Community Advisory Council member organizations

Appendix I: CHNA Healing, connectedness, and mental health virtual conversation presenters

Appendix J: Top 10 barriers list for the priority needs

Appendix K: 2022 to 2024 Grand Itasca CHNA Action Plan

Appendix A: Grand Itasca community map
2024 Fairview Community Health Needs Assessment Grand Itasca community
City: Grand Rapids, MN
County: Itasca County



Appendix B Grand Itasca community zip codes, cities, and counties

Zip	City	County
55709	Bovey	Itasca
55716	Calumet	Itasca
55721	Cohasset	Itasca
55722	Coleraine	Itasca
55744	Grand Rapids	Itasca
55748	Hill City	Aitkin
55764	Marble	Itasca
55786	Taconite	Itasca

Zip	City	County
55793	Warba	Itasca
56628	Bigfork	Itasca
56636	Deer River	Itasca
56657	Marcell	Itasca
56672	Remer	Cass
55730	Grand Rapids	Itasca
56631	Bowstring	Itasca

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Appendix C: Grand Itasca community demographics table

	Grand Itasca Clinic & Hospital CHNA Community				Itasca County				Minnesota			
Year	**2024**		**2029**		**2024**		**2029**		**2024**		**2029**	
Total population	**41,312**		**42,194**		**44,189**		**45,034**		**5,760,091**		**5,899,521**	
By race												
White	36,903	89.3%	37,616	89.2%	39,536	89.5%	40,207	89.3%	4,372,255	75.9%	4,347,825	73.7%
Black / African American	174	0.4%	188	0.4%	177	0.4%	193	0.4%	436,744	7.6%	496,453	8.4%
American Indian / Alaskan Native	1,425	3.4%	1,396	3.3%	1,501	3.4%	1,475	3.3%	70,489	1.2%	73,764	1.3%
Asian	140	0.3%	155	0.4%	147	0.3%	163	0.4%	313,942	5.5%	339,409	5.8%
Native Hawaiian / Pacific Islander	5	0.0%	6	0.0%	9	0.0%	9	0.0%	3,354	0.1%	4,005	0.1%
Some Other Race	204	0.5%	213	0.5%	213	0.5%	222	0.5%	183,847	3.2%	207,424	3.5%
Two or More Races	2,461	6.0%	2,620	6.2%	2,606	5.9%	2,765	6.1%	379,460	6.6%	430,641	7.3%
By ethnicity												
Hispanic / Latino	603	1.5%	682	1.6%	664	1.5%	746	1.7%	384,140	6.7%	442,333	7.5%
By age												
Median age	47.1	-	47.4	-	46.9	-	47.2	-	40.3	-	41.2	-
Age 0-17	8,389	20.3%	8,225	19.5%	8,946	20.2%	8,750	19.4%	1,282,646	22.3%	1,264,010	21.4%
Age 18-44	11,357	27.5%	11,853	28.1%	12,276	27.8%	12,761	28.3%	2,023,603	35.1%	2,040,717	34.6%
Age 45-64	10,146	24.6%	9,279	22.0%	10,953	24.8%	10,019	22.2%	1,390,700	24.1%	1,382,795	23.4%
Age 65+	11,420	27.6%	12,837	30.4%	12,014	27.2%	13,504	30.0%	1,063,142	18.5%	1,211,999	20.5%

Source: Claritas, 2024

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Appendix D: Grand Itasca community characteristics table

	Grand Itasca Clinic & Hospital CHNA Community			Itasca County			Minnesota		
	Total	**#**	**%**	**Total**	**#**	**%**	**Total**	**#**	**%**
Economic									
Below 200% federal poverty level[1] (total pop)	38,425	11,592	30.2%	43,870	13,250	30.2%	5,550,433	1,257,815	22.7%
Below 50% federal poverty level[1] (total pop)	38,425	2,142	5.6%	43,870	2,359	5.4%	5,550,433	229,643	4.1%
Median household income[4]	17,419	$70,066	-	18,649	$70,198	-	2,277,321	$88,864	-
Access to care									
Uninsured[3]	38,799	1,876	4.8%	44,247	2,160	4.9%	5,614,768	258,292	4.6%
Food, housing, and transportation									
Housing cost burden (30%) (total hh)	15,693	4,016	25.6%	18,210	4,599	25.3%	2,229,100	558,132	25.0%
Households with no vehicle (total hh)	15,693	926	5.9%	18,210	1,028	5.7%	2,229,100	144,942	6.5%
Food insecurity rate[2] (total pop)	39,361	3,392	8.6%	44,767	3,850	8.6%	5,650,048	342,640	6.1%
Civic engagement									
Voter participation rate (total pop 18+)	31,194	23,454	75.2%	35,476	26,561	74.9%	4,069,677	3,277,171	80.5%
Education									
Population with No High School Diploma (Age 25+)	28,186	1,428	5.1%	32,556	1,829	5.6%	3,847,501	247,610	6.4%
Employment									
Unemployed[4] (total pop 16+)	18,814	1,277	6.8%	20,316	1,337	6.6%	3,174,444	137,941	4.3%
Language and culture									
Limited English Proficiency (total pop 5+)	37,223	143	0.4%	42,685	173	0.0%	5,322,004	239,624	5.0%
Foreign-born population	39,356	229	0.6%	44,969	334	0.7%	5,670,472	479,231	8.45%
Risk Factors									
4 or more ACEs[5] (total student respondents)	-	-	-	784	84	10.7%	82,650	5,729	6.9%

