

POLK-NORMAN-MAHNOMEN COMMUNITY HEALTH SERVICES

COMMUNITY HEALTH IMPROVEMENT PLAN

*Developed in years 2018-2019
For Implementation in 2020-2024*

November 22, 2019



Polk County Public Health

Norman-Mahnomen Public Health



Public Health
Prevent. Promote. Protect.

TABLE OF CONTENTS

Acknowledgements	3
Letter to the Community	4
Executive Summary	5
Polk-Norman-Mahnomen Community Health Services	5
Background and Process	7
Top 10 Health Priorities	10
Priorities Selected	11
CHIP Engagement Journey	13-15
Adults Overweight	16
Mental Health and Well-being	22
Poverty	30
Call to Action	38
Sustainability	39
Appendix A-E	40-51

ACKNOWLEDGEMENTS

PNM CHS would like to thank these people and organizations for participating in the planning process that led to this plan:

Alanna Strom, Altru Health System
Amanda Lien, PCPH
Andrew Larson, Tri-County Community Corrections
Angel Korynta, PCPH
Ann Longtin, Longtin Insurance Agency
Ann March, Minnesota Department of Health
April Grunhovd, RiverView Health
Brooke Novak, University of Minnesota Crookston
Caidyn Johnson, Youth Advisory Board
Carol Bye, Dancing Sky Area Agency on Aging, Northwest Regional Development Commission
Carrie Danielson, Essentia Health Fosston
Cassie Heide, City of Fosston
Cheryl Smart, Polk County Social Services
Colleen MacRae, Polk County Collaborative/Northwestern Mental Health Center
Darcey Larsen, RiverView Health
Dean Vikan, Fosston Community Volunteer
Jami Lee, Tri-Valley Opportunity Council
Janet Denison, Northwestern Mental Health Center
Jason Carlson, Tri-Valley Opportunity Council
Jeremy Olson, Crookston Schools
Joshua Mailhot, Fisher School
Jim Tadman, Polk County Sheriff's Office
Julie Praska-Moser, Luthern Social Services
Karen Warmack, Polk County Social Services
Kari Bolstad, Fertile-Beltrami High School
Kelsey Billing, RiverView Health
Kirsten Fagerlund, PCPH
Laura Heller, RiverView Health
Leif Olson, Essentia Health Fosston
Lisa Loegoring, UMN Extension
Lynae Finseth, Essentia Health Fosston
Maia Bowman, Youth Advisory Board
Malissa Burnette, Peer Recovery, Northwestern Mental Health Center
Marita Kendig, Crookston High School
Megan Starr, Polk County Social Services
Mike Hedlund, East Grand Forks Police Department
Mike Norland, Polk County Sheriff's Office

Mitch Bakken, Tri-Valley Opportunity Council
Naomi Swanson, Youth Advisory Board
Nate Dorr, Northwest Minnesota Foundation
Phil Larsen, Pastor
Sarah Nereson, Fertile-Beltrami School
Shannon Kronlund, Northwestern Mental Health Center
Shannon Stassen, City of Crookston
Shayla Solberg, Altru Health System
Stacey Grunewald, University of Minnesota-Crookston
Sue Chase, Fosston School District
Suraya Driscoll, East Grand Forks Schools
Terri Heggie, Crookston Chamber of Commerce/Visitor's Bureau
Victoria Ramirez, Polk County Social Services
Kimberly Myers, NMPH
Erin Stoltman, Essentia Health Ada
John Rosenberger, Veteran Service Officer
Angie Nelson, Halstad Living Center
Karie Kirschbaum, City of Gary, NC EDA
Karen Pifher, Essentia Health
Julie Hanson, Mahnommen County Human Services
Jeff Bisek, Mahnommen Schools
Karen Ahmann, Mahnommen County Commissioner
Mark Askelson, KRJB Radio, NC EDA
Liz Kuoppala, Mahube-Otwa Community Action Partnership
Melinda Anderson, Norman County East School
Hilary Chisholm, Norman County DAC
Jessica Spaeth, Compass Business Consulting, NC EDA
Curt Johannsen, City of Hendrum, NC EDA
Lee Ann Hall, Norman County Commissioner, NC EDA
John Hintz, Norman County EDA, NC EDA
Rachel Johnson, City of Twin Valley
Patricia Bowen, Community Member
Marijo Vik, Norman County News Online
LeAnn Moen, Community Member
Cindy Julin, Julin Law Office
Kristi Melting, Local business owner
Jeremy Melting, City of Halstad
Sheila Capistran, Local business owner

LETTER TO THE COMMUNITY

Dear Polk, Norman and Mahnomen County Residents,

It is with great gratitude and pride that we introduce the 2020-2024 Community Health Improvement Plan (CHIP) for Polk, Norman and Mahnomen counties.

While the creation of a collaborative regional CHIP was launched and stewarded by local public health, the product is the result of engagement and expertise of organizations and individuals from multiple sectors across our three-county region. Thank you to all who've participated in, and provided support for, the collaborative planning process so far. If you're new, we encourage you to join in as we take action together.

We recognize the circumstances in which people are born, live, learn, work and age directly shape their health and well-being, and that no single organization or sector can improve the health of the community alone. Public Health works diligently to break down the partnership silos, to a system of working in collaboration with each other (and having a little fun doing it!). We have an opportunity to work more intentionally in collaboration with the people most impacted. Polk County Public Health and Norman-Mahnomen Public Health continues to challenge ourselves and our partners to ask these questions: "Who's most impacted?" and "Who is missing from the conversation and decision-making process?". With intent and purpose, our goal is to invite, listen, engage, learn from and work with those most impacted to improve health outcomes and the communities where people live, work and play.

Sincerely,



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



Sarah Kjono, RN, PHN, Director
Norman-Mahnomen Public Health

EXECUTIVE SUMMARY

A community health improvement plan is a long-term plan, describing how the local health departments and a broad set of community partners and stakeholders plan to address needs identified in recent community health assessments. This 2020-2024 plan is based on a community health assessment completed for Polk, Norman and Mahnomen Counties in 2017 and 2018. The top 10 PNM health issues were identified from the assessment. Partners cultivated and established strategies for addressing the three health priorities (focus areas) for 2020-2024. **The Polk, Norman and Mahnomen counties focus areas will be decreasing adults overweight, improving mental health and well-being, and decreasing poverty.**

Community Health Vision: *Healthy Behaviors. Healthy Communities...an opportunity for all PNM residents to experience optimal health and well-being.*

Community Health Advisory Committee/Partners Role: *Serve as a community representative and to work with health department staff to guide and participate in the community health improvement process... towards a shared goal of improving community health together.*

Definitions and Concepts Guiding Our CHIP Process

“Community Health” refers to the health of the whole population of Polk, Norman and Mahnomen Counties, as opposed to the health of any one individual. To improve health at the community level requires convening and engaging the community. Community health improvement often includes a range of evidence-based to innovative strategies and making changes to policies and systems. There are many collaborative initiatives in Polk, Norman and Mahnomen Counties, led by a variety of organizations. Efforts to improve equity, education, transportation, housing, or access to mental health care can all prevent illness, injury, and health care expenditures.

“Health Equity” as defined by the Minnesota Department of Health as “the opportunity for every person to realize their health potential—the highest level of health possible for that person - without limits imposed by structural inequities” (*Advancing Health Equity in Minnesota: Report to the Legislature, 2014*). Health inequities are differences in health between groups due to social, economic, geographic, etc. conditions, known as the social determinants of health. Health inequities specifically result from social conditions that we can transform through the implementation of policies and practices.

POLK-NORMAN-MAHNOMEN COMMUNITY HEALTH SERVICES

The Polk-Norman-Mahnomen Community Health Services (PNM CHS) comprised of Polk County Public Health (PCPH) and Norman-Mahnomen Public Health (NMPH) is a multi-county community health services entity responsible for protecting and promoting the health of Polk, Norman and Mahnomen County residents. The two public health departments are assigned the general authority and responsibility for ongoing planning, development, implementation and evaluation of an integrated system of local community health services. We maintain a diverse board of directors (elected officials and community representatives) and staff, in terms of geographical and professional backgrounds.

Making progress towards improving the data indicators and monitoring the plan, in collaboration with community stakeholders and partners, is a responsibility of Polk-Norman-Mahnomen CHS under Minnesota Statutes §145A.

Description of Polk, Norman and Mahnomen Counties

Located in Northwest Minnesota, the three counties cover 3,403 square miles and are home to 43,704 people (US Census, 2016). The three counties consist of 98 townships, 26 small towns/cities and Mahnomen County has one "Census Designated Place" known as Naytahwaush, MN. Mahnomen County is also the home to the majority of the White Earth Indian Reservation. The counties lie close to the North Dakota and Canadian borders with agricultural production and related agri-business as dominant factors in the economy. According to the Health Resources and Services Administration (HRSA), most of the region is sparsely populated. Overall, the population density within the proposed project area is a scarce 12.8 people/square mile, vs the state of Minnesota at 69.3 people/square mile.

The population landscape in NW Minnesota is changing. We are altering our path from a single cultural lens (primarily Caucasian) to a multi-cultural worldview that is welcoming and reflective of values, beliefs, customs, traditions and practices of all people. For us, this includes, but is not limited to, Indigenous/First Nations people, original settlers (primarily Scandinavian and German), established immigrant populations (Mexican, Hispanic, Latino, Russian Orthodox and Amish) and relative newcomers (Somalian and Arabian), persons identifying as LGBTQI, veterans/military and their families, farmers and their families, ag-related businesses, and other persons arriving who may have a variety of beliefs choosing to live in Polk, Norman and Mahnomen counties.

BACKGROUND

Purpose

Community health issues require community solutions, and a wide range of organizations and community partners play a role in addressing the factors and conditions that create health. Public health convened partners and coordinated a community health assessment and planning process.

The Community Health Assessment (CHA) provided the community with important information on the population's health, the factors that influence health, and assets and resources available to address health issues. During the assessment process, quantitative and qualitative data was collected, analyzed, shared, and used to prioritize health issues. This Community Health Improvement Plan (CHIP) reflects the collaborative planning process that followed the Community Health Assessment and serves as a roadmap to guide our communities to taking collective action to address specific population health issues and achieve a shared vision of community health.

The CHIP is intended to be a community plan, rather than a public health agency plan.

A community-driven improvement framework called *Results Based Accountability (RBA)*, and *Art of Hosting* facilitation style, was used to guide the health improvement planning process. The CHIP, created with community members and organizations, broadens and builds upon successful local PNM initiatives. It is an action-oriented, living document to mobilize partners in areas where we can be most impactful on improving the health of residents, particularly those most vulnerable or impacted.

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

Our CHIP is truly an example of meeting people and organizations where they are at and empowering people to contribute in ways that are personally and professionally meaningful while always working towards common goals.

No issue can be addressed alone; it requires a multifaceted approach in building and sustaining healthy communities.

We are asset 'rich' in people with passion, loyalty, determination, and willingness to facilitate change to improve the lives and well-being of our communities.

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

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

Polk County Public Health <https://www.co.polk.mn.us/191/Public-Health> Norman-Mahnomen Public Health www.co.norman.mn.us/publichealth

Planning Process

In 2019, after consultation with various partners the PNM CHIP process transitioned to a more local route (health department specific) for our important community health conversations, planning, and, perhaps more importantly, action. Some people, local public health included, have been unsatisfied by past efforts that felt more like talk with limited action. Each health department is utilizing the Results-Based Accountability (RBA) process that gets us from talking to action quickly. RBA uses a data-driven, decision-making process. It uses "common language, common sense and common ground".

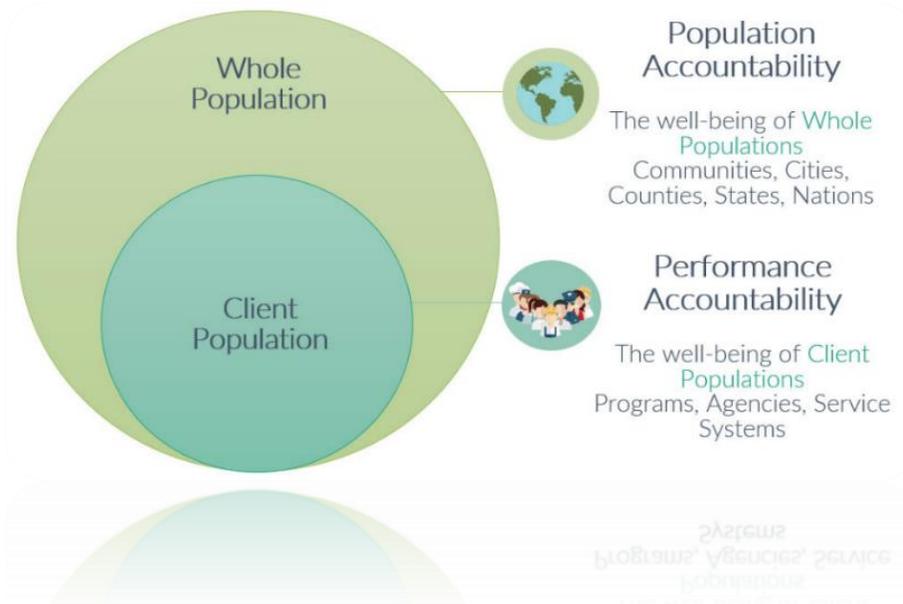
RBA is made up of two parts:

- **Population Accountability: Well-being of whole populations**
(community, county, state)
- **Performance Accountability: Well-being of client/customer populations**
(programs, agencies, service systems)



Who is responsible for what? Population accountability organizes the work with **co-equal partners** to promote health and well-being whereas performance accountability is **what partners do for customers/clients**, which are our contributions to the **collective community impact**.

Results-Based Accountability



PNM Result: **Healthy Behaviors, Healthy Communities**

The Top 10 - Priority Health Issues Resulting from the Community Health Assessment (quantitative and qualitative) and partners local expertise/recommendations are access to health care services, aging population, economic stability Education, mental health, neighborhood and built environment, parenting-family systems, physical activity, social connectedness and general substance use.

In effort to keep the CHIP realistic and manageable, three population indicators were selected. Population indicators were chosen based on overall communication, importance and data power.

