Overview

Essentia Health-Fosston
900 Hilligoss Blvd SE
Fosston, MN

EH Fosston 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-Fosston is a 25-bed Critical-Access hospital in Fosston, Minn. It has served the people of Polk County and surrounding communities for more than a century, providing quality health care and helping patients and their families lead active and fulfilling lives. The hospital has a primary care clinic. The facility also offers rehabilitative services, home health and hospice care. The hospital is certified as Trauma Level IV and designated as Acute Stroke Ready. Other services include obstetrics and birthing services, surgical services and urgent care.

Essentia Health-Fosston is connected with First Care Living Center, a skilled nursing facility that serves up to 50 people who need skilled care beyond the hospital and want to remain in the community. Prairie Pines Community Housing provides independent living apartments with a menu of services that can be accessed based on need.

The hospital offers care to a large geographical area in northern Minnesota, primarily serving people from Polk, Clearwater and Red Lake counties.

Essentia Health-Fosston takes community health very seriously and for past two years it has partnered with community stakeholders in an initiative called Healthier Fosston. The group’s goal is to address health in a multifaceted way that includes schools, businesses, county health department and hospital services. Interventions have included a community 5K, building a more walkable city through walking paths, and a local health fair.

LEAD PARTIES ON THE ASSESSMENT

Kevin Gish, Administrator

Ann Malmberg, Regional Director of Community Health, West Region

TABLE OF CONTENTS
Overview................................................................. 1
Essentia Health: Here With You ............................. 2
Executive Summary .............................................. 3
Progress to Date on 2013 Community Health Needs Assessment 4
Objectives .............................................................. 5
Description of Community Served ......................... 6
Description of how the Community was determined.... 6
Description of the Process and Methods used to conduct the CHNA ...................................................... 7
Phase 1: Assessment.................................................. 10
Phase 2: Prioritization.............................................. 21
Phase 3: Design of Strategy and Implementation Plan... 32
Conclusion ................................................................. 43
Appendices:
B. Polk-Norman-Mahnomen 2014 Northwest Region Adult Health Behavior Survey Summary
C. Asset Map for EH Fosston
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.

**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-Fosston, we provide health care on a daily basis to make a healthy difference in our patients' lives. We are 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 Fosston and our greater community, including Polk, Clearwater and Red Lake counties. We reviewed and discussed survey-identified priorities with our Healthier Fosston Community Group and asked them to choose the categories with the highest priority. The prioritization tool with voting and comments is attached. Two areas that had both risk and opportunity for change were chosen:

1. Physical health, with a focus on four areas: tobacco cessation, increasing physical activity, improving nutrition (promotion of a healthier lifestyle), and prenatal care.
2. Access to mental health services with emphasis on depression and other barriers to well-being and access to alcohol and drug abuse services.

Increasing physical activity and improving nutrition were prioritized in 2012 and that work will continue. Healthier Fosston wants to continue to improve the walking environment; work with both schools and seniors to improve healthier options; and evaluate and intervene where there are inadequate sources of food. The National Diabetes Prevention Plan has shown great outcomes to individuals and Essentia Health-Fosston will continue the class as a free resource to anyone with the early risk of diabetes.

Mental health is a serious health concern for our community and work is needed to ensure there is awareness of the services available. Gaps can be identified so solutions can be determined. A subcommittee of Healthier Fosston will convene both mental health providers and consumers to begin that process and assist in future planning.

Action planning around both these priorities will continue to evolve with a three-year strategy identified by this fall.

At Essentia Health-Fosston, our mission is to make a healthy difference in people’s lives. To that end, we have been doing comprehensive health care for more than a century. We’re committed to work with our partners to improve the overall health of our community.

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**Essentia Health Fosston Progress to Date on 2013 Community Health Needs Assessment**

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Obesity, physical inactivity and poor nutrition as risk factors for chronic health</th>
</tr>
</thead>
</table>
diseases such as Type 2 Diabetes.

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Adults, ages 18 and older, who are currently prediabetic or possess risk factors for developing Type 2 diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal</td>
<td>Reduce body weight and increase physical activity in program participants, thereby reducing their risk for Type 2 diabetes.</td>
</tr>
</tbody>
</table>

Obesity, lack of physical activity and poor nutrition were prioritized for Essentia Health-Fosston. The primary focus has been to provide the National Diabetes Prevention Program (NDPP) sponsored by the Centers for Disease Control and Prevention (CDC). The program is offered free to the community with particular focus on those who have prediabetes risk factors. Accomplishments to date include:

- Forty (40) participants have completed the program.
- Average weight-loss for participants was 19.57 pounds, which equates to 9.43% loss in body weight.
- After completing the year-long program, participants recorded an average of 109 minutes of physical activity per week.

Essentia Health-Fosston has done tremendous work to achieve these results. Not included in this data are classes either underway or recently launched. The hospital has done outreach for the NDPP through the newspaper, radio, referrals from providers and word of mouth. The hospital recognizes that there is an opportunity for additional outreach to the community at large. As the program’s momentum continues to grow, it is apparent that this is an ongoing need that Essentia Health-Fosston is helping to address.

Essentia Health-Fosston participates with Polk County Public Health and the Healthier Fosston community group to promote improved health and wellness. The focus of this growing initiative is to improve healthy eating habits, increase physical activity and reduce tobacco use. This group continues to meet on a regular basis and helped prioritize issues from the community needs assessment in 2012. One accomplishment of this group work is the Fit Trail, which celebrated its grand opening in 2015. The initiative was led by the Fosston Rotary Club with broad community support. This trail provides access to physical activities such as running, walking and biking. It is also handicapped-accessible, which serves senior citizens and nursing home residents. The hospital also continues to sponsor a local 5K race held in early May 2015.

Essentia Health-Fosston is a major participant in the area’s Health Fair, which was attended by 245 people last year. Essentia staff did blood sugar screenings, offered a diabetes risk assessment, took blood pressure readings and offered balance tests. We also provided information on stroke prevention, heart disease and reducing consumption of sugar beverages.

Because access to healthcare services was a community concern during the last survey, Essentia Health-Fosston has taken measures to address this issue. Dr. Brittany Beeson, a primary care physician, joined
the medical staff in Fosston last August. She cares for patients in Fosston and also provides outreach to the clinic in Bagley, Minn. An advanced practitioner will join the clinic this fall and recruiting continues for another provider.

In the last year, specialist visit days to the Fosston clinic have increased in orthopedics, cardiology and otolaryngology (ENT). Also, telemedicine capabilities are available for services such as medication management and child psychiatry.

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. Not only can we improve the health of our communities, but we can also enhance the quality of care patients receive when they are here. In conducting the Community Health Needs Assessment, Essentia Health, in a collaborative effort and through working together with our community partners has embraced the following 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, worksites, medical centers, public health) to improve community health, engagement and commitment focused on improving community health
- 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 are to:
1. Assess the health needs, disparities, assets and forces of change in the Essentia Health-Fosston 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 Community Served by Essentia Health Fosston

The community served by Essentia Health-Fosston was determined from ZIP codes in admission information. This data demonstrate that the majority of patients come from Polk (72%), Clearwater (13%), and Red Lake (4%) counties in Minnesota.

