2022 ST. CROIX REGIONAL MEDICAL CENTER COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) AND IMPLEMENTATION STRATEGIES

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1. EXECUTIVE SUMMARY

Understanding the current health status of a community is a necessary first step towards identifying priorities for future planning and funding, existing strengths and assets on which to build, and areas for further collaboration and coordination across organizations, institutions, and community groups. This report is comprised of two main elements:

- Assessment – identifies health-related needs in Chisago, Polk, and Burnett County and uses primary and secondary data.
- Implementation Plan – determines and prioritizes the significant health needs of the community identified through the CHNA, overarching goals, and specific strategies to implement across the service area.

DATA COLLECTION METHODS

Qualitative and quantitative data were collected and reviewed throughout the CHNA process. Primary data collection utilized a multi-sector approach, inviting over 100 local organizations/agencies, to key informant interviews/community conversations/focus groups asking four questions:

1. For you, what does it mean to be *healthy and happy*?
2. What does it mean for our *community* to be healthy and happy?
3. What would make it *easier to live a healthier and happier life*?
4. What should our *community* do *together* to *improve health and well-being*?

Two quantitative ranking questions were included, in addition to the four open-ended qualitative questions, asking participants to rank their top three community strengths and challenges in order of importance. A survey, with the same questions, was sent to community members that could not attend one of the listening sessions.

Secondary data sources included, but are not limited to, the U.S. Census, U.S. Bureau of Labor Statistics, Centers for Disease Control and Prevention, State of Wisconsin Department of Public Health, State of Minnesota Department of Public Health, Behavioral Risk Factor Surveillance System, National Center for Health Statistics, as well as local organizations and agencies. The County Health Rankings Model was used as the overarching framework.

KEY FINDINGS

Numerous factors are associated with the health of a community including what resources and services are available as well as who lives in the community. Chisago, Polk, and Burnett counties have a combined population of about 115,991.

From primary data collection, the following were ranked as the top community challenges:

- Employment and Income
- Transportation
- Reliable Internet and Cellular Service
- Access to Care
- Family & Social Support
- Housing

Secondary data supported primary data findings. In expanding further from the rankings data and categorizing consistent themes from the listening sessions, **significant health needs identified** could be broken down into six categories:

- Basic needs and safety needs that make up the deficiency portion of Maslow's Hierarchy of Needs Pyramid are not being met.
    - Basic needs - food, housing; safety needs - income, employment, education, transportation, child care, financial security, broadband.
- There is a lack of a comprehensive "community support system."
    - This includes a lack of strong social and support networks, coordinated and comprehensive care, resources or resource capacity, volunteer opportunities.
- Access to care, services, and opportunities is not equitable.
    - Medical appointments, transportation, social opportunities, early childhood development, income, employment, education, broadband, inclusion, diversity, health equity.
- It is imperative to address mental/behavioral health and substance use/chemical dependency/addiction.
- Community leaders do not effectively collaborate at a strategic level and work as "one team."
- Communication is not consistent.
    - It is not easy to know where to go to get help and clear direction.
    - Residents and leaders do not have a one-stop site to obtain information.

HEALTH PRIORITIES

After reviewing theory and models (Maslow's Hierarchy of Needs Theory of Motivation; Social Ecological Model of Health; Health Impact Pyramid), primary data, and secondary data, the SCRMC CHNA steering team collaborated and came to the consensus that the **July 1, 2022 – June 30, 2025 priority areas** will be as follows:

Access

- Access to care, services, and opportunities is equitable for all community members (regardless of socioeconomic status).

Support

- Community leaders work together to align strategic efforts and develop a "community health system" that is easy to use, creates seamless transitions, and is built around supporting community members' ability to live healthier, happier, and longer lives (regardless of socioeconomic status).

Inclusion

- Community members feel like they belong and are empowered to help themselves and each other live healthier, happier, and longer lives (regardless of socioeconomic status).

COMMUNITY IMPLEMENTATION STRATEGY

To address the priority areas, the **implementation strategies** may include, but is not limited to, the following:

Access

- Increase convenient opportunities to visit a health care provider.
- Increase technology utilization to improve patient engagement and self-care.
- Create a personalized, professional development plan for every employee.
- Create clear pathways for employee growth and development.
- Create local workforce opportunities to support socioeconomic efforts (employment/income, family/social support).
- Reduce barriers to job opportunities by providing supportive childcare options.
- Develop plan to create new, visionary physical structure.

Support

- Establish and strengthen relationships with other community sectors.
- Become a community partnership leader.
- Increase resource referrals for patients with unmet social needs.
- Connect vulnerable populations to community resources.
- Provide patients with reliable and affordable transportation options.
- Provide support in navigating the health care system.

Inclusion

- Decrease stigma associated with getting mental health support.
- Promote a culture of "belonging" by increasing awareness in health equity, diversity, and inclusion.
- Create opportunities to increase the voice of the patient/community members.

SCRMC is passionate about delivering our community the care and services they need (**access**), with the help that they deserve (**support**), in an environment where they feel they belong (**inclusion**). We will work together **fluidly** to acquire, promote, and protect wellbeing across the lifespan. Our overarching strategy will be to **build systemic community infrastructure that drives health equity and social justice for all**. SCRMC will focus on multi-sectoral policy and action, integrated services, and empowering people and communities through collaboration.

2. INTRODUCTION

a. OVERVIEW

Improving the health of a community is critical to ensuring the quality of life of its residents and fostering sustainability and future prosperity. Health is intertwined with multiple facets of our lives, and where we work, live, learn, and play all have an impact on our health. Understanding the current health status of a community – and the multitude of factors that influence health – is important in order to identify priorities for future planning and funding, the existing strengths and assets on which to build, and areas for further collaboration and coordination across organizations, institutions, and community groups.

Polk United - Healthier Together, a multi-sector coalition, led a collaborative Community Health Needs Assessment (CHNA) effort. Leading partners, in addition to St. Croix Regional Medical Center (SCRMC), included Amery Hospital & Clinic, Osceola Medical Center, United Way St. Croix Valley, Polk County Public Health, University of Wisconsin-Extension, and the Polk County Mental Health Task Force.

This effort was comprised of two main elements:

- Assessment – identify the health-related needs in our area using primary and secondary data.
- Implementation Plan – determine and prioritize the significant health needs of the community identified through the CHNA, overarching goals, and specific strategies to implement across the service area resulting in a Community Health Improvement Plan (CHIP).

This report details the findings of the CHNA conducted from October 2021 – April 2022.

b. ADVISORY STRUCTURE AND PROCESS

The CHNA was spearheaded and managed by the Polk United –Healthier Together coalition. The organizations in the coalition are representative of those in the community who serve underserved, low-income, and hard to reach populations. Representatives from these organizations provided regular input as part of the CHNA process by routinely attending monthly, bi-monthly, or weekly meetings. The coalition provided feedback and guidance at each stage of the CHNA process, identifying specific populations for community conversations and key informant interviews, attending community forums and prioritization sessions, and by being valued community partners.

Once the assessment was complete, a steering team was formed at SCRMC to select and approve priority areas based off the CHNA results.

c. PURPOSE AND COMMUNITY SERVED

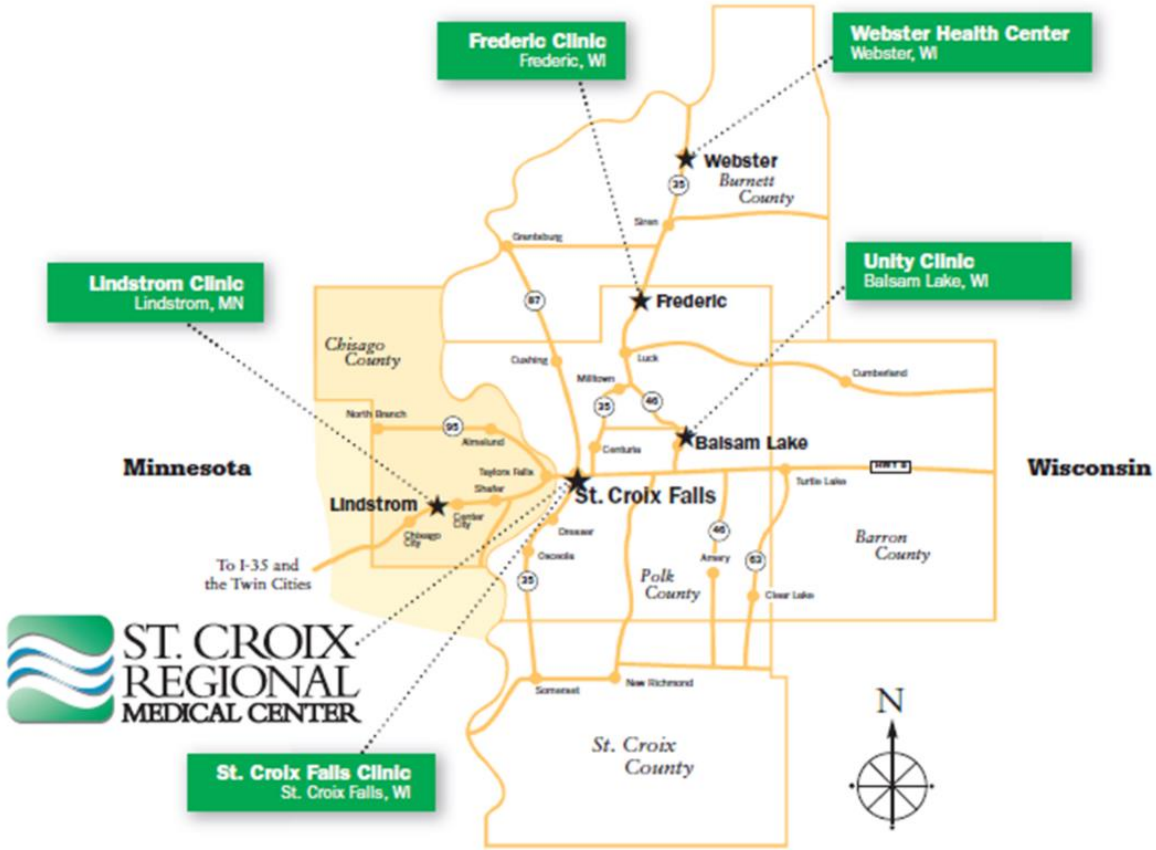
A CHNA is a systemic process involving the community to identify and analyze community health needs and assets, prioritize the needs, and implement a plan to address significant unmet community needs.

The overarching goals are as follows:

1. Examine the current health status of the community.
2. Explore current health priorities – as well as emerging health concerns – among residents within the social context of their communities.
3. Meet the legal requirements, as stipulated by the Internal Revenue Service (IRS), to conduct a CHNA at least once every three years and to adopt a written implementation strategy to meet the needs identified through the CHNA.
4. Meet voluntary health department Public Health Accreditation Board requirements.

To define community for IRS requirements, this CHNA uses a geographic approach focusing on SCRMC's three county primary service area – Chisago County (MN), Polk County (WI), and Burnett County (WI). SCRMC is a not-for-profit healthcare system located in St. Croix Falls, WI dedicated to helping people live healthier, happier, and longer lives. SCRMC offers the services of 80+ providers and 20 specialties with five community clinics in Minnesota and Wisconsin all supported by a critical access hospital on the main campus in St. Croix Falls.

In addition to the hospital and two community clinics located in Polk County (WI), SCRMC also serves community members at clinics in Chisago County (MN) and Burnett County (WI). Upon defining the geographic area and population served, the team was diligent to ensure that no groups, especially minority, low-income or medically under-served, were excluded.



Demographics, separated by county:

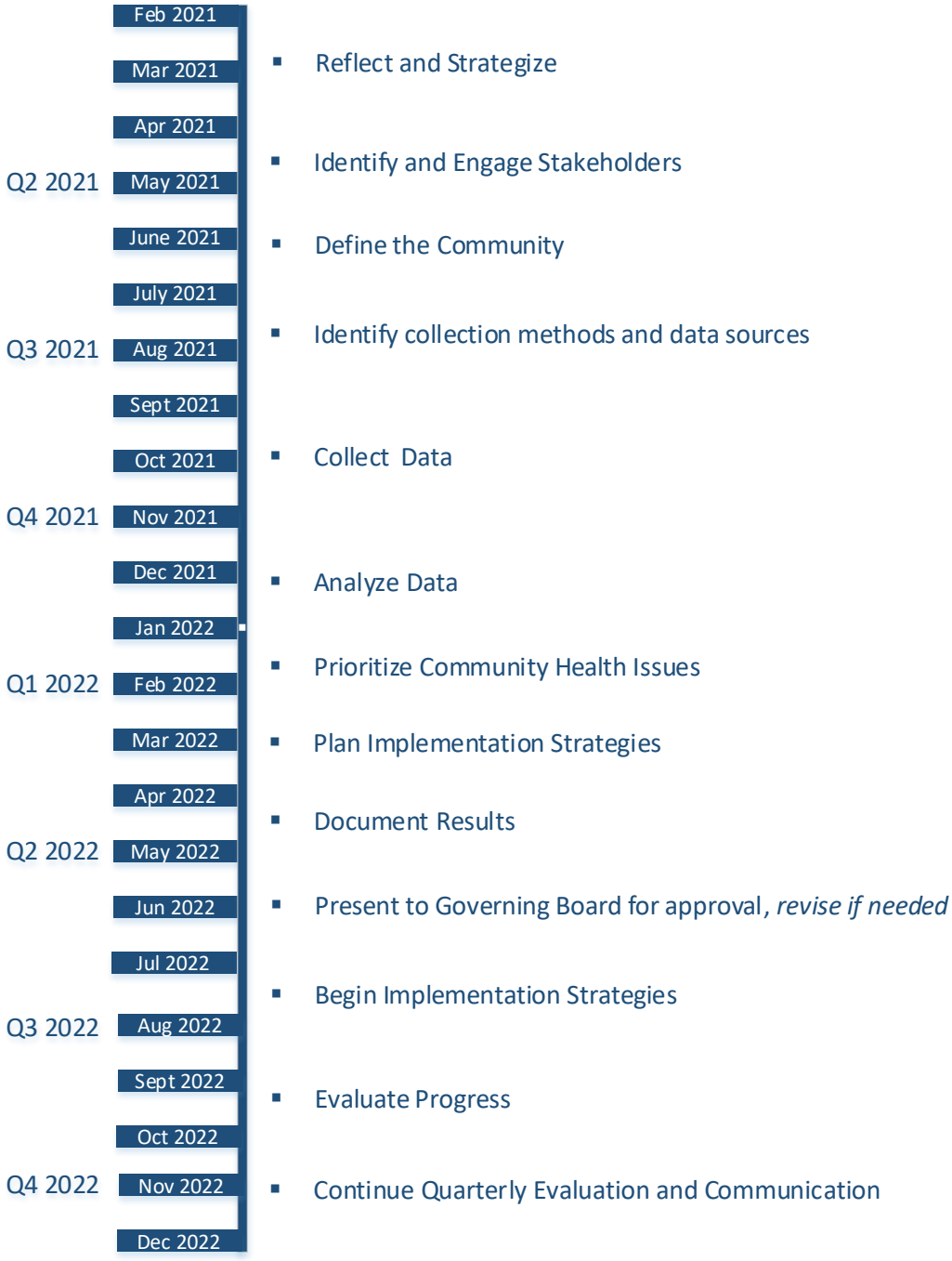
	MN	Chisago	WI	Polk	Burnett
Population	5,657,342	56,794	5,822,434	43,783	15,414
% Below 18 Years of Age	23%	22.4%	21.80%	20.60%	17.40%
% 65 and Older	16.80%	16.4%	17.50%	21.30%	29.40%
% Non-Hispanic Black	7%	1.30%	6.40%	0.40%	0.80%
% American Indian & Alaska Native	1.40%	0.80%	1.20%	1.10%	4.60%
% Asian	5.3%	1.40%	3.00%	0.60%	0.50%
% Native Hawaiian/Other Pacific Islander	0.10%	0.00%	0.10%	0.00%	0.10%
% Hispanic	5.70%	2.50%	7.10%	1.90%	2.00%
% Non-Hispanic White	78.6%	92.60%	80.90%	94.90%	90.20%
% Not proficient in English	2.00%	0.00%	1.00%	0.00%	0.00%
% Females	50.20%	48.40%	50.20%	49.60%	48.80%
% Population Change, 2010 - 2020	7.59%	5.07%	3.63%	1.75%	6.92%

County Health Rankings, 2021; US Census Bureau, Decennial Census, 2020

3. METHODS

This section provides the overall timeline and overarching framework that helped guide CHNA development. It describes the process and methods used to conduct the CHNA, including the qualitative and quantitative data compiled and how it was analyzed, as well as a description of the broader lens used. Specifically, the CHNA defines health in the broadest sense and recognizes that numerous factors at multiple levels impact a community's health – from lifestyle behaviors, clinical care, social and economic factors, and the physical environment.

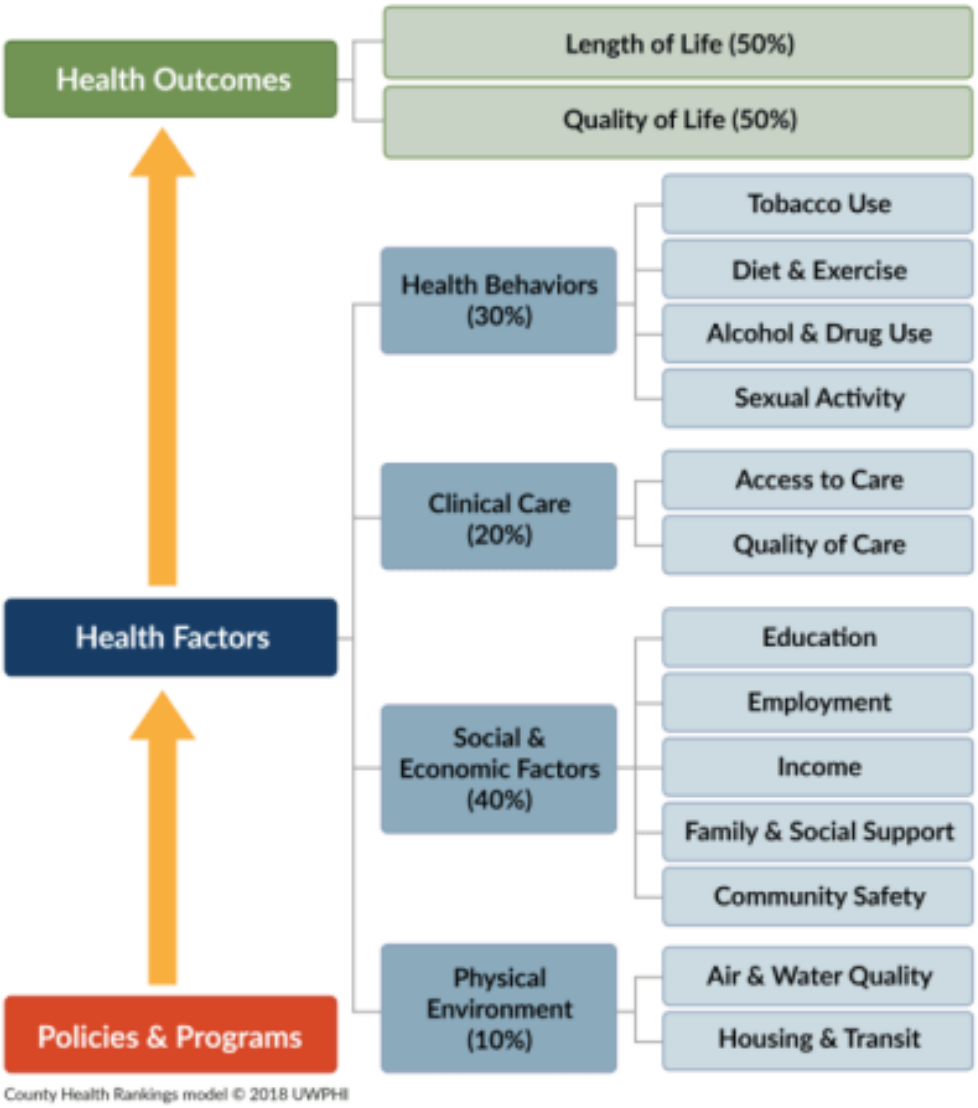
a. THE PROCESS TIMELINE



b. THE OVERARCHING FRAMEWORK, MODELS, AND THEORY

It is important to recognize that multiple factors have an impact on health and that there is a dynamic relationship between real people and their environments. Where we are born, grow, live, work, and age – from the environment in the womb to our community environment later in life – and the interconnections among these factors are critical to consider when examining health status. Health outcomes are influenced by more than just an individual's genetic code. In fact, zip code is more predictive of health as it is associated with lifestyle behaviors and upstream factors such as income, education, employment, and quality of housing stock.

The following diagram provides a visual representation of this relationship, demonstrating how individual lifestyle factors, which are most often viewed as the most proximate to health outcomes, are influenced by more upstream factors such as education, literacy, and physical environments.



County Health Rankings & Roadmaps
Building a Culture of Health, County by County

University of Wisconsin Population Health Institute
SCHOOL OF MEDICINE AND PUBLIC HEALTH

Support provided by
Robert Wood Johnson Foundation

Health outcomes are influenced by the many factors that influence health, from the quality of medical care received to the availability of good jobs, clean water, and affordable housing. These health factors are then influenced by programs and policies in place at the local, state, and federal levels. There are significant differences in health outcomes according to where we live, how much money we make, our race and ethnicity, and other characteristics.

