CENTRAL MN ALLIANCE

STRENGTHENING PARTNERSHIPS FOR CHANGE

Community Health Improvement Plan

July 1, 2019-June 30, 2022

Version 1: September 2019

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 2019-2022

Message to the Community,

In an effort to be more effective in meeting the needs of the community, the three Public Health Agencies in the counties of Benton, Sherburne, and Stearns, along with CentraCare, have developed a partnership called the Central Minnesota Community Health Partnership (Central MN Alliance).

Every three years, CentraCare is required to complete a Community Health Needs Assessment and develop an 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 an improvement plan every five years. Going forward, 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 in order 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 done 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 or changes to the document. This is significant because it is not only a guide for these initial partners but is also the plan for interventions by you, the community.

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

Katy Kirchner	Nicole Ruhoff	Amanda Larson	Renee Frauendienst
CentraCare	Benton County Public Health	Sherburne County Public Health	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 Health Improvement Plan (CHIP), the action plan to execute community goals and strategies.

Executive Summary

Structure of Process, Vision, Priorities, and Guiding Principles

The Community Health Improvement Plan (CHIP) is an action plan to address the community priorities identified in the Community Health Needs Assessment (CHNA) process. The CHNA process is guided by MAPP (Mobilizing Action through Planning and Partnerships) and identifies key health needs and priorities through data collection and analysis. The Central Minnesota Alliance utilized the process to conduct the CHNA and arrive at the CHIP for the time period of July 1, 2019 through June 30, 2022. The full CHNA that accompanies the CHIP can be found in Appendix 2 of this document.

"MAPP – Your Community Roadmap to Health!", National Association of County and City Health Officials (NACCHO); Mobilizing for Action through Planning and Partnerships (MAPP) Handbook

Central MN Alliance Vision

We are a community whereby all are involved in healthy living through:

- Safe, equitable, resilient and sustainable communities
- Healthy environments (food, water, housing, recreation, transportation)
- Vibrant economic opportunities
- Dynamic, engaged community partnerships
- Nurturing social, cultural, and spiritual opportunities
- Affordable, accessible, high-quality healthcare
- Shared and informed leadership toward achieving community health

Community Health Improvement Plan 2019-2022

Central MN Alliance 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 2019-2022

What are the top priorities?

Building Families

Mental Health

How will we get there?

The guiding principles below were themes established through community input meetings and will be used to guide strategy.

Community Collaboration

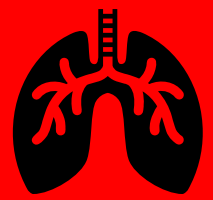
Equity

Awareness

Resilience

Education

Health Organizations



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How to read this document:

- A guiding principle is the value that established a framework for expected behavior and decision-making
- Each guiding principle will have a matching icon and color

Guiding Principle

- A strategy is a plan of action or policy designed to achieve the performance measure
- Each guiding principle can have multiple strategies

Strategy:

Agency:	**Outcome:**	**Persons in Charge of Strategy:**

- An outcome is the intended consequence of each strategy
- Each strategy can have multiple projected outcomes

Priority: ☐Building Families ☐Mental Health

Target Date:

Progress Notes:

- Progress Notes: Central MN Alliance will follow up with every agency involved with each strategy quarterly to document developments

- A performance measure is a quantifiable indicator used to assess how well the agencies are achieving the desired outcome to improve the overall priorities

Performance Measure:

Population Measures:

- Population measures are the health outcomes of a group of individuals ***indirectly*** effected by each guiding principle

How to get involved:

- How to get involved: under construction… Central MN Alliance will add in information at the end of each guiding principle to act as a connector for the CHIP and community involvement

Everyone in the community shares responsibility to be engaged, monitor and revise the CHIP. If you wish to get involved or have any questions or concerns regarding the CHIP, plan to attend the Central MN Alliance annual Steering Committee meeting and reach out to any of the contacts listed in this document.

Community Collaboration

Strategy 1: Expand reach and capacity to serve more at-risk families in central Minnesota through best practices or evidence-based practice for prenatal education and parenting skills.

Agency:	**Outcome:**	**Persons in Charge of Strategy:**
Benton County Public Health Sherburne County Public Health Stearns County Public Health CentraCare St. Cloud Hospital CentraCare - Melrose CentraCare - Paynesville CentraCare - Sauk Centre	Family Home Visiting Coalition: 85% of Family Home Visits target caseloads reached.	Benton County Nicole Ruhoff, Public Health Supervisor Sherburne County Amanda Larson, Manager Public Health and Econ. Supports Gloria Sorem, Lead Public Health Nurse Stearns County Renee Frauendienst, Public Health Director Mike Matanich, Public Health Supervisor Lindsy Hackett, Public Health Supervisor Adam Johnson, Public Health Supervisor Mary Zelenak, Public Health Supervisor
	CentraCare to offer Childbirth Classes & Car Seat Clinics.	CentraCare Melissa Bruns, Regional Outreach Educator, St. Cloud Hospital
	CentraCare Correctional Care to explore programs for incarcerated parents.	CentraCare Katy Kirchner, Director of Coordinated and Correctional Care Mark Maslonkowski, Stearns County Jail Administrator Susan Johnson, Benton County Jail Administrator

Priority: ☒Building Families ☒Mental Health

Target Date: Ongoing 2019-2022

Progress Notes:

- CentraCare Pediatrics Healthy Steps Curriculum- 0 to 3 years social-emotional learning

Community Collaboration

Strategy 2: CentraCare will annually discuss utilization of hospital and clinic space by community partners at each affiliated CentraCare operational meeting and connect with partners as needed.

Agency:	**Outcome:**	**Persons in Charge of Strategy:**
CentraCare St. Cloud Hospital CentraCare - Melrose CentraCare - Paynesville CentraCare - Sauk Centre	Space will be allocated to services of greatest need for the community to include all CentraCare Clinics and hospitals: • Ex: Women, Infants, and Children (WIC) to promote healthy food choices for pregnant women, infants, and children • Ex: Alcoholics Anonymous to provide optimal peer support in addiction recovery	CentraCare Kathy Parsons, VP Population Health Joy Plamann, VP Operations and Acute Care Division Gerry Gilbertson, Administrator Melrose Brandon Pietsch, Administrator Paynesville Del Christianson, Administrator Sauk Centre
	Utilization of hospital and clinic space will be tracked and reported to the CentraCare Community Benefit IRS report.	CentraCare Community Benefit Reporting Lori Eiynck, Planning Specialist, St. Cloud Hospital

Priority: ☒Building Families ☒Mental Health

Target Date: CentraCare operational meetings annually 2020-2022

Progress Notes:

Community Collaboration

Strategy 3: CentraCare Population Health will continue the community collaborative initiative Feeling Good MN to support making the healthy choice the easy choice through education, outreach programs, and lobbying.

Agency:	**Outcome:**	**Persons in Charge of Strategy:**
CentraCare St. Cloud Hospital CentraCare - Melrose CentraCare - Paynesville CentraCare - Sauk Centre	CentraCare- Melrose will launch and sustain a Power of Produce (PoP) Club program at the Melrose Community Farmers Market. CentraCare- Melrose will implement three recommendations listed in the Melrose 2018 Master Bicycle & Pedestrian Plan.	CentraCare Jodi Gertken, Community Wellness Program Director
	CentraCare- Paynesville will host annual Community Event such as Children's Fun Run and Pet Show to promote community involvement in a healthy activity and participation activities with residents.	CentraCare Paulette Hagen, Director HR/Administrative Services
	CentraCare- Sauk Centre will collaborate with the City Planning Commission to establish safe routes to school.	CentraCare Jodi Gertken, Community Wellness Program Director
	Feeling Good MN will lead and support advocacy work at the State, County and City level with stakeholders and community partners to pass and implement strong tobacco prevention polices to reduce youth access and initiation.	CentraCare Jodi Gertken, Community Wellness Program Director

Priority: ☒Building Families ☒Mental Health

Target Date: Ongoing 2019-2022

Progress Notes:

Community Health Improvement Plan 2019-2022

Performance and Population Measures for all Community Collaboration Strategies

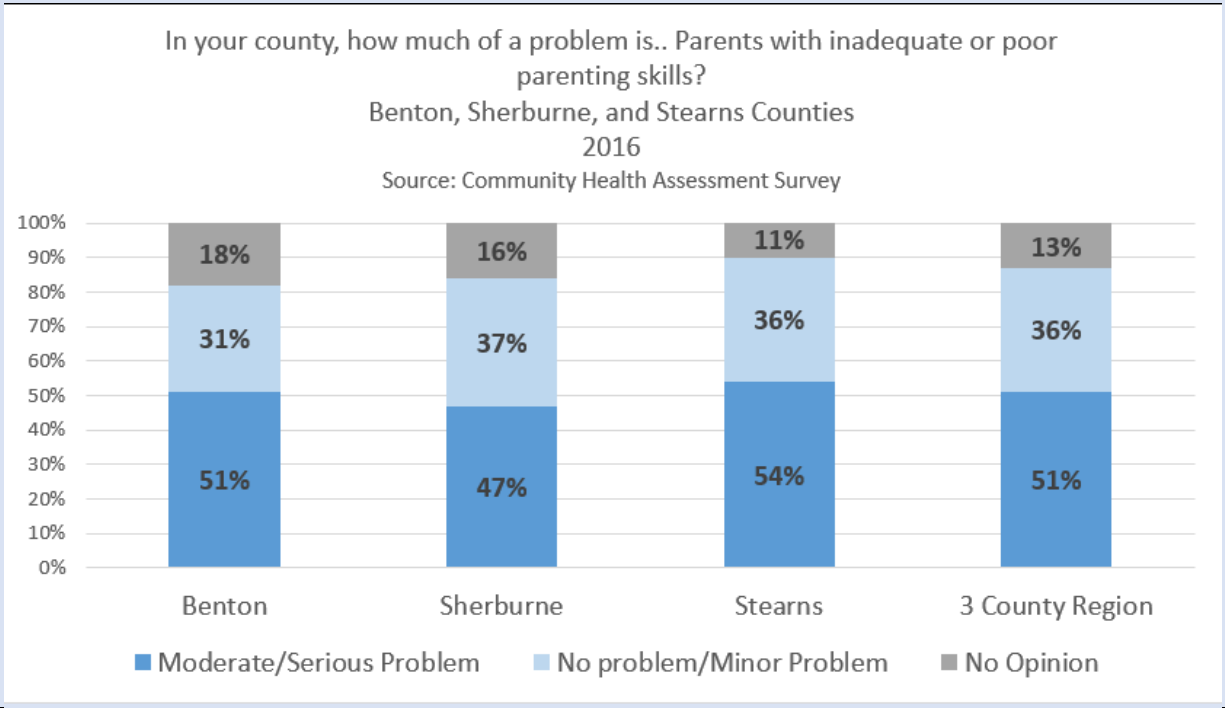
Community Collaboration Performance Measure:

Collaborative groups identified within the strategies of Community Collaboration will discuss community collaboration at 50% of their meetings by creating a standing agenda item “Are the right partners at this table?” for collaborative meetings. Ex: FHV Coalition held 8 meetings in 2018, they discussed partnership at 4 of those meetings- 50% rate of discussing community collaboration.

Community Collaboration Population Measures*:

Percentage of adults in the 3-county region view parents with inadequate or poor parenting skills as a moderate or serious problem in the community

- 51% of adults in the 3-county region view parents with inadequate or poor parenting skills as a moderate or serious problem in the community - 2016 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.



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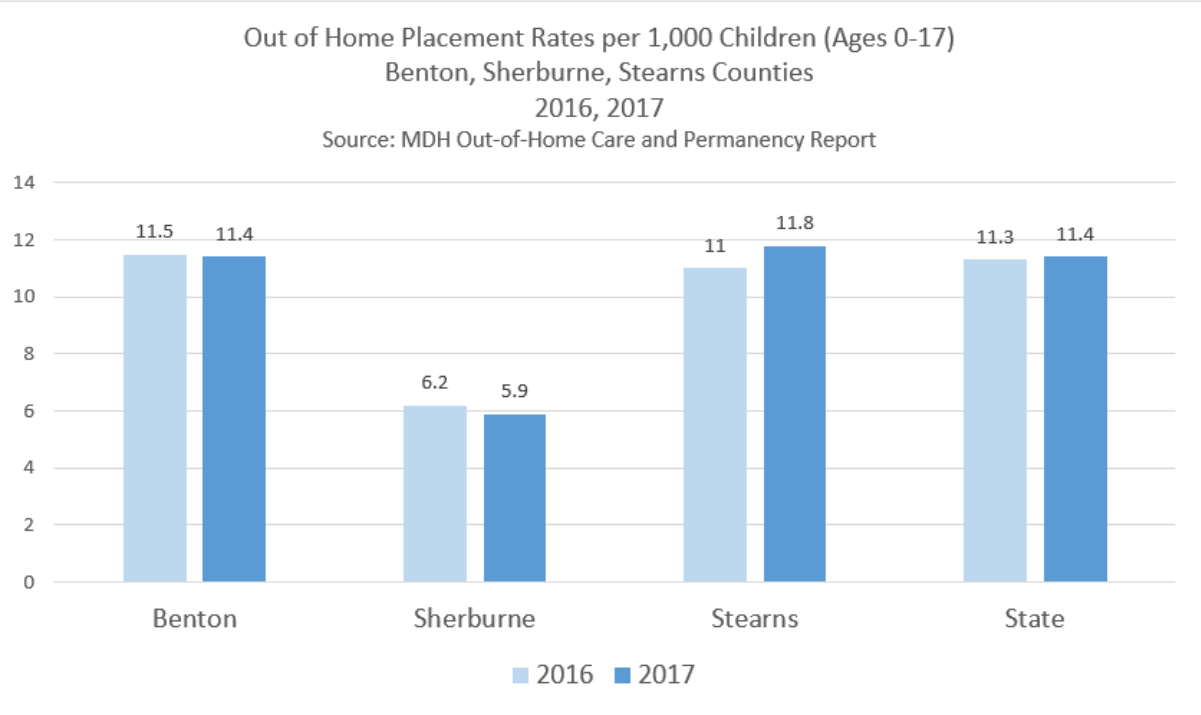
Children in out of home placement (OHP)-

- 10 out of 1,000 children in the 3-county region are in out-of-home placements- MN Department of Human Services, Minnesota's Out-of-Home Care and Permanency Report 2017, 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, 2017.



How to get involved:

Under construction...

Equity

Strategy 1: Participating agencies will increase understanding and knowledge of equity.

Agency:	**Outcome:**	**Persons in Charge of Strategy:**
Benton County Public Health Sherburne County Public Health Stearns County Public Health CentraCare Population Health • St. Cloud Hospital • CentraCare- Melrose • CentraCare- Paynesville • CentraCare- Sauk Centre	Public health will leverage staff involved in HEDA activities.	Benton County Nicole Ruhoff, Public Health Supervisor Sherburne County Cody Engelhaupt, Lead Community Health Coordinator Stearns County Mike Matanich, Public Health Supervisor Lindsy Hackett, Public Health Supervisor Adam Johnson, Public Health Supervisor Mary Zelenak, Public Health Supervisor
	All agencies will attempt to allocate resources to equity training.	All agencies
	CentraCare Population Health will consider equitable practices while using population health data.	CentraCare Population Health Rachael Lesch, Senior Director of Population Health Pam Beckering, Trauma Informed Care Program Manager

Priority: ☒Building Families ☒Mental Health

Target Date: Ongoing 2019-2022

Progress Notes:

Equity

Strategy 2: Increase understanding of the Workplace & Patient Diversity department including the CentraCare Equity Steering Committee framework.

Agency:	**Outcome:**	**Persons in Charge of Strategy:**
CentraCare St. Cloud Hospital CentraCare- Melrose CentraCare- Paynesville CentraCare- Sauk Centre	Identify the leaders and strategies within CentraCare focusing on engaging patients as partners to advance health equity. Create awareness within CentraCare about the Workplace & Patient Diversity department. Increase awareness among Central MN Alliance partners of Workplace & Patient Diversity department and its services.	CentraCare Julia Gordon, Community Resource Liaison Katy Kirchner, Director Coordinated Care More persons in charge to come...

Priority: ☒Building Families ☒Mental Health

Target Date: Report to Central MN Alliance at yearly Steering Committee meeting

Progress Notes:

Equity

Strategy 3: Engage under-represented populations in Steering Committee.

Agency:	**Outcome:**	**Persons in Charge of Strategy:**
Benton County Public Health Sherburne County Public Health Stearns County Public Health CentraCare St. Cloud Hospital CentraCare- Melrose CentraCare- Paynesville CentraCare- Sauk Centre	Encourage attendance from groups that are under-represented or work with under-represented populations to attend the annual Steering Committee meeting.	All agencies

Priority: ☒Building Families ☒Mental Health

Target Date: Annual Steering Committee meetings

Progress Notes:

Community Health Improvement Plan 2019-2022

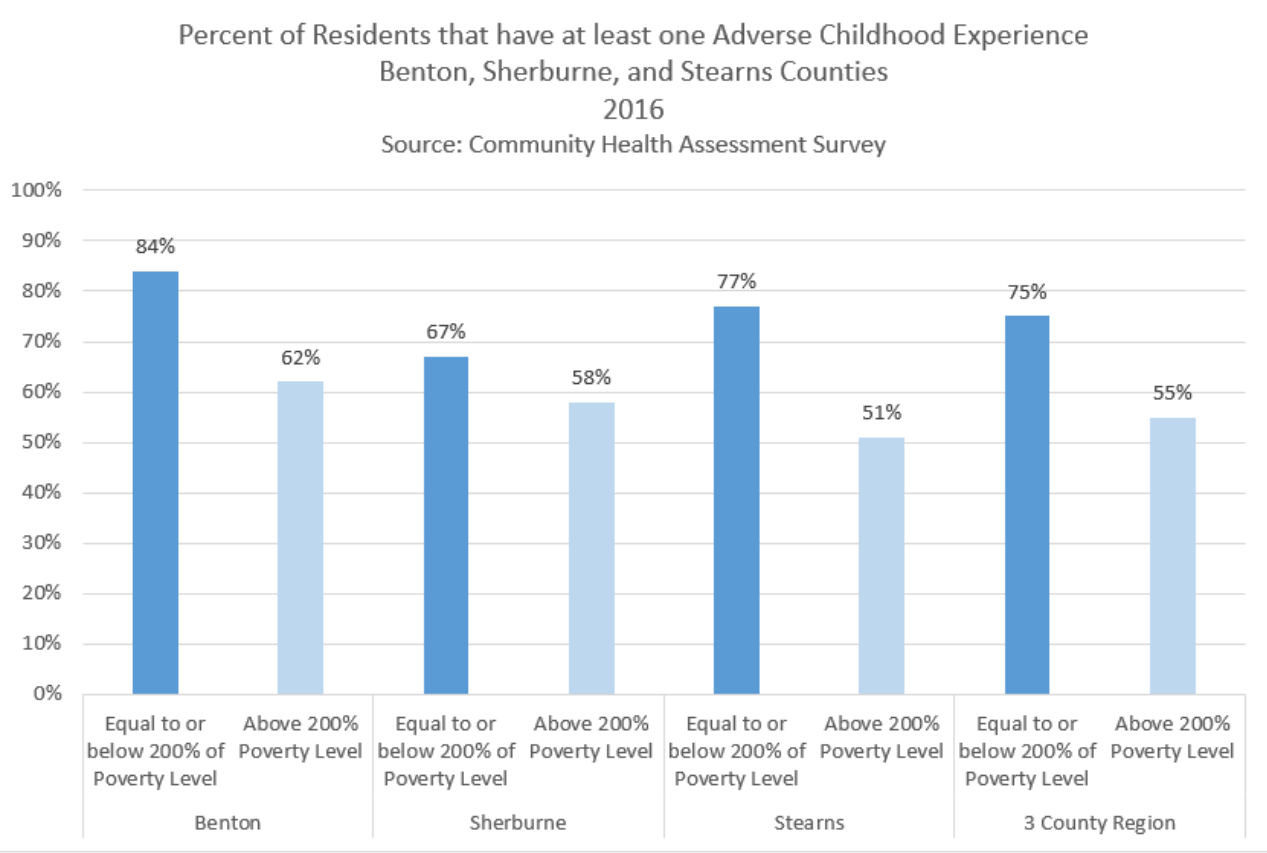
Performance and Population Measures for all Equity Strategies

Equity Performance Measure:

By April 2021, develop a framework within which Central MN Alliance identifies a process to address equity. Measuring active and engaged persons and agencies contributing to the creation of the framework.

Equity Population Measures*:

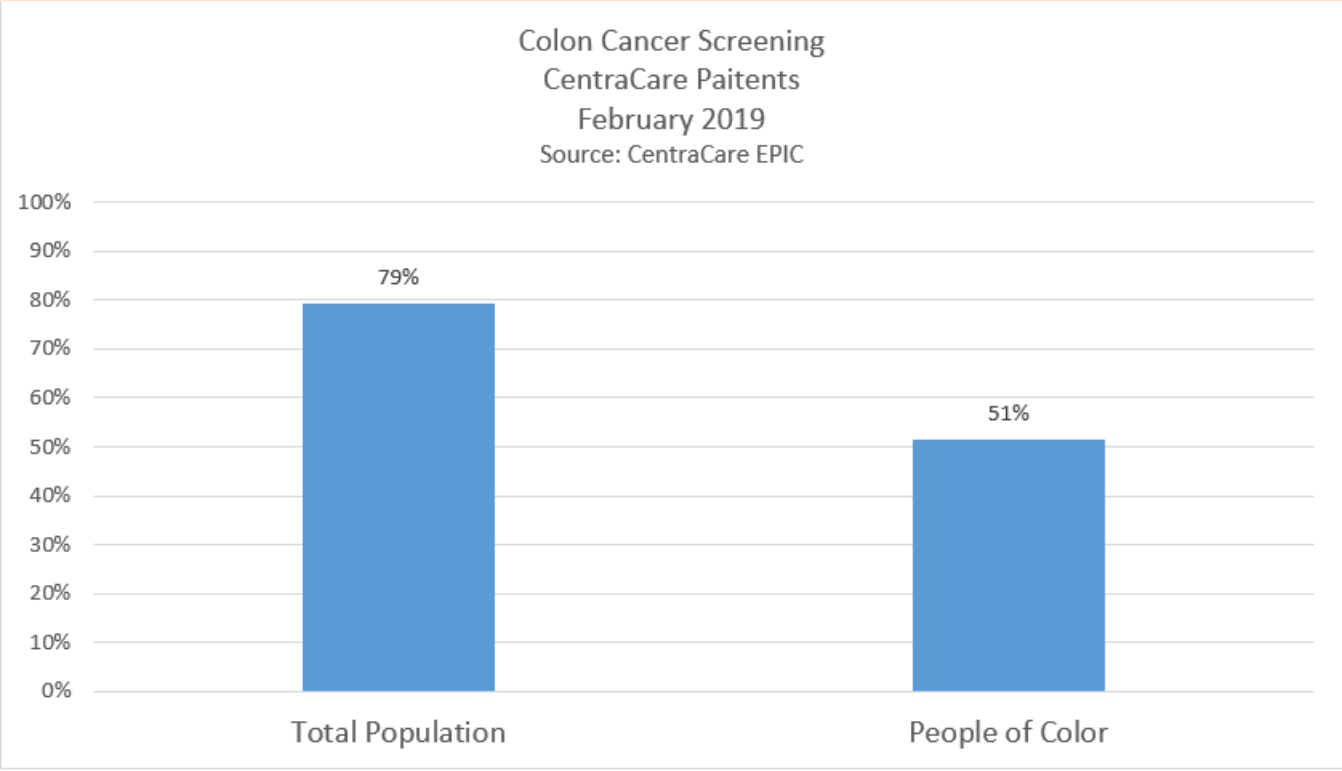
Percent difference of 1 or more ACEs by income level (< or > 200% Poverty Level).



Community Health Improvement Plan 2019-2022

Colon Cancer screen total population

- Baseline February 2019- 79.4%, 0.7 % above target rate of 78.7%) and colon cancer screen people of color (baseline February 2019- 51.4%, 0.8% below target rate of 52.2%)- CentraCare quality data.



How to get involved:

Under construction...

Awareness

Strategy 1: Collaborate with Central MN CAMHI (CommUNITY Adult Mental Health Initiative) to get the word out about their website and increase resources that pertain to mental well-being.

Agency:	**Outcome:**	**Persons in Charge of Strategy:**
Benton County Public Health Sherburne County Public Health Stearns County Public Health CentraCare St. Cloud Hospital CentraCare- Melrose CentraCare- Paynesville CentraCare- Sauk Centre	Increased use of the CAMHI website. Increase community knowledge and awareness of CAMHI. Increased support of single platform (CAMHI) for mental health.	Benton County Nicole Ruhoff, Public Health Supervisor Sherburne County Amanda Larson, Manager Public Health and Econ. Supports Stearns County Peggy Sammons, Human Services Planning Coordinator CentraCare Katy Kirchner, Director Coordinated and Correctional Care Julia Gordon, Community Resource Liaison

Priority: ☒Building Families ☒Mental Health

Target Date: April 2022 (3-year campaign)

Progress Notes:

Awareness

Strategy 2: Central MN Suicide Prevention Coalition will work to spread suicide prevention awareness for veterans and community members.

Agency:	**Outcome:**	**Persons in Charge of Strategy:**
Stearns County Public Health St. Cloud Veterans Affairs CentraCare St. Cloud Hospital CentraCare- Melrose CentraCare- Paynesville CentraCare- Sauk Centre	Nurses in Action is a part of the Central MN Suicide Prevention Coalition. Nurses in Action will hold annual events surrounding suicide awareness. Each agency will invite relevant participants to these events and support staff in attending these events.	Stearns County Renee Frauendienst, Public Health Division Director Veterans Affairs Person in charge to come... CentraCare Joy Plamann, VP Operations Acute Care Division

Priority: ☐Building Families ☒Mental Health

Target Date: Ongoing from 2020 through 2022

Progress Notes:

Awareness

Strategy 3: Support community partners in integrating mental well-being into daily practice.