1. Data pulled from Spark Maps, source unless indicated: American Community Survey, 2017-2021
2. Total Population: For whom poverty status is determined (50% FPL: Family of 4, less than $13,250, 200% FPL: Family of 4, less than $53,000)
3. Source: Feeding America, 2021.
4. Total population: Civilian noninstitutionalized population
5. Source: Claritas, 2024
6. ACES: Adverse Childhood Experiences, Source: Minnesota Student Survey, 2022

grand itasca Clinic & Hospital | Part of Fairview Health Services

Appendix E: Grand Itasca community: social determinants of health snapshot

2024 Grand Itasca Clinic & Hospital community social determinants of health snapshot

The percentage of the population with **no high school diploma** is slightly lower in the Grand Itasca community than statewide.

5% Grand Itasca community

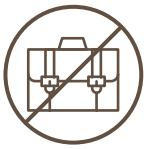
6% Minnesota

About the same percentage of the Grand Itasca community is **uninsured** as statewide.

5% Minnesota

5% Grand Itasca community

The **unemployed** rate in the Grand Itasca community is higher than the state's rate.



6% Minnesota

7% Grand Itasca community

The percentage of the population who **speak a language other than English at home** is lower in the Grand Itasca community than statewide.

2% Grand Itasca community

12% Minnesota

A slightly higher percentage of households in the Grand Itasca community are cost burdened **(spend one-third or more of their income on housing)** than statewide.

26% Grand Itasca community

25% Minnesota

A **slightly higher** percentage of households in the Grand Itasca community **receive SNAP benefits** than statewide.

8% Minnesota

9% Grand Itasca community

The **median household income** in the Grand Itasca community is **lower than** the state's.

$70,066
Grand Itasca community

$88,864
Minnesota

The percentage of individuals **living in households below the federal poverty level** is higher in the Grand Itasca community than in the state.

12% Grand Itasca community

Family of four, annual income of $26,500

9% Minnesota

Sources: Claritas, 2024; American Community Survey 2017-2021

Appendix F: CCHE community engagement spectrum

	Inform	Consult	Involve	Collaborate	Community Led
Community engagement goal	To provide the community with information to assist them in understanding the problem, alternatives, opportunities or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the community throughout a process to ensure that concerns and aspirations are consistently taken into consideration.	To partner with the community in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.	To respect community led decision making.
Promise to the community	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how community input influenced the decision.	We will work with you to ensure your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how community input influences the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decision to the maximum extent possible.	To support and/or align our actions with community led efforts.
CHNA examples	• CHNA Roadshow • CHNA Explainer Videos (5 languages)	• Surveys • Community Health and Healing Summit	• Community Advisory Groups • Patient and Family Advisory Groups	• Listening and Learning Sessions (Partner Grants)	

Appendix G: Grand Itasca Community Advisory Committee member organizations

Organization	Sector	Organization description
Bigfork Valley	Healthcare	Bigfork Valley provides health care and community services at their hospital, clinics, and senior living communities in Bigfork, MN.
Blandin Foundation	Coalitions/Collaborators	Blandin Foundation is a private foundation in Grand Rapids, MN which works to strengthen rural communities, especially the Grand Rapids area.
City of Grand Rapids City Council	Government	The City of Grand Rapids City Council serves all residents of the City of Grand Rapids, MN and is responsible for all policy decisions and legislative activities.
ElderCircle	Social Services	ElderCircle is a non-profit organization which works to empower older adults in Itasca County to maintain active living and healthy independence through services, resources, and referrals.
Essentia Health	Healthcare	Essentia Health is an integrated health system serving patients in Minnesota, Wisconsin, and North Dakota at their hospitals, clinics, long-term care facilities, ambulance services, retail pharmacies and research institutes.
Fairview Range Medical Center	Healthcare	Fairview Range Medical Center, part of Fairview Health Services, is a healthcare network in northeastern Minnesota which includes Fairview Range Medical Center, Fairview Mesaba Clinics (with locations in Hibbing, Nashwauk and Mountain Iron), home care, and hospice services.
Get Fit Itasca	Coalitions/Collaborators	Get Fit Itasca is a community led collaborative sponsored by the Itasca County Family YMCA which works to engage all people in Itasca County to make healthy choices and participate in activities that improve their quality of life.
Grand Itasca Clinic and Hospital	Healthcare	Grand Itasca Clinic and Hospital, part of Fairview Health Services, provides a range of health services at several locations in Grand Rapids, MN.
Deer River Schools	Education	Deer River Schools is a pre-K through grade 12 public school district serving the community of Deer River, MN.
Itasca County Family YMCA	Social Services	The Itasca County Family YMCA is a nonprofit organization that offers programs and facilities for health, wellness, and community development.
Itasca County Public Health	Local Public Health	Itasca County Public Health supports policies and offers programming designed to promote the

