Park Nicollet® Methodist Hospital

HealthPartners®

Community Health Needs Assessment

November 2018

Prepared by:
The Improve Group

Table of Contents

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

Executive Summary

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.

Between 2016 and 2018, HealthPartners and Park Nicollet Health Services, including Park Nicollet Methodist Hospital, engaged with local public health partners in Dakota, Hennepin and Scott Counties, as well as local coalitions, the Center for Community Health (CCH) and community partners to conduct a comprehensive Community Health Needs Assessment (CHNA). The CHNA identifies the significant health needs of the community as well as measures and resources to address those needs. The results will enable community partners to more strategically establish priorities, develop interventions and direct resources to improve the health of people living in the community.

This assessment meets all the federal requirements of the Patient Protection and Affordable Care Act (ACA) and the Internal Revenue Service final regulations. It was approved by the Park Nicollet Health Services Methodist Hospital Board on December 18, 2018. In accordance with federal requirements, this report is made widely available to the public on our website at

2018 Park Nicollet Health Services Community Health Needs Assessment (CHNA)

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.

Methodology

In 2018, HealthPartners and Park Nicollet Health Services contracted with The Improve Group to analyze and report on data describing the community we serve. Because the work of Methodist Hospital is so integrated with the work of the system as a whole, Park Nicollet Health Services has elected to look at the health needs of its system service area. HealthPartners provided The Improve Group with the definitions of the service area, the indicators to study for the health and demographic data summaries and data collected during community conversations. Community input was collected in partnership with HealthPartners through community conversations and multiple surveys. The Improve Group then gathered secondary data from public sources, analyzed community input data and developed summary reports to guide a prioritization process.

Prioritized Needs

The HealthPartners CHNA Team included representatives from each HealthPartners hospital and HealthPartners leadership. In September 2018, the CHNA Team met to review the data and prioritize the community health needs across the system.

HealthPartners collectively prioritized community health needs using a process informed by the Hanlon method and other commonly used prioritization methods. Each hospital shared its 4 or 5 priority topic areas and rationale for each topic area based on: *size, seriousness, equity, value and change*. HealthPartners CHNA Team worked in a thorough, facilitated large and small group process to reach consensus on top priorities using both

the criteria described above and community input data. The five priorities are of equal importance and are presented in alphabetical order. The five priority areas and priority area definitions are:

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.

Next Steps

Park Nicollet Health Services and HealthPartners will continue to work collaboratively with the community to develop shared goals and actions that address the highest priority needs identified in the CHNA. These shared goals and actions will be presented in our implementation strategy, which is a required companion report to the CHNA. Each need addressed will be tailored to the hospital's programs, resources, priorities, plans and/or collaboration with governmental, non-profit or other health care organizations.

About the Community Health Needs Assessment (CHNA) process

Background and goals

HealthPartners and Park Nicollet Health Services' mission is to improve health and well-being in partnership with our members, patients and community. One of the ways we bring the mission to life is to work with community partners to better understand what contributes to and stands in the way of good health, and how we can work together to improve health outcomes.

The Community Health Needs Assessment (CHNA) process is an opportunity for us to identify the significant health needs of the community and the measures and resources required to address those needs. HealthPartners worked with local health departments, local coalitions, the Center for Community Health (CCH) and community partners to conduct a comprehensive CHNA. Our next step is to develop an implementation plan for the period 2019 to 2021 to address the CHNA priorities.

This CHNA was conducted in accordance with requirements identified in the Patient Protection and Affordable Care Act and the Internal Revenue Service final regulations released on December 29, 2014. This CHNA was designed to:

- Meet federal government and regulatory requirements;
- Review secondary health and demographic data describing Park Nicollet Health Services' community;
- Gather input from community members on health needs and priorities, including input from members of underserved, low income and minority populations;
- Analyze the secondary data and community input data; and
- Prioritize the health needs of the community served by HealthPartners and Park Nicollet Health Services.

Methodology

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 Park Nicollet Methodist Hospital (St. Louis Park, MN)
- Regions Hospital (St. Paul, MN)
- Westfields Hospital & Clinic (New Richmond, WI)

HealthPartners contracted with The Improve Group to analyze and report on the data describing the communities we serve. HealthPartners provided The Improve Group with the definitions of the hospital's service area, the indicators to study for the health and demographic data summaries and data collected during community input sessions. Because the work of Methodist Hospital is so integrated with the work of the system as a whole, Park Nicollet Health Services has elected to look at the health needs of its system service area. Community input was collected by HealthPartners and partner organizations through community conversations and surveys. The Improve Group gathered secondary data from public sources, analyzed community input data provided by HealthPartners and developed summary reports to guide a prioritization process.

In addition, each hospital engaged with local public health partners and other local health care organizations on the CHNA process through participation in two local collaboratives: The Center for Community Health East Metro Community Health Assessment (CHA)/CHNA Collaborative and the West Metro CHNA Collaboration.

Core health data indicators

Core health data indicators for this report were collaboratively selected by the CCH for inclusion in CHNAs conducted in the Minneapolis-St. Paul metropolitan area. The CCH is a collaborative between public health agencies, non-profit health plans and not-for-profit hospital/health systems in the seven-county Twin Cities metropolitan area. The list of indicators was updated based on a pilot testing process that occurred in 2017. HealthPartners hospitals in western Wisconsin adopted the list of indicators established by CCH and identified additional indicators and relevant themes identified through community input.

Secondary data in this report is specific to Park Nicollet Health Services. While most of the data in this report is from our primary service area of Dakota, Hennepin and Scott Counties, some data is not available at the county level. If county level data is not available, data is presented at the regional or state level as noted. Comparison data is included where available. All survey data is self-reported.

Additional data sources include:

- American Community Survey (ACS), an ongoing survey by the U.S. Census Bureau;
- Metro SHAPE Survey (Metro SHAPE), a community survey by six Minneapolis-St. Paul metropolitan area counties;
- Minnesota Student Survey (MSS), a statewide survey by the Minnesota Department of Education; and
- Data from the Minnesota Department of Health and other state agencies.

This report also includes additional data sources provided by HealthPartners, including:

- HealthPartners Electronic Health Records (EHR);
- IMPACT Survey, a survey on mental illness stigma, developed and analyzed by HealthPartners; and
- Family Community Survey, a survey on health behaviors of children, developed and analyzed by HealthPartners.

Community input data

As part of its CHNA process, Park Nicollet Health Services conducted community input activities in Dakota, Hennepin and Scott counties to understand community member and health care providers' top health priorities. Park Nicollet Health Services also solicited community feedback and comments on its 2015 CHNA but did not receive any community comments.

The community input for in this report includes:

County priority data: Each county in the Park Nicollet Health Services area determined the top health priorities for its community through a county-level Community Health Assessment process (CHA). This report includes a crosswalk with each county's most recent community health priorities.

Community dialogues: In 2018, Park Nicollet Health Services hosted and/or partnered with others, including Regions Hospital, to host nine community dialogues to understand priority health issues facing various populations. The groups included:

- Adult HealthPartners members who are experiencing homelessness;
- Diamondhead School-Based Health Resource Center Advisory Committee;
- Members from the predominantly African-American MN Church of God in Christ;
- Members of West African, African American, Southeast Asian, Latino and European American communities (conducted by the Northwest Hennepin Family Services Collaborative);
- Seniors and providers of Senior Services in St. Louis Park;
- Members of the Northwest Hennepin Healthy Community Partnership;
- The Park Nicollet Foundation Board of Directors;

- Staff and contracted interpreters serving Methodist and Regions Hospitals; and
- A Marnita's Table community input session in Scott County.

Provider survey: In 2018, Park Nicollet Health Services surveyed health care providers to understand their perceptions of leading health needs and community resources available to help their patients. The survey also asked providers to identify barriers they or their patients face in addressing health needs and providing resources. One hundred and one health care providers completed the survey.

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 shape our approach 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

The HealthPartners CHNA Team included representatives from each HealthPartners hospital and HealthPartners leadership. On September 14, 2018, the CHNA Team met to review the data and prioritize the community health needs across the system. Following the CHNA Team meeting, the Park Nicollet Health Services team will conduct a level two prioritization process to build its implementation plans and prioritize its interventions.

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 or 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 CHNA Team worked in 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. The five priority areas are:

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

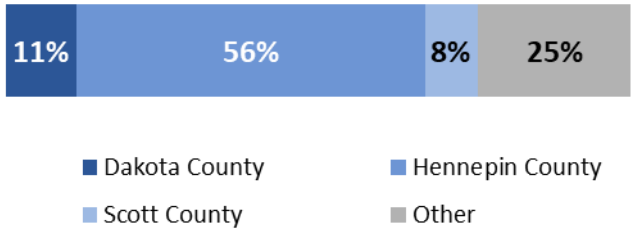
Substance abuse and addiction are the excessive use of substances including alcohol, tobacco, prescription drugs, opioids and other drugs in a manner that is harmful to health and well-being.

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 top five priorities in the consensus building process, however, the themes will be considered in the implementation plan for the selected priority areas.

About the community we serve

People served

Park Nicollet Health Services patients by county of residence.

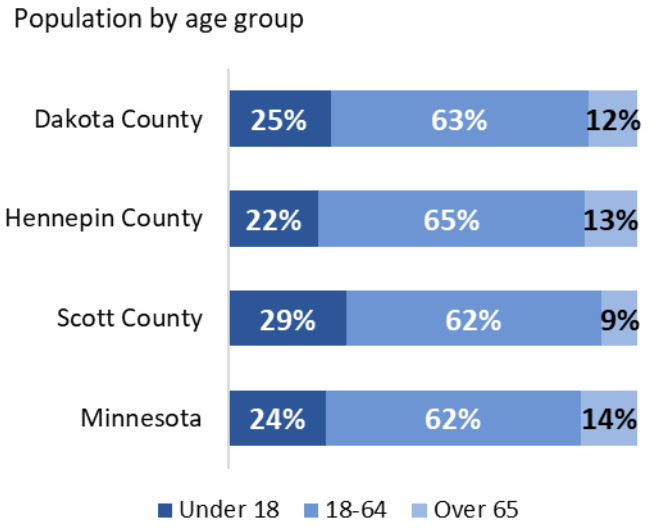


Source: HealthPartners Electronic Health Records, 2017

While we serve patients from everywhere, 75 percent of patients live in Dakota, Hennepin and Scott Counties. Throughout this report, we refer to these three counties as “our community” and primarily use data from those areas.

