The Community Health Needs Assessment (CHNA), a statutory requirement from the federal government Affordable Care Act, was instituted to justify a hospital’s 501(c)(3) tax-exempt status. Every three years, a Community Health Needs Assessment is to be completed and needs to include a written three-year Implementation Plan (“Plan”). The Plan is to be reviewed and updated annually.

We at HealthPartners believe the Community Health Needs Assessment (CHNA) is a written extension of our mission to improve health and well-being in partnership with our members, patients and community. We welcome the opportunity to share this executive summary.

Our HealthPartners hospitals’ first CHNAs, in 2012, identified the greatest needs in the communities we serve. Comprehensive assessments were conducted by the following HealthPartners hospitals: Regions Hospital in St. Paul, MN; Lakeview Hospital in Stillwater, MN; Methodist Hospital in St. Louis Park, MN; Hudson Hospital in Hudson, WI; Westfields Hospitals in New Richmond, WI and Amery Regional Medical Center in Amery, WI. Both the CHNAs and Implementation Plans at each of the hospitals were approved by their respective hospital boards, Q4 2012.

The first year of each hospital’s Plan was 2013. This executive summary is a report back of the 2013 implementation activities.

Rather than limiting the CHNA only to Methodist Hospital, Park Nicollet Health Services (PNHS) assessed how to harness the broader resources of the system as a whole to address the needs of its community. The key themes identified by the CHNA for PNHS/Methodist Hospital were:

- Mental health
- Obesity
- Seniors
- Connecting community resources
- Access & affordability
- Wellness
- Culturally sensitive care

Additional themes identified were:

- Teen and young adult drug and alcohol abuse
- Teen pregnancy and teen parenting
- Smoking cessation

The CHNA steering committee determined that these additional themes receive significant funding and support from federal, state and county agencies and numerous non-profit organizations. Therefore, they are not addressed in the Plan.
The Plan assigns two tracks of responsibility for CHNA implementation initiatives: to program-specific areas within PNHS and to Park Nicollet Foundation.

**The role of Park Nicollet Foundation**

The Park Nicollet Foundation Board of Directors prioritized the issues identified in the CHNA based on how effectively they could be addressed through the Foundation’s community-focused grant process. They paid particular attention to the severity/degree of needs, the number of other organizations addressing the issues and the strengths of the Foundation. The following framework was developed for the Foundation’s 2013-15 CHNA implementation strategy:

![Well-being umbrella](image)

Under the general umbrella of well-being, mental health and concerns of seniors are the top priorities for Foundation CHNA implementation efforts. Access & affordability, culturally sensitive care and connecting community resources are secondary, or “supporting” priorities. The Board believes that obesity receives significant attention from the PNHS International Diabetes Center and other PNHS departments and, therefore, made this a lower priority in 2013 community funding.

**Executive Summary: An update of the Implementation Plan for 2013**

Note: All of the Foundation initiatives reference hiring a .5 program officer to shepherd CHNA implementation activities. A new program officer joined the Foundation in January 2013.

<table>
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<tr>
<th>Priority: Mental health</th>
<th>Need: MN has fewer psychiatrists per capita than the national average. There are long waits times for patients to receive care.</th>
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<td>Objective: Utilize a collaborative care model involving primary care, mid-level mental health professionals and qualified community agencies.</td>
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<th>Foundation Implementation Activity: 2013-14 Goal</th>
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| Explore and develop relationships with key community partners in the area of mental health for collective impact. | • Granted over $210,000 to community organizations providing direct mental health services, particularly for youth.  
• Granted an additional $90,000+ to fund programs within PHNS addressing mental health needs of patients and staff.  
• Sponsored the third annual Mental Health Summit of the Dakota County Healthy Community Collaborative, attended by over 600 community members and 350 mental health service providers.  
• Developed a pilot program (NOW! - No Obstacles to Well-being) in partnership with the St. Louis Park middle school to provide mental health services via telemedicine. |
| PHNS Implementation Activity: 2013-14 Goal | PHNS Implementation Activity: 2013 Actual |
| Embed mental health clinicians closer to care teams in the clinics and hospital so that patients with underlying mental health issues can quickly access the expertise of a mental health provider in that setting. | • Successfully embedded a full-time PhD psychologist at the Eagan Clinic and a child psychiatrist in the developmental pediatrics clinic in Eden Prairie.  
• Began planning to embed psychologists at the Bloomington and, possibly, Burnsville clinics.  
• Arranged for dedicated mental health space to be included in the to-be-built Maple Grove site; the goal is to have multiple psychologists and psychiatrists at the site to provide a hub of service to PNHS’s northern region. |
| **Priority: Obesity** | Need: The community would like to receive health information and education about childhood obesity in a more proactive and preventive manner.  
Objective: Collaborate with health plans, local cities and other groups focused on the well-being of children. |
<p>| Foundation Implementation Activity: 2013-14 Goal | Foundation Implementation Activity: 2013 Actual |
| Support community organizations addressing childhood obesity. | • Granted a total of $10,000 to Camp Heartland/Camp 5210 and Youth Determined to Succeed to support childhood obesity prevention programs. |</p>
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| Solidify the PN “Flash Program,” an intensive multidisciplinary approach to obesity for elementary and middle school children and their families. | • The Flash Program – Families Living Actively, Striving for Health – launched its pilot in 2013. The program provides counseling for families at risk for developing diabetes. It is multi-disciplinary, involving pediatricians, dieticians, physical therapists and mental health therapists. Health education is a major component of the program.  
• A cross-disciplinary pediatric obesity task force meets quarterly.  
• The Pediatric Obesity Toolkit assists primary care providers in dealing with patients struggling with obesity.  
• President of Foundation is a member of the Optimal Lifestyle Management Committee, which guides health priorities of the enterprise. |

