

# 2016

## COMMUNITY HEALTH NEEDS ASSESSMENT



**EH-Ada, Minnesota**



**Essentia Health**

Here with you

## West Region

**Essentia Health-Ada**  
**201 Ninth Street West**  
**Ada, MN 56510**

Bridges Medical Center, doing business as Essentia Health-Ada, is part of Essentia Health, a nonprofit, integrated health system caring for patients in Minnesota, Wisconsin, North Dakota and Idaho. Headquartered in Duluth, Minn., Essentia Health combines the strengths and talents of 14,000 employees, who serve our patients and communities through the mission of being called to make a healthy difference in people’s lives.

Essentia Health-Ada is a 14-bed critical-access hospital in Ada, Minnesota, that began serving Ada and Norman County in 1926. The entire hospital, clinic and nursing home were destroyed by flooding in 1997. This resilient community reopened the clinic in temporary locations within days and, later in the same year, reopened eight beds of the hospital, outpatient services, lab, X-ray and physical therapy departments. The city supported a \$15 million building project and the current hospital opened in 2000. The wide range of services now available includes a rural health clinic with both primary care and specialty care services. In addition, Essentia Health-Ada offers emergency services with Level IV Trauma designation, ambulance, hospital and rehabilitation.

Essentia Health-Ada is no longer directly affiliated with the Benedictine Health System but remains closely tied as BHS continues to operate the skilled nursing facility that shares a campus.

## LEAD PARTIES ON THE ASSESSMENT

Erin Stoltman, Director of Operations  
Ann Malmberg, Regional Director of  
Community Health

## TABLE OF CONTENTS

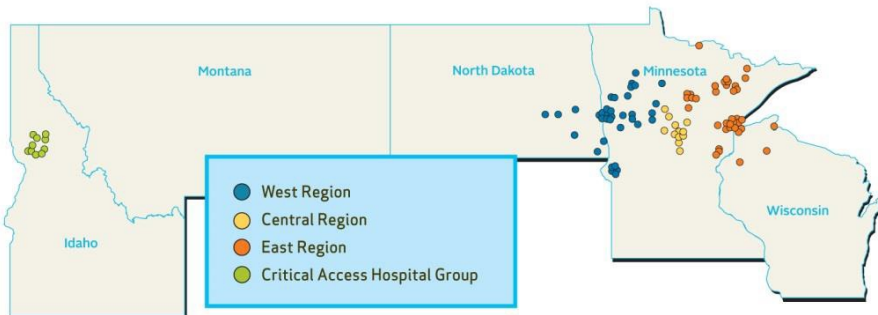
<i>Overview</i> .....	1
Essentia Health: Here With You .....	2
Executive Summary... ..	3
Progress to Date on 2013 Community Health Needs Assessment.....	5
2016 Community Health Needs Assessment .....	7
Description of Community Served by EH Ada .....	8
Process Overview .....	7
Assessment Process .....	7
Phase 1: Assessment.....	13
Phase 2: Prioritization .....	15
Phase 3: Design of Strategy and Implementation Plan .....	16
Conclusion.....	16
Appendix A. Norman County patients by Zip Code 12/20/2015.....	17
Appendix B. 2014 Northwest Region (March 2015)	
Appendix C. Polk Norman Mahnomen Community Health Improvement Plan	
Appendix D. Norman County Asset Map	

# Essentia Health at a Glance



**Essentia Health**

together as one—  
for the needs of all



**14,079 total employees**  
907 physicians  
920 advanced practitioners  
12,252 other staff

**68 clinics**  
15 hospitals  
7 long-term care facilities  
5 ambulance services  
2 assisted living facilities  
4 independent living facilities  
1 research & education institute

## Essentia Health: Here With You

At Essentia, our mission and values guide us every day. Together, we deliver on our promise to be here with our patients and members of our communities from the beginning to the end of life, both in our facilities and where they live, work and play. Thanks to our mission and our Benedictine roots, Essentia addresses the health needs of all with special concern for the poor and powerless.

### *Mission*

We are called to make a healthy difference in people's lives.

### *Vision*

Essentia Health will be a national leader in providing high quality, cost effective, integrated health care services.

### *Values*

- Quality
- Hospitality
- Respect
- Justice
- Stewardship
- Teamwork

### *Belief Statements*

- Our highest priority is the people we serve.
- We believe that the highest quality health care requires a regard for both the soul and science of healing and a focus on continuous improvement.
- We believe in the synergy of sponsorship among faith-based and secular organizations.
- We believe in the value of integrated health care services.
- We believe in having a meaningful presence in the communities we serve.

## Executive Summary

At Essentia Health-Ada, we provide health care on a daily basis to make a healthy difference in the lives of our patients. We are also committed to investing in making a healthy difference to the broader community that we serve. To that end, we've been getting community feedback on the greatest health issues that can be most readily impacted in our service area. Many issues impact both Ada and our greater community, which is primarily Norman County.

In 2012, obesity was identified as our greatest issue. In response, we've recently started to provide the National Diabetes Prevention Program free to our community. Other interventions to improve health include:

- Training a certified tobacco-cessation counselor.
- Partnering with Norman Public Health on a free family-planning clinic.
- Providing athletic trainers at athletic events for three area schools.
- Promoting both pediatric and adult immunizations.
- Increasing access to mental health services by increasing the availability of both counseling and clinical child psychology.
- Adding a community paramedic program.

In the Northwest Region Adult Behavior Survey, our community members identified where we are currently. Some highlights are included below:

<b>Norman County responses 2014</b>	
Overweight or obese	71%
Have been told by a healthcare provider they are overweight or obese	43%
Identify they are in good health	88%
Indicate no physical activity other than work	33%
Indicate they eat five or more servings of fruit and vegetables	39%
Informed by a healthcare professional they have high blood pressure (excluding pregnancy)	41%
Smoke (Minnesota average is 14.4%)	11.7%
Of 62 % of persons who drink alcohol, the number that report binge drinking	28%
Informed they have depression	20%
Informed they have anxiety or panic attacks	16%
2014 Northwest Region Adult Behavior Survey	Norman County, March 2015

Two areas where Essentia Health-Ada could have high impact, expertise to implement solutions, and the availability of community resources to respond to health needs were chosen as priorities. They are:

1. Improvement in behavioral and physical health in Norman County through care coordination.
2. Physical inactivity and poor nutrition as risk factors for chronic diseases, such as Type 2 diabetes.

Other initiatives identified where Essentia Health-Ada will participate but not lead include decreasing persistent poverty and increasing positive social connections for youth. These are areas that we don't have the expertise or resources to directly affect.

Action planning around the priorities will continue to evolve in partnership with our community groups and a three-year strategy will be identified by this fall.

### **Caring for our Community**

Our commitment to community health and wellness goes well beyond the work of the Community Health Needs Assessment. Through donations of funds, along with employees' time and talents, Essentia Health invests in a variety of programs and outreach efforts. Across the organization, we support community coalitions, housing, food shelves, mental health, congregational outreach, community infrastructure, public health, education, safety and other nonprofit organizations. These investments are designed to promote better health, help lessen inequities in our communities, improve access to health care and strengthen relationships with those we serve. EH Ada is a vital part of the Ada community providing primary care to all ages and facilitating specialty services that can reduce travel. Access to needed care is also the biggest challenge and efforts are ongoing to provide service close to home when possible.

## Progress to Date on 2013 Community Health Needs Assessment

<b>Priority Area</b>	<b>Obesity, physical inactivity and poor nutrition as risk factors for chronic diseases such as Type 2 Diabetes</b>
<b>Target Population</b>	Adults, ages 18 and older, who are currently pre-diabetic or possess risk factors for developing Type 2 diabetes
<b>Goal</b>	Reduce body weight and increase physical activity in program participants, thereby reducing their risk for Type 2 diabetes.

Obesity, lack of physical activity and poor nutrition were prioritized as the primary areas of focus for Essentia Health-Ada. The class, "I Can Prevent Diabetes," was to be offered in collaboration with the University of Minnesota Extension Service in the past fiscal year but was not held because we were unable to get enough participants who met the program's low-income guidelines. The hospital is now partnering with Norman-Mahnomen Public Health to deliver this service to patients and community members. The first class has nine participants. Additional Life Coaches to teach the course will be trained over the next fiscal year.

These health issues were also addressed:

### **Preventative care**

Essentia Health-Ada provides athletic trainers to attend athletic events for three area schools to advise on injury prevention and assist when treatment is needed for injuries. This is an ongoing service and relationship with community schools since 2011.

The hospital has also partnered with Norman-Mahnomen Public Health for one year to provide a free monthly family-planning clinic in the community, which is open to all. It has been well received and we've now turned it over to Public Health.

### **Tobacco use**

The Essentia Health-Ada Clinic, which shares a location with the hospital, is now registered to refer patients to "Call It Quits," the Minnesota tobacco-cessation program. The clinic has a registered nurse who is a smoking cessation specialist and assists any community member interested in quitting.

### **Immunizations**

The implementation of the EPIC electronic medical records in May 2014 has led to increased tracking and screening tools that are available to patients. With patient engagement, the hospital and clinic have successfully increased the number of patients, both pediatric and adult, receiving recommended immunizations. As of April 2016, infant immunization compliance for those ages 2 and younger was 84 percent.

**Access to mental health services**

Essentia Health-Ada increased the availability of a clinical licensed social worker from half-days to full days in September 2014. This provides patients with more counseling services. The clinical child psychologist also has increased the frequency of services provided in the community.

**Community paramedic program**

The hospital and clinic initiated a community paramedic program in October 2014, which allows a paramedic to go directly to the patient's home when non-covered home services are needed. Examples of services are drawing blood for lab work and assisting with medication set-ups. This program has increased access to health care in the Essentia Health-Ada service area.

**Emergency services and telehealth**

To address Ada's distance from the urban hospital, we now partner with LifeLink to expedite emergency helicopter transport with a one call system. The hospital's Emergency Room uses telemedicine technology to connect with a board-certified emergency medicine physician in Fargo whenever needed.

Both the hospital and clinic have telehealth services, including wound care and weight-loss consultation with a bariatric physician. Options being explored include psychiatry, nephrology, medication management and cardiology. Telehealth services increase access by reducing the transportation barrier.

**Secondary Prevention/Screening**

Essentia Health-Ada collaborates with community health partners to conduct an annual Health Fair each fall. In 2015, 400 people attended and 225 lab tests came from blood screenings at the fair.

The hospital works in partnership with Norman-Mahnomen Public Health, Polk County Public Health, Social Services, Northwest Mental Health Center, Altru, Medica, and Blue Cross Blue Shield on a Minnesota Department of Health grant aimed to improve access to electronic communications of shared clients to ensure the coordination of care and services. This project began in December 2014 and will continue through 2016.

A social worker was hired in 2016 to ensure ongoing supportive services for patients in the Emergency Department, hospital and clinic. This improves access from past services that were consultant-based only.

Our CHNA activities are available on the website with updates reported annually. No written comments have been submitted at the time of this report.

## 2016 Community Health Needs Assessment

### Objectives

Essentia Health is called to make a healthy difference in people's lives. To fulfill that mission, we seek opportunities to both enhance the care we provide and improve the health of our communities. In conducting the Community Health Needs Assessment, Essentia Health has collaborated with community partners to embrace these guiding principles:

- Seek to create and sustain a united approach to improving health and wellness in our community and surrounding area;
- Seek collaboration towards solutions with multiple stakeholders (e.g. schools, work sites, medical centers, public health) to improve engagement and commitment focused on improving community health; and
- Seek to prioritize evidence-based efforts around the greatest community good that can be achieved through our available resources.

The goals of the 2016 Community Health Needs Assessment is to:

1. Assess the health needs, disparities, assets and forces of change in the Essentia Health-Ada service area.
2. Prioritize health needs based on community input and feedback.
3. Design an implementation strategy to reflect the optimal usage of resources in our community.
4. Engage our community partners and stakeholders in all aspects of the Community Health Needs Assessment process.



### Description of the Community Served by Essentia Health-Ada

The community served by Essentia Health-Ada is Norman County in Minnesota. This primary service area was determined by looking at the ZIP codes of our patients, which found 95.3 percent reside in Norman County. We are the only hospital in the county, are located in the county seat, and operate one of only three clinics in Norman County.

Characteristics of the Norman County population as identified by the U.S. Census Bureau show a higher percentage of poverty than the Minnesota average. This is also an aging population, with almost 22 percent being age 65 and older. This is consistent with other rural areas that have a migration to urban areas. Overall population has dropped from 6,852 in 2010 to 6,639 in 2014. According to the State of Minnesota Department of Employment, Norman County's current unemployment rate is 6.4 percent compared to 4.5 percent for the state as a whole (Feb. 2016).

Poverty is often concentrated in rural areas and results in higher risks for diabetes and other chronic diseases, including higher mental health needs. These are challenges that EH Ada must address to improve the health of the community.

<b>Population Characteristics</b>		
	<b>Norman County estimate 2014</b>	<b>Minnesota estimate 2014</b>
Population	6,639	5,457,173
Median household income 2009-2013	\$45,389	\$59,836
Below poverty level, 2009- 2013	13.1%	11.5%
Some high school, no diploma	9.1%	5%
High school graduate (or GED)	35%	30%
Persons under age 5	5.3%	6.4%
Persons under age 18	23.2	23.5
Persons age 65 and over	21.8%	14.3%

Source U.S. Census Bureau: State and County Quick Facts 2014.

Health problems remain a barrier to the population as evidenced by the perception of those responding to the community survey. These data points represent the significant health needs of the community.

Norman County responses 2014	
Overweight or obese	71%
Have been told by a healthcare provider they are overweight or obese	43%
Identify they are in good health	88%
Indicate no physical activity other than work	33%
Indicate they eat five or more servings of fruit and vegetables	39%
Informed by a healthcare professional they have high blood pressure (excluding pregnancy)	41%
Smoke (Minnesota average is 14.4%)	11.7%
Of 62% of persons who drink alcohol, the number that report binge drinking	28%
Informed they have depression	20%
Informed they have anxiety or panic attacks	16%
2014 Northwest Region Adult Behavior Survey Summary: Norman County, March 2015 (Full report Appendix B)	

## Process Overview

Essentia's Community Health Committee developed a shared plan for the 15 hospitals within the system to conduct their 2016 Community Health Needs Assessments (CHNA). This plan was based on best practices from the Catholic Health Association and lessons learned from the completion of Essentia's first CHNAs in 2013. This process was designed to:

- Incorporate community surveys and existing public data.
- Directly engage community stakeholders.
- Collaborate with local public health and other healthcare providers.

From there, each of Essentia's three regions was responsible for adapting and carrying out the plan within their communities and hospital service areas.

In 2014, Evaluation Group, LLC was contracted by the county to conduct a Northwest Region Adult Health Behavior Survey that included Norman County. Results, including the Norman County summary, were returned in March 2015. A broad stakeholder group met on December 31, 2014, to discuss earlier results, evaluate progress and identify priorities. This group included the hospitals, public health representatives, social service departments, police, sheriff departments, community stakeholders, educational representatives, and non-profit organizations from the counties of Polk, Norman, and Mahanomen Community Health. In all, 38 people attended. Specific representation for low income and underserved people came from social services and public health. This group identified priorities by voting on the top 10 identified health indicators. (See Appendix C for the Polk Norman Mahanomen Community Health Improvement Plan including attendees).

Members of the same group reconvened after the survey results were returned and confirmed the following three priorities:

- Decrease persistent poverty.
- Coordinate behavioral and physical health services.
- Develop positive social connections with youth.

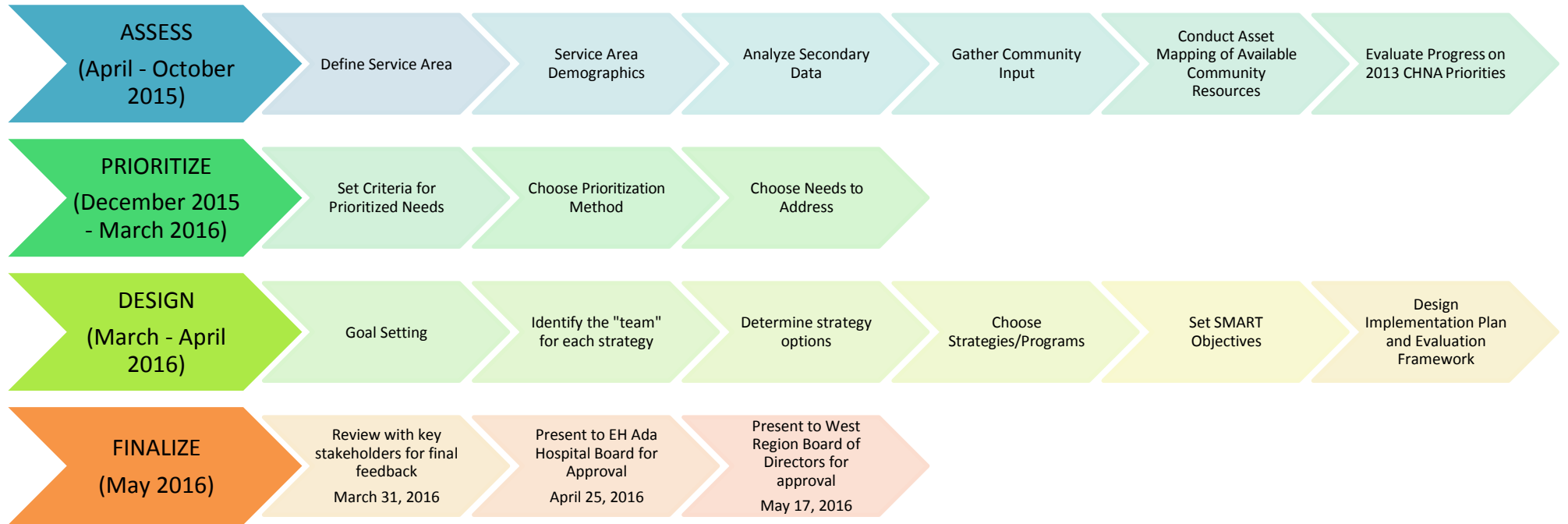
Essentia Health- Ada is participating with our community groups on these priorities. However, we are specifically directing our resources to the areas that the hospital can have the greatest influence. They are:

- Improve behavioral and physical health through care coordination.
- Obesity, physical inactivity and poor nutrition as risk factors for chronic diseases such as Type 2 diabetes.

These were prioritized based on the impact of these problems, our expertise to implement solutions, the feasibility of interventions, and the availability of resources. We already have a partnership with services directed by public health and other mental health partners to address the first issue. We also have a strong coalition with public health, schools, the fitness center, and the city of Ada to drive the second initiative. Community resources have been identified and documented in an Asset Map for Norman County (See Appendix D).

The Essentia Health-Ada's assessment was conducted in four stages: assessment, prioritization, design and finalization. The process began in December 2014 and will be completed in May 2016 with the final presentation of the Community Health Needs Assessment to the hospital's Board of Directors on April 25, 2016, and to the West Region Board of Directors on May 17, 2016. A full three (3) year implementation plan will be completed by November, 2016.

The following page describes the assessment steps and timeline:



## Assessment Process

### Phase 1: Assessment

An initial community survey packet included a cover letter, the survey instrument, and a postage-paid return envelope. It was mailed October 14-15, 2014, to 14,400 sampled households (1,200 from each county). Two weeks after the first survey packets were mailed (October 28), a reminder postcard was sent to all sampled households, reminding those who had not yet returned a survey to do so, and thanking those who had already responded. Two weeks after the reminder postcards were mailed (November 12), another full survey packet was sent to all households that still had not returned the survey. The remaining completed surveys were received over the next six weeks, with the final date for the receipt of surveys being December 30, 2014.

### Completed Surveys and Response Rate

Completed surveys were received from 4,012 adult residents of the 12 counties; thus, the overall response rate was 27.9 percent (4,012/14,400). Norman County's response rate was 31.6 percent.

### Data Entry and Weighting

The responses from the completed surveys were scanned into an electronic file by Survey Systems, Inc. To ensure that the survey results are best representative of the adult populations in each of the 12 counties, the data were weighted when analyzed. The weighting accounts for the sample design by adjusting for the number of adults living in each sampled household. The weighting also includes a post-stratification adjustment so that the gender and age distribution of the survey respondents mirrors the gender and age distribution of the adult populations of the 12 counties, according to U.S. Census Bureau 2010 estimates.

### Strengths and Weaknesses of Current Survey Design Methods

#### Strengths

No other adult behavioral risk study focusing on a broad range of health topics has been conducted in the region other than the BRFSS (Behavioral Risk Factor Surveillance System through CDC), which have traditionally sampled very few individuals in the region.

Randomized sampling of county residential addresses was used. This procedure helps eliminate data that is either positively or negatively skewed due to selection biases often associated with convenience sampling.

#### Weaknesses

It must be assumed (through the process of weighting) that individuals responding to the survey who fall within specific demographic groups (for example males aged 18-35), are not different in any substantial way from their peers within that subgroup who did not respond to the survey. It is possible in some instances where responses within individual demographic categories were small enough that the assumption of similarity between those two groups is of concern. Unfortunately, it is impossible to know to what degree of accuracy is achieved ultimately except to examine each data point individually, in context, and through conversations with experienced healthcare professionals serving the region.

Members of the convened group included county, schools and non-profit members who represent the underserved and those in poverty. This group has been actively involved in community activities since the 2012 survey period.

This engaged group that meets to address community priorities has been the most positive outcome of the previous survey period. Specific changes in the health of the community remain unchanged from the 2012 period. However, the stakeholders are meeting regularly and are driving efforts that will have impact over time.

#### **Comments from 2013 Community Health Needs Assessment**

No comments were received from the 2013 Community Health Needs Assessment. Any comments received would have been reviewed, evaluated and taken into consideration when preparing the 2016 Community Health Needs Assessment.