Agency:	**Outcome:**	**Persons in Charge of Strategy:**
Benton County Public Health Sherburne County Public Health Stearns County Public Health CentraCare St. Cloud Hospital CentraCare- Melrose CentraCare- Paynesville CentraCare- Sauk Centre	Community ownership of family and mental well-being programs, as demonstrated by increased volunteerism and resource allocation. Family Fun Nights, Safe Families, and Trauma-Informed Congregations.	Benton County Nicole Ruhoff, Public Health Supervisor Sherburne County Amanda Larson, Manager Public Health and Econ. Supports Stearns County Mike Matanich, Public Health Supervisor Lindsy Hackett, Public Health Supervisor Adam Johnson, Public Health Supervisor Mary Zelenak, Public Health Supervisor
	Continue the work of CentraCare Population Health- Community Wellness activities around mental well-being.	CentraCare Jodi Gertken, Community Wellness Program Director Pam Beckering, Trauma-Informed Care Program Manager
	Suicide prevention education and training within CentraCare and in the community in partnership with the Regional Suicide Prevention Coordinator from Central MN Mental Health Center.	CentraCare Lisa Bershok, Suicide Prevention Program Manager

Priority: ☒Building Families ☒Mental Health

Target Date: Ongoing from 2020 through 2022

Progress Notes:

Performance and Population Measures for all Awareness Strategies

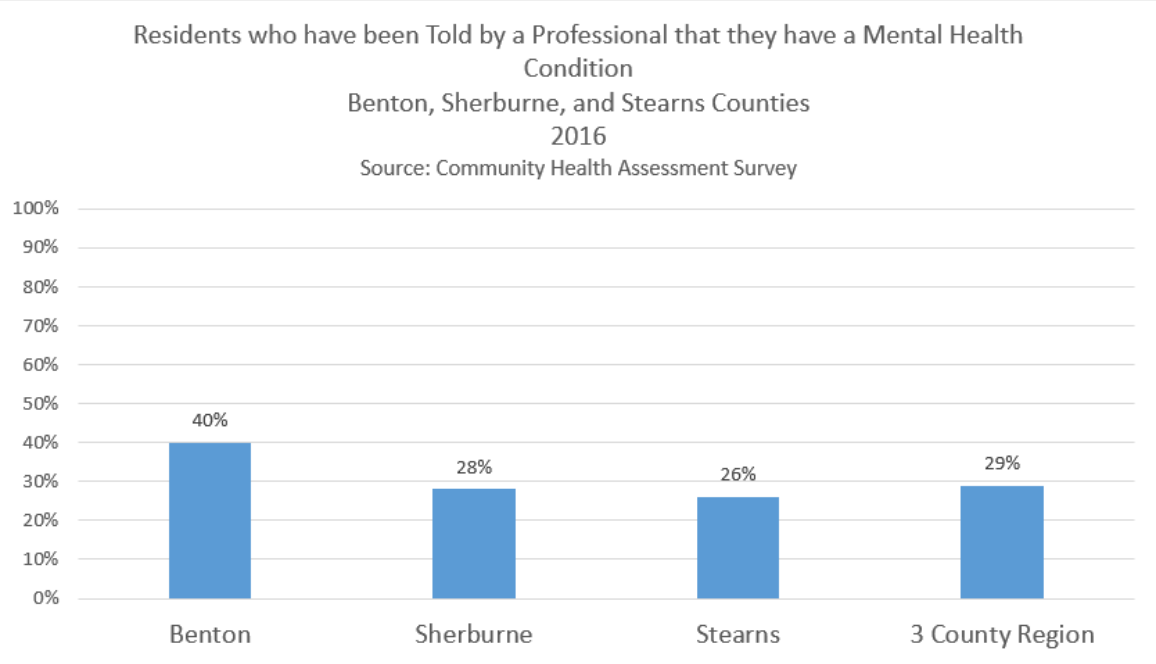
Awareness Performance Measure:

Create a community education campaign of easily digestible education messaging around the priorities of building families and mental well-being, work with partners (including schools & faith communities) to distribute the messaging, report quarterly at Central MN Alliance Core Support Team meetings on experience with distribution activities. The number of attendees at outreach activities will be counted.

Awareness Population Measures*:

Number of adults who have been told they have a mental health condition-

- Baseline: 40% of Benton County residents, 28% of Sherburne County residents, and 26% of Stearns County residents have been told they have a mental health condition- 2016 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 other mental health issues? Responses: Yes or No.



- Baseline: suicide is 7th leading cause of death and 4th leading cause of premature death for deaths under the age of 75 years old)- Minnesota Department of Health, Minnesota County Health Tables, Mortality Table 4: Minnesota 10 Leading Causes of Death by State and County 2016, Mortality Table 5: Minnesota Premature Deaths (under age 75) by Number and Age Adjusted Death Rates by State and County, 2012-2016.

2016 Leading Causes of Death for the 3 County Region	**2016 Premature Deaths (Under age 75) for the 3 County Region**
Cancer	Cancer
Heart Disease	Heart Disease
Unintentional Injury	Unintentional Injury
Stroke	**Suicide**
Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease
Diabetes	Stroke
Suicide	Cirrhosis
Pneumonia and Influenza	Diabetes
Nephritis	Pneumonia and Influenza
Liver Disease and Cirrhosis	Nephritis

How to get involved:

Under construction...

Resilience

Strategy 1: Create an index of community partners participating in resiliency programs.

Agency:	**Outcome**:	**Persons in Charge of Strategy**:
Benton County Public Health Sherburne County Public Health Stearns County Public Health CentraCare St. Cloud Hospital CentraCare- Melrose CentraCare- Paynesville CentraCare- Sauk Centre	An index will be created and made available to Central MN Alliance partners.	Benton County Nicole Ruhoff, Public Health Supervisor Sherburne County Amanda Larson, Manager Public Health and Econ. Supports Stearns County Peggy Sammons, Human Services Planning Coordinator CentraCare Jodi Gertken, Community Wellness Program Director

Priority: ☒Building Families ☒Mental Health

Target Date: By 2/28 of each fiscal year 2019-2022

Progress Notes:

Resilience

Strategy 2: Establish or grow at least one resiliency program (Bounce Back Project, Yellow Zones, Change to Chill, 40 Developmental Assets, Positive Community Norms) in each County or community.

Agency:	**Outcome:**	**Persons in Charge of Strategy:**
Benton County Public Health Sherburne County Public Health Stearns County Public Health CentraCare St. Cloud Hospital CentraCare- Melrose CentraCare- Paynesville CentraCare- Sauk Centre	Sectors utilize resiliency program (Bounce Back Project, Yellow Zones, Change to Chill, 40 Developmental Assets, Positive Community Norms): • Yellow Zones toolkit- Stearns County • Positive Community Norms- CentraCare Progress on ACEs Collaborative Work Plan will be shared at community meetings.	Benton County Nicole Ruhoff, Public Health Supervisor Gina Loterbauer, Public Health Nurse Sherburne County Kara Zoller, Health Promotion Supervisor Kristen Sanders, Lead Public Health Nurse Stearns County Mike Matanich, Public Health Supervisor Danielle Protivinsky, Public Health Coordinator CentraCare Joy Plamann, VP Operation and Acute Care Division Gerry Gilbertson, Administrator Melrose Brandon Pietsch, Administrator Paynesville Del Christianson, Administrator Sauk Centre Pam Beckering, Trauma Informed Program Manager
	CentraCare-Paynesville to provide an annual educational session or event to promote resilience.	CentraCare Paulette Hagen, Director HR/Administrative Services
	Establish Elk River (in Sherburne County) as a Bounce Back community.	Sherburne County Kara Zoller, Health Promotion Supervisor Kristen Sanders, Lead Public Health Nurse CentraCare Melissa Pribyl, Community Health/Wellness Specialist

Priority: ☒Building Families ☒Mental Health

Target Date: Ongoing 2019-2022

Progress Notes:

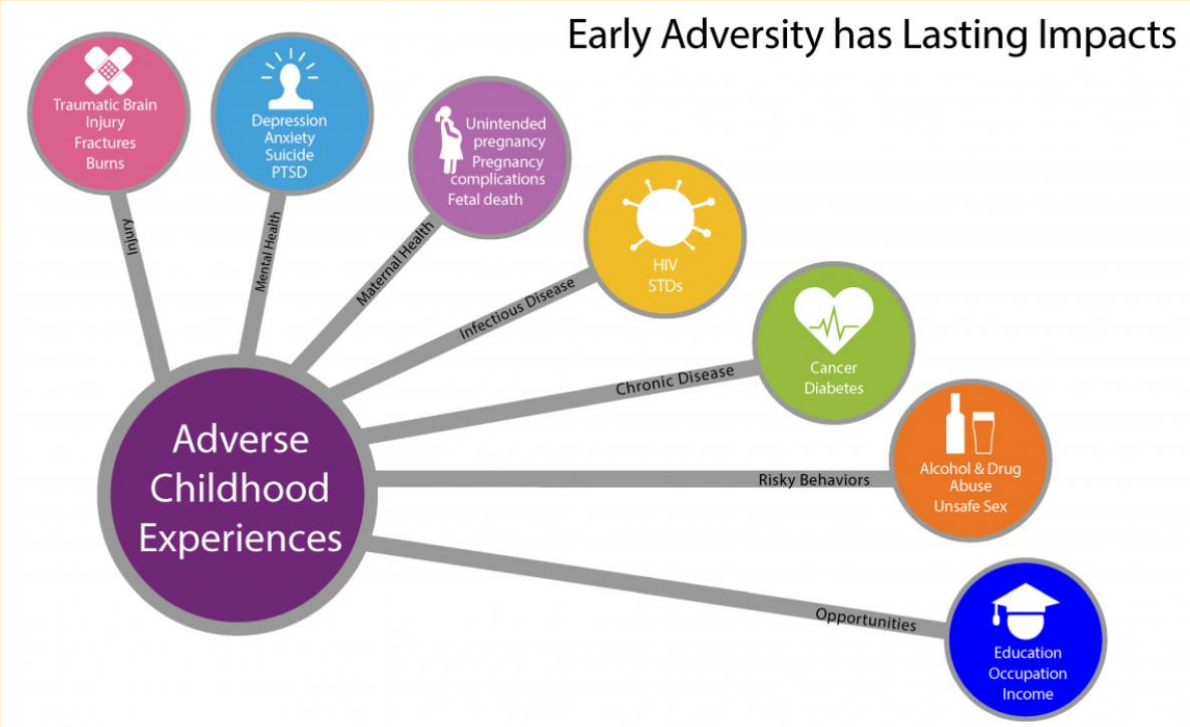
Performance and Population Measures for all Resilience Strategies

Resilience Performance Measure:

Utilize existing partner resilience programming (i.e. Bounce Back Project, Change to Chill, Yellow Zone, etc.) to ensure at least one presentation per quarter in each county. Ultimately these programs will grow in our region.

Resilience Population Measures*:

According to the Centers for Disease Control and Prevention, Adverse Childhood Experiences (ACEs) is the term used to describe all types of abuse, neglect, and other potentially traumatic experiences that occur to people under the age of 18. Adverse Childhood Experiences have been linked to risky health behaviors, chronic health conditions, low life potential, and early death. As the number of ACEs increases, so does the risk for these outcomes. (CDC, https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/aboutace.html, accessed September 19, 2019)



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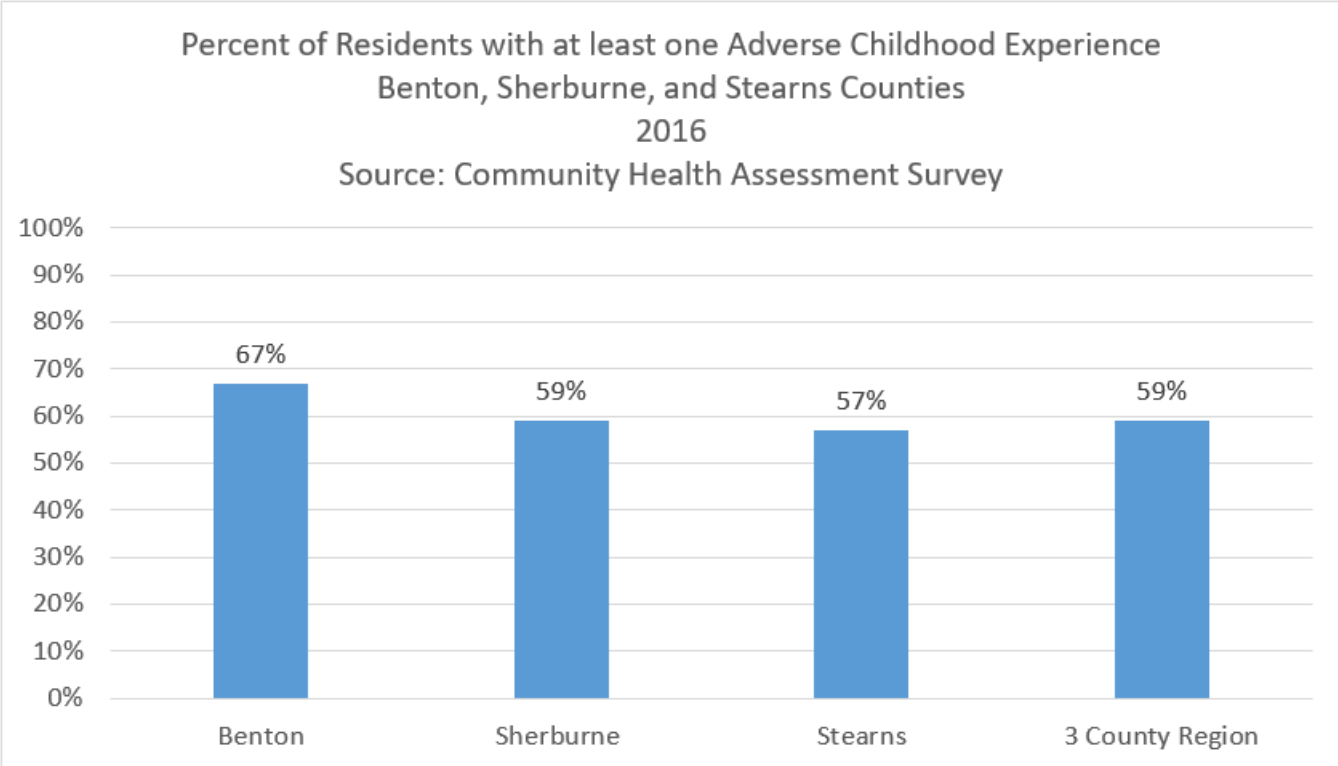
Percentage of residents who experience ACEs-

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



Chronic disease data for diabetes, depression, asthma, tobacco use

- Baseline: Point in time 2019, CentraCare quality and electronic health record data
  - Optimal Diabetes- 47.4%, 8% below target rate of 55.4%
  - Depression 6-month remission- adult 11.8%, 7.2% below target rate of 19%
  - Depression 6-month remission- Adolescent 10.6%, 8.4% below target rate of 19%
  - Optimal Asthma- adult 60.8%, 11.4 % below target rate of 72.2%
  - Optimal Asthma- peds 76.3%, 1.9% below target rate of 78.2%

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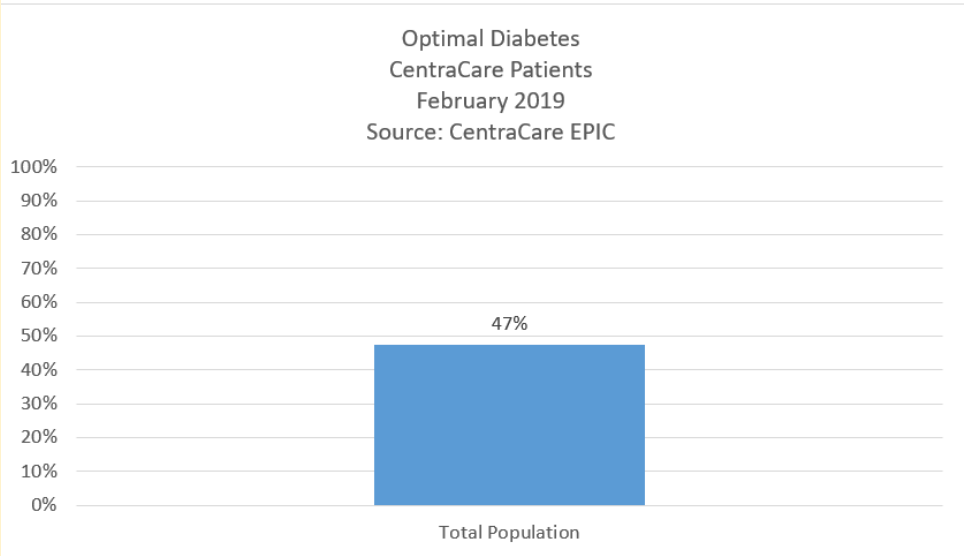
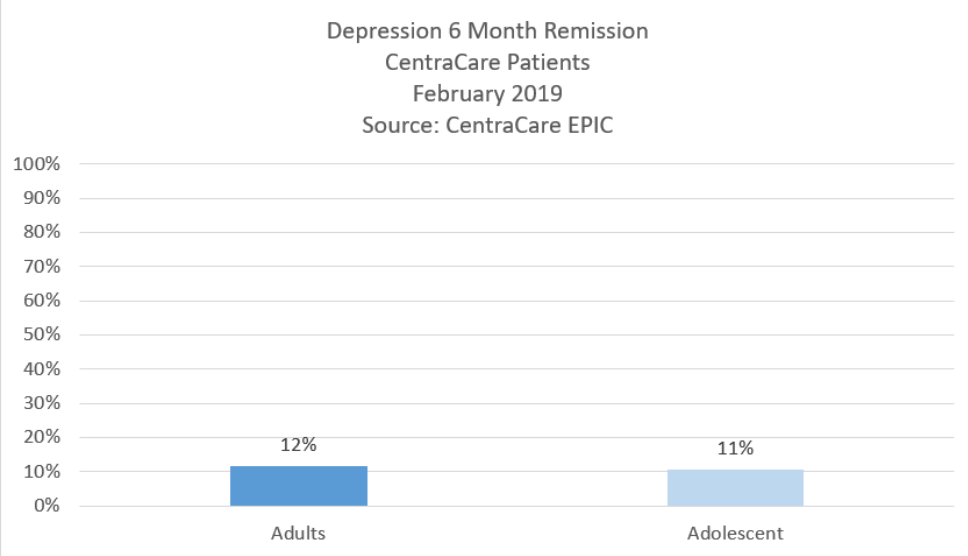
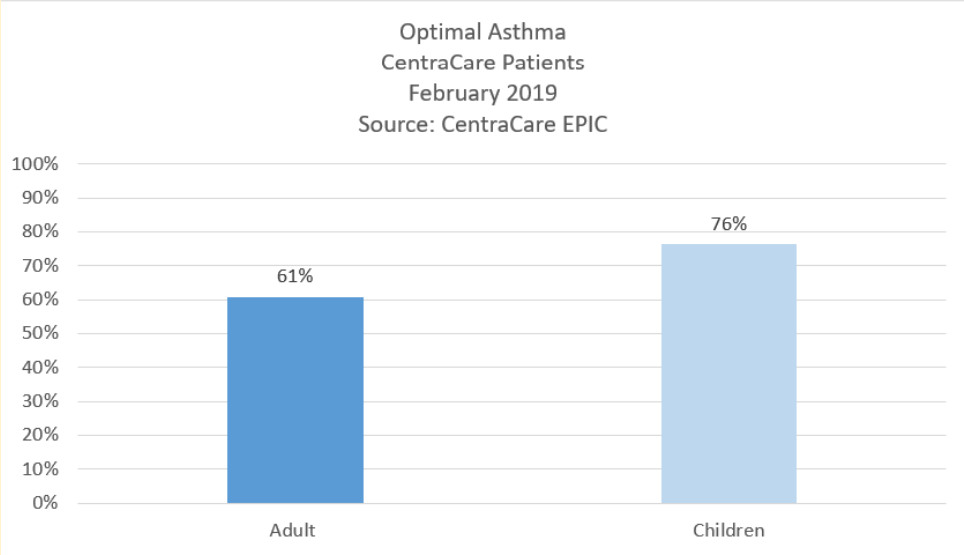
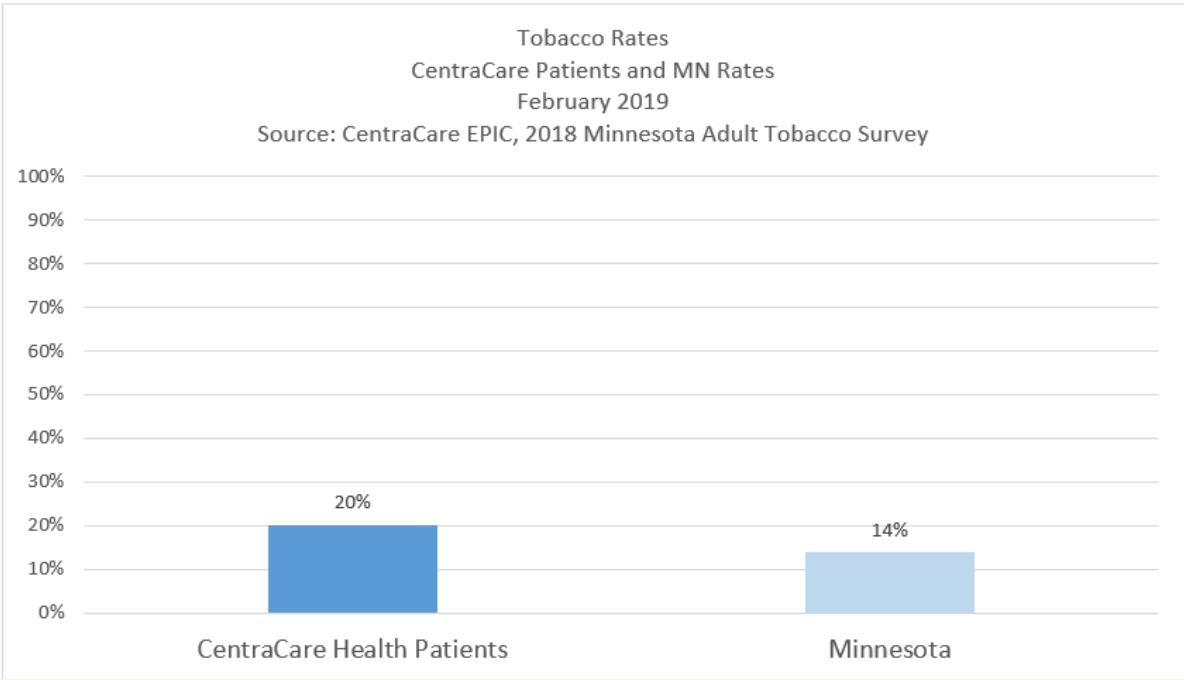






Community Health Improvement Plan 2019-2022

- Baseline: In 2017, St. Cloud Hospital had 12,568 tobacco users admitted, with average charges $7,074 higher than non-tobacco users. Also, in 2017 20% of all CentraCare patients used tobacco- CentraCare electronic health record, 2017.
- Baseline Tobacco: 13.8% of MN adults used tobacco. 2018 Minnesota Adult Tobacco Survey, Clearway and Minnesota Department of Health
- Baseline: 20% of residents in Benton County with less than a high school education are smokers, and 25% of Sherburne County residents with this same education level (Stearns County rate is 14% for this same population). These rates are high compared to the 3-county region rate of 14% of residents classified as a current smoker, regardless of education levels- 2016 Central Minnesota Community Health Survey, Question: Cigarette Smoking Status. Responses: Current Smoker, Former Smoker, Never Smoked.



How to get involved:

Under construction...

Education

Strategy 1: Package the work that is being done in the other goals of the Central MN Alliance CHNA and CHIP in a way that can be shared with school personnel.

Agency:	**Outcome:**	**Persons in Charge of Strategy:**
Benton County Public Health Sherburne County Public Health Stearns County Public Health CentraCare St. Cloud Hospital CentraCare- Melrose CentraCare- Paynesville CentraCare- Sauk Centre	Talking points on CHNA and CHIP developed and shared with school partners.	Benton County Nicole Ruhoff, Public Health Supervisor Sherburne County Amanda Larson, Manager Public Health and Econ. Supports Stearns County Peggy Sammons, Human Services Planning Coordinator CentraCare Jodi Gertken, Community Wellness Program Director

Priority: ☒Building Families ☒Mental Health

Target Date: New materials created by April of each fiscal year 2019-2022

Progress Notes:

Education

Strategy 2: Expansion of school outreach will take place in each county.

Agency:	**Outcome:**	**Persons in Charge of Strategy:**
Benton County Public Health Sherburne County Public Health Stearns County Public Health CentraCare St. Cloud Hospital CentraCare- Melrose CentraCare- Paynesville CentraCare- Sauk Centre	Support United Way Resource Centers & explore Birth to 8 Initiative in Benton County.	Benton County Nicole Ruhoff, Public Health Supervisor
	Expand preventive health services/education in school buildings in Sherburne County.	Sherburne County Tammy Seifert, Public Health Supervisor
	Collaborate through Stearns County Youth Services Taskforce & Stearns County Family Services Collaborative when relevant.	Stearns County Mike Matanich, Public Health Supervisor Melissa Godwin, Public Health Coordinator
	Feeling Good MN staff will collaborate with area schools on healthier lunchroom programs, safe routes to schools and tobacco prevention initiatives to support healthy learning.	CentraCare Jodi Gertken, Community Wellness Program Director
	Suicide prevention education and training in schools with teachers, staff, and students in partnership with the Regional Suicide Prevention Coordinator from Central MN Mental Health Center.	CentraCare Lisa Bershok

Priority: ☒Building Families ☒Mental Health

Target Date: 2021

Progress Notes:

Education

Strategy 3: Prepare families for childbirth, familiarize new parents with the process of labor, delivery, postpartum, and breastfeeding.

Agency:	**Outcome:**	**Persons in Charge of Strategy:**
CentraCare St. Cloud Hospital CentraCare- Melrose CentraCare- Paynesville CentraCare- Sauk Centre	Regional OB educator hired by St. Cloud Hospital will coordinate the offering of childbirth classes at all CentraCare OB sites. Breast Feeding- evidence based and best practice through CentraCare.	CentraCare Melissa Bruns, Regional Outreach Educator, St. Cloud Hospital Rustin Nielsen, Director Patient Care- Melrose Rachel Walz, Director Patient Care- Paynesville Patricia Roth, Director Patient Care- Sauk Centre

Priority: ☒Building Families ☒Mental Health

Target Date: Ongoing

Progress Notes:

Performance and Population Measures for all Education Strategies

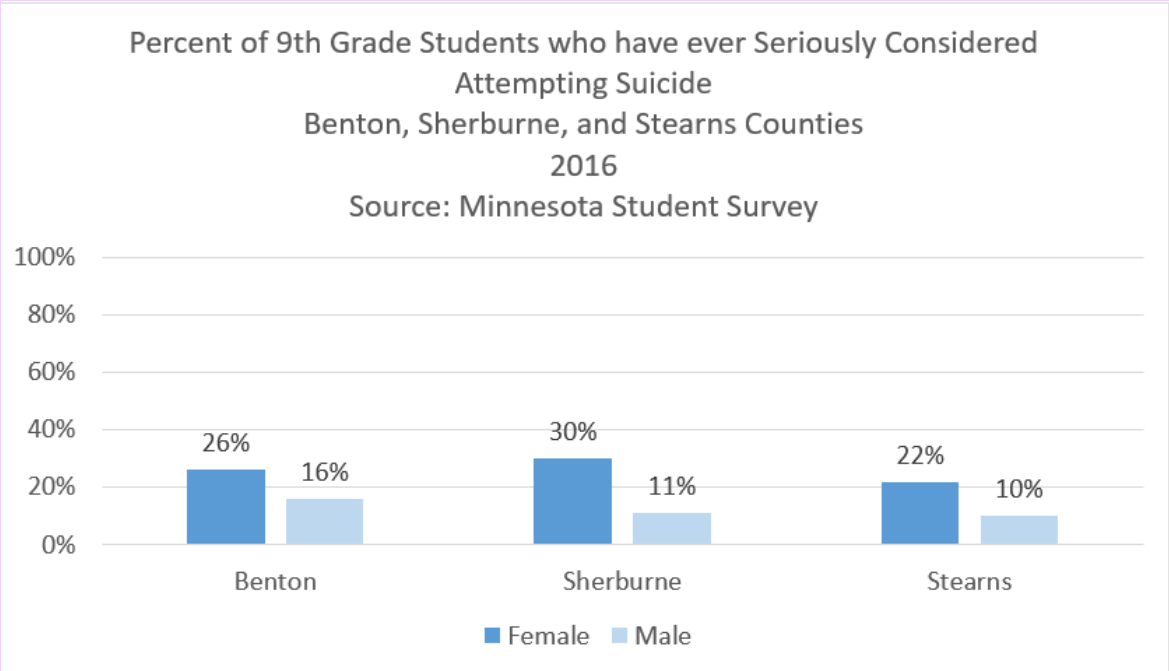
Education Performance Measure:

Increase engagement with schools and early childhood education programs to build relationships between school and community health system personnel. Meetings held between schools/early childhood education programs and community health system personnel will be counted by number of meetings and number of participants at each meeting.

