CENTRAL MN ALLIANCE
STRENGTHENING PARTNERSHIPS FOR CHANGE

Community Health Improvement Plan

July 1, 2022-June 30, 2025

Version 1: 6/30/22

Stearns County Minnesota

CentraCare™

BENTON COUNTY MINNESOTA

SHERBURNE COUNTY

LEGAL REQUIREMENTS

This document provides documentation of the following legal requirements:

The Minnesota Community Health Services Act (Minn. Stat. § 145A) of 1976, which was subsequently revised in 1987 and 2003, and is now called the Local Public Health Act. This document describes the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHIP).

The United States Patient Protection and Affordable Care Act of 2010 (PPACA) imposed reporting requirements under new Internal Revenue Code (IRC) § 501(r) for charitable hospitals regarding the fulfillment of their charitable purpose as tax-exempt organizations starting in 2011. This document describes the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan.

Americans with Disabilities Act Advisory:

This information is available in accessible formats to individuals with disabilities and for information about equal access to services, call 320-656-6000 (voice). TTY users place calls through 320-656-6204 (TTY).

Community Health Improvement Plan 2023-2025

Message to the Community,

To be more effective in meeting the needs of the community, Public Health in the counties of Benton, Sherburne, and Stearns, alongwith CentraCare, have developed a partnership called the Central MN Alliance.

Every three years, CentraCare is required to complete a Community Health Needs Assessment and develop a Community Health Improvement Plan to address identified needs. At the same time, all Local Public Health Agencies in Minnesota are required to complete this same type of assessment and improvement plan every five years. Effective July 1, 2019, Local Public Health will align with CentraCare and complete this work, as a region, every three years.

This essential collaboration between hospitals and public health is important to address population health needs and to decrease the duplicative nature of these two separate assessment and planning requirements. Therefore, this document serves as the Community Health Needs Assessment and Community Health Improvement Plan for CentraCare and serves as the Community Health Assessment and Community Health Implementation Plan for Benton, Sherburne, and Stearns Counties.

Furthermore, this work has not been conducted in isolation but in collaboration with the community. There have been and will continue to be opportunities for input into the process, the product, and future needs and changes to the document.

We encourage you to continue to partner with us as we strive to make the Central Region of Minnesota the healthiest in the state!

Danielle Protivinsky	*Jaclyn Litfin*	*Nicole Ruhoff*	*Janet Goligowski*
Danielle Protivinsky CentraCare	Jaclyn Litfin Benton County Public Health	Nicole Ruhoff Sherburne County Public Health	Janet Goligowski Stearns County Public Health

About this report: The Central MN Alliance prepares a comprehensive assessment every three years. This report is considered a living document and is updated periodically and this, along with other data profiles, can be found at each partner website along with contact information for the partners found in Community HealthImprovement Plan (CHIP), the action plan to execute community goals and action steps.

Executive Summary

Vision, Structure of Process, Priorities, Guiding Principles, and Root Causes/Drivers of Inequities

The Central MN Alliance Vision: In Central MN, every voice counts, every need is important, every culture respected, and everyone is involved in building a better community life with equitable services for all.

This Community Health Improvement Plan (CHIP) is an action plan to address the community priorities identified in the Community Health Needs Assessment (CHNA) process.

The Central MN Alliance used the MAPP (Mobilizing Action through Planning and Partnerships) Evolution Framework to conduct a community health assessment and identify root cause areas within which to concentrate efforts to improve community health. The Implementation Phase of this CHIP is July 1, 2022, through June 30, 2025. Documentation for the Community Health Needs Assessment that was conducted resulting in this CHIP can be found in Appendix 2 of this document.

This is the second CHIP on which the Central MN Alliance partners have collaborated. The infrastructure from the previous process was maintained to identify the top two community priorities of Building Families and Mental Well-Being and the guiding principles of community collaboration, equity, resilience, education, awareness, and health organizations.

MAPP Framework: Mobilizing for Action through Planning & Partnerships

MAPP is a product of NACCHO, National Association of County and City Health Officials

Community Health Improvement Plan 2023-2025

Top Community Priorities:

Building Families

Mental Health

Guiding Principles to conduct the work:

- **Community Collaboration**
- **Equity Lens**
- **Focus on Strengths & Resilience**
- **Build Awareness**
- **Educate and Inform**
- **Involve Health Organizations**

Drivers of Inequities on which to focus:

Data Access & Systems	**Structural Racism**	**Lived Experience**	**Historical Context**

Community Health Improvement Plan 2023-2025

Central MN Alliance Continuing Community Priorities

	Priority	Examples
1	**Building Families**	Individual/family intervention Child well-being Parenting skills
2	**Mental Health**	Awareness Access Well-being Addiction
3	**Encouraging Social Connection**	Across the age spectrum Building social connections Community intervention
4	**Adverse Childhood Experiences (ACEs)**	Awareness Cultural Preventative measures Leading to chronic disease
5	**Tobacco/Nicotine Use**	E-cigarettes Addiction
6	**Health Care**	Access Cost
7	**Risky Youth Behavior**	Education Trafficking Mental health Homelessness Alcohol, tobacco, and other drugs Physical health Safety
8	**Financial Stress**	Living wage Unemployment Affordable living
9	**Trauma**	Across the lifespan
10	**Educating Policy Makers and Key Community Stakeholders**	Educating on emerging issues in the community

Community Health Improvement Plan 2023-2025

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Working toward Community Health Improvement, The Community's Plan

The 2023-2025 Community Health Improvement Plan (CHIP) builds upon the infrastructure of the 2019-2022 CHIP.

There were many strategies within the 2019-2022 CHIP that focused more on partner engagement and equity. The global COVID-19 pandemic struck shortly into the Implementation Phase of the 2019-2022 CHIP and most specific activities of the CHIP were put on hold while local public health and health organizations – clinics and hospitals – responded to pandemic.

While the specific strategies of the 2019-2022 CHIP were not all completed, where the focus landed was on partner engagement and how best to reach and serve all persons within the community for COVID-19 response.

Central MN Alliance (CMA) partners followed the guiding principles of the CHIP to collaborate with the community and use an equity lens to focus on the strengths and resilience of all persons. For COVID-19 response, there was a drive to build awareness and educate and inform the community on resources and services. The health organizations were heavily involved in data collection and surveillance and service provision.

The 2023-2025 CHIP incorporates the energy of the 2019-2022 plan and incorporates the lessons learned from ongoing and new partner engagement during the pandemic years of 2020 and 2021.

The intention is that this CHIP will be The Community's Plan. For the purposes of state statute and federal law, the CMA staff will assist in ensuring the processes are tracked for reporting purposes, but the aim is to have the community see themselves in the document and the work it describes.

The 2023-2025 CHIP will be a living document which will reside on all CMA partner websites for ease of community access. The initial 7/1/2022 version will list that CMA partners will monitor process, but there will not be any specific "Agencies working on Strategy" listed until additional engagement takes place after 7/1/22.

According to statute and law, all persons in the community share responsibility to be engaged, monitor, and revise the CHIP. If you wish to get involved or have any questions or concerns regarding the CHIP, would like to attend any Central MN Alliance (CMA) meetings, or would like CMA staff to attend any of your meetings, please reach out to any of the contacts listed in this document.

Community Health Improvement Plan 2023-2025

Driver / Influencer: Data Access & Systems (DAS). Data available across partners, data sharing, data transparency, data infrastructure to track impact on inequities.

Data Access & Systems – Data Availability & Transparency - **Desired Outcomes**
Identified by the Community Partners Committee through an Interrelationship Diagraph Exercise of Drivers

Support Families and Increase Mental Well-Being by
-Public policies will use an equity lens to impact inequities
-Community participates in shaping programs

Data Access & Systems (DAS) Goal 1: Share local equity data by developing data visuals coordinated with National recognition months, i.e.: Mental Health Awareness Month.

Anticipated Impact: Partner agencies and community members across the 3-county region will have access to local equity related data that is useful for their purposes.

Performance Measure: Social media views of data visuals will be monitored and tracked to adjust practice to increase views and use of the data.

Target Date: After initial analysis of the 2021 Central MN Community Health Survey and Ongoing for the remainder of the Implementation Phase, through 6/30/25

Agencies working on Action Steps: list is a work in progress

Person/Agency monitoring progress for this document: Central MN Alliance Process Managers and Leadership Team

Community Health Improvement Plan 2023-2025

Data Access & Systems (DAS) Goal 1 Action Steps (re: Data Accessibility & Transparency)	
Data Access & Systems (DAS) Action Step 1.1: Communicate with community partners about the Central MN Community Health Survey and other secondary data sources used by Local Public Health and CentraCare to find out data needs in the community.	Measure of Success: Within the first 6 months of having the Health Survey data analyzed, 20 community partner conversations will take place. Community partner conversations will be tracked, and data source needs will be compiled.
Data Access & Systems (DAS) Action Step 1.2: Identify a monthly calendar of recognition months that correspond with the local data needs of the community.	Measure of Success: By the 8th month of having the Health Survey data analyzed, the first 4 months of data campaigns will be identified – the calendar will be added to monthly.
Data Access & Systems (DAS) Action Step 1.3: Create data visuals for recognition months (examples: newsletter articles, social media posts, 1-pager fact sheets, image visuals)	Measure of Success: Data Visuals will be stored in a centralized location for use by all Central MN Alliance members. A method will be identified and created for partners to access the data visuals.
Data Access & Systems (DAS) Action Step 1.4: Share the visuals with the community during the recognition months. Examples of places to share: Somali radio, Somali TV, BIPOC social media outlets, partner social media, newspaper, partners websites.	Measure of Success: Location where data visuals are shared will be tracked and monitored for views and use. A media partners list will be maintained.

Community Health Improvement Plan 2023-2025

Driver / Influencer: Data Access & Systems (DAS). Access to technology/broadband.

Data Access & Systems – Access to technology - **Desired Outcomes**
Identified by the Community Context Committee through an Interrelationship Diagraph Exercise of Community Themes

Support Families and Increase Mental Well-Being by
-Decrease social isolation
-Decrease domestic violence, child abuse, and vulnerable adult abuse
-Increase community engagement opportunities
-Increase LGBTQ+ services and support gaps
-Increase access to healthy and affordable foods
-Increase access to all types of healthcare (dental, mental health, substance use, increase diverse providers and linguistically appropriate care, culturally competent addiction clinics)

Data Access & Systems (DAS) Goal 2: Increase access to broadband across the 3-county region.
Anticipated Impact: Broadband household use will increase across the 3-county region.
Performance Measure: Increase household use of broadband, particularly for households that qualify for affordability programs. Increase the flexibility of broadband affordability programs.
Target Date: Ongoing for the Implementation Phase, 7/1/22 through 6/30/25
Agencies working on Action Steps: list is a work in progress
Person/Agency monitoring progress for this document: Central MN Alliance Process Managers and Leadership Team

Data Access & Systems (DAS) Goal 2 Action Steps (re: Access to Technology/Broadband)	
Data Access & Systems (DAS) Action Step 2.1: Identify existing activities to increase broadband access in all three counties. One example is the USAC (Universal Service Administrative Co.) Affordable Connectivity Program.	Measure of Success: Create and maintain a list of partners conducting broadband accessibility work.
Data Access & Systems (DAS) Action Step 2.2: Prepare educational materials regarding how access or lack of access to broadband impacts health.	Measure of Success: Educational materials will be prepared and stored in a centralized location for use by all Central MN Alliance members. A method will be identified and created for partners to access the educational materials.
Data Access & Systems (DAS) Action Step 2.3: Actively advocate for increasing access to broadband utilizing the educational materials.	Measure of Success: Social media views of educational materials will be monitored and tracked to adjust practice to increase action.

Community Health Improvement Plan 2023-2025

Driver / Influencer: Structural Racism (SR) & Community Power: the ability to control the processes of agenda setting, resource distribution, and decision making, as well as to determine who is included and excluded from these processes.

Structural Racism & Community Power - **Desired Outcomes**
Identified by the Community Context Committee through Interrelationship Diagraph Exercises of Drivers and Community Themes

Support Families and Increase Mental Well-Being by
- -Systems recognize the strengths and assets of the communities served
- -Systems prioritize the needs as identified by the communities served
- -Decrease social isolation
- -Decrease domestic violence, child abuse, and vulnerable adult abuse
- -Increase community engagement opportunities
- -Increase LGBTQ+ services and support gaps
- -Increase access to healthy and affordable foods
- -Increase access to all types of healthcare (dental, mental health, substance use, increase diverse providers and linguistically appropriate care, culturally competent addiction clinics)

Structural Racism & Community Power (SR) Goal 1: Create and build upon Human Resource toolkits regarding diverse workforce recruitment, implementation, and support. Make toolkits widely accessible.

Anticipated Impact: Equitable hiring processes will be utilized across the 3-county region.

Performance Measure: Identify the number of agencies utilizing strategies to recruit a diverse workforce.

Target Date: Ongoing for the Implementation Phase, 7/1/22 through 6/30/25

Agencies working on Action Steps: list is a work in progress

Person/Agency monitoring progress for this document: Central MN Alliance Process Managers and Leadership Team

Community Health Improvement Plan 2023-2025

Structural Racism & Community Power (SR) Goal 1 Action Steps	
Structural Racism & Community Power (SR) Action Step 1.1: Identify who in the community is conducting this work.	Measure of Success: Maintain a list of agencies within the community building and creating Human Resources tips and tools for diverse workforce recruitment.
Structural Racism & Community Power (SR) Action Step 1.2: Collaborate for toolkit creation. Ensure toolkits include: sample job descriptions; sample interview questions; suggestions on how to recruit a more diverse population; listings for resume building opportunities, internships, shadowing opportunities.	Measure of Success: Identification of a toolkit or toolkits for distribution, sharing, etc.
Structural Racism & Community Power (SR) Action Step 1.3: Support agencies conducting this work.	Measure of Success: Actions taken to support the distribution of Human Resources toolkit/s for diverse workforce recruitment will be tracked.
Structural Racism & Community Power (SR) Action Step 1.4: Connect with all ages of youth to increase representation of our communities. Showcase BIPOC (Black, Indigenous, People of Color) persons across all career fields.	Measure of Success: Actions taken to showcase BIPOC persons across all career fields will be tracked.

Community Health Improvement Plan 2023-2025

Driver / Influencer: Lived Experience (LE); the perceptions, insights, values, culture, and priorities of those experiencing inequities

Lived Experience - **Desired Outcomes**
Identified by the Community Context Committee through Interrelationship Diagraph Exercises of Drivers and Community Themes

Support Families and Increase Mental Well-Being by
-Systems recognize the strengths and assets of the communities served
-Systems prioritize the needs as identified by the communities served

-Decrease social isolation
-Decrease domestic violence, child abuse, and vulnerable adult abuse
-Increase community engagement opportunities
-Increase LGBTQ+ services and support gaps
-Increase access to healthy and affordable foods
-Increase access to all types of healthcare (dental, mental health, substance use, increase diverse providers and linguistically appropriate care, culturally competent addiction clinics)

Lived Experience (LE) Goal 1: Create or Build Upon "What Creates Health" Campaigns. Instill this information as facts into the community experience; policies and built environment impact our health more than personal behavior or the health care system.

Anticipated Impact: It will be more broadly understood by the residents of the 3-county region that 70% or more of our health is beyond personal behavior. 30% personal behavior, 20% clinical care, 40% social/environmental, 10% environment.

Performance Measure: The number of conversations utilizing culturally/linguistically appropriate methods to gather and provide education will be tracked.

Target Date: Ongoing for the Implementation Phase, 7/1/22 through 6/30/25

Agencies working on Action Steps: list is a work in progress

Person/Agency monitoring progress for this document: Central MN Alliance Process Managers and Leadership Team

Community Health Improvement Plan 2023-2025

Lived Experience (SR) Goal 1 Action Steps	
Lived Experience (LE) Action Step 1.1: Build relationships with community members and use personal stories from people in our three-county area to illustrate 'what creates health?' Include history, backgrounds, and success stories.	Measure of Success: Gather feedback from persons who have their story shared to ensure their story was respected and they felt safe sharing their story.
Lived Experience (LE) Action Step 1.2: A measurement tool will be identified to ensure that when creating materials to be shared with the community, (such as flyers, social media posts, infographics, etc.), they will be created using culturally appropriate methods including but not limited to translated materials, photos/videos of those from diverse or minority populations, ADA compliance with color contrast, captioning, etc.	Measure of Success: Each piece of education material will be scored using the measurement tool. The education materials will be stored with the measurement tool results. The measurement tool will be modified when necessary.
Lived Experience (LE) Action Step 1.3: Utilize social media to push out ad campaigns to build awareness around "What Creates Health" and things that are taking place that impact health. (i.e., promoting actual policy changes that are taking place, or changes to the built environment)	Measure of Success: Social media views of educational materials will be monitored and tracked to adjust practice to increase reach and interaction.
Lived Experience (LE) Action Step 1.4: Provide information and outreach around trauma and healing; outreach / education / programming around Adverse Childhood Experiences (ACEs), Resilience, and Hope.	Measure of Success: ACEs, Resilience, and Hope outreach activities will be documented and tracked.

Community Health Improvement Plan 2023-2025

Driver / Influencer: Historical Context (HC). Research of community's history to understand the institutional and structural root causes of inequities.

Historical Context - **Desired Outcomes**
Identified by the Community Context Committee through Interrelationship Diagraph Exercises of Drivers and Community Themes

Support Families and Increase Mental Well-Being by
-Systems recognize the strengths and assets of the communities served
-Systems prioritize the needs as identified by the communities served

-Decrease social isolation
-Decrease domestic violence, child abuse, and vulnerable adult abuse
-Increase community engagement opportunities
-Increase LGBTQ+ services and support gaps
-Increase access to healthy and affordable foods
-Increase access to all types of healthcare (dental, mental health, substance use, increase diverse providers and linguistically appropriate care, culturally competent addiction clinics)

Historical Context (HC) Goal 1: Encourage all agencies to adopt Land Acknowledgements – in a broad sense of acknowledging the ancestral lands of the Minnesota Indians, as well as peoples who were brought to this land against their will, peoples forced into labor to build infrastructure that benefits us today, and peoples who came here from distance lands in hope of a better life. (i.e., acknowledge the legacies of violence, displacement, migration, and settlement)

Anticipated Impact: Awareness amongst residents of the 3-county region will be increased about the systemic, structural, & institutional root causes of inequities

Performance Measure: Policy-related measure: Number of agencies implementing their Land Acknowledgement Use Plan.

Target Date: Ongoing for the Implementation Phase, 7/1/22 through 6/30/25

Agencies working on Action Steps: list is a work in progress

Person/Agency monitoring progress for this document: Central MN Alliance Process Managers and Leadership Team

Historical Context (HC) Goal 1 Action Steps	
Historical Context (HC) Action Step 1.1: Inquire with agencies that have instituted Land Acknowledgements to explore the processes they employed.	Measure of Success: Reach out to a minimum of 10 agencies that have instituted Land Acknowledgements to learn about their process. A count of agencies and notes about lessons learned will be documented.
Historical Context (HC) Action Step 1.2: Engage with community to discuss what a Land Acknowledgement means to them. Engage with Tribal leaders, Black Americans, generational farmers, etc. Use this information to inform the writing of the Acknowledgement.	Measure of Success: Partners engaged in this conversation will be tracked.
Historical Context (HC) Action Step 1.3: Develop the Land Acknowledgement.	Measure of Success: The number of land acknowledgements will be tracked.
Historical Context (HC) Action Step 1.4: Prominently post the Land Acknowledgement in physical buildings and on websites. Use Land Acknowledgement at all presentations.	Measure of Success: Land Acknowledgement Use Policies will be tracked and use examples will be documented.

Population Measures for the 2023-2025 CHIP:

Population Measures to be tracked include:

- Housing Ownership: Owner Occupied %
- Median Income
- Unemployment Rate

When contemplating the population measures to track for the 2023-2025 Central Minnesota Alliance (CMA) Community Health Improvement Plan (CHIP), the Drivers of Inequities and the availability of data were considered.

The population measures that were identified are all economic related as it was identified that the Driver of Structural Racism/Community Power can be impacted by increasing the amount of income and wealth to which an individual and family have access.

These population measures do not change much from year-to-year and while it is recognized that they are best examined by disaggregation, we are only including the primary data trends in this report.

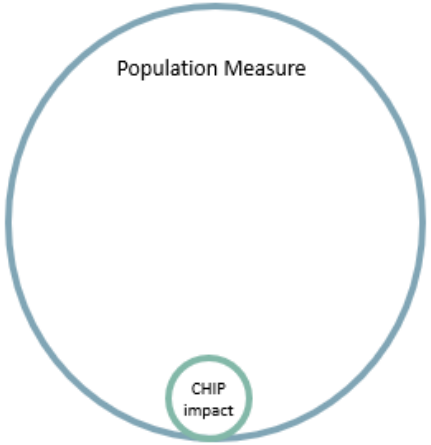
We do so, by also recognizing that it is our goal to continue to examine these data by multiple variables of disaggregation. We have included one example with the Percent of Owner-Occupied Housing dataset. There is a parallel data project occurring in the St. Cloud Area, Central Minnesota Communities of Excellence – Granite Table, which includes examining data at the census tract level. CMA members are involved in this project and the CMA CHIP population measures are being analyzed along with other community indicators.

There was a November 2021 Report released by 247WallSt.com that ranked St. Cloud as the worst city in the United States for Black Americans. They looked at the following data indicators by race: median income, unemployment, homeownership rates, and highs school attainment rates.

Presenting the CMA CHIP population measures by race was considered. Upon consultation with our local data resource regarding data from DEED (the MN Department of Employment and Economic Development), due to the margins of error when looking at smaller geographies, the decision was made to not provide these CHIP population measures by race.

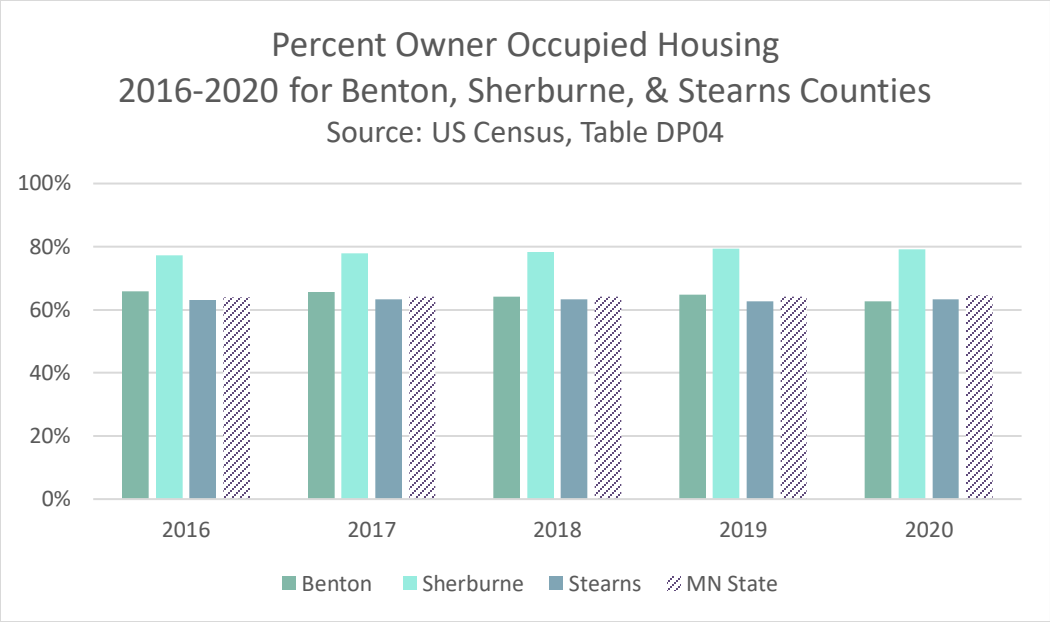
It is recognized that wealth is not the only way for an individual or community to increase power. Economic data indicators are the most available data currently.

Finally, it is additionally recognized that the work that is completed in this CHIP by CMA members and community partners is a portion of the myriads of projects, policies, and programs that impact these measures. Despite that, reasons for using these measures include: the data are easily accessible, they are used to judge our community by outside entities, and others are familiar with these data as indicators.



Community Health Improvement Plan 2023-2025

Population Measures for the 2023-2025 CHIP. Percent Owner Occupied Housing by County



	Benton	Sherburne	Stearns	MN State
2016	66%	77%	63%	64%
2017	66%	78%	63%	64%
2018	64%	78%	63%	64%
2019	65%	79%	63%	64%
2020	63%	79%	63%	65%

Notes about the data: See US Census Table DP04. Desired trend is upward.

