We are of this place, not just from it.

COMMUNITY HEALTH NEEDS ASSESSMENT

FY 2020-2022

Essentia Health-Ada
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Appendix A – 2017 PNM Regional Report
Appendix B – 2016 Tri-Valley Community Needs Assessment
Appendix C – PNM CHB 2018 CHIP Annual Report
Lead parties on the assessment

Erin Stoltman- Administrator, Essentia Health-Ada

Karen Pifher- Community Health Program Manager

Acknowledgements

This report is based on a collaborative process with the following community members and organizations. Essentia Health would like to express our gratitude to the many steering committee members and community members for their contribution to planning, development, and analysis of community health needs. Additional thanks to the community members who shared their expertise and helped us include the voices of diverse sectors of our community.

- Statewide Health Improvement Partnership
- Polk-Norman-Mahnomen Public Health
- All Partners Collaborative
- Norman County Social Services
- Northwestern Mental Health
- Tri-Valley Opportunity Council
- Area Agency on Aging
- Norman County Sheriff’s Department
- City of Ada
- Ada Alive
- Norman County Collaborative
- IMPACT coalition
- Northwest Minnesota Foundation
- Norman County East School District
- Ada-Borup School District
- University of Minnesota Extension Service
- Wild Rice Lutheran Church
- Ada Police Department
- Tri County Community Corrections
- Dekko Community Center
- 4-H
Executive Summary

Essentia Health-Ada is part of Essentia Health, a nonprofit, integrated health system caring for patients in Minnesota, Wisconsin, North Dakota and Idaho. Essentia Health is called to make a healthy difference in people’s lives. To fulfill that mission, we seek opportunities to both enhance the care we provide and improve the health of our communities.

Every three years, each Essentia Health hospital conducts a Community Health Needs Assessment (CHNA) to systematically identify, analyze and prioritize community health needs. The process is conducted in collaboration with many community partners including other health care systems, local public health departments, and organizations or individuals that represent broad interests in the community, including members of medically underserved, low-income, and populations at higher health risk.

Once priority health needs are identified, Essentia Health-Ada designed an implementation strategy to address the needs with internal stakeholders and community partners. The plan is designed to leverage existing community strengths and resources available to improve health.

From August to December 2018, Essentia Health-Ada analyzed data, convened community partners, sought input from community members, and led a process to identify the following priority areas for the 2020-2022 Community Health Needs Assessment:

Priority:

1. Physical activity
2. Mental wellness

The 2020-2022 Implementation Plan outlines the multiple objectives, activities and strategies to address each priority area.
Introduction

Essentia Health is called to make a healthy difference in people’s lives. To fulfill that mission, we seek opportunities to both enhance the care we provide and improve the health of our communities. In conducting the Community Health Needs Assessment, Essentia Health has collaborated with community partners to embrace these guiding principles.
Headquartered in Duluth, Minnesota, Essentia Health combines the strengths and talents of 14,400 employees, who serve our patients and communities through the mission of being called to make a healthy difference in people’s lives.

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

Caring for our Community: Our commitment to our community’s health and wellness goes well beyond the work of the Community Health Needs Assessment. Through contributions of over $1 million annually to numerous community organizations, we’re working together with our communities to improve the health and vitality of our neighborhoods. In addition, we’re proud to say our employees donated more than 22,000 hours of their time and talents to a variety of programs and outreach efforts. Our community investments are designed to promote better health, help lessen inequities in our communities, improve access to health care and strengthen the fabric of our communities.
Hospital Service Area

Essentia Health-Ada provides services in the community of Ada and primarily serves Norman County. For the purposes of this assessment, community is defined as the Essentia Health-Ada planning area combined with the ZIP codes where 80 percent of inpatients resided for fiscal year 2018. This includes the ZIP codes of Ada (56510) and Twin Valley (56584). Additional communities served by the hospital with between 1-5% of hospital discharges include Mahnomen (56557), Gary (56545), and Ulen (56585). The community was defined based on the hospital’s ability to have the greatest impact with the available resources. The hospital is committed to building and sustaining partnerships with area organizations in order to extend its reach to all areas within this region.

Existing health care facilities within the region include Sanford clinics on east and west sides of Norman County. A dental access clinic with community health workers opened in 2018 in Halstad in western Norman County.
Demographics & Socioeconomic Factors

Table A. Overall demographics (2016)

<table>
<thead>
<tr>
<th></th>
<th>Ada</th>
<th>Norman County</th>
<th>MN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Population</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population</td>
<td>1,729</td>
<td>6,638</td>
<td>5,450,868</td>
</tr>
<tr>
<td>Population age 65 and over (%)</td>
<td>18.90%</td>
<td>21.80%</td>
<td>779,405</td>
</tr>
<tr>
<td><strong>Poverty</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median household income</td>
<td>$39,464</td>
<td>$52,083</td>
<td>$63,217</td>
</tr>
<tr>
<td>People of all ages living in poverty (%)</td>
<td>14.90%</td>
<td>11.70%</td>
<td>10.80%</td>
</tr>
<tr>
<td>People under 18 years living in poverty (%)</td>
<td>25.40%</td>
<td>20.20%</td>
<td>13.69%</td>
</tr>
<tr>
<td>Unemployment rate</td>
<td>3.80%</td>
<td>2.10%</td>
<td>3.40%</td>
</tr>
<tr>
<td><strong>Educational Attainment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High School graduate or higher, person's age 25 years+ (%)</td>
<td>86.70%</td>
<td>90.80%</td>
<td>92.80%</td>
</tr>
<tr>
<td>Population ages 25+ with bachelor’s degree or higher</td>
<td>18.60%</td>
<td>15.60%</td>
<td>34.30%</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of owner-occupied homes (%)</td>
<td>68.90%</td>
<td>81.30%</td>
<td>71.40%</td>
</tr>
<tr>
<td>Population spending more than 30% of income on rent (%)</td>
<td>53.10%</td>
<td>49.20%</td>
<td>47.30%</td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Households with no motor vehicle available (%)</td>
<td>6.20%</td>
<td>4.20%</td>
<td>7.00%</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau 2016, American Community Survey

Table B. Race/Ethnicity Distribution (2016)

<table>
<thead>
<tr>
<th>Race Distribution – Ada, MN</th>
<th>2016</th>
<th>Percent</th>
<th>2015</th>
<th>Percent</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>1,729</td>
<td>100.00%</td>
<td>1,681</td>
<td>100.00%</td>
<td>2.86%</td>
</tr>
<tr>
<td>One Race</td>
<td>1,679</td>
<td>97.10%</td>
<td>1,666</td>
<td>99.10%</td>
<td>0.78%</td>
</tr>
<tr>
<td>White</td>
<td>1,609</td>
<td>93.10%</td>
<td>1,588</td>
<td>94.50%</td>
<td>1.32%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>6</td>
<td>0.30%</td>
<td>4</td>
<td>0.20%</td>
<td>50.00%</td>
</tr>
<tr>
<td>American Indian and Alaska Native</td>
<td>0</td>
<td>0.00%</td>
<td>9</td>
<td>0.50%</td>
<td>-100.00%</td>
</tr>
<tr>
<td>Asian</td>
<td>10</td>
<td>0.60%</td>
<td>9</td>
<td>0.50%</td>
<td>11.11%</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Other Race</td>
<td>54</td>
<td>3.10%</td>
<td>56</td>
<td>3.30%</td>
<td>-3.57%</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>50</td>
<td>2.90%</td>
<td>15</td>
<td>0.90%</td>
<td>233.33%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>115</td>
<td>6.70%</td>
<td>122</td>
<td>7.30%</td>
<td>-5.74%</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau 2014-2016, American Community Survey

Residents of Norman County are significantly older than the state average. It is primarily a rural farming community with limited jobs for people with higher education. The area experiences high poverty rates with lower than average household income and especially high rates of children living in poverty. Norman County is increasing in population, but at a slower rate than the rest of West Central Minnesota. The population is primarily Caucasian but has Hispanic or Latino residents as the second highest racial classification.
Evaluation of 2016–2019 Implementation Plan

During 2016-2019, Essentia Health addressed significant needs identified in the 2016 assessment: behavioral and physical health as well as poor nutrition. Some activities were led by the hospital, while others were part of larger collaborative efforts with local partners. The following describes significant accomplishments and outcomes.

**Priority Area #1: Improve behavioral and physical health through care coordination**

**Strategy 1: Improve overall mental and physical health of residents and patients in service area**

**Partners:** Norman/Mahnomen/Polk County Public Health and Social Services, Northwest Mental Health Center, Altru Health System, BCBS, Medica, Stratis Health, and the Minnesota Department of Health

**Results:** A broadband-shared electronic medical record, or Health Information Exchange strategy, was created through collaboration. In 2017, three partner organizations participated in shared utilization to improve care coordination. Due to Minnesota Health Privacy Law, not all organizations could implement. The ability to share information has improved patient care because organizations can exchange information that helps improve assessment processes, alignment and enrollment of services. It also reduces duplicated paperwork.

**Strategy 2: Coordinate behavioral and physical health**

**Partners:** Norman-Mahnomen Public Health

**Results:** A full-time population health care coordinator was hired in Ada to assist patients with high needs to improve health. The population health coordinator served 34 patients in Norman County in 2018.

In collaboration with Norman-Mahnomen Public Health, a reduced-cost or no-cost family planning clinic was moved from the courthouse to the Essentia Health-Ada Clinic. This has improved access to family planning care for Norman County residents.

**Priority Area #2: Physical inactivity and poor nutrition as risk factors for chronic diseases**

**Strategy 1: Improve activity and diet in the community**

**Partners:** Ada Alive, Essentia Health-Ada, Norman-Mahnomen-Polk County Public Health, Ada-Borup School District, Dekko Community Center

**Results:** Essentia Health-Ada held a National Diabetes Prevention class in 2016 for 22 participants who achieved a total of 5% weight-loss. Essentia Health also partnered with Dekko (Ada’s
community center) on wellness programming and offered four classes over the three years related to physical health and nutrition. Each class was an eight-week program with classes held twice per week. A dietitian also provided a full day of nutrition consults reaching 11 people during a wellness fair at the community center.

In collaboration with the Ada-Borup school district, Essentia Health-Ada provided wellness programming for students in grades 1-8. The wellness programming included exercise, nutrition, first aid and mental health. Essentia Health-Ada also hosted a community health fair providing information on nutrition, exercise, hand hygiene, advanced care directives, child car seat screenings, lab panels and flu shots.

To improve physical health and risk of obesity Essentia Health-Ada passed a policy that eliminated sugared beverages on site in 2017.

**Priority Area # 3: Advanced Care Planning is promoted**

**Strategy 1: Increase the number of advanced care planning (ACP) done by employees and the community**

**Partners:** Thrivent Financial

**Results:** Community health fairs in 2017 and 2018 offered information on advance care planning resources to more than 800 attendees.

In 2018, 45 Essentia Health staff members received information on advanced care planning at a staff meeting. Essentia Health-Ada also provided information on completing advanced care directives at a community business meeting in 2018.
2020-2022 CHNA Process and Timeline

Essentia Health’s Community Health Advisory Committee developed a shared plan for the 15 hospitals within the system. The plan was based on best practices from the Catholic Hospital Association and lessons learned from the 2016-2019 CHNA process. The process was designed to:

- Incorporate input from persons representing broad interests of the community
- Collaborate with local public health and other health care providers
- Utilize multiple sources of public health data to make data-driven decisions

Each individual hospital worked with community partners to carry out the plan in their service area. Aspects of the plan were adapted to meet the unique needs of each location. Hospital leadership teams and local hospital boards received and approved each implementation plan, followed by final approval by the Essentia Health Board of Directors. The following visual describes the assessment steps and timeline.

**Timeline**

**Assess** *(April - August 2018)*
- Define Service Area
- Service Area Demographics
- Select Health Status Indicators
- Analyze Data & Inventory available resources

**Prioritize** *(Sept. - Dec. 2018)*
- Choose Prioritization Process
- Prioritize Issues
- Justify needs that will not be addressed and provide reasoning why
- Gather Community Input on Priority Issues

**Design** *(January - April 2019)*
- Develop Goals and Measurable Objectives
- Choose Strategies and Tactics
- Identify the “team” and resources for each strategy
- Identify Performance Indicators

**Finalize** *(May - June 2019)*
- Prepare reports, and review with key stakeholders for final feedback
- Present to Hospital Board for Approval
- Share results and action plans with key stakeholders and leaders systemwide
- Post to website, and share plan with the broader community

**Adoption of implementation strategy:** The Community Health Needs Assessment and implementation strategy were approved by the Essentia Health West Region Board of Directors on May 1, 2019 and the Essentia Health-Ada Directors Council reviewed on May 20, 2019 and approved through an electronic resolution before June 30th, 2019.
Assess

A survey was completed in 2017 in partnership with Polk-Norman-Mahnomen County Public Health called the PNM Regional Report, secondary data was analyzed to show trending issues, and key informant interviews were conducted in 2018 as part of the assessment process (Appendix A). The survey is a two-stage sampling strategy for obtaining responses, and data was weighted when analyzed. Residents were surveyed on various health topics including health conditions, access to care, economic barriers, health behaviors, and access to health opportunities in their community. There were 383 respondents in Norman County with a 23.9% response rate. Gaps are that the survey is only completed every three years, and so information may change between surveys and is not measurable in between.

Data sources of the 2016 Tri-Valley Community Needs Assessment were used to inform the community All Partners meeting in addition to the PNM Regional Report and include data from the Minnesota Department of Health, Minnesota Student Survey, Tri-Valley Opportunity Council and Norman County Public Health data which included trends showing demographics, obesity rates, tobacco use, nutrition, income, ethnicity, child care, homeownership and unemployment rates (Appendix B).

Final data was provided by Polk-Norman-Mahnomen Public Health stemming from the All Partners Meeting showing the community input results and top priorities called the PNM CHB 2018 CHIP Annual Report (Appendix C).

Prioritize

Essentia Health participated in a community health prioritization process with two different groups: the Norman-Mahnomen-Polk County All Partners group and Ada Alive. Ada Alive is a local group led by the Statewide Health Improvement Partnership (SHIP) that focuses on local strategies to improve health and well-being. The NMP All Partners Meeting discussed secondary data relative to the results of the survey and current data trends from data sources. This group identified priorities by using results of the survey, key informant interviews and data trends and asking partners to review 70+ health indicators by listing 3-5 that were important from their view. The notes were displayed and organized into sub-sections, and individuals used dots to rate the priorities as 1st and 2nd priority. Of the priorities identified, Essentia Health Ada administration identified priority areas that intersect with both the Norman County Collaborative and Ada Alive and that would have the greatest impact: physical and mental well-being.

