



Community Health Implementation Plan 2026



Priorities & Strategies

ASTERA HEALTH COMMUNITY HEALTH PRIORITIES – 2025 ASSESSMENT

As a result of work completed through the MAPP process in collaboration with community members and organizations, the following items were identified as the top significant issues for the purpose of this assessment:



Hypertension



Obesity



Substance Use Disorder

Hypertension

Hypertension is the top diagnosis among Astera Health patients and contributes to heart disease—the second leading cause of death in the service area with rates significantly above the Minnesota average (e.g., Wadena 197.25 vs. MN 123.87 per 100,000).

Hypertension is a community priority because it has been identified through data analysis and stakeholder forums as a key preventable chronic disease. From a health equity perspective, we know lower median household incomes and higher uninsured rates in the service area increase barriers to ongoing blood pressure management.

Astera Health offers free 24-hour blood pressure testing with use of the Oscar 2 ambulatory blood pressure machine. This is the gold standard in 24-hour ambulatory blood pressure monitoring. This tool helps us provide valuable diagnostic information that in-clinic and home blood pressure monitoring systems are incapable of measuring, the data received from using a 24-hour blood pressure machine helps to provide patient-centered care and guide patient specific treatment decisions, without needing to refer patient elsewhere to obtain these measures.

A home blood pressure machine allows the patient to be in charge of their health, get an accurate depiction of their blood pressure and guide the best treatment plan.

When home blood pressure monitoring is advised by a provider, but a patient is unable to afford to purchase their own machine and insurance does not cover the device, Astera Health offers a free validated BP machine for home use. Proper use of the machine is demonstrated; they are given education on lifestyle modifications to help improve treatment of hypertension, and the consequences of untreated hypertension are discussed. Once the patient has checked their home readings for the requested amount of time, the results are either given via phone, MyChart or reviewed in person.

Hypertension Playbook for Astera Health

Goal: Improve hypertension control rates and reduce incidence in Wadena and surrounding rural communities. **Metric:** Control high blood pressure in 74% of patients aged 18-85.

A. Monitoring Program

Description: Currently offer validated BP machines with manual entry by patients. MyChart Flowsheet for Blood Pressure Monitoring–Provider places order for adding this feature to their MyChart. Patients enter their blood pressure results electronically.

Future state: Explore providing Bluetooth-enabled BP cuffs synced with a patient app/EHR. Nurses/health coaches monitor daily logs.

Partners: Clinic staff, nurse educators.

B. Explore Pharmacist-Led Hypertension Clinics

Description: Empower pharmacists to adjust meds through use of protocols. Focus on adherence, affordability, and side effects.

Partners: Local pharmacies, retail chains (Thrifty White, Walmart), hospital pharmacy.

C. Community Paramedic (CP) Home Visits

Description: CP to assess BP when referral received for home bound patients without access to home BP monitor or ability to come in easily for clinic nurse BP check; CP provides additional education and can connect families to additional resources.

Partners: Provider team for referrals, social service agencies.

D. Explore Food-as-Medicine

Description: Provide DASH-diet education - patients are taught about healthy eating, reduced sodium intake, and encouraged to exercise. Mrs. Dash packets are provided to newly diagnosed hypertensive patients. Give “prescriptions” for fruits/vegetables; explore option of fresh produce vouchers from local co-ops or DASH-diet meal kits. Dietitian visits are ordered for hypertensive patients.

Partners: Local farmers, grocery stores, co-ops, food pantries, dietitians.

E. Free Blood Pressure Readings

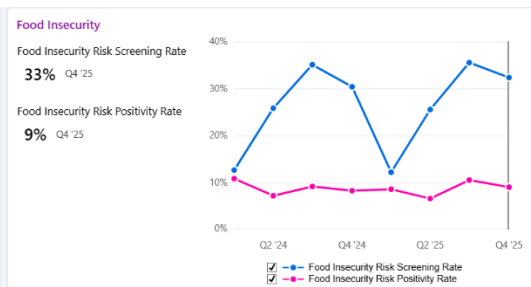
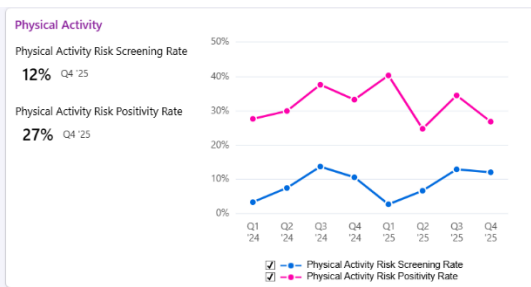
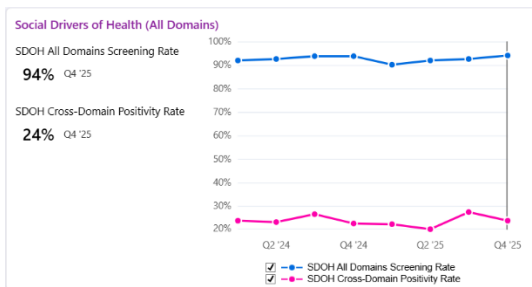
Description: Patients can walk-in for a blood pressure reading at any time.

