



Polk-Norman-Mahnomen
Community Health Services

COMMUNITY HEALTH IMPROVEMENT PLAN

FOR IMPLEMENTATION IN 2025-2029
APPROVED: DECEMBER 13, 2024

*Top health priorities
identified in Polk, Norman
& Mahnomen Counties
in Minnesota.*

TOGETHER WE CAN *build a better future!*



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Executive Summary

The **Community Health Improvement Plan (CHIP)** is a strategic, collaborative roadmap designed to address key community health issues, identified through an in-depth community assessment and planning process.

Community health priorities require community solutions.

Polk-Norman-Mahnomen Community Health Services (PNM CHS) is responsible for *convening, facilitating, guiding implementation, and conducting ongoing evaluations* of the CHIP process.

The CHIP was created through a formalized approach, utilizing the MAPP (Mobilizing Action through Planning and Partnerships) and Results-Based Accountability frameworks in partnership with local community members and partners. Together, four priorities and their corresponding strategies were selected:

<p>1 Access to Care</p> <ul style="list-style-type: none">✓ Expand Care Options & Explore Service Delivery Innovation✓ Increase Workforce Development & Support✓ Create and/or Increase Transportation and Accessibility	<p>2 Mental Health & Well-being</p> <ul style="list-style-type: none">✓ Create and Foster Supportive Environments & Social Connections✓ Advocate for Change and Integrate Mental Health into Policy✓ Expand & Ensure Access to Resources
<p>3 Socioeconomic Stability</p> <ul style="list-style-type: none">✓ Prioritize Employment, Economic Stability & Economic Development Initiatives✓ Access to Education & Empowerment✓ Ensure Childcare & Early Child Development	<p>4 Substance Use & Misuse</p> <ul style="list-style-type: none">✓ Create Supportive Environments✓ Foster a Culture of Resilience and Trauma-Informed Care

PNM CHS is committed to leading and participating in collaborative efforts with community members and partners, ensuring the CHIP serves as both a resource & call to action for the betterment of Polk, Norman, and Mahnomen communities.

Together we can improve the health and well-being of the Polk, Norman, & Mahnomen communities through collective action, planning, and sustained commitment.

TOGETHER WE CAN *build a better future!*



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Polk-Norman-Mahnomen 4 Health Priorities

2025-2029



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Acknowledgements

Polk-Norman-Mahnomen Community Health Services would like to thank these people and organizations for participating in the planning process that led to this plan:



Education

Dan Dalchow, **Climax Shelly Public School**
Gina Gunderson, **Crookston Public Schools**
Todd Selk, **Fosston Public Schools**
Amanda Bosman, **Fertile-Beltrami School**
Kevin Grover, **East Grand Forks Public Schools**
Desiree Linden, **Mahnomen Public School**
Denise Staehnke, **Fosston School District**
Lisa Loegering, **University of MN Extension**
Shannon Stassen, **University of MN Extension**
Megan Hruby, **University of MN Extension**
Shayla Ouellette, **MN State University Moorhead**



Government/Tribal

Bruce Starkey, **Mahnomen County Administrator**
Kristie Tjon, **Mahnomen County Human Services**
Mark Askelson, **Twin Valley**
Paul Bissonette, **Tri-County Community Corrections**
Johanna Christensen, **Minnesota Department of Health**
Michael Hedlund, **East Grand Forks Police Department**
Michael Norland, **Polk County Sheriff's Office**
Cassie Heide, **City of Fosston**
Joan Lee, **Polk County Commissioner**
Molly Paulsrud, **Polk County Social Services**
Jen Erdmann, **Polk County Social Services**
Jon Street, **Polk County Social Services**
Alicia Kieckbusch, **Polk County Social Services**
Alicia Caputo, **Polk County Social Services**
Victoria Ramirez, **Polk County Social Services**



Public Health

Codi Lehmann, **Polk County Public Health**
Angel Korynta, **Polk County Public Health**
Amanda Lien, **Polk County Public Health**
Kirsten Fagerlund, **Polk County Public Health/SHIP**
Sarah Kjono, **Norman-Mahnomen Public Health**
Kim Myers, **Norman-Mahnomen Public Health/SHIP**
Sarah Reese, **Polk County Public Health**



Community Organization

Heidi Danos, **Saeter Consulting & Firefly Center**
Laura Gullickson, **Lake Agassiz Regional Libraries**
Nicole Benson, **Blue Zones Project**
Lori Wollman, **Inter-County Community Council**
D'Anne Johnson, **Inter-County Community Council**
Cindy Scott, **Tri-Valley Opportunity Council**
Brandi Knutson, **Tri-Valley Opportunity Council - FRC**
Jason Carlson, **Tri-Valley Opportunity Council**
Tami Byklum, **Tri-Valley Opportunity Council**
Val Mattison, **Dancing Sky Area Agency on Aging**
Susie Boelter, **North County Food Bank, Inc**
Kayla Waslaski, **Care and Share of Crookston, Inc**
Anna Corona, **Community Health Service, Inc**
Jennifer Compeau, **Polk County Family Resource Centers**



Healthcare

Erin Stoltman, **Essentia Health Ada**
Alli Fast, **Essentia Health**
Katie Vasey, **Essentia Health**
Judy Meyer, **Alluma**
Colleen MacRae, **Alluma**
Shannon Kronlund, **Alluma**
Michelle Gunufson, **Fair Meadow Nursing Home**
Kiley Desrosier, **Fair Meadow Nursing Home**
Carrie Danielson, **Essentia Health Fosston, Bagley, Oklee**

Thank
you

Partners listed participated in either the community partner survey and/or community health meetings. Many other community members that contributed may not be listed.

Letter to the Community

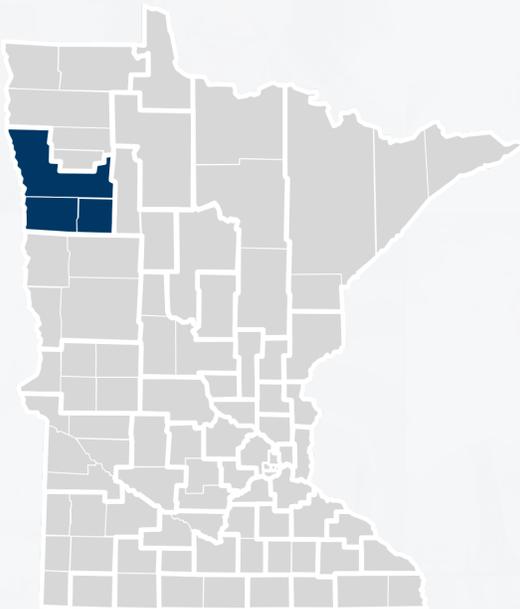
To our county residents and community members -

While the creation of a collaborative regional Community Health Improvement Plan (CHIP) was launched and stewarded by our local public health team, the product is the **result of engagement and expertise of organizations, partners, and community members** across our three-county region. We are proud to have a collaborative process and thank all who have participated in and provided support for the 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 to improve health and well-being across Polk, Norman, and Mahnomen counties.

Be well,

Sarah Reese, Sarah Kiono, Angel Korynta, Codi Lehmann, Kim Myers & Amanda Lien

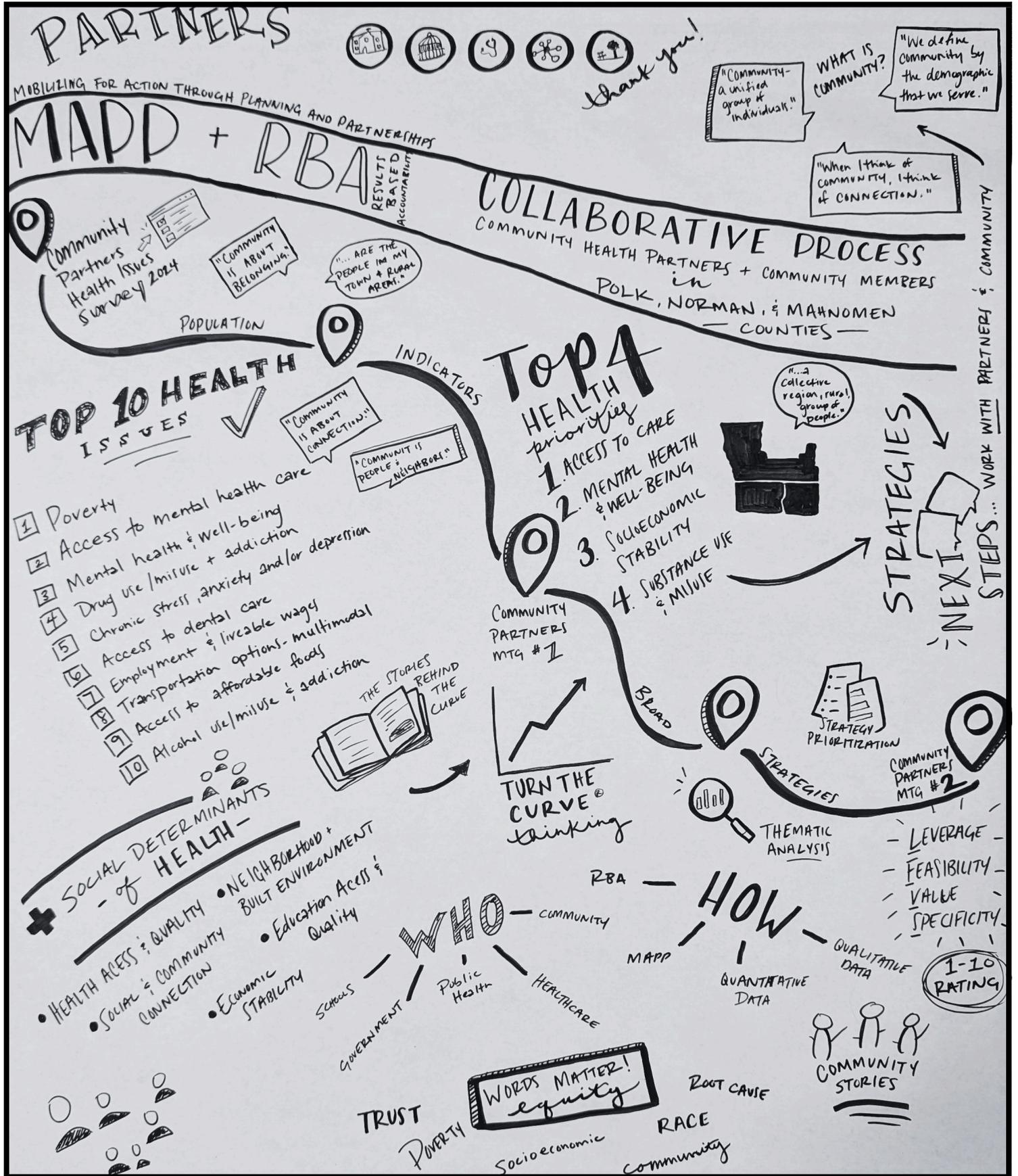


Polk, Norman, Mahnomen Counties

- 3,402 square miles
- 43,044 people (2022 US Census)
- 98 townships; 26 small towns/cities; Mahnomen County has one 'Census Designated Place' known as Naytahwaush
- White Earth Reservation encompasses all of Mahnomen County
- Most of the region is sparsely populated
- 12.6 people per square mile
- White (82.1%), American Indian and Alaska Native (6.7%), Latino/Hispanic (5.67%), Black or African American (2.3%), Two or More Races (6.6%)

The Polk-Norman-Mahnomen Community Board (CHB), is a multi-county community health services (CHS) entity, including Polk County Public Health and Norman-Mahnomen Public Health who are responsible for providing local governmental public health services across Polk, Norman, and Mahnomen Counties.

