VERSION 1: 6/30/2024

CentraCare-Redwood Community Health Improvement Plan

JULY 1, 2024 - JUNE 30, 2027

A HEALTHIER SOUTHWEST
Building healthy communities / Encouraging healthy lifestyles

CentraCare®

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COMMUNITY HEALTH IMPROVEMENT PLAN

Acknowledgements: The 2024 Community Health Needs Assessment (CHNA) is based on a collaborative process with leadership from the Southwest Minnesota Health and Human Services (SWHHS) agency to systematically identify, analyze and prioritize community healthy needs. CentraCare - Redwood appreciates our partnership, and the opportunity to collaborate, with the following key stakeholder organization who represent broad interests in the community. We acknowledge the following leaders:

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Legal Requirements

THIS DOCUMENT PROVIDES DOCUMENTATION OF THE FOLLOWING LEGAL REQUIREMENTS

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

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

AMERICANS WITH DISABILITIES ACT ADVISORY:

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

CLASS STANDARDS:

Culturally and linguistically appropriate services (CLAS) are a way to improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and achieve health equity. CLAS is about respect and responsiveness: Respect the whole individual and Respond to the individual’s health needs and preferences.

Health inequities in our nation are well documented. Providing CLAS is one strategy to help eliminate health inequities. By tailoring services to an individual's culture and language preferences, health professionals can help bring about positive health outcomes for diverse populations.

Message to the Community

To be more effective in meeting the needs of the community, Southwest Health and Human Services and CentraCare-Redwood developed a partnership.

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

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

Furthermore, this work has not been conducted in isolation but in collaboration with the community. There have been and will continue to be opportunities for input into the process, the product, and future needs and changes to the document.
We encourage you to continue to partner with us as we strive to make our communities of Minnesota the healthiest in the state!

Danielle Protivinsky

Danielle Protivinsky DrPH, MPH, MBA - Senior Director
CentraCare

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

CentraCare Overview

CentraCare's roots go back to when St. Cloud Hospital was built to serve the health care needs of people living in Central Minnesota. In 1995, CentraCare, a nonprofit, integrated health system was formed, which today includes nine hospitals in St Cloud, Long Prairie, Melrose, Monticello, Paynesville, Redwood Falls, Sauk Centre, Willmar and Benson.

Insert infographic of CentraCare statistics

CentraCare has grown to meet the needs of the communities and is now one of the largest health systems in Minnesota, serving the health needs of over 800,00 residents in a 19-county service area. This means the latest advancements in care, technology, and treatments are offered close to home.

Insert CentraCare locations

CentraCare - Redwood Overview

CentraCare - Redwood Hospital provides comprehensive, high quality care to people throughout Southwest Minnesota. our network is comprised of:

- 25-bed critical access hospital (Redwood, Minnesota)
- 100-bed, Level 3 Trauma hospital (Willmar, Minnesota)
- 5 primary care clinics (Benson, New London, Redwood Falls, Willmar)
- 2 multi-specialty clinics (Willmar)

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

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

CentraCare Overview

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

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

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

Southwest Minnesota Healthy Communities Survey 2023 - Redwood County

Demographic Characteristic		Unweighted Data		Weighted Data
n=355		Frequency	Percent	Percent
Gender				
	Male	146	41.1	50.0
	Female	209	58.9	50.0
	Transgender	1		
	Non-binary	0		
	Other	0		
Age Group				
	18-34	17	4.8	23.7
	35-44	23	6.5	14.4
	45-54	46	13.0	14.8
	55-64	80	22.5	18.7
	65-74	101	28.5	15.4
	75+	88	24.8	13.0
Race/Ethnicity				
	White	348	98.3	98.7
	Not white	6	1.7	1.3
	Hispanic	1		
	American Indian	5		
	Asian	2		
	Pacific Islander	0		
	Black or African American or African	0		
	Other race	2		
Education				
	Did not complete 8th grade	0	0.0	0.0
	Did not complete high school	11	3.1	1.3
	High school diploma/GED	90	25.4	17.8
	Trade/Vocational school	65	18.4	13.2
	Some college	49	13.8	16.2
	Associate degree	31	8.8	9.2
	Bachelor's degree	63	17.8	30.1
	Graduate/professional degree	45	12.7	12.2
Relationship status				
	Married	205	58.2	68.4
	Living with a partner	11	3.1	3.1
	Divorced	47	13.4	8.1
	Separated	1	0.3	0.2
	Widowed	51	14.5	5.3
	Never married	37	10.5	14.9
Income				
	Less than $20,000	36	11.2	8.1
	$20,000-$34,999	54	16.8	12.9
	$35,000-$49,999	58	18.0	12.8
	$50,000-$74,999	60	18.6	20.6
	$75,000-$99,999	52	16.1	18.4
	$100,000 or more	62	19.3	27.2
Employment status				
(These do not add up to 100% because respondents could choose more than one)	Employed	134	37.7	53.5
	Self-employed or farmer	54	15.2	18.7
	Unemployed	6	1.7	1.1
	Homemaker/stay at home parent	11	3.1	3.6
	Student	3	0.8	3.7
	Retired	159	44.8	24.8
	Unable to work because of a disability	23	6.5	6.5

Executive Summary

Vision, structure of process, Priorities, Guiding Principles, and Root Causes/ Drivers of Inequities

Part I: Community Health Needs Assessment

Regional Collaboration:

The collaboration of partners has been growing for years and results in combined efforts for the greater good of the community. The infrastructure from this process is maintained to identify the top two community priorities and the guiding principles of community collaboration, equity, resilience, education, awareness, and health organizations.