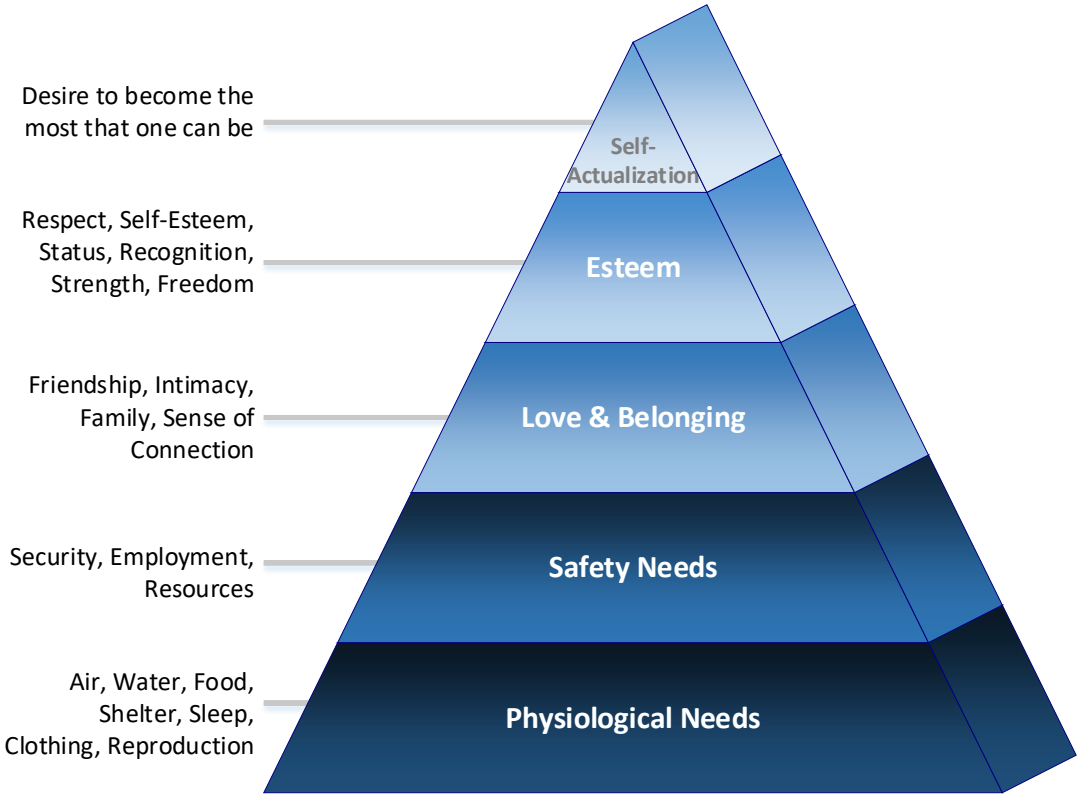
There is no one factor that dictates the overall health of an individual or community. A combination of multiple modifiable factors, from clean air and water to stable and affordable housing, need to be considered to ensure good community health for all.

The County Health Rankings model illustrates the many factors that, if improved, can help make communities healthier places to live, learn, work, and play. Policies and programs at the local, state, and federal levels play an important role in influencing these factors. By implementing strategies that target the specific health challenges of a community, there is an opportunity to influence how long and how well people live.

There is a wide range of policies, programs, systems, and environmental changes that can make a difference locally. Some interventions target individual behaviors, such as influencing dietary choices, exercise levels, or alcohol consumption. Other strategies tackle systems and structures, such as enhancing opportunities for education, stimulating economic development, and increasing neighborhood safety.

No single strategy will ensure that everyone in the community can be healthier, and many policies and practices in the past have marginalized groups of residents, such as people of color, keeping them from the resources and support necessary to thrive. Our collective health and well-being depend on building opportunity for everyone (County Health Rankings, 2021).

When looking at the County Health Ranking diagram above and recognizing that 40% of health is attributed to social and economic factors, it is important to recognize where social determinants of health (SDOH) fall within Maslow's Hierarchy of Needs Pyramid. Maslow's Hierarchy of Needs pyramid is a well-known theory of motivation stating that people are motivated by satisfying lower-level needs such as food, water, shelter, and security, before they can move on to being motivated by higher-level needs (see figure below).



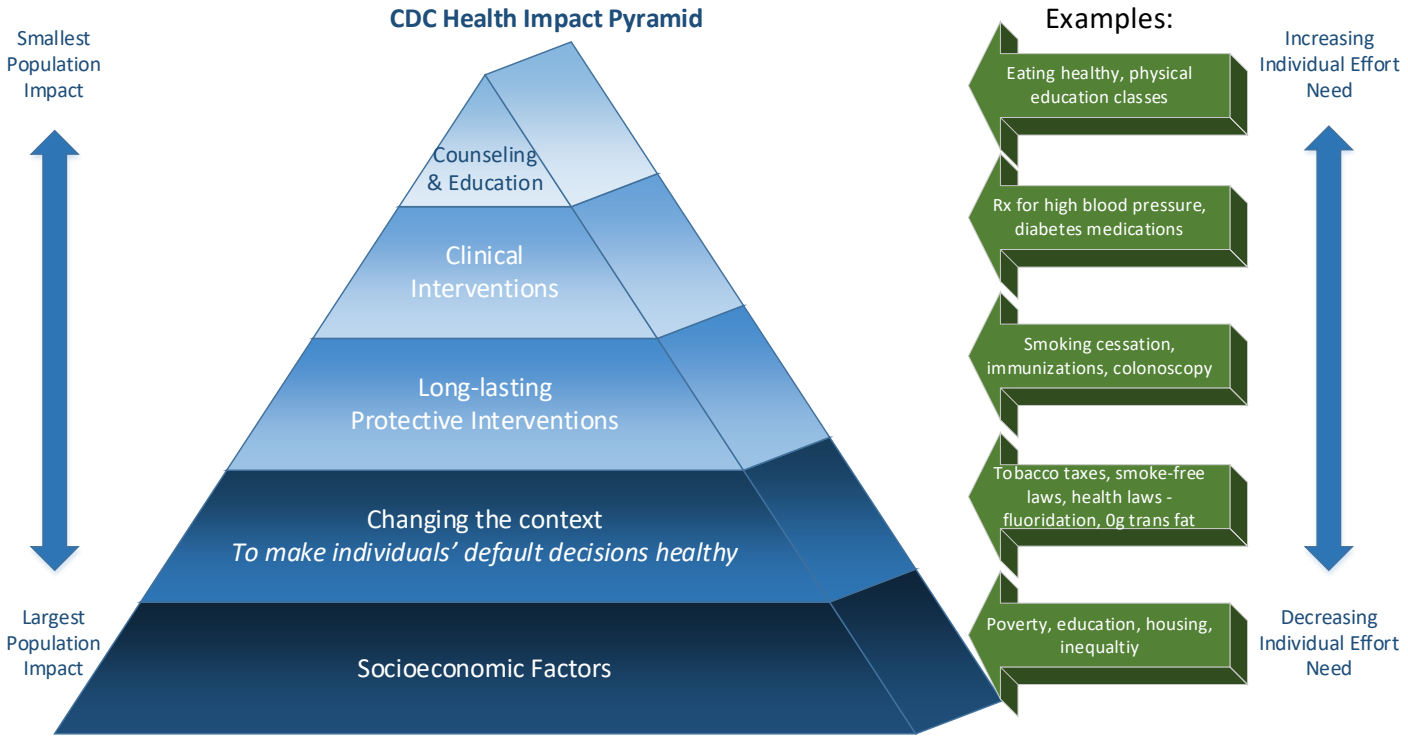
Maslow, A.H. (1943). A theory of human motivation. Psychological Review, Vol. 50, pp. 370-396.

Maslow's theory of motivation has grown throughout the years, but at the base of its core, the theory of motivation has two important components: (1) there are multiple and independent fundamental motivational systems and (2) these motives have a hierarchy in which some motives have priority over others.

- Physiological needs are necessary to maintain life: oxygen, food, and water. These basic needs are required by all animals and are the primary focus of infants.
- When an individual's physiological needs are met, the focus typically shifts to safety needs, which may include health, freedom from war, and financial security.
- If physiological and safety needs are met, a person will focus on the need for a connection and love. These needs are typically met by friends, family, and romantic partners.
- Esteem is necessary for self-actualization, and a person may work to achieve esteem once needs for love and a sense of belonging are met. Self-confidence and acceptance from others are important components of this need.
- Self-actualization is the ability to meet one's true potential, and the necessary components of self-actualization vary from person to person. A scientist may be self-actualized when able to complete research in a chosen field. A father might be self-actualized when able to competently care for his children.

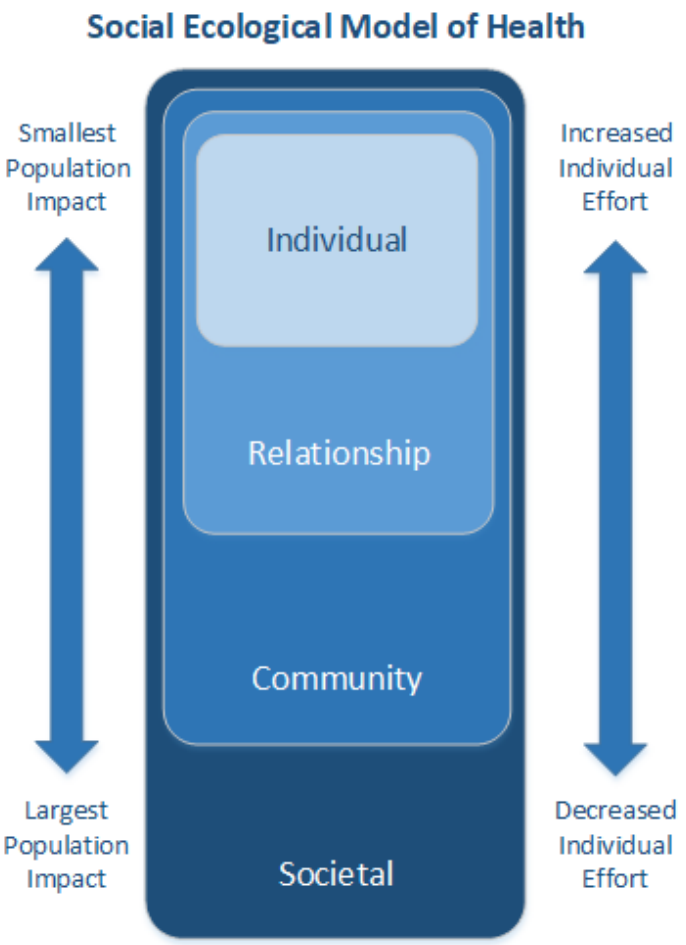
Deficient needs – basic, psychological, and belongingness – must be met before one can move toward growth – self-fulfillment and self-actualization.

Next, you will find the Health Impact Pyramid that was created with the same conceptual prioritization as Maslow's Hierarchy of Needs Pyramid yet relates it to where healthcare interventions lie in overall health impact. Traditionally, healthcare has focused on areas toward the top of the pyramid, not consistently addressing base-level needs. This takes high individual effort and the health impact is low. Focusing only on interventions, counseling, and education at visits will not be an effective means to health unless it is built on strong foundational factors. To move from quality sick care to quality well care, healthcare must prioritize strategies that address the lower-level tiers/base levels of the Health Impact Pyramid before interventions can be truly effective.



Frieden, T. A Framework for Public Health Action: The Health Impact Pyramid. Am J Public Health. 2010; April; 100(4): 590-595.

The last model that is important to acknowledge and understand is the the social ecological model of health first proposed by McLeroy and colleagues in 1988. This model reinforces that health is not solely determined by biological factors, but instead is influenced by a collection of subsystems that occur at various levels. Mainly, these levels include individual, relationship, community, and societal. Understanding how multi-level social factors and systems produce and sustain inequities is imperative to understanding health disparities and our ability to impact populations. The larger and darker the area in the model, the greater the impact on populations and the lower individual effort needed.



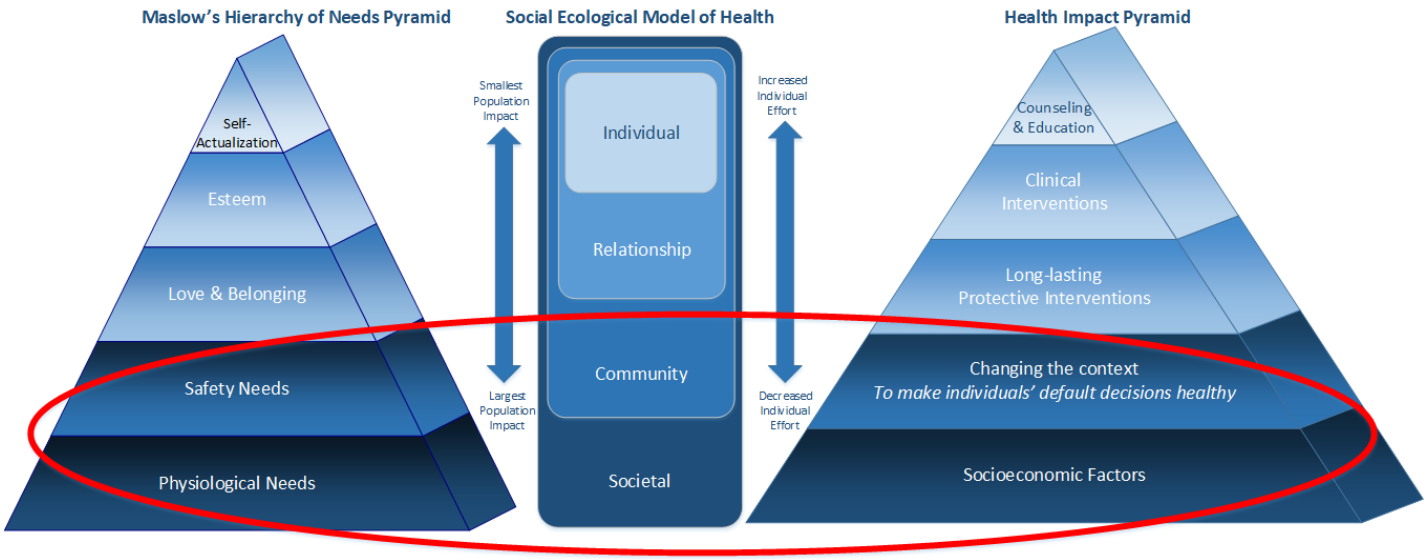
Centers for Disease Control and Prevention, The Social-Ecological Model: A Framework for Prevention, 2022.

Below is an example of the four-level model as it relates to violence and the effect of potential prevention strategies.

- **Individual**: The first level identifies biological and personal history factors that increase the likelihood of becoming a victim or perpetrator of violence. Some of these factors are age, education, income, substance use, or history of abuse. Prevention strategies at this level promote attitudes, beliefs, and behaviors that prevent violence. Specific approaches may include conflict resolution and life skills training, social-emotional learning, and safe dating and healthy relationship skill programs.
- **Relationship**: The second level examines close relationships that may increase the risk of experiencing violence as a victim or perpetrator. A person's closest social circle-peers, partners and family members-influences their behavior and contribute to their experience. Prevention strategies at this level may include parenting or family-focused prevention programs and mentoring and peer programs designed to strengthen parent-child communication, promote positive peer norms, problem-solving skills, and promote healthy relationships.
- **Community**: The third level explores the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpetrators of violence. Prevention strategies at this level focus on improving the physical and social environment in these settings (e.g., by creating safe places where people live, learn, work, and play) and by addressing other conditions that give rise to violence in communities (e.g., neighborhood poverty, residential segregation, and instability, high density of alcohol outlets).

- **Societal**: The fourth level looks at the broad societal factors that help create a climate in which violence is encouraged or inhibited. These factors include social and cultural norms that support violence as an acceptable way to resolve conflicts. Other large societal factors include the health, economic, educational, and social policies that help to maintain economic or social inequalities between groups in society. Prevention strategies at this level include efforts to promote societal norms that protect against violence as well as efforts to strengthen household financial security, education and employment opportunities, and other policies that affect the structural determinants of health.

As you compare the three models (see figure below), it is apparent that the pathway to move from quality sick care to quality well care that is sustainable and affordable is by aiming focus at the levels circled in red below. The greatest impact on population health with the lowest individual effort needed is to focus on SDOH and incorporate these elements into each clinic/hospital visit.



c. QUALITATIVE AND QUANTITATIVE DATA COLLECTION METHODS AND ANALYSIS

Using a multi-sector approach (*Substance Abuse Organizations, State/Local/Tribal Government, Healthcare Professionals, Religious/Fraternal Organizations, Civic/Volunteer Organizations, Law Enforcement, Youth Serving Organizations, Schools, Media, Business, Parents, Youth*), over 100 organizations were identified and invited to participate in Community Conversations/Key Informant Interviews. Of the twelve sectors, in the seventeen listening sessions, the only sectors not represented are the *Media* and *Youth* sectors.

During the Community Conversations/Key Informant Interviews, four open-ended questions were asked:

1. For you, what does it mean to be healthy and happy?
2. What does it mean for our community to be healthy and happy?
3. What would make it easier to live a healthier and happier life?
4. What should our community do together to improve health and well-being?

There was a minimum of two coalition leaders at each Community Conversation/Key Informant Interview, one to facilitate and one to take notes. The facilitator was intentional not to "lead" the conversation when a question was asked as to not skew data or drive answers in a certain direction. When the facilitator(s) asked questions, it was for clarification purposes to ensure understanding.

In addition to the four open-ended questions, participants were asked to rank what they viewed as their top three community strengths and top three community challenges. If participants were not comfortable, or ready, to give this information during the conversation, they were sent a follow-up survey (created through Qualtrics XM ®) that asked them to rank their top three community strengths and challenges.

Once the Community Conversations/Key Informant Interviews were complete, a survey (created through Qualtrics XM ®) asking the same four open-ended questions and two ranking questions, was sent to the over 100 organizations invited asking them to distribute the survey to other key informants and to the community members they served.

Secondary data was collected from a multitude of reliable and valid sources. This includes, but is not limited to, the U.S. Census Bureau, the U.S. Bureau of Labor Statistics, the Centers for Disease Control and Prevention, and so forth, to name a few. You can find specific sources associated with data points identified on the corresponding page of this report.

The framework used as a guide to the multiple factors that influence how long and how well people live is the County Health Rankings Model developed by the University of Wisconsin's Population Health Institute and supported by the Robert Wood Johnson Foundation.

Data was separated into four areas:

1. Community Conversations/Key Informant Interview Data
2. Ranking Data
3. Survey Data
4. Secondary Data

Once the Community Conversations/Key Informant Interviews data and the survey data was reviewed and compiled, common themes were identified, and the data was separated into respective categories. When the respective categories were developed and established, comparison evaluations took place to determine if the qualitative data coincided with the quantitative ranking data. Once primary data synthesis was complete, robust secondary data was gathered to validate or reject the trends being revealed, in addition to ensuring that the multiple factors that encompass health were not being overlooked.

4. FINDINGS

a. PRIMARY DATA

i. Community Conversations/Focus Groups/Key Informant Interviews

ii. Survey

The following data is the information received from the Community Conversation focus groups and Key Informant Interviews. The first two questions asked essentially the same thing, with the first question focusing on "you" as an individual and the second focusing on the "community" at large. See below.

1. **For YOU, what does it mean to be healthy and happy?**
2. **What does it mean for your COMMUNITY to be healthy and happy?**

This slight variation was done intentionally to see if people separated themselves from their community or viewed them as one and the same. We found that the two concepts almost always flowed into one with people having difficulty separating one from the other, thus, reinforcing the importance of community connection and zip codes to overall health. For ease of review, the advisory team separated responses into common areas/themes and added examples of what was commonly associated with each area. Since those participating had a difficult time separating individual and community responses, the two questions were merged as one.

Results from questions one and two:

Basic needs met consistently	Affordable housing Nutritious and affordable food
Easy, affordable access to services	Transportation, reliable transportation Access to health (includes medical, dental, behavioral; strong healthcare system) Prenatal care Dental care Health care Psychological and therapy services, mental health services Affordable medication
Strong social and support networks	Social connections; people out and about Living in a strong, supportive community Social opportunities Being engaged Pride where I live, community pride Meet the needs of all individuals Know how to get help Navigate service options Volunteer opportunities Lots of community resources Encouragement

Safety and security	Financial security Family and loved ones are comfortable and taken care of Being able to live at home when older Safe environment Equal opportunities Strong community leaders
Local opportunities	Ability to access the things you enjoy Low-cost activities Recreational opportunities Access to larger populations Things to do for all ages Community is growing, vibrant
Employment and income	Career opportunities Livable wages Economic relief
Education	Good education system Higher education Growth opportunities
Inclusion/Belonging	Respect Appreciation Feeling included Health equity
Resiliency	Work-life balance Low stress Knowing how to cope, meditation Having energy Adaptability Feeling good in physical, emotional, mental, spiritual, and social health Having time for yourself Opportunities to relieve stress
Purpose	Sense of accomplishment, sense of purpose Satisfaction at the end of the day Opportunities to grow and thrive Strong in faith
Health	Free from illness Not being sick

	Being active Mobile and independent
Positive attitude/perspective	Positive outlook Being happy

Similarly, as with questions one and two, questions three and four had slight variations in wording to acknowledge that people interpret information and questions differently. Question three had an individualized characteristic surrounding it, and question four expanded into what our community should do together to improve health and well-being.

1. **What would make it easier to live a healthier and happier life?**
2. **What should our community do together to improve health and well-being?**

At a time where collaboration is critical, it was important to gain community "buy-in" and to find out where the movement and passion is in the community. The advisory team felt that initiating conversations this way was a great potential pathway to begin future partnerships once the assessment is complete.