COMMUNITY HEALTH IMPROVEMENT PROCESS GRAPHIC RECORDING





Planning Process

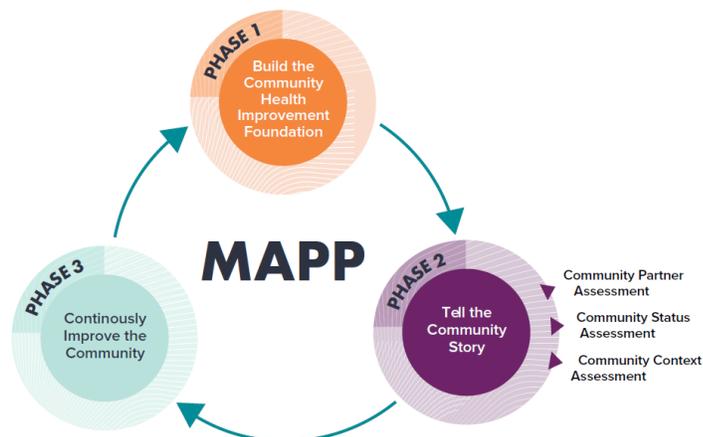
Introduction

A community health assessment and health improvement plan are customary practices of public health and are the responsibility of community health boards under Minnesota Statutes §145A. Public Health convened partners and coordinated a community health assessment and planning process.

This Community Health Improvement Plan (CHIP) reflects the collaborative planning process and serves as a roadmap to guide collective action to address specific population health priorities and achieve a shared vision of community health.

MAPP

The Mobilizing for Action through Planning and Partnerships (MAPP) model is a community-driven strategic planning process for improving community health. This framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them.

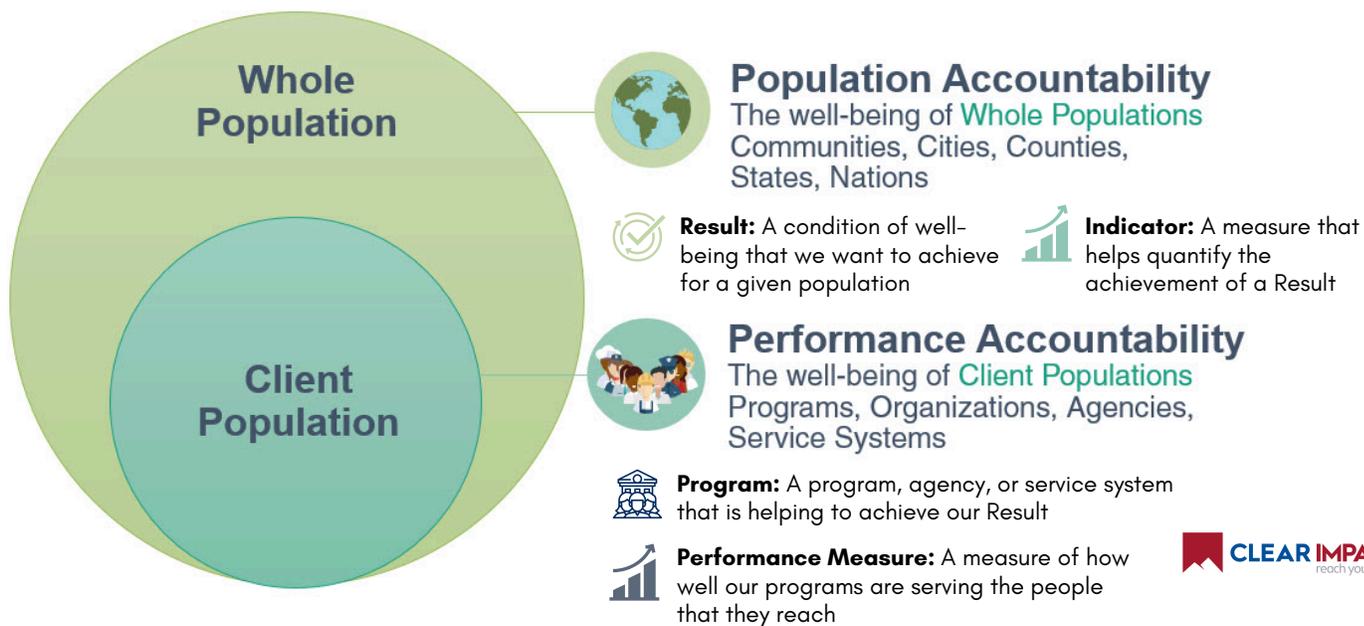


PNM and its partners used a modified MAPP approach to accommodate local capacity.

Results-Based Accountability [®]

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 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.

Results-Based Accountability [®]

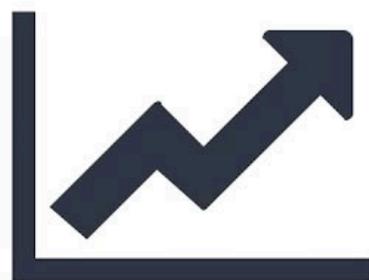


Turn the Curve Thinking

“Turn the Curve” thinking involves five key steps. The process is short and succinct to get from talk to action more quickly.

5 Core Questions

01. How are we doing?
02. What is the story behind the curve? (i.e. what is the story behind the data, root causes, why here/locally?)
03. Who are the partners who have a role to turn the curve? Who can impact the data/issue; asked the question “who is missing?”
04. What will work to turn the curve or improve the data/issue? (Leverage, Feasibility, Specificity, & Value)*
05. What is our action plan to turn the curve? What do we propose to do?



*Definitions listed in Appendix E

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

Community Partner Survey

Community health assessment data was utilized by Public Health to identify 50 community health issues. Community partners then were asked to 1) select what they considered to be the top ten issues currently impacting the community's health; 2) how they defined community; and 3) an example or story of an asset, resource or service in community that supports health and well-being in a survey emailed out by Public Health staff.



Top 10 Priority Health Issues:

1. Poverty
2. Access to mental health care
3. Mental health & well-being
4. Drug use/misuse & addiction
5. Chronic stress, anxiety and/or depression
6. Access to dental care
7. Employment & livable wages
8. Transportation options - multimodal
9. Access to affordable foods
10. Alcohol use/misuse and addiction

Based on survey results, four population results and indicators were offered for consideration at the community health meeting. Population indicators for each were identified for each of the priority areas based on overall communication, importance and data power (RBA).

1. Mental health & well-being / access to care
2. Access to care/delayed healthcare due to inability to pay
3. Poverty, employment & liveable wages
4. Substance use/misuse & addiction - drugs, alcohol & tobacco

Community Health Partner Meetings

September 26, 2024

Fertile, Minnesota

Priority Areas Identified

Population results and indicators presented and Fist-to-5 Consensus Model used to select top four health priority areas among group participants.

Turn the Curve

RBA was introduced and World Cafe was used to run Turn the Curve process:

- Story Behind the Curve
 - Social Determinants of Health and Health Disparities
- Partners & Who is Missing?
- Strategies (evidence-based, promising practices, low cost/no cost options & off the wall)

October 31, 2024

Fertile, Minnesota

Strategy Prioritization

- Thematic analysis of brainstormed strategies from September meeting
- Public health offered broad strategies for review and ranking
*See Appendix D

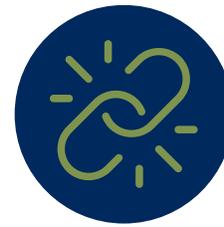
Individual Ranking

Individually, partners ranked strategies based on **Leverage, Feasibility, Specificity, and Value** through Mentimeter. *See Appendix E for Definitions & Results

Small Group Ranking

Discussed strategy rankings; used Dotmocracy to select top strategies for collective action.

Health Priority #1 Access to Care

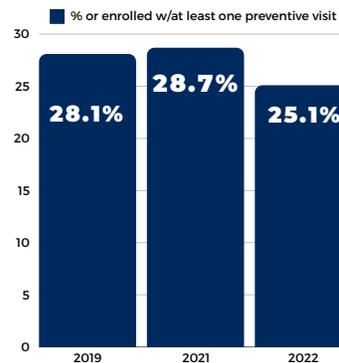
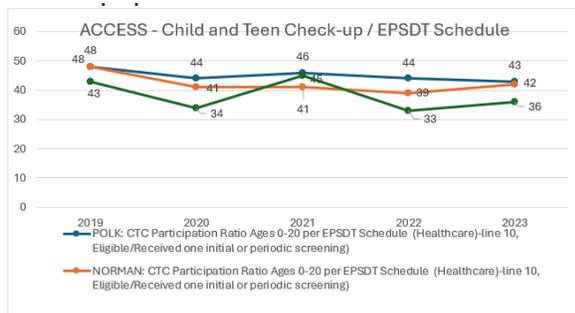


For Overview & Importance see Appendix D

Result 1: All people have access to healthcare.

Population Indicators:

- Child & Teen Check-up (C&TC) Participation Ratio Ages 0-20 per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Schedule
- % of enrolled with at least one preventive visit

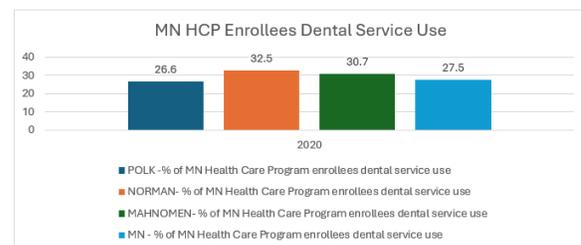
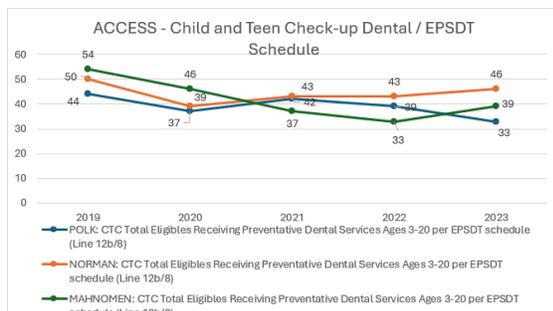


In 2022, 25% of members (with enrollment in Medicare Advantage, MHCP, commercial, or who were Dually-Eligible) who resided in the three-county area had at least one preventive visit.

Result 2: All people have access to preventive dental screenings.

Population Indicators:

- % of MN Health Care Program enrollees dental service use
- C&TC Total Eligibles Receiving Preventative Dental Services 3-20 per EPSDT schedule



Result 3: All people have access to mental health and well-being resources.

Population Indicators:

- About 26% of adults reported experienced delay in seeking professional help for mental health during pandemic
- % of 8th graders in the PNM service area who report they feel "somewhat or very comfortable" talking to a counselor or social worker at school when they are upset (MSS, New '22)

Note: School districts in Norman County did not participate in the 2022 Minnesota Student Survey (MSS); Mahnomen County 11th graders did not participate in the 2022 MSS.

% of 8th graders in the PNM service area who report they feel "somewhat or very comfortable" talking to a counselor or social worker at school when they are upset (MSS, new qu 2022)



Action Plan Strategies

Access to Care

Result 1: All people have access to healthcare.

Result 2: All people have access to preventive dental screenings.

Result 3: All people have access to mental health & well-being resources.

STRATEGY

1

Expand Care Options and Explore Service Delivery Innovations

- **Alternative Hours and Flexible Services:** Explore non-traditional hours of operation to better serve patients with diverse schedules.
- **School-Based Health Services:** Provide physical and mental health services on school campuses through a team of nurses, nurse practitioners, and physicians to ensure easy access for students.
- **Community/School-Based Dental Services:** Establish and expand dental clinics in schools/community offering preventive and restorative care.
- **Oral Health in Non-Traditional Settings:** Implement strategies like teledentistry in settings such as WIC clinics, Head Start, early childhood centers, and long-term care facilities.

STRATEGY

2

Increase Workforce Development and Support

- **Train More Medical Professionals:** Increase programs or supports that train healthcare, behavioral health, Emergency Medical Services (EMS), long-term care, public health and dental health care professionals.
- **Improve Work Environments for Care Providers:** Focus on leadership development, organizational support, and fostering supportive workplace culture.
- **Financial Incentives:** Expand scholarships, loan forgiveness, and repayment programs to attract and retain health professionals.
- **Community Health Workers:** Integrate lay health workers to perform education, referral, case management, and home visiting for individuals with barriers to accessing healthcare.