A Community Health Needs Assessment (CHNA) is a systematic, data-driven approach to evaluating the health status, behaviors, and needs of residents in a specific community. It aims to identify critical health issues and resource gaps to guide efforts in improving community health through:

- Data Collection
- Stakeholder Engagement
- Prioritization

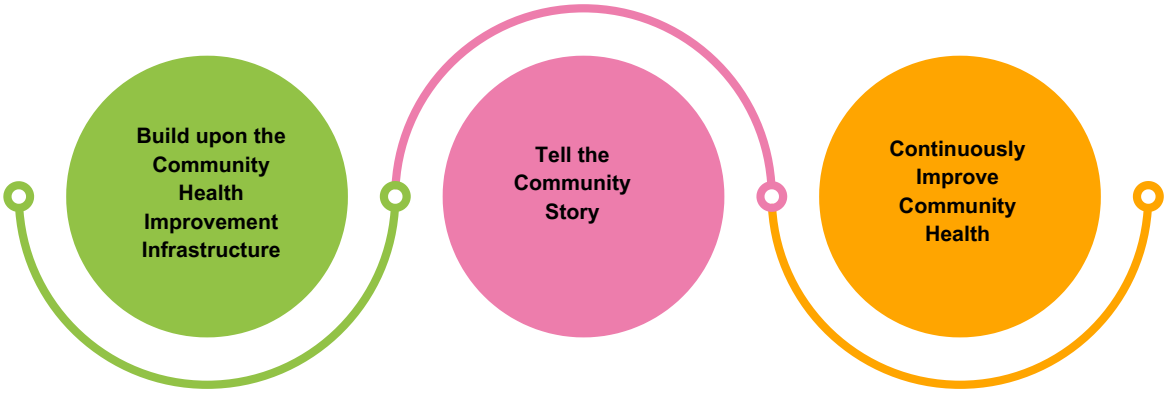
A Community Health Improvement Plan (CHIP) is a strategic plan developed and based on the findings of the CHNA. It outlines specific actions and initiatives to address the prioritized health needs of the community by:

- Setting Priorities
- Developing Strategies
- Partnerships & Collaboration
- Monitoring & Evaluation

SWHHS used the MAPP (Mobilizing Action through Planning and Partnerships) Evolution Framework to conduct a community health assessment and identify root cause areas within which to concentrate efforts to improve community health. They also created and used a “Quality of Life” survey, as well as conducted Focus Groups. The Implementation Phase of the CHIP is July 1, 2024, through June 30, 2027.

Executive Summary

MAPP Framework: Mobilizing for Action through Planning & Partnerships



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

GUIDING PRINCIPLES TO CONDUCT THE WORK:

- Community Collaboration
- Equity Lens
- Focus on Strengths and Resilience
- Build Awareness
- Educate and Inform
- Involve Health Organizations
- Community surveys and focus groups
- Focus on gaps that are not already being worked on by other community champions
- Focus on priorities in which we have the capacity and resources to create change

DRIVER OF INEQUITIES ON WHICH TO FOCUS:

Data Access and Systems	Structural Racism	Lived Experience	Historical Context

Survey Methodology

The data collected in this document does not represent a total picture of the health of SWHHS. It was meant to be a snapshot of where the health of citizens in the six-county area is and to help focus decision-makers as to where to place limited resources. Data collection was limited by the availability of county-level data or lack of study or survey in an area. Not all areas of health were covered due to the sheer volume of topics and the time limitations of this assessment process.

Community Health Assessment data was collected from various local, state, and federal data sources. Some of these resources include the 2023 Southwest Minnesota Healthy Communities Survey, the Minnesota Student Survey (1998 through 2022), Minnesota Center for Health Statistics, Atlas of Minnesota Online, Minnesota State Demographer, Minnesota Department Economic and Employment Development, Minnesota Department of Public Safety, Minnesota Court System, Minnesota Department of Natural Resources, various departments at Minnesota Department of Health, Minnesota Electronic Record Consortium, various disease foundations, Behavioral Risk Factor Surveillance System, Environmental Protection Agency, U. S. Census Bureau, U.S. Department of Agriculture, and Centers for Disease Control.

Wilder Research partnered with Southwest Health and Human Services to conduct focus groups with people across southwest Minnesota to learn more about their health needs. Participants were recruited from eight communities including people with disabilities, Karen, Spanish-speaking, gay, lesbian, bisexual, and transgender (LGBT) people, Native American, Somali, veterans, and elders. Participants were asked about their health needs and ideas to improve health and well-being within their communities. Wilder staff prepared this report summarizing the focus groups to provide Southwest Health and Human Services with recommendations for promoting health for diverse communities in southwest Minnesota.

Eight focus groups were conducted with people from eight different identity groups in southwest Minnesota to better understand barriers to health and well-being and ideas for improving healthy behaviors. Wilder Research developed semi-structured interview guides that included questions such as “What does being healthy mean to you?”, “What kinds of health issues do you see in your community?”, “What helps you to be healthy?”, and “What would help you to be healthier?” Six of the focus groups were conducted in person and two were conducted virtually (the disability group and the LGBT group). Three of the groups were conducted in languages other than English with interpretation (Karen, Somali, and Spanish-speaking). A note taker took notes for each of the groups and the notes were utilized for data analysis.

At the end of the focus groups, participants were asked if they had any advice for Southwest Health and Human Services staff as they build programs to support community health and well-being. Many of the participants reiterated needs described above, including transportation, living wage employment, and health insurance. However, the primary message in these responses was the need for health care and social service staff who are kind, respectful, and inclusive of people with minority identities. Participants in almost every group reported wanting more staff who represent and respect their multiple identities.

The Community's Plan

WORKING TOWARDS COMMUNITY HEALTH IMPROVEMENT

Below are a list of top priorities that influence strategies for health Improvement across the Southwest Region.

