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

2021 Community Health Needs Assessment Report

Grand Itasca Clinic & Hospital

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Acknowledgements

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

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- Dr. Michael Raich, President, Northeast Higher Education District
- Jessalyn Sabin, Academic Dean, Hibbing Community College and Rainy River Community College; Chair, Fairview Range Board of Directors

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

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Letter from our President and CEO

Our triennial community health needs assessment process provides an important opportunity to engage with and understand our community, analyze what has changed—for better or worse—since the last assessment, and prioritize together with the community the issues we must urgently address in order to improve wellbeing and resilience.

In partnership with our community and in response to the challenges presented by the pandemic, we pulled together to meet the urgent, emerging needs of the community by:

- Offering outreach vaccine clinics in partnership with Second Harvest Food Bank during food distribution events
- Putting in place a food security program providing immediate access to shelf-stable foods and resources for continued access to food for families in need
- Collaborating with local organizations to bring youth suicide prevention education and resources to area schools
- Adapting community health programming to a virtual platform so that learning could continue throughout the pandemic

By listening and engaging with our neighbors and collaborating with community-based organizations, local public health departments, and other health systems, we better understand the current local health needs and assets.

For the 2021-2024 reporting period, the priority needs that we will focus on are:

- Healing, connectedness, and mental health
- Addressing structural racism and barriers to achieving health equity
- Navigating and accessing care and resources

Our efforts will center on two priority populations across their lifespans – all persons experiencing poverty and racial or ethnic populations experiencing health disparities.

Our work is guided by and developed in partnership with the communities we serve. This process helps us, in alignment with our partners, direct our investments to make the biggest impact.

Jean MacDonell

Grand Itasca President and CEO

"By partnering with other local organizations and listening to their needs, we have a better understanding of how to better serve the community as a whole. At Grand Itasca, we remain committed to our community and will continue to strive to improve the lives of the people we serve, both within our walls and beyond them."

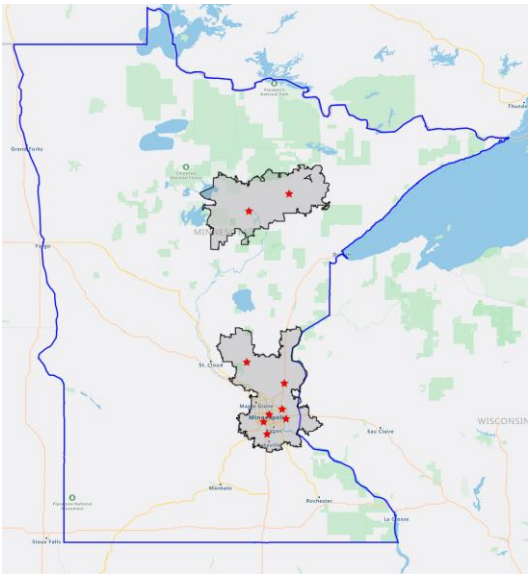
– Jean MacDonell,
Grand Itasca President and CEO

We know that only 20 percent of our health is shaped by health care. The remaining 80 percent is impacted by the **social determinants of health** meaning our health behaviors (diet and exercise, substance use, and sexual activity), socioeconomic factors (education, job status, income, and family and social support), and our physical environment (housing, air quality, connection, and safety). When resources are limited, it can contribute to poor health outcomes, preventable diseases, increased chronic stress, and obesity rates.

As an **anchor institution** — an organization rooted in our community — we are committed to **addressing barriers to achieving health equity**, such as access to care and resources, transportation, cost, and cultural gaps, and the social determinants of health. In addition, as one of Minnesota's largest employers, we are directly confronting **structural racism** (implicit biases in an organization's policies, practices, and staff) by employing values-based hiring, bringing community voices into our institutional operations, and strategically providing services in conjunction with community.

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.



★ Fairview Hospitals and Medical Centers

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

The names listed below reflect the Minnesota Department of Health licensed names. Through the remainder of this report all hospitals or medical centers will be referred to by the name they are more commonly referred to in the community.

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

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

Our approach

Fairview's 2021 Community Health Needs Assessment (CHNA) builds upon previous assessments and was developed in partnership with community members and organizations, local public health agencies, and other hospitals and health systems. It serves as a tool for guiding policy, advocacy, and program planning. It also fulfills 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.

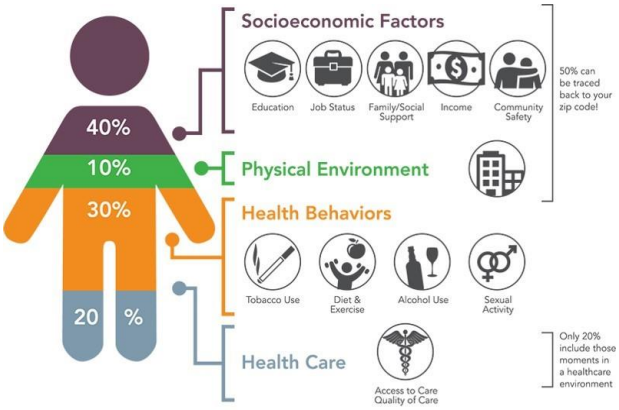
Through this process, Grand Itasca Clinic and Hospital aims to:

- 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 it serves by analyzing current demographics and social determinants of health indicators, as well as by collecting direct input from community members and organizations.
- Inform Grand Itasca Clinic and Hospital's CHNA implementation strategy and action plan development.

As part of the 2021 CHNA process, we reexamined and built upon the extensive community insights shared during our 2018 CHNA, while also surveying the community for current and emerging needs. We have identified three system-wide priority need areas, and we will collaborate with our hospitals and shared services to address these priorities. Our specific response will vary by hospital based on the ways in which the priority needs manifest across a given community as well as the partnerships, both ongoing and new, that we have developed to address those needs.

Social determinants of health

Social determinants of health are the conditions in which people are born, grow, live, work, play, pray, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. Social determinants of health include a range of socioeconomic factors, combined with factors related to an individual's physical environment, health behaviors, and healthcare quality and access.



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Our CHNA uses social determinants of health as a lens through which we frame our understanding of our community's most significant health needs. According to the Kaiser Family Foundation, interactions within a healthcare environment account for only 20 percent of a person's health outcomes.[1] That means that most of the factors that affect a person's health happen outside the doctor's office or hospital, in the person's day-to-day life. Based on this, healthcare institutions must look beyond their own walls and expand their understanding of the scope of care to improve health.

Social determinants of health also enable us to identify inequitable distribution of resources and access that negatively impacts health. Half of the factors that contribute to an individual's health depend on where that person lives, in both socioeconomic and physical terms.[2] Life expectancy can vary as much as 15 years between communities, sometimes within a few square miles. For example, the average life expectancy for Itasca County is 79.9 years, but among the census tracts within the county, the life expectancy ranges from 74.7 years to 88.4 years.

An issue brief from the American Action Forum further explains how social determinants of health interact with healthcare:

"While the health care delivery system impacts health during episodes of injury or illness, the social determinants interact with health much earlier, and on a day-to-day basis. They encompass the conditions in which people live, learn, work, and age, along with the broader social positions in which individuals find themselves that impact health. The social determinants can impact health directly but also can indirectly impact health by shaping how people behave. Poverty, unemployment, and housing insecurity are all examples of social determinants that result in poor health outcomes. Of course, while the factors and conditions considered here are referred to as "social determinants," they may be more aptly discussed as "influencers" or "predictors" rather than direct determinants of an individual's or community's health status. Most of these conditions are highly correlated with one's health but not necessarily causal; further, all social determinants of health (except race) can change throughout one's life."[3]

Indicator category descriptions

When considering data to analyze and include in our CHNA, we grouped indicators into broader categories as outlined below. The following information explains why we chose each indicator category and what the data helps us to understand about the community we serve.

Demographics

Demographic data captures the characteristics and diversity of people in communities. Socioeconomic information such as age, race, and language spoken are used to analyze who lives in a community. This information leads to a better understanding of the needs of specific communities within the broader population of a given service area. Analyzing data from the perspective of different demographic categories can reveal a multiplicity of stories, rather than the single set of conclusions that is most often derived from monolithic, population-wide data. In this way, demographic data can help bring visibility to the needs of specific subgroups within a community.

Nevertheless, by its very nature, demographic data groups individuals, populations, and communities together, resulting in analysis that focuses on similarities within groups while flattening or obscuring unique differences among people. It is important to recognize that, as the Minnesota Department of Health notes in its 2017 Minnesota Statewide Health Assessment, "Although much of the data here are presented by race/ethnicity to reflect the diversity of the state's populations, the differences within each population group can be as great as the differences between different population groups… Data throughout the assessment should be understood as providing clues to the health of different populations, but not the whole story."[4]

Physical environment

The physical environment in which an individual works or lives has a direct correlation with that individual's health. Certain aspects of the physical environment in which someone lives affects that person's ability to live a long and healthy life. To give just one example, a safe community may encourage more social interactions and connections and physical activity, while a community without those attributes can make those interactions and activities more difficult for the people who live there. Physical distance can also have an impact, making it more difficult to stop by the grocery store for fresh, healthy food and curtailing availability of resources, including health care clinics and community organizations. Housing and transportation are important subsets of the physical environment. Whether a person has stable housing and reliable transportation are important factors that contribute to an individual's ability to secure and maintain employment as well as lead a long and healthy life.

- **Housing:** Having safe and affordable housing reduces the likelihood of homelessness and improves physical and mental health. According to research from the Robert Wood Johnson Foundation, housing stability, housing quality and safety, neighborhood characteristics, and affordability all affect health.[5]
- **Transportation:** Reliable transportation is fundamental to securing employment and being able to pay household expenses. It makes it easier and less time consuming to get to and from work and take children to and from daycare. In rural communities, having access to a personal vehicle is key. People may live far away from community and commercial centers, and public transportation options may be limited or nonexistent. Access to transportation also enables other healthy behaviors, such as buying and bringing home fresh groceries, going to the doctor's office, and filling a prescription at the pharmacy.

Socioeconomic factors

Socioeconomic factors influence health both directly and indirectly. They can have a direct positive or negative impact on a person's health and wellbeing, and they can also influence health in a wider range of ways by influencing that individual's behavior. Analyzing socioeconomic data, therefore, can help us better identify the causes and broader contributing factors helping to drive specific health needs among community members.