STRATEGY

3

Create and/or Increase Transportation & Accessibility

- **Expand Transportation Services:** Partner with transportation programs to create and/or improve access in low-density areas, providing rides to healthcare facilities for residents.
- **Telemedicine and Telehealth:** Use remote diagnostics, consultations, and treatments to improve access for those in remote areas or with transportation/mobility limitations.

**Listed strategy examples are not all encompassing of potential partner contributions.*

Health Priority #2 Mental Health & Well-being

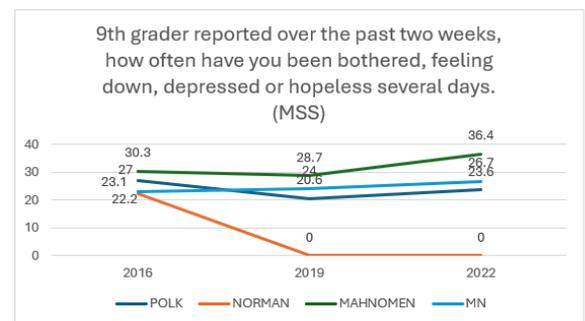


For Overview & Importance see Appendix D

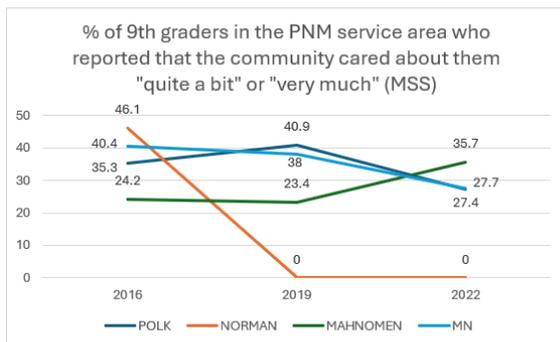
Result: All people foster, support and experience positive mental health and well-being.

Population Indicators:

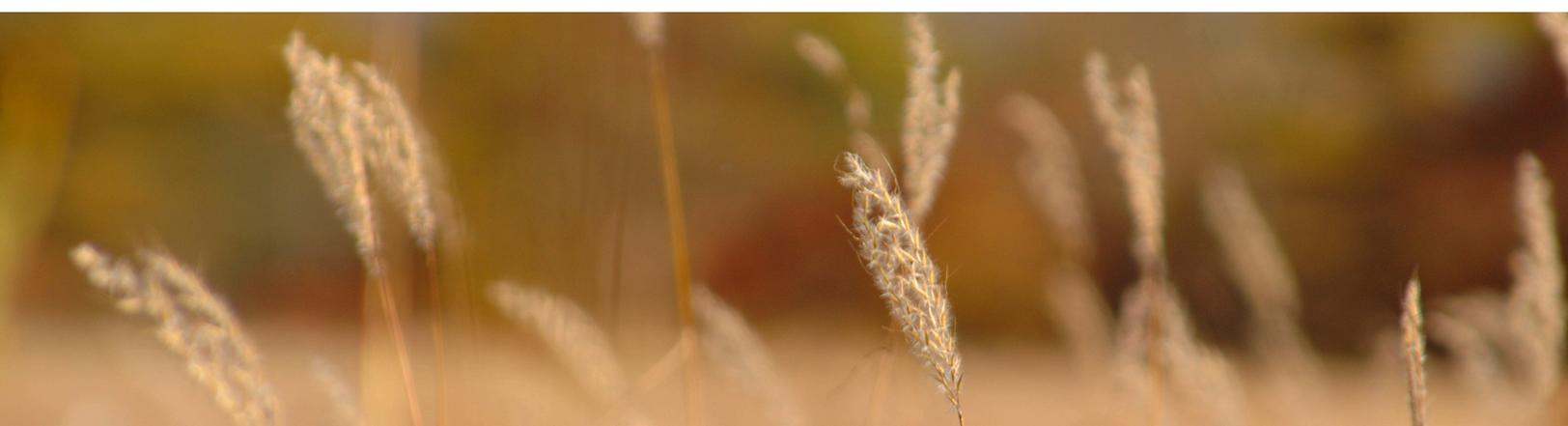
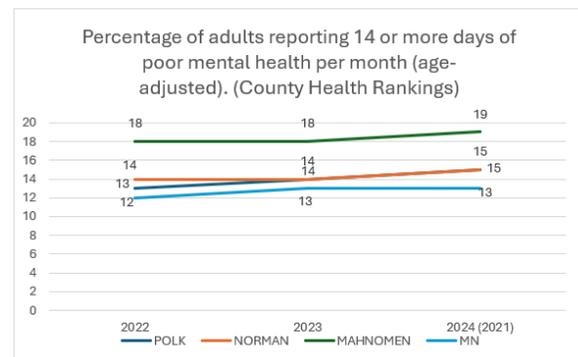
- % of 9th graders in the PNM service area who reported the community cared about them "quite a bit" or "very much"
- PNM 9th graders reported "over the past two weeks, how often have you been bothered, feeling down, depressed or hopeless several days"
- % of PNM adults reporting 14 or more days of poor mental health per month (age-adjusted)



Note: Data point from previous CHIP, Mahnomens 2022 8th graders, N=11



Note: Mahnomens 2022 8th graders, N=5



Action Plan Strategies

Mental Health & Well-being

Result: All people foster, support and experience positive mental health and well-being.

STRATEGY

1

Create and Foster Supportive Environments and Social Connections

- **Safe Spaces:** Establish/support environments where individuals feel comfortable discussing their mental health; community initiatives that support wellbeing.
- **Intergenerational Mentoring/Community Building:** Organize events/relationships that encourage social interaction and support networks.

STRATEGY

2

Expand and Ensure Access to Resources

- **Support Services:** Ensure availability of mental health professionals, hotlines, telehealth, culturally adapted care and mobile/online resources.
- **Self Help Mindfulness/Stress Management:** Techniques/strategies, tools.
- **Mobile Mental Health Support:** Utilize mobile devices and apps for mental health support, including crisis intervention, education, and therapy.

STRATEGY

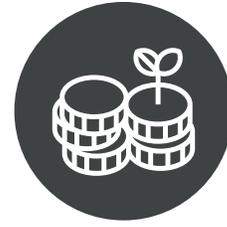
3

Advocate for Change and Integrate Mental Health into Policy

- **Legislation/Policy:** Mental health (and SUD) insurance coverage; Resources/funding for mental health approaches that focus on prevention, rather than punitive systems.
- **Workplace Initiatives:** Explore mental health days, flexible work hours, work culture, trauma informed care/mental health training, and employee assistance programs.
- **School Programs:** Embed mental health and wellbeing programming/education in school curricula (or initiatives in partnership with partners); trauma-informed counseling services.
- **Anti-racism:** Examine/change policies, processes and decision making of organizations supporting child, youth and family mental well-being.

**Listed strategy examples are not all encompassing of potential partner contributions.*

Health Priority #3 **Socioeconomic Stability**

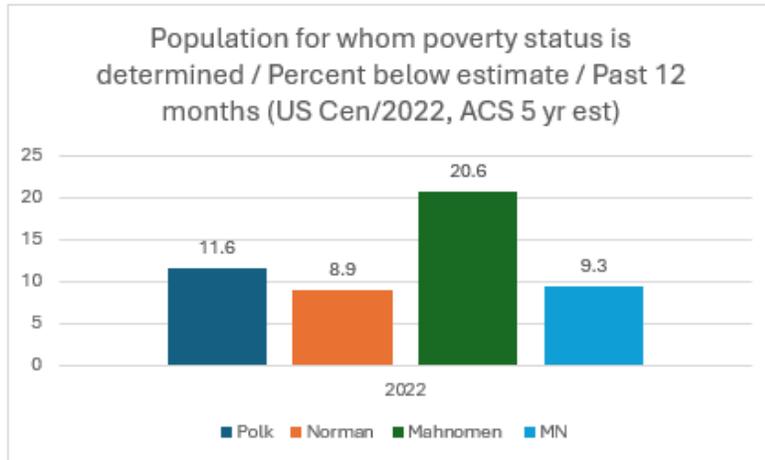


For Overview & Importance see *Appendix D*

Result: All PNM residents are free from the negative impacts of poverty.

Population Indicators:

- Population for whom poverty status is determined / Percent below estimate / Past 12 months



Action Plan Strategies

Socioeconomic Stability

Result: All PNM residents are free from the impacts of poverty.

STRATEGY

1

Prioritize Employment, Economic Stability & Economic Development Initiatives

- **Flexible Work Arrangements:** Adopt flexible hours, remote work options, and other arrangements to support work-life balance.
- **Workplace Supports for Active Commuting:** Provide facilities and incentives for biking, walking, or public transportation.
- **Living Wage and Financial Supports:** Advocate for minimum wage increases, baseline income, paid family leave, and Earned Sick and Safe Time (ESST) leave.

STRATEGY

2

Access to Education and Empowerment

- **Early childhood education** and recommended reading rates for 0-5.
- **Affordable Education Programs:** Provide scholarships, grants, and pathways to ensure access to quality education to support graduation, secondary education and future career paths.
- **Vocational/Trade School Training:** Develop job training programs and incentives that align with local job markets to enhance job/industry focused skill training and employability.
- **Mentorships and Education Pathways:** Support youth graduation and pathways to higher education or career readiness.
- **Safe Spaces for Families:** Establish community centers where children and families can gather in safe, supportive environments.
- **Workforce Training and Trade Incentives:** Fund or encourage programs that help individuals gain skills, access paid internships, or enter trade schools.

STRATEGY

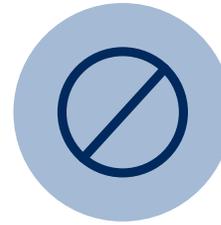
3

Ensure Childcare and Early Childhood Development

- **Childcare Accessibility:** Expand childcare options, such as employer-provided care and flexible hours.
- **Financial Assistance for Childcare:** Provide assistance for working parents or students to afford childcare.
- **Prenatal, Parental and Early Childhood Education:** Support early education programs and reading rates for children ages 0-5.

**Listed strategy examples are not all encompassing of potential partner contributions.*

Health Priority #4 Substance Use & Misuse



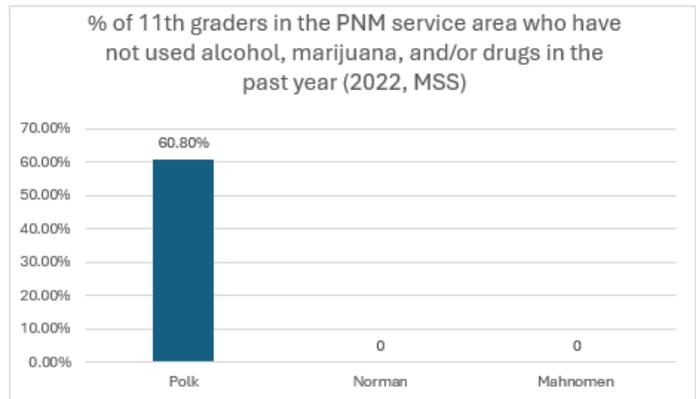
For Overview & Importance see Appendix D

Result 1: All youth are free of substance use, misuse and abuse.

Population Indicators:

- % of 11th graders in the PNM service area who have not used alcohol, marijuana, and/or drugs in the past year

Note: Norman County school districts did not participate in the 2022 Minnesota Student Survey (MSS); Mahnomen County 11th graders did not participate in the 2022 MSS.

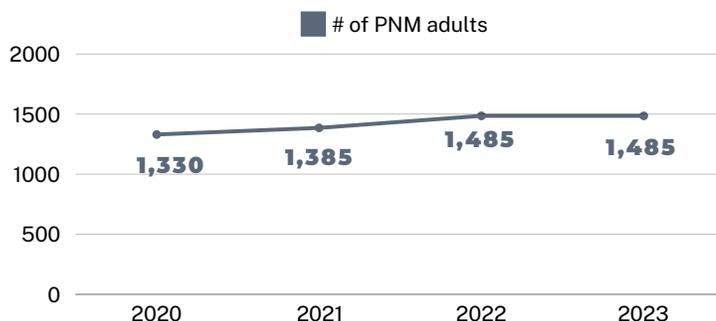


Result 2: All adults are free of substance misuse and abuse.