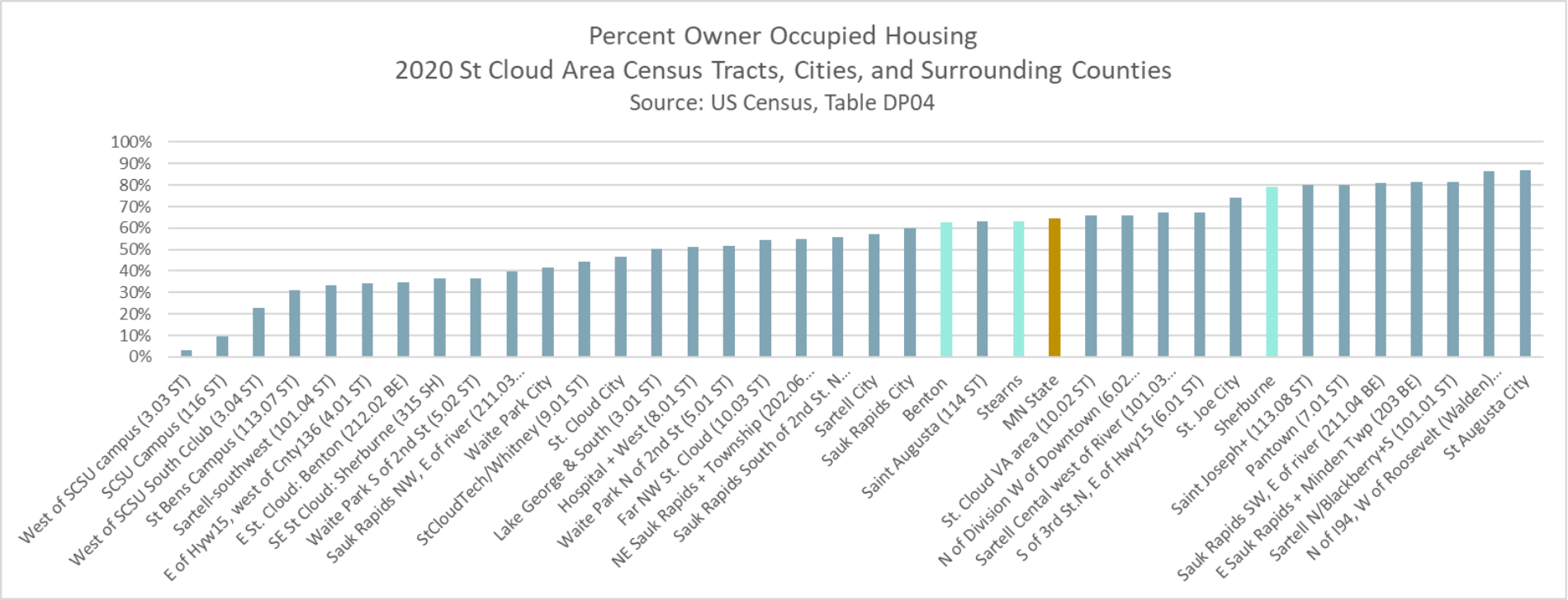
Key Data Points: Benton and Stearns Counties have similar percent owner occupied housing rates as the State.

Equity Analysis Goals: To review these data by race, ethnicity, and smaller geographies such as Census Tract and City. Have conversations with individuals and partners regarding the data.

Trend Discussion: These data are fairly stable over this five-year period.

Community Health Improvement Plan 2023-2025

Population Measures for the 2023-2025 CHIP. Percent Owner Occupied Housing – disaggregation example.



Notes about the data: Parenthetical coding within geographic names: (Census Tract #, ST= Stearns, BE=Benton, SH=Sherburne). Desired trend is upward.

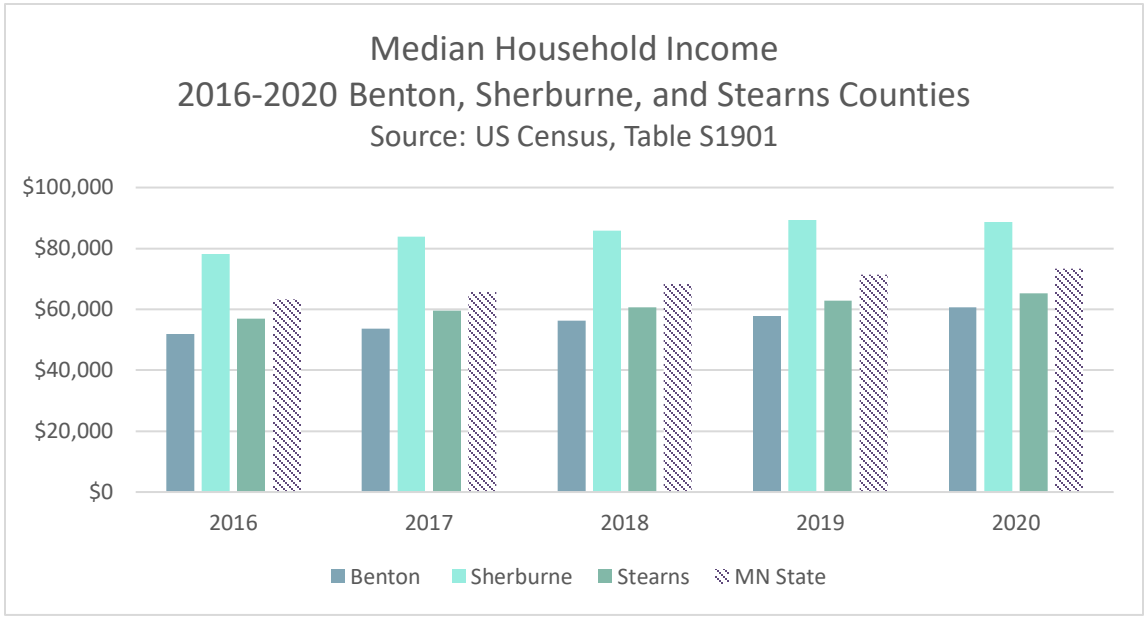
Key Data Points: More nuances can be seen in the data by looking at Census Tract.

Equity Analysis Goals: have conversations with persons living in these neighborhoods about the data.

Trend Discussion: Goal is to look at these data over time. The number of Census tracts change at the decennial census. These are baseline data.

Community Health Improvement Plan 2023-2025

Population Measures for the 2023-2025 CHIP. Median Income.



	Benton	Sherburne	Stearns	MN State
2016	$51,841	$78,081	$56,977	$63,217
2017	$53,574	$83,895	$59,564	$65,699
2018	$56,357	$85,818	$60,606	$68,411
2019	$57,715	$89,250	$62,789	$71,306
2020	$60,564	$88,671	$65,244	$73,382

Notes about the data: See US Census Table S1901. Desired trend is upward.

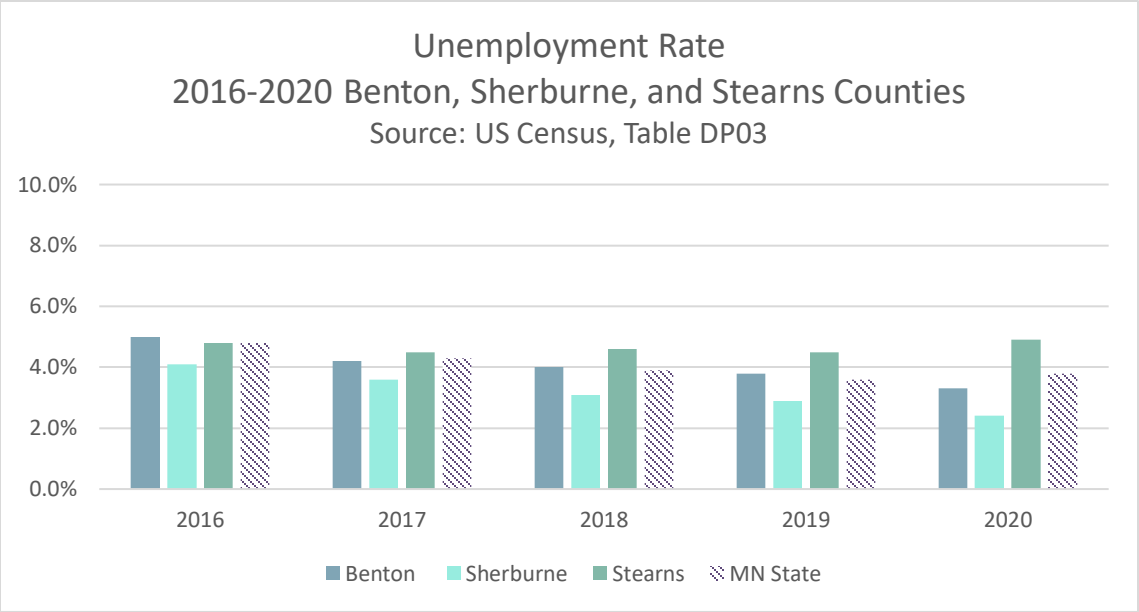
Key Data Points: Benton and Stearns Counties are below the State Median Income.

Equity Analysis Goals: To review these data by race, ethnicity, and smaller geographies such as Census Tract and City. Have conversations with individuals and partners regarding the data. Compare these data to inflation, cost of living, food costs, and housing costs.

Trend Discussion: From 2016 to 2020, there is a general upward trend of these data.

Community Health Improvement Plan 2023-2025

Population Measures for the 2023-2025 CHIP. Unemployment Rate.



	Benton	Sherburne	Stearns	MN State
2016	5.0%	4.1%	4.8%	4.8%
2017	4.2%	3.6%	4.5%	4.3%
2018	4.0%	3.1%	4.6%	3.9%
2019	3.8%	2.9%	4.5%	3.6%
2020	3.3%	2.4%	4.9%	3.8%

Notes about the data: See US Census Table DP03. Desired trend is downward.

Key Data Points: Generally, the unemployment rate has gone down for all three counties over the course of the five years. One exception is Stearns County in 2020.

Equity Analysis Goals: Explore disaggregating these data by race, gender, ethnicity, or other characteristics identified by additional conversation about these data with partners and individuals in the three counties.

Trend Discussion: From 2016 to 2020, there is a general downward trend of these data.

Community Health Improvement Plan 2023-2025

BENTON COUNTY MINNESOTA

Data Access & Systems

- Partner agencies and community members across the 3-county region will have access to local equity related data that is useful for their purposes
- Broadband household use will increase across the 3-county region

Structural Racism/Community Power

- Equitable hiring processes will be utilized across the 3-county region activities

Lived Experience

- It will be more broadly understood by the residents of the 3-county region that 70% or more of our health is beyond personal behavior. 30% personal behavior, 20% clinical care, 40% social/environmental, 10% environment

Historical Context

- Awareness amongst the residents of the 3-county region will be increased about the systemic, structural, and institutional root causes of inequities

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Community Health Improvement Plan 2023-2025

SHERBURNE COUNTY

Data Access & Systems

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Community Health Improvement Plan 2023-2025

CentraCare™

Hospitals include: St. Cloud Hospital, Melrose, Sauk Centre, Paynesville, Long Prairie, Monticello

CentraCare is committed to working on initiatives that support drivers of **data access & systems, structural racism/ community power, lived experience, and historical context.** CentraCare's goals and strategies to place focus on areas above, action items in areas of Community Collaboration, Equity, Awareness, Resilience, Education, and Connections to access through Health Organizations. Below are goals and strategies aligned with the identified drivers that allow for a collective impact.

Equity & Community Collaboration

- CentraCare will continue to share data with local partners showcasing population health measures that impact overall health of communities served
- CentraCare will work to disseminate communication and connections focused on increasing broadband access
- CentraCare Population Health Leadership Team will consider equitable practices while analyzing data that drives work
- The Community Wellness team will collaborate with local community partners to provide and coordinate methods of health education, prevention, and intervention.
- The CentraCare Community Wellness Team will be a pillar of support to all Hospitals to drive population measures through health education, health promotion, Mental Health & Well-being, areas of prevention, Connection & Collaborations.
- Utilization of hospital and clinic space by community partners will be allocated to serve of greatest need for community and will be tracked and reported to the CentraCare Community Benefit IRS report.
- The Community Wellness team will work across communities to increase access to preventive services, connections to primary care with the goal of improving outcomes, access, and decreased emergency room utilization.

Awareness & Resilience

- Equitable hiring processes will be utilized across the 3-county region activities
- Create awareness within CentraCare about the workplace and patient diversity
- Identify the leaders and strategies within CentraCare focused on engaging patients and partners to advance health equity
- CentraCare will continue to progress on ACE's Collaborative work
- CentraCare will partner with the community to offer Bounce Back Project.
- Utilize resiliency index created for Mental Health programming and progress in areas of Adverse Childhood Experiences and Trauma
- The Community Wellness team will work enterprise wide supporting all hospital and clinic sites in activities to support mental health & well-being.
- CentraCare will partner with Aging organizations to support seniors and address senior wellness
- Increase Community knowledge and awareness of CommUNITY Adult Mental Health Initiative
- Community Wellness team will work closely with each region on focused areas of trauma informed care, depress, anxiety, post-partum depression, and more.

Community Health Improvement Plan 2023-2025

CentraCare™ Continued…

Education & Health Organizations

- It will be more broadly understood by the residents of the 3-county region that 70% or more of our health is beyond personal behavior. 30% personal behavior, 20% clinical care, 40% social/environmental, 10% environment
- Integration of support services like WIC into health system accessibility, access, and improved customer service
- CentraCare and Community Wellness will offer a variety of educational classes focused around childbirth, car seat safety, breastfeeding, diabetes, and more.
- The Community Wellness team will collaborate with safe routes and tobacco prevention initiatives to support healthy learning
- CentraCare will partner with local public health to improve OB and post-partum education
- CentraCare will provide community education for end-of-life discussions and quality of life planning.
- Awareness amongst the residents of the 3-county region will be increased about the systemic, structural, and institutional root causes of inequities
- The Community Wellness team will lead and support advocacy work with stakeholders and community partners to implement prevention policies through a lens of health equity
- CentraCare will work to address social determinants of health through patient and community outreach in all regions
- Roll out patient outreach for social determents of health system-wide with utilization of EPIC electronic medical record
- Address areas of substance use, harm reduction, and improve care for people experiencing pain and addiction
- Suicide prevention education and training in schools for teachers, staff, and students in coordination with Central MN Mental Health Center
- Breast feeding and evidence based and best practices through CentraCare
- Increase education and connection to community partner organizations to increase support in areas of transportation, food insecurity, housing, financial strain, and well-being.
- Address key health measures with patients and our communities
- Disseminate health education and health promotion materials that are culturally and linguistically appropriate

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CentraCare is committed to cultivating partnerships across all areas we serve to address the broad spectrum of changing needs of our communities. As we continue to make the wellness of our patients and the community our priority, we will continue to align our work appropriately across the system.

Central MN Alliance
Strengthening Partnerships for Change

Potential Partners

Potential Partners for Building Families

- 4H Clubs
- Anna Marie's Alliance
- Avivo
- ARC Midstate
- Baby Café
- Big Brothers and Big Sisters of Central Minnesota
- Bi-lingual cultural representative-leaders (to help discuss cultural norms)
- Birthline
- Boys and Girls Club of Central Minnesota
- CAMHI (CommUNITY Adult Mental Health Initiative)
- Car Seat Collaborative
- Catholic Charities
- Center for Victims of Torture (Waite Park)
- Central MN Breastfeeding Coalition
- Central MN Council on Aging
- Central MN Falls Prevention Workgroup
- Central MN Sexual Assault Center
- Chief health officer/family CentraCare
- Community health workers
- County Attorney Offices
- County Human Services Partners: *Family andChildren Services, Adult Services, Corrections/Probation Services, Financial Services*
- County Sheriff Offices
- Faith-based groups
- Families in Transition Services, Inc.
- Family physicians
- First Steps Collaborative of Central MN
- Food Pantries
- Goodwill Easter Seals
- Greater St. Cloud Area Thrive Initiative
- Hands Across the World
- Health Care Providers (*including Rejuv Medical, Williams IntegraCare, Health Partners, etc.*)
- Health Plans (UCare, HealthPartners, Medica)
- Help Me Connect
- Holdingford Helping Hands
- HRA
- Independent Lifestyles
- Initiative Foundation
- Kiwanis
- Law Enforcement
- Lions
- Lutheran Social Services
- Milestones
- Minnesota Department of Health
- Minnesota Department of Human Services
- Nurses
- Minnesota Fathers and Families Network
- New Beginnings
- PACER Center
- Parent Connect by ARC Midstate, meetings forthose who are parenting children with special needs
- Parish Nurses
- Pathways for Youth
- Place of Hope
- Prevent Child Abuse Minnesota/Minnesota Communities Caring for Children
- Reach-Up, Inc., Head Start, Early Head Start
- Recovery Plus, Recovery Plus- Adolescent, Journey Home, and Family Unity
- Resource Training and Solutions

Potential Partners for Building Families (continuation)

- Rotary
- RSVP
- Salvation Army
- Sauk Rapids/Rice Early Childhood Programs
- Schools, teachers, Title I Staff, early childhood educators
- Service Providers for Mental Health (Central Minnesota Mental Health Center, Village Family Services, Caritas Mental Health Clinic, Catholic Charities Young Learners Program, Center for Psychological Services, Child and Adolescent Specialty Care [CentraCare Health Plaza], Clara's House, HealthPartners Behavioral Health, ISD 742/St. Cloud School District Triage System, Lutheran Social Services, Pinecone Family Counseling, Four County Crisis Response Team, and individual therapists and counselors)
- SNAP educators/U of M Extension
- St. Cloud Area Crisis Nursery
- St. Cloud Area YMCA St. Cloud Feeding Area Children Together (FACT)
- St. Cloud State University Child and Family Studies Department
- TriCap (Community Action Program)
- Young Parent Program (YPP)
- United Way
- Veterans Affairs

**Note: Our intent is to have community-driven strategies that encompass all sectors. These lists are in no way meant to be exhaustive. They are meant to be used as considerations when working on community initiatives and identify gap areas of inclusion. If you would like another resource added to these lists, contact any member of the Process Managers or Leadership Group. (Note: For a list of existing resources, refer to CHNA Section I: Existing Community Resources.*

Potential Partners for Mental Health

- 180 Degrees Emergency Youth Center – St. Cloud
- Anna Marie's Alliance
- ARC Midstate
- Avivo
- Boys and Girls Club of Central Minnesota
- Center for Victims of Torture (Waite Park)
- CentraCare OB Clinic
- CentraCare Stroke Program
- Central MN Community Empowerment Organizations (CMCEO)
- Central Minnesota Mental Health Center
- Central MN Suicide Prevention Coalition
- Coalition to End Social Isolation and Loneliness (CESIL)
- Community Non-Profits
- Community Paramedics
- County Attorney Offices
- County Human Services Partners: Family and Children Services, Adult Services, Corrections/Probation Services, Financial Services
- County Sheriff Offices
- Emergency Rooms, Behavioral Access Nurses
- Families for Depression Awareness (Massachusetts Non-profit)
- Fe y Justicia
- Goodwill Easter Seals
- Greater St. Cloud Area Thrive Initiative
- Health Care Providers (*including RejuvMedical, Williams IntegraCare, HealthPartners, etc.)*
- Health Care Home Coordinators
- Health Plans (UCare, HealthPartners, Medica)
- HealthForce Minnesota
- Higher Ground
- Initiative Foundation
- Law Enforcement
- Local policymakers
- Mental Health Service Providers (Central Minnesota Mental Health Center, Village Family Services, Caritas Mental Health Clinic, Catholic Charities Young Learners Program, Center for Psychological Services, Child and Adolescent Specialty Care [CentraCare Health Plaza], Clara's House, HealthPartners Behavioral Health, ISD 742/St. Cloud School District Triage System, Lutheran Social Services, Pinecone Family Counseling, Four County Crisis Response Team, St. Cloud VA Health Care System, and individual therapists, psychologists, social workers, and counselors)
- Minnesota Association for Children's Mental Health
- Minnesota CIT (Crisis Intervention Training) Association
- Minnesota Department of Economic and Educational Development
- Minnesota Department of Health Minnesota Department of Human Services
- Minnesota Psychological Association
- National Alliance on Mental Health
- New Beginnings
- Parish Nurses

Potential Partners for Mental Health (continuation)

- Reach-Up, Inc., Head Start Early Head Start
- Recovery Plus, Recovery Plus- Adolescent, Journey Home, and Family Unity
- Resource Training and Solutions
- Rise
- Rural Assistance Center
- Sauk Rapids/Rice Early Childhood Programs
- Schools
- St. Cloud Area Crisis Nursery
- St. Cloud State University Child and Family Studies Department
- STIR (Stronger Together Inspiring Resilience) – Sherburne County
- Thumbs Up
- United Way
- Universities/Colleges
- United Way
- WAYCAN
- Wellness in the Wood
- Yellow Zones
- YMCA
- Veterans Affairs

**Note: Our intent is to have community-driven strategies that encompass all sectors. These lists are in no way meant to be exhaustive. They are meant to be used as considerations when working on community initiatives and identify gap areas of inclusion. If you would like another resource added to these lists, contact any member of the Process Managers or Leadership Group. (Note: For a list of existing resources, refer to CHNA Section I: Existing Community Resources.*

Community Health Improvement Plan 2023-2025

Leadership System & Process for Monitoring and Revision

Accountability:
Administrative support to conduct work on this Community Health Improvement Plan will be a collective effort by all CMA partners. This will include ongoing accountability to move the CHIP forward over the three-year period, help ensure performance measurement, and include progress notes each year.

[Lead Agency]: Strategy	Target Date	Person/See Contact info on the last page	Anticipated Outcome/Result	Progress Notes
1. Central MN Alliance: Annual Report to the Community	Ongoing	CMA Leadership Group and Process Managers	One Annual Report to be developed each year. Partners will be engaged to identify how best to share the information: may be via written format, electronic/virtual, or in-person. Topics to discuss include CHNA, CHIP, and performance and population measures	
2. Central MN Alliance: Quarterly Leadership Group meetings	Ongoing	CMA Leadership Group and Process Managers	Central MN Alliance agencies will remain up to date on CHIP Goal progress.	
3. Central MN Alliance: Delegated Authorities / Boards will receive at least annual updates	Ongoing	CMA Partner Agency Leadership	Delegated Authorities will remain up to date on CHIP Goal progress.	
4. Central MN Alliance: Data Group will meet at least monthly	Ongoing	CMA Data Group	Data surveillance will take place on a regional level.	

Community Health Improvement Plan 2023-2025

[Lead Agency]: Strategy	Target Date	Person/See Contact info on the last page	Anticipated Outcome/Result	Progress Notes
5. Central MN Alliance: Process Managers will meet at least monthly.	Ongoing	CMA Process Managers	This CHIP document will be kept up to date and the next formal CHNA will begin July 2024.	
6. Central MN Alliance: Educate Policy Makers and all key community stakeholders on issues/emerging issues in the community	Ongoing	CMA Partner Agency Leadership and Community Action Work Group Leaders Central MN Communities of Excellence	Policy makers and key community stakeholders will be aware of this CHIP and progress being made.	
7. CentraCare: IRS reporting on CHNA process	Every third year after CHNA completion	Danielle Protivinsky, CentraCare Community Wellness Program Director	Information will be provided for the IRS Report tax form describing CHNA components, prioritization process, partners, and how input from the community was utilized.	
8. Central MN Alliance Maintain CHIP as a living document. Stored on CentraCare website and other members link to the document.	At least monthly the links will be checked.	CMA Process Managers.	A process is in place to allow for the CHIP to be a Living Document while still ensuring access on all member websites.	

Community Health Improvement Plan 2023-2025

[Lead Agency]: Strategy	Target Date	Person/See Contact info on the last page	Anticipate Outcome/Result	Progress Notes
9. Local Public Health Agencies Annual Reporting, CHIP Monitoring	Annually in March	PH agency lead or directors	**Describe how you will track implementation of the CHIP? Indicates review frequency** Progress notes and "how to get involved" are embedded in the document and this will be utilized to track progress. Reviews will be annually or as determined by co-chairs. **Describe the data you will monitor to determine progress made towards objectives, strategies and implementing activities?** Population measures and performance measures are embedded into the CHIP. The Population Measure Tracking supplement document that will be utilized by the CHA subcommittee for ongoing monitoring and evaluation. **Describe how community stakeholders and partners are engaged and share responsibility to monitor and revise the CHIP? Describes decision making process for making and approving revisions?** Information will be communicated through the core support team, co-chairs, delegated authorities and steering committee regarding progress, barriers, trends, and data in the various strategies noted in the above sections of this table utilizing the MAPP process.	

Community Health Improvement Plan 2023-2025

Created On: 06/30/2022

Approved By:

Benton County Board: TBD

CentraCare- Melrose Operating Committee: TBD

CentraCare- Paynesville Operating Committee: TBD

CentraCare- Sauk Centre Operating Committee: TBD

CentraCare- St. Cloud Hospital Board of Directors: 6/15/2022

Sherburne County Board: 06/07/2022

Stearns County Board: 06/28/2022

What is a revision? The CHIP is a living document, the posted document will be updated annually or as determined by Process Managers.

Revised On:

Date	Description of what was revised.

Community Health Improvement Plan 2023-2025

Contact Information

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Community Health Improvement Plan 2023-2025

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Partner Agency Website Addresses	
Partner	**Website Address**
Benton County	https://www.co.benton.mn.us/
Sherburne County	https://www.co.sherburne.mn.us/
Stearns County	https://co.stearns.mn.us/
CentraCare Health	https://www.centracare.com/

CHIP Appendices

Appendix 1: Public Comments Received for Community Health Improvement Plan

The Drivers/Goals/Action Steps for July 2022 through June 2025 were shared via email and partner discussions for public comment from 4/6/22 through 5/13/22. The link for public comment was shared by all CMA Members: Stearns, Benton, and Sherburne Counties, as well as CentraCare. Twenty-three survey responses were returned with ten responses provided narrative comment. The narrative responses are below. All responses were considered when completing the final draft of this document.