## Phase 2: Prioritization

Top health needs were categorized into 10 areas. The stakeholders met and needs were prioritized based on the following criteria:

- Alignment with facility's strengths/priorities/mission
- Magnitude – number of people impacted by problem
- Severity – the rate or risk of morbidity and mortality
- Opportunity for partnership

These top areas were discussed and sheets representing each were placed on the walls of the room. Stakeholders prioritized twice. The first vote included each voting with four sticky dots to identify priorities. After this count, the health priorities were trimmed to five and stakeholders voted using a clicker (see details in Polk-Norman-Mahnomen Community Improvement Plan Appendix C). As discussed in the introduction, three areas were identified:

- Decrease persistent poverty.
- Coordinate behavioral and physical health services.
- Develop positive social connections with youth.

For the purpose of this report and in line with the hospital's available resources, Essentia Health-Ada will focus on coordinating behavioral and physical health services. This also aligns with our mission and is the area where the health facility can make a difference. It also fits with three of the four Essentia Health System Community Health and Wellness priorities: Healthy Choices, Mental Fitness, and Community Connections. There will also be indirect benefit in the priority of Workplace Wellness.

Because Essentia Health-Ada was unable to implement NDPP for pre-diabetics earlier and given the county results on obesity, physical inactivity and poor nutrition as risk factors for chronic disease, the program will be the second focus and action plan.

The other needs of addressing poverty and developing positive social connections with youth are important. Essentia Health-Ada will continue to partner with those community committees but play a secondary role. The hospital does not have expertise or special services in this area. These will be led by Norman County Public Health and Essentia Health-Ada will participate as resources, expertise and community needs dictate.



### Phase 3: Design of Strategy and Implementation Plan

The teams will continue to meet to further identify a three-year plan with outcome measurements identified by November 1, 2016. The partners included in this implementation plan represent the existing healthcare facilities and resources within the community that are available to respond to the health needs of the community. Additional partners will be added as necessary and able.

PRIORITY AREA	GOALS
Improve behavioral and physical health in Norman County through care coordination.	Coordinate behavioral and physical health services.
	<ul style="list-style-type: none"> <li>• Implement care coordination.</li> <li>• Improve sharing of patient information between providers.</li> </ul>
Goal: Improve overall mental health of residents and patients in service area	Partners: Norman County Collaborative, including Essentia Health-Ada, Norman Polk County Health, Northwest Mental Health Center, NDHIN (contracted to assist) and Minnesota Department of Health
STRATEGY	
Strategy #1 Implement Health Information Exchange (HIE) to allow shared electronic care plans.	Action(s): Individual facilities will continue to define and implement requirements.
Expected Short-Term Outcomes	Sources of Measuring Outcomes
Care plan access for shared patients.	
PRIORITY AREA	GOALS
Physical inactivity and poor nutrition as risk factors for chronic diseases such as Type 2 diabetes.	Improve activity and diet in the community.

Goal: Physical activity	Partners: Essentia Health-Ada, Norman Polk County Health, Norman County Schools, Dekko Center, etc.
STRATEGIES FOR EACH PRIORITY	
Strategy #1 Increase walking activities in Ada.	Actions: Bike to school and other events, partner with Minnesota Bike Alliance to do “walking school bus” training for educators; increase access to indoor and outdoor tracks; improve the one-mile community forest.
Strategy #2 Improve access to healthy foods.	Action: Prescription for vegetables and other healthy food options.
Strategy #3 Educate the community on healthy choices.	Actions: NDPP, community interventions for school lunches, concession stands, and other opportunities

## **Conclusion**

As part of a nonprofit health system, Essentia Health-Ada is called to make a healthy difference in people's lives. This needs assessment and implementation plan illustrates the importance of collaboration between our hospital and its community partners. By working collaboratively, we can have a positive impact on the identified health needs of our community during Fiscal Years 2017-2019. There are other ways in which Essentia Health-Ada will indirectly address local health needs, including the provision of charity care, the support of Medicare and Medicaid programs, discounts to the uninsured and others. Over the next three years, Essentia Health-Ada will continue to work with the community to ensure that this implementation plan is relevant and effective and to make modifications as need.

Appendix A: Norman County patients by zip code 12/20/2015

Zip Code	City	Sum Of Discharges	Percentage	Cumulative Percentage	County
56510	Ada	123	73.2%	73.2%	Norman
56584	Twin Valley	30	17.9%	91.1%	Norman
56557	Mahnomen	5	3.0%	94.0%	Mahnomen
56545	Gary	5	3.0%	97.0%	Norman
56585	Ulen	2	1.2%	98.2%	Clay
56550	Hendrum	1	0.6%	98.8%	Norman
56540	Fertile	1	0.6%	99.4%	Polk
56519	Borup	1	0.6%	100.0%	Norman
		168			

Norman County equals 95.3%.

# EvaluationGroup,LLC

---

## Polk-Norman-Mahnomen Community Health Services

### 2014 NORTHWEST REGION ADULT HEALTH BEHAVIOR SURVEY SUMMARY

### NORMAN COUNTY

March  
2015

Authored by  
Garth Kruger, Ph.D.

## Executive Summary

- 71% of individuals residing in Norman county are considered either overweight (33%) or obese (37.9%).
  - This is higher than the state average of 64% (37.5 overweight; 26.5%, obese).
- Only a total of 43% of respondents had been told by a healthcare provider that they were overweight or obese.
  - Room for improvement may exist in providing feedback to patients about their weight.
- 88% of Norman County respondents indicated they had good health, yet 71% of them were overweight or obese.
  - This raises the question of peoples' understanding of what constitutes good health.
- In Norman County, 33% percent of survey respondents indicated that other than their regular job, they did not participate in any physical activity or exercises such as running, calisthenics, golf, gardening, or walking for exercise.
  - The state average on this measure is approximately 13%.
- A total of 39% of adults eat five or more servings of fruit and vegetables combined per day which is the daily recommended intake. That total rises to 66% if you include those who get 3-4 servings a day -just below the recommended intake.
- 41% of respondents reported that they had at one time or another been informed by a healthcare provider they had high blood pressure (non-pregnancy related).
  - 35% had been informed they had elevated cholesterol.
- Of the 62% of respondents who consumed alcoholic beverages during the 30 days preceding the survey, 28% of them binge drank (5 or more drinks per sitting male, 4 or more female)
- Study results found that each county remained higher than the statewide average on estimates of diabetes (as was previously suggested in earlier studies).
  - However the extent of these differences seems to have grown worse.
- Approximately 12% of adults in Norman County are smokers.
  - This compares slightly below the state average of 14.4%.
  - 29.7% of smokers tried to quit for one day or longer over the past 12 months.

## Recommendations

- Focus additional resources and ideas on areas that develop and encourage physical activity in adult populations.
  - Given the findings on nutrition intake compared to exercise, the data suggest that more immediate gains addressing obesity/overweight issues might be had targeting improved access to physical fitness initiatives.
  - Future survey questions should include asking what type of employment (e.g. day-laborer, office work, etc.) Given the agrarian nature of the region, it is possible that many respondents actually get substantial physical activity through their vocation.
- Health officials should examine and discuss findings presented herein to determine how closely results mirror what they are encountering.
- Future surveys and data collection efforts should explore questions pertaining to e-cigarette use.

## Appendix B

- Blood pressure is a significant issue. Thus, conducting blood pressure screenings can continue to be a highly effective way to identify individuals who are both unaware of this dangerous condition and at-risk of complications.

Appendix B  
**Overall Perceived Health Status**

Survey participants were asked: “In general, would you say that your health is... poor, fair, good, very good or excellent?” Eighty eight percent reported “good”, “very good”, or “excellent” health whereas 12% reported “fair” or “poor” health.

Figure 1

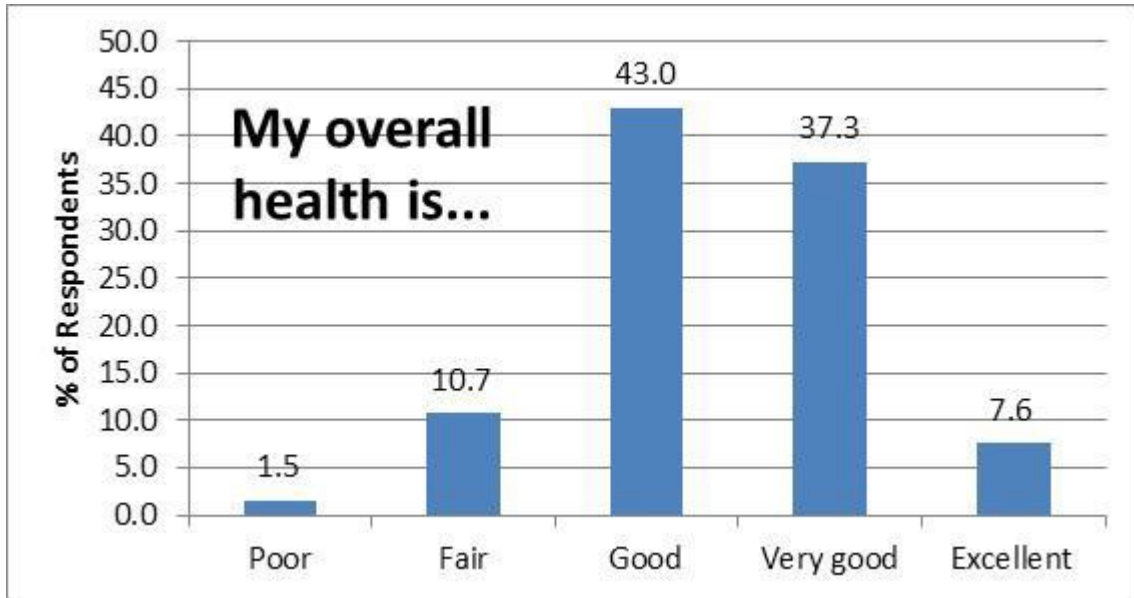


Table 1 highlights the percentage of respondents who reported having the listed chronic health conditions (in descending order from greatest percentage afflicted to least). These findings indicate that blood pressure is a significant issue. Thus, conducting blood pressure screenings can continue to be a highly effective way to identify individuals who are both unaware of this dangerous condition and at-risk of complications.

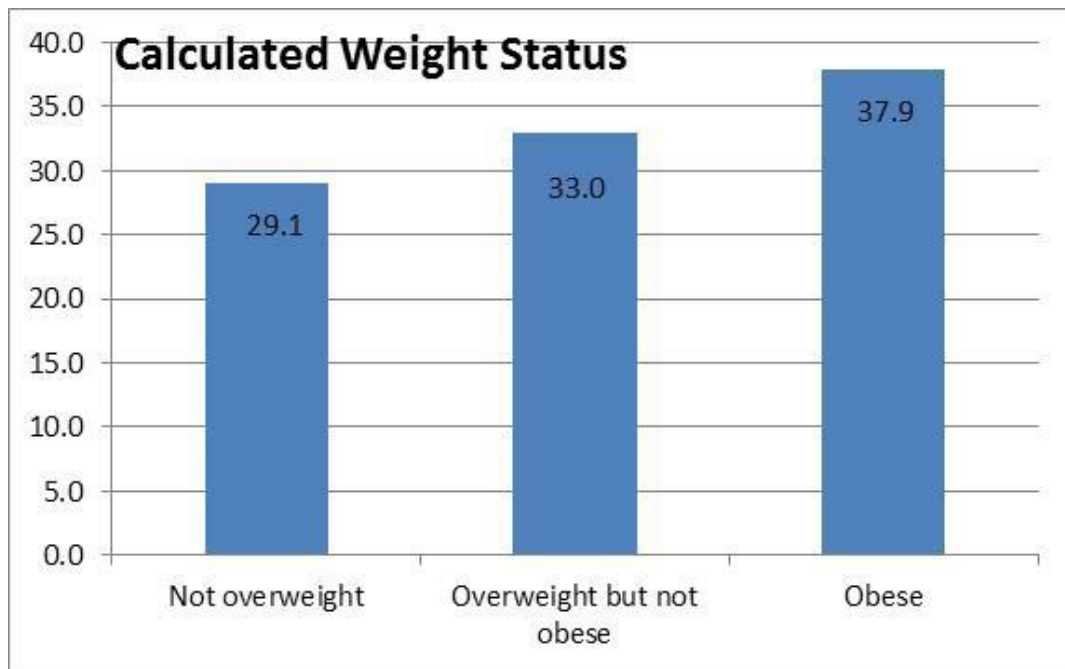
Table 1

<i>Have you ever been told by a doctor, nurse or other health care professional that you had any of the following health conditions?</i>		
	<b>No %</b>	<b>Yes%</b>
High blood pressure	58.1	41.3
High cholesterol or triglycerides	65.4	34.6
Overweight	66.8	33.2
Arthritis	69.0	31.0
Depression	79.8	20.2
Anxiety or panic attacks	84.4	15.6
Diabetes	86.9	11.4
Asthma	89.5	10.5
Heart trouble or angina	90.0	10.0
Obesity	90.1	9.9
Cancer	91.2	8.8
Chronic lung disease	95.0	5.0
Other mental health	95.3	4.7

**Weight Status**

Survey respondents were asked to report their height and weight. From those data, a Body Mass Index (BMI) was calculated. There are some exceptions to be considered in using BMI to accurately assess the health of individuals; however they are considered a generally accurate measure for the body mass composite a population. As Figure 2 shows below, 71% of individuals residing in Norman county are considered either overweight (33%) or obese (37.9%). This is higher than the state average of 64% (37.5 overweight; 26.5%, obese).

Figure 2



Room for improvement appears to exist in providing feedback to patients about their weight. While 71% of survey respondents were overweight/obese, only a total of 43% had been told by a healthcare provider. Several possibilities for this include: 1) providers are not acknowledging the extent of their patients weight for a variety of reasons, or 2) patients only marginally meet the requirements for overweight and so do not physically appear to be at risk. It is difficult to determine which of these scenarios (or others) exist without further investigation and discussion.



## Appendix B

Regardless, respondents perceptions of what constitutes health seem to be skewed because 88% of them responded that they had good health yet 71% are overweight/obese. This raises the

Figure 3

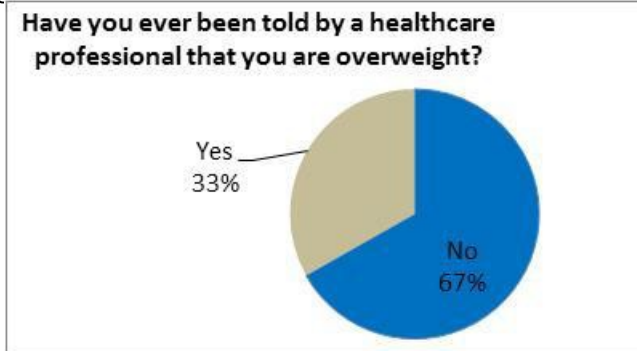
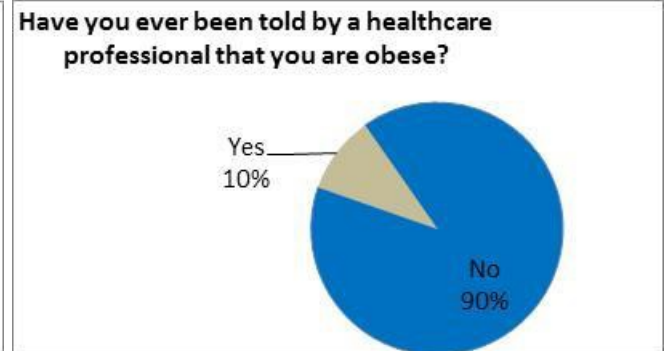


Figure 4



question of peoples understanding of what constitutes good health. One suggestion is to consider conducting focus groups exploring how different age groups define what constitutes health and then to design marketing messages that portray what good health is and can provide. When the daily norm is obese/overweight, sometimes it is easy to lose sight of what constitutes healthy.

A further recommendation for future action in this area would be to confer with local healthcare providers to ensure that they are talking to their patients about weight and have available to them a range of referral options –especially as related to physical activity opportunities.

### ***Blood Pressure/Cholesterol***

High blood pressure combined with elevated cholesterol levels is a recipe for heart-related problems. The 2014 Regional Health Assessment Survey found that 41% of respondents reported having been informed by a healthcare provider they had high blood pressure (non-pregnancy related). Thirty five percent had been informed they had elevated cholesterol.

It is impossible to know from these data whether these findings are the result of significant efforts by primary and public health healthcare providers to reach out to the public to assist them in learning their blood pressure/cholesterol, or if in fact the rates of high blood pressure/cholesterol are greater than reported here because people have not had them checked or were not informed. In the case of blood pressure, the test and information relay is straightforward during a healthcare visit, whereas cholesterol tests involve a blood draw and follow-up. Future surveys should consider asking respondents if they have had their blood pressure/cholesterol checked within the past two years.

Figure 5

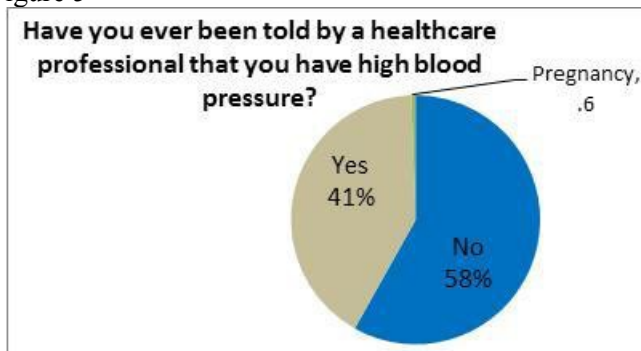
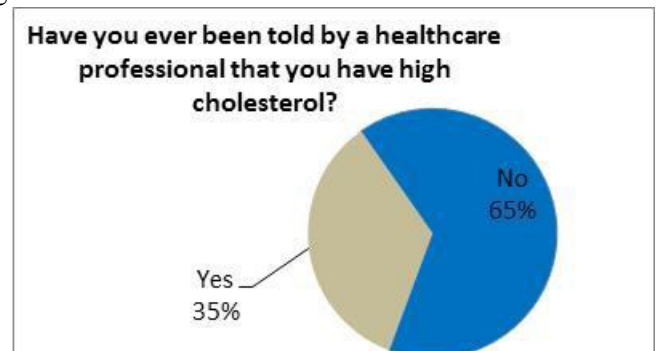


Figure 6

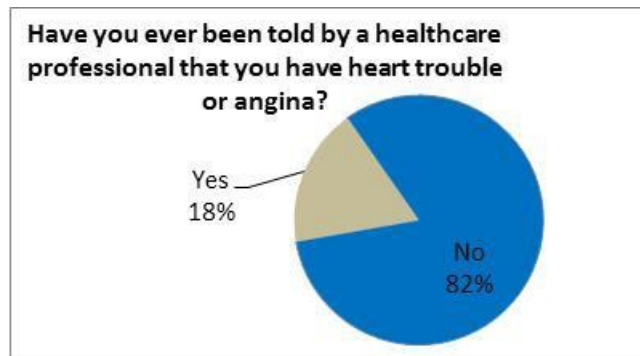


Appendix B

Because high blood pressure and cholesterol are only pre-cursor indicators, elevations are not a guarantee of heart problems. Eighteen percent of survey respondents indicated having heart trouble or angina. This may or may not be an accurate reflection of the population.

Results for the 2006-10 time frame found death rates in the 1.48 per 10,000 people in Polk and for Norman-Mahnomen 1.53 per 10,000. These Regional findings were higher than state averages (1.26) during the same period. Suggestions for further research on this issue includes discussing current survey findings with primary health care providers to determine if results are generally in line with their perceptions.

Figure 7



**Diabetes**

The 2014 NW Region Adult Health Behavior Survey found that each county remained higher than statewide average on estimates of diabetes (as was previously suggested via the Behavioral Risk Factor Surveillance Data). However the extent of these differences seems to have grown.

Table 2

<b>Age-Adjusted Estimates of the Percentage of Adults with Diagnosed Diabetes in Minnesota</b>				
	2009* %	Difference from State	2014+ %	Difference from State
Statewide	5.8	‘--	7.3^	‘--
Mahnomen	9.1	+3.3	16.9	+9.6
Norman	8.1	+2.3	11.4	+4.1
Polk	7.7	+1.9	9.4	+2.1

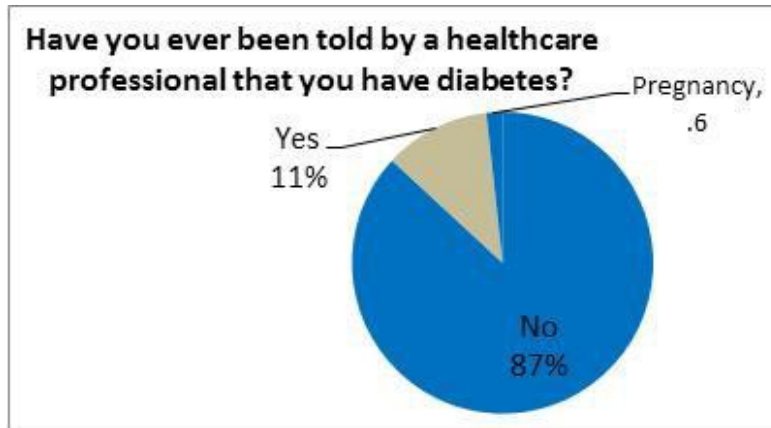
\*BRFSS Synthetic estimates: Source: Centers for Disease Control and Prevention.  
 +2014 NW Region Adult Health Behavior Survey  
 ^2012 Data

In past data analytic studies, local public health staff expressed the belief that BRFSS diabetes estimates were low. The current study suggests that in fact they were correct to question the data. It remains then to answer to what extent the current statistics collected are believed to be accurate. Future public health discussions should examine this issue.