Population Indicators:

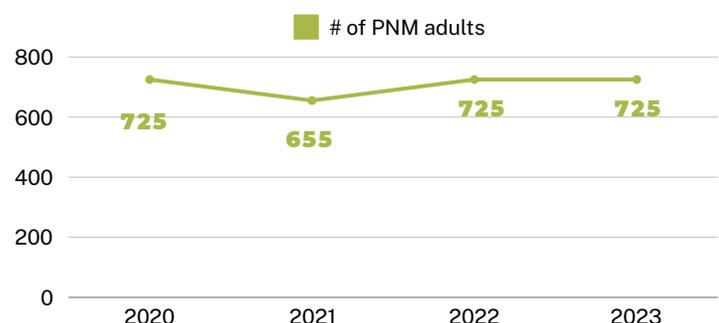
- Adults who were seen at any participating health system within the last 3 years and received a diagnosis of alcohol use in the last 5 years (Health Trends Across Communities (HTAC))
- Adults who were seen at any participating health system within the last 3 years and received a diagnosis of opioid use in the last 5 years (HTAC)

Alcohol Use



*Counts rounded to the nearest 5 for data privacy purposes.

Opioid Use



*Counts rounded to the nearest 5 for data privacy purposes.

Action Plan Strategies

Substance Use/Misuse

Result 1: All youth are free of substance use, misuse, and abuse.

Result 2: All adults are free of substance misuse and abuse.

STRATEGY

1

Create Supportive Environments

- **Extracurricular Programs:** Encourage participation in sports, arts, and clubs that offer healthy outlets.
- **Mentorships:** Facilitate opportunities that foster a sense of purpose and community connection.
- **Safe Spaces:** Create and sustain environments where youth feel comfortable .
- **Support Groups Family Treatment and Recovery Centers:** Family based recovery and other support groups for recovery.
- **Family Involvement:** Encourage family participation in events and activities to strengthen bonds and support substance-free choices.

STRATEGY

2

Foster a Culture of Resilience and Trauma-Informed Care

- **Decision-Making Skills/Stress Management:** Policies, practices and environmental changes that offer/teach critical thinking, problem-solving, coping with stress and refusal skills to help youth make informed choices.
- **Positive Messaging:** Work to change the narrative around youth culture to emphasize the benefits and joys of a substance-free life.
- **Building Resilience:** Develop and implement policies, practices, and environmental changes in homes, schools, and communities to foster resilience.
- **Understanding Behavioral Health:** Promote awareness of behavioral health, trauma's impact, and substance use disorders within the community.
- **Protective Factors for Youth:** Increase opportunities for protective connections across individual, family, peer, school, & community levels.

**Listed strategy examples are not all encompassing of potential partner contributions.*



Call to Action

Throughout the planning process, community members and organizations were 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 to help develop recommendations, implement strategies, and evaluate our collective efforts.

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 & 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.

Invitation to Join

Within our local communities, there are many people working towards improving health.

We welcome new people and partners to get involved by connecting with us locally:

Polk County Public Health

218.281.3385

Norman-Mahnomen Public Health

218.784.5425

218.935.2527



Polk-Norman-Mahnomen

Community Engagement & Implementation

Community Engagement

- ✓ Through Results Based Accountability (RBA), Public Health and community interest holders will have shared decision-making and actively collaborate to ensure that initiatives and resources are aligned.
- ✓ PNM Community Health meetings will be scheduled two times each year for relationship building, celebrating success and ongoing evaluation and feedback, along with County Collaborative and/or topic specific workgroup meetings as needed.

Implementation

- ✓ Action Plan: Confirm partner implementation or intent to implement strategies. Update action plans that outline who will do what, when, and how.
- ✓ Communication and Awareness: Use various communication channels like social media and public meetings to invite current and new community members and organizations to participate in the CHIP.

Monitoring and Sustainability

Monitor & Evaluate

- ✓ Using Data to Track Progress: RBA relies on quantitative and qualitative data to assess the current state of community health and measure progress toward specific population health priorities. Regular data collection allows for more real-time adjustments to strategies. Public Health will work with community partners to create a *Clear Impact Scorecard** to track key indicators providing transparent progress.

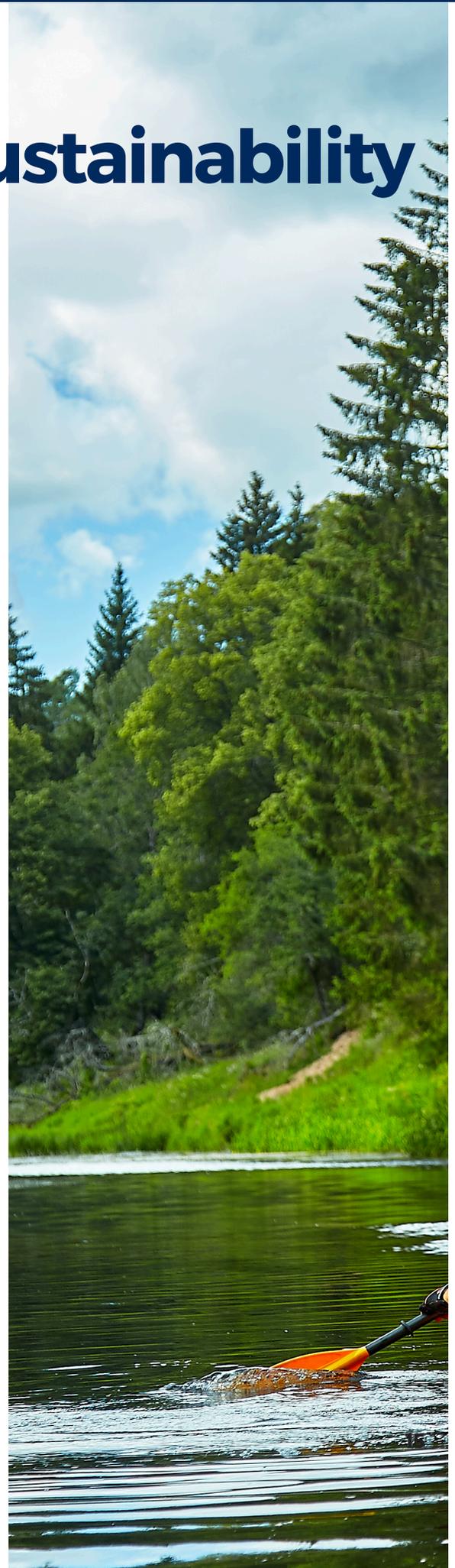
**This online tool was created to initiate, sustain, & reinforce the work of results-based accountability. The scorecard has the ability to foster collaboration between partners, easily share data, & track trends.*

- ✓ Continuous Monitoring, Adjustments, and Improvements: Based on ongoing monitoring, make adjustments to the plan as needed. If certain initiatives are not working, modify or replace them with more effective approaches.
- ✓ Reporting and Transparency: Communicate progress to the PNM Community Health partners and governing boards at least annually through reports or meetings.

Sustainability

- ✓ Maintain and develop community partnerships creating an opportunity for ongoing community health improvement and advancement of health equity.
- ✓ Keep strategies and actions realistic and manageable among partners.
- ✓ Implement policy, systems, and environmental change strategies for sustainable solutions.
- ✓ Acknowledge the progress made and celebrate milestones to maintain momentum and encourage continued involvement.

The CHIP is a living document that will be revised over time.





PNM CHS extends gratitude to the community members and partners who participated in the development of the CHIP. We look forward to working together to improve the health & well-being of our communities.

Appendix A

Community Health Survey 2022 Executive Summary

Polk Norman Mahnomen Community Health Survey 2022

Survey consisted of questions related to general, mental, oral health, access to health care, impact of COVID-19 on health and quality of life, substance use and community wellbeing. The survey was completed by 855 adult individuals. Out of the 855 survey responses, 821 were included in the analysis as the remaining 34 respondents were not from the PNM region.

“Poor” health status was primarily reported by White and Black or African American population.

About 26% of people experienced delay in seeking professional help for mental health during pandemic and this was mainly because the mental health care was expensive, or they did not think that the problem was serious enough.

Most reported reason for delay in obtaining oral health care were expense, unable to get an appointment and lack of insurance coverage.

47% of survey respondents consume alcohol, tobacco, or illegal drugs. Stress (16%) and boredom (13%) are the primary reason for the increase in substance use since March 2020.

Majority of respondents received health information from social media, family, friends, health officials or county media website and television news. However, about 37.63% doubted whether the source was trustworthy. 19% of people also had issue with understanding medical terms and about 12% did not know where to find health information.

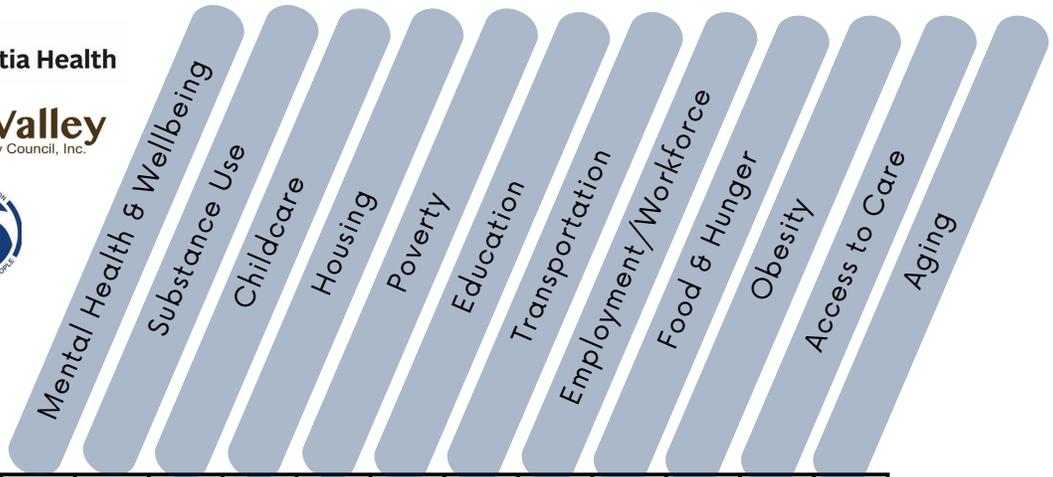
People with an annual income less than \$20k and between \$35k-\$49,999 mainly reported worsening of financial situation.

About 8% survey respondents faced transportation issue and they reported to be from 25-44 years of age.

Appendixes

CHNA & CNA Partner Inventory

This document is an accumulation of most recent Community Health Needs Assessments (*healthcare partners*) and Community Needs Assessments (*Community Action agencies*) of our partners. It is not intended to be all encompassing; partners continue to have current & emerging priorities in response to the needs of community. *Links to full assessments are provided.*



	Mental Health & Wellbeing	Substance Use	Childcare	Housing	Poverty	Education	Transportation	Employment/Workforce	Food & Hunger	Obesity	Access to Care	Aging
Alluma	X	X		X	X	X	X	X		X	X	
Altru Health	X	X	X				X		X	X		
Essentia Health Ada	X						X					
Essentia Health Fosston	X								X			
Inter-County Community Council			X	X		X	X			X		
MAHUBE-OTWA			X	X		X	X	X				X
Riverview Health	X	X							X			
Sanford Health	X									X		
Tri-Valley Opportunity Council			X	X	X		X	X				X
White Earth Nation Tribal Public Health	X	X		X		X			X			
PNM Public Health	X	X			X					X		

Microsoft Forms Survey Responses

Health Issues

Appendixes

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Technology and social media use	15
Housing instability	15
Delayed healthcare due to inability to pay	14
Vaping	13
Sedentary life/lack of physical activity	12
Changing family systems	12
Access to healthy, safe, nutritious foods	12
Access to food and water/food insecurity/hunger	12
Quantity of housing	11
Access to specialty health care	9
Transportation options - safety and walkability	9
Access to primary health care	8
Education/Truancy	8
Social isolation	8
Quality and quantity of sleep	8
Civic/community engagement	7
Mental health stigma	6

Quality of life for persons aged 65 & older	6
Other tobacco use (cigarettes, chew)	5
Quality of housing	5
Access to the outdoor/parks and recreation	5
Access to preventative screenings	5
Cancer	4
Dementia (Alzheimer's Vascular, etc)	4
Safe environments - crime and violence	4
Education - trades, specialized workforce training or higher education	4
Education/High School Graduation	3
Access to trustworthy health information	3
Access to health information in preferred language	3
Air quality, water quality and indoor clean air	2
Motor vehicle crashes (due to texting & driving, impaired substance use or lack of seatbelt)	2
Discrimination	2
Type II Diabetes	1
Broadband access	1
Artificial intelligence	1
Infectious diseases	1
Vaccine preventable disease	1
Early Childhood screenings	0
Unintentional injuries	0
COPD/Heart Disease	0
Human trafficking	0

*47 survey respondents total

To keep anonymous, qualitative data is not shared in the appendix. Themes pulled from the qualitative data aligned with our Top 10 Priorities and helped guide our CHIP process.