<table>
<thead>
<tr>
<th></th>
<th>Polk</th>
<th>Clearwater</th>
<th>Red Lake</th>
<th>Minn. Est. 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>31,569</td>
<td>8,838</td>
<td>4,043</td>
<td>5,457,173</td>
</tr>
<tr>
<td>Diversity</td>
<td>White 93.7% Black 1.4% American Indian 1.7%</td>
<td>White 87.2% American Indian 9%</td>
<td>White 95.2% American Indian 2.2%</td>
<td>White 85.7% Black 5.9% American Indian 1.3% Asian 4.7%</td>
</tr>
<tr>
<td>Unemployment</td>
<td>3.8%</td>
<td>10.5%</td>
<td>7.3%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Median household income in 2014 dollars, 2010-2014</td>
<td>$51,025</td>
<td>$39,924</td>
<td>$47,198</td>
<td>$60,828</td>
</tr>
<tr>
<td>Persons in poverty, percent</td>
<td>12.7%</td>
<td>17.8%</td>
<td>9.2%</td>
<td>11.5%</td>
</tr>
<tr>
<td>High school graduate or higher</td>
<td>89.6%</td>
<td>85.8%</td>
<td>90.2%</td>
<td>92.3%</td>
</tr>
<tr>
<td>Bachelor’s degree or higher</td>
<td>21.3%</td>
<td>14.2%</td>
<td>16.1%</td>
<td>29.3%</td>
</tr>
<tr>
<td>Persons under age 5</td>
<td>6.4%</td>
<td>6%</td>
<td>7.4%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Persons under age 18</td>
<td>23.4%</td>
<td>24.7%</td>
<td>24.9%</td>
<td>23.5</td>
</tr>
<tr>
<td>Persons age 65 and over</td>
<td>17.1%</td>
<td>19.5%</td>
<td>18.5%</td>
<td>14.3%</td>
</tr>
</tbody>
</table>

Data from US Census Bureau: http://quickfacts.census.gov/qfd/states/27000.html

Unemployment from MN Department of Employment and Economic Development (2015 not seasonally adjusted):
http://mn.gov/deed/data/current-econ-highlights/county-unemployment.jsp

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-Fosston must address to improve the health of the community.

Unemployment for the service area varies widely across counties and runs higher than Minnesota as a whole except for Polk County. Average household salary is also lower than the state average. This holds true for the percentage of individuals living at or below poverty with the exception of Red Lake County.
Primary barriers to care are access, including transportation challenges, and the cost of care. EH-Fosston is the only hospital in Polk County. There is an Altru Health Care clinic in Red Lake Falls and Sanford Clinic in nearby Mahnomen County. See full asset map of available resources Appendix C.

**Process Overview**

In 2014, Essentia Health-Fosston and other community partners contracted with Evaluation Group, LLC to conduct a Northwest Region Adult Health Behavior Survey. This included Polk, Red Lake and Clearwater counties. (This group also polled Norman County and data was used for Essentia Health-Ada’s CHNA report). Results were returned in March 2015. A broad stakeholder group met on Dec. 31, 2014, to review past community health initiatives, evaluate progress and identify priorities. This group included the hospitals, public health representatives, social service departments, police, sheriff departments, community stakeholders, educational representatives and representatives from non-profit organizations in Northwest Minnesota. In all, 38 people attended. This group identified priorities by voting on the top 10 identified health indicators from the survey. They were:

1. Persistent poverty
2. Resources for aging adults
3. Chronic diseases
4. Teen pregnancy
5. Childhood/adolescent obesity
6. Tobacco use
7. Drug use
8. Comorbidities
9. Positive role-models for youth
10. Fatal and serious motor vehicle crashes

(See Appendix 1, Page 3 for attendees and the Polk-Norman-Mahnomen Community Health Improvement Plan).

Health problems remain a barrier to the population as evidenced by the perception of those responding to the community survey.

<table>
<thead>
<tr>
<th><strong>Northwest Region County responses 2014</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight or obese</td>
<td>72.5%</td>
</tr>
<tr>
<td>Have been told by a healthcare provider they are overweight or obese</td>
<td>52%</td>
</tr>
<tr>
<td>Identify they are in good health</td>
<td>88%</td>
</tr>
<tr>
<td>Indicate no physical activity other than work</td>
<td>31%</td>
</tr>
<tr>
<td>Indicate they eat five or more servings of fruit and vegetables</td>
<td>36.3%</td>
</tr>
<tr>
<td>Informed by a healthcare professional they have high blood pressure (excluding pregnancy)</td>
<td>40%</td>
</tr>
<tr>
<td>Smoke (Minnesota average is 14.4%)</td>
<td>16%</td>
</tr>
<tr>
<td>Of the 63% of people who drink alcohol, the number that report binge drinking</td>
<td>30%</td>
</tr>
</tbody>
</table>
Survey information along with feedback from the broader community focus group was brought to a stakeholder group from Healthier Fosston to discuss and prioritize the best way to improve this specific service area of Polk, Clearwater and Red Lake counties. This included public health which represents those underserved, uninsured and those in poverty.

Members discussed opportunities to improve health and voted on the top two priority problems where the greatest impact could be made. Voting resulted in a focus on two areas. Physical health is a priority with emphasis on tobacco cessation, increasing physical activity, improving nutrition (promotion of a healthier lifestyle), and prenatal care. Mental health was the second highest priority and areas of concern were inadequate access, depression and other barriers to well-being, and alcohol and drug abuse. There were also a small number of votes around affordable long-term care and lack of affordable day care.

Essentia Health-Fosston will work with Healthier Fosston to address the first two priorities. While affordable long-term care and affordable day care are important, it was determined that Essentia Health-Fosston and Healthier Fosston are not able to directly impact resolution or action. For that reason, these areas will not be addressed directly through the community improvement plan.

Essentia Health-Fosston’s Community Health Needs Assessment (CHNA) 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 presented to leadership and the Board of Directors on March 28, 2016, and the West Region Board of Directors on May 17, 2016. The following page describes the assessment steps and timeline.
ASSESS (January-June 2014)
- Define Service Area
- Service Area Demographics
- Analyze Secondary Data
- Gather Community Input
- Conduct Asset Mapping of Available Community Resources
- Evaluate Progress on 2013 CHNA Priorities

PRIORITIZE (Dec. 2014-Sept. 2015)
- Set Criteria for Prioritized Needs
- Choose Prioritization Method
- Choose Needs to Address

DESIGN (Sept. 2015 to February 2016)
- Goal Setting
- Identify the "team" for each strategy
- Determine strategy options
- Choose Strategies/Programs
- Set SMART Objectives
- Design Implementation Plan and Evaluation Framework

FINALIZE (May 2016)
- Review with key stakeholders for final feedback
- Present to local Fosston Board of Directors March 28, 2016
- Present to EH West Region Board of Directors May 17, 2016
Assessment Process

Phase 1: Assessment
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 14,400 sampled households (1,200 from each county). Two weeks after the first survey, packets were mailed on 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% (4,012/14,400). Response from Polk County was 30.3%; Clearwater County, 28.5%; and Red Lake County, 30.3%.