Appendix B

Regionally, the aggregated data skew the results lower on the average slightly as Polk County has a far larger population. Again, this data may be underestimating the actual incidence of diabetes as it reports only those who have been told they have it by a healthcare professional. Furthermore, we have to assume that the 30% of respondents are generally similar to the 70% of non-respondents on this and all other issues. Unfortunately, there is no way of assessing this truthfulness other than by “truth testing” the data that has been collected. See methodology strengths and weaknesses for more discussion on this topic.

Figure 8



**Cancer**

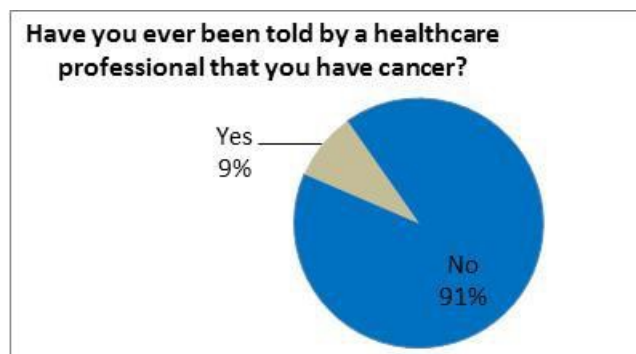
Cancer age adjusted death rates from 2006-2010 were slightly higher than state averages in Norman-Mahnomen Counties. Slightly different data examining the same issue through the current study explored the percentage of individuals ever told by a healthcare professional that they have cancer. Approximately 9% reported having ever been diagnosed with cancer. (Mahnomen=10%, Norman=8.8%, and Polk=6.5).

Table 3

<b>Cancer Age Adjusted Death Rates per 1,000 people</b>	
	2006-2010
State	1.7
Polk	1.7
Norman-Mahnomen	2.1

Source: MN Department of Vital Statistics

Figure 9

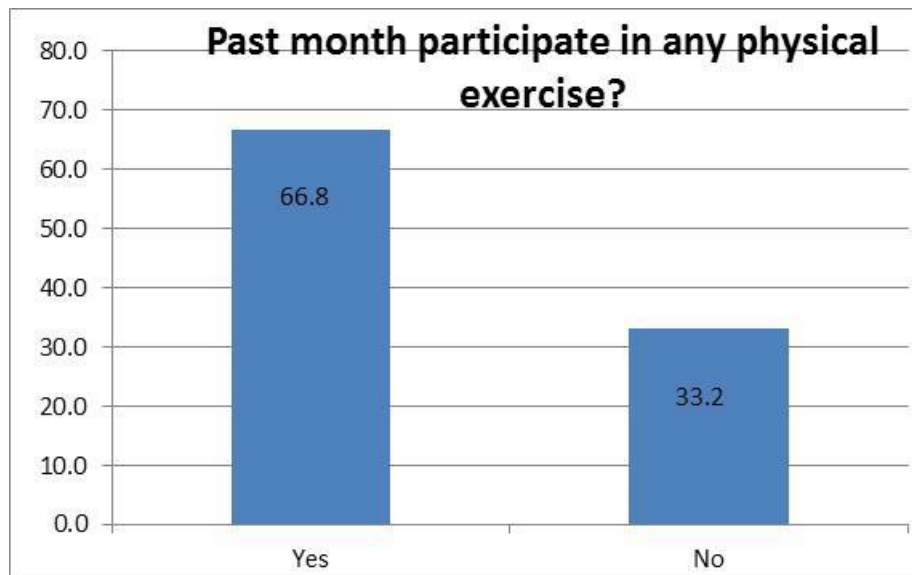


**Physical Activity**

A clear path exists for combating disease states created through poor diet and exercise. That path includes identifying the current status of both and then engaging the general public in ways that makes eating healthy and getting physical activity easier.

Participants were asked “during the past 30 days, other than your regular job, did you participate in any physical activity or exercises such as running, calisthenics, golf, gardening, or walking for exercise.” Thirty-three percent of survey respondents indicated “no”. The state average on this measure is approximately 13%.

Figure 10



A similar question asked “During an average week, other than your regular job, how many days do you get at least 30 minutes of moderate (or vigorous) exercise. Moderate exercises are defined as those that “cause only light sweating and a small increase in breathing or heart rate, and vigorous are those that “cause heavy sweating and a large increase in breathing or heart rate.” Those responding to this question provided additional support to the idea that the region’s residents do not participate in enough physical activity. For substantial health benefits, adults should do at least 150 minutes (2 hours and 30 minutes) a week of moderate-intensity, or 75 minutes (1 hour and 15 minutes) a week of vigorous-intensity aerobic physical activity, or an

Figure 11

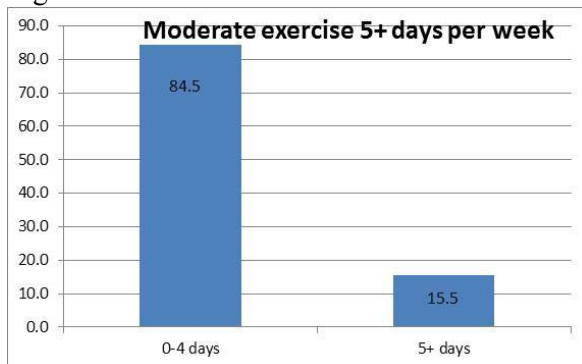


Figure 12



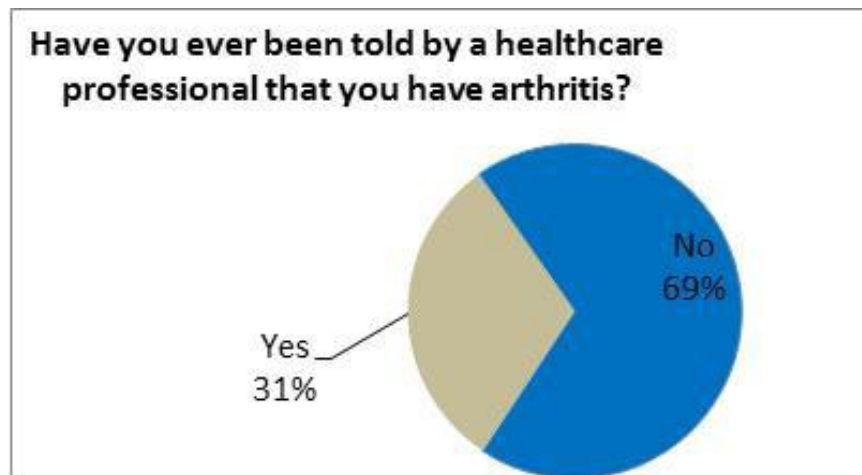
## Appendix B

equivalent combination of moderate- and vigorous intensity aerobic activity<sup>1</sup>.

In Norman County, only an estimated 16% of individuals are getting their recommended levels of physical activity; whereas 84% are not. A recommendation for health planners in the future is to focus additional resources on areas that develop and encourage physical activity in adult populations. A second suggestion is that future survey questions should include asking type of employment (e.g. day-laborer, office work, etc.). Given the agrarian nature of the region, it is possible that many respondents actually get lots of physical activity through their vocation.

One potential reason for a lack of physical activity is that many of the regions residents may be suffering from arthritis.

Figure 13



---

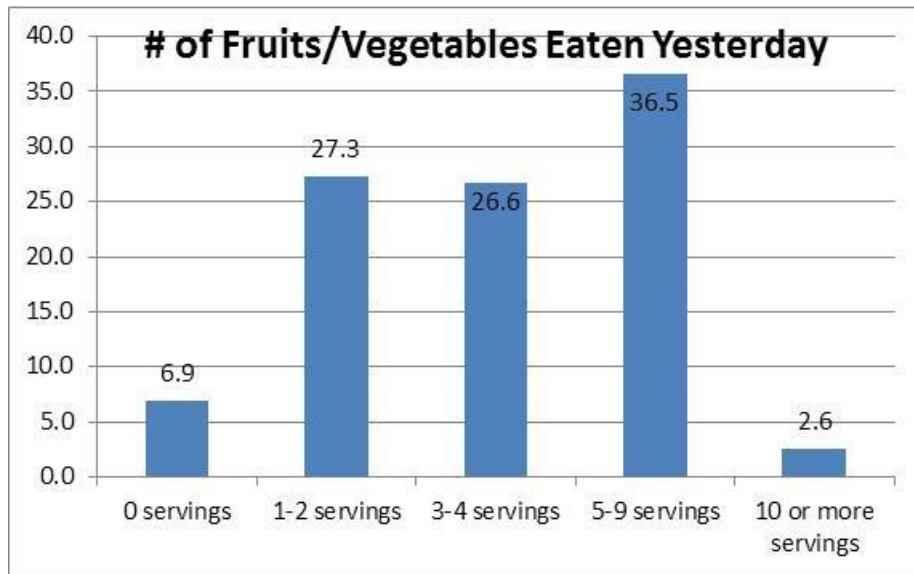
<sup>1</sup><http://www.health.gov/paguidelines/guidelines/summary.aspx>

**Nutrition**

A total of 39.1% of adults eat five or more servings of fruit and vegetables combined per day which is the daily recommended intake. That total rises to 66% if you include those who get 3-4 servings a day -just below the recommended intake.

This data suggests that two-thirds of the population in the region gets a fair amount of nutritious food. This finding may be higher than the actual amount or alternatively could be reflective of the numerous fresh fruit/vegetable initiatives undertaken in recent years. In any case this data should be a discussion point for local health planners. Given the findings on nutrition intake compared to exercise, the data suggest that more immediate and impactful gains might be had targeting improved access to physical fitness initiatives.

Figure 14



Upon closer examination, approximately the same amounts of fruits are eaten as vegetables. This differs from other counties and the region in that those areas report more vegetable consumption on the average compared to fruits.

Figure 15

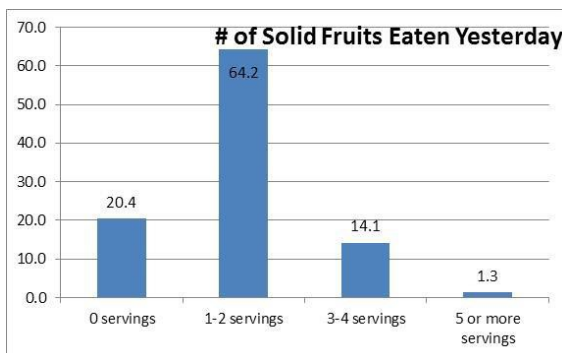
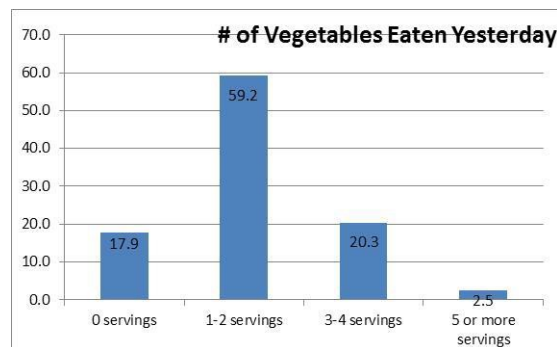


Figure 16



**Tobacco Use**

Approximately sixteen percent of adults in the Region are smokers -Mahnomen County has the highest rates at 20.5%. This compares slightly above the state average of 14.4%. In Norman County, 29.7% of current smokers indicated that during the past 12 months they had stopped smoking for one day or longer because they were trying to quit.

Table 4

	<b>Mahnomen County (%)</b>	<b>Polk County (%)</b>	<b>Norman County (%)</b>	<b>MN State (%)</b>
<b>Current smokers</b>	20.5	15.6	11.7	14.4

Results also found that 5% of adults are smokeless tobacco users. This finding is in stark contrast to past Minnesota Student Survey data which has found upwards of 20% use in youth in the past. And while youth populations possess significant differences from adult populations, they often tend to use similar products at higher levels.

Reasons for a lower than expected rate of smokeless tobacco use include: 1) a switch to using e-cigarettes (or other tobacco products) or 2) inaccurate reports of tobacco use. Response rates to the survey for younger males were lower than for other groups. Given that smokeless tobacco use occurs primarily in 18-35 year old males it is possible that the present survey is significantly underestimating use. Health officials should examine and discuss findings to determine how closely results mirror what they are encountering. Furthermore, future surveys and data collection efforts should explore questions pertaining to e-cigarette use.

Figure 17

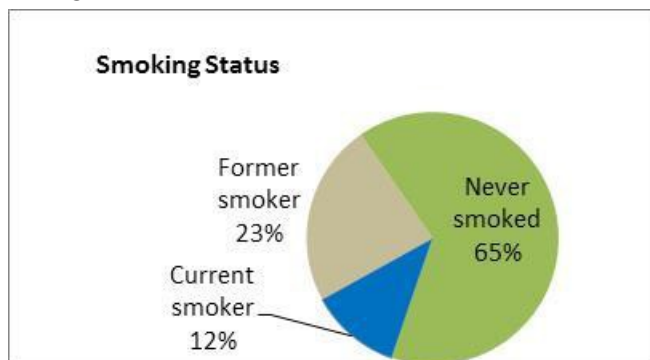
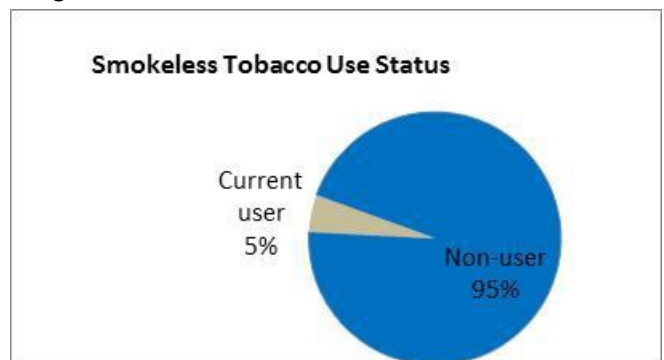


Figure 18



**Alcohol Use**

Participants were asked “during the past 30 days, have you had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor?” Respondents indicated that 38% of them consumed no alcohol.

Those who did drink alcohol were further partitioned into heavy and infrequent consumers. Males and females were classified as heavy drinkers if they had 60 or more drinks (males) or 50 or more (females) in the past 30 days. Only 9% of respondents met this definition.

Binge drinkers were defined as males who consumed on average 5 or more drinks and females 4 or more drinks on the days they drank. According to these classifications, 28% of respondents were binge drinkers.

Figure 19

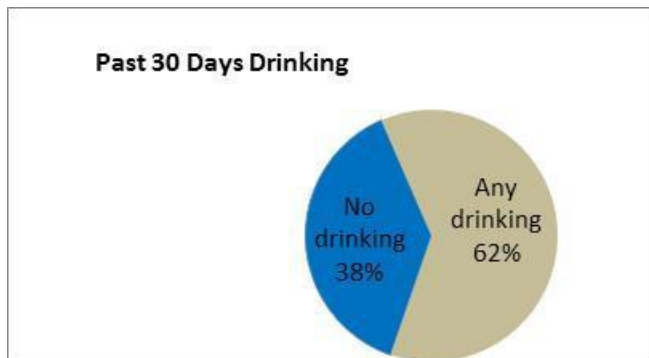


Figure 20

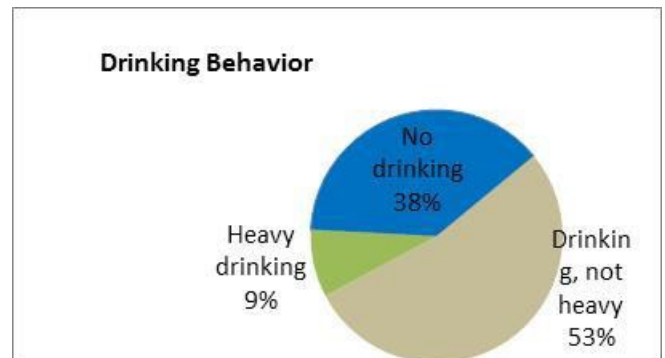
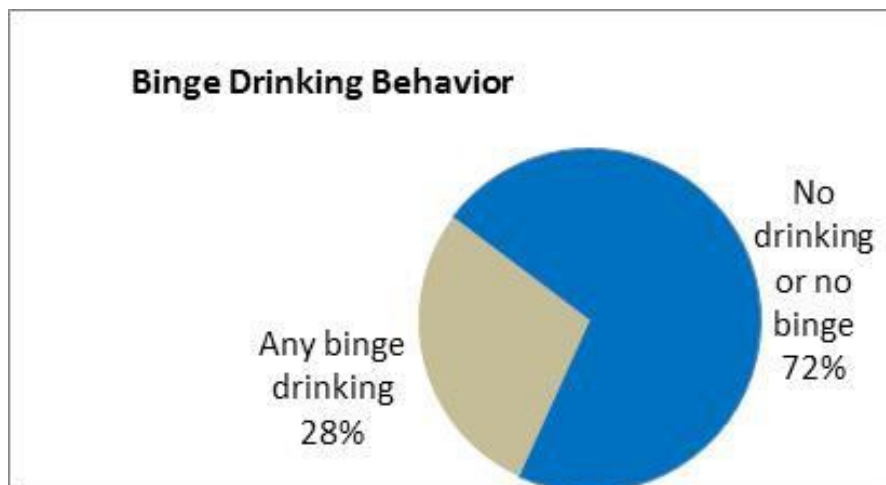


Figure 21





***Mental Health***

Approximately 16-20% of individuals living in Norman County have been told at some point in their lives by a healthcare professional that they have depression or panic attacks (see Figure 22 and 23). The good news is that only 10% of people have delayed getting mental health treatment when it was needed. Of the 10%, the delay occurred for a variety of reasons, including perceived lack of severity (57%), fear of getting treatment (45%) and cost (20%). Only 7% across the indicated transportation was a problem.

Figure 22

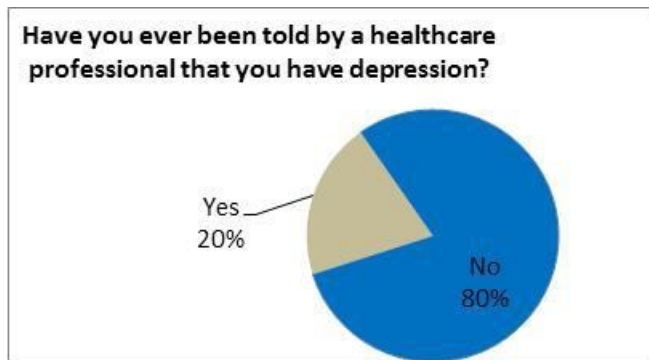
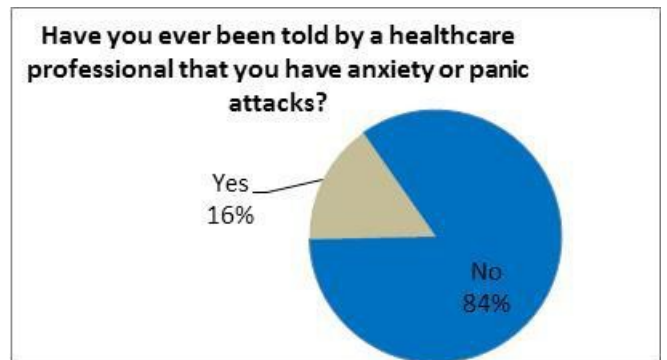


Figure 23



Similarly, over the past 30 days, 16% of respondents expressed feelings of hopelessness, anxiety or loss of interest in things they used to enjoy. On a positive note, only 5% of respondents indicated other mental health problems. It is unclear if respondents to this question included substance abuse as a mental health problem. Identifying whether these two issues are combined or separate should be addressed in future surveys. Another suggestion is that physical fitness programs can help improve physical and mental health. While not all individuals with depression or anxiety will be impacted, it provides a place to start.

Figure 24

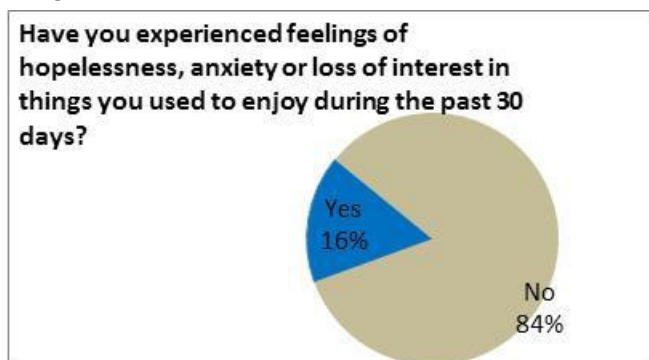
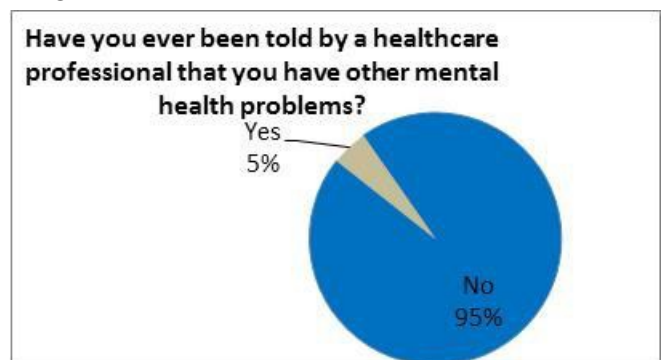


Figure 25



## ***Methods***

### **Survey Instrument**

Staff from the public health agencies representing Beltrami, Clearwater, Hubbard, Kittson, Lake of the Woods, Mahnomon, Marshall, Norman, Pennington, Polk, Red Lake and Roseau counties developed the questions for the survey instrument with technical assistance from the Minnesota Department of Health Center for Health Statistics. Existing items from the Behavior Risk Factor Surveillance System (BRFSS) survey and from recent county-level surveys in Minnesota were used to design some of the items on the survey instrument. The survey was formatted by the survey vendor, Survey Systems, Inc. of New Brighton, MN, as a scan-able, self-administered English-language questionnaire.

