Community Health Implementation Plan

February 26, 2019

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About HealthPartners

HealthPartners is the largest consumer-governed, non-profit health care organization in the nation with a mission to improve health and well-being in partnership with members, patients and the community. For more information, visit healthpartners.com.

Mission, Vision and Values

Our mission – to improve the health and well-being of those we serve – is the foundation of our work. And that work is guided by our vision and values, creating a culture of Head + Heart, Together.

Mission

To improve health and well-being in partnership with our members, patients and community

Vision

Health as it could be, affordability as it must be, through relationships built on trust

Values

Excellence, compassion, partnership, integrity

About Park Nicollet Health Services

Park Nicollet Health Services is part of HealthPartners, the largest consumer-governed, non-profit health care organization in the nation with a mission to improve health and well-being in partnership with members, patients and the community. Park Nicollet Health Services is an integrated care system that includes Park Nicollet Methodist Hospital, Park Nicollet Clinics, Park Nicollet Specialty Centers, and Park Nicollet Foundation. This report describes the current Community Health Needs Assessment (CHNA) process and results for Park Nicollet Health Services.

Community Served

While Park Nicollet Health Services serves patients from everywhere, 75 percent of our patients live in Dakota, Hennepin and Scott Counties in Minnesota. Park Nicollet Methodist Hospital is located in the city of St. Louis Park in Hennepin County. In total, these three counties that make up our community have 2.4 million people. In 2017, nearly 600,000 patients living in these counties received care from Park Nicollet Health Services.

Summary of the Community Health Needs Assessment (CHNA) process

HealthPartners collaborated across six hospitals within its family of care for the CHNA:

- Amery Hospital & Clinic (Amery, WI)
- Hudson Hospital & Clinic (Hudson, WI)
- Lakeview Hospital (Stillwater, MN)
- Park Nicollet Health Services including Methodist Hospital (St. Louis Park, MN)
- Regions Hospital (St. Paul, MN)
- Westfields Hospital & Clinic (New Richmond, WI)

Each hospital engaged with local public health partners, local health organizations and community members for input on community assets and resources as well as primary and secondary data.

HealthPartners Approach to Equity

At HealthPartners, a top priority is to make sure everyone has equal access to excellent and reliable health care and services, to work toward a day where every person, regardless of their social circumstances, has the chance to reach their best health. This requires us to identify and work towards eliminating health disparities, defined by the CDC as "preventable differences in the burden of disease, injury, violence or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups and communities."

Our commitment to health equity shaped our approach to our CHNA and will continue to as we develop an implementation plan to address community health needs in partnership with our community. This includes considering factors such as race, ethnicity, age, gender identity, socioeconomic status and education levels when setting priorities and developing implementation plans.

CHNA Prioritization Process

HealthPartners collectively prioritized community health needs using a process informed by a modified Hanlon method and other commonly used prioritization methods. Each hospital shared its 4-5 priority topic areas and rationale for each topic area based on:

- Size: Number of persons affected, taking into account variance from benchmark data and targets;
- Seriousness: The degree to which the problem leads to death, disability and impairment of one's quality of life (mortality and morbidity);
- Equity: Degree to which specific groups are affected by the problem;
- Value: The importance of the problem to the community; and
- Change: What is the same and what is different from your previous CHNA?

HealthPartners hospitals used a thorough, facilitated large and small group process to reach consensus on top priorities. The CHNA Team considered the criteria described above as well as community input data in these discussions. The five priorities are of equal importance and are presented in alphabetical order:

Key Priority Areas

Access to care

Access to care refers to having equitable access to appropriate, convenient and affordable health care. This includes factors such as proximity to care, access to providers, cost, insurance coverage, medical transportation, care coordination within the health care system and cultural sensitivity and responsiveness.

Access to health

Access to health refers to the social and environmental conditions that directly and indirectly affect people's health, such as housing, income, employment, education and more. These factors, also referred to as social determinants of health, disproportionately impact low income communities and communities of color.