Results from questions three and four:

Access to Services	Address basic needs	
	Transportation	Coordinate transportation options
	Resources	▪ Awareness ▪ Coordination ▪ Clear referral pathways ▪ Increase capacity ▪ Easy to find ▪ Non-electronic information option for elderly population
	Chemical Dependency/Addiction Treatment and Mental/Behavioral Health	▪ Appropriate ER services in crisis situations; improve chemical dependency process in hospitals ▪ Build a better mental health system (law enforcement, hospitals, etc.) ▪ Assessment services such as PFC therapy ▪ Inpatient services ▪ Inpatient treatment funding ▪ Appropriate crisis assessment akin to MN Rule 25

		▪ Diagnosis and expertise ▪ More professionals ▪ Referral access ▪ Stigma reduction ▪ Closer proximity crisis management options
	Food	▪ Limited hours at food banks ▪ Lack of transportation
	Repair/handyman services	To those living on the margins
	Access to resources already there	Support systems
	Equality	
	Adult protective services	
	Dementia “friendly” health care	
Family, Social, and Community Support	Address basic needs	
	Resources	▪ Resource coordination ▪ Decrease repetition ▪ Easy to find ▪ Comprehensive one-stop site ▪ Communication ▪ Awareness ▪ Capacity
	Volunteer Opportunities	▪ Comprehensive community site ▪ Communication
	Support systems	▪ Collaboration ▪ Seamless transitions ▪ Comprehensive ▪ Life balance ▪ Well-publicized support systems ▪ Care coordination focus group
	Opportunities to socialize	▪ Natural “gathering” spaces ▪ Connectedness ▪ Classroom success ▪ Communication
	Early childhood development	▪ Teach parents

		▪ Give them resources ▪ Include those that do not attend daycare/pre-school ▪ Social skills
	Decrease stress	▪ Biking paths ▪ Walking lights ▪ Safe sidewalks and spaces ▪ Activities for families to do together ▪ Decrease/eliminate social media
Basic needs	Housing	▪ Lack of affordable housing ▪ Shelter for those living on the "margin" ▪ Make homeless shelter
	Food	▪ Food is available, but not connecting people to the food (awareness, stigma)
	Transportation	▪ Appointments ▪ Food banks ▪ Crisis care facilities ▪ Community coordination
	Internet (broadband) and cellular service	▪ Reliable ▪ Affordable
Strong collaboration	▪ Address basic needs ▪ Build partnerships and relationships ▪ Build comprehensive "systems" ▪ Align strategically ▪ Integrate data ▪ Make sure the right people are "at the table" ▪ Find a way for common funds to cross municipalities ▪ Bring in many partners, identify roles, develop action steps	▪ Have community-wide protocols in place for collaboration with partners ▪ Don't focus on too many things at once, select specific target areas ▪ Move in the same direction ▪ Don't compete with each other ▪ Be proactive, not reactionary ▪ Decrease wasted time ▪ Work together ▪ Bring in "fresh" eyes ▪ Don't turn a "blind" eye ▪ Better collaboration between area hospitals and county
Life balance	Flexibility Pursue interests Decrease stress	

Sense of security and "togetherness"	Societal division, no politics Belonging, inclusion Conflict, fear uncertainty, safety Misinformation Lack of cooperation Health equity Diversity Safe spaces, safe sidewalks	
Communication	Build community communication strategy	All available activities and events in one place Volunteer opportunities in one place

Next, we looked at what participants viewed as **community strengths**:

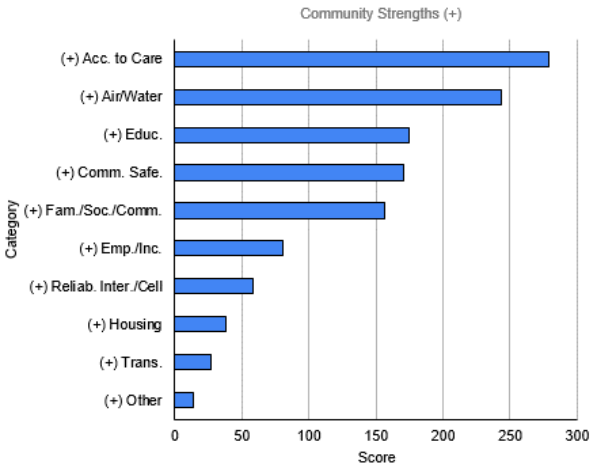
Access to Care	▪ Healthcare options ▪ Forward-thinking hospitals ▪ Quality
Air/Water	▪ Lakes ▪ Nature ▪ Beautiful surroundings
Education	▪ Extraordinary school districts, school systems, extra-curricular activities/sports offerings ▪ Schools collaborate even when they are in competition for students
Community safety	▪ Feel safe in community
Community Pride and Uniqueness	▪ Sense of community, welcoming community ▪ Community pride, sense of pride, pride in schools ▪ Unique ▪ Community/civic groups ▪ Arts community ▪ Adaptability and resilience ▪ People willing to help, work together, volunteer ▪ Rural setting
Generosity	▪ So many people wanting to step up and help ▪ People committed to making a better place to live ▪ Desire to help
Family and Social Support	Available food and food resources Good mental health options when you can get in Resources we have are strong

Opportunities	Many recreational opportunities Natural resources Things to do for all ages Large employers in area for economic growth
Collaboration	Strong desire to collaborate Positive attitudes

In addition to verbal conversation, the survey asked participants to rate what they viewed as the top three community strengths. Noted strengths, from the survey ranking in order, are as follows:

- Access to Care
- Air/Water
- Education
- Community Safety
- Family & Social Support

See graph below extracted directly from survey results:



Next, you will find the **community challenges** cited by those that participated in the community conversations, key informant interviews, and surveys. It was difficult to label or put responses into only one category since most of the cited challenges crossed through multiple focus areas. The interconnectedness and complexity of each area was very apparent in how the conversation(s) flowed back and forth from one area to the next.

Please note that the term “access” has become more broadly defined and does not only encompass “access to care” in this report. It is not limited to health care and having provider access, it also consists of a multitude of factors including, but not limited to, resources and support systems. Please be cognizant that most challenges in the table below could be placed in multiple areas.

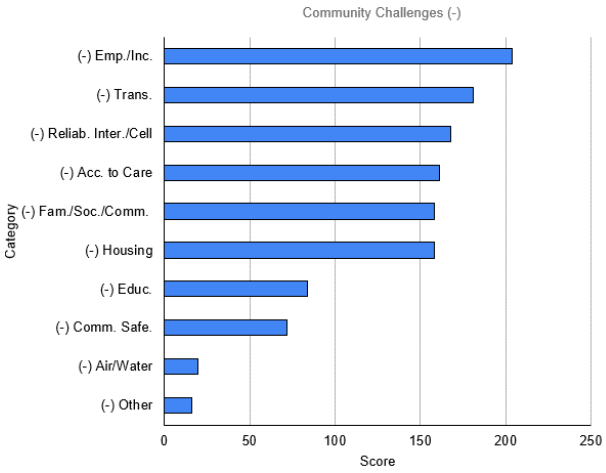
Collaboration	▪ Political divide ▪ Not strategically aligned ▪ Integrate data between organizations ▪ Need diverse leadership ▪ More collaboration among area hospitals ▪ Think in terms of "systems" to connect all parts ▪ Crisis management – hospitals sharing situation with schools
Care Coordination, Resource Coordination, Family and Social Support	▪ Need "system" work ▪ Confusing referral patterns ▪ Meet basic needs ▪ Make it easy to find information ▪ Reduce stress, uncertainty ▪ Connect people to food
Access	▪ Substance use and abuse ▪ Crisis management options ▪ Funding ▪ Health equity ▪ Mental Health ▪ Transportation ▪ Employment and Income ▪ Affordable housing ▪ Reliable internet and cellular service ▪ Northwoods Grace Place always full – turn empty nursing homes (Luck) into homeless shelters ▪ Lack of treatment facilities ▪ Transportation ▪ Food resources
Connectedness and Belonging	▪ Political divide from Federal to local levels ▪ Lack of trust ▪ Socialization opportunities ▪ Uncertainty ▪ Stigma ▪ Diversity awareness ▪ Mental health and substance use are major factors tearing the community apart (with meth, you either have mental health issues or it creates mental health issues. Schools not involved in mental health multi-district collaboration)

	▪ How to reach those in rural areas
Mental Health and Chemical Dependency	▪ Hospitals sharing crisis situations with schools to be able to help students ▪ Getting parents to allow their student(s) to complete a Youth Risk Behavior Survey to qualify for funding ▪ Crisis management options ▪ Training and education needed for hospital staff and law enforcement ▪ Treatment options have improved (i.e., PFC), but services are swamped
Employment and Income	▪ County growth is outpacing planning ▪ Livable wages ▪ Employers provide addiction treatment services for families – seeing it as a generational cycle; the people we are hiring now are the people with trauma
Transportation	▪ Medical appointments ▪ No access ▪ Transportation access to mental health care (why not an hour across the river rather than half a day to Winnebago)
Family and Social Support	▪ Increase awareness to relieve stress (hiking, biking) ▪ Care and resource coordination ▪ "Systems" approach
Housing	▪ Affordable housing ▪ Create more accessible neighborhoods, such as, no more 10-acre lots
Internet and Cellular Service	▪ Reliable, affordable
Communication	▪ Keep community informed and updated ▪ Comprehensive ▪ Easy

Again, in addition to verbal conversation, the survey asked participants to rate what they viewed as the top three community challenges. Noted challenges, from the survey ranking in order, are as follows:

- Employment and Income
- Transportation
- Reliable Internet and Cellular Service
- Access to Care
- Family & Social Support
- Housing

See graph below extracted directly from survey results:



Interestingly, you will see that "Access to Care" and "Family & Social Support" were identified as both a strength and a challenge. Community conversations and key informant interviews, along with survey results came down to this:

Our community has many quality resources and providers, but…

- People are not connecting to them – it is difficult to find information, getting help is not easy
- Not enough availability to meet the high demand, capacity constraints
- High amount of work duplication throughout the community keeps organizations at maximum capacity
- No comprehensive support or service coordination; need seamless transitions from one organization to the next
- Limited follow-up

This data shows us that we have great opportunities available to us to create long-term, sustainable, and impactful change if we work together collaboratively and create alignment in our strategies.

iii. Community Roundtable Discussion

A "community health needs roundtable" event (sponsored by SCRMC), held in February of 2021, brought together community experts (12 in person, 2 via telecom, 6 via email feedback) that specialize in early childhood development areas to discuss the greatest SDOH areas of need.

Participants involved NOT employed by SCRMC:

- Polk County Community Services Division – Department of Children & Families Director
- Polk County WIC Director
- CESA #11 Head Start/Early Head Start – Social Worker/Family Service Coordinator
- United Way St. Croix Valley – Success by 6 Program Director
- Family Resource Center, St. Croix Valley – Parent Educator Lead
- Mental Health Task Force – Executive Director
- Polk County – Birth to Three
- Unity Elementary School – Counselor and Pre-K Teacher

Participants involved employed by SCRMC:

- Director of Quality and Patient Engagement
- Director of Emergency Services and OB
- Director of Community Health and Wellness
- Director of Primary Care and Counseling & Psychological Services
- Social Services Supervisor
- Lactation Consultant and Childbirth Educator
- Provider
- Clinic Manager
- Clinic Supervisors

The target audience being discussed was pregnant women to six-year-olds. The event was triggered by a grant awarded from the Roots and Wings Foundation to target specific areas as SCRMC created a role description for a Community Health Worker (CHW) that would serve as a liaison between community sectors. A CHW links a person (or family) to the resources they need. They are the front line for providing advocacy, education, and support. SCRMC wanted robust community collaboration in place to ensure cross-sector support when a CHW was hired.

The objective of the event was to identify community health needs, gaps in community resources, and gaps in community resource collaboration. The overall goal was to help low-income families and children reach their full potential by improving the community health system. For this event, a "community health system" was defined as (since there is, currently, no universal definition) community partners working in collaboration to improve health and wellbeing that includes multi-sector engagement and an "in this together" mentality.

Here are the gaps and ideas for improvement that were discussed/brought forward by the group:

Food Insecurity

What are the contributing factors to the topic for our population?	*What are ideas for interventions to address those factors?*
GAPS	***IDEAS***
In between $ to qualify and afford	Hands on education
New people with insecurities and knowing what we have	Going to farmers market
Pride	Farm to table field trips
Feel others needs are greater – worse than them	Home gardens
Don't have what they need - meat/fruit/veggies	Community gardens
Understand food choices/nutrition	Resources to share
Cooking skills/time	Asking about food at well child visits
Perception – healthy foods expensive	Mobile food pantry/mobilize pantries, be consistent - delivery
Availability/Transport	Food at the clinic/hospital to take home - Food Rx
Perception - children don't like healthy foods (continue to try; 7-8 times)	Open food pantry in Balsam Lake
Parents need to be involved	Ready Meals
Education (food storage, prep, variety, budget, how to feed kids, juice)	Take home extra food from school/cafeterias/restaurants
Lack of employment opportunities	Make WIC appointment more flexible. Have WIC house visits.
Inflexible WIC hours (if you can't make appts, you lose WIC funds)	

Transportation

What are the contributing factors to the topic for our population?	*What are ideas for interventions to address those factors?*
GAPS	***IDEAS***
No public transportation	Partner with ride share company
No emergent transportation on evenings/wkds	Donated repair
Drivers license – cost/access	Gas vouchers
Dependent on others for ride/car	
Gas $	
Car seats	
Overwhelming to load multiple kids in car	
Medical transport (can't bring multiple kids)	
Covid or symptoms – no one will take	
Can't afford to repair vehicle	
Safe transportation	
Don't have a car	

Mental Health and Substance Abuse

What are the contributing factors to the topic for our population?	*What are ideas for interventions to address those factors?*
GAPS	***IDEAS***
Services to see children – full or long wait times	Drug screening
WI providers cannot put a "hold" on a patient – only police officers	Place families in foster care (everyone together)
Can't go outside WI to see a provider	ACEs screening (add to visit)
Number of providers	Mental Health drop in center
Treated differently if repeat instances	Non-crisis line
No inpatient beds	Periscope project for post partum depression, integration to clinic
Badgercare won't pay for it	Trauma support group
Access to care	Use of trauma informed parenting (SFS)
Treatment options for parents	Expanded use of treatment court
80% of kids taken out of home due to parents using meth	Expand mental health screening
Programming in jails	Reduce stigma
Parent education in treatment court	Expand kinship program (parents too? Sponsor)
Education on mental health (coping skills, resilience, types of therapy	Community approach +coach/building empathy
Trauma or neglect	Education on emotional identifiers
Learned behaviors passed on for generations	Friends program (teaching listening skills/reflection practice)
Rural; people feel isolated	Parent University at schools (first school Unity in November 6 2021)
	Events that aren't alcohol based
	Increase telemedicine opportunities (need reliable internet)
	Educate mental health providers on socioeconomic struggles

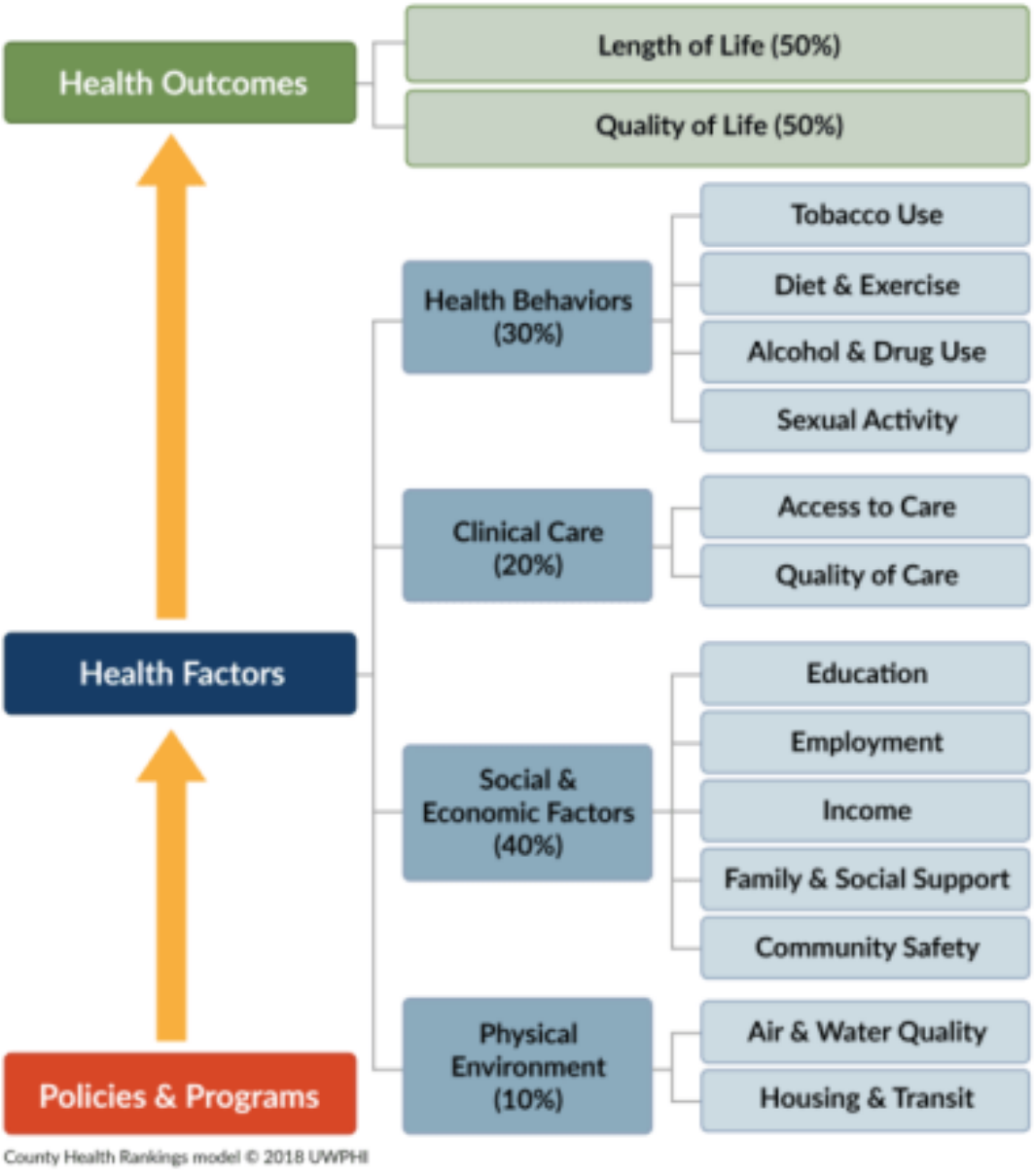
Other contributing factors and/or ideas:

- Affordable Housing
  - Close to being homeless
  - Leaving abusive relationship (safety)
  - Homeless shelters
  - What to do with pets
  - Rent assistance
  - Short notice eviction
  - Provide smoke and carbon monoxide detectors
- MCRC – physical abuse exams only in St. Paul
- Forensic sexual abuse interviews
- Dental services
- Dental clinics not accepting Badgercare
- Internet access
- Childcare (2nd shift, assistance, safe); "Child Cares" system (daycare reimbursement through state)
- Licensed daycare centers; within all school systems; attached to clinic
- Conception Planning
- Rushed at clinic visits
- Classes/groups/support for new moms
- Vision/hearing screenings
- Grandparents raising kids
- Connecting all pieces for families
- Height/weight/hemoglobin/lead
- Diaper Bank - operation help for St. Croix
- Coordination of volunteers (centralize)
- Job training assistance and placement
- Electricity shut off in April due to not paying their bill over winter months (education on budgeting; get them on budget plan with Propane/electricity vouchers
- Poor hygiene - lack of laundry access/more laundromats, access to free laundry; through school systems?
- running water/hot water
- increase on-site home visits to assess needs
- Home loan programs
- Habitat for Humanity
- Lack of OB providers in rural areas/hire antepartum provider

Also mentioned at this event was the goal of a future Community Pathways HUB. A brief update was provided explaining that a Community Pathways HUB decreases the duplication of care coordination and provides incentives to focus on high-risk individuals to ensure that all risk factors are identified through a CHW. The heightened level of accountability has been shown to lead to improved outcomes and reduced costs. Centralized tracking and data collection methods help target collaborative population health improvement efforts.

a. SECONDARY DATA

Secondary data references data collected by someone else earlier, whereas primary data refers to data gathered firsthand by the researcher(s). To ensure important data points were not missed in primary data collection, it was important to obtain and review data from other sources to make sure we were seeing the overall view of health. The County Health Ranking Model was the framework used as a guide in the secondary data collection and review process.



Health outcomes are influenced by the many factors that influence health, from the quality of medical care received to the availability of good jobs, clean water, and affordable housing. These health factors are then influenced by programs and policies in place at the local, state, and federal levels. There are significant differences in health outcomes according to where we live, how much money we make, our race and ethnicity, and other characteristics.

There is no one factor that dictates the overall health of an individual or community. A combination of multiple modifiable factors, from clean air and water to stable and affordable housing, needs to be considered to ensure good community health for all.

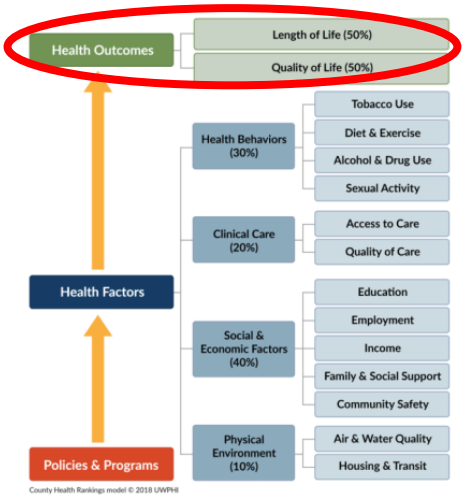
The County Health Rankings model illustrates the many factors that, if improved, can help make communities healthier places to live, learn, work, and play. Policies and programs at the local, state, and federal levels play an important role in influencing these factors. By implementing strategies that target the specific health challenges of a community, there is an opportunity to influence how long and how well people live.

There is a wide range of policies, programs, systems, and environmental changes that can make a difference locally. Some interventions target individual behaviors, such as influencing dietary choices, exercise levels, or alcohol consumption. Other strategies tackle systems and structures, such as enhancing opportunities for education, stimulating economic development, and increasing neighborhood safety.

No single strategy will ensure that everyone in the community can be healthier, and many policies and practices in the past have marginalized groups of residents, such as people of color, keeping them from the resources and support necessary to thrive. Our collective health and well-being depend on building opportunities for everyone (County Health Rankings, 2021).