Population Accountability

About the well-being of whole populations

Neighborhoods - Cities - Counties

 **Result:** A condition of well being that we want to achieve for a given population

 **Indicator:** A measure that helps quantify the achievement of a Result

- *Youth succeeding in school*
- *A healthy environment*
- *A Safe community*
- *Graduation rate*
- *Air quality index*
- *Crime rate*

Performance Accountability

About the well-being of client populations

The people who are directly affected by a program

 **Program:** A program, agency, or service system that is helping to achieve our Result

 **Performance Measure:** A measure of how well our programs are serving the people that they reach

- *How much did we do?*
- *How well did we do it?*
- *Is anyone better off?*

Top 10 - Priority Health Issues Resulting from the Community Health Assessment

Health issue	Statement of Context
Access to health care services	Broad access to healthcare services (health, mental and dental). Access to appropriate, timely and affordable healthcare and preventing the delayment of needed treatment because of high cost/deductibles are concerns impacting quality of life.
Aging population	Our counties are aging at a faster rate than the state of MN. Anticipation of future needs is a high priority. Lack of timely transportation, stigma of riding the public transportation and elderly depression/social isolation are concerns impacting quality of life.
Economic stability	Poverty (generational, situational and working poor), employment, food insecurity, housing instability - These issues continue to remain a high priority in our counties.
Education	High school graduation rates are good in most of our districts but are still an area of concern in Mahnomen County. Experience higher education challenges to meet workforce needs.
Mental health	The spectrum of mental health and well-being is a concern for all ages. Reducing the stigma, and increasing resiliency and coping strategies for stress, depression and anxiety are needed. Adverse Childhood Experiences (ACE's), trauma and hope informed care are high priority for many agencies and school districts.
Neighborhood and built environment	Transportation, quality housing, and access to affordable, healthy foods.
Parenting-family systems	Changing family systems and lack of supports/isolation are a continuous issue that affects health and well-being.
Physical activity	Adults in all counties are far below the state average in getting the recommended levels of physical activity. Our counties continue to have a high percent of overweight and obese residents. Physical inactivity expressed as a contributing factor to preventable chronic diseases.

Health issue	Statement of Context
Social connectedness	Increased social isolation is seen as an issue in both children and adults. Lack of informal/formal supports, increased use of technology and lack of civic engagement noted in our assessment.
Substance use: General	Alcohol, tobacco and other drugs all continue to be issues. The specific issue varies by area which is why we chose general. <i>i.e. Opioids are a larger issue in Mahnomen county. Vaping is seen as a larger issue in Norman and Polk County schools. Mahnomen administration say cigarettes are still a larger issue than vaping in school. Alcohol is viewed as socially acceptable and a rite of passage across much of the three counties. Methamphetamines concern law enforcement across the three counties.</i>

CHIP PRIORITIES SELECTED - PNM Indicators:

- 1) *Decreasing the percentage of adults overweight.*
- 2) *Decreasing the percentage of adults feeling hopelessness, anxiety or loss on interest and percent of 9th graders feeling bothered, down, depressed, hopeless.*
- 3) *Decreasing the percentage of all people whose income in the last 12 months is below the poverty level.*

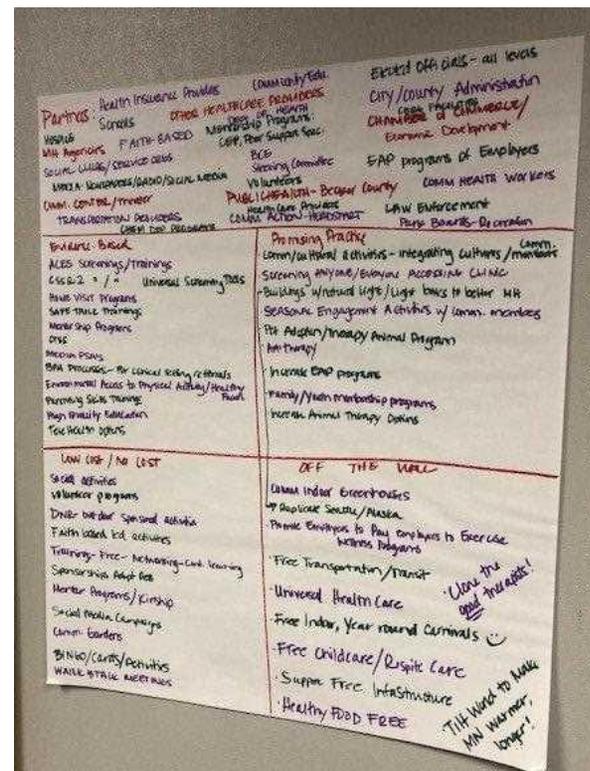
Results-Based Accountability

For each population data indicator, PCPH and NMPH partners used a step-by-step process to get from ends to means. This is called “Turn the Curve” thinking and involves five steps. The process is short and succinct to get from talk to action more quickly.

1. **How are we doing?**
2. **What is the story behind the data?** (root causes, why here/locally?)
3. **Who are the partners who have a role in impacting the data/issue?** (asked partners “who is missing”)
4. **What will work to improve the data/issue?**

Evidence Based, Promising Practices, Low Cost/No Cost, Off the Wall Strategies

- ✓ **Leverage:** How much difference will it make on the result and indicator? (Most important criteria)
- ✓ **Feasibility:** Is the proposed strategy feasible and affordable? Can it be done? (Rank low cost/no cost higher)
- ✓ **Specificity:** Is the strategy specific enough to be implemented?
- ✓ **Value:** Is the strategy consistent with the values of the community?



5. **What is our action plan? What do we propose to do?**

For more information on Turn the Curve thinking see: <https://clearimpact.com/results-based-accountability/turn-the-curve-thinking/>.

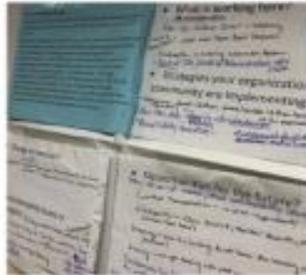
2015-2019 Focus Areas

- Decreasing Persistent Poverty
- Coordination of Behavioral and Physical Health
- Positive Social Connections for Youth

JULY 18 2017

PNM All Partners Meeting

- Partners examined strategies, agreed to keep focus areas
- Explored data and agreed 50+ outcome data needed to be narrowed
- Participants agreed that "more is not always better" and having less outcome data would be valuable



DEC 2017

Draft Indicator Data Sets

NOV 2017

Art of Hosting (AoH) Conversations that Matter

- PH Directors attended workshop
- Co-creation of innovation to address complex challenges

JAN 30 2018

PNM All Partners Mtg

- CHIP Open Space: Time & space for partners to engage around 3 focus areas.
- Identify common data indicators, definitions & sources.



OPEN SPACE PRINCIPLES

Whoever comes are the right people •
Whenever it starts is the right time •
Whatever happens is the only thing that could have • and when it's over, it's over.

DEC 2017 - APR 2018

2017 NW Region Adult Health Behavior Survey

- Executive Summary of Results & Methods [Appendix A]
- Response Rates:
 - Polk 21.9%
 - Norman 23.9%
 - Mahanomen 18.7%

APR 30 2018

SHIP Health Equity Data Analysis

- Engage with PNM clients [Appendix B]



NOV 18 - APR 19

Norman County Making it Home

- Facilitated study circle focused on community member lived experiences
- Action planning forum held with the community to identify & prioritize strategies

NOV 2018 + JAN 2019

Essentia Health invited PNM to participate in Results Based Accountability (RBA) Workshops

"WHAT ARE THE 2-3 MOST IMPORTANT ISSUES TO ADDRESS IN ORDER TO HELP-FURTHER IMPROVE QUALITY OF LIFE IN OUR COMMUNITY?"

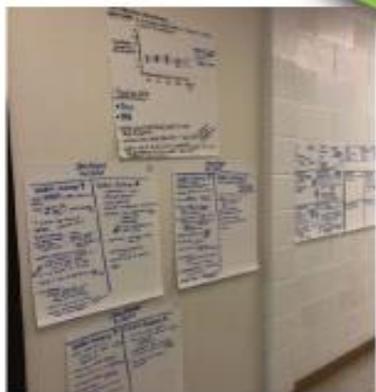
MAY - SEPT 2018

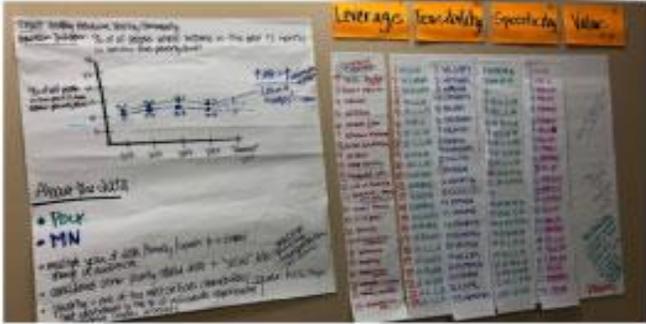
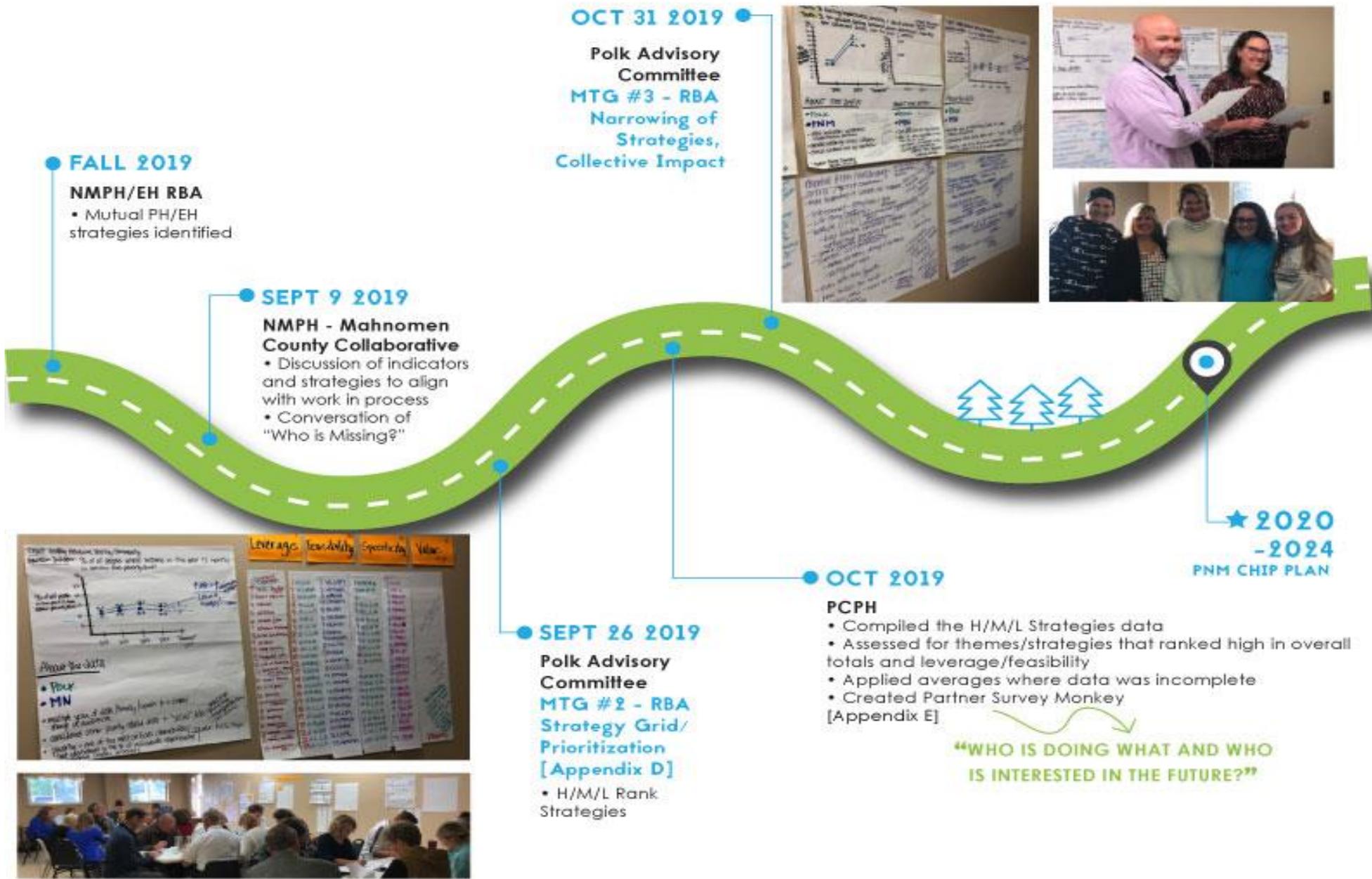
55+ Key Informant Interviews

- Variance / Concept Map [Appendix C]