Education Population Measures*:

Number of 9th grade females who have considered suicide

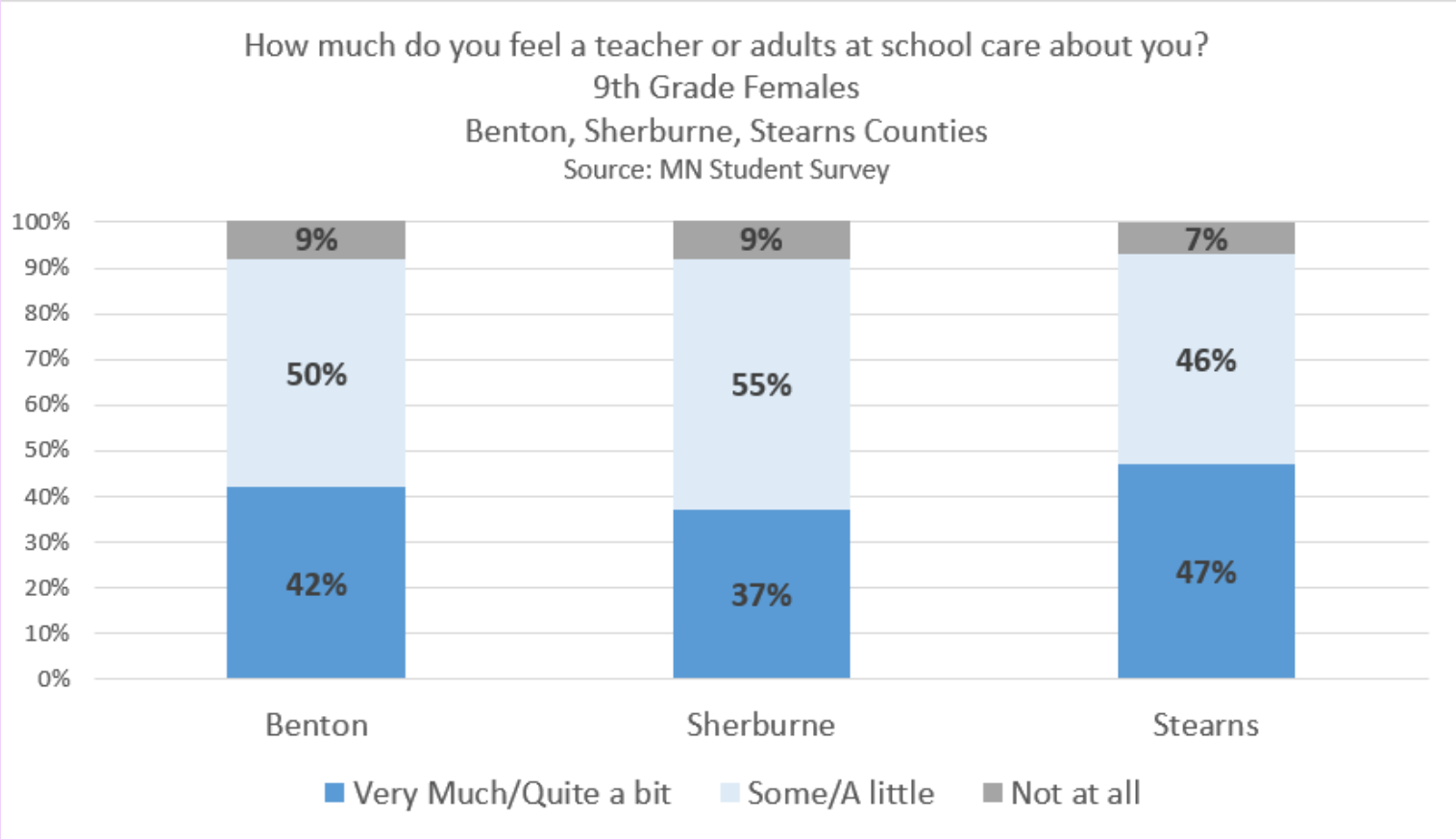
- Baseline: 1 in 4 female 9th graders has considered suicide. Females are 3 times more likely to have considered suicide in the past year- 2016 Minnesota Student Survey, Graph 5A, Question: Have you ever seriously considered attempting suicide (Mark all that apply)? Responses: No; Yes, during the last year; Yes, more than a year ago



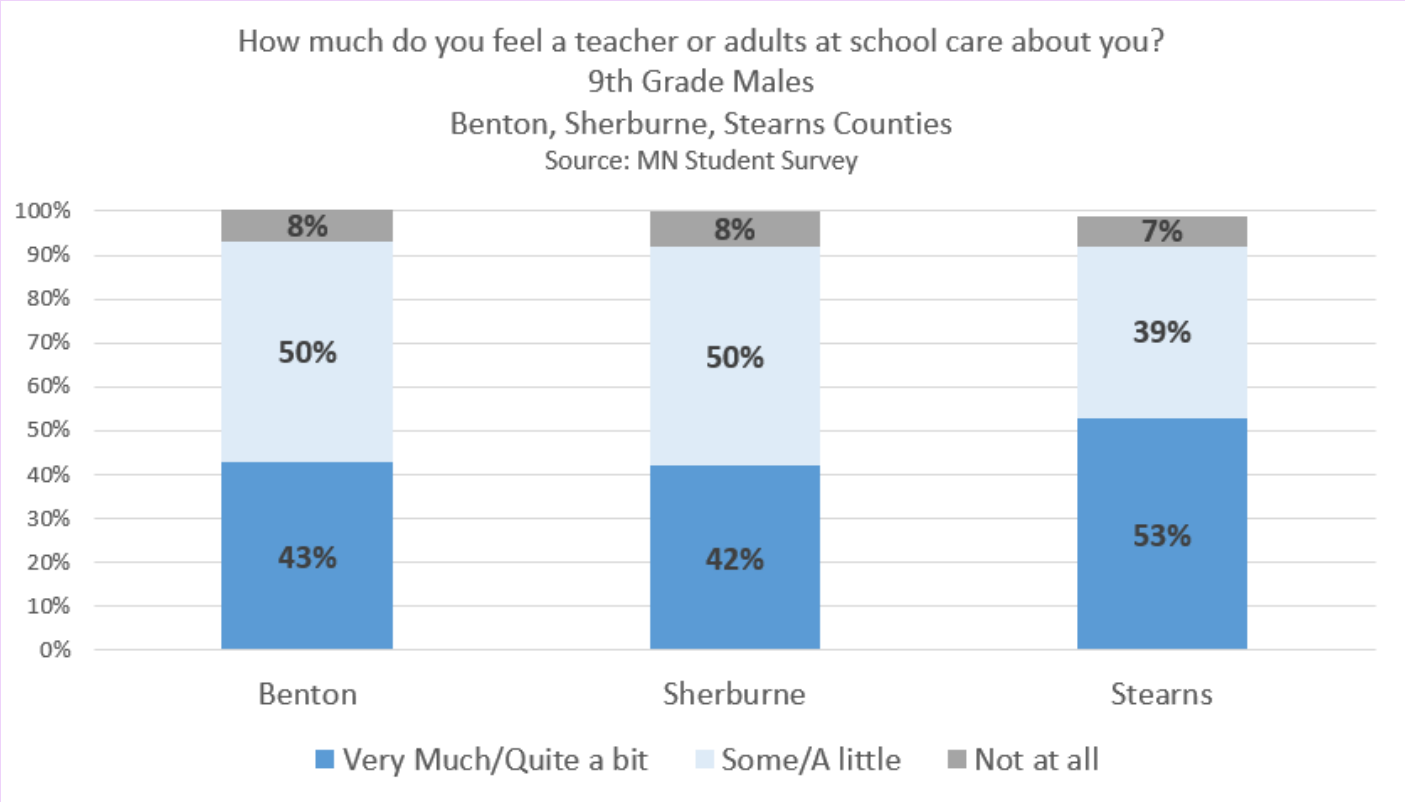
Community Health Improvement Plan 2019-2022

Percent of 9th graders who feel that teachers and adults in their school care about them

- Baseline: Males are more likely to feel that teachers or adults at school care about them- 2016 Minnesota Student Survey, Graph 5B, Question: How much do you feel a teacher or adults at school care about you? Responses: Very much/Quite a bit; Some/A little; Not at all



Community Health Improvement Plan 2019-2022



How to get involved:

Under construction...

Health Organizations

Strategy 1: Promote development of integrated clinics in the region.

Agency:	**Outcome:**	**Persons in Charge of Strategy:**
Benton County Public Health CentraCare St. Cloud Hospital CentraCare- Melrose CentraCare- Paynesville CentraCare- Sauk Centre	Advocate for rural and western end of Benton County for improved mental health provider access.	Benton County Nicole Ruhoff, Public Health Supervisor
	CentraCare- St. Cloud Hospital to integrate monthly OB GYN services to regional sites to continue in-network care.	CentraCare Dave Walz, Senior Director Family Birthing
	WIC clinics will be integrated with the health system by expanded WIC accessibility and improved customer service.	CentraCare Kathy Parsons, VP Population Health Dave Walz, Senior Director Family Birthing Gerry Gilbertson, Administrator Melrose Brandon Pietsch, Administrator Paynesville Del Christianson, Administrator Sauk Centre
	Complete the roll-out of in-person and telehealth Integrated Behavioral Health (IBH) to primary care sites across CentraCare.	CentraCare Ryan Engdahl, Director of Operations, Behavioral Health Julia Draxten, Director of Clinic Operations- Melrose Linda Bethke, Director of Clinic Operations- Paynesville Carolyn Koglin, Director of Family Med- Sauk Centre

Priority: ☐Building Families ☒Mental Health

Target Date: 2022

Progress Notes:

Health Organizations

Strategy 2: Address depression as a quality metric within CentraCare.

Agency:	**Outcome**:	**Persons in Charge of Strategy**:
CentraCare St. Cloud Hospital CentraCare- Melrose CentraCare- Paynesville CentraCare- Sauk Centre	Implement "Depression" as one of the four focus social determinants of health recognized in Epic electronic medical record.	CentraCare Dan Backes, Manager of Population Health
	CentraCare- Sauk Centre will refer inpatients that score high on the Columbia screening tool to behavioral health services prior to discharge.	CentraCare Del Christianson, Administrator Sauk Centre Patricia Roth, Director of Patient Care- Sauk Centre Ryan Engdahl, Director of Operations, Behavioral Health Lisa Bershok, Suicide Prevention Coordinator

Priority: ☐Building Families ☒Mental Health

Target Date: 2022

Progress Notes:

Health Organizations

Strategy 3: Address opioid prescribing, overdose deaths, and improve care for people experiencing pain and addiction.

Agency:	**Outcome**:	**Persons in Charge of Strategy**:
CentraCare Internal Medicine CentraCare- Melrose CentraCare- Paynesville CentraCare- Sauk Centre	Establish care plans for patients to reduce opioid use through the Chronic Opioid Management Program available CentraCare-wide. Decrease chronic opioid prescriptions for patients with chronic pain that is not related to end of life care	CentraCare Jason (Jay) Ophoven, Dir Amb Spec, Internal Medicine Jennifer Tschida, Manager Clinic Nursing- Melrose Angela Bonnema, Manager Clinic Nursing- Paynesville Lindsay Christensen, Manager Clinic Nursing- Sauk Centre Katy Kirchner, Director Coordinated and Correctional Care

Priority: ☐Building Families ☒Mental Health

Target Date: Ongoing 2019-2022

Progress Notes:

Community Health Improvement Plan 2019-2022

Performance and Population Measures for all Health Organizations Strategies

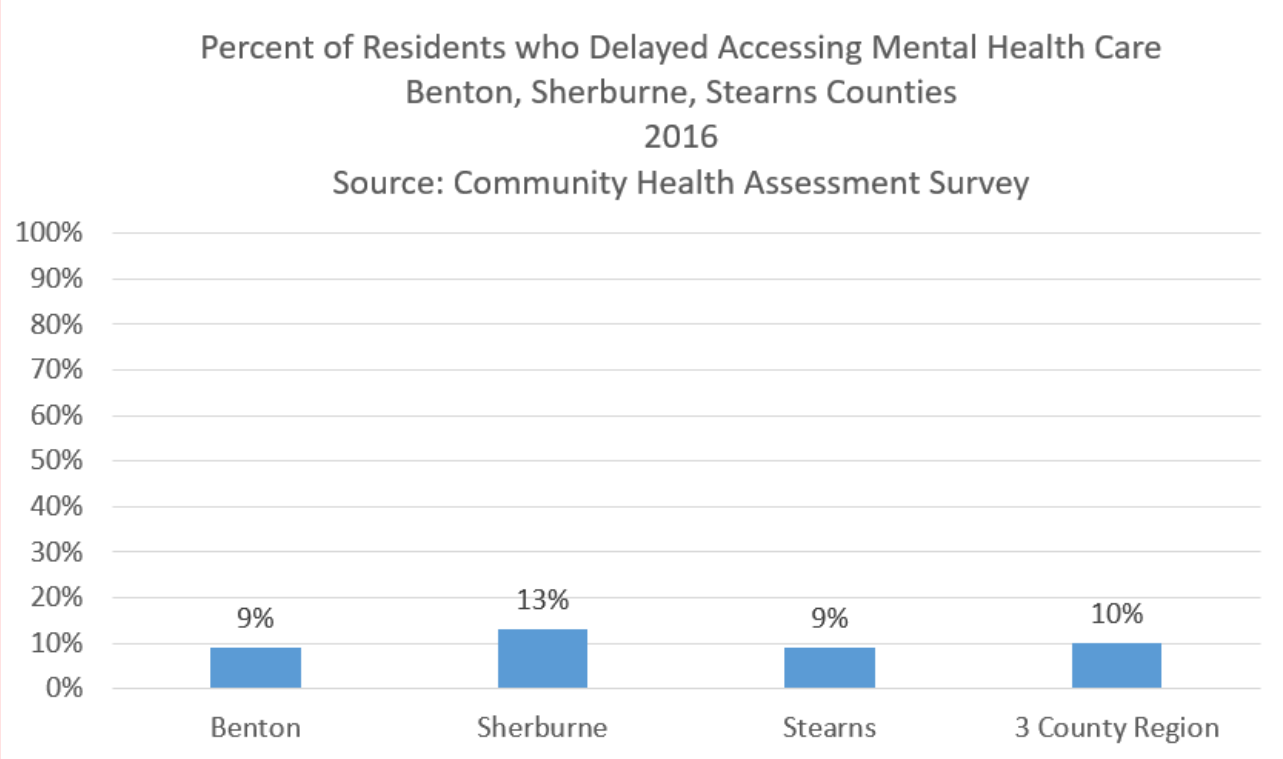
Health Organization Performance Measure:

Promote the use of preventive screenings in the region by measuring the number of screenings completed

Health Organizations Population Measures*:

Delays in residents getting mental health care

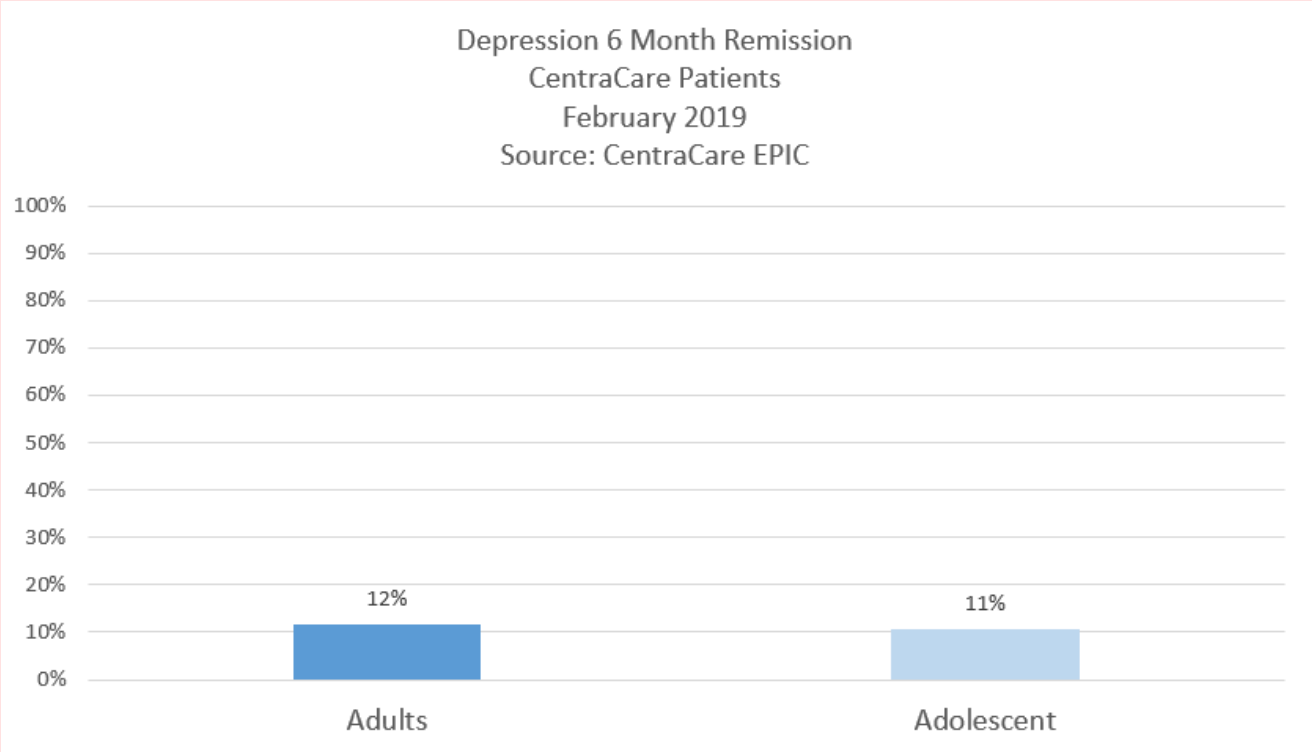
- Baseline: 10% of residents in the 3-county region did not get or delayed getting Mental Health care. Among females, 15% did not get or delayed getting Mental Health care they needed. Rate also increases among residents living below 200% of the poverty line at 19% not getting or a delay in getting mental health care- 2016 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



Community Health Improvement Plan 2019-2022

Percentage of CentraCare patients with “Depression 6-month remission” rates for adults and adolescent

- Baseline: Depression 6-month remission- adult February 2019 11.8%, 7.2% below target rate of 19%
- Baseline: Depression 6-month remission- Adolescent February 2019 10.6%, 8.4% below target rate of 19%



How to get involved:

Under construction...

Community Health Improvement Plan 2019-2022

BENTON COUNTY
MINNESOTA

Community Collaboration

- Family Home Visiting Coalition: goal of 85% of Family Home Visits target caseloads reached for Stearns, Benton, and Sherburne counties

Equity

- Leverage staff involved in HEDA activities
- Attempt to allocate resources to equity training
- Encourage attendance from groups that are under-represented or work with under-represented populations to attend the annual Steering Committee meeting

Awareness

- Increase community knowledge and awareness of CommUNITY Adult Mental Health Initiative (CAMHI)
- Community ownership of family and mental well-being programs, as demonstrated by volunteerism and resource allocation, ie. Family Fun Nights, Safe Families, and Trauma-Informed Congregations

Resilience

- A resiliency index will be created and made available to Central MN Alliance partners
- Utilize resiliency programming
- Progress on ACEs Collaborative Work Plan will be shared at community meetings

Education

- Talking points on CHNA and CHIP developed and shared with school partners
- Support United Way Resource Centers & explore Birth to 8 Initiative

Health Organizations

- Advocate for rural and western end of Benton County for improved mental health provider access
- WIC clinics will be integrated with the health system for expanded WIC accessibility and improved customer service

CENTRAL MN ALLIANCE
STRENGTHENING PARTNERSHIPS FOR CHANGE

Community Health Improvement Plan 2019-2022

SHERBURNE COUNTY

Community Collaboration

- Family Home Visiting Coalition: goal of 85% of Family Home Visits target caseloads reached for Stearns, Benton, and Sherburne counties

Equity

- Leverage staff involved in HEDA activities
- Attempt to allocate resources to equity training
- Encourage attendance from groups that are under-represented or work with under-represented populations to attend the annual Steering Committee meeting

Awareness

- Increase community knowledge and awareness of CommUNITY Adult Mental Health Initiative (CAMHI)
- Community ownership of family and mental well-being programs, as demonstrated by volunteerism and resource allocation, ie. Family Fun Nights, Safe Families, and Trauma-Informed Congregations

Resilience

- A resiliency index will be created and made available to Central MN Alliance partners
- Establish Elk River (in Sherburne County) as a Bounce Back Community
- Utilize resiliency programming
- Progress on ACEs Collaborative Work Plan will be shared at community meetings

Education

- Talking points on CHNA and CHIP developed and shared with school partners
- Expand preventive health services/education in school buildings

Health Organizations

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

CENTRAL MN ALLIANCE
STRENGTHENING PARTNERSHIPS FOR CHANGE

Community Health Improvement Plan 2019-2022

Community Collaboration

- Family Home Visiting Coalition: goal of 85% of Family Home Visits target caseloads reached for Stearns, Benton, and Sherburne counties

Equity

- Leverage staff involved in HEDA activities
- Attempt to allocate resources to equity training
- Encourage attendance from groups that are under-represented or work with under-represented populations to attend the annual Steering Committee meeting

Awareness

- Increase community knowledge and awareness of CommUNITY Adult Mental Health Initiative (CAMHI)
- Nurses in Action to hold at least annual events surrounding suicide awareness
- Community ownership of family and mental well-being programs, as demonstrated by volunteerism and resource allocation, ie. Family Fun Nights, Safe Families, and Trauma-Informed Congregations

Resilience

- A resiliency index will be created and made available to Central MN Alliance partners
- Utilize Yellow Zones toolkit for resiliency programming
- Progress on ACEs Collaborative Work Plan will be shared at community meetings

Education

- Talking points on CHNA and CHIP developed and shared with school partners
- Collaborate through Stearns County Youth Services Taskforce & Stearns County Family Services Collaborative when relevant to expand school outreach

Health Organizations

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

CENTRAL MN ALLIANCE
STRENGTHENING PARTNERSHIPS FOR CHANGE

Community Health Improvement Plan 2019-2022

CentraCare™ -Melrose

Community Collaboration

- Launch and sustain a Power of Produce (PoP) Club program at the Melrose Community Farmers Market
- Implement three (3) recommendations listed in the 2018 Master Bicycle & Pedestrian Plan
- Offer childbirth classes and car seat clinics through Regional Outreach Educator
- Utilization of hospital and clinic space by community partners will be allocated to services of greatest need for community and will be tracked and reported to the CentraCare Community Benefit IRS report
- Feeling Good MN will lead and support advocacy work at the State, County and City level with stakeholders and community partners to pass and implement strong tobacco prevention policies

Equity

- CentraCare Population Health Leadership Team will consider equitable practices while analyzing data
- Identify the leaders and strategies within CentraCare focusing on engaging patients as partners to advance health equity
- Create awareness within CentraCare about the Workplace & Patient Diversity department

Awareness

- Continue the work of Population Health- Community Wellness activities around mental well-being
- Suicide prevention education and training within CentraCare and in the community in partnership with the Regional Suicide Prevention Coordinator from Central MN Mental Health Center
- Increase community knowledge and awareness of CommUNITY Adult Mental Health Initiative (CAMHI)
- Nurses in Action to hold at least annual events for suicide awareness

Resilience

- Implement Bounce Back Project to the Melrose Area Community
- A resiliency index will be created and made available to partners
- Utilize resiliency programming surrounding Positive Community Norms
- Progress on ACEs Collaborative Work Plan shared at community meetings

Education

- Feeling Good MN staff will collaborate with area schools on healthier lunchroom programs, safe routes to schools and tobacco prevention initiatives to support healthy learning
- Suicide prevention education and training in schools with teachers, staff, and students in partnership with the Regional Suicide Prevention Coordinator from Central MN Mental Health Center
- Regional OB educator hired by St. Cloud Hospital will coordinate the offering of childbirth classes at all CentraCare OB sites
- Breast Feeding- evidence based and best practice through CentraCare

Health Organizations

- WIC clinics will be integrated with the health system for expanded WIC accessibility and improved customer service
- CentraCare- St. Cloud Hospital to integrate monthly OB GYN services to regional sites to continue in-network care
- Complete the roll-out of in-person and telehealth Integrated Behavioral Health (IBH) to primary care sites across CentraCare
- Implement “Depression” as one of the four focus social determinants of health recognized in Epic electronic medical record
- Address opioid prescribing, overdose deaths, and improve care for people experiencing pain and addiction

Central MN Alliance
Strengthening Partnerships for Change

Community Health Improvement Plan 2019-2022

CentraCare™ -Paynesville

Community Collaboration

- Host annual Community Event such as Children's Fun Run and Pet Show to promote community involvement in a healthy activity and participation activities with residents
- Offer childbirth classes and car seat clinics through Regional Outreach Educator
- Utilization of hospital and clinic space by community partners will be allocated to services of greatest need for community and will be tracked and reported to the CentraCare Community Benefit IRS report
- Feeling Good MN will lead and support advocacy work at the State, County and City level with stakeholders and community partners to pass and implement strong tobacco prevention policies

Equity

- CentraCare Population Health Leadership Team will consider equitable practices while analyzing data
- Identify the leaders and strategies within CentraCare focusing on engaging patients as partners to advance health equity
- Create awareness within CentraCare about the Workplace & Patient Diversity department

Awareness

- Continue the work of Population Health- Community Wellness activities around mental well-being
- Suicide prevention education and training within CentraCare and in the community in partnership with the Regional Suicide Prevention Coordinator from Central MN Mental Health Center
- Increase community knowledge and awareness of CommUNITY Adult Mental Health Initiative (CAMHI)
- Nurses in Action to hold at least annual events for suicide awareness

Resilience

- Provide an annual educational session or event to promote resilience- Some activities may include random acts of kindness, 3 good things, gratitude message, etc.
- A resiliency index will be created and made available to partners
- Utilize resiliency programming surrounding Positive Community Norms
- Progress on ACEs Collaborative Work Plan shared at community meetings

Education

- Feeling Good MN staff will collaborate with area schools on healthier lunchroom programs, safe routes to schools and tobacco prevention initiatives to support healthy learning
- Suicide prevention education and training in schools with teachers, staff, and students in partnership with the Regional Suicide Prevention Coordinator from Central MN Mental Health Center
- Regional OB educator hired by St. Cloud Hospital will coordinate the offering of childbirth classes at all CentraCare OB sites
- Breast Feeding- evidence based and best practice through CentraCare

