Partnership4Health
Community Health Board

Community Health Improvement Plan

2020-2024

Becker, Clay, Otter Tail, and Wilkin Counties

Public Health
Prevent. Promote. Protect.

EXECUTIVE SUMMARY

To Protect, Promote, and Preserve the Health of the Public

(Partnership4Health Community Health Board Mission Statement)

In 2015, following several years of partnering to address community needs, public health agencies in Becker, Clay, Otter Tail, and Wilkin counties in rural West Central Minnesota formed Partnership4Health, a multi-county community health board. In accordance with MN Statute 145A and governed as a joint power's entity under MN Statute 471.59, the CHB serves a combined population of 161,052. Each of the four counties maintains a separate public health department and public health director. The four directors review and compare services and strategies and identify ways to align, merge, and/or expand to increase efficiency and impact.

At least every five years, the P4H-CHB invites local stakeholders such as hospitals, clinics, county administrators, commissioners, community organizations, and community members, to engage in community health assessment (CHA) and community health improvement planning (CHIP). The CHB facilitates an evidence-based process to review priority issues, formulate goals, develop interventions, and evaluate effectiveness to improve community health in our four counties.

The 2020-2024 P4H-CHB CHIP systematically addresses priority issues identified during the 2018-2019 Community Health Assessment (CHA). Analysis of health, social, and economic data as well as community input led to the identification of the top health priorities: Mental Well-Being and Dental Access. The CHIP details objectives, strategies, and action steps for public health and community partner actions aimed at these priority areas.

The CHIP aims to improve the health of everyone in the four-county area. This plan does not represent all the health improvement efforts initiated and implemented by P4H-CHB and its partners. It addresses how we collectively impact the health status of our community in the selected priority areas.

The impact of this plan grows as residents, community partners, and public health embrace it together. We thank those who provided input and we now invite you to participate in the plan. We thank-you in advance for partnering with us in creating a healthier community not just for ourselves, but also for our children and generations to come.

We hope that this CHIP ignites our shared passion and increases the community commitment towards making our communities a great place to call home - for everyone.

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OUR MISSION

To Protect, Promote, and Preserve the Health of the Public

OUR VISION

All constituents of Becker, Clay, Otter Tail and Wilkin counties are provided essential public health services through a strong and sustainable public health partnership demonstrated by:

An effective and responsive Community Health Board

- ✓ Collaboration across communities and incorporation of multiple perspectives
- ✓ Professional, ethical, and honest practice
- ✓ High standards of excellence

Cross jurisdictional sharing

- ✓ Multi-disciplinary teams with specialized expertise work across county lines
- ✓ State Health Improvement Partnership, MnCHOICES, Family Home Visiting, Health Information Exchange, Quality Improvement, Child and Teen Checkups, Environmental Health, and Follow-Along Program

A focus on the social determinants of health

- ✓ Addressing the social determinants of health such as neighborhood and built environment, health and health care, social and community context, education and economic stability
- ✓ Creating opportunities for all to achieve health

Fiscal stewardship

- ✓ Budget development reflecting the needs of the community
- ✓ Standardized financial management
- ✓ Limited or non-existent redundancy
- ✓ Leveraged funding related to community needs
- ✓ Transparent and accountable

Authentic community engagement in promoting health

- ✓ Community involvement and input into program and service development and delivery
- ✓ Purposeful conversations with the public, those facing health inequities, the media, decision makers, and all community partners

Engaged, knowledgeable leadership

- ✓ Trusted partners
- ✓ Open communication
- ✓ Recognize and reward performance and effectiveness
- ✓ Clear decision making
- ✓ Health equity/workforce

Innovative approach to public health

- ✓ Excellence
- ✓ Creativity
- ✓ Innovation
- ✓ Flexibility
- ✓ Inclusiveness

OUR VALUES

Relationships are key: Teamwork, Collaboration, Integrity, Engaging all voices

Accountability: Dependable, Equitable, Efficiency, Effective

Fiscal Stewardship: Transparent and Accountable

High public health standards: Excellence, Creativity, Innovation, Flexibility, Inclusiveness

What is a Community Health Assessment?

Community members and organizations use a community health assessment to gain an understanding of the key health concerns and needs of the community. Public health departments in Becker, Clay, Otter Tail, and Wilkin counties facilitated the Partnership4Health-Community Health Board (P4H-CHB) 2018 community health assessment with input from community members and stake holders.

Process used in Community Health Assessment

The 2018 Community Health Assessment was driven by the public health departments located in Becker, Clay, Otter Tail, and Wilkin counties. Quantitative and qualitative data from multiple sources were reviewed and analyzed to identify issues that impact health and the health outcomes within our population.

The public health departments partnered with the following hospitals within the four counties to collect information from community stakeholders and the general population utilizing surveys distributed via email:

- Essentia Health in Detroit Lakes and Fargo
- Lake Region Healthcare in Fergus Falls
- Perham Health in Perham
- St. Francis Healthcare in Breckenridge
- Sanford Health in Fargo

The hospitals also analyzed aggregate data from their electronic health records. Perham Health and Lake Region Healthcare examined aggregate data received through the Integrated Health Programs serving low income families enrolled in Minnesota Medical Assistance.

The four public health departments partnered with the Statewide Health Improvement Partnership (SHIP) and utilized a randomized mailed household survey to collect additional information related to nutrition, physical activity, tobacco use, mental health, and breastfeeding support as required by specific grant programs. Local Public Health collected and analyzed aggregated Omaha System electronic data including Omaha System Problems and their associated signs and symptoms for public health clients.

Meetings with community organizations and partners provided qualitative information regarding health factors occurring in our community. These partners were able to provide current situational information not yet found in the traditional data sources. Stakeholder surveys were sent out to key contacts in all four counties. Focus Groups were conducted in Becker, Clay, and Wilkin counties.

In Wilkin County, in addition to stakeholder surveys and meetings, three focus groups were held with 19 participants representing a cross-section of providers. Three questions were asked: 1) Top three issues your clients face, 2) Obstacles that prevent resolution of issues, 3) Ways to resolve issues.

In Becker County, in addition to stakeholder surveys and Becker County Energize steering committee meetings, eight focus groups were held with 354 participants. They were asked to brainstorm unmet needs in our community. They also rated these needs on leverage, feasibility, specificity and value following the results-based accountability model.

In Clay County the stakeholder group reviewed the community needs assessment and broke into eight facilitated discussion groups to consider the biggest needs as indicated in the needs assessment and possible solutions/resources to address the needs. Clay County also had the New Americans Consortium and Family Health Care work with diverse populations groups to complete the community survey.

Otter Tail County participated in key stakeholder meetings to hear feedback and participate in discussion around community needs that were identified amongst the larger groups. Large group review of the data, along with smaller tabletop discussions, drove the group to identify priority needs.