Data Entry and Weighting
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 was 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.

<table>
<thead>
<tr>
<th>County</th>
<th>Completed Surveys</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beltrami</td>
<td>264</td>
<td>22.0%</td>
</tr>
<tr>
<td>Clearwater</td>
<td>342</td>
<td>28.5%</td>
</tr>
<tr>
<td>Hubbard</td>
<td>381</td>
<td>31.8%</td>
</tr>
<tr>
<td>Kittson</td>
<td>395</td>
<td>32.9%</td>
</tr>
<tr>
<td>Lake of the Woods</td>
<td>340</td>
<td>28.3%</td>
</tr>
<tr>
<td>Mahnomen</td>
<td>291</td>
<td>24.3%</td>
</tr>
<tr>
<td>Marshall</td>
<td>336</td>
<td>28.0%</td>
</tr>
<tr>
<td>Norman</td>
<td>379</td>
<td>31.6%</td>
</tr>
<tr>
<td>Pennington</td>
<td>295</td>
<td>24.6%</td>
</tr>
<tr>
<td>Polk</td>
<td>301</td>
<td>25.1%</td>
</tr>
<tr>
<td>Red Lake</td>
<td>364</td>
<td>30.3%</td>
</tr>
<tr>
<td>Roseau</td>
<td>324</td>
<td>27.0%</td>
</tr>
<tr>
<td>Total</td>
<td>4012</td>
<td>27.9%</td>
</tr>
<tr>
<td>Total for service area</td>
<td>1,007</td>
<td></td>
</tr>
</tbody>
</table>

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 (Behavioral Risk Factor Surveillance System through CDC), which has 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.

The convened group included public health, schools and non-profit members who represent both the general population and those underserved and in poverty. This group has been actively involved in community activities and also participated in the 2012 CHNA process.

This engaged group that meets to address community priorities has been the most positive outcome of the previous survey period. The group worked together to address, educate and promote a healthier community. Members bring resources from health care, public health, schools, the business community, and other engaged citizens. The work to date has been impactful but there is more to do. Stakeholders are meeting regularly and are driving efforts that will have continued impact over time.

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 voting sheets were provided to all stakeholders. Two areas were identified:

1. Physical Health, with a focus on tobacco cessation, increasing physical activity, improving nutrition (promotion of a healthier lifestyle) and prenatal care.
2. Mental Health, which includes inadequate access, depression and other barriers to well-being, and alcohol and drug abuse.

For the purpose of this report and in line with the hospital’s available resources, Essentia Health-Fosston will work with Healthier Fosston members on their three-year action plan that also aligns with our mission and works in those areas where there is the most likely impact. It also will work within the four Essentia Health Community Health and Wellness priorities: Healthy Choices, Mental Fitness, Community Connections and Workplace Wellness.

Essentia Health-Fosston along with Healthier Fosston has made strides on the 2012 priority of obesity, physical inactivity and poor nutrition as risk factors for chronic disease and that work will continue. Therefore, all agree that will make up the first strategy. Mental health services need to be further assessed through a broad community focus group and that will start next steps to drive improved mental health access.
Essentia Health-Fosston will participate with Healthier Fosston as the community works on long-term care and the cost of day care but will not lead these initiatives or include them in the strategy for the next three years. These are not within the organization’s direct control.

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

**SUMMARY OF COMMUNITY DEFINED PRIORITIES/STRATEGIES:** A full three year implementation plan will be finalized by November 1st, 2016.

**STRATEGIES FOR EACH PRIORITY**

<table>
<thead>
<tr>
<th>Priority: Physical Health</th>
<th>Partners: Healthier Fosston partners to include Kirsten Fagerland and Bethany Brandvold from Polk County Health; Lynae Finseth, RN; Candy Keller, RD, CDE; Devra Carlson, RN; Kristie Sveningson, RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal: Increase community engagement in physical activity.</td>
<td>Action(s): Develop a tool of resources for community use. Develop a comprehensive sidewalk plan for the city of Fosston.</td>
</tr>
</tbody>
</table>

**Strategy #1 Assess Fosston and community-wide resources and make those available to get physical activity.**

**Strategy #2 Assess and improve community nutrition options.**

<table>
<thead>
<tr>
<th>Expected Short-Term Outcomes</th>
<th>Sources of Measuring Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement in awareness of the benefit of physical exercise and nutrition on overall wellness.</td>
<td>Re-survey in one year the percentage of community receiving exercise outside of work and percentage eating the daily recommendation for fruits and vegetables.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expected Long-Term Outcomes</th>
<th>Sources of Measuring Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing trend to increase activity and improve diet.</td>
<td>Determine effectiveness of community surveys and use that or focus groups to poll improved health through exercise and diet.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority: Mental Health</th>
<th>Partners: Healthier Fosston partners to include Kirsten Fagerland and Bethany Brandvold from Polk County Health; Lynae Finseth RN; Candy Keller RD, CDE; Devra Carlson, RN; Kristie Sveningson, RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal: Improve awareness of, and access to, mental health services</td>
<td>Action(s): Gather stakeholders to a discussion about services and gaps in service. Develop a resource that identifies all these services. Discuss gaps and options to fill in those gaps.</td>
</tr>
</tbody>
</table>

**Strategy #1 Ensure there is a community-specific resource that identifies resources for mental health and ways to access those resources.**

<table>
<thead>
<tr>
<th>Expected Short-Term Outcomes</th>
<th>Sources of Measuring Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community is aware of mental health services available and ways to access them.</td>
<td>Pre- and post-survey of the Essentia Health-Fosston service area for awareness of mental</td>
</tr>
<tr>
<td>Efforts are made to fill gaps in mental health services.</td>
<td>health services.</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Expected Long Term Outcomes</td>
<td>Sources of Measuring Outcomes</td>
</tr>
</tbody>
</table>

**Conclusion**

As a not-for-profit hospital, Essentia Health-Fosston is called to make a healthy difference in people’s lives. This needs assessment and implementation plan are intended to illustrate the importance of collaboration between the hospital and community partners and outline support in order to positively impact the identified health needs specific to the service area during FY2017-2019. There are other ways in which Essentia Health-Fosston will indirectly address these priority issues along with other needs, through the provision of charity care, support of Medicaid programs, discounts to the uninsured and others. Essentia Health-Fosston will continue to engage with Healthier Fosston and the community at large to ensure that the work in the plan is relevant and effective and to modify its use accordingly.
EvaluationGroup, LLC

Polk-Norman-Mahnomen
Community Health Services

2014
NORTHWEST REGION
ADULT HEALTH BEHAVIOR SURVEY SUMMARY

March
2015

Authored by
Garth Kruger, Ph.D.
Executive Summary

- 72.5% of individuals residing in the Polk, Norman Mahnomen county region are considered either overweight (35.9%) or obese (36.6%).
  - This is higher than the state average of 64% (37.5 overweight; 26.5%, obese).