Partners: Patient care team, nurses

F. Social Determinants Screening

Description: Screen for food insecurity, financial stress, housing, and connect patients with resources.

Partners: Nurses, providers, social workers, public health, community paramedic.



G. Community Education

Description: Provide hypertension education via Bite-Size Conversation events (free monthly offering in person or online), website, blog, Healthy Times magazine, and social media posts.

Partners: Clinic staff, Marketing Lead, Foundation Lead

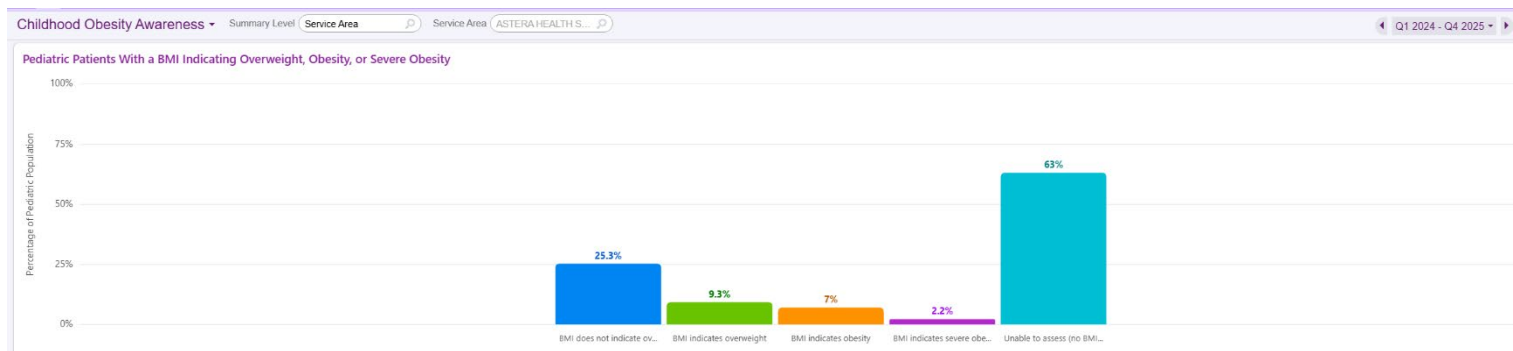
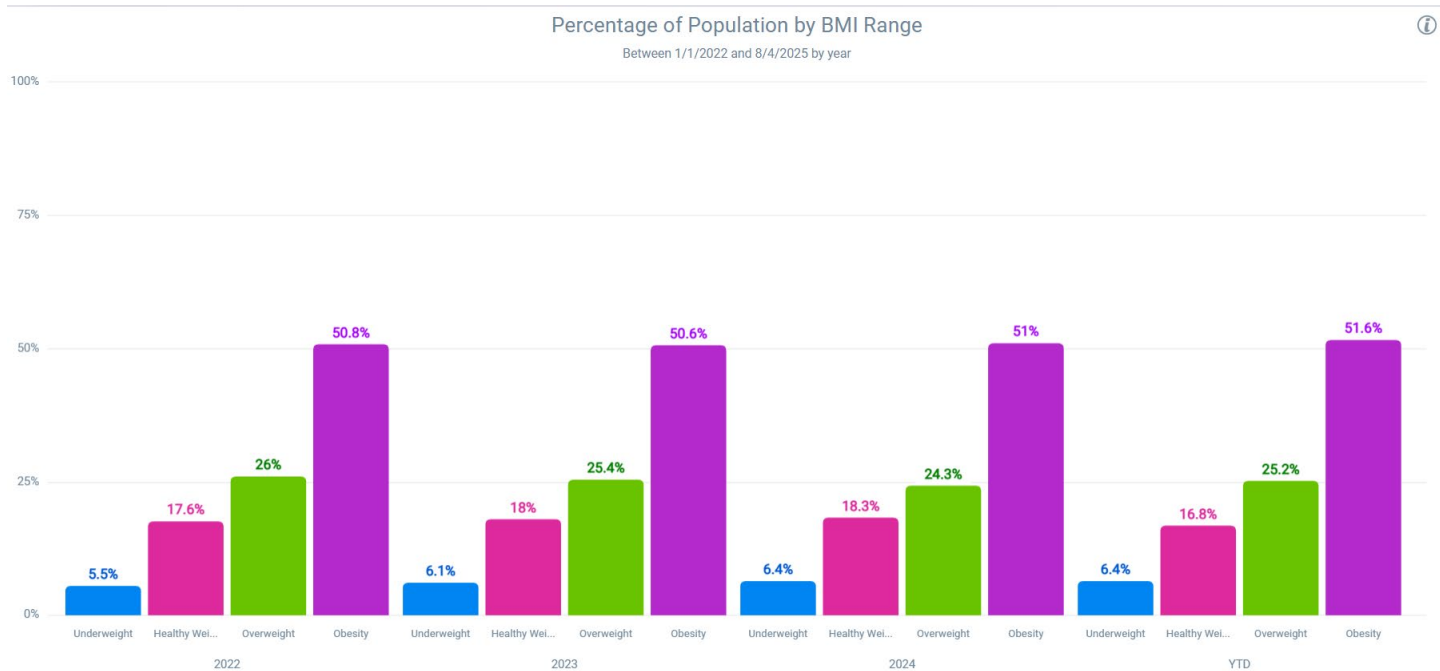
Obesity