TOP COMMUNITY PRIORITIES

Mental Health

Drug-related illness and death

COMMUNITY HEALTH IMPROVEMENT PLAN

	Priority	Examples
1	**Mental Health**	• more holistic healing options and more mental health resources
2	**Drug-related illness and death**	
3	**Aging problems**	
4	**Cancers**	• top 4 cancers; lung and bronchus, colorectal, melanoma, bladder
5	**Obesity**	• 37.5 % overweight but not obese • 35.7 % obese
6	**Loneliness/isolation** **Health Care**	• increase since COVID-19 pandemic • lists of physicians and therapists who are safe and supportive of LGBT people • need for dental services
7	Alcohol-related illness and death **Transportation**	• transportation on weekends and evenings • need for specialty medical services • need for transportation services in order to access health care
8	**Lack of physical activity** Financial Stress	• 53.7 % insufficient activity • 14.6 no moderate physical activity • Living wage • Unemployment • Affordable living • Lack of jobs • more living-wage jobs • lack of health insurance
9	Tobacco and e-cigarette use and exposure	
Tied for 10	**Dental Problems and Domestic Violence**	29% receive any dental/oral health service

The Community's Plan

WORKING TOWARDS COMMUNITY HEALTH IMPROVEMENT

They need someone in the community who informs what benefits people eligible are for. No one told me about some resources, and I feel like when you sign up for disability, you can sign up for other things. - Disability group People at SWHHS need to be respectful. We go there and don't speak the language so we get treated disrespectfully or aren't welcomed. SWHHS needs to treat people with dignity and respect. It will be better for the staff if they learn more about another ethnicity. That department should have diverse staff—even if it is not a Karen or Somali or Spanish or Hmong person, seeing more diverse people will show that diverse people are welcomed. -Karen group The dawn of our pipe ceremony started here. it was handed to our people on this land. This is where it started. It's important they [SWHHS] understand where they are and diversify their employee base. I am looking for inclusion. I would encourage them to be more in tune with where they are. - Native American group SWHHS can be a scary place for LGBTQ. Having time to discuss in a safe place is really necessary. Visibility, awareness, and non-judgmental care. Extra sensitivity. - LGBT group.

Participants highlighted a number of ways that Southwest Health and Human Services can continue to develop high quality health services for community members. Some of these recommendations can support community members across a number of identities, while others are tailored to culturally specific groups. ■ Increase access to local resources such as the YMCA, parks, and local walking trails. This could include sliding scale fees at the YMCA and other exercise facilities and improving walking trails. ■ Increase transportation options to specialty health services outside of rural areas, especially during weekend and evening hours. ■ Increase in-person interpretation services at health clinics and other social service agencies. ■ Provide cultural training for health and social service providers about racial and ethnic groups in the community. ■ Increase access to gender-affirming health care for LGBT community members and provide training about LGBT health care for providers. ■ Provide cultural brokers or community health workers to act as a bridge between ethnic community groups and health care services. ■ Partner with Native American groups to incorporate Indigenous medicines and ways of healing into health and social service care.

Part II: Community Health Improvement Plan

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

Drivers of Inequalities, Goals, and Performance Measures

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

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

Support Families and Increase Mental Well-Being by:

- Public policies will use an equity lens to impact inequities
- Community participates in shaping programs

Data Access $ Systems (DAS) Goal 1: Share local equity data by developing data visuals coordinated with National recognition months, i.e.: Mental Health Awareness Month.
Anticipated Impact: Partner agencies and community members across the 6-county region will have access to local equity related data that is useful for their purposes.
Performance Measure: Social media views of data visuals will be monitored and tracked to adjust practice to increase views and use of data.
Target Date:
Agencies working on Action Steps: list is a work in progress.
Person/Agency monitoring progress for this document: CentraCare-Redwood Workgroup.

The Community's Plan

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

The Community's Plan

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

Data Access & Systems - Data Availability & Transparency - **Desired Outcomes** Identified by the Community Context Committee through an interrelationship Diagraph Exercise of Community Themes.
Support Families and Increase Mental Well-Being by:

- Decrease social isolation
- Decrease domestic violence, child abuse, and vulnerable adult abuse
- Increase community engagement opportunities
- Increase LBGTQ+ services and support gaps
- Increase access to healthy affordable food
- Increase access to all types of healthcare

Data Access $ Systems (DAS) Goal 2: Increase access to broadband across the 6-county region.
Anticipated Impact: Broadband household use will increase across the 6-county region.
Performance Measure: Increase household use of broadband, particularly for households that qualify for affordability programs.Increase the flexibility of broadband affordability programs.
Target Date: Ongoing for the Implementation Phase.
Agencies working on Action Steps: list is a work in progress.
Person/Agency monitoring progress for this document: CentraCare-Redwood Workgroup.

Data Access & Systems (DAS) Goal 2 Action Steps (re: Access to Technology/Broadband)

Data Access & Systems (DAS) Action Step 2.1: Identify existing activities to increase broadband access in all 6 counties. One example is the USAC (Universal Service Administrative Co.) Affordable Connectivity Program.	Measure of Success: Create and maintain a list of partners conducting broadband accessibility work.
Data Access & Systems (DAS) Action Step 2.2: Prepare educational materials regarding how access or lack of access to broadband impacts health.	Measure of Success: Educational materials will be prepared and stored in a centralized location. A method will be identified and created for partners to access the educational materials.
Data Access & Systems (DAS) Action Step 2.3: Actively advocate for increasing access to broadband utilizing the educational materials.	Measure of Success: Social media views of educational materials will be monitored and tracked to adjust practice to increase action.

The Community's Plan

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

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

Support Families and Increase Mental Well-Being by:

- Systems recognize the strengths and assets of the communities served
- Systems prioritize the needs as identified by the communities served
- Decrease social isolation
- Decrease domestic violence, child abuse, and vulnerable adult abuse
- Increase community engagement opportunities
- Increase LGBTQ+ services and support gaps
- Increase access to healthy and affordable foods
- Increase access to all types of healthcare

Structural Racism & Community Power (SR) Goal 1: Create and build upon Human Resource toolkits regarding diverse workforce recruitment, implementation, and support. Make toolkit widely accessible.
Anticipated Impact: Equitable hiring processes will be utilized across the 6-county region.
Performance Measure: Identify the number of agencies utilizing stratgeies to recruit a diverse workforce.
Target Date: Ongoing for the implementation Phase.
Agencies working on Action Steps: list is a work in progress.
Person/Agency monitoring progress for this document: CentraCare-Redwood Workgroup.