Each public health department also participated in meetings with community stakeholder groups including:

- Becker County Energize and Family Services Collaborative, Senior Networking Committee
- Clay County ReThink Mental Health and Family Services Collaborative
- Otter Tail County Family Services Collaborative, Live Well Fergus Falls, Senior Services Network, and County Sponsored Long Range Planning Focus Groups
- Wilkin County We Care Coalition, Family Services Collaborative, Lakes & Prairie, Wilkin Richland Community Health Assessment Steering Committee, and Active Living Committee
- Moorhead and Pelican Rapids: New American Consortium for Wellness and Empowerment
- PartnerSHIP 4 Health (PS4H) Statewide Health Improvement Partnership (SHIP) Community Leadership Team and partners

The top issues and themes identified per county were as follows:

County	Community Stakeholders	Top Issues and Themes Identified
Becker	• Becker County Energize • Family Services Collaborative • Senior Networking Committee • Essentia Health	• Mental Wellbeing and Adverse Childhood Experiences • Substance Abuse • Access to Childcare
Clay	• ReThink Mental Health • Family Services Collaborative • Essentia Health • Family Healthcare • Sanford Health • New American Consortium for Wellness and Empowerment	• Substance Use/Abuse • Mental Health/Behavioral Health • Affordable housing • Economic Stability • Physical Health/Nutrition • Cost of Healthcare & Health Insurance
Otter Tail	• Family Services Collaborative • Live Well Fergus Falls • Senior Services Network • County Sponsored Long Range Planning Focus Groups • Lake Region Healthcare • Perham Health	• Mental Health and Well Being • Substance Abuse • Healthy Lifestyles • Chronic Disease- Obesity, Cancer, Heart Disease, Diabetes • Lack of awareness of available resources
Wilkin	• We Care Coalition • Family Services Children's Collaborative • Lakes & Prairie • CHI St. Francis Health	• Obesity • Behavioral Health/Mental Health • Child Care
All Four Counties	• Partnership 4Health (PS4H) Statewide Health Improvement Partnership (SHIP) Community Leadership Team and partners	• Obesity • Tobacco Use • Mental Health/Behavioral Health

TOP TEN COMMUNITY HEALTH PRIORITY ISSUES

The P4H-CHB leadership team reviewed the top issues and themes found in the Community Health Assessment and identified the top ten health priority issues as follows and listed in random order:

Mental Wellbeing

Adverse Childhood Experiences often negatively impact lifelong health. In Becker, Clay, Otter Tail, and Wilkin counties, 51.6%, 44.3%, 51.1%, and 47.9% respectively experience one or more adverse childhood experience and 12% of 11th grade males and 30% of 11th grade females report a long-term mental health problem.

Source: Minnesota Department of Health 2019 MN Student Survey

Child Care Access

Parents in the four counties experience limited access to quality child-care. In Becker County there are 250 families that need childcare. A Richland/Wilkin County Child-Care Survey showed affordability, backup coverage, and newborn services as primary concerns for parents.

Sources: Richland/Wilkin County Child-Care Survey, http://beckercountyenergize.com/child-care-access

Substance Abuse

Excessive use of alcohol, tobacco, prescription drugs, opioids and other drugs harms individual and community health. In our four counties, vaping usage among teens and people seeking treatment for substance abuse continues to rise. All four counties have higher than the adult state average who drink excessively (Wilkin County: 41.8%). In Becker County, Essentia Hospital reported that 23% of all meconium and cord tissue collection tested positive for chemical use in 2018, and opioid abuse is on the rise. Essentia Health. Social Services. 2018

Sources: Community Commons. (n.d.). *Community health needs assessment*. Retrieved November 7, 2018 from https://assessment.communitycommons.org/CHNA/report?page=1&id=725&reporttype=libraryCHNA, Essentia Health. Social Services Plan. 2018

Aging Population

By 2030 the percentage of persons 65 and older is expected to increase across our four counties: Becker - 20 to 28%, Clay - 12.9 to 20%, Otter Tail - 23.2 to 32% and Wilkin - 18.7 to 29%. Programs and services need to be continued and expanded and new ones developed to meet the needs of our aging populations.

Source: Minnesota State Demographic Center. (n.d.). *Aging.* Retrieved April 13, 2017, from https://mn.gov/admin/demography/date-by-topic/aging/.

Transportation

Transportation is a key to daily activities, including access to food, healthcare, and family and support systems. Focus groups in the four counties identified this as a top 10 health concern. After hours and weekend transportation was reported especially difficult to find in our rural areas.

Obesity/Physical Activity/Nutrition

Obesity effects all ages. A healthy weight is key to prevention and management of serious chronic diseases. All four of our counties have higher than the 28% MN average for adult obesity rates: Becker - 32%, Clay - 29%, Otter Tail - 31%, and Wilkin - 30%. In a randomized P4H-CHB survey, 10.2% of people reported they worry about food running out or not lasting.

Source: Partnership 4 Health, Community Health Board. (2018). *Community Health Assessment Survey (mailed/randomized).*

Breastfeeding

Breastfeeding offers the ideal nutrition for infants. Despite recent progress, gaps in the rate of breastfeeding persist. 2018 WIC data shows our four counties below the 57.5% statewide average for mothers' breastfeeding their infants past 3 months of age: Becker - 30.1%, Clay - 47.7%, Otter Tail - 45.1% and Wilkin - 50%.

Source: Minnesota Department of Health: 2018 WIC Program [dataset].

Access to Dental Care

Access to appropriate, convenient and affordable dental care impacts health. Access considerations include proximity to care, provider availability, cost, insurance coverage, transportation, care coordination within the dental care system, and cultural sensitivity and responsiveness. The percentage of children who have received any type of dental or oral health care in our four counties: Becker - 52%, Clay - 42%, Otter Tail - 51%, and Wilkin - 41%.

Source: Minnesota Department of Health, Child and Teen Checkup Program. (n.d.). *2017 Child and Teen Checkup Program* [dataset].

Immunization

The percentage of students not receiving immunizations raises concerns. Low immunizations rates leave more children susceptible to disease. Otter Tail County has a lower than state rate of children receiving the full series of vaccinations by 24-35 months. Otter Tail and Wilkin counties trail the state rate for series of completion of adolescents ages 13-17.

Source: Southwest MIIC. (n.d.). 2018-2019 Immunizations [dataset].

Environmental Factors

Our health is impacted by our connection to and interactions with the natural environment. Our four-county area had elevated radon levels. Becker and Otter Tail counties have more wells with high levels of arsenic than the state average.

Sources: Minnesota Department of Health (n.d.) *Radon in Minnesota*. MDH Indoor Air Unit fact sheet, https://sosradon.org/files/sosradon/MN%20Radon%20Facts.pdf, Minnesota Department of Health, Minnesota Public Health Data Access. (n.d.). *Childhood lead exposure.* Retrieved November 13, 2018, from https://data.web.health.state.mn.us/lead.

PRIORITIZATION PROCESS

After identifying the top 10 priority health issues, the P4H-CHB leaders discussed the selection of the top two priority issues to address in the Community Health Improvement Plan. The consideration of questions from previous community health planning processes served as a valuable guide. The P4H-CHB leaders considered the overall importance of the public health issue by using the following criteria:

- How many of the individuals in the four counties are potentially at risk?
- How many of the individuals in the four counties are impacted by the issue?
- What are the consequences of not addressing the issue?
- What is the potential economic burden surrounding the issue?
- How concerned is the public over the issue?
- Is there an identifiable prevention component to address the issue?

In addition to assessing each of the top ten issues using these criteria, the next step in the prioritization included a more focused look at the feasibility of addressing the issue. During the discussion P4H-CHB leaders considered:

- What is the level of community readiness to address the issue?
- Are there sufficient resources, including staff with adequate knowledge and skills to address the issue?
- Can sufficient funding be secured to effectively address the issue?
- What's the gap between the resources needed and the resources available?