Adult obesity rates in the service area are markedly higher than the Minnesota average (Wadena 43%, Otter Tail 38%, Todd 41% vs. state 34%). Physical inactivity is similarly elevated (24-27% vs. 20%

state average) shown below.

Health Outcome ¹	Wadena	Otter Tail	Todd	MN
Adult Obesity	43%	38%	41%	34%
Physical Inactivity	24%	27%	24%	20%

Obesity is a well-established risk factor for hypertension, type 2 diabetes, heart disease, certain cancers, and mental health conditions. Addressing root causes of chronic disease and social determinants; obesity intersects with nutrition, physical activity, and economic barriers. BMI is tracked at Astera Health for all patients. The chart below shows steady rates since 2021.



Surveys and forums consistently highlighted poor eating habits and chronic disease prevention as top concerns, making obesity a top priority to address at Astera Health.

Obesity Playbook for Astera Health

¹ County Health Rankings and Roadmaps: A Healthier Nation County by County, 2025

- **Goal:** Decrease BMI rates and reduce incidence in primary service area. **Metric:** Produce $\geq 5\%$ average weight reduction in pilot cohort at 12 months.

A. Clinical Enhancements for Current Patients

Description: Identify high-risk patients via EHR screening (BMI, comorbidities) and proactively invite them into programs. Provide GLP-1 med management and create a workflow for referrals to dietitian for obese patients to create a plan of care for healthy eating and increased exercise.

Partners: Clinic staff, nurse educators, Epic optimizers and IT, [Get with the Guidelines](#) program with the American Heart Association for Rural Hospitals.

B. Community Education

Description: Provide obesity education via Bite-Size Conversation events (free monthly offering in person or online), website, blog, Healthy Times magazine, and social media posts.

Partners: Clinic staff, Marketing Lead, Foundation Lead, American Heart Association ([Healthy for Good](#)), CDC ([Obesity Strategies: What Can Be Done | Obesity | CDC](#))

C. Explore Walking Clubs in Schools

Description: Explore community walking groups: Start with volunteer leaders (staff, church members, teachers) to build a culture of low-barrier exercise. Check with each school district about public use of indoor tracks.

Partners: Nurse educators, local school districts, community leaders

D. Staff & Culture Building

Description: Run an internal wellness challenge quarterly (walking, water intake, healthy lunches) for Astera staff—leading by example builds trust with the community. Post winning groups on internal and external sites. Partner with employers on workplace wellness initiatives (healthy cafeterias, walking meetings, step challenges).