Priority area:

1. Physical fitness
2. Mental wellness

**Significant needs not addressed in the CHNA:** Other issues identified through the process but not included as a top priority include a focus on connected families and children, reducing poverty, child care access, substance abuse and transportation. Essentia Health-Ada will continue to partner with organizations that lead efforts to address these issues.
Community Input

Key stakeholders from multiple organizations that make up the All Partners Meeting and Ada Alive represent multiple ages, populations and organizations that represent Norman County. Input was gathered by sharing data from the community and surveys and asking for their input on what current issues are their top priority. Post-it notes were used to identify top priorities with the group that included more than 20 partnering agencies. The overall top priority was behavioral and physical health. Even though poverty/social determinants came in for the first priority, Essentia Health collaborates on the issue, but does not lead it so a decision was made to have physical fitness and mental wellness as the top two priorities for Essentia Health.

Community input was obtained through key informant interviews conducted by Norman-Mahnomen-Polk County Public Health with 55 individuals in 2018. Individuals were asked what issues they feel are the top priority for the community to address.

Participants in key informant interviews came from the following areas:

- 4-H
- SHIP
- Ada-Borup Schools
- Ada Community Center
- Law enforcement
- City of Ada
- Essentia Health
- Northwest Regional Development Commission
- Ada Farmers Market
Key Findings

Priority #1: Physical Fitness

Supporting Data:

74.5% of respondents residing in the Polk-Norman-Mahnomen county region are considered either overweight or obese (2017 Polk Norman Mahnomen Regional Report)

Only 26% of adults are getting their recommended levels of physical activity, far lower than the state rate of 55% (2017 Polk Norman Mahnomen Regional Report)

14% of people in Norman County report poor or fair health compared to 13% in 2015 (County Rankings and Roadmaps. 2019).

Community Input: Discussion identified that we have incredibly high obesity rates and low access to physical activity. There was a concern that the low access to physical activity rate might be deceiving because many of the jobs in the rural community are farm and labor jobs. However, for people in other jobs, the lack of physical activity is very low partially due to weather as a barrier.

Community Strengths and Resources Available:

The All Partner Collaborative, Norman County Council and Ada Alive have strategies that include addressing components of physical well-being:

- Northwestern Mental Health Center
- Ada-Borup Schools
- Essentia Health
- Norman County Social Services and Public Health
- Norman County Sheriff’s Office
- Essentia Health
- Norman Public Health
- Dekko (Ada Community Center)
- Mahnomen-Polk-Norman Public Health
- Ada Alive
- University of Minnesota Extension
- City of Ada
- Norman County Collaborative
**Priority #2: Mental Wellness**

**Supporting Data:**

29% of respondents have been told at some point in their lives by a health care professional that they had a mental health condition (2017 Polk Norman Mahnomen Regional Report)

People report an average number of mentally unhealthy days at 3.1 a month in 2019 compared to 2.9 in 2016 (County Rankings and Roadmaps, RWJF)

**Community Input:** Discussion identified farmer suicide as a special concern as well as youth mental well-being and adverse childhood experiences.

**Community Strengths and Resources Available:**

The All Partner Collaborative, Norman County Council and Ada Alive have strategies that include addressing components of mental wellness:

- Northwestern Mental Health Center
- Ada-Borup Schools
- Essentia Health
- Norman County Social Services and Public Health
- Norman County Sheriff’s Office
- Essentia Health
- Norman Public Health
- Dekko (Ada Community Center)
- Mahnomen-Polk-Norman Public Health
- Ada Alive
- University of Minnesota Extension
- City of Ada
- Norman County Collaborative
Design

Essentia Health worked with internal stakeholders as well as community partners to design a strategy to address each of the priority needs identified in the CHNA process. The plan outlines actions that will be taken to respond to the identified community needs including goals and measurable objectives, strategies, tactics, and performance indicators.

The implementation plan is a three-year plan to address priority needs. The implementation plan will be reviewed annually, with progress shared with hospital leadership and the Board of Directors on an annual basis.

Additionally, the following three priorities were determined by the Community Health Advisory Committee (CHAC) at a retreat in January 2019. The retreat included input from Community Health staff from across the Essentia Health system. Prioritization was based on common themes from the 15 Community Health Needs Assessments.

- Mental health and wellness
- Substance use
- Nutrition and physical activity

During the FY2020-FY2022 assessment cycle, some activities will be led by the individual hospitals/markets, while others will be coordinated across the health system. This will help Essentia Health make the greatest impact with available resources.

No written comments were received from the 2013 CHNA. Any comments would have been taken into consideration in this report.

Conclusion

As a nonprofit health system, Essentia Health is called to make a healthy difference in people’s lives. This needs assessment illustrates the importance of collaboration between our hospitals and community partners. By working collaboratively, we can have a positive impact on the identified health needs in our community in FY 2020–2022.

For questions or comments about the community health needs assessment, please contact: chna.comments@essentiahealth.org

Copies of this plan can be downloaded from our website: https://www.essentiahealth.org/about/chna/
Ada Alive Committee

Our Mission: Support a healthier community for all.

As Ada Alive Committee, Essentia Health will work together with partners to address each aspect of this implementation plan. The Essentia Health system has outlined an allocation of resources available to each hospital as a percentage of net revenue to address the priorities set forth in the Community Health Needs Assessments. A committee within the Essentia Health West Market will best determine the ways to utilize resources to address the priority needs.

Our Results

- People in Norman County experience physical fitness
- People in Norman County experience mental wellness

Our Indicators

- 74.5% of respondents residing in the county are considered either overweight or obese
- Only 26% of adults are getting their recommended levels of physical activity
- 14% of people in Norman County report poor or fair health compared to 13% in 2015
- 29% of respondents have been told that they have a mental health condition
- People report an average number of mentally unhealthy days at 3.1 per month in 2019 compared to 2.9 in 2016
### Result: People in Norman County experience physical fitness

#### Indicators
- 74.5% of respondents residing in the county are considered either overweight or obese
- Only 26% of adults are getting their recommended levels of physical activity
- 14% of people in Norman County report poor or fair health compared to 13% in 2015 (County Rankings and Roadmaps. 2019).

#### Partners who can help
- Dekko Communith Center, Northwestern Mental Health Center, Ada-Borup West Schools, Norman County Social Services and Public Health, SHIP, law enforcement, Wellness in the Woods

### Story behind the data

#### Factors that contribute to improvements:
- Therapy
- Medication
- Social connection / Caring adult
- Screening/early intervention
- Health insurance
- Services within close proximity
- Care coordination
- Expertise to know what to look for and who to connect with
- Access to active living/parks/recreation
- Access to healthy foods
- Access to health care
- Safe living conditions
- Positive social determinants
- Positive or healthy relationships
- Healthy coping skills and resilient behaviors

#### Factors that cause the problem:
- Poverty
- Unsafe living conditions
- Poor coping skills
- Lack of access to active living or recreational opportunities
- Lack of transportation
- Lack of access to healthy foods
- ACES
- Suicide rates
- Social isolation
- Substance abuse
- Socioeconomic factors

### What we are going to do

#### Strategy #1: Engage and collaborate with community to provide education on nutrition and healthy living
**Actions:**
1. Identify current community education plans and gaps
2. Allocate resources for education to support an expanded and holistic schedule to address specific needs

#### Strategy #2: Partner with the schools to support concussion testing, health education and athletic training
**Actions:**
1. Continue to partner with Ada-Borup schools to address needs in athletic training and concussion protocols and testing
2. Identify health education needs and allocate resources to support educational needs

#### Strategy #3: Engage in planning of access to park and recreational opportunities
**Actions:**
1. Collaborate with Ada and Norman County Parks and Rec committees and the city to identify areas of opportunity for additional parks, trails and recreation
2. Identify and allocate resources to support expansion of identified opportunities

#### Strategy #4: Engage in planning and implementation of new community garden
**Actions:**
1. Collaborate with Dekko and Ada Alive to develop a process and protocol for a new community garden
2. Allocate resources to support development of new garden
### Result: People in Norman County experience mental wellness

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Partners who can help</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 29% of respondents have been told that they have a mental health condition</td>
<td>Dekko Community Center, Northwestern Mental Health Center, Ada-Borup West Schools, Norman County Social Services and Public Health, SHIP, law enforcement, Wellness in the Woods</td>
</tr>
<tr>
<td>• People report an average number of mentally unhealthy days at 3.1 in 2019 compared to 2.9 in 2016 (County Rankings and Roadmaps, RWJF)</td>
<td></td>
</tr>
</tbody>
</table>

### Story behind the data

<table>
<thead>
<tr>
<th>What we are going to do</th>
</tr>
</thead>
</table>

#### Factors that contribute to improvements:
- Therapy
- Medication
- Social connection / Caring adult
- Screening/early intervention
- Health insurance
- Services within close proximity
- Care coordination
- Expertise to know what to look for and who to connect with
- Access to health care
- Positive social determinants
- Positive or healthy relationships
- Healthy coping skills and resilient behaviors

#### Factors that cause the problem:
- Poverty
- Unsafe living conditions
- Poor coping skills
- Lack of access to active living or recreational opportunities
- Lack of transportation
- Lack of access to healthy foods
- ACES
- Suicide rates
- Social isolation
- Substance abuse
- Socioeconomic factors

#### Strategy #1: Increase access to telehealth mental health services through collaboration

**Actions:**
1. Collaborate with Northwestern Mental Health to identify areas of opportunity to expand crisis and mental health outpatient services to the community
2. Allocate resources to implement new or expanded service lines

#### Strategy #2: Engage and collaborate with community to provide mental wellness education to reduce stigma and improve skills for mental wellbeing

**Actions:**
1. Identify current community education plans and gaps
2. Allocate resources for education to support an expanded and holistic schedule to address specific needs
Polk-Norman-Mahnomen Community Health Services

2017
NORTHWEST REGION
ADULT HEALTH BEHAVIOR SURVEY SUMMARY

Three-County CHB-Level Report

April 2018

Authored by
Garth Kruger, Ph.D.
## Executive Summary

### Weight

74.5% of respondents residing in the Polk-Norman-Mahnomen (P-N-M) county region are considered either overweight (37.6%) or obese (36.9%).

- This is a generally flat trend from 2014 and is higher than the state average of 64.5% (36.7% overweight; 27.8%, obese).
  - The percentage of individuals who are overweight or obese increases with age.
  - Males tend to be both more overweight and obese than females.

### Physical Activity

Across the three-county region, an estimated 26% of adults are getting their recommended levels of physical activity, far lower than the state rate of 55%.

- The attainment of Physical Activity Guidelines in the P-N-M region has little/no relationship to age, gender, education or income.
- Lack of time is cited by 63% of respondents as the second largest barrier to being physically active, with adverse weather being the greatest at 67% exercise after adverse weather 67%.

### Fruit/Veg. Consumption

Middle-income households are less likely to consume their daily recommended intake of fruits and vegetables than those from both the upper and lower ends of the income distribution (22% vs. 42%).

### Tobacco

Approximately 12% of all adults in the P-N-M region are smokers.

- This is 3.5% lower than three years previously and suggests that significant positive impacts may be the result of tobacco prevention efforts.
- Current smokers are split equally across genders but differ significantly by income and education.
  - Individuals with less than $35,000 annual household income smoke three times more than all other income groups (24% vs. 8%).
  - Only 5% of those with 4-year degrees or more smoke compared to all other educational demographic groups which smoke at approximately 16%.

### Alcohol

The percentages of individuals that report drinking at least once/past 30 days are split evenly across genders at approximately 64%.

- 26% of respondents indicated that alcohol had a “harmful effect” on themselves or a family member. Income level did not change the outcome.
  - 38% of respondents aged 34 and younger report experiencing “harmful effects” from alcohol.

### Mental Health

29% of respondents had been told at some point in their lives by a healthcare professional that they had a mental health condition.

- Over the past 30 days, nearly 25% of respondents expressed feelings of hopelessness, anxiety or loss of interest in things they used to enjoy.
  - This figure jumps to 37% for those who are 34 years old or less and compares to 17% for those aged 55 or older.

### Recommendations

- Continue to focus resources on areas that develop and encourage physical activity.
  - Assist in structuring school, workplace and community environments to make it easier for residents to integrate physical activity into daily routines.
  - Prevention efforts need to help people prioritize time in their day to be physically active.
- Track alcohol (especially binge drinking), tobacco (e-cigarette adoption) and other drugs, such as opioid use. Maintain focus on tobacco prevention. Explore local conditions using multiple methods to collect data across sectors, seek applicable funding opportunities and implement/evaluate local strategies.
- Opportunities exists for local public health and healthcare facilities to jointly identify and describe factors that affect the health of the community, and plan/implement mutually agreed upon action steps.
Weight Status

Survey respondents were asked to report their height and weight. From the data a Body Mass Index (BMI) was calculated.¹ As Figure 1 shows below, 74.5% of respondents residing in the Polk-Norman-Mahnomen (PNM) county region are considered either overweight (37.6%) or obese (36.9%). This is a generally flat trend from 2014 and is higher than the state average of 64.5% (36.7% overweight; 27.8%, obese). To learn more, see https://stateofobesity.org/states/mn. In terms of gender and age as related to weight, older males tend to be heaviest while younger females weigh the least (see Figures 2 and 3).

¹ There are some exceptions to be considered in using BMI to accurately assess the health of individuals; however, it is assumed here to be a generally accurate measure for the body mass composite a population.
Physical Activity

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-eight percent (38%) of survey respondents in 2017 indicated “no” whereas in 2014 only 31% said no. The MN state average on this measure is approximately 18%.2,3

Attainment of Physical Activity Guidelines (PAG) were assessed. This was achieved through a series of questions examining the extent of moderate physical activity (30 minutes/day for 5+ days) and vigorous physical activity (20 minutes a day for 3+ days).4

Across the three-county region, only an estimated 26% of individuals are getting their recommended levels of physical activity. This is far lower than the average rate of 55% of all Minnesotans. Overall, no noteworthy distinctions were found between the educational attainment of respondents and PAG achievement. Both males and females tended to meet PAG at the same rates (27% vs. 25.8%). However, individuals aged 55+ achieved PAG 5% more often compared to those aged 34 or less, and were 10% more likely to have engaged physical activity over the past month. Individuals with both higher ($75k+) and lower (<$35k) incomes tended to achieve PAG slightly less than those in the middle of the income spectrum (See Figure 7). Reasons for this are unclear. In sum, the attainment of PAG in the P-N-M region had little relationship with age, gender, education or income.