As a result of these considerations and based upon group consensus, the following two issues were identified for inclusion in the 2020-2024 P4H-CHB Community Health Improvement Plan:

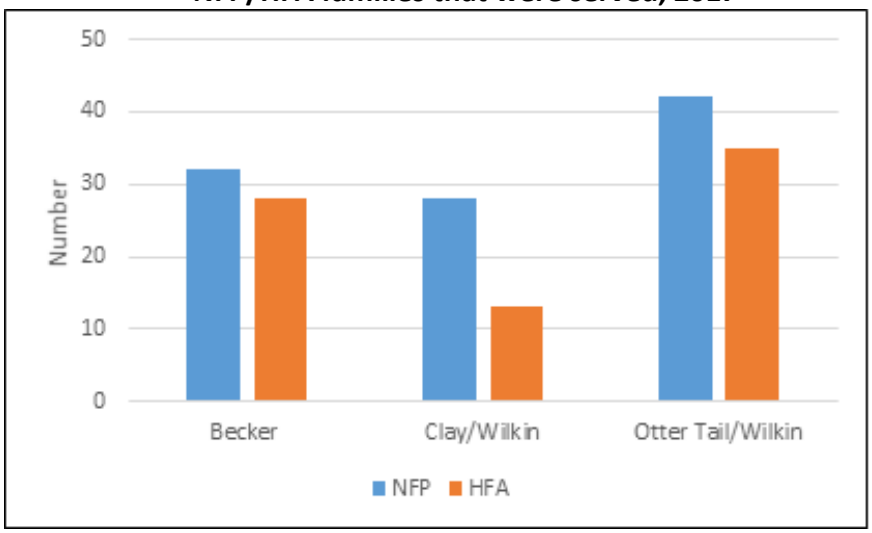
- Priority #1: Mental Wellbeing
- Priority #2: Dental Access

Priority #1: Mental Well-Being

Adverse Childhood Experiences

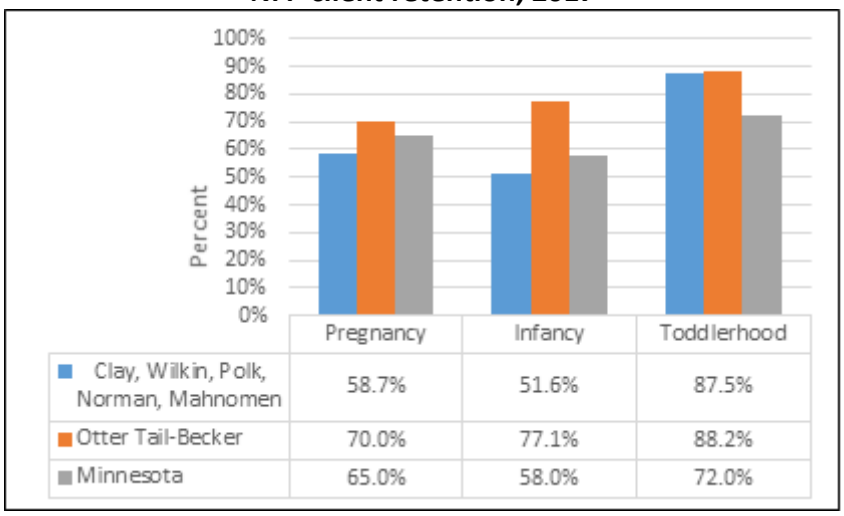
Childhood experiences, both positive and negative, have a tremendous impact on future health. Adverse childhood experiences (ACES) have been linked to risky health behaviors, chronic health conditions, low life potential, and early death. P4H-CHB home visiting programs such as the Nurse Family Partnership (NFP) and Healthy Families America (HFA) for pregnant women and families with newborns seek to prevent ACES. P4H-CHB partners with their local Family Services Collaborative to address the impacts of childhood trauma.

NFP/HFA families that were served, 2017



Source: Kristi Wentworth, Family Health Supervisor, Otter Tail County and Jamie Hennen, Director of Nursing, Clay County. Public Health clientele data retrieved from PHDOC.

NFP client retention, 2017



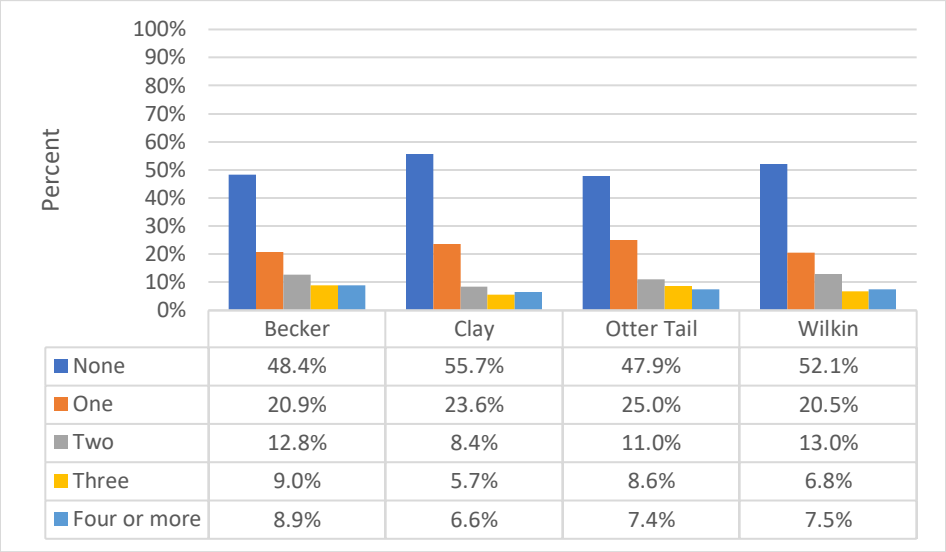
	Pregnancy	Infancy	Toddlerhood
Clay, Wilkin, Polk, Norman, Mahnomen	58.7%	51.6%	87.5%
Otter Tail-Becker	70.0%	77.1%	88.2%
Minnesota	65.0%	58.0%	72.0%

Source: Kristi Wentworth, RN, BSN, PHN Family Health Supervisor, Otter Tail County, and Elizabeth Bjur, RN, BSN, PHN, Clay County.

In 2017, P4H-CHB served 76 families with HFA. Otter Tail, Becker, Clay, Wilkin, Polk, Norman, and Mahnomen counties served 99 families with NFP.

There are nine different types of ACEs in an "ACEs Score": physical abuse, sexual abuse, verbal abuse, mental illness of a household member, problematic drinking or alcoholism of a household member, illegal street or prescription drug use by a household member, divorce or separation of a parent, witnessing domestic violence towards a parent, and incarceration of a household member. The more ACEs experienced; the more likely health problems will be experienced later in life. The table below reveals that between 30-40% of P4H-CHB students experience one or more ACEs.

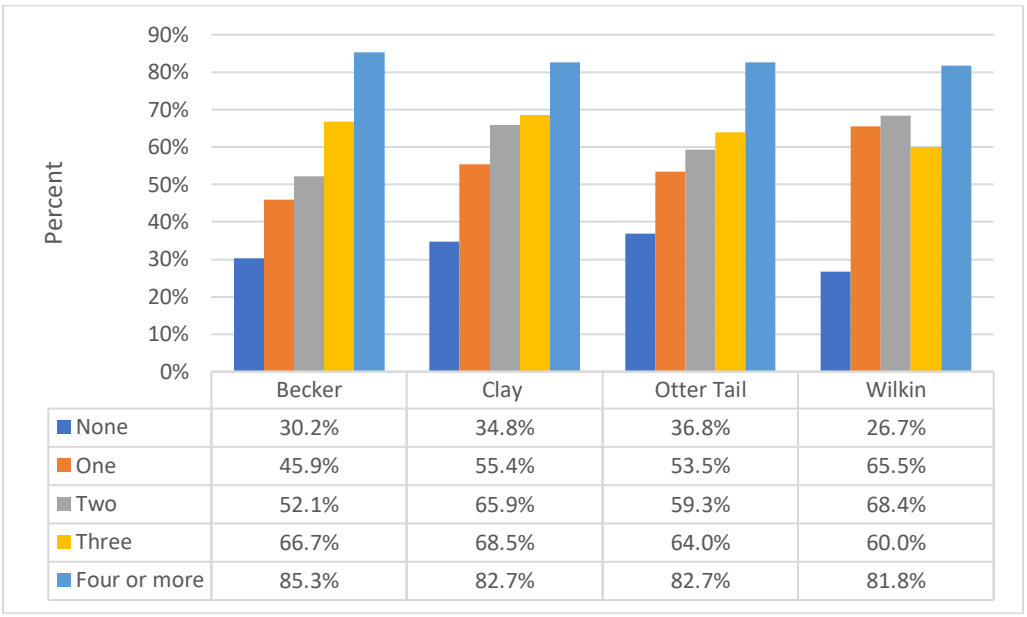
Student ACEs score, 2019



	Becker	Clay	Otter Tail	Wilkin
None	48.4%	55.7%	47.9%	52.1%
One	20.9%	23.6%	25.0%	20.5%
Two	12.8%	8.4%	11.0%	13.0%
Three	9.0%	5.7%	8.6%	6.8%
Four or more	8.9%	6.6%	7.4%	7.5%

Source: Minnesota Department of Health, Minnesota Center for Health Statistics. (2019). *Minnesota Student Survey*. Available from https://www.health.state.mn.us/data/mchs/surveys/mss/index.html.