In total, these counties we consider our community have 2.4 million people. In 2017, nearly 600,000 patients living in these three counties received care from Park Nicollet Health Services.

Age and population

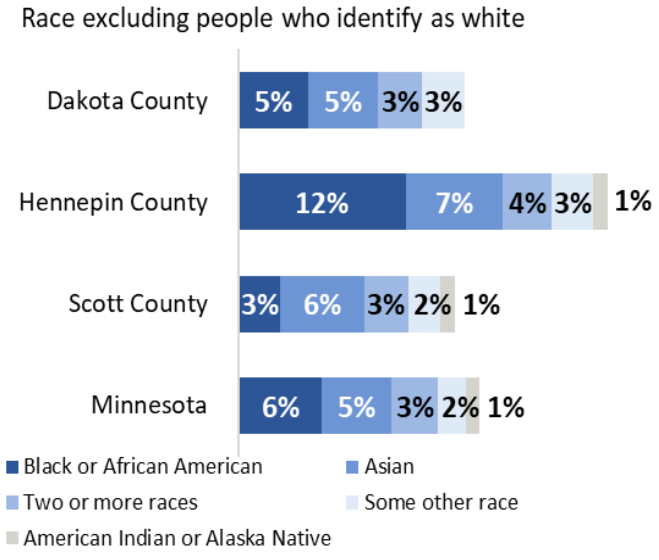


Source: US Census Bureau, American Community Survey, 2012-16

The median age of our community is between 35 and 38 years old. About 1 in 4 people in our community is under 18, and 1 in 6 people in our community is over 65. Scott County has a higher percentage of people under age 18 and a lower percentage of people over age 65 than the other counties and the state average.

We know that people have different health needs at different stages in their lives. Throughout the CHNA process, we considered how each need, community resources and barrier impact different age groups.

Race and ethnicity



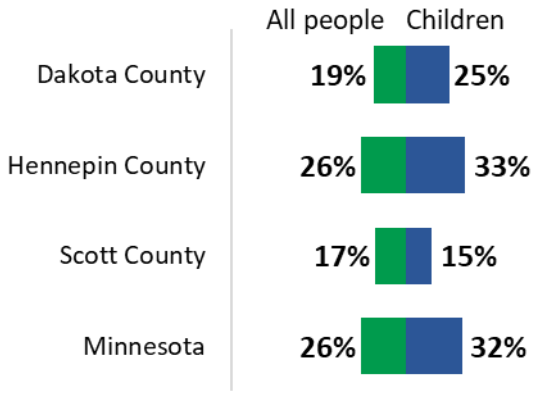
Source: US Census Bureau, American Community Survey. 2012-16.

People of color are disproportionately impacted by social and environmental conditions that affect health.

Hennepin County is more racially diverse than the rest of the state, with 27 percent of Hennepin County residents identifying as a race other than white. In comparison, 16 percent of people in Dakota and Scott Counties identify as a race other than white. Between 5 and 7 percent of people in our community identify as Hispanic or Latino.

Poverty

Percentage of people with **household incomes at or below 200%** of the federal poverty level.



Source: US Census Bureau, American Community Survey. 2012-16.

People who are experiencing poverty face health disparities. People who live in households earning at or below 200 percent of the federal poverty level (FPL) are considered low income.

In our community, poverty is more concentrated in Hennepin County, with 26 percent of residents and 33 percent of children living in low income households. While rates are higher in Hennepin County, more than 1 in 5 people in the community we serve are currently living in low income households.

Across our community, the percentage of people of color in poverty is 3 to 4 times higher than that of people who identify as white.

Education status

Percentage of high school students who graduate with a regular diploma in 4 years.

Source: Minnesota Department of Education, 2017

An individual's education level can impact their ability to be healthy. People with less than a high school education are more likely to experience health disparities than people with higher education levels. Higher levels of education are also strongly associated with higher incomes.

In our community, 8 in 10 students graduate from high school in four years. However, significant disparities exist by race.

In Hennepin County, only 6 in 10 students who identify as black or Hispanic graduate in four years. Across our community, four-year graduation rates are lowest among students who identify as American Indian; these rates range from 35 percent in Hennepin County to 58 percent in Scott County.

Priorities and definitions

The following sections describe the health priorities identified during the CHNA process, all of which include data related to equity.

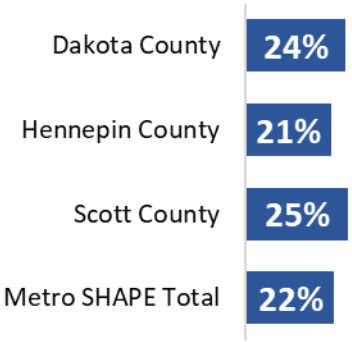
Priority: Access to care

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.

The following indicators provide a snapshot of conditions in our community that influence access to care. Extensive research exists providing the link between these conditions and health.

Cost of insurance

Percentage of adults who report it has been **somewhat or very difficult** to pay for health insurance premiums, co-pays, and deductible during the past year.



Source: Metro SHAPE, 2014

"I had a stroke, and knew I had symptoms but I didn't have health insurance so I didn't go in."

– Community conversation participant

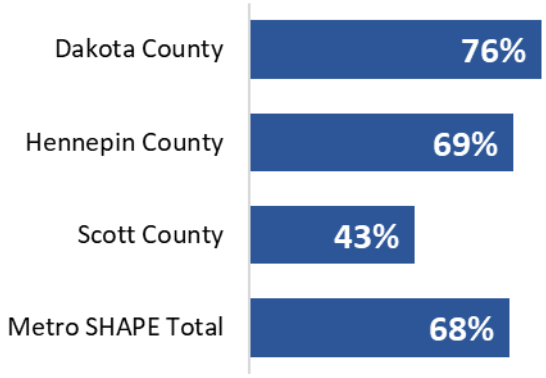
According to the 2016 American Community Survey, more than 90 percent of people in our community have health insurance.

Despite having insurance, many people find it difficult to pay for insurance premiums, co-pays and deductibles. Nearly 1 in 4 community members with health insurance said they struggle to pay for it.

Health care providers agreed that medical costs are difficult for many of their patients. A few providers said high deductible plans and the cost of care are significant barriers to accessing care.

Cost of care

Percentage of adults who needed **medical care** but who delayed or did not get care due to cost or lack of insurance.



Source: Metro SHAPE, 2014

"If they can't afford it, they just won't go for help. They end up so sick that they have to go to the emergency room."

- Community conversation participant

When people cannot afford to pay for insurance or other health care costs, they are less likely to get the care they need.

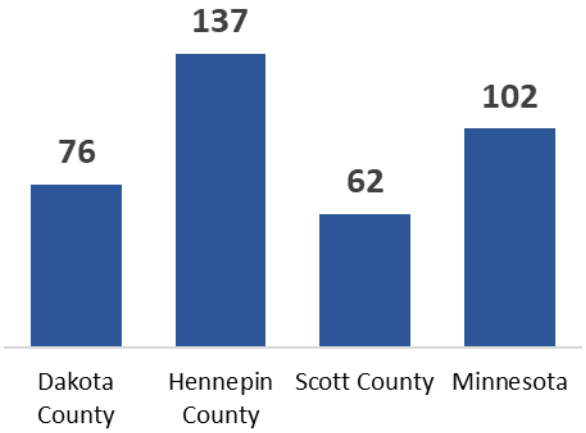
More than half of adults in our community who delayed or skipped medical care did so because of cost. In Dakota County specifically, 76 percent of adults who needed but did not get medical care said they delayed or skipped getting care because of cost.

The cost of care also impacts people's ability to access mental health care when they need it. Across our community, more than 1 in 4 adults delayed or skipped mental health care due to cost or lack of insurance. A greater percent of Dakota County residents skipped care compared to Hennepin and Scott County residents.

In addition, HealthPartners research shows the cost of medication is a top reason people skip doses of medication or do not get their prescriptions filled. The Centers for Disease Control and Prevention (CDC) found that almost 8 percent of adults in the U.S. do not take medication as prescribed in order to save on costs.

Availability of care

Number of **primary care providers** per 100,000 residents.



Source: US Department of Health and Human Services, Health Resources and Services Administration, Area Health Resource File, 2014

Unlike other communities served by HealthPartners, Hennepin County does not have a shortage of primary care providers. Dakota and Scott County residents may have barriers accessing primary care because of the relatively low number of physicians based on the population.

However, there are not enough mental health services in the area to meet community members' needs. Both Dakota and Scott Counties fall well below the state average of mental health providers per resident which is 205 per 100,000 people. In Dakota County, 134 mental health providers exist per 100,000 residents; in Scott County there are 88 providers per 100,000 residents. As a result, people may need to wait

months to see a mental health care provider, especially a psychiatrist.

HealthPartners providers cited a need for same-day mental health appointments and more availability of evening and weekend appointments.

One measure of availability of care is Emergency Center (EC) diverts, which is when an emergency center's patient census exceeds its ability to treat additional patients promptly and they are diverted to another facility. In 2017, Park Nicollet Methodist Hospital Emergency Center was on divert a total of 13 times.

Transportation and scheduling

"Many patients have a hard time getting off work or getting transportation to specialists located far from [their] home clinic."