Survey Summary Statistics:

Are you responding as a representative of an agency (14) or individual (4)? Blank (5)

What county do you represent? Mark all that apply. Benton (8), Sherburne (12), Stearns (15), Other (2). Blank (5)

On What Driver would you like to comment? Mark all that apply. Data Systems and Access (10), Structural Racism/Community Power (9), Lived Experience (11), Historical Context (7). Blank. (5)

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Maybe (3), Yes (10), No (0). Blank (10)

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Maybe (2), Yes (9), No (2). Blank (10)

Narrative Responses:

Date:
Agency or Individual:
County/ies:
Comment about Data Access and Systems (DAS):
Comment about Structural Racism/Community Power (SR):
Comment about Lived Experiences (LE):
Comment about Historical Context (HC):
General Comment:
Will you or your agency work on any of these drivers, goals, or activities in the next three years?
Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years?

Date: 4/13/22
Agency or Individual: Agency
County/ies: Stearns
Comment about Structural Racism/Community Power (SR): I like the promotion of BIPOC in the work force, what about more career events for youth to start learning what certain fields are?
General Comment: No additional comments. The information is clear.
Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes
Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes

Date: 4/14/22
Agency or Individual: Individual
County/ies: Sherburne, Stearns
Comment about Lived Experiences (LE): Keep in mind the branding or representation as this focus continues. Representation is everything and it boils down to the people we see in the community or positions of power, printed materials, messages, etc. A vast majority of our areas lack spaces of empowerment that really encourage individuals to feel safe or themselves when engaging in various activities; whether that be for fun, personal errands, or even daily working environments.
General Comment: My only concern personally would be identifying or collecting personal stories from individuals who feel safe enough to provide the information that can work as a driver going forward in the initiative.
Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes
Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes

Date: 4/20/22
Agency or Individual: Agency
County/ies: Benton, Sherburne, Stearns, Other
Comment about Structural Racism/Community Power (SR): Is there any thought to include something about reduction of aggression/racism? Things aren't going to change unless those in power recognize their bias and how it needs to change for the benefit of the community.
Will you or your agency work on any of these drivers, goals, or activities in the next three years? Maybe
Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes

Date: 4/21/22
Agency or Individual: Agency
County/ies: Stearns
Comment about Lived Experiences (LE): Everything is very clear and laid out
General Comment: Looks great!
Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes
Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Maybe

Date: 4/22/22
Agency or Individual: Agency
County/ies: Benton, Sherburne, Stearns
Comment about Data Access and Systems (DAS): Blue Plus shares the same priorities and we would like to learn how we can collaborate to support and expand access
Comment about Structural Racism/Community Power (SR): Blue Plus shares the same priorities and would like to collaborate with you to provide consistent messaging around equity and support the development of the toolkits
General Comment: Listening and learning from communities are key to inform community health goals and strategies. Really like the LE section and the action steps in it.
Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes
Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes

Date: 4/22/22
Agency or Individual: Agency
County/ies: Benton, Sherburne, Stearns
Comment about Data Access and Systems (DAS): Access to Broadband: demonstrate root cause of a driver of inequity because it limits access to providers and resources specifically with an emphasis on telemedicine. By increasing broadband access will improve barriers to access. Data Access and Systems: by increasing data access between providers, providers will have a better understanding of inequities of the community they are serving. It will allow opportunities to educate the health awareness of the community.
Comment about Structural Racism/Community Power (SR): Further goals should be set to address and help understand the institutional and structural root causes of inequities and meet any of the desired outcomes. Set goals that aim at including member voice and participation. Incorporate that community voice would increase involvement in decision making and understand of equitable ways to distribute resources.
Comment about Lived Experiences (LE): Lived Experience: Using personal stories from community in the 3 county is good. Consider creating opportunities for persons from the community as part of the conversations and projects, i.e. persons who look like them, relatable. Consider other communication venues; some communities don't have access to internet, so would text or audio be available for the other types of communication.
Comment about Historical Context (HC): Further goals should be set. For example, setting aims at including community members/stakeholders to the table where decision making happens. We don't quite understand how developing the Land Acknowledgements document will increase community engagement opportunities and design outcomes. We see there can be opportunities with engaging with community through resource sharing and community dialogues to further support other areas such as public health and decreases barriers.
General Comment: Overall, we acknowledge these are purposeful goals, however they may not achieve the result that is identified as the purpose of the drivers
Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes
Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes

Date: 4/26/22
Agency or Individual: Agency
County/ies: Stearns
Comment about Structural Racism/Community Power (SR): Of course, this is extremely important to name as an issue.
General Comment: Most of the goals and the drivers are about how to use the data. But, what if folks don't know WHY they need to pay attention to this? Some education may be needed.
Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes
Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes

Date: 4/28/22
Agency or Individual: Individual
County/ies:
Comment about Data Access and Systems (DAS): County IT Departments and County EDA have been active in identifying the factors of broadband for Sherburne County they can be helpful in the Action steps.
General Comment: It sounds like DAS is more advertising of the issue in general and less about resolve.
Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes
Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? No

Date: 4/29/22
Agency or Individual: Agency
County/ies: Stearns
Comment about Data Access and Systems (DAS): Driver is understood as presented. Goal 1 seems appropriate for creating awareness. Goal 2 is a necessary effort to work on as the digital world transforms.
Comment about Structural Racism/Community Power (SR): Driver is timely in today's environment. Action items are aligned with the goal.
Comment about Lived Experiences (LE): Driver and goals are well aligned. This embraces our community focus in Paynesville.
Comment about Historical Context (HC): This would be a new area of learning and understanding for our community.
Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes
Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Maybe

Date: 5/2/22
Agency or Individual: Agency
County/ies: Benton, Sherburne, Stearns
Comment about Data Access and Systems (DAS): Community partners, like the library system, can help amplify the messages that come through this goal.
Comment about Structural Racism/Community Power (SR): Some work is already taking place in the community regarding diverse workforce recruitment, such as the I-We initiative through DEED.
Comment about Lived Experiences (LE): Personalize the messaging so it is clear that those from diverse populations are our neighbors and current and future workforce.
Comment about Historical Context (HC): A lot of work needs to be done to explain what a land acknowledgement is and why it matters.
General Comment: A lot of organizations in our community are doing this work. It is important to align efforts and not recreate the wheel.
Will you or your agency work on any of these drivers, goals, or activities in the next three years? Maybe
Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes

Community Health Improvement Plan 2023-2025

Summarized public comment received on April 6, via virtual presentation and discussion held with persons representing six agencies throughout the three counties. The presentation was to gather in-person feedback on the Drivers/Goals/Action Steps. Points made during that conversation are as follows:

One person had only been part of one assessment before, they found the drivers very different from previous processes and outcomes. They expected to see an emphasis on mental health and were excited to see the drivers that rose to the top.

It was agreed that broadband is a barrier. An example was shared of someone not being able to attend an online class/session due to no broadband accessibility.

Working around equity is important in the community

It was noted that Historical Context and Land Acknowledgements weren't the first thought to be expected as a result of a Community Assessment.

Structural racism impacts mental health and poverty affects health/mental health.

Confirmation that we cannot start talking about poverty and health/mental health until we start talking about the historical context and lived experience of the family/individual

Broadband is so important during COVID - there are structural and systematic issues across this region regarding access.

Confirmed that the assessment identified true root causes of inequities in our community.

RE: HR toolkits. One participant agreed there is a need and that their organization would like to utilize this information. Also discussed how to integrate the workforce.

Another participant confirmed that mental health and building families are top priority needs in the community. Mental health needs have increased during COVID, especially in young children and parents. One example was shared regarding young children being stuck in a small home together during COVID.

The partner feedback survey was discussed particularly because it was not translated into other languages. Attendees offered to help with making the process more inclusive.

One of the 4/6 attendees also provided additional feedback via email on 4/25/22 specifically about the PowerPoint that was proposed to be used to explain the CHIP at Board meetings. The information they shared is summarized below:

Try to be clear about the difference between the guiding principles, domains, and community priorities.

Consider having less words per slide – on a virtual meeting, the slides are hard to read.

Where do you address taking care of older adults? Where are most of our healthcare dollars spent in our community? What about social isolation of older adults and our diverse populations?

Don't assume the audience understands the definitions and language.

Perhaps include a definition for the drivers.

CENTRAL MN ALLIANCE
STRENGTHENING PARTNERSHIPS FOR CHANGE

Community Health Needs Assessment

Conducted July 2021 – February 2022

June 2022

LEGAL REQUIREMENTS

This document provides documentation of the following legal requirements:

The Minnesota Community Health Services Act (Minn. Stat. § 145A) of 1976, which was subsequently revised in 1987 and 2003, and is now called the Local Public Health Act. This document describes the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHIP).

The United States Patient Protection and Affordable Care Act of 2010 (PPACA) imposed reporting requirements under new Internal Revenue Code (IRC) § 501(r) for charitable hospitals regarding the fulfillment of their charitable purpose as tax-exempt organizations starting in 2011. This document describes the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan.

Americans with Disabilities Act Advisory:

This information is available in accessible formats to individuals with disabilities and for information about equal access to services, call 320-656-6000 (voice). TTY users place calls through 320-656-6204 (TTY).

Executive Summary:

Vision, Structure of Process, Continuing Guiding Principles, Root Causes/Drivers of Inequities, and Continuing Priorities

Vision

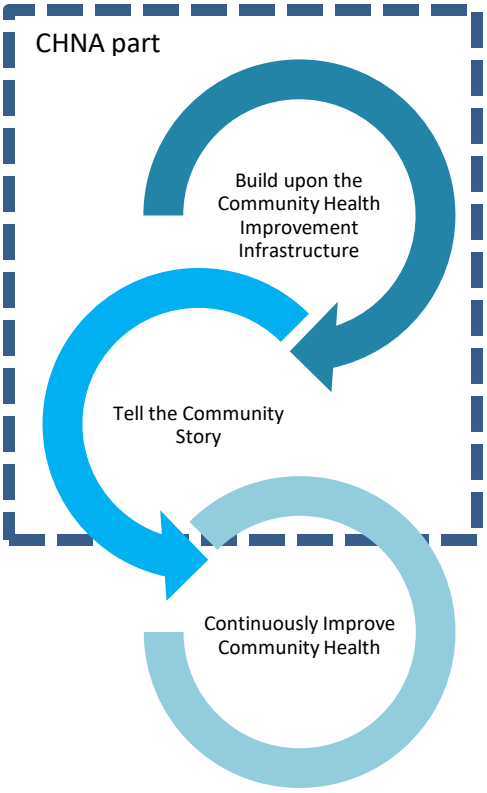
The Central MN Alliance Vision: In Central MN, every voice counts, every need is important, every culture respected, and everyone is involved in building a better community life with equitable services for all.

Structure of Process

The Community Health Needs Assessment (CHNA) is a document that identifies key health needs and priorities through systematic, comprehensive data collection and analysis. The Central Minnesota Alliance (CMA) utilized the MAPP (Mobilizing Action through Planning and Partnerships) Evolution process to conduct the CHNA and arrive at the Community Health Improvement Plan (CHIP) for the time period of July1, 2022 through June 30, 2025.

MAPP Framework: Mobilizing for Action through Planning & Partnerships

Note: MAPP is a product of NACCHO, National Association of County and City Health Officials



The CMA used the MAPP framework for the 2019-2022 CHIP and there was a solid community health improvement infrastructure in place regarding the community priorities and guiding principles. In February 2021, NACCHO released information about the MAPP Evolution process. While they did not have any tools available, yet CMA members liked the additional concepts of addressing structural racism, community power, and root causes of inequities and the decision was made to utilize the MAPP Evolution framework. Telling the Story involved the use of three assessments: Community Status, Community Partner, and Community Context.

Continuing Guiding Principles

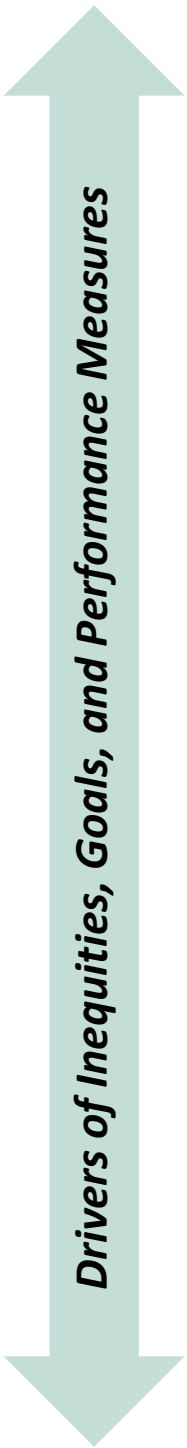
- Community Collaboration
- Equity Lens
- Focus on Strengths & Resilience
- Build Awareness
- Educate and Inform
- Involve Health Organizations

Root Cause of Inequities [Results of the Community Health Needs Assessment/CHNA]:

- Data Access & Systems (DAS)
- Structural Racism/Community Power (SR)
- Lived Experience (LE)
- Historical Context (HC)

Central MN Alliance Continuing Priorities

	Priority	Examples
1	**Building Families**	Individual/family interventionChild well-being Parenting skills
2	**Mental Health**	AwarenessAccess Well-being Addiction
3	**Encouraging Social Connection**	Across the age spectrum Building social connections Community intervention
4	**Adverse Childhood Experiences (ACEs)**	AwarenessCultural Preventative measures Leading to chronic disease
5	**Tobacco/Nicotine Use**	E-cigarettes Addiction
6	**Health Care**	Access Cost
7	**Risky Youth Behavior**	Education Trafficking Mental health Homelessness Alcohol, tobacco, and other drugsPhysical health Safety
8	**Financial Stress**	Living wage Unemployment Affordable living
9	**Trauma**	Across the lifespan
10	**Educating Policy Makers and Key Community Stakeholders**	Educating on emerging issues in the community



Data Access & System

- Goal 1: Share local equity data by developing data visuals coordinated with National recognition months, i.e.: Mental Health Awareness Month
    - Performance Measure: Partner agencies and community members across the 3-county region will have access to local equity related data that is useful for their purposes
- Goal 2: Increase access to broadband across the 3-county region
    - Performance Measure: Broadband household use will increase across the 3-county region

Structural Racism/Community Power

- Goal 1: Create and build upon Human Resource toolkits regarding diverse workforce recruitment, implementation, and support. Make toolkits widely accessible
    - Performance Measure: Equitable hiring processes will be utilized across the 3-county region. activities

Lived Experience

- Goal 1: Create or Build Upon "What Creates Health" Campaigns. Instill this information as facts into the community experience; policies and built environment impact our health more than personal behavior or the health care system
    - Performance Measure: It will be more broadly understood by the residents of the 3-county region that 70% or more of our health is beyond personal behavior. 30% personal behavior, 20% clinical care, 40% social/environmental, 10% environment

Historical Context

- Goal 1: Encourage all agencies to adopt Land Acknowledgements – in a broad sense of acknowledging the ancestral lands of the Minnesota Indians, as well as peoples who were brought to this land against their will, peoples forced into labor to build infrastructure that benefits us today, and peoples who came here from distance lands in hope of a better life. (i.e., acknowledge the legacies of violence, displacement, migration, and settlement)
    - Performance Measure: Awareness amongst the residents of the 3-county region will be increased about the systemic, structural, and institutional root causes of inequities

Table of Contents

CHNA Appendices

A. Regional Collaboration

Central MN Alliance

In April 2018, the first meeting of the Central Minnesota Alliance was held. The members of this partnership include Benton County Human Services, Public Health; CentraCare; Sherburne County Health and Human Services, Public Health; and Stearns County Human Services, Public Health Division.

These relationships have been building over time and as a result, a more formal structure of this partnership in community planning was developed. The group collectively decided to use the Mobilizing for Action through Planning and Partnerships (MAPP) process and to follow the hospital IRS requirement of a 3-year timeframe for each CHNA cycle. The MAPP framework was utilized for the 2019-2022 CHIP.

In February 2021, the National Association of County and City Health Officials (NACCHO) announced a MAPP Evolution. This revised MAPP framework encompassed key focus areas where CMA members also wanted to explore: Equity, Community Power, Inclusion, Trusted Relationships, Strategic Collaboration and Alignment, Data and Community Informed Action, Full Spectrum Actions, improved flexibility, and the move to practice continuous improvement with a living improvement planning document.

Despite a lack of tools for this new MAPP Revision, the CMA Partners agreed to utilize the existing community health improvement (CHI) infrastructure and move forward with the guidance that was available. Three assessments were conducted to complete the Community Health Needs Assessment: Community Status, Community Context, and Community Partners. All four CMA member agencies had staff involved in each of the assessment committees.

The structure of the partnership involves layers of groups of people from each agency with differing levels of involvement.

Key Authorities:
Key Authorities have the ultimate statutory responsibility for completion of the CHNA and CHIP.

Benton County Board of Commissioners
Scott Johnson, First District
Ed Popp, Second District
Steve Heinen, Third District
Jared J. Gapinski, Fourth District
Beth Schlangen, Fifth District
Sherburne County Board of Commissioners
Barbara Burandt, First District
Raeanne Danielowski, Second District
Tim Dolan, Third District
Felix Schmeising, Fourth District
Lisa Fobbe, Fifth District

Stearns County Board of Commissioners
Tarryl Clark, First District
Joe Perske, Second District
Jeff Mergen, Third District
Leigh Lenzmeier, Fourth District
Steve Notch, Fifth District
CentraCare
St. Cloud Hospital Board of Directors
Joy Plamann, RN Senior VP of Central Operations/ President of St. Cloud Hospital
Annesa Cheek, Ed.D President of St. Cloud Technical & Community College
Shonda Craft, PhD Dean of School of Health & Human Services SCSU
Ryan Daniel, MBA WSO-CSE Chief Executive Officer, St. Cloud Metro Bus
Kenneth Holmen, MD, President/CEO, CentraCare
Eileen Dauer, MD Physician, St. Cloud ENT
Jacob Eiler, MD Anesthesiologist/ St. Cloud Hospital & Chief of staff
Renee Frauendienst, RN Retired Public Health Division Director, Stearns County
Willie Jett, St. Cloud School District
Bob Kovell CPA/ABV, CVA Miller, Welle, Heiser & Co. Ltd
Bob Thueringer, Retired COO Coborns, Inc.
Nathan Lee, MD Family Birthing Laborist
Edward Martin-Chaffee, MD Neonatologist/ Pediatric Cardiologist
Joel Mercuri, MD Hospitalist, CentraCare- St. Cloud Hospital/ CentraCare Clinic
Colleen Quinlivan, OSB Assistant Chancellor, Diocese of St. Cloud
Patricia Snizek, OSB, Director of Monastic Health Services, Certified Nurse Practitioner, St. Benedict's Monastery
CentraCare-Melrose Operating Committee
Bryan Bauck, Executive Director, Rural Health – Western Region CentraCare
John Beste, Owner, Famo Feeds, Freeport
Cindy Firkins Smith, MD, Senior Vice President, Rural Health, CentraCare
Patrick Heller, MD, Family Medicine Physician, CentraCare – Melrose
Vicky Herkenhoff, VP, Administration and Finance, Stearns Electric Association, Melrose
Rustin Nielsen, Senior Director, Acute Care, CentraCare - Melrose
Jennifer Tschida, Senior Director Ambulatory Care, CentraCare – Melrose
CentraCare- Paynesville Operating Committee
Bob Brauchler, Chairperson
Cindy Firkins Smith, MD, Vice President, Rural Health, CentraCare
Kurt Habben, MD, Ex Officio, CentraCare – Paynesville, Chief of Staff
Kimberly Nelson, Appointed Community Member
Steve Peterson, Appointed Community Member
Brandon Pietsch, Ex Officio/Secretary
Daniel Rea, Vice-Chairperson, Appointed Community Member
Bruce Stang, Appointed Community Member

CentraCare- Sauk Centre Operating Committee
Bryan Bauck, Executive Director, Rural Health, Western Region, CentraCare
Tim Borgmann, CPA, Board Vice Chair
Cindy Firkins Smith, MD, Senior Vice President Rural Health CentraCare
Benedict Haeg, MD, Family Medicine Physician, CentraCare – Sauk Centre
Carolyn Koglin, Sr. Director Ambulatory Care, CentraCare – Sauk Centre
Neil Linscheid, Community Member
Patricia Roth, Sr. Director Acute Care, CentraCare – Sauk Centre
Rebecca Stepan, MD, Family Medicine Physician, CentraCare – Sauk Centre
Joe Uphus, Managing Partner, The Mutual Fund Store, Board Chair

CMA Member Directors:
Member Directors set major timelines, monitor the progress, and give updates to the Key Authorities.

Benton County
Jaclyn Litfin, Community Health Services Administrator
Sherburne County
Nicole Ruhoff, Manager Public Health
Stearns County
Janet Goligowski, Public Health Division Director
CentraCare
Danielle Protivinsky, Community Wellness Director

Leadership Group:
Leadership Group accomplishes the day-to-day work of the work plan and engage with the community. *Process Managers* include representation from each agency. *Process Managers* assist in guiding the *Leadership Group* and provide updates to the *CMA Member Directors*.

Benton County
Jaclyn Litfin, Community Health Services Administrator (Process Manager)
Samantha Hageman, Community Health Specialist
Jennifer Lezer, Community Health Specialist
Mariah Klein, Community Health Specialist
Sherburne County
Nicole Ruhoff, Manager Public Health (Process Manager)
Tammy Seifert, Public Health Supervisor
Kara Zoller, Health Promotion Supervisor
Peggy Sammons, Public Health Planner (Process Manager)
Alison Miller, Community Health Coordinator
Janine Foggia, Community Health Coordinator

Stearns County
Janet Goligowski, Public Health Director
Mike Matanich, Human Services Supervisor, Public Health (Process Manager)
Corinne Dahl, Human Services Supervisor, Public Health
Janelle Boeckermann, Human Services Supervisor, Finance & Technology
CentraCare
Danielle Protivinsky, Community Wellness Director (Process Manager)
Hani Jacobson, Community Health & Wellness Nurse
Kim Tjaden, MD, Medical Director for Benton and Stearns Counties
Liz D. Vicente, Community Health and Wellness Nurse
Melissa Pribyl, Community Health and Wellness Specialist
Michelle Kiefer, Regional Community Wellness Specialist
Charlotte Merchlwicz, Regional Community Wellness Specialist
Angelica Hight, Community Health & Wellness Nurse
Pam Beckering, Community Wellness Specialist II
Ellen De la torre, Regional Community Wellness Specialist
Minnesota Department of Health
Bob Kuziej, Senior Research Scientist
Ann March, Public Health Assessment Planner

Steering Committee:
Steering Committee represents the broad community and interacts with the *Leadership Group* at community meetings.

Steering Committee
Members of the broad community.

Other CentraCare Regional Collaborations: CentraCare Long Prairie and Monticello

CentraCare Long Prairie and Monticello also execute community-driven strategic planning with local public health and community partners. This section gives a summary of those partnerships.

CentraCare: Long Prairie

The Todd-Morrison-Wadena CHNA Collaborative includes seven local organizations: CentraCare- Long Prairie, Lakewood Health System, Tri-County Health Care, CHI St. Gabriel's Health, and Morrison-Todd-Wadena Community Health Board (Todd County Health and Human Services, Morrison County Public Health and Wadena County Public Health). They use the Mobilizing for Action through Planning and Partnerships (MAPP) process to organize the CHNA.

[space to describe 2021-2022 Assessment Process]

[space to describe Long Prairie 2021-2022 Assessment Process]

CentraCare: Monticello

The Wright County Community Health Collaborative includes four local organizations: CentraCare – Monticello, Buffalo Hospital- Allina Health, Wright County Community Action, and Wright County Public Health. They use the Mobilizing for Action through Planning and Partnerships (MAPP) process to organize the CHNA.

[space to describe 2021-2022 Assessment Process]

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B. Definition of Community to be Served

The table below shows service area zip codes within each county that are part of Central MN Alliance and CentraCare's service area zip codes, including Carris Health. Carris Health is a partnership formed in January 2018 between CentraCare, Rice Memorial Hospital in Willmar, and Affiliated Community Medical Centers (ACMC Health).