Structural Racism & Community Power (SR) Goal 1 Action Steps

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

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

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

Support Families and Increase Mental Well-Being by:

- Systems recognize the strengths and assets of the communities served
- Systems prioritize the needs as identified by the communities served
- Increase LGBTQ+ services and support gaps
- Increase access to healthy and affordable foods
- Increase access to all types of healthcare

Lived Experience (LE) Goal 1: Create or Build Upon "What Creates Health" Campaigns. Instill this information as facts into the community experience; policies and built environment impact our health more than personal behavior of the healthcare system.
Anticipated Impact: It will be more broadly understood by the residents of the 6-county region that 70% or more of our health is beyond personal behavior. 30% personal behavior, 20% clinical care, 40% social/environmental, 10% environment.
Performance Measure: The number of conversations utilizing culturally/linguistically appropriate methods to gather and provide education will be tracked.
Target Date: Ongoing for the implementation Phase.
Agencies working on Action Steps: list is a work in progress.
Person/Agency monitoring progress for this document: CentraCare-Redwood Workgroup.

Lived Experience (LE) Goal 1 Action Steps

Lived Experience (LE) Action Step 1.1: Build relationships with community members and use personal stories from people in our 6-county area to illustrate 'what creates health?' Include history, backgrounds, and success stories.	Measure of Success: Gather feedback from persons who have their story shared to ensure their story was respected and they felt safe sharing their story.
Lived Experience (LE) Action Step 1.2: A measurement tool will be identified to ensure that when creating materials to be shared with the community, (such as flyers, social media posts, infographics, etc.), they will be created using culturally appropriate methods including but not limited to translated materials, photos/videos of those from diverse or minority populations, ADA compliance with color contrast, captioning, etc.	Measure of Success: : Each piece of education material will be scored using the measurement tool. The education materials will be stored with the measurement tool results. The measurement tool will be modified when necessary.
Lived Experience (LE) Action Step 1.3: Utilize social media to push out ad campaigns to build awareness around "What CreatesHealth" and things that are taking place that impact health. (i.e., promoting actual policy changes that are taking place, or changes to the built environment)	Measure of Success: Social media views of educational materials will be monitored and tracked to adjust practice to increase reach and interaction.
Lived Experience (LE) Action Step 1.4: Provide information and outreach around trauma and healing; outreach / education / programming around Adverse Childhood Experiences (ACEs), Resilience, and Hope.	Measure of Success: ACEs, Resilience, and Hope outreach activities will be documented and tracked.

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

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

Support Families and Increase Mental Well-Being by:

- Systems recognize the strengths and assets of the communities served
- Systems prioritize the needs as identified by the communities served
- Increase LGBTQ+ services and support gaps
- Increase access to healthy and affordable foods
- Increase access to all types of healthcare

Population Measures

2024-2027 CHIP

Population health measures are designed to assess the health outcomes of a group of individuals and the effectiveness of health care services and interventions. CMS uses these measures to evaluate and improve the quality of care delivered to beneficiaries across various settings.

CentraCare focuses on the following quality measures such as cost & utilization, Attribution, Quality Metrics for Chronic Disease, and Quality Measures for Preventive Care. Measures include;
(into a table)
Diabetes
Vascular Care
Hypertension
Depression 6 Month Remission-Adult
Depression 6 Month Remission-Adolescent
Asthma-Adult
Asthma-Pediatric
Colon Cancer- Total Population
Breast Cancer
Cervical Cancer
Adolescent Immunizations
Childhood Immunizations
Healthcare Directive/POLST

A strong Focus on Health Equity, Quality, & Safety

Health equity measures are critical in population health management for health systems, as they address disparities and ensure that all individuals have fair opportunities to achieve optimal health. Here's why these measures are essential:
1. Addressing Disparities:

- Targeting Inequities: Health equity measures identify disparities in health outcomes and access to care among different demographic groups, such as race, ethnicity, socioeconomic status, and geographic location. By highlighting these gaps, health systems can implement targeted interventions to reduce inequities and improve health outcomes for marginalized populations.

2. Improving Overall Population Health:
   - Equitable Health Outcomes: Ensuring that health services are equitably distributed and accessible helps improve overall population health. Addressing social determinants of health (e.g., income, education, housing) and reducing disparities leads to better health outcomes for everyone, not just those who are disadvantaged.
3. Enhancing Care Quality:
   - Comprehensive Quality Improvement: Health equity measures contribute to a more comprehensive approach to quality improvement by focusing on the quality of care provided to all groups. They help health systems understand how well they are meeting the needs of diverse populations and identify areas where improvements are needed.
4. Promoting Fair Access to Care:
   - Reducing Barriers: By tracking and addressing barriers to care, health equity measures ensure that all individuals have fair access to healthcare services, regardless of their background. This includes reducing disparities in preventive care, treatment options, and follow-up services.
5. Meeting Regulatory and Reporting Requirements:
   - Compliance and Accountability: Many health systems are required to report on health equity metrics as part of regulatory and accreditation requirements. Tracking these measures helps ensure compliance with standards set by organizations like CMS and other accrediting bodies.
6. Enhancing Patient Experience and Satisfaction:
   - Inclusive Care: Health equity measures contribute to a more inclusive approach to patient care, which can improve patient satisfaction. When care is tailored to meet the diverse needs of the population, patients are more likely to feel valued and receive the support they need.
7. Driving Policy and System Changes:
   - Informed Decision-Making: Data from health equity measures can inform policy decisions and strategic planning within health systems. By understanding disparities and their root causes, health systems can develop policies and practices that promote equity and address systemic issues.
8. Supporting Community Engagement:
   - Building Trust: Engaging with communities and addressing their specific health needs through equity measures helps build trust and strengthen relationships between health systems and the communities they serve. This fosters better collaboration and support for health initiatives.
9. Improving Health Outcomes and Reducing Costs:
   - Preventive and Proactive Care: By focusing on health equity, health systems can implement preventive and proactive care strategies that address issues before they escalate. This approach not only improves health outcomes but also reduces overall healthcare costs by preventing more severe and costly conditions.
10. Promoting a Culture of Equity:
    - Organizational Values: Incorporating health equity measures into population health management reinforces a health system’s commitment to equity and inclusion. It helps create a culture that values and prioritizes the health and well-being of all individuals.

Population Measures

2024-2027 CHIP. MEDIAN INCOME.

Your Integrating health equity measures into population health strategies is essential for creating a fair and effective healthcare system. It ensures that health systems are addressing the needs of all population groups, reducing disparities, and improving overall health outcomes.