2 https://stateofobesity.org/physical-inactivity/
4 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. To learn more see http://www.health.gov/paguidelines/guidelines/summary.aspx
Workplace wellness initiatives are popular efforts, and as the data in Figure 6 suggest these efforts are focused on a population that is lower in their attainment of Physical Activity Guidelines relative to other demographic groups (e.g. students, unemployed, homemakers). Therefore, **P-N-M public health should continue to focus resources on developing and encouraging physical activity in workplace settings.**

68% of respondents indicated ‘weather’ was the greatest reason for lack of physical activity followed by ‘lack of time’ at 63%. All other reasons were endorsed approximately 20% of the time including poor maintenance of sidewalks or walking paths/trails, public facilities not available when I want to use them, fear of injury, long-term illness, injury or disability, traffic problems, and not having sidewalks or walking paths/trails.
In 2017, a total of 34.3% of adults reported eating five or more servings of the daily recommended intake of fruit and vegetables combined per day. That total increases to 66.4% if you include those who get 3-4 servings a day, which is just below recommendations.

Survey results indicate that two-thirds of the population in the region regularly consume fruits and vegetables (F/V). Given the findings on nutrition intake compared to exercise, the data suggests that the problem it seems is not in a lack of eating F/V but rather lack of physical activity.

Both fruits and vegetables are consumed at generally similar rates with vegetables having a slight edge. Differences on F/V consumption relative to age or education are negligible. The relationship between F/V consumption and income is slightly unclear, however there appears to be some variation among income groups as shown in Figure 9. Middle-income households ($35k - $75k) are less likely to consume their daily recommended intake of fruits and vegetables than those from both the upper ($75k+) and lower (< $35k) ends of the income distribution. One hypothesis could be that individuals with lower-incomes (< $35k) qualify for food program(s) and those with higher incomes ($75k+) can afford food, but those in the middle-income ranges feel the most pinch when it comes to making a choice between F/V vs. other items. Another hypothesis could be that middle-income working families look for fast, convenient meals.
Tobacco Use

Approximately 12% of all adults in the region are smokers. This is 3.5% lower than what was found three years previously and suggests that significant positive impacts may be the result of numerous prevention efforts. Current smokers are split equally across genders but differ significantly by income and education. Individuals with less than $35,000 annual household income had three times the rate of smoking compared to all other income classes (26% vs. 9%). With only 7.5% of those with 4-year degrees smoked compared to all other educational demographic groups which smoked at approximately 15%.

Mahnomen County has the highest smoking rates at 23.6%. This is nearly double the state average of 14.4%. For the three-county region, 29.1% of current smokers indicated that during the past 12 months they had stopped smoking for a day or longer because they were trying to quit. People attempting to quit smoking decreased 22% from 2014. It is unclear why this might be the case.

Table 1: Percent of Adults Who Smoke by County and CHB

<table>
<thead>
<tr>
<th></th>
<th>PNM CHB Region</th>
<th>Mahnomen County</th>
<th>Polk County</th>
<th>Norman County</th>
<th>MN State</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current smokers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>15.5</td>
<td>20.5</td>
<td>15.6</td>
<td>11.7</td>
<td>14.4</td>
</tr>
<tr>
<td>2017</td>
<td>12</td>
<td>23.6</td>
<td>10.3</td>
<td>11.7</td>
<td>14.4*</td>
</tr>
<tr>
<td><strong>Net increase/decrease</strong></td>
<td>-3.5</td>
<td>+3.1</td>
<td>-5.3</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Results also found that 5% of adults are smokeless tobacco users. Of the 56 smokeless tobacco users in the sample, 48 of them were males. E-cigarette use is even lower at 1.4%. Statewide surveys estimate adult e-cigarette use in Minnesota at 6%. 5. Northwest Minnesota region estimated range is 2-6% from the 2014 MN Adult Tobacco Survey. 5

Figure 10

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 64% of them had consumed alcohol. Of that, twenty-six percent of respondents indicated that alcohol had a ‘harmful effect’ on themselves or a family member. Income levels seemed to have no impact on harmful effects as each income group was equally impacted, however that was not the case for age or educational attainment. Respondents aged 34 or less reported 38% of them were adversely impacted compared to 22% of those aged 35+. Similarly, 18% of individuals with a high-school diploma or less experienced harmful effects compared to 30% of those with more than a high-school education.

Drinking percentages were split evenly across the genders, however 69% of individuals younger than 55 reported drinking versus 58% for all other age groups. Eighty-one percent of individuals from higher income households (> $75k) reported drinking over the past 30 days compared to 37% of those earning less than $35k. Furthermore, individuals with a bachelor’s degree or higher educational attainment were more likely to report alcohol consumption over the past 30 days (76%) than those with a high-school diploma or less (53%). It should be noted that ‘any drinking’ does not mean problem drinking. Future surveys should include questions pertaining to binge drinking as included in the 2014 data.

Figure 11

Any drinking past 30 days?

Mental Health

- Approximately 13.4% of individuals living in the PNM region self-reported having Fair or Poor general mental health at the time of the survey.
- 29% have been told at some point in their lives by a healthcare professional that they had a mental health condition.
- 17% delayed getting mental health treatment when it was needed.
  - Of this group, the delay occurred for a variety of reasons, including perceived lack of severity (50%), fear of getting treatment (25%) cost (25%), ‘did not know where to go’ (22%), and deductible too expensive (15%).
Over the past 30 days, nearly 25% of respondents expressed feelings of hopelessness, anxiety or loss of interest in things they used to enjoy. This figure jumps to 37% for those who are 34 years old or less and compares to 17% for those aged 55 or older.

Medical Care

Approximately two-thirds of the regions residents reported having a medical checkup over the past year. Nineteen percent delayed seeking medical care over the past 12 months when they felt they needed it (See figure 14). The primary reason for not seeking care was cost (50%) and high deductible (30%) (See Figure 15). Instead of people not seeking medical care because of no health insurance, many may not be seeking medical care because the deductibles and associated costs.
Figure 14

**Question:** During the past 12 months, was there a time when you thought you needed medical care but did not get it or delayed getting it?

**Graph:**
- Yes: 21.3% (2014), 19.0% (2017)
- No: 78.7% (2014), 81.0% (2017)

Figure 15

**Medical care delay reasons**

<table>
<thead>
<tr>
<th>Reason</th>
<th>2014</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Could not get appointment</td>
<td>10.9</td>
<td>7.9</td>
</tr>
<tr>
<td>Not serious enough</td>
<td>54.7</td>
<td>36.8</td>
</tr>
<tr>
<td>Transportation problems</td>
<td>5.1</td>
<td>3.7</td>
</tr>
<tr>
<td>Cost</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>No insurance</td>
<td>1.8</td>
<td>1.8</td>
</tr>
<tr>
<td>Not covered by insurance</td>
<td>15.9</td>
<td>9.9</td>
</tr>
<tr>
<td>Other</td>
<td>30.5</td>
<td>30.5</td>
</tr>
</tbody>
</table>

% of Respondents
Appendix A:

![Graph showing 2017 Adults overweight/Obese PNM CHB](#)
Appendix B: Methodology

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 November 27, 2017, to 18,679 households in the 12-county region. In nine of the counties, survey packets were mailed to samples of 1600 households per county. Three of the counties have fewer than 1600 households; in these cases, survey packets were mailed to all households.

About one week after the first survey packets were mailed (December 5), 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. Three weeks after the reminder postcards were mailed (December 27), 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 January 31, 2018.

Completed Surveys and Response Rate

Completed surveys were received from 4296 adult residents of the twelve counties; thus, the overall response rate was 22.9% (4296/18679). 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 representative of the adult population of 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 American
Community Survey 2012-2016 estimates.

<table>
<thead>
<tr>
<th>County</th>
<th>Surveys mailed</th>
<th>Completed Surveys</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beltrami</td>
<td>1600</td>
<td>316</td>
<td>19.8%</td>
</tr>
<tr>
<td>Clearwater</td>
<td>1600</td>
<td>354</td>
<td>22.1%</td>
</tr>
<tr>
<td>Hubbard</td>
<td>1600</td>
<td>376</td>
<td>23.5%</td>
</tr>
<tr>
<td>Kittson</td>
<td>1402</td>
<td>445</td>
<td>31.7%</td>
</tr>
<tr>
<td>Lake of the Woods</td>
<td>1553</td>
<td>337</td>
<td>21.7%</td>
</tr>
<tr>
<td>Mahnomen</td>
<td>1600</td>
<td>299</td>
<td>18.7%</td>
</tr>
<tr>
<td>Marshall</td>
<td>1600</td>
<td>401</td>
<td>25.1%</td>
</tr>
<tr>
<td>Norman</td>
<td>1600</td>
<td>383</td>
<td>23.9%</td>
</tr>
<tr>
<td>Pennington</td>
<td>1600</td>
<td>301</td>
<td>18.8%</td>
</tr>
<tr>
<td>Polk</td>
<td>1600</td>
<td>351</td>
<td>21.9%</td>
</tr>
<tr>
<td>Red Lake</td>
<td>1414</td>
<td>373</td>
<td>26.4%</td>
</tr>
<tr>
<td>Roseau</td>
<td>1600</td>
<td>360</td>
<td>22.5%</td>
</tr>
<tr>
<td>Total</td>
<td>18769</td>
<td>4296</td>
<td>22.9%</td>
</tr>
</tbody>
</table>

The term ‘respondents’ in this report refers to those who responded to this survey and can be taken to assume
that they represent the population in so far as the reader believes the response rates and weightings to be
representative of the population.

**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.
2016 Tri-Valley Community Needs Assessment

Tri-Valley Opportunity Council, Inc.

Board of Directors Priorities

Priority 1 – Improve/promote/advance the objective of coordinating the various services for area preschool children with Head Start:

- Schedule meetings with local school districts to plan coordination of services after legislative or funding policy changes.
- Coordinate Head Start and Pathways services with area child care providers.
- Work with Early Childhood Initiative groups in the area to improve lines of communication between all area Early Childhood service providers.

Priority 2 – Improve/promote/advance the objective of keeping seniors in their homes and avoiding premature nursing home placement:

- Caring Companion Program will begin services.
- Foster Grandparent recruitment process will be revamped.
- Tri-Valley will increase its presence at area service provider meetings.

Priority 3 – Improve/promote/advance housing options in the service area:

- Work with partner agencies to create a plan for the delivery of Transitional Housing and other supportive housing services.
- Marsh resources to assist area communities in meeting housing needs.
- Create a position focused on the various housing needs in the area, understanding that needs go far beyond a physical structure in which to live.

Priority 4 – Improve/promote/advance Financial Literacy in the service area:

- Provide Four Cornerstones of Financial Literacy training and other recognized training programs to the service area.
- Recruit clients for FAIM savings accounts.
- Work with the Minnesota Asset Building Coalition to create a comprehensive strategy for Tri-Valley’s service area.
Population
Population change within the report area from 2000-2014 is shown below. During the fourteen-year period, total population estimates for the report area declined by -2.38 percent, decreasing from 48,966 persons in 2000 to 47,802 persons in 2014.

The greatest loss occurred in Norman County which experienced a -9.63% decrease in population, whereas Polk County experienced a positive change of 0.83%. Of our population, 6.46% are under the age of 5, 17.17% are age 5 to 17, 59.30% are 18 to 64, and 17.07% are over 64 years old. (Data Source: US Census Bureau, American Community Survey. US Census Bureau, Decennial Census. 2010-14. Source geography: County)

Income
According to the U.S. Census, median annual household incomes ranged from a low of $50,175 in Polk County to a high of $54,433 in Marshall County. The median income for the state of Minnesota is $61,473. (Data Source: US Census Bureau, Small Area Income & Poverty Estimates. Source geography: County)

Homeownership
The U.S. Census Bureau estimated there were 14,814 homeowners in the report area in 2000, and 77.23% owner occupied homes in the report area for the 5 year estimated period from 2010 - 2014. (Data Source: US Census Bureau, American Community Survey. 2010-14. Source geography: County)

According to the Tri-Valley Community Needs Assessment survey, affordable housing was seen as the biggest concern in the report area.

Nutrition
The report area showed that 3147 students (or 41.25 percent) were eligible for free or reduced price lunches during the 2013 - 2014 school year, which is more than the national average of 52.35 percent. (Data Source: National Center for Education Statistics, NCES - Common Core of Data. 2013-14. Source geography: Address)

Poverty
2014 poverty estimates show a total of 5,634 persons living below the poverty level in the report area. According to the U.S. Census, the poverty rate for the area increased by 1.93%, compared to a national increase of 4.2%. According to the American Community Survey 5 year estimates, an average of 11.95 percent of all persons lived in a state of poverty during the 2010 - 2014 period. The poverty rate for all persons living in the report area is less than the national average of 15.59 percent. (Data Source: US Census Bureau, American Community Survey. 2010-14. Source geography: county)

Ethnicity
According to ACS 2010-2014 5 year population estimates, the white population comprised 95.16% of the report area, black population represented 0.89%, and other races combined were 3.95%. Persons identifying themselves as mixed race made up 2.32% of the population. (Data Source: US Census Bureau, American Community Survey. 2010-14. Source geography: County)

Child Care
The number of children ages 0 - 5 potentially needing child care in the three county area is 3,056. The capacity of licensed child care providers for children 0 - 5 is 2,598. This shows a decrease of 203 spaces from last year. These numbers indicate that an estimate of 458 children and their families must find alternative sources of care which is generally unlicensed friends, family or neighbor care.