Benton County	55371, 56333, 56367, 56377, 56379, 56357, 56329, 56304
Sherburne County	55309, 55308, 55330, 55398, 55319, 56304, 55371, 55377
Stearns County	55353, 56307, 56310, 56312, 56316, 56320, 56321, 56325, 56340, 56352, 56335, 56356, 56331, 56362, 56368, 56369, 56371, 56374, 56375, 56376, 56377, 56378, 56387, 56301, 56303, 55329, 55382, 55320
CentraCare Service Areas Including Carris Health	56333, 56367, 56379, 56357, 56329, 56304, 55309, 55308, 55330, 55398, 55319, 55353, 56307, 56310, 56312, 56316, 56320, 56321, 56325, 56340, 56352, 56335, 56356, 56331, 56362, 56368, 56369, 56371, 56374, 56375, 56376, 56377, 56378, 56387, 55359, 55389, 56301, 56303, 55329, 55362, 56440, 56347, 56438, 56446, 55301, 56201, 56209, 56215, 56222, 56251, 56252, 56271, 56273, 56279, 56282, 56288, 55310, 55324, 55325, 55333, 55355, 56157, 56169, 56214, 56216, 56223, 56224, 56226, 56229, 56230, 56231, 56237, 56239, 56241, 56243, 56245, 56246, 56253, 56255, 56258, 56260, 56262, 56263, 56264, 56265, 56266, 56270, 56277, 56281, 56283, 56284, 56285, 56287, 56289, 56291, 56292, 56293, 56295, 56297

Benton County

Located in Central Minnesota, Benton County is part of the St. Cloud Metropolitan Statistical Area. Benton County is one hour north of the Twin Cities and one hour south of premier lake and resort areas. The center of the County is the City of Foley, the County Seat, home to 2,711 residents. Most of the County's larger communities (St. Cloud, Sauk Rapids, Sartell, and Rice) are located on its western edge. The largest city is Sauk Rapids, which has 13,862 residents. The part of St. Cloud that is located in Benton County includes 6,669 residents. Benton County's portion of Sartell includes 2,462 people. Rice, with a population of 1,975, is located on the northwestern edge of the County. The total Benton County population is 41,379 with a 8% population growth rate over the last 10 years (population of Benton County in 2011 was 38,357). Approximately 61% of our population is between the ages of 18-64, with the biggest population cohort in the 25-34 year range. The gender ratio in Benton County is relatively equal with 49.8% males and 50.2% females. Approximately 89% of our population in Benton County identifies as white non-Hispanic, 5% as black, 3% as Hispanic, 1% as Asian Pacific Islander, and 3% as multiracial. The median home value is $187,300, with 62.7% owner-occupied homes. Residents have a median household income of $60,564. The percent of residents living under the poverty line is about 9%, impacting our 65 years and older population at 8%. We have a high-school graduation rate of about 85% overall. Our disabled population is about 11.1%. The majority of adults in Benton County take 10-19 minutes a day to travel to work. We have 17,201 people employed with 1,018 total businesses/employer establishments. The unemployment rate is about 3%. Data sources used for these statistics were MN Compass, U.S. Census 2020 ACS Estimates, and the MN Department of Employment and Economic Development.

Sherburne County

Sherburne County is located in East Central Minnesota between two growing and economically healthy metropolitan areas - the Minneapolis-St. Paul and St. Cloud Metropolitan Statistical Areas. Sherburne County is triangular in shape with the Mississippi River forming the southwestern boundary. The county seat in Sherburne County is Elk River, which is also the largest city, with 25,835 residents. Sherburne County is home to seven communities that are located along the major roadway arteries of U.S. Highways 10 and 169. The total population of Sherburne County is 97,183 with a 10.6% growth rate over the last 10 years (population of Sherburne County in 2011 was 87,881). Approximately 62% of the population is between the ages of 18-64, with the biggest population cohort in the 45-54 year range. The gender distribution is 51% males and 49% females. Approximately 90% of our population identifies as white non-Hispanic, 3% as black, 3% Hispanic, 1% Asian PI, 3% multiracial, less than 1% American Indian, less than 1% other race. The median home value is $244,700, with 79% owner-occupied homes. Residents have a median household income of $88,671. The percent of residents living under the poverty line is about 5%, impacting our 65 year and over populations at 9%. Sherburne County has a high-school graduation rate of 87% overall. The disabled population is about 10%. The majority of adults in SherburneCounty take over 30 minutes a day to travel to work. Sherburne County has 26,005 people employed with 2,264 total businesses/employer establishments. The unemployment rate is about 2%. Data sources used for these statistics were MN Compass, U.S. Census 2020 ACS Estimates, and the MN Department of Employment and Economic Development.

Stearns County

Stearns County is home to 30 cities. The smallest is St. Rosa and the largest is St. Cloud with a population of 54,560, which also serves as the County Seat. Portions of St. Cloud also lie in Benton County and Sherburne County; the total population of the City of St. Cloud is 68,390. The total population of Stearns County is 159,788 with a 7% growth rate over the last 10 years (population of Stearns County in 2011 was 149,337). Approximately 62%of the population is between the ages of 18-64, with the biggest population cohort in the 18-24 year range. The gender distribution is 50% males and 50% females. Approximately 85% of our population identifies as white, 14% as persons of color, and 4% Hispanic. The median home value is $193,500 with 63% owner-occupied homes. Residents have a median income of $65,244. The percent of residents living under the poverty line is about 12%, impacting our 17 and under population at 15%. Stearns County has a high-school graduation rate of 83% overall. The disabled population is about 11%. The majority of adults in Stearns County take 10-19 minutes a day to travel to work. Stearns County has 82,331 people employed with 4,421 total businesses. The unemployment rate is about 5%. Data sources used for these statistics were MN Compass, U.S. Census 2020 ACS Estimates, and the MN Department of Employment and Economic Development.

Table: County Demographic Data Indicators

County Demographic Data Indicators		
Benton County	County Seat	Foley
	Largest City	Sauk Rapids
	Population	41,379
	Population Growth (2011-2020)	8%
	Median Household Income	$60,564
	Poverty Rate	9%
	Unemployment Rate	3%
Sherburne County	County Seat	Elk River
	Largest City	Elk River
	Population	97,183
	Population Growth (2011-2020)	10.6%
	Median Household Income	$88,671
	Poverty Rate	5%
	Unemployment Rate	2%
Stearns County	County Seat	St. Cloud
	Largest City	St. Cloud
	Population	159,788
	Population Growth (2011-2020)	7%
	Median Household Income	$65,244
	Poverty Rate	12%
	Unemployment Rate	5%

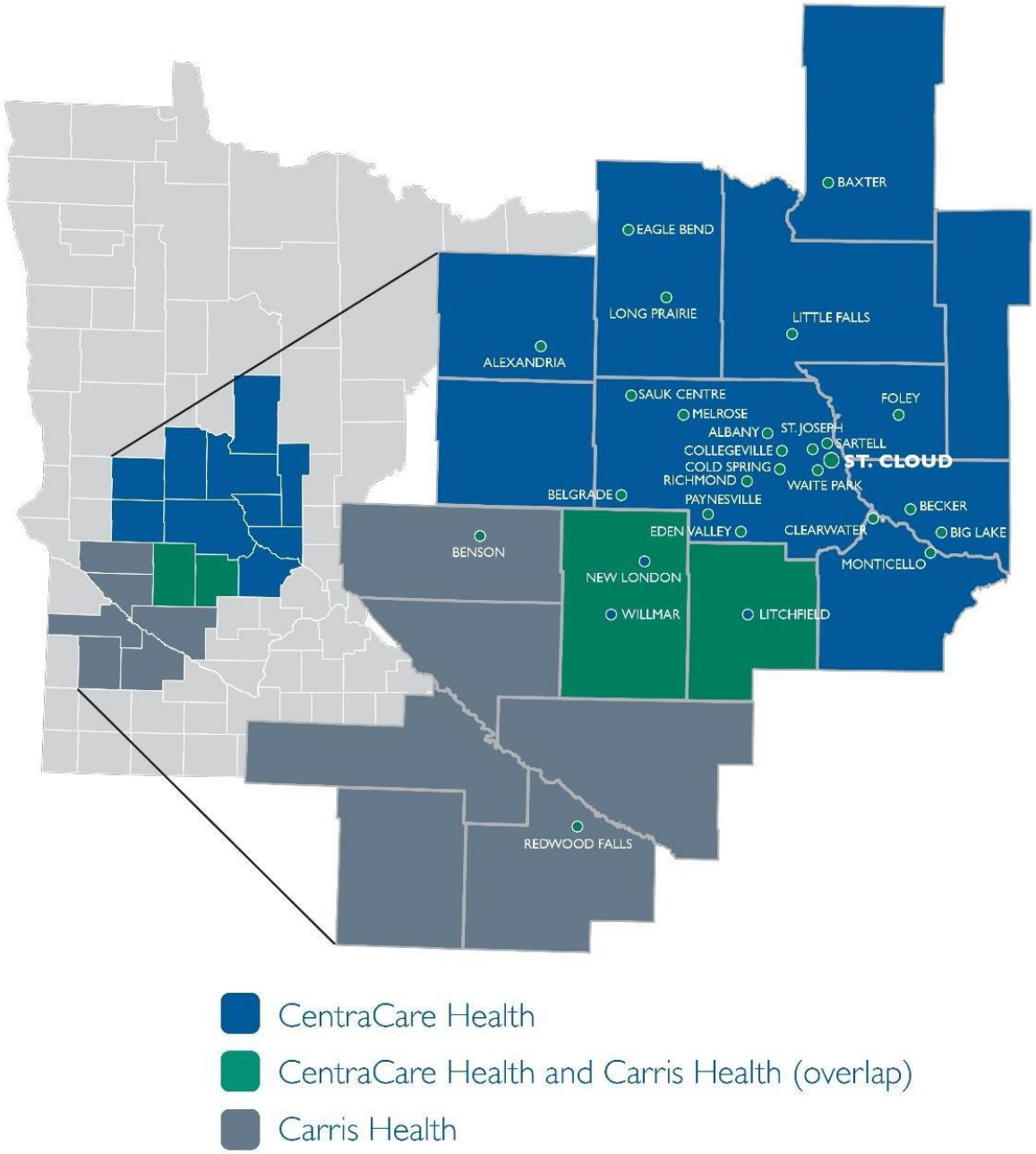
Source: MN Compass

CentraCare

CentraCare works to improve the health of every patient, every day by providing high quality, comprehensive care to the residents of Central Minnesota. The parent corporation of CentraCare was formed in 1995 by a merger of St. Cloud Hospital and the St. Cloud Clinic of Internal Medicine. Over the last twenty-three years, the organization has grown to include not only St. Cloud Hospital and CentraCare Clinic, but hospitals, clinics, and nursing homes/senior living in the communities of Long Prairie, Melrose, Sauk Centre, Monticello, and Paynesville. This wide service area allows us to care for patients in urban, suburban, and rural locations and includes beneficiaries that are underserved. CentraCare began operating the wholly owned subsidiary of Carris Health, which expanded our service area to West Central and Southwest Minnesota.

St. Cloud Hospital	• Catholic, not-for-profit regional hospital • 489 licensed beds • Largest health care facility in the Region • Magnet-designated hospital since 2004 • Hospital service area consists primarily of Benton, Sherburne, and Stearns Counties
CentraCare-Long Prairie	• Not-for-profit • 25-bed critical access hospital, clinic, and 70-bed long-term care facility and senior apartment building/assisted living facility • Primary service area located in the middle of Todd County • Collaborative group including CentraCare-Long Prairie, Lakewood Health System, Tri-County Health Care, CHI St. Gabriel's Health, and Morrison-Todd-Wadena Community Health Board, are following the Mobilizing for Action through Planning and Partnerships (MAPP) framework for their continued work
CentraCare-Monticello	• Not-for-profit • 25-bed critical access hospital, clinic, cancer center, and 89-bed long-term care facility • Service area primarily in Wright and Sherburne Counties • Collaborative group including CentraCare- Monticello, Buffalo Hospital (part of Allina Health), Wright County Community Action, and Wright County Public Health, are following the Mobilizing for Action through Planning and Partnerships (MAPP) framework for their continued work
CentraCare-Melrose	• Not-for-profit • 25-bed critical access hospital, clinic, 75-bed long-term care facility, and 61-unit senior apartment building/assisted living facility • Service area primarily consists of western Stearns County
CentraCare-Paynesville	• Not-for-profit • Level-4 trauma/critical access hospital, four family medicine clinics, plus long-term care, assisted living and senior housing facilities • Service area primarily consists of the southwestern corner of Stearns County • CentraCare Clinics/hospitals included in the service area: Eden Valley, Richmond, and Paynesville clinics
CentraCare-Sauk Centre	• Not-for-profit • 25-bed critical access hospital, clinic, and 60-bed long-term care facility with an adjacent 30-unit independent living facility • Service area primarily consists of the northwestern corner of Stearns County
CentraCare Clinics	• Consists of 360 physicians and 173 advanced practice providers who practice in 35 medical specialties and offer a variety of outreach services in 40 communities
Carris Health	• A wholly-owned subsidiary of CentraCare • Formed in January 2018 to deliver health care to West Central and Southwest Minnesota • Comprised of a partnership between CentraCare, Rice Memorial Hospital in Willmar, Redwood Area Hospital in Redwood Falls, and ACMC Health- including 10 clinics in SW Region of the State

CentraCare Health and Carris Health Service Area



CentraCare Health

CentraCare Health and Carris Health (overlap)

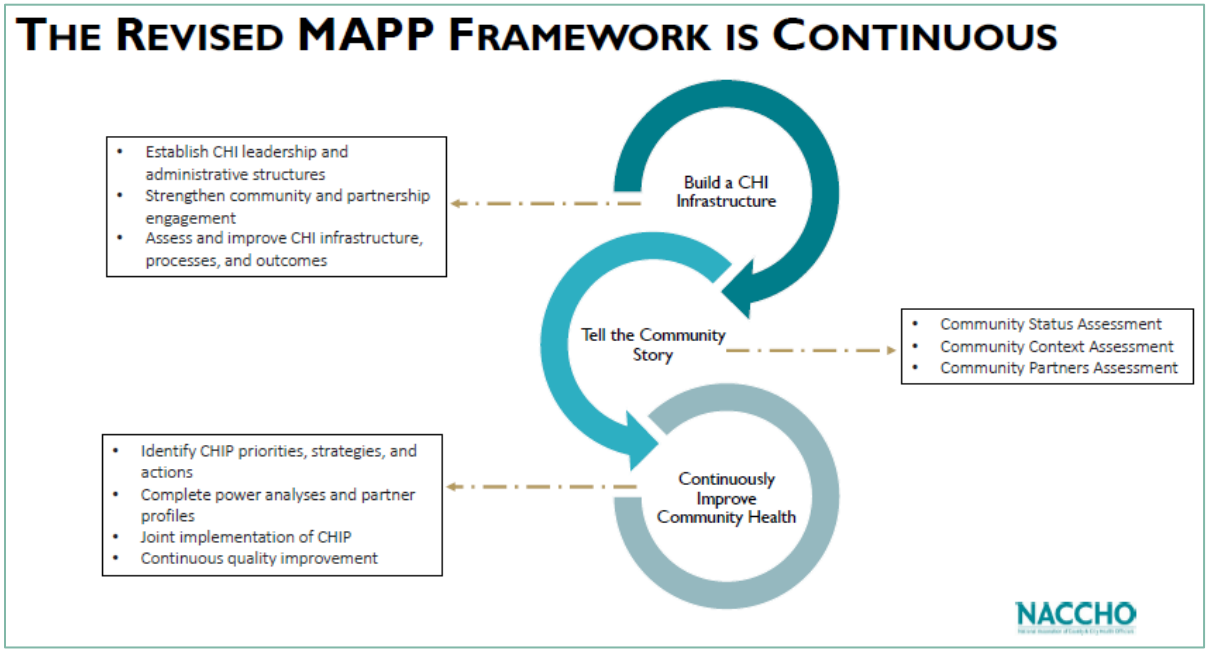
Carris Health

Map effective as of 2/27/2019

C. Process and Methods to Conduct the CHNA

The Central MN Alliance (CMA) agreed to utilize the MAPP (Mobilizing for Action through Planning and Partnerships) Evolution process to conduct the Community Health Needs Assessment (CHNA) and prepare the Community Health Improvement Plan (CHIP). The MAPP Revision process consists of three phases outlined in detail in this section: Build upon the community health improvement infrastructure, tell the community story, and continuously improve community health. The CHNA largely encompasses the first two phases and identifies the priorities, goals, and action steps for the third, ongoing phase.

While this document is a static document describing the process employed from July 2021 through February 2022, community assessment is also a continuous task.



Build on the Community Health Improvement (CHI) Infrastructure

As described in the section titled *Regional Collaboration*, the partnership development for the creation of the Central MN Alliance was formalized between May 2017 and April 2018. At a June 29, 2021 meeting, the CMA members agreed to continue the partnership for the July 2022 through June 2025 CHIP. The CMA members also agreed to:

- utilize the MAPP Evolution framework
- continue with the 2019-2022 Community Priorities and Guiding Principles (see Appendix A & Appendix B)
- revisit the vision
- establish three assessment committees
- utilize an equity lens
- agreed that community partnerships were essential to our new assessment goals

Revisiting the Vision

The Central Minnesota Alliance (CMA) Leadership Group discussed the Vision at two meetings in June and July 2021. In-between the two meetings, a small group including members of all CMA members met and a new vision was agreed upon. The partnership agrees that the statement is a living statement, and any member can ask to revisit the Vision to make changes at any time.

CMA Vision

In Central MN, every voice counts, every need is important, every culture respected, and everyone is involved in building a better community life with equitable services for all.

Telling the Community Story & Identifying Root Causes of Inequities

Three assessments were completed from July 2021 through February 2022: Community Status, Community Context, and Community Partners. It was a goal to impart more emphasis on what resulted from the Community Context and Community Partner assessments than from the quantitative data within the Status Assessment.

Without any tools from NACCHO, the three-assessment circle diagram was utilized as the primary tool. The bullets within each of the circles were defined as the domains of the assessment. The goal of the first step of the assessment process was for each Assessment Committee to determine which domains were the most important to focus the work on when the Implementation Phase starts in July 2022. The Context and Partner Assessment groups also made use of several interrelationship digraphs, which show cause-and-effect relationships, and help analyze the natural links between different aspects of a complex situation (source: Minnesota Department of Health).

Each Assessment was conducted by an Assessment Committee made up of people from each of the four CMA members. Each Committee met on a regular schedule. As discussions took place within the Context and Partner Assessment Committees, the domains were considered too large, and they were disaggregated with the resulting components used to conduct the interrelationship digraph exercises.

Community Context Assessment Committee

Please see Appendix C for the report of activities conducted by the Community Context Assessment Committee.

The top Drivers of Inequities identified by the Community Context Assessment Committee included:

- Structural Racism as it relates to Community Power: the ability to control the processes of agenda setting, resource distribution, and decision-making, as well as to determine who is included and excluded from these processes
- Lived Experience as it relates to the importance of perceptions, insights, values, culture, and priorities of those experiencing inequities
- Historical Context as it relates to the research of community's history to understand the institutional and structural root causes of inequities (e.g., redlining, segregation)

An additional exercise was conducted by the Community Context Assessment Committee to look at themes and the top theme that emerged was:

- The community barrier of Access to Technology, particularly Broadband, which we combined with Data Access and Systems.

Community Partner Assessment Committee

Please see Appendix D for the report of activities conducted by the Community Partner Assessment Committee.

The top Driver of Inequity identified by the Community Partner Assessment Committee

- Data Access and Systems as it relates to data being available across partners, transparent data share, and data infrastructure to track inequities.

Community Status Assessment Committee

Please see Appendix F for a list of Data Sources to Explore – the most common sources CMA uses.
Please see Appendix G for a copy of the 2021 Survey instrument.

The Status Assessment Committee conducted a modified assessment by continuing the trending of the top data points of concern from the 2019-2022 process as well as analyzing new community data. The Committee reviewed the list of Data Sources to Explore (Appendix F) and each committee member identified a source for which they felt interest and they explored that data.

The third iteration of the Central MN Community Health Survey was conducted in 2021 (Appendix G). The survey instrument was developed from 9/16/20 through 4/1/21. The CMA worked with the MN Department of Health and vendor SSI Inc. to conduct a statistically designed random sample mailed survey; it was in the field from 4/1/21 through 6/18/21. The same instrument was converted to a web-based survey using ArcGIS Survey 123 and that was in the field from 5/18/21 through 9/30/21 and was available via convenience sample. Most of the data from this survey are yet to be analyzed. A few data points – as they related to trending past data of concern – are included in the Top Data Points of Concern Report (Appendix E).

The focus of the 2022-2025 CMA CHIP will be the following Drivers of Inequities:

Identify Goals and Action Steps

After the Drivers of Inequities had been identified, the CMA Leadership Group started work on developing potential Goals and Action Steps that would fit under each category. Members of the Leadership Group used a Goals and Action Steps Worksheet stored on Microsoft Teams to collaboratively, prepare a list of goals and action steps. This was discussed at the January 27th, February 10th, and February 22nd Leadership meetings. To keep the CHIP at a workable level, it was decided that we would try to identify one goal with action steps to include in the CHIP. On March 25th, a prioritization exercise was completed using Miro.com to identify the goal with action steps that would be included in the CHIP document. Just because the goal was not included in the CHIP, does not mean that the CMA will not work on it.

It is the intention of the CMA members that the CHIP will be a living document and as more conversations take place with community partners, the goals and action steps may change. The changes to the document will be reported at least annually when local public health is required to report on CHIP work.

Implementation Phase

While continuous improvement is the goal, administratively, the implementation phase of the CHIP that results from this CHNA will be for three years from July 1, 2022, through June 30, 2025.

D. Input from the Broad Community

The three assessment committees and the Leadership group engaged individuals and organizations regarding this community health work. Please reference Appendix C and Appendix D for a full description of engagement during the Committee work.

Engagement with the broad community was an area with limitations. It is acknowledged that the CHNA and CHIP processes into the future will include a deliberate approach to authentic community engagement that includes a deeper focus on diversity and at-risk populations.

E. Prioritization of Community Priorities

At the Central MN Alliance (CMA) Leadership meeting on 6/29/21, the decision was made to utilize the community priority list from the 2019-2022 CHNA/CHIP Process. Please reference Appendix A. The prioritization process is thoroughly described in the 2019-2022 CHNA/CHIP and was conducted using multiple processes.

F. Community Priorities

Please reference Appendix A.

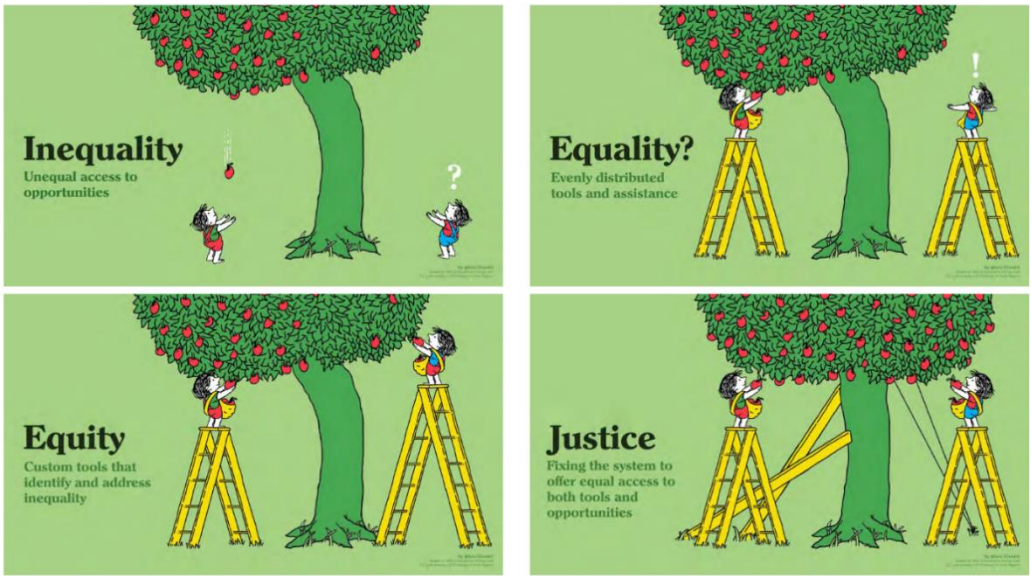
1. Building Families
2. Mental Health
3. Encouraging Social Connection
4. Adverse Childhood Experiences (ACEs)
5. Tobacco / Nicotine Use
6. Health Care
7. Risky Youth Behaviors
8. Financial Stress
9. Trauma
10. Educating Policy Makers and Key Community Stakeholders

G. Health Equity Assessment

Health Equity Overview

The following definitions were used to influence the work of the CMA:

- "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."
    - Source: Robert Wood Johnson Foundation (RWJF)
- "Diversity is the inclusion of individuals representing more than one national origin, ability, color, religion, socioeconomic stratum, and/or sexual orientation."
    - Source: (https://www.termpaperwarehouse.com/essay-on/Efp1-Task-1/435651#:~:text=Diversity%20is%20defined%20as%20variety%2C%20the%20inclusion%20of,race%2C%20et)
- "Health equity arises from access to the social determinants of health, specifically from wealth, power and prestige. Individuals who have consistently been deprived of these three determinants are significantly disadvantaged from health inequities, and face worse health outcomes than those who are able to access certain resources. It is not equity to simply provide every individual with the same resources; that would be equality. In order to achieve health equity, resources must be allocated based on an individual need-based principle."
    - Source: (Journal of Epidemiology and Community Health 57 (4): 254–8. April 2003. doi:10.1136/jech.57.4.254. PMID 12646539.)