The PNM public health planning team and partners acknowledged that many of the 50+ health issues are interrelated so that if we have improvement in one area, we will likely see improvement in other areas.

Appendixes

Health Priority #1 Access to Care



Overview & Importance

Access to Healthcare

The Minnesota Department of Health's *Health Economic Program analysis of Hospital Annual Reports 2012-2020 Service Utilization of MN Community Hospitals* shows a decrease in emergency room visits from 2018 to 2020 at PNM providers including RiverView Health, Essentia Health-Fosston, Essentia Health-Ada, and Mahnommen Health Center.

Number of ER Visits

**Hospital
Annual Reports
2012-2022
Service Utilization
of MN Community
Hospitals**

	2018	2019	2020
RiverView Health	6,033	5,748	4,805
Essentia Health-Fosston	2,939	2,943	2,528
Essentia Health - Ada	1,378	1,235	1,138
Mahnommen Health	3,226	2,924	2,536

MDH Health Economic Program analysis

Access to Dental Care

--Most reported reason for **delay in obtaining oral health care** were **expense, unable to get an appointment and lack of insurance coverage** (2022 PNM Community Health Survey).

--In 2022, there was one dentist per 1,290 people registered in Minnesota. This ranged from one dentist per 0 people to one dentist per 750 people across counties in the state (*County Health Rankings*). In 2019, more Minnesota residents of isolated, small rural towns were unable to receive needed dental care due to cost (MN Department of Health, 2021).

--The Minnesota Department of Human Services (DHS) administers the Minnesota Health Care Programs (MHCP) for qualifying low income Minnesotans. The two major programs included in these data are Medical Assistance and MinnesotaCare. A *dental service is any diagnostic, preventive, or treatment service provided by or under the supervision of a dentist*. In 2020, statistically fewer Minnesota Health Care Program (MHCP) enrollees received at least one dental service (28%), compared to the previous year (34%). This may be due in part to the COVID-19 pandemic (March 2020-present), which affected dental clinics' mode of operation.

--Children under age 6 years were 55% less likely to have received a dental service compared to those ages 6 to 84 years. The American Academy of Pediatric Dentistry and the American Academy of Pediatrics recommend at least one dental visit each year, starting by a child's first birthday, when the first tooth appears, or whichever comes first.

--In 2023, 42% of dental facilities in health professional shortage areas were rural health clinics (MN *Statewide Health Assessment (SHA)*, pg. 67). Rural Minnesotans were more likely to say they were unable to get an appointment with a primary care provider or a dentist when needed. Rural Minnesotans also had more problems finding dentists that were accepting new patients.

--In 2022, 80% of Minnesota counties qualified as mental health professional shortage areas. In 2021, 20.2% of people in Minnesota reported not seeking health care (dental, mental, prescriptions, routine medical, or specialist care) due to cost. Some groups of people were more likely not to seek care, including people who were uninsured; had individual or public insurance plans; American Indian or Hispanic/Latine between the ages of 26 and 64; had a chronic condition; or had income at or below 200% of the federal poverty guidelines.

Access to Mental Health Care

The top reasons for delaying **mental health care** were that people **didn't think it was serious, cost, and Covid-related** (2022 PNM Community Health Survey Results).

Many research papers highlight the existence of **health disparities and inequities in rural and frontier communities**. Locally, these manifest as barriers including:

- 1) **lack of timely access to services**, distances greater than 30+ miles between providers with limited transportation options for persons seeking services; limited broadband coverage for telemedicine services;
- 2) **affordability/poverty**, poverty significantly affects health and is often an overlooked inequity in our area. Low incomes can result in individuals not seeking forms of preventive and routine healthcare due to financial burdens of out of pocket cost or missing work;
- 3) **acceptability/stigma** (albeit increasingly improving – i.e. reducing stigma) and
- 4) **availability** – limited number of providers and cost, lack of available health data to information organizational services, resource allocation, policies and community needs; lack of workforce and lack of workforce diversity means non-dominant population are not always able to connect with providers of their cultural choice with whom they feel a cultural/ethnic connection.

In 2022, the top adult diagnosis' were Depression and Anxiety.

All people across the life span, with or without a mental health diagnosis, experience emotional turmoil within daily life which is evidenced by the drastic year-over-year increases in Urgent Care (Same Day) services delivered by Alluma; there was a 10,500% increase from 2017 to 2022. Likewise, Crisis Services for adults have increased by nearly 300% between 2017 and 2022 (from 231 to 689). Crisis Services for school-aged children (under 18) have increased by approximately 244% between 2017 and 2022 (Alluma). The 988 crisis call contact volume has been steadily increasing across the NW region as well. The bad news is that it is increasing. The good news is also that it is increasing, suggesting that our collective efforts are making a difference in terms of reducing stigma and willingness to access services in a crisis. (Crisis Screening Calls from Jan-Aug 204 for Polk, Norman, Mahnomen and Red Lake Counties: 223 Children and 1088 Adults, Alluma).

		2024	2023	2022
Ratio of population to Mental Health Providers	Polk	390 to 1	370 to 1	390 to 1
	Norman	NA	NA	NA
	Mahnomen	NA	NA	NA
	Minnesota	300 to 1	320 to 1	340 to 1

**The 2024 Annual Data Release used from 2022 for this measure. (County Health Rankings)*

<https://www.countyhealthrankings.org/health-data/health-factors/clinical-care/access-to-care/dentists?state=27&year=2023&tab=1>
<https://data.web.health.state.mn.us/mnhas-forgone#byUrban>
<https://www.countyhealthrankings.org/health-data/health-factors/clinical-care/access-to-care/mental-health-providers?state=27&year=2024#map-anchor>

Health Priority #2 Mental Health & Well-being



Overview & Importance

The 2022 PNM Community Health Survey indicated a positive overall response in terms of connectedness to the community. 39.19% people felt a strong connection to their community. 41.19% people felt that the community they lived in was inclusive and welcoming and 47.50% believe that they can make a difference by being involved in the community.

Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted). The 2024 Annual Data Release used data from 2021 for this measure. Frequent Mental Distress is an analogous measure to Poor Mental Health Days. It provides a slightly different picture which emphasizes those who are experiencing more chronic, and likely severe, mental health issues. MN SHA pg 92. Of 82,000 Minnesota students surveyed in 2022, 47% reported experiencing at least one adverse childhood experience; in particular, the rate of students experiencing sexual abuse or living with someone with mental health issues increased from 2019 to 2022.

Feelings of connectedness to the community

*2022 PNM Community
Health Survey

39.2% felt a strong connection to community

41.2% felt their community they lived in was inclusive and welcoming

47.5% believe that they can make a difference by being involved in the community

2019 Minnesota Student Survey

8th, 9th and 11th graders - ACES - number of adverse experiences reported by each student.

Of **Polk County's** 8th, 9th, and 11th graders, **49%** reported experiencing at least one ACE, compared to 52% statewide. More than half of adolescents experiencing any ACEs report more than one.

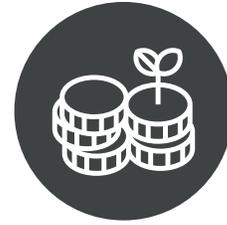
Of **Norman County's** 8th, 9th, and 11th graders, **58%** reported experiencing at least one ACE, compared to 52% statewide. More than half of adolescents experiencing any ACEs report more than one.

Of **Mahnomen County's** 8th, 9th, and 11th graders, **74%** reported experiencing at least one ACE, compared to 52% statewide.

Minnesota students with 4+ ACEs are 3.4 times more likely to report feeling down, depressed, or hopeless in the past 2 weeks (49% vs. 14%).

Health Priority #3

Socioeconomic Stability



Overview & Importance

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. While poverty significantly affects health, it is often an overlooked inequity in our region. Even within our three-county region, we have varying inequities between the three counties. Some people live in deep poverty, meaning their income is 50% or more below the poverty line. In 2023, this is equal to a monthly income of \$607.50 (*MN Statewide Health Assessment, pg 54*). Adults in deep poverty have higher rates of every chronic condition measured in a study on deep poverty and health in Minnesota, including a death rate two times higher than adults who are less poor. **Adults in deep poverty experience 40% more preventable emergency department visits and 23% more preventable hospitalizations than those who are less poor.**

The rate of death for children living in deep poverty is twice as high as other children, and the rate of PTSD for children in deep poverty is also higher. Families with income below the federal poverty level may struggle to consistently meet the basic needs of their children. Exposure to chronic stress, including unreliable access to food, health care and stable housing, may impair the development of children in poverty and can affect their health at any stage:

Birth: Mothers living in low-income neighborhoods are more likely to give birth prematurely and have low birthweight babies.

Childhood: Obesity, asthma and emergency room visits are more common among children living in poverty compared with those not living in poverty.

Adolescence: Students experiencing poverty are significantly less likely to graduate high school.

Living in poverty affects a child's ability to succeed in school and may impact potential future earnings. One estimate of the cost of U.S. childhood poverty totaled \$1.03 trillion annually, factoring in lost potential earnings and costs of poor health.

Health Priority #3

Socioeconomic Stability

The prevalence of poverty in children is higher among: **Non-Hispanic Black and American Indian/Alaska Native children**, who both have a prevalence more than two times higher than non-Hispanic white and Asian children. Children of single mothers compared with children who live in two-parent households or in single-father households. Children ages 0-5 compared with children ages 12-17. (America's Health Rankings)

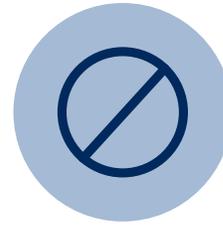
The connection between education and health is well-documented. Higher educational attainment is associated with better jobs, higher earnings, increased health literacy, better self-reported health and fewer chronic conditions. Individuals with lower educational attainment are at a greater risk of adverse health outcomes such as obesity, cardiovascular disease, lung disease, mental health problems and premature death. Additionally, students who drop out of high school are more likely to experience incarceration. Each high school dropout costs the United States more than \$272,000 in lost revenue over a lifetime based on the differences between dropouts and graduates in income, taxes paid and government spending on health, crime and welfare. Increased time in school is also associated with higher civic engagement in adulthood. Increasing the proportion of students who graduate in four years with a regular diploma is a Healthy People 2030 adolescent health objective (*America's Health Rankings analysis of U.S. Census Bureau, American Community Survey, United Health Foundation, AmericasHealthRankings.org, accessed 2024*).