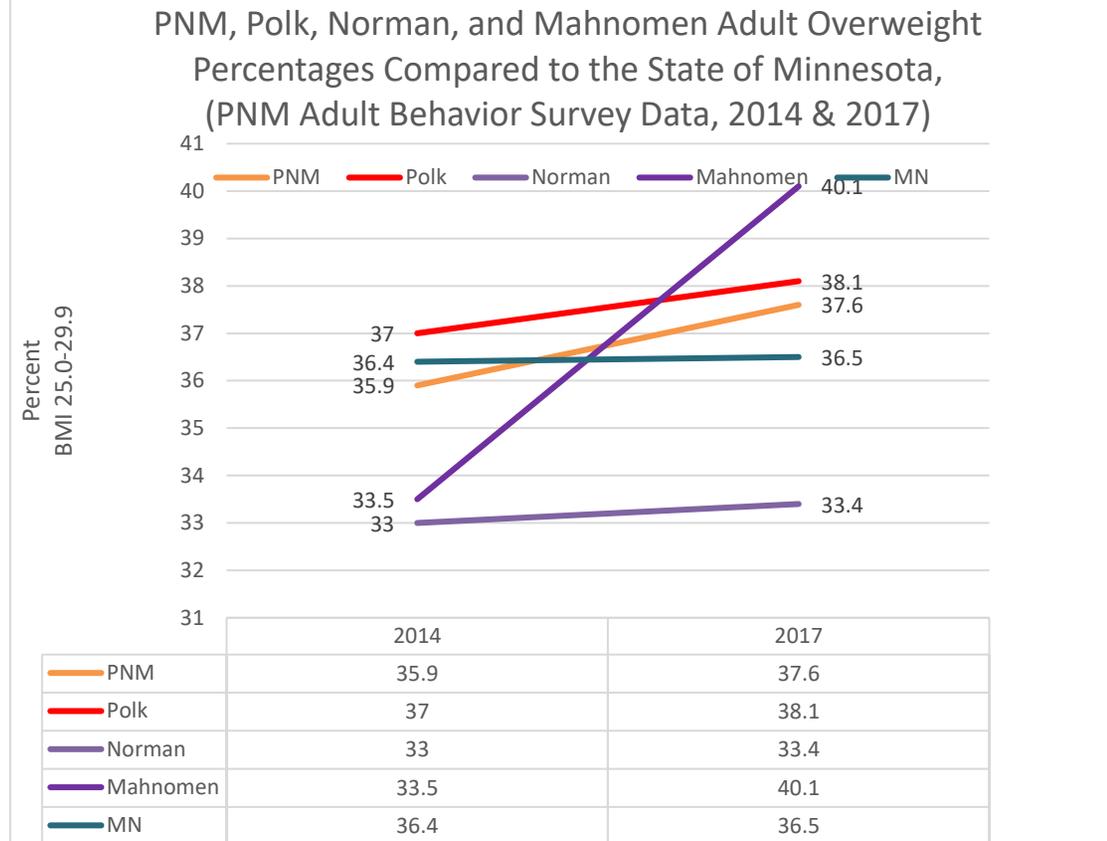
"WHERE WE'VE BEEN & WHERE WE'RE GOING"





Result: Healthy Behaviors, Healthy Community

Population Indicator: Percent adults overweight



Process to Selecting Population Indicator:

- Indicator data was reviewed and analyzed by local public health with consultation from local/regional content experts.
- Indicator was recommended to PNM All Partners (previous workgroup) and both Health Department (Health Improvement Advisory Committees) (current workgroups).
- Partners reviewed recommended population indicator data based on: *Can this indicator speak to a broad range of audiences? Is quality data available on a timely basis? Does this indicator rise above other metrics in its ability to impact the result (healthy behaviors, healthy community)?*
- Partners agreed to keep the recommended population indicator.

Why was this population data indicator recommended? What other data was considered?

- PNM Adult Behavior Survey (Dec 2017)
- CHIP Priorities Exercise at All Partners Meeting (Jan 2018)
- Variance/Concept Map Results (Summer 2018)

Further analysis...Deeper dive=

-CDC - Prediabetes Rate (fasting glucose/A1C level*) -considered, couldn't access county level data
(Around 1 in 3 (34%) of American adults have prediabetes. If we wanted to use this Indicator (vs Overweight that is recommended) we could do the math of 34% of adults in each county of the three counties as estimates.)

<http://www.health.state.mn.us/divs/healthimprovement/data/quick-facts/prediabetes.html>

**People without diabetes were classified as having prediabetes if they had fasting plasma glucose values of 100 to 125 mg/dL or A1C values of 5.7% to 6.4%.*

<https://www.cdc.gov/diabetes/data/statistics-report/appendix.html#methods-7> Reviewed the root causes of pre/diabetes and the groups' CHIP priorities, overweight was risk factor.

-Physical Activity and meeting the recommended PA Guidelines was reviewed for consideration as the Population Indicator – however, people could be physically active and overweight which can lead to pre/diabetes.

-Overweight is a risk factor for prediabetes and other chronic diseases – if we address overweight (physical activity/nutrition/stress, etc) then we reduce risk factor for pre/diabetes and other chronic diseases (heart disease, etc)

-Reviewed the MN Community Measurement– HealthScores – data is related to adult diabetes care.

Links below. After review, we noted that these are Program/Clinic-Performance Measures (vs. Population Indicators).

<http://www.mnhealthscores.org/all-measure-topics>

<http://www.mnhealthscores.org/diabetes-13184>

D5 - D5 is a set of five treatment goals that when reached together, represent the gold standard for managing diabetes.

<http://mncm.org/reports-and-websites/the-d5/#the-d5-for-diabetes>

-MDH/State-level indicators - meant to present a broad picture of diabetes in Minnesota:

<http://www.health.state.mn.us/divs/healthimprovement/diabetes-dashboard/index.html>

NORMAN-MAHNOMEN PUBLIC HEALTH – TURN THE CURVE (Facilitated conversation with partners)

Story Behind the Data

What factors are pushing up on the data?

- Poverty
- Unsafe living conditions
- Poor coping skills, lack of resilience
- Lack of access to recreational opportunities
- Lack of transportation
- Lack of access to healthy foods
- ACES
- Suicide rates
- Social isolation
- Substance abuse
- Socioeconomic factors

What factors are pushing down on the data?

- Therapy
- Medication
- Social connection/caring adult
- Screening/early intervention
- Health insurance (affordable)
- Services within close proximity
- Care coordination
- Expertise to know what to look for and who to connect with
- Access to active living/parks/recreation
- Access to healthy foods
- Access to healthcare
- Safe living conditions
- Positive social determinants
- Positive/healthy relationships
- Coping skills and resilient behaviors

Partners who can help?

NMPH PARTNERS

EDUCATION

- Norman Mahnomen School Districts
- U of MN Extension

HEALTHCARE

- NW Mental Health Center
- Sanford Health
- Essentia Health
- Mahnomen Health Center

GOVERNMENT/TRIBAL

- Social Services
- Public Health
- Law Enforcement
- White Earth
- City Government
- Dekko Center

OTHER

- Norman County East Early Childhood Initiative
- Tri-Valley Opportunity Council / Head Start
- Mahube-OTWA
- Wellness in the Woods
- Churches

Who's Missing?

NMPH is committed to routinely asking "Who is missing?" and intentionally including individuals and communities most impacted.

What are we going to do?

Strategy #1: Engage and collaborate with community to provide education on nutrition and healthy living.

Action Steps:

- Identify current community education plans and gaps, assess need for evidence-based programs that are for all ages of the lifespan.
- Allocate resources for education within the school system to meet identified needs

Strategy #2: Engage in planning of access to parks and recreational opportunities.

Action Steps:

- Collaborate with local government/EDA’s and parks and recreational committees to identify areas of opportunity for expanded additional parks, trails and recreation.

Strategy #3: Continue to support Safe Routes of School activities.

- Assess current plans/funding opportunities
- Assist schools without current funding and plans to apply for SRTS funding.

POLK COUNTY PUBLIC HEALTH – TURN THE CURVE (Facilitated conversation with partners)

Story Behind the Data

What factors are pushing up on the data?

- Sedentary lifestyles – social media – use the car for everything
- Desk jobs
- Quick food isn’t healthy XX
- Healthy food is expensive XX
- Winter or perception that winter is sedentary XXX
- Less family mealtimes due to busy lifestyles
- No knowledge on how to prep healthy foods
- People in early recovery– sugar becomes an addiction
- Binge use disorder
- Less education on what is “Healthy food”
- Video games for Young adults/middle age now
- Decrease in extracurricular participation and availability for adults
- Genetics
- Generational – less modeling of healthier behaviors
- Screen time/Technology - parents and kids
- Food deserts
- Youth choosing not to go into sports
 - schools cutting programs
 - expensive

What factors are pushing down on the data?

- Increase in # programs around PA/ increase awareness of them
- More 5K/10K/ more are focused on fun – everybody can walk and have a good time.
- Employer wellness opportunities
- Integrative care in healthcare – looking at whole person
- Hospital design for new Altru/“In the Park” farmers market on premises, etc.
- Greenspaces/Bike paths/Community efforts
- SNAP program/POP program – increase education and access
- Technology – online programs – FIT BITS
- “Challenges”
- Insurance benefits
- Mental Health access in Polk is good
- Physical care access in Polk is good
- Farmers Markets access is increasing (Fertile)
- Food boxes; mobile food trucks are reality

<ul style="list-style-type: none"> ○ parents too busy to get students to activities/rural living/drive too far to go home and back many times ○ incarcerated parents ○ coaches – kids don't like so don't join ○ Coaches – hard to get good people to coach – parents and students are too much to deal with/not worth it ○ Youth don't have enough time to do homework; too much time away from school for games, etc. ○ Sports are all about winning instead of the health benefits ● Education – public gets too many messages – online, FAD diets; fad information, quick fix surgery <ul style="list-style-type: none"> ○ Less family consumer science classes/ "Home Ec" ● Embarrassment to walk into a gym – people judge – only for those already fit. ● No PE required past 9th grade ● Cultural – Farmers used to be very active in their jobs so didn't need to worry about healthy eating and lifestyle – farming now is less active / Cultural – "entitlement" ● Parents don't want to play actively with their kids – they play video games – they want to sit and watch ● Parents worried about safety, abductions ● No indoor playgrounds in the area – weather ● Daycare is expensive – makes everything else more expensive and harder to access ● Stress – busy lives – goes across all income sectors ● Technology ● Need convenient food that is healthy – Drive through salad bar! ● Kids are more sedentary – video games; kids like them and now they are readily available to all ages and incomes ● Parents fear letting their kids just go and be outside for the day ● No insurance; paperwork for applying for insurance is very detailed and hard to understand; overwhelming ● Isolation of kids and adults and families <ul style="list-style-type: none"> ○ Faith based organizations used to be more central to the lives of families; more active; more opportunities for social connections; ○ Other community groups; not as important in people's lives ● Poverty – transportation to opportunities – memberships ● Prescriptions for every illness – side effects of drugs – cause wt. gain ● Physical disabilities limit mobility to be active 	<ul style="list-style-type: none"> ● Community gardens are increasing ● Community Partners – Polk works together ● Summer free meals ● Various groups promoting healthy options <ul style="list-style-type: none"> ○ Grocery stores/WLF ○ Increase number of Farmers Markets ● Schools – getting some funds for fresh foods and equipment ● Healthcare – more holistic/more preventative care in healthcare – offering free classes ● Cities – <ul style="list-style-type: none"> ○ Safe Kids Programs ○ Working to make streets safer – starting ○ Helmets – promotes by police – DQ tickets ● Cornerstone Residence – incentives are healthier for residents/fruit for prizes instead of candy, etc. ● Smaller rural area – we work together ● Splash parks/Pools ● Health insurance – incentives offered; rates lower for healthier numbers and lifestyles ● Lots of initiatives – Bike groups; grassroots groups; FFF/Activities ● Wellness Committees at work – incentives ● Food Shelves – getting messages out – better messages ● Better access to healthy foods ● School menus offer more healthy options ● Summer Food Programs/Backpack program ● Sugar Free Beverage policies – Healthy food access ● Healthy insurance benefits ● Bike paths/trails ● Increase of MNDOT funding for non-motorized ● \$ for City Bus is from MNDOT – helps people get to things ● Technology – good - FIT BITS – online exercise classes/workouts ● Increase in education from internet ● Increase education and information on restaurant menus
--	--

Partners who can help?

Current Partners:

PCPH PARTNERS

EDUCATION	HEALTHCARE	GOVERNMENT/TRIBAL	OTHER
<ul style="list-style-type: none"> University of Minnesota Crookston - Brooke Navak, Stacey Grunewald Crookston Schools - Jeremy Olson, Marita Kendig Fisher School - Joshua Mallhot Fertile-Beltrami Schools - Karl Bolstad, Sarah Nereson UMN Extension - Lisa Laegaring Fosston School District - Sue Chase East Grand Forks Schools - Suraya Driscoll 	<ul style="list-style-type: none"> Altru Health System - Alanna Strom, Shayla Solberg Longtin Insurance Agency - Ann Longtin RiverView Health - April Grunhøvd, Darcey Larsen, Kelsey Billing, Laura Heller Essentia Health Fosston - Carrie Danielson, Leif Olson, Lynae Finseth Polk County Collaborative - Colleen MacRae Northwestern Mental Health Center - Colleen MacRae, Janet Denison, Malissa Burnette, Shannon Kronlund 	<ul style="list-style-type: none"> Tri-County Community Corrections - Andrew Larson MN Department of Health - Ann March Dancing Sky Area Agency on Aging, NW Regional Development Commission - Carol Bye City of Fosston - Cassie Heide Polk County Social Services - Cheryl Smart, Karen Warmack, Megan Starr, Victoria Ramirez Polk County Sheriff's Office - Jim Tadman, Mike Norland East Grant Forks Police Department - Mike Hedlund City of Crookston - Shannon Stassen Polk County Public Health - Amanda Lien, Angel Korynta, Kirsten Fagerlund, Sarah Reese 	<ul style="list-style-type: none"> Youth Advisory Board - Caidyn Johnson, Maia Bowman, Naomi Swanson Fosston Community Volunteer - Dean Vikan Tri-Valley Opportunity Council - Jami Lee, Mitch Bakken, Jason Carlson Luthern Social Services - Julie Praska-Moser Northwest Minnesota Foundation - Nate Dorr Pastor Phil Larsen Crookston Chamber of Commerce / Visitor's Bureau - Terri Heggie

● ● ● ● **Who's Missing?**
 PCPH is committed to routinely asking "Who is missing?" and intentionally including individuals and communities most impacted.