Source: https://efcl.org/wp-content/uploads/2020/09/Module4_EquityEqualityJustice.pdf (this was the original citation that was used in the above report Determine citation for image: Source: "Addressing Imbalance," by Tony Ruth for the 2019 Design in Tech Report

Health Equity of Building Families and Mental Well-being

Building Families

The Context Committee reviewed the findings found within the prior assessment and incorporated additional findings from the most recent Context Assessment within the summary below.

It was found that building families looks different depending on the availability of services, food, education, and access to transportation in certain areas of our communities. There are portions of the community that have limited access to health services, quality education, dependable transportation, adequate housing, or healthy food. Poverty has a significant effect on the health of communities.

Families experiencing poverty struggle with the issues identified in this assessment and other issues like inadequate childcare and insufficient wages. These struggles add to the stress of raising families and encourage surviving as opposed to thriving. This is amplified when considering issues such as chronic health, substance use, incarceration, and intergenerational trauma.

Safety of families in areas of the community due to racism is a huge concern and leads to sedate living, chronic stress, and further isolates subpopulations from the general population. Other impacts include chronic health problems, stigma, and a high risk for involvement within criminal activities and poverty. It is clear there is a distinct divide between different areas of our community, and structural racism is a large contributor to this divide.

Mental Well-being

The Context Committee reviewed the findings found within the prior assessment and incorporated additional findings from the most recent Context Assessment within the summary below.

Mental well-being in our communities differs greatly depending on the community within which they reside. There are gaps in understanding what mental health is and a lack of knowledge about available mental health resources. In addition, there is a lack of culturally and linguistically appropriate resources, diverse providers, stigma surrounding mental health, and a lack of engagement with mental health treatments. Other challenges include significant wait times, available resources, individuals who are without insurance or under insured, and expensive services and out-of-pocket costs.

Limited access to health services, quality education, dependable transportation, adequate housing, and healthy food, as well as the struggle and stress involved with poverty and structural racism, all weigh heavily on specific areas of our community and impact mental health. Mental health is not a priority when a family is struggling to find affordable and adequate housing or food for an evening meal. In addition, lack of dependable transportation to mental health services along with the inability to take time off from work remain key factors in individuals not being able to see a mental health professional. It was found that mental health is significantly affecting academic success, especially in areas of the community that have an 80% poverty rate or higher. For some of the population, this leads to involvement with the justice system, including incarceration.

Impacts of COVID-19 on Building Families and Mental Well-Being:

COVID-19 has had and continues to have a significant impact on society as a whole, our families, children, communities, and more. The Context Committee recognizes the additional impacts of COVID-19 on Building Families and Mental Well-Being, those impacts are outlined below.

Challenges

- Loss of jobs/income
- Instability of routine
- Interruptions in food access
- Interruptions in education/distance learning
- Daycare challenges
- Loss of family members
- Mental health/well-being impacts
- Business closures
- Substance use/misuse
- Political divides
- Racism
- Health inequities
- Delay in preventative/routine care
- Increased time at home/social isolation
- Added stress on family units
- Broadband challenges due to high use (causing lower speeds and availability)
- Information overload/data overload

Strengths

- Increased family time, time outdoors away from technology
- Increased awareness of health disparities and impacts of disparities, e.g., health inequities are more visible
- Development and creation of new ways to reach individuals, communities, e.g., improved use of technology for telehealth services/access to care, remote work, flexible work schedules)
- Improved community collaborations and partnership development

Health Equity specific to St. Cloud- East Side (56304)

The 56304-zip code- where East side St. Cloud is located- has the poorest health outcomes in the Central MN Alliance region. For this reason, CentraCare and St. Cloud State University completed additional research and analyzed the data to identify potential root causes of these poorer health outcomes.

Interviews with eleven community leaders representing the diversity of the East St. Cloud neighborhood revealed major themes relevant to community health in the 56304-zip code area. The 56304 quantitative study highlighted the importance of the interconnectedness of health and socioeconomic issues. Concerns about health were focused on poverty and lack of access to healthy food. Also, leaders

expressed that mental/behavioral health was an important part of overall health and these needs were not adequately addressed. Many respondents noted the stress caused by poverty contributes to mental/behavioral health issues for adults in the community. Vice versa, dealing with stress and instability was cited as challenging, and believed to be a determinant in keeping people in poverty, as mental health conditions made it harder for people to get stable, high-paying jobs.

H. Similarities to National, State, and Other Local Planning Processes

National, State, Local, or Other Planning Process	Priority: Building Families	Priority: Mental Health
Local: Anna Marie's Alliance https://annamaries.org/	Provides a safe place for women and children who experience domestic violence and creates systems change that reduces violence. Community advocacy programs offer criminal justice advocacy, connection to community resources and specialized advocacy with a Latino/a Advocate, an East African Immigrant Advocate and an LGBTQ advocate. Prevention services work in schools to promote social-emotional learning and healthy relationship skills for children in grades K-12.	
Local: Arc Midstate https://arcminnesota.org/regions/midstate-region/	The Arc promotes and protects the human rights of people with intellectual and developmental disabilities, actively supporting them and their families in a lifetime of full inclusion and participation in their communities. People with intellectual and developmental disabilities and their families trust Advocates at The Arc for help in addressing issues that affect their lives. Advocates provide personalized information, navigation, and referrals on disability issues and systems throughout the lifespan. The Arc engages people in public policy advocacy to protect and promote the human rights of people with disabilities.	
Local: Center for Victims of Torture https://www.cvt.org/where-we-work/stcloud	Parenting	
Local: Central MN Council on Aging http://www.cmcoa.org/	Age-Friendly and Dementia Friendly community support	Social Communication Engagement Suicide Prevention Coalition participation
Local: Granite Table: Central MN Communities of Excellence https://www.communitygiving.org/communitypillars	Mission: Enriching lives in Central MN through intentional, collaborative, and equitable action. Vision: Central MN is recognized as a community of inclusion where people thrive and feel a sense of belonging. Values: Engage Community, Create Equity, Welcome All	
Local: Initiative Foundation https://www.ifound.org/	High quality, affordable childcare in Central MN	
Local: Reach-Up Head Start https://reachupinc.org/	Children who have been in the Reach-Up Head Start program all year will demonstrate developmental progress in the five domains (Social Emotional Development, Language and Literacy, Approaches to Learning, Cognitive and General Knowledge, Physical Development and Health).	85% of families who set housing, financial, or health goals (and have follow-up) will meet at least one goal. A minimum of 200 Reach-Up families will demonstrate parent participation/education (e.g., parent meetings, parent education classes, socializations, conferences/referral visits).
Local: Building Equity through Dialogue (Central MN Community Foundation and Filsan Talent Partners)	Five Action Groups: Community Engagement, Education, Employment/Economy, Healthcare, and Housing.	
Local: Central Minnesota	Engaging People. Connecting Resources. Building Community	

National, State, Local, or Other Planning Process	Priority: Building Families	Priority: Mental Health
Community Foundation https://www.communitygiving.org/cmcf	Community-We bring people together to leave our world better than we found it. Everyone is welcome at the Community Foundation table. Integrity - We recognize that our assets are our people, capital and reputation. If any of these is ever diminished, the last is the most difficult to restore.	
Local: Thriving Young Minds-THRIVE https://thrivecentralmn.org/	Embeds early childhood social-emotional development & mental health into existing services. Provides high quality, relevant training on issues of early childhood mental health. Raises awareness of the vital importance of social-emotional development. Develops family focused, integrated service delivery systems. Help families access knowledge and encouragement to be successful in infant and child mental health through ongoing reflective practices. A whole family approach is taken across all disciplines.	
Local: United Way of Central MN https://www.unitedwayhelps.org/	Access to ongoing quality learning and literacy services for families with children, birth through 3rd grade. Youths should have at least one caring mentor supporting and guiding them in development of positive life skills. Access to emergency, transitional or permanent housing with a special focus on youth and families with children.	Connecting individuals with resources to stabilize living conditions, maintain independence and lessen dependency. Build knowledge and skills related to cost-effective food choices, food preparation, safe food storage and nutrition. Connecting individuals to free & confidential resources they need that build support and safe environments for families around mental health.
National: Alliance on Mental illness https://www.nami.org/Home	NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness	
National: Center for Disease Control Mental Health for Children & Parents Mental health of children and parents —a strong connection (cdc.gov) https://www.cdc.gov/childrensmentalhealth/index.html		
National: National Prevention Strategy, Healthy People 2030 https://health.gov/healthypeople/objectives-and-data/browse-objectives	5 Topic areas: Health Conditions-20 goals, Health Behaviors-14 goals, Populations-10 goals, Settings & Systems 13 goals, SDOH-5 goals	
National: Robert Wood Johnson Foundation Commission to Build a Healthier America https://www.rwjf.org/en/how-we-work/grants-explorer/featured-programs/rwjf-commission-to-build-a-healthier-america.html	Focus Area: Healthy Children and Families Child and Family Well-Being Childhood Obesity Early Childhood	Focus Area: Healthy Communities Build environment and Health Disease Prevention and Health Promotion Health Disparities

National, State, Local, or Other Planning Process	Priority: Building Families	Priority: Mental Health
		Social Determinant of Health
National: YMCA https://www.ymca.org/ **Local:** St. Cloud Area Family YMCA https://scymca.org/	Parent Enrichment Classes: Parenting the Love and Logic Way and 1-2-3 Magic	Supervised Visitations and Exchanges for area families.
State: Early Childhood Family Education (ECFE) https://education.mn.gov/MDE/fam/elsprog/ECFE/	Early Childhood Family Education. Early Childhood Family Education (ECFE) is a program for all Minnesota families with children between the ages of birth to 48 months. ECFE's goal is to enhance the ability of all families to provide the best possible environment for their child's learning and growth.	
State: Healthy MN 2022 https://www.health.state.mn.us/communities/practice/healthymnpartnership/framework.html	The opportunity to be healthy is available everywhere for everyone (early life experiences & economic well-being). Places and systems are designed for health and well-being (healthy surroundings & supportive systems).	All can participate in decisions that shape health and well-being (just and violence-free communities & engaged populations).
State: Minnesota Department of Health Assessment (MDH) https://www.health.state.mn.us/statewidehealthassessment	The MN statewide health assessment provides a snapshot of health and well-being across MN and within our communities. The assessment provides data, opportunities in communities, partners, and stories/ community context. This assessment is the result of a collaboration led by the Healthy Minnesota Partnership and supported by the Minnesota Department of Health (MDH).	

I. Existing Community Resources

Existing Community Resources for Building Families

- ABE Classes
- ACT on Alzheimer's
- Affordable housing
- AL-ANON
- Alcoholics Anonymous
- Assisted living activities
- Baby Café
- Bark Park Program
- Block parties
- Career center gathering with the community
- Car Seat Training
- Center for Victims of Torture (Waite Park)
- CentraCare Hospital Breast Milk Depot
- Central MN ACE'S Collaborative
- Central MN Breastfeeding Coalition
- Central MN Mental Health Center
- Central MN Community Empowerment Organization
- Central MN Council on Aging
- Central MN Falls Prevention Workgroup
- Central MN Suicide Prevention Coalition
- Child Protection
- Childbirth, Prenatal Classes
- Church of the Week
- Church Organizations
- Church/School Mentors
- Circle of Parents
- Circle of Security, trauma-informed curricula training sponsored by THRIVE
- Clara's House, partial hospitalization program for children with mental illness
- Classes for Interested Foster Parents (*CommUNITY Adult Mental Health Initiative*)
- Coborn's Nutritional Resources
- Community Centers
- Community Ed
- Community Events - movie in the park, summertime by George, etc.
- Community Garden
- Community Outpost (COP House)
- Day Care Licensing
- DHS - health, Childcare, SNAP/EBT
- Dial-a-ride
- East side of St. Cloud Revitalization
- ECFE Classes
- ESL Classes
- Faith in Action
- Family Counseling
- Fare-For-All
- Farmers Market
- Fe y Justicia
- Financial Assistance programs
- First Steps Collaborative of Central MN
- Follow Along program
- Foster Grand Parent Program
- Goodwill Easter Seals - Father Project
- Governor Walz' One Minnesota Council on Diversity, Inclusion, and Equity
- Greater St. Cloud Area Thrive
- Habitat for Humanity
- Healthy Families America
- Help Me Connect
- Help me Grow Program
- Higher Ground
- Home visits as follow up to hospital stays
- Imagination Library
- Immigrant family resources
- In-home educators
- Inside Out Connections Project, addressing the needs of children with incarcerated parents
- Intensive home visiting programs (*Healthy Families America, Nurse-Family Partnership*)
- Interpreter/Translation Services
- KidStop
- La Cruz Community
- Legal aid accessibilityto undocumented families
- Library - book clubs,events
- Madison/North Elementary/Discoveryschools - Feeding areachildren together
- Meals on wheels
- Mental Health Programs - county
- Mental Health Providers offering Circle of Security, a relationship based early intervention program for parentsand children
- Minnesota Fatherhoodand Family Services Summit
- Mom groups
- Neighborhood organizations - promise neighborhood
- Nurse-Family Partnership
- PACER Center
- Parent Aware
- Partners for Student Success, St. Cloud School District (#742)
- Pathways for Youth
- Preschool Programs
- Project Heal
- Public Health Division programs: WIC and Child and Teen Checkups
- Reach out and read
- Reach Up, Inc, Head Start
- Re-location Services (*County & Lutheran Social Services*)
- Resource navigators

Existing Community Resources for Building Families (continued)

- Ruby's Pantry
- School District programs (Early Childhood Family Education, Family Literacy, Special Ed)
- School Resource Centers
- Scouts program
- Senior linkage line
- Sharing & Caring Hands
- SHIP (Statewide Health Improvement Partnership)
- SNAP
- Social Media groups
- St. Cloud Feeding Area Children Together (FACT)
- St. Cloud Area Crisis Nursery
- St. Cloud Area Crisis Response Initiative
- St. Cloud Area Human Service Council
- Stepping Stones Program (Birthline)
- Strengthening Father Involvement Co-parenting, trauma-informed curricula training through THRIVE
- Support groups for parents
- Thumbs Up
- Whitney Center
- Workforce Center
- Young Parent Program (YPP)

**Note: Our intent is to have community-driven strategies that encompass all sectors. These lists are in no way meant to be exhaustive. They are meant to be used as considerations when working on community initiatives and identify gap areas of inclusion. If you would like another resource to be added to this list, contact any member of the Core Support Team. (Note: For a list of potential partners, see the list of Potential Partners in the CHIP.)*

Existing Community Resources for Mental Health

- 180 Degrees Emergency Youth Center – St. Cloud
- 4 county crisis response line
- 40 Developmental assets
- ACT (Assertive Community treatment) and IRTS (Intensive Residential Treatment Services) through the Central MN Mental Health Center
- Alzheimer's Support Group for Caregivers
- Anger Management, Domestic Violence, and Co-Parenting Support Groups, Trauma Informed Support Groups at the Village Family Services
- Anna Marie's domestic
- violence crisis hotline
- Beautiful Mind Project
- Birth to 5 screenings, services, and referrals
- Bounce Back Project
- CAMHI (CommUNITY Adult Mental Health Initiative) Adult Mental Health Resource Guide
- CAMHI (CommUNITY Adult Mental Health Initiative) website [MNMentalHealth.org]
- Center for Victims of Torture (Waite Park)
- CentraCare Integrated Behavioral Health
- Child and Teen Checkups
- Children's Mental Health Collaboratives
- Church Organizations
- Clara's House, partial hospitalization program for children with mental illness
- Coalition to End Social Isolation and Loneliness (CESIL)
- Community ACT Team
- Community groups
- Community walks/5K / NAMI walk
- Conflict Resolutions Center (Mediation)
- Crisis Line
- Dog parks / Splash pads / walking paths
- Evidence-based programs for seniors (Falls prevention)
- Family Services Collaborative
- Gearing Up for Action: Mental Health Workforce Plan for Minnesota Report from the Minnesota Health Workforce Steering Committee
- Governor Walz' One Minnesota Council on Diversity, Inclusion, and Equity
- Greater St. Cloud Area Thrive
- Intensive home visiting programs (Early Head Start, Healthy Families America, Nurse-Family Partnership)
- Lutheran Social Services (Refugee Resettlement Services Resiliency Program for Children)
- Make It OK Campaign
- Mental Health First Aid
- Mental Health providers offering Circle of Security, a relationship based early intervention program
- Mental Health Workforce Development Steering Committee
- Mental Well-Being and Resilience Learning Community
- Minnesota State Advisory Council on Mental Health and its subcommittee on
- Children's Mental Health, 2014 Report to the Governor and Legislature
- Minnesota Statewide Suicide Prevention Plan
- Mobile crisis team
- PHQ assessments [Patient Healthcare Questionnaire]
- Preeminent Medical Discovery, Education, and Workforce for a Healthy Minnesota Final Report from the MN Governor's Blue-Ribbon Commission on the University of Minnesota Medical School
- Private Pay respite care
- Project Know, Understanding Addiction – Behavior Section
- Report and recommendation on Strengthening Minnesota's Health Care workforce from the Legislative Health Care Workforce Commission
- RSVP curriculum on Opioid Addiction
- School District school counselors
- Senior Linkage Line
- SHIP (Statewide Health Improvement Partnership)
- St. Cloud Area Human Service Council
- St. Cloud Area Trauma Response Initiative at the St. Cloud Police Department
- STIR (Stronger Together Inspiring Resilience) – Sherburne County

Existing Community Resources for Building Families (continued)

- Telehealth
- Terabinth Refuge
- Thumbs Up
- United Way 2-1-1
- United Way Success by Six
- Video Conferencing for schools
- Well-Connect
- WAYCAN
- WIC
- Yellow Zones – Stearns website
- Young children mental health service

**Note: Our intent is to have community-driven strategies that encompass all sectors. These lists are in no way meant to be exhaustive. They are meant to be used as considerations when working on community initiatives and identify gap areas of inclusion. If you would like another resource to be added to this list, contact any member of the Core Support Team. (Note: For a list of potential partners, see the list of Potential Partners in the CHIP.)*

J. Evaluation of actions conducted since the previous CHNA process

Benton Update

Benton will add updated info

Sherburne Update

Community Collaboration

Strategy: Family Home Visiting Coalition: Goal of 85% of Family Home Visits target caseloads reached for Stearns, Benton, and Sherburne.

Strategy Outcome: During the COVID-19 pandemic, many home visiting programs had to downsize and adapt to fulfil response duties. The First Steps program staff and staff with capacity, maintained family support by a variety of strategies including resource connection, newsletters, virtual visits, and door-step connections. The collaborative shifted to a new model in mid-2021 and there has been steady growth towards the 85%.

Equity

Strategy: Leverage staff involved in HEDA activities

Strategy Outcome: There has been an agency priority to do our work with a health equity approach. COVID-19 highlighted many inequities in our communities as well as our community health assessment survey. Staff with HEDA experience have supported many of the efforts implemented and much capacity has been built county wide. There is a commitment throughout the county to build capacity in DEI work.

Awareness

Strategy: Increase community knowledge and awareness of CommUNITY Adult Mental Health Initiative (CAMHI).

Strategy Outcome: Sherburne County HHS has designated staff that participate in CAMHI as well many on the list serve. This information is then shared throughout the community through our individual programs and social media platforms. CAMHI made many of their supports and trainings available virtually and opened them up to those outside their service areas.

Strategy: Community ownership of family and mental well-being programs, as demonstrated by volunteerism and resource allocation, i.e., Family Fun Nights, Safe Families, and Trauma-Informed Congregations.

Strategy Outcome: Since 2022, we have seen that many of the community led family and mental well-being programs have moved back to in-person venues but also created or maintained virtual options to have a greater reach. If these programs are willing, they are encouraged to add their group/program to the MN Thrives index.

Resilience

Strategy: A resiliency index will be created and made available to Central MN Alliance partners.

Strategy Outcome: The Minnesota Department of Health developed a statewide index called "Minnesota Thrives" https://mnthrives.web.health.state.mn.us/#/ . The index information is shared across the Alliance as well as with community partners.

Strategy: Establish Elk River as a Bounce Back Community.

Strategy Outcome: While Elk River has not become a Bounce Back community, there was the development of STIR, Stronger Together Inspiring Resilience in 2019. https://www.stirmn.org/resources

Since that time, the partnerships have grown, and the collaborative has developed a range of strategies and supports available to the Sherburne County community and beyond. This group is a core part of community Well-Being.

Strategy: Utilize resiliency programing.

Strategy Outcome: Through the ongoing development of STIR and work of community partners there is a calendar of supports and events focusing on areas of wellbeing.

Strategy: Progress on ACEs Collaborative Work Plan will be shared at community meetings.

Strategy Outcome: The ACE's Collaborative did not meet as an entire group from 2020-2022. A core group of people did meet and as the COVID-19 response evolved, aligned the work more closely with the Central MN Alliance. The work has evolved over the past couple of years and is embedded in many other collaboratives/community organizations. STIR is a leader here in Sherburne.

Education

Strategy: Talking points on the CHNA and CHIP developed and shared with school partners.

Strategy Outcome: During COVID-19, our relationship with the schools focused on the areas identified as most in need. No talking points were developed or specifically addressed but the relationship with school partners was expanded. We plan to continue to engage with schools as they plan for the fall of 2022 and determine how we can align work with the drivers of inequities.

Strategy: Expand preventative health services/education in school building.

Strategy Outcome: SCPH has offered contraceptive classes, "change to chill" wellbeing classes and recently piloted dental varnishing with preschool screening. As schools shift priorities following COVIC-19, we will assess what gaps may exist and support strategies for addressing.

Health Organizations

Strategy: WIC clinics will be integrated with the health system for expanded WIC accessibility and improved customer service.

Strategy Outcome: Discussions early in 2019 continued to build support for WIC clinics located within the CentraCare location as well as Benton County moving towards a St Cloud location offering WIC where public transportation is available. The COVID-19 response moved WIC to a virtual/phone service, therefore making the program very accessible for the majority of the WIC families. This is currently in place and we will resume discussions about accessibility as the federal authorities evaluate this new service delivery model.

Stearns

The 2015-2019 Stearns County Human Services, Public Health Division Community Health Improvement Plan (CHIP) was created through the Community Health Assessment (CHA); community meeting feedback; qualitative data from three focus groups specific to mental health, binge drinking, and dental access; and a public comment period on the draft document. The assessment was developed using data collected from the 2013 Central Region Community Health Survey along with other primary data sources within Stearns County Human Services as well as secondary data sources from the Minnesota Department of Health, Minnesota Department of Human Services, Minnesota Student Survey, and others. The ten community priorities identified for the 2015-2019 CHIP, in ranked order, were: Parenting Skills, Mental Health, Lack of Physical Activity, Poor Nutrition, Tobacco Use by Women, Alcohol Use/Binge Drinking, Integration of Newly Arrived Persons, Sexually Transmitted Infections, Financial Stress, and Dental Access. CHIP goals, objectives, and suggested strategies were designed to allow the community to utilize the document to fit their needs as well as move progress on these issues within the community. The CHIP was monitored, evaluated, and revised as necessary.

Stearns County Public Health partnered with community coalitions to assist in making progress on addressing these community issues. To address the priority of Parenting Skills, Public Health was a key partner in creating the Central Minnesota ACEs (Adverse Childhood Experiences) Collaborative. The initial work plan for this collaborative that has broad community support was taken almost straight from the CHIP. As the years have progressed, Public Health has taken a lead on providing staff support to maintain regular meetings of the Administrative Team as well as supporting Work Groups of the Collaborative. To address the priority of Mental Health, Public Health has been a strong partner in the Community Multi-Disciplinary Team (CMDT) in the St. Cloud Area. This is a collaboration along with the local health system, law enforcement, and justice system partners. This subgroup of the Stearns County Mental Health Steering Committee is working on identifying people who are the highest utilizers of services such as detox, emergency department, and jail visits, and formulating a new plan for services that are tailored to the individual's specific needs. This community partnership has brought in additional dollars to the area to work with persons experiencing homelessness with mental illness.

Stearns County Public Health has also partnered with agencies within the county to address the other priorities. A great data collaboration was achieved with CentraCare to examine the data about women and tobacco rates. The health system was seeing the same surprising rates that were identified in the community survey. Grant funds were obtained and billboards were strategically placed within the county to reach the target population. The St. Cloud Rotary worked with many community partners to build a Community OutPost, which opened in 2016. Stearns County Public Health staff conducts outreach and provides selected services to the targeted neighborhood of immigrants, newly arrived persons, and college students. One of the services that has been brought in during 2018 is a mobile dental services unit. One key measure that is tracked to identify progress on the priorities is child maltreatment determinations. These determinations continue on an upward trajectory. We are uncertain as to whether the problem is increasing or if reporting is improving. These data continue to be important as we move into the new Community Health Improvement Plan with a focus on building families and building mental well-being within the community.

CentraCare

CentraCare has a rich history of partnering in central Minnesota. Since the early 1990s, CentraCare's hospitals have regularly assessed the changing needs of our communities and responded with appropriate programming and support for special projects. Since adoption of the Community Health Needs Assessment (CHNA) for not-for-profit hospitals was included in the Patient Protection and Affordable Care Act (ACA) those activities have been formalized and coordinated across the hospitals of CentraCare.