Health Organizations

- WIC clinics will be integrated with the health system for expanded WIC accessibility and improved customer service
- CentraCare- St. Cloud Hospital to integrate monthly OB GYN services to regional sites to continue in-network care.
- Complete the roll-out of in-person and telehealth Integrated Behavioral Health (IBH) to primary care sites across CentraCare
- Implement "Depression" as one of the four focus social determinants of health recognized in Epic electronic medical record
- Address opioid prescribing, overdose deaths, and improve care for people experiencing pain and addiction

Central MN Alliance
Strengthening Partnerships for Change

Community Health Improvement Plan 2019-2022

CentraCare™ -Sauk Centre

Community Collaboration

- Collaborate with the City of Sauk Centre Planning Commission to establish safe routes to school
- Offer childbirth classes and car seat clinics through Regional Outreach Educator
- Utilization of hospital and clinic space by community partners will be allocated to services of greatest need for community and will be tracked and reported to the CentraCare Community Benefit IRS report
- Feeling Good MN will lead and support advocacy work at the State, County and City level with stakeholders and community partners to pass and implement strong tobacco prevention policies

Equity

- CentraCare Population Health Leadership Team will consider equitable practices while analyzing data
- Identify the leaders and strategies within CentraCare focusing on engaging patients as partners to advance health equity
- Create awareness within CentraCare about the Workplace & Patient Diversity department

Awareness

- Continue the work of Population Health- Community Wellness activities around mental well-being
- Suicide prevention education and training within CentraCare and in the community in partnership with the Regional Suicide Prevention Coordinator from Central MN Mental Health Center
- Increase community knowledge and awareness of CommUNITY Adult Mental Health Initiative (CAMHI)
- Nurses in Action to hold at least annual events for suicide awareness

Resilience

- A resiliency index will be created and made available to partners
- Utilize resiliency programming surrounding Positive Community Norms
- Progress on ACEs Collaborative Work Plan shared at community meetings

Education

- Feeling Good MN staff will collaborate with area schools on healthier lunchroom programs, safe routes to schools and tobacco prevention initiatives to support healthy learning
- Suicide prevention education and training in schools with teachers, staff, and students in partnership with the Regional Suicide Prevention Coordinator from Central MN Mental Health Center
- Regional OB educator hired by St. Cloud Hospital will coordinate the offering of childbirth classes at all CentraCare OB sites
- Breast Feeding- evidence based and best practice through CentraCare

Health Organizations

- CentraCare- St. Cloud Hospital to integrate monthly OB GYN services to regional sites to continue in-network care.
- Refer inpatients that score high on the Columbia screening tool to behavioral health services prior to discharge
- WIC clinics will be integrated with the health system for expanded WIC accessibility and improved customer service
- Complete the roll-out of in-person and telehealth Integrated Behavioral Health (IBH) to primary care sites across CentraCare
- Implement “Depression” as one of the four focus social determinants of health recognized in Epic electronic medical record
- Address opioid prescribing, overdose deaths, and improve care for people experiencing pain and addiction

Central MN Alliance
Strengthening Partnerships for Change

Community Health Improvement Plan 2019-2022

CentraCare™ -St. Cloud Hospital

Community Collaboration

- Offer childbirth classes and car seat clinics through Regional Outreach Educator
- Utilization of hospital and clinic space by community partners will be allocated to services of greatest need for community and will be tracked and reported to the CentraCare Community Benefit IRS report
- Feeling Good MN will lead and support advocacy work at the State, County and City level with stakeholders and community partners to pass and implement strong tobacco prevention policies

Equity

- CentraCare Population Health Leadership Team will consider equitable practices while analyzing data
- Identify the leaders and strategies within CentraCare focusing on engaging patients as partners to advance health equity
- Create awareness within CentraCare about the Workplace & Patient Diversity department

Awareness

- Continue the work of Population Health- Community Wellness activities around mental well-being
- Suicide prevention education and training within CentraCare and in the community in partnership with the Regional Suicide Prevention Coordinator from Central MN Mental Health Center
- Increase community knowledge and awareness of CommUNITY Adult Mental Health Initiative (CAMHI)
- Nurses in Action to hold at least annual events for suicide awareness

Resilience

- A resiliency index will be created and made available to partners
- Utilize resiliency programming surrounding Positive Community Norms
- Progress on ACEs Collaborative Work Plan shared at community meetings

Education

- Feeling Good MN staff will collaborate with area schools on healthier lunchroom programs, safe routes to schools and tobacco prevention initiatives to support healthy learning
- Suicide prevention education and training in schools with teachers, staff, and students in partnership with the Regional Suicide Prevention Coordinator from Central MN Mental Health Center
- Regional OB educator hired by St. Cloud Hospital will coordinate the offering of childbirth classes at all CentraCare OB sites
- Breast Feeding- evidence based and best practice through CentraCare

Health Organizations

- WIC clinics will be integrated with the health system for expanded WIC accessibility and improved customer service
- CentraCare- St. Cloud Hospital to integrate monthly OB GYN services to regional sites to continue in-network care.
- Complete the roll-out of in-person and telehealth Integrated Behavioral Health (IBH) to primary care sites across CentraCare
- Implement “Depression” as one of the four focus social determinants of health recognized in Epic electronic medical record
- Address opioid prescribing, overdose deaths, and improve care for people experiencing pain and addiction

Central MN Alliance
Strengthening Partnerships for Change

Potential Partners

Potential Partners for Building Families

- 4H Clubs
- Anna Marie's Alliance
- Avivo
- ARC Midstate
- 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
- Central MN Sexual Assault Center
- Chief health officer/family CentraCare
- Community health workers
- County Attorney Offices
- County Human Services Partners: *Family and Children Services, Adult Services, Corrections/Probation Services, Financial Services*
- County Sheriff Offices
- Faith-based groups
- Families in Transition Services, Inc.
- Family physicians
- 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)
- 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
- Parent Connect by ARC Midstate, meetings for those who are parenting children with special needs
- Parish Nurses
- 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
- 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 State University Child and Family Studies Department
- TriCap
- United Way
- Veterans Affairs

Potential Partners for Mental Health

- Anna Marie's Alliance
- ARC Midstate
- Avivo
- Boys and Girls Club of Central Minnesota
- CentraCare OB Clinic
- CentraCare Stroke Program
- Central Minnesota Mental Health Center
- 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)
- Goodwill Easter Seals
- Greater St. Cloud Area Thrive Initiative
- Health Care Providers (*including Rejuv Medical, Williams IntegraCare, Health Partners, etc.)*
- Health Care Home Coordinators
- Health Plans (Ucare, HealthPartners, Medica)
- HealthForce Minnesota
- 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
- 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
- United Way
- Universities/Colleges
- United Way
- Wellness in the Wood
- 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 Core Support Team. (Note: For a list of existing resources, refer to Part 1: Community Health Needs Assessment)*

Community Health Improvement Plan 2019-2022

Leadership System & Process for Monitoring and Revision

Accountability:
Administrative support to conduct work on this Implementation Strategy will be a collective effort by all partners. This will include ongoing accountability to move the CHIP forward over the three-year period and measure the strategies that have 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 Central MN Alliance Core Support Team meetings	Ongoing	Central MN Alliance Core Support Team	One community meeting (Steering Committee) will be held each year to bring partners together to discuss the CHNA, CHIP, and Population Measure Tracking Supplement.	
2. Central MN Alliance: Quarterly Central MN Alliance Core Support Team meetings	Ongoing	Central MN Alliance Core Support Team Co-Chairs	Central MN Alliance agencies will remain up to date on Goal progress.	
3. Central MN Alliance: Delegated Authorities biannual meetings	Ongoing	Central MN Alliance Core Support Team Co-Chairs	Delegated Authorities will remain up to date on Goal progress.	
4. Central MN Alliance: Regular meetings for a Central MN Alliance data group	Ongoing	Central MN Alliance Core Support Team Co-Chairs	Data surveillance will take place on a regional level.	

Community Health Improvement Plan 2019-2022

[Lead Agency]: Strategy	Target Date	Person/See Contact info on the last page	Anticipated Outcome/Result	Progress Notes
5. Central MN Alliance: Educate Policy Makers and all key community stakeholders on issues/emerging issues in the community	Ongoing	Delegated Authorities	Policy makers and key community stakeholders will be aware of this CHIP.	The Greater St. Cloud Region, led by CentraCare, was chosen to participate in the Communities of Excellence (COE) 2026. The COE is a community planning framework focused on improving the performance of communities and the people who lead and live in them. It is based on the recognition that the social determinants of economic vitality, educational achievement, and health status are inextricably interwoven. They require commitment among leaders across sectors and generations to take a systems approach to community performance. As such, the Central MN Alliance anticipates the CHNA/CHIP process to represent the health area in the COE areas of economics, health, education, and quality of life.
6. CentraCare: IRS reporting on CHNA process	Every third year after CHNA completion	Jodi Gertken, 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.	

[Lead Agency]: Strategy	Target Date	Person/See Contact info on the last page	Anticipate Outcome/Result	Progress Notes
7. Local Public Health Agencies: Annual Reporting on 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 use 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 2019-2022

Created On: 05/20/2019

Approved By:

Benton County Board: 06/04/2019

CentraCare- Melrose Operating Committee: 06/24/2019

CentraCare- Paynesville Operating Committee: 06/25/2019

CentraCare- Sauk Centre Operating Committee: 05/22/2019

CentraCare- St. Cloud Hospital Board of Directors: 06/20/2019

Sherburne County Board: 05/21/2019

Stearns County Board: 06/25/2019

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

Revised On:

Date	Description of what was revised.

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Sherburne County	https://www.co.sherburne.mn.us/
Stearns County	https://co.stearns.mn.us/
CentraCare Health	https://www.centracare.com/

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CHIP Appendices

Appendix 1: Public Comments Received for Community Health Improvement Plan

The Implementation Strategy for July 2019 through June 2022 was posted online for public comment for a two-week period from 5/01/2019 through 5/14/2019. The link for public comment was posted on the websites for Stearns, Benton, and Sherburne Counties, as well as CentraCare. A total of seven public comment surveys were received from community members, and their responses are documented below. All responses were considered when completing the final draft of this document.

Date: 5/7/2019
Agency of Survey Participant: Financial
County: Benton
How assessment will be used: Agency/Organization Planning, Program planning, Networking
Comment for Specific Goal: N/A
General Comment: "This is really good. I like the collaboration and resilience themes."
Will agency use document/Will agency work on any strategies in next 3 years: Yes/Yes

Date: 5/7/2019
Agency of Survey Participant: CentraCare Health - Monticello
County: Other
How assessment will be used: Agency/Organization Planning
Comment for Goal #4: "Could you please change BounceBack to Bounce Back Project? Thank you!"
General Comment: N/A
Will agency use document/Will agency work on any strategies in next 3 years: Yes/Yes

Date: 5/8/2019
Agency of Survey Participant: Anna Marie's Alliance
County: Sherburne, Stearns
How assessment will be used: Program planning, Networking
Comment for Specific Goal: N/A
General Comment: N/A
Will agency use document/Will agency work on any strategies in next 3 years: Yes/Yes

Date: 5/10/2019
Agency of Survey Participant: UCare
County: Other
How assessment will be used: Program planning, Future Grant Writing
Comment for Goal #1: "UCare would like to discuss how we can best support family home visiting in your region."
General Comment: N/A
Will agency use document/Will agency work on any strategies in next 3 years: Yes/Yes

Date: 5/10/2019
Agency of Survey Participant: Resident, CentraCare Health
County: Benton, Sherburne, Stearns
How assessment will be used: Agency/Organization Planning, Program Planning, Future Grant Writing, Networking
Comment for Goal #2: "I am confused as to how colon cancer screening relates to equity?"
General Comment: "Was the community engaged in the creation of the action plan? It appears as though the community was greatly engaged in the assessment process, which is wonderful. It appears in the action plan and draft that the team formulated the approach as to how they would solve the issues that the community decided upon as a priority. I may have missed something as I read, but this question was left in my mind upon review. I see value in also engaging the community in the action planning process. This may have been the discussion at the January meeting? Where was the meeting located? Being that the partnership is located across a large geographical distance, I hope that meetings were held in various locations to allow a more diverse population to attend. Thank you for the opportunity to share my thoughts."
Will agency use document/Will agency work on any strategies in next 3 years: Yes/Yes

Date: 5/13/2019
Agency of Survey Participant: N/A
County: N/A
How assessment will be used: N/A
Comment for Goal #6: "There are other health care providers in the area besides CentraCare. Do not forget about the clinic in Foley, Rejuv in Waite Park, Chris Wenner in Cold Spring, Dr. Smith in Sartell and Williams-IntegraCare in Sartell, & HealthPartners in Sartell among others."
General Comment: N/A
Will agency use document/Will agency work on any strategies in next 3 years: No/No

Date: 5/13/2019
Agency of Survey Participant: N/A
County: Benton, Sherburne, Stearns
How assessment will be used: N/A
Comment for Specific Goal: N/A
General Comment: N/A
Will agency use document/Will agency work on any strategies in next 3 years: No/Yes

Date: 5/14/2019
Agency of Survey Participant: Reach Up- Head Start
County: Benton, Sherburne, Stearns
How Assessment will be used: N/A
Comment for Goal #5: "The Early Childhood/School section appears to have 9th grade girl suicide ideation as the measurement tool. I am curious to know how they are linking early childhood into that; The objective for that section doesn't state that they will work with early childhood education programs – just "schools"; Overall it seems more "big kid school based" than early childhood driven but maybe that is the area of focus for now?"
General Comment: "Another partner for them to consider might be Greater St Cloud Area Thrive Initiative; There is some excellent data in there. I knew there were some struggles with families having access to services, but this really shows where the needs are!"
Will agency use document/Will agency work on any strategies in next 3 years: N/A

Date: 5/14/2019
Agency of Survey Participant: Milestones
County: Benton, Sherburne, Stearns
How assessment will be used: N/A
Comment for Goal #5: "We looked this over as a team and noticed that there does not seem to be as big of an emphasis on early childhood age as there is on school age. Or when the term "school" is used, does that include early childhood? There did not seem to be any mention of working with family childcare or childcare centers. Or maybe that's not a priority or you weren't planning on working with those groups? Other than that, we thought it looked good."
General Comment: "In the partners list you can delete Child Care Choices and leave Milestones. It looks like we are listed twice."
Will agency use document/Will agency work on any strategies in next 3 years: N/A

CENTRAL MN ALLIANCE
STRENGTHENING PARTNERSHIPS FOR CHANGE

Community Health Needs Assessment

July 1, 2019-June 30, 2022

Version 1: September 2019

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).

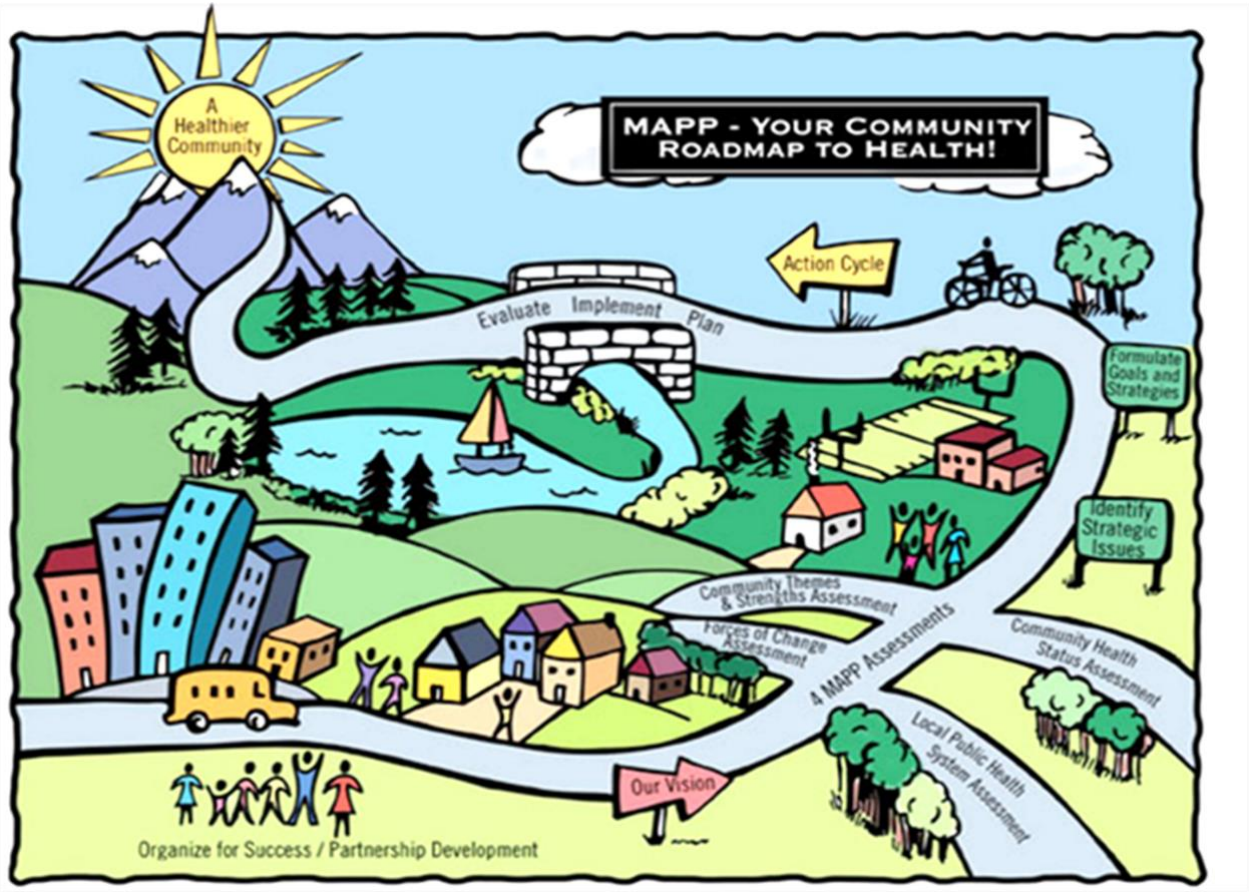
The United States Patient Protection and Affordable Care Act of 2010 (PPACA) imposed reporting requirements under new Internal Revenue Code (IRC) § 501(r) for charitable hospitals regarding the fulfillment of their charitable purpose as tax-exempt organizations starting in 2011. This document describes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

Executive Summary:

Structure of Process, Vision, Priorities, and Guiding Principles



"MAPP – Your Community Roadmap to Health!", National Association of County and City Health Officials (NACCHO); Mobilizing for Action through Planning and Partnerships (MAPP) Handbook.

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 utilized the MAPP (Mobilizing Action through Planning and Partnerships) process to conduct the CHNA and arrive at the Community Health Improvement Plan (CHIP) for the time period of July 1, 2019 through June 30, 2022.

Central MN Alliance Vision

We are a community whereby all are involved in healthy living through:

- *Safe, equitable, resilient and sustainable communities*
- *Healthy environments (food, water, housing, recreation, transportation)*
- *Vibrant economic opportunities*
- *Dynamic, engaged community partnerships*
- *Nurturing social, cultural, and spiritual opportunities*
- *Affordable, accessible, high-quality healthcare*
- *Shared and informed leadership toward achieving community health*

Central MN Alliance 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 Collaboration

Expand reach and capacity to serve more at-risk families in central Minnesota through best practices or evidence-based practice for prenatal education and awareness.

CentraCare will annually discuss utilization of hospital and clinic space by community partners at each affiliated CentraCare operational meeting and connect with partners as needed.

CentraCare Population Health will continue the community collaborative initiative Feeling Good MN to support making the healthy choice the easy choice through education, outreach programs, and lobbying.

Equity

Participating agencies will increase understanding and knowledge of equity.

Increase understanding of the Workplace & Patient Diversity department including the CentraCare Equity Steering Committee framework.

Engage under-represented populations in Steering Committee.

Awareness

Collaborate with Central MN CAMHI (CommUNITY Adult Mental Health Initiative) to get the word out about their website and increase resources that pertain to mental well-being.

Central MN Suicide Prevention Coalition will work to spread suicide prevention awareness for veterans and community members.

Support community partners in integrating mental well-being into daily practice.

Resilience

Create an index of community partners participating in resiliency programs.

Establish or grow at least one resiliency program (Bounce Back Project, Yellow Zones, Change to Chill, 40 Developmental Assets, Positive Community Norms) in each County or community.

Education

Package the work that is being done in the other goals of the Central MN Alliance CHNA and CHIP in a way that can be shared with school personnel.

Expansion of school outreach will take place in each county.

Prepare families for childbirth, familiarize new parents with the process of labor, delivery, postpartum, and breastfeeding.

Health Organizations

Promote development of integrated clinics in the region.

Address depression as a quality metric within CentraCare.

Decrease chronic opioid prescriptions for patients with chronic pain that is not related to end of life care.

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 as a best practice in creating a complete, long-term, system-wide paradigm shift.

The MAPP Paradigm Shift

FROM	TO
Operational planning	Strategic Planning
Focus on the agency	Focus on community & entire public health system
Needs assessment	Emphasis on assets and resources
Medically oriented model	Broad definition of health
Agency knows all	Everyone knows something

In May 2017, staff from participating agencies attended a training on the MAPP process sponsored by NACCHO (National Association of County and City Health Officials). Several meetings were held between May 2017 and April 2018 to develop the relationship for creating a unified Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP). The partnership agreed to follow the hospital IRS requirement of a 3-year timeframe for each CHNA cycle which starts and ends during the hospital fiscal year. 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.

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Steve Heinen, Third District
Spencer Buerkle, Fourth District
Allen “Jake” Bauerly, 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
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Willie Jett, St. Cloud School District Superintendent
Merryn Jolkovsky, MD, Palliative Care Physician, CentraCare Clinic & Past Chief of Staff
Richard Jolkovsky, MD, Physician, CentraCare Heart & Vascular Center
Father Tom Knoblach, Church of the Holy Spirit
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Kelly Kasner, Community Member
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Jody LaVoi, PharmD., Coborn's Pharmacy
James Sayovitz, MD, Family Medicine Physician, CentraCare- Sauk Centre
Joe Uphus, Managing Partner, The Mutual Fund Store, Board Chair

Delegated Authorities:

Delegated Authorities set major timelines, monitor the progress, give updates to the Key Authorities, and meet with the Core Support team co-chairs.

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Amanda Larson, Manager Public Health and Economics Supports Division
Stearns County
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CentraCare
Katy Kirchner, Director Coordinated Care & Correctional Care
Kathy Parsons, VP Revenue Cycle & Population Health
Joy Plamann, VP Operations Acute Care Division & Chief Nursing Officer

Core Support Team:

Core Support Team accomplishes the day-to-day work of the work plan and engage with the steering committee. *Core Support Team Co-Chairs* include representation from each agency. They assist in guiding the Core Support Team and provide updates to the Delegated Authorities.

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Jennifer Lezer, Community Health Specialist
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Adam Johnson, Supervisor Family Health
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Dan Backes, Population Health Coordinator
Audrey O'Driscoll, Grants Program and Compliance Manager
Seth Royce, Director of Emergency Trauma Center
Jennifer Salzer, St Cloud Hospital Manager of Care Management
Pam Beckering, Trauma Informed Care Program Manager
Minnesota Department of Health
Ann Kinney, Senior Research Scientist
Ann March, Public Health Assessment Planner

Steering Committee:
Steering Committee represents the broad community and interacts with the Core Support Team at community meetings.

Steering Committee
Community stakeholders and partners will be invited to an annual, open community meeting to monitor and revise the CHIP

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.

This group meets bi-monthly to complete the MAPP process: Forces of Change assessment, a Community Health Survey (goal is 400 completed surveys per county, sent out in January 2019), Community Stakeholder Interviews (following the 12 sector model, each county will select 20-30 names for interviews), and self-reported data collection through a Prepaid Medical Assistance Program (PMAP) targeted population assessment. Other sources of data collection include local Electronic Medical

Record data, Integrated Health Plan and health equity data, county data tables, Minnesota Student Surveys and results from the 2013 and 2016 regional community health survey data. Once the 2019 priorities are identified, each organization will work on the priorities independently. The collaborative group will continue to meet to review goals and strategies and update current efforts and measures of success over the designated Community Health Needs Assessment period.

The main community health issues from 2013 remained the same for 2016: adult and childhood obesity, mental health, and social determinants of health. Within social determinants of health, the main areas that are being addressed include food insecurity and tobacco use in low-income populations. As of this publication, the 2019 priorities had not been chosen.

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.

This group meets bi-monthly to complete the MAPP process: community input has been included via a Visioning Event held in October 2017 (51 attendees forming 7 small groups completing a World Café exercise guided by the Minnesota Department of Health facilitator), a Community Dialogue session held in May 2018 (30 attendees forming four small groups completing Forces of Change and Assets guided discussion), and anecdotal self-reported data collection at the Wright County Fair in July 2018. Other sources of data collection included local Electronic Medical Record data pull (5 indicators) by Allina and CentraCare and reviewing the 2015 and 2018 Wright County Public Health Community Health Surveys and 2016 Minnesota Student Survey.

Three priorities have been selected for 2020-2022: Mental Health and Wellness, Dental Care, and Substance Use and Abuse (including alcohol, tobacco, and drugs). The four organizations will each work on these priorities independently, as well as collectively when possible. Upon completion of the 2019 Community Health Needs Assessment and Implementation Plan, the group will continue to meet monthly to review goals and strategies and update current efforts and measures of success with an established system for information sharing and plan updating. Three existing community coalitions were identified (Mental Health & Wellness: Mental Health Advisory Council; Dental Care: Dental Care subcommittee of the Public Health Task Force; Substance Use & Abuse: Mentorship, Education and Drug Awareness – MEADA) that will be the hubs for the priority area work and the four collaborative organizations will support their efforts.

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	56333, 56367, 56379, 56357, 56329, 56304
Sherburne County	55309, 55308, 55330, 55398, 55319, 56304, 55371
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 over 2,600 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 over 12,000 residents. The part of St. Cloud that is located in Benton County includes about 6,400 residents. Benton County's portion of Sartell includes over 2,000 people. Rice, with a population of over 1,200, is located on the northwestern edge of the County. The total Benton County population is 40,128 with a 2% population growth rate over the last 5 years. Approximately 61% of our population is between the ages of 18-64, with the biggest population cohort in the 25-34 year range. We are pretty equal on gender numbers, with 90% identifying as white, 10% as persons of color, and about 2% Hispanic. The median home value is $162,600, with 69% owner-occupied homes. Residents have a median household income of $53,574. The percent of residents living under the poverty line is about 14%, primarily impacting our 17 years and under population at 18%. We have a high-school graduation rate of about 90% overall. Our disabled population is about 13%. The majority of adults in Benton County take 10-19 minutes a day to

travel to work. We have 17,789 people employed with 943 total businesses. The unemployment rate is about 4%. Data sources used for these statistics were MN Compass, U.S. Census 2017 ACS Estimates, and the MN Department of Employment and Economic Development's 2017 Quarterly Census of Employment and Wages data tool.