Potential Partners:

- City Councils
- Park and Rec
- Schools/Schools Boards
- Food Service
- Coaches
- ECFE, PTA - parents
- Small and large businesses
- Human Resources - Worksite Wellness
- Clubs that support athletics
- Fitness instructors/centers
- Senior Centers
- Addt. Insurance Companies
- Addt. CAP Agencies
- Probation
- Health Care – Weight management programs
- Local Media Outlets
- Food Shelves
- Daycare/childcare/Head Start
- Government grants
- Policy Makers
- Medicare
- Mentors
- Leaders of local groups
- Farmers Markets
- Master Gardeners
- 4-H
- Restaurants
- Faith Based sports/activity – safe place

What are we going to do? (# of current partners invested in strategy)

Strategy #1: Implement/support workplace wellness initiatives in healthy eating, active living, tobacco reduction, breastfeeding support and resiliency (formerly called stress management). (18)

Strategy #2: Facilitate conversations that educate, engage and lead to policies or agreements that support the gathering/storage of healthier food choices. (10)

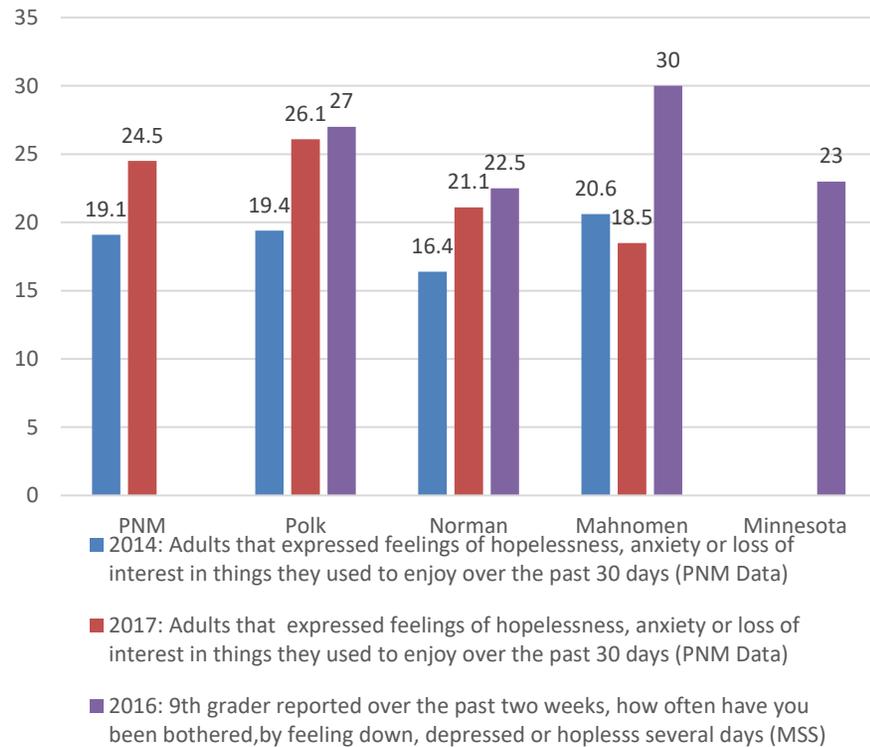
Strategy #3: Facilitate conversations that educate, engage and lead to policies and practices that create active communities by increasing opportunities for physical activity, such as use of *trails and rivers, open streets, community-wide campaigns, supporting/hosting walk/bike events, etc.* (10)

Strategy #4: Engage with partners and media to make routine physical activity and healthy food choices the social norm. (New, TBD)

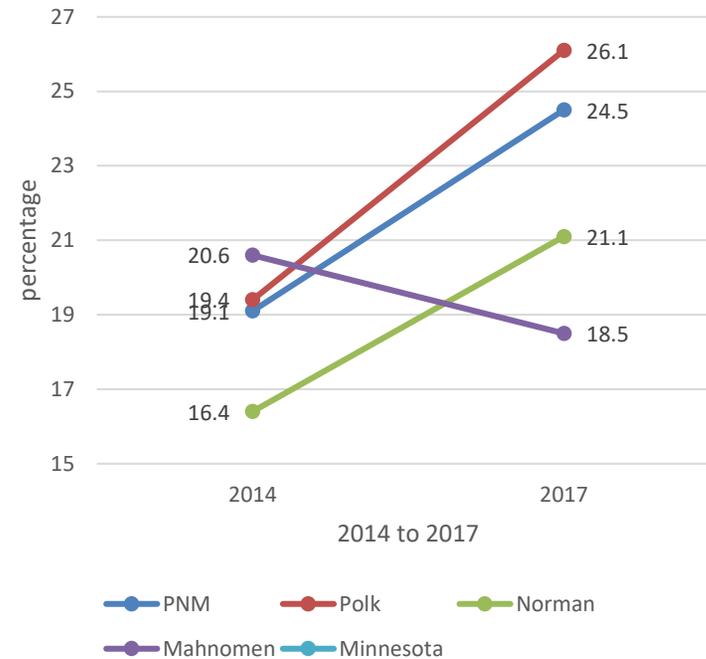
POPULATION Result: Healthy Behaviors, Healthy Community

Population Indicator: Percent of Adults feeling hopelessness, anxiety and depression / 9th graders feeling bothered, down, depressed, hopeless for several days

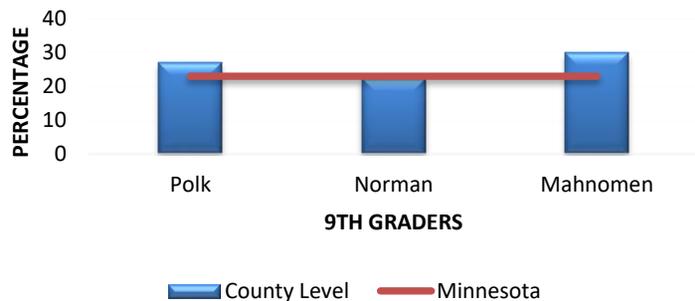
Hopelessness, Anxiety and Depression



The percent of PNM residents who reported feeling of hopelessness, anxiety or loss of interest from 2014 to 2017 (PNM Data)



Percentage 9th Graders Who Reported Over the Past Two Weeks, How Often Have You Been Bothered, by Feeling Down, Depressed or Hopeless Several Days (2016, MSS)



Process to Selecting Population Indicator:

- Indicator data was reviewed and analyzed by local public health with consultation from local/regional content experts.
- Indicator was recommended to PNM All Partners (previous workgroup) and both Health Department (Health Improvement Advisory Committees) (current workgroups).
- Partners reviewed recommended population indicator data based on: *Can this indicator speak to a broad range of audiences? Is quality data available on a timely basis? Does this indicator rise above other metrics in its ability to impact the result (healthy behaviors, healthy community)?*
- Partners agreed to keep the recommended population indicator.

Why was this population data indicator recommended? What other data was considered?

-PNM Adult Behavior Survey (Dec 2017) – alarming change from 2014 to 2017

-CHIP Priorities Exercise at All Partners Meeting (Jan 2018)

-Variance/Concept Map (Summer 2018)

-Further analysis...Deeper dive=

-**Group priority was mental wellbeing/mental health across the lifespan.** Recommend indicators (adult + youth) to paint picture of mental health/well-being across the life span and be population based (vs clinic/program based).

-**Reviewed 2016 MN Student Survey Report and Questions –**

Reviewed the *Health of Adolescents 2016* (Report from MN Student Survey) - Pg 2 Mental and Emotional Health

[http://www.health.state.mn.us/divs/chs/surveys/mss/Health-related fact sheet MSS 2016 10-31-16.pdf](http://www.health.state.mn.us/divs/chs/surveys/mss/Health-related%20fact%20sheet%20MSS%202016%2010-31-16.pdf)

-MSS Questions review- Caring adult, School/parent/community cares about you, # of Adverse Childhood Experiences (ACES), ACES relative to ATOD. Caution - We wanted to be careful not to say “*no caring adult, so youth have poor mental health*” and we wanted to be inclusive of the spectrum of mental health that each person has.

For the youth Indicator that is recommended, one constraint is only 1 survey year of MSS data available b/c it was a new question.

-Vetted indicators from the CHIP Priorities/All Partners Mtg with Content Experts Meeting with Shauna Reitmeier and Colleen MacRae, Northwestern Mental Health Center (Jan 2019) – Short story... realized that many of the proposed “indicators” from the *CHIP Priorities/All Partners Meeting* are clinic or program performance measures (vs population indicators). Clinical screeners like PHQ9 are not necessarily a whole population indicator, rather they are clinic/program compliant with screener, and assessing if improvements are being seen 6-12 months out using the screener as a tool.

-Suicide is certainly a concern, perhaps not the best indicator to choose if we want to focus on *mental wellbeing/mental health across the lifespan* – suicide has a more narrow scope, inadvertent suicide can skew data, we want the indicator to speak to a broad range of audiences so want a broader reaching indicator.

-Individuals with a co-occurring disorder (physical and mental health) have a mortality rate 8-25 years earlier than the general population.

-Reviewed the 2017 MN Statewide Health Assessment

<http://www.health.state.mn.us/healthymnpartnership/docs/2017MNStatewideHealthAssessment.pdf>

Noted/Considered: Partner/Program/Clinic Performance Measures:

-Rate of ER visits related to mental health crisis.

-Core healthy days (BRFSS): % of population with good-excellent health screening.

-% of adults (18-75) with PHQ9 depression screening composit score of >10 (moderate to severe).

-% of adolescents (12-17) who have had mental health and/or depression screening documented.

NORMAN-MAHNOMEN PUBLIC HEALTH – TURN THE CURVE (Facilitated conversation with partners)

Story Behind the Data

What factors are pushing up on the data?

- ACES
- Suicide rates
- Social isolation
- Substance misuse/abuse
- Poverty
- Unsafe living conditions
- Lack of resiliency
- Lack of transportation
- Socioeconomic factors
- Lack of access to active living/recreational opportunities

What factors are pushing down on the data?

- Social connections/caring adult
- Screening/early intervention
- Therapy
- Medication
- Health insurance
- Services within close proximity
- Care coordination
- Access to healthcare
- Positive social determinants
- Positive or healthy relationships
- Healthy coping skills and resilient behaviors

Partners who can help

NMPH PARTNERS

EDUCATION

- Norman Mahnomen School Districts
- U of MN Extension

HEALTHCARE

- NW Mental Health Center
- Sanford Health
- Essentia Health
- Mahnomen Health Center

GOVERNMENT/TRIBAL

- Social Services
- Public Health
- Law Enforcement
- White Earth
- City Government
- Dekko Center

OTHER

- Norman County East Early Childhood Initiative
- Tri-Valley Opportunity Council / Head Start
- Mahube-OTWA
- Wellness in the Woods
- Churches

Who's Missing?

NMPH is committed to routinely asking "Who is missing?" and intentionally including individuals and communities most impacted.

What we are going to do?

Strategy #1: Support programs focused on increasing awareness and support among community members so that they are comfortable having conversations about mental health, are able to identify the signs of psychological distress, and know how to refer a person to appropriate resources when they are experiencing pre-crisis and crisis situations.

Action Steps:

- Identify current community education plans and gaps
- Partner with the Ada Alive committee to host a community forum around suicide/ mental health crisis to increase awareness of the issue and resources available
- Continue to host the Mental Wellbeing Learning Community provided through MDH and expand outreach to increase participation from local community partners.
- Research implementation of a stigma reducing campaign such as “Make it Okay”

Strategy #2: Increase access to mental health service through collaboration

- Collaborate with mental health providers to identify areas of opportunity to expand crisis and mental health outpatient services to the community.
- Continue to support school-linked mental health grants

POLK COUNTY PUBLIC HEALTH – *TURN THE CURVE (Facilitated conversation with partners)*

Story Behind the Data

What factors are pushing up on the data?

Forecast: Adults: The consensus between the groups 5-10% increase.

Mental Health worker felt it would decrease 2-3%.

Youth: The consensus between the groups was an 2-10% increase. The group forecasted 2-3%, but youth participant felt it would be higher based on acceptance.

- Work/home life balance=stressful*
- Lack of socialization skills
- Farming stressors*
- Broken home: Divorce
- Opioid addiction/Hopelessness
- Poverty – Transportation, Cost of living*
- Elderly population increasing*
- Parents stressors increase child stressors
- Social Media
 - Constant negative media
 - Cat fishing-scam*

What factors are pushing down on the data?

- Less Stigma
- Zero Suicide
- Youth are talking more**
- Employer recognition
 - EAP
 - Okay to use sick days for mental health well-being
- Early recognition (screeners)= earlier intervention
- Social Media
 - Support groups
 - Education
- Relationship with healthcare providers
- Increase in screeners
- Technology
 - Access to EHR
 - Learning about signs/symptoms
- Accessible routes

- Perception of life: Everyone’s life looks great and people compare their life to it-not as great.
- Selective sharing: people share all the awesome stuff going on
- Sensationalization?
- Cellphone use
- Bullying
- Expectations/Perception - feels like more expectations in life.
- Materialistic life -affects expectation bullet
- Isolation
 - Perception there is nothing to do**
 - Lack of social connection
- Isolation-rural*
- Transient culture—no longer the generations staying around AND new people community members- welcomed?
- Work ethic-people won’t take a self-care day
- Faith-Based community
 - Lack of Access
- Acceptance-people are willing to talk (decrease stigma)
- Family history—genetics
- Figuring out who you are**
- Access to a provider
 - Transportation
- Looking for attention (more youth)
 - Low self-esteem
 - Lack of coping skills
- Trauma
- Treatment options- cost, side effects
- Income: Affects many things (ie. purchase of meds or other things people feel they need based on expectations/perception)

- Empowerment of youth by leaders/adults
- Faith-Based Community
- Mentors
- Recognizing symptoms sooner
- More resources
 - Support groups
 - Learning about side effects
 - Learning about signs and symptoms
- Texting options-nice to have resources that are not local.
- Support groups
- EMDR- Trauma informed care
- Cultural change=change in narrative
- Increased access to Mental Health Providers
- MN Nice
- Lots of efforts being made/implemented
- People have options
- Adult Mentor Programs
 - Foster Grandparent Program
 - Ignite Program
 - COVE

- Some group activities cost money=can't pay bills* (casino night)
- Family dynamics-both working parents, structure change
- Decrease in coping skills
- Sexual identity **
- School stressors **
- Lack of mental health providers
- Lack of community/sense of community

Partners who can help

Current Partners:

PCPH PARTNERS

EDUCATION

- University of Minnesota Crookston - Brooke Navak, Stacey Grunewald
- Crookston Schools - Jeremy Olson, Marita Kendig
- Fisher School - Joshua Mailhot
- Fertile-Beltrami Schools- Kari Bolstad, Sarah Nereson
- UMN Extension - Lisa Loegoring
- Fosston School District - Sue Chase
- East Grand Forks Schools - Suraya Driscoll

HEALTHCARE

- Altru Health System - Alanna Strom, Shayla Solberg
- Longtin Insurance Agency - Ann Longtin
- RiverView Health - April Grunhova, Darcey Larsen, Kelsey Billing, Laura Heller
- Essentia Health Fosston - Carrie Danielson, Leif Olson, Lynae Finseth
- Polk County Collaborative - Colleen MacRae
- Northwestern Mental Health Center - Colleen MacRae, Janet Denison, Malissa Burnette, Shannon Kronlund

GOVERNMENT/TRIBAL

- Tri-County Community Corrections - Andrew Larson
- MN Department of Health - Ann March
- Dancing Sky Area Agency on Aging, NW Regional Development Comission - Carol Bye
- City of Fosston - Cassie Heide
- Polk County Social Services - Cheryl Smart, Karen Warmack, Megan Starr, Victoria Ramirez
- Polk County Sheriff's Office - Jim Tadman, Mike Norland
- East Grant Forks Police Department- Mike Hedlund
- City of Crookston - Shannon Stassen
- Polk County Public Health - Amanda Lien, Angel Korynta, Kirsten Fagerlund, Sarah Reese

OTHER

- Youth Advisory Board - Caidyn Johnson, Maia Bowman, Naomi Swanson
- Fosston Community Volunteer Dean Vikan
- Tri-Valley Opportunity Council- Jami Lee, Mitch Bakken, Jason Carlson
- Luthern Social Services - Julie Praska-Moser
- Northwest Minnesota Foundation - Nate Dorr
- Pastor Phil Larsen
- Crookston Chamber of Commerce / Visitor's Bureau - Terri Heggie

• • • • Who's Missing?