- **Community safety:** Feeling safe in the area in which a person lives and works is crucial to a person's health and wellbeing. Community safety can have an immediate impact on one's health and personal safety. Not feeling safe in one's surroundings can cause chronic stress, anxiety, and depression. It can influence the likelihood of connecting with neighbors, keep people from exercising or walking to necessities, and can even influence job availability. Community safety can have a direct and profound impact on a person's health and longevity.
- **Education:** Health and wellbeing are linked to the level of education a person has attained. More education means more opportunities: A higher level of educational attainment is correlated with securing good employment, increasing income, boosting wealth-building activities such as homeownership, and making it easier to increase other healthy behaviors. Life expectancy and other important health indicators improve with higher levels of educational attainment.
- **Employment:** Employment status is an important measure of health. Employment provides the financial resources individuals and families need to ensure that basic needs are met. From stable employment flows many other positive influences on health, such as food security, adequate housing, and health care access. Conversely, a lack of stable employment is a stressor in itself and also increases the risk of negative social determinants of health, including food insecurity, homelessness, and lack of access to health care. Unemployment and job loss are also linked to depression and anxiety, which can lead to stress-related illnesses such as heart disease, heart attack, and stroke.[6]
- **Family and social support:** Humans are social creatures. As the COVID-19 pandemic has demonstrated so clearly, isolation can be devastating to a person's health and wellbeing. Individuals who are socially isolated are at a greater risk of dying early compared to those with strong family and social support systems.[7] Recent studies have concluded that loneliness can shorten a person's life by as much as 15 years – equivalent to smoking almost a pack of cigarettes a day or being obese.[8] Children who lack family support from a caring adult and those age 65+ and living alone are at risk of social isolation.[9] Family and social support are important to decrease likelihood of depression, anxiety, and suicide.

- **Income:** Poverty is defined as not having enough income to meet basic needs, including food, clothing, and housing. The federal poverty guidelines for 2021 established the "poverty line" in the United States as a household income of $26,500 for a family of four.[10] Low-income status and poverty are correlated with a range of adverse health outcomes.[11] More generally, income affects a household's ability to buy food, have reliable transportation, afford adequate housing, secure childcare, and access health care.

Health care

Clinical care refers to the medical treatment, screening, or vaccination of patients and is a critical part of reducing a person's risk of disease, disability, and death. The rate at which individuals in a specific community receive clinical care can give insight into the community's ability to access care and the barriers they may face.

- **Health insurance:** When people are uninsured or underinsured, they may forego preventive health care and may delay care for illnesses or injuries until they become emergencies. Having health insurance helps ensure access to care. Looking at the overall uninsured population, those age 65+ who are uninsured, and those who are on Medicaid allows us to better understand how these populations find care, receive preventive services, and pay for care. Improving access to care by improving health insurance access can help more people achieve the best health outcomes.
- **Availability of health care resources:** In rural areas, many people do not have a clinic or hospital nearby. Clinic closures in recent years, and a dearth of specialty care providers who serve these areas, exacerbates the challenge. A lack of availability of health care resources for people living in rural areas can be just as much of a barrier as health care costs for those who are uninsured or underinsured.

Health outcomes

Our goal is for every member of our community to thrive and live long and healthy lives. Studying the health outcomes of people in our community today, helps us to bring that goal closer by assessing the myriad factors that are currently influencing health outcomes to chart a path forward and track progress over time.

- **Length of life:** Length of life includes indicators that predict how many years an individual can expect to live. Leading causes of death, premature death, and suicide rates are also key indicators that reveal the major threats to life and health among the population.
- **Quality of life:** What makes life worth living? Quality of life is an outcome measured through self-assessed mental and physical health indicators. How individuals view their own emotional and physical quality of life affects their ability to enjoy life activities and have positive health-related outcomes. Quality of life is an important consideration in measuring unmet needs and designing interventions necessary for a specific population.

It is our hope and intention that by approaching our understanding of community needs through these multilayered indicators, we will be able to see our community more clearly and plan interventions that will have the greatest impact. For a full list of the core indicators used for the assessment, please see Appendix B.

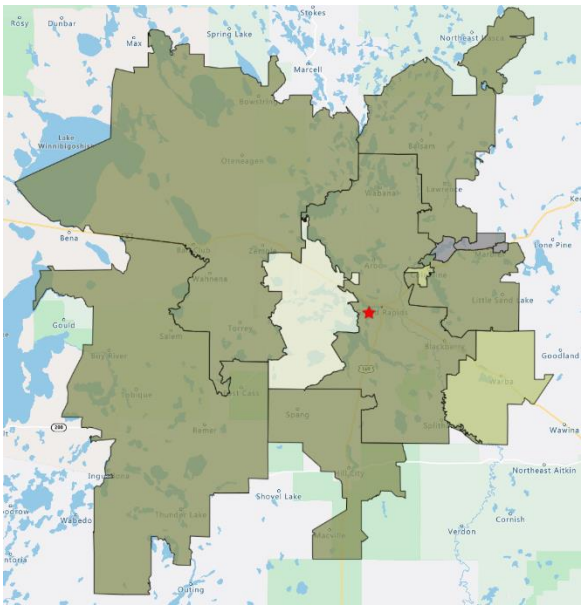
Community Need Index for Grand Itasca Clinic & Hospital

A Community Need Index score is a tool used to identify the severity of health disparities by zip code. Research has shown that zip codes with high Community Need Index scores show a strong correlation to high hospital use for both preventable and nonpreventable admissions.[12] Community Need Index scores are based upon five prominent socioeconomic barriers to healthcare access and range by zip code from a score of one (lowest need) to five (highest need).

Socioeconomic barriers considered in the Community Need Index score are:

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

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



Source: Truven Health Analytics

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.

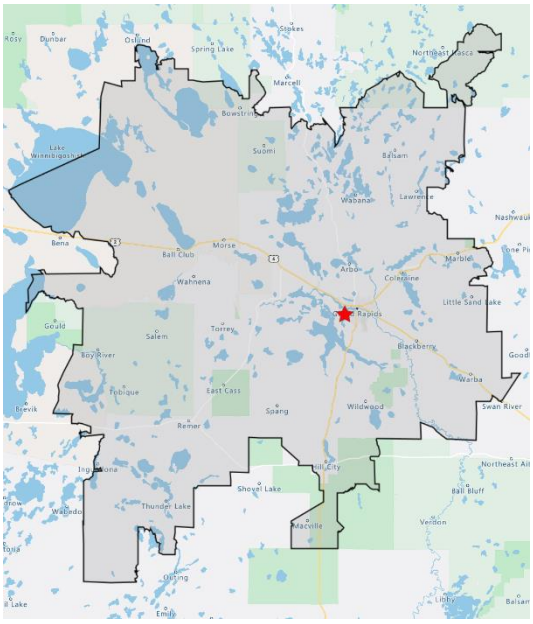
Key services

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

Grand Itasca Clinic & Hospital CHNA community

For the purposes of the CHNA, the Grand Itasca Clinic and Hospital community includes 11 zip codes. The total population of this geographic community is 39,446 people, and it covers 1,778 square miles. Itasca County boasts more than 1,000 lakes within its borders and has a rich history of both mining and logging industries.

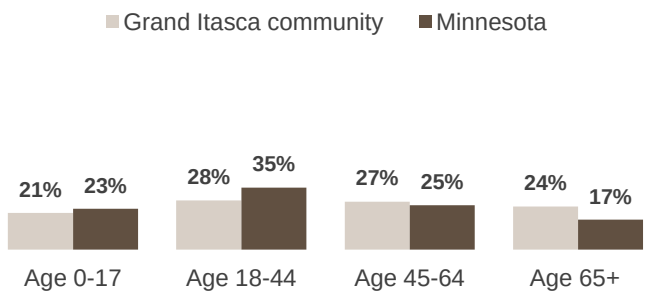
See Appendix C for a list of zip codes and the corresponding cities and counties that fall within the Grand Itasca Clinic and Hospital CHNA community.



Demographics

The Grand Itasca community has an older population. Its median age is 46.3 years, which is 6.6 years older than the state median. This is mostly because a larger percent of its population that is ages 65 and older (24 percent) than the statewide percentage (17 percent).

Population by age

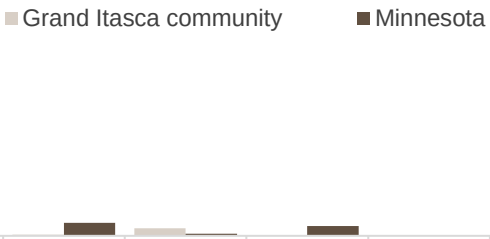


Source: Claritas, 2021

Over the next five years, the Grand Itasca community will have an even larger share of the population age 65+ as the percentage will increase from 24 percent in 2021 to 27 percent in 2026.

The Grand Itasca community has a much larger percentage of people who identify as American Indian/Alaskan Native (4.1 percent) than the statewide percentage (1.2 percent). There Is projected to be very little change in the racial or ethnic diversity in the Grand Itasca community between 2021 and 2026.

Population by race and ethnicity



	White	Black / African American	American Indian / Alaskan Native	Asian	Native Hawaiian / Pacific Islander	Some other race	Two or more races	Hispanic / Latino
Grand Itasca community	91.6%	0.6%	4.1%	0.3%	0.1%	0.3%	3.1%	2.0%
Minnesota	81.0%	7.0%	1.2%	5.3%	0.1%	2.4%	3.0%	5.9%

Source: Claritas, 2021

Premature death

The table below shows the top five leading causes of premature death (before age 75) for Itasca County, Minnesota overall, and the Healthy People (HP) 2030 target. For all Minnesota counties, cancer is the leading cause of death, with breast cancer incidence and mortality the highest, followed by lung, prostate, and colon cancers, respectively.[13] Heart disease, while the leading cause of death in many states, is second in Minnesota generally and Itasca County in particular.