- Only a total of 52% 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 respondents indicated they had good health, yet 72% of them were overweight or obese.
  - This raises the question of peoples’ understanding of what constitutes good health.

- Over the three-county region, only an estimated 15% of individuals are getting their recommended levels of physical activity whereas 85% are not.
  - 31% percent of survey respondents indicated no physical activity. The state average on this measure is approximately 13%.

- A total of 36.3% of adults eat five or more servings of fruit and vegetables combined per day which is the daily recommended intake. That total rises to 68.2% if you include those who get 3-4 servings a day.

- 40% 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).
  - 31% had been informed they had elevated cholesterol.

- Of the 63% of respondents who consumed alcoholic beverages during the 30 days preceding the survey, 30% 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 16% of adults in the Region are smokers. Mahnomen County has the highest rates at 20.5%. These findings are above the state average of 14.4%.
  - 51.4% 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.

- 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.
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

<table>
<thead>
<tr>
<th>Chronic Health Conditions</th>
<th>No %</th>
<th>Yes %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight</td>
<td>59.8</td>
<td>40.2</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>59.5</td>
<td>39.8</td>
</tr>
<tr>
<td>High cholesterol or triglycerides</td>
<td>68.7</td>
<td>31.3</td>
</tr>
<tr>
<td>Arthritis</td>
<td>73.0</td>
<td>27.0</td>
</tr>
<tr>
<td>Depression</td>
<td>78.4</td>
<td>21.6</td>
</tr>
<tr>
<td>Anxiety or panic attacks</td>
<td>80.7</td>
<td>19.3</td>
</tr>
<tr>
<td>Asthma</td>
<td>85.9</td>
<td>14.1</td>
</tr>
<tr>
<td>Obesity</td>
<td>87.2</td>
<td>12.8</td>
</tr>
<tr>
<td>Heart trouble or angina</td>
<td>88.2</td>
<td>11.8</td>
</tr>
<tr>
<td>Diabetes</td>
<td>88.7</td>
<td>10.6</td>
</tr>
<tr>
<td>Cancer</td>
<td>92.7</td>
<td>7.3</td>
</tr>
<tr>
<td>Other mental health</td>
<td>94.2</td>
<td>5.8</td>
</tr>
<tr>
<td>Chronic lung disease</td>
<td>94.8</td>
<td>5.2</td>
</tr>
<tr>
<td>Stroke or stroke-related problems</td>
<td>97.5</td>
<td>2.5</td>
</tr>
</tbody>
</table>
**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, 72.5% of individuals residing in the Polk, Norman Mahnomen county region are considered either overweight (35.9%) or obese (36.6%). This is higher than the state average of 64% (37.5 overweight; 26.5%, obese).

Room for improvement appears to exist in providing feedback to patients about their weight. While 72.5% of survey respondents were overweight/obese, only a total of 52% 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.

Regardless, respondents perceptions of what constitutes health seem to be skewed because 88% of them responded that they had good health yet 72% are overweight/obese. This raises the 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.

Figure 3

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 40% of respondents reported having been informed by a healthcare provider they had high blood pressure (non-pregnancy related). Thirty-one 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.
Because high blood pressure and cholesterol are only pre-cursor indicators, elevations are not a guarantee of heart problems. Twelve 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 1,000 people and for Norman-Mahnomen in the 1.53 per 1,000. 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.

| Age-Adjusted Estimates of the Percentage of Adults with Diagnosed Diabetes in Minnesota |
|-----------------------------------|---------------------------------|-----------------|-----------------|
|                                   | 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.
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 7% reported having ever been diagnosed with cancer. (Mahnomen=10%, Norman=8.8%, and Polk=6.5).

**Table 3**

<table>
<thead>
<tr>
<th>Cancer Age Adjusted Death Rates per 1,000 people</th>
<th>2006-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>1.7</td>
</tr>
<tr>
<td>Polk</td>
<td>1.7</td>
</tr>
<tr>
<td>Norman-Mahnomen</td>
<td>2.1</td>
</tr>
</tbody>
</table>

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-one 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
equivalent combination of moderate- and vigorous intensity aerobic activity\(^1\).

Over the three-county region, only an estimated 15% of individuals are getting their recommended levels of physical activity; whereas 85% 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 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 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

\[\text{http://www.health.gov/paguidelines/guidelines/summary.aspx}\]
**Nutrition**

A total of 36.3% of adults eat five or more servings of fruit and vegetables combined per day which is the daily recommended intake. That total rises to 68.2% if you include those who get 3-4 servings a day, which is just below the recommended intake.

This data suggests that two-thirds of the population in the region gets a fair amount of nutritious food. Results 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, fewer fruits appear to be eaten than vegetables. One possible reason for this may be that locally grown vegetables occur more often through one’s own garden or are available for purchase at local farmer’s markets. Vegetables are also generally easier to store in their raw state for longer periods of time.

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 the three-county region, 51.4% 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>
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<th>Table 4</th>
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<td></td>
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<td>Current smokers</td>
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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 this 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.
**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 37% 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 7% 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, thirty percent of respondents were binge drinkers.
Mental Health

Approximately 19-22% of individuals living in the Region 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 region indicated transportation was a problem, although in Mahnomen County this was much higher (28%). Also, costs in Norman and Mahnomen were cited more frequently at 25% and 35% respectively.

Similarly, over the past 30 days, 19% of respondents expressed feelings of hopelessness, anxiety or loss of interest in things they used to enjoy. On a positive note, only 6% 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 have been shown to help improve physical and mental health. While not all individuals with depression or anxiety will be impacted, it provides a place to start.
Methods

Survey Instrument

Staff from the public health agencies representing Beltrami, Clearwater, Hubbard, Kittson, Lake of the Woods, Mahnomen, 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 scannable, 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.
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.

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

**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

Polk County Public Health
Norman-Mahnomen Public Health
# TABLE OF CONTENTS

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

<table>
<thead>
<tr>
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<th>Organization</th>
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“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 Mahnomen County Residents,

The 2015 Polk-Norman-Mahnomen 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 Mahnomen 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-Mahnomen 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 Mahnomen 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 Mahnomen 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 Mahnomen counties.
POLK-NORMAN-MAHNONEN COMMUNITY HEALTH SERVICES

The Polk-Norman-Mahnonen Community Health Services (PNM CHS) comprised of Polk County Public Health (PCPH) and Norman-Mahnonen 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 on the county websites of each county:

- Polk County: www.co.polk.mn.us
- Norman County: www.co.norman.mn.us
- Mahnomen County: www.co.mahnomen.mn.us
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 PRIORITZATION 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 Mahnomen 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.