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

Health Priority Issue #4

Substance Use & Misuse

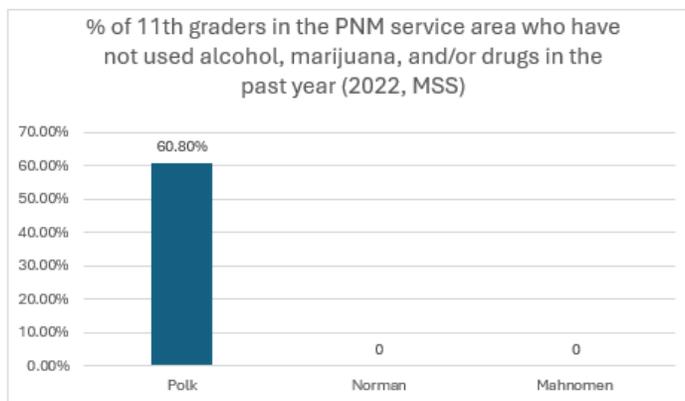


Overview & Importance

Addressing the issues of substance use, misuse and abuse requires a comprehensive approach many multiple partners tackling the root causes of substance misuse which include priority health issues already being addressed by PNM - poverty, mental health and lack of access to and care. By focusing on lowering substance use, misuse and abuse, initiatives can not only improve well-being but also foster healthier individuals and communities, reduce healthcare costs and promote overall community resilience.

Future data point for PNM - MN Student Survey: 11th graders who reported using alcohol, marijuana and/or drugs in the past year.

11th grader's perception of using alcohol, marijuana, and/or other drugs in the past year is higher than actual use (MDE, MSS).



Question: Any alcohol and/or other drug use during the past year (excluding tobacco). Response: No alcohol or marijuana or other drug use in the past year. (This is a computed variable based on combinations of responses to two or more survey items.)

2019 Minnesota Student Survey

During the last 12 months, one how many occasions have you had alcoholic beverages to drink?

Polk County

0 62.5% of 11 graders

During the last 30 days, on how many day did you vape or use an e-cigarette?

0 67% of 11 graders

2019 MSS

During the last 12 months, one how many occasions have you had alcoholic beverages to drink?

Norman County

0 51.9% of 11 graders

During the last 30 days, on how many day did you vape or use an e-cigarette?

0 85.2% of 11 graders

2019 MSS

During the last 12 months, one how many occasions have you had alcoholic beverages to drink?

Mahnomen County

0 44.4% of 11 graders

During the last 30 days, on how many day did you vape or use an e-cigarette?

0 80.6% of 11 graders

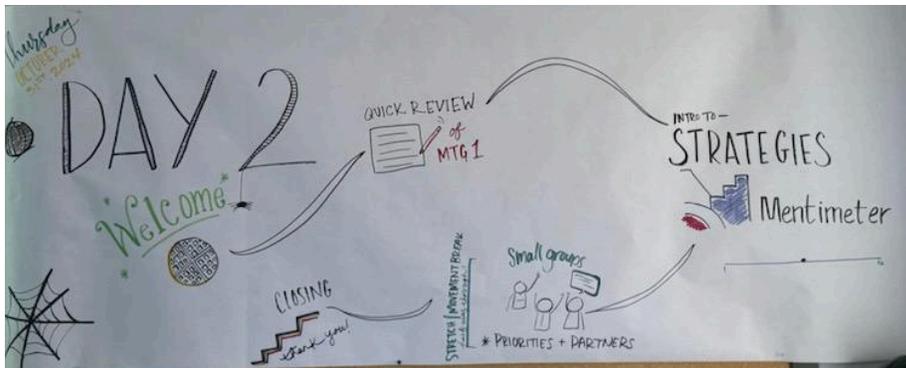
2022 Mahnomen, 8 gr (N=9 count) - During the last 12 months, on how many occasions have you had alcoholic beverages to drink. 100% said "0".

2022 Mahnomen, 8 gr (N=9 count) - During the last 30 days, on how many days did you vape or use an e-cigarette? 100% said "0"

Appendix E

Community Meeting Results - RBA Turn the Curve and Strategy Prioritization

Appendixes



Priority Health Issue #1

Access to Care

Meeting #1

The Story Behind the Curve

Factors Pushing Up on the Data

- More dental/MH/HC providers
- Increase MH providers
- Providers accepting MA
- Better reimbursement for dental
- Telehealth (mental health)
- Educating families
- Education reimbursement
- Quality of life and messaging
- Cultural practices
- Telehealth options

Factors Pushing Down on the Data

- Lack of transportation
- Lack of providers or providers that accept insurance
- Distance to provider
- Lack of family education
- Dental providers won't take kids under 3, limit # of MA, hours of clinic
- Stipulations/stresses to open clinics
- Internet connection for telehealth or lack of device
- Lack of dentist
- Insurance not accepted/private pay
- Access to primary care
- Cost to access care
- Billing red tape
- Lack of MH providers & therapists
- Lack of available hours
- Providers not being reimbursed to cover cost of services by MA
- Do not take EAP
- Cost of training to become providers
- Retention of the providers
- Transportation access
- Workforce capacity
- Housing needs for providers
- No shows

Partners

1. Policymakers (state, local, federal)
2. Providers
3. Schools (dental access)
4. Health systems
5. Mental health
6. State (DHS/MDH)
7. People receiving services
8. Community action/social services
- 9....partners from prior (peers with lived experiences, all agencies represented here today, policymakers, schools, social services, CAP agencies, faith communities, Tribal entities, WIC, Community Health Centers, SNAP, Social services/ICW, businesses/employers, Senior Linkage Line)
10. MCO's - BCBS, Medica, Ucare
11. Physical Health/Dental/MH (Essentia, Riverview, Alluma, Sanford, MHC, WEMH)
12. Social services
13. Public health
14. Community action partners
15. Dental sealant.com (school-based services)
16. HRSA designations
17. Nystrom - MH - EGF
18. Northern Dental Access
19. Spectra
20. W/TW - Wellness in the Woods

Strategies

EVIDENCE-BASED

- Head Start
- Tele-health

PROMISING PRACTICES

- CDS clinics
- School based sealants
- Fluoride varnish
- Northern Dental Access
- Head Start
- Transportation Programs
- Ipdd/hotspot for telehealth
- Financial support/reimbursement for providers
- Pop up doctor clinics in schools
- Grow your own
- MID level providers - Dental

LOW COST / NO COST

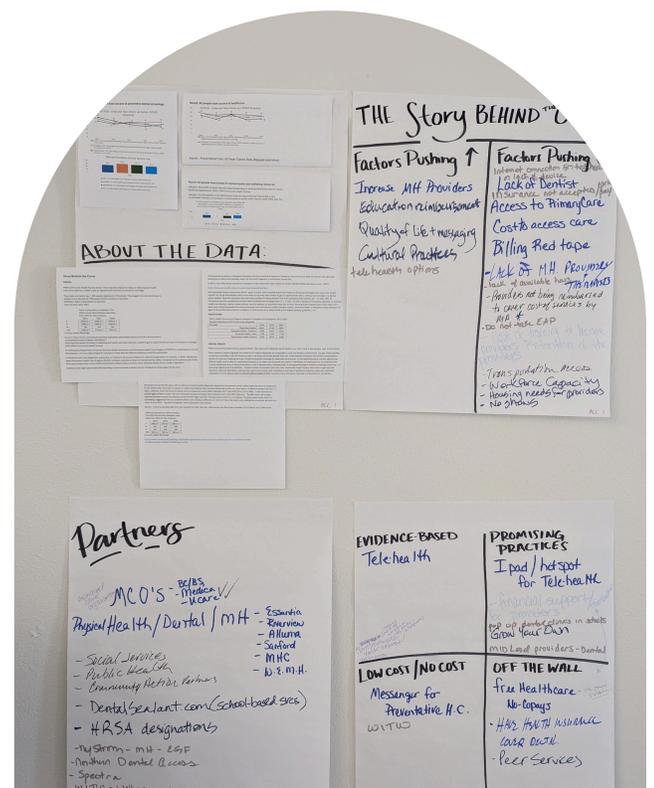
- Resource Connection for Families
- Alternative hours of service
- Messenger for preventative HC
- WITC

OFF THE WALL

- All "health" coverage combined
- Family Resource Center expansion
- Free healthcare - one payer system
- No copays
- Have health insurance cover dental
- Peer services

WHO IS MISSING?

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



Access to Care

Result 1: All people have access to preventative dental screenings.

Result 2: All people have access to healthcare.

Result 3: All people have access to mental health and well-being resources.

1 Increase Workforce Development and Support

- **Train More Medical Professionals:** Increase programs or supports that train healthcare, behavioral health, EMS, long term care, public health and dental health care professionals.
- **Improve Work Environments for Care Providers:** Focus on leadership development, organizational support, and fostering supportive workplace culture.
- **Financial Incentives:** Expand scholarships, loan forgiveness, and repayment programs to attract and retain health professionals.
- **Community Health Workers:** Integrate lay health workers to perform education, referral, case management, and home visiting for individuals with barriers to accessing healthcare.

2 Expand Care Options and Explore Service Delivery Innovations

- **Alternative Hours and Flexible Services:** Explore non-traditional hours of operation to better serve patients with diverse schedules.
- **School-Based Health Services:** Provide physical and mental health services on school campuses through a team of nurses, nurse practitioners, and physicians to ensure easy access for students.
- **Community/School-Based Dental Services:** Establish and expand dental clinics in schools/community offering preventive and restorative care.
- **Oral Health in Non-Traditional Settings:** Implement strategies like teledentistry in settings such as WIC clinics, Head Start, early childhood centers, and long-term care facilities

3 Increase Transportation and Accessibility

- **Expand Transportation Services:** Partner with transportation programs to improve access in low-density areas, providing rides to healthcare facilities for residents.
- **Telemedicine and Telehealth:** Use remote diagnostics, consultations, and treatments to improve access for those in remote areas or with transportation/mobility limitations.

4 Prioritize Preventive and Community-Based Health Initiatives and Outreach

- **Resource Connections and Family Resource Centers:** Strengthen connections for families, supporting local resource centers that offer health education and social services.
- **Community Water Fluoridation:** Partner with public health agencies to maintain optimal fluoride levels in community water supplies to promote oral health.
- **Provide Education** to navigate healthcare systems and assist in connecting individuals to healthcare services.
- **Collaborate** with community partners/healthcare providers/health plan

5 Increase Digital Health Interventions

- **Text-Message-Based Health Interventions:** Use text messaging to provide preventive care reminders, chronic disease education, and self-management support.
- **Mobile Health for Chronic Disease Management:** Leverage mobile applications and messaging to assist patients in managing chronic diseases and adhering to treatment plans.

6 Increase Cultural Awareness & Inclusive Care

- **Culturally Adapted Healthcare Services:** Increase awareness and training around cultural sensitivities in healthcare delivery to ensure services are respectful, accessible, and tailored to diverse populations.
- **Culturally Relevant Outreach:** Ensure that outreach efforts are culturally sensitive and tailored to the needs of diverse populations.

7 Advocate for Insurance and Financial Accessibility and Policy Change

- **Challenge Healthcare Insurance Structure:** Advocate for universal healthcare options like a single-payer system, reduced copays, and inclusive coverage that includes dental and other traditionally excluded services.
- **Local Government Initiatives:** Work with local authorities/community partners to develop policies and programs that prioritize funding or partnerships for dental health services.
- **Allied Dental Professional Scope of Practice:** Expand roles of allied dental prof (hygienists/therapists) via changes to statute/dentist supervision requirements.
- **Subsidized Care Programs**
- **Dental Coverage in Policies**
- **Healthcare Coverage in Policies (MnCare, etc)**

Priority Health Issue #2

Mental Health & Well-being

Meeting #1

The Story Behind the Curve

Factors Pushing Up on the Data

- Race/rural
- Stigma
- Poverty
- Family engagement
- Social media
- Lack of transportation
- Truancy
- Cultural community disparities
- Policies
- Workforce capacity
- Stigma
- Hesitancy of person in need
- Overwhelmedness
- Cyclical challenges
- Social media!
- Isolation / lack of communication skill
- Lack of resources in schools to help MH for students
- Poverty/addiction
- Increase work stress = unbalanced

Factors Pushing Down on the Data

- Community connections
- Welcoming communities
- Reducing access/time spend on social media
- School cell phone policies
- Outdoor activities
- Collaboration
- Partnerships
- Improved broadband/tech
- Awareness of effects of poor MH
- Awareness of need for personal connection, etc
- Awareness of effects of the lack of professionals in schools?
- Foster grandparent programs; schools and caring ?? programs - RSVP prog??