Top 5 leading causes of premature death in Itasca County, 2015 – 2019

Rate per 100,000 people

Rank	Leading cause of premature death	Rate	MN rate	Above or below MN	HP 2030 target
1.	Cancer	89.7	72.8	↑	122.7
2.	Heart disease	49.9	34.8	↑	n/a
3.	Unintentional injury	36.6	26.6	↑	43.2
4.	Suicide	22.4	12.7	↑	12.8
5.	Chronic lower respiratory disease	16.4	11.0	↑	n/a

Source: Minnesota Department of Health, County Health Tables, 2015-2019

The leading causes of death do not impact all communities the same. According to a 2019 analysis, across the U.S., "rural counties had higher rates of premature death than urban counties, regardless of a county's racial and ethnic composition. It is well-established that rural communities have higher morbidity and mortality rates than urban communities, due to a number of both structural and individual risk factors that include higher rates of poverty and environmental risks, as well as more limited access to medical care and poorer health behaviors."[14] An analysis of life expectancy between 1969 and 2009 found that urban areas experienced larger gains in life expectancy than nonmetropolitan areas, which means that the gap between urban and rural continues to widen.[15]

Premature death rates also vary by income level, with a disproportionate number of premature deaths occurring among people experiencing poverty. A study by the Minnesota Department of Health found that people experiencing poverty were more likely to die from diseases or conditions that are treatable, resulting in a high rate of avoidable deaths in this segment of the population.[16] Feeding America has found that poverty and food insecurity are more prevalent in rural areas than in urban areas – more people in rural areas are living in poverty (13.3 percent in 2019, compared to 10.0 percent in urban areas).[17]

Among young people (ages one to 24), early death is both tragic and generally preventable. Significant disparities among marginalized race and ethnic groups lead to higher mortality rates for this group. One recent study's results "strongly suggest that eliminating socioeconomic gaps across groups is the key to enhanced survival for children and adolescents in racial/ethnic minority groups."[18]

Many of the leading causes of premature death can be prevented by changes in health behavior. Residents who follow a healthy diet, maintain a healthy weight, exercise regularly, and avoid tobacco products have a lower risk of developing many chronic health conditions. Changes in behavior like these are greatly influenced by the social determinants of health such as access to healthy food and reliable transportation, safe spaces to exercise, reduced stressors as a result of job security, financial security, and stable and safe housing.

On the next page is the snapshot of the Grand Itasca community, including select indicators that give a picture of the social determinants of health. Most of the data in this report, including the snapshot, is presented at the CHNA hospital community, county, or state level. This is an important consideration when reading the report as data being shared at larger geographies can mask local differences in need.

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.

6% Grand Itasca community

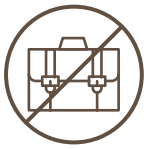
7% Minnesota

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.



4% Minnesota

5% 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 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 **higher** percentage of households in the Grand Itasca community **receive SNAP benefits**

8% Minnesota

10% Grand Itasca community

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

$59,233 Grand Itasca community

$80,714 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 $25,750

10% Minnesota

Sources: Claritas, 2021; American Community Survey 2015-2019

Our priorities

Fairview is committed to transparency and accountability in all we do, including our efforts to assess – and respond to – our community's most pressing health needs. The community benefit work that we do across Fairview must reflect our community's actual needs, not our assumptions about what those needs might or should be.

Because we understand that change cannot happen when we work in silos, and it cannot happen in a single year, we grounded our 2021 CHNA process in alignment with our 2018 CHNA needs, existing data, and the voices of community members and community partners. Once we had collected, analyzed, and synthesized the information we received from both primary and secondary data sources, we established a prioritization process through which we could identify the community health needs that, if effectively addressed, would have the greatest positive impact on our communities and particularly on our priority populations. Having a consistent, defined process helps reduce the skewing effect of conscious and unconscious biases and enables us to define priority need areas that reflect our community's top health needs rather than our perception of those needs.

We evaluated areas of need based on four broad criteria:

- Has this need been voiced by the community? Has this need been vetted by the community?
- Does this need align with Fairview's strategies and priorities?
- Does this need align with existing public health strategies and community health assessments?
- Does this need build upon Fairview's 2018 CHNA priority needs?

Priority needs

Our process resulted in the identification of three priority need areas. They are:

Navigating and accessing care and resources	Healing, connectedness, and mental health	Addressing structural racism and barriers to equity

For more details on our priority need areas, see the corresponding report section for each area below.

Priority populations

In the course of our work with the communities we serve, we have come to the realization that to have the greatest impact, we must take a targeted approach. We have learned that 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.

That is why, although not required for a CHNA, the process of defining and articulating specific priority populations is a key facet of Fairview's approach to creating lasting, meaningful change for the better.

The priority populations are:

Across the lifespan, rural to urban	
Racial or ethnic populations experiencing health disparities	Persons experiencing poverty

The priority populations span both geography and age, extending across the lifespan and across our service area. Social determinants of health can look different in urban and rural environments, but the systemic inequalities underpinning them are the same. The effect of social determinants of health on health disparities can begin before birth and follow an individual for a lifetime, forming an ever-widening gulf as individuals age. No matter where on the lifespan an individual is, we can respond with effective initiatives that will make a real difference.

Another aim of identifying specific priority populations is to bring visibility to communities whose concerns and needs are often silenced and rendered invisible. Examining the data through the lens of specific communities is one way to develop a fuller understanding of community members' experiences. And because people experiencing poverty and minoritized racial and ethnic groups often do not have a formal voice in decision-making that affects them, we intend to take a collaborative approach as we move forward with our implementation plan that ensures these priority populations a seat at the table and elicits feedback at every stage.

Language is important. Because words have the power to reflect our intentions, we devoted significant energy to deciding how to frame the priority populations. Before deciding on the priority population terminology for this report, we had a series of conversations, specifically about language, with organizations that represent the priority populations, public health agencies, community committees, and internal staff. Guided by these conversations, and as a result of much thought and consideration, we have chosen to use the term "racial or ethnic populations experiencing health disparities" in this report.

Although this decision is the best one for this report at this time, we also recognize that language is fluid. While for now, "racial or ethnic populations experiencing health disparities" is most appropriate for this report, that may change with time.

We will also use the term minoritized racial and ethnic groups.19 This includes all minoritized communities, including but not limited to: African American, Alaska Native, Arab, Asian, Black, Cambodian (Khmer), Chinese, Ethiopian, Filipino, Hispanic/Latino, Hmong, Karen, Kenyan, Korean, Lao, Liberian, Middle Eastern, Native American, Native Hawaiian, Nigerian, Oromo, Pacific Islander, Somali, Vietnamese.

You will also see the term Black, Indigenous, and people of color or (BIPOC) in some instances, as this term is currently used by many. This term was developed to highlight the unique relationship to whiteness that Black, Indigenous, and people of color experience. We also recognize these two groups (Black and Indigenous) are not always at the center of the issue being discussed at certain points within the report, and that the term BIPOC can further marginalize other communities of color, reinforcing their already low visibility.

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, Kenyan, Korean, Lao, Liberian, Middle Eastern, Native American, Native Hawaiian, Nigerian, Oromo, Pacific Islander, Somali, Vietnamese and white.

For more details on the priority populations, including the intersection between the priority populations and our priority needs areas, please see the following three sections below. The following three sections are designed to bring our priority needs areas, and their impact on the priority populations, into focus.

Navigating and accessing care and resources

At Fairview, we offer exceptional care. Our world-renowned experts lead the way in breakthrough care and innovative research, with specialty programs among the nation's finest. None of that matters, though, if people can't access our care and resources. We must connect the dots between the care we offer and the people who need it, making it simpler and easier for more people to access our health system across the care continuum and in ways that work for them.

The communities we serve face barriers to accessing care at several levels. First, the availability of hospitals, clinics, pharmacies, and providers is extremely limited in some rural areas. Some residents must travel for hours to see the doctor or fill a prescription; and for specialty care, it is even more difficult.

Home-based services, from home health care and hospice care to durable medical equipment services, are simply not available in some areas because no agencies or companies serve that region.

For the uninsured or underinsured, the cost of care can be prohibitive. Even if individuals do have insurance, navigating the complex world of preauthorization, deductibles, and fine print leaves many unsure about what they will have to pay for the care they need. That uncertainty can itself make people less likely to seek care.

Logistical and technological complexities present challenges as well. For those without a personal vehicle, simply getting to the clinic can require a long trip, and in many rural areas, public transportation is not a viable option. Others may work several jobs or have unpredictable work hours, making scheduling difficult. The increased use of telemedicine is seen by some as one silver lining of the COVID-19 pandemic. In rural regions, however, many areas do not have broadband internet service at all – more than 20 million people in the U.S. do not have broadband access.[20] Without access to fast, reliable internet, rural communities are at risk of being left behind. For some households, especially those with limited digital proficiency or people living in poverty, access to a computer or smartphone may also be a barrier, as may the technological savvy to manage appointments using email and videoconferencing.

Grand Itasca Clinic & Hospital community: Navigating and accessing care and resources

Within the Grand Itasca Clinic and Hospital community, six percent of households do not have a motor vehicle to make it easier to get to doctor's appointments or the pharmacy. Telemedicine has the potential to improve access to care, but one in five households within the Grand Itasca community either have no internet access in their home, use a dial-up connection for internet, or have access to the internet but don't pay for the service, putting virtual provider visits out of reach. Without fast, reliable internet access, individuals and families cannot take advantage of telehealth technology and are at risk of being left behind.

Access to care and resources can also be hampered by a lack of health insurance, which affects 5.2 percent of the Grand Itasca community's residents, a rate that is about the same as uninsured rates in Itasca County (5.3 percent) and the statewide rate (4.5 percent). Approximately 4.8 percent of children ages 0 to 17 are uninsured in the Grand Itasca community.

Grand Itasca community

21% slow or no internet

6% households with no vehicle

Source: American Community Survey 2015-2019

Uninsured population by race and ethnicity
Grand Itasca community

Race and ethnicity	Total	#	Percent
Asian	175	2	1.1%
Black or African American	135	10	7.4%
Hispanic or Latino	490	69	14.1%
Multiple race	1,009	23	2.3%
Native American or Alaska Native	1,636	311	19.0%
Native Hawaiian or Pacific Islander	0	0	0.0%
Some other race	0	0	0.0%
White	35,108	1,629	4.6%

Source: American Community Survey 2015-2019

Through a series of conversations with members of the Grand Itasca community, we learned about a variety of needs and challenges facing the community. The table below summarizes what we heard related to navigating and accessing care and resources.