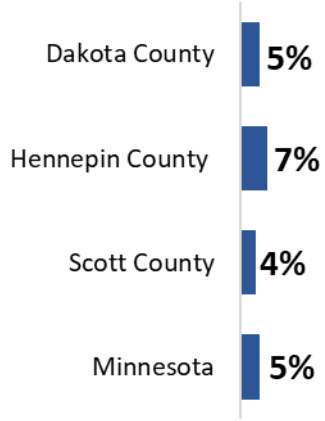
– Provider survey participant

A lack of evening and weekend appointments is a barrier because many community members cannot take time off work to get care during the day.

Transportation to appointments is another barrier to care. Not having access to a car, long travel distances to specialty providers and relying on family members for rides affect people's ability to access health care.

Language and cultural barriers

Percentage of population 5 years and older who speak English **less than "very well."**



Source: US Census Bureau, American Community Survey. 2012-16.

Many patients face barriers when scheduling appointments and communicating with providers. These barriers are especially significant for community members who do not speak English as a primary language or who speak English less than "very well." In Hennepin County, 7 percent of residents over age 5 speak English less than very well.

A lack of culturally appropriate care is also a barrier to accessing care. Community members expressed the need for health care providers to respect and support their cultural traditions. This may include routines related to nutrition and physical activity. Health care providers also identified the need for more culturally competent care.

Immigration and political climate

"The fear [of ICE] is great. Immigrants aren't going to the doctor, the mosque, WIC, the grocery store… their basic needs aren't being met."

– Community conversation participant

The current political climate has caused many families to avoid seeking health care services.

Community conversation participants expressed the need to address policies regarding immigration. They added that HealthPartners could better coordinate with immigrant community leaders to address these concerns.

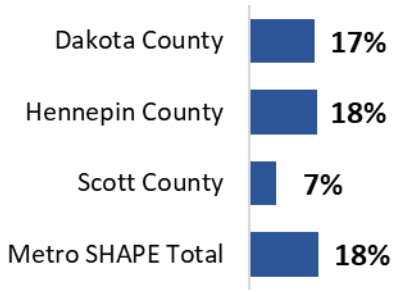
Priority: Access to health

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.

The following is a snapshot of conditions in our communities that influence our health. Extensive research exists providing the link between these conditions and health.

Food insecurity

Percentage of adults who worried that their **food would run out** before they had money to buy more, last 12 months.



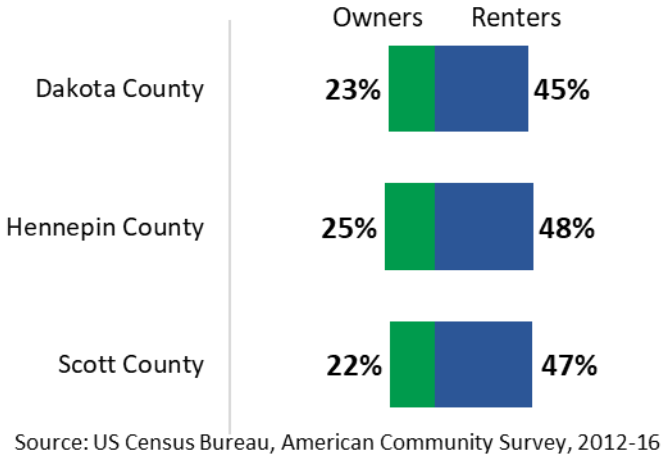
Source: Metro SHAPE, 2014

People experiencing food insecurity do not have consistent access to adequate food due to lack of money. Expenses for food are one of the first reductions people make under economic stress. People who experience food insecurity may forego adequate food for other expenses such as housing and health care.

In 2014, nearly 1 in 5 adults in Dakota and Hennepin Counties and 1 in 10 adults in Scott County identified as food insecure. This means they worried their food would run out before they had money to buy more.

Housing cost burden

Percentage of homeowners and renters **using 30% or more of their income on housing costs.**



Source: US Census Bureau, American Community Survey, 2012-16

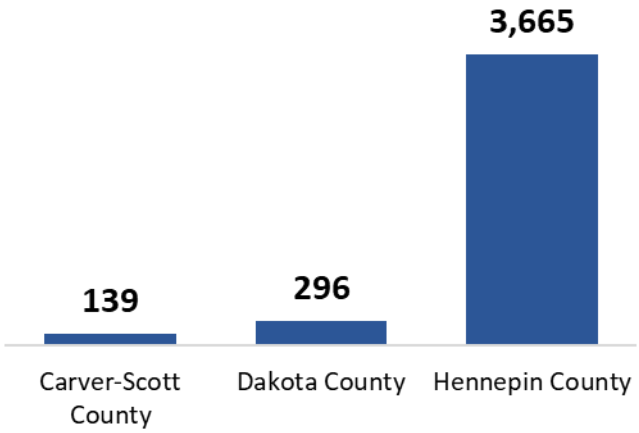
Social workers and case managers indicated housing was a top concern, especially for people with behavioral health and medical needs.

People are considered "housing cost burdened" when they spend 30 percent or more of their income on housing costs. According to the American Community Survey, nearly 1 in 4 homeowners in our community are housing cost burdened. Almost half of renters in our community are housing cost burdened.

Additionally, between 4 percent of Scott County adults and nearly 6 percent of Hennepin County adults said they missed a mortgage payment due to lack of money in the past 12 months.

Housing instability and homelessness

Number of persons experiencing **homelessness.**



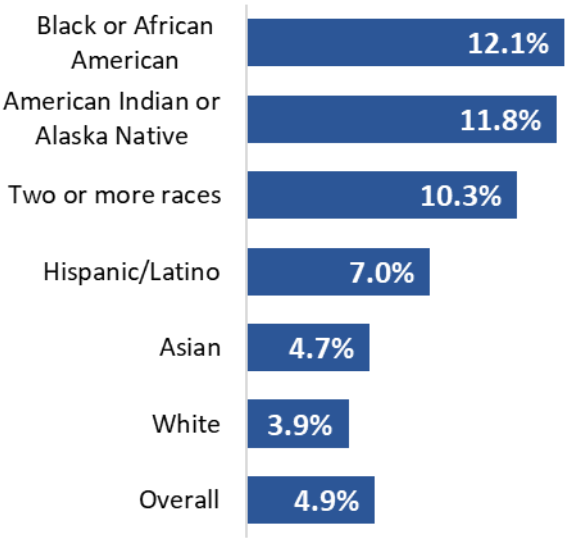
Source: Wilder Homeless Study, 2015

Many people experience homelessness in our community, with the vast majority of people experiencing homelessness living in Hennepin County. Homelessness includes people who are living in emergency or transitional housing, living in places not meant for human habitation, who are fleeing domestic violence and have no other residence and people who are losing their primary residence within 14 days. According to the Wilder Homeless Study, nearly 4,100 people in our community were homeless in 2015.

Additionally, moving frequently is an indicator of housing instability. About 6 percent of people in our community moved two times in a two-year time period while 80 percent did not move at all. Across the metro area, 4 percent of adults have moved two or more times in a two-year period. This measure represents adults who are precariously housed.

Unemployment

Unemployment rates by race, estimated across Dakota, Hennepin, and Scott Counties.



Source: US Census Bureau, American Community Survey, 2012-16

According to the Minnesota Department of Employment and Economic Development, the unemployment rate in our community is approximately 2.6 percent. However, significant unemployment disparities exist by race.

While current county-level unemployment rates by race are not available, data from the American Community Survey is useful for identifying employment disparities. According to this data, unemployment rates among people who identify as black or African American or who identify as American Indian are 3 times higher than people who identify as white. People who identify as two or more races or as Hispanic/Latino or who identify with another race are unemployed at twice the rate as people who identify as white.

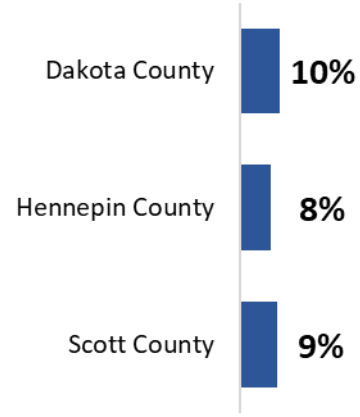
Priority: Mental health and well-being

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.

The following is a snapshot of conditions in our community that influence our mental health and well-being.

Adult mental health

Percentage of adults who reported 14 or more **poor mental health** days in the past month.



Source: Metro SHAPE, 2014

Nearly 1 in 10 adults in our community report that they have poor mental health on 14 or more days in a month. Poor mental health includes feeling sad, stressed or depressed. Adults living in Hennepin County and adults over 65 in the Minneapolis-St. Paul metropolitan area indicated they had the fewer days feeling sad, stressed or depressed in the past month.

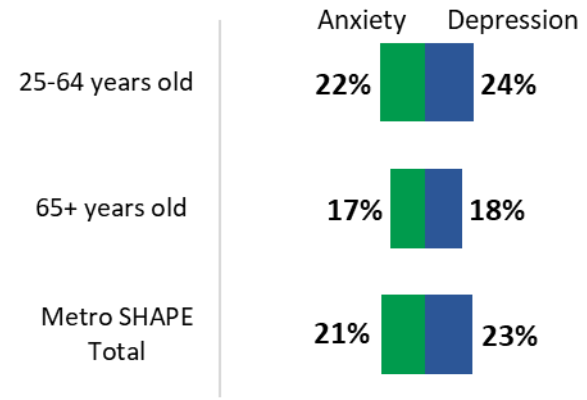
Community members identified mental health and well-being as one of their top concerns for the community. They said mental health should be viewed like chronic diseases that require ongoing care. The need to reduce stigma associated with mental health was another prominent theme.

Health care providers also shared that mental health and well-being impact many of the people

they serve. They highlighted the need to improve access to mental health services in the community.