### **Sample**

A two-stage sampling strategy was used for obtaining probability samples of adults living in each of the twelve counties. A separate sample was drawn for each county. For the first stage of sampling, a random sample of county residential addresses was purchased from a national sampling vendor (Marketing Systems Group of Horsham, PA). Address-based sampling was used so that all households would have an equal chance of being sampled for the survey. Marketing Systems Group obtained the list of addresses from the U.S. Postal Service. For the second stage of sampling, the “most recent birthday” method of within-household respondent selection was used to specify one adult from each selected household to complete the survey.

### **Survey Administration**

An initial survey packet that included a cover letter, the survey instrument, and a postage-paid return envelope was mailed October 14-15 2014, to 14400 sampled households (1200 from each county). Two weeks after the first survey packets were mailed (October 28), a reminder postcard was sent to all sampled households, reminding those who had not yet returned a survey to do so, and thanking those who had already responded. Two weeks after the reminder postcards were mailed (November 12), another full survey packet was sent to all households that still had not returned the survey. The remaining completed surveys were received over the next six weeks, with the final date for the receipt of surveys being December 30, 2014.

### **Completed Surveys and Response Rate**

Completed surveys were received from 4012 adult residents of the twelve counties; thus, the overall response rate was 27.9% (4012/14400). County-specific response rates can be found on the next page.

### **Data Entry and Weighting**

The responses from the completed surveys were scanned into an electronic file by Survey Systems, Inc.

## Appendix B

To ensure that the survey results are best representative of the adult populations in each of the twelve counties, the data were weighted when analyzed. The weighting accounts for the sample design by adjusting for the number of adults living in each sampled household. The weighting also includes a post-stratification adjustment so that the gender and age distribution of the survey respondents mirrors the gender and age distribution of the adult populations of the twelve counties, according to U.S. Census Bureau 2010 estimates.

County	Completed Surveys	Response Rate
Beltrami	264	22.0%
Clearwater	342	28.5%
Hubbard	381	31.8%
Kittson	395	32.9%
Lake of the Woods	340	28.3%
Mahnomen	291	24.3%
Marshall	336	28.0%
Norman	379	31.6%
Pennington	295	24.6%
Polk	301	25.1%
Red Lake	364	30.3%
Roseau	324	27.0%
Total	4012	27.9%

### Strengths and Weaknesses of Current Survey Design Methods

#### Strengths

1. No other adult behavioral risk study focusing on a broad range of health topics has been conducted in the region other than the BRFSS studies (which have traditionally sampled very few individuals in the region)
2. Randomized sampling of county residential addresses was used. This procedure helps eliminate data that is either positively or negatively skewed due to selection biases often associated with convenience sampling.

#### Weaknesses

1. It must be assumed (through the process of weighting) that individuals responding to the survey who fall within specific demographic groups (for example males aged 18-35), are not different in any substantial way from their peers within that subgroup who did not respond to the survey. It is possible in some instances where responses within individual demographic categories were small enough that the assumption of similarity between those two groups is of concern. Unfortunately, it is impossible to know to what degree of accuracy is achieved ultimately except to examine each data point individually, in context, and through conversations with experienced healthcare professionals serving the region.

# POLK-NORMAN-MAHNOMEN COMMUNITY HEALTH SERVICES

## COMMUNITY HEALTH IMPROVEMENT PLAN

*Developed in years 2013-2014  
For Implementation in 2015-2019  
**December 31, 2014***



**Public Health**  
Prevent. Promote. Protect.

**Polk County Public Health  
Norman-Mahnomen Public Health**

## TABLE OF CONTENTS

---

Acknowledgements	3
Letter to the Community	4
Executive Summary	5
Polk-Norman-Mahnommen Community Health Services	6
Determining Health Priorities	6
Community Prioritization Process	7
Priorities Selected	9
Addressing Social Determinants of Health	12
Partnership Tool	12
Decrease Persistent Poverty	14
Coordination of Behavioral and Physical Health	25
Positive Social Connections for Youth	36
Call to Action	42
Sustainability	43
End Notes	45
Appendix 1: Partnership Tool	51

## ACKNOWLEDGEMENTS

---

*“Never doubt that a small group of thoughtful committed citizens can change the world; indeed, it’s the only thing that ever has.”- Margaret Mead*

PNM CHS would like to thank the following people and organizations for participating in the planning that led to this report:

---

*Shannon Kronlund  
Chris Kujava  
April Grunhovi  
Ben Fall  
Julie Hanson  
Jason Carlson  
Tracy Smith  
Velma Axtell  
Sheila Razmyslowski  
Patty Herndon  
Dan Svedarsky  
Cindy Bruun  
Chris Bruggeman  
Shannon Stassen  
Sue Knutson  
Candy Keller  
Danica Robson  
Michael T. Norland  
Erin Stoltman  
Susan Klassen  
Rhoda Habedank  
Al Brooks, Pastor  
Leah Pigatti  
Jeff Cadwell  
Jeff Bisek  
Brian Clarke  
Mike Hedlund  
Tim Denney  
Kent Johnson  
Barbara Muesing  
Shellie Bueng  
Sarah Kjono  
Kirsten Fagerlund  
Kathy Girdler  
Dawn Ganje  
Terri Oliver  
Wendy Kvale  
Phyllis Brashler  
Becky Sechrist*

*Northwestern Mental Health Center  
Norman County Social Services  
Riverview Health  
Norman County Sheriff’s Office  
Mahnomen County Social Services  
Tri-Valley Opportunity Council  
Polk County Social Services  
Polk County Social Services  
Polk County Social Services  
Polk County Social Services  
University of Minnesota, Crookston  
Altru Health System  
Riverview Health  
City of Crookston  
Altru Health System  
Essentia Health - Fosston  
Area Agency on Aging  
Polk County Sheriff’s Office  
Essentia Health – Ada  
Sanford Health/Mahnomen Health Center  
Norman County East Schools  
Wild Rice Parish Twin Valley  
Mahube-OTWA  
City of Mahnomen  
Mahnomen School  
Fertile-Beltrami School  
East Grand Forks Police Department  
Northwestern Mental Health Center  
Polk County Social Services  
PNM Community Health Board Member/  
Essentia Health Fosston Trustee  
Norman-Mahnomen Public Health  
Norman-Mahnomen Public Health  
Polk County Public Health  
Polk County Public Health  
Northwest Minnesota Foundation  
Polk County Public Health  
Minnesota Department of Health  
Minnesota Department of Health  
Minnesota Department of Health*

*“If you want to walk fast, walk alone.  
If you want to walk far, walk together.”- African proverb*

## LETTER TO THE COMMUNITY

---

Dear Polk, Norman and Mahanomen County Residents,

The 2015 Polk-Norman-Mahanomen Community Health Improvement Plan (CHIP) is the result of a robust Community Health Assessment process in which data was collected regarding the community health issues that are most important to Polk, Norman and Mahanomen County residents.

The CHIP is an action-oriented, living document to mobilize the community in areas where we can be most impactful on improving the health of residents, particularly those most vulnerable. It serves as a comprehensive set of policy and program recommendations for our community based on the most current information we have regarding the health status of our communities.

Clearly, health is influenced by things such as individual behaviors, age, genetics, and medical care. However, social and economic factors such as education, health insurance, employment and income, and living and working conditions all shape the overall health and vitality of our communities.

We envision a place where everyone has access to health care and preventative services, where we're celebrated for embracing healthy lifestyles and where our communities and neighborhoods are strong and vibrant. As partners in the local health system, we recognize we can only achieve this goal through partnerships and positive changes at the individual, school, workplace, healthcare and community level.

This plan provides a foundation to stimulate strategic new partnerships towards a broad agenda to collectively influence a healthier region. Implementation of the Community Health Improvement Plan strategies and activities will commence beginning in the spring of 2015.

Sincerely,



Sarah Reese, MS, CHES, Director  
Polk County Public Health



Jamie Hennen, RN, PHN, Director  
Norman-Mahanomen Public Health

## EXECUTIVE SUMMARY

---

What do you think of when you think of the word “health”? Some people think about eating healthy, and some associate health with visiting the doctor’s office. Every day we make choices that affect our health- small things like choosing to floss our teeth or big things like making the decision to seek medical care. Some health-related decisions are made for you, like the passage of the Affordable Care Act, or recommendations by national associations. Benjamin Franklin said, “an ounce of prevention is worth a pound of cure,” we know that prevention is cheaper, more effective and better for the individual and society than addressing health conditions once they have been diagnosed. So, how can we, as a community, make a difference when it comes to health?

Health is a very large multi-faceted topic. Measuring health and effectively addressing health challenges requires an effort on behalf of a community. Measuring the health of Polk, Norman and Mahanomen counties was a large undertaking, which is why the process was conducted through a collaborative effort. Public health and community partners/stakeholders worked in partnership to conduct a comprehensive multi-county health assessment utilizing the Mobilizing Action through Planning and Partnership Process, the results which were published in the Community Health Needs Assessment in October 2013. In order to prioritize health issues and make sense of all of the data, stakeholders reviewed assessment results and met in June 2014 to prioritize issues that they felt were important to address, for the health of the community.

The priority areas that Polk, Norman and Mahanomen counties communities will be addressing include:

- DECREASE PERSISTENT POVERTY
- COORDINATION OF BEHAVIORAL AND PHYSICAL HEALTH SERVICES
- POSITIVE SOCIAL CONNECTIONS FOR YOUTH

The following document outlines the strategies that community groups and stakeholders are working on together in order to improve the health of residents of Polk, Norman and Mahanomen counties.



## **POLK-NORMAN-MAHNOMEN COMMUNITY HEALTH SERVICES**

---

The Polk-Norman-Mahnomen Community Health Services (PNM CHS) comprised of Polk County Public Health (PCPH) and Norman-Mahnomen Public Health (NMPH) is a multi-county community health services entity responsible by Minnesota Statute 145A for protecting and promoting the health of Polk, Norman and Mahnomen County residents. The two public health departments are assigned the general authority and responsibility for ongoing planning, development, implementation and evaluation of an integrated system of local community health services.

## **DETERMINING HEALTH PRIORITIES**

---

### **HOW DID WE GET HERE?**

The purpose of the Community Health Improvement Plan is to identify how to strategically and collaboratively address community priority areas to improve the health and well-being of the community. A community-driven health improvement framework called Mobilizing Action through Planning and Partnership (MAPP) was used to guide the health improvement process.

The Community Health Needs Assessment is the document that was created from the first phase of the process in which the results and findings are detailed. The Community Health Assessment identifies and describes factors that affect the health of a population, and factors that determine the availability of resources within the community to adequately address health concerns. The Community Health Assessment, therefore, assures that local resources are directed toward activities and interventions that address critical and timely public health needs.

The Community Health Improvement Plan was guided by MAPP as well, and this document will detail strategic issues that came out of the assessment process and outline goals and strategies to address these health issues.

The data related to the health of Polk, Norman and Mahnomen counties that is referenced throughout this document and this report can be found in the on the county websites of each county.

Polk County	<a href="http://www.co.polk.mn.us">www.co.polk.mn.us</a>
Norman County	<a href="http://www.co.norman.mn.us">www.co.norman.mn.us</a>
Mahnomen County	<a href="http://www.co.mahnomen.mn.us">www.co.mahnomen.mn.us</a>

## **PURPOSE**

We recognize that by working together we can accomplish more than we could alone. The purpose of the CHIP is not to create more work for our partners, but to align and leverage the efforts of multiple organizations and to move toward improved health for the residents of PNM in a strategic manner.

What follows is the result of the community's deliberation and planning to address health concerns in a strategic way that aligns resources and energy to make a measurable impact on health issues in PNM. We recognize that there are many assets in PNM that will help this process move toward accomplishing its goals.

## **COMMUNITY PRIORITIZATION PROCESS**

---

The first step to developing the Community Health Improvement Plan was to examine the results of the community health assessment for common themes and discuss what the assessments revealed about the health of our community. Through these discussions, several strategic issues, or things that need to be addressed in order to achieve the community health vision, emerged.

On June 13, 2014, twenty-eight (28) community representatives from the counties of Polk, Norman and Mahanomen met in Fertile, MN to determine the priority strategic issues necessary to build for the first time a regional Community Health Improvement Plan for the three county region. Prior to the community prioritization meeting, the stakeholders in attendance were emailed the community health needs assessment and tasked with reviewing the results. At the meeting, a summary of community health assessment findings were highlighted.

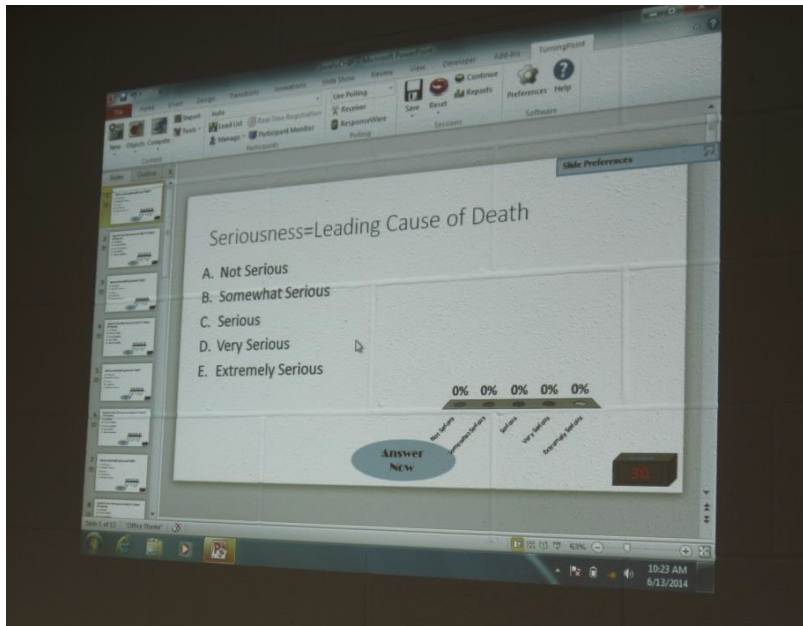
## 10 Most Important Community Health Issues\*

1. Decrease persistent poverty
2. Older adults 65+ and resources for living safely alone
3. Preventing chronic diseases- cancer, diabetes, heart disease
4. Reduce teen pregnancy
5. Reduce children/adolescent obesity
6. Reduce tobacco use
7. Reduce drug abuse
8. Comorbidities of behavioral health and physical health
9. Increased positive role models/relationships early and often for youth
10. Reduce fatal and serious injury motor vehicle crashes



*\*Identified in the recent Community Health Assessment and not numerically listed in order of importance*

Each of the top 10 health indicators was written out on sheets of paper and put on a wall for stakeholders to prioritize. Two prioritization techniques were used for two rounds of prioritization. In round one, each participant was given for 4 sticky circle dots and they selected four health indicators from the master list of 10 using the “democracy” prioritization method. Each participant was allowed to use the four dots as they wished; hence more than one dot could have been placed per indicator.



After all of the dots for each indicator were counted and the group discussed issues based on themes and relationships between and among issues, five indicators emerged for round two of the prioritization process. The indicators scored in round two involved a prioritization matrix comprised of two criteria:

- Seriousness (leading cause of death) and
- “Do”ability (can we make a difference).




Each participant used a clicker to score each of the 5 indicators twice according to a five-point scale: once for seriousness and once for “do”ability.

## **PRIORITIES SELECTED**

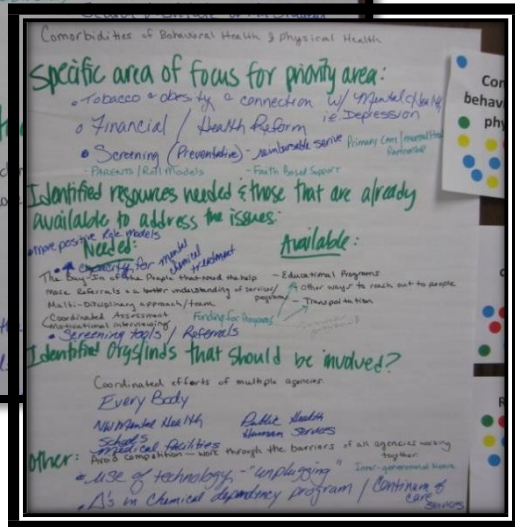
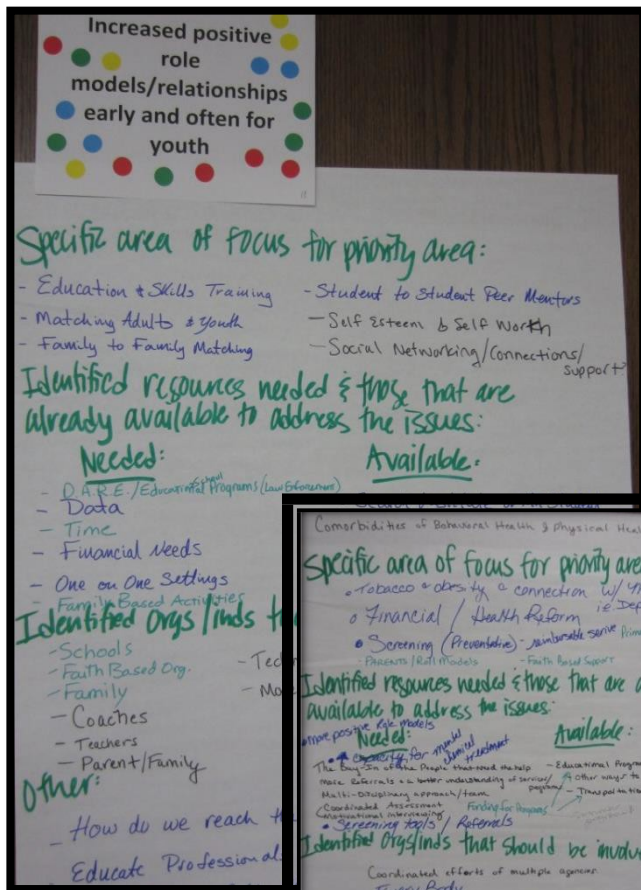
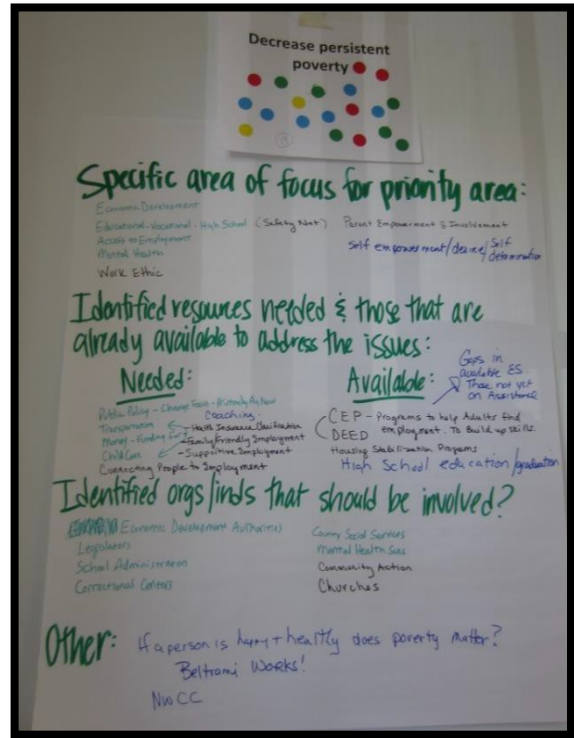
---

In effort to keep the CHIP realistic and manageable, three strategic issues were chosen among partners to focus on for improvement. The resulting assignment of issues does not mean that any item is unimportant or not feasible, it only signifies what the group felt would be more serious and feasible at this time. Being able to show progress and accomplishments is important to the community leadership team and sustainability of the community health improvement projects. The group agreed that other issues may be added or removed from the plan as applicable.

To ensure readability, please note the icons below. Each icon corresponds to a different priority for action.

	<b>Priority 1: DECREASE PERSISTENT POVERTY</b>
	<b>Priority 2: COORDINATION OF BEHAVIORAL AND PHYSICAL HEALTH SERVICES</b>
	<b>Priority 3: POSITIVE SOCIAL CONNECTIONS FOR YOUTH</b>

In reviewing the prioritization results and a subsequent facilitated discussion<sup>1</sup>, coalition members/organizational stakeholders gave input on each priority area and identified that some of the indicators were inter-related. The team believed that this first regional effort must remain manageable and not duplicate other efforts in the community.



## ADDRESSING SOCIAL DETERMINANTS OF HEALTH

---

The group felt the issues around economic disparities were important enough to have their own priority and participants voiced interest that other priority areas should address the social determinants of health<sup>2</sup> with health equity<sup>3</sup> in some way. Not addressing the social determinants of health would undermine the good work that is being undertaken in the other priority area.

Public Health Administration has long expressed that the environments and financial resources (or lack thereof) in which people live, work, learn and play have a tremendous impact on their health. Administration acknowledges its surprise to the group's interest in the importance of addressing the social determinants of health, such as economic opportunities, transportation, education and more. The bottom line is that no matter how we look at health, our coalition members, community stakeholders and partners are saying and prioritizing the need to collaboratively address these highly complex and often linked challenges- ultimately effecting health.

## PARTNERSHIP TOOL

---

The partnership tool (Appendix 1) was distributed to organizations and persons assisting in establishing the "priority areas" as well as additional potential partners/stakeholders. It is understood and anticipated that the community may not be able to implement all of the strategies recommended in the Community Health Improvement Plan but rather a selection of those with significant interest, readiness and capacity as we explore, plan and implement mutually beneficial strategies.

The partnership tool defined a "lead, partner or support organization"<sup>4</sup> and collected responses as to how partner organizations envisioned their role. Additionally, partners were asked to review the work plan and provide input for clarity on the strategies and outcomes.