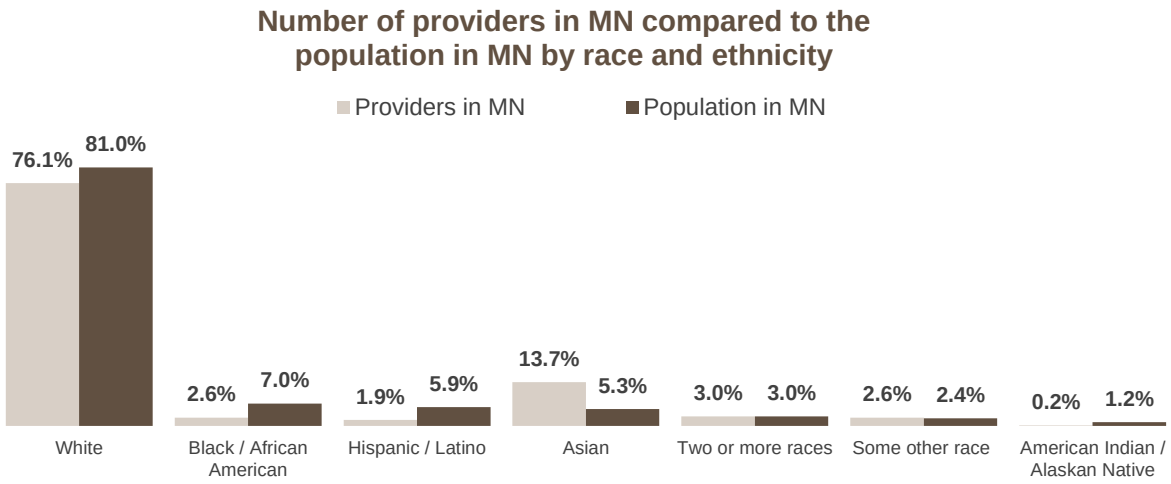
Navigating and accessing care and resources: Community voice summary		
Barriers presented by being in a rural community	Difficulty scheduling appointments (clinic hours, provider shortage, wait time to appointment dates)	Not enough inpatient beds for youth
Barriers to accessing insurance (healthcare/dental)	Healthcare is not culturally responsive	Not enough telehealth/virtual classes
Barriers to nutrition and physical activity	Lack of awareness of resources available in the community	Overmedication of senior population
Care is inaccessible	Lack of coordination with other external services/agencies upon hospital discharge of vulnerable adults	Psychiatrist shortage
Caregivers needs	Lack of knowledge of resources	Technology barriers (broadband, virtual interpretation, device access, virtual burn out)
Chronic conditions (diabetes, obesity)	Limited local specialty care	Translation services/services in multiple languages
Cost of care	Limited representation in providers	Transportation (cost, taxi cost, no vehicle, limited bus system, wheelchair friendly)
Cost of health insurance	Need for care navigation	Understanding of health care system
Cost of medications	Need for patient advocate/navigator	Uninsured population
Delayed health care	Need more preventative care and screenings	Unintentional injury
Dental care barriers		
Dental care needs of children		

For more details on our community conversation process, please see the “Primary data collection and review” section of the report below.

Priority populations: Navigating and accessing care and resources

Racial or ethnic populations experiencing health disparities

The U.S. healthcare system – a web of providers, facilities, insurers, private industry, and many other entities – can be difficult for anyone to navigate. Having a strong relationship with a trusted physician can make it easier for people to coordinate and manage their health care. Sharing a common cultural background is one way to establish a foundation of trust, yet for many racial or ethnic populations experiencing health disparities in Minnesota, that common ground is difficult to find. Of the 17,216 physicians surveyed in Minnesota in 2017, 24 percent identified as Asian, American Indian/Alaskan Native, Black/African American, Hispanic/Latinx, multiple races, or another race not listed. While this percentage is higher than the statewide average, for those who identify as Black/African American, American Indian/Alaskan Native or Hispanic/Latino, the percentage is much lower. More significantly, it means that many of the available doctors in our service area don’t share their patients of color’s racial, ethnic, or cultural background.



*Providers in MN unavailable for Native Hawaiian/Pacific Islander
Source: Claritas, 2021; Minnesota Department of Health, Office of Rural Health and Primary Care, Physician Workforce Survey, 2019

Language barriers pose a big challenge for people seeking to access care, and they contribute significantly to healthcare disparities. According to a report from the Robert Wood Johnson Foundation, “Everyday experience is teaching hospitals that the quality of their medical care is closely linked to how well they meet the language needs of their patients – and language barriers are often complicated by cultural differences.”[21]

Although a smaller percentage of the population face language barriers in Minnesota’s rural areas, this also means that residents who are limited English proficient, which means they speak a language other than English at home and speak English less than "very well", may have reduced access to materials and resources in their language as well as interpreter services. Across Minnesota, only eight percent of physicians communicate in Spanish in their practices, less than two percent speak French or Arabic, and less than one percent speak another language other than English. In the Grand Itasca community, 2.3 percent of the population speak a language other than English, and 0.3 percent of the population are limited English proficient.

0.3% of individuals are **limited English proficient** in the Grand Itasca community

Source: American Community Survey 2015-2019

People experiencing poverty

Poverty is associated with poorer health outcomes. For example, socioeconomic inequalities in cancer mortality are widening, with the most notable gaps for the most preventable cancers.[22] Most adults experiencing homelessness in Minnesota (81 percent) have a chronic physical health condition (57 percent), serious mental illness (64 percent), or substance use disorder (24 percent). Half of Minnesota adults experiencing homelessness have more than one of these conditions.[23]

For example, a recent analysis outlined the confluence of factors that combine to create disparities related to COVID-19 among older adults in rural areas, including lower economic stability: “Rural areas are older, on average, than urban areas, and have more underlying health conditions and fewer economic resources. Rural health care is more limited, as is access to technology and online connectivity. Altogether, this puts rural older adults at risk of not only the virus, but of not being able to meet their health care, social, and basic needs. Rural/urban inequities, combined with within-rural inequities in health, health care, and financial resources cause particular challenges to health and wellbeing from COVID-19 for some older adults.”[24]

Since so many individuals and families access health insurance through their employers, unemployment increases result in higher poverty levels and greater barriers to healthcare access. Losing employment places significant financial strain on individuals and families as they may lose both income and benefits, including health insurance. Minoritized racial and ethnic groups experienced higher job losses during the COVID-19 pandemic, causing increased financial instability, which may lead to food and housing insecurity. The Minnesota Department of Employment and Economic Development reports that an estimated one in two Black workers in Minnesota have applied for unemployment between mid-March and July 2020, compared with one in four white workers.[25]

Medicaid is the nation's public health insurance program for people with low income. One in five Americans are covered by Medicaid. Children account for more than four in ten (43 percent) of all Medicaid enrollees, and the elderly and people with disabilities account for about one in four enrollees.[26] In the Grand Itasca community, 24 percent of the population receive Medicaid.

24% of the Grand Itasca population is receiving **Medicaid**

Source: American Community Survey 2015-2019

COVID-19 and navigating and accessing care and resources

Due to the rise of telehealth technology and its widespread adoption, the COVID-19 pandemic resulted in expanded modes of access to care for many people. However, a dependence on telehealth can prove to be a significant barrier for disadvantaged groups, including people experiencing poverty, people who speak a language other than English, and older adults who may have a lower comfort level with technological tools. In some communities, broadband internet may not even be available.

COVID-19 had a devastating impact on people without health insurance – and that number increased dramatically among the most vulnerable populations throughout the economic upheaval that COVID-19 caused.[27] Difficulty accessing health care makes it harder to get a COVID-19 test, undergo treatment for symptoms (including symptoms of "long COVID"), and receive a vaccine to protect against the disease. Vaccination rates among the priority populations are lower than statewide averages.

Healing, connectedness, and mental health

Mental health challenges are a pervasive, and too often silent, threat to health. According to the U.S. Centers for Disease Control and Prevention, approximately one in five U.S. adults – that's more than 51 million people – experience mental illness in a given year.[28] Therefore, it is no surprise that the U.S. Department of Health and Human Services' Healthy People 2030 initiative has defined mental health as one of its priority areas.[29]

Yet according to the National Institute of Mental Health, only about half of people experiencing mental illness get the treatment they need.[30] And although mental health challenges are experienced by people across every demographic group, the health disparities that disproportionately affect minoritized racial or ethnic populations and people experiencing poverty result in poorer mental health outcomes for those groups.

Social isolation can compound these issues. A recent national survey found that more than half of U.S. adults felt loneliness and isolation.[31] Social isolation is correlated with a range of negative health outcomes, including depression, sleep problems, cognitive decline, heart disease, and decreased immune system function.[32] Loneliness raises an individual's risk of depression, anxiety, and suicide.[33]

Substance use is closely interrelated with other mental disorders. According to the National Institute of Mental Health, about half of individuals with substance use disorder also have another, co-occurring mental health issue, such as depression or anxiety. Mental health challenges also increase a person's risk of developing a substance use disorder, partly stemming from an individual's attempt to self-medicate with drugs or alcohol. Environmental stressors, including trauma, food insecurity, lack of safe housing, low income, and other social determinants of health, can also cause changes in the brain that may increase a person's risk of developing a mental health disorder or substance use disorder.[34]

Grand Itasca Clinic & Hospital community: Healing, connectedness, and mental health

In the Grand Itasca Clinic and Hospital community, 12 percent of people ages 18 and over reported 14 or more days a month of poor mental health. Depression rates have been found to be slightly, but significantly, higher in rural areas than in urban ones.[35]

Isolation is a significant problem in rural communities. Not only do many people live alone, but physical distance and lack of access to community resources can make it harder for people to connect with one another. Moreover, anecdotal reports indicate that some tight-knit rural communities, within which many families have roots going back generations, can be difficult places for new arrivals to find a sense of connection and belonging. In the Grand Itasca community, 15 percent of adults ages 65 and over live alone, increasing their risk of social isolation.

In Itasca County, suicide is the fourth leading cause of premature death at a rate of 22.4 per 100,000 people, which is almost twice that of the statewide rate (12.7 per 100,000 people). Also, 11.9 percent of ninth graders in Itasca County reported having attempted suicide.[36] Each suicide is a tragedy, the damaging effects of which reverberate not only within families, but across entire communities.

Adverse childhood experiences (ACEs) are potentially traumatic events that occur in childhood (0 to 17 years of age). ACEs can have lasting, negative effects on health and wellbeing and can impact life opportunities such as education and job potential. The ACE score is a measure of cumulative exposure to adverse childhood conditions. Exposure to a single ACE condition is counted as one point. In Itasca County, one in five ninth graders reported an ACEs score of four or more.[37]

Grand Itasca community

15% of the population **ages 65+ live alone**

12% of those ages 18+ reported 14 or more days during the past 30 days during which their **mental health was not good**

Sources: American Community Survey 2015-2019; CDC, Behavioral Risk Factor Surveillance System, 2020

In their most recent Public Health Community Health Assessments, mental health was designated a priority area of need in all three counties that overlap with the Grand Itasca community: Aitkin, Cass, and Itasca counties.

We heard a variety of community concerns related to healing, connectedness, and mental health during a series of conversations with the Grand Itasca community. We have summarized the most common needs and challenges that we heard through our community conversation process in the table below.