Depression and Anxiety

Percentage of adults that have been told by a health professional that they have **anxiety or depression.**



Source: Metro SHAPE, 2014

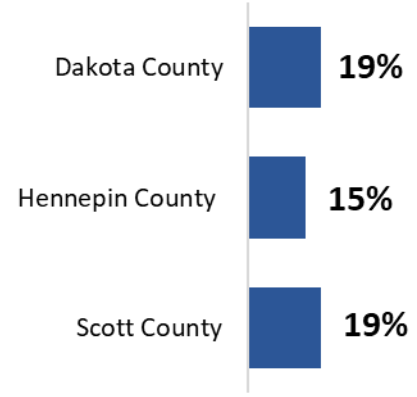
Many adults in our community say they have been diagnosed with a mental illness such as anxiety or depression. More than 1 in 5 adults in our community have been diagnosed with anxiety and nearly 1 in 4 have been diagnosed with depression.

Rates of mental illness are highest in low income communities. Nearly 1 in 3 adults in low income households reported an anxiety or depression diagnosis.

HealthPartners data indicates nearly 7,000 HealthPartners patients in our community had a positive screening for depression.

Youth mental health

Percentage of youth that have **been bothered by feeling down, depressed or hopeless** more than half the days in the last 30 days.



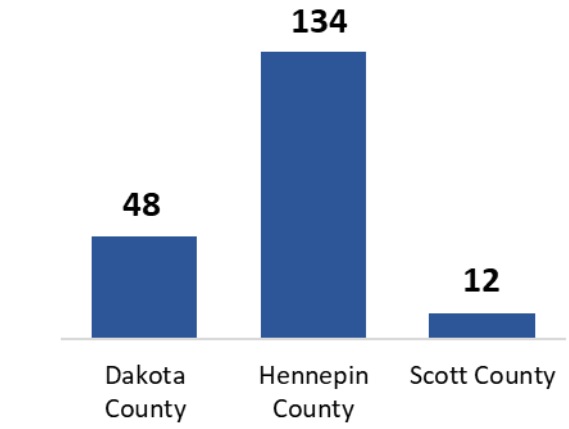
Source: Minnesota Student Survey, 2016

While more than half of young people in our community are experiencing good mental health, many report frequently feeling down, depressed or hopeless. Approximately 1 in 5 young people experience poor mental health more than half the days in a month.

Participants in many community dialogues focused on youth mental health concerns, including adverse childhood experiences (ACEs), trauma, depression, stress, anxiety and disciplinary issues within classrooms. Youth participants echoed these themes and all groups agreed that direct services within schools would address these needs.

Suicide rates

Number of **deaths by suicide** in 2016.



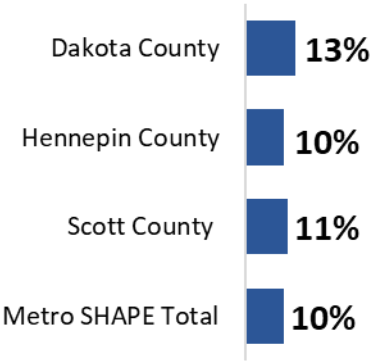
Source: Minnesota Office of Vital Statistics, 2016

Death by suicide is a significant concern for our community. In 2016, 194 adults in our community died by suicide. According to the CDC, suicide rates have increased 40 percent in Minnesota over the past 18 years.

According to the Minnesota Student Survey, between 10 and 13 percent of 9th and 11th graders in our community had suicidal thoughts in the past year. Rates were fairly consistent across grades and counties.

Social isolation

Percentage of adults who **get together or talk** with friends or neighbors **never** or **less than monthly.**



Source: Metro SHAPE, 2014

According to HealthPartners IMPACT Survey, 86 percent of adults believe mental health has a large impact on a person's overall health and well-being.

Social isolation and loneliness put people at higher risk for mental illness. Many people in our community are at risk of social isolation. About 1 in 10 adults get together to talk with friends or neighbors less than once a month. About 1 in 5 adults in our community never participate in school, community or neighborhood activities.

While most people are socially connected, more nuance is revealed when taking age into account. A greater percent of adults over 65 visit and talk with friends on a regular basis than younger community members. Over 60 percent of all adults in our community also report they are involved in school, community or neighborhood activities at least several times per year.

According to the IMPACT Survey, only 68 percent of adults in Hennepin and Ramsey Counties are comfortable talking with others about their mental illness. In Hennepin and Ramsey Counties, 94 percent of adults believe reducing stigma is important to their community.

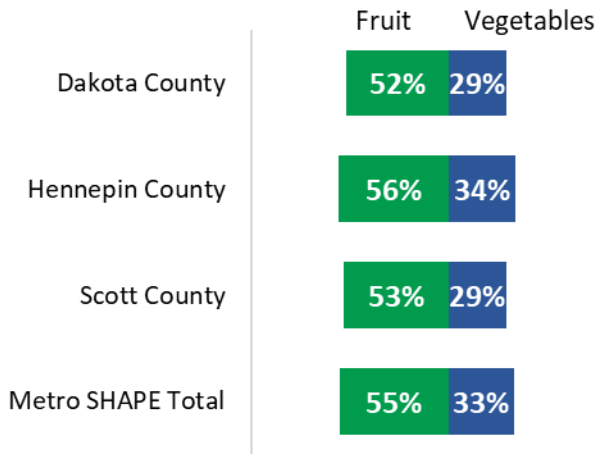
Priority: Nutrition and physical activity

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.

The following is a snapshot of nutrition and physical activity behaviors and factors in our community.

Adult fruit and vegetable consumption

Percentage of adults who eat **2 servings of fruit and 3 servings of vegetables** per day.



Source: Metro SHAPE, 2016

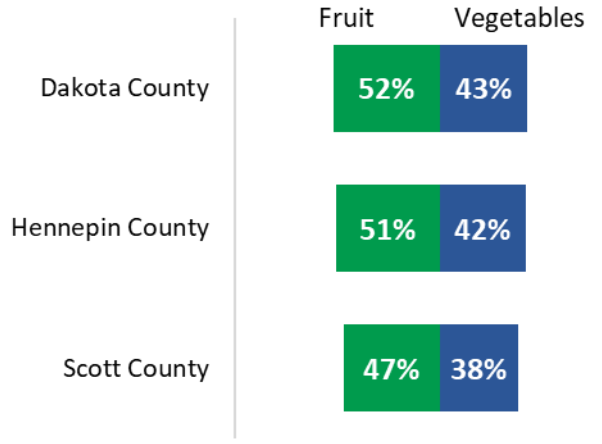
A diet rich in fruits, vegetables, whole grains and lean proteins is a key protective factor in preventing chronic disease. The current recommendation for adults is to eat 5 or more servings of fruit and vegetables per day.

About 1 in 3 adults eat the recommended servings of vegetables each day and slightly more than half of adults in our community get the recommended servings of fruit.

During community conversations, healthy eating and physical activity were mentioned as some of the top reasons a person, their family and the community stay healthy. Conversely, lack of healthy eating and physical activity were also the top reasons shared for keeping someone from being healthy.

Youth fruit and vegetable consumption

Percentage of youth **consuming at least 1 serving of fruits and vegetables** daily.



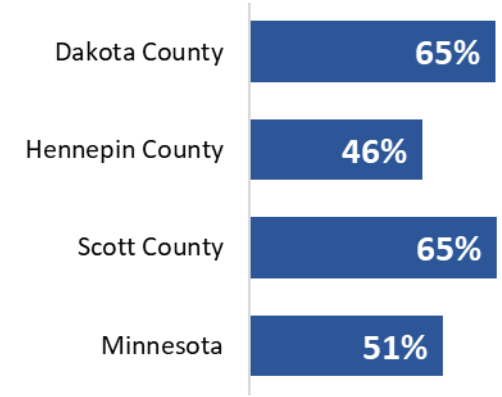
Source: Minnesota Student Survey, 2016

Less than half of 9th grade students in our community report eating at least one serving of vegetables per day. About half of youth eat one or more servings of fruit.

Despite being low, rates in our community are similar to or higher than the state average.

Access to healthy food: food deserts

Percentage of population living in neighborhoods that are considered **food deserts**.



Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2015

"[Top concern is having] adequate access to food and having the money to pay for it."

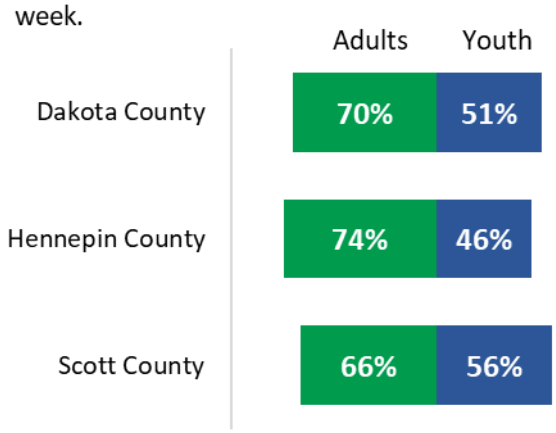
– Provider survey participant

A neighborhood is considered a food desert if 500 people or 33 percent of the population live more than one mile from a supermarket or large grocery store (10 miles for a rural community).

According to the U.S. Department of Agriculture (USDA), 51 percent of community members live in neighborhoods considered food deserts. Suburban residents are more likely to live in a food desert, with 65 percent of Dakota County and Scott County residents living in food deserts.

Physical activity

Percentage of adults and youth who **meet the recommended amount of physical activity** in a week.