Students who show little interest/pleasure in doing things for several days or more in the past 2 weeks by ACEs score, 2019

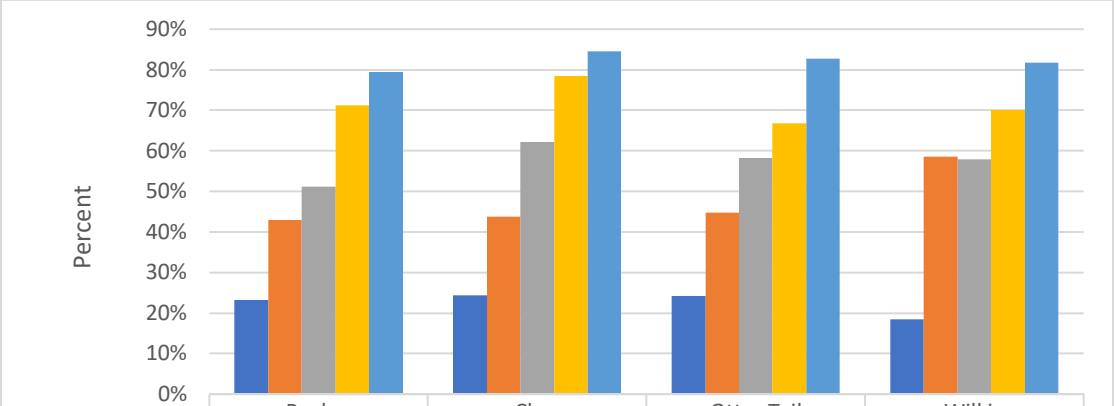


	Becker	Clay	Otter Tail	Wilkin
None	30.2%	34.8%	36.8%	26.7%
One	45.9%	55.4%	53.5%	65.5%
Two	52.1%	65.9%	59.3%	68.4%
Three	66.7%	68.5%	64.0%	60.0%
Four or more	85.3%	82.7%	82.7%	81.8%

Source: Minnesota Department of Health, Minnesota Center for Health Statistics. (2019). *Minnesota Student Survey*. Available from https://www.heatlth.state.mn.us/date/chhs/surveys/mss/index.html.

In the P4H-CHB, students with four or more ACEs report little interest/pleasure in doing things for several days or more in the past 2 weeks. Becker (85.3%) county has the highest rate, followed by Clay, Otter Tail, and Wilkin counties.

Students who reported feeling down/depressed/hopeless for several days or more in the past 2 weeks by ACEs score, 2019

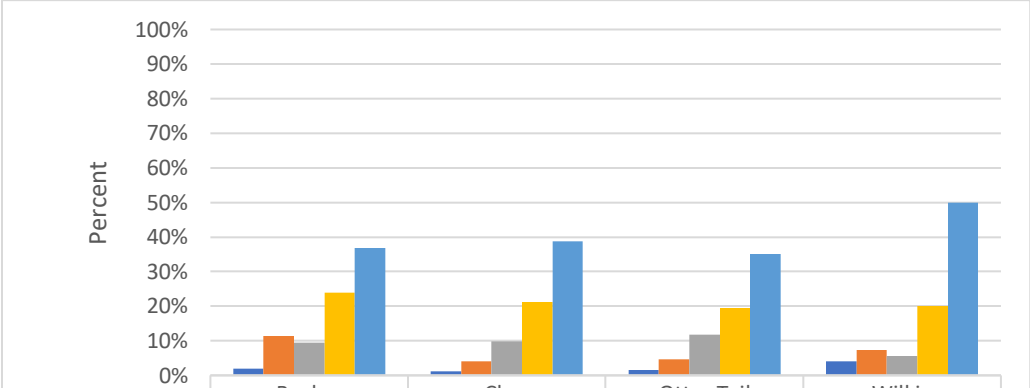


	Becker	Clay	Otter Tail	Wilkin
None	23.2%	24.3%	24.2%	18.4%
One	43.0%	43.8%	44.8%	58.6%
Two	51.1%	62.1%	58.2%	57.9%
Three	71.2%	78.4%	66.7%	70.0%
Four or more	79.4%	84.6%	82.8%	81.8%

Source: Minnesota Department of Health, Minnesota Center for Health Statistics. (2019). *Minnesota Student Survey*. Available from https://www.health.state.mn.us/data/mchs/surveys/mss/index.html.

Students in the P4H-CHB with 3 or more ACEs who report feeling down/depressed/hopeless for several days or more in the past 2 weeks is much higher than the students reporting no aces. Over 84% of the students in Clay County with 4 or more ACEs report feeling down/depressed or hopeless for several days in the past two weeks.

Students who attempted suicide by ACEs score, 2019



	Becker	Clay	Otter Tail	Wilkin
None	1.9%	1.1%	1.6%	4.1%
One	11.4%	4.1%	4.6%	7.4%
Two	9.5%	9.8%	11.7%	5.6%
Three	23.9%	21.3%	19.5%	20.0%
Four or more	36.9%	38.8%	35.1%	50.0%

Source: Minnesota Department of Health, Minnesota Center for Health Statistics. (2019). *Minnesota Student Survey*. Available from https://www.health.state.mn.us/data/mchs/surveys/mss/index.html.

In Wilkin County, of the students with 4 or more ACEs, 50% attempted suicide.

Priority #2: Dental Access

For children, untreated tooth decay can cause pain and infections that may lead to problems with eating, speaking, playing, and learning.

Source: Centers for Disease Control and Prevention. (n.d.). *Children's oral health*. Retrieved June 28, 2017 from https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Foralhealth%2Fchildren_adults%2Fchild.htm).

There is a lack of dental service available to residents on Medical Assistance, especially those that are disabled and elderly. According to county waiver case managers, local access providers are not taking new patients. For existing clients there can be a considerable wait time, often 3-6 months. Families and adults are referred to other areas in the region. For some people, transportation and/or the ability to take extended time away from work are barriers to accessing dental care in other areas of the region.

The Early Childhood Dental Network in West Central Minnesota has been addressing access to dental care for young children. This community collaborative comprised of schools, Head Start, community action agencies, and public health agencies have been instrumental in the creation of the Apple Tree Dental Clinic based in Fergus Falls and Hawley; Caring Hands Dental Clinic in Alexandria and Children's Dental Services Clinics. These clinics provide portable dental clinics in Detroit Lakes, Moorhead, New York Mills, Pelican Rapids, and Breckenridge.

The Dental Outreach Clinics sponsored by the Early Childhood Dental Network are specifically designed to provide dental services to children between the ages of 1 and 17 years of age. Dental health staff are available to provide all dental services for children covered by Minnesota Health Care Programs.