- ✓ *Lead Organization: A lead organization takes a primary responsibility for implementing a particular strategy, which may include any of these: staff time, organizational resources, internal funding realignments, program development, maintaining a multi-sectored coalition, developing collaborative partnerships, marketing/public relations to increase the community's capacity to address the issue or rigorous advocacy for policy changes.*
  
- ✓ *Partner Organization: Organizations are visible partners along with other entities in the community; take on a significant role in accomplishing the strategy.*

- ✓ *Support Organization: This category includes a variety of actions that indicate that the organization will support a strategy. Support may include willingness to serve on an existing coalition or workgroup, prioritizing local funding to encourage adoption of a strategy, or willingness to serve as an advocate on the issue in your own circle of influence.*

Public Health will serve as a “collaborative convener” to engage, support and/or bring together partners with missions that align with the goals of the action plan to improve community health through community member and partner engagement.





## **DECREASE PERSISTENT POVERTY**

---

*How can we increase availability of living wage jobs? How can we, as a community, assure that everyone has basic resources to live in good health?*

### CURRENT SITUATION

Poverty level is one of the most critical characteristics that contribute to the number of individuals experiencing preventable chronic diseases. Decreasing persistent poverty specifically unemployment and underemployment were identified as one of the three highest priorities. This belief was supported by the Community Health Assessment where the 5-year unemployment rate within Norman-Mahnomen (6.1) is higher than the state average of 5.2, whereas in Polk County it is 5.1. Additionally, educational levels of area residents are substantially lower than in comparison to the rest of the state. Between 47-55% of the population in the region aged 25 and older has less than or equal to a high school education or equivalent compared to 37% of the population statewide.

According to the Kids County Data Center, in 2011, 12% of Minnesota people were living in poverty. There is a culture of extreme poverty, as Mahnomen County ranks the poorest county in the state of Minnesota with 50% of people of all ages living at or below 200% of poverty and all 3 CHB counties exceed the state average of 26% of people living at or below 200% of poverty (2012 MN County Health Tables). These poverty statistics parallel the percentages of people who are uninsured.

Asset poverty is an economic and social condition that is more persistent and prevalent than income poverty. It can be defined as a household's inability to access wealth resources that are sufficient enough to provide for basic needs for a period of three months. While 20.7 percent of all Minnesota households are asset poor, 43.3 percent of Native Americans in Minnesota are asset poor. Low-income households are more likely to be asset poor, the issue goes well up the income scale. Nearly one-quarter of households with incomes of \$37,741 to \$59,604 live in asset poverty.

Most of the participants agreed with the notion that there were not usually easy answers to this issue- that often, the root causes of the stemmed from circumstances and situations that were in place decades in the past, and potentially resulting from things outside of an individuals' control. Responses from the participants related to specific area of focus/identified resources needed was the concept of empowerment, coaching, access and

connection to employment. It was noted that the Northwest Council of Collaboratives also identifies unemployment and underemployment as an important issue. Recognition of the effects of unemployment and low paying jobs on the health of community members was determined to be a priority for strategic planning.

## The Roadmap and Results-Based Accountability

Polk-Norman-Mahnomen Community Health Services (Polk County Public Health and Norman-Mahnomen Public Health) like other areas across the country are interested in cross-jurisdictional sharing (CJS) arrangements. CJS is a deliberate exercise to enable collaboration across jurisdictional boundaries to deliver essential public health services.

We recently participated in a national Shared Services Learning Community. The Center for Sharing Public Health Services created “A Roadmap to Develop Cross-Jurisdictional Sharing Initiatives” to help guide jurisdictions through the process of considering or establishing cross-jurisdictional sharing (CJS) arrangements.

There are three distinct phases on the roadmap:

- Phase One: Explore
- Phase Two: Prepare and Plan
- Phase Three: Implement and Improve



Collaboration allows communities to solve problems that cannot be solved — or easily solved — by single organizations or jurisdictions. Some of the issues, such as “decreasing persistent poverty” are highly complex and generational issues. While the roadmap was developed for public health services, the guide is applicable, and will be used by stakeholders and interested parties in improving effectiveness and efficiencies around common topics and goals found within the improvement plans.

Results-Based Accountability, or RBA, is a way of thinking that can be used to improve the quality of life in communities. It's made up of two parts:

1. Population Accountability: wellbeing of whole populations (community, county, state)

2. Performance Accountability: wellbeing of customer populations (programs, agencies, service systems)

RBA uses a data-driven, decision-making process to help us to get beyond talking about problems to taking action to solve problems. It focuses on “common language, common sense and common ground”. RBA asks three simple questions to get at the most important performance measures:

1. How much did we do?
2. How well did we do it?
3. Is anyone better off?

### **Suggested Actions from the Facilitated Discussion - Decreasing Persistent Poverty**

#### *SPECIFIC AREA OF FOCUS FOR PRIORITY AREA:*

- *Economic Development*
- *Educational-Vocational-High School (Safety Net)*
- *Access to Employment*
- *Mental Health*
- *Work Ethic*
- *Parent Empowerment and Involvement*
- *Self-empowerment/Desire/Self-determination*

#### *IDENTIFIED RESOURCES NEEDED & THOSE THAT ARE ALREADY AVAILABLE TO ADDRESS THE ISSUES:*

##### *Needed:*

- *Public Policy – Primarily Agriculture Now*
- *Money – Funding for Childcare, Transportation*
- *Connecting People to Employment*
- *Coaching*
- *Health Insurance Clarification*
- *Family/Friendly Employment*
- *Supportive Employment*

##### *Available:*

- *CEP/DEED-Programs to help adults find employment/build up skills*
- *Housing Stabilization Programs*
- *High School Education/Graduation*

### **Suggested Actions from the Facilitated Discussion - Decreasing Persistent Poverty**

*IDENTIFIED ORGS/INDS THAT SHOULD BE INVOLVED?*

- *Economic Development Authorities*
- *Legislators*
- *School Administrators*
- *Correctional Centers*
- *County Social Services*
- *Mental Health Services*
- *Community Action Agencies*
- *Churches*

*OTHER:*

- *If a person is happy and healthy does poverty matter?*
- *Beltrami works!*
- *NWCC*



## DECREASE PERSISTENT POVERTY

*How can we increase availability of living wage jobs? How can we, as a community, assure that everyone has basic resources to live in good health?*

GOALS	OBJECTIVES	STRATEGIES	LEAD (BOLD) PARTNER or SUPPORT ORGANIZATION
Goal Collaboration	Increase partnerships between organizations addressing poverty	1. Establish clarity of objectives 2. Assess trust using the organizational "Trust Scale" <sup>5</sup> 3. Train partners on principles of successful cross jurisdictional planning and sharing 4. Communicate information about what contributes to poverty and how it can be addressed	<ul style="list-style-type: none"> <li>✓ <b>Community Action Agencies</b></li> <li>✓ <b>Social/human services</b></li> <li>✓ <b>Public Health</b></li> <li>✓ <b>Behavioral health</b></li> <li>✓ Clergy</li> <li>✓ Hospitals/ clinics</li> <li>✓ Schools</li> <li>✓ Businesses</li> <li>✓ Law Enforcement</li> </ul>
	Increase the number of agencies and organizations that are formal partners in the ongoing Community Health Improvement process	1. Explore <sup>6</sup> <i>Why?</i> Articulate why this is important. Assess trust using the organizational "Trust Scale" <i>What?</i> Goals being considered (functions/programs/ capacity). How can we mitigate current gaps? <i>Who?</i> Partners that should be involved and how 2. Prepare and Plan <i>How exactly will it work?</i> <i>Establish clarity of</i>	<ul style="list-style-type: none"> <li>✓ <b>Public Health</b></li> <li>✓ <b>Hospitals/ clinics</b></li> <li>✓ <b>Community Action Agencies</b></li> <li>✓ <b>Behavioral health</b></li> <li>✓ Social/ human services</li> <li>✓ Schools</li> <li>✓ Businesses</li> </ul>

GOALS	OBJECTIVES	STRATEGIES	LEAD (BOLD) PARTNER or SUPPORT ORGANIZATION
		<p><i>objectives?</i> 3. Train partners on principles of successful cross jurisdictional planning and sharing</p>	
<p>Goal All people have opportunity for increased living wage jobs &amp; resources that meet their family's needs</p>	<p>Enhance partnerships for increased qualified candidates for employment thru workforce development (school/college /community)</p>	<p>1. Explore <i>Why?</i> Articulate why this is important (cycle of poverty, local needs, Private vs. Public) <i>What?</i> Goals being considered (functions/programs/ capacity). (such as career academies*, career pathway and bridge programs*, dropout prevention programs*) <i>(*Scientifically Supported- County Health Rankings<sup>7</sup>)</i> How can we mitigate current gaps? <i>Who?</i> Partners that should be involved and how</p> <p>2. Prepare and Plan How exactly will it work utilizing a health equity lens? Ex. increased advocacy and coordination of support services - address fiscal and service implications, logistical issues, communications, change management, timeline</p> <p>3. Implement and</p>	<ul style="list-style-type: none"> <li>✓ <b>Community Action Agencies</b></li> <li>✓ <b>Hospitals/ clinics</b></li> <li>✓ <b>Behavioral Health</b></li> <li>✓ Public Health</li> <li>✓ Employers</li> <li>✓ Northwest Council of Collaboratives members<sup>8</sup></li> <li>✓ Northwest Minnesota Foundation</li> <li>✓ Workforce Development Center</li> <li>✓ Higher Education</li> <li>✓ Northwest Services Cooperative Adult Basic Education</li> </ul>

GOALS	OBJECTIVES	STRATEGIES	LEAD (BOLD) PARTNER or SUPPORT ORGANIZATION
		monitor 4. Support Northwest Council of Collaboratives current efforts 5. Support NW MN Foundation- Impact 20/20 Initiative- currently hosts workforce and education taskforces	
	Increased quantity and quality of safe, affordable housing	1. Use RBA to Explore Why? Assess future needs, priorities and barriers What? Healthy, safe and affordable housing Who? -Support and learn from Tri-Valley's housing feasibility study currently underway in Crookston -Engage NW Regional Development Commission, Headwaters Regional Development Commission and NW MN Foundation regarding their regular communication about affordable housing 2. Prepare and Plan How exactly will it work utilizing a healthy equity lens? -Support Public Health's Healthy Homes grant to complete 100 Healthy	<ul style="list-style-type: none"> <li>✓ <b>Community Action Agencies</b></li> <li>✓ <b>NW Regional Development Commission</b></li> <li>✓ <b>Headwaters Regional Development Commission</b></li> <li>✓ <b>NW Minnesota Foundation</b></li> <li>✓ <b>HUD</b></li> <li>✓ <b>Economic Development</b></li> <li>✓ City Planning and Zoning</li> <li>✓ Public Health- Healthy Homes</li> </ul>

GOALS	OBJECTIVES	STRATEGIES	LEAD (BOLD) PARTNER or SUPPORT ORGANIZATION
		Homes assessment and mitigate hazards as applicable 3. Implement and monitor	
	Increased safe and affordable modes of transportation and non-motorized safe routes	<p>1. Use RBA to Explore- Motorized transportation and non-motorized safe routes <i>Why? What? Who?</i></p> <p>2. Prepare and Plan How exactly will it work utilizing a health equity lens? Such as, what are existing and potential funding streams that can assure adequate and sustainable operational funding? -Support the Transportation Advisory Committee convened by Tri-Valley</p> <p>3. Implement and monitor</p>	<ul style="list-style-type: none"> <li>✓ <b>Community Action Agencies</b></li> <li>✓ <b>Wellness Coalitions/ Workgroups</b></li> <li>✓ <b>City</b></li> <li>✓ <b>Employers</b></li> <li>✓ <b>Transit Services</b></li> <li>✓ <b>Public Health- Statewide Health Improvement Program Safe Routes</b></li> <li>✓ Transportation engineers</li> <li>✓ Clergy</li> </ul>
	Increased access and decreased barriers to childcare services	<p>1. Explore – Use RBA to explore current situation and desired outcomes for feasibility <i>Why? What? Who?</i> (such as increased funding for childcare subsidy*)</p> <p>-Support Community Action Agencies: Child Care Aware, Head Start and transportation options</p> <p>-Engage with NW MN</p>	<ul style="list-style-type: none"> <li>✓ <b>Community Action Agencies</b></li> <li>✓ <b>Human/ Social Services</b></li> <li>✓ <b>Employers</b></li> <li>✓ NW MN Foundation</li> <li>✓ Child Care Assistance Program</li> <li>✓ MN Dept of Education,</li> <li>✓ MN Dept of Health</li> </ul>



GOALS	OBJECTIVES	STRATEGIES	LEAD (BOLD) PARTNER or SUPPORT ORGANIZATION
		Foundation, Child Care Assistance Program, MN Dept of Education, MN Dept of Health and the Children's Finance to build quality childcare 2. Prepare and Plan How exactly will it work? 3. Implement and monitor -Social Services advocate for changes through the MN Association of County Social Services Administrators -Social Services continue to actively recruit foster and child care	<ul style="list-style-type: none"> <li>✓ Children's Finance</li> <li>✓ Childcare Licensors</li> <li>✓ Childcare Associations</li> </ul>
Goal Reduce stress associated with poverty	Increased focus on stress management (including financial literacy and overall mental health)	1. Use RBA to Explore Why? What? Who? 2. Prepare and Plan How exactly will it work? 3. Implement and monitor -Support Family Assets for Independence in Minnesota (FAIM)? which connects low-income Minnesotans with asset building opportunities through the innovative use of Individual Development Accounts (IDAs),	<ul style="list-style-type: none"> <li>✓ <b>Behavioral health</b></li> <li>✓ <b>Human/ Social Services</b></li> <li>✓ <b>Public Health</b></li> <li>✓ <b>Hospitals/clinics</b></li> <li>✓ <b>Community Action Agencies</b></li> <li>✓ Employers</li> <li>✓ Wellness Coalitions/ Workgroups</li> <li>✓ Clergy</li> </ul>

GOALS	OBJECTIVES	STRATEGIES	LEAD (BOLD) PARTNER or SUPPORT ORGANIZATION
		financial literacy education, personalized coaching and access to economic security support services. -Social Services assist people with serious and persistent mental illness to address financial and budgeting matters	

**Outcome Indicators**

1. Documentation of organizations collaborating (common goals, trust, team approach, training, apply for funding) for the purpose of continuous community health improvement addressing poverty and health equity throughout the process.
2. At least three strategies will be implemented to help meet the goal. (annual progress review)
  - o Explore: Conceptual feasibility study/established vision for project strategies
  - o Prepare and Plan: Implementation plan/determine baseline and establish measurement targets
  - o Implement and Monitoring: progress and evaluation reports, knowledge-sharing documents, quality improvement reports, revised plans
3. The Northwest Council of Collaboratives will consider health equity when reviewing monthly grant opportunities.
4. Documentation of the Community Health Board and Community Leadership Team discussion on health equity to address policy, system and environmental change in Polk, Norman, and Mahnomen.
5. A formal training on cross jurisdictional planning and sharing for least 3 community collaboratives across the 3 county area.
6. Public Health will have 65% of sectors represented and engaged in community health improvement assessment and improvement plan. (letters of support and participation)
7. Qualitative findings related to “opportunities for health” (Theme from Minnesota Statewide Health Assessment)<sup>10</sup>

8. Decrease in dropout rates and increase in the % of students who graduate high school. (MDE) (VS Trends) (*Rationale: Education often results in higher incomes, on average, and more resources than a job that does not require education*).
9. Percentage of adults with a living wage job and income.
10. Percentage of adults who have an industry recognized credential (Bureau of Labor Statistics)
11. Percentage of high school students participating in job preparedness programs or curricula (survey)
12. Percentage of related children ages 5 to 17 in families in poverty (Census Bureau)
13. 100 healthy home assessments will be completed by public health across the 3 counties improving healthy home environments for citizens.
14. Increase transportation opportunities to support employment: Number of communities served, Number of days served, Number of trips made, Number of riders (transit data)

*\*Outcome Indicators to be refined as needed*



## COORDINATION OF BEHAVIORAL AND PHYSICAL HEALTH SERVICES

---

*How can we strengthen communication and coordination among health care and community partners to support healthy behaviors across the life span?*

### CURRENT SITUATION

A second priority identified was health behaviors related to the comorbidities of behavioral health and physical health. Specific “unhealthful behaviors” identified from the discussion were eating behaviors, lack of physical exercise, tobacco use, and drug abuse (legal and illegal). Further conversation led to the group combining “reducing drug abuse” and “reducing children/adolescent obesity” within focus area of addressing “comorbidities of behavioral health and physical health”. More specific issues teased out were a multi-disciplinary approach/team, coordinated assessment/screening (screening tools/motivational interviewing), referrals (with better understanding of community/healthcare services/programs), and financial reform for preventative services.

Minnesota Student Survey (MNSS) results for area 12th graders indicate that overall, those students within the 3-county region are significantly more overweight than other 12th graders from across the state, and furthermore they are significantly more likely to believe they are overweight than other seniors from across the state. Consumption of fresh fruits, vegetables and other nutritious foods and regular physical activity are critical to attaining and maintaining a healthy weight. The Behavioral Risk Factor Surveillance Data suggest that lack of exercise for adult populations within the three counties may be a significant issue as nearly 18% of residents in each county are estimated to not participate in any form of exercise compared to the state average of nearly 13%.

Drug use/abuse was considered to be one of the most risky behaviors in the community. Ben Fall, Norman County Chief Deputy, states “There are many people in our area who are directly affected by the use of illegal drugs. We are also seeing firsthand, the effects that the misuse and abuse of prescription drugs is having on our population, including children and young adults. These children and young adults are experiencing this on their own, through a family member, friend, neighbor or sometimes even a co-worker.”

Tobacco is a leading cause of death and preventable disease among the PNM CHS area. Young people from low-income families are roughly twice as likely to smoke cigarettes. Thirty-one percent of 12th grade students across PNM CHB smoked a in the previous 30 days as compared to 22% statewide (MN Student Survey 2010). Also of great concern for the region is the reported frequent use of smokeless tobacco.

Excerpts from the *"Findings and Recommendations based on the 2011 Minnesota Behavioral Risk Factor Surveillance System- Executive Summary"*<sup>11</sup> state,

*"Minnesota Department of Health has collected data regarding the effects of adverse childhood experiences (ACEs) on the lifelong health and well-being of adults in Minnesota. For two decades, research by the Centers for Disease Control and Prevention (CDC) and other states has demonstrated over and over again the powerful impact of ACEs on health, behavioral, and social problems.*

*An adverse childhood experience (ace) describes a traumatic experience in a person's life occurring before the age of 18 that the person recalls as an adult. In the Minnesota BRFSS survey, respondents were asked if they had experienced any of the following nine types of ACEs: physical abuse, sexual abuse, emotional abuse, mental illness of a household member, problematic drinking or alcoholism of a household member, illegal street or prescription drug use by a household member, divorce or separation of a parent, domestic violence towards a parent, and incarceration of a household member.*

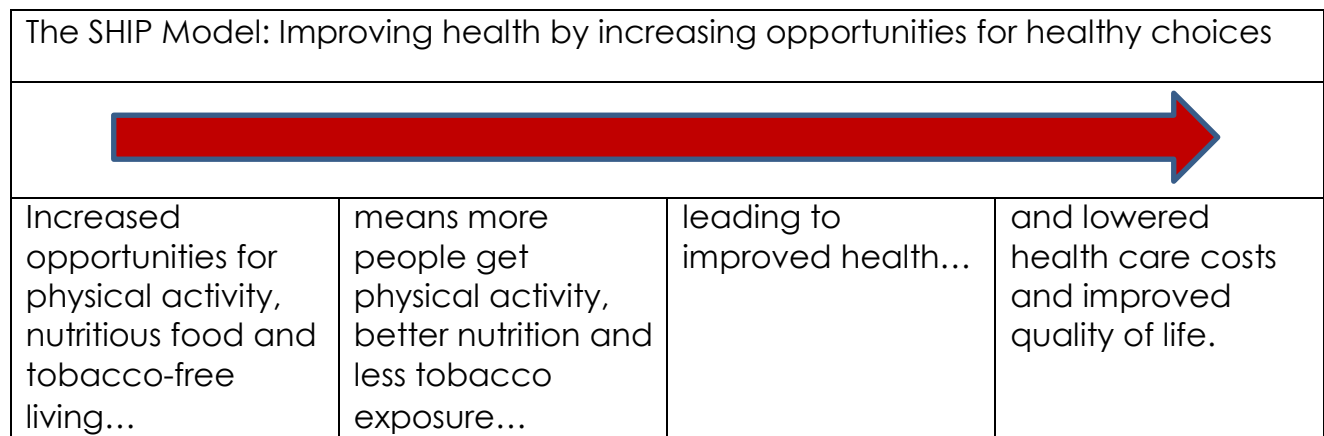
*Results indicate that ACEs are common among Minnesota adults. Over half of the Minnesotans responding to ACE module questions reported experiencing at least one ACE in childhood. The five most common ACEs reported by Minnesotans in the survey are emotional abuse (28 percent), living with a problem drinker (24 percent), separation or divorce of a parent (21 percent), mental illness in the household (17 percent), and physical abuse (16 percent).*

*As the number of ACEs increases, the risk for health problems increases in a strong and graded fashion in areas such as alcohol and substance abuse, depression, anxiety, and smoking. ACEs have a strong and cumulative impact on the health and functioning of adults in Minnesota."*

To understand the impact of mental illness we can look at individuals with a chronic behavioral health disorder such as schizophrenia, bi-polar and major

depression. They are at a greater risk of having a co-occurring physical and behavioral health disorder. Due to the pharmacological interventions to manage behavioral health symptoms, they experience significant side effects that cause physical health disorders such as diabetes, obesity and cardiovascular disease. As a result, individuals with a co-occurring disorder have a mortality rate 8-25 years earlier than the general population.

Public Health's, Statewide Health Improvement Program (SHIP), helps Minnesotans live longer, healthier lives by preventing the leading causes of chronic disease: tobacco and obesity. SHIP launched as part of Minnesota's Vision for a Better State of Health, was a bipartisan health reform package enacted in 2008. Evidence based chronic disease strategies utilizing policy, system and environmental changes make it easier for Minnesotans to have healthy choices where we live, learn, work, play and seek healthcare. Public Health and its community/healthcare partners seek to achieve more equitable health, where people are able to attain their highest level of health possible.