PCPH is committed to routinely asking "Who is missing?" and intentionally including individuals and communities most impacted.

Potential Partners:

- Other Schools - Parents, coaches, teachers, administration, students;
- Additional employers/businesses
- Additional faith-based organizations
- Additional cities
- Elected officials
- Minnesota Department of Agriculture
- Minnesota Department of Transportation
- Citizens/community members/consumers
- Media outlets
- Recovery centers
- Fitness centers
- Grant writers
- Retired Senior Volunteer Program
- Parks N Recreation
- Service clubs
- Community action coalitions/United Way

What we are going to do? (# of current partners invested in strategy)

Strategy #1: Add well-being to worksite wellness/safety and provide mental health and well-being employee engagement/training opportunities on social skills, coping, dealing with grief, compassion, compassion fatigue, joy, work-life balance, etc. (13)

Strategy #2: Adopt/create intergenerational programs (i.e. youth go into elders' homes – assist, senior companion) (6)

Strategy #3: Outreach programs/initiatives & model/encourage behaviors of sense of community, kindness, belonging, gratitude, etc. (10)

Strategy #4: Seek opportunities to normalize the spectrum of mental health by having conversations and supporting programs, such as *Make It OK and Mental Health First-Aid*, to increase awareness and support community members so that they are comfortable having conversations about mental health, are able to identify the signs of psychological distress, and know how to refer a person to appropriate resources when they are experiencing pre-crisis situations. (New, TBD)

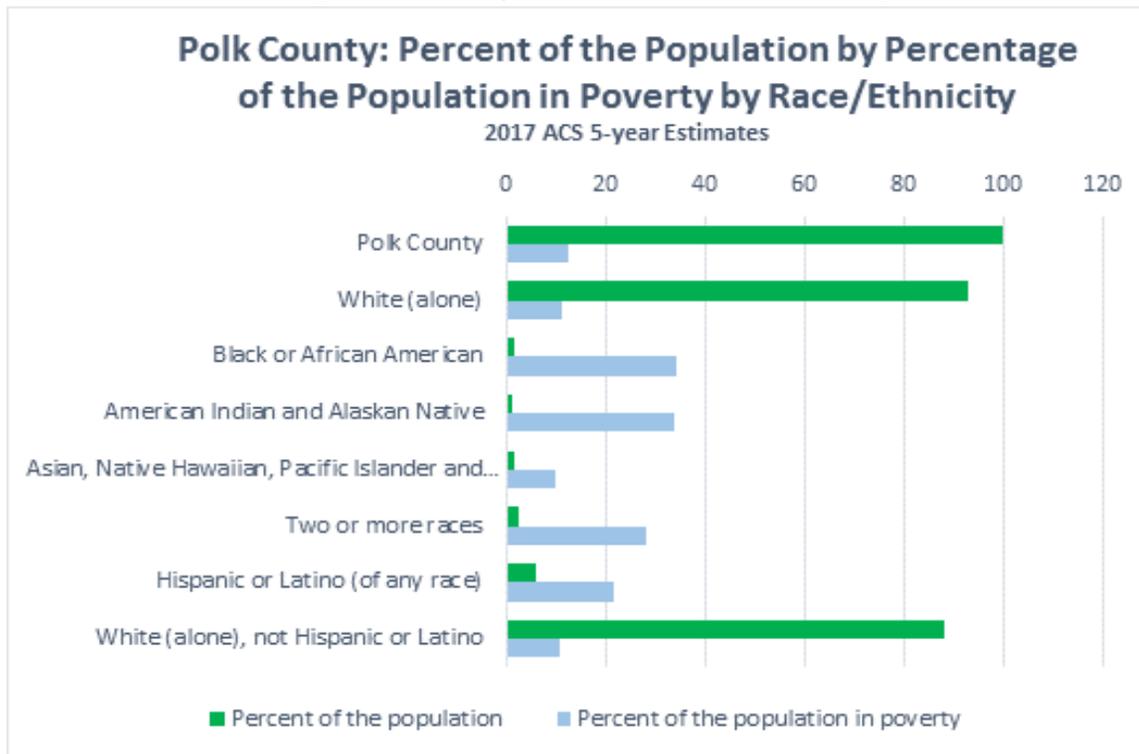
Strategy #5: Health and behavioral health care systems adopt the Zero Suicide framework for integrating evidence-based treatments and suicide prevention interventions into safety planning and care. (7)

Strategy #6: Offer higher risk individuals with programming/services (such as Nurse Family Partnership) that focus on mental well-being in the curriculum. (6)

POVERTY

The region's poverty level is one of the most critical characteristics that contribute to the number of individuals experiencing health disparities and health inequities. Reinforcing poverty as one of three PNM Community Health Improvement Plan (CHIP) priorities. Most of the participants agreed with the notion that there were not usually easy answers to this issue- that often, the root causes have stemmed from circumstances and situations that were in place decades in the past, and potentially resulting from things outside of an individuals' control. While poverty significantly affects health, it is often an overlooked inequity in our region. Further, part of the reason we moved to a more local planning process was because even within our three-county region we have varying inequities between the three counties.

Charts showed inequities in the jurisdiction for which the plan is created. Taking a deeper dive into the data, local public

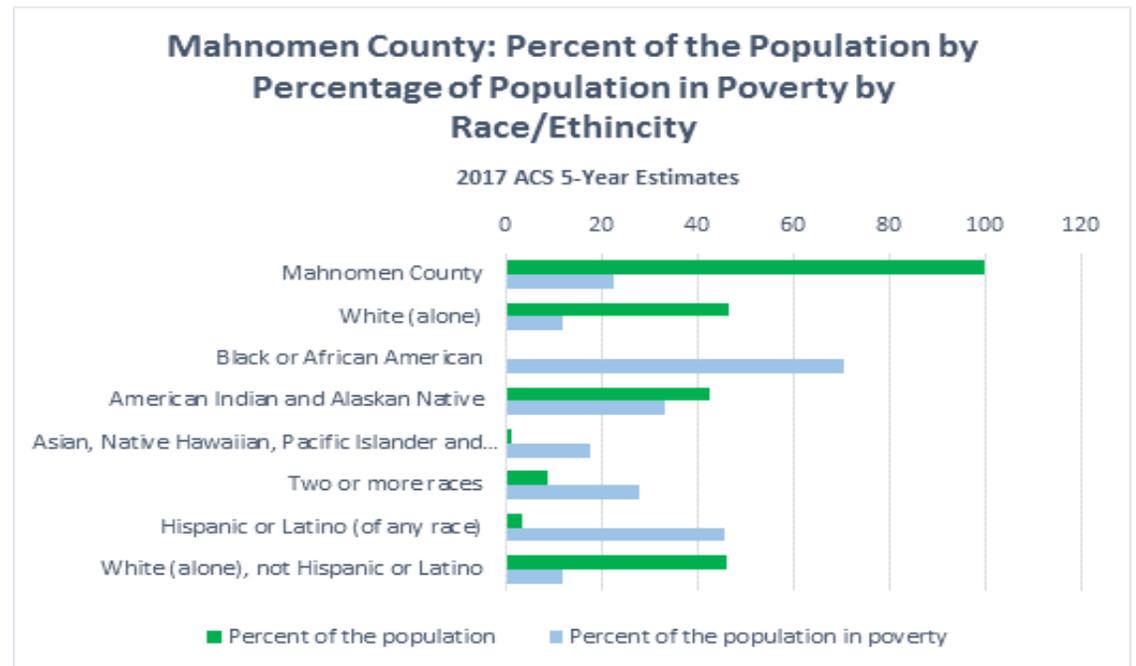
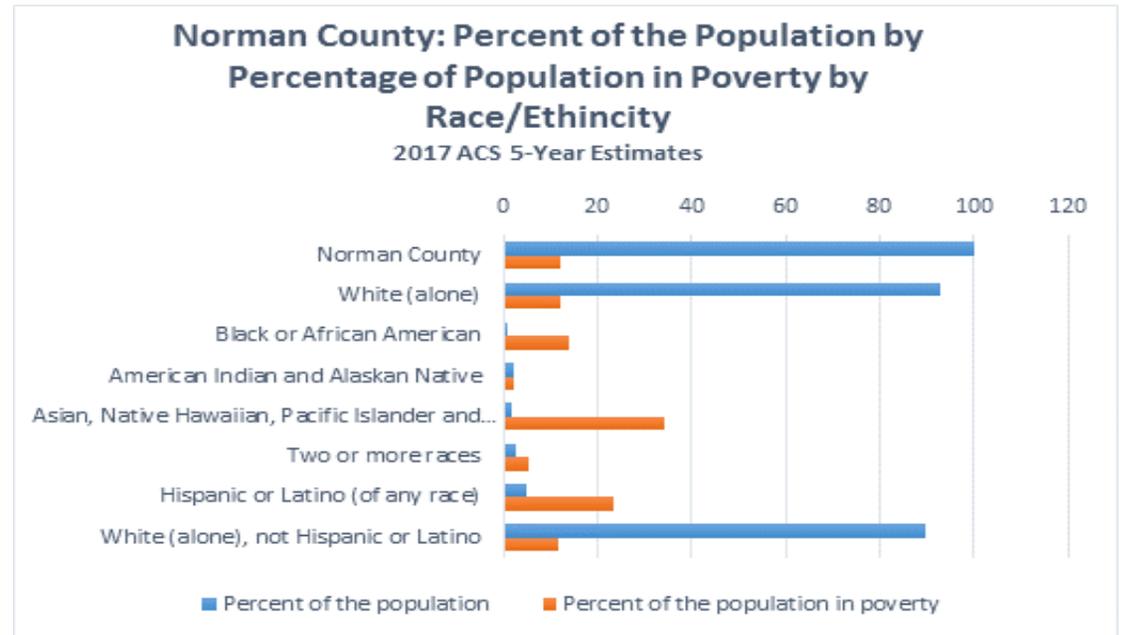


health has pointed out the disproportionate number of people living in poverty for our nonwhite minority. Albeit the charts are not all encompassing, the following data describes our population and was gathered by local public health to take a deeper dive into the data when reflecting on the "Story Behind the Curve" (RBA).

The group felt the issues around economic disparities- specifically poverty, was important enough to have its own priority. Not addressing the social determinants of health would undermine the good work that is being undertaken in the other priority areas.

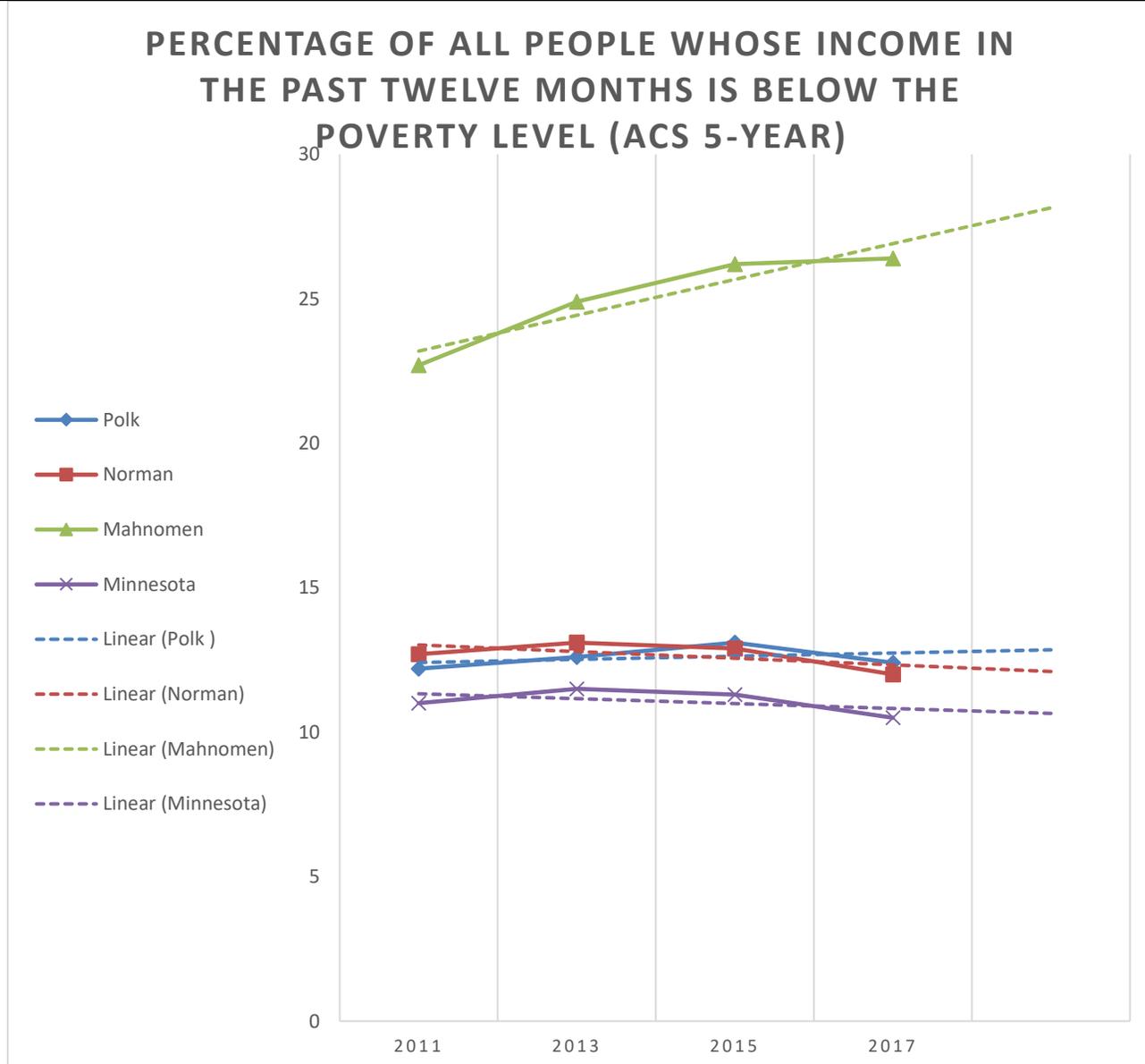
Public Health Administration has long expressed that the environments and financial resources (or lack thereof) in which people live, work, learn and play have a tremendous impact on their health. Administration appreciates the partner's interest in exploring, discussing and addressing the social determinants of health, such as poverty.