Children's Dental Services (CDS) also serve Clay County and Breckenridge. CDS serves children from birth to 26 years old (up to 21 without insurance) and pregnant woman of all ages, regardless of family income. They accept all insurance and MA. They have staff members available to speak to clients in 20 different languages.

Persons completing the non-generalizable email survey conducted in the four counties in 2018 identified lack of access to dental insurance as a major barrier to seeking dental care. While progress had been made, a large percentage of children and families remain underserved.

Child and Teen Checkup children receiving any type of dental or oral health care

County	2017	2018
Becker	45.0%	52.0%
Clay	38.0%	42.0%
Otter Tail	43.0%	51.0%
Wilkin	35.0%	41.0%

Source: Minnesota Department of Health, Child and Teen Checkup Program. (n.d.). *Child and Teen Checkup Program* [dataset].

Adults have unmet dental needs as evidenced by the Healthy People 2020 statistics:

- 1 in 7 adults age 35 to 44 has gum disease; after age 65, the rate increases to 1 in 4.
- 1 in 4 U.S. adults ages 65 or older have lost all their teeth.
- 44.5 percent of persons aged 2 years and over had a dental visit in the past year in 2007 (age adjusted to the year 2000 standard population)

Source: https://www.healthypeople.gov/2020/leading-health-indications/2020/lhi/determinates

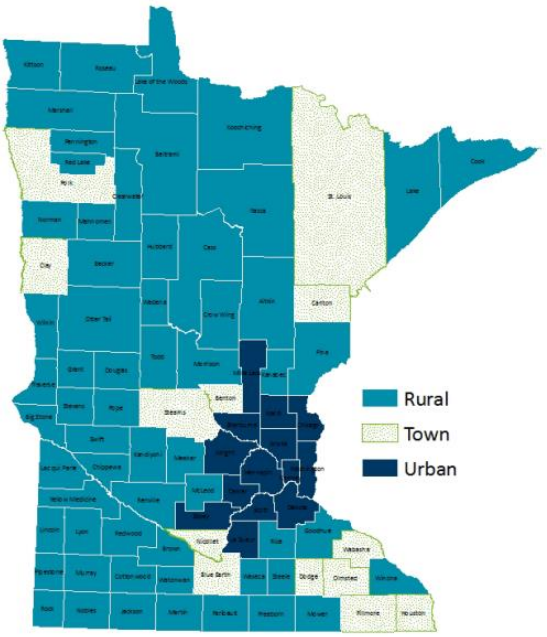
ALIGNMENT WITH STATE/NATIONAL PRIORITIES: Mental Well-Being			
Obj #	**Healthy Minnesota 2020**	**Health People 2020**	**National Prevention Strategy**
1	Strategy: Capitalize on the opportunity to influence health in early childhood. (MN Dept. of Health, 2012)	EMC Objective 1: Increase the proportion of children who are ready for school in all five domains of healthy development: physical development, social-emotional development, approaches to learning, language, and cognitive development. (HealthyPeople.gov, 2020)	Mental and Emotional Wellbeing: Promote positive early childhood development, including positive parenting and violence-free homes. (National Prevention Counsel, 2011 pg. 48)
2	Intervention: Increase community-based opportunities for social interaction. (MN Dept. of Health, 2012)	MDMD Objective-4.1: Reduce the proportion of adolescents aged 12 to 17 years who experience major depressive episodes. (HealthyPeople.gov, 2020)	Mental and Emotional Wellbeing: Provide individuals and families with the support necessary to maintain positive mental well-being. (National Prevention Counsel, 2011 pg. 48)
3	Intervention: Create positive school climates to foster youth development, learning, and on-time graduation. (MN Dept. of Health, 2012)	MDMH Goal- Improve mental health through prevention and by ensuring access to appropriate, quality mental health services. (HealthyPeople.gov, 2020)	Mental and Emotional Wellbeing: Facilitate social connectedness and community engagement across the lifespan. (National Prevention Counsel, 2011 pg. 48)

ALIGNMENT WITH STATE/NATIONAL PRIORITIES: Dental Access		
Obj #	**Minnesota Oral Health Plan 2013-2018**	**Healthy People 2020**
1	Access is increased to preventive, restorative, and emergency oral health care services. (State Oral Health Plan, 2013-2018)	Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year - 44.5 to 49%. (HealthyPeople.gov, 2020)
2	The dental workforce is prepared for and addresses the oral health needs of all Minnesotans. (State Oral Health Plan, 2013-2018)	Reduce the proportion of children aged 3 to 5 years with dental caries experience in their primary teeth - 33.3 to 30%. (HealthyPeople.gov, 2020)
3	Access to population statistics, population-level oral health surveillance information, and aggregate data on oral health indicators is readily available to all. (State Oral Health Plan, 2013-2018)	Reduce the proportion of adults aged 45 to 64 years who have ever had a permanent tooth extracted because of dental caries or periodontal disease – 76.4 to 68.8%. (HealthyPeople.gov, 2020)

HEALTH INEQUITIES IN THE PARTNERSHIP4HEALTH COMMUNITY HEALTH BOARD REGION

Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age (World Health Organization, 2017). P4H-CHB residents face inequities related to geography (rural), income (low socio-economic status), age (elderly), and race (ethnic minorities). The small numbers of ethnic minority population individuals and groups (ex. Native Americans = 3% of the P4H-CHB population) within the jurisdiction of the P4H-CHB makes it challenging to obtain and analyze data related to racial inequities.

Rural Americans are a population group that experiences significant health disparities. Higher rates of chronic illness and poor overall health are found in rural communities when compared to urban populations. According to the National Center for Health Statistics Urban-Rural Classification Scheme for Counties, Becker, Otter Tail, and Wilkin counties are considered rural, and Clay County is considered town.



We do know this about our four-county region:

- There are fewer healthcare providers per population in rural than urban areas.
- Mortality rates are greater in rural Minnesota.
- Our young children face a growing rate of poverty.
- Increasing number of families struggle to make ends meet.
- Aging populations challenge capacity to adapt to the growing needs of the elderly.
- We have increasing racial and ethnic diversity.
- Scarcity of affordable housing limits the ability of young families, refugees, and new immigrants to establish themselves and provide a healthy living environment for their children.

COMMUNITY HEALTH IMPROVEMENT PLAN

A community health improvement plan (CHIP) serves as "a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process." (Public Health Accreditation Board, 2012). Health and human service agencies collaborate with community partners to create a working document that set priorities, coordinate and target resources, develop policies, and define actions targeting efforts that promote health.

The strategies and action steps in the CHIP provide opportunities for residents, partners, and stakeholder engagement and participation. The CHIP is a living tool to improve health outcomes and address health equity: it is imperative that the community own the CHIP and work collaboratively to make a difference in the priority areas.

COMMUNITY ENGAGEMENT

The community health assessment was shared with both consumers and stake holders in our four-county area through existing relationships and regularly scheduled community and coalition meetings.

Community input was solicited through existing relationships with area stakeholders in all four counties. Interviews were conducted with consumers and stakeholders to:

- obtain a better understanding of the communities' definition of community health
- identify community assets
- develop a list of priorities
- understand their thoughts related to the priority issues

Community engagement in the CHIP continues as partners work to support progress in the two priority areas, as well as engage in the monitoring and revision of community organization, health system, and public health agency-related action plans and strategies.