Mental health and well-being

Mental health and well-being refers to the interconnection between mental illness, mental health, mental well-being and the associated stigma. Poor mental health is associated with poor quality of life, higher rates of chronic disease and a shorter lifespan.

Nutrition and physical activity

Nutrition and physical activity refers to equitable access to nutrition, physical activity and food and feeding choices. Poor nutrition and physical inactivity are major contributors to obesity and chronic diseases such as diabetes, heart disease and stroke, which disproportionally impact low income communities and communities of color.

Substance abuse

Substance abuse and addiction are the excessive use of substances including alcohol, tobacco, prescription drugs, opioids and other drugs in a manner that is harmful to health and well-being.

Other Priorities Not Selected

HealthPartners discussed and considered additional or alternative priorities during the prioritization process, including culturally competent care and sensitivity and coordination of services. These needs were not selected as one of the top five priorities but will be considered in the implementation plans for the selected priority areas.

Community Health Implementation Plan FY 2019-2021

Priority: Access to care

Definition: Access to care refers to having equitable access to appropriate, convenient and affordable health care. This includes factors such as proximity to care, access to providers, cost, insurance coverage, and medical transportation, care coordination within the health care system and cultural sensitivity and responsiveness.

Goal: Provide culturally competent care and service with members, patients and community.

Strategies:	**Anticipated Impact:**
• Ensure that providers and staff are equipped and have skills needed • Ensure services are available through Care Coordinators to bridge the care gap for patients both within Park Nicollet Health Services and to external partners • Methodist Hospital Equity Committee will provide consultation and partnership services to all PNHS departments and specialty areas focused on data and strategies to identify disparities and work toward equity	• An inclusive culture where every person including whom we serve and our workforce is welcomed, included, and valued • Decrease health disparities and outcomes for patients of color

Goal: Increase capacity to meet proximity and type of care and patient care needs.

Strategies:	**Anticipated Impact:**
• Sustain and improve Telemedicine • Increase psychiatry and mental health access (see also mental health priority) • Promote Virtuwell, phone lines • Provide Diabetes education in the hospital and provide a warm handoff for transition patients to transitional care units and nursing homes • Provide homeless patients with Frio packet to maintain integrity of insulin used to manage diabetes and prevent high blood sugars • Roll out Continuous Glucose Monitoring for patients with Diabetes to primary care clinics • International Diabetes Center and Frauenshuh Cancer Center collaborate to ensure blood sugars are managed in cancer patients with diabetes	• Timely care delivery • Increased use • Decreased hospitalizations • Increased effectiveness of cancer treatments • Increased convenience and decreased cost of care for diabetes patients • Decreased readmissions

• Make it affordable for our patients and community members to attend Stroke INSPIRE programming by providing most programming free of charge. • Continue to partner with local Transitional Care Units (TCU) in our preferred network to offer priority admissions to patients discharging from Methodist Hospital. Provide Care Transition Guide services to patients in these TCUs to get them to the next appropriate stage of care • Continue, expand and explore options for Palliative care offerings to more outpatient settings including oncology, cardiology, pulmonary, nephrology, neurology • Transfer the population health program to Palliative Care in order to provide services to patients in assisted living and community homes. This team approach service will focus on access to care and referrals for this population.	• One less barrier for patients and family members increasing their knowledge • Increased variety of patients have more options for different types of care

Goal: Increase screening rates in all populations.	
Strategies:	**Anticipated Impact:**
• Continue mobile mammogram service and add second Mammo a-go-go truck • Explore potential for colorectal screening by adding screening options to mobile mammogram service at community events • Increase breast cancer screening access to communities in need. Partner with nonprofits serving diverse communities and women in need to provide free breast cancer screening events for those in need (mobile mammography and diagnostic services); Seek funding to sustain and expand the program	• Increased access to mammography • Increased early diagnosis for underserved populations

Goal: Make it simple and affordable for our patients, members and community to access care and coverage.	
Strategies:	**Anticipated Impact:**
• Promote resources to assist community members on how to obtain insurance coverage and make informed health care access decisions. • Offer expanded and simplified options for patients accessing care and simplify • Provide access to Advanced Care Planning resources and support to complete Advanced Directives	• Improved health literacy • Fewer people uninsured • Timely access to care • Primary Care Call Center for scheduling is now open 7 days a week • On-line scheduling for Primary Care for both new and established patients will go live at the end of March 2019.