<table>
<thead>
<tr>
<th>Icon</th>
<th>Priority 1: DECREASE PERSISTENT POVERTY</th>
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<tbody>
<tr>
<td>![Heart Icon]</td>
<td>Priority 2: COORDINATION OF BEHAVIORAL AND PHYSICAL HEALTH SERVICES</td>
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<tr>
<td>![Compass Icon]</td>
<td>Priority 3: POSITIVE SOCIAL CONNECTIONS FOR YOUTH</td>
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</tbody>
</table>
In reviewing the prioritization results and a subsequent facilitated discussion\(^1\), 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 with health equity 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 longed 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” 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?*

<table>
<thead>
<tr>
<th>GOALS</th>
<th>OBJECTIVES</th>
<th>STRATEGIES</th>
<th>LEAD (BOLD) PARTNER or SUPPORT ORGANIZATION</th>
</tr>
</thead>
</table>
| Goal Collaboration | Increase partnerships between organizations addressing poverty | 1. Establish clarity of objectives  
2. Assess trust using the organizational “Trust Scale”\(^5\)  
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 | ✓ Community Action Agencies  
✓ Social/human services  
✓ Public Health  
✓ Behavioral health  
✓ Clergy  
✓ Hospitals/ clinics  
✓ Schools  
✓ Businesses  
✓ Law Enforcement |
| Increase the number of agencies and organizations that are formal partners in the ongoing Community Health Improvement process | 1. Explore\(^6\) Why? Articulate why this is important. Assess trust using the organizational “Trust Scale”  
What? Goals being considered (functions/programs/capacity). How can we mitigate current gaps?  
Who? Partners that should be involved and how  
2. Prepare and Plan How exactly will it work? Establish clarity of | ✓ Public Health  
✓ Hospitals/ clinics  
✓ Community Action Agencies  
✓ Behavioral health  
✓ Social/ human services  
✓ Schools  
✓ Businesses |
<table>
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<tbody>
<tr>
<td><strong>Goal</strong>&lt;br&gt; All people have opportunity for increased living wage jobs &amp; resources that meet their family’s needs</td>
<td>Enhance partnerships for increased qualified candidates for employment thru workforce development (school/college/community)</td>
<td><strong>1. Explore</strong>&lt;br&gt; Why? Articulate why this is important (cycle of poverty, local needs, Private vs. Public)&lt;br&gt; <strong>What?</strong> Goals being considered (functions/programs/capacity). (such as career academies*, career pathway and bridge programs*, dropout prevention programs*)&lt;br&gt; (*Scientifically Supported- County Health Rankings?)&lt;br&gt; <strong>How can we mitigate current gaps?</strong>&lt;br&gt; <strong>Who?</strong> Partners that should be involved and how</td>
<td>✓ Community Action Agencies&lt;br&gt; ✓ Hospitals/clinics&lt;br&gt; ✓ Behavioral Health&lt;br&gt; ✓ Public Health&lt;br&gt; ✓ Employers&lt;br&gt; ✓ Northwest Council of Collaboratives members&lt;br&gt; ✓ Northwest Minnesota Foundation&lt;br&gt; ✓ Workforce Development Center&lt;br&gt; ✓ Higher Education&lt;br&gt; ✓ Northwest Services Cooperative&lt;br&gt; Adult Basic Education</td>
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<td></td>
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<td><strong>2. Prepare and Plan</strong>&lt;br&gt; 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</td>
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<td></td>
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<td><strong>3. Implement and</strong></td>
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Polk-Norman-Mahomen Community Health Services Community Health Improvement Plan
2015-2019
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<thead>
<tr>
<th>GOALS</th>
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<td></td>
<td></td>
<td>monitor</td>
<td>✓ Community Action Agencies</td>
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<td></td>
<td></td>
<td>4. Support Northwest Council of Collaboratives current efforts</td>
<td>✓ NW Regional Development Commission</td>
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<td></td>
<td>5. Support NW MN Foundation- Impact 20/20 Initiative- currently hosts workforce and education taskforces</td>
<td>✓ Headwaters Regional Development Commission</td>
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<tr>
<td></td>
<td>Increased quantity and quality of safe, affordable housing</td>
<td>1. Use RBA to Explore Why? Assess future needs, priorities and barriers</td>
<td>✓ NW Minnesota Foundation</td>
</tr>
<tr>
<td></td>
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<td>What? Healthy, safe and affordable housing</td>
<td>✓ HUD</td>
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<td>Who?</td>
<td>✓ Economic Development</td>
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<td></td>
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<td>-Support and learn from Tri-Valley’s housing feasibility study currently underway in Crookston</td>
<td>✓ City Planning and Zoning</td>
</tr>
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<td></td>
<td>-Engage NW Regional Development Commission, Headwaters Regional Development Commission and NW MN Foundation regarding their regular communication about affordable housing</td>
<td>✓ Public Health-Healthy Homes</td>
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<td>2. Prepare and Plan How exactly will it work utilizing a healthy equity lens?</td>
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<td>-Support Public Health’s Healthy Homes grant to complete 100 Healthy</td>
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<tr>
<td>GOALS</td>
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<td>Homes assessment and mitigate hazards as applicable 3. Implement and monitor</td>
<td>✓ Community Action Agencies ✓ Wellness Coalitions/ Workgroups ✓ City ✓ Employers ✓ Transit Services ✓ Public Health-Statewide Health Improvement Program Safe Routes ✓ Transportation engineers ✓ Clergy</td>
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<td>Increased safe and affordable modes of transportation and non-motorized safe routes</td>
<td>1. Use RBA to Explore-Motorized transportation and non-motorized safe routes Why? What? Who? 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 3. Implement and monitor</td>
<td>✓ Community Action Agencies ✓ Wellness Coalitions/ Workgroups ✓ City ✓ Employer ✓ Transit Services ✓ Public Health-Statewide Health Improvement Program Safe Routes ✓ Transportation engineers ✓ Clergy</td>
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<td></td>
<td>Increased access and decreased barriers to childcare services</td>
<td>1. Explore – Use RBA to explore current situation and desired outcomes for feasibility Why? What? Who? (such as increased funding for childcare subsidy*) -Support Community Action Agencies: Child Care Aware, Head Start and transportation options -Engage with NW MN</td>
<td>✓ Community Action Agencies ✓ Human/ Social Services ✓ Employers ✓ NW MN Foundation ✓ Child Care Assistance Program ✓ MN Dept of Education, ✓ MN Dept of Health</td>
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<tr>
<td>GOALS</td>
<td>OBJECTIVES</td>
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<td>LEAD (BOLD) PARTNER or SUPPORT ORGANIZATION</td>
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</table>
| Goal Reduce stress        | Increased focus on stress management (including financial literacy and      | 1. Use RBA to Explore Why? What? Who?  
| associated with poverty    | overall mental health)                                                      | 2. Prepare and Plan How exactly will it work?  
|                            |                                                                             | 3. Implement and monitor  
|                            |                                                                             | -Support Family Assets for Independence in Minnesota (FAIM)\(^9\) which connects low-income Minnesotans with asset building opportunities through the innovative use of Individual Development Accounts (IDAs), |
|                            |                                                                             | ✓ Behavioral health  
|                            |                                                                             | ✓ Human/ Social Services  
|                            |                                                                             | ✓ Public Health  
|                            |                                                                             | ✓ Hospitals/clinics  
|                            |                                                                             | ✓ Community Action Agencies  
|                            |                                                                             | ✓ Employers  
|                            |                                                                             | ✓ Wellness Coalitions/ Workgroups  
|                            |                                                                             | ✓ Clergy |
|                            |                                                                             | -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 childcare |
|                            |                                                                             | ✓ Children’s Finance  
|                            |                                                                             | ✓ Childcare Licensors  
|                            |                                                                             | ✓ Childcare Associations |
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)
   - 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
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)
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 preventatives 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 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” 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.