The CHNAs for CentraCare's six hospitals as of January 1, 2019, were presented individually for each hospital. The Implementation Strategies focused heavily on health metrics as defined by the Community Health Status Indicators (CHSI) 2015 online web application made available by the Centers for Disease Control and Prevention. Throughout the last three years, each hospital has been gaining progress on their respective strategies and a report out will be conducted internally within CentraCare on the progress. A high-level overview of progress from Paynesville, Sauk Centre, Melrose and St Cloud hospitals can be seen in the table below. This list is in no way inclusive but provides an update on some of the work that our regional hospitals have been executing.

At CentraCare and of course at SCH we are committed to improving the health and wellbeing of our community inside and outside our hospital and clinic walls. As we all know, only 20% of a persons health is shaped by the time they spend within our hospitals and clinics. The other 80% is influenced by things like health behaviors, socioeconomic factors and our physical environment. We see these impacts daily. We don't have to wait for our patients to get sick, be admitted to SCH hospital or even be prescribed medicine or treatments to support health and wellbeing.

We are deeply committed to addressing inequities in health care, whether we think about it in terms of who delivers that care or the impact of that care. Our responsibility and our opportunity is to think much broader than that. To think about the 80% of social influences of health that happen outside of our services. That is the purpose of our discussion tonight. To share with you how we assess our community needs and how that informs our workplans to improve community wellness and equity for our patients and our community.

This is not work that CentraCare can do alone. The collaborations we have across our service area to create these assessments and plans with our local public health partners across our regions.

We use an evidence-based framework that helps us apply strategic thinking to prioritize community health issues and identify strategies and resources to address them. This works best when the process is community driven with highly engaged partners from many areas that address our most pressing social determinants and needs. We have built these partnerships and relationships over the course of the last 15 years. Those relationships were instrumental in our ability to respond as a community during the pandemic.

Our 2022 approach has evolved as a continuous improvement design to our community health improvement plan or CHIP. We are committed to this not being a document that is filed on our website for the next three years. Instead, we will approach our work in phases to identify trends and priority areas that allow for expanded work and reach with our committed community partners.

With the formation of the Central MN Alliance, the CHNA process and prioritization of community health issues is broadly focused on community issues rather than disease conditions specifically. The new framework relies on a mixture of national, state, and local data. The responsibility of coordinating the CHNA process for CentraCare now lies with the population health leadership team (PHLT). The team was formed in early 2017 dedicated to provides direction for all risk- based contracts and identify opportunities to increase value, improve quality, improve access, and decrease cost of care for patients.

CentraCare's health condition focus areas in 2019 include the following: diabetes, asthma, hypertension, depression, cardiovascular care (including preventive care and management of Congestive Heart Failure), and preventive care and health screenings (colorectal cancer screening, breast cancer screening, cervical cancer screening, and immunizations). These health condition focus areas will be used as population measures within the Community Health Improvement Plan with appropriate priorities.

CHNA Appendices

Appendix A: Existing Infrastructure: Continuing the Community Priorities

The 2019-2022 Community Priorities were identified via thorough multi-level prioritization processes and are explained in detail in the 2019-2022 CHNA. With COVID-19 side-lining many of the specific tasks outlined in the 2019-2022 CHIP, it was discussed, and the consensus was that the top community priorities remained the same and the 2022-2025 process would involve delving into the root causes of barriers to the community priorities.

Central MN Alliance Continuing Priorities

	Priority	Examples
1	**Building Families**	Individual/family intervention Child well-being Parenting skills
2	**Mental Health**	Awareness Access Well- being Addiction
3	**Encouraging Social Connection**	Across the age spectrum Building social connections Community intervention
4	**Adverse Childhood Experiences (ACEs)**	Awareness Cultural Preventative measures Leading to chronic disease
5	**Tobacco/Nicotine Use**	E-cigarettes Addiction
6	**Health Care**	Access Cost
7	**Risky Youth Behavior**	Education Trafficking Mental Health Homelessness Alcohol, tobacco, and other drugs Physical health Safety
8	**Financial Stress**	Living wage Unemployment Affordable living
9	**Trauma**	Across the lifespan
10	**Educating Policy Makers and Key Community Stakeholders**	Educating on emerging issues in the community

Appendix B: Existing Infrastructure: Jan 2019 Guiding Principles

Process to get to the lists on the following two pages.

A community meeting was held on January 16, 2019. Ninety-four (94) people attended and sat in groups around the room at seventeen (17) tables. Note takers were assigned to each of the 17 tables. In a World-Café-format discussion, the community meeting participants were asked to identify local resources and potential action steps to address the top two priorities, Building Families and Mental Well-Being.

After the meeting, the action steps identified by the note takers were categorized into themes. The themes were measured by frequency (the number of action steps in a category) and extensiveness (the number of times a category of action step was identified at a table). See the next two pages for the Community Meeting Action Step Category Themes.

In the 2019-2022 Process, the goals and action steps were built around these themes. In the current process, we identify that these guiding principles are key to how we work.

Guiding Principles:
- Community Collaboration (COL)
- Equity Lens (EQ)
- Focus on Strengths & Resilience (RES, SUP)
- Build Awareness (AW)
- Educate and Inform (EDO)
- Involve Health Organizations (HC)

BUILDING FAMILIES - Sorted Largest to Smallest on Frequency

CODE	Frequency	Extensiveness
COL: Community Collaboration,	36	8
SUP: Support Groups/People Supporting People,	34	11
EQ: Equity,	33	12
FUND: Funding,	32	10
AW: Awareness,	24	11
EDO: Education Opportunity (class/instruction, but not necessarily formal in a school),	21	10
HC: Health Care,	15	8
JOB: Job/worksite/business/staffing,	14	8
CHILD: Early Childhood,	13	6
GOV: Government,	12	7
TRANS: Transportation,	12	9
ISD: Integrated Service Delivery,	11	7
SCH: Schools,	11	8
CC: Child Care,	10	5
HOUS: Housing,	10	8
NAV: System Navigation,	10	7
SEN: Seniors,	9	6
NUT: Nutrition,	8	8
ACT: Physical Activity & Community Events,	7	5
TECH: Technologies,	7	5
FHV: Family Home Visiting,	6	4
COURT: Court System (Corrections, Jail, Law Enforcement),	5	3
FT: Family Time,	5	4
HS: High School,	5	5
RES: Encourage Resilience,	5	5
VOL: Volunteers	5	5
ATOD: Alcohol, Tobacco, Other Drugs,	2	2
FAITH: Faith related,	2	1
UNI: college/university	2	2
RESP: Respite Care,	1	1
SAFE: Safety,	1	1
VET: Veterans,	1	1

MENTAL WELL-BEING, Sorted Largest to Smallest on Frequency

CODE	Frequency	Extensiveness
RES: Encourage Resilience,	36	13
COL: Community Collaboration,	28	12
SCH: Schools,	20	11
HC: Health Care,	19	9
SUP: Support Groups/People Supporting People,	17	10
ACT: Physical Activity & Community Events,	16	7
EDO: Education Opportunity (class/instruction, but not necessarily formal in a school),	15	10
FUND: Funding,	14	11
STIG: Stigma,	14	9
ISD: Integrated Service Delivery,	13	10
TECH: Technologies,	12	6
EQ: Equity,	11	7
JOB: Job/worksite/business/staffing,	9	7
NAV: System Navigation,	9	6
SAFE: Safety,	9	6
CHILD: Early Childhood,	7	6
HS: High School,	6	2
ATOD: Alcohol, Tobacco, Other Drugs,	5	3
GOV: Government,	5	4
AW: Awareness,	4	4
FAITH: Faith related,	3	3
TRANS: Transportation,	3	2
COURT: Court System (Corrections, Jail, Law Enforcement),	2	2
NUT: Nutrition,	2	2
RUR: Rural,	2	2
UNI: college/university,	2	2
ACE: Adverse Childhood Experiences,	1	1
FARM: Farmers,	1	1
FT: Family Time,	1	1
HOUS: Housing,	1	1
SEN: Seniors,	1	1
SLEEP: Sleep related,	1	1
TIC: Trauma Informed Care,	1	1
VET: Veterans,	1	1
VOL: Volunteers	1	1

Appendix C: Community Context Assessment Committee Report

Overview

The Community Context Assessment builds on the former Community Themes and Strengths Assessment, digging deeper to understand inequities, fill in data gaps from the Community Status Assessment, and explores the context of the community through the lens of those with lived experience. This assessment is designed to move beyond perceived community needs and perpetuation of dependency on programs and services to understanding a community's strengths, assets, and culture, recognizing that all communities have a vibrancy that must be leveraged in community improvement.

This assessment intersects with the Community Partners Assessment, highlighting how community members may work with organizations to co-design and implement solutions.

Further, this assessment will explore historical policies, events, and other societal structures that have shaped the community and offer insight into what created the inequities in the first place.

COMMUNITY CONTEXT ASSESSMENT

Community Context Assessment: Assessment Tool

Each of the agencies within the CMA conducted a Community Context Assessment for their agency to determine the context of our community within the following domain areas:

- Lived Experience: Assessed perceptions, insights, values, culture, and priorities of those experiencing inequities
    - LE1: Perceptions, insights, values, culture
    - LE2: Priorities of those experiencing inequities
- Strengths, Assets, and Culture: Assessed strengths and assets possessed by community members (e.g., skills, education, job experience) which may be leveraged or built upon so that community members may be active participants in the MAPP process
    - SAC1: Strengths and assets possessed by community members (e.g., skills, education, job experience)
    - SAC2: Community is aware of strengths and assets and can utilize them to solve problems
- Built Environment: Assessed the built environment within neighborhoods experiencing the greatest inequities (e.g., public transit, complete streets, library)
    - BE1: Asset mapping of the built environment within neighborhoods experiencing the greatest inequities (e.g., public transit, complete streets, library)
- Historical Context: Assessed community's history to understand the institutional and structural root causes of disparate outcomes and existing systems and policies that perpetuate the inequities.
    - HC1: Research of community's history to understand the institutional and structural root causes of inequities (e.g., redlining, segregation)
    - HC2: Existing systems and policies that perpetuate inequities
- Structural Racism: Assessed modern-day forms of structural racism and oppression that continue to maintain the power structures that perpetuate inequities.
    - SR1: Power: the ability to control the processes of agenda setting, resource distribution, and decision-making, as well as to determine who is included and excluded from these processes. Power imbalances contribute to various forms of oppressions and are crucial

to making the shift from mitigating inequities to actively confronting the root causes of health inequity through collective power building strategies.

- SR2: Mitigating inequities to actively confront the root causes of health inequity through collective power building strategies.
- SR3: Community Power: the ability of communities most impacted by structural inequity to develop, sustain and grow an organized base of people who act together through democratic structures to set agendas, shift public discourse, influence who makes decisions, and cultivate ongoing relationships of mutual accountability with decision-makers that change systems and advance health equity.

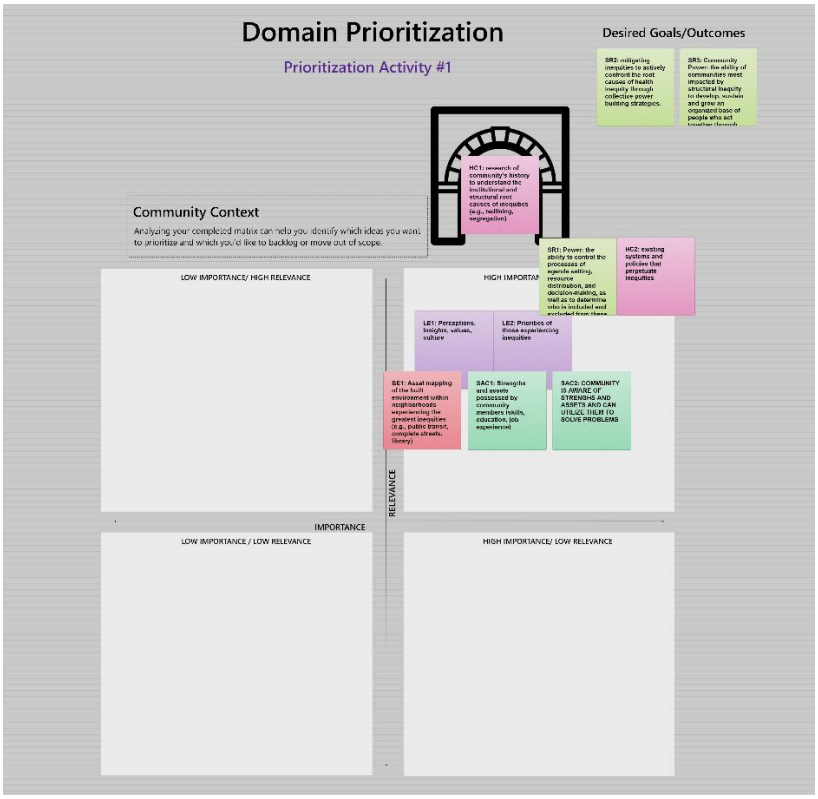
Committee members reflected on the above areas and gathered information for each of their respective agencies to assess the context of our communities within each of the domain areas, completing a Context Committee Assessment, one for each of the CMA Members of Benton, Stearns, Sherburne and CentraCare. This assessment tool completion was developed through information gathering, partnership, community conversations, individual conversations, and observations of community needs. CMA Members brought each of their Context Assessment tools back to the Context Committee. The Context Committee identified shared findings, trends, gaps and unique features for each of the domains for the region.

The Context Committee then presented to the larger leadership group where the group had an opportunity to ask questions, clarify concerns, and make recommendations. Following the leadership group meeting, the Context Committee updated the context assessment tool that captured the most significant findings among our CMA region.

Community Context Assessment: Prioritization of Domain Areas

The committee took the feedback gained from the larger leadership group back to the context committee and completed an importance/relevance prioritization activity to identify the top domains within our Central Minnesota Alliance.

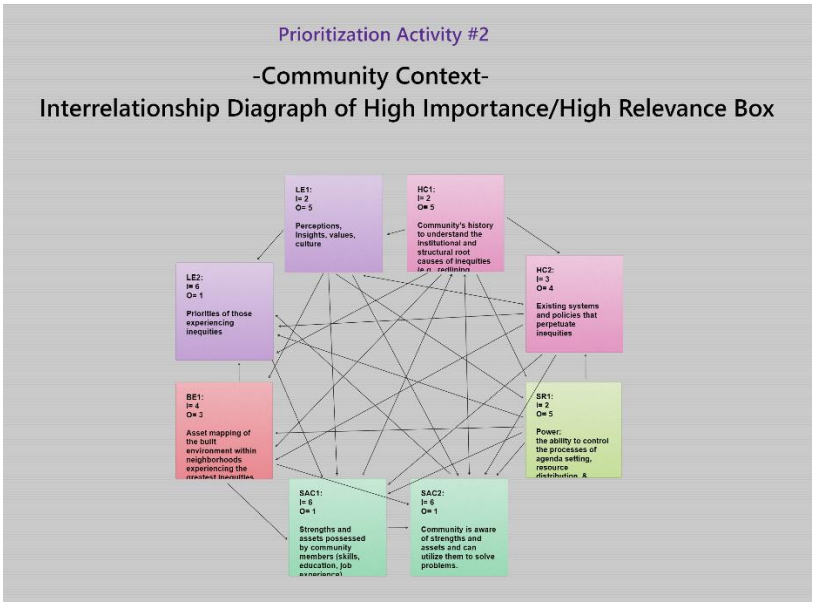
Figure: Context Assessment_Domain Prioritization Activity



Community Context Assessment: Interrelationship Diagraph

The committee then conducted an interrelationship diagraph of the top domains that fell within the high importance/high relevance box of the importance/relevance prioritization activity.

Figure: Context Assessment_Domain Interrelationship Diagraph

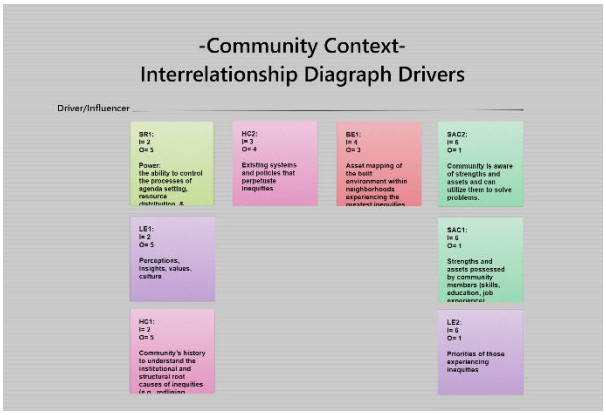


Community Context Assessment: Top Drivers of Inequities

The top domain areas identified as drivers of inequities for the CMA Community Context Committee through the Community Context Assessment were:

- Structural Racism
- Lived Experience
- Historical Context

Figure: Context Assessment_Domain Drivers



The Context Committee then presented to the larger leadership group on the top domain areas identified, where the leadership group had an opportunity to ask questions and clarify concerns.

The Context Committee then took a deeper dive into the drivers of inequities within our region through a Community Top Themes Assessment process, which included an assessment, prioritization activity and interrelationship diagraph.

Deeper Dive into our Community Context

Each CMA Member further gathered information related to top issues, concerns, barriers, and strengths heard from our community members and information gathered from the community through individual and community conversations, observations, and data sources related to top themes identified for their respective agencies.

COMMUNITY TOP THEMES ASSESSMENT

Community Top Themes Assessment

Each CMA Member brought their top themes identified back to the Context Committee. The top themes occurring within each CMA Member agency are outlined below (in no particular order):

Benton County Top Themes:

- Mental health/social Isolation/substance Use
- Political climate
- Government services/programs
- Skilled jobs/trade skills/diverse workforce/lack of access to jobs and higher education within the county
- Access to healthy and affordable foods
- Access to all types of healthcare (dental, mental health, providers that accept MA)
- COVID-19
- Access to transportation (walking, biking, bus, ride shares, etc.)
- Access to broadband/technology
- Lack of community engagement opportunities
- Need for health focused policies/positive health behaviors
- Access to childcare/affordable childcare

CentraCare Top Themes:

- Housing
- Mental health
- Access to culturally competent providers
- Childcare access
- Children struggling at school
- Health and literacy disparities
- Public communication disparities
- Racism/Islamophobia
- Technology barriers
- Transportation
- Lack of professional opportunities for college educated BIPOC adults
- Decreased graduation rates in high school

Sherburne County Top Themes:

- Access to all types of healthcare (dental, mental health, providers that accept MA)
- Access to transportation
- Mental health/social isolation/substance Use
- Housing

Stearns County Top Themes:

- Diversity, equity, and inclusion
- Mental health/chemical Health
- Housing
- Healthcare access
- Childcare access
- Nutrition

The Community Top Themes were compiled into a collective list representing the top themes for the CMA. The top themes identified for the CMA were:

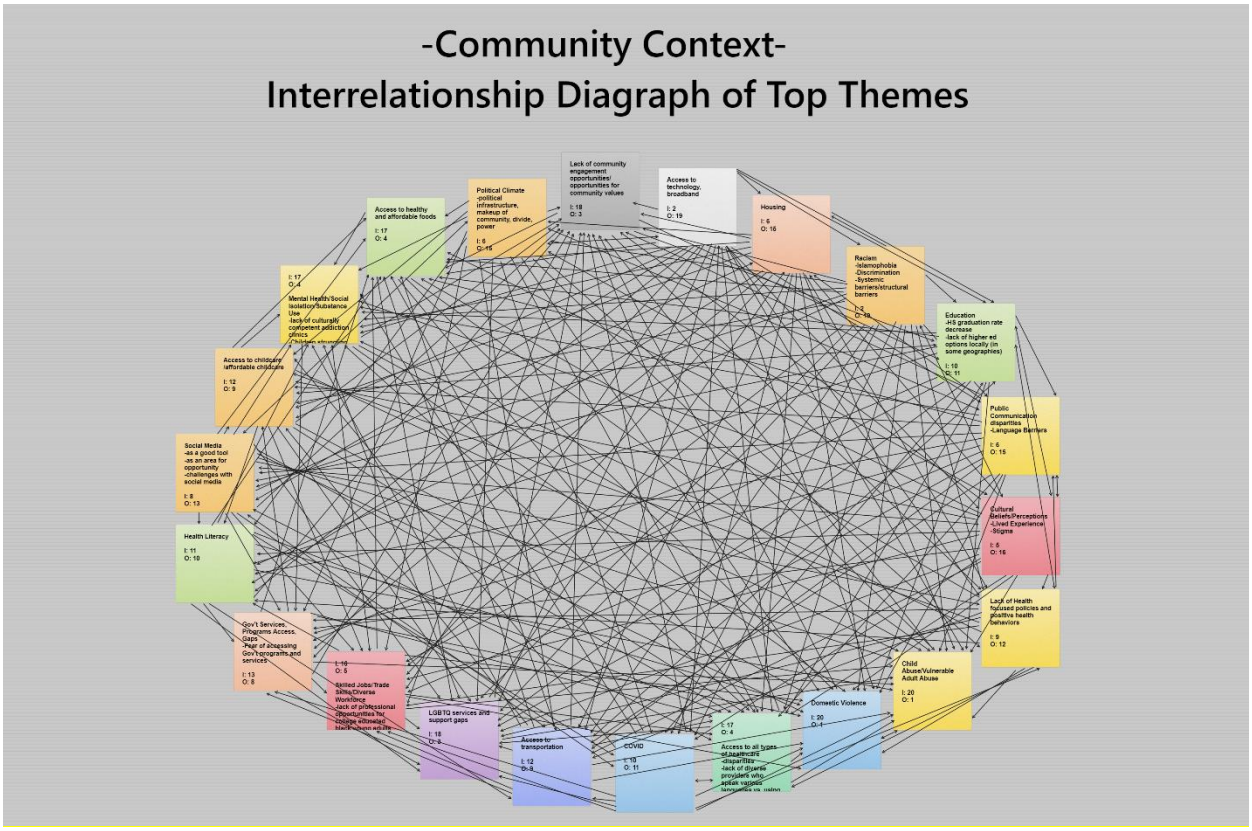
Community Top Themes for CMA:

- Lack of community engagement opportunities/opportunities for community values.
- Access to technology, broadband
- Housing
- Racism, Islamophobia, Discrimination, Systemic barriers, Structural Barriers
- Education, high school graduation rate decrease, lack of higher education options locally in some geographies)
- Public communication disparities/language barriers
- Cultural beliefs, perceptions, lived experience, stigma
- Lack of health focused policies and positive health behaviors
- Child abuse, vulnerable adult abuse
- Domestic violence
- Access to all types of healthcare
- COVID-19
- Access to transportation
- LGBTQ services and supports gaps
- Skilled jobs, Trade skills, Diverse workforce, lack of professional opportunities for college educated black young adults
- Government services, programs access, gaps, fear of accessing governmental programs and services
- Health Literacy
- Social Media, as a good tool, as an area for opportunity, and as a challenge
- Access to affordable childcare
- Mental Health, Social Isolation, Substance Use, lack of culturally competent addiction clinics, children struggling with school, LGBTQ Mental health services and supports
- Access to healthy and affordable foods
- Political Climate, political infrastructure, makeup of community, divides, power

Community Top Themes Assessment: Interrelationship Diagraph

The Context Committee then conducted an interrelationship diagraph of the Community Top Themes identified for the CMA.

Figure: Context Assessment_Top Themes_Interrelationship Diagraph

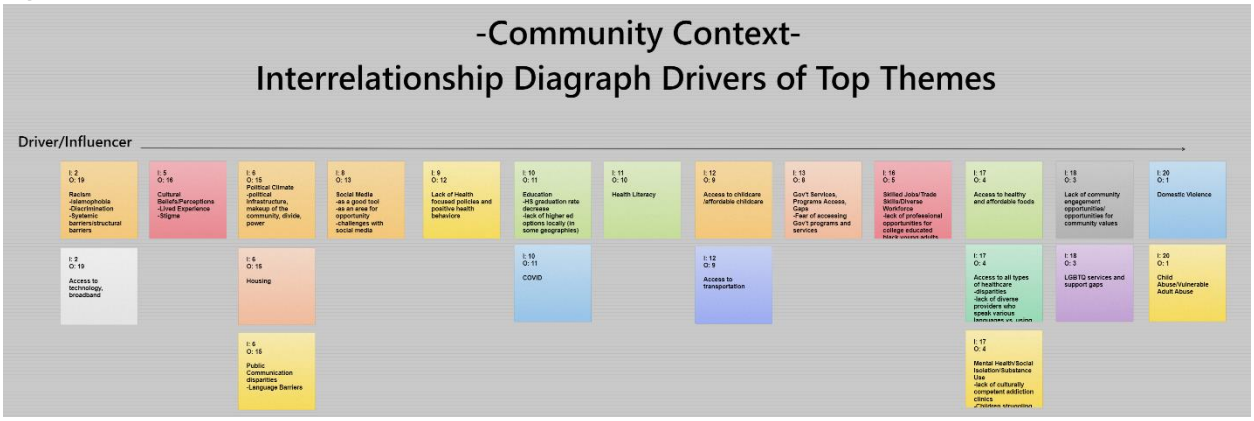


Community Top Themes Assessment: Top Drivers of Inequities

The top themes identified as drivers of inequities from the Community Top Themes Assessment for the CMA Context Committee were:

- Racism (Islamophobia, Discrimination, Systemic/Structural Barriers)
- Access to Technology/Broadband
- Cultural Beliefs, Perceptions, Lived Experience, Stigma

Figure: Context Assessment_Top Themes Drivers



The Context Committee then presented to the CMA Leadership Group the top drivers of inequities identified for the region through the top themes assessment, where the leadership group had an opportunity to ask questions, clarify concerns, and reflect on the information obtained.