Source: Metro SHAPE, 2014; Minnesota Student Survey, 2016

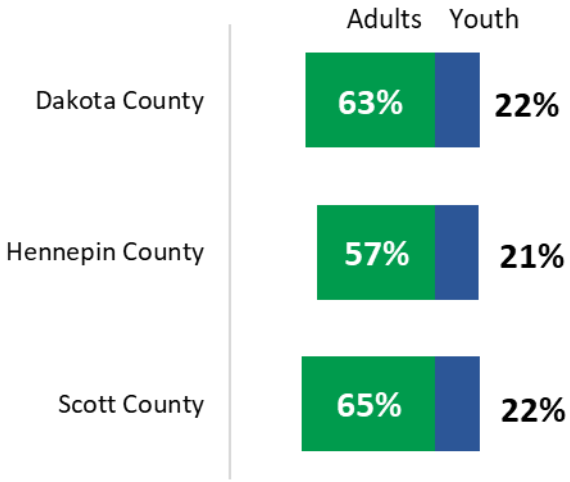
Physical activity is defined as exercise and other activities which involve bodily movement. Physical activity includes playing, working, active transportation, household chores and recreational activities. The current recommendation for adults is 150 minutes of moderate activity a week. Youth should be active 60 minutes or more at least 5 days a week.

More than 70 percent of adults in our community report they are meeting the physical activity recommendations. However, 34 percent of Scott County adults and 30 percent of Dakota County adults do not get the recommended amount of physical activity.

Compared to adults, fewer youth get the recommended levels of physical activity. In fact, between 44 and 54 percent of youth do not get the recommended amount physical activity across our community. According to self-reported data, rates of physical inactivity in our community are similar to overall rates in Minnesota.

Unhealthy weight

Percentage of adults and youth who are **overweight or obese**.



Source: Metro SHAPE, 2014, Minnesota Student Survey, 2016

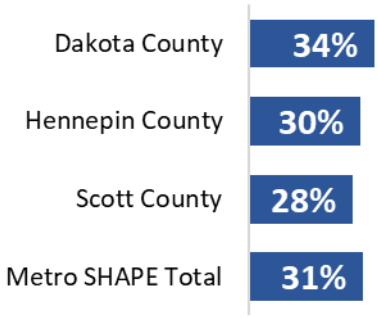
Being overweight or obese puts people at higher risk for heart disease, diabetes and other chronic conditions. Health care providers indicated obesity was one of their most important concerns.

According to self-reported height and weight information, the percent of people who are overweight or obese ranges from 57 percent in Hennepin County to 65 percent in Scott County. These findings are consistent with HealthPartners clinic data.

Far fewer youth are overweight or obese. In our community, approximately 1 in 5 youth are at an unhealthy weight.

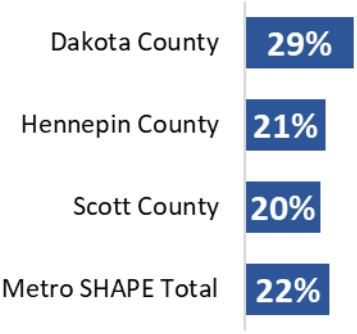
Adults with high blood pressure or high cholesterol diagnosis

Percentage of adults 18-85 who have been told they have **high cholesterol**.



Source: Metro SHAPE, 2014

Percentage of adults 18-85 who have been told they have **high blood pressure.**



Source: Metro SHAPE, 2014

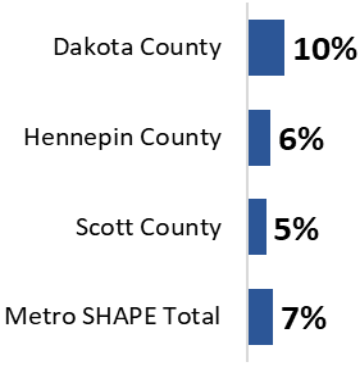
Chronic diseases associated with poor nutrition and lack of physical activity include diabetes, heart disease, stroke and some cancers. This includes the risk factors of high cholesterol and hypertension.

Across our community, approximately 1 in 3 adults have high cholesterol, which is similar to the rate in the Minneapolis-St. Paul metropolitan area. More Dakota County adults have been diagnosed with high blood pressure than in the metro area overall. High blood pressure rates are lowest in Scott County.

Significant health disparities in rates of chronic disease exist by race. These disparities can also be found in chronic disease performance measures. According to the 2018 Minnesota Community Measurement Report, people who identify as black or American Indian have rates below statewide measures for controlling blood pressure. These disparities are often the result of socioeconomic barriers and the lack of culturally appropriate care experienced by these communities.

Adults with a diabetes diagnosis

Percentage of adults 18-85 who have been told they have **diabetes**.

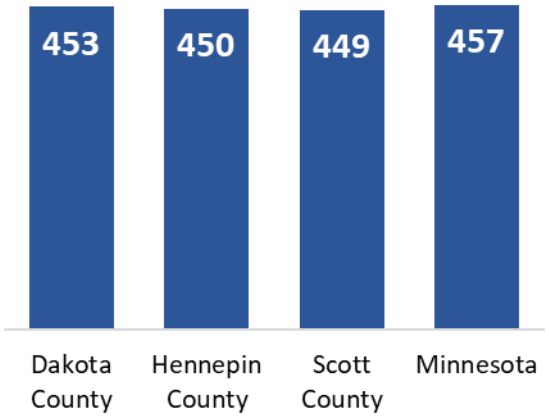


Source: Metro SHAPE, 2014

Having diabetes puts people at high risk for long term problems affecting the eyes, kidneys, heart, brain, feet and nerves. Between 5 and 10 percent of adults in our community have been told by a health care provider that they have diabetes. Dakota County has the highest rate of adults with diabetes.

Cancer rates

Cancer rate per 100,000 people, all cancer types.



Source: Minnesota Public Health Data Access, 2010-14

According to the Minnesota Department of Health, 1 in 4 Minnesotans die of cancer. The incidence of all cancers in our community is similar to the Minnesota rate overall, with Dakota County experiencing a slightly higher incidence rate than the rest of our community.

Breast and prostate cancers have the highest incidence of any cancer type among women and men.

Breast cancer rates range from 133 per 100,000 people in Hennepin County to 138 per 100,000 people in Dakota County.

Prostate cancer rates may range from as low as 125 per 100,000 people in Hennepin County to as high as 163 per 100,000 people in Scott and Dakota Counties.

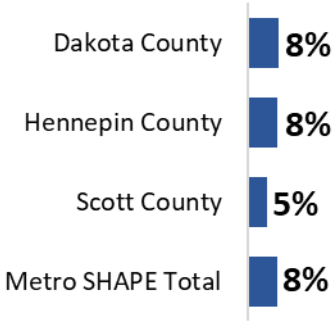
Priority: Substance abuse

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.

The following is a snapshot of substance abuse concerns in our communities.

Tobacco use

Percentage of adults who currently **smoke cigarettes**.



Source: Metro SHAPE, 2014

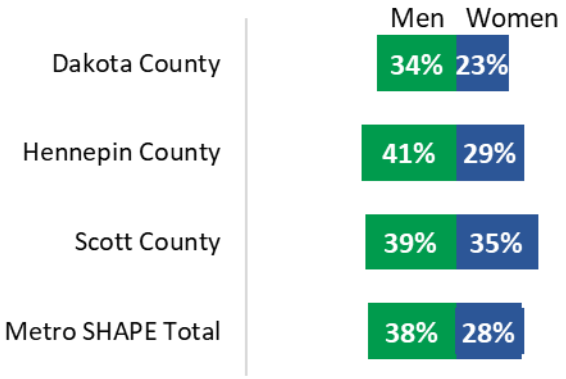
Tobacco use is associated with many chronic diseases and health conditions, including respiratory disease, heart disease and cancer.

About 8 percent of adults in our community say they currently smoke cigarettes. Only 5 percent of Scott County adults self-report smoking. However, according to EHR data, smoking rates among HealthPartners patients from Scott County are higher than self-reported data, with 14 percent of patients identifying as current smokers.

According to the Minnesota Student Survey, between 2 and 3 percent of 9th grade students in Dakota and Hennepin Counties smoked cigarettes in the last month. Youth smoking rates were highest in Scott County, where 6 percent of 9th grade students reported smoking.

Adult binge drinking

Percentage of adults who reported drinking **five or more** alcoholic beverages on one occasion.



Source: Metro SHAPE, 2014

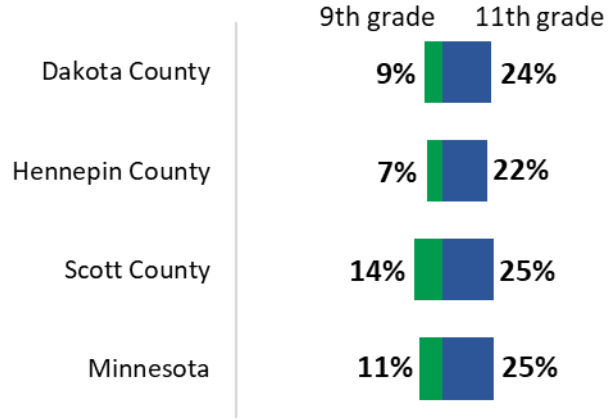
Binge drinking is defined as having five or more drinks on one occasion.

Across the metro area, 38 percent of men and 28 percent of women reported binge drinking in the last 30 days. Among men, binge drinking rates are highest in Hennepin County, where 41 percent reported binge drinking. For women, binge drinking rates are highest in Scott County, where 35 percent of women reported binge drinking.

Health care providers report drug and alcohol abuse as a high priority concern for their patient population and indicate a culture of promoting substance misuse as a risk factor.

Youth alcohol use

Percentage of 9th and 11th graders who report **using alcohol** in the past 30 days.



Source: Minnesota Student Survey, 2016

"[A top concern is how] acceptable alcohol and drug use is by our youth."

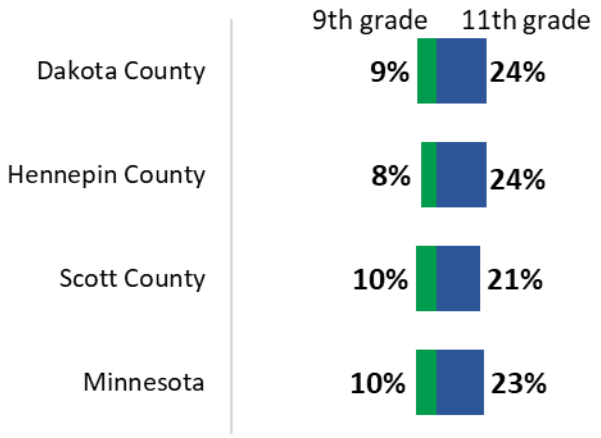
– Provider survey participant

In our community, about 10 percent of 9th grade students and 24 percent of 11th grade students reported using alcohol in the past month.