Healing, connectedness, and mental health: Community voice summary

- Adverse childhood experiences
- Alcohol use, substance use and addiction
- Chemical and drug use in the family
- Disconnection between mental health and primary care
- Families with young kids are disconnected
- Hopelessness that comes with chemical dependency
- Lack of coping skills
- Lack of knowledge of mental health medication side effects
- Limited cultural mental health providers
- Mental health and addiction services are inaccessible
- Need more community education on drug trends
- Negative patterns of behavior- hard to break
- Neglecting children due to unmet mental health needs
- Opioid crisis
- Self-esteem and its effect on cycle of poverty
- Social isolation
- Stigma – mental health
- Suicide
- Tobacco use
- Trauma
- Untreated mental health concerns
- Youth mental health needs (limited services, limited inpatient beds)

For more details on our community conversation process, please see the “Primary data collection and review” section of the report below.

Priority populations: Healing, connectedness, and mental health

Racial or ethnic populations experiencing health disparities

Race-related stressors – including overt discrimination as well as more insidious systemic racism woven through many aspects of American culture – can negatively affect the mental health of those who were discriminated against.[38] The U.S. Department of Health and Human Services Office of Minority Health has found that Black adults are more likely to report severe psychological distress than whites are. At the same time, Black adults have lower levels of mental health treatment.[39] In Minnesota specifically, adults who are Black, Indigenous/Native, multiracial, or Hispanic/Latinx are less likely to receive optimal follow-up care for depression than average.[40]

We see similar inequities in Minnesota youth as American Indian or Alaskan Native students reported higher rates of suicidal thoughts or attempted suicide and lower rates of feeling safe at home. Nearly three out of four (71 percent) of multiple race students reported feeling down, depressed, or hopeless or feeling nervous, anxious, or on edge on several days or more compared to 55 percent of Black, African or African American students, according to data from the 2019 Minnesota Student Survey.[41]

Although one contributing factor may be stigma associated with mental disorders and mental health treatment among some individuals in minoritized racial and ethnic populations, as an article in the National Council for Mental Wellbeing argues:

"It is arrogant to believe that we can decide to focus on communities that have gone underserved and be embraced and trusted, without earning that trust. We must start by listening and seeking to understand not only Black, Indigenous, and people of color but all underserved or inappropriately served communities, including the LGBTQ and socio-economically disadvantaged communities."[42]

Untreated trauma and generational stressors can combine to form a high level of ambient background stress that affects both physical and mental wellbeing over time.

People experiencing poverty

Low income is associated with higher rates of mental disorders and substance use disorders. The stressors associated with poverty – from lack of access to nutritious food and safe housing to toxic exposures – have also been shown to correlate with an increased risk of problems with cognitive development in children that may begin before birth and last throughout an individual's life.[43] Moreover, some individuals and families who struggle to meet basic needs have income that falls above federal poverty guidelines: They don't have enough income to meet their needs, yet they also don't qualify for federal or state programs that are designed to help. These individuals and families fall through the cracks.

People experiencing poverty are at a higher risk of homelessness. In rural communities, however, so-called "hidden homelessness" can often be hard to detect. An individual or family may circulate among friends' or families' homes, or they may live in their car – they are experiencing all of the stressors of housing instability, although they may be difficult to identify.

Homelessness – whether a person is living on the street or crashing on a friend's couch – can ravage mental health: the stress associated with housing instability is immense and makes it more difficult to seek gainful employment and care for personal health and wellbeing. To make matters worse, most adults experiencing homelessness in Minnesota (81 percent) have a chronic physical health condition (57 percent), serious mental illness (64 percent), or substance use disorder (24 percent). Half of Minnesota adults experiencing homelessness have more than one of these conditions.[44]

COVID-19 and healing, connectedness, and mental health

COVID-19 exacerbated many of the factors that contribute to poor mental health, according to the CDC. In June 2020, 40 percent of U.S. adults reported struggling with mental health or substance use.

“During June 24–30, 2020, U.S. adults reported considerably elevated adverse mental health conditions associated with COVID-19. Younger adults, racial/ethnic minorities, essential workers, and unpaid adult caregivers reported having experienced disproportionately worse mental health outcomes, increased substance use, and elevated suicidal ideation.”[45]

As we look ahead, the worsened mental health and wellbeing that remain after the pandemic will continue to represent a significant community health need for both priority populations. During the COVID-19 pandemic, health disparities and psychosocial stressors for some racial and ethnic minority groups, especially Hispanic respondents, resulted in higher rates of mental health disorders, including substance use disorders.[46]

Addressing structural racism and barriers to equity

We are dedicated to confronting the ways in which racial and ethnic inequalities intertwine with social determinants of health to result in health disparities. Providing excellent health care to everyone in an environment that values diversity, equity, and inclusion is foundational to the ongoing work of dismantling the structures and systems that have worked to secure and promote inequities that disadvantage racial or ethnic populations experiencing health disparities and other marginalized individuals and groups.

In many ways, the concerns and challenges outlined in our other priority needs categories are deeply intertwined with structural racism and the barriers that have been erected to withhold opportunities from racial or ethnic populations experiencing health disparities for generations. The lives of minoritized racial and ethnic groups have been devalued and undervalued for centuries in the U.S. It's not enough to see and understand what's happening now; it is our responsibility to honor those who came before us and heed history’s lessons. This is the only way we can chart a path forward into a more just and equitable future for everyone.

Structural racism has resulted in a persistent wealth gap between white people and minoritized racial and ethnic groups, which in turn affects long-term health outcomes minoritized racial and ethnic groups. According to the Robert Wood Johnson Foundation:

“A long history of discrimination and structural racism explains the wealth gap among people in America. Race-based unfair treatment built into institutions, policies, and practices — such as residential segregation in impoverished neighborhoods; discrimination in bank lending to residents of largely minority neighborhoods; and discriminatory policing and sentencing practices — continue to play a major role in wealth inequality between people of color and white people in the United States.”[47]

The Robert Wood Johnson Foundation concludes that building wealth within communities that have been afforded fewer opportunities is critically important to building health equity. The U.S. Department of Health and Human Services has connected wealth and health equity by focusing on the role of social determinants of health — including racism and discrimination as well as financial stability — in determining an individual’s health.

Social determinants of health also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Simply promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.[48]

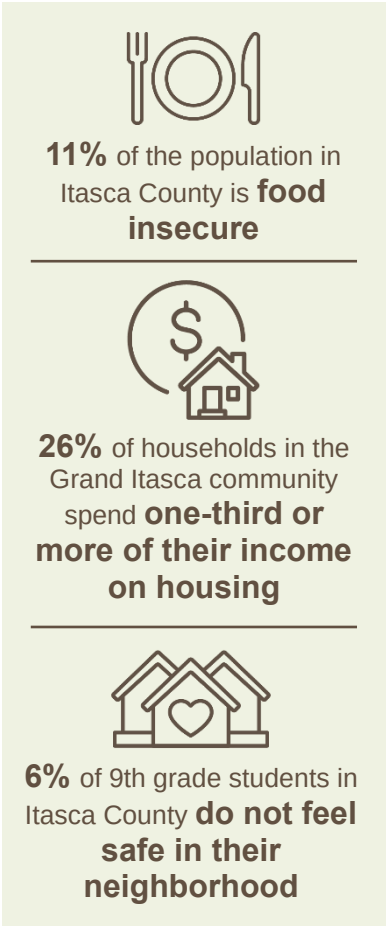
Grand Itasca Clinic & Hospital: Structural racism and barriers to equity

Food insecurity occurs when an individual or a household does not have easy access to enough nutritious food to maintain a high-quality diet. Food insecurity can result in increased consumption of low-cost, unhealthy foods, which can have a harmful effect on household members' physical and mental health. According to Feeding America, many food insecure households do not qualify for federal nutrition benefits such as SNAP (Supplemental Nutrition Assistance Program), depending instead on community programs like local food banks.[49] The vast majority of the counties at highest risk for food insecurity (87 percent) and most of the counties with the greatest percentage of children who are food insecure (86 percent) are rural counties.[50]

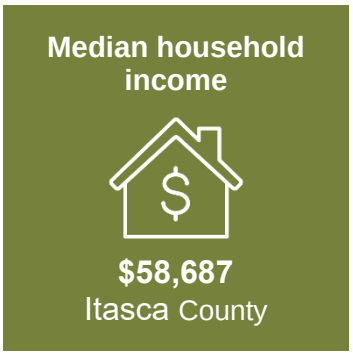
In 2017, an estimated 11 percent of Itasca County's population experienced food insecurity at some point during the year. Among children ages 0 to 17 in Itasca County, the precent is much higher with an estimated 18 percent experienced food insecurity as well.[51]

The physical environment is a key component of the health and wellbeing of individuals and families. According to the Minnesota Department of Health, the built environment's "physical characteristics may promote health by providing safe places for children to play and for adults to exercise that are free from crime, violence, and pollution."[52] In the 2019 Minnesota Student Survey results for Itasca County, six percent of ninth graders disagreed or strongly disagreed with the statement, "I feel safe in my neighborhood."[53]

Housing is generally the line item that consumes the greatest share of a household's budget, followed by food and transportation. Yet in Minnesota, housing continues to get more expensive. According to the Minnesota Housing Partnership, "Housing costs continue to increase disproportionately to income. Between 2000 and 2019, the median renter income in Minnesota increased by just one percent, while median gross rent for the state increased by 14 percent. This has led to an increase in cost burdened households."[54]



Sources: Feeding America, 2017; American Community Survey 2015-2019; Minnesota Student Survey, 2019

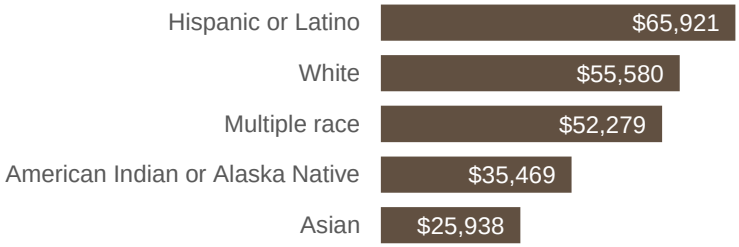


Source: Claritas, 2021

There is a strong link between income and health. When groups of people are marginalized and kept from building wealth, it affects communities in not only financial terms, but in health terms as well. Study after study has shown "longitudinal associations between greater wealth and many favorable health outcomes, including lower mortality, higher life expectancy, and decreased risks of obesity, smoking, hypertension, and asthma."[55]

This link is intergenerational. It persists as a child's family status influences that child's access to education and opportunities that can shape the individual's future. Having fewer opportunities increases the chance that a child will make fewer economic gains over a lifetime, further perpetuating the cycle. The median household income in Itasca County ($58,687) is lower than the state's ($80,714). We also see disparities in median household income by race and ethnicity.