The bottom line is that no matter how we look at health, our coalition members, community stakeholders and partners are saying and prioritizing the need to collaboratively address highly complex and often linked challenges- ultimately affecting health.



Result: Healthy Behaviors, Healthy Community

Population Indicator: Percent of all people whose income in the past 12 months is below the poverty level.



Process to Selecting Population Indicator:

- Indicator data was reviewed and analyzed by local public health with consultation from local/regional content experts.
- Indicator was recommended to PNM All Partners (previous workgroup) and both Health Department (Health Improvement Advisory Committees) (current workgroups).
- Partners reviewed recommended population indicator data based on: *Can this indicator speak to a broad range of audiences? Is quality data available on a timely basis? Does this indicator rise above other metrics in its ability to impact the result (healthy behaviors, healthy community)?*
- Partners agreed to keep the recommended population indicator.

Why was this population data indicator recommended? What other data was considered?

-PNM Adult Behavior Survey (Dec 2017)

-CHIP Priorities Exercise at All Partners Meeting (Jan 2018)

-Variance/Concept Map (Summer 2018)

-Further analysis...Deeper dive=

- CHIP Priorities/All Partners Mtg – poverty across the whole population/lifespan was noted as important

Reviewed and vetted multiple indicators of poverty for example, children 5 and under, all children 18 and under, individuals living 100%/185%/250% of poverty

-Poverty- American Community Survey – reviewed variety of poverty indicators, recommend indicator b/c multiple years of data available, timely data, indicator speaks to a broad range of audiences. *Note: Children under 18 – poverty rates were higher (ACS)*

-Other data considered: graduation rate, safe and affordable housing, transportation, childcare, and equity (we reviewed and noted that these are not solely the measurement that will help quantify the achievement of our result.

-As in the past, we continue to recognize that collectively tackling poverty is a huge undertaking.

Poverty level is one of the most critical characteristics that contribute to the number of individuals experiencing preventable chronic diseases.

People and communities experiencing the greatest differences in health are also the people and communities experiencing the greatest differences in the opportunity for health, in education, income, health care and living environments.

NORMAN-MAHNOMEN PUBLIC HEALTH – *TURN THE CURVE (Facilitated conversation with partners)*

Story Behind the Data

What factors are pushing up on the data?

- Family income and earnings potential
- Family structure and support
- Trauma
- Mental health
- Generational poverty
- Lack of access to resources
- Health insurance
- Housing
- Public transportation options
- Access to services
- ACES
- Teenage pregnancy
- Childcare availability and affordability

What factors are pushing down on the data?

- Safety net programs
- Education
- Increased access/utilization of safety net programs
- Health insurance
- Family Navigator Initiative

Partners who can help

NMPH PARTNERS

- | EDUCATION | HEALTHCARE | GOVERNMENT/TRIBAL | OTHER |
|---|--|---|--|
| <ul style="list-style-type: none"> ● Norman Mahnomen School Districts ● U of MN Extension | <ul style="list-style-type: none"> ● NW Mental Health Center ● Sanford Health ● Essentia Health ● Mahnomen Health Center | <ul style="list-style-type: none"> ● Social Services ● Public Health ● Law Enforcement ● White Earth ● City Government ● Dekko Center | <ul style="list-style-type: none"> ● Norman County East Early Childhood Initiative ● Tri-Valley Opportunity Council / Head Start ● Mahube-OTWA ● Wellness in the Woods ● Churches |

● ● **Who's Missing?** ● ●
NMPH is committed to routinely asking "Who is missing?" and intentionally including individuals and communities most impacted.

What we are going to do?

Strategy #1: Increase outreach of and access to safety net programs

Action Steps:

- Explore need to renew the county resource groups so staff have a good understanding of partner programs and services to increase referrals.
- Support expanded services/locations and hours to better meet the community needs (after hours clinics, additional locations).
- Continue partnership with Family Navigator Initiative (currently A-B schools) to help better help families access services.

Strategy #2: Increase public awareness of poverty levels and the impact it has in our communities

- Explore need to hold additional poverty simulation events locally.
- Educate policymakers at all levels on Health in all Policies Roadmap (Cook County example)

POLK COUNTY PUBLIC HEALTH – *TURN THE CURVE (Facilitated conversation with partners)*

Story Behind the Data

What factors are pushing up on the data?

- Addiction broadly
- Top heavy/wage disparities
- Increased mental health and increased unemployment
- Decreased lifestyle/quality of life
- Cost of formal education for working poor (asset limited, income constrained)- start out in debt
- Lack of early education on personal finances, managing credit and financial literacy
- Unwillingness to work – prefer government help, entitlement, “if I work, I get less”- ripple effect, and some people need to work less b/c of health issues and cost of insurance/medications
- Stricter rules/paperwork (fed/state/local)
- Individuals in the justice system- no MA in jail, lack sustainable housing and workforce options
- Generational poverty, situational poverty and resources
- Compassion fatigue
- Diversity of culture/language and lack of understanding diverse life experiences
- Mnsure- assets/misappropriation of funds
- History of mental illness
- Childhood trauma and related health outcomes

What factors are pushing down on the data?

- Loan forgiveness (limited/lack of knowledge of availability, certain professions and certain geo areas)
- Assistance programs/benefits in place
- Financial planning, debt consolidation (NWSC)
- Social networks, employment and job placement
- Tri-Valley/CDA services
- Work at home (individuals are employed in a non-traditional way)
- Jobs with shift pay differential
- Felony friendly workplaces
- County programs/supports
- NWMHC/employment – individual placements/matching
- Jail/NWMHC- care coordination in preparation for leaving the jail setting, resource fair at the jail, work release, focus on stabilizing factors- learn a new skill, structure and meds as needed.
- More trades – construction related and technical skills
- Childcare asst programs
- Connecting people to resources already available
- CAP agencies and nonprofits working on specific solutions with community members

<ul style="list-style-type: none"> • Technology is changing work environment (work at home, fewer social connections) • Cost of childcare and lack of childcare • Lack of motivation- long winters, welfare benefits/assistance, can be learned behavior • Living beyond means (choice) • Cost of living, cost of medications • Constantly looking for employees- things important to staff don't align with individual/generational priorities or are a mismatch for organizational needs • College is expensive/people aren't going to college so less job options (when 4 yr degree is required) • Transportation – no driver's license in rural setting (by choice- use walk/bike/public transit, medically unable to drive or have had driving privileges removed)- can't get to work, healthcare clinic or amenities easily, lack access of transportation through social supports -timing and coordination, • Cost of living is rapidly increasing- barrier to higher education, costs associated and opportunities in the workforce for high paying jobs • Farming/Ag Business- tariffs and weather, increased drug use and mental health concerns; impact employability • Not enough supports- not being inclusive of minorities/people who are different points of view, homeless shelter, immigration – takes time to get situated (housing, job) in a new community • Crime/punitive discipline/hard to get out of the cycle, leaving jail it can be difficult to resettle in the community • High deductible health plans/financial impact • Childcare costs • Families have less informal supports to weather difficult circumstances • Less overall people • Employee turnover • Loss of wages and poverty • Unintended employment difficulty/consequences of association- having a family member who is incarcerated 	<ul style="list-style-type: none"> • Federal/2yr pilot- integrative care + social factors at NWMHC- mental health, chemical health and primary care, opportunities for people in generational poverty • More companies coming in/expansion – employment opportunities, tight market-push wages up
---	---

Partners who can help-

Current Partners:

PCPH PARTNERS

EDUCATION	HEALTHCARE	GOVERNMENT/TRIBAL	OTHER
<ul style="list-style-type: none"> University of Minnesota Crookston - Brooke Novak, Stacey Grunewald Crookston Schools - Jeremy Olson, Maria Kenzig Fisher School - Joshua Mathiol Fertile-Beltrami Schools - Karl Bolslad, Sarah Nereson UMN Extension - Lisa Loegering Fosston School District - Sue Chase East Grand Forks Schools - Suraya Driscoll 	<ul style="list-style-type: none"> Altru Health System - Akanna Strom, Shayla Solberg Longfin Insurance Agency - Ann Longfin RiverView Health - April Grunhova, Darcey Larsen, Kebeey Billing, Laura Heller Essentia Health Fosston - Carlie Danielson, Lefi Olson, Lynae Finseth Polk County Collaborative - Colleen MacRae Northwestern Mental Health Center - Colleen MacRae, Janet Denison, Malissa Burnette, Shannon Kronlund 	<ul style="list-style-type: none"> Tri-County Community Corrections - Andrew Larson MN Department of Health - Ann March Dancing Sky Area Agency on Aging, NW Regional Development Commission - Carol Bye City of Fosston - Cassie Heide Polk County Social Services - Cheryl Smart, Karon Wasmack, Megan Starr, Victoria Ramirez Polk County Sheriff's Office - Jim Tadman, Mike Norland East Grand Forks Police Department - Mike Hedlund City of Crookston - Shannon Stassen Polk County Public Health - Amanda Lien, Angel Korynta, Kirsten Fagenlund, Sarah Reese 	<ul style="list-style-type: none"> Youth Advisory Board - Caidyn Johnson, Maia Bowman, Naomi Swanson Fosston Community Volunteer Dean Vikan Tri-Valley Opportunity Council - Jami Lee, Mich Bakken, Jason Carlson Luthern Social Services - Julie Praska-Moser Northwest Minnesota Foundation - Nate Dorr Pastor Phil Larsen Crookston Chamber of Commerce / Visitor's Bureau - Teri Heggie

PCPH is committed to routinely asking "Who is missing?" and intentionally including individuals and communities most impacted.

Potential Partners:

State/federal legislation
 Financial Planners/Banks
 Utility companies
 Food bank/shelters
 Lifestyle coaches
 Employers/Chambers
 Parents/families/residents
 Support groups- generational, addictions, college kids in poverty/share common concern
 Advisory Committee- individuals experiencing poverty
 Addt Church/faith based
 Community Action- ICCC
 Judicial system- judges, attorneys
 Nonprofits
 Childcare providers/universities teaching soon to be early childhood Teachers
 Service clubs
 Workforce Development Center/MN DEED
 Northwest Private Industry Council/NW Region 1, CareerForce

What we are going to do? (# of current partners invested in strategy)

- Strategy #1:** Create awareness about poverty and its effects on health by talking with family and friends. (New, TBD)
- Strategy #2:** Explore opportunities to offer financial education in schools and at worksites (financial literacy, debt ratio, cc company vs. bank lending and so forth). (8)
- Strategy #3:** Increase/Ensure K-12 high school graduation. (9)
- Strategy #4:** Engage employers in planning and creating positive, welcoming workplaces. (12)
- Strategy #5:** Instill hope and increase life skills for personal and community resiliency (ability to bounce back from difficult situations). (8)
- Strategy #6:** Update and maintain *Polk County Resource Group* website, a list of local resources to refer residents/clients to. (11)
- Strategy #7:** Support and advocate for public transit availability at a lower cost. (7)
- Strategy #8:** Raise community awareness related to housing issues and partner to make housing affordable, safe and possible. (6)

CALL TO ACTION

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

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

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

Here are some things you might consider:

Advocate for the plan’s adoption in your organization or other parts of the community

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

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

Stay involved with groups working to implement the plan

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

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

SUSTAINABILITY

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

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

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

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

2017 Polk-Norman-Mahnomen Adult Health Behavior Survey- Executive Summary and Methods

Weight

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

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

Physical Activity

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

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

Tobacco

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

- This is lower than 15.5% found three years previously and suggests that significant positive impacts may be the result of tobacco prevention efforts.
- Current smokers are split equally across genders but differ significantly by income and education.
 - Individuals with less than \$34,000 annual household income smoke at three times the rate of all other income groups (24% vs. 8%).
 - Only 5% of those with 4-year degrees smoke compared to all other educational demographic groups which smoke at approximately 16%.

Alcohol

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

- 81% of individuals from higher income households (>\$75k) report any drinking compared to those earning \$34k or less (37%).
- 26% of respondents indicated that alcohol had a ‘harmful effect’ on themselves or a family member. Income level did not change the outcome.
 - 38% of respondents aged 34 and younger report experiencing harmful effects from alcohol.

Mental Health

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

- Over the past 30 days, nearly 25% of respondents expressed feelings of hopelessness, anxiety or loss of interest in things they used to enjoy.