Youth alcohol use is highest in Scott County, where 14 percent of 9th grade students and 25 percent of 11th grade students drank alcohol in the past month. These rates are slightly higher than the state averages.

Illicit drug use including prescription drug use

Percentage of 9th and 11th graders who report **using marijuana** in the past 12 months.



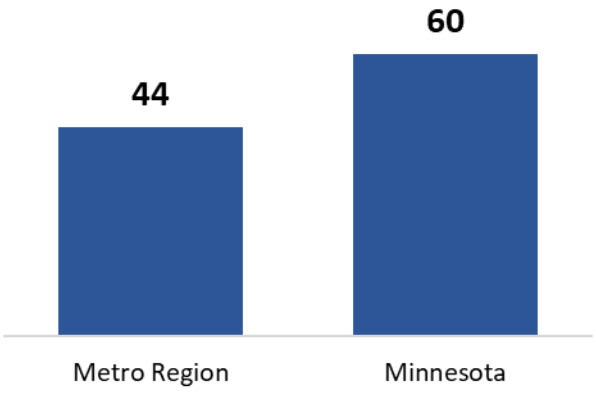
Source: Minnesota Student Survey, 2016

Marijuana use among adolescents more than doubles between 9th grade and 11th grade. 1 in 4 Dakota and Hennepin County 11th grade students and 1 in 5 Scott County 11th grade students reported using marijuana in the past 12 months.

Five percent or fewer youth in our community reported using cough medicine, cold medicine or diet pills to get high. Slightly more youth, especially 11th grade students, reported using prescription drugs that were prescribed for someone else in the past month.

Babies born addicted to opioids

Babies born **addicted to opioids**, per 10,000 births.



Source: Minnesota Department of Health, 2016

There is increasing concern about opioid use in our community and across the state. The rate of babies born addicted to opioids in the Minneapolis-St. Paul metropolitan area is 44 per every 10,000 births, which is lower than the overall Minnesota rate of 60 per 10,000 births.

Evaluation of Impact, 2016-2018 CHNA Implementation Strategy

(This section was added to the CHNA report on 12/12/2019)

The Community Health Needs Assessment conducted in 2015 identified the following priorities in our community:

1. Mental and Behavioral Health
2. Access and Affordability of Health Care
3. Chronic Disease and Illness Prevention
4. Equitable Care

Park Nicollet Health Services and Methodist Hospital developed a Community Health Implementation Plan with supporting objectives and action steps to address these priority needs and to serve as the implementation roadmap for fiscal years 2016, 2017 and 2018. Through collaboration, engagement and partnership with our communities, we addressed these priorities with a specific focus on health equity in special populations. With the growing population of people over age 65, Park Nicollet Health Services identified seniors as one of these special populations for increased focus through Park Nicollet Foundation, its philanthropic arm. The following is a summary of impact over the past three years:

Mental and Behavioral Health

- Melrose Center expanded eating disorder services to the Burnsville area in 2017.
- New Pediatrics/Adolescents brochures distributed throughout.
- Melrose Center staff conducted 35+ presentations to non-Park Nicollet provider groups.
- Park Nicollet Foundation
    - Partnered with local Family Service Collaboratives to provide Youth Mental Health First Aid and other mental health educational programs in 2018.
    - Partnered with Fairview Health Systems to fund certification for multi-cultural trainers for Youth Mental Health First Aid.
    - Completed year 2 of a 3-year, $50,000 Foundation grant to NAMI to provide and deliver Youth and Adult Mental Health First Aid classes and other educational programming.
    - Completed year 3 of a 3-year grant to NAMI to provide mental health educational programming throughout the Park Nicollet community**.**
    - Partnered with the Center for Community Health to promote Mental Health First Aid and other educational programming i.e. Make it OK stigma reducing program.
    - Launched a $5 million campaign to support Children's Mental Health & Wellbeing in 2018.
    - Awarded $30,000 in grants to community organizations providing transportation or food delivery services for seniors to help reduce isolation in 2017.
    - Awarded $262,000 in grants in 2016, $600,000 in 2017 and $625,000 in 2018 to support schools and community programs providing mental health services to youth through annual grants and partnerships.

- PNHS partnered with HealthPartners to train Make it OK ambassadors and offer Make it OK sessions to team members within Park Nicollet.
- The Make it OK campaign was folded into the Be Well program and offered to the wellness champions as a tool to share with employees.
- To improve access to mental health services, Park Nicollet hired 10 new therapists and three new mental health prescribers in 2016 and 18 new clinicians, 8 new support staff and 4 new RNs in 2017.
- Embedded therapists in three additional primary care sites in 2016.
- Added a psychologist in Physical Medicine and Rehabilitation two days/week in 2016.
- Began actively using new depression protocols from 2016-2018.
- Opened a free-standing behavioral health clinic in Burnsville which will employ 12 new clinicians; Melrose Eating Disorder Center now (2018) also offers services at this site.
- Piloted "Empowering Well-Being" groups designed to assist in the treatment and management of anxiety and depression.
- Embedded pediatric therapists at Shakopee and Chanhassen Primary Care clinics (in addition to existing adult therapists) 2017.
- Actively moving many depression and anxiety care follow-ups to phone visits.
- Eight new clinicians were hired for the new Maple Grove Behavioral Health unit, including six therapists and two M.D. psychiatrists.
- Developed a cancer survivorship program at Frauenshuh Cancer Center to support cancer survivors in dealing with the emotional and psychological aftereffects of cancer.
- Implemented The NOW! tele-mental health program at Richfield High School with a Spanish-speaking therapist. 2016.
- Expanded NOW! tele-mental health program to Burnsville High School. At three schools, 487 therapy sessions were provided at no charge to 53 unique students in 2017.
- NOW! provided 796 sessions to 73 unique students in 2018.
- Employee Health
    - Promoted Vital Work Life Employee Assistance resources, with on-site services two days/week
    - Sponsored Be Well fairs focused on mindfulness and attracted over 1000 team members
    - Held a 'Be Well' summit in fall 2017, focused on building resiliency skills.

Access and Affordability of Health Care

- Expanded annual free skin cancer screening services to provide access to greater numbers of community members. 2017 saw an 11.6% increase in community participation. 27% of individuals needed follow up and 7 cancers were diagnosed.
- Continued to increase the volume of phone and e-visits and expand the ability to schedule appointments online. Patients can now access care via scheduled telephone visits and E-Visits via MyChart.
- Parents of children ages birth to 11 years can sign up to received text reminders about recommended preventive care, screening and immunizations.
- YumPower healthy eating materials distributed to children and families at time of every Well Child visit.

- TRIA established six new partnerships in the community as well as relationships to offer our sports medicine services and concussion education and baseline testing to more than 15 organizations. TRIA maintained the existing 50+ partnerships and relationships.
- TRIA athletic trainers provided medical services at over 7,000 events totaling over 21,800 hours in 2018, including sideline services, educational events, movement screening, pre-placement exams, and ImPACT concussion testing. In addition to these events, TRIA Athletic Trainers provided the St Paul and Minneapolis Public Schools over 10,000 hours of medical services to a mostly underserved population. This included over 30 education sessions provided to parents and coaches in the community by the Sports Medicine staff in 2018.
- TRIA provided 377 free Minnesota State High School League pre-participation exams for area high school athletes prior to the fall season. TRIA also gave families the option to have a baseline impact test and functional movement screen at the time of the exam.
- Additional pre-participation physicals were subsidized for student athletes at Dakota County Technical College and hockey players for the Minnesota Magicians junior hockey team as well as the Minnesota Whitecaps NWHL team.
- Continued 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)In 2018, Park Nicollet Foundation sponsored school based health clinics provided 5,450 children free care including 1,298 immunizations, 608 acute symptoms, 770 sexual health visits and 1,208 children without health coverage.
- Expand access to free and low-cost health care services for youth in need by opening a new, school-based health center in Richfield in 2016.
- Established tele-medicine steering committees for both acute care and ambulatory care
- Continued 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.

Chronic Disease and Illness Prevention

- Behavior change campaigns were offered quarterly to employees. Each campaign had a specific focus such as: reducing/eliminating sugared beverages, maintaining a healthy weight over the holiday season and Lose Weight in 8 focused on being active while focusing on healthy habits.
- Expanded the Fruit and Veggie prescription program to all Park Nicollet clinics to give youth an incentive to learn how to shop for and prepare healthy foods.
- Reduced food insecurity among seniors by providing grant support to community organizations addressing the issue.
- HVC Fitness Center available for team member use at Methodist Hospital, for a small fee ($20 per month). Frequent Fitness program encouraging activity throughout the month while offering a discount of up to $20 if the team member visits the participating club 8 or more times during the month.
- Yoga classes offered at several Park Nicollet locations throughout 2016. The cost of classes were paid for by the team member.
- Farmers markets at Methodist Hospital and St. Louis Park offered in the summer months to provide to access to healthy fruits and vegetables to staff and visitors.
- CSA (community supported agricultural shares) offered at 8 different Park Nicollet locations as drop sites.