Summarize information from SWHHS report:
U.S. Census demographics
The racial and ethnic makeup of the county of Redwood
The service area's number of social and economic challenges

*from Redwood County found on page 6

Population Measures

2024-2027 CHIP. UNEMPLOYMENT RATE.

CentraCare Summary

Hospitals included - Redwood Falls

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

Equity & Community Collaboration

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

Education & Health Organizations

- It will be more broadly understood by the residents of the 6-county region that 70% or more of our health is beyond personal behavior. 30% personal behavior, 20% clinical care, 40% social/environmental, 10% environment
- Integration of support services like WIC into health accessibility, access, and improved customer service
- CentraCare and Community Health Improvement will offer a variety of educational classes focused on Diabetes, Hypertension and more.
- The Community Health Improvement team will collaborate with tobacco prevention initiatives to support healthy learning
- CentraCare will provide community education for end-of-life discussions and quality-of-life planning.
- Awareness amongst the residents of the 6-county region will be increased about the systemic, structural, and institutional root causes of inequities.
- The Community Health Improvement team will lead and support advocacy work with stakeholders and community partners to implement prevention policies through a lens of health equity.
- CentraCare will work to address social determinants of health through patient and community outreach in all regions.
- Roll outpatient outreach for social determents of health system-wide with the utilization of EPIC electronic medical record.
- Address areas of substance use, harm reduction, and improve care for people experiencing pain and addiction.
- Suicide prevention education and training in schools for teachers, staff, and students in coordination with Suicide Prevention and Mental Health Awareness.
- Increase education and connection to community partner organizations to increase support in areas of transportation, food insecurity, housing, financial strain, and well-being.
- Address key health measures with patients and our communities.
- Disseminate health education and health promotion materials that are culturally and linguistically appropriate.

Awareness & Resilience

- Identify the leaders and strategies within CentraCare focused on engaging patients and partners to advance health equity.
- CentraCare will continue to progress on ACE's Collaborative work.
- CentraCare will partner with the community to offer Bounce Back Project.
- Utilize resiliency index created for Mental Health programming and progress in areas of Adverse Childhood Experience.
- The Community Health Improvement team will work enterprise wide supporting all hospital and clinic sites in activities to support mental health & well-being.
- CentraCare will partner with Aging organizations to support seniors and address senior wellness.
- Community Health Improvement team will work closely with each region on focused areas of trauma informed care, depress, anxiety, post-partum depression, and more.

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

Potential Partners

POTENTIAL PARTNERS FOR BUILDING FAMILIES:

- 4H Clubs
- Anna Marie's Alliance
- Avivo
- ARC Midstate
- Baby Café
- Big Brothers and Big Sisters of Central Minnesota
- Bi-lingual cultural representative leaders (to help discuss cultural norms)
- Birth line
- Boys and Girls Club of Central Minnesota
- CAMHI (CommUNITY Adult Mental Health Initiative
- Car Seat Collaborative
- Catholic Charities
- Center for Victims of Torture (WaitePark)
- Central MN Breastfeeding Coalition
- Central MN Council on Aging
- Central MN Falls Prevention Workgroup
- Central MN Sexual AssaultCenter
- Chief health officer/family CentraCare
- Community health workers
- County AttorneyOffices
- County Human Services Partners: Family and Children Services, Adult Services, Corrections/Probation Services, Financial Services
- County SheriffOffices
- Faith-based groups
- Families in Transition Services, Inc.
- Family physicians
- First Steps Collaborative of Central MN
- Food Pantries
- Goodwill EasterSeals
- Greater St. Cloud Area Thrive Initiative
- Hands Across the World

POTENTIAL PARTNERS FOR BUILDING FAMILIES:

- Health Care Providers (including Rejuv Medical, Williams IntegraCare, Health partners, etc.)
- Health Plans (UCare, HealthPartners, Medica)
- Help Me Connect
- Holding ford HelpingHands
- HRA
- Independent Lifestyles
- Initiative Foundation
- Kiwanis
- Law Enforcement
- Lions
- Lutheran SocialServices
- Milestones
- Minnesota Department of Health
- Minnesota Department of Human Services
- Nurses
- Minnesota Fathers and Families Network
- New Beginnings
- PACER Center
- Parent Connect by ARC Mid-state, meetings for those who are parenting children with special needs
- Parish Nurses
- Pathways for Youth
- Place of Hope
- Prevent Child Abuse Minnesota/Minnesota Communities Caring for Children
- Reach-Up, Inc., Head Start, Early Head Start
- Recovery Plus, Recovery Plus- Adolescent, Journey Home, and Family Unity
- Resource Training and Solutions
- Rotary
- RSVP
- Salvation Army
- Sauk Rapids/Rice Early Childhood Programs
- Schools, teachers, Title I Staff, early childhood educators

POTENTIAL PARTNERS FOR BUILDING FAMILIES:

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

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

POTENTIAL PARTNERS FOR MENTAL HEALTH:

- 180 DegreesEmergency Youth Center– St. Cloud
- Anna Marie's Alliance
- ARC Midstate
- Avivo
- Boys and Girls Club of Central Minnesota
- Center for Victims of Torture (WaitePark)
- CentraCare OB Clinic
- CentraCare Stroke Program
- Central MN Community Empowerment Organizations (CMCEO)
- Central MinnesotaMental Health Center
- Central MN Suicide Prevention Coalition
- Coalition to End SocialIsolation and Loneliness (CESIL)
- Community Non-Profits
- Community Paramedics
- County AttorneyOffices
- County Human Services Partners: Family and Children Services, Adult Services, Corrections/Probation Services, Financial Services
- County SheriffOffices
- Emergency Rooms, Behavioral Access Nurses
- Families for Depression Awareness (Massachusetts Non-profit)
- Fe y Justicia
- Goodwill EasterSeals
- Greater St. Cloud Area Thrive Initiative
- Health Care Providers (including Rejuv Medical, Williams IntegraCare, HealthPartners, etc.)
- Health Care Home Coordinators
- Health Plans (UCare, HealthPartners, Medica)
- HealthForce Minnesota
- Higher Ground
- Initiative Foundation
- Law Enforcement
- Local policymakers

POTENTIAL PARTNERS FOR MENTAL HEALTH:

- Mental Health Providers (Central Minnesota Mental Health Center, Village Family Services, Caritas Mental Health Clinic, Catholic Charities Young Learners Program, Center for Psychological Services, Child and Adolescent Specialty Care[CentraCare Health Plaza], Clara's House, HealthPartners Behavioral Health, ISD 742/St. Cloud School District Triage System, Lutheran Social Services, Pinecone Family Counseling, Four County Crisis Response Team, St. Cloud VA Health Care System, and individual therapists, psychologists, social workers, and counselors)
- Minnesota Association for Children's Mental Health
- Minnesota CIT (Crisis Intervention Training) Association
- Minnesota Department of Economic and Educational Development
- Minnesota Department of Health Minnesota Department of Human Services
- Minnesota Psychological Association
- National Alliance on Mental Health
- New Beginnings
- Parish Nurses
- Reach-Up, Inc., Head Start Early Head Start
- Recovery Plus, Recovery Plus- Adolescent, Journey Home, and Family Unity
- Resource Training and Solutions
- Rise
- Rural Assistance Center
- Sauk Rapids/Rice Early Childhood Programs
- Schools
- St. Cloud Area CrisisNursery
- St. Cloud State University Child and Family Studies Department
- STIR (Stronger Together InspiringResilience) - Sherburne County
- Thumbs Up
- United Way
- Universities/Colleges
- United Way
- WAYCAN

POTENTIAL PARTNERS FOR MENTAL HEALTH:

- Wellness in the Wood
- Yellow Zones
- YMCA
- Veterans Affairs

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

Leadership & Monitoring

LEADERSHIP SYSTEM & PROCESS FOR MONITORING AND REVISION

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

[Lead Agency]: Strategy	Target Date	Person (see contact Info on last page)	Anticipated Outcome/ Result	Progress Notes
CentraCare CHNA Workgroup	Ongoing	Michelle Kiefer	One Annual Report to be developed each year. Partners will be engaged to identify how best to share the information: may be via written format, electronic/virtual, or in-person. Topics to discuss include CHNA, CHIP, and performance and population measures.	
CentraCare CHNA Workgroup	Ongoing		Delegated Authorities will remain up to date on CHIP Goal progress.	
CentraCare CHNA Workgroup	Ongoing		Data surveillance will take place on a regional level.	

Leadership & Monitoring

[Lead Agency]: Strategy	Target Date	Person (see contact Info on last page)	Anticipated Outcome/ Result	Progress Notes
CentraCare CHNA Workgroup	Ongoing		This CHIP document will be kept up to date and the next formal CHNA will begin July 2026.	
CentraCare CHNA Workgroup	Ongoing		Policy makers and key community stakeholders will be aware of this CHIP and progress being made.	
CentraCare CHNA Workgroup	Every third year after CHNA completion	Danielle Protivinsky, CentraCare Community Health Improvement Senior Director	Information will be provided for the IRS Report tax form describing CHNA components, prioritization process, partners, and how input from the community was utilized.	
CentraCare CHNA Workgroup	At east monthly the links will be checked.		A process is in place to allow for the CHIP to be a LivingDocument while still ensuring access on all member websites.	

Leadership & Monitoring

[Lead Agency]: Strategy	Target Date	Person (see contact Info on last page)	Anticipated Outcome/ Result	Progress Notes
SWHHS CentraCare Workgroup	Annually in March	Ann Orren Michelle Kiefer Michelle Salfer	**Describe how you will track implementation of the CHIP? Indicates review frequency.** Progress notes and "how to get involved" are embedded in the document and this will be utilized to track progress. Reviews will be annually or as determined by co-chairs. **Describe the data you will monitor to determine progress made towards objectives, strategies and implementing activities?** Population measures and performance measures are embedded into the CHIP. The Population Measure Tracking supplement document that will be utilized by the CHA subcommittee for ongoing monitoring and evaluation. **Describe how community stakeholders and partners are engaged and share responsibility to monitor and revise the CHIP? Describes decision making process for making and approving revisions?** Information will be communicated through the core support team, co-chairs, delegated authorities and steering committee regarding progress, barriers, trends, and data in the various strategies noted in the above sections of this table utilizing the MAPP process.	

Leadership & Monitoring

Created On: August 2024

Approved By: Redwood Hospital Advisory Board - June 3rd, 2024

This Community Health Improvement Plan is a fluid document and will be revised to align with strategic programming quarterly to remain in line with the organization strategy to make rural life healthier.

Revised On: September 6, 2024

Date	Description

Contact Information

LEADERSHIP GROUP

Name	Title	Organization	Email
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CHIP Appendices

APPENDIX 1: PUBLIC COMMENTS RECEIVED FOR COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

INPUT FROM THE BROAD COMMUNITY

Southwest Health and Human Services and the CentraCare-Redwood workgroup engaged individuals and organizations regarding this community health work. Engagement with the broad community was an area with limitations. It is acknowledged that the CHNA and CHIP processes into the future will include a deliberate approach to authentic community engagement that includes a deeper focus on diversity and at-risk populations.

COMMUNITY PRIORITIES

*Community Priorities will be added as implemented in 24' into 25'

I. EXISTING COMMUNITY RESOURCES

Existing Community Resources for Building Families

- ABE Classes
- ACT on Alzheimer's
- Affordable housing
- AL-ANON
- Alcoholics Anonymous
- Assisted living activities
- Baby Café
- Bark Park Program
- Block parties
- Career center gathering with the community
- Car Seat Training
- Center for Victims of Torture (Waite Park)
- CentraCare Hospital Breast Milk Depot
- Central MN ACE'S Collaborative
- Central MN Breastfeeding Coalition
- Central MN Mental Health Center
- Central MN Community Empowerment Organization
- Central MN Council on Aging
- Central MN Falls Prevention Workgroup
- Central MN Suicide Prevention Coalition
- Child Protection
- Childbirth, Prenatal Classes
- Church of the Week
- Church Organizations
- Church/School Mentors
- Circle of Parents
- Circle of Security, trauma-informed curricula training sponsored by THRIVE
- Clara's House, partial hospitalization program for children with mental illness
- Classes for Interested Foster Parents (CommUNITY Adult Mental Health Initiative)
- Coborn's Nutritional Resources
- Community Centers • Community Ed
- Community Events - movie in the park, summertime by George, etc.
- Community Garden
- Community Outpost (COP House)
- Day Care Licensing
- DHS - health, Childcare, SNAP/EBT
- Dial-a-ride
- East side of St. Cloud Revitalization
- ECFE Classes
- ESL Classes
- Faith in Action
- Family Counseling
- Fare-For-All
- Farmers Market
- Fe y Justicia
- Financial Assistance programs
- First Steps Collaborative of Central MN
- Follow Along program
- Foster Grand Parent Program
- Goodwill Easter Seals - Father Project
- Governor Walz' One Minnesota Council on Diversity, Inclusion, and Equity
- Greater St. Cloud Area Thrive
- Habitat for Humanity