Partners: Employee Light Committee, marketing, hospital leadership, Chamber of Commerce

E. Explore a Community Garden Program

Description: Explore a community garden program—Astera could sponsor seeds, tools, and volunteer days.

Partners: Grant writer, Astera Health facilities team, volunteers, Celestial Givers (Employee Giving Committee)

Substance Use Disorder

From 2014–2023, Wadena, Todd, and Otter Tail counties experienced a steady increase in drug overdose fatalities, largely driven by synthetic opioids such as fentanyl. Excessive drinking rates are higher than the state average (Wadena 24%, Otter Tail 25%, Todd 23% vs. MN 23%) and alcohol-impaired driving deaths remain high.

Substance use disorder ranked second among priorities chosen by community stakeholders and we know rural geography and provider shortages limit timely treatment and recovery support in our rural area.

Strategies include measurable objectives (screening rates, BMI tracking, SUD treatment uptake) and align with Astera’s 2025–2030 Strategic Plan.

Opioid Management Program Overview

Our program focuses on two distinct patient groups to address opioid management effectively – 1. Chronic Opioid Users: Patients currently undergoing long-term opioid management including Medication Assisted Treatment* (MAT), requiring structured controlled substance agreements (CSAs - previously referred to as care plans) monitoring, and support to reduce dependency and prevent misuse. 2. Acute Opioid Patients: Individuals prescribed opioids for acute pain management, with targeted interventions aimed at preventing progression to chronic use.

**While MAT patients fall under the target population, they do not pose the same challenges as chronic and acute opioid patients.*

Chronic opioid use continues to pose significant challenges for patients, families, and the broader Wadena County community. The risks associated with dependency, overdose, and unmanaged pain are compounded by social and economic barriers that disproportionately impact the region. As a healthcare provider and community partner, Astera Health recognizes the urgent need to address these issues through targeted interventions that fill gaps in care, support at-risk populations, and improve overall health and safety. Here is an outline of key issues this intervention is designed to address:

Chronic Opioid Use as a Health Crisis:

Chronic opioid use poses serious risks, including dependency, overdose, and reduced quality of life, making it a critical health issue for our patient population.

Wadena County has experienced a notable burden, including three non-fatal overdoses and one fatal overdose in 2023 alone. These numbers underscore the need for intervention to prevent further harm. Of the two facilities that serve Wadena County, Astera Health has had no fatal overdoses at our facility from 2022-24.

Violence in the emergency room has increased since 2019, with incidents including verbal, written, and physical threats or aggression. The rise reflects both an increase in events and improved reporting after staff education in 2021.

Trends in violence:

2019: 7 events (2 with harm)

2020: 8 events (0 with harm)

2021: 20 events (5 with harm) – following education on reporting.

2022: 23 events (4 with harm)

2023: 17 events (0 with harm)

2024 through Q3: 17 events (2 with harm)

This highlights the need for continued prevention strategies, staff training, and enhanced safety protocols to address violence, especially related to patients with opioid dependency or withdrawal.

Gaps in Care and Risk Management:

Approximately 39% of opioid-prescribed patients in our care lack an established CSA, leaving them vulnerable to unmanaged chronic use and its associated risks.

Without targeted intervention, patients often miss opportunities for tapering, alternative pain management options, or access to MAT.

The closure of Bell Hill Recovery Center at the end of 2024 marks a significant loss of addiction recovery services in our area. Located near Wadena, Minnesota, Bell Hill had provided long-term chemical dependency treatment for adult males since 1973. The center specialized in a relapse-based inpatient program for individuals with multiple treatment exposures, offering a slower-paced, comprehensive approach that included individual counseling, chemical dependency education, group therapy, and work therapy. With a typical 60-day length of stay, the program focused on helping clients develop a responsible, chemically free lifestyle through psychological

and spiritual counseling, GED tutoring, and aftercare planning. Its closure underscores the urgent need for Astera Health to expand its opioid program to fill this critical gap in care for our community.

High-Need, At-Risk Population:

As the county seat and regional healthcare hub, Astera Health serves a diverse population, including individuals receiving care from external prescribers but filling opioid prescriptions at local pharmacies. This creates an added layer of complexity and reinforces the need for proactive, coordinated care strategies.

Patients with chronic pain, substance use history, or socioeconomic barriers require structured support to avoid the cycle of misuse and overdose.