Organization	Sector	Organization description
		health of residents of Itasca County including social services, nursing, education, immunizations, and other health services.
Itasca County Public Health	Local Public Health	The Statewide Health Improvement Partnership (SHIP) is a Minnesota Department of Health initiative which supports community-driven solutions to expand opportunities for active living, healthy eating, and commercial tobacco-free living to help people in Minnesota prevent chronic diseases including cancer, heart disease, stroke, and type 2 diabetes.
Kiesler Wellness Center	Social Services	Kiesler Wellness Center is a peer-driven community support program for adults impacted by mental illness.
Kootasca Community Action	Social Services	Kootasca Community Action helps individuals, families, and communities fight the multiple causes and challenges of poverty. Programs include early childhood, community engagement, health and safety, homeowners and renter programming.
National Alliance on Mental Illness Grand Rapids Area	Social Services	National Alliance on Mental Illness (NAMI) Grand Rapids Area is a nonprofit organization which provides education, support, and advocacy for children and adults with mental illness and their families.
Northland Counseling Center	Social Services	Northland Counseling Center offers out-patient mental health services that include diagnostic assessments, medication management, and individual, family, couples, and group therapy for all ages.
The Pillars of Grand Rapids	Social Services	The Pillars of Grand Rapids is a senior living facility, providing independent living, assisted living, memory care and stay-by-day services.
Project Care Free Clinic	Healthcare	Project Care Free Clinic is a non-profit organization which provides basic healthcare services to people who are uninsured and underinsured in Minnesota's Iron Range communities at their clinics in Grand Rapids, Hibbing, and Virginia.
Second Harvest Northland	Social Services	Second Harvest Northland is a nonprofit organization which works to relieve hunger in Minnesota by partnering with other organizations and delivering food to food shelves, homeless shelters, senior community centers and children's feeding programs.
Youth for Christ	Social Services	Youth for Christ is a nonprofit organization with a mission to care for, mentor, and build

Organization	Sector	Organization description
		relationships with youth that are faith-based, providing opportunities that are safe, inviting, and inclusive.

Appendix H: Fairview Health Services System Community Advisory Council member organizations

Community Organization	Sector	Representing	Organization description
360 Communities	Social Services	Ridges LCAC	360 Communities is a non-profit organization based out of Burnsville, MN that provides holistic programming focused on violence prevention and intervention, school success, and providing community resources.
African Career Education and Resource (ACER)	Social services	Priority Population	African Career, Education, and Resource is a nonprofit organization serving African immigrants in the north and northwest suburbs through engagement, advocacy, and other programs which advance racial and economic equity.
American Indian Family Center	Social services	Priority Population	Serves approximately 700 American Indian families each year with mental health, recovery, employment, housing, family and youth services. We are a community gathering space for the American Indian community in St. Paul and the East Metro
Arrowhead Area Agency on Aging	Social services	Range LCAC	The Arrowhead Area Agency on Aging (AAAA) is the agency designated by the state to address the needs and concerns of all older adults at the regional and local levels in the Arrowhead Region of Minnesota.
Augsburg College	Higher Education	UMMC LCAC	Set in a vibrant neighborhood at the heart of the Twin Cities, Augsburg offers undergraduate and graduate degrees to students of diverse backgrounds.
Bloomington Public Health	Local Public Health	Ridges LCAC	City of Bloomington Public Health engages the community to promote, protect, and improve the health of all through services such as immunizations, family health home visits, and WIC services.
Bremer State Bank	Financial Institution	Northland LCAC	Bremer Bank offers mortgage, investment, wealth management, trust and insurance in Minnesota, North Dakota and Wisconsin.
Catholic Charities	Social services	Priority Population	With 25 programs in 21 sites across the Twin Cities, we work to prevent poverty before it starts, respond to immediate crises, and offer pathways to greater stability. Our programs for children, families and adults help nearly

Community Organization	Sector	Representing	Organization description
			23,000 people every year — regardless of faith, background, or circumstance.
Central Minnesota Council on Aging	Social Services	Lakes LCAC	The Central Minnesota Council on Aging is a non-profit organization which works to help adults in the 14 county Central Minnesota region age successfully by building community capacity, advocating for aging issues, maximizing service effectiveness and linking people with information
Century College	Education	St. John's LCAC	Century College is a two-year community and technical college located in White Bear Lake, Minnesota.
Chisago County Public Health	Local Public Health	Lakes LCAC	Chisago County Public Health is a government organization which works to protect and enhance the health of Chisago County through data, education, evidence-based prevention strategies, partnerships and the promotion of health equity.
Dakota Electric Association	Utilities	Ridges LCAC	Dakota County Public Health is a government agency which provides programs and services that help improve the health of all Dakota County Residents.
Ebenezer Senior Living	Senior services	Priority Population	Ebenezer believes in creating environments for seniors where residents can continue to grow, develop new skills, and pursue longer, healthier, and more meaningful lives. We serve a number of different needs through our various housing and service programs.
Family Values for Life	Social services	Priority Population	Family Values for Life works with families to help them chart a path out of crisis through spiritual empowerment, mental alertness, physical fitness, and financial stability. Together we build capacities for families to network and leverage resources within their community. Strong healthy families cultivate secure communities.
Minnesota North College	Higher Education	Range and Grand Itasca LCAC	Created to make quality education accessible to all. Prepares lifelong learners and engaged citizens through inclusive, transformative experiences reflecting the character and natural environment of the region.