HEALTH OUTCOMES

Health Outcomes represent how healthy a county is right now. They reflect the physical and mental well-being of residents within a community through measures representing not only the length of life but quality of life as well *(County Health Rankings, 2021).*



	Chisago (Out of 87 counties in MN)	Polk (Out of 72 counties in WI)	Burnett (Out of 72 counties in WI)
Overall Ranking in Health Outcomes	#24	#39	#58

County Health Rankings, 2021

HEALTH OUTCOMES > **Length of Life**

Measuring how long people in a community live tells us whether people are dying too early, and it prompts us to look at what is driving premature deaths *(County Health Rankings, 2021*).

	Chisago	Polk	Burnett	
Premature death	4,800	6,800	8,700	Years of potential life lost before age 75 per 100,000 population (age-adjusted).
COVID-19 age adjusted mortality	38	44	87	All deaths occurring between January 1,2020 and December 31,2020 due to COVID-19 per 100,000 population (age adjusted).
Life expectancy	80.1	78.8	78.9	Average number of years a person can expect to live.
Premature age-adjusted mortality	260	330	400	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).
Child mortality	30	60	Not available	Number of deaths among residents under age 18 per 100,000 population.

County Health Rankings, 2021; National Center for Health Statistics – Mortality Files, 2018-2020.

HEALTH OUTCOMES > **Quality of Life**

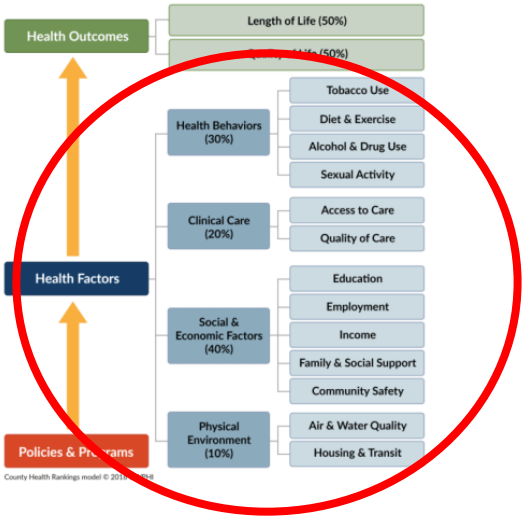
Quality of Life refers to how healthy people feel while alive. It represents the well-being of a community, and underscores the importance of physical, mental, social, and emotional health from birth to adulthood *(County Health Rankings, 2021*).

	Chisago	Polk	Burnett	
Poor or fair health	14%	14%	16%	Percentage of adults reporting fair or poor health (age-adjusted).
Poor physical health days	3.2	3.6	3.9	Average number of physically unhealthy days reported in past 30 days (age-adjusted).
Poor mental health days	4.0	4.5	4.6	Average number of mentally unhealthy days reported in past 30 days (age-adjusted)
Low birthweight	7%	6%	5%	Percentage of live births with low birthweight (< 2,500 grams).
Frequent physical distress	10%	11%	12%	Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted).
Frequent mental distress	13%	14%	15%	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted).
Diabetes prevalence	8%	8%	9%	Percentage of adults aged 20 and above with diagnosed diabetes (age-adjusted).
HIV prevalence	44	19	44	Number of people aged 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population.

County Health Rankings, 2021; Behavioral Risk Factor Surveillance System, 2019; National Center for Health Statistics – Natality files, 2014-2020; United States Diabetes Surveillance System, 2017; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2019.

HEALTH FACTORS

There are many things that influence how well and how long we live. Everything from our education to our environment impacts our health. Health factors represent those things we can modify to improve the length and quality of life for residents. They are predictors of how healthy our communities can be in the future *(County Health Rankings, 2021)*.



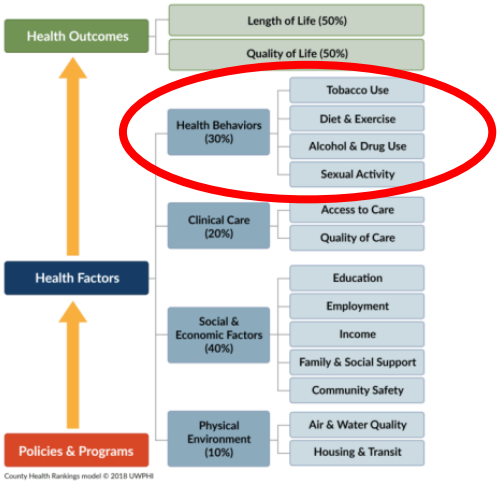
	Chisago (out of 87 counties in MN)	Polk (out of 72 counties in WI)	Burnett (out of 72 counties in WI)
Overall Ranking in Health Factors	#25	#37	#62

HEALTH FACTORS > **HEALTH BEHAVIORS**

Health behaviors are actions individuals take that affect their health. They include actions that lead to improved health, such as eating well and being physically active, and actions that increase one's risk of disease, such as smoking, excessive alcohol intake, and risky sexual behavior.

In the United States, many of the leading causes of death and disease are attributed to unhealthy behaviors. For example, poor nutrition and low levels of physical activity are associated with higher risk of cardiovascular disease, type 2 diabetes, and obesity. Tobacco use is associated with heart disease, cancer, and poor pregnancy outcomes if the mother smokes during pregnancy. Excessive alcohol use is associated with injuries, certain types of cancers, and cirrhosis.

It is important to consider that not everyone has the means and opportunity to make healthy decisions. Policies and programs put in place have marginalized some population groups and communities, keeping them from the support and resources necessary to thrive. Addressing health behaviors requires strategies to encourage individuals to engage in healthy behaviors, as well as ensuring that they can access nutritious food, safe spaces to be physically active, and supports to make healthy choices *(County Health Rankings, 2021)*.



HEALTH FACTORS > HEALTH BEHAVIORS > **Tobacco Use**

Tobacco use is the leading cause of preventable death in the United States. (The term "tobacco" in this context refers to commercial tobacco and not ceremonial or traditional tobacco.)

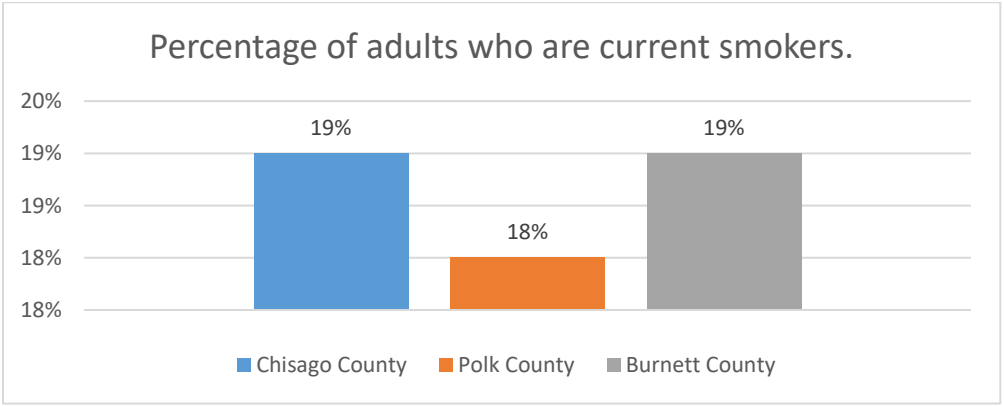
Why is this important?

Each year, smoking kills 480,000 Americans, including about 41,000 from exposure to secondhand smoke. **Smoking causes cancer, heart disease, stroke, lung diseases, diabetes and chronic obstructive pulmonary disease**, which includes emphysema and chronic bronchitis. Tobacco use also costs the nation about **$170 billion annually to treat tobacco-related illnesses, and another $156 billion in productivity losses**. On average, smokers die 10 years earlier than non-smokers.

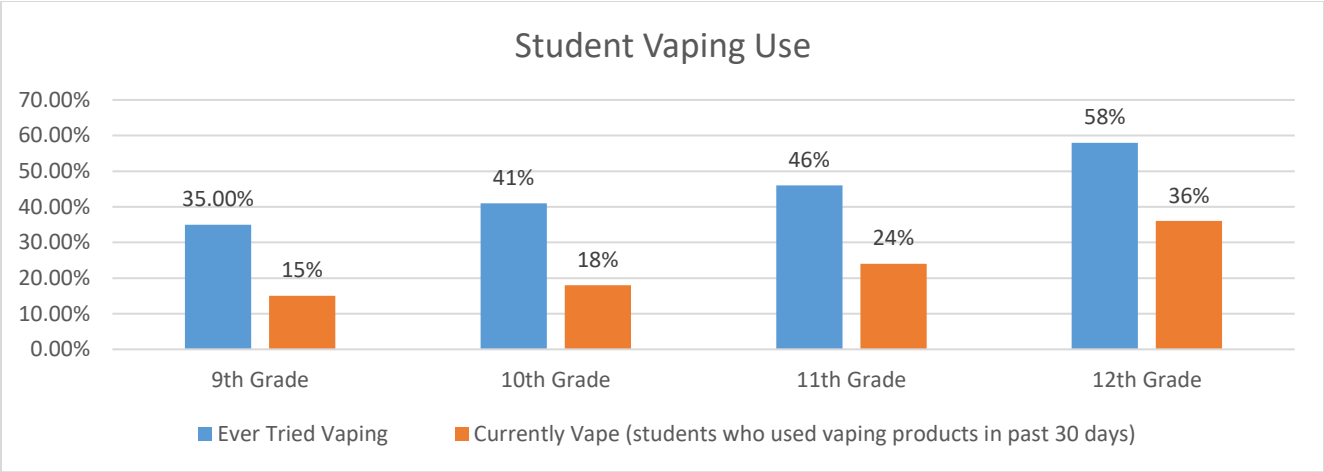
Tobacco is not only smoked. Smokeless tobacco, while less lethal, can lead to various cancers, gum and teeth problems, and nicotine addiction. Almost 6% of young adults use smokeless tobacco and half of new users are younger than 18.

About 18% of American adults smoke. **Each day, nearly 3,200 youth smoke their first cigarette and 2,100 transition from occasional to daily smokers**.

County Health Rankings, 2021; Centers for Disease Control and Prevention. Smoking & tobacco use. Last reviewed February 6, 2019. Accessed March 12, 2019; American Cancer Society. Smokeless tobacco. Last reviewed November 13, 2015. Accessed February 28, 2018; Robert Wood Johnson Foundation. Fifty years after first surgeon general's report on smoking and health, tobacco advocacy groups pledge to "end the tobacco epidemic for good." NewPublicHealth blog. January 8, 2014. Accessed March 3, 2014.



Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019



Centers for Disease Control and Prevention, Youth Risk Behavior Survey – Polk County, 2019

HEALTH FACTORS > HEALTH BEHAVIORS > **Diet and Exercise**

Balanced nutrition and physical activity are essential for health, yet only about one-third of adults engage in the recommended amount of weekly physical activity. Many American diets exceed calorie recommendations while being insufficient in servings of fruits and vegetables. Poor nutrition can hinder growth and development, while excessive calorie consumption can lead to obesity, especially when paired with too little physical activity. Inadequate physical activity also contributes to increased risk of conditions such as coronary heart disease, diabetes and some cancers.

Why is this important?

Some 30 million Americans live in a food desert, without access to affordable, healthy food. **Poor diet can lead to both malnutrition and obesity, which is one of the biggest drivers of preventable chronic diseases**. Being overweight or obese increases the risk for many health conditions, including type 2 diabetes, heart disease, stroke, hypertension, dementia, kidney disease and respiratory problems. Adults with more balanced diets are shown to have better mental and physical health outcomes, with recent studies finding similar trends in adolescent mental health.

When performed **routinely, exercise has been shown to lower symptoms of depression, reduce risk of chronic disease and premature death, and delay age-related cognitive decline.** However, nearly 73% of high school students in the U.S. do not meet the CDC's recommended physical activity levels.

Current estimates for obesity-related health-care costs in the U.S. range from **$147 billion to nearly $210 billion annually, and productivity losses due to obesity-related job absenteeism cost an additional $4 billion**. Inadequate physical activity results in $117 million in health-care costs.

Statistics show that 19.6% of people 20 and older said that outside of work hours, they did not participate in any physical activities or exercise such as running, calisthenics, golf, gardening or walking.

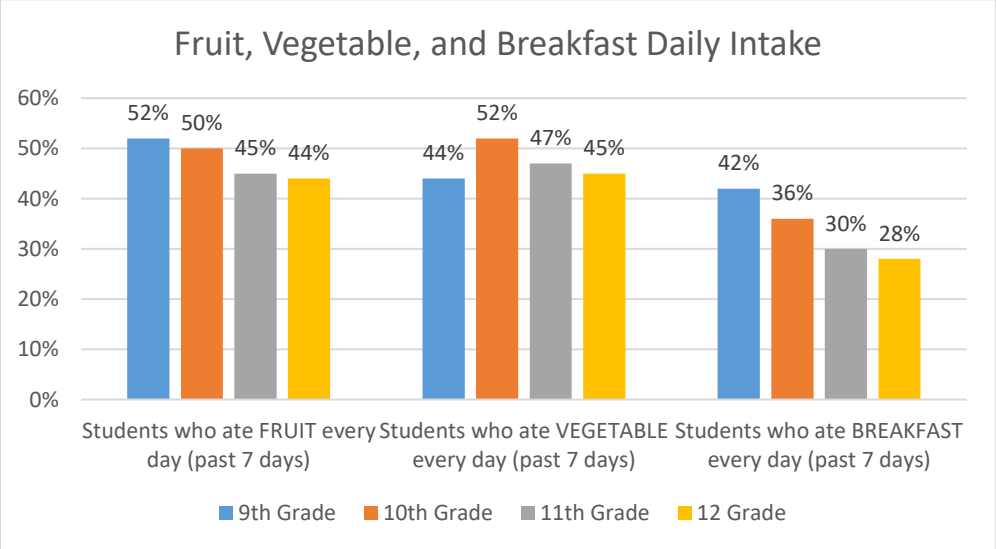
County Health Rankings, 2021; US Department of Health and Human Services. Facts & Statistics. Last reviewed January 26, 2017. https://www.hhs.gov/fitness/resource-center/facts-and-statistics/index.html; CDC. Physical Activity Facts. Last reviewed April 9, 2018. Accessed March 13, 2019; Stanton R, Reaburn P. Exercise and the treatment of depression: a review of the exercise program variables. J Sci Med Sport. 2014;17(2):177–182. doi:10.1016/j.jsams.2013.03.010; Deslandes A, Moraes H, Ferreira C, et al. Exercise and mental health: many reasons to move. Neuropsychobiology. 2009;59(4):191–198. doi:10.1159/000223730; CDC. Physical Activity Builds a Healthy and Strong America. Accessed January

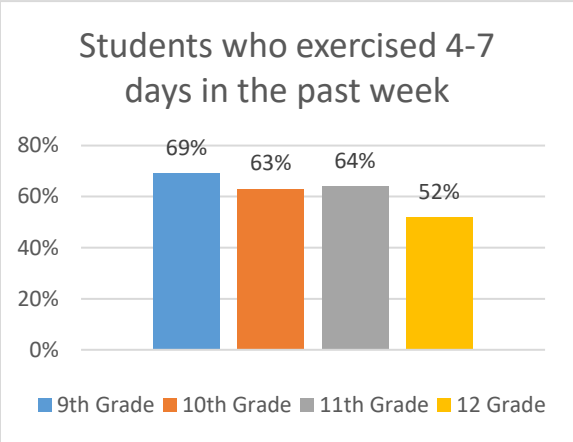
27, 2020; Christopher G, Harris CM, Spencer T, et al. F as in fat: How obesity threatens America's future. Washington, DC: Trust for America's Health (TFAH); 2013; O'Neil A, Quirk SE, Housden S, et al. Relationship between diet and mental health in children and adolescents: a systematic review. Am J Public Health. 2014;104(10):e31–e42. doi:10.2105/AJPH.2014.302110.

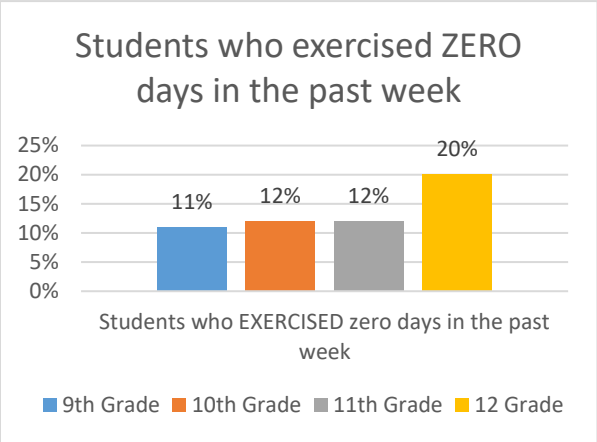
	Chisago	Polk	Burnett	
Adult obesity	33%	35%	36%	Percentage of the adult population (age 18 and older) that report a body mass index (BMI) greater than or equal to 30 kg/m^2 (age-adjusted).
Food environment index	9.1	8.9	8.3	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).
Physical inactivity	21%	23%	24%	Percentage of adults age 18 and over reporting no leisure-time physical activity (age-adjusted).
Access to exercise opportunities	60%	54%	58%	Percentage of population with adequate access to locations for physical activity.
Food insecurity	6% *(3,560)*	9%	11%	Percentage of population who lack adequate access to food.
Limited access to health foods	5%	2%	3%	Percentage of population who are low-income and do not live close to a grocery store.

County Health Rankings, 2021; Behavioral Risk Factor Surveillance System, 2018; USDA Food Environment Atlas, Map the Meal Gap from Feeding America, 2019; Business Analyst, ESRI, YMCA & US Census Tigerline Files, 2010 & 2021; Gundersen, C., Strayer, M., Dewey, A., Hake, M., & Engelhard, E. (2021). Map the Meal Gap 2021: An Analysis of County and Congressional District Food Insecurity and County Food Cost in the United States in 2019. Feeding America.

Less than 45% of students are getting enough exercise, eating enough fruits and vegetables, and eating breakfast everyday *(Youth Risk Behavior Survey, 2019*).







Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance – Polk County, 2019

Percent change in fast food restaurants from 2011 – 2016
Chisago County: 8% increase (25 to 27)
Polk County: -10.71% decrease (28 to 25)
Burnett County: 50% increase (2 to 3)
USDA Food Environment Atlas (2011-2016 % change).

HEALTH FACTORS > HEALTH BEHAVIORS > **Alcohol and Drug Use**

When consumed in excess, alcohol is harmful to the health and well-being of those that drink as well as their families, friends, and communities. Prescription drug misuse and illicit drug use also have substantial health, economic, and social consequences. Excessive alcohol use causes 88,000 deaths in the U.S. each year. More than 46 people died every day from drug overdoses involving prescription opioids in 2016.

Why is this important?
In 2015, **27% of people ages 18 and older reported binge drinking in the past month**, while 7% reported heavy alcohol use. Over time, excessive alcohol consumption is a risk factor for high blood pressure, heart disease, fetal alcohol syndrome, liver disease and certain cancers. In the short-term, excessive drinking is also linked to alcohol poisoning, intimate partner violence, risky sexual behaviors, and motor vehicle crashes. Alcohol-impaired crashes accounted for nearly one-third of all traffic-related deaths in 2016—more than 10,000 fatalities.

From 1999 to 2017, **overdose deaths from prescription painkillers increased fivefold, with 218,000 deaths from overdoses related to prescription opioids** during this time. Prescription drug misuse now accounts for more than 35% of opioid drug overdose deaths. Since 2002, rates of use for cocaine and hallucinogens have either declined or remained steady, while rates of marijuana and heroin use have increased. As of 2018, more teens smoke marijuana than cigarettes and tens of thousands of people reported starting to use heroin. Marijuana, now legal in some states, is the most frequently used illicit drug. Teenagers account for over half of all new illicit drug users.

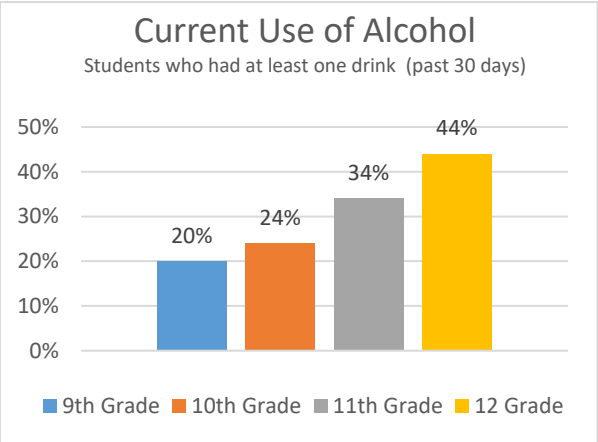
Alcohol and drug use have significant economic costs. Excessive **alcohol use costs $249 billion in lost productivity, health care, and criminal justice expenses** each year, whereas **illicit drug use costs $193 billion** related to crime, health care, and lost productivity.