- Wellness fairs in conducted in April of each year at Methodist and St. Louis Park clinic. Over 1,000 team members visited the fairs to learn benefits information, master gardening information, better eating, volunteering, career development and more.
- Continued routine screening for STIs in the target age group during Primary Care visits 2017
- Park Nicollet is also 100% sugar beverage free as of January 1, 2016. We have also worked with the vending machine vendors to provide better for you snacks.
- "Be Well" Rewards program expanded and tied to our benefits plan encourages team members to take steps towards better choices by participating in a variety of well-being challenges, programs and resources. 2018.
- Continued to partner with the Brookdale YMCA on the pre-diabetes prevention program; solicit funding to expand to additional locations.
- Employed risk stratification methods to help identify patients who are not managing their chronic conditions well, allowing for earlier intervention to prevent the need for hospitalization or other high-cost treatment options.
- Expanded the team management model of care, with physicians, nurses, pharmacists, dietitians, care coordinators and other providers collaborating to work with patients with chronic diseases. Beginning in 2017, all Primary Care clinics have a Care Coordinator for both adults and children.
- Coordinated with the HealthPartners Children's Health Initiative team to identify and implement best practices in working with adolescents on sexual health issues.
- Continued to provide grant and other resource support to the Park Nicollet school-based health centers and community organizations offering free immunizations and sexual health services to adolescents.
- Expanded free immunizations, primary care and sexual health services to a new, school-based health center in Richfield.

Equitable Care

- Implemented an Equitable Care Champion program to increase awareness of organizational priorities and resources around health equity:
    - 170 Champions recruited across the organization, including Dental group
    - 4 Champions orientations held (Regions, Park Nicollet, and HPMG)
- Equitable Care Champions Annual networking event was held at the Wilder Foundation with key note speakers Dr. Miguel Ruiz and Dr. Victor Montori.
- Equitable Care Website relaunched as a resource for Champions.
- Equitable Care presentation added to our Clinical Quality Training Program. (Champions serve as faculty)
- Equitable Care Champions distribution list created for networking and sharing of internal and external education and resources.
- Seven editions of Cultural Roots newsletter were written and distributed in 2016 to HealthPartners team members to build equity education. Topics include: Healthcare access and Health disparities, Health literacy, Importance of trained interpreters, implicit Bias, disparities of colorectal cancer screening, Cultural humility in Care for LGBTQ individuals, and preparing pilgrims for travel to Hajj.
- Continued to offer "It's Time to Talk," Team Dialogues and other diversity and inclusion focused trainings for leaders and employees throughout the organization:
    - Completed two Diversity & Inclusion Team Talks across organization sessions and there were at least five team dialogues.
    - Held "It's Time to Talk" about gender identity and gender expression - LGBT, which had over 100 attendees from all areas of the organization and various positions.

    - Held 8 “Breaking Ice” video discussions at Methodist Hospital open to all employees with a total of 130 attendees. “Breaking Ice” video discussion shared in departments across PN.
    - Held 26 Diversity and Inclusion leader and team development sessions across Park Nicollet, touching nearly 1000 unique individuals.
- Increased employee recruitment and retention strategies to create a more diverse workforce.
- Completed training for Primary Care to conduct immediate and “warm handoffs” to the mammogram schedulers – patient is transferred to a live person, not a recording, to schedule to directly schedule. mammograms to remove the barrier of the patient having to make a separate call to schedule.
- Established a system to call patients that are over two years overdue for their mammogram.
- Maintained a community outreach coordinator in the Jane Brattain Breast Center to build relationships and trust in diverse communities and facilitate screening events.
- Offer Fecal Immunochemical Testing (FIT) for colorectal cancer to increase the likelihood of patients of color following through on screening. FIT was implemented in primary care clinics and are now mailed to patients who have not had previous screenings.
- Focused grant making in locations that have been shown to have high levels of health inequities. Priority was given to grant applications from organizations providing services in the communities served by the Park Nicollet school-based health centers, which are located in areas of high levels of health inequities.

Next steps

Park Nicollet Health Services and HealthPartners will continue to work collaboratively with the community to develop shared goals and actions that address the top five priority needs identified in the CHNA. These shared goals and actions will be presented in our implementation strategy, which is a required companion report to the CHNA. Each need addressed will be tailored to the hospital’s programs, resources, priorities, plans and/or collaboration with governmental, non-profit or other health care organizations.

While Park Nicollet Health Services and HealthPartners hospitals jointly prioritized systems-level needs, the U.S. Department of the Treasury and the IRS require a hospital organization to separately document the implementation strategy for each of its hospital facilities. The board of each hospital must approve the implementation strategy by May 2019.

Contact Information

For more information or questions about this report, please contact the Park Nicollet Foundation at:

Park Nicollet Foundation
6500 Excelsior Blvd.
St. Louis Park, MN 55426
Foundation@parknicollet.com
952-993-5023

Paul Danicic
Donor and Community Relations Officer
Park Nicollet Foundation
Paul.Danicic@parknicollet.com
952-993-7130

Sources

This study used health and demographic data packaged and analyzed by Community Commons. Data from Community Commons was retrieved in June 2018 from www.communitycommons.org.

Data retrieved from Community Commons includes the following:

US Census Bureau, American Community Survey, 2012-16.

US Department of Agriculture, Economic Research Service, 2015.

US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2006-10.

US Department of Health and Human Services, Health Resources and Services Administration, Area Health Resource File. 2015.

Additional health and demographic data was retrieved from the following sources:

Dakota County Community Health Assessment. 2013. https://www.co.dakota.mn.us/Government/publiccommittees/CHA/Documents/CommunityHealthAssessment.pdf

Food Access Research Atlas. 2015. https://www.ers.usda.gov/data-products/food-access-research-atlas/download-the-data.aspx

HealthPartners. Electronic Health Records. 2017.

HealthPartners. Family Community Survey. 2018.

HealthPartners. IMPACT Survey. 2018.

Hennepin County Community Health Assessment. 2017. https://www.hennepin.us/-/media/hennepinus/your-government/projects-initiatives/documents/chip-book.pdf?la=en&hash=126C4C3EBA3E43155AC602707D2D1EB132C099C5

Metro SHAPE Survey. 2014. https://www.ramseycounty.us/sites/default/files/Open%20Government/Public%20Health%20Data/metro_SHAPE_data_book_20160127.pdf

Minnesota Department of Education. 2017. https://rc.education.state.mn.us/#

Minnesota Department of Health. 2016. http://www.health.state.mn.us/macros/topics/stats.html

Minnesota Department of Health, Center for Health Statistics. 2016. http://www.health.state.mn.us/divs/chs/

Minnesota Department of Health Data Access Portal. Cancer in Minnesota. 2018. https://data.web.health.state.mn.us/cancer

Minnesota Public Health Data Access Portal. 2010-14. https://data.web.health.state.mn.us/web/mndata

Minnesota Statewide Health Assessment. 2017. http://www.health.state.mn.us/healthymnpartnership/docs/2017MNStatewideHealthAssessment.pdf

Minnesota Student Survey. 2016. https://education.mn.gov/mdeprod/groups/communications/documents/basic/bwrl/mdu5/~edisp/mde059325.pdf

Minnesota Vital Statistics Interactive Queries. 2011-16. https://mhsq.web.health.state.mn.us/frontPage.jsp

Scott County Statewide Health Improvement Plan 2015 – 2019 Report: http://mn-scottcounty.civicplus.com/DocumentCenter/View/627/Scott-County-Community-Health-Improvement-Plan-2015-2019-PDF?bidId=

US Census Bureau, American Community Survey. 2012-16. Retrieved from: https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml?

Wilder Homelessness Study. 2015. http://mnhomeless.org/minnesota-homeless-study/homelessness-in-minnesota.php#1-3457-g

Appendix

Community Committee Participation

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Building Resilience: Preventing Diseases of Despair	Funded by the Catalyst Initiative of the Minneapolis Foundation, this guided community conversation focused on Building Resilience: Preventing Diseases of Despair. The group explored strategies for primary prevention of addiction and suicide. It was an all-day event centering on community voices, emergent research, and trauma responsive approaches to supporting individual and collective resilience.	9/18/2018	DeDee Varner Pakou Xiong Thia Bryan
Center for Community Health (CCH) Assessment and Alignment Workgroup	This subgroup of CCH services as a catalyst to align the community health assessment process	Monthly	DeDee Varner
Center for Community Health (CCH) Collective Action Collective Impact (CACI)	This is one of two subgroups from CCH. The CACI Subgroup is charged to develop and implement an improvement project to address a *shared priority* based upon the community health needs assessments of the participating CCH organizations in the 7-county Twin Cities Metropolitan area.	Monthly	Pakou Xiong Libby Lincoln Amy Homstad
CACI - May's Mental Health Month (MMHM) Committee	A subcommittee of the CACI subgroup of CACI, tasked to carry the planning and inventory of May's Mental Health Month Activities across the 7 metro county sectors.	Monthly	Pakou Xiong

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Center for Community Health (CCH) Steering Committee	The Center for Community Health (CCH) is a collaborative between public health agencies, non-profit health plans, and not-for-profit hospital/health systems in the seven-county metropolitan area in Minnesota. The mission is to advance community health, well-being, and equity through collective understanding of needs and innovative approaches to foster community strengths.		Nancy Hoyt-Taff Marna Canterbury
Dakota County Healthy Communities Collaborative	The mission of the DCHCC is to bring together healthcare providers, county staff, school representatives, faith communities, nonprofit staff and other organizations to support the health and well-being of Dakota County citizens. The goal of the DCHCC is to identify needs, connect community resources, and create solutions	Monthly	DeDee Varner Libby Lincoln
Hmong Community Stroke Education and Awareness Initiative	Originally initiated from Regions Hospital Stroke Center as an awareness of high rates of Stroke in Hmong Community, through St. Paul School partnerships, has turned into a Hmong Stroke Translation project with funding from the Regions Foundation to translate 8 selected American Heart Association Stroke documents into Hmong and to make it ethnically appropriate.	Monthly	Pakou Xiong