Wadena County remains on the higher side of opioid prescriptions per capita. In 2020, the MN Board of Pharmacy reported 1.5 opioid prescriptions per person, ranking Wadena County as the eighth highest in Minnesota. While opioid prescriptions have decreased from 8,784 in 2020 to 8,172 in 2022, Wadena County continues to grapple with significant social determinants of health, including limited transportation, poverty rates above the state average, lower-than-average education levels, and higher-than-average unemployment rates.

The opioid prescription rates across Wadena, Todd, and Otter Tail Counties highlight the high-need, at-risk population in Astera Health's service area and reinforce the critical importance of the opioid management program.

Wadena County:

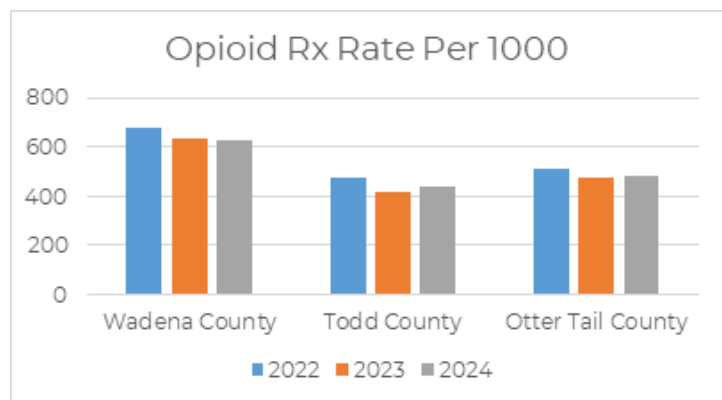
2022: 680.6 per 1,000
2023: 638.2 per 1,000
2024: 626.6 per 1,000

Todd County:

2022: 476.3 per 1,000
2023: 417.1 per 1,000
2024: 438.4 per 1,000

Otter Tail County:

2022: 510.7 per 1,000
2023: 473.5 per 1,000
2024: 484.9 per 1,000



(Source: MN Board of Pharmacy)

The declining trends across all three counties show some progress, but the persistently high rates, particularly in Wadena County, highlight the importance of continuing and expanding Astera Health's opioid management program. By addressing this high-need population, the program can help further reduce prescription rates, support at-risk patients, and improve community health outcomes.

Opioid Overdose Fatalities: From 2018 to 2023, Wadena County reported 5 opioid-related fatal overdoses, Todd County reported 3, and Otter Tail County reported 14 (source: Minnesota Department of Health). These figures highlight the ongoing risk of opioid misuse and overdose across Astera Health's primary and secondary service areas, emphasizing the need for targeted interventions and expanded support systems.

Community Health and Safety:

Chronic opioid use impacts not only individual patients but also families, caregivers, and the broader community. By reducing misuse, overdose rates, and dependency, Astera Health aims to improve overall health outcomes and safety across the region.

Proposed solution: To address the ongoing challenges of chronic opioid use and improve patient outcomes, Astera Health proposes a multi-faceted, multi-year solution that builds on current successes, addresses gaps, and incorporates innovative strategies to deliver comprehensive care.

Performance Periods 1-2 (July 2025 – December 2026): Strengthening Foundations and Expanding Integration

Integrate Behavioral Health into the Suboxone Program:

- Partner with behavioral health professionals to address mental health, trauma, and coping mechanisms, ensuring a holistic approach to addiction treatment.
- Incorporate behavioral health services into existing workflows to reduce relapse risk and improve patient outcomes.

Standardize Controlled Substance Agreements:

- Develop and implement standardized language and workflows for CSAs across the organization to ensure consistency and accountability.

Expand Tapering Plan Integration:

- Transition from a referral-based program to an EHR-driven system by implementing triggers that alert care teams to patients meeting criteria for establishing a care plan.
- Implement tapering plan workflows directly into the Epic EHR system to streamline processes and educate providers.

Enhance Controlled Substance Stewardship Committee:

- Continue quarterly meetings to engage stakeholders, including high-prescribing providers, and identify actionable goals for controlled substance management.
- Advance alternative pain management discussions to identify safer options for patients with chronic pain.