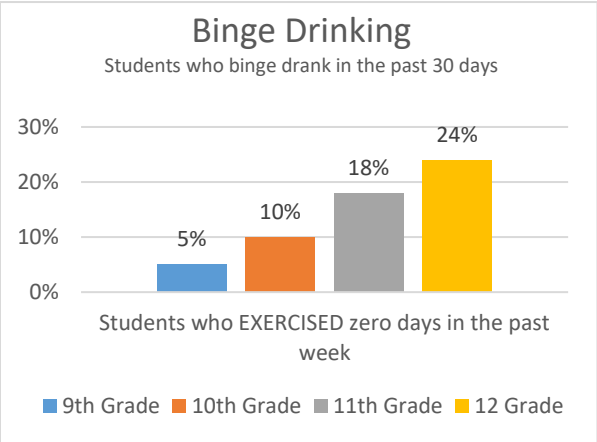
County Health Rankings, 2021; Mayo Clinic. Alcohol use: If you drink, keep it moderate. Last reviewed August 30, 2016. Accessed March 5, 2018; National Center for Chronic Disease Prevention and Health Promotion. Excessive alcohol use: preventing a leading risk for death, chronic disease, and injury. Atlanta: CDC; 2015; CDC. Prescription Drug Overdose Data Last reviewed December 19, 2019. Accessed March 13, 2019; National Institute on Alcohol Abuse and Alcoholism. Alcohol Facts and Statistics. Last reviewed June 2017. Accessed February 21, 2018; CDC. Fact Sheets – Alcohol Use and Your Health. Last reviewed January 3, 2018. Accessed March 13, 2019; Dept of Transportation (US), National Highway Traffic Safety Administration (NHTSA). Traffic Safety Facts 2016: Alcohol-Impaired Driving. Washington (DC): NHTSA; January, 2018; National Institutes of Health, National Institute on Drug Abuse. DrugFacts: Nationwide trends. Last reviewed June 2015. Accessed March 13, 2019; National Institute on Drug Abuse (NIDA). NIDA Research report series: Heroin. National Institute of Health; 2018. NIH Publication No. 14-0165; National Institutes of Health, National Institute on Drug Abuse. DrugFacts: High School and Youth Trends. Last reviewed December 2018. Accessed March 13, 2019; National Institutes of Health, National Institute on Drug Abuse. Trends and statistics: Costs of substance abuse. Last reviewed April 2017. Accessed March 13, 2019.

	Chisago	Polk	Burnett	
Excessive drinking	28%	26%	26%	Percentage of adults reporting binge or heavy drinking.
Alcohol-impaired driving deaths	24%	36%	56%	Percentage of driving deaths with alcohol involvement.
Drug overdose deaths	9	Not available	Not available	Number of drug poisoning deaths per 100,000 population.
Motor vehicle crash deaths	9	20	31	Number of motor vehicle crash deaths per 100,000 population.

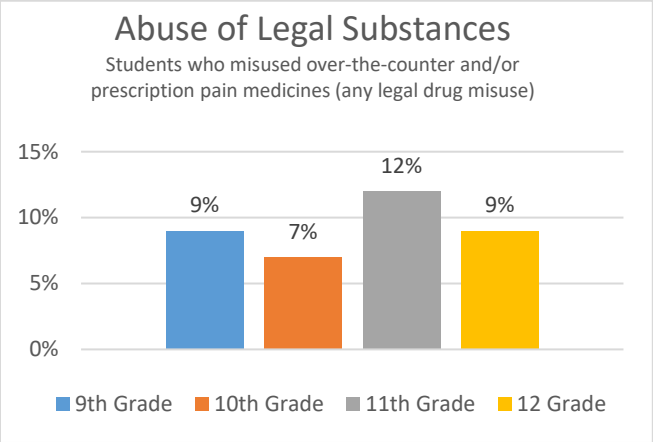
County Health Rankings, 2021; Behavioral Risk Factor Surveillance System, 2018; Fatality Analysis Reporting System, 2016-2020; National Center for Health Statistics – Mortality Files, 2018-2020; National Center for Health Statistics – Mortality Files, 2014-2020.

By the 12th grade, more than 44% of students are drinking regularly, and 24% are binge drinking *(Youth Risk Behavior Survey, 2019)*.

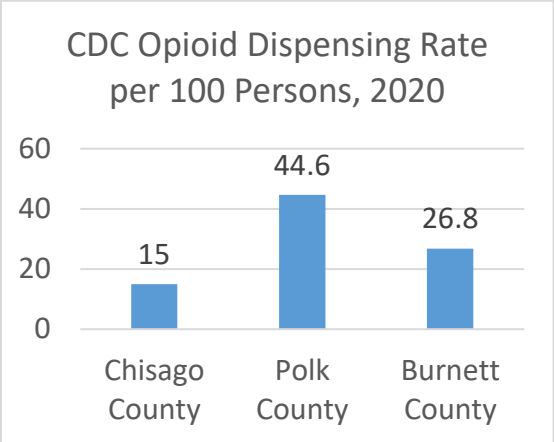




Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance – Polk County, 2019

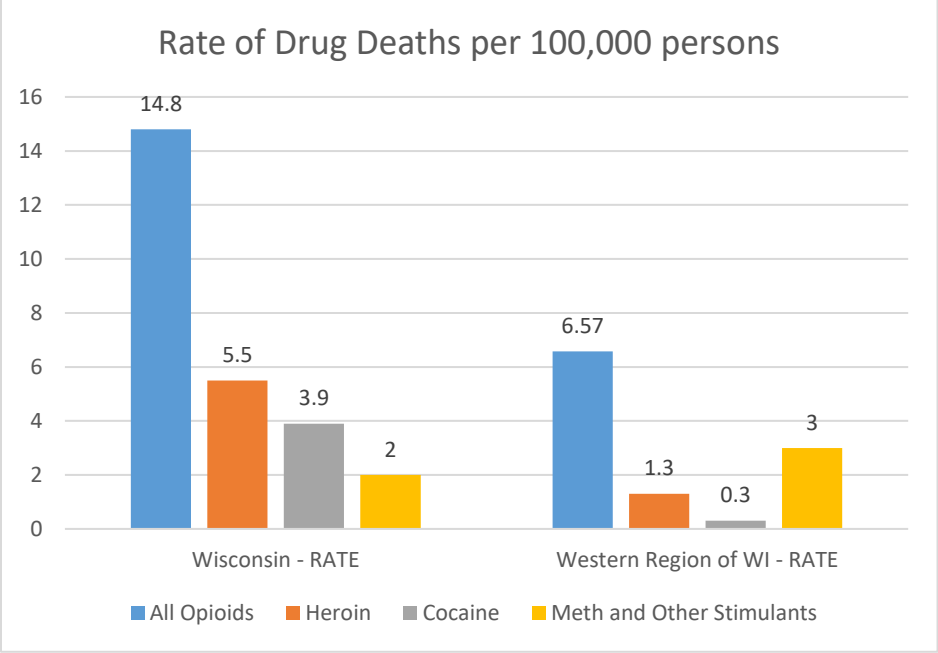


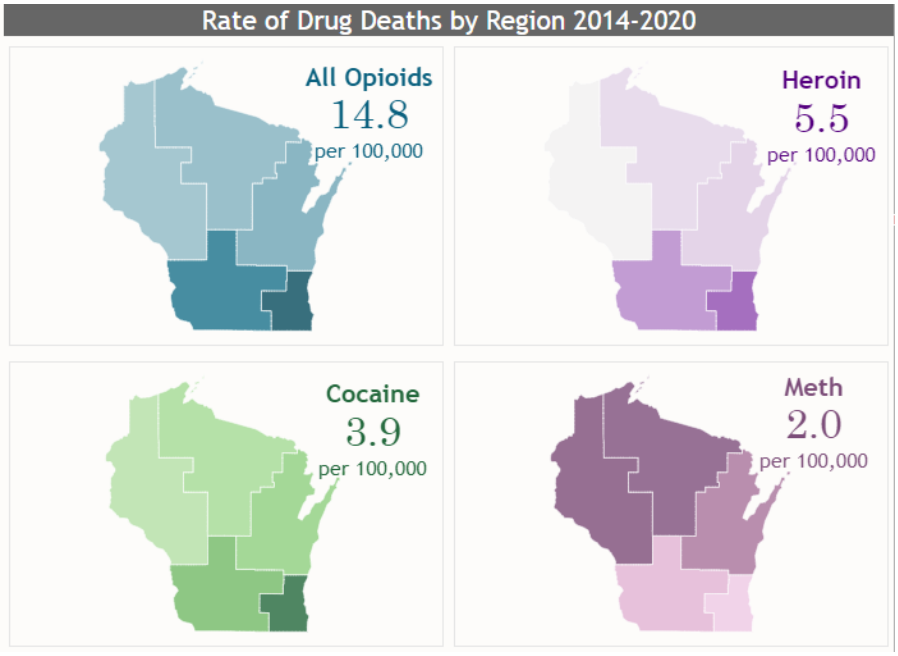
7% of students reported use of prescription painkillers without a doctor's prescription and 5% reported use of an over-the counter drug to get high. The chart above shows the percent of students who answered affirmatively to one or both of these questions.

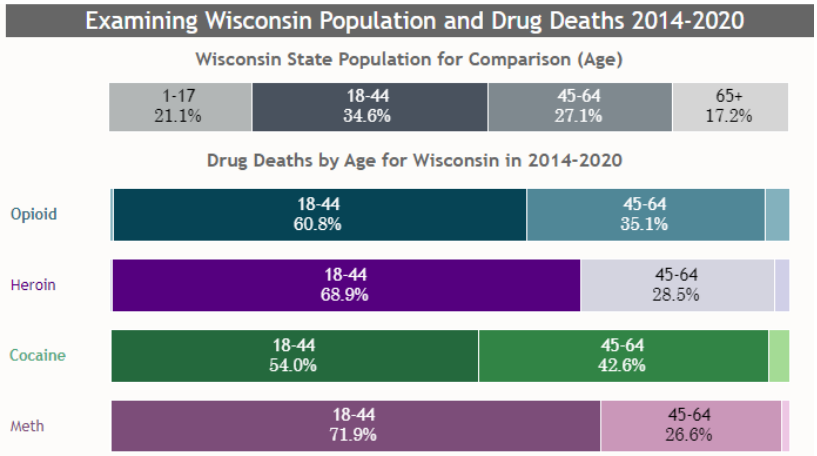


CDC US Opioid Dispensing Rates, 2020

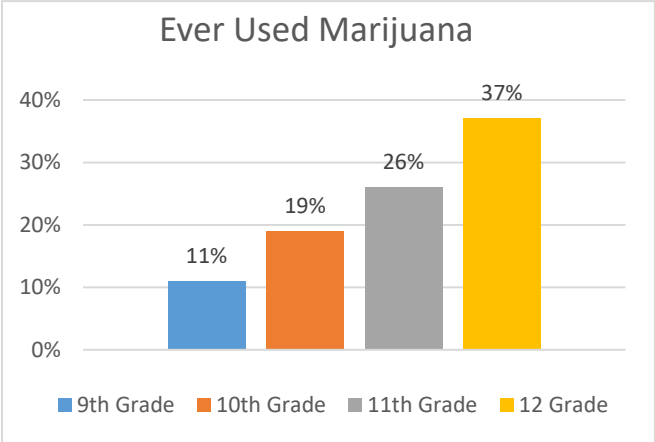
Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance – Polk County, 2019

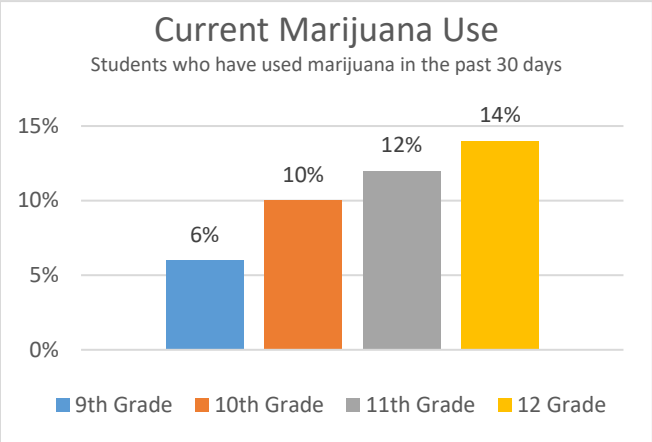






WI DHS Substance Use Drug Overdose Deaths Dashboard, 2014-2020





Centers for Disease Control and Prevention, Youth Risk Behavior Survey – Polk County, 2019

HEALTH FACTORS > HEALTH BEHAVIORS > **Sexual Activity**

High-risk sexual practices such as unsafe sex and higher numbers of lifetime sexual partners can lead to sexually transmitted infections and unplanned pregnancies, which can affect immediate and long-term health as well as the economic and social well-being of individuals, families, and communities.

Why is this important?

Recent data show **increasing rates of syphilis, gonorrhea, and chlamydia infections**. Young people, gay men, and bi-sexual men are at higher risk for STIs, which can have severe reproductive health complications, particularly for young women. Human papillomavirus (HPV) causes almost all cervical and anal cancers, as well as the majority of vaginal, vulvar, penile, and oropharyngeal cancers. Some STIs, such as HIV and herpes, cannot be cured.

There are about 3 million unintended pregnancies in the US each year. Rates are highest among poor, minority, young, and cohabiting women. Unintended pregnancy is associated with delayed prenatal care.

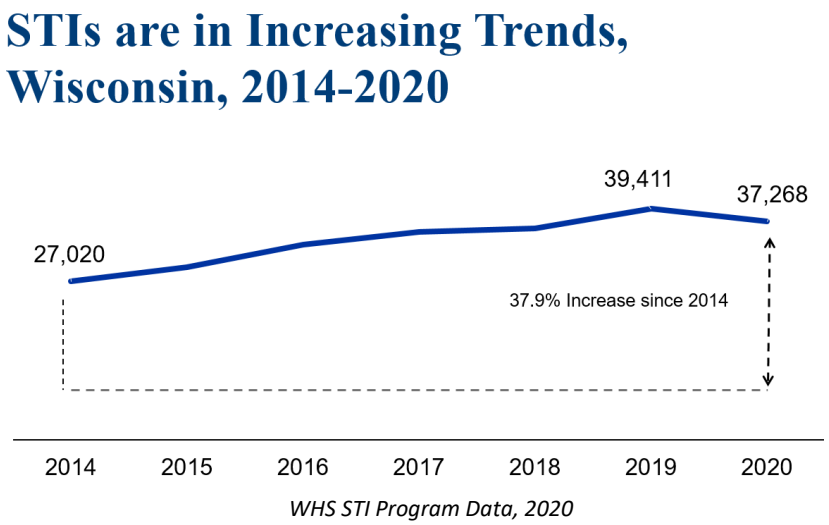
The teen pregnancy rate is falling, but there are still as many as 200,000 teen pregnancies annually. Pregnant teens are less likely than older women to receive recommended prenatal care and more likely to have pre-term or low birthweight babies. Teen mothers are also more often at increased risk for STIs and repeat pregnancies, are less likely than their peers to complete high school, and more likely to live below the poverty level and rely on public assistance.

Risky sexual behaviors can have high economic costs for communities and individuals. STIs cost the U.S. health-care system almost $16 billion every year and the costs of teens childbearing is also in the billions.

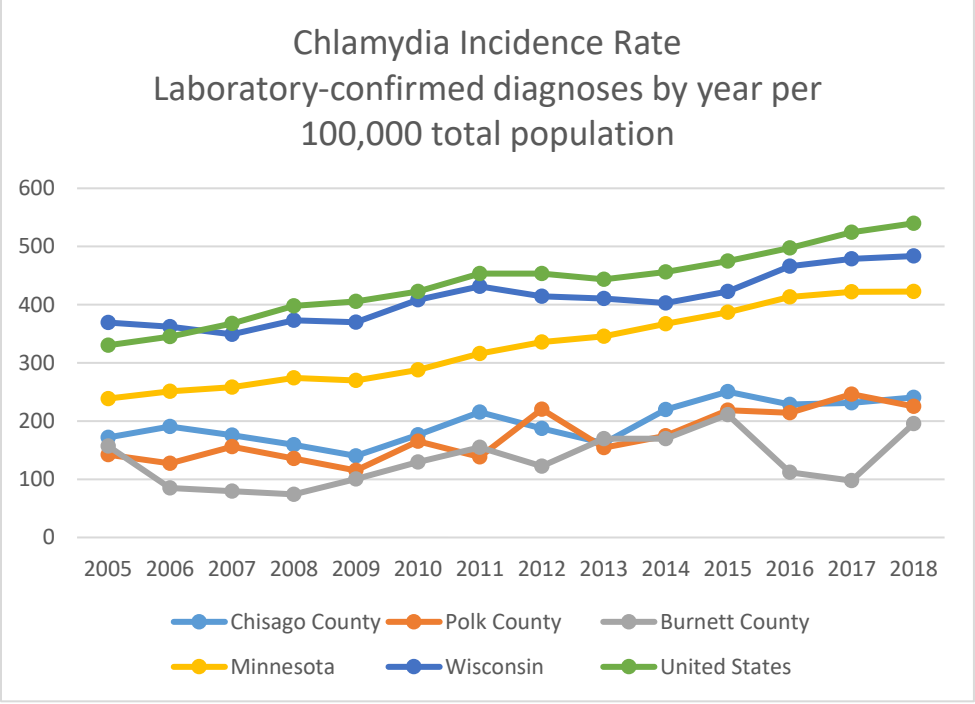
CommunityHealthRankings.org; CDC. 2017 Sexually Transmitted Disease Surveillance. Reported STDs in the United States, 2017. Last reviewed September 2018. Accessed March 14, 2019; National Cancer Institute. HPV and Cancer. Last reviewed March 1, 2019. Accessed March 14, 2019: Guttmacher Institute. Unintended pregnancy in the United States. New York: Guttmacher Institute; 2016; National Campaign to Prevent Teen and Unplanned Pregnancy. National & state data. 2017: Lee SH, Lee SM, Lim NG, et al. Differences in pregnancy outcomes, prenatal care utilization, and maternal complications between teenagers and adult women in Korea: A nationwide epidemiological study. Desapriya, E, ed. Medicine. 2016; Chandra PC, Schiavello HJ, Ravi B, Weinstein AG, Hook FB. Pregnancy outcomes in urban teenagers. Int J Gynaecol Obstet. 2002;79:117-122; Meade CS, Ickovics JR. Systematic review of sexual risk among pregnant and mothering teens in the USA: Pregnancy as an opportunity for integrated prevention of STD and repeat pregnancy. Soc Sci Med. 2005;60:661-678; National Campaign to Prevent Teen Pregnancy. Why it Matters: Teen childbearing, education, and economic well-being. July 2012.

	Chisago	Polk	Burnett	
Sexually transmitted infections	194.4	228.4	136.2	Number of newly diagnosed chlamydia cases per 100,000 population
Teen births	10	13	20	Number of births per 1,000 female population ages 15-19.

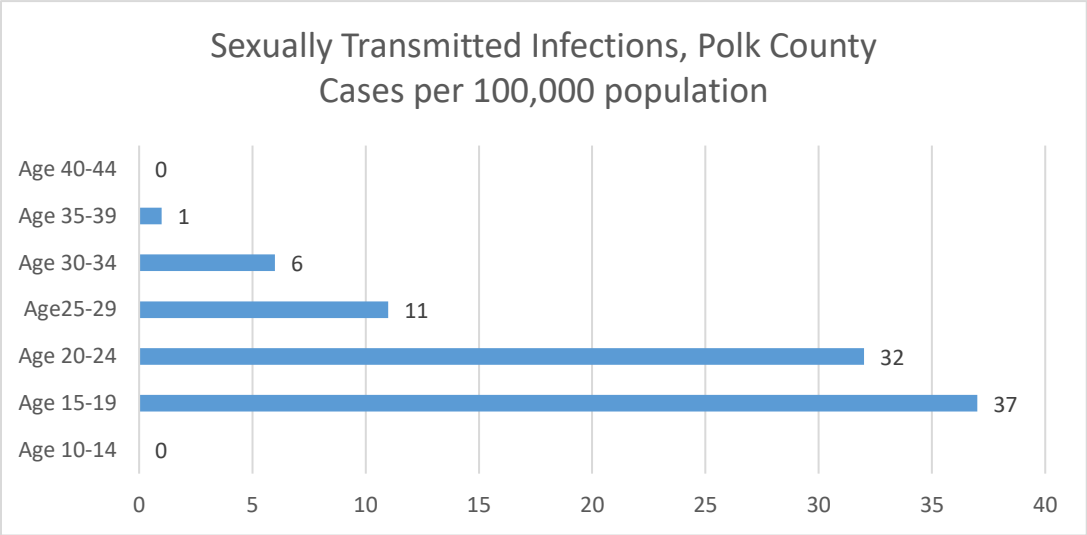
County Health Rankings, 2021; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2019; National Center for Health Statistics – Natality files, 2014-2020.



WHS STI Program Data, 2020

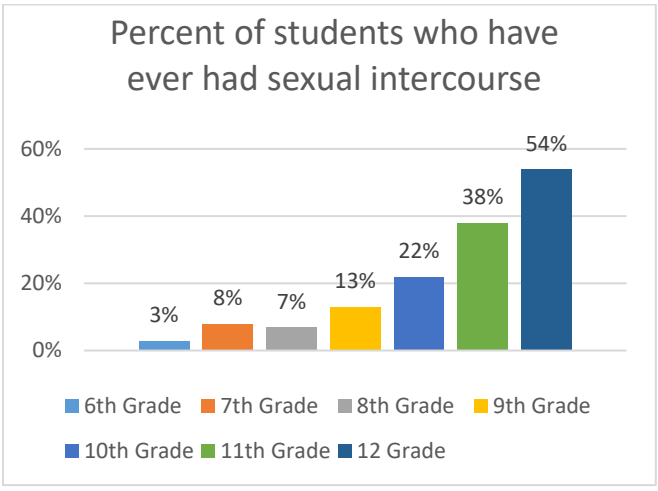


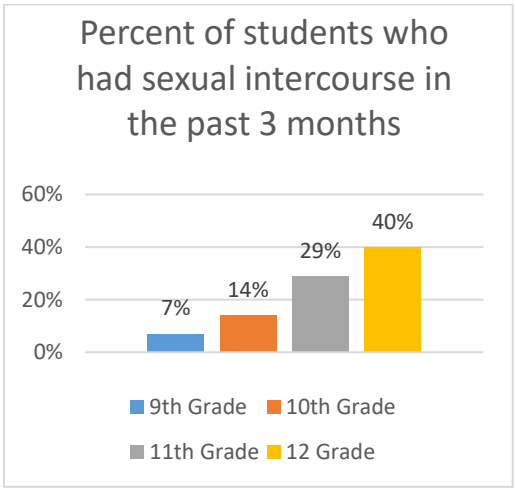
Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention; 2018.



Wisconsin Sexually Transmitted Infections Surveillance Report, Polk County, 2020.