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<th>Priority: Seniors</th>
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| Need: The growing senior population needs more, and better access to, services.  
Objective: Engage Population Health strategy, continue the St. Louis Park Successful Aging Initiative and explore means to expand Successful Aging in other western suburbs. | Initiated relationships with the MN Chapter of the National Alliance on Mental Illness, Darts Senior Services in Dakota County and Senior Community Services in the western suburbs.  
• Worked with the Dakota County Healthy Community Collaborative to develop plans for a Living Longer Summit targeting providers of services for seniors.  
• Began community discussion of expanding the Successful Aging program to Wayzata.  
• Sponsored publication of Creating Vital Aging Communities: How You and Your Community Can Age Successfully Together – a resource for communities to help improve the “senior friendliness” of their services, amenities and infrastructure. |
- Provided focused education on issues related to seniors for the Foundation Grant Committee to ensure good alignment of grant-making strategies with areas of need identified in the CHNA.
- Added a community advisor with expertise in senior issues to the Foundation Grant Committee.

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| Continue a focus on the senior population in population health strategies. | - As part of PNHS’s participation in Medicare’s Pioneer Accountable Care Organization (ACO) program, Population Health developed the RN Care Consultant program. This intensive case management program matches a high risk ACO patient with an RN Care Consultant. The Care Consultant meets with the patient in the patient’s home and a care plan based on the patient’s goals is established. Since the inception of the program, hundreds of patients have been served, barriers to care have been eliminated, goals have been met, and unnecessary utilization of health care services has decreased.
- Senior Services Nurse Practitioners and Geriatricians continued the after-hours call program. The purpose of this program is to ensure that the right clinician is taking calls for the right patients. The majority of calls after-hours come from Skilled Nursing Facilities (SNFs) and may be around a condition change in a patient, test results or medication needs. The clinicians from Senior Services are experts in caring for the frail elderly and are well versed in the capabilities of the external facilities. This results in more care being delivered at the SNFs and fewer unnecessary ER transfers.
  - From October 15, 2012 to December 31, 2013 there were 7,676 calls to the Senior Services After-Hours call team. Of these calls, 664 resulted in care being delivered at the SNF vs. an ER setting, thereby averting a transfer to the hospital. Savings have been calculated at $1.5 to 2 million dollars in health care costs.
- Maintained a strong emphasis on advanced care planning. Provided 35 community presentations, 48 advanced care planning classes open to the public, and 10 individual... |
| Priority: Connecting Community Resources | Need: Better communication and coordination among community resources.  
Objective: Continue to serve as a trusted community convener and connector. |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| **Foundation Implementation Activity: 2013-14 Goal** | **Foundation Implementation Activity: 2013 Actual**  
- Continued to facilitate and support the Dakota County, Scott County and Northwest Hennepin Healthy Community Collaboratives and the St. Louis Park Successful Aging Initiative, all groups started for the purpose of connecting community resources.  
- Began discussion with city, faith and business groups in Wayzata to convene a Successful Aging Initiative in that community.  
- Continued financial and other resource support for the Children First and Meadowbrook collaborations among PNHS, the school district and the city in St. Louis Park.  
- Began conversations with IBM regarding a system for connecting community resources that is being used in Olmsted County. |
| **PNHS Implementation Activity: 2013-14 Goal** | **PNHS Implementation Activity: 2013 Actual**  
- Worked in collaboration with the Foundation to raise $1.2 million in the Women’s Center and Services Campaign to support centralized, coordinated care and community resources for women.  
- Given the 2013 combination with HealthPartners, it no longer makes sense to focus on developing additional systems to centralize resources and services just within PNHS. This item has been removed from the Implementation Plan, but coordination of resources and services is being addressed in a broader context throughout HealthPartners. |
| Remain active in learning about and supporting community organizations with the goal of enhancing coordination and communication among them. |  
- Continued to facilitate and support the Dakota County, Scott County and Northwest Hennepin Healthy Community Collaboratives and the St. Louis Park Successful Aging Initiative, all groups started for the purpose of connecting community resources.  
- Began discussion with city, faith and business groups in Wayzata to convene a Successful Aging Initiative in that community.  
- Continued financial and other resource support for the Children First and Meadowbrook collaborations among PNHS, the school district and the city in St. Louis Park.  
- Began conversations with IBM regarding a system for connecting community resources that is being used in Olmsted County. |
### Priority: Access & Affordability of Healthcare

**Need:** Greater access to and affordability of health care that is too often limited by such barriers as lack of insurance, high deductibles, lack of transportation and language.