Unemployment
According to the U.S. Department of Labor, unemployment for this one year period grew from 1,674 persons to 1,802 persons, a rate change of 0.44% percent. Overall, the report area experienced an average 6.6% percent unemployment rate in March 2016. (Data Source: US Department of Labor, Bureau of Labor Statistics. 2016 - March. Source geography: County)

Overall
Community perceptions indicate that this area has a high quality of living standard with ability to meet basic needs the greatest strength of the report area.
The report area has higher rates of children staying in school and getting an associates degree as compared to the rest of the state. *(Data Source: US Census Bureau, American Community Survey. 2010-14. Source geography: County)*

The percentage of persons uninsured ranged from 10% in Polk County, to 10.5% in Norman and Marshall County. The service area percentage of uninsured is 8.07% compared to the national average of 14.16%. *(Data Source: US Census Bureau, American Community Survey. US Census Bureau, Small Area Health Insurance Estimates. 2009-13. Source geography: County)*

The report area has one of the lowest rates of Child Protective Services needs in the state in 2013. *(Data Source: Minnesota Department of Human Services, Minnesota’s Child Welfare Report for 2014)*

According to the Tri-Valley Community Needs Assessment survey, basic needs, education, and health care were seen as the biggest strengths of the report area.

The change in the poverty rate in the report area from 2000 - 2014 increased by 1.93%. The poverty rate change in Minnesota was 4.51% and the national rate change was 4.2%.

The median commute time for the report area of 18.22 minutes is shorter than the national median commute time of 24.6 minutes. *(Data Source: US Census Bureau, American Community Survey. 2010-14. Source geography: County)*

**Note:** Tri-Valley has services in 84 counties in Minnesota and North Dakota.
Quality of Life Indicators

POVERTY INCIDENCES (Rate Change 2000-2014)

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>4,828</td>
<td>10.25%</td>
<td>5,634</td>
<td>12.18%</td>
<td>1.93%</td>
</tr>
<tr>
<td>Marshall County, MN</td>
<td>877</td>
<td>8.9%</td>
<td>891</td>
<td>9.6%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Norman County, MN</td>
<td>734</td>
<td>10.2%</td>
<td>868</td>
<td>13.4%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Polk County, MN</td>
<td>3,217</td>
<td>10.7%</td>
<td>3,875</td>
<td>12.7%</td>
<td>2%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>673,188</td>
<td>6.89%</td>
<td>1,215,740</td>
<td>11.4%</td>
<td>4.51%</td>
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<tr>
<td>United States</td>
<td>31,581,086</td>
<td>11.3%</td>
<td>48,208,387</td>
<td>15.5%</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

(Data Source: US Census Bureau, Small Area Income & Poverty Estimates. 2013. Source geography: County)

Top Five Values Tri-Valley Demonstrates:

#1 = Commitment  #4 = Quality  
#2 = Compassion   #5 = Respect  
#3 = Knowledge
Quality of Life Indicators

MEDIAN FAMILY INCOME (2014)

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Median Household Income</th>
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<tbody>
<tr>
<td>Marshall County, MN</td>
<td>$54,433</td>
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<td>Norman County, MN</td>
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<td>Polk County, MN</td>
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<td>Minnesota</td>
<td>$61,473</td>
</tr>
<tr>
<td>United States</td>
<td>$53,657</td>
</tr>
</tbody>
</table>

(Data Source: US Census Bureau, Small Area Income & Poverty Estimates. 2010-14. Source geography: County)

Top 10 Strengths of the Report Area:

#1 = Basic Needs   #6 = Individual and Family Life
#2 = Education     #7 = Consumer Services
#3 = Health Care   #8 = Community Services
#4 = Environmental Quality #9 = Mental Health Care
#5 = Income Security #10 = Criminal Justice & Legal Services
Quality of Life Indicators

EMPLOYMENT (March 2016)

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Labor Force</th>
<th>Number Employed</th>
<th>Number Unemployed</th>
<th>Unemployment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>27,236</td>
<td>25,434</td>
<td>1,802</td>
<td>6.6%</td>
</tr>
<tr>
<td>Marshall County, MN</td>
<td>5,913</td>
<td>5,287</td>
<td>626</td>
<td>10.6%</td>
</tr>
<tr>
<td>Norman County, MN</td>
<td>3,442</td>
<td>3,222</td>
<td>220</td>
<td>6.4%</td>
</tr>
<tr>
<td>Polk County, MN</td>
<td>17,881</td>
<td>16,925</td>
<td>956</td>
<td>5.3%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>3,055,197</td>
<td>2,915,604</td>
<td>139,593</td>
<td>4.6%</td>
</tr>
<tr>
<td>United States</td>
<td>159,988,338</td>
<td>151,733,570</td>
<td>8,254,768</td>
<td>5.2%</td>
</tr>
</tbody>
</table>


Top 10 Weaknesses of the Report Area:

#1 = Affordable Housing  #6 = Domestic Violence / Abuse
#2 = Crime            #7 = Substandard Housing
#3 = Poverty          #8 = Affordable Medical Care
#4 = Alcohol Abuse    #9 = Shortage of Child Care
#5 = Drug Abuse       #10 = Young People Leaving the Area
## Quality of Life Indicators

### HOMEOWNERSHIP (2000 - 2014)

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Owner Occupied Homes 2000</th>
<th>Owner Occupied Homes 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>14,814</td>
<td>14,567</td>
</tr>
<tr>
<td>Marshall County, MN</td>
<td>3,427</td>
<td>3,289</td>
</tr>
<tr>
<td>Norman County, MN</td>
<td>2,438</td>
<td>2,223</td>
</tr>
<tr>
<td>Polk County, MN</td>
<td>8,949</td>
<td>9,055</td>
</tr>
<tr>
<td>Minnesota</td>
<td>1,412,865</td>
<td>1,525,201</td>
</tr>
<tr>
<td>United States</td>
<td>69,815,753</td>
<td>74,787,460</td>
</tr>
</tbody>
</table>

(Data Source: US Census Bureau, American Community Survey. 2010-14. Source geography: County)

### Possible Report Area Needs Over the Next 12 Months:

1. Finding a job where the employer offers benefits
2. Finding a job which pays enough to meet your family’s basic needs
3. Finding quality child care providers
4. Need for summer activities for older students and young teens
5. Help with having enough money to buy needed clothing and shoes

(Results based on Tri-Valley's Community Needs Assessment Survey)
### EDUCATION (2010-2014)

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Percent No High School Diploma</th>
<th>Percent High School Only</th>
<th>Percent Some College</th>
<th>Percent Associates Degree</th>
<th>Percent Bachelors Degree</th>
<th>Percent Graduate or Professional Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>10.76%</td>
<td>33.98%</td>
<td>23.21%</td>
<td>12.41%</td>
<td>14.54%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Marshall County, MN</td>
<td>11.43%</td>
<td>38.7%</td>
<td>20.7%</td>
<td>11.3%</td>
<td>14.3%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Norman County, MN</td>
<td>11.28%</td>
<td>39.3%</td>
<td>21.8%</td>
<td>12.9%</td>
<td>12.3%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Polk County, MN</td>
<td>10.43%</td>
<td>31.3%</td>
<td>24.3%</td>
<td>12.6%</td>
<td>15.1%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>7.72%</td>
<td>26.4%</td>
<td>22.2%</td>
<td>10.5%</td>
<td>22.3%</td>
<td>10.9%</td>
</tr>
<tr>
<td>United States</td>
<td>13.67%</td>
<td>28%</td>
<td>21.2%</td>
<td>7.9%</td>
<td>18.3%</td>
<td>11%</td>
</tr>
</tbody>
</table>

(Data Source: US Census Bureau, American Community Survey. 2010-14. Source geography: County)
Who Did We Serve?

FOR SENIORS:
- Provided programs and activities to 3,377 seniors to help maintain their independent living.
- Provided programs and activities to 3,237 individuals with disabilities to help maintain their independent living.
- Provided emergency rent or mortgage assistance to 124 seniors.
- Provided emergency car or home repair to 156 senior households.
- Provided referrals for emergency food assistance to 232 seniors.
- Provided referrals for temporary shelter to 11 seniors.
- Provided referrals for emergency medical care to 10 seniors.

FOR INFANTS/CHILDREN AND FAMILIES:
- Assisted 1,112 infants and children obtain age appropriate immunizations, medical, and dental care.
- Improved the health and physical development of 1,092 infants and children as a result of providing adequate nutrition.
- Provided preschool activities to develop school readiness to 351 children.
- Ensured that 351 children from low-income families are ready for school having developed pre-literacy and pre-numeracy skills as measured by assessment.
- Assisted 1,207 parents and other adults learned and exhibited improved parenting skills.
- Ensured that 1,194 parents and other adults learned and exhibited improved family functioning skills.

FOR THOSE UNABLE TO WORK:
- Assisted 69 in obtaining care for their child or other dependent.
- Assisted 18,226 in obtaining access to reliable transportation.
- Assisted 91 in obtaining health care services for themselves or family member.
- Assisted 152 in obtaining safe and affordable housing.
- Assisted 1,438 in obtaining food assistance.
- Assisted 1,521 in obtaining non-emergency LIHEAP energy assistance.

FOR LOW-INCOME INDIVIDUALS AND/OR FAMILIES:
- Provided 142,860 rides.
- Provided 3,605 information and referral calls.
- Provided emergency payments to vendors for fuel and energy bills for 1,193 low-income individuals.
- Assisted 80 individuals complete ABE/GED and receive certificate or diploma.
- Assisted 40,807 individuals get access to reliable transportation and/or driver's license.
POLK-NORMAN-MAHNOMEN
COMMUNITY HEALTH SERVICES

COMMUNITY HEALTH IMPROVEMENT PLAN
2018 ANNUAL REPORT

Polk County Public Health
Norman-Mahnomen Public Health
December 31, 2018
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Partnerships

- Mahnomen Local Advisory Team
- Mahnomen Opioid Subcommittee
- Ada Alive
- IMPACT Coalition
- Polk County Wellness Coalition, Opioid Taskforce
- Healthier Fosston
- First National Bank/United Valley Bank
- Ultima Bank-Fosston
- Northwest Minnesota Foundation
- Headwaters Regional Development Commission
- White Earth Tobacco Coalition, Public Health, Harm Reduction, Public Safety, Ambulance
- Mahnomen County Highway Department
- University of MN Extension, includes SNAP Education
- Mahnomen Health Center
- Indian Health Services – White Earth Reservation
- Essentia Health Clinic Ada
- Essentia Health Clinic Fosston
- RiverView Health
- RiverView Recovery
- Altru- Crookston/Grand Forks
- Northwestern Mental Health Center
- Norman County East School District
- Mahnomen School District
- Ada-Borup School District
- Climax-Shelly School District
- Fertile-Beltrami School District
- Win-E-Mac School District
- Crookston School District
- East Grand Forks School District
- Fisher School District
- Fosston School District
- Tri-Valley Opportunity Council
- Crookston National Guard
- Minnesota Prevention Resource Region 1
- City of Gary
- City of Ada
- Mahube-Otwa
- City of Fertile
- City of Fosston
- University of Minnesota-Crookston
- University of Minnesota Extension Service
- Northwest Regional Sustainable Development Partnership
- Wild Rice Lutheran Church
- First Lutheran Church
- Mahnomen County Social Services
- Polk County Social Services
- Polk County Environmental Services
- Norman County Sheriff’s Office
- Mahnomen County Sheriff’s Office
- Polk County Sheriff’s Office
- Polk County Attorney’s Office
- Ada Police Department
- East Grand Forks Police Department
- Crookston Police Department
- MN State Highway Patrol
- Pine to Prairie Drug Task Force
- Tri-County Community Corrections
- Mahnomen County Resource Officers
- Dekko Community Center Ada
- 4-H
- Fosston Chiropractic Center
- Biermaier Chiropractic Center
- Nord’s Pharmacy, Fosston
- Trinity Lutheran Church, Crookston
- Northwest Regional Development Center
- Level 5 Services
- NW Partnership for Workforce Solutions
- Polk County Breastfeeding Coalition
- Polk County Towards Zero Deaths Coalition
- Bike Crookston
- Early Childhood Initiatives
- City of Crookston
- City of Mahnomen
- Polk County Breastfeeding Coalition
- Many COMMUNITY volunteers

A huge THANK YOU to all of the partners across Polk, Norman and Mahnomen.
Introduction

The 2015 Polk-Norman-Mahnomen (PNM) Community Health Improvement Plan (CHIP) is the result of a robust data collection Community Health Assessment regarding community health issues most important to Polk, Norman and Mahnomen County residents. A community-driven health improvement framework called Mobilizing Action through Planning and Partnership (MAPP) was used to guide the health improvement process. Working with the Minnesota Department of Health (MDH) as part of the Community of Practice for the Community Health Assessment and CHIP and partnering with Essentia Health, PNM is transitioning to the Results-Based Accountability (RBA) Model.

The CHIP, created by community members and organizations, broadens and builds upon successful local initiatives. It is an action-oriented, living document to mobilize partners and community members in areas where we can be most impactful on improving the health of residents, particularly those most vulnerable. The health improvement plan identifies specific evidence-based components based on community health needs including social determinants of health. We recognize that by working together, we can accomplish more than we could alone. The policy, systems and environmental recommendations included are designed to address collective public health concerns, guide the implementation of the strategies proposed in this CHIP, and promote a “health in all things” approach. The purpose of the CHIP is not to create more work for public health or our partners, but to align and leverage the efforts of multiple organizations and to move towards improved health for the residents of PNM in a strategic manner.

Our CHIP is indeed an example of meeting people and organizations where they are at and empowering people to contribute in ways that are personally and professionally meaningful while always working towards common goals. Due to the comprehensive and inclusive scope, we would be remiss if we did not recognize our inability to capture every strategy happening across the three-county region.
No issue can be addressed alone; it requires a multifaceted approach in building and sustaining healthy communities. We are asset ‘rich’ in people with passion, loyalty, determination, and willingness to facilitate change to improve the lives and well-being of our communities.

Two All Partners meetings were planned in 2018 to evaluate where we’ve been and where we are going. Information gathered from the first All-Partner Meeting laid the platform for discussion on specific indicators/strategies for the second All Partners meeting using the RBA model around four indicators. Due to inclement weather, the second All Partners meeting was postponed twice. After consultation with various community partners and evaluating past efforts, it was reiterated by many that the current process felt more like talk with limited action. Moving from talking to action, we have proposed moving to a more county route for these vital community health conversations and perhaps more importantly, action to take place. Collectively we acknowledge and understand the importance of locally engaging and collaborating with local organizations and community members to implement long-lasting changes, and has been proven over the years with several strategies being executed at community and county specific meetings.