Community Organization	Sector	Representing	Organization description
Hmong American Partnership	Social services	Priority Population	A nonprofit social service organization that addresses the needs of more than 25000 immigrants and refugees across the Twin Cities.
Itasca Economic Development Corporation (IEDC)	Economic development	Grand Itasca LCAC	Creates and retains quality jobs in Itasca County through education, research, and connections with businesses.
Karen Organization of MN	Social services	Priority Population	Builds on the strengths of refugee and immigrant communities and remove barriers to achieving economic, social, and cultural wellbeing. We provide multilingual services including job training, financial coaching, refugee new arrival services, MNsure navigation, elders and caregivers programming, preventive health education, youth case management, and after-school programs.
Minnesota Department of Health	Public health	Regional/Statewide	Protecting, maintaining and improving the health of all Minnesotans.
Minnesota Recovery Connection	Social services	UMMC LCAC	A grassroots recovery community organization. We offer peer-to-peer recovery support services, including telephone recovery support, recovery navigation services, and 1:1 recovery coaching for people seeking or sustaining long-term recovery from substance use disorder.
Open Path Resources	Social services	Priority Population	Open Path Resources is a Minnesota based nonprofit that serves East African immigrant families and community-led centers by building their capacity to have greater influence upon public policies that affect their current and future interests.
Project Care Free Clinic	Healthcare	Grand Itasca and Range LCAC	Project Care Free Clinic is a non-profit organization which provides basic healthcare services to people who are uninsured and underinsured in Minnesota's Iron Range communities at their clinics in Grand Rapids, Hibbing, and Virginia.
Saint Paul- Ramsey County Public Health	Local Public Health	St. John's LCAC	Saint Paul-Ramsey County Public Health is a government agency which provides a range of services to protect and

Community Organization	Sector	Representing	Organization description
			improve the health of people and the environment in Saint Paul and all other cities in Ramsey County.
Second Harvest Heartland	Hunger relief	UMMC LCAC	One of the nation's largest food banks, distributing more than 100 million pounds of food to community food shelves, meal distribution sites, and emergency grocery pop-ups across 57 Minnesota and Western Wisconsin counties
Sherburne County Health and Human Services	Local Public Health	Northland LCAC	Sherburne County Health and Human Services is a government agency which works to promote the health, safety, wellbeing, and self-sufficiency of Sherburne County residents.
SoWashCo CARES	Social Services	Woodwinds LCAC	SoWashCo CARES acts as the central connection point between the schools and the community for needs and resources going both ways. They meet immediate needs in real time through social media. School staff will let us know if there is a student who is in need and coming to school without proper shoes or school supplies or whatever it is.
StairStep Foundation	Social services	Priority population	Stairstep's mission is to reignite and sustain a spirit of community among African Americans.
Washington County Public Health and Environment	Local Public Health	Woodwinds LCAC	Washington County Public Health and Environment is a government organization which provides services to protect, promote and improve the Washington County community's health and environment.
World Youth Connect	Youth development	Priority Population	A youth led organization based in Saint Paul that gives young people the opportunity to take on leadership roles and create change in the community. World Youth Connect builds communities across cultures and beyond borders. By creating and encouraging civic engagement opportunities, we help young people gain the skills and experience they need to be successful.
YMCA of the North	Social services	Regional/Statewide	By nurturing the potential of every child and teen, improving health and well-being, and supporting and serving our neighbors, the Y ensures that everyone has the opportunity to become healthier, more confident, connected and secure.

Community Organization	Sector	Representing	Organization description
Youthprise	Youth development	Priority Population	Leverages its financial, political, and relational capital and expertise in youth development to increase funding for Minnesota youth programming and promote innovation in how our communities work with youth. As a philanthropic intermediary, Youthprise is designed to invest more than just money. Youthprise partners with youth and youth service organizations to share knowledge, capture lessons learned, and spread best practices to advance outcomes for young people throughout Minnesota.

Fairview organizational roles represented
Chief of Primary Care / Assoc Chief Medical Officer
Vice President & Treasurer
Chief Operating Officer, Acute Care Hospitals and Periop Domain
Chief Quality Officer
Family Medicine Physician, Roselawn Clinic
System Director Equity Initiatives
Fairview Foundation
Executive Vice President & Chief Public Affairs Officer
Lead Chief Nursing Officer - Fairview Nursing Services; Vice President/Chief Nursing Officer, University of Minnesota Medical Center and Masonic Children's Hospital
Director, Tax
Vice President, Community Advancement
Vice President, People Experience and Inclusion
Vice President, Clinical Integration

Fairview organizational roles represented
System Director, Customer Experience
System Executive Director, Community Health Equity and Engagement
Regional Director Foundation, Community Relations, Interfaith Health

Appendix I: Healing, connectedness, and mental health virtual conversation presentation partners

Virtual Conversation	Partner	Presentation topic
Healing, connectedness, and mental health: Youth	Annex Teen clinic	Programs & Services & How We Do It!
Healing, connectedness, and mental health: Youth	University of Minnesota, School of Nursing	Protecting and Promoting Adolescent Mental Health
Healing, connectedness, and mental health: Older Adults	Ebenezer	Older adults, spiritualty, and mental health
Healing, connectedness, and mental health: Older Adults	University of Minnesota's Earl E. Bakken Center for Spirituality & Healing	Cultivating awareness and focusing on a virtuous mind during traumatic experiences (Ethnographic research, 2016-2017)
Native approaches to healing, connectedness, and mental health	Minneapolis Health Department	Community conversation – American Indian approaches to healing, connectedness, and mental health
Native approaches to healing, connectedness, and mental health	University of Minnesota Internal Medicine	Connection for Indigenous health

Appendix J: Top ten barriers for priority needs

Top 10 barriers to navigate and access care and resources

Health insurance and cost of care

- Lack of insurance.
- Lack of cost transparency.
- Cost of medications, mental health services, etc.
- Lack of awareness of affordable insurance plans.