A concerning trend is age 15-19. By grade 12, more than 50% of students have been sexually active. Educating young students is extremely important in reducing the STI incidence rate.





Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance – Polk County, 2019

Centers for Disease Control and Prevention, Youth Risk Behavior Survey – Polk County, 2019

HEALTH FACTORS > HEALTH BEHAVIORS > **Insufficient Sleep**

30.7% of adults age 18 and older who report usually getting insufficient sleep (<7 hours, on average, during a 24-hour period).

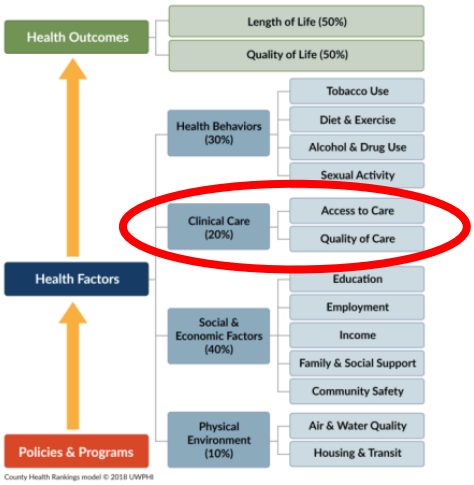
Centers for Disease Control and Prevention, Behavioral Risk Surveillance System, 2018.

HEALTH FACTORS > **CLINICAL CARE**

Access to affordable, quality, and timely health care can help prevent diseases and detect issues sooner, enabling individuals to live longer, healthier lives. While part of a larger context, looking at clinical care helps us understand why some communities can be healthier than others.

Advances in clinical care over the last century, including breakthroughs in vaccinations, surgical procedures like transplants and chemotherapy, and preventive screenings, have contributed significantly to increases in life expectancy. Care continues to evolve, with promising advances in fields like tele-health and care coordination leading to improved quality and availability.

Despite these advances, many individuals do not have access to a provider. Nearly 30 million Americans remain without health insurance, generally considered the first barrier to receiving quality health care. Others do not access health services because of high deductible costs, language barriers, distance to a provider, or lack of specialists in their geographic area or health network. Those without regular access to quality providers and care are often diagnosed at later, less treatable stages of a disease than those with insurance, and, overall, have worse health outcomes, lower quality of life, and higher mortality rates *(County Health Rankings, 2021)*.



HEALTH FACTORS > CLINICAL CARE > **Access to Care**

Access to affordable, quality health care is important to physical, social and mental health. Health insurance helps individuals and family's access and pay for needed primary care, specialists and emergency care, but does not ensure access on its own. It is also necessary for providers to offer affordable care, be available to treat patients and be in relatively close proximity to patients.

<u>Why is this important?</u>
Those without insurance are often diagnosed at later, less treatable disease stages, generally have worse health outcomes, have a lower quality of life, and have higher mortality rates. The **uninsured are much less likely to have primary care providers, and receive less preventive care**, dental care, chronic disease management, and behavioral health counseling.

Even with insurance, barriers remain, such as language barriers, distance to care, and racial disparities. Nationally, **many counties do not have enough providers to meet patient needs**. There are as many as 18,000 areas designated federally as "Health Professional Shortage Areas" because of a lack of primary care, mental health services, and dental health providers.

Having a primary care provider is associated with a higher likelihood of appropriate care and better health outcomes. Having a primary provider is also linked to higher incomes. Those with low incomes are less likely to have a primary provider, and the uninsured were twice as unlikely. Additionally, neighborhoods with low health insurance rates often have

fewer providers, hospital beds, and emergency resources than areas with higher rates. Even the insured have more difficulty getting care in these areas.

Costs are also a barrier to care even for those who have insurance. Health spending in the U.S. increased by 4.6% in 2019 to $3.8 trillion. By some accounts, **per capita out-of-pocket costs have risen to some $1,200 a person**.

County Health Rankings, 2021; Kaiser Commission on Medicaid and the Uninsured. Key facts about the uninsured population. Henry J. Kaiser Family Foundation; November 2017. Fact sheet; Serakos M, Wolfe B. The ACA: Impacts on Health, Access, and Employment. Forum Health Econ Policy. 2016;19(2):201–259; Clancy C, Munier W, Brady J, et al. 2012 National healthcare quality report. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ); 2013; Maina IW, Belton TD, Ginzberg S, Singh A, Johnson TJ. A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test. Soc Sci Med. 2018 Feb;199:219-229; Buzza, C., Ono, S.S., Turvey, C. et al. J GEN INTERN MED (2011) 26(Suppl 2): 648. https://doi.org/10.1007/s11606-011-1762-1; Steinberg EM, Valenzuela-Araujo D, Zickafoose JS, Kieffer E, DeCamp LR. The "Battle" of Managing Language Barriers in Health Care. Clin Pediatr (Phila). 2016 Dec;55(14):1318-1327; US Department of Health and Human Services. Health Resources and Services Administration (HRSA). Shortage Areas. Last reviewed September 30, 2018. Accessed March 14, 2019; Robert Wood Johnson Foundation (RWJF). What is the link between having health insurance and getting adequate health care? Princeton: Robert Wood Johnson Foundation (RWJF); August 2011. Health policy snapshot; American Medical Association; Statista.com.

	Chisago	Polk	Burnett	
Uninsured	4%	7%	9%	Percentage of population under age 65 without health insurance.
Primary care physicians	2,100:1	1,330:1	7,710:1	Ratio of population to primary care physicians.
Dentists	2,370:1	1,750:1	2,590:1	Ratio of population to dentists.
Mental health providers	680:1	520:1	710:1	Ratio of population to mental health providers.
Uninsured adults	5%	8%	10%	Percentage of adults under age 65 without health insurance
Uninsured children	3%	5%	6%	Percentage of children under age 19 without health insurance.
Other primary care providers	1,620:1	1,460:1	1,200:1	Ratio of population to primary care providers other than physicians.

County Health Rankings, 2021; Small Area Health Insurance Estimates, 2019; Area Health Resource File/American Medical Association, 2019; Area Health Resource File/National Provider Identification file, 2020; CMS, National Provider Identification, 2021.

HEALTH FACTORS > CLINICAL CARE > **Quality of Care**

High quality health care is timely, safe, effective and affordable – the right care for the right person at the right time. High quality care also involves efforts to improve quality, reduce errors, and involve patients in care decisions, all to improve health and reduce the likelihood of receiving unnecessary or inappropriate care.

Why is this important?

Despite efforts towards higher quality care, **as many as 30% of patients do not receive recommended preventive care or treatment**. Poor care coordination within and among facilities can lead to poor health outcomes and readmissions; about 20% of discharged elderly patients return to the hospital within 30 days. Nationally, hospital acquired infections kill some 100,000 Americans and between 44,000 and 98,000 Americans are estimated to die from medical errors each year.

Quality varies widely by state, race, ethnicity, and income. One study even found that women and minorities get lower quality care than their counterparts even when insurance status, income, and condition are considered.

Even with the highest per capita healthcare spending in the world, **the U.S. has shorter lifespans and higher infant mortality rates than other wealthy nations**. Costs of preventable hospitalizations and medical errors are both in the billions of dollars.

County Health Rankings, 2021; Cosgrove D, Fisher M, Gabow P, et al. A CEO checklist for high-value health care. Washington, DC: Institute of Medicine (IOM); June 2012; Clancy C, Munier W, Brady J, et al. 2012 National healthcare quality report. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ); 2013; Aligning Forces for Quality (AF4Q). Improving health care quality: Why you should get involved and how you can make a difference. Princeton: Robert Wood Johnson Foundation (RWJF); 2010; Robert Wood Johnson Foundation (RWJF). What we're learning: Clinicians are using data from public reports on their performance to improve care. Princeton: Robert Wood Johnson Foundation (RWJF); 2013. Quality Field Notes Issue Brief No 2.

	Chisago	Polk	Burnett	
Preventable hospital stays	2,102	3,110	3,476	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.
Mammography screening	45%	48%	45%	Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening.
Flu vaccinations	51%	29%	26%	Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination.
COVID-19 Fully Vaccinated Adults	Not available	59%	Not available	Continue to obtain data from the Vaccine Coverage Index. This is a score of how challenging vaccine rollout may be in some communities compared to others, with values ranging from 0 (least challenging) to 1 (most challenging).

County Health Rankings, 2021; Mapping Medicare Disparities Tool, 2019; Center for Disease Control and Prevention and the National Center for Health Statistics, CDC – GRASP, 2021.

HEALTH FACTORS > **SOCIAL AND ECONOMIC FACTORS**

Social and economic factors, such as income, education, employment, community safety, and social supports, can significantly affect how well and how long we live. These factors affect our ability to make healthy choices, afford medical care and housing, manage stress, and more.

The social and economic opportunities we have, such as good schools, stable jobs, and strong social networks, are foundational to achieving long and healthy lives. For example, employment provides income that shapes choices about housing, education, childcare, food, medical care, and more. In contrast, unemployment limits these choices and the ability to accumulate savings and assets that can help cushion in times of economic distress.

Social and economic factors are not commonly considered when it comes to health, yet strategies to improve these factors can have an even greater impact on health over time than those traditionally associated with health improvement, such as strategies to improve health behaviors.

Across the nation, there are meaningful differences in social and economic opportunities for residents in communities that have been cut off from investments or have experienced discrimination. These gaps disproportionately affect people of color, especially children and youth (County Health Rankings, 2021).

HEALTH FACTORS > SOCIAL AND ECONOMIC FACTORS > **Education**

Better educated individuals live longer and healthier lives than those with less education, and their children are more likely to thrive. This is true even when factors like income are considered.

Why is this important?

More schooling is linked to higher incomes, better employment options, and increased social supports that, together, support opportunities for healthier choices. Yet in 2017, about 10% of adults older than 24 had not graduated high school, and of those who did, 32% had no education beyond high school.

Higher levels of education also can lead to a greater sense of control over one's life, which is linked to better health, healthier lifestyle decisions, and fewer chronic conditions. Education is also connected to lifespan: on average, college graduates live nine more years than high school dropouts.

Researchers estimate that **each additional year of schooling leads to about 11% more income annually**. Higher paying jobs are more likely than lower paying jobs to provide workers with safe work environments, and offer benefits such as health insurance and sick leave. More educated workers also fare better in economic downturns.

Parental education is also linked to children's health and educational attainment. Children whose mothers graduated from college are twice as likely to live past their first birthday. Stress and poor health early in life, common among those whose parents have lower levels of education, are linked to decreased cognitive development, increased tobacco and drug use, and a higher risk of cardiovascular disease, diabetes, depression, and other conditions.

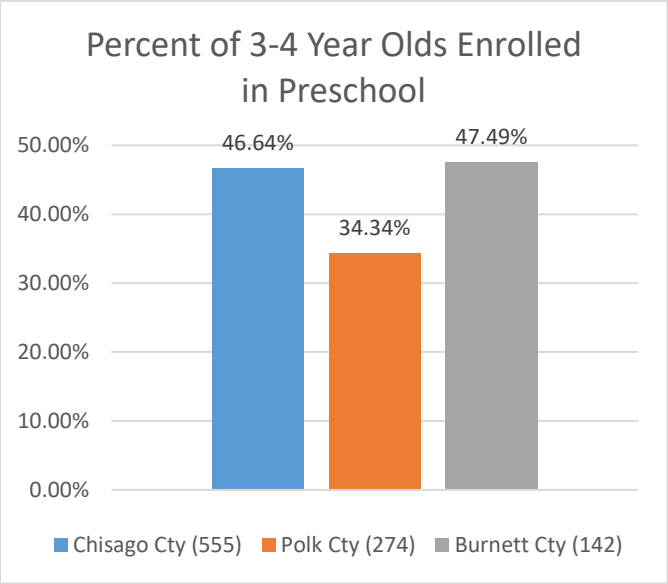
County Health Rankings, 2021; US Department of Commerce. Educational Attainment of the Population 18 Years and Over, by Age, Sex, Race, and Hispanic Origin: 2017. US Bureau of the Census; 2017; Organization for Economic Co-operation and Development (OECD). OECD Skills outlook 2013: First results from the survey of adult skills. Washington, DC: OECD Publishing; 2013; Egerter S, Braveman P, Sadegh-Nobari T, Grossman-Kahn R, Dekker M. Education and health. Princeton: Robert Wood Johnson Foundation (RWJF); 2011. Exploring the Social Determinants of Health Issue Brief No. 5; Center on Society and Health. Education: It matters more to health than ever before. Richmond: Center on Society and Health, Virginia Commonwealth University (VCU); 2014.

	Chisago	Polk	Burnett	
High school completion	95%	94%	93%	Percentage of adults ages 25 and over with a high school diploma or equivalent.
Some college	66%	65%	62%	Percentage of adults ages 25-44 with some post-secondary education.
High school graduation	87%	96%	82%	Percentage of ninth-grade cohort that graduates in four years.
Disconnected youth	Not available	6%	Not available	Percentage of teens and young adults ages 16-19 who are neither working nor in school.
Reading scores	3.1	3.1	3.0	Average grade level performance for 3rd graders on English Language Arts standardized tests.
Math scores	3.3	3.2	3.0	Average grade level performance for 3rd graders on math standardized tests.
School segregation	.03	.06	.11	The extent to which students within different race and ethnicity groups are unevenly distributed across schools when compared with the racial and ethnic composition of the local population. The index ranges from 0 to 1 with lower values representing a school composition that approximates race and ethnicity distributions in the student populations within the county, and higher values representing more segregation.
School funding adequacy	$3,949	$3,028	$117	The average gap in dollars between actual and required spending per pupil among public school districts. Required spending is an estimate of dollars needed to achieve U.S. average test scores in each district.

County Health Rankings, 2021; American Community Survey, 5-year estimates, 2016-2020; EDFacts, 2018-2019; Stanford Education Data Archive, 2018; National Center for Education Statistics, 2020-2021; School Finance Indicators Database, 2019.

21.17% of the population aged 25 and older in the tri-county area, or 17,232, have obtained a bachelor's degree or higher.

US Census Bureau, American Community Survey, 2015-2019.

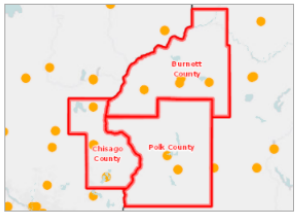


US Census Bureau, American Community Survey, 2015-2019.

Data Attributes

- Children Under Age 5
- Total Head Start Programs
- Head Start Programs, Rate (Per 10,000 Children)

Map



Head Start Facilities, All Facilities, ACF 2019

Head Start Facilities, All Facilities, ACF 2019
Report Location

View larger map

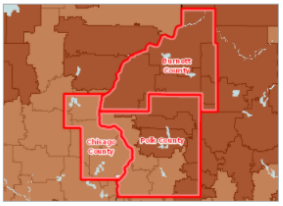
Data Source

US Department of Health & Human Services, HRSA - Administration for Children and Families. 2019.

Data Attributes

- Students with Valid Test Scores
- Students Scoring 'Proficient' or Better, Percent
- Students Scoring 'Not Proficient' or Worse, Percent

Map



Language Arts Test Scores, Grade 4, Percent Not Proficient by School District (Elementary), EDFacts 2017-18

Over 50.0%
30.1 - 50.0%
20.1 - 30.0%
Under 20.1%
No Data or Data Suppressed
Report Location

View larger map

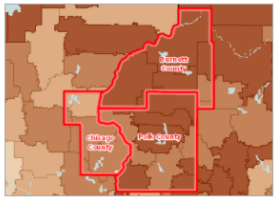
Data Source

US Department of Education, EDFacts. Additional data analysis by CARES. 2018-19.

Data Attributes

- Students with Valid Test Scores
- Students Scoring 'Proficient' or Better, Percent
- Students Scoring 'Not Proficient' or Worse, Percent

Map



Math Test Scores, Grade 4, Percent Not Proficient by School District (Elementary), EDFacts 2017-18

Over 50.0%
30.1 - 50.0%
20.1 - 30.0%
Under 20.1%
No Data or Data Suppressed
Report Location

View larger map

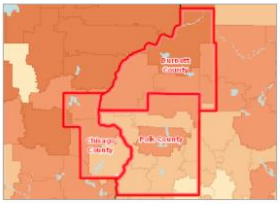
Data Source

US Department of Education, EDFacts. Additional data analysis by CARES. 2018-19.

Data Attributes

- Student Cohort
- Number Chronically Absent
- Chronic Absence Rate

Map



Chronic Absenteeism, Children Enrolled in Public Schools, Rate by School District, CRDC 2017-18

- Over 20.0%
- 12.1 - 20.0%
- 6.1 - 12.0%
- Under 6.1%
- No Data or Data Suppressed
- Report Location

View larger map

Supplemental Data

- Chronic Absence Rate by Race / Ethnicity

Data Source

U.S. Department of Education, US Department of Education - Civil Rights Data Collection. 2017-18.

HEALTH FACTORS > SOCIAL AND ECONOMIC FACTORS > **Employment**

Employment provides income and often benefits that can support healthy lifestyle choices. Unemployment and under employment limit these choices and negatively affect both quality of life and overall health. The economic condition of both a community's and an individual's level of educational attainment play important roles in shaping employment opportunities (County Health Rankings, 2021).

Why is this important?

Most adults spend nearly half their waking hours at work. **Working in a safe environment with fair compensation often provides not only income but also benefits such as health insurance, paid sick leave, and workplace wellness programs** that, together, support opportunities for healthy choices.

These opportunities, however, are greater for higher-wage earners, usually those with more education. The estimated 10 million workers who are part of **the "working poor" face many challenges: they are less likely to have health insurance and access to preventive care**, and are more likely to work in hazardous jobs. Working poor parents may not be able to afford quality childcare and often lack paid leave to care for their families and themselves.

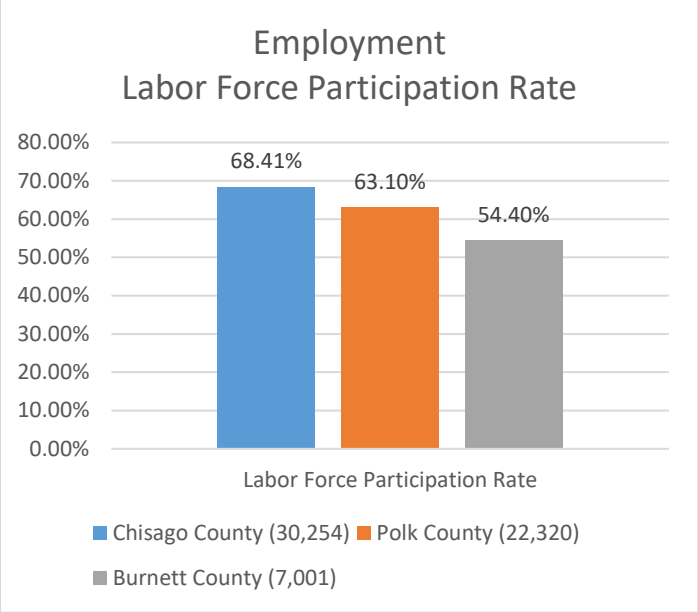
Those who are unemployed face even greater challenges, including lost income and often no health insurance. Unemployed individuals are 54% more likely to be in poor to fair health and are more likely to suffer from increased stress, high blood pressure, heart disease and depression.

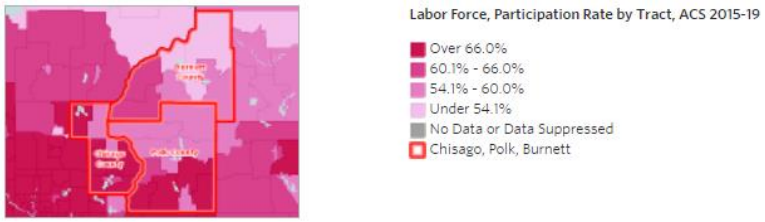
Some jobs pose risks to mental and physical health. Lack of control over working conditions and non-standard hours are associated with increased illness, injury and mortality. Thousands of fatal work-related injuries occur each year. Nonfatal work-related injuries number in the millions, and cost billions of dollars in lost income, workers compensation, and productivity.

County Health Rankings, 2021; An J, Braveman P, Dekker M, Egerter S, Grossman-Kahn R. Work, workplaces and health. Princeton: Robert Wood Johnson Foundation (RWJF); 2011. Exploring the Social Determinants of Health Issue Brief No. 4; Robert Wood Johnson Foundation. How does employment - or unemployment - affect health? Princeton; March 2013. Health Policy Snapshot Issue Brief. Accessed March 8, 2018.

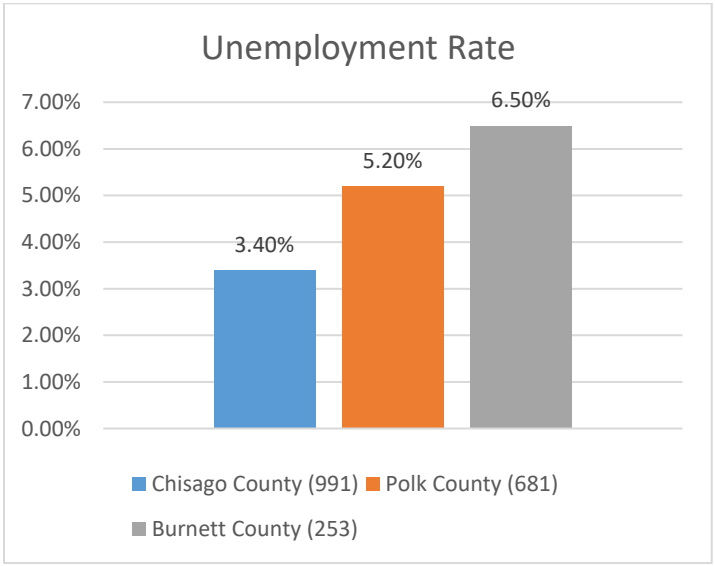
	Chisago	Polk	Burnett	
Unemployment	6.6%	7.2%	9.1%	Percentage of population age 16 and older unemployed but seeking work.