The three priorities areas are *Decreasing Persistent Poverty, Coordination of Behavioral and Physical Health and Positive Social Connections for Youth*. Being able to show progress and accomplishments, as well as being sustainable is important to community leaders.

Collectively, we are collaborating, sharing ideas and seeing our part in common goals to tackle current and emerging priorities.
Overview of the Process, Successes and Challenges of CHIP

Collaboration allows communities to solve problems that cannot be solved — or easily solved — by single organizations or jurisdictions, especially when working towards changes in policies, systems and environment. Social determinants of health affect everyone and every entity; we as a community are only as ‘strong’ or ‘healthy’ as our weakest link.

It has been evident by the collaboration and passion of the group that it takes ‘the community’ to ‘improve the community.’ Public health, as the convener, initiated and facilitated the conversation to work collectively towards agreed priority issues, being mindful and purposeful in ensuring an equity lens, such as ‘who’s missing?, who benefits?, and who are negatively impacted?’ and how can the narrative in PNM counties be more inclusive, accepting, and empowering to all community members? To make a collective impact, it requires civic engagement, openness, willingness and collaboration from all partners and community members.

CHIP All Partners Meeting Recap:

CHIP review and monitoring was conducted on January 30th, 2018: “Where We’ve Been and Where We’re Going”

✓ Core Indicators Set: Recommendations and Group Dialogue on Indicators, Definitions and Sources

Goals: 1) Provide PNM cross-sectoral partners with common population health indicators and definitions. 2) Improve consistency among organizations in using population health data to track/build consensus on health improvement priorities/targets. 3) Include indicators that are most commonly used across organizations, reflect current priority health topics and use a mix of available data sources (primary, secondary, electronic health record)
Community partners were asked to review the 70+ indicators and list 3-5 indicators that were important from their view; either organizational or personally. After, all post-it (N=69) notes were displayed and organized into sub-sections, individuals used dots to rate the indicators/priorities as 1st and 2nd priority.

CHIP Open Space: Open Space Technology is a simple, powerful way to catalyze effective working conversation and truly invite organizations to thrive in times of swirling change. The methodological tool enables self-organizing groups of all sizes to deal with hugely complex issues in a short period of time. It supports positive transformation while inspiring creative solution, improving communication and enhances collaboration. It is one of the most effective processes for organization and communities to identify critical issues, voice their passions and concerns and learn from each other and, when appropriate, take collective responsibility to find solutions. Convened around the core concepts of the three priorities of the CHIP, time and space was allocated during the All Partners Meeting for people to engage around issues of concerns or interest. Principles of Open Space is whoever comes are the right people, whenever it starts is the right time, whatever happens is the only thing that could have and when it’s over it is over. People were encouraged that if they were not contributing or learning to move somewhere where they could.
Summary of important concepts were collected and posted on the “News Wall” for the entire group. At Harvest/closing people were asked to share comments and insights.

✔ **Community Health Assessment**: Partners were updated that as part of population health surveillance for the Statewide Health Improvement Partnership (SHIP) and our Local Public Health Grant (assess and address local needs), PNM CHB is required to conduct a community health needs assessment. The NW MN Public Health entities worked together on the NW Adult Health Behavior Survey. All partners received a copy of the survey that was mailed out by random selection to residents.

✔ At the All Partners meeting participants decided that the three strategic issues chosen among partners in from 2015, would remain for 2018. Data collected was analyzed from the All Partners meeting for themes and priority areas. PNM staff planned to discuss the results and steps in moving forward with the four indicators using Results-Based Accountability at the All Partners meeting that was postponed. An overview of the results ascertained from the data is provided in Appendix E.

**Successes**: PNM CHS diligently works to continually improve the CHIP process, applying evidence-based practices and Art of Hosting techniques to maximize our partners valuable time in working towards improving our community’s health. PNM CHB was selected to participate in a MDH Health Equity Learning Community supported by one-on-one MDH coaching and taking action to use and bring a health equity lens into CHIP implementation.

PNM CHS has been actively participating in the MDH CHA/CHIP Community of Practice (CoP) to access support from MDH through the entire process; using best practices in the assessment and planning stage. The CoP provides health departments a time for support, learning and coaching of new methods for assessment, implementation, evaluation and engagement.
In 2018, local public health SHIP partners from Essentia Health in Ada and Fosston invited PNM CHS staff to participate in two two-day trainings focused on Results Based (RBA) Accountability as members of Essentia’s local community health assessment teams with the rest of the Essentia Health Team statewide. RBA is a data-driven decision-making approach that utilizes a structure to work together as a community with a clear set of steps using a shared accountability culture amongst partners. The RBA platform will be used with partners for desired population results, indicators and establishing commitment to action steps. Local PH is grateful for the opportunity, partnership and collaboration.

**Challenges:** When working towards the root cause of what affects health, i.e., social determinants of health (SDOH) it is hard to compartmentalize the issues as many are intertwined. With community-level change and working towards the root cause, the momentum of moving the dial/making progress seems daunting at times. Additionally, the workforce, partners and community volunteers are consistently changing (such as retirement, moving, etc.) so building and nurturing a trusted network of partners to address common goals can be time and resource consuming; reinforcing the direction of moving towards a Community Health Improvement Advisory Committee with an annual All Partners Meeting. We have made great strides and continue to do great work across Polk-Norman-Mahnomen. In 2019, using the Results-Based Accountability model, partners and communities will have a tool to help define and measure ‘what success looks like’ for their community.

A challenge for each entity involved is genuinely engaging with populations that face inequities, versus engaging with the organizations that serve communities we want to reach. It is evident that several organizations are committed to improving conditions where people live, learn, work and play, but we have an opportunity for more intentional inclusion of cross-generational community engagement from residents who have not historically been at the forefront of community planning and implementation.

It was evident this year that communities are continuously changing. After completing our Adult Health Behavioral Survey, Key Informant interviews, Variance/Concept Map, developing new relationships/partners and analyzing data from the All-Partners Meeting, we are see shifts and clarity in our priorities. Because our partners are diligent and motivated, many of the strategies were put into motion and did not align 100% with the original definition of our three priorities but are still applicable and essential with the changing times. The amount of excellent work PNM and our partners completed, implemented and strengthen is astonishing.
Next Steps: In 2019, after consultation with various partners, we’d like to transition to a more local route (County specific) for these important community health conversations and, perhaps more importantly, action. Some people, ourselves included, have been frustrated by past efforts that felt more like talk with limited action. We will utilize an inclusive process that gets us from talking to action quickly. This disciplined way of thinking and taking action will improve the quality of life in our communities. Narrowing our outcome indicators down to four will allow PNM, partners and the community to apply Results Based Accountability Model to our work.

Partners and community members will be asked personally by the Local Public Health Directors to be part of the Community Health Improvement Advisory Community, the Polk-Norman Community Health Improvement Plan-All Partners Meeting or both. The Community Health Improvement Advisory Committees role is to serve as a community representative, working directly with local public health staff to guide and participate in collaborative health improvement processes frequently throughout the year. The goal will be to meet a few hours, three times a year. With intentionality, the meeting dates/times will hopefully be held on the same day as our County Collaborative meetings. PNM CHS continues to strategize on how to actively engage and involve community members in the process, being mindful of common barriers of those who live in poverty. The tentative agenda for the first three meetings is:

- **Meeting 1 (3 hours – 1 hour on each health priority):**
  - Do we have the “right” population health indicators?
  - Story Behind the Data– Why is it an issue? Why is this an issue HERE?
  - Solutions? – What would work to create impact?
  - Partners? – Who can help?

- **Meeting 2: (3 hours- 1 hour on each health priority)**
  - What are we going to do? – Rank Strategies - Consider leverage, feasibility, specificity and value of strategy.
  - Action Plan- Who will do what by when?

- **Meeting 3: (2 hours)**
  - Monitor and celebrate progress (population data, performance data, accomplishments, stories)
  - Forecasting and Next Steps
The Polk-Norman Mahnomen Community Health Improvement Plan-All Partners Meeting will be a time to assemble, to share and celebrate the advisory committee progress, success and challenges annually. Using Open Space Technology meeting concept we will network and engage around issues of concerns and interest going from exploration of ideas to solutions.

On the pages to follow, Polk-Norman-Mahnomen CHS has highlighted key successes within in each priority area. Additional detailed lists of successes are included in the Appendix section.
**Decreasing Persistent Poverty**

*How can we, as a community, assure that everyone has basic resources to live in good health?*

**About this priority:**

- Poverty level is one of the most critical characteristics that contribute to the number of individuals experiencing preventable chronic diseases.
- People and communities experiencing the greatest differences in health are also the people and communities experiencing the greatest differences in the opportunity for health, in education, income, health care and living environments.
- Overarching objectives include partner collaboration, workforce development, high school graduation, safe and affordable housing, transportation, childcare services and stress management (financial literacy and overall mental well-being).

**Poverty Data:**

In 2017, Public Health completed a Health Equity Data Analysis (HEDA) interviewing PNM residents at local food shelves and WIC clinics. Findings indicated individuals who are low income have daily challenges such as transportation, lack of childcare and food access - which are all predictors of health.

- **Polk County, PNM CHB and the state of Minnesota saw** **an increase** **in poverty rates.**
- **Norman County and Mahnomen County saw a decrease** **in poverty rates.**
- **Where are the disparities, inequities? Next steps?**
Poverty Successes:

PNM and Tri-Valley Opportunity Council co-hosted a Poverty Simulation from the Minnesota Community Actions Partnership. Three school districts, city officials, public health, TVOC, mental health, corrections, social services and juvenile center participated, reaching eighteen organizations.

- Goal to sensitize audiences to the realities low-come individuals.
- Designed to help participants begin to understand what it might be like to live in a typical low-income situation.

Feedback/Next Steps:

- Biggest barrier TRANSPORTATION
- How do we meet individuals where they are at?
  - Client led conversations
  - Flexible hours
  - Capturing authentic voice

In Polk, Norman and Mahommen Counties, individuals with low income (less than $35,000) have greater risk than those who an income above $35,000

Source: CDC

2017 Polk Norman Mahomen Health Equity Data Analysis

<table>
<thead>
<tr>
<th>Condition</th>
<th>Low Income</th>
<th>High Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
<td>38%</td>
<td>29.60%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>11%</td>
<td>21%</td>
</tr>
<tr>
<td>Heart Trouble</td>
<td>14%</td>
<td>7.40%</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>32.90%</td>
<td>28.10%</td>
</tr>
<tr>
<td>Depression</td>
<td>31.50%</td>
<td>16%</td>
</tr>
</tbody>
</table>

High Blood Pressure, Diabetes, Heart Trouble, High Cholesterol, Depression

2017 Polk Norman Mahomen Health Equity Data Analysis
Homelessness Data

Lack of safe, affordable and clean housing options, and financial barriers are just some of the reasons NW MN residents are experiencing homelessness. In the 2016-2017 school year, the report of unaccompanied homeless students was 38. Students experiencing significant housing instability was substantial for our region.

Homelessness/Housing Successes:

✔ **Northwest Minnesota Youth Committee**: Coming together to end youth homelessness
  ➢ Vision is to bring new and existing stakeholders together to end homelessness for unaccompanied youth, age 24 or younger in the NW region
  ➢ Collaborative planning: Requires that our region work collaboratively and think creatively to find solutions to end youth homelessness.
  ➢ NW MN Continuum of Care Organizational Structure and partners listed in Appendix A.

✔ **Agassiz Townhomes Project**: The City of Crookston, CHEDA, Tri-Valley Opportunity Council along with 15 businesses came together in support of building 30 smoke free townhomes in Crookston, MN. This collaboration was a demonstration of community engagement and dedication to provide safe and affordable housing to community members.
Tri-Valley Opportunity Council Housing Strategies

- House and Support
- Single Family Housing
- Housing Rehab
- Landlord Mitigations Fund/Hard to House
- Financial Literacy: Renter and homeowner education
- Report Rent (Building Credit)

Transportation Successes:

Tri-Valley T.H.E. BUS
Public transportation services for medical, nutritional, social, recreational, shopping, work, school, and other personal activities.

Promoting health equity:
- Access to Affordable Public Health Services
- Bike racks available on the bus (Healthy choice is the easy choice.)

Communities Served:

- Crookston and Thief River Falls 7 days per week
- Bagley and Mahnomen 5 days per week
- Ada, Hallock, Karlstad, Warren, Red Lake Falls and other cities are provided services on rural trips and usually one day per week into town.

“Finding housing for a big family is hard”
“Transportation is my barrier—I don't drive. Bus only runs at certain times”
“Groceries are limited, produce is limited, quality is limited”

-Health Equity Data Analysis Interviews
High School Graduation Data and Successes:

Approximately 1 out of 10 residents in Polk, Norman and Mahnomen County, 25+ years have less than a high school degree or GED.
Actual 9.4%, ACS 2013-2017
Note: Indicator changed from previous year.

Successes:
- **Birth to 8 Initiative**
- **Communities in Schools**
  - Crookston School District
  - East Grand Forks School
- **Family Navigator Initiative**
  - Ada School
  - Win-E-Mac School

*Details in Appendix A.

Why does it matter?
Education is associated with:
- Longer life expectancy
- Improved health and quality of life
- Health promoting behaviors (regular physical activity, not smoking and preventive care)
*See Appendix A for a detailed list of successes and progress for decreasing persistent poverty.

**Successes and Challenges:** It was and continues to be our goal that organizations from all sectors of the community – schools, health care providers, local government, faith organizations, service providers, community members and others – will actively adopt and participate in this community health plan in a way that is meaningful to themselves or the organization they may work with. Community stakeholders, community members and partners are collaboratively working to address highly complex and often linked challenges—ultimately affecting health.

**Next Steps:** Continue to strengthen our partnerships, and actively engage with community members to ensure people have the basic resources to live in good health. Asking ourselves, who’s missing, who’s negatively impacted? Who’s this affecting? and so forth. In 2019, poverty continues to be a top priority to our community, as it is the root cause of many inequities and disparities seen in our communities.

Indicator for poverty was reviewed and changed to: **percent of all people whose income in the last 12 months is below the poverty level in 2019.** See our next steps, details, thought processes and concepts moving forward using the RBA model in Appendix E.
How can we strengthen communication and coordination among health care and community partners to support healthy behaviors across the life span?