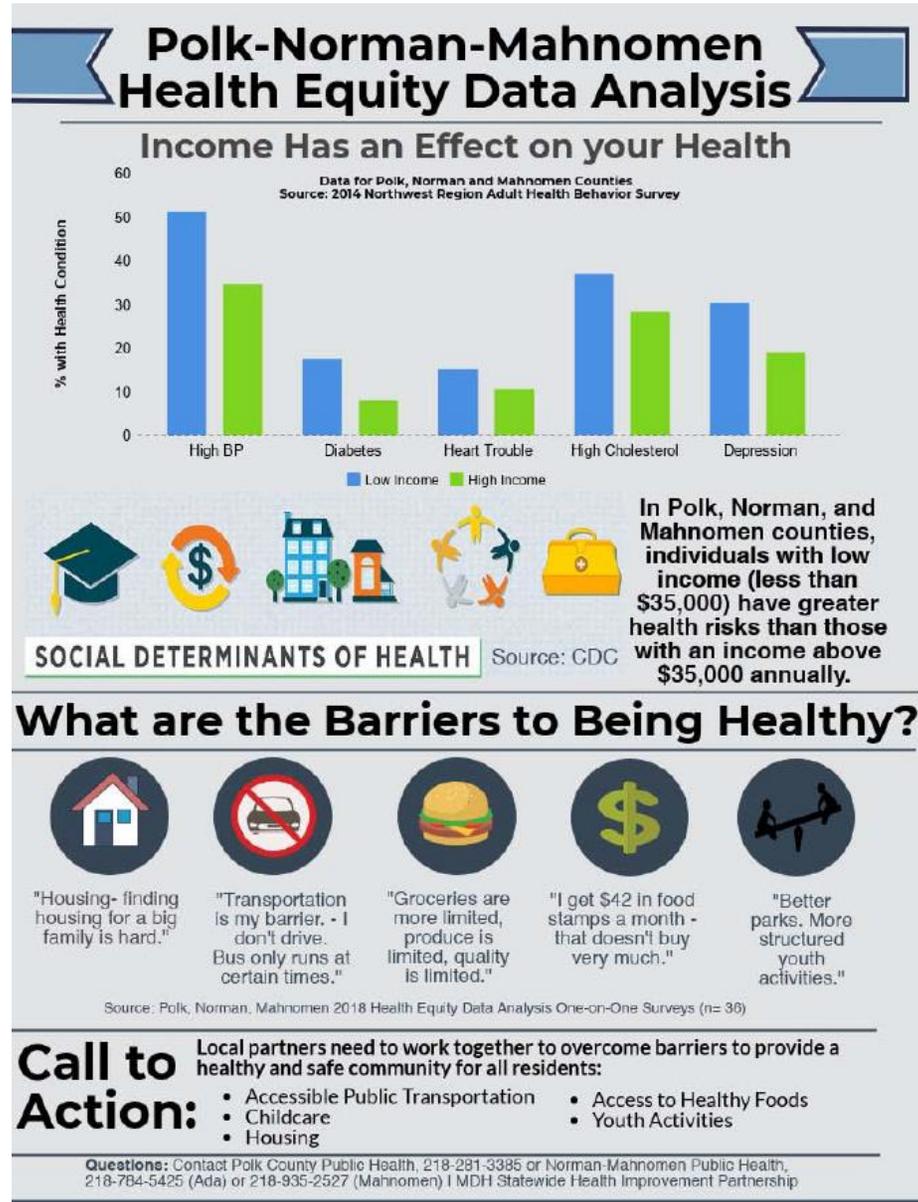
Survey Instrument - Staff from the public health agencies representing Beltrami, Clearwater, Hubbard, Kittson, Lake of the Woods, Mahnomen, Marshall, Norman, Pennington, Polk, Red Lake and Roseau counties developed the questions for the survey instrument with technical assistance from the Minnesota Department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

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

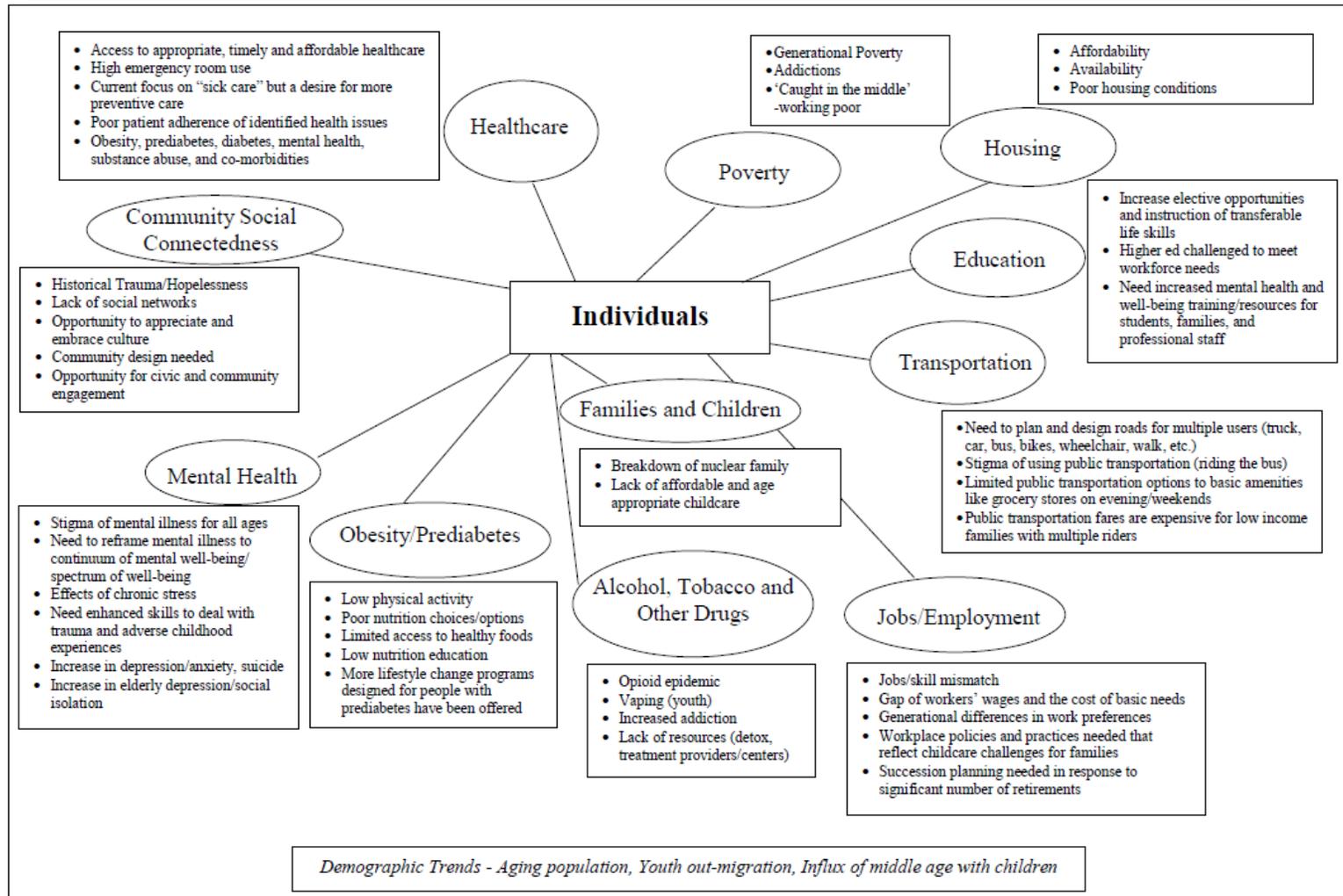
Survey Administration - An initial survey packet that included a cover letter, the survey instrument, and a postage-paid return envelope was mailed November 27, 2017, to 18,679 households in the 12-county region. In nine of the counties, survey packets were mailed to samples of 1600 households per county. Three of the counties have fewer than 1600 households; in these cases, survey packets were mailed to all households.

About one week after the first survey packets were mailed (December 5), a reminder postcard was sent to all sampled households, reminding those who had not yet returned a survey to do so, and thanking those who had already responded. Three weeks after the reminder postcards were mailed (December 27), another full survey packet was sent to all households that still had not returned the survey. The remaining completed surveys were received over the next six weeks, with the final date for the receipt of surveys being January 31, 2018.

Data Entry and Weighting - The responses from the completed surveys were scanned into an electronic file by Survey Systems, Inc. To ensure that the survey results are representative of the adult population of each of the twelve counties, the data were weighted when analyzed. The weighting accounts for the sample design by adjusting for the number of adults living in each sampled household. The weighting also includes a post-stratification adjustment so that the gender and age distribution of the survey respondents mirrors the gender and age distribution of the adult populations of the twelve counties, according to U.S. Census Bureau American Community Survey 2012-2016 estimates.



Variance (Concept) Map of Polk-Norman-Mahnomen CHS - 2018 Top Concerns Impacting Quality of Life



From May-June 2018, over 55 individuals participated in Key Informant interviews with public health staff held throughout Polk, Norman and Mahnomen Counties. Participants were asked to think broadly about different recurring needs and concerns of clients and the general population. An in-depth analysis of the question, “What do you believe are the 2-3 most important issues that should be addressed in order to help further improve the quality of life for people in our community (county)?” is provided through a concept map. A concept map was developed in order to assist readers in understanding the large volume of information provided. While the qualitative items identified in the concept map are incomplete in terms of exhausting phenomena contributing to the quality of life within the region, at this time it is a highlight of those recurring items viewed by participants as most influential.

Strategy Prioritization

This worksheet helps partners determine the right strategies to undertake.

Partners are invited to do the following:

- For the indicator being addressed, write down each one of the solutions on a separate row.
- Each solution should be assessed by the four criteria in the corresponding columns to the right. Partners should ask themselves if the solution ranks High (H), Medium (M), or Low (L) according to each of the following criteria:

Leverage - How strongly will the proposed strategy impact progress as measured by the baselines?

Given that resources are finite, decisions with respect to the dedication of resources to a proposed strategy must be based on the expected impact of those resources on progress. One way to gauge impact is to assess the importance of the underlying root cause(s) an option is designed to address. In other words, the strategy that is proposed should address the most important root causes identified and, therefore, be geared to having the greatest potential impact on the trend for the corresponding baseline.

Feasibility - Is the proposed strategy feasible? Can it be done?

Counterpart to the question of leverage. Leverage and feasibility must be weighed and balanced in choosing the strategy. A strategy that has high leverage and high feasibility will be a prime candidate for action. The choice among other options, however, will likely involve trade-offs between leverage and feasibility and will need to be weighed accordingly.

Specificity - Is the strategy specific enough to be implemented?

Is there a timeline? Do the deliverables answer the questions of: *Who? What? When? Where? How?*

Values - Is the strategy consistent with the values of the community?

There are many actions that are specific and high leverage but not consistent with our values. For example to improve rates of entry into foster care, we could slow down or stop conducting investigations on child abuse. It may be even be effective, but completely out of line with our shared values.

Adults Overweight – Polk Strategies (Mtg 2):	Leverage	Feasibility	Specificity	Value
Marketing/promotion of physical activity and nutrition	H M L	H M L	H M L	H M L
Offer classes/community education on healthy eating, cooking and/or physical activity.	H M L	H M L	H M L	H M L
Build awareness of how policies and practices facilitate and inhibit individual’s choice to be active (ex. walk/bike) thereby affecting health and quality of life	H M L	H M L	H M L	H M L
Develop and implement policies and practices that create active communities by increasing opportunities for physical activity	H M L	H M L	H M L	H M L
Hold events or opportunities to engage partners and general public around physical activity – ex, Trails and Rivers, Open Streets, community-wide campaigns, supporting walk/bike events, etc.	H M L	H M L	H M L	H M L
Promote preventative health exams with a primary care provider.	H M L	H M L	H M L	H M L
Confirm/establish system for healthcare/mental health provider to screen, counsel, refer and follow-up.	H M L	H M L	H M L	H M L
Provide access to a wellness/lifestyle coach, Registered Dietician and/or Integrative Medicine.	H M L	H M L	H M L	H M L
Empower local stakeholders with knowledge and capacity to positively impact their community’s local food and farm economy.	H M L	H M L	H M L	H M L
Mobilize resources to create/expand healthy food access (Farm to School, Power of Produce, Healthy Food Trucks, etc).	H M L	H M L	H M L	H M L
Advocate for policy, systems and environmental changes that support healthy eating behaviors.	H M L	H M L	H M L	H M L
Build partnerships with diverse community work groups/people to plan and integrate healthy eating activities into existing systems and policies.	H M L	H M L	H M L	H M L
Facilitate conversations that educate and lead to policies or agreements that support the gathering/storage of healthier food choices.	H M L	H M L	H M L	H M L
Increase access, availability and selection of healthier foods offered through food assistance programs (food shelves, SNAP, etc).	H M L	H M L	H M L	H M L
Implement/support workplace wellness initiatives.	H M L	H M L	H M L	H M L
Improve the work environment in healthy eating, active living, tobacco reduction, breastfeeding support and resiliency (formerly called stress management).	H M L	H M L	H M L	H M L
Provide breastfeeding supports to individuals, families, communities and workplaces.	H M L	H M L	H M L	H M L
Work with insurance companies to increase coverage, incentives (alternative gym memberships – ex. online class) and reduced prior authorizations	H M L	H M L	H M L	H M L
Ensure K-12 students graduate from high school.	H M L	H M L	H M L	H M L