• Continue Advanced Care Planning helpline • Promote resources to assist community on how to access medical specialties and resources • Incorporate the telemedicine steering committee into the Care Group Council to guide the expansion of telemedicine efforts to improve access to services • Continue to support existing Park Nicollet school based health centers providing free or low-cost medical, dental and vision services to youth in need (financial support, personnel and other resources) • Expand access to free and low-cost health care services for youth by leveraging community partnerships • Expand annual free skin cancer screening services to provide access to greater numbers of community members • Continue to support, through annual grants, Park Nicollet and community programs that provide patients in need with free medications, transportation and other resources to remove financial and other barriers to accessing care • Improve access to health care for seniors by providing grant support to community organizations providing transportation services • Make it affordable for our patients to attend Rehab by providing assistance from the Rehab HOPE Chest (Patient Special Needs Fund) to assist patients who have barriers. • Evaluate Care Transition Guide position funded by the Foundation. Make recommendations to continue or expand position(s)	• Telephone visits is being piloted and will be rolled out in Primary Care in 2019 • Higher amount of patients and families receiving care focused on their goals. • Minimize likelihood of overtreatment and reduce likelihood of conflicts between patients and families and providers • Care available where students are frequently located • Increase number of patients planning care • Increased screening for underserved communities

Goal: Help our organization achieve its full potential by ensuring that every person we touch feels welcomed, included, and valued.	
Strategies: • Develop inclusion acumen and strengthen our people's ability to practice these competencies • Build processes to minimize organizational risk related to protected class • Grow leadership skills with emphasis on effective communication and embraces diversity • Increase diverse representation at professional, supervisor, and manager roles • Close retention gap of diverse colleagues	**Anticipated Impact:** • An inclusive culture where every person, including whom we serve and our workforce is welcomed, included, and valued • An employee base that better reflects and interacts with the diversity of patients and community we serve • Provide care at the right level for patient health needs

• Partner with senior leadership to define systems for accountability for all leaders on the composition of their teams • Decrease disparities in service. Seek to decrease the admission rate disparity in populations of color • Decrease readmissions rates for populations of color	

Priority: Access to health

Definition: Access to health refers to the social and environmental conditions that directly and indirectly affect people's health, such as housing, income, employment, education and more. These factors, also referred to as social determinants of health, disproportionately impact low income communities and communities of color.

Goal: Understand Social Determinants of health and address equity issues.

Strategies:	**Anticipated Impact:**
• Gather information and create action plans surrounding food insecurity, housing and poverty at the point of care • Methodist Hospital Equity Committee will provide consultation and partnership services to all PNHS departments and specialty areas focused on data and strategies to identify disparities and work toward equity • In making grant decisions, consider how community grant applicants incorporate diversity and health equity into their culture, focus and manner of providing services • Focus grant making in locations that have been shown to have high levels of health inequities. Promote equity among community partner groups • Strengthen community organizations that impact social determinants. Continue to provide grant and other resource support to the Park Nicollet school-based health centers and community partner organizations offering free services	• Refer patient to appropriate community resources to address specific social determinants of health • Decrease health disparities and outcomes for patients of color • Increased equity in grant making throughout community • Higher health improvement impact from broader source of community organizations

Goal: Promote sustainable operations to positively impact the community.