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 24,507 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 94,748 with a 5% growth rate over the last 5 years. Approximately 63% 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 92% of our population identifies as white, 8% as persons of color, and about 3% as Hispanic. The median home value is $204,100, with 83% owner-occupied homes. Residents have a median household income of $83,895. The percent of residents living under the poverty line is about 6%, impacting our 17 years and under population at 9%. Sherburne County has a high-school graduation rate of 89% overall. The disabled population is about 9%. The majority of adults in Sherburne County take over 30 minutes a day to travel to work. Sherburne County has 26,265 people employed with 1,922 total businesses. The unemployment rate is about 3%. Data sources used for these statistics were MN Compass, U.S. Census 2017 ACS Estimates, and the MN Department of Employment and Economic Development's 2017 Quarterly Census of Employment and Wages data tool.

Stearns County

Stearns County is home to 30 cities. The smallest is St. Rosa and the largest is St. Cloud with a population of 53,626, 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 67,093. The total population of Stearns County is 157,660 with a 4% growth rate over the last 5 years. 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 51% males and 49% females. Approximately 86% of our population identifies as white, 14% as persons of color, and 3% Hispanic. The median home value is $171,300 with 69% owner-occupied homes. Residents have a median income of $59,564. The percent of residents living under the poverty line is about 13%, impacting our 17 and under population at 15%. Stearns County has a high-school graduation rate of 86% 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 87,106 people employed with 4,315 total businesses. The unemployment rate is about 4%. Data sources used for these statistics were MN Compass, U.S. Census 2017 ACS Estimates, and the MN Department of Employment and Economic Development's 2017 Quarterly Census of Employment and Wages data tool.

Table: County Demographic Data Indicators

County Demographic Data Indicators		
Benton County (2017)	County Seat	Foley
	Largest City	Sauk Rapids
	Population	40,128
	Population Growth (2013-2017)	2%
	Median Household Income	$53,574
	Poverty Rate	14%
	Unemployment Rate	4%
Sherburne County (2017)	County Seat	Elk River
	Largest City	Elk River
	Population	94,748
	Population Growth (2013-2017)	5%
	Median Household Income	$83,895
	Poverty Rate	6%
	Unemployment Rate	3%
Stearns County (2017)	County Seat	St. Cloud
	Largest City	St. Cloud
	Population	157,660
	Population Growth (2013-2017)	4%
	Median Household Income	$59,564
	Poverty Rate	13%
	Unemployment Rate	4%

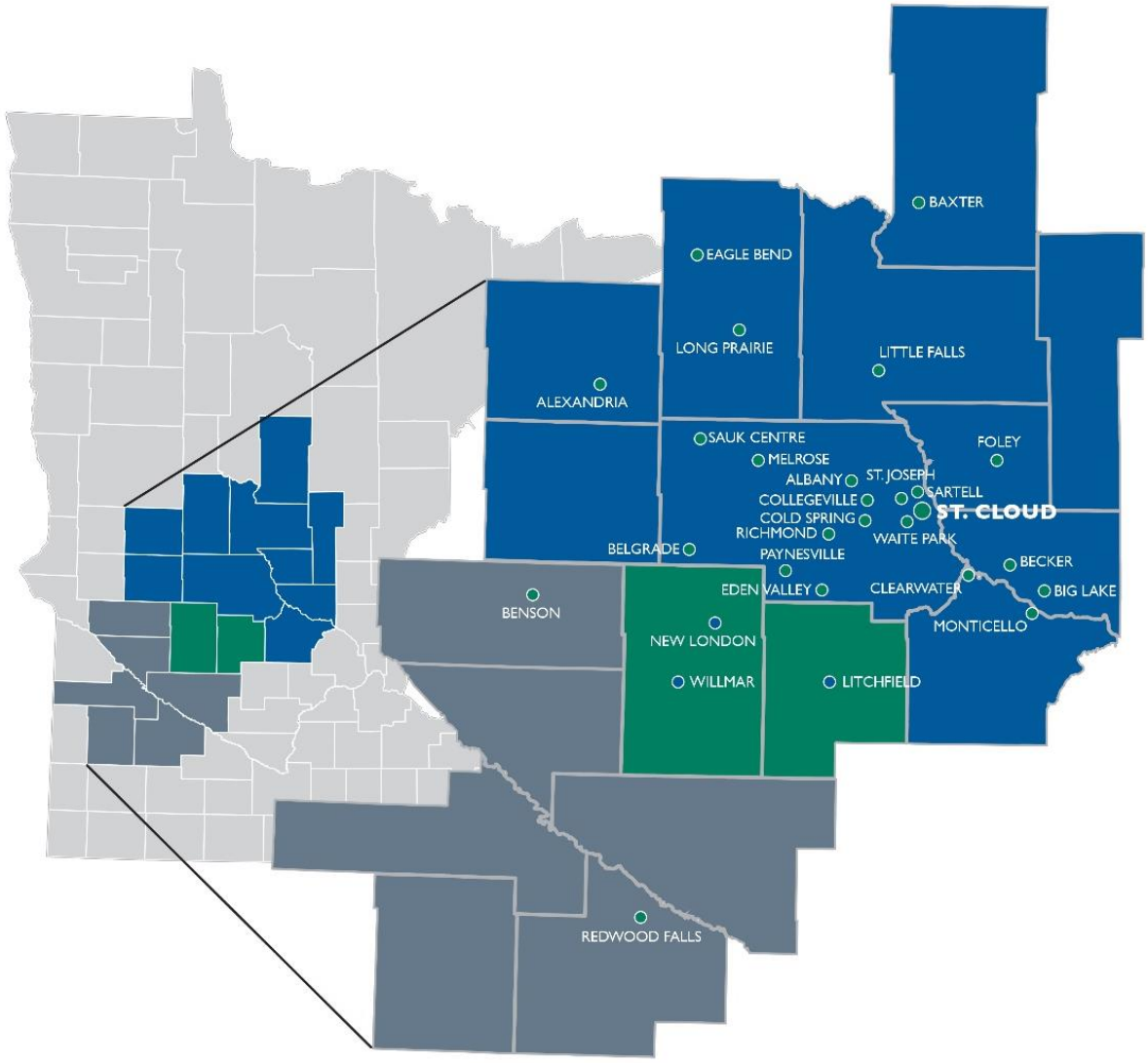
Source: MN Compass

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. In 2018, 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

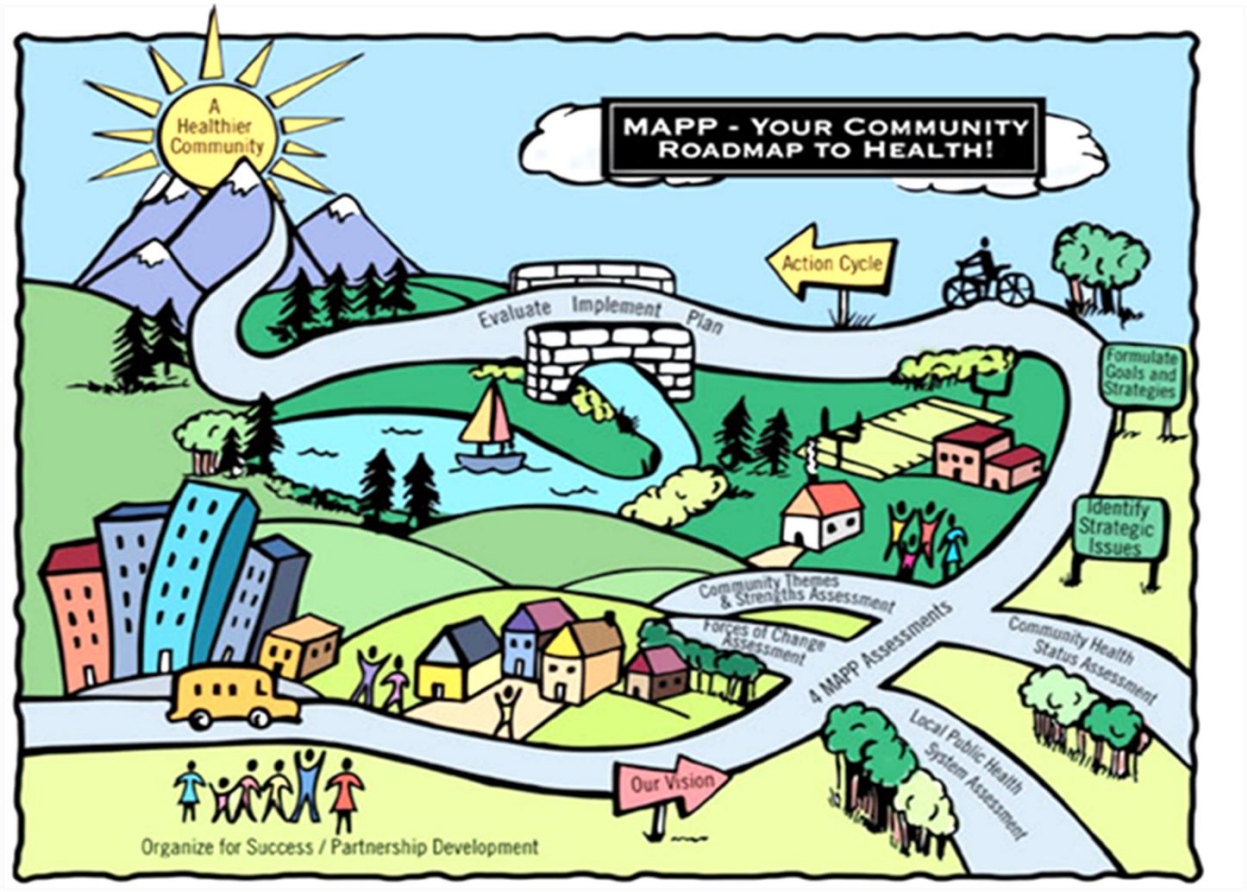
CentraCare Health and Carris Health (overlap)

Carris Health

2.27.19

C. Process and Methods to Conduct the CHNA

The Central MN Alliance agreed to utilize the MAPP (Mobilizing for Action through Planning and Partnerships) process to conduct the CHNA and prepare the CHIP. The MAPP Process consists of six phases outlined in detail in this section: (Phase 1) Organize for Success & Partnership Development, (Phase 2) Visioning, (Phase 3) The Four Assessments, (Phase 4) Identify Strategic Issues, (Phase 5) Formulate Goals and Strategies, and (Phase 6) Action Cycle.



Phase 1: Organize for Success & Partnership Development

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.

Phase 2: Visioning

The Core Support Team discussed the Vision at two meetings in April and May of 2018. In-between the two meetings, each agency discussed the vision statement within their agencies to identify if there were missing components. The Delegated Authorities also discussed the vision statement at a meeting in May 2018. The partnership agreed that the statement is a living statement and any member can ask to revisit the Vision to potentially make changes at any time.

Central MN Alliance Vision

We are a community whereby all are involved in healthy living through:

- *Safe, equitable, resilient and sustainable communities*
- *Healthy environments (food, water, housing, recreation, transportation)*
- *Vibrant economic opportunities*
- *Dynamic, engaged community partnerships*
- *Nurturing social, cultural, and spiritual opportunities*
- *Affordable, accessible, high-quality healthcare*
- *Shared and informed leadership toward achieving community health*

Phase 3: The 4 MAPP Assessments

The four assessments gather qualitative and quantitative data to drive the priority selection process. To complete the four assessments, the Core Support Team broke into four subgroups. Each subgroup had members from each of the four agencies. The sub-groups completed the assessments between May and October 2018. Each assessment resulted in a list of ten community priorities.

Community Health Status Assessment (CHSA)

The Community Health Status Assessment (CHSA) provides quantitative information on community health conditions. A majority of this data was collected from the Community Health Assessment completed in 2016, CentraCare patient data, Minnesota Student Survey data, and Minnesota Public Health vital statistics. The CHSA sub-group met from April through September 2018, to identify the top community concerns with the communities' quantitative data.

The CHSA sub-group members identified a common data gathering template to capture elements about data points identified as a concern: main topic, target population, geographies, time/date/year, notes about any acronyms or abbreviations, notes about equity, and source information.

Next, the sub-group reviewed a series of documents and datasets: MN statewide health assessment (SHA), Central MN Community Health Survey data, previous planning process priority lists, Health Equity Data Analyses (HEDA) from each county, types of data requests our agencies were getting from the public, and the MN Department of Health data indicator list. Each sub-group member was assigned data of interest to them. The sub-group member then reviewed their assigned data and if there was a concern with the data, such as there was an increase when a decrease was expected or vice versa, then the data was put into the data gathering template.

Community Health Status

Each sub-group member had a data gathering template into which they added the data they reviewed and found a concern. In July and August, the data reviewed to date was analyzed to see if any data sources were missing. Additional data was reviewed to address identified gaps.

Once the sub-group felt that the data sources were adequately analyzed, all of the data points from the sub-group members' data gathering templates were summarized into a single document. The sub-group assigned a "community priority category" to each data point to identify a list of community priorities. Out of 53 data points, 11 community priorities were identified. In a separate meeting, the sub-group prioritized those 11 to come up with a top 10 for the CHSA.

The Community Health Status Assessment top 10 community priorities in ranked order were: (1) child well-being/parenting skills, (2) illegal drug use, (3) tobacco/nicotine use, (4) mental health, (5) adverse childhood experiences (leading to chronic disease), (6) financial stress/strain, (7) preventive health care, (8) nutrition, (9) alcohol use, and (10) physical activity. See Appendix A for the CHSA Sub-group Report, which includes the key data points. See Appendix B for the data shared with the public who attended the community meeting to discuss the top two priority areas.

Community Themes and Strengths Assessment

Community Themes and Strengths Assessment (CTSA)

The Community Themes and Strengths Assessment (CTSA) provides an understanding of the issues residents feel are important by assessing what is important to the community, how the quality of life is perceived in the community, and what assets the community has to improve community health.

In the summer of 2018, key stakeholder interviews were conducted with a wide variety of community partners throughout the three counties. Kassidy Steen, a biomedical sciences undergraduate student from St. Cloud State University completed the one-to-one stakeholder interviews by phone and summarized the information. Using a neutral individual for stakeholder interviews promoted impartiality and more honest and direct answers from the interviewees. A total of 50 stakeholders were interviewed, including 17 stakeholders from Stearns County, 14 from Benton County, and 19 from Sherburne County. The questions asked to the stakeholder can be found in Appendix C.

The Core Support Team brainstormed a list of interviewees from at least twelve sectors using the Drug-Free Communities Support Program's twelve required sectors for gathering community coalitions through Community Anti-Drug Coalitions of America and the National Community Anti-Drug Coalition Institute. The Core Support Team ultimately narrowed the list of interviewees down to 20 stakeholders per county. The 20 stakeholder sectors surveyed in each county were:

1. Youth
2. Parent
3. Small Business Owner
4. Corporate Business Owner
5. Media
6. School/Education
7. Youth-Serving Organization
8. Law Enforcement
9. Religious or Faith-Based Organization
10. Primary Healthcare
11. Behavioral Health
12. Hospital-Based Healthcare
13. State/Local Government- Elected
14. State/Local Government- Non-Elected
15. Non-Profit
16. Civic/Volunteer Group
17. Veterans Interest Group
18. Aging Population Interest Group
19. Environmental Interest Group
20. Minority Interest Group

Despite the nature of the selection process, every effort was made to separate the relationship between the interviewees and sponsors. Special emphasis was made to include individuals who were representative of or with knowledge about the underserved and disadvantaged people in the respective communities as emphasized by the Affordable Care Act (ACA) recommendation that the needs of the poor be considered as part of the CHNA process.

Ms. Steen prepared four separate summaries of the stakeholder interviews, one representing themes widespread across counties and one for each county.

CTSA Common Themes

While completing the interview process and analyzing the results, a few prominent themes presented themselves. The first theme was what many stakeholders across all three counties considered to be the top issue regarding health: mental health and lack of resources associated with the issue. A total of 29 out of 50 stakeholders, 58%, mentioned mental health as a top three issue, while another 23 of those individuals listed it as top priority. This adds up to 46% of stakeholders listing mental health as their number one issue. Some subcategories quoted regarding mental health were the lack of caretakers, providers, services, facilities, and money being put into mental health care. It was frequently stated that as a region, we do not have enough trained professionals in the field who can work with preventative care patients before they get to a critical point. It was also common for stakeholders to feel like the services that are currently being provided are not offered on a reasonable time frame; that is, many offices or clinics are open 9-5, falling right in the middle of a normal work or school day.

A second prominent theme observed was that most stakeholders- over 75%- mentioned transportation (or lack of it) as a huge problem and a barrier to solving other issues as well. Of those stakeholders, 10% also listed it as one of their top three issues. Stakeholders from all counties suggested implementation of better transportation routes or paths. Whether it be bringing these services to the aging population who can no longer drive, transportation for those who do not have a car and need to get their families to health services, or more options for walkers and bikers, most indicated that transportation issues need to be addressed in some way. Some suggested creating a more robust and frequent public busing system with more health services stops along the way (including YMCAs, clinics, farmers markets, etc.), some suggested hiring more assisted living caretakers to drive those who are unable to appointments, the grocery store, or even social events, and many even specified the addition of safer and more frequent walking paths.

Next, parental health and wellness seemed to be a key theme while conducting the interviews. When asked “what would you do for an initiative targeted at parenting?” many responded with “healthy parents’ equal healthy kids.” Stakeholders thought it would be a good idea to offer parenting classes, but the main concern lied with whether parents had the right financial, mental, and social support because deficits in these areas will cause the most problems for children. Ideas to start addressing these issues came first with providing proper education on how to properly feed themselves, and in turn their children, and how much exercise they should be getting per day. In addition, offering mental health services or stress management services would help reduce stress and lead to more beneficial interaction between parents and children. Along these lines, financial counseling was offered up to reduce stress during an expensive time in a parent’s life and hopefully increase positive attitudes in homes.

Finally, education and collaboration with different parts of the community seemed to be pronounced in these interviews as well. It was noted that education is one of the biggest keys to tackling many of the

key issues mentioned, as many people simply do not know how to begin eating healthy or where to find services for mental health issues, among other health-related issues. In accordance with this, many of these issues cannot be tackled by one single entity; there must be a collaboration with businesses, healthcare professionals, government officials, and schools to begin tackling these issues.

CTSA Themes Throughout Specific Questions

Certain questions within the interview received very unanimous answers throughout all the counties; for example, the most common response for what the cause of good health versus bad health had to do with socioeconomic status, namely money, seemed to be the biggest factor in whether you could afford to buy good healthcare, food, or transportation services. Money is also one of the biggest stressors, leading to adverse health effects, as many stakeholders mentioned as well. In addition, the most common service stakeholders would add to their community was mental health services, or better access to more affordable mental health care. Similarly, making more facilities available, adding more trained staff, and reducing stigma about what mental health is and is not were the most common results when asked how to address current mental health issues.

When asked about addressing or preventing obesity, by far the most common suggestion was giving people the knowledge and tools to manage their weight or nutrition by themselves. Advocates for this argued that one could not force others to eat right or exercise enough, but if individuals are given the knowledge of where to start, they can begin to take these issues into their own hands. Surprisingly enough, many also mentioned that weight problems are often connected with mental health problems as well. It was stated that feeling depressed or ashamed of yourself will continue the downward spiral of poor nutrition and lack of exercise.

When asked to address distracted driving, most stakeholders began with “I have no clue”. They offered that creating technology to force cellphones to shut off while driving would be the only way to keep people focused on the road. Others proposed that laws can only be so strict, so taking away the source of the most common distraction would be the most efficient way to address the issue. However, many “I have no idea” answers were not backed up by any other alternatives, suggesting that this initiative would require drastic change.

Additionally, the most common response to addressing substance abuse was to educate the youth on the dangers of substances and where to find help for yourself or those around you. Stakeholders from across the board stated that increasing laws around this issue would not prevent people from continued abuse. However, finding ways to prevent it from the start, along with offering help and recovery options to those struggling would be the best approach.

Finally, the most frequent answer regarding strengthening families and engaging people to improve their own health was to offer more free activities for all types of families. It was stressed that these activities need to be friendly to all ages (including the aging population) and to all cultural groups as well (including immigrants or those who moved to the area recently). It was also stressed that these activities should be free to encourage low-income families to be involved in the community and at a reasonable time of day so working families can attend as well. Some stakeholders also mentioned that these types of activities would also be a good time to add in a few educational pieces or different health initiatives in a fun, collaborative way.

CTSA Themes Across Each County: Benton

In contrast, Benton county voted substance abuse and obesity/nutrition as the top 2 issues (each at 57% of stakeholders), with mental health coming in third at 50%. However, of all the people who listed mental health as a top three issue in this county, more than 90% of those stakeholders also chose it as the overall most important issue, paralleling the overall results. Stakeholders from this county also mentioned that one of the best ways to combat obesity is to incorporate more facilities or better activities to encourage exercise. More affordable workout facilities and better walking and biking paths were of concern to this population as well. Like the overall themes, one of the most common responses to assist parents is to offer classes that deal with stress management and help for when they are struggling. Overall, Benton County had a little better idea of aging population services than Stearns but still did not have a very good idea of the specific services. However, the most popular response to better support the aging population is to keep them engaged in the community or to make them feel supported by regular visits or events that they can attend. Along with this, many said that creating a better community connection through volunteering or other activities would help strengthen families as well as engage the older community. Finally, an overall lifestyle shift and motivational tactics were the most frequent suggestion for engaging people to improve overall health.

CTSA Themes Across Each County: Sherburne

Sherburne County also differed regarding top issues. In this county, substance abuse ranked as first (74%), followed by obesity/nutrition and mental health tied for second (58%). However, as mentioned before, of those who noted mental health as a "top three", 73% also listed it as the top issue. Regarding why people experience good or bad health, home life, including stressors or poor support systems was mentioned most frequently. In addition, offering better food choices at events, schools, restaurants, along with the pricing and access to good foods in the community was one of the more common ways to address obesity. To address distracted driving, many considered increasing the penalty for using phones while driving, including losing your license or even your car. To help parents, stakeholders suggested offering classes on how to interact with children instead of "using electronics as a babysitter." Finally, this county seemed to lack awareness about what aging population services are offered. Many said they had a general idea of what was offered but could not name a specific service. Like the other counties, keeping the aging population connected to the community, informing them about services, and offering more facilities for the ever-rising aging population is what would help this population the most.

CTSA Themes Across Each County: Stearns

Different counties exhibited different responses to specific issues. The top three issues in Stearns County were mental health (65%), access to healthcare and affordability of healthcare (41%), and substance abuse (29%), in that order. In addition, mental health was the majority top issue, as 53% of Stearns stakeholders listed it as top priority. While this county did not differ too much from the whole region, some issues were addressed with more intensity. For example, many stakeholders from this county suggested that a required exercise program for school age kids should be implemented, as this is the age at which children can learn how to live an active lifestyle. When asked how they would address parenting initiatives, this county predominantly suggested educating parents on how to properly feed and take care of their children, including training on sickness warning signs or disability training. This county also had a very vague idea of what services

for the aging population are available in the community, and most mentioned that making sure the aging population has the information they need about what services are being offered for them is of utmost importance.

Unique Perspectives

As most answers received were not surprising, a few unique perspectives were offered up throughout this process. The first was regarding sex trafficking. More recently, public awareness has increased with this issue; yet during the interviews, it appears many were unaware that it exists. However, it is important to note that it is on the radars and should receive attention.

Another unique perspective that parallels a lot of other issues is that social determinants of health, such as socioeconomic status, can lead to a lot of stress. One interview did mention that they would add financial coaching services in each community, as worrying about money can lead to very adverse effects including lack of nutrition, high blood pressure, and lack of motivation. In addition, it was brought up by a few different stakeholders that early childhood is a very key point in a person's life. These stakeholders prioritized making sure children are well equipped and prepared when they enter school. Starting behind classmates from the first day is already discouraging and makes it hard to catch up in the long run. Similarly, making sure all families have access to a good preschool program would help combat this disadvantage. Along with that, mental health concerns can arise early in a child's life, so making sure to extend mental health resources all the way down to school-age children can help prevent issues from arising later and gives children the tools to be able to deal with any issues they have early in life. Finally, as many stakeholders did mention, sometimes it isn't enough to just offer services. It's important to find out what kind of services different populations of people need, and plan events, activities, or other assistance based on that. Including the community in understanding the needs of the population was most often mentioned as the most effective way to achieve impactful, sustainable change.

The interviewer, Kassidy Steen is currently in her junior year of her undergraduate studies at St. Cloud State University. She is majoring in biomedical sciences with a minor in chemistry and hopes to continue her studies toward a Doctor of Dental Surgery degree after receiving a bachelor's degree. She is a member of the women's basketball team at SCSU, an active participant and representative in the Student Athlete Advisory Committee (SAAC), member of the University Ambassadors, Pre-Dental Club Vice President, and a chemistry and biology tutor at the Richard Green House on campus.

The top three issues in order of importance from the stakeholder interviews: (1) mental health (resources, access, and education), (2) transportation, and (3) parental health and wellness. The rest of the top ten list in no certain order: socioeconomic status, access to healthcare, substance abuse, obesity/nutrition, stress, community connectedness, and distracted driving. The top strategies to deal with these issues in no certain order from the stakeholder interviews are: education, awareness, access, collaboration within community partners, and involvement of targeted community populations.

Local Public Health System Assessment

Local Public Health System Assessment (LPHSA)

The Local Public Health System Assessment (LPHSA) measures how well various organizations and entities collaborate to deliver the Essential Public Health Services (please see this website for the list of 10 Essential Public Health Services: https://www.cdc.gov/nceh/ehs/ephli/core_ess.htm). The LPHSA subgroup reviewed the MAPP assessment process for this area and decided to adapt the process to meet the timeline and structure needs. With three (3) independent agencies participating, the subgroup completed a review of each agency's reported annual performance measures from the past 3 years. Data from each agency was obtained and placed into one document so comparisons could be made related to measures met, partially met or cannot meet. This information drove the identification for the SWOT analysis which indicated challenges and opportunities.

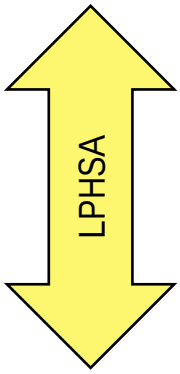
The three county public health agencies did not feel local public health had strong working relationships with some of the other system organizations. The Public Health agencies then started to identify those partners in the community that are part of the local public health system. The group discussed the possibility of organizing facilitated discussions with these partners, however, due to varying levels of local capacity and lack of connection with outside partners they decided against that strategy. The subgroup decided to assess what other organizations knew of LPH's roles and at what level the agencies delivered the essential services through a survey.

Public Health
Prevent. Promote. Protect.