County Health Rankings, 2021; Bureau of Labor Statistics, 2020.

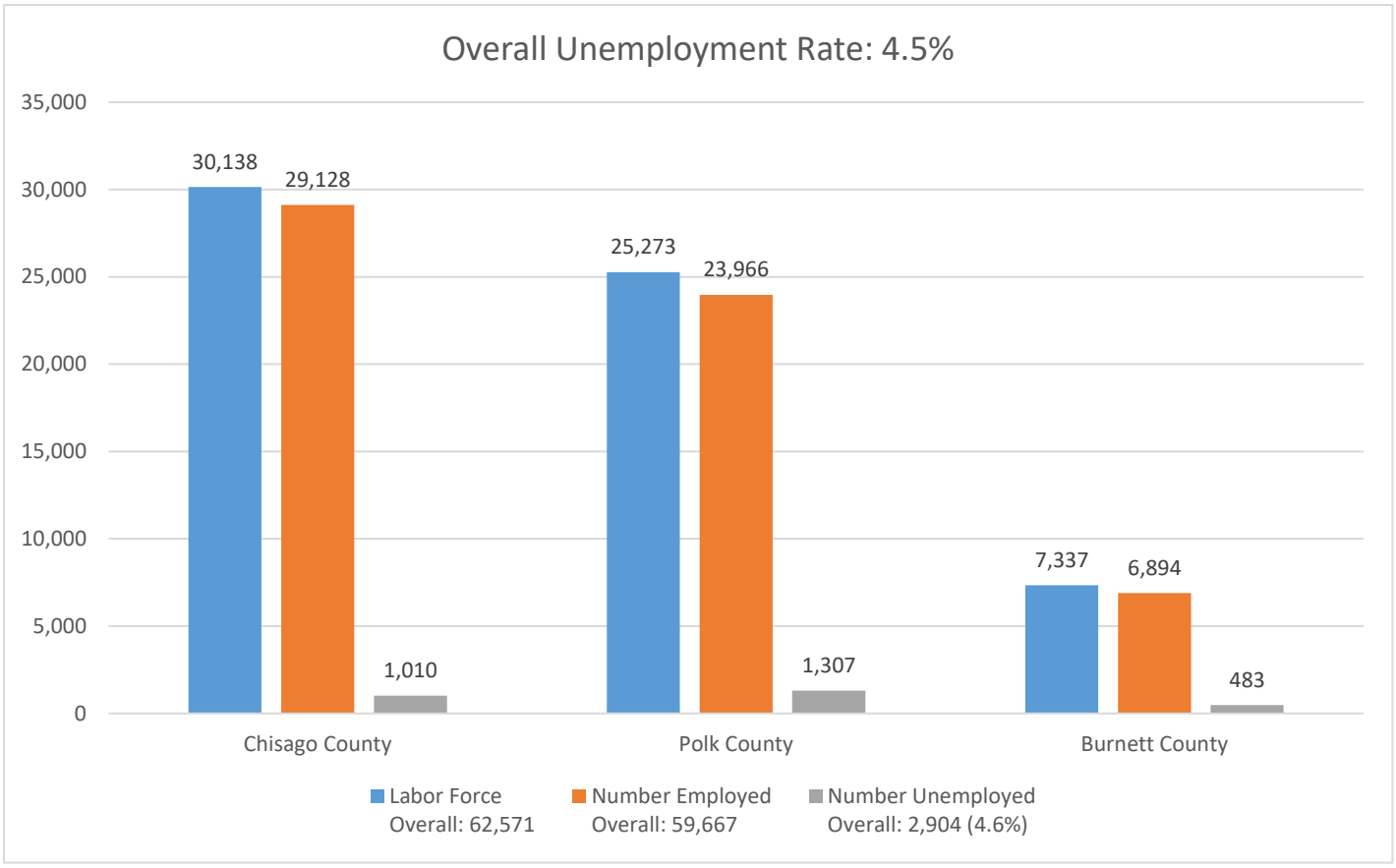




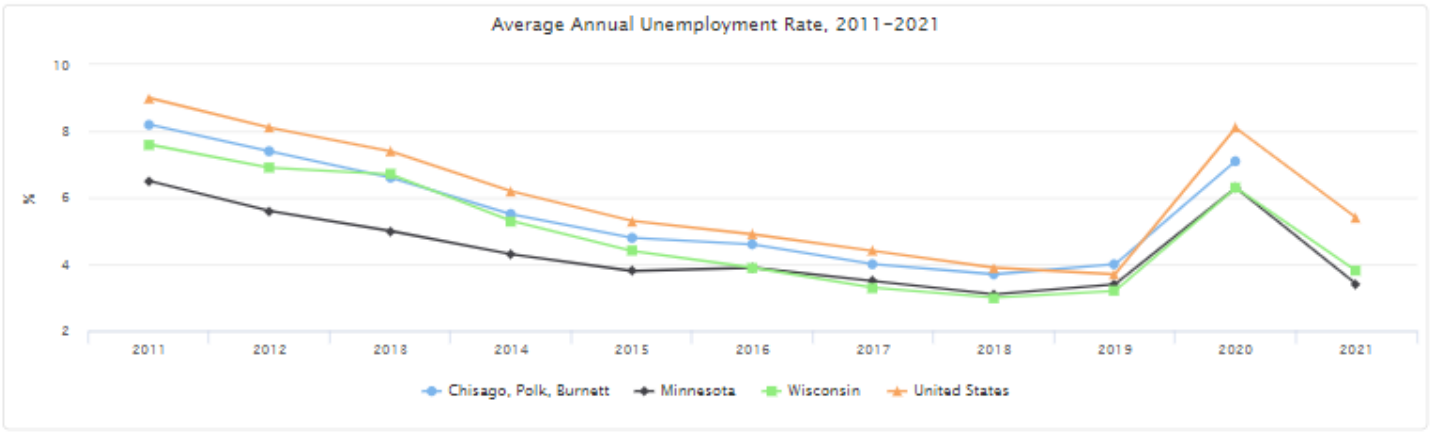
US Census Bureau, American Community Survey, 2015-2019

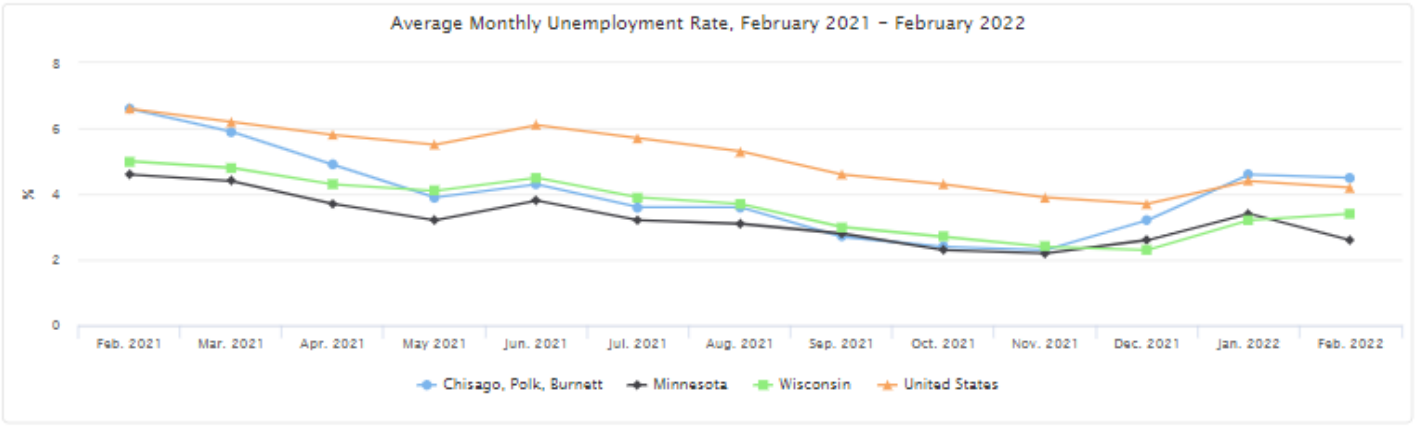


US Department of Labor, Bureau of Labor Statistics, 2022 – February.



US Department of Labor, Bureau of Labor Statistics, 2022 – February.




Average Monthly Unemployment Rate, February 2021 – February 2022
%
8
6
4
2
0
Feb. 2021
Mar. 2021
Apr. 2021
May 2021
Jun. 2021
Jul. 2021
Aug. 2021
Sep. 2021
Oct. 2021
Nov. 2021
Dec. 2021
Jan. 2022
Feb. 2022
Chisago, Polk, Burnett
Minnesota
Wisconsin
United States

HEALTH FACTORS > SOCIAL AND ECONOMIC FACTORS > **Income**

Income provides economic resources that shape choices about housing, education, childcare, food, medical care, and more. Wealth, the accumulation of savings and assets, helps cushion and protect us in times of economic distress. As income and wealth increase or decrease, so does health.

Why is this important?

Income can come from jobs, investments, government assistance programs, or retirement plans. **Income allows families and individuals to purchase health insurance and medical care and provides options for healthy lifestyle choices.** Poor families and individuals are most likely to live in unsafe homes and neighborhoods, often with limited access to healthy foods, employment options, and quality schools.

While the starkest difference in health is between those with the highest and lowest incomes, this relationship persists throughout all income brackets. Adults in the highest income brackets are healthier than those in the middle class and will live, on average, more than six years longer than those with the lowest incomes.

The ongoing stress and challenges associated with poverty can lead to cumulative health damage, both physically and mentally. Chronic illness is more likely to affect those with the lowest incomes, and children in low-income families are sicker than their high-income counterparts. Low-income mothers are more likely to have pre-term or low birthweight babies, who are then at higher risk for chronic diseases and behavioral problems.

Income inequality is a measure of the divide between the poor and the affluent. Income inequality in our communities affects how long and how well we live, and is particularly harmful to the health of poorer individuals. It can have broad health impacts, including increased risk of mortality, poor health and increased cardiovascular disease, and can accentuate differences in social class and status, creating social stressors. Loss of social connectedness, as well as decreases in trust, social support, and a sense of community for all residents, are also influenced.

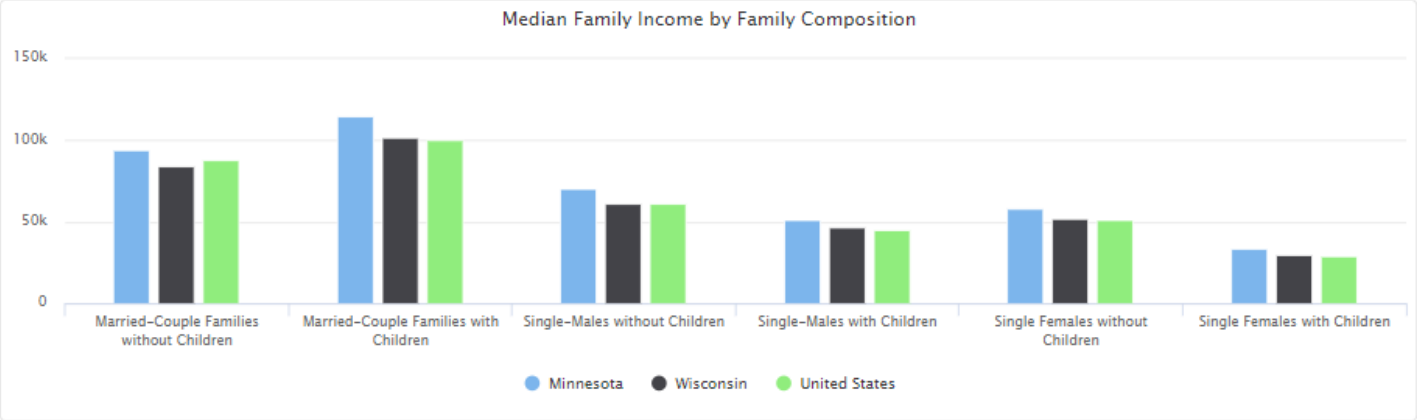
County Health Rankings, 2021; Braveman P, Egerter S, Barclay C. Income, wealth and health. Princeton: Robert Wood Johnson Foundation (RWJF); 2011. Exploring the Social Determinants of Health Issue Brief No. 4; Lynch J, Smith GD, Harper S, Hillemeier M. Is income inequality a determinant of population health? Part 2. U.S. National and regional trends in income inequality and age- and cause-specific mortality. Milbank Q. 2004;82(2):355-400.

	Chisago	Polk	Burnett	
Children in poverty	6%	11%	13%	Percentage of people under age 18 in poverty.
Income inequality	3.4	4.2	4.2	Ratio of household income at the 80th percentile to income at the 20th percentile.
Gender pay gap	.82	.82	.82	Ratio of women's median earnings to men's median earnings for all full-time, year-round workers, presented as "cents on the dollar."
Median household income	$85,200	$65,300	$57,900	The income where half of households in a county earn more and half of households earn less.
Living wage	$40.55	$35.73	$35.65	The hourly wage needed to cover basic household expenses plus all relevant taxes for a household of one adult and two children.
Children eligible for free or reduced-price lunch	24%	41%	55%	Percentage of children enrolled in public schools that are eligible for free or reduced-price lunch.

County Health Rankings, 2021; Small Area Income and Poverty Estimates, 2020; American Community Survey, 5-year estimates, 2016-2020; The Living Wage Calculator, 2021; Massachusetts Institute of Technology (MIT), https://livingwage.mit.edu, 2022; National Center for Education Statistics, 2019-2020.

	Chisago	Polk	Burnett
Workers commuting over 60 minutes	15.07%	24.66%	28.99%

US Census Bureau, American Community Survey, 2015-2019.



Out of the 17,607 students we have in our area, 6,210 students are eligible for free or reduced-price lunch.

	Total Students	Students Eligible for Free or Reduced Lunch	Students Eligible for Free or Reduced Lunch, Percent	Poverty – Population Below 185% FPL	Poverty – Percent Population with Income at or Below 185% FPL
Chisago, Polk, Burnett	17,607	6,210	35.27%	23,045	20.63%
Chisago County	7,918	1,884	23.79%	8,100	15.07%
Polk County	7,010	2,857	40.76%	10,567	24.66%
Burnett County	2,679	1,469	54.83%	4.378	28.99%

National Center for Education Statistics, NCES – Common Core of Data 2019-20.

HEALTH FACTORS > SOCIAL AND ECONOMIC FACTORS > **Family and Social Support**

People with greater social support, less isolation and greater interpersonal trust live longer and healthier lives than those who are socially isolated. Neighborhoods rich in social capital provide residents with greater access to support and resources than those with less social capital.

Why is this important?

Social support stems from relationships with family members, friends, colleagues, and acquaintances. "Social capital" are the features of society that facilitate cooperation for mutual benefit, such as interpersonal trust and civic associations. Individual social support and cohesive, capital-rich communities help to protect physical and mental health, and facilitate healthy behaviors and choices.

Socially isolated individuals have an increased risk for poor health outcomes and are particularly vulnerable to the effects of stress, which has been linked to cardiovascular disease and unhealthy behaviors in adults, and obesity in children and adolescents.

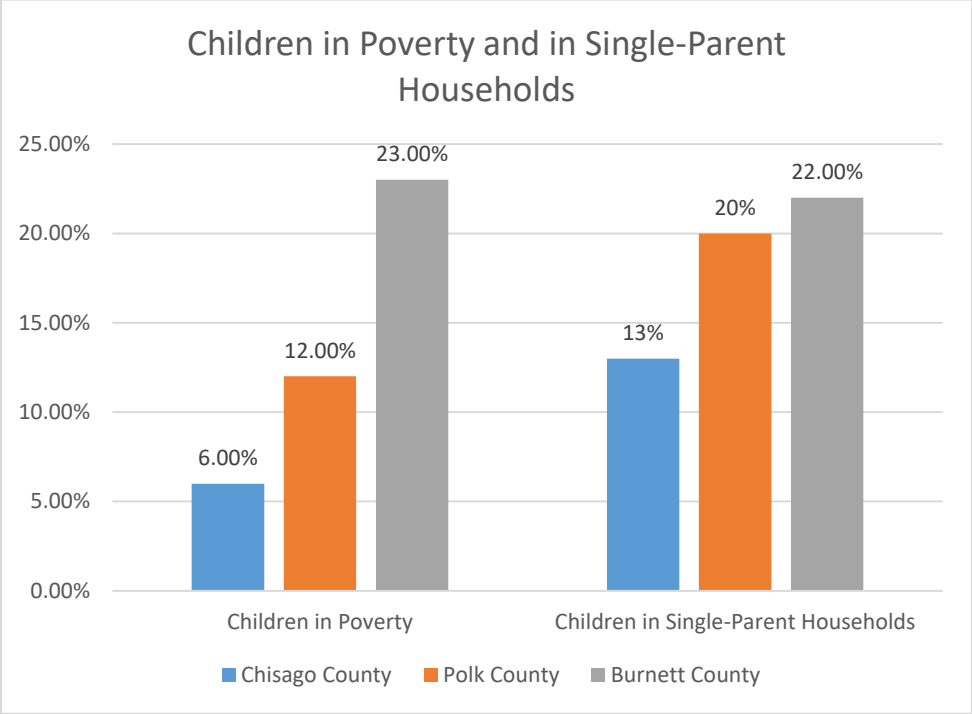
Residents of neighborhoods with low social capital are more likely to rate their health status as fair or poor, and may be more likely to suffer anxiety and depression. Neighborhoods with lower social capital may be more prone to violence and often have limited community resources and role models. Socially isolated individuals are more likely to be concentrated in communities with limited social capital.

Individuals with higher educational attainment and higher status jobs are more likely to have greater social support than those with less education and lower incomes. Adults and children in single-parent households, often at-risk for social isolation, have an increased risk for illness, mental health problems and mortality, and are more likely to engage in unhealthy behaviors than their counterparts.

County Health Rankings, 2021; Kawachi IK, Bruce P, Glass R. Social capital and self-rated health: A contextual analysis. Am J Public Health. 1999;89:1187-1193; Egerter S, Braveman P, Barclay C. Stress and health. Princeton: Robert Wood Johnson Foundation (RWJF); 2011. Exploring the Social Determinants of Health Issue Brief No. 3; House JS. Social isolation kills, but how and why? Psychosom Med. 2001;63:273-274; Braveman P, Cubbin C, Egerter S, Pedregon V. Neighborhoods and health. Princeton: Robert Wood Johnson Foundation (RWJF); 2011. Exploring the Social Determinants of Health Issue Brief No. 8; Braveman P, Egerter S, Barclay C. What shapes health-related behaviors?Princeton: Robert Wood Johnson Foundation (RWJF); 2011. Exploring the Social Determinants of Health Issue Brief No. 1; Fergusson DM, Boden JM, Horwood LJ. Exposure to single parenthood in childhood and later mental health, educational, economic, and criminal behavior outcomes. Arch Gen Psychiatry. 2007;64:1089-1095; Wille N, Bettge S, Ravens-Sieberer U, BELLA Study Group. Risk and protective factors for children's and adolescents' mental health: Results of the BELLA study. Eur Child Adolesc Psychiatry. 2008;17:133-147; Rahkonen O, Laaksonen M, Karvonen S. The contribution of lone parenthood and economic difficulties to smoking. Soc Sci Med. 2005;61:211-216; Ringbäck Weitoft G, Burström B, Rosén M. Premature mortality among lone fathers and childless men. Soc Sci Med. 2004;59:1449-1459; Weitoft GR, Haglund B, Hjern A, Rosén M. Mortality, severe morbidity and injury among long-term lone mothers in Sweden. Int J Epidemiol. 2002;31:573-580.

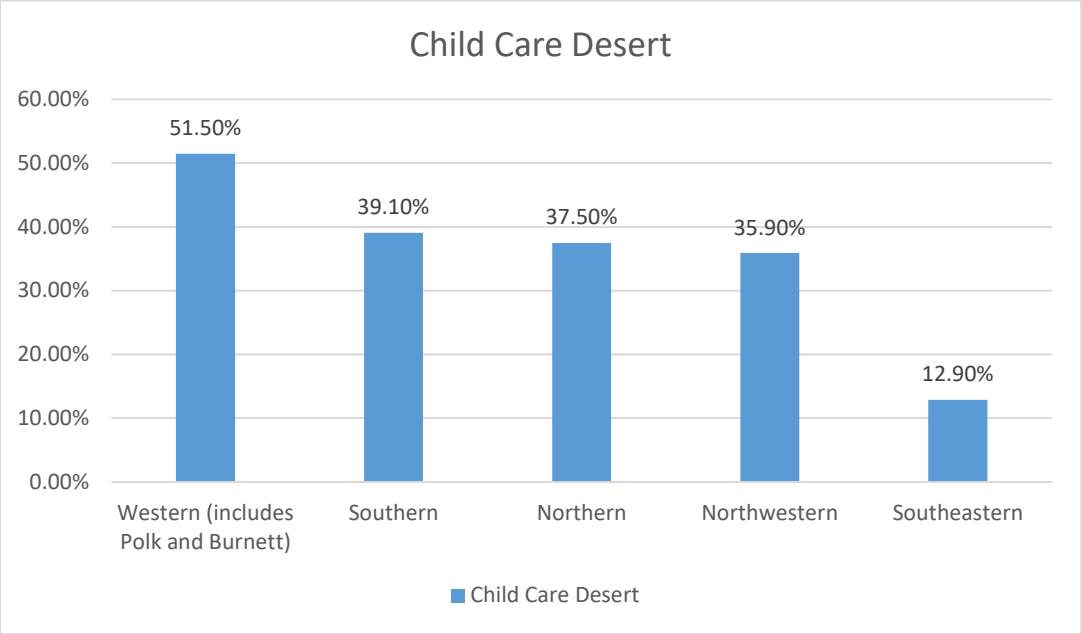
	Chisago	Polk	Burnett	
Children in single-parent households	14%	20%	21%	Percentage of children that live in a household headed by a single parent.
Social associations	9.7	16.0	16.0	Number of membership associations per 10,000 population.
Residential segregation – non-white/white	30	32	29	Index of dissimilarity where higher values indicate greater residential segregation between non-white and white county residents.
Childcare cost burden	19%	22%	26%	Childcare costs for a household with two children as a percent of median household income.
Childcare centers	4	6	9	Number of childcare centers per 1,000 population under 5 years old.