Mental Health and Well-being- Polk Strategies (Mtg 2):	Leverage	Feasibility	Specificity	Value
Educate staff to identify and assist persons at-risk using a variety of tools: gatekeeper training, suicide screenings, evidence-based depression /anxiety screener, and knowing warning signs	H M L	H M L	H M L	H M L
Outreach campaign to improve community awareness of existing resources, that reduce the stigmatism around mental health and promotes mental well-being/resilience	H M L	H M L	H M L	H M L
Make mental health services more convenient, affordable and culturally appropriate using evidence-based best practice (CBT, DBT, EMDR).	H M L	H M L	H M L	H M L
Health and behavioral health care systems adopt the Zero Suicide framework for integrating evidence-based treatments and suicide prevention interventions into safety planning and care	H M L	H M L	H M L	H M L
Support safe care transitions and create organizational linkages (i.e. formal referral protocols, interagency agreements, rapid referrals, and follow-up contacts)	H M L	H M L	H M L	H M L
Improve response to individuals in crisis (hotlines, mobile crisis teams, walk in crisis clinics, peer-support programs; Vidyo 24/7)	H M L	H M L	H M L	H M L
Model/encourage behaviors of: sense of community, kindness, gratitude (I.e. host a neighborhood grill)	H M L	H M L	H M L	H M L
Build a 'sense of community' curriculum that can be imbedded in school. (Pre-K through post-graduate). Require parents to complete sections with children.	H M L	H M L	H M L	H M L
Increase life/social skills in community, such as workshops on critical thinking, stress management, coping, economic stress, mindfulness, self-care, divorce and physical illness in the school/workplace (life span)	H M L	H M L	H M L	H M L
Build resilience, optimism, positive self-concepts, and hopefulness	H M L	H M L	H M L	H M L
Enhance social connectedness and support through social programs for specific population groups (such as older adults, Vets, or LGBT youth)	H M L	H M L	H M L	H M L
Encourage volunteering opportunities. Look at local incentive programs (ie. x amount of volunteer= x amount donated to a local cause).	H M L	H M L	H M L	H M L
Outreach programs to support kindness, sense of belonging, gratitude, etc	H M L	H M L	H M L	H M L
Adopt trauma informed care models in schools and health care	H M L	H M L	H M L	H M L
Provide ACES screening and education to parents and children at enrollment starting in pre-school.	H M L	H M L	H M L	H M L
Create opportunities for staff to have walking meetings	H M L	H M L	H M L	H M L
Adopt the acceptance of mental health days at work and school.	H M L	H M L	H M L	H M L
Create Partnership/Resource Center for Polk County	H M L	H M L	H M L	H M L
Create policies or workplace norms around work-life balance.	H M L	H M L	H M L	H M L
Offer programs that focus on mental well-being in the curriculum to higher risk individuals (NFP, MH, SS)	H M L	H M L	H M L	H M L
Look at systems in your organization that may cause stigma. Ex: Situation depression stays in chart forever	H M L	H M L	H M L	H M L
Adopt/create intergenerational programs (i.e. youth go into elders' homes – assist, senior companion)	H M L	H M L	H M L	H M L
Add well-being to worksite wellness. Provide annual mental health and well-being trainings on social skills, coping, dealing with grief, compassion, compassion fatigue, etc.	H M L	H M L	H M L	H M L

Poverty – Polk Strategies (Mtg 2):	Leverage	Feasibility	Specificity	Value
Create opportunities for co-location of services (Social worker/nurses, DEED) at other locations, including but not limited to: shelters, library, WIC	H M L	H M L	H M L	H M L
Implement Pathways for Success/collaborate on skills development (employment, education, skills, on the job training, financial literacy)	H M L	H M L	H M L	H M L
Enhance student pipeline				
Support local policies and initiatives to improve broadband internet across Polk County	H M L	H M L	H M L	H M L
Provide and support free/available/high quality childcare options	H M L	H M L	H M L	H M L
Develop pathways for inmates leaving the jail to attain jobs. (Steps before and after)	H M L	H M L	H M L	H M L
Challenge/evaluate current healthcare insurance structure	H M L	H M L	H M L	H M L
Create a campaign to control advertising that target vulnerable populations (ie. Credit card, debit, consignment, rent-to-own)	H M L	H M L	H M L	H M L
Work collectively to host job fairs in Polk County	H M L	H M L	H M L	H M L
Create/support DRIVE Fundraisers: (Supporting children from Polk County entering college living poverty)	H M L	H M L	H M L	H M L
Implement financial education in schools and at the worksite (financial literacy, debt ratio, cc company vs. bank lending and so forth)	H M L	H M L	H M L	H M L
Create a list of local resources to refer clients to: SNAP, Sexual Health, Health Coaches, Health Insurance Benefits, EGF tech-financial literacy, DEED/NW Private Industry, Riverview Community Care	H M L	H M L	H M L	H M L
Provide education/opportunity to learn about personal farming practices and nutrition education (UMN)	H M L	H M L	H M L	H M L
Support and advocate for public transit availability at lower cost. (IE Fosston 50 cents per ride, no cost for parents getting their kids to daycare)	H M L	H M L	H M L	H M L
Ensure K-12 high school graduation	H M L	H M L	H M L	H M L
Partner to make housing affordable and safe	H M L	H M L	H M L	H M L
Partner to increase personal and community resiliency (ability to bounce back from difficult situations)	H M L	H M L	H M L	H M L
Increase accessibility of timely and affordable healthcare	H M L	H M L	H M L	H M L
Recognize value of diversity and jointly assess -Are we as welcoming as we think? Underrepresented? Opportunities?	H M L	H M L	H M L	H M L
Attract new talent to the area (workforce)	H M L	H M L	H M L	H M L
Engage employers in planning and creating positive workplace cultures, welcoming workplace	H M L	H M L	H M L	H M L
Create family relocation package/supports for families, partners, spouses	H M L	H M L	H M L	H M L
Branding of benefits to living in NW MN/Collaborate on outreach marketing to immigrants, new residents, return to work individuals (disability/incarcerated, etc)	H M L	H M L	H M L	H M L

Example of Strategy Prioritization Themes (completed after the H/M/L Ranking)

Indicator: Mental Health and Well-being

Leverage, Feasibility, Specificity and Values- High (3), Medium (2) and Low (1), 4 groups

Means were calculated for strategies that partner break out groups did not have time to rank.

Yellow = Strategy Included in Survey Monkey

Overall Totals

Add well-being to worksite wellness. Provide annual mental health and well-being trainings on social skills, coping, dealing with grief, compassion, compassion fatigue, etc.	46
Offer programs that focus on mental well-being in the curriculum to higher risk individuals (NFP, MH, SS)	44
Adopt/create intergenerational programs (i.e. youth go into elders' homes – assist, senior companion)	44
Health and behavioral health care systems adopt the Zero Suicide framework for integrating evidence-based treatments and suicide prevention interventions into safety planning and care	43
Improve response to individuals in crisis (hotlines, mobile crisis teams, walk in crisis clinics, peer-support programs; Vidyo 24/7)	43
Model/encourage behaviors of: sense of community, kindness, gratitude (I.e. host a neighborhood grill)	43
Outreach programs to support kindness, sense of belonging, gratitude, etc	43
Adopt trauma informed care models in schools and health care	43
Increase life/social skills in community, such as workshops on critical thinking, stress management, coping, economic stress, mindfulness, self-care, divorce and physical illness in the school/workplace (life span)	42
Create policies or workplace norms around work-life balance.	42
Create opportunities for staff to have walking meetings	41.33
Support safe care transitions and create organizational linkages (i.e. formal referral protocols, interagency agreements, rapid referrals, and follow-up contacts)	41
Outreach campaign to improve community awareness of existing resources, that reduce the stigmatism around mental health and promotes mental well-being/resilience	41
Support safe care transitions and create organizational linkages (i.e. formal referral protocols, interagency agreements, rapid referrals, and follow-up contacts)	41
Enhance social connectedness and support through social programs for specific population groups (such as older adults, Vets, or LGBT youth)	40
Create Partnership/Resource Center for Polk County	40
Look at systems in your organization that may cause stigma. Ex: Situation depression stays in chart forever	40
Adopt the acceptance of mental health days at work and school.	38.67
Provide ACES screening and education to parents and children at enrollment starting in pre-school.	38
Build a 'sense of community' curriculum that can be imbedded in school. (Pre-K through post-graduate). Require parents to complete sections with children.	37

Build resilience, optimism, positive self-concepts, and hopefulness	37
Make mental health services more convenient, affordable and culturally appropriate using evidence-based best practice (CBT, DBT, EMDR).	36
Encourage volunteering opportunities. Look at local incentive programs (ie. x amount of volunteer= x amount donated to a local cause).	35
Leverage and Feasibility - strategy with high leverage and feasibility are a prime candidate for action	
Model/encourage behaviors of: sense of community, kindness, gratitude (I.e. host a neighborhood grill)	22
Outreach programs to support kindness, sense of belonging, gratitude, etc	22
Create policies or workplace norms around work-life balance.	22
Adopt/create intergenerational programs (i.e. youth go into elders' homes – assist, senior companion)	22
Add well-being to worksite wellness. Provide annual mental health and well-being trainings on social skills, coping, dealing with grief, compassion, compassion fatigue, etc.	22
Outreach campaign to improve community awareness of existing resources, that reduce the stigmatism around mental health and promotes mental well-being/resilience	21
Health and behavioral health care systems adopt the Zero Suicide framework for integrating evidence-based treatments and suicide prevention interventions into safety planning and care	21
Offer/Continue programs that focus on mental well-being in the curriculum to higher risk individuals (NFP, MH, SS)	20
Educate staff to identify and assist persons at-risk using a variety of tools: gatekeeper training, suicide screenings, evidence-based depression /anxiety screener, and knowing warning signs	20
Improve response to individuals in crisis (hotlines, mobile crisis teams, walk in crisis clinics, peer-support programs; Vidyo 24/7)	20
Increase life/social skills in community, such as workshops on critical thinking, stress management, coping, economic stress, mindfulness, self-care, divorce and physical illness in the school/workplace (life span)	20
Enhance social connectedness and support through social programs for specific population groups (such as older adults, Vets, or LGBT youth)	20
Adopt trauma informed care models in schools and health care	20
Look at systems in your organization that may cause stigma. Ex: Situation depression stays in chart forever	20
Support safe care transitions and create organizational linkages (i.e. formal referral protocols, interagency agreements, rapid referrals, and follow-up contacts)	19
Build resilience, optimism, positive self-concepts, and hopefulness	19
Adopt the acceptance of mental health days at work and school.	18.67
Create Partnership/Resource Center for Polk County	18.67
Create opportunities for staff to have walking meetings	18.66
Make mental health services more convenient, affordable and culturally appropriate using evidence-based best practice (CBT, DBT, EMDR).	17
Build a 'sense of community' curriculum that can be imbedded in school. (Pre-K through post-graduate). Require parents to complete sections with children.	17
Encourage volunteering opportunities. Look at local incentive programs (ie. x amount of volunteer= x amount donated to a local cause).	17
Provide ACES screening and education to parents and children at enrollment starting in pre-school.	17

Total plus Leverage and Feasibility

Add well-being to worksite wellness. Provide annual mental health and well-being trainings on social skills, coping, dealing with grief, compassion, compassion fatigue, etc.	68
Adopt/create intergenerational programs (i.e. youth go into elders' homes – assist, senior companion)	66
Model/encourage behaviors of: sense of community, kindness, gratitude (I.e. host a neighborhood grill)	65
Outreach programs to support kindness, sense of belonging, gratitude, etc	65
Health and behavioral health care systems adopt the Zero Suicide framework for integrating evidence-based treatments and suicide prevention interventions into safety planning and care	64
Create policies or workplace norms around work-life balance.	64
Offer programs that focus on mental well-being in the curriculum to higher risk individuals (NFP, MH, SS)	64
Improve response to individuals in crisis (hotlines, mobile crisis teams, walk in crisis clinics, peer-support programs; Vidyo 24/7)	63
Adopt trauma informed care models in schools and health care	63
Outreach campaign to improve community awareness of existing resources, that reduce the stigmatism around mental health and promotes mental well-being/resilience	62
Increase life/social skills in community, such as workshops on critical thinking, stress management, coping, economic stress, mindfulness, self-care, divorce and physical illness in the school/workplace (life span)	62
Educate staff to identify and assist persons at-risk using a variety of tools: gatekeeper training, suicide screenings, evidence-based depression /anxiety screener, and knowing warning signs	61
Support safe care transitions and create organizational linkages (i.e. formal referral protocols, interagency agreements, rapid referrals, and follow-up contacts)	60
Enhance social connectedness and support through social programs for specific population groups (such as older adults, Vets, or LGBT youth)	60
Look at systems in your organization that may cause stigma. Ex: Situation depression stays in chart forever	60
Create opportunities for staff to have walking meetings	59.99
Create Partnership/Resource Center for Polk County	58.67
Adopt the acceptance of mental health days at work and school.	57.34
Build resilience, optimism, positive self-concepts, and hopefulness	56
Provide ACES screening and education to parents and children at enrollment starting in pre-school.	55
Build a 'sense of community' curriculum that can be imbedded in school. (Pre-K through post-graduate). Require parents to complete sections with children.	54
Make mental health services more convenient, affordable and culturally appropriate using evidence-based best practice (CBT, DBT, EMDR).	53
Encourage volunteering opportunities. Look at local incentive programs (ie. x amount of volunteer= x amount donated to a local cause).	52

Appendix E

Sample from Polk Survey Monkey – *Partners completed questionnaire in preparation for Mtg 3.*

Healthy Behaviors, Healthy Communities

Welcome - Thank you for participating in the Polk County Community Health Improvement Plan. At our last in-person meeting we evaluated each strategy that was proposed at our first meeting when we discussed how we could turn the curve on the data around adults overweight, mental health/mental well-being and poverty. Using a strategy grid each group provided a high, low or medium ranking for Leverage, Feasibility, Specificity and Value for each strategy. Polk County Public Health compiled the data and looked for themes and strategies that ranked high in overall totals and leverage/feasibility.

The next step of the process is for you or your organization to select which strategies you or your organization can or feel invested in to TURN THE CURVE on decreasing the percentage of adults overweight, decreasing poverty and improving overall mental health and mental well-being.

Our expectation is NOT that you or your organization try to tackle each strategy, but to select strategies are being implemented or you plan on implementing in the next year.

Overweight

Improve the work environment in healthy eating, active living, tobacco reduction, breastfeeding support and resiliency (formerly called stress management).

Have you or your organization implemented or plan to implement the strategy?

Yes No **If yes, what are the plans or future plans?**

How will success be measured? (How much, how well, who is better off?)