## Suggested Actions from the Facilitated Discussions –Coordination of Physical and Behavioral Health

---

### SPECIFIC AREA OF FOCUS FOR PRIORITY AREA:

- Tobacco & Obesity and Connection with Mental Health (i.e. Depression)
- Financial/Health Reform
- Screening (Preventative) – Reimbursable Service
- Parents/Role Models
- Faith Based Support
- Primary Care/Public Health/Mental Health Partnership

### IDENTIFIED RESOURCES NEEDED AND THOSE THAT ARE ALREADY AVAILABLE TO ADDRESS THE ISSUES:

#### Needed:

- More Positive Role Models
- Capacity for Mental & Chemical Treatment
- Client/patient buy-in/trust
- More Referrals & a Better Understanding of Services/Programs
- Multi-Disciplinary Approach/Team
- Coordinated Assessment
- Motivational Interviewing
- Screening Tools/Referrals
- Funding for Programs

#### Available:

- Educational Programs/Other Ways to reach out to people
- Transportation

### IDENTIFIED ORGS/INDS THAT SHOULD BE INVOLVED?

- Coordinated efforts of multiple agencies
- Everybody
- NW Mental Health
- Schools
- Medical Facilities
- Public Health/Human Services

### OTHER:

- Avoid Competition – work through the barriers of all agencies working together
- Use of Technology – “Unplugging”
- Changes in Chemical Dependency Program/Continue of Care Services

### **Suggested Actions from the Facilitated Discussions (continued)**

- *Inter-Generational Nature*

*Healthcare partners are operating in silos. The critical access hospitals, primary care, behavioral health, public health and social services are fiscally vulnerable and challenged to meet the requirements for electronic medical records, system and technological improvements. Health reform will require system improvements to broaden and deepen the involvement of multiple stakeholders on policy, service and assessment issues. Healthcare partners should utilize a multi-disciplinary team to increase integration and coordination of services across the continuum of care and increase connection of individuals to the preventative screening and health services they need.*

*Healthcare partners should engage the client/patient in a two-way information exchange where the clinician can share options, benefits and harms and the client/patient can share their level of risk tolerance, values, and preferences for care.*

*Healthcare providers should go beyond providing medical service by serving as a source of preventative health information and should gain a better understanding of services/programs available to provide patients more referrals to community supports.*

*Client/patient navigators should be considered/utilized to create buy-in and develop trust and rapport with clients/patients who are experiencing a co-occurring physical and behavioral health disorder.*

*Support the use of health care extenders (i.e. health educators, community paramedics, nutritionists, etc.) to improve engagement of disparate populations in evidence-based lifestyle change and prevention programs.*





## COORDINATION OF BEHAVIORAL AND PHYSICAL HEALTH SERVICES

*How can we strengthen communication and coordination among health care and community partners to support healthy behaviors across the life span?*

GOALS	OBJECTIVES	STRATEGIES	LEAD ROLE PARTNER or SUPPORT ORGANIZATION
<p>Goal Achieve the Institutes for Healthcare Improvement's Triple Aim:</p> <ul style="list-style-type: none"> <li>• <i>Improve the health of the population;</i></li> <li>• <i>Improve the patient/consumer experience;</i></li> <li>and</li> <li>• <i>Improve the affordability of health care</i></li> </ul>	<p>Enhance coordination and integration of clinical, behavioral, and complementary health services.</p>	<p>1. Explore -Implement/ support effective care coordination models (i.e. medical homes<sup>12</sup>, behavioral healthcare homes, etc)* <i>(*Scientifically Supported- County Health Rankings)</i> -Integrate behavioral health into primary care practice* -Reference Community Measures -Social Services and Public Health professionals to work closely with providers in a way that is mutually beneficial</p> <p>2. Prepare and Plan <i>How exactly will it work?</i></p> <p>3. Implement and monitor</p>	<ul style="list-style-type: none"> <li>✓ <b>Hospital/Clinics</b></li> <li>✓ <b>Behavioral Health</b></li> <li>✓ <b>Public Health</b></li> <li>✓ <b>Social/Human Services</b></li> </ul>
		<p>Electronic health information exchange*- Prepare and implement the NW Minnesota E-Health Initiative</p>	<ul style="list-style-type: none"> <li>✓ <b>Stratis Health</b></li> <li>✓ <b>NW Mental Health Center</b></li> <li>✓ <b>E-Health Collaborative</b></li> </ul>

GOALS	OBJECTIVES	STRATEGIES	LEAD ROLE PARTNER or SUPPORT ORGANIZATION
		(shares information securely and safely; develop the technological infrastructure to share information for coordination of care; engage in Care Coordination Efforts and Integrated Health Partnership options)	<b>Partners</b>
		<p>1. Explore</p> <ul style="list-style-type: none"> <li>-Engage primary care providers (and others in direct contact with individuals) in conducting screening and making referrals for these resources while using the evidence-based model* (screen, counsel and referral to treatment) (such as chronic disease self- management programs*).</li> <li>-Computerized clinical decision support systems*</li> <li>-Reference Community Measures</li> </ul> <p>2. Prepare and Plan <i>How exactly will it work?</i></p> <ul style="list-style-type: none"> <li>-Motivational interviewing –patient shared decision making*</li> <li>-Focus on holistic health</li> </ul> <p>3. Implement and monitor</p>	<ul style="list-style-type: none"> <li>✓ <b>Hospital/Clinics</b></li> <li>✓ <b>Public Health</b></li> <li>✓ <b>Behavioral Health</b></li> <li>✓ Social/Human Services</li> <li>✓ Clergy</li> </ul>

<b>GOALS</b>	<b>OBJECTIVES</b>	<b>STRATEGIES</b>	<b>LEAD ROLE PARTNER or SUPPORT ORGANIZATION</b>
	Reduce the gaps in services and resources and increase the utilization of services and resources.	<p>1. Explore - Increased network of systems navigators<sup>13</sup> Individuals in each agency increase access to and support for utilizing resources to engage in healthy behaviors and preventative care.*  <i>(*County Health Rankings Evidence Based/Promising Strategy).</i></p> <p>-Support implementation of community-based preventive services and enhance linkages with primary care* (i.e. tobacco cessation; quitline and asthma home environment intervention program linked to clinicians as referral points).</p> <p>-Reference Community Measures  <i>Why? What? Who?</i></p> <p>2. Prepare and Plan  <i>How exactly will it work?</i></p> <p>3. Implement and monitor</p>	<ul style="list-style-type: none"> <li>✓ <b>Hospital/Clinics</b></li> <li>✓ <b>Public Health</b></li> <li>✓ <b>Behavioral Health</b></li> <li>✓ Social/Human Services</li> </ul>
	Increase population's understanding of the benefits of preventative care and reduce stigma	<p>1. Use RBA to Explore  <i>Why? What? Who?</i></p> <p>-Identify community events that reach out to target population</p> <p>-Seek ways to integrate recommended</p>	<ul style="list-style-type: none"> <li>✓ <b>Behavioral Health</b></li> <li>✓ Public Health</li> <li>✓ Hospital/Clinics</li> <li>✓ Social/Human Services</li> <li>✓ Community Action Agencies</li> </ul>

<b>GOALS</b>	<b>OBJECTIVES</b>	<b>STRATEGIES</b>	<b>LEAD ROLE PARTNER or SUPPORT ORGANIZATION</b>
	related to A)having mental illness and B)seeking care for mental illness while reducing cultural and health literacy barriers	preventive care services and expand health literacy. -Offer Mental Health First Aid training 2. Prepare and Plan <i>How exactly will it work?</i> 3. Implement and monitor	<ul style="list-style-type: none"> <li>✓ Law Enforcement</li> <li>✓ Clergy</li> <li>✓ Schools</li> </ul>
Goal To create an environment and culture, through policy and systems change, that makes physical activity and healthy foods easier and more rewarding for people of all ages and abilities.	Make it easier for residents to walk, bike, and wheel to everyday destinations	<ol style="list-style-type: none"> <li>1. Explore <i>Why? What? Who?</i> (such as improve streetscape design*, point of decision prompts*, land use master plans*)</li> <li>2. Prepare and Plan <i>How exactly will it work?</i></li> <li>3. Implement and monitor</li> </ol>	<ul style="list-style-type: none"> <li>✓ <b>City</b></li> <li>✓ <b>Public Health (SHIP)</b></li> <li>✓ <b>Wellness Coalitions/ Workgroups</b></li> <li>✓ Schools</li> <li>✓ City and County Building/ Zoning/GIS</li> <li>✓ Regional Development Commission</li> <li>✓ Employers</li> </ul>
	Encourage active living at work	<ol style="list-style-type: none"> <li>1. Use RBA to Explore <i>Why? What? Who?</i> (such as worksites that have adopted policies supporting physical activity*)</li> <li>2. Prepare and Plan <i>How exactly will it work?</i></li> <li>3. Implement and monitor</li> </ol>	<ul style="list-style-type: none"> <li>✓ <b>Public Health</b></li> <li>✓ <b>Employers</b></li> <li>✓ <b>Hospital/Clinics</b></li> <li>✓ <b>Schools</b></li> <li>✓ <b>County/City Wellness Coalitions</b></li> <li>✓ Clergy</li> </ul>
	Increased access to healthy foods	<ol style="list-style-type: none"> <li>1. Use RBA to Explore <i>Why? What? Who?</i> (such as policies and environments</li> </ol>	<ul style="list-style-type: none"> <li>✓ <b>Public Health</b></li> <li>✓ <b>NW Regional Sustainable Development</b></li> </ul>

<b>GOALS</b>	<b>OBJECTIVES</b>	<b>STRATEGIES</b>	<b>LEAD ROLE PARTNER or SUPPORT ORGANIZATION</b>
		supporting access/availability of healthy foods and/or breastfeeding promotion programs*) 2. Prepare and Plan How exactly will it work? 3. Implement and monitor	<b>Partnership</b> ✓ <b>UMN Extension</b> ✓ <b>Employers</b> ✓ <b>Breastfeeding Coalition</b> ✓ <b>Wellness Coalition/ Workgroups</b> ✓ Food Bank/Food Shelf ✓ Clergy
Goal Prevent and address alcohol, tobacco and other drug (ATOD) use	Convene ATOD stakeholders to create a county-wide strategy to prevent and address ATOD use and misuse	1. Explore <i>Why? What? Who?</i> 2. Prepare and Plan <i>How exactly will it work?</i> 3. Implement and monitor Apply for funding that supports preventing and addressing ATOD use and misuse	✓ <b>Public Health</b> ✓ <b>Wellness Coalitions/ Workgroups</b> ✓ <b>Behavioral Health</b> ✓ Law enforcement ✓ Schools ✓ Tobacco and alcohol retailers ✓ Employers

**Outcome Indicators**

1. At least three strategies will be implemented to help meet the goal. (annual progress review)
  - Explore: Conceptual feasibility study/established vision for project strategies
  - Prepare and Plan: Implementation plan/determine baseline and establish measurement targets
  - Implement and Monitoring: progress and evaluation reports, knowledge-sharing documents, quality improvement reports, revised plans
2. E-Health: Completed Privacy and Security Risk Assessments, Minnesota Accountable Health Model: Continuum of Accountability Matrix, subscribe to a state certified eHealth option (direct or connect) to share information, implement strategies (direct/connect), identify and implement one Use Case scenario for using eHealth to advance care coordination)

3. Increase in the percentage of adults on medical assistance who have a personal health care provider (medical home). (National Quality Measures Clearinghouse/survey local healthcare partners)
4. Increase the number of healthcare providers trained to implement screen/counsel/refer/follow-up and/or motivational interviewing or similar efforts.
5. Increase the percentage of patients that have met the targets for preventative screenings (Community Measures/survey partners)
6. Increase the percentage of patients that have received evidence-based preventive treatment (Community Measures/survey partners)
7. Increase in the number of system/patient navigators in use in the three county area. (survey local partners)
8. Increase the amount of accessible safe routes and frequency of use of walking and biking routes (linear feet and Environmental Observation)
9. Increase the number of worksites that have existing or adopted policies supporting physical activity and/or nutrition. (survey)
10. Increase the availability of fruits and vegetables in food deserts through retail, gardens, and food banks (environmental observation)
11. Action plan for addressing and preventing ATOD created.

*\*Outcome Indicators to be refined as needed*



## POSITIVE SOCIAL CONNECTIONS FOR YOUTH

---

*How can we promote and support social connection efforts and opportunities in our community?*

### CURRENT SITUATION

This priority strategic issue is a social determinant of health- meaning that a feeling of having social connections affects people's behavior, which in turn affects health outcomes. People with more positive social connections are protected from poor health outcomes.

The Search Institute confirms that *“both researchers and practitioners have long embraced the idea that interaction with caring adults is central to young people’s development.”* New research finds that in addition to expressing care, *“young people also need people in their lives who challenge growth, provide support, share power, and expand possibilities”*. (2014, <http://www.search-institute.org/sites/default/files/a/Dev-Relationships-Framework.pdf>)

This issue is unique in that it focuses on a specific age group-youth. This is strategic for a number of reasons. First, we know that the health trajectory of an entire life is established very early on in child development. The negative impact of poverty on the developing brain means that children who are deprived will have worse health as adults, even if they practice good health behaviors. Behaviors are set very early in a child's life and impacted by the role models and relationships in their lives.

Youth are a unique population in that they are “sponge”-constantly learning new information, skills and expectations (norms) about ways of acting and living that contribute to health and their future (or not). Additionally, children (because their brain is still developing) are much likelier (than adults) to be able to establish and sustain healthy behaviors based on positive adult role modeling and education. It is important to provide individuals, especially children, with knowledge, skills and tools to facilitate social connectedness and community engagement across the lifespan.

During the community dialogue issues related to child health and positive role models/relationships were repeatedly raised. The criteria used to determine the final strategic priority issues were: Seriousness and Do-ability. After voting and a hearty discussion, the participants ranked positive role models/relationships for children high in “seriousness” and “do-ability”.

## Suggested Actions from the Facilitated Discussion- Positive Social Connections for Youth

---

### SPECIFIC AREA OF FOCUS FOR PRIORITY AREA:

- Education and Skills Training
- Matching Adults and Youth
- Family to Family Matching
- Student to Student Peer Mentors
- Self-esteem and Self-worth
- Social Networking/Connections/Support

### IDENTIFIED RESOURCES NEEDED AND THOSE THAT ARE ALREADY AVAILABLE TO ADDRESS THE ISSUES:

#### Needed:

- D.A.R.E./Educational School Programs (Law Enforcement)
- Data
- Time
- Financial Needs
- One-on-one Settings vs. Family Based Activities

#### Available:

- Search Institute or MN Student Survey
- Existing Mentors: ECI, Foster Grandparents, NFP, RSVP, Family Voice & Choice, NW Mental Health Center, Parks & Rec, Latch Key, Law Enforcement, Faith Community

### IDENTIFIED ORGS/INDS THAT SHOULD BE INVOLVED?

- Schools
- Faith Based Org.
- Parent/Family
- Coaches/Teachers
- Technical Professionals involved
- More FACS/Ag/Auto/Life Skills

### OTHER:

- How do we reach the demographic? Connect them with services.
- Educate professionals as to resources available
- Make resources culturally appropriate





## POSITIVE SOCIAL CONNECTIONS FOR YOUTH

*How can we promote and support social connection efforts and opportunities in our community?*

GOALS	OBJECTIVES	STRATEGIES	LEAD ROLE, PARTNER or SUPPORT ORGANIZATION
Goal A thriving mindset producing productive, happy, and contributing members of society	Increase social connectedness/developmental relationships <sup>14</sup> among youth	1. Use RBA to Prepare and Plan - Fostering healthy relationships and positive mental health (such as mentoring*, home room time, summer learning programs*, NorthStar Summer Program) <i>(*Scientificallly Supported-County Health Rankings)</i> 2. Implement and monitor	<ul style="list-style-type: none"> <li>✓ <b>Behavioral Health</b></li> <li>✓ <b>Schools</b></li> <li>✓ Law enforcement</li> <li>✓ Mentors</li> <li>✓ Public Health</li> <li>✓ Clergy</li> </ul>
		Support and promote current extracurricular activities and afterschool programs  When applicable, examine underutilization through RBA.	<ul style="list-style-type: none"> <li>✓ <b>Schools</b></li> <li>✓ <b>Activities Directors</b></li> <li>✓ <b>Parks and Recreation</b></li> <li>✓ Clergy</li> <li>✓ Mentors</li> </ul>
		Support School-Based (Policy/Social Capital) Interventions to establish safe and socially connected schools and provide individuals with knowledge, skills, and resiliency through: -School based social and emotional development instruction* (such as school	<ul style="list-style-type: none"> <li>✓ <b>Schools</b></li> <li>✓ <b>Behavioral Health</b></li> <li>✓ NW MN Foundation</li> <li>✓ Law enforcement</li> <li>✓ Public Health</li> <li>✓ Social/Human Services</li> </ul>

GOALS	OBJECTIVES	STRATEGIES	LEAD ROLE, PARTNER or SUPPORT ORGANIZATION
		<p>based mental health services)</p> <p>-School based programs to reduce violence and bullying* (such as the DARE program- currently implemented in East Grand Forks by Police Department)</p> <p>-Support and possibly expand the Students Teaching Attitudes of Respect (STAR) program: increase awareness for students in the areas of community building, media, skills needed to deal with conflict, and the utilization of personal power and strengths. The goal is to model and support a positive school culture. Currently offered at Norman County East, Naytahwaush and Waubun Schools</p> <p>-Support NW MN Foundation's offering of "Social and Emotional Learning" Trainings for school staff</p>	
	<p>Increase health-related self-efficacy among children and their caregivers<sup>15</sup></p>	<p>Provide individuals with knowledge, skills, and self-esteem through:</p> <p>-Parent and family skill based support programs that support positive family interactions* (such as school based mental</p>	<ul style="list-style-type: none"> <li>✓ <b>Behavioral Health</b></li> <li>✓ <b>Schools</b></li> <li>✓ <b>Public Health-Family Home Visiting</b></li> <li>✓ <b>Community Action</b></li> </ul>

GOALS	OBJECTIVES	STRATEGIES	LEAD ROLE, PARTNER or SUPPORT ORGANIZATION
		health services or experiential education*)	Agencies ✓ Social/Human Services
		Provide individuals with knowledge, skills, and self-esteem through: -Increased early home visitation among high risk families* and Nurse Family Partnership <sup>16*</sup> (2015- PNM CHS plans to expand NFP into Polk County)	✓ <b>Public Health</b> ✓ <b>Community Action Agencies</b> ✓ Behavioral Health ✓ Social/Human Services ✓ Schools ✓ Clergy
		-Increase the proportion of children in poverty who participate in preschool programs (designed to improve cognitive and social development)*	✓ <b>Community Action Agencies</b> ✓ <b>Early Childhood Family Education</b> ✓ Schools ✓ Childcare Association
Goal Personal and organizational ownership of the need for increasing social connectedness as a means of improving the health and wellness of the community, and creating a more inclusive community	Creation of wide-scale awareness for the value of and the processes for improving of social connectedness within organizations, the communities, and across the county's	1. Explore and identify the adaptive challenges to improving social connectedness, cultural inclusion, and better health and wellness in the organizations and communities <i>Why? What? Who?</i> 2. Prepare and Plan <i>How exactly will it work?</i> 3. Implement and monitor	✓ <b>Public Health</b> ✓ <b>City's</b> ✓ UMN Extension ✓ Behavioral Health ✓ Social/Human Services ✓ Schools ✓ Clergy

GOALS	OBJECTIVES	STRATEGIES	LEAD ROLE, PARTNER or SUPPORT ORGANIZATION
	<p>Deliver high-quality facilitation that will focus on bridging relationships, linking social capital, population community health and mental health, cultural inclusion, and adaptive leadership for improving social connectedness and system transformation.</p>	<p>1. Prepare and Plan: Facilitation for the development of “The Shift” in the thinking of individuals and the community in regard to prioritizing social connectedness, health and wellness, and cultural inclusion. 2. Implement and monitor</p>	<ul style="list-style-type: none"> <li>✓ Behavioral Health</li> <li>✓ Public Health</li> <li>✓ Northwest Council of Collaborative Partners</li> <li>✓ Hospital/Clinics</li> <li>✓ Employers</li> </ul>
	<p>Increased connection of people to resources</p>	<p>1. Prepare and Plan: Develop asset maps of organizational and social resources based upon increased participation and input from individuals and groups not normally “at the table” in systems transformation discussions, by means of social bridging, linking, and inclusion practices. 2. Implement and monitor</p>	<ul style="list-style-type: none"> <li>✓ Northwest Council of Collaborative Partners</li> <li>✓ Hospital/Clinics</li> <li>✓ Employers</li> </ul>

## Outcome Indicators

1. At least three strategies will be implemented to help meet the goal.  
(annual progress review)
  - Explore: Conceptual feasibility study/established vision for project strategies
  - Prepare and Plan: Implementation plan/determine baseline and establish measurement targets
  - Implement and Monitoring: progress and evaluation reports, knowledge-sharing documents, quality improvement reports, revised plans
2. Community asset map developed defining existing resources and utilization.
3. Increase in the number of clients served by home visiting programs that begin prenatally.
4. Increase in child welfare referrals to a family home visiting program (public health, early head start, children's mental health)
5. Increase the percentage of families receiving service coordination when multiple providers are serving a family.
6. Increase the number of children in poverty participating in preschool programs.
7. Increase the percentage of parents who have attended a family skills based training program
8. Increase the number of schools with a bullying prevention curriculum and/or policy.
9. Increase in the number of schools who are implementing evidence-based bullying prevention programs.
10. Training completed on social connectedness, health and wellness, and cultural inclusion.