Performance Period 3 (January 2027 – December 2027): Measuring Impact and Improving Engagement

Evaluate and Expand Patient Goal Setting:

- Work with patients to establish individualized goals as part of their CSA, improving engagement and accountability.
- Track and measure progress on patient goals, integrating these outcomes into the program's success metrics.
- Leverage the 100% adherence rate to CSAs achieved through opioid health coaching, while expanding efforts to engage the 39% of opioid-prescribed patients in our care who currently lack CSAs.

Build Provider Engagement and Expand Champions:

- Increase provider involvement by identifying additional "champion" providers who advocate for opioid stewardship initiatives and help drive adherence to workflows.
- Conduct regular training to ensure providers are comfortable with tapering plans, Suboxone workflows, and behavioral health integration.

Establish Metrics for Program Effectiveness:

- Collect data on patient outcomes, relapse rates, adherence to CSAs, and provider engagement.
- Use patient and provider feedback to refine processes, evaluate social determinants, and address barriers.

Launch Patient and Family Advisory Group:

- Form a patient and family advisory group to ensure the program meets the needs of those affected by opioid use and incorporates their perspectives into decision-making.

Performance Period 4 (January 2028 – December 2028): Transitioning to Safer and Sustainable Practices

Evaluate Transition to Safer Medication Regimens:

- For patients unable to taper off opioids due to chronic conditions, evaluate and implement alternatives such as partial opioid agonists to balance pain relief and quality of life.

Explore and Expand Alternative Pain Management Options:

- Build workflows and recruit providers trained in non-opioid pain management, such as physical therapy, integrative therapies, or alternative pharmacological treatments.

Measure Long-Term Outcomes and Sustainability:

- Assess the impact of the intervention on:
 - Patient Outcomes - measured by their achievement of goals established by care team and patient
 - Provider Engagement – Adherence to controlled substance care management policy, requirements/guidelines set by CDC and State of MN
 - Community Health – Reduction in number of overdoses, utilization of alternative pain management options, increasing number of patients in a successful taper plan, continuing to ensure availability of Narcan as harm reduction, reduction in drug-related arrests
 - Education and Community Awareness – Utilize feedback gained from Patient and Family Advisory Group established in Year 2.
 - Use these results to determine the next steps for program expansion and sustainability.

Medication Assisted Treatment Integration: Patients with opioid use disorder are offered MAT, such as Suboxone.

Patients with opioid use disorder are offered MAT, such as Suboxone, as a core component of Astera Health’s opioid stewardship program. The program shows consistent success, with adherence rates of 91% in 2022 and 2023 and 94% in 2024, reflecting the program’s effectiveness in retaining patients and reducing opioid dependency.

To further enhance MAT success rates and address the underlying causes of opioid use disorder, Astera Health plans to:

- Integrate Behavioral Health Services: Partnering with behavioral health teams allow for the treatment of co-occurring mental health conditions, addressing trauma, and building coping mechanisms to reduce relapse risk.
- Expand Opioid Health Coaching Support: Opioid Health coaches will continue to provide individualized guidance and monitor adherence, with plans to scale up engagement and incorporate patient-centered goals.
- Strengthen Community Partnerships: Collaborate with organizations like the Steve Rummier Hope Foundation and Mahube-Otwa to expand access to harm-reduction tools and provide essential resources for patient support. Astera Health will also actively seek additional partnership opportunities to better serve our target population.

Controlled Substance Agreements (CSAs): The tool implemented and updated annually with all enrolled patients to ensure compliance and accountability.

- Electronic CSAs are implemented and maintained.
- CSAs are integrated into the EHR to improve continuity of care for our target population.
- Providers are continually partnered with to ensure compliance across the target population.

Alternative pain management

- Chiropractic care service is utilized and offered at multiple locations.
- Rehabilitation services to include dry needling.
- Aquatic therapy program is maintained.

Support and Monitoring

- Health Coaching: Opioid health coaches provide ongoing support, achieving 100% adherence to CSAs among enrolled patients. This success reflects the effectiveness of individualized guidance in fostering compliance and positive patient outcomes.
- Behavioral Health Referrals: Patients receive referrals to behavioral health services to address underlying mental health and trauma issues.
- Care Coordination: Opioid health coaches conduct regular follow-ups to monitor progress and adjust CSAs as needed.