I. EXISTING COMMUNITY RESOURCES

- Healthy Families America
- Help Me Connect
- Help me Grow Program
- Higher Ground
- Home visits as follow up to hospital stays
- Imagination Library
- Immigrant family resources
- In-home educators
- Inside Out Connections Project, addressing the needs of children with incarcerated parents
- Intensive home visiting programs (Healthy Families America, Nurse-Family Partnership)
- Interpreter/Translation Services
- KidStop
- La Cruz Community
- Legal aid accessibilityto undocumented families
- Library - book clubs,events
- Madison/North Elementary/Discoveryschools - Feeding areachildren together
- Meals on wheels
- Mental Health Programs - county
- Mental Health Providers offering Circle of Security, a relationship based early intervention program for parentsand children
- Minnesota Fatherhoodand Family Services Summit
- Mom groups
- Neighborhood organizations - promise neighborhood • Nurse-Family Partnership
- PACER Center
- Parent Aware
- Partners for Student Success, St. Cloud School District (#742)
- Pathways for Youth
- Preschool Programs
- Project Heal
- Public Health Division programs: WIC and Child and Teen Checkups
- Reach out and read
- Reach Up, Inc, Head Start
- Re-location Services (County & Lutheran Social Services)
- Resource navigators
- Ruby's Pantry
- School District programs (Early Childhood Family Education, Family Literacy, Special Ed)
- School Resource Centers
- Scouts program
- Senior linkage line
- Sharing & Caring Hands
- SHIP (Statewide Health Improvement Partnership)
- SNAP
- Social Media groups • St. Cloud Feeding Area Children Together (FACT)
- St. Cloud Area Crisis Nursery
- St. Cloud Area Crisis Response Initiative
- St. Cloud Area Human Service Council
- Stepping Stones Program (Birthline)
- Strengthening Father Involvement Coparenting, trauma informed curricula training through THRIVE
- Support groups for parents

I. EXISTING COMMUNITY RESOURCES

- Thumbs Up
- Whitney Center
- Workforce Center
- Young Parent Program (YPP)

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

Existing Community Resources for Mental Health

- 180 Degrees Emergency Youth Center – St. Cloud
- 4 county crisis response line • 40 Developmental assets
- ACT (Assertive Community treatment) and IRTS (Intensive Residential Treatment Services) through the Central MN Mental Health Center
- Alzheimer's Support Group for Caregivers
- Anger Management, Domestic Violence, and Co-Parenting Support Groups, Trauma Informed Support Groups at the Village Family Services
- Anna Marie's domestic
- Violence Crisis Hotline
- Beautiful Mind Project
- Birth to 5 screenings, services, and referrals
- Bounce Back Project
- CAMHI (CommUNITY Adult Mental Health Initiative) Adult Mental Health Resource Guide
- CAMHI (CommUNITY Adult Mental Health Initiative) website [MNMentalHealth.org]
- Center for Victims of Torture (Waite Park)
- CentraCare Integrated Behavioral Health
- Child and Teen Checkups
- Children's Mental Health Collaboratives
- Church Organizations
- Clara's House, partial hospitalization program for children with mental illness
- Coalition to End Social Isolation and Loneliness (CESIL)
- Community ACT Team
- Community groups
- Community walks/5K / NAMI walk
- Conflict Resolutions Center (Mediation)

I. EXISTING COMMUNITY RESOURCES

- Crisis Line
- Dog parks / Splash pads / walking paths
- Evidence-based programs for seniors (Falls prevention)
- Family Services Collaborative
- Gearing Up for Action: Mental Health Workforce Plan for Minnesota Report from the Minnesota Health Workforce Steering Committee
- Governor Walz' One Minnesota Council on Diversity, Inclusion, and Equity
- Greater St. Cloud Area Thrive
- Intensive home visiting programs (Early Head Start, Healthy Families America, Nurse-Family Partnership)
- Lutheran Social Services (Refugee Resettlement Services Resiliency Program for Children)
- Make It OK Campaign
- Mental Health First Aid
- Mental Health providers offering Circle of Security, a relationship based early intervention program
- Mental Health Workforce Development Steering Committee
- Mental Well-Being and Resilience Learning Community
- Minnesota State Advisory Council on Mental Health and its subcommittee on
- Children's Mental Health, 2014 Report to the Governor and Legislature
- Minnesota Statewide Suicide Prevention Plan
- Mobile crisis team
- PHQ assessments [Patient Healthcare Questionnaire]
- Preeminent Medical Discovery, Education, and Workforce for a Healthy Minnesota Final Report from the MN Governor's Blue-Ribbon Commission on the University of Minnesota Medical School
- Private Pay respite care
- Project Know, Understanding Addiction – Behavior Section
- Report and recommendation on Strengthening Minnesota's Health Care workforce from the Legislative Health Care Workforce Commission
- RSVP curriculum on Opioid Addiction
- School District school counselors
- Senior Linkage Line
- SHIP (Statewide Health Improvement Partnership)
- St. Cloud Area Human Service Council
- St. Cloud Area Trauma Response Initiative at the St. Cloud Police Department
- STIR (Stronger Together Inspiring Resilience) – Sherburne County
- Telehealth
- Terabinth Refuge
- Thumbs Up
- United Way 2-1-1
- United Way Success by Six
- Video Conferencing for schools
- Well-Connect
- WAYCAN
- WIC
- Yellow Zones – Stearns website
- Young children mental health service

I. EXISTING COMMUNITY RESOURCES

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

II. EVALUATION OF ACTIONS CONDUCTED SINCE THE PREVIOUS CHNA PROCESS

Strategy Outcome: Since 2019, we have seen that many of the community led family and mental wellbeing programs have moved back to in-person venues but also created or maintained virtual options to have a greater reach. If these programs are willing, they are encouraged to add their group/program to the MN Thrives index.