About this priority:

- 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).
- Groups of people that experience inequities in social and economic opportunities that create health, result in health disparities. For example,
- Main objectives include:
  - Coordination and integration of clinical, behavioral and complementary health services;
  - Reducing gaps in services/resources;
  - Increase understanding of preventative care;
  - Reduce stigma related to mental illness;
  - Creating an environment that makes active living and healthy foods accessible;
  - Preventing and curtailing alcohol, tobacco and drug use.

Persons with serious and persistent mental illness die on average 25 years younger than the general population.

Mental Health Data:

The age-adjusted suicide rate for most rural counties in 2017 was 53% higher than the rate in 1999. (CDC)

Rate of suicide by a GUN

National: 50.4%
OUR rates: 58%

Source: Prelim MN Suicide Death Data 2016-2018 (DHS)
Successes:

✓ Suicide Prevention
  ➢ Suicide Awareness and prevention presentations to high school and secondary students, substance-abuse recovery groups
  ➢ Suicide prevention skills training using Question, Persuade, Refer (QPR) for school staff in all three counties, QPR for community groups and service providers in all three counties
  ➢ Crisis Text Line
  ➢ Crookston Suicide Prevention Coalition

✓ Northwestern Mental Health Center - Mobile Crisis Response Team (MCRT)
  ➢ 8 Mental health practitioners and professionals and 5 Mental Health crisis Rehabilitation office-based staff
  ➢ Crookston Team Responds to Polk, Norman, Red Lake, Mahnomen and Norman
    o Staffed 24/7, 2 beds available for client to be admitted for short-term crisis stabilization services.
    o Responded to over 1,800 calls (2018):

~575 face-to-face mental health crisis assessment with 143 in collaboration with Riverview Health Emergency Room

✓ Zero Suicide NWMHC & Riverview Health
  ➢ System-wide organizational commitment to safer suicide care.
  ➢ Referral, coordination and consultation decreasing number of clients who might fall through the cracks.
  ➢ Education, trainings and support implemented, then extended throughout the community.

✓ Altru Health
  ➢ TEARS Program

Challenges/Next Steps: The stigma continues around mental health in our region hindering the important steps in receiving treatment, seeking help or even talking about it. Increasing positive psychology, increasing community/social connections, encouraging/teaching empathy, acceptance and understanding are steps PNM as a community need to be intentional and purposeful to work on in collaboration with partners.
Chronic Disease Data:

Being overweight is a risk factor for many obesity-related conditions including heart disease, stroke, type 2 diabetes and certain types of cancer that are some of the leading causes of preventable, premature death (CDC).

Chronic Disease Prevention Successes:

✔ Essentia Health
  ➢ Screening all patients for BMI, counseling as appropriate, refer and follow-up as appropriate.
  ➢ Partnerships with PNM CHS, Healthier Fosston, Ada Alive, Dekko on wellness activities, school for cougar pack programming and other wellness education
  ➢ Health Fair for the community in October

✔ Riverview Health
  ➢ Recognized partner program by the CDC for Type 2 Diabetes Prevention Classes
  ➢ Launched a Diabetes Self-Management Program. Being offered in 2019 to more locations.
- **Altru Health System-Crookston**
  - Rural MN Diabetes Optimal care is 43%, Altru Crookston Region pre-audit results 54.63%
  - Rural MN Vascular Optimal Care is 59%-Altru Crookston pre-audit results 71.11%

- **Polk-Norman-Mahnomen Statewide Health Improvement Partnership (SHIP)**
  - Working with Riverview and Essentia Health Prevent T2 Diabetes to implement the “FARM”acy program. The “FARM”acy Program offers vouchers for their local farmers markets or grocery store to be used on fruit and vegetables. Participants who engaged lost more weight on average than those who didn’t.
  - Collaborative partnerships with **Altru Health System** and several local partnerships in the Greater Grand Forks area to lower the rate of obesity.
    - Community Gardens
    - Working with E. Grand Forks Park District to increase physical activity
    - Increase the number of employers that have lactation support programs.
    - Increase number of organizations with policies that encourage healthy eating, breastfeeding and physical activity. Total 22

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**Alcohol, Tobacco, Opioids and Other Drugs Data:**

![Graph showing the number of pills seized by Pine to Praire Drug Task Force from 2013 to 2018.](image)

*2017: Removed 185,000 pills from one case

**2013-2018 Pine to Praire Arrest (excluding RX)**

![Graph showing the quantity of cocaine, heroin, marijuana, and methamphetamine seized from 2013 to 2018.](image)

**Youth tobacco use in Polk County**

![Bar chart showing tobacco use among Polk County’s 9th and 11th grade students, 2016.](image)

*Statewide, over 17% of 11th graders use e-cigarettes, while only 8.4% use cigarettes and 5.1% use smokeless tobacco.*

*Source: Minnesota Youth Tobacco Survey (2017)*
**IMPACT Coalition Survey Results**

In the fall of 2018, the IMPACT coalition surveyed three school districts in Norman and Mahnomen counties. Students were surveyed at Ada-Borup West, Norman County East and Mahnomen. Waubun administration declined our request. There was a total of 700 respondents in grades 6-12th. The survey was optional, and parents had the option to opt their child out. The evaluator threw out 21 respondents (of the 700 responses which left a total of 683 responses) for unclear, missing or inconsistent responses (like saying they don't drink in one area and then responding about how much they do drink in another).

80.80% did **NOT** drink alcohol in the past 30 days

81.70% did **NOT** use any TOBACCO products in the past 30 days

80.4% did **NOT** use any MARIJUANA in the past 30 days

86.6% did **NOT** misuse their own or consume someone else’s PRESCRIPTION in the past 30 days

During the past 30 days how often do you think the students at your school have used:

- Alcohol (beer, wine or hard liquor)
- Tobacco (cigarettes, chew, e-cigarettes, cigars, etc.)
- Marijuana
- Prescription drugs not prescribed to you
Successes:

- Opioid Crisis and the desire to see a healthy community. RiverView Health, the Recovery Center and Glenmore Foundation invested in community initiatives through educational opportunities for individuals and family suffering in the grasps of addictions, so we may have hope in recovery and sobriety.

- RiverView Health formed a multi-disciplinary Opioid/Pain Management Committee

- Impaired and distracted driving: Riverview Healthcare, Riverview Recovery and Glenmore Foundation have responded to the need for safer highways with best-practice education process Driving with Care. Total 86 participants.

- Polk County Opioid Taskforce sponsored two forums with a LIVE Facebook feed in response to local request. The documentary HEROIN(E) was viewed with a panel of professionals focused on current and future strategies to impact not only opioids but ALL substances.

"This isn’t just a law enforcement issue, a public health issue, a court issue, treatment provider issue or just a community issue. THIS IS ALL OF OUR ISSUE and WE NEED EVERYONE’S HELP TO COMBAT IT" - Polk County Sheriff, James Tadman

- Following the national trends, youth e-cigarette use has risen dramatically across Minnesota in the last three years. Along with our community partners, the Statewide Health Improvement Partnership (SHIP) grant at Polk County Public Health is working to raise awareness of this public health concern. Education, policy and curriculum recommendations provided at local schools, county fair and community events.
Polk County Opioid Taskforce, a sub-group of the Polk County Wellness Committee, is engaging with the whole Polk County Community to find and implement local solutions. See Appendix D for Polk County Wellness Coalition Opioid Taskforce Update and Call to Action Report.

Mahnomen Opioid Subcommittee held five community events in 2018, including the Mahnomen Opioid Panel with 125 people in attendance and over 1000 views on Facebook. The Mahnomen and Naytahwaush Community Even had just shy of 850 people present. These events provided opportunities for community members to come together, enjoy a lite meal, and learn about various substance abuse prevention efforts in the area.

The IMPACT Coalition addresses substance abuse in Norman and Mahnomen Counties by assessing the scope of the problem and developing plans to implement sustainable, prevention strategies that will reduce youth substance use and abuse.

- Completed the 1st ever Drug Free Communities Youth Survey
- RX Take Back Programs: Multiple locations across PNM. In 2018, we secured funds to purchase a mini-Rx Take Back box for Norman County. This will be used at various events throughout Norman County. At these events, the box will be patrolled by a law enforcement officer.
- Tobacco Compliance Checks
Actively collaborating and educating the community through many vehicles: Social media, in-person, community events, and programs.

*See Appendix B for a detailed list of successes and process for Coordination of Behavioral and Physical Health

Successes and Challenges: With the geographic distance between many of our community partners, we have been strategic, resourceful and determined to work in collaboration across sectors to improve the experience and outcomes of clients, patients, community members and communities. In Northwest Minnesota, we rely on our partners to provide holistic care that encapsulates the ‘whole person’ and the ‘whole community’ being healthy physically, mentally, behaviorally and spiritually. Examples of these are our warm referrals between entities and working towards our electronic health information exchange. Furthermore, as we meet entities where they are, Public Health can show how our partners’ strategies and initiatives have and continue to work towards the priorities of the community health improvement plan.

One challenge was the progress of the health care electronic health exchange with local health care providers, corrections, mental health and schools. A steering committee was charged with moving the dial in 2018, though motivated, the process was slower than anticipated. One setback for PNM is that majority of our health care entities reside in bordering states, creating legal barriers to work through. Moving towards electronic health exchange and data exchange with local partners remains a priority.

It is evident with the 2018 successes there has been a shift in emerging priorities, the strategies do not 100% align with the priority as initially defined. We are moving the scope from collaboration of physical and mental health to collaboration of partners and community members to have healthy communities and healthy community members (physically, mentally and financially).

In 2018 at the All-Partner meeting when discussing indicators and priorities little to no emphasis was on opioid or drug use. What we saw was individuals focused more on root causes and conditions that affect health. A strong emphasis was on mental well-being across the age-span. Communities have started to take and implement strategies to tackle current, emerging and preventative methods moving forward. This response was seen especially around the opioid and substance abuse work.
Next Steps: We have six primary care health systems in the three-county area. Opportunities exist to be more involved with the Hospital Community Health Assessment processes, resulting priorities and collaboration on implementation of strategies. For the first time, our local health care systems in Polk County will be working together on their Community Health Implementation Plan. Further exploration of Community Measures data will be discussed as it relates to comparative population health data across PNM. We will continue to engage in meaningful relationships and connect with people, communities and organizations.

Indicated in the 2016 CHIP Annual Report, we considered making this section into two separate priorities. It was evident in the data collected from community partners and emerging trends; revisions will be made. We will be focusing on healthy behaviors and healthy communities. Using RBA on four specific indicators: 1) Overweight 2) Percent feeling hopelessness, anxiety or loss on interest 3) Percent 9th graders feeling bothered, down, depressed, hopeless and 4) Poverty. Through the RBA process, local strategies and interventions will be developed.
How can we promote and support social connection efforts and opportunities in our community?

About this priority: This priority issue is unique in that it focuses on a specific age group, youth.

- Youth are a unique population in that they are a “sponge”-constantly learning new information, skills and expectations (norms) about ways of acting and living that contribute to health and their future (or not).
- The life time health trajectory is established very early on in child development. 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.
- Adverse childhood experiences (ACES) in early childhood create changes in the architecture of the brain that affect everything from physical to emotional development, to the capacity of making healthy choices as adults.
- Overarching objectives includes social connectedness/developmental relationships among youth, school and community-based resources for fostering healthy relationships, positive mental health, socially connected schools and communities and increasing health related self-efficacy.

Youth Connectedness Data:

- I feel valued and appreciated in my school.
- I feel valued and appreciated at home.
Successes:

Programs/Services to Increase Protective Factors, Social Connectedness, Community Awareness & Engagement and Relationships

- **Nurse Family Partnership** provided by PNM public health. Focuses on improving maternal and infant outcomes, and self-efficacy by partnering soon to be parents with a personalized nurse. In 2018, 428 visits were made to N=47 clients.

- **Maternal Child Visits (MCH)** provided by PNM CHS. Focuses on improving maternal and infant outcomes.

- **Universal Postpartum Visits (PPHV)** are offered for all babies born in PNM counties. Providing education, resources, and support to families.

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**STATISTICS**

Percentage of all students reporting that they feel that their community cares about them quite a bit or very much.

- Polk: 44.8%
- Norman: 44.1%
- Mahnomen: 31.3%

Percentage of students reporting higher levels of empowerment, as determined by the developmental assets scale.

- Polk: 53.8%
- Norman: 53.2%
- Mahnomen: 35.4%

Percentage of 8th, 9th and 11th grades reporting two Adverse Childhood Experiences (ACES) experienced.

- Polk: 10.1%
- Norman: 8.8%
- Mahnomen 14.7%

Percentage of students reporting higher levels of positive identity, as determined by the developmental assets scale.

- Polk: 32.6%
- Norman: 28.1%
- Mahnomen: 18.7%

(MN Student Survey, 2016)
PNM WIC has been working together to expand and improve joint services. An increase in participation was seen in 2018. Not only does WIC provide nutritional education, WIC helps connect families to local resources (food shelf, assistance, housing, social services), and mental health and medical providers.

Children and Family Services provided by Northwest Mental Health Center (County Contract Services, School Based, NorthStar Summer Program, Early Childhood, and Children Therapeutic Services and Support (CTSS) (individual and family skill building). Minnesota DHS School Linked Mental Health Grant provides co-located behavioral health services in over 21 school districts in NW Minnesota.

Total number of children served in 2018: N= 719
Polk: N=514
Norman: N=121
Mahnomen: N=84

Backpack lunch program implemented in multiple communities. For example, in Fertile, MN partners include City of Fertile, North Country Food Bank, Fertile Lion’s Club and School. At Crookston’s two locations, a total of 4725 meals served over 32 days.

Multiple school districts collaborate with Tri-Valley Opportunity Council and the Foster Grandparent program. The Foster Grandparent program matches the skills of Foster Grandparents to the needs of our children in several locations. Activities range from arts, childcare, providing emotional support to assisting with schooling—the list is endless as it meets the needs of each child individually. Total number of foster grandparents for the region is 28.

Red River Corridor—Community Paddle Event. Three events held to intentionally connect community members to the Red Lake River. The events were the result of great collaboration.