In August of 2017, all LPH agencies participated in a capacity assessment to help determine the extent to which required local public health activities are in place statewide. The self-assessment gave clarity about the variability of the service delivery throughout the state, and insight into each agencies ability to carry out required activities. The subgroup utilized the assessment questions to formulate a survey for three sectors of the local public health system: Emergency Preparedness, Environmental Health, and Healthcare Access/Infectious Disease. The questions asked to the stakeholder can be found in Appendix D and a link to the survey: https://co.stearns.mn.us/Government/CountyDepartments/HumanServices/LocalPublicHealthSystemAssessment

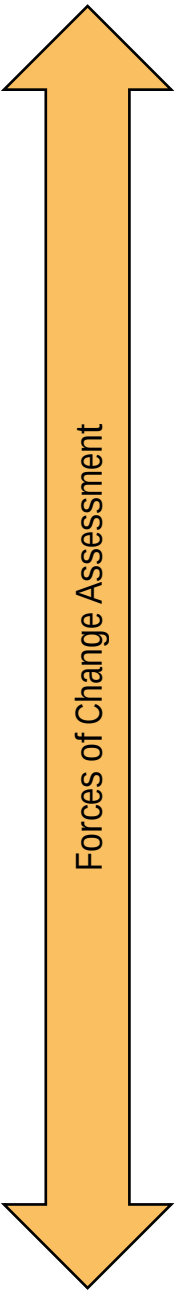
Community partners were invited to participate in the survey via email. The response rate was a bit of a setback, as many partners did not respond. For those that did respond, there was a wide range of response from "low" to "high" level of service delivery, to a number who answered "unsure".

The group reviewed the results and identified challenges and opportunities. The representative from each local public health agency tallied the responses and noted trends for their assigned sector. When each sector was complete the partners looked for common themes and areas of priority. The information was mapped out on a grid in the following categories: Success/maintain efforts, Success/cut back efforts, Challenges/increase activities, and Challenges/increase coordination. The group also reviewed responses to the health equity questions, some issues were noted but overall the responses were minimal. After analyzing the results, the LPHSA subgroup developed a list of their top 10 recommendations from all 3 sectors to support the development of the Community Community Health Improvement Plan. This list was presented to the core support team and the results of this assessment



helped to provide some direction in the prioritization exercises that were used to determine the region's top community priorities.

Since much of this group's work was focused on the public health system, the top priorities will most likely be used by agencies during strategic planning. In summary, ensuring service to underserved or underrepresented populations, local public health should add Environmental health, Emergency management and Healthcare access to strategic plans, focus on environmental health communication, connect with healthcare to discuss LPH role in regards to; cities, consumers, infectious diseases and immunization rates, continued assessment of community health data and education policymakers and stakeholders.



Forces of Change (FoC) Assessment

The Forces of Change (FoC) Assessment identifies forces that may affect a community and opportunities and threats associated with those forces. The FoC team facilitated a conversation on what creates health, forces, trends, factors and events affecting health, and strategies to overcome barriers to healthy living. On August 28, 2018, a Forces of Change community meeting was held at the Sauk Rapids Government Center. The agenda for the meeting included an overview of what a Forces of Change assessment was, instructions of the Forces of Change brainstorming activity (including an example and a definition of how to use a 'health equity lens' when doing the exercise) and time in small group and large group discussion.

A Save the Date flier was distributed via email with options to call or email to RSVP. RSVP's were encouraged, but not required. There were 68 people that attended the meeting representing 27 organizations and two that identified their affiliation as 'community member'. Organizations that were represented included local government (City of St. Joseph, Benton, Sherburne, and Stearns Counties), healthcare (primarily CentraCare), local nonprofits (Central MN Council on Aging, YMCA, and Second Harvest Heartland), education (SCSU, ISD #747), underrepresented communities (Cairo MN, WACOSA and The Center for African Immigrants), the faith community (Parish Nurses), and others.

On the day of the meeting, tables were set up in small group formation. The meeting was three hours in length. Participants were given two prioritizations to complete, one as individuals and one as a table group. The individual exercise asked attendees to list all brainstormed forces, including factors, events, and trends. The group exercise asked tables to then list those categories that were listed on individual brainstorm sheets (grouping together same/similar) and for each category, identify the opportunities and threats (Opp/Threat) for the public health system or community created by each. Table groups then reported out to the large group.

The data for the Forces of Change are based solely off the individual and group exercise sheets that were turned in. On these worksheets, there were a total of 419 Forces of Change items identified that were grouped into 24 categories which opportunities and threats were noted. The Forces of Change items were compiled and assigned codes that related to the different layers of categories. The first layer of categorization was Trend, Event, or Factor. The second layer of categorization was general Forces of Change categories where participants were asked to consider if it was social, economic, political, technological, environmental, scientific, legal, and ethical. The final layer of categorization was the items' connection to community issues. Many of the identified items fell within more than one category within each layer.

Forces of Change Assessment

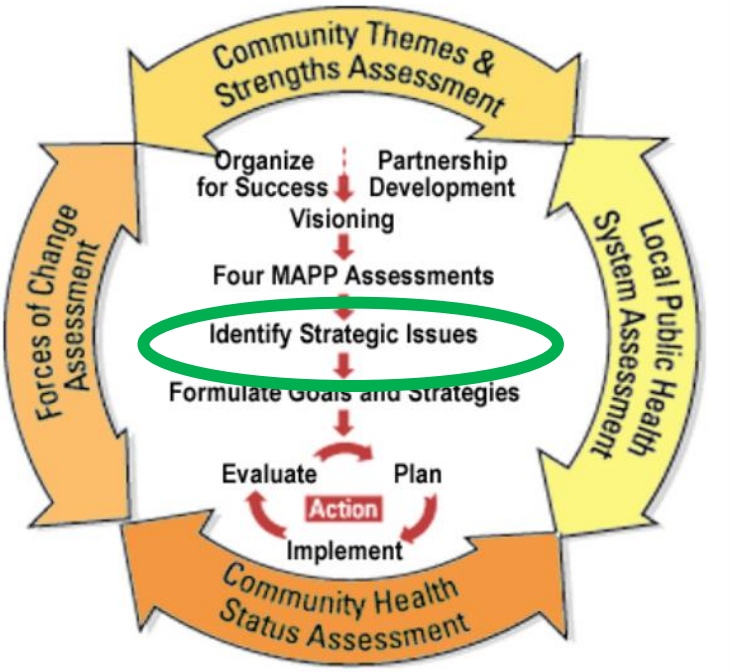
The top community issues that emerged from the Forces of Change meeting, as categorized by extensiveness (how many different people mentioned the same topic) and frequency (the number of times a topic is mentioned) are:

Forces of Change Community Issue Categories	Frequency	Extensiveness	Opp/Threat Discussed
Health Care	78	42	2
Financial Stress	62	35	4
Integration of Immigrants	48	34	6
Infrastructure	40	26	2
Technology	37	29	2
Other	35	26	2
Youth	31	20	1
Mental Health	28	24	1
Poor Nutrition	20	18	2
Aging Population	20	19	1
Affordable Housing	18	18	1

Phase 4: Identify Strategic Issues

The four assessments each resulted in a list of 10 community priorities. Those four lists were shared with the Core Support Team at the end of October. In November, the team was led through a facilitated exercise using the Vision statement to narrow the four lists of ten to a single list of ten.

The top ten list identified by the Core Support Team was discussed at the Delegated Authorities meeting where two prioritization tools were used to identify the final top ten community priorities and the two priorities that will be addressed in the Community Health Improvement Plan.



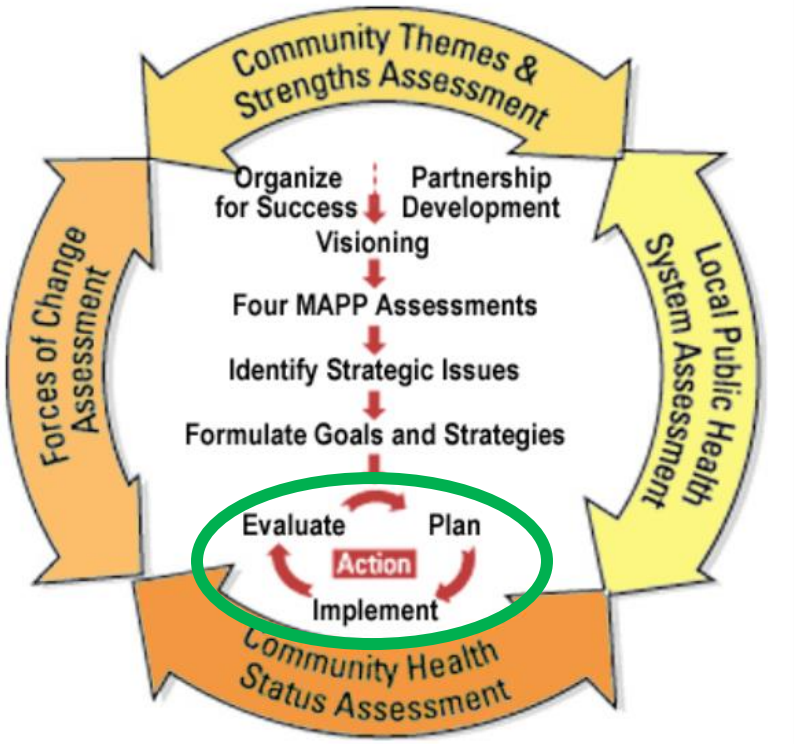
Phase 5: Formulate Goals and Strategies

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 Appendix F for the Community Meeting Action Step Category Themes. The Core Support Team considered the themes and the potential action steps collected at the community meeting and built goal statements and performance measures. Regional, community-wide strategies were developed to address the goals.

Phase 6: Action Cycle

The action cycle for this CHNA will be July 1, 2019 through June 30, 2022.



D. Input from the Broad Community

The four assessment subgroups engaged individuals or organizations with a perspective of at-risk populations. To reach out to a variety of the communities, focus-group meetings were held on three separate occasions at the Great River Library in St. Cloud and community input was gathered at the Benton, Sherburne, and Stearns County fairs. In total, there were 30 Somali adults who discussed positives, negatives, and areas-to-improve-on within the community. At the county fairs, information was gathered from respondents from the 56304-zip code. See Appendix E for themes that were identified through this data collection.

As a follow up to the Forces of Change community meeting in August of 2018, a World Café (see invitation below), was held at the Sauk Rapids Government Center for members of the community to come and talk about their perception of needs in the surrounding communities. There were 94 people that attended the meeting representing 32 organizations and three that identified their affiliation as 'community member'. Organizations that were represented included local government (Cities of Big Lake, St. Cloud, and St. Joseph; Counties of Benton, Sherburne, and Stearns), healthcare (CentraCare, Medica, and UCare), local nonprofits (Catholic Charities, Tri-CAP, United Way of Central MN), education (Rasmussen College), and underrepresented communities (Advocates for Independence, The Bridge World Languages, Foley Area CARE, and WACOSA), as well as others. See Appendix F for themes that were identified through this data collection.

Engagement with the broad community was an area with limitations. It was 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. Process to Rank the Community Priorities

The prioritization process took place in November of 2018. The MAPP process was utilized, and the work of each of the four MAPP Assessment sub-groups resulted in four lists of 10 community priorities. As a reminder, the four assessments include: Community Health Status Assessment, Community Themes and Strengths Assessment, Local Public Health Status Assessment, and Forces of Change Assessment. Those four lists of 10 are included in the narrative earlier in this document.

The Core Support Team was provided those four lists of ten priorities. They took those lists and talked with their agency staff to identify any themes or commonalities amongst the four lists. The Core Support Team then came together in a meeting and went through a facilitated process using the Central MN Alliance Vision as a guide to come up with a top 10 list to send on to the Delegated Authorities.

The Delegated Authorities met and continued the discussion about the priority list. The priorities passed on by the Core Support Team were run through two prioritization exercises. The first was a ranking discussion with points assigned for certain criteria. Ranks included 3 for high, 2 for medium, and 1 for low. The criteria included:

- Urgency: Is this a priority issue that needs to be addressed in the next 1-3 years?
- Potential Impact: Is it likely that addressing this critical issue will have a significant impact on one or more specific populations? Do you have reason to believe you can be successful on this issue?
- Actionable/Feasible: Are there opportunities for action to address the critical issue? Is there room to make meaningful improvement on the issue?
- Resources: Are resources (funds, staff, & expertise) either readily available or likely resources can be obtained to address the critical issue? Are there resources through the state and community members to work on the issue? If not, can resources be acquired?
- Community Readiness: Is this a critical issue identified as important by the community? Are people in the community interested in the issue? Is there community momentum to move this initiative forward?
- Integration: Is there opportunity for collaboration? Is there opportunity to build on existing initiatives? Will this duplicate efforts?

Finally, the priorities were placed on a control/influence grid.

	Control	No Control
Influence	***Areas to address***	***Areas to further assess***
No Influence	***Areas for future development***	***Areas to monitor***

The resulting priorities are listed in the next section. The priority listed third, encouraging social connections, was discussed as being an action step that could be applied to address Building Families and Mental Health. The priority listed as tenth was also discussed as an essential action step that could be used to address the top priorities as well.

F. Community Priorities

Below is the table of priorities in community informed ranking. Due to the newness of the collaboration on this work, a decision was made to focus on the top two priorities for the Community Health Improvement Plan. The priorities three through ten will not specifically be addressed through action planning or measurement, however, there are ways many of these priorities are being addressed either within the top two priorities or the community. In the future, the group will assess the capacity to expand the number of priorities being addressed and measured.

	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

G. Health Equity Assessment

"...health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment."

Center for Disease Control and Prevention
https://www.cdc.gov/chronicdisease/healthequity/index.htm
Accessed September 19, 2019

"Research shows that the conditions needed for health are peace, shelter, education, food, income, and social justice. In short, health is created where people live, work, and play. Minnesota needs to address health disparities as part of a broad spectrum of public investments in housing, transportation, education, economic opportunity and criminal justice."

Minnesota Department of Health
https://www.health.state.mn.us/communities/equity/
Accessed September 19, 2019

The Central MN Alliance gathered community input at community focus-group meetings and the county fairs by the county public health departments. The community priority themes found during these events were public safety, food, health care, schools, technology, navigating systems/forms, economics/job opportunities/childcare access, and differing perceptions of "what is health?"

Findings from the Health Equity Assessment:

Building Families

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 communities 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 seem to struggle with the issues identified in this assessment and other issues like inadequate childcare and insufficient wages. These struggles seem to 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 and further isolates subpopulations from the general population. It is clear there is a distinct divide between different areas of our communities, and structural racism is a large contributor to this divide.

Mental Health

Mental well-being in our communities differs greatly depending on the community within which they reside. There are gaps in understanding of what mental health is, mental health services have a significant wait time, and there is a lack of knowledge about available mental health resources. Again, limited access to health services, diverse providers, 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 communities. 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 were 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. This affects not only the incarcerated individual, but also their families and children. It has been found that the number one Adverse Childhood Experience (ACE) in the greater St. Cloud area is children with an incarcerated parent (2016 Central Minnesota Community Health Survey).

East Side St. Cloud Health Equity Research

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 around 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: Greater St Cloud Community Pillars	The community will create sustainable environments to encourage healthy choices and to support mental and physical well-being.	
Local: United Way of Central MN	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.
Local: Reach-Up Head Start	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: St. Cloud Community Priorities	Support student success through a cradle to career approach for education and workforce development. Enhance recreational amenities and natural resources. Assist those facing poverty.	
Local: Thriving Young Minds-THRIVE	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.	
Local: ARC Midstate	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.	

National, State, Local, or Other Planning Process	Priority: Building Families	Priority: Mental Health
Local: Initiative Foundation	Enhance kindergarten readiness for children (ages 0-5) living in poverty.	Improve the economic status of financially disadvantaged people.
Local: Central MN Council on Aging		Is committed to maintaining the highest level of independence of older people by developing and coordinating community care, reducing isolation, and improving access to services.
Local: Anna Marie's Alliance	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.	
Other: YMCA	Youth Development: Nurturing the potential of every child and teen.	Healthy Living: Improving the nation's health and well-being in communities across the nation.
Other: Robert Wood Johnson Foundation Commission to Build a Healthier America	Invest in early childhood for a lifetime of good health.	
State: Healthy MN 2022	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: Early Childhood Family Education (ECFE)	Provides quality learning opportunities and resources for parents and children from birth to kindergarten entry. Class includes time to discuss parenting concerns with other families.	
National: National Prevention Strategy, Healthy People 2020	Mental & Emotional Well-Being Tobacco-free living Prevent drug and alcohol abuse Injury & violence-free living Healthy eating/nutrition Active Living Reproductive and sexual health	

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
- Bark Park Program
- Block parties
- Career center gathering with the community
- Car Seat Training
- CentraCare Hospital Breast Milk Depot
- Central MN ACE'S Collaborative
- Central MN Mental Health Center
- 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
- 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
- Financial Assistance programs
- 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 Grow Program
- 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 accessibility to undocumented families
- Library - book clubs, events
- Madison/North Elementary/Discovery schools - Feeding area children together
- Meals on wheels
- Mental Health Programs - county
- Mental Health Providers offering Circle of Security, a relationship based early intervention program for parents and children
- Minnesota Fatherhood and Family Services Summit
- Mom groups
- Neighborhood organizations - promise neighborhood
- Nurse-Family Partnership
- 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
- Re-location Services (*County & Lutheran Social Services*)
- Resource navigators
- 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 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
- Whitney Center
- Workforce Center

Existing Community Resources for Mental Health

- 4 county crisis response line
- 40 Developmental Assets
- ACT (*Assertive Community Treatment*), and IRTS (*Intensive Residential Treatment Services*) through the Central Minnesota 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]
- 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
- 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 Health section
- Report and Recommendations 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
- Telehealth
- Terabinth Refuge
- United Way 2-1-1
- United Way Success by Six
- Video Conferencing for schools
- Well-Connect
- WIC
- 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, refer to Part 2: Community Health Improvement Plan)*

J. Evaluation of actions conducted since the previous CHNA process

Benton

In February 2013, Benton County worked in collaboration with other partners to conduct a local behavior and perception survey of the residents of Benton County-The Central Minnesota Community Health Survey. Along with survey information, data from the Minnesota Department of Health and other credible sources were gathered and reviewed. The quantitative data helped lead conversations about qualitative data or trying to "tell the story behind the data". Public Health staff then determined the "Ten Most Important Community Health Issues in Benton County" using prioritization exercises. In 2014, Benton County Public health, community partners and members engaged in a discussion and after reviewing the completed 2013 community health survey, community health assessment data and Top 10 Priorities. From these discussions, our top 3 priorities emerged: Mental Wellbeing, Substance Use Prevention and Family Health (parenting concerns).

Public Health staff developed a set of goals, objectives, possible strategies and measures to describe what can happen to improve the health around the priorities identified. This work included assessing the current situation, identifying assets and resources and searching for evidence-based strategies that address the issues identified. Staff drafted goals, objectives and potential strategies to be shared with the larger work group made up of community partners and stakeholders. The Community Health Improvement Plan (CHIP) had a strong focus on Public Health-lead strategies. The draft was shared with the larger group for feedback and discussion related to the assets, resources, potential partners as well as the objectives and strategies. The CHIP is a local public health requirement and it was largely written by and for local public health staff. Since that initial plan, work has been done to make it a "community plan". In the last 2 years we have worked diligently to include and engage the community in the plan and revisions have been made accordingly.

For Mental Wellbeing, three measures were chosen to help evaluate the progress made. We see improvement with fewer people saying they delayed seeking help from a health professional for emotional problems. There has been strategic work in anti-stigma messaging as well as mental wellbeing promotion. This has occurred in a variety of areas; social media campaigns, community advertising, monthly network meetings, resiliency trainings, ACEs documentary to name a few. The other two measures were around opinions about how large the problem is around mental illness and youth seriously considering committing suicide. Both measures did not show improvement between 2013 and 2016. For Substance Use Prevention, three measures were chosen to help evaluate the progress made. Smoking rates have decreased from 2013 to 2016 and new goal levels were made in 2018. We do know that our local school districts have had increases in the student e-cig use rate based on disciplinary reports. We are monitoring the MSS results for usage for both e-cigs and chewing tobacco. Partnership with schools around education for students and parents has been implemented in the districts and we continue to work towards a tobacco retails ordinance change for 2019. For Family Health, two measures were chosen to help evaluate the progress made. We have focused more referrals to our partners in Early Head Start as Benton continues to not have an evidenced-based model within public health. EHS is showing improvement in reaching developmental goals in 5 domains. The other measure is the county's children in out of home placement. That number has continued to increase since 2013. We continue to advocate for more preventative work to support families to be successful.

Sherburne

The Sherburne County Health and Human Services (SCHHS) Community Health Improvement Plan (CHIP) was developed using data collected from the 2013 Central Region Community Health Survey (which included health status, health behavior, and perception of health data obtained from community members), along with information from the Minnesota Department of Health and other credible sources. After quantitative and qualitative data was collected, Public Health staff determined the "Ten Most Important Community Health Issues in Sherburne County" which was presented, as well as a summary of the Community Health Assessment, during three town hall meetings throughout the County. Participants at the meetings (which included stakeholders and community members) were asked to rank the ten community health issues in order of importance to both gather public feedback and to narrow the scope of work for staff over the next five years. The top three priority areas that emerged from this process were: ***Community Mental Health, Overweight/Obesity, and Substance Use and Abuse*.** Public Health staff worked with the partners to identify potential strategies that would address each priority area. Staff then identified goals, objectives, strategies and action steps for each priority area. CHIP action plans were designed to serve as a starting point to guide collective action. These action plans were routinely monitored, evaluated, and revised as the CHIP process evolved.

Since 2017, Sherburne County has worked hard to increase our engagement with stakeholders. The CHIP was a local public health requirement, and as such, it was largely written by and for local public health staff. Midway through the cycle, SCHHS put great energy to streamline efforts with existing partners that helped coordinate large-scale efforts, ensuring the work is in alignment with existing community projects and coalitions. Before these revisions were made, our CHIP included strategies that were fairly lofty, far exceeding our capacity, or that were simply outside our scope/power to implement. Staff feel confident that revisions have created a CHIP that is more representative of community efforts and less on the initiatives that are occurring internally with our public health department.

In these efforts to increase our coordination with the community on priority areas, Public Health staff engaged with three groups who were already doing the work on established coalitions and collaboratives in priority areas. In our Overweight/Obesity area, Public Health uses SHIP strategies as our work plan in that category, ensuring that we are engaged with the various community groups and sectors represented on our Community Leadership Team (CLT). In the Community Mental Health priority, Public Health staff took an active role on the BRIDGES Children's Mental Health Collaborative. Represented on that group are schools, providers, mental health social workers, parents, and advocates. In the Substance Use and Abuse area, Public Health coordinated efforts and strategies with our Sherburne County Substance Use Prevention (SUP) Coalition. This coalition has representatives from twelve different sectors from the community to include: law enforcement, local government, youth-serving agencies, faith community, schools, youth, parents, businesses, civic, and health care. Our CHIP reflects revised objectives and strategies that represent what each of these groups are working on collectively in their respective areas. Goal areas included on our CHIP are measurements that are being tracked by each of these community coalitions.

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.

For the most current annual report around the 2015-2019 CHIP, please see Appendix G.

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, 2016, 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.

2016 Action Plan Goals	Hospital/Region	Actions Conducted since 2016
Goal: Decrease stroke deaths	St. Cloud Hospital	• SCH Stroke Center received the Get with the Guidelines- Stroke Silver Quality Achievement Award • Tele-stroke Program implemented • CentraCare website expanded to include stroke signs and risk factors • Stroke and blood vessel screening services expanded to new locations
	Melrose	• Tele-Stroke Program implemented • Designated as a Stroke-Ready-Hospital by MN Dept. of Health 4/2017
	Sauk Centre	• Added the Tele-stroke services for follow up care with stroke patients. • Have had 17 patients that have qualified for the post stroke visit, and 65% completed their post-stroke follow up via telehealth.
Goal: Decrease deaths resulting from Coronary Heart Disease	St. Cloud Hospital	• Mission: Lifeline STEMI transfer program implemented • SCH received AHA recognition at Silver Level
	Sauk Centre	• Sauk Centre refers patients with heart specific issues to the Cardiac Rehab program; over 100% of the patients had an increase in their overall Quality of Life Scores upon completion of the program.
Goal: Increase Awareness of Cancer risk factors and need for early intervention	St. Cloud Hospital	• Colorectal Cancer Risk Assessment Tool added to CentraNet along with other links with info about causes and prevention
	Sauk Centre	• Colorectal Cancer Screening began 6/2017; goal was 71.6%, now at 74.4% • Updated Infusion Center and expanded to 5 days per week • Added Tele-Oncology • Planning to update software to have 3D mammography

2016 Action Plan Goals	Hospital/Region	Actions Conducted since 2016
Goal: Decrease disease burden of Diabetes and improve well-being of those living with Diabetes	St. Cloud Hospital	• Education, screening, and decision-making tools surrounding Diabetes added to Centracare website
	Melrose	• Hired new staff through Accountable Communities for Health Grant to address Diabetes in Hispanic Population • Partnered with Catholic Charities to offer 6-week classes certified by the American Diabetes Association on Diabetes Self-Management • Continued partnership with Project H.E.A.L.
	Paynesville	• ICAN program established for diabetes support/education • The BASICS education program from International Diabetes Center was implemented by campus Dietician • Quarterly community-wide pre-diabetes education imployed 9/2016 • Annual Lunch and Learn education has included topics such as Diabetes on a Budget and Optimizing Medication/Treatment Goals
	Sauk Centre	• Diabetes Center now comes to Sauk Centre twice a month • Staff participated in 2-day training session with the IDC to provide improved care for our diabetic patients as well as a 90-day action plan to improve A1C in diabetic population
Goal: Decrease preventable hospital admissions for older adults	St. Cloud Hospital	• Community Paramedic Program expanded to additional regional sites
	Melrose	• Offered fall education at Melrose Spring Expo 4/2017 • Held an 'Aging Safely at Home' educational/community event 5/2018 • Started a Heart Failure Support Group 11/2017
	Paynesville	• CCH-P has participated in the Paynesville and Cold Spring Community EXPOs promoting healthy lifestyles
	Sauk Centre	• Utilized 'Health Care Home' to create a partnership between patient, family, provider, care coordinator, etc.
Goal: Increase Mental Health Care Access	St. Cloud Hospital	• Expanded Integrated Behavioral Health access to additional primary care clinics throughout the region • Expanded Adverse Childhood Events (ACEs) awareness resources in Trauma Informed Care
	Sauk Centre	• Sauk Centre clinic implemented SBIRT for patients with addictions to drugs and alcohol. This allows for screening and early intervention • Implemented Integrated Behavioral Health 3 days a week in Hospital Specialty Services effective 5/2017 • Implemented Tele-Behavioral health in the Emergency Room
	Melrose	• Met with Superintendent of Melrose Area School District to support and help pass referendum to build a more accessible footprint for exercise, including a new community Center • Collaborated with BLEND (now Feeling Good MN) and Chamber of Commerce to start local farmer's market in Melrose
	Paynesville	• Fare for All began providing food packs to the community 12/2016 • The CCH-P Farmer's Market completed its third year in 2018 • Two additional courses surrounding weight-related topics were added to CCH-P Lunch & Learn program in 2018-19 through Lifestyle Health • CCH Weight Management program extended to Paynesville 11/2017 • Campus Dietician has expanded services to Medicare and other insurance members for 1-to-1 weight management support
	Sauk Centre	• Yearly education on the NuVal food grading system at Coborn's takes place yearly at health fair

2016 Action Plan Goals	Hospital/Region	Actions Conducted since 2016
Goal: Decrease percentage of adults who report smoking	St. Cloud Hospital	• Implemented a tobacco treatment program allowing for both internal and external referrals • Now has 14 Tobacco Treatment Specialists that are available to see patients within an average of 4 miles of all primary care clinics • Feeling Good MN was created in 2/2018 from "Crave the Change" to decrease youth tobacco use rates and exposure to secondhand smoke • Supported 32 local policies raising age to purchase tobacco to 21 • Represents CentraCare on Sherburne Counties Federally Funded Drug-Free Communities Grant, exclusively working on the prevention of youth electronic cigarette use. • Annually participates in the legislative session; lobbying elected officials for tobacco prevention and control efforts.
	Paynesville	• Two Paynesville providers have been certified in tobacco cessation
	Sauk Centre	• Effective 7/2017 Tobacco Treatment appointments offered in Sauk Centre
Goal: Increase percentage of adults who report regular physical activity	St. Cloud Hospital	• CentraCare Wellness Website created to provide education, awareness, and resource directory centered around wellness
	Melrose	• Promote and encourage Melrose Riverfest 1K/5K Run & Walk; have had increased participation each year since 2017
	Paynesville	• CCH-P Co-sponsored 5K/10K runs annually in Coldspring, Richmond and Paynesville • Lunch and Learn opportunities have focused on health lifestyles including topics such as The Benefits of Mobility/Exercise. • CCH-P employee survey was completed, and results were shared with Paynesville Community Education to assist in identifying community opportunities to increase physical activity
	Sauk Centre	• Offers Silver Sneakers classes on site 3 days per week • Collaborates with Sauk Centre Chamber of Commerce to host an annual "Walk Your Sauks Off" fun walk; worked with Chamber to have 5K race during Sinclair Lewis Days 2017 • Working to bring BLEND program into schools • Created 'Women's Night Out' to promote community wellness

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.