System complexity and need for care coordination

- Lack of coordination with external agencies.
- Limited follow-up after care or hospitalization.

Transportation

- Public transport doesn't connect with services.
- Cost of parking and gas.
- Lack of access to a vehicle.
- Reliability and availability of public transit.
- Unable to drive.

Trust

- Lack of trust in providers and healthcare system.
- Patient feels their symptoms are not being taken seriously.
- Fear of experiencing racism.
- Fear of being deported.
- Perception of system putting profits before patients.

Inaccessible care

- Appointment barriers.
- Wait times and difficulty scheduling.
- Excessive paperwork.
- Long wait time at emergency room.
- Inability to take time off work for illness or appointments.

Specialty care

- Access issues for eye care.
- Insurance doesn't cover dental care.
- Foot care.
- Pain management barriers and needs.
- Limited specialty care

Population-specific barriers (Youth, older adults, new immigrants, LGBTQIA2S+, veterans, etc.)

- Respect for patient's gender identity.
- Lack of post-discharge resources for veterans.

Language and interpretation

- Limited/ineffective translation services.
- Lack of translation services in multiple languages.

Health education

- Lack of education on nutrition, diabetes, first aid, how to navigate insurance, etc.
- Need for medication education and management.

Cultural competency & responsiveness

- Need for cultural advocates and traditional healers.
- Availability/respect of use of alternative medicine.
- Lack of culturally competent care.

grand itasca Clinic & Hospital | Part of Fairview Health Services

Top 10 barriers to healing, connectedness, and mental health

Connection

- Loneliness/social isolation.
- Lack of safe spaces for Native Americans to encourage them to be proud of their culture and heritage.
- Need for safe spaces to come together.

Connect with healthcare

- Lack of continuity of care.
- Disconnection between mental health and primary care.
- Insufficient follow-up after mental health inpatient discharge.

Compounding conditions

- Tie between mental health and substance use.
- Self-esteem and its effect on cycle of poverty.
- Stigma.
- Mental health is a barrier to physical health.

Mental health providers

- Psychiatrist shortage.
- Limited availability of mental health providers.
- Limited diversity of providers/limited culturally representative mental health providers.

Mental health services

- Availability.
- Awareness of how to access mental health services.
- High cost.
- Lack of mental health programming.

Community social conditions

- Community divide.
- Community not welcoming.
- Lack of community spaces and events.

Culturally appropriate healing

- Historical trauma.
- Lack of culturally competent mental health care.
- Limited spiritual and holistic health resources.

Substance use services

- Lack of addiction programming.
- Lack of access to help or treatment for substance use.
- Need more chemical health services.

Knowledge and Education

- Lack of coping skills.
- Lack of knowledge of mental health medication side effects.
- Need more community education on drug tendencies.

Population-specific barriers & needs

(Youth, older adults, new immigrants, LGBTQIA2S+, veterans, etc.)

- Lack of community activities for older adults.
- Lack of community programming for youth and families.
- Lack of post-discharge follow-up with veterans.

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Top 10 barriers to structural racism and barriers to equity

Financial

- Economic inequality.
- Poverty (generational, fixed income, non-livable wages, cycle of poverty).
- Stress of poverty.
- Children living in poverty.
- Income inequities.

Community resources

- Lack of youth resources in rural and suburban areas.
- Eligibility criteria (age and geographic limitations).
- Lack of culturally relevant resources.

Stigma

- Youth and students worry about privacy; they prefer discreet distribution of food.
- Stigma specifically connected to federal nutrition programs.

Transportation

- Lack of transportation for clients (access to bus lines, lack of vehicle, etc.).
- Lack of transportation support for volunteers.
- Home delivery services are distance-constrained.
- Some older adults cannot drive.

Housing

- Accessing safe, stable, and affordable housing.
- Long wait lists for housing for seniors.
- Lack of safe and stable housing for children.
- Lack of transitional housing or care resources.
- Limited support for unhoused individuals.

Trust

- Distrust of government.
- Fear of being undocumented.
- Distrust in systems.
- Clients are hesitant to provide identifying information.

Discrimination

- Islamophobia.
- Racism.
- Lack of inclusive spaces.
- Ableism.

Access to Food

- Limited food shelves hours.
- Stigma of being food insecure.
- Lack of access to cooking spaces for homeless individuals.
- Access to affordable, culturally relevant, healthy food is inconsistent.

Historical trauma

- Generational poverty
- Historical distrust in systems.
- Lack of culturally relevant and trauma-informed services.
- Racism.

Marginalization/ unheard voices

- Lack of safe spaces for BIPOC communities.
- Invisibility of minoritized racial and ethnic populations.
- Invisibility of LGBTQIA2S+ community.