- 219 community members paddled, ranging in age of 5 years old to 60+
Norman County Bike and Walk to School Days. Both events connect youth with adults. Coming together to help the youth were members of the 4-H clubs, law enforcement, city personnel, retired teachers, and retired community members. While safety is the most important factor, being active and connecting our community members, both young and old, is just as important.

Gary Pines: The Gary Pines includes a natural play space, bike racks, hiking trails and more. Due to the nature of the space, regular activity by users is evident through manipulation of pieces and parts in the space- and, literally, foot/hand prints in the sand, dirt, and snow. Working in collaboration with many partners the scope is endless.

A large focus of the Gary Pines is around multi-use multigenerational play and the positive impact it has on relationships.
Polk County Public Health Youth Advisory Board (YAB): Implemented in 2018, the YAB will provide a vehicle for young people in Polk County to become involved in governmental public health services, merging civic engagement and leadership development for high school students. By engaging youth in our agency’s policies, practices and procedures, we bring new energy, information and knowledge into our mission-based work through youth targeted, age and gender sensitive interventions. As part of developing future leaders of our communities, youth will plan, implement and reflect on limited, yet meaningful programming determined by the YAB.

** See Appendix C for a detailed list of successes and process for Positive Social Connections for Youth

Successes and Challenges: To have a sense of self-worth, engage in positive relationships, build resiliency, develop a sense of community and social contribution requires diligence and commitment from the community. We are mindful that positive social connections for youth cannot be taken for granted and recognize critical components that should be cultivated throughout the lifespan. Partners are working autonomously and together to build and foster resilience and skills to manage stress, find balance and focus, and engage socially among youth and adults. We are frequently reminded about the power of “1”.

"Every youth needs at least one positive adult role model in their life"

Next Steps: With the new addition of the Youth Advisory Board, tapping into the minds of our target population on social connectedness is exciting. Maximizing their skills and knowledge will require us to be purposeful and mindful to not making assumption or strategies without their valuable input. Implementing a YAB for both Norman and Mahnomen will be on our radar.

Using the RBA model in 2019, the indicator being monitored will be: % 9th graders feeling bothered, down, depressed, hopeless from the Minnesota Student Survey. We would be remised if we believed that other conditions that affect health do not also impact social connectedness, making us be mindful of opportunities for our youth moving forward. (i.e. SDOH/poverty and obesity work –parks, community centers, good food access, trails, etc.)
Next Steps Summary

Formally inviting and bringing together partners and community members to be part of the Community Health Improvement Advisory Community, the Polk-Norman Community Health Improvement Plan-All Partners Meeting or both to work on PNM priorities.

See Appendix E: Next Steps.
Appendix A: Decrease Persistent Poverty

We focused on emphasizing the success/progress of the strong partnerships throughout the body of the CHIP Annual Report. As stated prior, we are very determined to meet organizations and stakeholders where they are at. The PNM community has shown dedication, commitment, and passion in addressing the three priority areas and therefore all the successes our partners shared with or by PNM CHS are highlighted below. This is not an all-inclusive list.

➢ **Birth-to-Eight Initiative.** The Polk County Birth to Age 8 Initiative was launched to address the challenge and opportunity of “Kindergarten surprises” – children who show up for Kindergarten who aren’t on the district census, haven’t been screened or offered other enrichment opportunities, simply because the district did not know they were in the community. Modeled after the Dakota County Birth to Age 8 Initiative, this collaboration is one part of a larger strategy to better align public support efforts for families. The partnership between Polk County’s Women, Infants and Children (WIC) program and Crookston ISD 593 began in August 2018. Through this collaboration, the school district receives contact information for families residing in their district, sent with consent by WIC. Then, school district staff make a personal connection with each family and continue to follow up with information on early childhood services and screening. As of December 2018, 13 referrals have been made to Crookston ISD 593.

➢ **Regional Workforce Alliance:** Partnership for Workforce Solution held 2018. A local panel presented successes, resources and challenges in hiring and employing former offenders. Two resources were provided “SOURCE” and “CREATE”. SOURCE: To effect change and implement solutions, strategies and tactics will be identified as falling under of the sources and appropriate partners to engage in to support relevant strategies. S: Students-develop and retain, O: Older workers-retain and value mature workers, U: Under-employed and under-represented workers, R: Residents-attract and retain new residents to the region, C: Caregivers-supporting parents and other caregivers to remain in the workforces, and E: Efficiency in the workforce. CREATE: Working together to create workforce solutions. C: Collaborate on Skill Development, R: Recognize Value of Diversity, E: Enhance Student Pipeline, A: Attract New Talent to Local Areas, T; Tap into Best Practice and E: Engage with untapped SOURCEs of talent.

➢ **Healthy Homes** assessments and mitigation provided by PNM CHS. Secured funding for the next three years to complete 100 assessments/mitigation, provide community outreach and training, and training to local community partners (hospitals, social services, public health, clinics, Northwest Mental Health Center, schools, contractors, constituents). In 2018,

➢ **Communities in Schools** (CIS) awarded to Crookston High School and East Grand Forks High School. CIS is a proven evidence-based solution that is efficient, cost effective and sustainable. CIS recognizes that today’s education must address non-academic issues kids are dealing with every day; poverty, lack of adult role models and the absence of basic needs. Communities experience higher graduation rates, lower dropout rates,
better outcomes in academics, higher rates of promotion and increased attendance in schools that implement CIS.

- **Tri-Valley Opportunity Council** hosted an informational session on the, “Need for Child Care”.
- **Fosston Daycare Center Plan.** In analyzing the data and needs, it was recommended that the community build a facility with immediate capacity for 42 children, focusing on infants through five years of age, which is the greatest need. Option #1: Construct a building that includes room for Early Childhood Education, Head Start and three childcare pods. Option #2: Purchase and renovate educational rooms, one multi-purpose room, administrative office, laundry and storage.
- **The Clubhouse Childcare** opened in McIntosh, MN to meet the growing needs in the community. Mission: Met the social, emotional, cogitative and physical need of all children in a safe, nurturing, simulation and positive environment.
- City of Crookston: Business Incentives for Crookston High School, UMC, Northwest Community Technical College.
- City of Crookston looking at startup funds for Home Daycare Centers.
- **Northwest Minnesota Continuum of Care: Homelessness**

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**CoC Organizational Structure**

- **CoC Board**
  - Executive Committee:
    - Elected CoC Chair, Chair Elect & Committee Chairs + non-voting (MICH & CoC Staff)
  - Data Committee
  - Performance Evaluation Committee
  - Coordinated Entry Committee
  - Youth Committee

- **Regional Homeless Committees**
  1. BI-CAP
     - Beltrami
  2. Tri-Valley Opportunity
     - Clearwater
     - Kittson
     - Lake of the Woods
     - Marshall
     - Norman
     - Pennington
     - Polk
     - Red Lake
     - Roseau
  3. Mahube-Otwa
     - Mahnomen
     - Hubbard

- **YHDF Exec**
- **Youth Action Board**
- **Youth Circles**

**YHDF Leadership/Executive Team:**
- Collaborative Applicant: Catherine Johnson, Inter-County Community Council
- Committee Chair/RHYA Representative: Dan McKeon, Evergreen Youth & Family Services
- Youth Action Board: Stacy Hans, Youth Representative
- NW CoC Coordinator: Becky Schueler
- Tribal Representatives: Charli Goodwin and Jordan May
- County Representatives: Chris Kujava, Marshall County
Appendix B: Coordination of Behavioral and Physical Health

We focused on emphasizing the success/progress of the strong partnerships throughout the body of the CHIP Annual Report. As stated prior, we are determined to meet organizations and stakeholders where they are at. The PNM community has shown dedication, commitment, and passion in addressing the three priority areas and therefore all the successes our partners shared with or by PNM Public Health are highlighted below. **This is not an all-inclusive list.**

- **Suicide Prevention Coalition:**
  - Suicide awareness and prevention presentations to high school and post-secondary students beginning 2016. Presentations lasting approximately 30 minutes are given to students in grades 7-12 and any high school or college requesting it. These may be given in large assemblies or in smaller grade level groupings. In Polk and Norman counties presentations have been provided to schools in East Grand Forks, Crookston, Win-E-Mac, Fosston, Fertile-Beltrami, Climax-Shelly, Fisher, and Norman County West districts. Mahnomen school presentations to students are provided by other resources. Some of these school districts have provided multiple presentations in these years. University of Minnesota, Crookston (UMC) has arranged for one student presentation to all student athletes in this time period. Ongoing initiative, delivery every two years.
  - Suicide awareness and prevention presentations to substance-abuse recovery groups beginning 2016. In partnership with Riverview Recovery, presentations the linkages between trauma, mental health difficulties, suicide, and substance use disorder have been provided to recovery groups in East Grand Forks and Crookston. An average of seven such presentations are provided each year.
  - Suicide prevention skills training using Question, Persuade, Refer (QPR) for school staff in all three counties beginning 2016. A nationally-recognized approach to suicide prevention, QPR is on the National Registry of Evidence-Based Practices. QPR has been provided for teachers, support staff, and administrators in Mahnomen, Crookston, Win-E-Mac, Fosston, Fertile-Beltrami, Climax-Shelly, Fisher, and Norman County West districts. It has also been provided for Catholic educators in the region, and for residence staff and support staff at UMC.
  - Suicide prevention skills training using Question, Persuade, Refer (QPR) for community groups and service providers in all three counties beginning 2016. QPR training has been provided for a wide variety of groups and industries in the three counties, including Riverview Health, Crookston Police, and community groups.

- Collaboration between PNM CHS, health care systems and the school district, Chlamydia cases from 2116-2017 in Mahnomen County dropped substantially.

- **Riverview Health** in Collaboration with UMN Extension had 10 participants complete the *I Can Prevent Diabetes Program* in 2018
Essentia Health
- Dr. Omokaro presented a Lunch-and-Learn for the community. “Stay Healthy and Double Your Prevention.”
- Ada Alive
- Clinical site for students
- Tobacco Cessation Counselors
- Community Paramedic Program
- Health Information Exchange collaborative with NWMHC.
- Donations made to Northern Dental Access Center in Halstad—opened end of 2018.
- Healthier Fosston
- Fosston Baby Friendly Hospital Application Prep

Altru Health System
- MN Average for Breast Cancer Screening is 77%, Crookston added mammography services in April of 2017 - 2018 data started at 74.38% & ended the year at 84.20% (pre-audit)
- MN Average for Colorectal Screening is 71% - Altru Crookston pre-audit results 73.57%

Six Child Passenger Events were put on in partnership with Altru Safe Kids in 2018
- PNM CHS distrusted 190 child restraints (car seats) in 2018
- Approximately 627.5 hours spent in 2018 providing educating on child passenger safety and crash prevention efforts.
- 125 citations and 2 child seat citations were given out in 2018.
- Reduce gaps in services/resources: Public Health, Women’s Infant and Children, Postpartum Home Visits, evidence-based family home visiting, breastfeeding support, sexual health/family planning, health promotion, tobacco cessation—referrals and warm hand off.
- Tobacco Compliance Checks completed across the region
- Riverview hosted provider education on Opioid Prescribing Guidelines
- RiverView Health/Essentia Health implement pain contracts

“Don’t Close Your Eyes” forum, a collaboration with healthcare professional, Polk County Drug Task Force, Northwest Mental Health Center, Polk County Public Health and Clearwater Life Servicer
- Riverview Health began organization supported provider enrollment in MN PDMP.
- PNM WIC working together to expand and improve joint services. Breastfeeding Peer Support offered across PNM service area.
- Increased awareness with community partners including law enforcement regarding tobacco compliance.
- Screeners implemented into public health services. Screeners include domestic violence, adverse childhood experiences, ages and
stages (developmental and social/emotional), depression and anxiety, and healthily behaviors. Warm referral/hand-off used when concerns arise.

- Polk County Public Health became recognized at a SILVER status as a Breastfeeding Friendly Public Health Department and Breastfeeding Friendly Worksites MDH Designation. Facilitate Polk County Breastfeeding Coalition. Rock-N-Rest tent offered at community events.

- **PNM CHS Family Planning/Sexual Health** clinic counseled **320** unduplicated clients, including males.

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<th><strong>Family Planning 2017-2018</strong></th>
<th><strong>2013 to 2018</strong></th>
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<tbody>
<tr>
<td>137 new birth controls started</td>
<td>12.3% TIER 1 Methods</td>
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<tr>
<td>22.6% of the client population reported American Indian race—highest in the state</td>
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<tr>
<td>49% were Tier 1 LARC’s (Long Acting Reversible Contraceptive), one of the highest % in the state.</td>
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- In 2018, with support of PNM SHIP and Healthier Fosston, the Fosston School District and the City of Fosston were awarded a *MnDOT Safe Routes to School Planning Grant* to be administered by the NW Regional Development Commission. Through SHIP, Polk County Public Health has played a key supportive and technical assistance role in the work plan of the grant. Furthermore, local SHIP advisory team, Healthier Fosston serves as the advisory board for the grant. During the fall/winter of 2018, parent surveys were administered and school district routes to school tallies were administered. A walking and biking audit was completed by the group with a community walking audit, led by Jennifer Olson of the RDC and Kirsten Fagerlund of PCPH/SHIP along with school, city, law enforcement and key community leaders. Draft strategies and action steps will be formulated. The City of Fosston and its partners, recently applied for a SRTS Implementation Grant to hopefully fund the proposed infrastructure and system upgrades to make all Fosston modes of transportation safer, creating an environment in Fosston where healthy choices are easier.
Appendix C: Positive Social Connections for Youth

We focused on emphasizing the success/progress of the strong partnerships throughout the body of the CHIP Revision. As stated prior, we are very determined to meet organizations and stakeholders where they are at. The PNM community has shown dedication, commitment, and passion in addressing the three priority areas and therefore all the successes our partners shared with or by PNM Public Health are highlighted below. **This is not an all-inclusive list.**

- **Fitness Fever** hosted in Crookston, MN by community volunteers/business with support from Polk County Public Health to provide activities for all ages four weekends in February.
- **Dekko Community Center** provides swim lesson scholarships for swimming lessons.
- Received the **Red Lake River Corridor Legacy Grant**. Promotes river access, creates a regional river trail system and overall promotes physical activity outdoors year-round. The grant connects six cities and three counties.
- **Crookston Schools** wrapped up the fourth year of the Eat United Summer Food Service Program. The program ran for 8 weeks (32 total days) and only had to cancel one day at Wildwood Park due to weather conditions. This year, we served a total of 4725 meals at two open sites and one closed location. 4580 of those were free meals served to students and the other 145 were served to paying adults. We had a great group of volunteers that helped serve the students daily from varying organizations which include Cathedral School, Crookston Public Schools, Trinity Lutheran Church, Tri-Valley Foster Grandparent Program, Polk County Public Health, St. Paul’s Lutheran Church, American Crystal Sugar, University of Minnesota Extension, Riverview Health, and the United Way of Crookston.
- **Mama’s Milk Connection** hosted by PCPH is a monthly breastfeeding support group. It celebrated its 11th year.
Appendix D: Polk County Wellness Coalition Opioid Community Action 2017-2018

POLK COUNTY WELLNESS COALITION
OPIOID TASKFORCE
Update and Call to Action
2017-2018

While prescription opioids serve an invaluable role for the treatment of cancer and chronic pain, their overuse for acute and chronic non-cancer pain as well as the increasing availability of heroin and illicit fentanyl, have contributed to the highest rates of overdose and opioid addiction not only in Polk County but also in U.S. history. Evidenced-based strategies must be included in the solutions to address these issues and to promote high-quality care for those with pain. This report is a response to that need. This report offers information and a path forward for Polk County stakeholders and residents who are committed to addressing injuries and deaths associated with opioids and other substance abuse in Polk County.