Partners

1. Mental health providers
2. Families and parents
3. Social services
4. Public Health
5. School staff
6. Social workers/guide co in school
7. Faith based communities
8. Community action agencies
9. Safe spaces for youth; youth center - The Cove
10. Volunteer activities for all
11. Healthcare
12. Insurance providers
13. State department - health, behavioral health, justice, etc
14. I.C.W
15. Tribal
16. Schools
17. State
18. School board
19. Alluma/MH
20. YMCA
21. Wellness in the Woods
22. Medical providers
23. Family Resource Centers
24. In Patient Facility organizations

Strategies

EVIDENCE-BASED

- Mental health
- School programming (PBS, BARR, etc)
- CASEL (Collaborative for Academic & Social Emotional Learning)

PROMISING PRACTICES

- Training
- Positive motivational plan in schools
- CAA's making referrals
- Social media training/education for parents
- ACES Education
- MH providers in schools
- Peer recovery specialist
- Mentorships
- Virtual providers

LOW COST / NO COST

- Train the Trainer
- Reduce stigma
- Volunteer programs

OFF THE WALL

- All staff trained in mental health - FREE
- All insurances cover mental health
- Identified staff - psychologist counselor, etc
- Youth based marketing by agencies - peer to peer
- Consumer-based system influencers

WHO IS MISSING?

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



Mental Health & Well-being

Result: All people foster, support and experience positive mental health and well-being.

1 Increase Awareness through Promotion and Education

- **Workshops and Training:** Provide information about mental health, signs of distress, and coping strategies; digital wellbeing/social media training.
- **Campaigns:** Use social media and community events to raise awareness (mental health and wellbeing), culturally based approaches and reduce stigma.
- **Youth/Peer-Led Initiatives:** Make the message more relatable.

2 Expand and Ensure Access to Resources

- **Support Services:** Ensure availability of mental health professionals, hotlines, telehealth, culturally adapted care and mobile/online resources.
- **Self Help Mindfulness/Stress Management:** Techniques/strategies, tools.
- **Mobile Mental Health Support:** Utilize mobile devices and apps for mental health support, including crisis intervention, education, and therapy.

3 Create and Foster Supportive Environments and Social Connections

- **Safe Spaces:** Establish/support environments where individuals feel comfortable discussing their mental health; community initiatives that support wellbeing.
- **Intergenerational Mentoring/Community Building:** Organize events/relationships that encourage social interaction and support networks.

4 Advocate for Change and Integrate Mental Health into Policy

- **Legislation/Policy:** Mental health (and SUD) insurance coverage; Resources/funding for mental health approaches that focus on prevention, rather than punitive systems.
- **Workplace Initiatives:** Explore mental health days, flexible work hours, work culture, trauma informed care/mental health training, and employee assistance programs.
- **School Programs:** Embed mental health and wellbeing programming/education in school curricula (or initiatives in partnership with partners), trauma informed counseling services.
- **Anti-racism:** Examine/Change policies, processes and decision making of orgs supporting child, youth and family mental wellbeing.

5 Conduct and Provide Regular Assessment and Feedback

- **Input and Feedback Loops:** Examine mental health needs of the community or organization, systems that may cause stigma or increase in support needs and adjust accordingly.

6 Provide Ongoing Crisis Intervention

- **Emergency Resources:** Ensure access to immediate crisis services and interventions.
- **Training for Staff:** Equip people with skills to identify and respond to mental health problems/crises.

Priority Health Issue #3 Socioeconomic Stability

Meeting #1

The Story Behind the Curve

Factors Pushing Up on the Data

- Inflation/cost
- Lack of housing
- Struggles with employment; lack of pay that is above liveable
- Having a liveable wage
- Underemployment
- "Benefit cliff"?
- Food desert (lacking)
- Reliance on technology
- Underfunded schools
- Lack of life skills
- Mhtsud?
- Lack of service providers to help maintain healthy workforce
- Lack of utilization
- Decreased literacy
- Systemic dependence
- Lack of affordable housing
- Cost of childcare or even access to people can work
- Cyclical positive
- Programs: WIC, Head start, Social services, SNAP, Tribal services, Community Health Centers



Factors Pushing Down on the Data

- Coordination of services
- Offered programs/services available in the area
- Education/literacy
- Trade schools
- Apprenticeships
- Liveable wages
- Affordable childcare or childcare access
- Youth goal setting/opportunities
- Exposure to a "different life"
- Transportation!!!
- Gas cost
- Education for families
- Food costs :(
- Lack of homeless 'shelters' or options
- "Benefits Cliff"

Partners

1. Polk County Social Services/County Social Services
2. Polk County Public Health
3. Tri-Valley/Community Action
4. Family Resource Center
5. Workforce/DEED
6. Legislators
7. County Commissioners
8. Landlords
9. Care and Share
10. Food Shelves
11. Vocational Rehab
12. MN Rural CEP
13. Community Clubs
14. Trade Schools
15. Peers with lived experiences
16. All agencies represented here today
17. Policymakers
18. Schools
19. Social services
20. CAP agencies
21. Faith communities
22. Tribal entities
23. WIC
24. Businesses/employers
25. Community Health Centers
26. SNAP
27. Social services/ICW
28. Senior Linkage Line

Strategies

EVIDENCE-BASED

- 0-5 early education
- Workforce programs
- NFP or other home visiting programs / Head Start
- Need more child care!
- Need more support of child care \$\$
- SAFE place for children & families to go (comm. centers)

PROMISING PRACTICES

- Guaranteed minimum wage/income
- ESST - leave
- Paid family leave
- Liveable wage
- Pay students to attend trade schools
- Paid internships
- Transportation + public (bus)
- Flexible work hours - remote work

LOW COST / NO COST

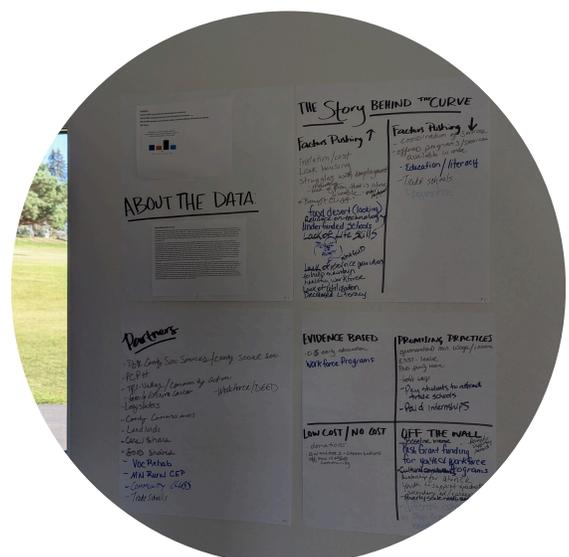
- Donations
- Awareness - conversations of how it affects community
- Flexible work environments/work from home, etc
- Child care assistance - less cost to families

OFF THE WALL

- Baseline income
- Parents support parents
- Push grant funding for youth and workforce programs
- Cultural considerations
- Mentorship for at risk youth to support graduation, secondary ed/career path
- Poverty scale needs readjustment
- Different options/education paths in High School (ex: Moorhead Public School Career Academy)
- Coordinated application process for services between agencies
- Employer provided childcare
- Flexible child care hours
- Flexible hours for school age students that have credit recovery to graduate on time
- Benefits diff - a graduated reduction, rather than a total drop

WHO IS MISSING?

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



Economic Stability/Poverty

Result: All PNM residents are free from the impacts of poverty.

1 Access to Education and Empowerment of Youth

- **Early childhood education** and recommended reading rates for 0-5
- **Affordable Education Programs:** Provide scholarships, grants, and pathways to ensure access to quality education to support graduation, secondary education and future career paths.
- **Vocational/Trade School Training:** Develop job training programs and incentives that align with local job markets to enhance job/industry focused skill training and employability.
- **Mentorships and Education Pathways:** Support youth graduation and pathways to higher education or career readiness.
- **Safe Spaces for Families:** Establish community centers where children and families can gather in safe, supportive environments.
- **Workforce Training and Trade Incentives:** Fund or encourage programs that help individuals gain skills, access paid internships, or enter trade schools.

2 Ensure Childcare and Early Childhood Development

- **Childcare Accessibility:** Expand childcare options, such as employer-provided care and flexible hours.
- **Financial Assistance for Childcare:** Provide assistance for working parents or students to afford childcare.
- **Prenatal, Parental and Early Childhood Education:** Support early education programs and reading rates for children ages 0-5.

3 Prioritize Employment, Economic Stability & Economic Development Initiatives

- **Flexible Work Arrangements:** Adopt flexible hours, remote work options, and other arrangements to support work-life balance.
- **Workplace Supports for Active Commuting:** Provide facilities and incentives for biking, walking, or public transportation.
- **Living Wage and Financial Supports:** Advocate for minimum wage increases, baseline income, paid family leave, and Earned Sick and Safe Time (ESST) leave.

4 Provide Family and Community Support Programs

- **Home Visiting Programs:** Continue programs like Headstart and the Nurse Family Partnership.
- **Parent-Support Systems:** Create peer-support networks where parents can connect and support each other.
- **Community Awareness and Training:** Raise awareness about systemic poverty and provide cultural awareness training.

5 Grow Cultural Awareness and Systemic Equity

- **Addressing Systemic Inequities:** Adjust poverty scales and consider cultural factors in program design.
- **Anti-Racism in Policy:** Implement anti-racism by adjusting policies and decision-making within supporting organizations.
- **Tenant and Housing Protections:** Advocate for rent stabilization and eviction protections for low-income tenants.

6 Increase Transportation and Access to Resources

- **Public Transit Expansion:** Advocate for low-cost public transit options and individual incentives.
- **Removing Barriers to Services:** Work to eliminate access barriers in areas like transportation, childcare, and food insecurity.
- **Coordinated Application Processes:** Streamline application processes across agencies to make services more accessible.

7 Advocate for Affordable Housing Solutions

- **Subsidized Housing/Housing Assistance**

Priority Health Issue #4 Substance Use & Misuse

Meeting #1

The Story Behind the Curve

Factors Pushing Up on the Data



- Parents are engaged & making a difference
- Activities for kids!
- Honesty of survey participants (question if kids are honestly reporting usage - 2019 Norman vaping % - 15% said yes, 85.2 said no, 67% said no in Polk)
- Availability of narcan
- Narcan training
- Positive community norms
- Youth friendly info on possible risk factors
- Informed parents
- Activities, sports, extra curricular
- Lead by example
- Community involvement
- Social media - more young kids/adults seeing public figures, "mocktails" being popular
- School programs being cut

Factors Pushing Down on the Data



- Changes in family systems
- Prevalence of mental health issues - use to cope
- Lack of schools taking survey - gives unreliable data
- Self medicate = Mental Health
- Lack of education
- What's the 'WHY' behind it?
- Peer pressure? Friend groups?
- Kids say "boring"
- Peer pressure
- Society norms - glamorize alcohol/drug use, i.e. movies, etc
- Lack of resources for treatment options
- Positive messaging

Partners

1. Schools/School Districts
2. Social workers
3. Businesses
4. Established youth groups!
5. Youth Peer Specialists
6. Insurance Companies
7. State Departments
8. Parents
9. Churches/Faith-based organizations
10. Adults in the communities
11. Law enforcement
12. Youth activities (school & community)!!
 - Free of cost & safe
13. Youth
14. Service organizations
15. Public Health
16. CD/MH providers
17. Athletic clubs
18. Social workers
19. 4H - Community club youth organizations
20. Churches
21. Ag organizations (Potato Growers, Sugarbeet, Soy)
22. U of MN, Northland, UND, etc
23. Cove - Firefly Center (Fosston)

Strategies

EVIDENCE-BASED

- School/evidence based curriculums
- Presenting with positive norms approach
- Safe place or youth to "hangout"
- Consequences of use "studies"
- What works - decreases use
- Prevention curriculum

PROMISING PRACTICES

- ex: "The Cove", "Elevate", Safe space for kids
- Offering opportunities for youth to be involved
- Schools and Public Health provide education
- More positive messaging in favor of not doing drugs/alcohol through social media and awareness in schools/communities

LOW COST / NO COST

- Increase civic mindedness of adults & youth - "ripple affect"
- Mentorships (Big Brothers, Big Sisters)
- F.C.A
- Cove
- Church group/youth groups

OFF THE WALL

- Positive Peer Groups
- MENTOR programs - "Big brother - little brother" program
- Narcan available to ALL!! - doesn't work on all substances
- Youth led messaging
- Artistic/Fine Arts

How to reach the kids who have substance use at home is the "norm"?