<table>
<thead>
<tr>
<th>The SHIP Model: Improving health by increasing opportunities for healthy choices</th>
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<tbody>
<tr>
<td>Increased opportunities for physical activity, nutritious food and tobacco-free living...</td>
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</table>
### 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/Roll 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?

<table>
<thead>
<tr>
<th>GOALS</th>
<th>OBJECTIVES</th>
<th>STRATEGIES</th>
<th>LEAD ROLE PARTNER or SUPPORT ORGANIZATION</th>
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</thead>
<tbody>
<tr>
<td>Goal Achieve the Institutes for Healthcare Improvement’s Triple Aim: • Improve the health of the population; • Improve the patient/consumer experience; and • Improve the affordability of health care</td>
<td>Enhance coordination and integration of clinical, behavioral, and complementary health services.</td>
<td>1. Explore - Implement/ support effective care coordination models (i.e. medical homes12, behavioral healthcare homes, etc)* (<em>Scientifically Supported- County Health Rankings) - Integrate behavioral health into primary care practice</em> - Reference Community Measures - Social Services and Public Health professionals to work closely with providers in a way that is mutually beneficial</td>
<td>√ Hospital/Clinics √ Behavioral Health √ Public Health √ Social/Human Services</td>
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<td></td>
<td></td>
<td>2. Prepare and Plan How exactly will it work?</td>
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<td></td>
<td>3. Implement and monitor</td>
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<td></td>
<td>Electronic health information exchange*- Prepare and implement the NW Minnesota E-Health Initiative</td>
<td></td>
<td>√ Stratis Health √ NW Mental Health Center √ E-Health Collaborative</td>
</tr>
<tr>
<td>GOALS</td>
<td>OBJECTIVES</td>
<td>STRATEGIES</td>
<td>LEAD ROLE PARTNER or SUPPORT ORGANIZATION</td>
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<td>(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)</td>
<td>Partners</td>
</tr>
<tr>
<td></td>
<td>1. Explore -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*). -Computerized clinical decision support systems* -Reference Community Measures</td>
<td>✓ Hospital/Clinics ✓ Public Health ✓ Behavioral Health ✓ Social/Human Services ✓ Clergy</td>
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<td></td>
<td>2. Prepare and Plan How exactly will it work? -Motivational interviewing –patient shared decision making* -Focus on holistic health</td>
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<td>3. Implement and monitor</td>
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<td>GOALS</td>
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<tr>
<td>Reduce the gaps in services and resources and increase the utilization of services and resources.</td>
<td>1. Explore - Increased network of systems navigators(^{13}) Individuals in each agency increase access to and support for utilizing resources to engage in healthy behaviors and preventative care.* (<em>County Health Rankings Evidence Based/Promising Strategy). -Support implementation of community-based preventive services and enhance linkages with primary care</em> (i.e. tobacco cessation; quitline and asthma home environment intervention program linked to clinicians as referral points). -Reference Community Measures Why? What? Who?</td>
<td>✓ Hospital/Clinics ✓ Public Health ✓ Behavioral Health ✓ Social/Human Services</td>
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<tr>
<td>Increase population’s understanding of the benefits of preventative care and reduce stigma</td>
<td>1. Use RBA to Explore Why? What? Who? -Identify community events that reach out to target population -Seek ways to integrate recommended</td>
<td>✓ Behavioral Health ✓ Public Health ✓ Hospital/Clinics ✓ Social/Human Services ✓ Community Action Agencies</td>
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<tr>
<td>GOALS</td>
<td>OBJECTIVES</td>
<td>STRATEGIES</td>
<td>LEAD ROLE Partner or SUPPORT Organization</td>
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<td>related to A) having mental illness and B) seeking care for mental illness while reducing cultural and health literacy barriers</td>
<td>preventive care services and expand health literacy. - Offer Mental Health First Aid training 2. Prepare and Plan How exactly will it work? 3. Implement and monitor</td>
<td>✅ Law Enforcement ✅ Clergy ✅ Schools</td>
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<tr>
<td>Goal Make it easier for residents to walk, bike, and wheel to everyday destinations</td>
<td>1. Explore Why? What? Who? (such as improve streetscape design*, point of decision prompts*, land use master plans*) 2. Prepare and Plan How exactly will it work? 3. Implement and monitor</td>
<td>✅ City ✅ Public Health (SHIP) ✅ Wellness Coalitions/ Workgroups ✅ Schools ✅ City and County Building/ Zoning/GIS ✅ Regional Development Commission ✅ Employers</td>
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<tr>
<td>Encourage active living at work</td>
<td>1. Use RBA to Explore Why? What? Who? (such as worksites that have adopted policies supporting physical activity*) 2. Prepare and Plan How exactly will it work? 3. Implement and monitor</td>
<td>✅ Public Health ✅ Employers ✅ Hospital/Clinics ✅ Schools ✅ County/City Wellness Coalitions ✅ Clergy</td>
<td></td>
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<tr>
<td>Increased access to healthy foods</td>
<td>1. Use RBA to Explore Why? What? Who? (such as policies and environments)</td>
<td>✅ Public Health ✅ NW Regional Sustainable Development</td>
<td></td>
</tr>
</tbody>
</table>
### GOALS

**Goal**
Prevent and address alcohol, tobacco and other drug (ATOD) use

### OBJECTIVES

Convene ATOD stakeholders to create a county-wide strategy to prevent and address ATOD use and misuse

### STRATEGIES

1. Explore
   - Why? What? Who?
2. Prepare and Plan
   - How exactly will it work?
3. Implement and monitor
   - Apply for funding that supports preventing and addressing ATOD use and misuse

### LEAD ROLE PARTNER or SUPPORT ORGANIZATION

- **Partnership**
  - UMN Extension
  - Employers
  - Breastfeeding Coalition
  - Wellness Coalition/Workgroups
  - Food Bank/Food Shelf
  - Clergy

- **Public Health**
- Wellness Coalitions/Workgroups
- Behavioral Health
- 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?