Resilience

Strategy: A resiliency index will be created and made available to SWHHS and CentraCare-Redwood partners.

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

Strategy:

Strategy Outcome:

Strategy: Utilize resiliency programing.

Strategy Outcome:

Strategy:

Strategy Outcome:

Quality of Life Community Health Survey 23.24
Body

Please give us your honest opinions about the community you live in. All of your individual responses will be kept anonymous. The survey results will be used to look at overall health trends in Southwest Health and Human Services service area. Any questions about this survey should be directed to Ann Orren at ann.orren@swmhhs.com. If you would like to take the survey online: https://www.surveymonkey.com/r/qualityoflife23_24

1. Zip code where you live _____ 2. Zip code where you work _____

3. County you live in: ☐ Lincoln ☐ Lyon ☐ Murray ☐ Pipestone ☐ Redwood ☐ Rock ☐ Other_____

4. Are you: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Other _____

☐ Native American/American Indian
☐ Asian or Pacific Islander
☐ Black or African American or African
☐ Hispanic/Latino
☐ White
☐ Other_____

5. Your age group:

☐ 12 or under
☐ 13-17
☐ 18-24
☐ 25-34
☐ 35-44
☐ 45-54
☐ 55-64
☐ 65-74
☐ 75 or older

6. Which of the following best describes you? **(Mark ALL that apply)**

7. What is the highest level of education you have completed? ***(Please mark only ONE)***

☐ Still in High School/Middle School
☐ Did not complete 8th grade
☐ Did not complete high school
☐ High school diploma/GED
☐ Trade/Vocational school
☐ Some college credit
☐ Associate degree
☐ Bachelor's degree
☐ Graduate/Professional degree

8. What is your employment status? ***(Please mark ALL that apply)***

☐ Employed
☐ Student
☐ Homemaker/Stay at home parent
☐ Unable to work due to disability
☐ Retired
☐ Unemployed
☐ Self-employed or farmer

9. Are you disabled? ☐ Yes ☐ No

10. Are you happy with the quality of life in your community? ☐ Yes ☐ No

11. Is your community a welcoming community? ☐ Yes ☐ No

12. Is your community a good place to raise children? ☐ Yes ☐ No ☐ Do not know

13. Is your community a good place to grow old? ☐ Yes ☐ No ☐ Do not know

14. Do you feel there are jobs available in your community where the pay meets your monthly bills?

Please turn OVER and complete page 2.

☐ Yes ☐ No ☐ Not applicable

15. Is your community a safe place to live? ☐ Yes –**SKIP** to Question 17 ☐ No –answer Question 16

16. If NO, what are the most likely causes? ***(Mark ALL that apply)***

☐ Alcohol/drug use	☐ Crisis response	☐ Race relations	☐ Street lighting
☐ Crime	☐ Family violence	☐ Sex trafficking	☐ Unsafe routes to walk
☐ Other _____		☐ Other _____	

17. How healthy would you say your community is?

☐ Very unhealthy ☐ Unhealthy ☐ Somewhat healthy ☐ Healthy ☐ Very healthy

18. Are you happy with the health care system in your community?

☐ Yes ☐ No ☐ I **have not** used the health care system-answer Question 18a.

18a. If you **have not** used the health care system in your community, why?

_____

19. What do you think are the **three MOST important factors** for a **"healthy community"**? ***(Please mark only THREE)***

☐ Access to affordable child care	☐ Arts and cultural events	☐ Good race relations
☐ Access to health care (physical and mental)	☐ Available housing	☐ Good schools
☐ Access to healthy food options	☐ Clean environment	☐ Low crime/safe neighborhoods
☐ Access to transportation	☐ Good jobs and healthy economy	☐ Religious or spiritual values
☐ Affordable healthy food options	☐ Good place to raise children	☐ Youth & family activities (e.g. parks & recreation)
☐ Affordable housing	☐ Other_____	

20. What do you think are the **three MOST important "health problems"** in your community? ***(Please mark only THREE)***

☐ Aging problems (e.g., arthritis hearing/vision loss, etc.)	☐ High blood pressure	☐ Mental health problems
☐ Alcohol related illness and death	☐ HIV/AIDS	☐ Motor vehicle crash injuries
☐ Alzheimer's disease	☐ Homicide	☐ Obesity
☐ Cancers	☐ Infant death	☐ Rape/sexual assault
☐ Child abuse/neglect	☐ Infectious diseases (e.g. hepatitis, TB, measles, pertussis, influenza, etc.)	☐ Respiratory/lung disease (e.g. asthma, COPD)
☐ Dental problems	☐ Kidney disease (nephritis)	☐ Sex trafficking
☐ Diabetes	☐ Lack of health screenings	☐ Sexually transmitted diseases
☐ Domestic violence	☐ Lack of healthy foods	☐ Suicide
☐ Drug related illness and death	☐ Lack of physical activity	☐ Teenage pregnancy
☐ Environment that is not healthy	☐ Lack of prenatal care	☐ Tobacco and e-cigarette use & exposure
☐ Firearm-related injuries	☐ Loneliness/isolation	☐ Unintentional injury
☐ Heart disease and stroke	☐ Marijuana (cannabis) use	☐ Other_____

Thank you for participating!

21. What is a community need you are more concerned about today than you were 3 years ago?

_____

22. What is preventing you from living a healthier life?

_____

23. Do you have any additional comments about the health of your community?

_____

24. Your total household income per year:

☐ Less than $20,000 ☐ $35,000 - $49,999 ☐ $75,000 - $99,999 ☐ Do not know
☐ $20,000 - $34,999 ☐ $50,000 - $74,999 ☐ $100,000 or more

Thank you for participating!

Appendix B: Existing Infrastructure: Continuing the Community Priorities

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