Median household income by race and ethnicity, Itasca County



**Unavailable fore Black. Native Hawaiian or Pacific Islander. and some other race.*

Source: American Community Survey 2015-2019

Racial and ethnic populations experiencing health disparities and other marginalized individuals and groups need to have a leading voice in the decisions being made about their communities. As we have conducted listening sessions with community members, we have learned that among the top challenges in the Grand Itasca community related to structural racism and barriers to equity are:

Structural racism and barriers to equity: Community voice summary

- Barriers for safe and healthy home atmosphere
- Community divisiveness
- COVID-19 disparities
- Geographic distance to resources
- Housing for seniors – long wait lists
- Inaccessible healthy foods (affordability, availability)
- Income inequality
- Invisibility of BIPOC
- Job inequality
- Lack of access to fitness facilities
- Limited wheelchair friendly vehicles
- Need for more community voice
- Need for more safe, stable, affordable housing (children, seniors)
- Poverty (generational, fixed income, non-livable wages, families)
- Racism
- Rural health disparities
- School disruption because of COVID-19
- Stress of poverty and living in constant survival mode
- Unemployment
- Vulnerable children and families

For more details on our community conversation process, please see the “Primary data collection and review” section of the report below.

Priority populations: Structural racism and barriers to equity

Racial or ethnic populations experiencing health disparities

Minnesota is one of the healthiest states in the nation,[56] but it is also among the states with the greatest health disparities between white people and minoritized racial and ethnic groups. Minoritized racial and ethnic groups in Minnesota face health disparities resulting from systemic racism and health inequities. A 2021 report of healthcare disparities in Minnesota concluded, “In general, Indigenous/Native, Black, and Hispanic/Latinx patients have significantly lower rates of optimal care compared to the statewide average in most of the reported measures,” including colorectal cancer screening, optimal diabetes care, optimal vascular care, optimal asthma control, and mental health screening.[57]

Inadequate access to supports for social determinants of health contribute to lower rates of preventive care, longer time to diagnosis, and more barriers to care. The ambient stressors of financial insecurity, food insecurity, lower wages, violence, and a host of other factors also affect individuals’ ability to maintain and improve their health — and these social determinants of health factors disproportionately affect racial or ethnic populations experiencing health disparities.

Systemic inequities such as zoning laws, have disproportionately driven down property values and driven out commercial investment in communities with high numbers of minoritized racial and ethnic groups. The effects of structural racism are revealed in the homeownership gap within the Grand Itasca community. In Itasca County, 34 percent of minoritized racial and ethnic householders own their homes, compared to 82 percent of white, non-Hispanic or Latino householders.

Educational inequality, and the generational wealth disparities that result from those inequities, affects the population we serve as well. Just 5.4 percent of the community's white residents do not have a high school diploma, whereas 39.0 percent of residents who identify as Black or African American do not have a high school diploma. Higher levels of education unlock a wider range of opportunities for good-paying jobs with benefits. In turn, those higher incomes can lead to a range of positive health-related outcomes, from living in a safe area to having easy access to healthy food and medical care. Conversely, lower levels of education lock many people out of this positive trajectory.

Homeownership in Itasca County

82% white householders

34% minoritized racial and ethnic householders

Source: American Community Survey 2015-2019

No high school diploma by race and ethnicity Grand Itasca community

Race and ethnicity	Total	#	Percent
Asian	0	0	0.0%
Black or African American	59	23	39.0%
Hispanic or Latino	292	44	15.1%
Multiple race	401	12	3.0%
Native American or Alaska Native	918	152	16.6%
Native Hawaiian or Pacific Islander	0	0	0.0%
Some other race	42	4	9.5%
White	26,418	1,416	5.4%

Source: American Community Survey 2015-2019

People experiencing poverty

Poverty correlates with increases in negative outcomes across the board, and it makes almost every aspect of life more difficult. Low income levels force individuals and families to make impossible choices — between buying food and buying medicine, for example. The health care system — like so many other social, economic, and cultural systems — are not designed with the needs of people experiencing poverty in mind.

Population below 100 percent federal poverty level by race and ethnicity, Grand Itasca community

Race and ethnicity	Total	#	Percent
Asian	162	44	27.2%
Black or African American	110	31	28.2%
Hispanic or Latino	473	81	17.1%
Multiple race	985	318	32.3%
Native American or Alaska Native	1,571	568	36.2%
Native Hawaiian or Pacific Islander	0	0	0.0%
Some other race	0	0	0.0%
White	35,362	3,713	10.5%

Source: American Community Survey 2015-2019

About five percent of the Grand Itasca community is living in a household with income below 50 percent of the federal poverty level. That means for a family of four, the household annual income is around $12,875.

Poverty and homelessness affect more people than ever in Minnesota. The Wilder Research study on homelessness in Minnesota found that homelessness increased 10 percent from 2015 to 2018 in Minnesota, with a 25 percent increase in homelessness among older adults (age 55+). A lack of affordable and subsidized housing in Minnesota is the primary barrier for getting out of homelessness.[58]

Homelessness presents significant challenges to succeeding at school, increasing the risk that a student will drop out before graduating from high school. Without a high school diploma, individuals face a narrower range of employment options, many of which are low-paying jobs without benefits. Jobs like these do not enable the upward mobility people experiencing poverty need to break out of their current situation and chart a brighter path forward. According to the Minnesota Student Survey, within the Grand Itasca community, 1.8 percent of the 5,483 students enrolled during the 2018-2019 school year were homeless, which Is lower than the statewide rate of 2.2 percent.

5% of individuals in the Grand Itasca community live in household with income below **50 percent federal poverty level**

For a **family of four**, the household annual income is around **$12,875**

Sources: American Community Survey 2015-2019; Department of Health and Human Services, 2019.

COVID-19 and structural racism and barrier to equity

COVID-19 is exposing what has always been true: racism is pervasive and persistent. This virus is exacerbating Minnesota's racial disparities on many fronts. The coronavirus pandemic disproportionately affected Hispanic or Latino, non-Hispanic Black or African American (Black), and non-Hispanic American Indian or Alaska Native populations — communities that have experienced higher infection rates and higher death rates throughout the pandemic[59] — as well as those experiencing poverty.[60]

Minoritized racial and ethnic groups have substantially higher rates of health inequities, making them more susceptible to getting infected and more susceptible to death from COVID-19. Indigenous Minnesotans have the highest proportion of positive cases that have resulted in hospitalization or spending time in the intensive care unit. Black and Latinx Minnesotans are testing positive, getting hospitalized, and needing care in intensive care units at higher rates compared to the overall population.[61]

Minoritized racial and ethnic groups experienced higher job losses during the COVID-19 pandemic, causing increased financial instability and may also result in loss of health insurance, reduced access to health care, and food and housing insecurity.

Assessment process and methods

This segment of the report details the methodology and processes we used to meet key Affordable Care Act regulatory requirements for the CHNA.

The assessment process and data collection methods we used during this CHNA cycle were different than ever before due to the COVID-19 pandemic. COVID-19 caused delays in data collection among local, state, and national organizations. As a result of these delays, the U.S. Census Bureau had not yet released finalized data from the 2020 U.S. Census by the time we began the CHNA process. As a result, we used 2015-2019 American Community Survey data. Local public health agencies also were not able to provide updated data as they have in the past. We acknowledge that, due to these setbacks, the data we used is less recent than desired.

Additionally, COVID-19 required us to add new safety precautions to our method of gathering community voice data. For example, all conversations and interviews, which had previously been in-person meetings, took place in a virtual format instead.

Secondary data review

Secondary data were gathered from five sources: American Community Survey, Claritas, The Minnesota Student Survey, Spark Maps, and Truven Health Analytics.

American Community Survey is an ongoing survey by the U.S. Census Bureau designed to provide information about how communities are changing. It annually gathers information previously contained only in the long form of the decennial U.S. Census such as ancestry, educational attainment, income, language proficiency, and housing characteristics. While Spark Maps contains most of the data from American Community Survey that was used. There was some that were not included in Spark Maps that we used straight from American Community Survey.

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 U.S. 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.

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.

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 sources from over 100 sources, among them 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.

Truven Health Analytics, together with Catholic Healthcare West, developed Community Need Index scores. Community Need Index scores combine publicly available and proprietary data to create an objective measure of socioeconomic barriers to healthcare access and their effect on hospital readmission rates for ambulatory sensitive conditions. The data used in this report is the index scores; the underlying data was not purchased.

- A **Community Need Index** score is a tool used to identify the severity of health disparities by zip code. Research has shown that zip codes with high Community Need Index scores show a strong correlation to inappropriately high 30-day hospital readmission rates.[62] Community Need Index scores are based on five prominent socioeconomic barriers to healthcare access and range by zip code from a score of one (lowest need) to five (highest need).

Primary data collection and review

Grounding in 2018 CHNA primary data

For this CHNA, we grounded ourselves in, and built outward from, the extensive qualitative data that we collected in 2018. During the summer of 2018, we talked with 515 individuals, across all Fairview communities, who represented a broad spectrum of views, experiences, and identities including, but not limited to, Black, Indigenous, and people of color; people experiencing poverty; and people ages 65 and older. We received a wealth of input from these conversations (please see our 2018 CHNA for more details).

Because we are building on and refining our priority needs from 2018 during this cycle, it was crucial for our work to be grounded in the conversations that we had conducted in 2018. Data collection in 2018 consisted of:

- **Facilitated discussion:** The hospital community health steering committee played a critical role in directing the focus of the hospital's primary data collection. The steering committee members are a diverse cross-section of area community leaders and key internal staff.
- **Internal focus groups**: Non-physician provider focus groups helped to inform the focus and guided the CHNA by increasing understanding of health needs, barriers, and assets among patients/populations served by the non-physician providers. Participants included care managers and care coordinators.
- **Community conversations:** Community conversations increased our understanding of health needs, barriers, and assets among specific community populations. The hospital community health steering committee helped to determine who should be included in these conversations.
- **Key stakeholder interviews:** We supplemented community input by conducting key stakeholder interviews with local officials, leaders of nonprofit organizations, public health leaders, content experts, and others who understand the needs of the community and the unique needs of seniors, people experiencing poverty, Black, Indigenous and people of color in the community.