**Objective:** Engage a Population Health strategy with adults and continue the upstream work of the four Foundation-sponsored community clinics for youth to prevent downstream challenges and burden in the ED and urgent care sites.

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| Continue to financially support programs that improve the access to and affordability of care. Relocate the Wayzata Community Clinic to increase utilization of services and eliminate perceived barriers to access for the youth of the community. | • Granted over $200,000 to support four community clinics and other community organizations addressing access and affordability. The community clinics had nearly 3000 visits from un- and underinsured youth.  
• Granted over $120,000 to fund programs within PNHS that provide medications, medical supplies and supportive services that patients cannot afford.  
• Raised funds and provided financial and organizational support to bring Mammo-a-go-go to community sites to provide free mammograms to un- and underinsured women.  
• Convened a community-based task force and began data gathering to assess potential relocation of the Wayzata Community Clinic to serve even greater numbers. |

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| Use population health strategies to proactively identify patients at high risk of experiencing adverse health events and incurring related high costs; taking action to intervene. | • Quarterly conferences were held at 22 Primary Care Clinics with the goal of identifying clinical care needs and care coordination opportunities for patients. Patients discussed at care conferences were matched with the resources they needed to optimize health.  
• High risk for readmission- Every day, forty to sixty patients hospitalized at Methodist hospital are identified as high risk for readmission. Care team members are notified of this risk via the electronic medical record; they assess each patient's needs to create a smooth discharge plan. The inpatient team |
communicates with the ambulatory team to pass on crucial information related to the plan of care.

| Priority: Wellness/Well-being | Need: The community wants to receive health information and education about individual health needs in a more proactive and preventive manner and to be treated as a "whole persons."
Objective: Collaborate with health plans, local cities and other groups focused on well-being. |
|---|---|
| Continue to convene, engage and support community organizations focused on well-being. | • Provided financial support for and continued facilitating the Dakota County Healthy Community Collaborative.
• Provided financial support for and continued active participation in the activities of the Northwest Hennepin Healthy Community Partnership.
• Continued active participation with the Scott County Healthy Community Collaborative.
• Participated with both the Scott County and Dakota County Public Health Departments in developing plans to implement their community health needs assessment initiatives.
• Provided over $200,000 in grants to community organizations focused on well-being, including Children First and the Meadowbrook Collaborative in St. Louis Park, Interfaith Outreach & Community Partners in Plymouth, and the Minnetonka Heights Housing Complex.
• Partnered with the city of St. Louis Park to begin a Health in the Park (HIP) community initiative. |

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<td>Continue to provide PNHS team members a confidential, personalized health promotion program to help make healthy lifestyle changes.</td>
<td>• In 2013, PNHS continued its commitment to supporting healthy lifestyles among team members, devoting significant resources to the Healthy Living Division of the Employee Health Department. Part of these resources funded a Wellness Coordinator and provided for numerous offerings, including:</td>
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| Priority: Culturally-friendly Care | Need: Diverse populations do not know how to access health care due to cultural myths, language, lack of insurance, lack of transportation and other barriers.  
Objective: Provide access to language interpreters and provide appropriate trainings to break down barriers to health care. |
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| Support local non-profits offering services related to improving culturally-friendly care. | • Provided a grant to The Family Partnership to support mental health outreach efforts with the West African immigrant community.  
• Provided a grant to the Brooklyn Center school district to offer mental health services in different languages.  
• Foundation president is a member of the PNHS Diversity and Inclusion Committee on Community Involvement and Planning.  
• Translated consent forms for the NOW! and Healthy Minds mental health programs into Somali and Spanish for the St. Louis Park and Hopkins school districts. |
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| Continue the efforts of the PNHS Diversity Program to heighten awareness among team members of opportunities to appreciate the cultural and interpersonal differences among patients and staff. Continue to provide interpreter services. | • In 2013, PNHS evolved from focusing diversity efforts in a committee to weaving diversity into the basic fabric of the PNHS culture. HR staff now work directly with their assigned departments to develop awareness and appreciation of cultural and demographic diversity at the front line level.  
• Appreciating diversity is also one of the Head + Heart, Together organizational competencies that is assessed in the interview process and woven into staff orientations.  
• Interpreter Services supports over 20,000 patients throughout the PNHS system with over 56,000 encounters per year. As of May, 2014, a nearly 15 percent growth in encounters has occurred year-over-year from 2013. Consent forms have been translated into the top six languages encountered at PNHS; these address 85 percent of the Limited English Proficiency patients in the system. |