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<tr>
<th>GOALS</th>
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<th>LEAD ROLE, PARTNER or SUPPORT ORGANIZATION</th>
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<tbody>
<tr>
<td>Goal</td>
<td>Increase social connectedness/developmental relationships among youth</td>
<td>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) (*Scientifically Supported-County Health Rankings) 2. Implement and monitor</td>
<td>✓ Behavioral Health ✓ Schools ✓ Law enforcement ✓ Mentors ✓ Public Health ✓ Clergy</td>
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<td></td>
<td>Support and promote current extracurricular activities and afterschool programs When applicable, examine underutilization through RBA.</td>
<td></td>
<td>✓ Schools ✓ Activities Directors ✓ Parks and Recreation ✓ Clergy ✓ Mentors</td>
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<tr>
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<td>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</td>
<td></td>
<td>✓ Schools ✓ Behavioral Health ✓ NW MN Foundation ✓ Law enforcement ✓ Public Health ✓ Social/Human Services</td>
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<td>GOALS</td>
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<td>Increase health-related self-efficacy among children and their caregivers&lt;sup&gt;15&lt;/sup&gt;</td>
<td>Provide individuals with knowledge, skills, and self-esteem through: -Parent and family skill based support programs that support positive family interactions* (such as school based mental health services) -School based programs to reduce violence and bullying* (such as the DARE program - currently implemented in East Grand Forks by Police Department) -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 -Support NW MN Foundation’s offering of “Social and Emotional Learning” Trainings for school staff</td>
<td>✓ Behavioral Health ✓ Schools ✓ Public Health-Family Home Visiting ✓ Community Action</td>
</tr>
<tr>
<td>GOALS</td>
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</table>
|       |            | 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 Partnership16* (2015- PNM CHS plans to expand NFP into Polk County) | ✓ Public Health  
✓ Community Action Agencies  
✓ 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)* | ✓ Community Action Agencies  
✓ Early Childhood Family Education  
✓ 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 social connectedness within organizations, the communities, and across the county’s | ✓ Public Health  
✓ City’s  
✓ UMN Extension  
✓ Behavioral Health  
✓ Social/Human Services  
✓ Schools  
✓ Clergy |
|       |            | 1. Explore and identify the adaptive challenges to improving social connectedness, cultural inclusion, and better health and wellness in the organizations and communities  
Why? What? Who?  
2. Prepare and Plan How exactly will it work?  
3. Implement and monitor | |

*(Note: * denotes initiatives and programs that require additional funding or resources for implementation.)

Polk-Norman-Mahnomen Community Health Services Community Health Improvement Plan 2015-2019
<table>
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<tr>
<th>GOALS</th>
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<th>LEAD ROLE, PARTNER or SUPPORT ORGANIZATION</th>
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| 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. | 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 | ✓ Behavioral Health  
✓ Public Health  
✓ Northwest Council of Collaborative Partners  
✓ Hospital/Clinics  
✓ Employers |
| Increased connection of people to resources | 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 | ✓ Northwest Council of Collaborative Partners  
✓ Hospital/Clinics  
✓ Employers |
Outcome Indicators

1. 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

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.
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:

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

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

4 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.

5 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/

6 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/
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.

<table>
<thead>
<tr>
<th>Health Behaviors (30%)</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Tobacco Use</td>
<td></td>
</tr>
<tr>
<td>Diet &amp; Exercise</td>
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</tr>
<tr>
<td>Alcohol &amp; Drug Use</td>
<td></td>
</tr>
<tr>
<td>Sexual Activity</td>
<td></td>
</tr>
<tr>
<td>Clinical Care (20%)</td>
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<tr>
<td>Access to Care</td>
<td></td>
</tr>
<tr>
<td>Quality of Care</td>
<td></td>
</tr>
<tr>
<td>Social &amp; Economic Factors (40%)</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td></td>
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<tr>
<td>Income</td>
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<tr>
<td>Family &amp; Social Support</td>
<td></td>
</tr>
<tr>
<td>Community Safety</td>
<td></td>
</tr>
<tr>
<td>Physical Environment (10%)</td>
<td></td>
</tr>
<tr>
<td>Air &amp; Water Quality</td>
<td></td>
</tr>
<tr>
<td>Housing &amp; Transit</td>
<td></td>
</tr>
</tbody>
</table>

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, Mahnomen, 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.

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.

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](https://www.health.state.mn.us/communities/practice/healthymnpartnership/docs/2017MNStatewideHealthAssessment.pdf)

11 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](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](https://www.health.state.mn.us/docs/communities/ace/acesum.pdf)

12 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:
Polk-Norman-Mahnomen Community Health Services Community Health Improvement Plan 2015-2019
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.

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.

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

15 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.

16 Nurse Family Partnership is offered in Norman and Mahnomen 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?*

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>STRATEGIES</th>
<th>Lead Organization</th>
<th>Partner Organization</th>
<th>Support Organization</th>
</tr>
</thead>
</table>
| 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 | | | |
### Hospitals

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Address</th>
<th>Town</th>
<th>State</th>
<th>Zip</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Altru Hospital</td>
<td>1200 S. Columbia Rd</td>
<td>Grand Forks</td>
<td>ND</td>
<td>58201</td>
<td>701-780-5000</td>
</tr>
<tr>
<td>Essentia Health Fosston</td>
<td>900 Hilligoss Blvd SE</td>
<td>Fosston</td>
<td>MN</td>
<td>56542</td>
<td>218-435-1133</td>
</tr>
<tr>
<td>Mahnomen Health Center</td>
<td>414 West Jefferson</td>
<td>Mahnomen</td>
<td>MN</td>
<td>56557</td>
<td>218-935-2511</td>
</tr>
<tr>
<td>Riverview Health</td>
<td>323 S. Minnesota St.</td>
<td>Crookston</td>
<td>MN</td>
<td>56716</td>
<td>218-281-9200</td>
</tr>
<tr>
<td>Sanford Bagley Medical Center</td>
<td>203 4th St NW</td>
<td>Bagley</td>
<td>MN</td>
<td>56621</td>
<td>218-694-6501</td>
</tr>
<tr>
<td>Sanford Thief River Falls Medical Center</td>
<td>120 Labree Ave S.</td>
<td>Thief River Falls</td>
<td>MN</td>
<td>56701</td>
<td>218-681-4240</td>
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### Clinics