Community and Harm Reduction Efforts

- Distribution of Narcan and fentanyl test strips through partnerships with organizations like the Steve Rummier Hope Foundation.
- Collaboration with community partners to provide additional resources, such as insurance navigation and education. (*Refer to background section)

Process Measures:

Behavioral Health Referrals:

- The number and percentage of patients referred to behavioral health services for co-occurring conditions. IHP will include the numerator, denominator, and rate.
- Average time from referral to first behavioral health appointment. (Note: This may also influence patient satisfaction.)

Controlled Substance Agreements (CSA):

- Number of patients with a CSA out of those eligible for a CSA.
- Increase percentage of patients with an active CSA by 20% by year 1. IHP will report the baseline rate and the year 1 rate.
- Compliance rate for CSAs as tracked through patient and provider adherence. IHP will include the numerator, denominator, and rate.

Tapering Program:

- Percentage of eligible patients enrolled in a tapering plan. IHP will include the numerator, denominator, and rate.
- Percentage of tapering plans successfully completed (reduction in MME or transition to MAT). IHP will include the numerator, denominator, and rate.

Medication Assisted Treatment (MAT):

- Number of patients enrolled in MAT annually.
- Adherence rate for MAT (e.g., percentage of patients who remain engaged for 1 year). IHP will include the numerator, denominator, and rate.

Alternative Pain Management Enrollment:

- Number of patients utilizing non-opioid pain management services (e.g., chiropractic care, dry needling, integrative therapies).
- The percentage of chronic pain patients transitioned to alternative therapies. IHP will include the numerator, denominator, and rate.

Provider Engagement:

- Number of providers completing opioid-related training or certifications
- Compliance with standardized workflows (IHP will provide a narrative response and any summary data that contributed to this assessment.)
- 100% of primary care providers to begin transitioning patients to CSAs by end of year 1. (IHP will provide a narrative response and any summary data that contributed to this assessment.)

Community Partnerships:

- Number and description of collaborative initiatives with community organizations for harm reduction (e.g., Narcan distribution, education campaigns).
- Utilization rates of resources provided through community partnerships (e.g., Narcan kits, fentanyl test strips). IHP will include the numerator, denominator, and rate for each.

Data Utilization:

- Utilization of Compass Rose to track social determinants of health (SDOH) and inform treatment planning. (IHP will provide a narrative response regarding its progress on implementing this tool for care coordination and SDOH tracking. As progress continues, IHP may include numeric information to further demonstrate progress.) Compass Rose is a screening tool integrated in Epic. It is designed to collect information on factors such as housing stability, food insecurity, transportation access, and financial strain.
- Number of reports generated via Epic tools (Slicer-Dicer) to track high-risk populations. Identify and use key reporting tools like Slicer-Dicer to track and analyze high-risk opioid patient populations. Assess the quality and utility of these reports to ensure they effectively support care planning, population management, and program evaluation.
- Track and report the number of advisory group meetings held, attendance, and key feedback shared, to evaluate and inform program improvements.

Outcome and Patient Experience Measures:

Reduction in Opioid Prescribing:

- Percentage decrease in total MME prescribed across Astera Health. IHP will include the numerator, denominator, rate and percent change.
- Reduction in the number of new opioid prescriptions for acute pain. IHP will also report the number of new opioid prescriptions for acute pain.

Overdose Prevention:

- Reduction in opioid-related non-fatal overdoses. IHP will also report the number of non-fatal overdoses.
- Reduction in opioid-related fatal overdoses in service areas. IHP will also report the number of fatal overdoses in the service area.

Tapering and MAT Outcomes:

- Percentage of patients successfully tapering off opioids or transitioning to safer regimens. IHP will include the numerator, denominator, and rate. (Note: This may also reflect perceived effectiveness.)
- MAT adherence rates at 6 months and 1 year. IHP will include the numerator, denominator, and rate for each time period.

Patient Outcomes:

- Percentage of patients achieving goals set in care plans (examples of goals include pain relief, improved quality of life, etc.) IHP will include the numerator, denominator, and rate.
- Improvement in SDOH indicators for patients enrolled in the program. IHP will provide details on its assessment of improvement, including SDOH indicators for patients broken down by type of needed, if available. Track improvement in SDOH indicators for patients enrolled in the program using standardized questionnaires. Astera will identify the most common needs like transportation, housing, food insecurity, and financial strain, and evaluate which gaps were addressed through referrals or support services and analyze barriers when needs remain unmet. This assessment will help identify systemic care gaps and guide efforts to connect patients with appropriate community resources, with findings reported by type of need when available.