COMMUNITY PARTNERS INVOLVED IN ASSESSMENT AND PLANNING

- Healthcare System Partners
    - Essentia Health in Detroit Lakes and Fargo
    - Lake Region Healthcare in Fergus Falls
    - Perham Health in Perham
    - CHI St. Francis Health in Breckenridge
    - Sanford Health in Fargo
    - Family HealthCare in Fargo
- Becker County Community Partners
    - Becker County Energize
    - Family Services Collaborative
    - Senior Networking Committee
- Clay County Community Partners
    - ReThink Mental Health
    - Family Services Collaborative
- Otter Tail County Community Partners
    - Family Services Collaborative
    - Live Well Fergus Falls
    - Senior Services Network
    - County Sponsored Long Range Planning Focus Groups
- Wilkin County Community Partners
    - We Care Coalition
    - Family Services Children's Collaborative
    - Lakes & Prairie
- Moorhead and Pelican Rapids Community Partners
    - New American Consortium for Wellness and Empowerment
- All Four Counties' Community Partners
    - PartnerSHIP 4 Health (PS4H) Statewide Health Improvement Partnership (SHIP) Community Leadership Team and partners
    - Blue Cross Blue Shield MN
    - Minnesota Department of Health

COMMUNITY ASSETS AND RESOURCES

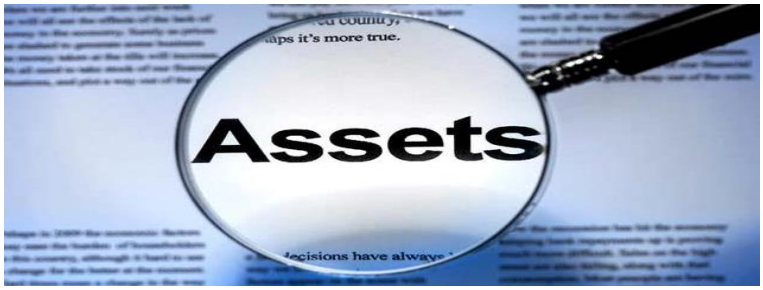
This Community Health Improvement Plan relied on contributions from our community assets and resources for its development. We value all the parties that provided input for its creation. We look forward to continuing to work with our community partners within the four counties to provide a better place to live.

Becker County: Becker County Human Services, Sanford Health, Essentia Health, Becker County EDA, Faith Communities, The Detroit Lakes Community and Cultural Center, Becker County Children's Initiative, Stellher Human Services, Minnesota Communities Caring for Children, United Way of Becker County, White Earth Tribal Services, Ecumen, Child Care Aware, A Place to Belong, MANNA Food Cooperative, Mahube OTWA, Lakes Area Chamber of Commerce, Detroit Lakes Public Schools, Frazee-Vergas Public Schools, Lake Park-Audubon Public Schools, Boys and Girls Club of Detroit Lakes, Early Childhood Initiative, Lakes Crisis and Resource Center, White Earth Indian Health Services, M-State Community College, Becker County 4-H, University of MN Extension.

Clay County: Sanford Health System (Fargo), Essentia Health System (Fargo), Fargo Cass Public Health, Family Health Care, Moorhead School Board, Clay County Commissioner Board, Moorhead City Council, Dilworth City Council, Moorhead School Board, Clay County Social Services, Lakes and Prairies Community Action Agency, New American Consortium, Law Enforcement, FM Ambulance, Horace City Officials, Cass County Commissioner Board, Clay and Cass Higher Education, Fargo Public Schools, West Fargo Public Schools.

Otter Tail County: Otter Tail County Community Services Divisions, Lake Region Health Care, Perham Health, Otter Tail County Family Services Collaborative and workgroups, LiveWell Fergus Falls, A Place2Belong, Productive Alternatives, Lakeland Mental Health Center, United Way of Otter Tail County, West Central Initiative, The Early Childhood Dental Network, M-State Community College, Faith Leaders, Otter Tail County School Districts, Senior Services Network, Fergus Falls YMCA, Perham Area Community Center, Law Enforcement, Safe Communities Coalition, Dancing Sky Area Agency on Aging

Wilkin County: St. Francis Medical Center, Richland County Public Health, Essentia and Sanford Clinics, St. Francis Medical Center Walk in Clinic, Faith Communities, Children's Collaborative, We Care Coalition, Lakes & Prairie, Law Enforcement, Children's Dental Services, Apple Tree Dental, Kinship, Wahpeton/Breckenridge Chamber of Commerce, Active Living Coalition, Breckenridge Public School, Campbell Public School, Rothsay Public School, St. Mary's Catholic School, North Dakota State School of Science, Minnesota Extension, Wilkin County Board of Commissioners, Wilkin County Family Services, Mental Health Crisis Unit, and Kelly Felton, Regional Prevention Coordinator West Central Region.



ACTION PLAN: MENTAL WELL-BEING

Priority #1: Mental Well-Being

Date Created: 11/7/2019 Date Reviewed/Updated:

GOAL: Improve the mental well-being of students and adults in Becker, Clay, Otter Tail, and Wilkin counties

OBJECTIVES:

Public Health Partners - Population Health Objectives

- By Dec. 31, 2023, decrease by 2% points the percentage of students in Becker, Clay, Otter Tail, and Wilkin counties that experienced at least one adverse childhood experience as reported in the 2016 MN Student Survey (37.6% in Becker, 33.3% in Clay, 38.5% in Otter Tail and 43.8% in Wilkin)
- By Dec. 31, 2023, decrease by 2% points the percentage of students in Becker, Clay, Otter Tail, and Wilkin counties that report having a long-term mental health problem as reported in the 2016 MN Student Survey (12% of 11th grade males and 30% of 11th grade females).

Public Health Partners – Agency Objectives

- By December 31, 2020 each P4H agency will consistently use Omaha System ratings to measure mental health wellbeing for clients served by the evidence-based family home visiting programs.
    - Documentation will include Omaha System baseline assessments of the Mental Health Problem and KBS rating scale for outcomes.
    - Additional Omaha System assessments and KBS rating under the Mental Health Problem will occur when new concerns are identified, at least annually and at time of agency discharge.
    - Baseline and periodic PHQ-9 screenings will be included as part of the Mental Health Problem assessment and KBS rating scale for outcomes documentation.
- By December 31, 2023 P4H will see improved admission to discharge KBS Ratings under the Omaha System Mental Health Problem assessment and KBS rating scale for outcomes documentation.

***(PHQ-9** total **score** for the nine items ranges from 0 to 27. In the above case, the **PHQ- 9** depression severity **score** is 16 (3 items **scored** 1, 2 items **scored** 2, and 3 items **scored** 3). **Scores** of 5, 10, 15, and 20 represent cut points for mild, moderate, moderately severe and severe depression, respectively.)

Community Organization Objectives/Strategies

County	Organization	Objectives/Goals	Strategies
Becker	Becker County Energize	• reduce the stigma of mental illness • address mental health	• create healthy environments and positive nurturing environments • expand mentoring programs and youth activities • improve prevention and early intervention strategies to address mental health
Source: Becker County Energize Score Card https://embed.resultsscorecard.com/Scorecard/Embed/32422			
Cass and Clay	Rethink Mental Health	• Create a community that flourishes • Employees learn resiliency skills via PERMA practices	• In January of 2019, ReThink Mental Health and its partners kicked off a yearlong effort entitled The People Project. • Participating organizations focus on one PERMA practice (positive emotion, engagement, positive relationships, meaning, and accomplishment) for individual and organizational use every two months.
Source: Rethink Mental Health: Mental Well-being			

http://re-thinkmentalhealth.org/mental-well-being/			
Otter Tail	LiveWell Fergus Falls	• promote living life to the fullest • make our community the healthiest place to live	• 7 components of wellness: physical, social, intellectual, emotional, spiritual, occupational and environmental • THRIVE Toolkit Implementation in community organizations
Source: LiveWell Fergus Falls Facebook Page https://forwardfergusfalls.files.wordpress.com/2019/04/thrive-complete-toolkit.pdf			
Wilkin	We Care Coalition	Provide Behavioral/Mental services to youth in Wilkin County Schools	• Breckenridge School to contract with Behavioral/Mental health provider to provide services in the school.
Wilkin	Children's Mental Health and Family Services Collaboratives	• Integrating ACEs Assets • Promote Mental Health and Well-Being of Children, Adults, and Young Adults	• Education • Evaluation of trauma-informed and/or resilience building approaches • Outreach • Collaboration
Source: 2017 Collaborative Report – Wilkin County Children's Collaborative https://www.co.wilkin.mn.us/vertical/sites/%7B6E7AB7CB-4769-4357-B6C8-90E546FFE488%7D/uploads/2017_Collaborative_Report.pdf https://www.co.wilkin.mn.us/?SEC=2570B398-CE56-451B-9251-DD7BFADBE247			