WHO IS MISSING?

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



Substance Use/Misuse

Result: All youth are free of substance use, misuse, and abuse.

Result: All adults are free of substance misuse and abuse.

1 Provide Education and Prevention Programs

- **School-Based Education:** Implement evidence-based information that educates students about healthy choices, the risks associated with substance use, resources for help and utilize positive norming approaches.
- **Awareness Campaigns/Online Platforms/Campaigns:** Use positive social media, youth-led messaging, and mass media to raise awareness in schools and communities about substance use risks.
- **Collaborative Resource Sharing:** Collaborate on content, events and initiatives to maximize reach and impact.
- **Restricting Substance Promotion:** Enforce restrictions on drug and alcohol advertising and access in public spaces through laws, ordinances, and industry regulations.
- **Provide training on MH/SUD to partners and community members.**

2 Create Supportive Environments

- **Extracurricular Programs:** Encourage participation in sports, arts, and clubs that offer healthy outlets.
- **Mentorships:** Facilitate opportunities that foster a sense of purpose and community connection.
- **Safe Spaces:** Create and sustain environments where youth feel comfortable .
- **Support Groups Family Treatment and Recovery Centers:** Family based recovery and other support groups for recovery.
- **Family Involvement:** Encourage family participation in events and activities to strengthen bonds and support substance-free choices.

3 Provide Family and Community Access to Support and Resources

- **Family Treatment and Recovery Centers:** Establish family-centered recovery & support groups to assist families affected by substance use.
- **Support/Treatment Services:** Ensure people know where to turn for help if they or someone they know is struggling with substance use.

4 Foster a Culture of Resilience and Trauma-Informed Care

- **Decision-Making Skills/Stress Management:** Policies, practices and environmental changes that offer/teach critical thinking, problem-solving, coping with stress and refusal skills to help youth make informed choices.
- **Positive Messaging:** Work to change the narrative around youth culture to emphasize the benefits and joys of a substance-free life.
- **Building Resilience:** Develop and implement policies, practices, and environmental changes in homes, schools, and communities to foster resilience.
- **Understanding Behavioral Health:** Promote awareness of behavioral health, trauma's impact, and substance use disorders within the community.
- **Protective Factors for Youth:** Increase opportunities for protective connections across individual, family, peer, school, & community levels.

5 Ensure Harm Reduction and Emergency Response

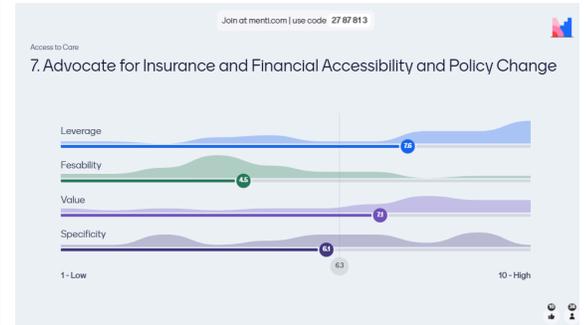
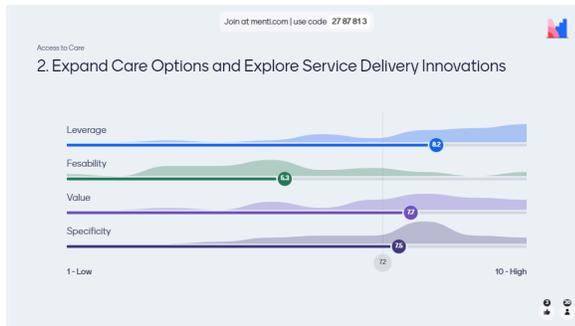
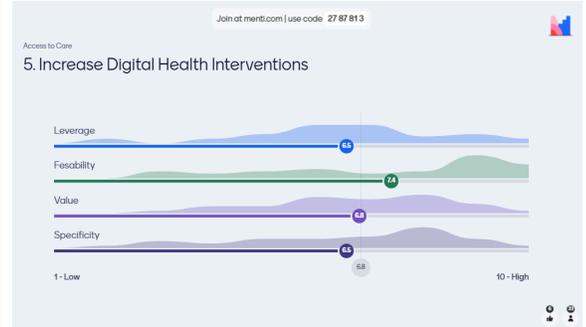
- **Naloxone Training and Distribution:** Provide ongoing training and distribute Naloxone to community members and first responders to address opioid overdoses.

6 Integrate and Advocate for Substance Use/Misuse Policies

- **Civic Mindedness:** Promote civic engagement and responsibility among both youth and adults to foster a supportive community environment.
- **Reimbursement for timely assessment and treatment**
- **Eligibility for MHCP coverage of incarcerated individuals (MH/SUD)**

Access to Care

Appendixes



Leverage: How strongly will the proposed strategy impact progress as measured by the baselines? How much difference will it make on the result & indicator? *(most important criteria)*

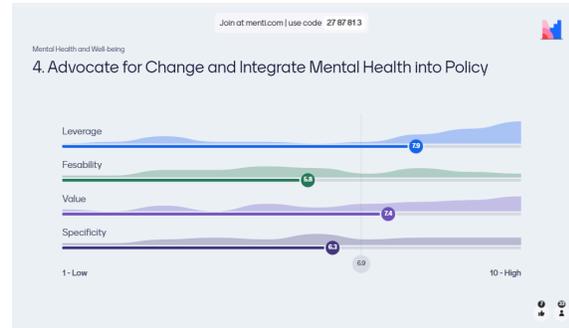
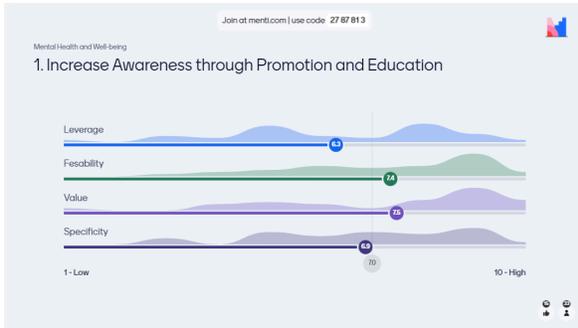
Feasibility (or reach): Is the proposed strategy feasible & affordable? Can it be done?

Specificity: Is the strategy specific enough to be implemented?

Value: Is the strategy consistent with the values of the community and/or agency?

1- 10 rating scale

Mental Health & Well-being



Leverage: How strongly will the proposed strategy impact progress as measured by the baselines? How much difference will it make on the result & indicator? *(most important criteria)*

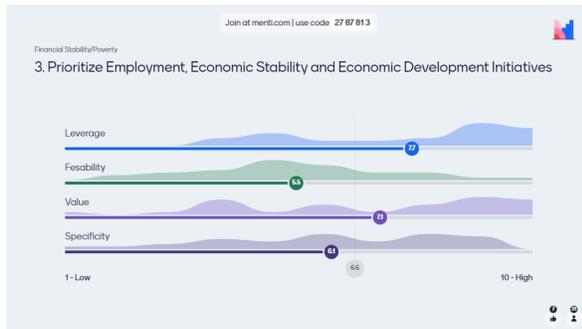
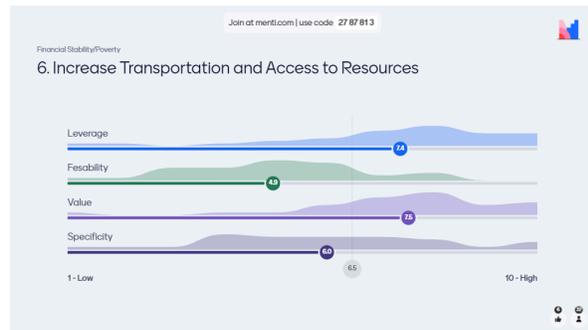
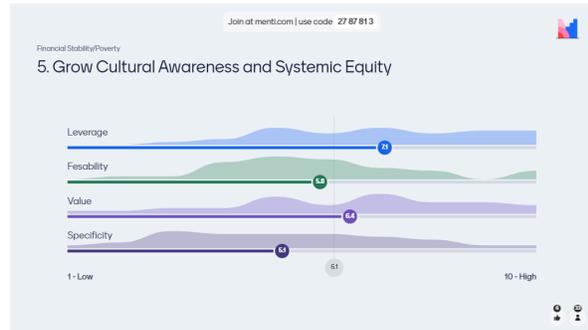
Feasibility (or reach): Is the proposed strategy feasible & affordable? Can it be done?

Specificity: Is the strategy specific enough to be implemented?

Value: Is the strategy consistent with the values of the community and/or agency?

1- 10 rating scale

Socioeconomic Status



Leverage: How strongly will the proposed strategy impact progress as measured by the baselines? How much difference will it make on the result & indicator? *(most important criteria)*

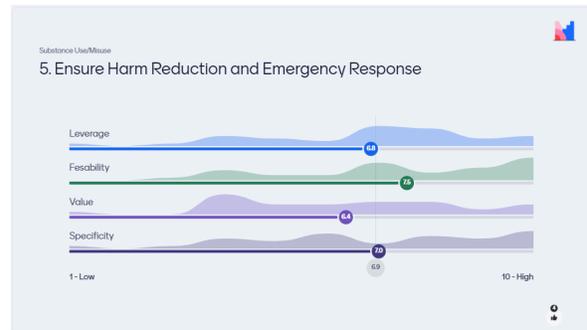
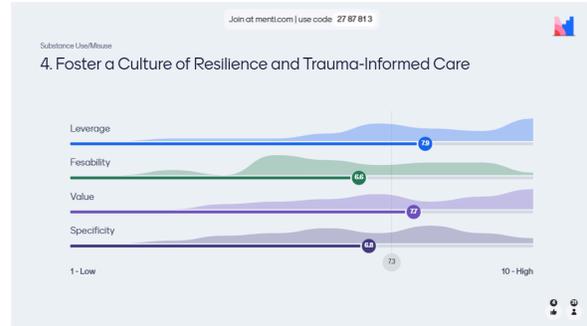
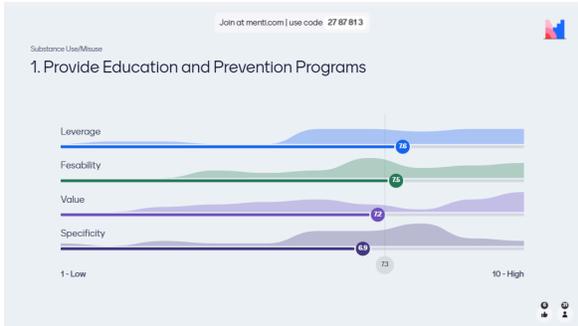
Feasibility (or reach): Is the proposed strategy feasible & affordable? Can it be done?

Specificity: Is the strategy specific enough to be implemented?

Value: Is the strategy consistent with the values of the community and/or agency?

1- 10 rating scale

Substance Use / Misuse



Leverage: How strongly will the proposed strategy impact progress as measured by the baselines? How much difference will it make on the result & indicator? *(most important criteria)*

Feasibility (or reach): Is the proposed strategy feasible & affordable? Can it be done?

Specificity: Is the strategy specific enough to be implemented?

Value: Is the strategy consistent with the values of the community and/or agency?

1- 10 rating scale



ship
statewide health
improvement partnership

TOGETHER WE CAN *build a better future!*