Strategies:	**Anticipated Impact:**
Within PNHS network • Promote reducing waste, share ideas • Promote recycling, farmer's markets • Conduct educational speaker series Across all of HP • Implement practices that that utilize resources efficiently, minimize waste and engage stakeholders • Engage community to leverage strength and build relationships • Install and operate facilities, equipment and vehicles efficiently • Purchase products with minimal community impact • Advocate for environmental protection, mitigation, and restoration with active community engagement	• Lower corporate waste and better informed employee community • Improved community health and well-being due to improved air and water quality • Enhanced standing in community • Positive financial impact

Goal: Promote early child brain development.	
Strategies:	**Anticipated Impact:**
• Promote Little Moments Count awareness campaign. • Implement Reach Out and Read Program at well—child visits	• Improved health literacy • Reduce health disparities • Improved literacy. 90% of child's brain develops during the first 5 years of life • Children are ready for kindergarten • Educational opportunities gap is narrowed • Reach out and Read books are given to all children at their Well Child visits beginning at 6 months through 5 years. The child gets a total of 10 books in this program. In 2018, park Nicollet distributed 26,364 individual books

Goal: Create stronger/easier access to communications, education and awareness of health and healthcare to the community.	
Strategies:	**Anticipated Impact:**
• Conduct open houses with fire departments providing education about blood pressure checks, preventative screening • Expand the use of technology (emails, text messages, MyChart messages, etc.) to engage patients between visits and promote healthy behaviors	• Increased amount of community resources for learning • Increased number of lives touched and an increase of volunteers

• Exercise programs and educational handouts made available through Medbridge, a new on-line electronic program for patients to access home exercise programs through phone or computer • Provide access and education to healthcare employment options to a diverse group of high school students through the Roosevelt Mentorship Program • Increase breast health awareness. Be Pink educational campaign to encourage women to be aware, proactive and empowered with their breast health using mammo a go go • Provide support and strategies to empower victims of domestic abuse. Conduct AdvoCare - system wide mobile on call 24/7 network	• Lower breast cancer rates

Priority: Mental health and well-being

Definition: Mental health and well-being refers to the interconnection between mental illness, mental health, mental well-being and the associated stigma. Poor mental health is associated with poor quality of life, higher rates of chronic disease and a shorter lifespan.

Goal: Reduce stigma surrounding mental illness.	
Strategies: • Continue Make It Ok anti-stigma campaign • Integrate Make It Ok into employee wellness programs for hospital staff • Support efforts to raise stigma awareness including participating in annual NAMI Walk • Support community organizations offering programs focused on reducing the stigma surrounding mental illness through annual grants and ongoing partnerships • Partner with HealthPartners to train Make it OK ambassadors and offer Make it OK sessions to team members within Park Nicollet	**Anticipated Impact:** • Increased awareness, less stigma around mental health issues • Earlier mental health related diagnosis

Goal: Increase access to education and resources around mental health, behavioral health and well-being.	
Strategies: • Promote Hilarious World of Depression	**Anticipated Impact:** • We provide activation codes to any patient who meets the criteria and the Clinician feels can benefit from the program. Karen Lloyd at the HP

• Offer HealthPartners "Beating the Blues" online program for both patients and employees to learn ways to better manage mood, stress and anxiety • Provide annual conference on stroke and regular support groups for patients and caregivers. Classes include mindful meditation and connectivity to foster a sense of purpose • Provide education and increase awareness of eating disorders among community clinicians • Support community organizations offering Mental Health First Aid, Youth Mental Health First Aid, Trauma Informed Care, ACEs, and other educational programs about mental health through annual grants and ongoing partnerships • Promote consistent and evidence-based messaging about the management of depression by developing content that can be used in print and electronic communications when delivering education on depression for adults and teens • Design and offer comprehensive medical education programs to support team-based education on the most up-to-date and evidenced based treatment and care of patients diagnosed with depression and patients diagnosed with diabetes to ensure mental well-being • Assist local collaboratives i.e. Dakota Cty Mental Health Summit, Scott County and NW Hennepin Family Collaborative in their education efforts	Plan will have data about how many patients have participated • Reduce conditions negatively affecting the mental health and isolation of stroke survivors and their families. • Reduce variation depression content throughout the health system • Clinicians and teams drive improvement in their practice and optimize the care, health and wellness of our patients diagnosed with depression and diabetes • Offer low cost high quality mental health training for MH professionals and increase awareness, lower stigma • Widely available information for community members, increased number of trained leaders