Health System Partner Objectives/Strategies

County	Organization	Objectives/Goals	Strategies
Becker	Essentia Health - Detroit Lakes	• All youth in Becker County are resilient and experience mental well-being	• Expand youth mentoring programs and opportunities for youth activities in communities • Increase education to destigmatize mental illness and improve resiliency • Improve access to services for at-risk youth • Decrease % of students in 8th grade who have seriously considered suicide • Decrease % of 8th grade students who feel that people in the community care about them • Decrease % of 8th grade students who have felt down, depressed or hopeless in the past two weeks.
Source: Essentia Health - St. Mary's COMMUNITY HEALTH NEEDS ASSESSMENT FY 2020-2022 https://www.essentiahealth.org/app/files/public/7033/detroit-lakes-chna-2020-2022.pdf (pp. 18-20) and https://www.essentiahealth.org/app/files/public/7459/chna-summary-2020-2022-detroit-lakes.pdf			
Cass and Clay	Essentia Health - Fargo	• Cass and Clay counties support mental health and well-being of residents	• Improve timely access to behavioral health services and supports • Promote mental well-being in schools and worksites • Decrease severity of depression, suicide and stress • Decrease % of students feeling sad or hopeless almost every day • Decrease % of students who have seriously considered suicide within the past 12 months
Source: Essentia Health - Fargo COMMUNITY HEALTH NEEDS ASSESSMENT FY 2020-2022 https://www.essentiahealth.org/app/files/public/7037/fargo-chna-2020-2022.pdf			
Cass and Clay	Sanford Health - Fargo	• Comprehensive services are available for patients with mental health and	• Reduce the opportunity for drug use and abuse. • Reduce the severity of depression for patients with a PHQ-9 score greater than 9. • Patient assessments are in place to determine the risk for suicide.

		substance abuse diagnosis.	
Source: Sanford Health 2018 Community Health Needs Assessment Executive Summary - Fargo https://www.sanfordhealth.org/-/media/org/files/about/community-health-needs-assessment/2018/019012-00354-booklet-ent-chna-bot-executive-summary-8_5x11.pdf (pp. 42)			
Otter Tail and City of Barnesville	Lake Region Healthcare	• Mental Health identified as a top priority issue	• Implementation plan TBD (11/01/2019).
Source: 2019-2021 Community Health Needs Assessment Lake Region Healthcare https://www.lrhc.org/media/3831/2019-lrhc-chna-final-8-22-2019.pdf (p. 45)			

Otter Tail and City of Perham	Perham Health	• To provide education regarding the importance of mental health for individuals, to help reduce stigma, and increase awareness of the prevalence of mental health issues and available resources.	• Invest in training facilitators of Mental Health First Aid (MHFA) to help with training more community members in MHFA. The purpose of this objective would be to reduce the stigma of mental health and help those who may be experiencing a mental health crisis to access the resources they need, rather than sending them to the emergency department.
			  • Develop a team and collaborate with area of mental health services to create a comprehensive continuum of care that will help prevent those who experience mental health issues from falling through the gaps of the health care system.
			  • Work with community partners to increase awareness of the importance of mental health through programming and campaigns.

Source: Perham Health Community Needs assessment & Action Plan Implementation 2019-2022 https://www.perhamhealth.org/wp-content/uploads/2019/09/CommunityHealthNeedsAssessment_2019.pdf			
Richland and Wilkin County	We Care Coalition Wahpeton DFC Grant	Reduce 30-day use of Alcohol, Tobacco and Marijuana by addressing risk factors to reduce ACEs scores	• Research and implement an evidence-based curriculum to increase resiliency among students and decrease Behavioral and Mental Health issues.
Richland and Wilkin	CHI St. Francis	• Develop a consistent and comprehensive approach to addressing substance use/abuse in the community	• The Behavioral Health Stakeholders Group will continue to develop strategies to address substance use/abuse as well as mental health issues • Develop a plan for transportation of individuals needing inpatient services for mental health and/or chemical dependency crises by June 2020
Source: 2019 Richland-Wilkin Community Health Needs Assessment- Implementation Strategy Report https://www.sfcare.org/content/dam/chi-st-francis-health/website/workfiles/2019-community-needs-assessment/CHN%20Assessment%20Implementation%20Report.pdf			

PUBLIC HEALTH AGENCY INTERVENTION STRATEGY 1: Increase organizational capacity to use the Omaha System Mental Health Problem and the PHQ-9 to assess and address mental well-being of clients					
Action Step	Target Date	Lead Person or Organization	Resources Needed	Potential Partners	Progress Notes
1. Determine the baseline ratings (Omaha System Mental Health Problem KBS and PHQ-9)	June 30, 2020	Public Health HFA and NFP Leads	Omaha System with KBS rating PHQ-9 screening tool	Evidenced Based Home Visitors and Leads PHDOC/Avenu Staff	Progress will be evaluated at monthly HFA and NFP team meetings.
Related Process Measures for Consideration: • Amount of time it took to educate and implement the OMAHA with KBS ratings • Amount of time it took to educate and implement the PHQ-9 screening • # and type of barriers to determine ratings					
2. Develop an Omaha System Mental Health documentation process that includes surveillance, TGC, and CM interventions	December 31, 2020 and ongoing	Public Health HFA and NFP Leads	Omaha System	Evidenced Based Home Visitors and Leads PHDOC/Avenu Staff	Written procedure will be developed and part of the orientation process for new evidenced based home visiting staff.
3. Annual assessment of the Omaha System Mental Health Pathway (environmental change) into client care plans.	December 31, 2021 and yearly	Public Health HFA and NFP Leads	Omaha System	Evidenced Based Home Visitors and Leads	Will assess Omaha System/MH Pathway every year and meeting notes will identify needs and changes that need to be made to written procedures.
4. Identify barriers related to the use of the Omaha System Mental Health documentation process.	December 31, 2020	HFA and NFP Leads and Home Visitors	Omaha System	Evidenced Based Home Visitors and Leads PHDOC/Avenu Staff	HFA leads and home visitors will address barriers at monthly meetings. Needed changes will be identified for follow through.
Related Process Measures for Consideration: • # and type of barriers • % of NFP/HFA staff using the Omaha System KBS Pathway					

5. Share at a minimum annual Omaha System and PHQ-9 data with staff	By December 31 in years 2021-2024	Public Health HFA and NFP Leads	Omaha System Time allocated at team meetings to share data	Public Health HFA and NFP Leads	HFA and NFP Leads will assess data annually and share with evidenced based home visiting staff at team meetings
6. Provide each staff member with training required by HFA and NFP programs.	Ongoing when new staff hired	HFA and NFP Leads	MIECHV and EBHV funds	HFA and NFP Staff that provide trainings PHDOC/Avenu Staff	New evidenced based home visiting staff will attend OMAHA system basic training upon hire. Training logs will be maintained.
Related Process Measures for Consideration: • % of NFP/HFA completing the required training • % of NFP/HFA agreeing that the required training met their training needs					