This information presented by the Context Committee was used to inform the top priorities for our larger CMA Leadership Group.

Comparison of Community Context Assessment of Domain Areas to Community Top Themes Assessment

The CMA Leadership Group compared what was learned from the Community Context Assessment of the domain areas to the Community Top Themes Assessment.

- Racism (Islamophobia, Discrimination, Systemic/Structural Barriers) from the Community Top Themes Assessment fit within the domain area of structural racism within the Community Context Assessment.
- Cultural Beliefs, Perceptions, Lived Experience, and Stigma noted from the Community Top Themes Assessment fit within the domain area of lived experience within the Community Context Assessment.
- Access to technology and broadband from the Community Top Themes Assessment was not captured within the Community Context Assessment domain areas. However, the impacts of technology and broadband on our communities and determinants of health were found to be substantial and therefore this was identified as a priority area within the data access and systems priority for the CMA (as identified by the Partner Assessment Committee).

Figure: Context Assessment_Comparison to Top Themes Assessment

Community Context

Top Themes Drivers Comparison to MAPP Domain Drivers

Appendix D: Community Partner Assessment Committee Report

Overview

Replacing the Local Public Health System Assessment (LPHSA), the Community Partner Assessment provides structure for all community partners to look critically within their own systems and processes, reflect on their role in the community's health and well-being, and understand the degree to which they are addressing or perpetuating health inequities across a spectrum of action ranging from the individual to systemic and structural levels.

It will offer an assessment instrument which, in contrast to the LPHSA, will be inclusive of but not grounded in the 10 Essential Public Health Services to broaden its relevance to community partners outside of the health and human services sector. Since the assessment tool was not available for our group to utilize during this time frame, we adapted by creating a table with the domain areas. Each CMA member was responsible to "assess" partners in their geographic or service area by the 9 domain areas.

Partners Assessment: Assessment Tool

Health Equity Capacity: Assessed each CMA member's and partner's understanding and commitment to health equity and related concepts, their role in addressing inequities, and analysis of existing interventions, programs, and services across a spectrum of action including individual, organizational, systemic, and structural level. These results can be used to assist each partner in identifying opportunities to move upstream in their own work and identify gaps across the spectrum that may be addressed through the CHIP.

- HEC1: Commitment to health equity and related concepts
- HEC2: Role in addressing inequities
- HEC3: Analysis of existing interventions, programs and services at the individual level
- HEC4: Analysis of existing interventions, programs and services at the organizational level
- HEC5: Analysis of existing interventions, programs and services at the system level

Community Engagement: Assessed CMA member's and partner's relationship with, and relative power in, the community (e.g., history of allyship or mistrust); success in meeting community needs; and opportunities for the community to participate in shaping programs, services, or other activities designed to help them. These results can be used to transfer power to those historically excluded from decision making.

- CE1: Relationship and power with the community
- CE2: Success in meeting community needs
- CE3: Opportunities for the community to participate in shaping programs
- CE4: Opportunities for the community to participate in shaping services
- CE5: Opportunities for the community to participate in shaping other activities designed to help them

Resources: Assessed CMA member's and partner's resources to meet community needs and how those resources are aligned to meet the needs of specific subpopulations. This data may inform decisions around funding and realigning resources to better meet the needs of those experiencing inequities.

- R1: Partner resources meet community need
- R2: Partner resources aligned to meet community need

Community Linkages: Assessed capacity to coordinate and align with CMA members and other partners and stakeholders within the community system to improve overall quality, efficiency, and effectiveness of programs, services, and interventions to address inequities. Also assessed how CMA members and partners are building allies and networks with those holding power. These results may be used to identify gaps or opportunities to make improvements to the community system at large.

- CL1: Coordinate and align with other partners to improve quality
- CL2: Coordinate and align with other partners to improve efficiency
- CL3: Coordinate and align with other partners to improve effectiveness
- CL4: Coordinate and align with other partners to address inequities
- CL5: Build allies and networks with those holding power

Leadership: Assessed CMA member's and partner's leadership support around both achieving equity as it relates to their mission and participation in the MAPP process. Results of this assessment may assist each partner to strengthen its position in the community to achieve its mission from an equity and community health improvement lens.

- L1: Support for achieving equity as it related to their mission and participation in MAPP

Workforce: CMA members and partners assessed whether their respective workforce is skilled, sufficient, and representative of community demographics to meet community needs and address inequities.

- W1: Skilled
- W2: Sufficient
- W3: Representative of community demographics

Policy Analysis: Assessed CMA member's and partner's internal organizational policies from an equity lens, and public policies which support or impede its ability to impact inequities in the community. These results can be used to identify concrete strategies for organizational, community, and public policy level change.

- PA1: Internal organizational policies use an equity lens to impact inequities
- PA2: Public policies use an equity lens to impact inequities

Data Access and Systems: Assessed inventories and data available across CMA members and partners that may inform and contribute to the larger CHNA; explores opportunities for data sharing and transparency across the community; and assessed each CMA member's and partner's data infrastructure for ongoing monitoring and evaluation to track its own impact on inequities and identify opportunities for shared measurement and evaluation in the CHI process.

- DAS1: Data available across partners
- DAS2: Data sharing
- DAS3: Data transparency
- DAS4: Data infrastructure to track its own impact on inequities

The CMA partners assessment tool included summaries from Benton, Stearns, Sherburne and CentraCare. Members assessed services provided across all of the geographies so their information was considered in that scope. A "Partner Engagement and Inquiries Tracking" form helped the members to track contacts made with partner organizations. This tracking document includes the agency name, contact information, sector, notes, next steps and follow up status. The CMA members used a variety of techniques both within their respective agencies and across the community to gather and report back to the Partners Committee. Members attended meetings, researched websites, observed partners within the community, reviewed strategic documents, completed surveys, engaged in one-on-one conversations with community residents and/or with partners on behalf of a community, provided lived experiences, and attended events that exemplified the work and mission of the partner.

Partners Assessment

Once the CMA members completed their assessments, the group then shared findings and identified trends, gaps and unique features for each of the domains. This was then presented to the larger CMA Leadership Group where the group had an opportunity to ask questions, clarify concerns and make recommendations. Following the CMA Leadership Group meeting, we updated the regional document that captured the most significant findings among our CMA members, partners, and geographic areas.

Although included in the 9 domains, each CMA member completed a separate forces of change assessment (FOC) for their geographic or service area. The Partner Committee chose to do this due to the enormity of the changes that have occurred over the past 2 years. The Partner Committee then had group discussions of the commonalities, trends and gaps. A regional FOC document was developed with feedback from the CMA Leadership Group.

Forces of Change Assessment

Forces of Change: Provided a structure for each CMA member and partner to reflect on the forces of change (e.g., COVID-19, disease outbreaks/public health emergencies, political climate, market shifts, funding) impacting its work and future scenario planning to identify the specific set of uncertainties of what may happen in the future. These results may be used to plan for different realities to enhance adaptability and preparation for most effectively building community resilience.

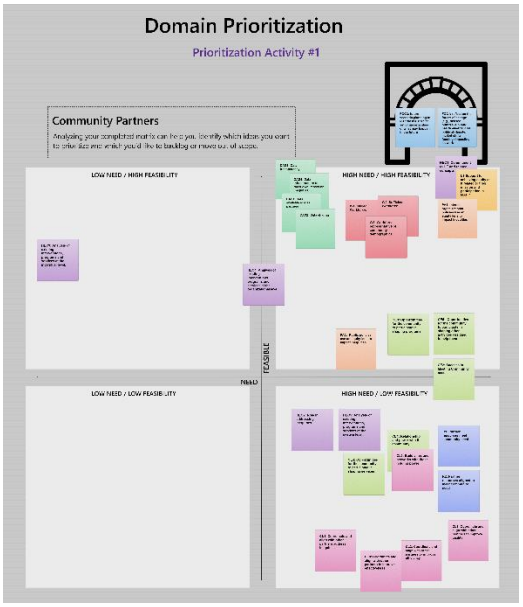
The forces of change assessment and partner assessment tools were then used in prioritization exercises to assist the Partners Committee in determining the most significant root causes or drivers that could impact health. The regional documents were labeled by the domain and a corresponding number to articulate the different domain factors (HEC1, HEC2, W1).

Prioritization of Partners Assessment of Domain Areas and Forces of Change Assessment

In order to set priorities on what actions to take first, this simple tool helped facilitate a consensus building discussion of options that have the highest need and are most feasible to accomplish. The tool helped to prioritize, match actions to our capacity, and stay realistic about what can be accomplished.

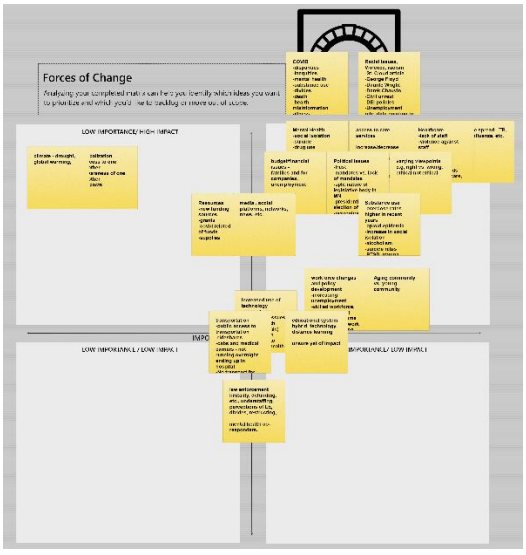
Partners Assessment of Domain Areas

Figure: Partners Assessment_Domain Prioritization Activity



Forces of Change

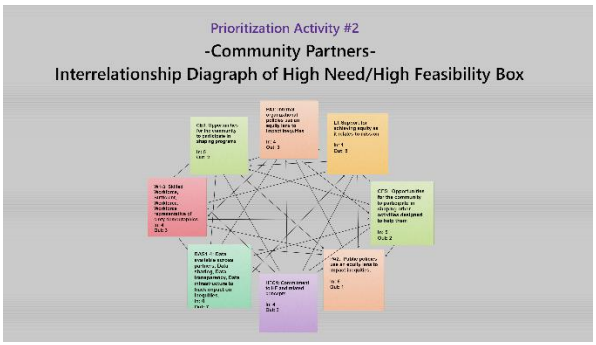
Figure: Forces of Change_Prioritization Activity



Partner Assessment: Interrelationship Diagraph of Domains Noted High Need/High Feasibility

This exercise was used to identify and analyze relationships among critical factors that impact an issue (health for us) and to hone in on key drivers and outcomes. We used this exercise to analyze the relationships among our most significant factors from the Need and Feasibility Analysis exercise.

Figure: Partners Assessment_Domain Interrelationship Diagraph

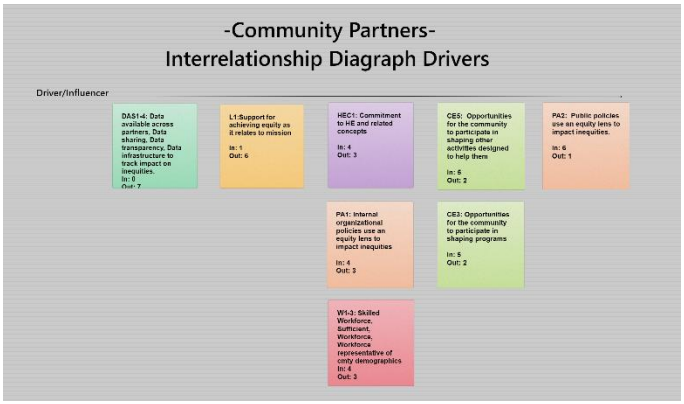


Partner Assessment: Top Drivers of Inequities

Recommendations to the CMA Leadership Group provided by the Partners Committee through these various activities found that the following rose to the top as main drivers of inequity:

- DAS1: Data available across partners
- DAS2: Data sharing
- DAS3: Data transparency
- DAS4: Data infrastructure to track own impact on inequities

Figure: Partner Assessment_Domain Drivers



Appendix E: Data Sources to Explore

Data Source	2021 Member Reviewed
**County-Level Indicators by Data Source: Resource for all to review. 17-page PDF	
Census Poverty & Income by county [Small Area Income and Poverty Estimates (SAIPE) Program]	
Minnesota Cancer Reporting System	x
Minnesota Compass	x
Minnesota County Health Tables	x
Minnesota Department of Education Data Center	
Minnesota Injury Data Access System (MIDAS)	x
Minnesota Kids Count Databook	
Minnesota Public Health Data Access Portal	x
Minnesota Sexually Transmitted Diseases, including HIV	x
Minnesota Student Survey, excluding substance use data	x
Minnesota Vital Statistics Interactive Queries, Birth Queries by County require a password, contact healthstats@state.mn.us	
Substance Use in Minnesota.org	x
Behavioral Risk Factor Surveillance System (state level data)	
Childhood Opportunity Index: The Geography of Child Opportunity: Why Neighborhoods Matter for Equity	
Minnesota Adult Tobacco Survey (state level data)	
Greater St. Cloud Equity Dashboard (while much of the data are from St. Cloud, Sauk Rapids/Rice, Sartell-St. Stephen, it is applicable across the three counties)	
Central Minnesota Social Capital Survey (15 mile radius around St. Cloud)	x
County Health Rankings, Robert Wood Johnson Foundation, University of Wisconsin Population Health Institute	
AARP Livability Index	

Central Minnesota Alliance

Community Status Assessment Committee

Data Points of Concern with Sources (7/1/21-2/2/22 Process)

Note: The data points are numbered for reference, but there is no prioritization of the data points. They are all considered data points of concern.

Central Minnesota Alliance is a partnership between the counties of Benton, Sherburne, and Stearns along with CentraCare to assess the health needs of our communities, identify priorities, and develop action plans for improvement.

The Community Status Assessment is one of three Assessment Committees conducting community health assessment tasks.

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Contents

Please note: MSS = Minnesota Student Survey

CHILDHOOD AND FAMILY CONCERNS

1: Parenting Skills.

59% of adults in the 3-county region view parents with inadequate or poor parenting skills as a moderate or serious problem in the community. (up from 51% in 2016) Source: 2021 Central Minnesota Community Health Survey, Question: In your opinion, how much of a problem is parent with poor parenting skills? Responses: No problem, Minor problem, Moderate problem, Serious problem.

2: Out of Home Placements.

9 out of 1,000 children in the 3-county region are in out-of-home placements. (2017 data was 10 out of 1,000 children) Source: Minnesota Department of Human Services, Minnesota's Out-of-Home Care and Permanency Report 2019, Table 6: Number of children in out-of-home care by sex and agency with U.S. Census child population estimate and rate per 1,000, 2019.

3: Child Maltreatment.

28 out of 1,000 children in the 3-county region have been an alleged victim of child maltreatment. The MN state rate is 29 per 1,000. (2017 data: 3-county area 23 out of 1,000, MN=31 per 1,000) Source: Minnesota Department of Human Services, Minnesota's Child maltreatment Report 2019, Table 9: Number of alleged victims in completed assessments/investigations by maltreatment type and rate per 1,000 children by agency, 2019.

4. MSS Bullying.

In 2019, 62.4% of Benton County 8th graders and 54.0% of Sherburne County 8th graders report they were bullied or harassed once or more in the past 30 days, which are both higher than the state rate of 53.7%; Stearns' rate is 50.2%. There is an upward trend from 2013 to 2019 and the rates are higher for females than males. Source: 2013, 2016, and 2019 Minnesota Student Survey via the Substance Use in Minnesota (sumn.org) website.

5. MSS Educational Engagement.

There is a downward trend in students reporting higher levels of educational engagement with males trending lower than females and 11th graders trending lower than 5th graders. Sherburne County 11th graders have the lowest rates in 2019 (MN: 68.6%, Sherburne: 63.9%, Stearns: 69.7%, Benton: 72.3%). Source: 2013, 2016, and 2019 Minnesota Student Survey via the Substance Use in Minnesota (sumn.org) website.

6. Childhood lead.

In 2019, 4.4% of Benton County children age 3 to less than 6 years of age tested for elevated blood levels had an elevated blood lead level (EBLL). (MN: 0.4%, Sherburne 0%, Stearns 0%). Source: Minnesota Department of Health Lead & Healthy Homes Program, 2019. Note: these data include small numbers of less than 20 EBLLs and the percent elevated can change dramatically with the addition or subtraction of one EBLL.

7. Childhood immunizations 24-35 months. **From 2019 through 2021, the percent of children age 24-35 months old receiving the seven-vaccine childhood immunization series has dropped in Sherburne and Stearns County, following the state trend. The 2021 immunization rate for children age 24-35 months old in Stearns County is at a 5-year low.** Source: Minnesota Department of Health, immunization queries, 2016-2019 and 2021.

CHRONIC ILLNESS

8: COPD. **Benton County COPD rate is 10.3 cases per 10,000 residents. Sherburne is 9.8 COPD cases per 10,000 residents and Stearns County at 8.3 cases per 10,000 residents. Minnesota rate is 14.6 cases per 10,000 residents.** (2009-2015 data: per 10,000 – 24.5 Benton, 14.6 Sherburne, 11.8 Stearns. While improving, the Committee would like to continue to track progress on this data point.] Source: Minnesota Department of Health, Minnesota Public Health Data Access, COPD hospitalizations query. Counties are a three-year average 2017-2019. Minnesota rate is for 2019. For additional information, the Minnesota rate per 10,000 residents for 2017=18.0 and 2018=13.3.

9: High Blood Pressure. **22% of residents in the 3-county region have been told by a doctor that they have High Blood Pressure.** [2016 = 23%] Source: 2021 Central Minnesota Community Health Survey, Question: Have you ever been told by a doctor, nurse, or other health care professional that you had High Blood Pressure/Hypertension? Responses: Yes; Yes, during pregnancy; No.

10. Colon Cancer Screening. **In Central Minnesota, there is a 26.9% disparity between the total population and people of color in completing colon cancer screening. As of September 30, 2021, 80.8% for the total population (3.3% above target rate of 77.5% [MN 90th percentile target]) versus 53.9% for people of color (2.3% below target rate of 56.2%) completed colon cancer screenings**. Source: CentraCare EPIC, 1/1/2021 through 9/30/2021. Target goal timeframe FY2022, 7/1/2021 through 6/30/2022.

11. Optimal Asthma Management. **In Central Minnesota, the rate of optimal asthma management is below the target rate. As of September 30, 2021, 52.2% of adults experienced optimal asthma (2.2% below the target rate of 54.4%).** Source: Source: CentraCare EPIC, 1/1/2021 through 9/30/2021. Target goal timeframe FY2022, 7/1/2021 through 6/30/2022.

12. Optimal Diabetes Management. **In Central Minnesota, the rate of optimal diabetes management is close to the target rate. As of September 30, 2021, 47.8% of adults experienced optimal diabetes (0.8% above the target rate of 47.0% [MN 90th percentile target]).** Source: Source: CentraCare EPIC, 1/1/2021 through 9/30/2021. Target goal timeframe FY2022, 7/1/2021 through 6/30/2022.

13. Depression 6-month remission, Adolescent. **In Central Minnesota, the rate of 6-month remission for adolescent depression is below the target rate. As of September 30, 2021, 6.5% of adolescents experienced a 6-month remission of their depression (2.6% below the target rate of 9.1%).** Source: Source: CentraCare EPIC, 1/1/2021 through 9/30/2021. Target goal timeframe FY2022, 7/1/2021 through 6/30/2022.

14. Depression 6-month remission, Adult. **In Central Minnesota, the rate of 6-month remission for adult depression is below the target rate. As of September 30, 2021, 7.4% of adults experienced a 6-month remission of their depression (1.0% below the target rate of 8.4%).** Source: Source: CentraCare EPIC, 1/1/2021 through 9/30/2021. Target goal timeframe FY2022, 7/1/2021 through 6/30/2022.

15. Alzheimer's Death Rate per 100,000. **The Benton County Age-Adjusted Alzheimer's Cause-Specific Death Rate per 100,000 is at 56.2, which is higher than the state rate of 32.6. (Sherburne 47.2, Stearns 23.8).** Source: Minnesota County Health Tables, Mortality Table 7. Age-Adjusted Cause-Specific Death Rates for 10 Leading Causes by State/County/CHB, 2015-2019. The rates are age adjusted to the 2000 U.S. standard population.

FINANCIAL

16: Financial Stress. **64% of adults in the 3-county region view families with financial stress as a moderate or serious problem in the community.** (up from 60% in 2016) Source: 2021 Central Minnesota Community Health Survey, Question: In your opinion, how much of a problem is families experiencing financial stress? Responses: No problem, Minor problem, Moderate problem, Serious problem.

17: Poverty Level. **Benton and Stearns Counties poverty levels are higher than the state rate of 23.7%. Benton County 28.0%, Sherburne County 15.9%, Stearns County 28.3%.** Source: Minnesota Department of Health, Minnesota County Health Tables, Demographics Table 5: Selected Minnesota Socioeconomic Statistics by State/County/CHB, 2019. American Community Survey 2015-2019.

18: Single Parent Households. **30.2% of Benton County children (under 18) and 24.9% of Stearns County children are living in single parent households. As compared to Sherburne County with 23.0% living in single parent households.** (2016 data: 29% Benton, 27.6% Stearns, 21.4% Sherburne). Source: Minnesota Department of Health, Minnesota County Health Tables, Demographics, Table 5. Selected Socioeconomic Statistics by State/County/CHB, Minnesota Residents, 2019.

19. Food insecurity in young adults. **In the St. Cloud Area, more than a third of young adults under age 24 indicated they had faced food insecurity at some point in the previous 12 months.** Source: Social Capital in Central Minnesota 2020/21 Report prepared by St. Cloud State University Survey Center, May 21, 2021, Commissioned by the Central Minnesota Community Foundation. Phone survey using a sample of adults with a landline or cell phone in a 15-mile radius around St. Cloud, Minnesota, which includes residents of Benton, Sherburne, and Stearns Counties.

20. Cost Burdened Households. **Cost burdened households for renters in the 3-county region is twice as much as owner cost burdened households. Benton County's all cost burdened households (28.4%) is higher than Sherburne (21.1%) and Stearns (24.9%) Counties**. Source: Minnesota Compass, 2015-2019 US Census estimates.

21. St. Cloud Area Worst in US for Black Americans. **According to a November 2021 Special Report by 24/7 Wall St., the St. Cloud Metro Area ranks as the worst United States city for Black Americans based on median income, unemployment, and home ownership data.** Source: 24/7 Wall St. Special Report. Released on November 19, 2021, Author: Grant Suneson. Website: https://247wallst.com/special-report/2021/11/19/the-worst-cities-for-black-americans-8/5/.

MENTAL WELL-BEING/MENTAL HEALTH

22: ACES. **75% of residents living below the 200% of poverty line have at least 1 Adverse childhood experience (ACE), compared to 55% of residents living above 200% poverty line.** Source: 2016 Central Minnesota Community Health Survey, Question: Combined ACE score. Responses: 0, 1, 2, 3, 4+.

23: Suicide Ideation. **Over a quarter of 9th grade females in the 3-county region have ever considered suicide - 29% for Benton County, 31% for Sherburne County, and 24% for Stearns County. Female 9th graders are about two times more likely than male 9th graders to have considered suicide in the 3-county region.** (2016 data: 26% Benton, 30% Sherburne, 22% Stearns) Source: 2019 Minnesota Student Survey, Table 28, Question: Have you ever seriously considered attempting suicide (Mark all that apply)? Responses: No; Yes, during the last year; Yes, more than a year ago. (calculated by subtracting the No responses from 100)

24: Mental Health Condition.

38% of Benton County residents have been told they have a mental health condition as compared to 26% of Sherburne County residents and 32% of Stearns County residents. Overall, 31% of residents in the 3-county region have been told that they had a mental health condition. (2016, Benton 40%, Sherburne 28%, Stearns 26%, Overall 29%) Source: 2021 Central Minnesota Community Health Survey, Question: Have you ever been told by a doctor, nurse, or other health care professional that you had depression or anxiety/panic attacks or PTSD or other mental health issues? Responses: Yes or No. The 2021 data were slightly different than the 2016 question in that PTSD was offered as a separate condition to respond to.

25: Suicide, Cause of Death.

In the 3-county region, suicide is the 8th leading cause of death and 4th leading cause in premature deaths (deaths under 75 years of age). (2016 data 7th & 4th) Source: Minnesota Department of Health, Minnesota County Health Tables, Mortality Table 7: Age-Adjusted Cause-specific Death Rates for 10 Leading Causes by State/County/CHB, 2015-2019, Mortality Table 8: Premature Deaths (Under age 75) for 10 Leading Causes by State/County/CHB, Minnesota, 2015-2019.