Policy, system, and environmental change initiatives (PSE)

Grand Itasca's mission and vision extend beyond traditional healthcare settings, driving a healthier future for the communities we serve. The PSE initiatives are implemented across the system (hospitals, clinics, etc.) to create sustainable and lasting change to advance health equity and community well-being.

= Priority need being addressed

= Community Benefit program

= Both priority populations are being served

Initiative	Partners
Habitat for Humanity ***Accessing structural racism and barriers to equity*** Grand Itasca supports health and affordable housing for all as a foundation for healthy, vibrant communities and inclusive growth. In 2023, Grand Itasca volunteered a work crew of 6 employees to assist with a home renovation for a deserving family.	Habitat for Humanity
Community Framework Grand Itasca understands the importance of working collaboratively with our community. Knowing the resources available and where there are gaps gives us the opportunity to work together to improve our community as a whole. Grand Itasca employees are part of numerous community discussions, meetings, and organizational boards. We make a conscious effort to be accessible to the community in various capacities.	Boys & Girls Club Community Café ElderCircle Grand Rapids Farmer's Market Itasca Economic Development Council ISD 316, 317, and 318 Itasca County Public Health Kiesler Wellness Center Kootasca Community Action National Alliance on Mental Illness Second Harvest YMCA And many others…

Programs, Collaboratives and Local Partnerships

Programs: Grand Itasca implements programming, activities, and initiatives, applying an equity-centered, culturally responsive approach, as we identify challenges and opportunities, create or expand programs and partnerships, and then scale or deepen learning and successes across our system and the communities we serve.

= Priority need being addressed

= Community Benefit program

= Both priority populations are being served

Program	Partners
VeggieRx ***Navigating and accessing care and resources*** In 2023, we partnered with the Grand Rapids Farmer's Market and held an 8-week healthy eating class, giving participants access to $20 in fresh produce each week. A weekly newsletter was sent, providing education on healthy eating, recipes, and local resources. A cooking demonstration by a Grand Itasca physician was attended by nearly all participants. Participants were primarily patients from our diabetes support group and cardiac rehab.	Grand Rapids Farmer's Market Grand Itasca Foundation
Itasca County Public Health (SHIP) *Navigating and accessing care and resources* Through a SHIP grant, Grand Itasca has been able to expand their food insecurity programming. As a result of this partnership, all patients are now screened for food insecurity. Patients in need can leave with a bag of groceries and a list of resources to help.	Itasca County Public Health SHIP (Statewide Health Improvement Partnership)

Program	Partners
Second Harvest Northern Lakes Food Bank  ***Accessing structural racism and barriers to equity***  Second Harvest North Central Food Bank (Grand Rapids) joined with Second Harvest Northern Lakes Food Bank (Duluth) on January 1, 2024 to form the Second Harvest Northland Food Bank. Grand Itasca will continue their partnership to address hunger in our region, which is a social determinant of health. • Grand Itasca supports our local food bank by sending a team of volunteers each month to help package food. Most foods come in bulk and need to be individually packaged. • A Grand Itasca director sits on the local board of directors for Second Harvest. • Grand Itasca is a sponsor of the annual Chef's Gala fundraiser for Second Harvest. Grand Itasca purchases emergency food bags from Second Harvest to provide to patients that indicate food insecurity.	Second Harvest Northland Food Bank
Code Lavender  ***Healing, connectedness, and mental health***  • Code Lavender is a self-care tool that uses Oshibori, essential oils, M Tech hand massage, etc. that Grand Itasca implemented for its employees. Our employees are part of our community and Code Lavender teaches them tools that help with life/work balance.	M Health Fairview Grand Itasca Foundation

Collaboratives and Local Partnerships

Grand Itasca partners with community members to support activities related to community health and wellbeing. We invest and engage in mutual projects and initiatives by sharing resources and actively exchanging information. A collaborative is to partner with the community in each aspect of the decision, including the development of alternatives and the identification and delivery of the preferred solution. When describing working with the community in this way, it is sometimes called co-design, co-build, or co- implement.

Collaboratives and partnerships	Partners
Project Care Free Clinic ***Navigating and accessing care and resources*** Grand Itasca provides free lab and radiology services for patients that are seen at Project Care. Many of the healthcare volunteers at Project Care are Grand Itasca providers and pharmacists.	Project Care Free Clinic
Twin Cities Gay Men's Chorus ***Accessing structural racism and barriers to equity*** Grand Itasca was a sponsor to bring the Twin Cities Gay Men's Chorus to Grand Rapids in January 2024. This event not only brought incredible musical talent to our community, but also brought awareness of and support for the LGBTQ+ community. "Our support for all people, regardless of race, ethnicity, gender, age, ability, religion, or sexual orientation, extends beyond our walls into the community."	Kootasca Community Action – Circles of Support Community Presbyterian Church Community Presbyterian Church Youth Group Second Harvest North Central Food Bank Itasca Area Indivisible Grand Rapids Human Rights Commission Itasca Unitarian Fellowship Zion Lutheran Church St. Andrew's Lutheran Church Itasca Pride