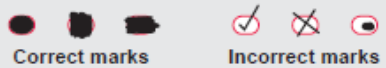
CentraCare's health condition focus areas in 2019 include the following: diabetes, asthma, hypertension, depression, cardiovascular care (including preventive care and management of Congestive Heart Failure), and preventive care and health screenings (colorectal cancer screening, breast cancer screening, 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: Community Health Status Assessment (CHSA) Survey Questions

CENTRAL MINNESOTA COMMUNITY HEALTH SURVEY

SURVEY INSTRUCTIONS



- 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.

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

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. Other mental health issues	○	○	
i. Cancer	○	○	
j. Heart trouble or angina	○	○	
k. Stroke or stroke-related health issues	○	○	
l. High cholesterol or triglycerides	○	○	
m. Overweight	○	○	
n. Obese	○	○	
o. Chronic lung disease (including COPD, chronic bronchitis or emphysema)	○	○	
p. Asthma	○	○	
q. Arthritis	○	○	
r. Sexually transmitted diseases/infections (Chlamydia, HIV, etc.)	○	○	

3. 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 5 years ○ Never
○ Within the past 2 years ○ 5 or more years ago

4. 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 6**

5. 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 did not think it was serious enough
○ I had transportation problems
○ Other reason _____

1

6. 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 8**

7. 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 was too nervous or afraid
- ○ I could not get an appointment
- ○ I did not think it was serious enough
- ○ I had transportation problems
- ○ Other reason_____

8. 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 10**

9. 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 was too nervous or afraid
- ○ I could not get an appointment
- ○ I did not think it was serious enough
- ○ I had transportation problems
- ○ I did not know where to go
- ○ Other reason_____

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

Write the number in the boxes, then fill in the appropriate circle beneath each box. ▶

11. How would you rate your overall level of stress?

- ○ High
- ○ Medium
- ○ Low

12. How well would you say you are able to cope with your stress?

- ○ Very well
- ○ Fairly well
- ○ Not very well
- ○ Not at all

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

- ○ I had no medications prescribed for me (GO TO QUESTION 15)
- ○ I had medications prescribed for me and I filled them all (GO TO QUESTION 15)
- ○ I had medications prescribed for me and I did not fill at least one of them

14. 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 _____

15. 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	○	○
e. Medicaid, Medical Assistance (MA), or Prepaid Medical Assistance Program (PMAP)	○	○
f. Minnesota Comprehensive Health Association (MCHA)	○	○
g. MinnesotaCare	○	○
h. CHAMPUS, TRICARE, or Veterans' benefits	○	○
i. Other health insurance or coverage *(please specify)*: _____	○	○

16. 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?

Servings

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

Servings

18. 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?

Write the number in the boxes, then fill in the appropriate circle beneath each box. ▶

Servings

19. During the past 12 months, have you used a community food shelf 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 one time per month	About one time per month	About two or three times per month	About one time per week	Two or more times per week
a. Supermarket or large grocery store	○	○	○	○	○
b. Small grocery store	○	○	○	○	○
c. Convenience store or gas station	○	○	○	○	○
d. Food shelf or food pantry	○	○	○	○	○
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

22. **During the past 30 days, other than your regular job, did you participate in any physical activity or exercise 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 you in terms of preventing you from being more physically active?	Not a problem	A small problem	A big problem
a. Lack of time	○	○	○
b. Lack of programs or facilities	○	○	○
c. No one to exercise with	○	○	○
d. The cost of fitness programs, gym memberships, or admission fees	○	○	○
e. Public facilities (schools, sports fields, etc.) are not open or available at the times I want to use them	○	○	○
f. I have a long-term illness, injury, or disability	○	○	○
g. Fear of injury	○	○	○
h. Distance I have to travel to a fitness or community center, parks or walking trails	○	○	○
i. No safe place to be physically active	○	○	○
j. Lack of self-discipline or willpower	○	○	○
k. Lack of energy	○	○	○
l. Not having sidewalks or walking paths/trails	○	○	○
m. Poor maintenance of sidewalks or walking paths/trails	○	○	○
n. Other reasons *(please specify)* _____	○	○	○

26. **How often do you wear a seat belt when you drive or ride in a car or other vehicle?**

○ Always ○ Often ○ Sometimes ○ Never

27. **Do you ever drive a car or other vehicle?**

○ Yes ○ No → **IF NO, GO TO QUESTION 29**

28. When DRIVING a car or other vehicle, how often do you...	Often	Sometimes	Never	Not applicable: I don't have a cell phone
a. Read or send text messages or emails?	○	○	○	○
b. Make or answer a phone call?	○	○	○	○
c. Use a phone for other activities, such as getting directions or checking Facebook or other social media?	○	○	○	○
d. Do other activities such as eat, apply makeup, or shave?	○	○	○	

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

○ Always ○ Often ○ Sometimes ○ Never

30. **Are you in a relationship where you are (or have ever been) physically hurt, threatened, or made to feel afraid?**

○ Yes ○ No

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

○ Yes ○ No ▶ IF NO, GO TO QUESTION 34

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

○ Every day
○ Some days
○ Not at all ▶ GO TO QUESTION 34

33. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit?

○ Yes ○ No

34. Do you live with someone who smokes?

○ Yes ○ No

35. 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	○	○	○
e. A hookah water pipe	○	○	○
f. Any other type of tobacco product	○	○	○

36. During the past 7 days, how many days did anyone (including yourself) smoke cigarettes, cigars, or pipes anywhere inside your home?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ Days

37. During the past 7 days, have you been in a car with someone (other than yourself) who was smoking?

○ Yes ○ No

38. During the past 30 days, have you had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?

○ Yes ○ No ▶ IF NO, GO TO QUESTION 43

39. During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage? → Days

⓪⓪ ①① ②② ③③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

40. During the past 30 days, on the days when you drank, about how many drinks did you drink on average? A drink is one can of beer, one glass of wine, or a drink with one shot of liquor.

○ 1 drink
○ 2 drinks
○ 3 drinks
○ 4 drinks
○ 5 drinks
○ 6 drinks
○ 7 drinks
○ 8 drinks
○ 9 drinks
○ 10 drinks or more

41. Considering all types of alcoholic beverages, how many times during the past 30 days did you have...?

FOR FEMALES: 4 or more drinks on an occasion — Times

⓪⓪ ①① ②② ③③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

FOR MALES: 5 or more drinks on an occasion — Times

⓪⓪ ①① ②② ③③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

42. During the past 30 days, how many times have you driven when you've had perhaps too much to drink? → Days

⓪⓪ ①① ②② ③③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

43. COMMUNITY CONCERNS *In your opinion, how much of a problem is each of these issues in your county?*

A. SOCIAL CONDITIONS	No problem	Minor problem	Moderate problem	Serious problem	No opinion
1. Crime	○	○	○	○	○
2. Unemployment	○	○	○	○	○
3. Children in poverty	○	○	○	○	○
4. Families experiencing financial stress	○	○	○	○	○
5. Youth not graduating high school	○	○	○	○	○
6. Distracted driving	○	○	○	○	○

B. PREGNANCY, BIRTH, AND CHILD DEVELOPMENT	No problem	Minor problem	Moderate problem	Serious problem	No opinion
1. Parents with inadequate or poor parenting skills	○	○	○	○	○
2. Teen pregnancy	○	○	○	○	○
3. Unplanned pregnancy	○	○	○	○	○

C. ALCOHOL, TOBACCO, AND OTHER DRUG USE	No problem	Minor problem	Moderate problem	Serious problem	No opinion
1. Smoking or other tobacco use	○	○	○	○	○
2. Abuse of prescription drugs	○	○	○	○	○
3. Alcohol abuse among those aged 21 or over	○	○	○	○	○
4. Alcohol use among those under 21	○	○	○	○	○
5. Adults allowing or tolerating youth alcohol use	○	○	○	○	○
6. Drinking and driving	○	○	○	○	○
7. Illegal drug use among youth	○	○	○	○	○
8. Illegal drug use among adults	○	○	○	○	○

D. CHRONIC DISEASE AND HEALTH HABITS	No problem	Minor problem	Moderate problem	Serious problem	No opinion
1. Obesity among adults	○	○	○	○	○
2. Obesity among children	○	○	○	○	○
3. Lack of physical exercise	○	○	○	○	○
4. Unhealthy eating habits	○	○	○	○	○
5. Lack of access to healthy food	○	○	○	○	○

E. MENTAL HEALTH	No problem	Minor problem	Moderate problem	Serious problem	No opinion
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	○	○	○	○	○

F. INJURY & VIOLENCE	No problem	Minor problem	Moderate problem	Serious problem	No opinion
1. Abuse and neglect of children	○	○	○	○	○
2. Abuse and neglect of vulnerable adults	○	○	○	○	○

44. Looking back before you were 18 years of age:

	Yes	No
a. Did you live with anyone who was depressed, mentally ill, or suicidal?	○	○
b. Did you live with anyone who was a problem drinker or alcoholic?	○	○
c. Did you live with anyone who used illegal street drugs or who abused prescription medications?	○	○
d. Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?	○	○
e. Were your parents separated or divorced?	○	○
f. Did you often or very often feel that no one in your family loved you or thought you were important or special, or that your family members didn't feel close to or look out for each other?	○	○
g. Did you often or very often feel that you didn't have enough to eat, had to wear dirty clothes, had no one to take you to the doctor if you needed it, or had no one to protect you or take care of you?	○	○

45. Looking back before you were 18 years of age:

	Never	Once	More than once
a. How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up?	○	○	○
b. How often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? Do not include spanking.	○	○	○
c. How often did a parent or adult in your home ever swear at you, insult you, or put you down?	○	○	○
d. How often did anyone at least 5 years older than you or an adult, ever touch you sexually?	○	○	○
e. How often did anyone at least 5 years older than you or an adult, try to make you touch them sexually?	○	○	○
f. How often did anyone at least 5 years older than you or an adult, force you to have sex?	○	○	○

46. There are many things that people might do to prepare for a serious emergency. Have you or anyone else in your household...

	Yes	No
a. Made a family emergency plan?	○	○
b. Stored enough medications to meet your household needs for at least three days?	○	○
c. Stored enough food, water, and supplies to meet your household needs for at least three days?	○	○
d. Obtained a working battery-operated or hand-cranked radio?	○	○
e. Assembled an emergency kit with basic medical supplies?	○	○

ABOUT YOU

47. Are you:

○ Male ○ Female ○ Other

48. Your age group:

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

49. How many adults (Including yourself) and children live in your household?

Number of Adults:
① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫ or more

Number of Children:
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫ or more

50. Do you think of yourself as...? *(Mark ALL that apply)*

○ Heterosexual or straight ○ Gay, lesbian, or homosexual ○ Bisexual ○ Transgender

51. **Do you own or rent your home?**
- ○ Own
- ○ Rent
- ○ Other arrangement

52. **How often in the past 12 months would you say you were worried or stressed about having enough money to pay your rent or mortgage?**
- ○ Always
- ○ Often
- ○ Sometimes
- ○ Rarely
- ○ Never

53. **How tall are you without shoes?**

Feet: 0 1 2 3 4 5 6 7

Inches: 0 1 2 3 4 5 6 7 8 9 10 11

54. **Approximately how much do you weigh without shoes?**

Pounds: 0 0 0 / 1 1 1 / 2 2 2 / 3 3 3 / 4 4 4 / 5 5 5 / 6 6 6 / 7 7 7 / 8 8 8 / 9 9 9

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

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

56. **Which of the following best describes you?** *(Mark ALL that apply)*
- ○ American Indian or Alaska Native
- ○ Asian or Pacific Islander
- ○ Black or African American
- ○ African Native
- ○ White
- ○ Other: _____

57. **Which of the following best describes your current relationship status?**
- ○ Married
- ○ Living with a partner
- ○ Divorced
- ○ Separated
- ○ Widowed
- ○ Never married

58. **Have you ever served on active duty in the United States Armed Forces, either in the regular military or in a National Guard or military reserve unit?**
- ○ Yes
- ○ No

59. **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

60. **What was your household's total income from all earners and all sources in 2015?**
- ○ $23,500 or less
- ○ $23,501 - $32,000
- ○ $32,001 - $40,000
- ○ $40,001 - $48,500
- ○ $48,001 - $57,000
- ○ $57,001 - $65,000
- ○ $65,001 - $73,500
- ○ $73,501 - $82,000
- ○ $82,001 - $100,000
- ○ More than $100,000

61. **Are you currently...** *(Mark ALL that apply)*
- ○ Employed ▶ **GO TO QUESTION 62**
- ○ Self-employed ▶ **GO TO QUESTION 62**
- ○ Unemployed or out of work
- ○ A homemaker or stay-at-home parent
- ○ A student
- ○ Retired
- ○ Unable to work because of a disability

62. **During an average week while you are working, 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 1 2 3 4 5 6 7 **Days**

Thank you!

Appendix B: Community Health Status Assessment (CHSA) Sub-group Report: Key Data Findings

2018 Central MN Alliance, Community Health Status Assessment (CHSA) Sub-group Report

Top Data Concerns and Supporting Data Points

Below are the data statements that support the top community health concerns. At the end of each statement are the initials of the partner that pulled the data, this allows us to trace back the data easily if there are any questions. All data points are summarized along with important tables and graphs in excel spreadsheets with links to original data also referred to as "data workbooks" with each member having his or her own Excel file. The initials indicate which Excel file the information is stored.

The CHSA Sub-group is composed of members from Benton, Sherburne, and Stearns Counties along with CentraCare. In order to find these data points and top concerns we split up topics by expertise, interest, and system access. Dividing the work allowed more time to dig deeper into the MDH Indicator list, the Community Health Survey data, and SUMN.org and find correlations between data we otherwise wouldn't have found. The team members compiled their findings into an Excel "work book" format, which allowed us to see original data, the main points that were of interest, and an easy way to trace where the original information is stored. The team then categorized each page of the Excel "data workbooks" and categorized them into a main topic or concern. Once all data points were categorized, the team did a prioritization exercise to generate a list of the top data concerns with the highest priority being concern #1 and the least priority being on concern #11. The results along with the accompanying data points are listed below.

Multiple data sources were used during the research of the data below and were not included for each data point in this document.

9/28/2018

1. Child Wellbeing/Parenting Skills
    - 29% of Benton County children (under 18) are living in single-parent households. JDI
    - Every 9.6 children out of 1,000 in the 3 county region are in out of home placements. JDI
    - Child maltreatment rate is 22.8 per 1,000 people for 3 county region. State rate is 30.9 per 1,000. There were 1,856 cases of maltreatment and 1,592 unique children, meaning there is usually more than 1 maltreatment per child. JDI
    - Birth rates in the African American community are rising throughout the state and throughout the 3 county region. Percentage of African American births in Stearns have gone from 9% in 2012 to 20% in 2016. MZ
    - % of mothers who smoke in Benton County is double the state average. MZ
    - 1 of 4 female 9th graders have ever considered suicide. Females are 3 times more likely to have considered suicide in the past year. PJS
    - Low-income residents are much more likely to have higher ACE scores. Only 25% of the low income population have a "0" ACE score. We would expect graduate degree level of education to have lower ACE scores, in Benton county Graduate degree education level has a higher probability than any other education level to have high ACE scores. SJH

- Marijuana usage for 9th graders is increasing drastically in Sherburne (8.4% to 10.8%) and Benton (4.8% to 7.7%) counties. JDI

2. Illegal Drug Use
    - Marijuana usage for 9th graders is increasing drastically in Sherburne (8.4% to 10.8%) and Benton (4.8% to 7.7%) counties. JDI
    - 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. JDI
    - Drug overdose rates broken down by race shows disparities and extreme growth in some areas. White (6.8 per 100,000 to 11.7 per 100,000) American Indian (29.0 per 100,000 to 64.6 per 100,000). JDI

3. Tobacco/Nicotine Use
    - Benton COPD rates are much higher than Sherburne, Stearns, and state rates. State rate is 13.5 per 10,000, Benton rate is 24.5. SKH
    - Smoking rates below poverty level, in Benton 20% smoke, Sherburne 35% as compared to the overall 14% of smokers. SKH
    - High smoking rates in low education levels, <=HS 28% in Benton, 29% in Sherburne. SKH
    - Attempts to quit smoking in Sherburne low. SKH
    - Income level seems to play a role in whether someone is likely to attempt to quit. People who are living below 200% poverty level has a much lower rate of quit attempts. Benton did not follow this model. SKH
    - Women have a much higher likelihood of living with someone who smokes. Lower income in Sherburne County have the highest percentage of those who live with people who smoke. SKH
    - Gender impact on tobacco use. Benton: males = higher Sherburne and Stearns: females = higher. Overall 25% of males are smokers. SKH
    - Benton county smoking among low income males. (60%) Benton county ages 18-34 was 26% as compared to Sherburne, 5% and Stearns, 9%. SKH
    - Chewing tobacco rates much higher in males. SKH
    - Low income males have highest rates of e-cigarette use. Also some correlation between low education and e-cigarette use. SKH
    - Sherburne county low income population 31% of residents said someone smoked in their home. Compared to Benton's 8% and Stearns, 5%. SKH
    - Smoking while in the car occurs at much higher rates for the low-income population. (17% vs. 8% for 3 county region). SKH
    - Percent of mothers who smoke in Benton County is double the state average. MZ

4. Mental Health
    - Suicide is the 7th highest cause of death in the 3 county region and the 4th highest in premature deaths. JDI
    - 10% of residents did not get Mental Health care or delayed getting it. 15% for females, 19% of people below the poverty line. JDI
    - 1 of 4 female 9th graders have ever considered suicide. Females are 3 times more likely to have considered suicide in the past year. PJS
    - 40% of the population does not get any vigorous physical activity. 50% of Benton females and low income Stearns county residents have had 0 days of vigorous physical activity in an average week. SJH
    - Low income residents are much more likely to have higher ACE scores. Only 25% of the low income population have a "0" ACE score. We would expect graduate degree level of education to have lower ACE scores, in Benton county Graduate degree education level has a higher probability than any other education level to have high ACE scores. SJH
    - 30% of Benton County Residents have been told that they have a mental health condition. DLB

5. ACE's – Adverse Childhood Experiences (Leading to Chronic Disease)
    - Male cancer rates are decreasing over time although female cancer rates have remained constant and in some cases increasing. SJH
    - Minnesota Heart attack hospitalization rates are decreasing although 3 county region has remained constant or even increased. SJH
    - Low income residents are much more likely to have higher ACE scores. Only 25% of the low income population have a "0" ACE score. We would expect graduate degree level of education to have lower ACE scores, in Benton county Graduate degree education level has a higher probability than any other education level to have high ACE scores. SJH

6. Financial Stress/Strain
    - 23% of residents did not seek medical care or delayed getting medical care. Roughly 1 out of 4 people. Top reasons for delaying are not serious enough and high cost. JDI
    - 26% of residents did not get dental care or delayed getting dental care, more than 1 out of 4 people. Primary reason is high cost. JDI
    - 25% of Stearns residents are on Medicare. JDI
    - Benton and Stearns poverty levels 5-7% higher than state avg. KJZ
    - 1 of 3 adults in the 3-county region were worried or stressed about money to pay their rent or mortgage. PJS
    - Women are more concerned about running out of food than men. We would expect higher education level to correlate with less concern for running out of food, for the 3-county region trade school education level does not follow this assumption. SJH
    - 46% of people have been worried about paying rent. In the 3-county region we see trade/voc. degree and bachelor's degree education sections to be below the high school or less education section. The Bachelor's degree education column for Benton County is considerably lower than high school and trade/voc. sections. SJH

- Low-income residents are much more likely to have higher ACE scores. Only 25% of the low-income population have a "0" ACE score. We would expect graduate degree level of education to have lower ACE scores, in Benton county Graduate degree education level has a higher probability than any other education level to have high ACE scores. SJH

7. Preventive Health Care
    - Male cancer rates are decreasing over time although female cancer rates have remained constant and, in some cases, increasing. SJH
    - Minnesota Heart attack hospitalization rates are decreasing although 3-county region has remained constant or even increased. SJH
    - Stearns Tuberculosis cases highest number of cases in past 15 years. DLB
    - Small number of dentists in Benton and Sherburne, 3 providers per 10,000 people. Stearns has 5 providers per 10,000 people. DLB
    - 33% of residents in the 3-county region have been told by a doctor that they have High Blood Pressure. DLB
    - 35% of residents in the 3-county region have high cholesterol or triglycerides. DLB
    - 22% of Benton County residents in the past year thought there was a time when they thought they needed medical care but didn't get/delayed getting it. 32% of residents in the 3-county region delayed getting med care or didn't get medical care because of cost and 36% didn't get it or delayed getting it because of high deductible. DLB

8. Nutrition
    - All top causes of premature deaths except unintentional injury and pneumonia are linked to lifestyle choices (eating, activity, tobacco, alcohol). JDI
    - Male cancer rates are decreasing over time although female cancer rates have remained constant and, in some cases, increasing. SJH
    - Minnesota Heart attack hospitalization rates are decreasing although 3-county region has remained constant or even increased. SJH
    - 40% of the population does not get any vigorous physical activity. 50% of Benton females and low-income Stearns county residents have had 0 days of vigorous physical activity in an average week. SJH
    - 38% of residents in the 3-county region are overweight. DLB

9. Alcohol Use
    - Stearns DWI rates are high as compared to Sherburne, Benton, and the State rates. DLB

10. Physical Activity
    - All top causes of premature deaths except unintentional injury and pneumonia are linked to lifestyle choices (eating, activity, tobacco, alcohol). JDI
    - Male cancer rates are decreasing over time although female cancer rates have remained constant and, in some cases, increasing. SJH
    - Minnesota Heart attack hospitalization rates are decreasing although 3 county region has remained constant or even increased. SJH

- 40% of the population does not get any vigorous physical activity. 50% of Benton females and low-income Stearns county residents have had 0 days of vigorous physical activity in an average week. SJH
- 38% of residents in the 3-county region are overweight. DLB
- 10% of residents' say that being concerned for their safety is a reason for not getting enough physical activity. SJH

11. Distracted Driving
    - ≈70% of residents' 18-34 read or send text messages often/sometimes while driving. KJZ
    - ≈70% of residents' 18-34 use phone for other activities often/sometimes while driving. KJZ
    - Residents with high school/GED education were the least likely to be distracted while driving. They were also the least likely to view distracted driving as a problem. KJZ
    - All types of vehicle crash rates in the 3-county region are above the state rate. Stearns and Benton especially higher than state rate. DLB

*some data points are used for multiple top concerns

---end of report---

Appendix C: Two-page Data Handouts for Building Families & Mental Well-Being

CENTRAL MN ALLIANCE

Building Families – Background Data

1/16/2019

Data Points:

1. 60% of adults in the 3-county region view families with financial stress as a moderate or serious problem in the community.

2. Benton and Stearns Counties poverty levels are 5-7% higher than state rate of 25.9%, with 32.5% of Benton County residents and 30.0% of Stearns County residents living below 200% of the poverty level. As compared to Sherburne County's 19.4% living below this level.

3. 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.

4. 51% of adults in the 3-county region view parents with inadequate or poor parenting skills as a moderate or serious problem in the community.

5. Every 10 children out of 1,000 in the 3-county region are in out of home placements.

6. Every 23 out of 1,000 children in the 3-county region have been an alleged victim of child maltreatment. The MN state rate is 31 per 1,000 children.

7. 17.6% of women in Benton County smoked during pregnancy, this is double the MN state rate of 8.8%. Sherburne County and Stearns County rates are 11.4% and 12.1%, respectively; all 3 counties are above the MN state rate.

8. 29% of Benton County children (under 18) and 27.6% of Stearns County children are living in single parent households. As compared to Sherburne County with 21.4% living in single parent households.

9. 1 in 4 female 9th graders have ever considered suicide. Females are 3 times more likely to have considered suicide in the past year.

10. 40% of Benton County residents have been told they have a mental health condition as compared to 28% of Sherburne County residents and 26% of Stearns County residents. Overall, 29% of residents in the 3-county region have been told that they had a mental health condition.

Sources:

1. 2016 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.
2. Minnesota Department of Health, Minnesota County Health Tables, Demographics Table 6: Selected Minnesota Socioeconomic Statistics by State and County 2012-2016 American Community Survey.
3. 2016 Central Minnesota Community Health Survey, Question: Combined ACE score. Responses: 0, 1, 2, 3, 4+.
4. 2016 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.
5. Minnesota Department of Human Services, Minnesota's Out-of-Home Care and Permanency Report 2017, 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, 2017.
6. Minnesota Department of Human Services, Minnesota's Child maltreatment Report 2017, Table 9: Number of alleged victims in completed assessments/investigations by maltreatment type and rate per 1,000 children by agency, 2017.
7. Minnesota Department of Health, Minnesota County Health Tables, Natality Table 8: Socio-Demographic Factors Related to Birth Outcomes in Minnesota by State, County and Community Health Board, 2016.
8. Minnesota Department of Health, Minnesota County Health Tables, Demographics Table 6: Selected Minnesota Socioeconomic Statistics by State and County 2012-2016 American Community Survey.
9. 2016 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.
10. 2016 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 other mental health issues? Responses: Yes or No.

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CENTRAL MN ALLIANCE

Mental Health – Background Data

1/16/2019

Data Points:

1. In the 3-county region, suicide is the 7th leading cause of death and 4th leading cause in premature deaths (deaths under 75 years of age).

2. 1 in 4 female 9th graders has considered suicide. Females are 3 times more likely to have considered suicide in the past year.

3. 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.

4. 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.

5. 40% of Benton County residents have been told they have a mental health condition as compared to 28% of Sherburne County residents and 26% of Stearns County residents. Overall, 29% of residents in the 3-county region have been told that they had a mental health condition.