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Mental Health and Wellness Action Team (MHWAT)	Part of the Saint Paul - Ramsey County Public Health (SPRCPH) Community Health Improvement Plan (CHIP), SPRCPH formed an authentic community engaged Mental Health and Wellness Action Team that informs the work of our department in responding to the integrated health care needs of Saint Paul - Ramsey County residents and greater communities. Ramsey County Mental Health and Wellness Action Team (MHWAT) is one of 5 SPRCPH Community Health Improvement Goals.	Monthly	Pakou Xiong
MHWAT Wellness Group	This is 1 or 4 subgroups of the MHWAT. The MHWAT Wellness Group's purpose is to increase mental well-being for students, families and school staff in Ramsey County by focusing on components of mental well-being for adolescent students.	Monthly	Pakou Xiong
Minnesota Department of Health Healthy Minnesota Partnership	The Healthy Minnesota Partnership brings community partners and the Minnesota Department of Health together to improve the health and quality of life for individuals, families, and communities in Minnesota. The Healthy Minnesota Partnership has been charged with developing a statewide health improvement plan around strategic initiatives that ensure the opportunity for healthy living for all Minnesotans, and that engages multiple sectors and communities across the state to implement the plan.	5x/year	Donna Zimmerman (representing Itasca Project) DeDee Varner
Minnesota Department of Health Mental Well-Being & Resilience Learning Community	The purpose is to expand understanding about a public health approach to mental health by profiling current community initiatives across a continuum of public health aligned strategies.	Monthly	DeDee Varner Libby Lincoln

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
St. Paul Ramsey County Community Health Services Advisory Committee	The board advises, consults with or makes recommendations to the Saint Paul City Council and the Ramsey County Board of Health on matters relating to policy development, legislation, maintenance, funding, and evaluation of community health services	Monthly	Dr. Kottke
St. Paul Ramsey County Public Health Statewide Health Improvement Program Community Leadership Team Meetings	The Minnesota Department of Health provides funding to Saint Paul – Ramsey County Public Health through the Statewide Health Improvement Partnership (SHIP) to work with a variety of partners to improve the health of our community. Saint Paul - Ramsey County Public Health is in its fourth cycle of SHIP funding. Three goals: Increasing physical activity; improving access to healthy foods; reducing the use of and exposure to tobacco.	4x/year	DeDee Varner
Forces of Change Affecting Community Health	The Center for Community Health hosted a dialogue for community leaders. This event aimed to increase collaboration and richness of conversation about health, broadly defined, across the Minneapolis Saint Paul Metro Region. Sixty participants contributed to insights and exchanged ideas.	10/25/2017	DeDee Varner Marna Canterbury Nancy Hoyt Taft Pakou Xiong Libby Lincoln
East Metro CHNA/CHA Pilot Workgroup	Dakota County Public Health, Washington County Public Health, St. Paul Ramsey County Public Health along with HealthEast, Regions Hospital, Lakeview Hospital, Park Nicollet Health Services are meeting to align respective community needs assessments which are all due in 2018.	Monthly	DeDee Varner Sidney Van Dyke Heather Walters Libby Lincoln Amy Homstad Marna Canterbury Andrea Weiler

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Community Health Action Team (CHAT)	CHAT meets monthly to discuss and address unmet community health needs in the area through action, networking and educational opportunities. Attendees are from Stillwater Area School District and Washington County partners.	Monthly	Andrea Weiler
East Metro Mental Health Roundtable	The East Metro Mental Health Roundtable and the associated Mental Health Alliance and Measurement Committees are focused on examining and improving the mental health system for adults in the East Metro. This study looks at a variety of metrics for the adult mental health system in the east metro to identify patterns, needs, and opportunities for improvement.		Megan Remark Wendy Waddell
Central Corridor Anchor Partnership	The Central Corridor Anchor Partnership is a group of colleges, universities, hospitals, and health care organizations located near the Green Line in Minneapolis – St. Paul. We have invested greatly in our physical infrastructure to serve our patients, students, and employees, and are anchored to the health, vitality, and growth of the neighborhoods around us.	Quarterly	Megan Remark Ruth Bremer
Catholic Charities Higher Ground Steering Committee	The Catholic Charities Higher Ground Steering Committee meets to support the work of Higher Ground, a shelter for adults with 171 shelter spaces and 80 Pay-For-Stay beds.	Every other month	Chris Boese John Clark Mona Olson Wendy Waddell Rachelle Brambach Katie Paulson

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
REASN	The Racial Equity Action Support Network (REASN) brings together racial equity champions and advocates from community, nonprofit, and government organizations across Minnesota, providing them a space for support in doing the challenging work of creating racial equity and to strategically advance new thinking and action in their work.	Quarterly	Sidney Van Dyke
Healthcare for the Homeless	The Healthcare for the Homeless group is part of Westside Community Health Services. They provide primary care to homeless patients that discharge from Regions and those who utilize the Higher Ground Homeless shelter. This group meets to discuss how Regions Care Management and Healthcare for the Homeless can work better together and communicate effectively to best provide care for our shared patients.	Quarterly	Rachelle Brombach
East Metro Coordination of Care	The East Metro Community is part of the Lake Superior Quality Innovation Network (LSQIN) Coordination of Care initiative, which is a community-based collaborative designed to improve coordination of care, care transitions, and reduce readmissions for Medicare beneficiaries and all patients in Minnesota. In addition to the monthly informational meetings there are several work groups that work on various topics related to reducing re-admissions.	Monthly	Rachelle Brombach Mona Olson
West Metro CHNA Collaborative	North Memorial & Maple Grove Hospital, Allina, Park Nicollet Health Services, Hennepin Health meet to align respective community needs assessments which are due in 2018 and beyond.	Ad hoc	Libby Lincoln Amy Homstad

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Scott County Health System Collaborative	The Health System Collaborative brings together representatives of area health systems, schools and community organizations to identify and address the health needs of the community.		Libby Lincoln
SHIP Community Leadership Team	The SHIP Community Leadership Team oversees the work being done in Scott County under the state SHIP grant.		Libby Lincoln
Brooklyn Center Health Resource Center Advisory Committee	The BCHRC Advisory Committee is a broad school, provider and community member group that develops and implements policies and procedures for the Health Resource Center.	Monthly	Libby Lincoln Paul Danicic Kari Hentges
Richfield Health Resource Center Advisory Committee	The RHRC Advisory Committee is a broad school, provider and community member group that develops and implements policies and procedures for the Health Resource Center.	Monthly	Libby Lincoln Paul Danicic Kari Hentges
Northwest Hennepin Healthy Community Partnership	The Partnership is a collaboration of healthcare, school, county and community organizations that come together to address the needs of the Northwest Hennepin community.	Monthly	Libby Lincoln Paul Danicic
Central Clinic Advisory Committee	The Central Clinic Advisory Committee is a broad school, provider and community member group that develops and implements policies and procedures for the clinic.	Quarterly	Libby Lincoln Paul Danicic Kari Hentges
Dakota County School Mental Health Practice Group	The Mental Health Practice Group is a collaboration of providers of mental health services in the Dakota County schools. They meet to share best practices and coordinate services.	Monthly	Libby Lincoln Paul Danicic

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Diamondhead Clinic Advisory Committee	The Diamondhead Advisory Committee is a broad school, provider and community member group that develops and implements policies and procedures for the clinic. It meets 3 - 4 times/year.	Quarterly	Libby Lincoln Paul Danicic Kari Hentges
Health and Wellbeing Advisory Committee (HWA)	The Health and Wellbeing Advisory Committee serves as the eyes and ears for Lakeview Hospital and provides resources and services to meet the health and wellbeing needs of the community.	Quarterly	Marna Canterbury Andrea Weiler
Healthier Together Pierce & St. Croix Counties	Healthier Together is a community coalition comprised of local health systems, public health agencies, local businesses, media, education, government and community members. Healthier Together provides strategic and collaborative framework for health improvement activities throughout the two-county region of Pierce & St. Croix Counties, Wisconsin.	Monthly	Jacob Hunt
Hudson School District Wellness Committee	The Hudson School District Wellness Committee is a group that meets three times throughout the school year to develop planning on student wellness. Areas that are addressed include mental health and well-being and physical activity/nutrition.	Triannually	Jacob Hunt
Physical Activity Action Team-Healthier Together	The goal of the physical activity action team is to decrease the percentage of the population in Pierce and St. Croix Counties that is overweight or obese. In order to achieve this goal, the action team is trying to increase physical activity and decrease food insecurity/improve nutrition through changes to policy, systems, environment and community support.	Monthly	Jacob Hunt

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Alcohol Action Team-Healthier Together	The goal of the alcohol action team is to decrease alcohol abuse in Pierce and St. Croix Counties. In order to achieve this goal, the action team is trying to decrease adult and youth alcohol use through changes to policy, systems, environment and community support.	Every other month	Jacob Hunt
Thrive Barron County	Thrive Barron County is a coalition of the Barron County Health Department, community partners, and healthcare partners that work together to conduct periodic community health assessments, evaluate the findings and develop strategies to address top health priorities in Barron County, Wisconsin.	Monthly	Katy Ellefson
Polk United	Polk United is a coalition of the Polk County Health Department, medical centers, and community partners that work together to evaluate community health needs, develop, and implement activities in Polk County, Wisconsin.	Monthly	Katy Ellefson
Polk County Nutrition & Physical Activity Workgroup	This subcommittee of Polk United works specifically on the priority area of nutrition and physical activity by developing and implementing plans and activities to address obesity and chronic disease. It is comprised of key stakeholders in Polk County.	Monthly	Katy Ellefson
Mental Health Taskforce of Polk County	The Mental Health Task Force of Polk County is a non-profit organization committed to addressing community mental health needs cooperatively. The task force is comprised of mental health care providers, government and law enforcement representatives, human service agencies, school personnel, and community members.	Monthly	Heather Erickson, Kesha Marson

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Polk County Substance Abuse Workgroup	This subcommittee of Polk United works specifically on the priority area of substance abuse by developing and implementing plans and activities to substance abuse issues. It is comprised of key stakeholders in Polk County.	Monthly	Brian Francis

6500 Excelsior Blvd.
St. Louis Park, MN 55426
952-993-5000
www.parknicollet.com