\*Outcome Indicators to be refined as needed

## CALL TO ACTION

---

### HOW CAN YOU HELP IMPROVE COMMUNITY HEALTH IN POLK, NORMAN AND MAHNOMEN COUNTY'S?

Throughout the planning process community members and organizations have been actively involved, and our goal is for that to continue! As you think about what you have read here, please think about ways YOU can contribute to building an even healthier region.

Community health improvement is not a static process. We promote a “Health in All things” approach to community health planning and are therefore looking for partners in a variety of sectors interested in partnering across the local public health system to help develop recommendations, implement strategies, and evaluate our efforts.

Here are some things you might consider:

#### **Advocate for the plan's adoption in your organization or other parts of the community**

It is our goal that organizations from all sectors of the community – schools, health care providers, local government, faith organizations, service providers, and others – will actively adopt and participate in this community health plan.

In our daily lives we touch other's lives throughout our community. Think about the specific opportunities for community action listed in this plan. How could some of these actions be supported in the places where you learn, work, and play? How can you personally help advocate change? Advocating for changes like this across all sectors of our community is important if we want to see true change.

#### **Stay involved with groups working to implement the plan**

Within the community there are already wellness coalitions and work groups that are active in efforts to improve community health.

If you, or your organization, are the missing partner in the CHIP please contact the Health Department to get more information about how you can help support our efforts to improve community health. We look forward to working with you!

## SUSTAINABILITY

---

The community health improvement plan (CHIP) created by community members and organizations broadens and builds upon successful local initiatives. Leadership of the efforts and resources needed to implement the plan will be shared across participating community and healthcare partners. The health improvement plan identifies specific evidence-based components based on community health needs (including social determinants of health).

The first priority issue involves strengthening the local public health system partnerships and structure. If this structure is enhanced and maintained, it will provide a platform for ongoing community health improvement.

We recognize that if we are to achieve our vision for community health improvement in Polk, Norman and Mahnomen counties and successfully implement the strategies highlighted in this document, then we need to explore, plan, implement and promote policies, systems and environments that reinforce this effort. Therefore the policy, systems and environmental recommendations included are designed to address our collective public health concerns, guide the implementation of the strategies proposed in this CHIP, and promote a "health in all things" approach.

In order to meet public health standards, Polk County Public Health and Norman-Mahnomen Public Health are committed to facilitating implementation of the Community Health Improvement Plan.

---

<sup>1</sup> Facilitated Discussion June 2014

Wendy Kvale, Nurse Consultant, Minnesota Department of Health, led participants in a facilitated discussion and rotation through each of the three priority areas discussing the following:

SPECIFIC AREA OF FOCUS FOR PRIORITY AREA:

IDENTIFIED RESOURCES NEEDED & THOSE THAT ARE ALREADY AVAILABLE TO ADDRESS THE ISSUES:

Needed:

Available:

IDENTIFIED ORGS/INDIVIDUALS THAT SHOULD BE INVOLVED?

OTHER:

<sup>2</sup> Social Determinants of Health

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

<http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health>

<sup>3</sup> Health Equity

Minnesota is one of the healthiest states in the country. However, a statewide assessment has found that not all Minnesotans have the same chances to be healthy. Those with less money, and populations of color and American Indians, consistently have less opportunity for health and experience worse health outcomes.

The Minnesota Legislature in 2013 directed the Minnesota Department of Health (MDH) and its partners to complete a report about advancing health equity (AHE) in Minnesota.

<https://www.health.state.mn.us/communities/equity/reports/index.html>

The Advancing Health Equity in Minnesota: Report to the Legislature was submitted to the Minnesota Legislature on Friday, January 31, 2014. The report assesses Minnesota's health disparities and recommends best practices, policies, processes, data strategies, and other steps that will promote health equity for all Minnesotans.

Advancing Health Equity in Minnesota: Report to the Legislature

[https://www.health.state.mn.us/communities/equity/reports/ahe\\_leg\\_report\\_020114.pdf](https://www.health.state.mn.us/communities/equity/reports/ahe_leg_report_020114.pdf)



---

#### <sup>4</sup> Definitions

**Lead Organization:** A lead organization takes a primary responsibility for implementing a particular strategy, which may include any of these: staff time, organizational resources, internal funding realignments, program development, maintaining a multi-sectored coalition, developing collaborative partnerships, marketing/public relations to increase the community's capacity to address the issue or rigorous advocacy for policy changes.

**Partner Organization:** Organizations are visible partners along with other entities in the community; take on a significant role in accomplishing the strategy.

**Support Organization:** This category includes a variety of actions that indicate that the organization will support a strategy. Support may include willingness to serve on an existing coalition or workgroup, prioritizing local funding to encourage adoption of a strategy, or willingness to serve as an advocate on the issue in your own circle of influence.

#### <sup>5</sup> Cross-Jurisdictional Sharing Agreements Collaborative Trust Scale

An anonymously collected survey to assess levels of trust between collaboration partner organizations. This scale can make discussions about trust safer and more productive. The survey is a useful tool to help people explore together their differing expectations and build stronger and more productive collaborative relationships.

[http://phsharing.org/assessment\\_tools/trust-scale/](http://phsharing.org/assessment_tools/trust-scale/)

#### <sup>6</sup> A ROADMAP TO DEVELOP CROSS-JURISDICTIONAL SHARING INITIATIVES

Cross-jurisdictional sharing (CJS) is the deliberate exercise of public authority to enable collaboration across jurisdictional boundaries to deliver essential public health services. [While the roadmap was developed for public health services, the guide is applicable to stakeholders and interested parties in improving effectiveness and efficiencies around a common topic or goal.]

Collaboration allows communities to solve problems that cannot be solved — or easily solved — by single organizations or jurisdictions.



This roadmap describes three phases to guide jurisdictions through the CJS process:

- Explore
- Prepare and Plan
- Implement and Improve

<http://phsharing.org/roadmap/>

---

<sup>7</sup> County Health Rankings and Roadmaps (<http://www.countyhealthrankings.org/roadmaps/what-works-for-health>)

What Works for Health provides communities with information to help select and implement evidence-informed policies, programs, and system changes that will improve the variety of factors we know affect health.

Health Behaviors (30%)	<input type="checkbox"/> Tobacco Use <input type="checkbox"/> Diet & Exercise <input type="checkbox"/> Alcohol & Drug Use <input type="checkbox"/> Sexual Activity
Clinical Care (20%)	<input type="checkbox"/> Access to Care <input type="checkbox"/> Quality of Care
Social & Economic Factors (40%)	<input type="checkbox"/> Education <input type="checkbox"/> Employment <input type="checkbox"/> Income <input type="checkbox"/> Family & Social Support <input type="checkbox"/> Community Safety
Physical Environment (10%)	<input type="checkbox"/> Air & Water Quality <input type="checkbox"/> Housing & Transit

<sup>8</sup> Northwest Council of Collaboratives

Collaboration among 50+ member organizations including public health, social services, school districts and special education districts, mental health and corrections in northwest Minnesota representing Polk, Norman, Mahnomon, Kittson, Marshall, Pennington and Red Lake counties. The primary goal of the NWCC is to promote the health and well-being of residents in the seven-county area by coordinating human and financial resources to maximize the efficiency of services offered by its members.

<sup>9</sup> Family Assets for Independent Living

FAIM is a comprehensive program focused on reducing asset poverty and building financial capability. FAIM connects low-income Minnesotans with asset building opportunities through the innovative use of Individual Development Accounts (IDAs), financial literacy education, personalized coaching and access to economic security support services. Research has shown that effective interventions that reduce asset poverty combine education with opportunities for behavioral change, encourage a shift to depository financial relationships, increase usage of tax credits and work supports, expand opportunities to build savings, and decrease use of predatory high-cost lenders. FAIM includes all of these elements

<sup>10</sup> ***The Health of Minnesota***, Minnesota's Statewide Health Assessment, was prepared under the auspices of the Healthy Minnesota Partnership, and is an overview of population characteristics, social and economic factors, and health outcomes for the people of Minnesota. This document presents a

---

wide array of indicators and information about statewide influences on health as well as individual indicators of health behaviors and health status.

<https://www.health.state.mn.us/communities/practice/healthymnpartnership/docs/2017MNStatewideHealthAssessment.pdf>

<sup>11</sup> An adverse childhood experience (ACE) describes a traumatic experience in a person's life occurring before the age of 18 that the person remembers as an adult.

In a 2011 Minnesota telephone survey, individuals were asked if they had experienced any of nine types of ACEs. The nine ACEs are:

- physical abuse
- sexual abuse
- emotional abuse
- mental illness of a household member
- problematic drinking or alcoholism of a household member
- illegal street or prescription drug use by a household member
- divorce or separation of a parent
- domestic violence towards a parent
- incarceration of a household member

The ACE score is a measure of cumulative exposure to adverse childhood conditions. Exposure to any single ACE condition is counted as one point. If a person experienced none of the conditions in childhood, the ACE score is zero. Points are then totaled for a final ACE score. It is important to note that the ACE score does not capture the frequency or severity of any given ACE in a person's life, focusing instead on the number of ACE conditions experienced. In addition, the ACE conditions used in the ACE survey reflect only a select list of experiences.

<https://www.health.state.mn.us/communities/ace/definition.html>

Findings and Recommendations based on the 2011 Minnesota Behavioral Risk Factor Surveillance System- Executive Summary <https://www.health.state.mn.us/docs/communities/ace/acesum.pdf>

<sup>12</sup> Definition of Medical Home: Medical homes provide continuous, comprehensive, whole person primary care. Personal physicians and their teams work with patients to address preventative, acute, and chronic health care needs. Medical homes offer enhanced access, practice evidence-based medicine, measure performance, and strive to improve care quality.

Adapted from County Health Rankings & Roadmaps: <http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/medical-homes>

---

Medical homes provide continuous, comprehensive, whole person primary care (NCQA – PCMH, PCPCC – PCMH). In this model of care, personal physicians and their teams coordinate care across the health care system, working with patients to address all their preventive, acute, and chronic health care needs, and arranging care with other qualified health professionals as needed. Medical homes offer enhanced access, including expanded hours and easy communication options for patients. They also practice evidence-based medicine, measure performance, and strive to improve care quality.

Rationale: There is strong evidence that medical homes improve health care quality. By proactively caring for patients, medical homes reduce preventable hospitalizations and emergency room visits. Medical homes can increase continuity of care, evidence-based care, and patient or family participation. By increasing patient monitoring and non-urgent care, medical homes reduce duplicate services and emergency room visits. Effects appear strongest for children with special health care needs and persons with chronic conditions such as diabetes or depression. Medical homes reduce emergency visits for asthmatics. They may also reduce disparities in health outcomes. Some medical homes have been shown to improve access and preventive care, increase continuity of care, and reduce emergency room visits for low income persons.

<sup>13</sup> Rationale: Systems navigators provide culturally sensitive assistance and care-coordination, guiding patients through available medical, insurance, and social support systems. These programs seek to reduce racial, ethnic, and economic disparities in access to care and disease outcomes.

Rationale: Increase the number of systems navigators and/or patient navigators to provide culturally sensitive assistance and guide patients through medical/support systems. Seeks to reduce disparities among those diagnosed and at risk.

Rationale: Shown to increase preventive service use along with increased coordination of care among those experience co-morbidities.

<sup>14</sup> Excerpt from the Search Institute:

What are developmental relationships and why do they matter?

A developmental relationship is a close connection between a young person and an adult or between a young person and a peer that powerfully and positively shapes the young person’s identity and helps the young person develop a thriving mindset. A thriving mindset is a multi-dimensional construct and the subject of ongoing Search Institute research. A thriving mindset can be summarized as the orientation not just to get by in life, but to flourish—not just to survive, but to thrive.

As anyone who has worked with young people can attest, once a child has developed the drive and, over time, the ability to be the best that he or she can be, an important step has been taken on the path to

---

becoming a productive, happy, and contributing member of society. When a thriving mindset shapes a young person's decisions and actions, he or she is more likely to work hard both inside and outside of school, and to develop a range of social and emotional skills that are essential for success in some type of college, work, and civic life.

Where does the Developmental Relationships Framework come from?

The Developmental Relationships Framework builds on Search Institute's foundational research on Developmental Assets as well as a year of focused quantitative and qualitative analyses and reviews of research on the importance, quality, and nature of relationships that make a positive difference in young people's lives. The Developmental Relationships Framework will be continually tested and refined through studies of relationships in families, schools, youth programs, and communities.

<http://www.search-institute.org/what-we-study/developmental-relationships>

<sup>15</sup> Rationale: Provide visitations to high risk families involving nurse visits, workers, community peers to help reduce and prevent mother and childhood violence.

Rationale: Children who participate in a high quality preschool are more prepared to enter kindergarten, more likely to succeed academically, and earn higher incomes as adults.

<sup>16</sup> Nurse Family Partnership is offered in Norman and Mahanomen counties and an expansion into Polk County is slated for 2015.

<http://www.nursefamilypartnership.org/>

---

## Appendix 1: PARTNERSHIP TOOL

Community health improvement is not a static process. We promote a “Health in All things” approach to community health planning and are therefore partners in a variety of sectors are critical to help develop recommendations, implement strategies, and evaluate our efforts.

This partnership tool was developed for partner organizations and persons assisting in establishing the “priority areas” as well as additional potential partners/stakeholders.

On the full document, you will notice a generalized list of potential partners by sector. This is not meant to be an exhaustive list but merely a starting point. It is subject to change based on your feedback.

*It is understood and anticipated that the community may not be able to implement all of the strategies recommended in the Community Health Improvement Plan but rather a selection of those with significant interest, readiness and capacity as we explore and plan.*

1. Below “lead, partner and support organization” are defined.
2. Please review the work plan below, save to your computer and return feedback to Jamie or Sarah:
  - A) Mark an “X” if you envision you or your organization as a “lead, partner and support organization”.  
*\*This is simply a planning tool and not binding in nature.*
  - B) Provide input (clarification/additions/corrections, etc) where applicable on the work plan strategies and outcomes. All comments are welcome.  
*\*If you have a strategic plan, community measure or alike that aligns with the strategy/outcome that would be helpful to make note of.*

### Definitions

**Lead Organization:** A lead organization takes a primary responsibility for implementing a particular strategy, which may include any of these: staff time, organizational resources, internal funding realignments, program development, maintaining a multi-sectored coalition, developing collaborative partnerships, marketing/public relations to increase the community’s capacity to address the issue or rigorous advocacy for policy changes.

**Partner Organization:** Organizations are visible partners along with other entities in the community; take on a significant role in accomplishing the strategy.

**Support Organization:** This category includes a variety of actions that indicate that the organization will support a strategy. Support may include willingness to serve on an existing coalition or workgroup, prioritizing local funding to encourage adoption of a strategy, or willingness to serve as an advocate on the issue in your own circle of influence.

---

EXAMPLE

**PRIORITY: DECREASE PERSISTENT POVERTY**

*How can we increase availability of living wage jobs?  
How can we, as a community, assure that everyone has  
basic resources to live in good health?*

OBJECTIVES	STRATEGIES	Lead Organization	Partner Organization	Support Organization
Increase partnerships between organizations addressing poverty	1. Establish clarity of objectives 2. Assess trust using the organizational "Trust Scale" 3. Train partners on principles of successful cross jurisdictional planning and sharing 4. Communicate information about what contributes to poverty and how it can be addressed			



**Appendix D**  
**Essentia Health Ada, Ada, MN**  
**Available Resources 2016**

**Appendix C – Available Resources**

Category	Description and/or examples	Obesity, physical activity, and nutrition as risk factors for chronic diseases, including diabetes, community resources	Preventive care community resources	Access to health care community resources
<p><b>Health care facilities (Essentia and other)</b></p>	<p><b>Hospitals, primary care clinics</b></p>	<p>County public health department</p> <ul style="list-style-type: none"> <li>• Norman-Mahnomen Public Health, 15 2nd Ave E., Room 107, Ada, MN 56510, 218-784-5425, Director of Norman-Mahnomen Public Health. Adult Health Nurse, Norman Mahnomen Public Health and Norman, Mahnomen, and Polk SHIP coordinator, PO Box 226, Mahnomen, MN, 56557, 218-935-2527. All grants they are currently working on are listed in the grant portion of this document.</li> </ul> <p>Chiropractor</p> <ul style="list-style-type: none"> <li>• Ada Chiropractic Clinic 406 East Main Street, Ada, MN 56510; 218-784-2330</li> </ul> <p>Dentists</p> <ul style="list-style-type: none"> <li>• Prairie Dental, 200 E. Main St. Ada, MN 56510, 218-784-7119</li> <li>• Dr. Joy’s Dental Clinic, 132 3rd St. W. Halstad, MN 56548, 218-456-2182</li> </ul> <p>Pharmacies</p> <ul style="list-style-type: none"> <li>• Thrifty White Pharmacy, 319 W. Main St., Ada, MN 56510, 218-784-2434</li> <li>• Twin Valley Drug, 120 Main Ave, Twin Valley, MN 56584, 218-584-5147</li> </ul> <p>Clinics</p> <ul style="list-style-type: none"> <li>• Essentia Health Ada Clinic, 201 9<sup>th</sup> Street West, Ada, MN 56510, 218-784-2727</li> <li>• Sanford Health Clinic - Twin Valley , 501 2<sup>nd</sup> St. NW, Twin Valley, MN 56584, 218-584-5142</li> <li>• Sanford health Clinic- Halstad, 445 1<sup>st</sup> St. E. Halstad, MN 56548, 218-456-2158</li> </ul>		





**Appendix D**  
**Essentia Health Ada, Ada, MN**  
**Available Resources 2016**

		Hospital <ul style="list-style-type: none"> <li>Essentia Health Ada, 201 9<sup>th</sup> Street West, Ada, MN 56510, 218-784-5000</li> </ul>	
<b>Human</b>	<b>Entities invited to the Town Hall meeting</b>	Invited entities included: <ul style="list-style-type: none"> <li>Community/patient focus group participants</li> <li>Ada Jaycees</li> <li>Ada-Borup Public Schools</li> <li>American Legion (VFW) Ada, Twin Valley, Gary</li> <li>City of Ada</li> <li>City of Gary</li> <li>City of Halstad</li> <li>City of Twin Valley</li> <li>Dr. Joy's Dental Office</li> <li>Essentia Health Ada</li> <li>Essentia Health Ada Governing Board</li> <li>Gary Lions</li> <li>Gary Rescue Squad</li> <li>Gary State Bank</li> <li>Lutheran Social Service</li> <li>Norman County</li> <li>Norman County East Public School</li> <li>Norman County Social Services</li> <li>Norman County West Public School</li> <li>Norman-Mahnomen Public Health</li> <li>Prairie Dental</li> <li>Sanford Health Clinic Twin Valley</li> <li>St. Mary's Home Health</li> <li>Twin Valley Living Center</li> <li>Valley Vision</li> </ul>	Prospective entities include: <ul style="list-style-type: none"> <li>Community/patient focus group participants</li> <li>Social service organization representatives</li> <li>Service organization representatives</li> <li>City and county government officials</li> <li>Tribal government/leadership/representatives if applicable and/or other minority population group members/ representatives</li> <li>Primary care and other health care providers</li> <li>Lead county public health officials</li> <li>Industry/business leaders/ representatives</li> <li>Educators/ educational administrators</li> <li>Examples: Entities invited to first Town Hall Meeting, City of Hendrum, City of Shelly, Norman County DAC, Northwestern Mental Health, Hospice of the Red River, Tri-Valley Opportunity Council, Halstad and Twin Valley Lions, American Federal Bank, Frandsen Bank, Bank of the West, Red River State Bank, First Financial Bank, Northwestern Bank Headwaters Regional Development Commission</li> </ul>



**Appendix D**  
**Essentia Health Ada, Ada, MN**  
**Available Resources 2016**

<p align="center"><b>Human</b></p>	<p align="center"><b>Additional individuals</b></p>	<p>A Certified Diabetes Educator provides services at Essentia Health Ada 2 days per month.</p> <p>Registered dietician</p> <ul style="list-style-type: none"> <li>• RD/LD, Essentia Health Ada, 201 9<sup>th</sup> St. West, Ada, MN 56510, 218-784-2727, also visits Sanford</li> </ul> <p>Primary care providers who could participate in intervention</p> <ul style="list-style-type: none"> <li>• MDs and PAs, Essentia Health Ada, 201 9<sup>th</sup> Street West, Ada, MN 56510, 218-784-2727</li> <li>• MD and PA, Sanford Clinic, Twin Valley , 501 2<sup>nd</sup> St. NW, Twin Valley, MN 56584, 218-584-5142</li> </ul>		
<p align="center"><b>Financial</b></p>	<p align="center"><b>Grants and hospital contribution</b></p>	<p>Grant possibilities: Minnesota Department of Health, Blue Cross Blue Shield of Minnesota, Dakota Medical Foundation, Essentia Health Ada Foundation and Northwest Minnesota Foundation. Also, Norman County Social Services and Essentia Health Community Care program.</p> <p>SHIP Grants:</p> <ul style="list-style-type: none"> <li>• All 3 schools are involved in SHIP 2.0 which is an Active School Day Strategy. It is based around getting kids up and moving during the school day. They will be implementing and training teachers with the Energizer Program that will give teachers activities to do throughout the day. Trying to get a structured recess back.</li> <li>• Farming in school concept is working with the school food service directors in all three schools to have healthier lunches, concessions, vending choices and the school store. Its goal is to have more local fresh fruit and vegetables in the school system.</li> <li>• Worksite Wellness: This is a greater northwest, central Minnesota grant to help employers implement worksite wellness programs. Essentia Health Ada is a part of this program. The program involves education, resources, and making new policies for tobacco free campuses, nursing rooms for breast feeding mothers, and healthier choices in the building for people to select with a discounted rate. This is partnered with BC/BS of Minnesota. Worksite</li> </ul>		