Goal: Improve access to mental health services.	
Strategies: • Expand access to mental health services through integration with Primary Care: e.g., the use of depression protocols, group therapy, and embedding of therapists at primary and subspecialty care clinics • Provide support groups, and educational programs about Stroke through our patient guides • Investigate opportunities to expand Transitional Care Unit outreach trough expanded peer visiting program to one additional Transitional Care Unit each year in 2019, 2020, 2021 • Continue survivorship program to support cancer survivors in dealing with the emotional and psychological after effects of cancer	**Anticipated Impact:** • Patients will receive care close to home and with their primary care provider whenever possible • Offer skill development and social engagement through group therapy offerings

• Sustain current Growing through Grief (GTG) program area and expand • Develop Growing through Grief curriculum to be used to expand reach beyond current footprint. Expand grief support to greater Minnesota/regionally through use of the curriculum by schools/counselors • Continue to embed mental health professionals in the cancer center to improve access to mental health services and support crisis management needs of cancer patients through partnerships with Gilda's Club and Pathways • Continue to embed mental health professionals in Bariatric Clinic and Sexual Medicine Clinic to support patients • Conduct special initiative campaign focusing on Children's Mental Health and Well-being for current signature programs such as NOW! (No Obstacles to Well Being!), Growing through Grief and Melrose Center. This includes partnering with community organizations to amplify impact • Support schools and community programs providing mental health services to youth through annual grants and partnerships • Enhance community response to mental health through the collaborative city leadership with the St. Louis Park Mental Health Collaborative Partnership • Reduce conditions negatively affecting the mental health of seniors by providing grant support to community organizations addressing isolation and lack of community connectedness • Continue to offer services to promote the mental wellbeing of Park Nicollet team members, including the Be Well and Your Life Support programs • Cardiac Rehab is starting a new support group program for patients to discuss their emotional health, concerns and fears after a heart event. Free parking available for those in need • Implement the "Integrated Diabetes Team Care" Project at the Maple Grove site (interdisciplinary team approach to the integration of primary care and behavioral health focused on diabetes registry patients at the Maple Grove clinic) • Develop new program offerings at Melrose Center to meet the unique needs of emerging patient populations	• Growing Through Grief services will continue to be provided in schools • Students will be supported long-term through their grief journey • Increased grief supportive services, more youth in more PNHS communities • GTG curriculum developed and available for new communities and greater Minnesota/Regional school staff • Increase awareness of the GTG program. Built in sustainability for children's mental health programs • Increase in diversity of services offered and more efficient distribution throughout communities • Decreased amount of isolated seniors, potential decrease in 911 calls • Increased patient knowledge, one less barrier to receiving training • Patients with diabetes will receive support in achieving optimal outcomes on key indicators of health • Patients will have access to specialized, evidence based care that best meets their needs • Improve timeliness in accessing care • Reduce delays in delivering critical clinical information to patients and/or external agencies to eliminate barriers to getting needed care and services

• Improve transitions of care between primary care and behavioral health and other care providers through improvements in scheduling into our system, communication to patients/families and external care providers, and collaboration between specialties within our system	

Priority: Nutrition and physical activity

Definition: Nutrition and physical activity refers to equitable access to nutrition, physical activity and food and feeding choices. Poor nutrition and physical inactivity are major contributors to obesity and chronic diseases such as diabetes, heart disease and stroke, which disproportionally impact low income communities and communities of color.

Goal: Improve the physical activity level of children and families.

Strategies:	**Anticipated Impact:**
• Promote PowerUp resources and education • Promote Silver Sneaker Program • Continue to partner with the Brookdale YMCA on the pre-diabetes prevention program. • Provide education to Stroke INSPIRE participants on physical activity through Tai Chi program and annual Step to ISNPIRE Walk	• Adults and children engage in 60 minutes of activity daily • Improved strength, flexibility, balance, endurance and overall fitness

Goal: Improve healthy eating behaviors.