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<tr>
<th>Clinics</th>
<th>Address</th>
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<th>Zip</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Altru Care</td>
<td>1140 Vanrooy Dr.</td>
<td>Thief River Falls</td>
<td>MN</td>
<td>56701</td>
<td>218-681-2225</td>
</tr>
<tr>
<td>Altru Main Clinic</td>
<td>1000 S Columbia Rd</td>
<td>Grand Forks</td>
<td>ND</td>
<td>58201</td>
<td>701-780-6000</td>
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<tr>
<td>Altru Clinic Crookston</td>
<td>400 S Minnesota St.</td>
<td>Crookston</td>
<td>MN</td>
<td>56716</td>
<td>218-281-9100</td>
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<tr>
<td>Altru Clinic Erskine</td>
<td>23076 347th St. SE</td>
<td>Erskine</td>
<td>MN</td>
<td>56535</td>
<td>218-687-5317</td>
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<tr>
<td>Altru Clinic Fertile</td>
<td>Mills St. &amp; Main Ave.</td>
<td>Fertile</td>
<td>MN</td>
<td>56540</td>
<td>218-945-6064</td>
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<tr>
<td>Altru Clinic Red Lake Falls</td>
<td>312 International Dr.</td>
<td>Red Lake Falls</td>
<td>MN</td>
<td>56750</td>
<td>218-253-4343</td>
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<tr>
<td>Location</td>
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<td>Essentia Health Fosston</td>
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<td>Fosston</td>
<td>MN</td>
<td>56542</td>
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</tr>
<tr>
<td>Essentia Health Bagley</td>
<td>121 Central St.</td>
<td>Bagley</td>
<td>MN</td>
<td>56621</td>
<td>218-694-6281</td>
</tr>
<tr>
<td>Essentia Health Oklee</td>
<td>Governor St. &amp; 3rd Ave</td>
<td>Oklee</td>
<td>MN</td>
<td>56742</td>
<td>218-796-4525</td>
</tr>
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<td>Riverview Clinics Crookston</td>
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<td>56540</td>
<td>218-945-6695</td>
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<td>Riverview Clinics Red Lake Falls</td>
<td>Park Place Mall</td>
<td>Red Lake Falls</td>
<td>MN</td>
<td>56750</td>
<td>218-253-4606</td>
</tr>
<tr>
<td>Riverview Clinics East Grand Forks</td>
<td>1428 Central Ave NE</td>
<td>East Grand Forks</td>
<td>MN</td>
<td>56721</td>
<td>218-773-1390</td>
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<tr>
<td>Sanford Health Mahnomen Clinic</td>
<td>410 W.4th St.</td>
<td>Mahnomen</td>
<td>MN</td>
<td>56557</td>
<td>218-935-2514</td>
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<tr>
<td>Sanford Thief River Falls</td>
<td>3001 Sanford Parkway</td>
<td>Thief River Falls</td>
<td>MN</td>
<td>56701</td>
<td>218-681-4747</td>
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<td>Sanford Bagley Clearbrook Clinic</td>
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<td>Clearbrook</td>
<td>MN</td>
<td>56634</td>
<td>218-776-3124</td>
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<td>Sanford Bagley Clinic</td>
<td>123 4th St. NW</td>
<td>Bagley</td>
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**Dentists**

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<th>Zip Code</th>
<th>Phone</th>
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<tr>
<td>Albright &amp; Nelson Dental Clinic</td>
<td>201 Hillestad Ave N</td>
<td>Fosston</td>
<td>MN</td>
<td>56542</td>
<td>218-435-1717</td>
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<td>Sandwick Orthodontics</td>
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<td>Fosston</td>
<td>MN</td>
<td>56542</td>
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<td>Sjulson Family Dentistry</td>
<td>109 N Johnson Ave</td>
<td>Fosston</td>
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<td>56542</td>
<td>218-435-1599</td>
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### Churches

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<th>Zip</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Baptist Church Fosston/New Journey Church</td>
<td>505 9th St. NW</td>
<td>Fosston</td>
<td>MN</td>
<td>56542</td>
<td>218-435-6338</td>
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<tr>
<td>Bethel Assembly Church</td>
<td>34647 410th St. SE</td>
<td>Fosston</td>
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<tr>
<td>Calvary Free Lutheran Church</td>
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<td>Fosston</td>
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<td>218-435-1590</td>
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<tr>
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<td>Fosston</td>
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<tr>
<td>Hope Lutheran Church</td>
<td>508 N Foss Ave</td>
<td>Fosston</td>
<td>MN</td>
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<tr>
<td>Kingo Lutheran Church</td>
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<td>Fosston</td>
<td>MN</td>
<td>56542</td>
<td>218-435-6331</td>
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<tr>
<td>Poplar Lake Lutheran Church</td>
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<td>Fosston</td>
<td>MN</td>
<td>56542</td>
<td>218-668-2288</td>
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<tr>
<td>St. Mary's Church Parish</td>
<td>725 6th NE</td>
<td>Fosston</td>
<td>MN</td>
<td>56542</td>
<td>218-435-6484</td>
</tr>
</tbody>
</table>

### Polk County Public Health

- **Address:** PO Box 403
- **City:** Crookston
- **State:** MN
- **Zip:** 56712
- **Phone:** 218-281-3385

### Polk County Social Services

- **Address:** 104 N Kaiser Ave
- **City:** Fosston
- **State:** MN
- **Zip:** 56542
- **Phone:** 218-435-1585

### Northwest Regional Development Commission

- **Address:** 115 South Main, Suite 1
- **City:** Warren
- **State:** MN
- **Zip:** 56762
- **Phone:** 800-333-2433, 218-745-6733
Serious Health Conditions Related to Being Overweight

- Diabetes (Type 2)
- High Blood Pressure
- Heart Disease and Stroke
- Elevated LDL "Bad" Cholesterol and Triglycerides
- Cancer (Colon, Breast, Uterine, and Prostate)
- Osteoarthritis (Knees, Hips)
- Sleep Apnea and Other Respiratory Problems
- Gallbladder Disease
- Low Back Pain
- Depression and Low Self-Esteem
- Social Discomfort

COMMUNITY RESOURCES

Indoor Walking
Fertile School (Open Fall-Winter): 218-945-6983
Fosston High School: 218-435-1909
McIntosh Community Center: 218-563-3043
Oklee Public School: 218-796-5136
Win-E-Mac School: 218-687-2236
Winger Community Center: 218-938-4150

Outdoor Walking/Biking
Rydell Wildlife Refuge – 7 Miles of Trails

Bone Builders
Erskine – Community Center: 218-687-4646
Fertile – Community Center: 218-945-3136
Fosston – Civic Center/Glass Room: 218-435-6434
Lenby – Community Center: 218-668-2219
McIntosh – Poplar Meadows: 218-563-2436

Fitness Centers
Fosston – Anytime Fitness
McIntosh – Shape It Up Fitness
Mentor – Some Exercise Equipment available in Mentor School

Exercise for Chronic Disease
Essentia Health – Fosston with Provider’s Prescription

Nutrition
T.O.P.S Brooks – Third Base
Weight Watchers – Fosston High School

Senior Nutrition Program Sites
Crookston – Meals served Monday thru Friday.
Congregate site at the Golden Link.
Crookston Diners Club – Located at RBJ’s Restaurant.
Served Monday thru Sunday.
Erskine – Meals are provided Monday thru Friday at the Community Center.
Fertile Diners Club – Located at LoLa ice Cream,
Coffee and Grill. Meals served from 11:30-1:30
Monday thru Friday.
Fosston – Meals served Monday, Tuesday and Thursday at the Embassy Community Center.

Gulley Senior Meals
McIntosh – Meals served Monday thru Friday from 11:30-1:30 at BB Café.
Mentor – Meals are satellite from the Erskine site
Monday thru Friday.
Winger Diners Club – Meals are served at the Depot Café and Patio Monday thru Friday.

Minnesota’s Vision
A Better State of Health
SHIP
Statewide Health Improvement Program

Essentia – Fosston, MN