Workforce Development  ***Accessing structural racism and barriers to equity***   Grand Itasca continues to look at ways to develop our local workforce by partnering with area schools. We partnered in high school career development programs/events, including GRHS Career Day, GRHS Student Pathway program, MN North-Itasca Mock Interviews, Greenway Mock Interviews, Summer Internship, Iron Range SCRUBS Camp, Greenway Career Expo, and Discover Health.	Lake Superior College Grand Rapids High School MN North – Itasca Greenway
YMCA: Childcare Classroom Support  ***Accessing structural racism and barriers to equity***   Due to a shortage of childcare in our community, the YMCA was approached by the city to expand their services into the IRC building. Several organizations donated to this project, including Grand Itasca.	YMCA
Memorial Blood Center  ***Navigating and accessing care and resources***  Grand Itasca supports blood donation from our employees through a partnership with Memorial Blood Center.	Memorial Blood Center

Kiesler Wellness Center  ***Healing, connectedness, and mental health***  Kiesler Wellness Center is a peer-driven community support program for adults impacted by mental illness. Grand Itasca works closely with Kiesler, as they have a shared patient/client base.	Kiesler Wellness Center
Boys & Girls Clubs of Grand Rapids and Greenway  ***Healing, connectedness, and mental health***  Contribute our time, talent, and expertise to support initiatives related to youth development.	Boys & Girls Clubs of Grand Rapids and Greenway
Lake Superior College – equipment donation  ***Healing, connectedness, and mental health***  Grand Itasca donated surgical instrument sets to Lake Superior College's Surgical Technologist program. Our Surgical Director is a member of their Surgical Technician Advisory Board.	Lake Superior College

Education, Training, and Outreach Events

Grand Itasca is committed to providing education to improve the health and well-being of our patients and community members.

= Priority need being addressed

= Community Benefit program

= Both priority populations are being served

Event	Partners
Living Well with Chronic Pain ***Navigating and accessing care and resources*** In partnership with Juniper, this evidence-based 6-part series supports those with chronic pain. Two peer leaders take the participants through a prescribed curriculum.	Juniper Eldercircle
Living Well with Diabetes ***Navigating and accessing care and resources*** In partnership with Juniper, this evidence-based 6-part series supports those with Diabetes. Two peer leaders take the participants through a prescribed curriculum.	Juniper Eldercircle
Living Well with Chronic Conditions ***Navigating and accessing care and resources*** In partnership with Juniper, this evidence-based 6-part series supports those with a chronic condition. Two peer leaders take the participants through a prescribed curriculum.	Juniper Eldercircle

Event	Partners
Walk With Ease ***Navigating and accessing care and resources*** In partnership with Juniper, this evidence-based 6-week series supports those with arthritis. This evidence-based program has been proven to help people with arthritis or other related conditions to reduce pain and improve overall health.	Juniper Eldercircle
Psychological First Aid ***Healing, Connectedness and Mental Health*** Psychological First Aid (PFA) is an evidence-informed training for all community members and professionals. Trainees will learn how to support healthy recovery in individuals following a traumatic event, public health emergency, natural disaster, or personal crisis. The curriculum integrates public health, community health and individual psychology by drawing upon skills the trainees probably already have. PFA is a two-hour training. Grand Itasca's Community Health Coordinator is a trained instructor for the M Health Fairview system.	M Health Fairview
YMCA Health Fair with UMD Pharmacy students ***Navigating and accessing care and resources*** The YMCA Health Fair is offered to the public at no cost. Participants can have a lipid panel and glucose assessment done by pharmacy students from UMD, along with bone density and blood pressure checks. Many health partners are on hand to offer their support and services, including memory, grip, and balance assessments. This health fair is a favorite in our community and a great learning partnership for the students	Itasca County YMCA UMD Pharmacy Itasca Public Health ElderCircle Senior Linkage Line NAMI CERDAR Alzheimer's Assoc. First Call for Help Lutz Consulting Solutions

Safe Routes to School ***Healing, connectedness, and mental health*** Safe Routes to School is an initiative that encourages physical activity for school-aged children. Grand Itasca partners with them twice a year by sending a team that walks kids to a designated pickup spot after school. Bikes have also been an option at some of the events.	ISD 318, East Elementary and West Elementary
Diabetes Support Group *Healing, connectedness, and mental health* Grand Itasca's Diabetes educator facilitates a support group for those in our community with Diabetes, along with their families.	YMCA
Cancer Support Group ***Healing, connectedness, and mental health*** Grand Itasca offers a cancer support group, in partnership with two local organizations, the Itasca County Breast Cancer Support Group and the Itasca County YMCA. GICH provides a monthly educational newsletter for the group.	YMCA Itasca County Breast Cancer Support Group
YMCA Together We Ride Bike Rodeo ***Healing, connectedness, and mental health*** The YMCA encourages families to get up, get out, and get moving. This event allows families to enjoy the YMCA's bike fleet or bring their own bikes, with free bike inspections, a bike obstacle course, games and bounce houses, and a free hot dog dinner. Grand Itasca provides materials for proper helmet ffittings and has given away bike helmets, as well as held drawings for bicycle giveaways throughout the years.	YMCA Ardent Bicycles