Strategies:	**Anticipated Impact:**
• Continue partnering with the YumPower program to teach youth about healthy eating • Explore expanding pilot of the Feeding Hearts Program to promote healthy foods by giving weekly allowance of fresh foods for 12 weeks to Cardiac Rehab patients • Provide affordable Exercise Programs for patients and community through the Medically Supervised Exercise Program and the Medical Weight Management Exercise Program. Funds available to support those who have a barrier to attending • Continue the Fruit and Veggie prescription program to more Park Nicollet clinics to give	• For the past three years, all park Nicollet primary care sites participate in the YumPower program. Each site receives a certain number of F&V RX vouchers based on their patients' redemption the previous year and the size of the clinic. Marketing tracks the redemption data • Decrease consumption of sugar Sweetened Beverages • Reduce the prevalence of childhood obesity • Adult and children receive personalized nutrition support to improve health and well-being • Reduce variation in nutrition care and content throughout the health system

youth an incentive to learn how to shop for and prepare healthy foods • Provide grant support to community organizations addressing seniors and food insecurity • Provide education through dietician lecture to Stroke INSPIRE program participants • Continue to promote an environment free of sugar-sweetened beverages at Methodist Hospital and Park Nicollet clinics • Refresh Be Well program to support Park Nicollet team members in maintaining healthy behaviors • Facilitate an enterprise-wide workgroup to design a standard approach to the treatment and prevention of childhood obesity • Increase access to outpatient Nutrition Services • Promote consistent and evidence-based nutrition care • Offer Camp 5-2-1-0 to Park Nicollet pediatric patients • Refresh Be Well program to support Park Nicollet team members in maintaining healthy behaviors • Promote breastfeeding to encourage mothers to feed their babies only human milk for the first 6 months by offering support and resources to patients, members and employees • Support the Maple Grove Health Club Clinic • Design and offer comprehensive medical education programs to support team-based education on the most up-to-date and evidenced based treatment and care to optimize nutritional health	• Increase awareness of the benefits of Healthy Eating and Physical Activity • Reduced food insecurity for seniors • Increase number of infants receiving breastmilk for the first 6 months of life • Improved individual patient health and health of the whole clinic community • Clinicians and teams drive improvement in their practice and optimize the nutritional health of patients

Goal: Increase access to better nutrition.	
Strategies: • Support efforts to increase fruit and vegetable consumption by promoting PowerUp resources and education and supporting the School Challenge in the St. Louis Park Schools • Expand Super shelf Program • Convene partner groups in St Louis Park and Brooklyn Center • Continue to provide medical weight management program in Bariatric clinic as an alternative to surgery	**Anticipated Impact:** • Adults and children are trying to eat at least 5 fruits and vegetable every day • Additional capacity focused on food issues in communities of need • Identify patients who are food insecure and refer to appropriate community resources • New services for NW Hennepin communities • Cancer patients with better nutrition and eating habits

• Explore partnership with Brooklyn Center area groups (Brookdale Clinic, Food Shelves, CEAP, and schools) to address food access and insecurity • Gather information and create action plans surrounding food insecurity, housing and poverty • Implement hunger screening tools and refer patients to Hunger Solutions as appropriate • Expand Supershelf Program • Add nutritional dietician to improve access to education, nutrition services and support of patients undergoing cancer treatment	

Priority: Substance Abuse

Definition: Substance abuse and addiction are the excessive use of substances including alcohol, tobacco, prescription drugs, opioids and other drugs in a manner that is harmful to health and well-being.

Goal: Reduce accidental poisoning and drug abuse.