The creation of the Polk County Opioid Taskforce, (2016) a sub-group of the Polk County Wellness Committee (PCWC), resulted from several local factors, however, perhaps the most salient factor was upon learning that, for the first time in history, deaths from drug overdoses surpassed deaths from traffic crashes. The opioid crisis affects all of us, not just those caught in its grip. It has destroyed lives, ripped families apart, weakened our communities, and prevented us from taking full advantage of our greatest resource—our people. We can’t afford to lose a single person. There is no single solution to this grave public health threat, but we know where to start. “This isn’t just a law enforcement issue, a public health issue, a courts issue, treatment provider issue or just a community issue. This is all of our issue and we need everyone’s help to combat it” (Sherriff James Tadman, 2019). Thus, using best practice strategies, The Polk County Wellness Coalition Opioid Taskforce is engaging the whole Polk County community to find and implement local solutions.

- We must acknowledge that opioid addiction is a disease that requires comprehensive treatment. Closing the path to addiction means addressing the over-prescription of legal opioids and the proliferation of illegal opioids such as heroin and drugs laced with fentanyl.
- We must build a comprehensive public health response so that families, first responders, and community groups have the support necessary to turn the tide on the epidemic, and in the meantime, they do not have to single-handedly bear the impossible economic and emotional burdens.
- We must work collaboratively across all community sectors to create a community of resilience to equip the population with tools and experiences to handle life’s stressors with positive coping mechanisms, preventing chronic diseases before they begin.
This report contains:

- Polk County Wellness Coalition Opioid Taskforce Community Action Plan
- Reported, currently available data from Local, State and Federal sources
- Changes implemented and reported by stakeholder to reduce opioid misuse and death
- Polk County Rate of opioid prescriptions per 1,000 residents 2015-2017 in relation to Heroin Meth use in Polk County during same time period.
- Polk County Wellness Coalition Opioid Taskforce Infographic
- Polk County Wellness Coalition Opioid Taskforce current know partners
- Recommendations for best practice strategies that will most effectively combat this crisis

Polk County Wellness Coalition Opioid Taskforce Partners

- Polk County Public Health
- Polk County Environmental Services
- Polk County Social Services
- Polk County Sheriff’s Office
- Polk County Attorney’s Office
- Polk County District Court
- Healthier Fosston
- UND School of Medicine and Health Sciences
- EGF PD
- Crookston PD
- Minnesota State Highway Patrol
- Pine to Prairie Drug Task Force
- Tri-County Community Corrections
- Riverview Health/Recovery
- Essentia Health Fosston
- Altru Clinic – Crookston
- Northwestern Mental Health Center
- Climax School District
- Fertile School District
- WEM School District
- Crookston School District
- EGF School District
- Fisher School District
- Fosston School District
- Tri Valley Opportunity Council
- Crookston National Guard
- Minnesota Prevention Resource—Region 1
- City of Crookston
- City of Fertile
- City of Fosston
- University of Minnesota Crookston
- University of Minnesota Extension Service
- Wonderful Life Foods
- Contact Level 5 Services
- Ultima Bank-Fosston
- Fosston Chiropractic Center
CALL TO ACTION/Next Steps

- Continue the work of the PCWC Opioid Taskforce as per community action plan

- In addition:
  - Reduce barriers as identified by justice system and other partners.
    - Lack of Quality Treatment Centers-in close proximity to deal with dual diagnosis (mental and chemical). i.e. during court-person may agree to treatment-opportunity, but w/2-week delay-something happens, reoffend or missed opportunity
    - Lack of Housing-to stabilize and support community members in their recovery process
    - Lack of Employment Opportunities-that will hire convicted felons
    - Lack of Transportation-and ability to obtain a driver’s license to get to work, treatment, support meetings and for daily living needs
  - Harm Reduction
    - Community access to Naloxone
    - Safe syringe services (Needle Exchange)
  - Decrease Infectious Disease re: substance use
  - Collect and use local data as per Community Action Plan, etc. in further planning including Results Based Accountability (RBA)

- Increase Resilience of Community Members to deal with stressors of life and mitigate toxic childhood stress. As the table below indicates, our current opioid crisis is now being overshadowed by a new crisis. We must position our policies, systems and the environment of our communities to deal with stressors before they arise.
Table 1 above details the number of opioid prescriptions written per 1,000 residents for Polk County in 2015-2017. It should be noted that there was a decrease of 23% in the number of prescriptions written in Polk County from 2015-2017. This represents a significant reduction in the number of prescriptions written (MN Prescription Monitoring Program). Unfortunately, as noted in the table, the use of meth has increased significantly and represents a serious public health concern that must be addressed as we move forward with our work.
The Polk County Wellness Coalition Opioid Task Force

“For the first time ever, overdose deaths outnumber deaths from car crashes in our region.”
~Dr. Maryann Sens, UND School of Medicine and Health Sciences/Regional Medical Examiner

# cases investigated by Pine to Prairie Drug Task Force—2015-2017
# of arrests by Pine to Prairie Drug Task Force—2015-2017

23.3% 25.2% 142%

OPIOID USE IS JUST ONE PART OF SUBSTANCE ABUSE People who are addicted to...

ALCOHOL MARIJUANA

2X 3X ...more likely to be addicted to an opioid.

Polk County Prevention: Future Landscape
- Improve access to treatment and recovery services
- Advance better practices for pain management
- Reduce childhood toxic stress
- Increase the number of Worksite Wellness Initiatives
- Implement Harm Reduction and Needle Exchange programs

CPD Chief Biermaier and PC Attorney Widseth November 2018
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Goals</th>
<th>Agencies Involved Current (Future)</th>
<th>Taking Action</th>
<th>Measuring Success</th>
</tr>
</thead>
</table>
| Engaging the Medical Community               | Reduce Opioid Prescriptions| Public Health Healthcare Agencies Physicians (Dentists) (Veterinarians) Chiropractic Acupuncturist | Safer Opioid Prescriber Training RiverView Health Essentia Health Fosston Altru-Crookston Polk County Public Health | Reducing opioid prescriptions  
• # Prescribers Trained  
• Reduced Number of prescriptions rates/1000  
  * 2015 — 851.0  
  * 2016 — 770.7  
  * 2017 — 652.6  
Essentia Fosston—Improving pain & treatment plans/Increasing number of patients referred to alternative options (Acupuncture, Chiropractic, etc.)/All patients on opioids must sign contracts/All Essentia clinics provide suboxone and mental health training, patient education and Resources. Work with clinics on SBIRT  
RiverView—Provider education on opioid prescribing guidelines; outpatient pain contracts; Opioid/Pain Committee |
| Safe Medication/Prescription Disposal Guide  | Reduce the amount of leftover drugs in the community | Law Enforcement Pharmacies Healthcare Agencies Environmental Service Public Health Funeral Homes (Dental and Veterinarian Clinics)(Long-Term Care Facilities) (Senior Citizen Centers) | Start or Expand Collection Opportunities Law Enforcement—CPD, EGF PD, PCSO Pharmacies—Thrifty White Drug, Walmart, Nords Healthcare—RiverView, Essentia Fosston, Altru-Crook Polk County Environmental Services Polk County Public Health | Reducing the amount of unused/unnecessary prescription drugs in Polk County  
• # Collection Sites in Polk County  
  * 2016—2018 — 004  
• # Pounds of drugs disposed  
  * 2016—PCSO & EGF — 299#  
  * 2017—PCSO/DEA/EGF/Croix/State Patrol/RLF—355#  
  * 2018—PCSO/DEA/EGF/Croix/State Patrol/RLF—685#  
PCPH promotes safe disposal options throughout the county incinerator (Brochure) Opioid Taskforce sent letter (brochures) to all PC funeral home directors re: family safe disposal  

<table>
<thead>
<tr>
<th>Preventing Overdose</th>
<th>Increase access to opioid antidote</th>
<th>Law Enforcement/First Responders Pharmacies Healthcare Agencies Public Health/Mental Health Parents Recovery Communities Schools/Second. Education/ECFE Funeral Homes (Long-Term Care Facilities/Seniors) (Local Employers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase Resiliency</td>
<td>Increase resiliency</td>
<td>Increase access to opioid antidote • Kits Distributed—(All local law enforcement carry for personal safety 1st, community 2nd) # People Trained—RiverView (outside of county)—17 (community only-- does not include law enforce.) # Overdose Reversals RiverView Health and outside of county trainings-Public trained on Narcan administration, City Police-Crookston, Fosston and EGF and PCSO trained and carry for personal officer use and public Thrifty White Drug &amp; Walmart Crookston carries Narcan for public use (Not covered by Insurance Companies) Reduce Stigma PCPH, PCSS and NWMHC working toward reducing stigma of addiction/mental illness-social and print media Increase Resiliency—PCPH has ACE trainer on staff; increased trainings of PCSS, Early Childhood, community PCPH is working with NWMH and other partners to focus on positive psychology, mental well.</td>
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<table>
<thead>
<tr>
<th>Public Education and Media</th>
<th>Inform about dangers of opioids</th>
<th>Public Health Parents/Schools Law Enforcement Healthcare Agencies Funeral Homes Recovery Communities Judicial/Coroner (Dental/Veterinarian/Long-Term Care/Senior Citizen Centers)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hold Awareness Events/School Prevention w/media Community/PC School Districts PCPH PC Attorney’s Office/Polk County Coroner CPD, EGF PD, P2P Task Force, PCSO NWMHC RiverView/RiverView Recovery, Essentia Fosston, Altru-Crookston Probation/UMC, UM-Extension, MDH</td>
<td></td>
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<tr>
<td></td>
<td>Inform about dangers of opioids</td>
<td># Events in Polk County 2017—2 2018—3 # Attendees (in person counts only) 2017—450 2018—100 # Media Outreach (PCPH Opioid re: Facebook Reach) 2018—3,433</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Early Intervention Treatment and Recovery</th>
<th>Increase awareness of treatment resources, expand access and availability of treatment, recovery resources</th>
<th>Substance Abuse Professionals Medical Providers Recovery Community Law Enforcement Social Services Public Health Judicial Community (Corrections) (Worksites)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Build Access/Resource/Referral Network/Systems</td>
<td>NWMHC RiverView/RiverView Recovery, Essentia Fosston, Altru-Crookston PC Attorney’s Office Judicial System Tri-County Community Corrections/Probation</td>
</tr>
<tr>
<td></td>
<td>Increase awareness of treatment resources, expand access and availability of treatment, recovery resources</td>
<td># Treatment Providers—Dr. Balaraman (3/6/19) MAT (Vivitrol); NWMH-MAT Reduction in Wait time for Treatment Increase Resource Guides and Referrals 3/21/2019 Polk County Child Protection Placements—19 * 16 removed or unable to unify due to meth or alcohol use of parent - The out of home placement cost is estimated at $471.09/day. Foster care cost only Northwestern Mental Health Center and RiverView Recovery provide treatment services and assessment. NWMHC-Increase of modalities of TX/ low intensity treatment for teens and adults/withdrawal management, use of MAT, assessment of SUD through CE, Rule 25s and Comp assessments, actively involved in drug and DWI courts. Integrated assessments for all patients; more chemical/mental health staff. TCCC-Transitions program for reintegration into community Recovery homes and recovery friendly jobs Employers that will employ post felony—Crookston Welding/Dee/New Flyer;</td>
</tr>
<tr>
<td>Change laws, policies or how systems address the issue</td>
<td>Parents, Community Members, Schools, Local, County and State Officials (Faith Community) (Non-Profits) (Government Agencies)</td>
<td>Engage Community Members in Advocacy Efforts</td>
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<tr>
<td>---</td>
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<tr>
<td># Laws or systems changed</td>
<td>Community members, PCHR, PCSO, PC Attorney’s Office, CPD, EGF PD, P2P Task Force, NWMHC, PC School Districts, Riverview, Essential Fosston, Altru-Crookston, UMC, UMC-Extension, Riverview Recovery, MDH Opioid Dashboard Association of MN Counties Policy Meeting MN Governor Dayton’s Strategic Plan Legislative Intervention for Opioid relation treatment</td>
<td>MN State law in effect January 2017—MDH/M Board of Pharmacy—get naloxone at Pharmacy w/out Pharmacy w/out #Polk County Pharmacies participating 2018—2 out of 9 Immunity Law in Minnesota - clarification of wording completed by Polk County Attorney for outreach Insurance companies changing prescribing policies (number of pills per pt.) Governor Dayton’s detailed strategic plan, includes demand for additional treatment resources, Narcan Legislation changed so Narcan available without prescription, Steve Rummel’s Law gives amnesty when calling 911 during OD’s, Change Laws, Policies, or How Organizational/Systems Address the Issues, Reduce ACE’s/Increase Resiliency, Association of MN Counties held conference last fall. Justice-Involved Population Supports</td>
</tr>
<tr>
<td># Polk County Pharmacies participating</td>
<td>2018—2 out of 9</td>
<td>Polk County Pharmacies participating</td>
</tr>
</tbody>
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Justice Involved Population Supports