See Appendix D for a more detailed description of the sectors we included and the organizations that participated.

Deepening our understanding

We collected additional community voice data by convening a broad array of stakeholders, with special focus on the priority populations. The process included discussions with community health steering committee, the Fairview community advisory council, the HOPE Commission listening and learning sessions, and key stakeholder interviews. Throughout this process, community members, local business leaders, government representatives, nonprofit and community organizations, and content experts shared their voices and perspectives about their community's health needs.

Community Health Steering Committees

Each hospital within Fairview has a community committee that is involved in the CHNA process throughout the three-year cycle. Each committee is comprised of local community and organizational leaders and is staffed by the Grand Itasca Community Relations department and the Fairview Community Advancement department. Community health steering committees met four times between April and October in 2021, three of which were individual committee meetings and one of which was a system-wide Community Impact Summit that brought all the committees together. Each committee meeting consisted of facilitated discussions through which our team gathered input about top community needs.

For a detailed description of Community Health Steering Committees' representation, see Appendix E.

Community Advisory Council

The Fairview Community Advisory Council, composed of key community leaders and staffed by Community Advancement, reviews the CHNA report and written implementation strategy and recommends it to the Patient Care and Experience Committee of the Fairview Board of Directors for adoption. Each member represents the member's respective community, and members represent a broad range of sectors, among them community organizations serving cultural communities, higher education organizations, banks, and a nonprofit electric company. The Community Advisory Council met from May through November 2021 to participate in the CHNA process, give feedback, and ultimately recommend the CHNA and implementation strategy for adoption.

For specific Community Advisory Council review dates, please see the "Next steps" section of this report.

HOPE listening and learning sessions and town halls

The HOPE Commission is a multi-year transformational change effort of M Health Fairview to drive more equitable outcomes and inclusive environments and experiences for our patients, employees, and communities. The Commission conducted a series of listening and learning sessions in 2020 and 2021. The objective was to hold a mirror to Fairview to assess where we are now and how we can make lasting change. Part of being an anti-racist health system is developing a candid understanding of our shortcomings. We particularly sought to hear perspectives and ideas from the most impacted populations: BIPOC employees and patients, front-line workers who care for underserved and marginalized patients, and those patients themselves. A survey was also made available each year to gather insights and suggestions from employees and patients who could not directly participate in a listening and learning session.

In 2020, the commission convened 32 virtual listening and learning sessions and two town halls involving more than 1,500 participants across Fairview sites. The sessions focused on employees but included patients and community members as well. In September 2021, the HOPE Commission continued the listening and learning sessions following the same model. In this iteration, however, the focus was primarily on gathering input from patients (and employees as patients). In both 2020 and 2021's listening and learning sessions, the facilitators and note takers reflected the community represented by the session's group to the greatest degree possible.

Key stakeholder interviews

In August and September 2021, Fairview's Community Advancement team conducted a series of interviews with staff members who work with communities. Each conversation followed a consistent interview protocol developed for this purpose, and each interview was captured by means of detailed notes. The goal of these interviews was to draw on staff expertise to gain a deeper understanding of our priority needs and to determine whether there are any emerging needs that we should be considering. Between Aug. 31 and Sept. 17, 2021, we conducted 17 interviews.

Focus groups

In August 2021, we held two focus groups in partnership with other organizations. We convened the first focus group in partnership with HealthPartners and Allina Health, and the participants were faith community nurses. We convened the second focus group in partnership with the organizations that are a part of the East Side Health and Well-being Collaborative. This meeting's focus was on accessing care and resources for different cultural communities.

Surveys

Fairview also participated in two large surveys. KRC Research conducted a survey around health and health care needs in St. Paul between June 8 and July 7, 2021 and administered it to community members, Fairview employees, patients, and community partners. Responses were received from 294 residents, more than 1,000 employees, 221 patients, and 20 partners. The survey was offered online and by phone and in five languages: English, Spanish, Hmong, Somali, and Karen.

Fairview also supported and was a partner organization in Bridge to Health, a survey that assesses the health needs of northern Minnesota residents. The Bridge to Health survey was administered between Aug. 28 and Oct. 23, 2020. The geographic areas that were sampled included Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, St. Louis, and Pine counties in Minnesota, as well as Douglas County in Wisconsin.[63]

Ongoing feedback from Community Advancement program participants
As a foundational part of program planning and evaluation, Community Advancement staff 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 and drive insights into the needs of the communities we serve.

Primary data methods
Fairview staff developed standardized tools, processes, instructions, and facilitator, interviewer, and note-taker protocols and training. All primary data was compiled, cleaned, and analyzed. Community conversations lasted various lengths from 30-120 minutes. All community input was captured by a note-taker.

Significant needs and needs not addressed

Prioritizing needs that are the root causes of almost all health disparities allows us to develop upstream strategies that will have a large and lasting impact in our communities. All of the significant needs we have identified will ultimately be positively impacted by addressing the root causes we have identified as our priority needs.

Definition of community

The CHNA community of each hospital and medical center is defined as a subset of zip codes within the Fairview service area, where 90 percent of its patients live. Each of the hospitals and medical centers were attributed unique zip codes and geographies. The Grand Itasca Clinic and Hospital is comprised of 11 zip codes. Our definition of communities includes all community members, including those who are patients and employees who live, work, and play in our service areas.

See Appendix C for list of zip codes, cities, and counties included.

Contract support

The Fairview team contracted with the following groups to support our assessment process:

- Loren Blinde, PhD of Writing Power, a copywriter and content strategist, on the writing of the report.
- Kristi Fordyce, an independent contractor, for analysis support.
- Weber Shandwick, for data collection and analysis of focus groups and stakeholder interviews focused on St. Paul.
- KRC Research for the administration and analysis of the St. Paul Community Survey.

Available resources and assets

As the Grand Itasca Clinic and Hospital develops its CHNA implementation strategy, we will look to both internal and external resources to address the significant health needs identified through the CHNA process described in this report.

External resources include existing initiatives, programs, and relationships, which are the foundation from which the implementation strategy will be built.

Next steps

Listening to the community and working with our academic partners
Through the end of 2021 and into 2022, we are engaging in a series of community-wide conversations about the impact of social determinants of health on health inequities in our community. By listening and learning, we are gaining valuable insight into what our implementation strategies and action plans should look like.

We're also working with our academic partners, including an ongoing engagement with the University of Minnesota's School of Public Health and other academic institutions, to conduct 10-year analyses using the data we've collected about social determinants of health, culturally competent care, and other critically important issues. We look forward to learning more about the ways health inequity is affecting our community, which will inform our implementation approach as well.

Adoption by the Fairview Board of Directors
The Grand Itasca Clinic and Hospital Board of Directors adopted the Grand Itasca Clinic and Hospital 2021 Community Health Needs Assessment report on December 15, 2021. This report is available on our website as of December 31, 2021.

Formulating implementation strategies
In late 2021, the Grand Itasca Clinic and Hospital will conduct the final steps in the assessment process by developing a written CHNA implementation strategy to address the identified priority health needs – navigating access to care and resources; healing, connectedness, and mental health; and addressing structural racism and barriers to equity. Local steering committees, the health system's Community Advisory Council, and the Patient Care and Experience Committee will review the implementation strategies in early 2022.

The Grand Itasca Clinic and Hospital Board of Directors will be asked to adopt the Grand Itasca Clinic and Hospital 2022-2024 Community Health Needs Assessment Implementation Strategy in May 2022. The document will be publicly available on our website by May 15, 2022 and executed during fiscal years 2022 to 2024.

2019-2021 Community Health Improvement Plan outcomes

Between 2019 and 2021, Grand Itasca implemented the Community Health Improvement Plan (CHIP) and evaluated outcomes. The CHIP programs are centered at the local hospital and implemented in collaboration with Fairview**.** Program leaders and instructors are from the local community, and the programs are executed in partnership with local organizations and agencies.

The program information we are sharing in this section is the tip of the proverbial iceberg — a great deal of other work is occurring, day in and day out. None of this work is done in a silo — we're engaging with a wide range of community partners to amplify our impact and engage in sustained, measurable, and meaningful change.

Finally, the COVID-19 pandemic brought with it many changes to the way we both executed our programs and measured their success. The data collection and measurement processes we had used to develop past CHNA reports needed to change in order to keep our staff and community safe. In addition, because many of our programs shifted from in-person to virtual formats, participants engaged in those programs were not necessarily confined to our community. Overall, we made intentional choices to measure data in new ways that would minimize the impact of our data collection on the communities we were serving.

Living Well suite of programs			
Chronic Disease Self-Management | Chronic Pain Self-Management | Diabetes Self-Management These are evidence-based programs developed by Stanford University's Patient Education Research Center. Workshops are offered to individuals and their caregivers who are living with chronic conditions, pain, or diabetes. Subjects addressed include medication use, communication with doctors and caregivers, nutrition and fitness with practical exercises and advice designed to meet participants' needs.			
Priority area(s)	**Anticipated impact**	**Anticipated impact response / results**	**Other program impacts**
Access to care and resources	Increase in participants who agree that the program helps them work with their health care providers.	67% of respondents strongly agree or agree, "I am confident I can work with healthcare professionals."	Number of participants: 39 Number of Chronic Disease Self-Management classes: 2 Number of Chronic Pain Self-Management classes: 3
Healthy lifestyles	Increase participants' confidence to manage a chronic condition.	90% of respondents strongly agree or agree, "I am confident I can manage a chronic condition."	
Partnership	Juniper		

Mental Health First Aid			
Mental Health First Aid is an internationally recognized evidence-based program that was created and is managed by the National Council for Behavioral Health. It is an eight-hour class that introduces participants to risk factors and warning signs of mental illnesses, builds understanding of their impact, and overviews common supports. There is a youth version that focuses on adults working with adolescents.			
Priority area(s)	**Anticipated impact**	**Anticipated impact response / results**	**Other program impacts**
Access to care and resources	Increase participants' confidence in assisting someone to connect with professional resources.	36% increase (from 58% to 94%) of respondents strongly agree or agree, "I can assist someone who may be dealing with a mental health problem, substance use challenge or crisis in seeking professional help."	Number of participants: 45 Number of adult classes: 1 Number of youth classes: 2 Number of older adult classes: 1
Mental health and wellbeing	Increase participants' ability to recognize and correct misconceptions about mental health and mental illness.	39% increase (from 58% to 97%) of respondents strongly agree or agree, "I can recognize and correct misconceptions about mental health, substance use and mental illness as I encounter them."	
Partners	National Council for Behavioral Health		