Strategies:	**Anticipated Impact:**
• Offer free, environmentally friendly medicine disposal at our hospitals and clinics for the community • Install medicine take-back kiosks • Implement training and processes to ensure compliance and success • Report as necessary and required • Promote community drug take-back locations • Expand access to opioid overdose reversal agent (naloxone) to patients of prescribers outside the organization • Partner with the University of Minnesota College of Pharmacy to expand knowledge of effective solutions for improving access to naloxone in the community • Offer free, environmentally friendly medicine disposal to Hospice patients and their families. Conduct drug diversion assessments and address suspicions. Provide lockboxes free of charge to patients in home to safely store medications	• Prevent prescriptions drugs from entering the drinking water system and help prevent accidental poisoning • Prevent medications from being misused • Increase access to life saving medication to up to 10% of opioid users at internal pharmacies • Scale up and spread awareness of naloxone access strategies to community pharmacy partners

Goal: Reduce Opioid and Benzodiazepine prescribing.	
Strategies: • Provide treatment options that are more effective for chronic pain than opioid prescribing. Pain Clinics: refer patients to HealthPartners specialized pain clinics that focus on the physical, emotional, lack of sleep, physical activity, social factors and addiction • Expand Pharmacist/Prescriber Collaborative Practice Agreements to allow prescribers to partner with MTM pharmacists to wean and taper patients off opioids. In 2019, to expand to benzodiazepines • Expand holistic interprofessional Pain Management Clinic, which includes a Medication Therapy Management pharmacist, to deemphasize opioid use while focusing on life goals and functionality. • 2019 will also bring on an Addiction Medicine Specialist • Back Pain: educated patients on promoting activity and exercise and refer to physical therapy rather than prescribing pain medication • Refer patients who receive multiple prescriptions from multiple clinicians to a program that limits care to one doctor, one pharmacy and one emergency department • Lower the automatic setting in the electronic medical record to 10 pills (half of the previous setting) • Decrease the postop prescription to 7 days and in some cases 0 days • Continue to promote Physical Therapy referrals or potential for direct access for Physical Therapy for low back pain entry point	**Anticipated Impact:** • Reduction in the use and misuse of opioid medications

Goal: Reduce alcohol, tobacco, marijuana and drug use during pregnancy and breast feeding.	
Strategies: • Support Healthy Beginnings program • Offer outpatient services to improve care and outcomes for those with substance use problems and disorders • Create new interdisciplinary program to include medical management, substance use disorder treatment, and mental health services for those seeking treatment	**Anticipated Impact:** • Provide comprehensive treatment services that improve outcomes • Clinicians and teams drive improvement in their practice and optimize the care, health and wellness of our patients diagnosed with pain • Reduce variation in pain and opioid content throughout the health system

• Design and offer comprehensive medical education programs to support team-based education on the most up-to-date and evidenced based treatment (appropriate use of opioids) and care of patients with pain • Promote consistent and evidence-based messaging about use of opioids to manage pain by developing content that can be used in print and electronic communications when delivering education on pain management and opioid use	

Goal: Increase education around vaping.	
Strategies: • Partner with Physicians Advocacy Network of the University of Minnesota	**Anticipated Impact:** • Increased community knowledge about vaping health impacts, knowns and unknowns

Appendix: Community Partners

360 Communities – Burnsville Emergency Program
Annex Teen Clinic
BeWell
Brooklyn Center Health Resource Center Advisory Committee
CEAP – Community Emergency Access Program
Center for Community Health (CCH) Collective Action Collective Impact (CACI)
Central Clinic Advisory Committee
Children First
Children's Dental Network
Dakota County Healthy Communities Collaborative
Dakota County School Mental Health Practice Group
Diamondhead Clinic Advisory Committee
Early Childhood Family Education
East Metro CHNA/CHA Pilot Workgroup
East Side Mental Health Collaborative
Eden Prairie Fire Department
Forces of Change Affecting Community Health
Gilda's Club
Habitat for Humanity
Honoring Choices Minnesota
Hopkins Fire Department
Hunger Solutions
ICA – Minnetonka Emergency Program
Interfaith Outreach and Community Partners
JustUs Health MN
Mills Clinic
Mind Body Solutions
Minnesota Department of Health Mental Well-Being & Resilience Learning Community
Minnesota Public Radio
Minnetonka Fire Department
MN Department of Health - SAGE
My Health
MyHealth – Hopkins
National Alliance on Mental HealthPartners
Northwest Community Collaborative
Northwest Hennepin Healthy Community Partnership
Open Arms
Parkshore Senior Housing
Pathways
Portico
Prairie Care
Reach Out and Read Minnesota and Wisconsin
Relate Counseling
Richfield Health Resource Center Advisory Committee
S.T.E.P. – St. Louis Park Emergency Program
Sandford Plan