6. 10% of residents in the 3-county region did not get or delayed getting Mental Health care. Among females, 15% 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 19% not getting or a delay in getting mental health care.

7. 29% of Benton County residents in the past year thought there was a time when they thought they needed medical care but didn't get/delayed getting it. 26% of Sherburne County residents and 20% of Stearns County residents did not or delayed getting medical care.

8. 20% of residents in Benton County with less than a high school education are smokers, and 25% of Sherburne County residents with this same education level (Stearns County rate is 14% for this same population). These rates are high compared to the 3-county region rate of 14% of residents classified as a current smoker, regardless of education levels.

9. Benton County COPD rate is 24.5 cases per 10,000 residents. Sherburne is 14.6 COPD cases per 10,000 residents and Stearns County at 11.8 cases per 10,000 residents.

10. 23% of residents in the 3-county region have been told by a doctor that they have High Blood Pressure.

Sources:

1. Minnesota Department of Health, Minnesota County Health Tables, Mortality Table 4: Minnesota 10 Leading Causes of Death by State and County 2016, Mortality Table 5: Minnesota Premature Deaths (under age 75) by Number and Age Adjusted Death Rates by State and County, 2012-2016.
2. 2016 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.
3. 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.
4. 2016 Central Minnesota Community Health Survey, Question: Combined ACE score. Responses: 0, 1, 2, 3, 4+.
5. **2016 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 other mental health issues? Responses: Yes or No.
6. 2016 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.
7. 2016 Central Minnesota Community Health Survey, Question: During the past 12 months, was there a time when you thought you needed medical care but didn't get/delayed getting it? Responses: Yes, No.
8. 2016 Central Minnesota Community Health Survey, Question: Cigarette Smoking Status. Responses: Current Smoker, Former Smoker, Never Smoked.
9. Minnesota Department of Health, Minnesota Public Health Data Access, COPD hospital query 2009-2015.
10. 2016 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.

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Appendix D: 2019 Community Health Needs Assessment Stakeholder Interview Questions

1. What are the three biggest health-related issues in the community and why? (Please think of health in the broadest sense of the word.)
2. Please prioritize those top three issues and explain why you put them in that order?
3. For your top issue, please list any ideas/strategies you believe might be effective in addressing that issue.
4. Think about those who experience relatively good health and those who experience poor health. Why do you think there is a difference?
5. Thinking outside the scope of clinical healthcare, what issues do you see impacting the overall health in the community?
6. If you could add services to improve overall health in the community that are currently unavailable or have limited availability - money was no object - what would your top choices be?
7. Mental health concerns (ex: depression, suicide, anxiety, eating disorders, etc.) were frequently expressed on previous community health surveys. What can be done to improve mental health in the community?
8. Obesity amongst children and adults was another issue identified as a significant local health concern. What ideas do you have for addressing or preventing obesity?
9. Distracted driving is a health concern. How do you define distracted driving and what do you think can be done to address it?
10. Substance abuse is a health concern. How do you define substance abuse and what do you think can be done to address it?
11. In regard to the aging population, are you aware of what services and/or programs are being offered in your community? What do you think could be implemented to support the aging population?
12. If I, again, told you money wasn't an issue and said you had to spend money on some initiative targeted at parenting, what would you do?
13. Strengthening families is a community health strategy, what can be done to strengthen families in the community?
14. In your opinion, what are some of the best strategies for engaging people in improving the overall health in the community?

Appendix E: Local Public Health System Assessment (LPHSA) Questions

The responses for each question are:

- Local public health completes this activity at a low level
- Local public health completes this activity at a moderate level
- Local public health completes this activity at a high level
- Local public health does not complete this activity
- I am unsure if local public health completes this activity

Emergency Preparedness

1. How well does local public health collaboratively conduct or participate in assessments to identify jurisdictional risks and their impact on the public's health?
2. How well does local public health develop, exercise, and maintain preparedness and response strategies and plans to address public health needs during all types of disasters and emergencies?
3. How well does local public health respond and support recovery efforts in incidents with an impact to the public's health?
4. How well does local public health provide timely, accurate, and appropriate information to elected officials, the public, community partners in the event of a public health emergency?
5. How well does local public health establish and maintain relationships and regular communication with state and local partners, emergency management, tribal governments, healthcare coalitions, community partners, and state agencies?

Environmental Health

1. How well does local public health include environmental health in the comprehensive community health assessment including air quality, water quality, the built environment, and food safety?
2. How well does local public health monitor significant and emerging environmental threats to human health in the jurisdiction? Including blood lead surveillance data, food-water-vector borne illness data, safety of food, pools, and lodging establishments, safety of drinking water sources and systems, air quality alerts, and extreme heat or cold events?
3. How well does local public health work with partners and stakeholders to identify and implement strategies to address the environmental threats to human health as needed?
4. How well does local public health, at least annually, inform policy makers of the environmental threats to human health in the jurisdiction, the prevention activities already taking place, and additional strategies for mitigating those threats?
5. How well does local public health coordinate with others to provide the public with information on how to protect their health from or reduce exposure to environmental threats that pose a risk to human health as needed?
6. How well does local public health support implementation of state and local laws, regulations, and guidelines that seek to protect the public's health from environmental health risks?
7. How well does local public health comply with state statutes for removal and abatement of public health nuisances?
8. How well does local public health maintain relationships and regular communication with federal, state, tribal, and local agencies with regulatory authority and/or provide environmental health services in the jurisdiction?

Health Care Access/Infectious Disease

1. How well does local public health disseminate guidelines to local providers regarding infectious disease reporting?
2. How well does local public health share reports and assess gaps and barriers?
3. How well does local public health assess adherence to immunization practice standards (i.e. Advisory Committee on Immunization Practices recommended schedules) and provide consultation, as needed?
4. How well does local public health assess health needs of the population living in the local public health jurisdiction related to infectious diseases?
5. How well does local public health review current disease prevention and control literature related to incidence of disease, barriers to health care, and other needs of the public and disenfranchised from the health care delivery system?
6. How well does local public health collaborate on special studies, as warranted, to better understand epidemiology of infectious diseases?
7. How well does local public health review the environmental health program activities related to food and water borne disease and other infectious diseases with environmental etiology?
8. How well does local public health develop policies and plans (e.g. All-Hazards, Pandemic) to assure capacity to respond to cases of infectious disease and disseminate guidelines to local providers?
9. How well does local public health develop and implement screening and referral strategies for high-risk groups when indicated and clinically appropriate?
10. How well does local public health assure vaccines for immunizations are available, viable, and properly administered?
11. How well does local public health maintain and provide consumer education information based on community needs to the public by maintaining resources, developing education programs, and alert providers?
12. How well does local public health collaborate regionally on infectious disease prevention efforts by exchanging information on a regular basis and maintaining MIIC (Minnesota Immunization Information Connection) contacts?
13. How well does local public health follow the Health Alert Network (HAN) operational guidelines by sending HAN messages in a timely manner?
14. How well does local public health conduct or assist with infectious disease?
15. How well does local public health conduct or assist with infectious disease investigations and/or refer information related to cases and suspect cases to partners?
16. How well does local public health, in outbreak situation, conduct mass or targeted immunization clinic, arranging for staffing, training, emergency supplies, and other logistical needs?
17. How well does local public health proactively implement local disease control programs, as indicated, from local surveillance data and trends?
18. How well does local public health maintain provisions for 24/7 emergency access to public health resources capable of providing rapid detection, investigation, and containment/mitigation of public health problem and environmental public health hazards?
19. How well does local public health assure 100% of persons with TB disease in local public health jurisdiction complete TB treatment by providing nurse case management and directly observed therapy (DOT) or other treatment supervision according to federal and state standards?
20. How well does your local public health lead or participate in a collaborative process to assess the availability of healthcare services? At a minimum, the local public health must: collaborate with the healthcare system and other stakeholders; identify barriers to healthcare services and populations that experience them; identify gaps in service and populations that experience them; and consider

emerging issues that may impact access to care (e.g. changes in healthcare system structure or healthcare reimbursement).

21. How well does your local public health inform policy makers and other stakeholders about gaps in the availability of healthcare services and potential strategies for addressing the identified gaps?
22. How well does your local public health lead or participate in collaborative efforts to identify and implement strategies to increase access to healthcare services?

What population groups are under-served in the county you are assessing?

What other information would you like to share with us on this topic?

The work of my agency is part of the public health system.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

Appendix F: Jan 2019 Community Meeting Action Step Category Themes

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 G: Accreditation- Stearns County

Stearns County Public Health is preparing to seek accreditation through the Public Health Accreditation Board. This appendix serves to provide further information about Stearns County in accordance with accreditation requirements.

2018 Annual Report

The Stearns County Community Health Improvement Plan (CHIP) is a living document that guides not only the Public Health Division's priorities but also the work in the community. In 2018, Stearns County continued its work from 2017 by engaging in a Regional Partnership focused on local public health assessment and planning.

A summary of priorities identified through this preliminary data as well as through the MAPP process in 2018 included social isolation, building families, mental health/well-being, adverse childhood experiences, tobacco/nicotine use, health care, risky youth behavior, financial stress, trauma, and a foundational agency strategy which includes educating policymakers on current and emerging community issues.

As the CHIP is a living document, the intent is to continually evaluate and update it as data and evidence of emerging activities informs efforts. The CHIP was formatted to allow for other work plans from community partners to be incorporated for each of the priorities into this document and through the implementation of the MAPP process, strategies are developed to address barriers and gaps in utilization of resources and continuity of services.

As Stearns County is in the process of developing the 2019-2022 CHIP through the regional partnership, this report entails an update of progress as well as plans for implementing strategies in the CHIP and for continual assessment, monitoring, and revisions of the CHIP in the near future. The monitoring and revision report in accordance with PHAB Standard 5.2.4 is outlined within the next section.

The Regional Partnership spent the latter half of 2018 in phase four of the MAPP process. The four subgroups analyzed the data that was collected from each assessment to unveil the underlying themes that needed to be addressed in order for the team to reach its vision. Each subgroup identified the top ten underlying issues that were determined after reviewing their data. The priorities were brought to the core support team, and they selected the top two issues that came out of all four assessments. It is this work that specifically influenced the content development of the regional CHIP, and the group established its top two priorities of Building Families and Mental Well-Being in December 2018.

Starting in 2019, the group will move onto phase five and formulate goals, performance measures, and strategies by May 2019, informed by the list of strategies identified at the second community meeting. Each partnership agency is developing strategies to address the regional goal. A plan to submit the draft of the regional CHIP to the community health boards exists for April of 2019, and the implementation phase is scheduled to begin by July 2019.

Stearns County will continue to perform activities specific to the two priority areas reported on last year regarding ACEs (parenting skills) and mental health. Both of the new regional priorities that emerged from the MAPP process in 2018 are closely associated with these two activities. Therefore, many of the interventions will continue in nearly the same capacity with a more coordinated effort by the regional partners.

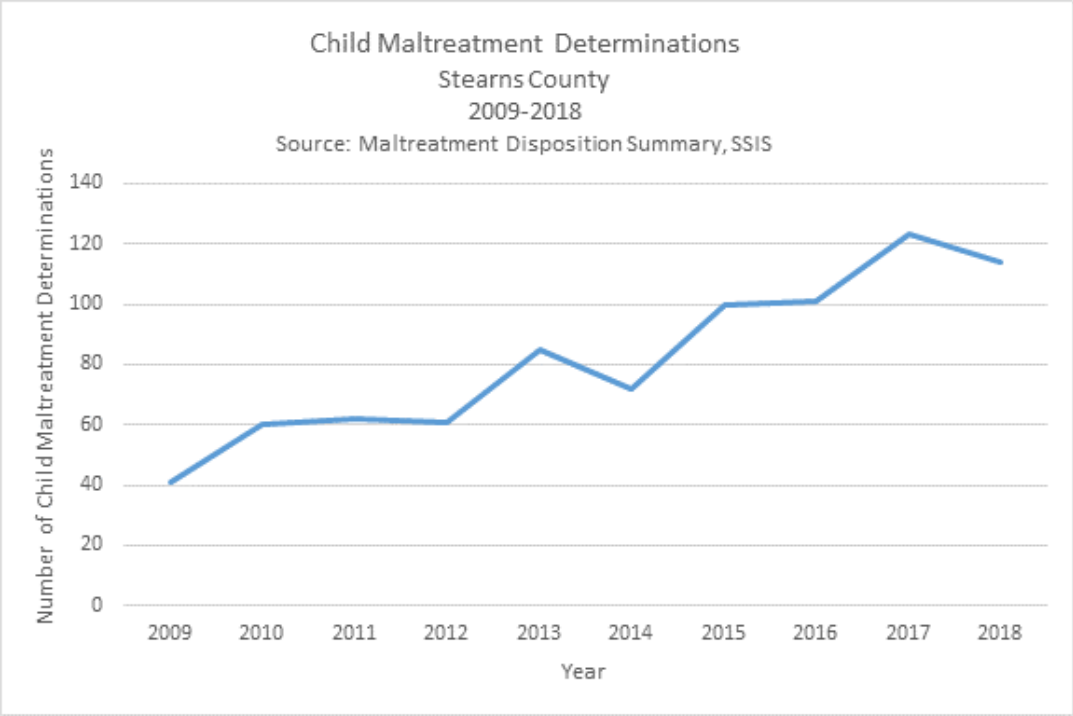
Furthermore, Stearns County Public Health is prioritizing well-being by offering resources through a resiliency initiative called Yellow Zone. Yellow Zone is an initiative to help schools, businesses, and the community establish an environment that supports positive well-being, productive and flourishing individuals. It is a place that cultivates mental well-being through five basic pillars; Helping, Socializing, Learning, Playing, and Spirituality. All five pillars are components that nurture the psychological, emotional, and social aspects of mental health.

Updates pertaining to these two priorities are outlined further in the last section of this document.
In 2019, based on what was learned through the MAPP process, ACEs will be addressed through the broader emphasis of building families, as this encompasses not only ACEs but also many other issues raised by the community during the World Café. Additionally, mental health will be included in the category of mental well-being. Lastly, Stearns County will be switching from a 5-year cycle to a 3-year cycle.

Priority 1 (Report based on the 2017 CHIP strategies)

Goal: P-3 Increase the community's awareness around the effects of trauma on children
Objectives: P3.1 Promote trauma based services across all providers and P3.2 Educate the community about the ACE (Adverse Childhood Experiences) Study
About this priority (2018): The top priority for Stearns County's 2017 CHIP is related to Lack of Parenting skills. This priority continues to be the high priority and actually dovetails well into the second priority of mental health. This imitative continues to grow in strength in the community as the Stearns County Family Services Collaborative has recently included ACE's in their current strategic plan. Public health has worked to guide their effort to align with the community ACE's Steering Committee.

Indicators:



Story behind this information:
One of the indicators the Collaborative is monitoring is the number of maltreatment determinations. We want to see a reduction in the number of determinations of Maltreatment, as we saw in 2018. While maltreatment has increased in recent years, the increase may have been a result of recent legislative changes as well as what is happening in the community. These data are a primary data set to be watched over time. Based on the recommendations of the Collective Impact workgroup of the steering committee, the set of ACE's questions was added to the 2016-17 community survey as a way to begin to establish a baseline. The plan is to continue monitoring for reductions over the next 5 years. If reductions do not occur, the committee would re-evaluate interventions being done by the sub-committees of the ACE's Collaborative. The other data set we will be monitoring is the ACE's score; using survey data every 10 years and EHR data when it becomes available.

What works to "turn" the curve?
We are working to provide a coordinated effort around variety to intervention work to turn the curve to a reduction direction.

Our Strategies:
1. Maintain the Steering Committee structure
2. Follow ACE's Outreach and Awareness Work Group Strategic Plan
3. Increase the number of providers who are using trauma-informed care
4. Educate community partners and the general community
5. Monitor key indicators for change over time.
6. Assess the community for ACE's scores using current data from the survey and EHR data from CentraCare.

Health Equity:
Stearns County just completed the Community Health Survey process at the end of 2016. This assessment survey included the 11 questions related to ACE's. A preliminary review of the is showing that factors such as income, stress levels and other determinants of health (DOH) may be associated with elevated ACE's scores.

Priority Progress:
The Steering Committee has also expanded and now not only includes the other partners from last year's work (the Stearns County Attorney's office, Human Services-Corrections/Child Protection/Public Health, St. Cloud and Waite Park Law Enforcement, Central Minnesota Mental Health Center, CentraCare-Behavioral Health/Data Analytics/Clinical Services/Spiritual Care, Chamber, Child Response Initiative (CRI), St. Cloud State University, St. Cloud School District and Interested Community Members) but also now has expanded to include Benton County. This committee continues to oversee the work and the final analysis and monitoring of the data and progress. In 2018 a full-time ACE's Coordinator was hired, with this addition the Outreach and Awareness group created a forward-thinking strategic plan to guide their efforts. The strategic plan is still currently in its beginning stages, but once it has become more finalized and a work plan developed, Stearns County will look to incorporate this work into the Community Health Improvement Plan. CentraCare, in collaboration with the Steering Committee also worked with TPT to create a series on ACE's called, "Whole People". This five-part series spotlights the impact of Adverse Childhood Experiences (ACES) through personal and community stories. It explores the long-term costs to personal well-being and society. This series was created to educate but also to highlight the many innovative developments to prevent and treat ACES. The event is to premiere on TPT starting in January of 2019.

Successes and Challenges:
The community continues to be engaged in this work; and in fact, has expanded to include the work of the family services collaborative. The addition of the full-time coordinator is helping move the initiative along much quicker and with greater consistency. Stearns also continues to include a variance request with the SHIP dollars to incorporate ACE's work into the SHIP work plan. This allows the committee to have two staff working (one private/one public) on this issue and engaging more and more of the community in this work.

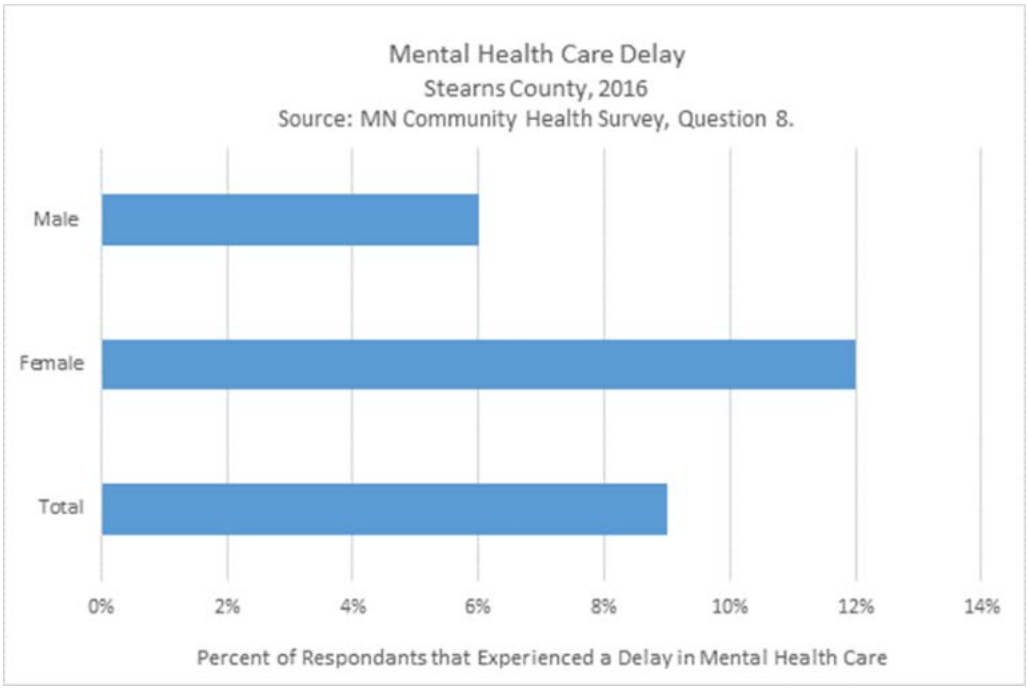
Next Steps:
The plan will be updated with the work plan with the new strategic plan developed by the steering committee. The Key Data Findings, Data, and Measurements of Success sections of the Parenting Skills Priority of the CHIP will be updated including any data gleaned from the review of the survey data from 201-17.

Priority 2 (Report based on the 2017 CHIP strategies)

Goal 1: Explore the collocation of primary care and behavioral health in a clinical setting
Goal 2: Maintain and enhance evidence-based training for Law Enforcement around mental health and integrate with behavioral health in the acute care setting
Goal 3: Develop strategies around early intervention and prevention strategies to decrease visits to Emergency Department, Detox and the jail.

About this priority:
This priority is one of the focus areas that interconnects with ACE's and has developed hand in hand with the ACE's work. This is a critical issue for Stearns County as mental health impacts many areas of a person's health and life in the community. It can impact one's ability to work, to parent and even to be a productive citizen. Care of individuals experiencing mental health issues are not only driving costs on government, health care, employers and the general public but is also taking a toll on our communities experiencing these issues. Lack of understanding, lack of coordinated services and even a lack of services in general drive a number of persons to these high cost areas such as the emergency department, detox centers and the jail. Often described as a broken system, the community has decided we can no longer afford to do what we were doing as it does not appear to be working. As a result, these three goals have been identified as where Stearns County wanted to start the change.

Indicator:



Analysis:
There are a number of indicators that have been discussed at the community level to monitor change in the area of mental health. Local law enforcement has public data on persons whose civil liberties have been taken away by month. These data are currently being evaluated to identify persons in need of service but also to develop baseline aggregate data that may be used to monitor change over a period of time before and after interventions. Other community partners have begun to analyze data related to cost savings in the emergency department and the jail and have realized the savings that early intervention brings. These partners are working together to intervene in different ways to make an impact on the individual and reduce high-cost reactive services such as the emergency department. Our initial baseline indicator relates to the number of persons from the 2016 community survey who indicated they did not seek help for mental health issues. These data will be monitored over the next several years as access for mental health services are addressed. At this point, the data is showing women are more likely than men to not seek assistance. Future community survey data responses will be monitored.

Health Equity:
Mental health issues are over-burdened with inequities. Homelessness, unemployment and chemical use, including tobacco use, are over-represented in this population. Initial assessment data around barriers to success are being incorporated into the processes for intervention and aggregate data should become available from both CentraCare and Stearns County. Discussions around other partners who may be able to assist with addressing these inequities are already taking place.

Priority Progress:
Connecting with the "right" community partners is important. When the different groups convened both Stearns and Benton reviewed Mental Health data from our CHAs, the St Cloud Hospital CHNA, our social service partners' data on bed availability & waiting lists for providers as well as information from local law enforcement and jail staff about the needs of the inmates. This group, spear headed by CentraCare, has many subgroups that are now working on specific mental health priorities. This has resulted in CentraCare a newly formed Coordinated Care Clinic which is now also providing jail health services in both Benton and Stearns County jails. This allows the clinic to address the mental health issues in the jail and upon release, serve them through this new clinic. The Release Advanced Planning (RAP) Team is also working with the jails to create a plan for individuals that may need extra help planning for release. The goals of the RAP Team is to minimize the challenges of leaving jail that lead to crisis, impact the individual's success in the community, and reduce recidivism. At the same time, Stearns County has expanded a veteran's court mental health workgroup to be broadly addressing mental health in general. Same partners as listed above, with the inclusion of the court system partners, is now developed a National Association of Counties, "Stepping Up" workgroup as well as a multi-disciplinary team around the high users of jail, detox and emergency department. This group has recently expanded to include Benton County as well.

Successes and Challenges:
The amount of collaborative efforts around Mental Health are unbelievable. There is support from local elected officials and from multi-systems to assure there is change that happens in the community around mental health. Data Privacy continues to be a barrier when trying to work collaboratively with community partners. However, with the explosion of activity, it is important to keep all the progress in this area coordinated; as well as keeping the ACE's work connected to this priority progress. At this point, there is a lack of resources for this to happen well.

Next Steps:
In 2019, we will continue working collaboratively with Benton, Sherburne and CentraCare system clinics and hospitals to better assure coordination continues. There is also a collaborative effort to assure there are data sets that will be identified and collected to assure there is measurement for evaluation. Those are yet to be determined.

Key Data Indicators and Impact
Note: This section is currently under development.

Emphasis on Equity
Note: This section is currently under development.

Appendix H: Public Comments Received for Community Health Needs Assessment

The 2019 Community Health Needs Assessment was posted online for public comment for a two-week period from 5/01/2019 through 5/14/2019. The link for public comment was posted on the websites for Stearns, Benton, and Sherburne Counties, as well as CentraCare. A total of five public comment surveys were received from community members, and their responses are documented below. All responses were considered when completing the final draft of this document.

**A separate survey was completed for the 2019-2022 Community Health Improvement Plan, and the results to that survey can be found in Appendix 1 of the Central MN Alliance Community Health Improvement Plan.*

Date: 5/7/2019
Agency of Survey Participant: Benton County
County: Benton
Process Comments: N/A
Related Processes Comments: N/A
Missing Info for Building Families: N/A
Missing Info for Mental Well-Being: N/A
General Comments: "Tax meat and soda. Teach people how to cook healthful meals. Looks good overall."

Date: 5/8/2019
Agency of Survey Participant: Anna Marie's Alliance
County: Sherburne, Stearns
Process Comments: N/A
Related Processes Comments: "Anna Marie's Alliance's mission statement is to provide a safe place for victims of domestic violence and to create systems change that reduces violence. One of our current areas of exploration related to prevention of violence is supporting healthy early childhood experiences and two-generation programming that will strengthen families to prevent violence from cycling down to the next generation. We are still exploring what implementation will look like."
Missing Info for Building Families: "Anna Marie's Alliance shelter offers housing and services to women and children experiencing domestic violence. Our 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. Our prevention services work in schools to promote social-emotional learning and healthy relationship skills for children in grades K-12."
Missing Info for Mental Well-Being: "Same as above"
General Comments: N/A

Date: 5/9/2019
Agency of Survey Participant: N/A
County: Sherburne
Process Comments: N/A
Related Processes Comments: N/A
Missing Info for Building Families: N/A
Missing Info for Mental Well-Being: N/A
General Comments: "Would appreciate seeing a list of organizations represented in regards to the stakeholder interviews to have a better understanding of community representation. Similarly, were any of these stakeholders community residents with lived experiences as they pertain to the identified health priorities? Appears that most input came from those representing organizations vs. community members with lived experiences, which lends itself to a different perspective regarding solutions."

Date: 5/10/2019
Agency of Survey Participant: N/A
County: Stearns
Process Comments: N/A
Related Processes Comments: N/A
Missing Info for Building Families: N/A
Missing Info for Mental Well-Being: "I may have missed it, I did not see Recovery Plus -Substance Use disorder outpatient treatment or Family Unity, support housing for women with children that are participating in out-patient treatment."
General Comments: N/A

Date: 5/13/2019
Agency of Survey Participant: N/A
County: N/A
Process Comments: "Did you survey or interview any of the community's religious leaders?"
Related Processes Comments: N/A
Missing Info for Building Families: "Many churches, private schools, and religious organizations are missing from the list."
Missing Info for Mental Well-Being: "Many churches and religious organizations are missing from the list."
General Comments: N/A