Provider and Patient Satisfaction:

- Provider satisfaction with workflows and resources to manage opioid use. In Performance Period 4, the IHP plans to see an increase in provider satisfaction.
- Patient satisfaction rates based on surveys (e.g., "strongly agreed" the program met their needs). IHP will include the numerator, denominator, and rate.
- Implementation of recommendations from the advisory group based on patient input. IHP will report on recommendations and how those were implemented.
- Perceived adequacy of education and resources provided about opioid use and alternative pain management strategies.

Community Impact:

- Increased distribution and use of harm reduction tools (Narcan kits, fentanyl test strips).
- Implementation and participation of Community Advisory Group.

2025 CHIP

Priority 1: Healthy Behaviors and Chronic Disease Management: Focus on Diabetes and Hypertension

Strategy 1: Community education and partnerships

Tactics:

- Bite Size Conversations: monthly education event providing healthy lunch
- Healthy Times magazine distribution every 4 months (3x per year) with articles aligned with healthy behaviors, education on chronic disease prevention and management

Strategy 2: Increase preventative medical visits

Tactics:

- Promote primary care services
- Conduct

Strategy 3: Employee wellness initiatives

Tactics:

- Sharing healthy articles with team via intranet
- Employee Light book club implemented

Strategy 4: Continue chronic disease management efforts to improve optimal care outcomes

Tactics:

- Reduce the percentage of patients aged 18-85 years old that have an A1C greater than 9 to 19 percent.
- Increase the percentage of patients aged 18 to 85 years old to control blood pressure to 77 percent.

Resources:

Wages of staff members

Costs of design and implementation

Collaboration: Community Advisory Council meetings held in each RHC community twice a year.

Priority 2: Mental Health/Opioid-Use Disorder and Prescription Management

Strategy 1: Identification of patient population

Tactics:

- Identify patients using opioids and controlled substances on a consistent basis, increase controlled substance care plans for patients, decrease the number of patients chronically using opioids and controlled substances, identify gaps in mental healthcare provided to patients, provide medication-assisted treatment for patients addicted to opioids.

- Screen 70% of all patients aged 12 years or older for depression and follow-up plan.

Strategy 2: Mental health service line assessment and strategic plan developed

Tactics:

- Recruit additional LICSW
- Expanding LICSW services to the Satellite locations.

Strategy 3: Opioid plan execution

Tactics:

- Provide Suboxone treatments

Resources:

Wages of staff members

Costs of design and implementation

Collaboration: Wadena County CHAMP (Chemical Health Awareness and Multi-drug Prevention), Ottertail County Opioid Taskforce, local businesses, area health care agencies. The RN Opioid Health Coaches attend the CHAMP meetings with Wadena County as well as the Ottertail County Opioid Taskforce.

Priority 3: Social Determinants of Health: Focus on Adult Obesity

Strategy 1: Tracking/system/identification

Tactics:

- Develop and implement a system for the identification of social determinants of health of patients within electronic health record We have identified and implemented a process within EPIC that assists in screening for social determinants of health.
- Determine and establish relationships with community stakeholders
- Identify resources for social needs determined through a screening process. Provide list of resources to patients based on screening results. Social Services department will meet with the patient on request of the patient/provider.
- Utilize data to determine patterns and trends of social challenges patients are facing

Strategy 2: Increase primary care visits

Tactics:

- Promote primary care services
- Promote Well Child Exams/preventative visits.
- Referrals are placed to our Nutrition/Dietitian services if identified.

Resources:

Wages of staff members

Costs of design and implementation

Collaboration: Wadena County Public Health, Todd County Public Health, Becker County Public Health, and Ottertail County Public Health to provide 1 week well baby visits and postpartum visits.

RESOURCES for 2025 Plan:

Hypertension:

https://www.nachc.org/wp-content/uploads/2025/05/Accelerating-Hypertension-Control-Guide_4.24.25.pdf

Valid BP machines: [Home](#) | [Validate BP](#)

Obesity:

[Programs, Services & Initiatives – American Obesity Foundation](#)
[Obesity Educational Materials and Resources | Rethink Obesity](#)

Substance Use Disorder

Astera Health IHP Application

[Substance Use Prevention Resources | SAMHSA](#)

[Alcohol & Drug Addiction Treatment Centers | Hazelden Betty Ford](#)