Scott County Health System Collaborative
SHIP Community Leadership Team
St. Louis Park Fire Department
Supershelf MN
Think Small
University of Minnesota Extension Office
Weight Watchers
West Metro CHNA Collaborative
YMCA / Silver Sneakers
Youth Link
YumPower
Wayzata School District Central Middle East Middle Gleason Lake Elementary Wayzata High West Middle School
Eden Prairie School District EP HS EP Central Middle Eagle Heights Spanish Elementary
Prior Lake-Savage School District Bridges (alternative school) Hidden Oaks Middle Prior Lake High Twin Oaks Middle
Eastern Carver County School District Carver Elementary Chanhassen High Chaska High Chaska Middle East Chaska Middle West Clover Ridge Elementary Integrated Arts Academy Pioneer Ridge Middle
Minnetonka School District Clear Springs Elementary Deephaven Elementary Excelsior Elementary Groveland Elementary Minnetonka High Minnetonka Middle East Minnetonka Middle West Minnewashta Elementary Scenic Heights Elementary
St. Louis Park School District Aquila Elementary Park Spanish Immersion

Peter Hobart Elementary St. Louis Park High School St. Louis Park Middle School
Hopkins School District Alice Smith Elementary Gatewood Elementary Glen Lake Hopkins High School Hopkins North Hopkins West Meadowbrook Elementary Tanglen Elementary
Minneapolis School District Patrick Henry HS Southwest HS
Edina School District Concord Elementary School Cornelia Elementary School Countryside Elementary School Edina High School Southview Middle School Valley View Middle School
Burnsville-Eagan-Savage School District Burnsville Alternative High School Burnsville HS Eagle Ridge JH Metcalf JH Nicollet JH
Apple Valley-Eagan-Rosemount School District Apple Valley HS Black Hawk MS Eagan HS Eastview HS Falcon Ridge MS Rosemount HS School for Environmental Studies Scott Highlands MS Thomas Lake Elementary
Westonka School District Grandview Middle Hilltop Elementary Mound Westonka High Shirley Hills Elementary
Osseo/Maple Grove School District Brooklyn Middle Maple Grove Middle School Maple Grove Senior High North View Middle Osseo Middle

Osseo Senior High
Park Center High

Preferred Senior Care Facilities

Ambassador Good Samaritan Center NH
Ambassador Good Samaritan TCU
Auburn Courts AL
Auburn Manor NH
Augustana Chapel View Apartments
Augustana Chapel View Health Care Center
Augustana Chapel View TCU
Casle Ridge Care Center NH
Castle Ridge Commons AL
Colonial Acres TCU
Estates at St. Louis Park NH
Friendship Manor NH
Friendship Village of Bloomington Board and Care
Friendship Village of Bloomington NH
Hillcrest of Wayzata Rehab and Health Care Center NH
Hillcrest of Wayzata Rehab and Health Care Center AL
Minnesota Masonic Homes AL
Minnesota Masonic Homes TCU
Minnesota Masonic Home Car Center NH
New Perspectives Senior Living - Prior Lake
Northridge Health and Rehab NH
Northridge Residence AL
Northridge Residence IL
Parkwood Shores AL
Presbyterian Home on Lake Minnetonka Shores TCU
Presbyterian Homes-Arbor AL
Presbyterian Homes-Lake Minnetonka Shores NH
Presbyterian Homes-The Commons AL
Shalom Home West NH
Shalom Home West TCU
St. Gertrude's Health Care NH
St. Gertrude's TCU
St. Therese Home NH
St. Therese Home TCU
The Glenn—Hopkins
Villa at St. Louis Park NH
Villa at St. Louis Park TCU
Walker Methodist NH

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