**Appendix D**  
**Essentia Health Ada, MN**  
**Available Resources 2016**

		<p>Wellness Consultant, Sr. Center of Prevention, M/S S113, BC/BS of Minnesota, 1750 Yankee Doodle Rd, Eagan, MN 55121.</p> <ul style="list-style-type: none"> <li>• SHIP grant for the community gardens in Twin Valley are being targeted. SHIP has been helping with the farmers market in Ada at Laughing Earth Garden in the form of advertising.</li> </ul> <p>Community Transformation Grant (CTG): This is a 5 year grant that is in the 2<sup>nd</sup> year. Different strategies are being implemented, such as active transport, ski trails, walking paths, etc. They hope to purchase mountain bikes to lend to people, and it would be run similarly to the ski trail in Twin Valley with Buckle’s Hardware storing the bikes. Ada is looking into doing the same thing.</p> <p>Carol White Grant: This grant is through the schools, and all three schools are involved. Norman County East just finished a pedometer challenge. The CWG is a Physical Education Program that provides grants for community-based organizations to initiate, expand, or enhance physical education programs, including after-school programs for students in kindergarten through 12<sup>th</sup> grade. Grant recipients must implement programs that help students make progress toward meeting state standards.</p> <p>The base guideline for the hospital’s financial contribution is 0.1% of net patient revenue less bad debt [i.e. 0.1%*(NPR-BD)] for each of the three interventions, each of which will last three years with the first beginning in Financial Year 2014. Additionally, all hospitals are strongly encouraged by Bert Norman, Essentia Health’s Chief Financial Officer, to reallocate current Community Benefit funding to supplement the base financial contribution guideline.</p>		
<p><b>Programmatic</b></p>	<p><b>Community health activities already occurring</b></p>	<p>Norman County Extension online resources, <a href="http://www.extension.umn.edu">www.extension.umn.edu</a>. Nutrition Education Assistant, Extension U of MN, 218-784-5550. UM Extension Norman County, 16 3<sup>rd</sup> Ave. Ste 107, Ada, MN 56510. Provides co-op with all three schools for education on healthy eating.</p> <p>Norman County Extension Office, 16 3<sup>rd</sup> Ave/ E # 101B, Ada, MN 56510, 218-784-5550. Regional Director, 218-236-2004. They run the 4-H programs and different</p>	<p>Bridges Care Community meals on wheels for the Ada area, 201 9th St West Ste 2, Ada, MN 56510, 218-784-5500</p> <p>Lutheran Social Services – 100 Jefferson Ave., Fertile, MN 56540, 218-945-6808</p>	<p>Norman County EMS and First Responders, 201 9<sup>th</sup> Street West, Ada, MN 56510, 218-784-5226</p> <p>Twin Valley Rescue Squad, 104 Norman Ave. Twin Valley, MN 56584, 218-584-5354</p>



**Essentia Health**

Here with you

**Appendix D**  
**Essentia Health Ada, Ada, MN**  
**Available Resources 2016**

		<p>educational opportunities for the Agriculture community.</p> <p>Nutritional consults by RD/LD</p> <p>Diabetic education provided by Essentia Health Ada.</p> <p>National Diabetes Prevention Program offered in partnership by Norman-Mahnomen Public Health and Essentia Health Ada.</p> <p>Essentia Health Ada Annual Health Fair to educate residents on a variety of healthcare topics. Information booths, door prizes, and \$25 blood screenings. Information on diabetes, cancer, bone density, nutrition and fitness. Held in October. 201 9<sup>th</sup> St W, Ada, MN, 218-784-2727.</p> <p>Ada-Borup High School runs the Community Education program with a committee that meets 2-3 times a year to consider which classes the community would like to have developed. Course offerings vary year to year. Norman County West only has a course for GED as their Community Ed program. Norman County East does not offer Community Education programming.</p> <p>Tops Weight loss Program, 102 2<sup>nd</sup> St E. Ada, MN 56510, 218-784-2660.</p> <p>Zumba Classes offered at the Ada-Borup School on Monday, Tuesday and Thursday nights. Cost is \$3.00.</p>	<p>Lutheran Social Service runs the Senior Meals and Meals on Wheels in Gary and Twin Valley, 324 N Main Street, Crookston, MN 56716, 218-281-6270</p>	<p>Gary Rescue Squad, 106 14st Ave. W., Gary, MN 56545, 218-356-8645</p> <p>Halstad Rescue Squad, 129 2<sup>nd</sup> Ave. W., Halstad, MN 56548, 218-456-2247</p> <p>Perley Rescue Squad, PO Box 419, Perley, MN 56574, 218-474-1328</p> <p>Hendrum Rescue Squad, Norman County West High School 225 2<sup>nd</sup> Ave., Halstad, MN 56548, 218-861-6237</p> <p>Shelly Rescue Squad, 109 Johnson St., Shelly, MN 56581, 218-886-7255</p> <p>Headwaters Regional Development Commission, Development Specialist, 218-333-6539</p>
<b>Infrastructure</b>	<b>Buildings or</b>	Schools with meetings spaces and/or fitness facilities		Valley Vision Clinic, 402 E. 3rd



**Appendix D**  
**Essentia Health Ada, Ada, MN**  
**Available Resources 2016**

	<p><b>other built environment features that may be useful for interventions, e.g. gyms, community centers, walking paths, etc.</b></p>	<ul style="list-style-type: none"> <li>• Ada-Borup School District, 604 W. Thorpe, Ada, MN 56510, 218-784-5300. <ul style="list-style-type: none"> <li>○ Ada school is open for public meetings. The cost depends on if it is for profit or non-profit, and if a custodian is needed such as weekends, which would require a possible varying cost.</li> <li>○ Ada-Borup School offers open gym for students on Sunday evenings. 6-9pm. No cost. Wednesday night open gym for adults, no cost 6-9 pm. There is a summer open gym program for the students that runs all summer. The cost is \$10.00.</li> <li>○ Speed and Strength program offered all summer lead by Essentia Health Ada Athletic Trainer for \$15.</li> <li>○ Weightlifting program offered all summer lead by ABHS staff for \$15.</li> </ul> </li> <li>• Norman County East School District, PO Box 420, Twin Valley, MN 56584, 218-584-5151. <ul style="list-style-type: none"> <li>○ School is available for use any time with no charge as long as there is no conflict.</li> <li>○ They have open walking for the public on days the school is open from 3:15-5:00 pm free of charge. They have open gym at both the high school and elementary on Wednesday nights from October to March for \$2.00 a night or \$10.00 a year, 6:30 pm - 9:00 pm. There is no Community Education.</li> </ul> </li> </ul>		<p>St., Ada, MN 56510, 218-784-4091</p> <p>Nursing homes/senior living</p> <ul style="list-style-type: none"> <li>• Twin Valley Living Center, 208 Oppegard Ave, Twin Valley, MN 56584, 218-584-5181</li> <li>• Halstad Living Center, 133 4<sup>th</sup> Ave. East, Halstad, MN 56548, 218-456-2105</li> <li>• Heritage House, 201 4<sup>th</sup> Ave. E. Halstad, MN 56548, 218-456-2105</li> <li>• Lincoln Terrace, 205 3<sup>rd</sup> St. NW Twin Valley, MN 56584, 218-584-5183</li> <li>• Valley Pines Senior Living, 400 Lincoln Ave., Twin Valley, MN 56584, 218-584-8202</li> <li>• Valley View Manor, 705 W. Main, Ada, MN 56510, 218-784-7246</li> </ul>
--	--	--	--	---



**Appendix D**  
**Essentia Health Ada, Ada, MN**  
**Available Resources 2016**

		<ul style="list-style-type: none"> <li>• Norman County West School District, 225 2nd Ave. E., Halstad, MN 56548, 218-456-2151. The school is available to the public for \$50.00.</li> <li>• There is a program that you can get a key to either the Halstad or Hendrum school to use the gym, locker room, weight room, and fitness center (Halstad only) for \$50.00 a year Jan-Dec. Must be 21 to be in alone; younger individuals must be with an adult.</li> </ul> <p>Benedictine Care Community, 201 9<sup>th</sup> street West, Ada, MN 56510, Bone Builders Class, 218-784-5576</p> <p>Churches with meetings spaces and/or fitness facilities</p> <ul style="list-style-type: none"> <li>• Holy Family Catholic, 307 5<sup>th</sup> Ave E, Halstad, MN 56548, 218-456-2400</li> <li>• United Church of Christ, 510 W. Thorpe, Ada, MN 56510, 218-784-4711</li> <li>• St. Joseph Catholic Church, 405 E. Thorpe Ave. Ada, MN 56510, 218-784-4131</li> <li>• First English Lutheran Church, 2435 297<sup>th</sup> Ave. Ada, MN 56510, 218-784-7438</li> <li>• St. John’s Lutheran Church, 2948 240<sup>th</sup> Ave. E. Ada, MN 56510, 218-784-4644</li> <li>• Zion Lutheran Church, PO Box 147, Ada, MN 56510, 218-784-7103</li> <li>• Augustana Lutheran, 1319 270<sup>th</sup> Ave., Halstad, MN 56548, 218-456-2499</li> <li>• Bethany Lutheran, 1894 Cty Hwy 3, Ada, MN 56510, 218-886-8123</li> </ul>		<p>Hospice of the Red River Valley, 103 S. Broadway, Crookston, MN 56716, 218-281-9236</p> <p>Northwestern Mental Health Center, 603 Bruce Street, Crookston, MN 56716, 218-281-5256</p> <p>Norman County DAC. 212 9<sup>th</sup> St. E. Ada, MN 56510, 218-784-4582</p> <p>Tri-Valley Opportunity Council, 102 N. Broadway, Crookston, MN 56716, 218-281-5832</p> <p>Essentia Health, Home Health, 201 9<sup>th</sup> St. West, Ada, MN 56510, 218-784-2209.</p> <p>Valley Pines Senior Living, 400 Lincoln Ave., Twin Valley, MN 56584, 218-584-8202</p> <p>Valley View Manor, 705 W. Main, Ada, MN 56510, 218-784-7246</p>
--	--	--	--	---



**Appendix D**  
**Essentia Health Ada, Ada, MN**  
**Available Resources 2016**

---

		<ul style="list-style-type: none"><li>• E. Marsh River Free Lutheran, 2352 Cty Hwy 10, Halstad, MN 56548, 218-456-2279</li><li>• Grace Lutheran, 110 E. 3<sup>rd</sup> Ave, Ada, MN 56510, 218-784-4010</li><li>• Halstad Lutheran, 304 5<sup>th</sup> St. E., Halstad, MN 56548, 218-456-2144</li><li>• Immanuel Lutheran, 321 Main St. Hendrum, MN 56550, 218-861-6218</li><li>• Winchester Lutheran, 12 Main Ave, Borup, MN 56519, 218-582-3310</li><li>• Jevnaker Lutheran, 1004 Co. Hwy 26, Borup, MN 56519, 218-582-3350</li><li>• Faith United Church, 510 W. Thorpe , Ada, MN 56510, 218-784-2343</li><li>• Sonrise Evangelical Free , 211 ½ W. Main Street, Ada, MN 56510, 218-784-3733</li><li>• Zion Lutheran Church, 212 Pleasant Ave., Twin Valley, MN 56584, 218-584-5105</li><li>• St. William Catholic Church, 500 Lincoln Ave., Twin Valley, MN 56584, 218-584-5352</li><li>• Gary/Rindahl Lutheran Church, 4389 340<sup>th</sup> Ave, Fertile, MN 56540, 218-945-6220</li><li>• Wild Rice Lutheran, 1540 Co. Hwy 36, Twin Valley, MN 56584, 218-584-8686</li><li>• Good News Fellowship, 2457 Co. Hwy 34, Gary, MN 56545, 218-356-8604</li><li>• Kirkebo Lutheran Church, 212 Walsch St. Perley, MN, 45474, 218-861-6541</li><li>• Trinity Lutheran, 106 Stenseth Ave., Twin Valley, MN 56584, 218-584-8440</li></ul>		
--	--	---	--	--



**Appendix D**  
**Essentia Health Ada, Ada, MN**  
**Available Resources 2016**

---

		<ul style="list-style-type: none"> <li>• Cowboy Church, Twin Valley, MN 56584</li> <li>• All churches have meeting space for people to use. There is no charge, but you are asked to clean up afterwards. If you want, you can pay a cleaning charge at some of them.</li> </ul> <p>Flom Town Hall, 1109 Cty Hwy 38, Flom, MN 56541, 218-567-8323, Flom Insurance Agency contact for Flom Community Club.</p> <p>Gym/fitness centers</p> <ul style="list-style-type: none"> <li>• Dekko Center, 107 4<sup>th</sup> Ave East, Ada, MN 56510, 218-784-7665</li> <li>• Halstad school fitness facility with equipment from previous SHIP – open to community. Norman County West School District, 225 2nd Ave. E., Halstad, MN 56548, 218-456-2151. The school is available to the public for \$50.00 a year for 21 and older. Younger have to be with an adult. This is for the gym, locker room, weight room, and fitness center in Halstad. You can also get a key for the Hendrum school for the gym and locker room use.</li> <li>• Gary Wellness Center, City of Gary, 211 1st Ave. E., Gary, MN 56545, 218-356-8564 or 218-356-8600. Memberships: Single \$60.00 a year, Family \$150.00 a year. \$15.00 a month per person.</li> </ul> <p>Community centers</p>		
--	--	--	--	--





**Appendix D**  
**Essentia Health Ada, Ada, MN**  
**Available Resources 2016**

---

		<ul style="list-style-type: none"> <li>• Dekko Center, 107 4<sup>th</sup> Ave East, Ada, MN 56510, 218-784-7665. Membership fees: <ul style="list-style-type: none"> <li>○ Daily: Youth 2-18 \$2.00, Adult \$5.00, 55+ \$4.50</li> <li>○ Monthly: Adult \$42.75, Jr. \$16.03 up to 17 years, Senior \$38.48, Family \$74.81, Senior family \$67.43</li> <li>○ Year: Junior \$190.00, Single \$304.59, Family \$670.11, Senior \$272.53, Senior family \$599.57</li> <li>○ College \$26.72 /mo.</li> <li>○ Discounts ACH's.</li> <li>○ Meeting room \$10.00/hour. Rent whole facility \$75.00/hour. Pool and lifeguard only \$45.00/hour.</li> </ul> </li> <li>• Halstad Community Center, City Hall, 405 2<sup>nd</sup> Ave. W., Halstad, MN 56548, 218-456-2338</li> <li>• Twin Valley Community Center, City of Twin Valley, 107 2<sup>nd</sup> St. SW, Twin Valley, MN 56584, 218-584-5254, Open to the public, Cost is \$25.00 for small meetings and up to \$150.00 for auctions. Benefits, WIC, etc. no charge. The community center is open in the winter for walking with no charge to the people. Open during working hours of the city employees.</li> <li>• American Legion Hall, 2758 330<sup>th</sup> St., Gary, MN 56545, 218-356-8678, free to non-profit. \$150.00 charge for all others.</li> </ul>		
		Swimming pool		



**Appendix D**  
**Essentia Health Ada, Ada, MN**  
**Available Resources 2016**

---

		<ul style="list-style-type: none"> <li>• Dekko Center, 107 4<sup>th</sup> Ave East, Ada, MN 56510, 218-784-7665</li> </ul> <p>Senior centers</p> <ul style="list-style-type: none"> <li>• Gary Senior Center, City Hall, 115 1st Ave. E., Gary, MN 56545, 218-356-8600, No charge to use facility.</li> </ul> <p>Transportation services</p> <ul style="list-style-type: none"> <li>• Heartland Express-The Bus, 209 6<sup>th</sup> St. W. Ada, MN 56510, 218-784-2656</li> <li>• Tri-Valley Family Service Center/THE BUS, Hendrum, MN 56550, 218-861-6738. Tri-Valley Public Transportation, 1345 Fairfax Ave., Crookston, MN 56716, 1-866-884-2695</li> </ul> <p>Local TV stations and other media (e.g. newspapers)</p> <ul style="list-style-type: none"> <li>• KRJB radio, 312 W. Main St., Ada, MN 56510, 218-784-2844</li> <li>• Norman County Index, 307 W. Main, Ada, MN 56510, 218-784-2541</li> <li>• Halstad Telephone Company, 345 2<sup>nd</sup> Ave. W., Halstad, MN 56548, 218-456-2125</li> <li>• Valley Journal, 301 3<sup>rd</sup> Ave. W., Halstad, MN 56548, 218-456-2133</li> <li>• Twin Valley Times, 101 Main Ave., Twin Valley, MN 56584, 218-584-5195</li> <li>• Loretel Systems, 13 E. 4<sup>th</sup> Ave., Ada, MN 56510, 218-784-5151</li> </ul>		
--	--	--	--	--



**Appendix D**  
**Essentia Health Ada, Ada, MN**  
**Available Resources 2016**

---

		<p>Grocery stores</p> <ul style="list-style-type: none"><li>• Ralph’s, 203 West Main Street, Ada, MN 56510, 218-784-2141</li><li>• Wangler’s Super Valu, 104 3<sup>rd</sup> St. W. Halstad, MN 56548, 218-456-2145</li><li>• Garberg Foods, 110 1<sup>st</sup> St. SW, Twin Valley, MN 56584, 218-584-5179</li></ul> <p>Ice skating and/or roller rinks</p> <ul style="list-style-type: none"><li>• City of Ada, 107 4<sup>th</sup> Ave. E. Ada, MN 56510, 218-784-5520</li><li>• City of Twin Valley, Lincoln Ave., Twin Valley, MN 56584, 218-584-5254</li></ul> <p>Major area employers</p> <ul style="list-style-type: none"><li>• Essentia Health, 201 9<sup>th</sup> Street, Ada, MN 56510, 218-784-5000</li><li>• Bridges Care Community, 201 9<sup>th</sup> Street West Ste 2, Ada, MN 56510, 218-784-5500</li><li>• Lutheran Memorial Nursing Homes located in Twin Valley and Halstad Nursing Home, 133 4<sup>th</sup> Ave. E. Halstad, MN 56548, 208 Oppegard Ave. Twin Valley, MN 56584. 218-584-5262.</li><li>• Ada-Borup School District, 209 6th St. West, Ada, MN 56510, 218-784-5300</li><li>• Norman County East School District, 408 Main Ave. W. Twin Valley, MN 56584, 218-584-5151</li><li>• Norman County West, 225 2<sup>nd</sup> Ave. E., Halstad, MN 56548, 218-456-2151</li><li>• Norman County, 16 3<sup>rd</sup> Ave. E. Ada, MN 56510,</li></ul>		
--	--	--	--	--



**Appendix D**  
**Essentia Health Ada, Ada, MN**  
**Available Resources 2016**

---

		<p style="text-align: center;">218-784-5473</p> <p>Ski trails and/or slopes</p> <ul style="list-style-type: none"><li>• Ski trails in Heiberg Park by Twin Valley, City of Twin Valley, 107 2<sup>nd</sup> St. SW, Twin Valley, MN 56584, 218-584-5254. Ski's stored at Buckle's Hardware, 115 Main Ave. Twin Valley, MN 58584, 218-584-5189</li><li>• One can borrow cross country skis from the Dekko with ski trail maps available.</li><li>• Bueng Hill, Hwy 29 East Side of Twin Valley, MN 56584. Open free to the public</li><li>• Dike West, Halstad, MN 56548 (sliding hill)</li><li>• ART trail goes from county line to county line through Twin Valley and Gary. This is the old railroad grade. Mainly used for snowmobile and ATV's. Could use for bikes and walking.</li></ul> <p>Kayak and boat ramp used for the public at Hieberg, Hwy 32, Twin Valley, MN 56584</p> <p>Farmers markets</p> <ul style="list-style-type: none"><li>• Laughing Earth's Farmers market, 703 4<sup>th</sup> Ave. alongside Hwy 200 in Ada every summer/fall on Friday mornings and Tuesday evenings. Laughing Earth, 703 Thorpe Ave, Ada, MN 56510, 218-784-3300</li><li>• Farmer's Market in Heiberg Park Twin Valley on Thursday nights. Contact 3389 195<sup>th</sup> Ave, MN</li></ul>		
--	--	--	--	--



**Appendix D**  
**Essentia Health Ada, MN**  
**Available Resources 2016**

		<p>56510, 218-784-2177</p> <ul style="list-style-type: none"> <li>• Hendrum Farmer’s Market, Held Monday nights in front of the fire Hall, Contact 218-861-6616 or 1354 County Hwy 21, Halstad, MN 56548, 218-456-2568</li> </ul> <p>Parks</p> <ul style="list-style-type: none"> <li>• Every community in the county has community parks which are open year round for everyone to enjoy. There are many different things at each park and all public is welcome.</li> </ul> <p>Public golf course</p> <ul style="list-style-type: none"> <li>• Heart of the Valley Golf Course, PO Box 68 , Ada, MN 56510, 218-784-4746, member run</li> </ul>		
<p><b>Local events</b></p>	<p><b>Major sporting events, festivals</b></p>	<ul style="list-style-type: none"> <li>• Norman County Fair, end of June every year, Norman County Fairgrounds, Ada, MN 56510, Fair Board President, PO Box 4, Ada, MN 56510, 218-784-4984</li> <li>• Every town in the county holds a day in honor of their town with activities for all ages</li> <li>• Norman County East Family Fair occurs every other year in April at the School. PO Box 420, Twin Valley, MN 56510, 218-584-5151.</li> <li>• City of Ada’s Fun in the Flatlands held every September. Lots of activities and events for the whole family. Run by the Ada Area Promotions Committee, 315 W. Main St. Ada, MN 56510, 218-784-3542.</li> <li>• Norman County Raceway- racing Thursday evenings 7-10PM June- September</li> <li>• National Night Out- held Aug in Ada</li> <li>• Old Fashioned Christmas Festival- held in Dec in Ada</li> </ul>		