Educational presentations to local organizations ***Navigating and accessing care and resources*** Grand Itasca provides speakers to various events throughout the community. From infection control to how to lift clients properly, we can provide many topics to community organizations that request our expertise.	ElderCircle The Pillars Van Dyke Elementary Bois Forte Reservation
NAMI Event – Waiting for Beds community event ***Healing, connectedness, and mental health*** NAMI strives to provide education, support and advocacy for children and adults with mental illness and their families. In May 2023, NAMI facilitated a community discussion to bring awareness about the mental health crisis that often escalates when someone is kept waiting in the ER, due to a shortage of beds in mental health facilities across the state. Grand Itasca's Dr. David Anderson was part of the discussion panel. Also contributing to the discussion was GICH's ED Director and their ED Manager.	NAMI Itasca County Mental Health Services Crisis Response Team (CRT) North Homes Itasca County Jail New Leaf Recovery Kiesler Wellness Center
NAMI – ED Mural ***Healing, connectedness, and mental health*** NAMI partnered with Grand Itasca in 2023 to renovate a patient room in the Emergency Department that is designated for patients in a mental health crisis. Partnering with a local artist, the room was transformed to create a more inviting, less chaotic, and calming atmosphere.	NAMI Itasca County Public Health

Forest History Center Bike Rodeo ***Healing, connectedness, and mental health*** Grand Itasca participated in the Bike Rodeo at the Forest History Center. Two members of our ED helped to fit bike helmets and handed out information about proper helmet fitting.	Forest History Center
Support Within Reach "Chalk Walk" ***Navigating and accessing care and resources*** Chalk Walk is a family friendly event to share community resources. Information of the organizations is provided, and kids do a chalk drawing at each booth. Those that complete all the drawings are entered into a drawing for fun prizes.	Support Within Reach Foster Love Kootasca Community Action AEOA GR Police Department GR Fire Department Additional organizations as well
Community Connect ***Navigating and accessing care and resources*** Community Connect is a community event hosted by Itasca County Health and Human Services, area church, and nonprofit agencies with a goal to connect people with community resources. Grand Itasca's diabetes educator was on site for the event, providing blood sugar checks and offering diabetes education.	Itasca County Health and Human Services
Free student sports physicals ***Navigating and accessing care and resources***	Promoted through many different channels – • Kootasca Community Action • MN North-Itasca • Second Harvest • GRHS

Grand Itasca designates a week during the summer to provide free sports physicals to high school and college age students. Appointments are required, as there are a set number of appointments available.	
Free Foot Care Foot care is an important part of health, especially for those that have chronic conditions. Grand Itasca offers this at no cost in order to meet the need in our community for this preventive service.  	

grand itasca Clinic & Hospital | Part of Fairview Health Services

Community Engagement

Community engagement: It is a continuous process of developing relationships with community members and partners to identify action steps to improve health equity and promote well-being. This intentional practice includes diverse community perspectives, addresses power dynamics, fosters long-term trusting relationships, and leads to action. Our community engagement approaches span across all our service areas and focus on all three priority areas and the two priority populations and are also responsive to emerging needs.

Approach	Objectives
Sponsorships 	All sponsorships to be in alignment with Grand Itasca's commitment to advancing racial equity and its focus on diversity, equity, and inclusion, as well as addressing poverty in our community.
Community Health Needs Assessment Under the 2010 Affordable Care Act all nonprofit hospitals are required to conduct triennial community health needs assessments with community involvement to prioritize community informed priority needs and develop implementation strategies and action plans to address those needs. Assessing and responding to community and patient needs is an important component of population health and integral part of Fairview. Fairview has conducted triennial assessments to inform our community outreach since the mid-1990s. During our last CHNA Fairview made a bold decision to commit to a 10-year vision of increased community health equity and supporting strategies. You can find the 2021 community health needs assessment reports which outline the prioritized needs, along with the CHNA Implementation strategy reports and the details of our commitment to forwarding community health equity found on our website. Contact: Jennifer Morman Jennifer.Morman@Fairview.org	Conduct a community health needs assessment process centered on deep, authentic community and organizational engagement which builds trust and capacity while increasing operational alignments and strengthening mechanisms for community feedback. Reach a large set of diverse stakeholders through CHNA engagement events and activities that inform needs and tactics. Stakeholders actively participate and provide guidance and partner with Fairview on assessment activities. To complete a CHNA report for each hospital that is approved by the community advisory council and board adopted.

Citations

[i] Native Governance Center. Beyond Land Acknowledgement: A Guide. Published September 21, 2021. Retrieved from https://nativegov.org/news/beyond-land-acknowledgment-guide/. Accessed August 20, 2024.
[ii] Minnesota Treaty Interactive. The U.S.-Dakota War of 1862. Retrieved from http://usdakotawar.org. Accessed October 16, 2024.
[iii] Office of the Minnesota Secretary of State. Tribal Government. Retrieved from https://www.sos.state.mn.us/about-minnesota/minnesota-government/tribal-government/. Accessed August 20, 2024.
[iv] Spark Maps' data sources include the American Community Survey, the U.S. Centers for Disease Control and Prevention, the Behavioral Risk Factor Surveillance System, and the USDA Access Research Atlas. Spark Maps was developed by the University of Missouri Extension Center for Applied Research and Engagement Systems.
[v] International Association for Public Participation. Retrieved from https://www.iap2.org/mpage/Home. Accessed July 2, 2024.
[vi] Including, but not limited to, doctors, nurses, nurse practitioners, care coordinators, social workers, dietitians, behavioral health providers, peer support specialists, and emergency medical services team members.