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Appendices

- Appendix A: Community Health Needs Assessment Section 501(r)(3) checklist
- Appendix B: CHNA core data indicator list
- Appendix C: Grand Itasca Clinic & Hospital cities, zip codes, and CNI scores
- Appendix D: 2018 Grand Itasca Clinic & Hospital Community voice summary
- Appendix E: Grand Itasca Clinic & Hospital Community Health Steering Committee

Appendix A: Community Health Needs Assessment Section 501(r)(3) checklist

Documentation of CHNA written report requirements	Page number
A definition of the community and a description of how the community was determined	12, 31
A description of the process and methods used to conduct the CHNA	27-31
Describes the data and other information used in the assessment	27-31
Describes the methods of collecting and analyzing this data and information (may rely on and describe in report) external source material in which case the hospital may simply cite the source material rather than describe the methods of collecting the data	27-31
Identifies any parties with whom the hospital facility collaborated or contracted for assistance in conducting the CHNA	31
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	29-31
Summarize, in general terms, the input provided by such persons	18, 21, 25, 29-31
Describe 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)	29-31
Provide the names of any organizations providing input and summarize the nature and extent of the organization's input	29-31, 45-47
Describe the medically underserved, low-income, or minority populations being represented by organizations or individual's that provided input	45-47
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	15
A description of the resources potentially available to address the significant health needs identified through the CHNA	32
An evaluation of the impact of any actions that were taken to address the significant health needs identified in the immediately preceding CHNA	33-34
Adopted for the hospital facility by an authorized body of the hospital facility	32

Appendix B: CHNA core indicators

Category	Indicators	Data source	Year
Access to Care	Addiction/Substance Abuse Providers	Centers for Medicare and Medicaid Services, CMS Geographic Variation Public Use File	May 2021
Access to Care	BIPOC Providers	Minnesota Department of Health; MDH ORHPC Physician Workforce Survey	2019
Access to Care	Dentists	U.S. Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File	2015
Access to Care	Lack of Prenatal Care	Centers for Disease Control and Prevention, National Vital Statistics System.	2019
Access to Care	Mental Health Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES)	2020
Access to Care	Physicians who Communicate in a Language Other than English, in Their Practice	Minnesota Department of Health; MDH ORHPC Physician Workforce Survey	2019
Access to Care	Population Receiving Medicaid	U.S. Census Bureau, American Community Survey	2015-2019
Access to Care	Primary Care Physicians	US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File	2017
Access to Care	Uninsured Population	U.S. Census Bureau, American Community Survey	2015-2019
Access to Care	Age 65+ Uninsured	U.S. Census Bureau, American Community Survey	2015-2019
Clinical Care	Colorectal Cancer Screening	Minnesota Community Measures	2020
Clinical Care	Flu Vaccinations	Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases (NCIRD)	2019-2020
Clinical Care	Optimal Diabetes Care	Minnesota Community Measures	2020
Clinical Care	Optimal Vascular Care	Minnesota Community Measures	2020
Community Safety	ACEs Score-Short	Minnesota Student Survey	2019
Community Safety	I feel safe in my neighborhood	Minnesota Student Survey	2019

Category	Indicators	Data source	Year
Demographics	Age 0-17	Claritas	2021, 2026
Demographics	Age 18-44	Claritas	2021, 2026
Demographics	Age 45-64	Claritas	2021, 2026
Demographics	Age 65+	Claritas	2021, 2026
Demographics	Median Age	Claritas	2021, 2026
Demographics	American Indian/Alaskan Native	Claritas	2021, 2026
Demographics	Asian	Claritas	2021, 2026
Demographics	Black/African American	Claritas	2021, 2026
Demographics	Native Hawaiian/Pacific Islander	Claritas	2021, 2026
Demographics	Some Other Race	Claritas	2021, 2026
Demographics	Two or More Races	Claritas	2021, 2026
Demographics	White	Claritas	2021, 2026
Demographics	Ethnicity: Hispanic/Latino	Claritas	2021, 2026
Demographics	Foreign-Born	U.S. Census Bureau, American Community Survey	2015-2019
Demographics	Language Other than English	U.S. Census Bureau, American Community Survey	2015-2019
Demographics	Population with Disability	U.S. Census Bureau, American Community Survey	2015-2019
Demographics	Population with Limited English Proficiency	U.S. Census Bureau, American Community Survey	2015-2019
Demographics	Veteran Population	U.S. Census Bureau, American Community Survey	2015-2019
Education	Bachelor's Degree or Higher	U.S. Census Bureau, American Community Survey	2015-2019
Education	High School Graduate or Higher	U.S. Census Bureau, American Community Survey	2015-2019
Education	No High School Diploma	U.S. Census Bureau, American Community Survey	2015-2019
Employment	Unemployed Population	Claritas	2021, 2026
Family & Social Support	Age 65+ Living Alone	U.S. Census Bureau, American Community Survey	2015-2019
Family & Social Support	Connection with Caring Adult	Minnesota Student Survey	2019
Housing & Transit	BIPOC Homeowners	U.S. Census Bureau, American Community Survey	2015-2019
Housing & Transit	Homeless Children and Youth	U.S. Department of Education, EDFacts	2018-2019

Category	Indicators	Data source	Year
Housing & Transit	Households Renting	U.S. Census Bureau, American Community Survey	2015-2019
Housing & Transit	Households with No Vehicle	U.S. Census Bureau, American Community Survey	2015-2019
Housing & Transit	Housing Cost Burden (30%)	U.S. Census Bureau, American Community Survey	2015-2019
Housing & Transit	Substandard Housing	U.S. Census Bureau, American Community Survey	2015-2019
Housing & Transit	White Alone, not Hispanic or Latino Homeowners	U.S. Census Bureau, American Community Survey	2015-2019
Income	Children Eligible for Free/Reduced Price Lunch	National Center for Education Statistics, NCES - Common Core of Data	2018-2019
Income	Food Insecurity	Feeding America	2017
Income	Households Receiving SNAP Benefits	U.S. Census Bureau, American Community Survey	2015-2019
Income	Low Food Access	U.S. Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas	2015
Income	Median Household Income	Claritas	2021, 2026
Income	Poverty – Below 100% Federal Poverty Level	U.S. Census Bureau, American Community Survey	2015-2019
Income	Poverty – Below 200% Federal Poverty Level	U.S. Census Bureau, American Community Survey	2015-2019
Income	Poverty – Below 50% Federal Poverty Level	U.S. Census Bureau, American Community Survey	2015-2019
Income	Ages 65+ – Below 100% Federal Poverty Level	U.S. Census Bureau, American Community Survey	2015-2019
Income	Children – Below 100% Federal Poverty Level	U.S. Census Bureau, American Community Survey	2015-2019
Length of Life	Leading Causes of Death	Minnesota Department of Health, County Health Tables	2019
Length of Life	Leading Causes of Premature Death	Minnesota Department of Health, County Health Tables	2019
Length of Life	Life Expectancy	Centers for Disease Control and Prevention and the National Center for Health Statistics, U.S. Small-Area Life Expectancy Estimates Project	2010-2015
Length of Life	Mortality, Suicide	Centers for Disease Control and Prevention, National Vital Statistics System.	2015-2019

Category	Indicators	Data source	Year
Length of Life	Suicidal Consideration	Minnesota Student Survey	2019
Other	Community Need Index (CNI) Score	Truven Health Analytics	2019
Physical Environment	Households with No or Slow Internet	U.S. Census Bureau, American Community Survey	2015-2019
Physical Environment	Park Access	U.S. Census Bureau, Decennial Census, Environmental Systems Research Institute Map Gallery	2013
Quality of Life	Poor Mental Health (14+ days per month)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System	2020
Quality of Life	Poor Physical Health (14+ days per month)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System	2020

Appendix C: Grand Itasca Clinic & Hospital community zip codes, cities, and Community Need Index (CNI) Scores

Zip code	City	County	2019 CNI score
55709	Bovey	Itasca	2.8
55716	Calum	Itasca	*
55721	Cohasset	Itasca	1.4
55722	Coleraine	Itasca	2.4
55744	Grand Rapids	Itasca	2.6
55748	Hill City	Aitkin	2.8
55764	Marble	Itasca	*
55786	Taconite	Itasca	*
55793	Warba	Itasca	1.8
56636	Deer River	Itasca	3.0
56672	Remer	Cass	2.8

*Community Need Index score not available due to low population

Appendix D: 2018 Grand Itasca Clinic & Hospital CHNA community voice

	Sectors	Organizations represented
Key stakeholder interviews	Education Government Healthcare Local Public Health Social Services	Blandin Foundation Grand Village Invest Early Itasca Community College Itasca County Health and Human Services North Homes Children and Family Services Ross Resources
Facilitated discussions	Education Funder Healthcare Local Public Health Social Services	Arrowhead Agency on Aging Blandin Foundation City of Grand Rapids ElderCircle GetFit Itasca Grand Itasca Clinic & Hospital Grand Rapids Area Community Foundation Independent School District 318 Itasca County Public Health Itasca County YMCA Keisler Wellness Center United Way of 1,000 Lakes
Focus group	Healthcare • Nursing • Rehab/Physical Therapy • Social Services	Grand Itasca Clinic & Hospital

	Populations	Collaborators
Community conversations	Aging population People experiencing poverty People of color and Indigenous people	ElderCircle Itasca County Public Health Itasca County YMCA Kiesler Wellness Center

Appendix E: Grand Itasca Clinic & Hospital Community Health Steering Committee

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 institute.
Fairview Range	Healthcare	Fairview Range, an affiliate of M Health Fairview, 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.
Head Start	Social Services	Head Start is a federally funded early childhood program serving children ages 3-5 and their families with education, family support, health services, disability services, and mental health support.
Hill City School District	Education	Hill City School is a pre-K through grade 12 public school district located in Hill City, MN and serving the cities of Hill City, Jacobson, and Swatara.

Organization	Sector	Organization description
ISD #317 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 Public Health	Local Public Health	Itasca County Public Health supports policies and offers programming designed to promote the health of residents of Itasca County including social services, nursing, education, immunizations, and other health services.
Itasca County Public Health/SHIP	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 in order to help people in Minnesota prevent chronic diseases including cancer, heart disease, stroke, and type 2 diabetes.
Kootasca Community Action	Social Services	Kootasca Community Action helps individuals, families, and communities fight the multiple causes and challenges of poverty.
NAMI 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.
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 Heartland	Social Services	Second Harvest Heartland 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.