26: Mental Health Care Delay.

14% of residents in the 3-county region did not get or delayed getting Mental Health care. Among females, 21% did not get or delayed getting the Mental Health care they needed. This rate also increases among residents living below 200% of the poverty line at 22% not getting or a delay in getting mental health care. (2016 related percentages: 10% delay, 15% females, 19% below 200% poverty). Source: 2021 Central Minnesota Community Health Survey, Question: During the past 12 months, was there a time when you wanted to speak with a health professional about mental health issues but didn't/delayed getting it. Responses: Yes or No.

27. MSS Depression.

In 2019, 33.7% of Benton County female 8th graders reported depressive symptoms in the past two weeks, which is 7.4% higher than the MN rate of 26.3% (Sherburne's rate 28.5%, Stearns' rate 23.2%). Source: 2019 Minnesota Student Survey via the Substance Use in Minnesota (sumn.org) website.

28. MSS Anxiety.

In 2019, over 40% of Benton County 8th and 11th grade females as well as Sherburne County 11th grade females reported symptoms of anxiety in the past 2-weeks. (8th grade females: MN 32.1%, Benton 41.7%, Sherburne 35.3%, Stearns 26.6%; 11th grade females: MN 38.5%, Benton 40.0%, Sherburne 40.5%, Stearns 31.1%). Source: 2019 Minnesota Student Survey via the Substance Use in Minnesota (sumn.org) website.

29. Less happiness reported by POC. **In the St. Cloud Area, respondents of Color indicated they are "not very happy" or "not happy at all" three times as frequently as White respondents (respondents of Color 15%, White respondents 5%).** Source: Social Capital in Central Minnesota 2020/21 Report prepared by St. Cloud State University Survey Center, May 21, 2021, Commissioned by the Central Minnesota Community Foundation. Phone survey using a sample of adults with a landline or cell phone in a 15-mile radius around St. Cloud, Minnesota, which includes residents of Benton, Sherburne, and Stearns Counties. (see page 17 of the report) Question: All things considered, would you say you are very happy, happy, not very happy, or not happy at all?

SOCIAL CONNECTION

30. Caring Teachers and Adults. **In Benton, Stearns, and Sherburne Counties, 8th, 9th, and 11th grade males are more likely to feel that teachers or other adults in school care for them. In response to the question of, How much do you feel teachers/other adults at school care about you?, less than 45% of the 8th, 9th, and 11th grade females answered very much or quite a bit. The females were more likely to answer some, a little, or not at all.** Source: 2019 Minnesota Student Survey. Table 17: Perceptions of Family and Others Caring. How much do you feel teachers/other adults at school care about you? Options for response: Very much, Quite a bit, Some, A little, Not at all.

31. MSS Student/Adult Relationships. **In 2019, 40.3% of Benton County 8th graders and 46.2% of Sherburne County 8th graders report that they have strong relationships with the adults in their schools, which are both lower than the state rate of 50.7% (Stearns' rate is 55.7%).** Source: 2019 Minnesota Student Survey via the Substance Use in Minnesota (sumn.org) website.

32. Less connected in communities of color. **In the St. Cloud Area, White communities compared to Communities of Color seem to be associated with more social capital. Social Capital Scale Mean Scores: Communities of Color= 12.96, White Community = 15.47.** Source: Social Capital in Central Minnesota 2020/21 Report prepared by St. Cloud State University Survey Center, May 21, 2021, Commissioned by the Central Minnesota Community Foundation. Phone survey using a sample of adults with a landline or cell phone in a 15-mile radius around St. Cloud, Minnesota, which includes residents of Benton, Sherburne, and Stearns Counties. Social Capital is measured using 24 data elements with a minimum score of 0 and a maximum score of 23. (see p.33, 34, and 40 of the report)

SUBSTANCE USE

33: Smoked During Pregnancy. **14.5% of women in Benton County smoked during pregnancy, this is double the MN state rate of 7.1%. Sherburne County and Stearns County rates are 7.8% and 8.0%, respectively; all 3 counties are above the MN state rate.** While we celebrate that these 2019 data are less than the 2016 data, they remain a concern. Source: Minnesota Department of Health, Minnesota County Health Tables, Natality Table 7b: Selected Characteristics of Births by State/County/CHB, Minnesota Residents, 2019.

34: Drug Overdoses. **Number of drug overdose deaths is increasing rapidly. In 2001, for the 3-county region, there were 8 deaths and in 2016, there were 38 drug overdose deaths.** Source: Minnesota Department of Health, Opioid Dashboard, Drug Overdose Deaths among Minnesota Residents Report 2000-2016, Appendix 1 – Drug Category Tables, Table 1: Number of opioid-involved overdose deaths (non-exclusive), by county of residence or metro area and year, 2000-2016. [Note: 2017 and 2018 county-level data for all three counties were suppressed because the number of deaths were equal or less than 10 per year. This indicates that this data point is decreasing as it is 30 or less, yet the exact number is not known. Source: Minnesota Department of Health, Drug Overdose Deaths among Minnesota Residents, 2000-2018, Appendix 1, Table 1: Number of opioid-involved overdose deaths (non-exclusive) by county of residence or metro area and year, 2000-2018.]

35: HS Education & Smoking. **17% of residents in Benton County with less than a high school education are smokers, and 50% of Sherburne County residents with this same education level (Stearns County rate is 11% for this same population). These rates are high compared to the 3-county region rate of 10% of residents classified as a current smoker, regardless of education levels**. (2016 data: 20% Benton, 25% Sherburne, 14% Stearns, 14% Region) Source: 2016 Central Minnesota Community Health Survey, Question: Cigarette Smoking Status. Responses: Current Smoker, Former Smoker, Never Smoked. This data point is about "Current Smokers".

36. MSS E-Cig Use. **From 2016 to 2019 there is an upward trend in e-cigarette use in 8th, 9th, and 11th grade males and females in Benton, Sherburne, and Stearns Counties.** Source: 2016 and 2019 Minnesota Student Survey via the Substance Use in Minnesota (sumn.org) website. Percent of students reporting using an e-cigarette on one or more days within the past 30 day.

37. MSS Marijuana Harm. **In Benton, Sherburne, and Stearns Counties, from 2013 to 2019, there is a downward trend of the percent of 8th, 9th, and 11th graders reporting that they believe people put themselves at a great or moderate risk of harm by smoking marijuana once or twice a week. Additionally, males report lower rates compared to females.** Source: 2013, 2016, and 2019 Minnesota Student Survey via the Substance Use in Minnesota (sumn.org) website.

38. MSS Marijuana Friend Perception. **In Benton, Sherburne, and Stearns Counties, from 2013 to 2019, there is a downward trend of the percent of 8th, 9th, and 11th graders reporting that they think their friends would feel it is wrong or very wrong for them to smoke marijuana. Additionally, males report lower rates compared to females.** Source: 2013, 2016, and 2019 Minnesota Student Survey via the Substance Use in Minnesota (sumn.org) website.

39. Substance Use Disorder Stigma. **75.2% of the U.S. public do not believe that a person with a substance use disorder (SUD) is experiencing a chronic medical illness such as diabetes, arthritis, or heart disease. There is also increased stigma toward non-white persons with SUD.** Source: Shatterproof Addiction Stigma Index, October 2021. n=7889.

Appendix G: 2021 Central MN Community Health Survey Instrument

CENTRAL MINNESOTA COMMUNITY HEALTH SURVEY

SURVEY INSTRUCTIONS


Correct marks


Incorrect marks

- Please use #2 pencil or blue or black pen to complete this survey.
- Do not use red pencil or ink.
- Do not use X's or check marks to indicate your responses.
- Fill response ovals completely with heavy, dark marks.

INSTRUCTION: Please give this survey to the adult (age 18 or over) in the household who has most recently had a birthday.

GENERAL HEALTH AND HEALTH CARE

1. In general, would you say that your health is:

○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

2. Have you ever been told by a doctor, nurse or other health care professional that you had any of the following health conditions?

	No	Yes	Yes, but only related to pregnancy
a. Diabetes	○	○	○
b. Pre-diabetes	○	○	○
c. High blood pressure/hypertension	○	○	○
d. Pre-hypertension	○	○	○
e. Depression	○	○	○
f. Anxiety or panic attacks	○	○	
g. Memory loss, Alzheimer's disease or another form of dementia	○	○	
h. Post-traumatic stress disorder (PTSD)	○	○	
i. Other mental health issues	○	○	
j. Sleep-related disorders (such as insomnia, restless leg syndrome or sleep apnea)	○	○	
k. Cancer	○	○	
l. Heart trouble or angina	○	○	
m. Stroke or stroke-related health issues	○	○	
n. High cholesterol or triglycerides	○	○	
o. Chronic lung disease (including COPD, chronic bronchitis or emphysema)	○	○	
p. Asthma	○	○	
q. Arthritis	○	○	
r. Risk of falling	○	○	
s. Sexually transmitted diseases/infections (Chlamydia, HIV, etc.)	○	○	

3. Is there a place that you usually go to when you are sick or need medical care?
(Mark only ONE answer)

○ I do not have a place I usually go when I need medical care
○ A doctor's office
○ A hospital outpatient clinic
○ Public health
○ A chiropractor's office
○ An urgent care center
○ An emergency room
○ Some other health center
○ Schedule an e-visit
○ Call a nurse line
○ Traditional healer
○ Religious healer
○ Google/Internet
○ Trusted family or friends
○ Some other place: _____

4. **About how long has it been since you last visited a doctor or other health care professional for a routine check-up?**

- ○ Within the past year
- ○ Within the past 2 years
- ○ Within the past 5 years
- ○ 5 or more years ago
- ○ Never

5. **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?**

- ○ Yes
- ○ No ▶ **IF NO, GO TO QUESTION 7**

6. **Why did you not get or delay getting the medical care you thought you needed?**
(Mark ALL that apply)

- ○ The care I needed cost too much
- ○ My co-pay was too expensive
- ○ My deductible was too expensive
- ○ My insurance did not cover it
- ○ I did not have insurance
- ○ I could not get an appointment
- ○ I had transportation problems
- ○ I did not think it was serious enough
- ○ I was too nervous or afraid
- ○ I don't trust the health care system
- ○ The clinic cancelled my appointment due to COVID-19
- ○ I cancelled my appointment due to COVID-19
- ○ I did not have access to telehealth or a virtual visit
- ○ Other reason _____

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

- ○ Yes
- ○ No ▶ **IF NO, GO TO QUESTION 9**

8. **Why did you not get or delay getting the dental care you thought you needed?**
(Mark ALL that apply)

- ○ The care I needed cost too much
- ○ My co-pay was too expensive
- ○ My deductible was too expensive
- ○ My insurance did not cover it
- ○ I did not have insurance
- ○ The dentist would not accept my insurance
- ○ I could not get an appointment
- ○ I had transportation problems
- ○ I did not think it was serious enough
- ○ I was too nervous or afraid
- ○ I don't trust the health care system
- ○ The office cancelled my appointment due to COVID-19
- ○ I cancelled my appointment due to COVID-19
- ○ I did not have access to telehealth or a virtual visit
- ○ Other reason _____

9. **During the past 12 months, was there a time when you wanted to talk with or seek help from a health professional about mental health issues such as stress, depression, excess worrying, troubling thoughts or emotional problems, but did not or delayed talking with someone?**

- ○ Yes
- ○ No ▶ **IF NO, GO TO QUESTION 11**

10. **Why did you not get or delay getting the mental health care you thought you needed?**
(Mark ALL that apply)

- ○ The care I needed cost too much
- ○ My co-pay was too expensive
- ○ My deductible was too expensive
- ○ My insurance did not cover it
- ○ I did not have insurance
- ○ I could not get an appointment
- ○ I had transportation problems
- ○ I did not think it was serious enough
- ○ I was too nervous or afraid
- ○ I was afraid someone I know would see me
- ○ I don't trust the health care system
- ○ The office cancelled my appointment due to COVID-19
- ○ I cancelled my appointment due to COVID-19
- ○ I did not have access to telehealth or a virtual visit
- ○ Other reason _____

11. **During the past 30 days, for about how many days have you felt sad, blue, or depressed?** → Days

00 01 02 03 04 05 06 07 08 09

12. **Which statement best describes the medications prescribed for you in the past 6 months?**

- ○ I had no medications prescribed for me ▶ **GO TO QUESTION 14**
- ○ I had medications prescribed for me and I filled them all ▶ **GO TO QUESTION 14**
- ○ I had medications prescribed for me and I did not fill at least one of them ▶ **GO TO QUESTION 13**

13. **Why did you not fill at least one prescription?**
(Mark ALL that apply)

- ○ The medication I needed cost too much
- ○ My co-pay was too expensive
- ○ My deductible was too expensive
- ○ My insurance did not cover it
- ○ I did not have insurance
- ○ I do not like taking medications
- ○ I did not like the side effects
- ○ I had transportation problems
- ○ Pharmacy services are not available in my community
- ○ Other reason _____

14. **Which of the following types of health insurance do you have?**
(Please mark yes or no for each.)

	Yes	No
a. Health insurance or coverage through your employer or your spouse/partner, parent, or someone else's employer	○	○
b. Health insurance or coverage bought directly by you or your family	○	○
c. Indian or Tribal Health Service	○	○
d. Medicare or Medicare Supplement (such as Part D)	○	○
e. Medicaid, Medical Assistance (MA), or Prepaid Medical Assistance Program (PMAP)	○	○
f. MinnesotaCare	○	○
g. Health Insurance through MnSure	○	○
h. CHAMPUS, TRICARE, or Veteran's benefits	○	○
i. Other health insurance or coverage (please specify) _____	○	○
j. I don't have health insurance	○	○

15. **A serving of fruit is a medium-sized fruit or a half cup chopped, cut, or canned fruit. How many servings of fruit did you have yesterday?**

Number of Servings:
00 01 02 03 04 05 06 07 08 09 10 11 12 or more

16. **A serving of 100% fruit juice is 6 ounces. How many servings of fruit juice did you have yesterday?**

Number of Servings:
00 01 02 03 04 05 06 07 08 09 10 11 12 or more

17. **A serving of vegetables-not including french fries- is one cup of salad greens or a half cup of vegetables. How many servings of vegetables did you have yesterday?**

Number of Servings:
00 01 02 03 04 05 06 07 08 09 10 11 12 or more

18. How often did you drink the following beverages in the past week?	Never or less than 1 time per week	1 time per week	2-4 times per week	5-6 times per week	1 time per day	2-3 times per day	4 or more times per day
a. Fruit drinks (such as Snapple, flavored teas, Capri Sun or Kool-Aid)	○	○	○	○	○	○	○
b. Sports drinks (such as Gatorade or Powerade); these drinks usually do not have caffeine	○	○	○	○	○	○	○
c. Regular soda or pop (include all kinds such as Coke, Pepsi, 7-Up, Sprite or root beer)	○	○	○	○	○	○	○
d. Energy drinks (such as Rockstar, Red Bull, Monster or Full Throttle); these drinks usually have caffeine	○	○	○	○	○	○	○

19. During the past 12 months, have you used a community food shelf program or a community food box program?

○ Yes ○ No

20. How often do you or others in your household buy or get food from the following places?	Never or less than 1 time per month	About 1 time per month	About 2 or 3 times per month	About 1 time per week	2 or more times per week
a. Supermarket or large grocery store	○	○	○	○	○
b. Small grocery store	○	○	○	○	○
c. Convenience store or gas station	○	○	○	○	○
d. Food shelf, food pantry or community food box program	○	○	○	○	○
e. Some other place:_____	○	○	○	○	○

21. During the past 12 months, how often did you worry that your food would run out before you had money to buy more?

○ Often ○ Sometimes ○ Rarely ○ Never

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22. 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?

○ Yes ○ No

23. During an average week, other than your regular job, on how many days do you get at least 30 minutes of *moderate* physical activity? *(Moderate activities cause only light sweating and a small increase in breathing or heart rate.)*

○ 0 days ○ 1 day ○ 2 days ○ 3 days ○ 4 days ○ 5 days ○ 6 days ○ 7 days

24. During an average week, other than your regular job, on how many days do you get at least 20 minutes of *vigorous* physical activity? *(Vigorous activities cause heavy sweating and a large increase in breathing and heart rate.)*

○ 0 days ○ 1 day ○ 2 days ○ 3 days ○ 4 days ○ 5 days ○ 6 days ○ 7 days

25. **How much of a problem are the following factors for <u>you</u> in terms of preventing you from being more physically active?**

	Not a problem	A small problem	A big problem
a. Lack of programs or facilities	○	○	○
b. Public facilities (schools, sports fields, etc.) are not open or available at the times I want to use them	○	○	○
c. Distance I have to travel to a fitness or community center, parks or walking trails	○	○	○
d. No safe place to be physically active	○	○	○
e. Not having sidewalks or walking paths/trails	○	○	○
f. Poor maintenance of sidewalks or walking paths/trails	○	○	○
g. Other reason (please specify): _____	○	○	○

26. **How often do you feel safe in your community?**

○ Often ○ Sometimes ○ Rarely ○ Never

26a. Why do you feel this way? _____

27. **If you were to experience or witness a crime or harassment in your community, how safe would you feel calling the police or sheriff for help?**

○ Very safe ○ Fairly safe ○ Not very safe ○ Not at all safe

28. **During the <u>past 12 months</u>, have you experienced any of the following situations? If yes, have you felt you were discriminated against during the situation?**

	Experienced the situation	Felt discriminated against
a. Applied for a job?	○ No ○ Yes→	○ No ○ Yes
b. Worked at a job?	○ No ○ Yes→	○ No ○ Yes
c. Received medical care?	○ No ○ Yes→	○ No ○ Yes
d. Looked for a different house or apartment?	○ No ○ Yes→	○ No ○ Yes
e. Applied for a credit card, bank loan or a mortgage?	○ No ○ Yes→	○ No ○ Yes
f. Shopped at a store or eaten at a restaurant?	○ No ○ Yes→	○ No ○ Yes
g. Applied for social services or public assistance?	○ No ○ Yes→	○ No ○ Yes
h. Dealt with the police?	○ No ○ Yes→	○ No ○ Yes
i. Appeared in court?	○ No ○ Yes→	○ No ○ Yes

29. **If you felt discriminated against in <u>any</u> of the above situations, what was the reason(s)?** *(Mark ALL that apply)*

○ I did not experience any discrimination
○ Race, color, ethnicity or country of origin
○ Age
○ Gender
○ Sexual orientation
○ Gender identity
○ Disability
○ Religion
○ Being overweight or obese
○ Other, please specify: _____

30. **Have you smoked at least 100 cigarettes in your entire life? (100 cigarettes = 5 packs)**

○ Yes
○ No ▶**GO TO QUESTION 33**

31. **Do you now smoke cigarettes every day, some days or not at all?**

○ Every day
○ Some days
○ Not at all ▶**GO TO QUESTION 33**

32. **During the <u>past 12 months</u>, have you stopped smoking for one day or longer because you were trying to quit?**

○ Yes
○ No

33. How often do you use any of the following products?

	Every day	Some days	Not at all
a. Cigars, cigarillos or little cigars	○	○	○
b. Pipes	○	○	○
c. Snuff, snus or chewing tobacco	○	○	○
d. E-cigarettes or vaping devices to smoke nicotine products (do not include marijuana or THC products)	○	○	○
e. A hookah water pipe	○	○	○
f. Any other type of tobacco product	○	○	○

34. How often do you feel lonely or isolated from those around you?

- ○ Always
- ○ Often
- ○ Sometimes
- ○ Rarely
- ○ Never

35. Have you ever considered attempting suicide? *(Mark ALL that apply)*

- ○ No
- ○ Yes, during the last 6 months
- ○ Yes, during the last year
- ○ Yes, more than a year ago

36. Have you experienced any losses related to the COVID-19 pandemic? *(Mark ALL that apply)*

- ○ None
- ○ Job (layoff, furlough, hours reduction)
- ○ Income
- ○ Housing
- ○ Health Insurance
- ○ Transportation
- ○ Child care
- ○ Regular school routine
- ○ Social connectedness
- ○ Social support
- ○ Sense of wellness
- ○ Recreation or entertainment
- ○ Exercise opportunities
- ○ Death of family member or friend
- ○ Other: _____

37. Where do you usually get health, wellness, and medical information?
(Please mark UP TO 3 sources)

- ○ E-mail alert or e-newsletter
- ○ Newspaper (print or online)
- ○ Brochure, newsletter, magazine or other print material
- ○ Text message
- ○ Social media such as Facebook or Twitter
- ○ Websites or internet
- ○ Phone apps
- ○ Nurse or other health professional at a church, synagogue, mosque, etc.
- ○ Television
- ○ Radio
- ○ Medical professionals
- ○ Pharmacy
- ○ Community Health Worker
- ○ Family or friends
- ○ Health fairs or other health-related community events
- ○ Other: _____

COMMUNITY CONCERNS

38. In your opinion, how much of a problem is each of these issues in your county?	No Problem	Minor Problem	Moderate Problem	Serious Problem	No Opinion
A. ISSUES FOR FAMILIES					
1. Families experiencing financial stress	○	○	○	○	○
2. Parents with inadequate or poor parenting skills	○	○	○	○	○
3. Childhood trauma	○	○	○	○	○
4. Bullying	○	○	○	○	○
5. Abuse and neglect of children	○	○	○	○	○
6. Abuse and neglect of vulnerable adults	○	○	○	○	○
B. SOCIAL EXPERIENCE					
1. Racism	○	○	○	○	○
2. White privilege (inherent advantages possessed by a white person on the basis of their race in a society characterized by racial inequality and injustice)	○	○	○	○	○
3. Police brutality	○	○	○	○	○
C. DISCRIMINATION					
1. Discrimination based on race, color, ethnicity or country of origin	○	○	○	○	○
2. Discrimination based on age	○	○	○	○	○
3. Discrimination based on gender	○	○	○	○	○
4. Discrimination based on sexual orientation	○	○	○	○	○
5. Discrimination based on gender identity	○	○	○	○	○
6. Discrimination based on disability	○	○	○	○	○
7. Discrimination based on religion	○	○	○	○	○
8. Discrimination based on being overweight or obese	○	○	○	○	○
9. Discrimination based on something else Please specify: _____	○	○	○	○	○
D. TOBACCO AND OTHER DRUG USE					
1. Smoking or other tobacco use	○	○	○	○	○
2. Use of e-cigarettes/vaping for nicotine products	○	○	○	○	○
3. Abuse of prescription drugs	○	○	○	○	○
4. Illegal drug use among youth	○	○	○	○	○
5. Illegal drug use among adults	○	○	○	○	○
E. MENTAL HEALTH					
1. Depression among youth	○	○	○	○	○
2. Depression among adults	○	○	○	○	○
3. Suicide among youth	○	○	○	○	○
4. Suicide among adults	○	○	○	○	○
5. Other mental health issues, such as anxiety or panic attacks, memory loss, Alzheimer's or another form of dementia, etc.	○	○	○	○	○
6. Difficulty obtaining mental health services for youth	○	○	○	○	○
7. Difficulty obtaining mental health services for adults	○	○	○	○	○

ABOUT YOU

39. What best describes your gender identity? *(Mark ALL that apply)*

○ Male ○ Female ○ Transgender Male ○ Transgender Female ○ Non-Binary
○ Please describe: _____

40. What best describes your sexual orientation? *(Mark ALL that apply)*

○ Straight/Heterosexual ○ Gay/Lesbian ○ Bisexual ○ Pansexual ○ Queer
○ Asexual ○ Please describe: _____

41. Your age group:

○ 18-24 ○ 35-44 ○ 55-64 ○ 75 or older
○ 25-34 ○ 45-54 ○ 65-74

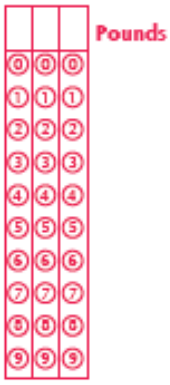
42. How many adults (including you) and children live in your household?

Number of adults age 18 or older (including you):
① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫ or more

Number of children under age 18:
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫ or more

43. About how tall are you without shoes?

44. About how much do you weigh without shoes?



45. Are you a member of either of the following ethnic or cultural groups?

	Yes	No
a. Hispanic or Latino/Latina	○	○
b. Somali	○	○

46. Which of the following best describe you? *(Mark ALL that apply)*

○ American Indian or Alaska Native
○ Asian or Asian American
○ Black or African American
○ African Native
○ Native Hawaiian or Pacific Islander
○ White
○ Other: _____

47. Your education level:

○ Did not complete 8th grade
○ Did not complete high school
○ High school diploma/GED
○ Trade/Vocational school
○ Some college
○ Associate degree
○ Bachelor's degree
○ Graduate/Professional degree

48. What was your household's total income from all earners and all sources in 2020?

○ $25,000 or less
○ $25,501 - $34,500
○ $34,501 - $43,500
○ $43,501 - $52,500
○ $52,501 - $61,500
○ $61,501 - $70,000
○ $70,001 - $79,000
○ $79,001 - $88,000
○ $88,001 - $100,000
○ More than $100,000

Thank you for your participation!