PUBLIC HEALTH AGENCY INTERVENTION STRATEGY 2:
Maintain active and intentional public health participation with community organizations during Mental Health Strategy-related meetings and CHAN/CHIP meetings

Action Step	Target Date	Lead Person or Organization	Resources Needed	Potential Partners	Progress Notes
1. Attend Meetings	Dec. 31, 2020 and ongoing	Public Health Directors and Assistant Directors	Collaborative meetings Public Health Director meetings	Family Services collaboratives in all four counties, Becker County Energize, ReThink Mental Health, Live Well Fergus Falls, We Care Coalition	Minutes will be kept from collaborative meetings.
Related Process Measures for Consideration: • % of meetings attended • % of meetings where a public health perspective (i.e. PSE strategies, SDOH considerations, or vulnerable population considerations) was shared					
2. Update on public health agency mental well-being initiative	December 31, 2020 and ongoing, but at least yearly	Public Health Directors and Assistant Directors	Collaborative meetings Public Health director meetings County Public Health staff meetings County commissioner meetings	Collaborative partners, County commissioners	Log will be kept when public health leaders give update on agency mental well-being initiative to any committee or group
Related Process Measures for Consideration: • % of meetings where public health agency update is an agenda item • % of meeting minutes referencing the public health agency update					
3. Share community organization's progress with other P4H-CHB public health partners	December 31, 2021	HFA and NFP Leads	Omaha System Collaborative meeting in all four counties	Evidenced Based Home Visitors and Leads Collaborative partners	HFA and NFP staff will share measure progress with community partners and documentation of meeting minutes will be maintained.
4. Embed meeting attendance expectation to job duties for HFA and NFP staff	December 31, 2020	Public Health Directors	Description of agency job duties for HFA and NFP positions	Public Health Directors, NFP and HFA Leads	Job duties will be updated to reflect this change.

ACTION PLAN: DENTAL ACCESS

Priority #2: Dental Access

Date Created: 11/7/2019 Date Reviewed/Updated:

GOAL: Improve access to dental care for students and adults in Becker, Clay, Otter Tail, and Wilkin counties

OBJECTIVES:

Population Health Objectives

- By Dec. 31, 2023, increase by 5% points the percentage of students in Becker, Clay, Otter Tail, and Wilkin counties that have accessed dental care as compared to Dec. 31, 2019
- By Dec. 31, 2023, increase by 5% points the percentage of adults in Becker, Clay, Otter Tail, and Wilkin counties that have accessed dental care as compared to Dec. 31, 2019

DENTAL ACCESS STRATEGY 1:
Partner with Blue Cross Blue Shield to recruit and hire and fund a Dental Innovations Coordinator

Action Step	Target Date	Lead Person or Organization	Resources Needed	Potential Partners	Progress Notes
1. Create a Dental Access Workgroup with representation from each of the four counties and BCBS and other key stakeholders (i.e. Early Childhood Dental Network)	June 30, 2020	Public Health Directors	Community members willing to be on workgroup	Dental providers Health plan representation Consumers Providers of adult services C&TC staff Early Childhood Dental Network School staff Other key stakeholders	List of Dental Access Workgroup members will be maintained.
Related Process Measures for Consideration: • # of work group members • # of community sectors represented in the workgroup • Amount of time it took to recruit the workgroup members					
2. Draft and implement an action plan for recruiting and hiring dental innovations coordinator	March 31, 2020	Public Health Directors	Hiring policy Job description for dental innovations coordinator	Interview Panel Human Relations Staff	Action plan is developed.

Related Process Measures for Consideration: • # and type of barriers to recruitment • % of applicants that receive interviews					
5. Hire Coordinator	June 30, 2020	Public Health directors	Interview questions Hiring policy and procedure	Interview panel	Hiring of dental innovations coordinator
6. Add Dental Innovations Coordinator as a member to the Dental Access Workgroup	June 30, 2020	Dental Innovation Coordinator	Community members with interest in dental services	Dental Innovation Coordinator Dental providers Health plan representation Consumers Providers of adult services C&TC staff Early Childhood Dental Network School staff Other key stakeholders	Minutes from Workgroup meetings with those present/absent will be maintained

DENTAL ACCESS STRATEGY 2:
Develop and Implement and Evaluate a Dental Access Workplan

Action Step	Target Date	Lead Person or Organization	Resources Needed	Potential Partners	Progress Notes
1. Meet monthly as a workgroup to draft a Dental Access Action Plan	December 31, 2020	Dental Innovations Coordinator	Community members willing to be on workgroup	Dental Innovation Coordinator Dental providers Health plan representation Consumers Providers of adult services C&TC staff Early Childhood Dental Network School staff	Dental Access Workgroup will meet monthly. Development of a Dental Access Action Plan.

				Other key stakeholders	
Related Process Measures for Consideration: • % of work group members attending monthly meetings • # of primary responsibilities included in the action plan (DRAFT JOB DESCRIPTION ITEMS: Bring dental resources to the community, develop strategies/programming to expand the utilization of dental varnish application, Address Dental Ombudsman responsibilities, Foster innovations and education and community engagement)					
2. Share the Action Plan with the P4H-CHB Board Members	March 31, 2021	Public Health Directors	Time allotted on P4H CHB meeting.	Public Health Directors P4H CHB Board Members	Minutes will be kept when Dental Health Access Plan is shared with CHB Board Members
3. Implement, Monitor, and Evaluate the Action Plan	June 30, 2021	Dental Innovations Coordinator	Will depend on Dental Health Action Plan that is developed	Will depend on the Dental Health Action Plan that is developed	Dental Health Action Plan will be written and changed as needed.
Related Process Measures for Consideration: • # and type of barriers to implementation • # of times action plan was revised					
4. Survey the Dental Access Workgroup for Member Satisfaction	December 31, 2021	Dental Innovations Coordinator	Workgroup Member Satisfaction Survey	Dental Innovations Coordinator Dental Access Workgroup Members	Survey date will be gathered and shared with Workgroup, P4H CHB, public health staff, community partners and stakeholders.
Related Process Measures for Consideration: • % of workgroup members completing the evaluation • % of respondents satisfied with the workgroup progress and process					

MONITOR AND REVISION PLAN

The P4H-CHB Directors will monitor, revise, and evaluate the effectiveness of the CHIP plan at least quarterly during Public Health Director's February, May, August, and November meetings.

Directors will share CHIP updates and request CHIP updates from the following county-level stakeholder groups during regularly scheduled meetings:

- Becker County: bimonthly Becker County Energize Steering Committee meetings and quarterly Family Services Collaborative meetings
- Clay County: monthly ReThink Mental Health and monthly Family Services Collaborative meetings
- Otter Tail: Family Services Collaborative Leadership meetings quarterly, LiveWell monthly meetings, as applicable at monthly Otter Tail County Community Services Division meetings
- Wilkin: monthly We Care Coalition and Family Service Collaborative meetings

The stakeholder meetings will include progress towards objectives and the effectiveness of strategies. Partners will be asked to reflect on the story behind the numbers, how actual performance or progress compares to intended progress, what contributes to or impedes progress, whether corrective action is necessary, and make recommendations for revisions. We will re-define as needed the information/data to collect to evaluate progress. Any recommended revisions to the CHIP will be discussed among the groups prior to making a CHIP revision.

Agendas and minutes will be maintained from these meetings for accountability.

LOOKING AHEAD

The P4H-CHB Community Health Improvement Plan (CHIP) is a living tool used to guide positive changes to produce better health outcomes for communities and individuals of all ages. The successful roll-out of plan depends on the commitment of individuals, families, community members, community organizations, stakeholders, and public health.

Together we can make a brighter future for each one of us and each of our communities.

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