American Community Survey, 5-year estimates, 2016-2020; County Business Partners, 2019; The Living Wage Calculator, Small Area Income and Poverty Estimates, 2020-2021; Homeland Infrastructure Foundation – Level Data (HIFLD), 2021.

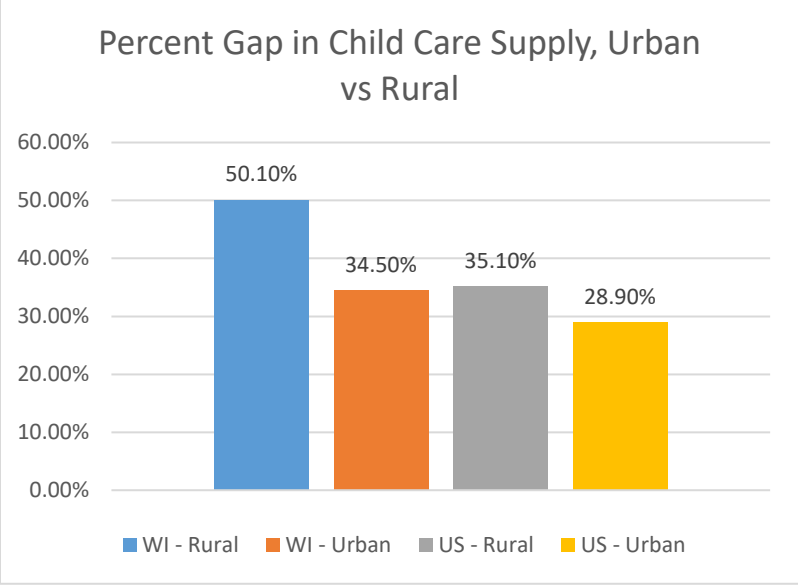


	Chisago	Polk	Burnett
Female, Spouse Absent	1,627	1,442	569
Male, Spouse Absent	1,014	821	421

US Census Bureau, American Community Survey, 2015-2019.
County Health Rankings, 2021



DCF Access to Childcare in Wisconsin Presentation to Early Childhood Advisory Counsel, 2018.



Bipartisan Policy Center. The Supply, Potential Need for, and Gaps in Child Care in Wisconsin in 2019.

HEALTH FACTORS > SOCIAL AND ECONOMIC FACTORS > **Community Safety**

Injuries through accidents or violence are the third leading cause of death in the United States, and the leading cause for those between the ages of 1 and 44. Accidents and violence affect health and quality of life in the short and long-term, both directly and indirectly. Living in unsafe neighborhoods can impact health in a multitude of ways.

Why is this important?

Community safety reflects violent acts in neighborhoods and homes, as well as injuries caused unintentionally through accidents. Many injuries are predictable and preventable, yet some 30 million Americans receive medical treatment for injuries each year, and more than 243,000 die.

Among unintentional injury deaths, drowning was the leading cause for children ages 1-4, motor vehicle traffic accidents for individuals ages 5–24, and poisoning for ages 25-64. Unintentional injury was the fifth leading cause of death for infants with suffocation as the most common cause.

Millions of violent crimes occur each year, including assault, robbery, and rape. Each year, thousands of children and adults are victims of homicide including from abuse or neglect. Children in unsafe circumstances can also suffer post-traumatic stress disorder and exhibit more aggressive behavior, alcohol and tobacco use, and sexual risk-taking than peers in safer environments.

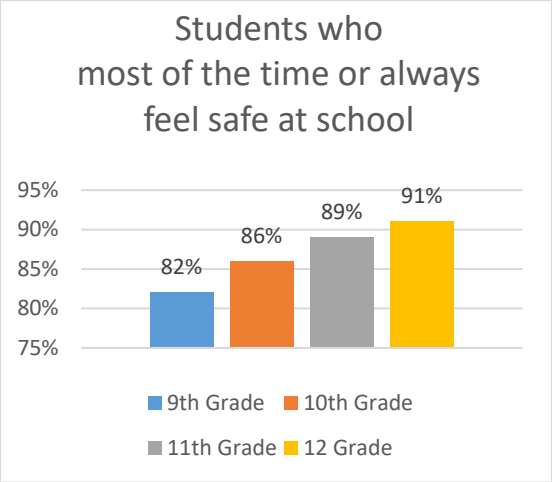
Chronic stress associated with living in unsafe neighborhoods can accelerate aging and cause anxiety, depression, and stress, and are linked to higher rates of pre-term births and low birthweight babies. Fear of violence can keep people indoors and away from neighbors, exercise, and healthy foods. Companies may be less willing to invest in unsafe neighborhoods, making jobs harder to find.

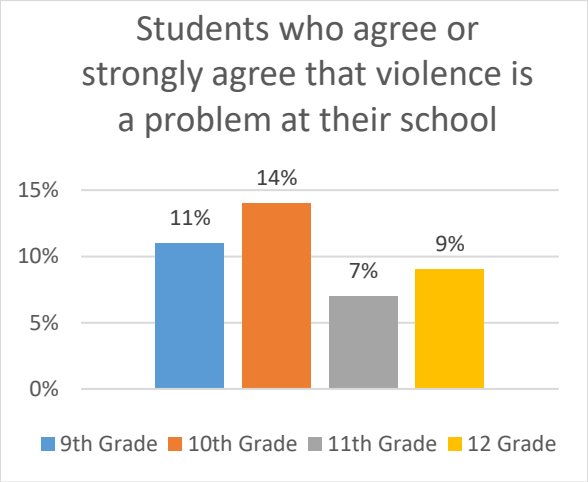
One in four women experience intimate partner violence (IPV), and more than 4 million are assaulted by their partners each year. IPV causes 2,000 deaths annually and increases the risk of depression, anxiety, post-traumatic stress disorder, substance abuse, and chronic pain. Injuries sustained in one year will generate more than $794 billion in lifetime costs.

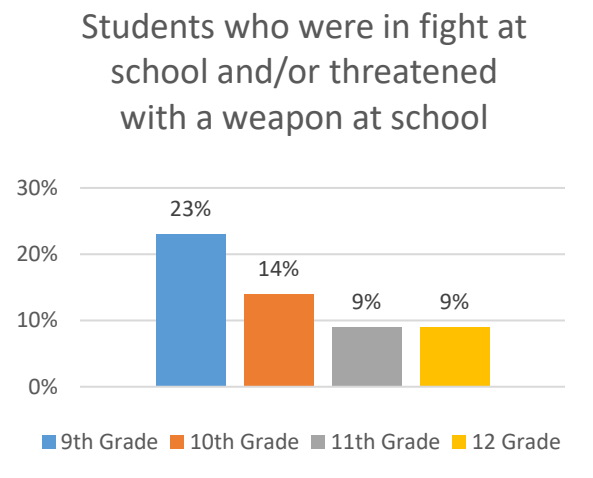
County Health Rankings, 2021; Levi J, Segal LM, Kohn D. The Facts Hurt – A State-by-State Injury Prevention Policy Report. Trust for America's Health. Robert Wood Johnson Foundation. June 2015; CDC, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) Fatal Injury Data. Updated January 18, 2019. Accessed March 14, 2019; Morgan RE, Kena G. Criminal Victimization, 2016. Bureau of Justice Statistics (BJS). December 2017. NCJ 251150; CDC. Child Abuse and Neglect Prevention. Updated April 10, 2018. Accessed March 14, 2019; Egerter S, Barclay C, Grossman-Kahn R, Braveman P. Violence, social disadvantage and health. Princeton: Robert Wood Johnson Foundation (RWJF); 2011. Exploring the Social Determinants of Health Issue Brief No. 10+

	Chisago	Polk	Burnett	
Violent crime	68	274	227	Number of reported violent crime offenses per 100,000 population.
Injury deaths	54	87	90	Number of deaths due to injury per 100,000 population.
Homicides	N/A	N/A	N/A	Number of deaths due to homicide per 100,000 population.
Suicides	12	18	16	Number of deaths due to suicide per 100,000 population (age-adjusted).
Firearm fatalities	8	11	Not available	Number of deaths due to firearms per 100,000 population.
Juvenile arrests	20	12	8	Rate of delinquency cases per 1,000 juveniles.

County Health Rankings, 2021; Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the inter-university Consortium for Political and Social Research. 2014 and 2016. National Center for Health Statistics – Mortality Files, 2016-2020; National Center for Health Statistics – Mortality Files,2014-2020; Easy Access to State and County Juvenile Court Case Counts (EZACO), 2019.







Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance – Polk County, 2019

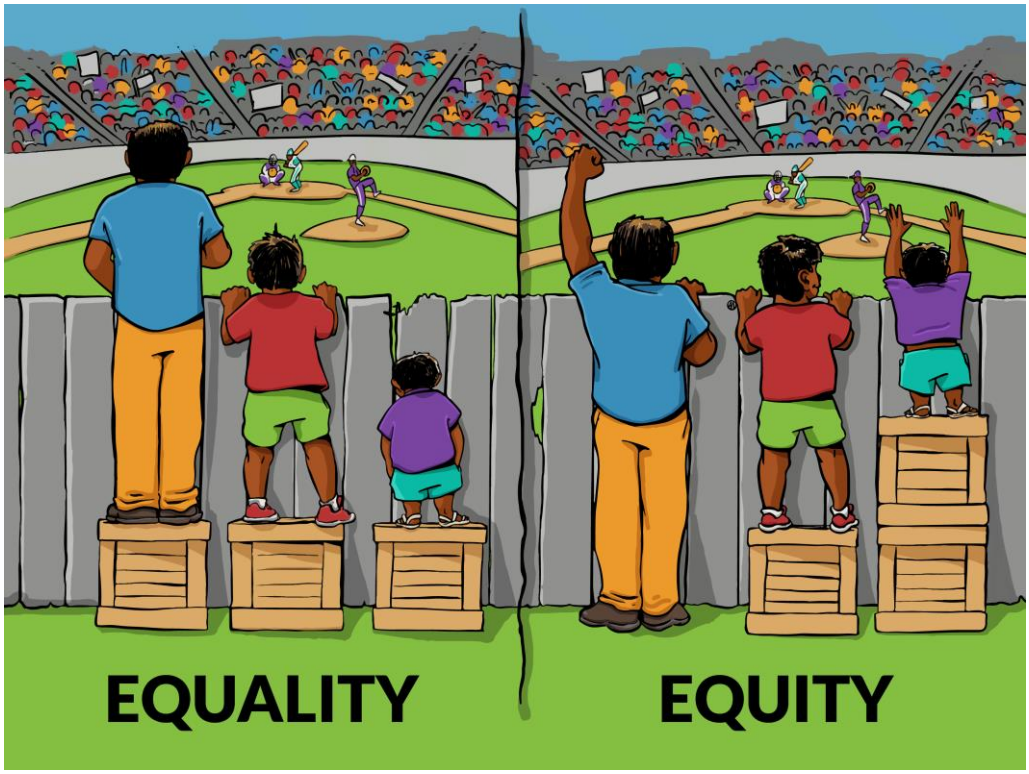
HEALTH FACTORS > SOCIAL AND ECONOMIC FACTORS > **Health Equity, Health Disparities, Diversity, and Inclusion**

Not included in the County Health Ranking Model yet, but important to recognize is health equity, diversity, and inclusion. It is a well-documented factor in both the cost of care and quality outcomes that health inequities contribute to health disparities (*American Hospital Association, 2020, Institute for Diversity and Health Equity, 2020).*

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty and discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

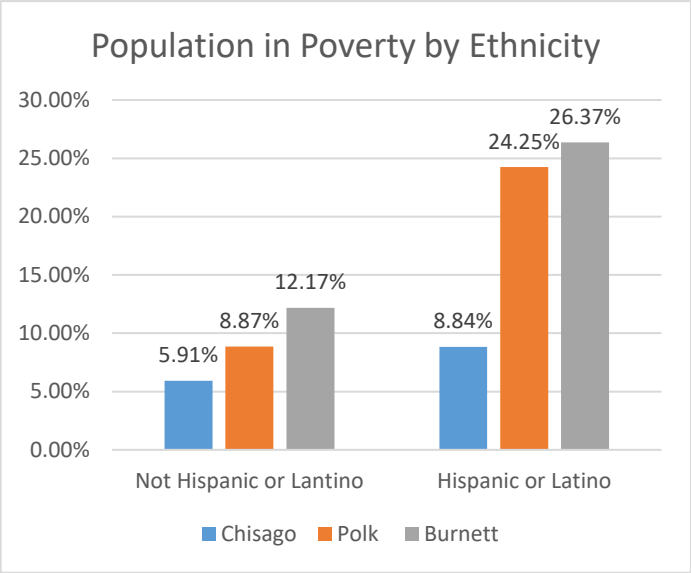
Health disparities are differences in health or in the key determinants of health, such as education, safe housing, and discrimination, which adversely affect marginalized or excluded groups.

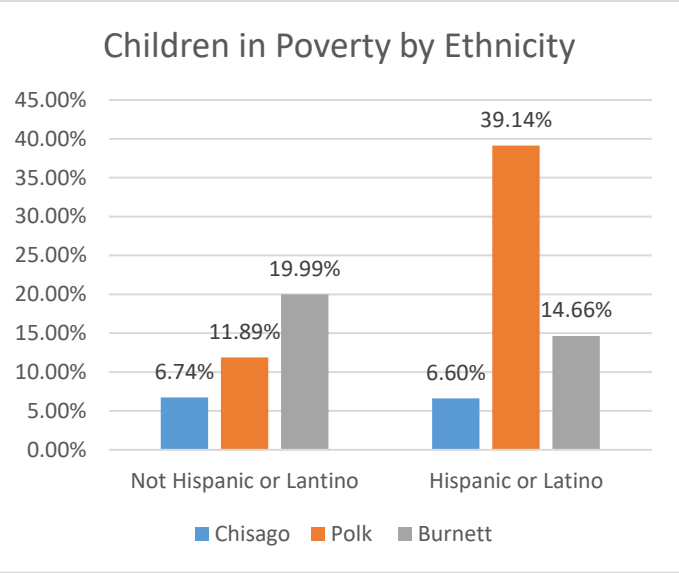
Many individuals believe that discrimination does not exist in this area due to having a high population of those that are Caucasian/white. Not all people understand that equity and discrimination is more than one's skin color and can include, but not limited to, sexuality or gender identification. This is the very reason that awareness and education need to be a part of community strategies. If people cannot understand it, it is difficult to help and get to root causes.

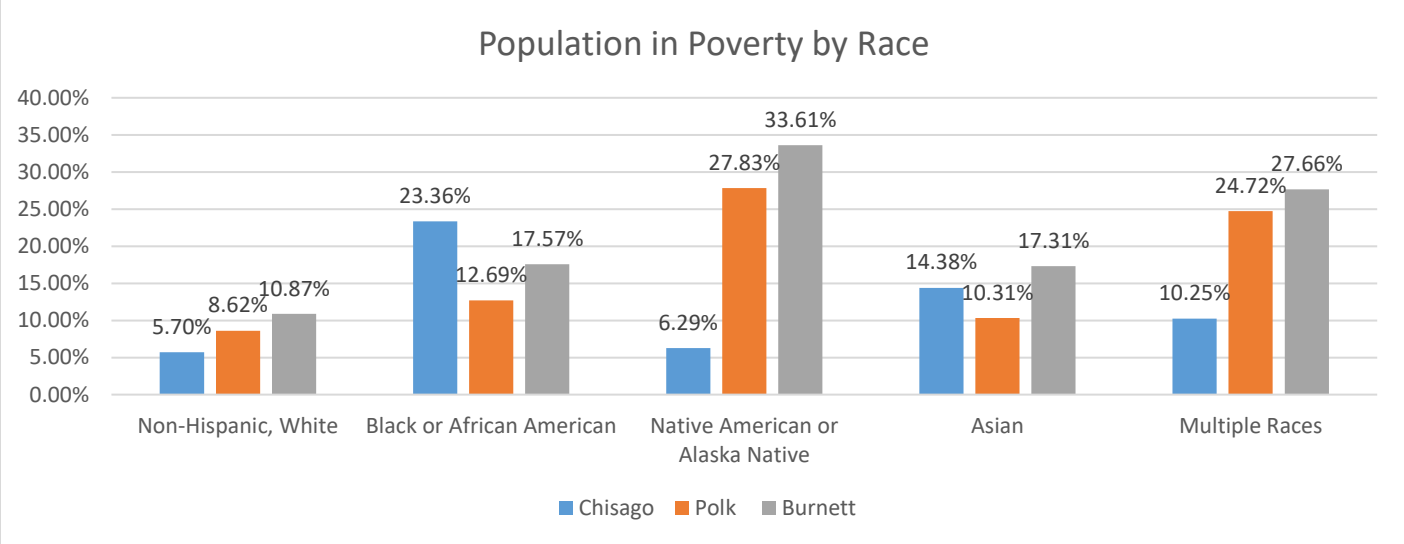


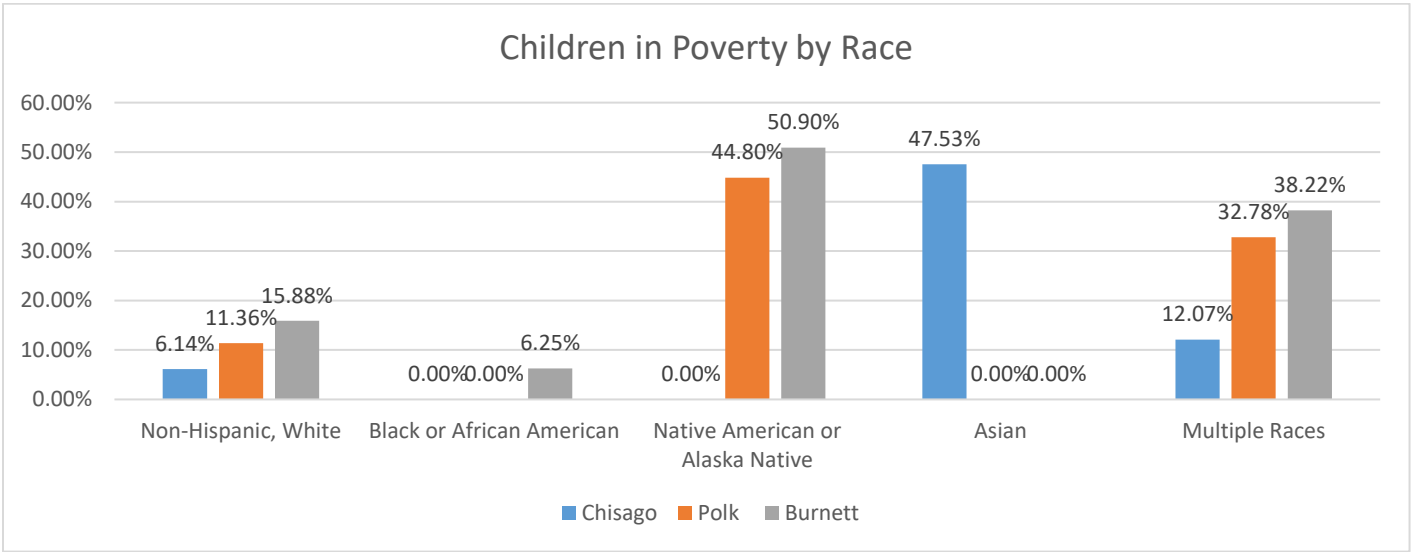
https://interactioninstitute.org/equality-equality-cartoon-gallery/

Race and ethnicity play an important role in addressing population health. See below.









US Census Bureau, American Community Survey, 2015-2019.

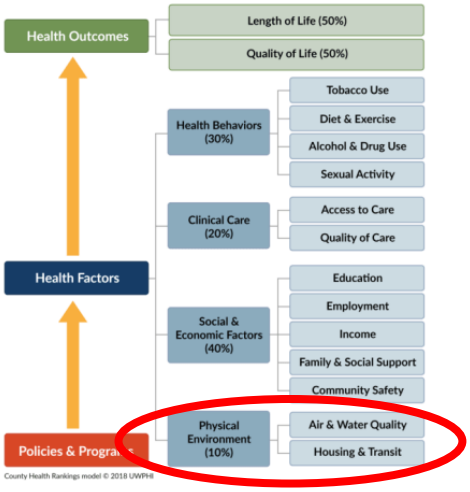
HEALTH FACTORS > **PHYSICAL ENVIRONMENT**

The physical environment is where individuals live, learn, work, and play. People interact with their physical environment through the air they breathe, water they drink, houses they live in, and the transportation they utilize to travel to work and school. Poor physical environment can affect our ability and that of our families and neighbors to live long and healthy lives.

Clean air and safe water are necessary for good health. Air pollution is associated with increased asthma rates and lung diseases, and an increase in the risk of premature death from heart or lung disease. Water contaminated with chemicals, pesticides, or other contaminants can lead to illness, infection, and increased risks of cancer.

Stable, affordable housing can provide a safe environment for families to live, learn, grow, and form social bonds. However, housing is often the single largest expense for a family and when too much of a paycheck goes to paying the rent or mortgage, this housing cost burden can force people to choose among paying for other essentials such as utilities, food, transportation, or medical care.

Our collective health and well-being depend on opportunity for everyone. Yet, across and within counties there are stark differences in the opportunities to live in safe, affordable homes, especially for people with low incomes and people of color. These differences emerge from discrimination and institutional racism in the form of long-standing, deep-rooted and unfair systems, policies, and practices such as redlining, restrictive zoning rules, and predatory bank lending practices that reinforce residential segregation and barriers to opportunity (County Health Rankings, 2021).



HEALTH FACTORS > PHYSICAL ENVIRONMENT > **Air and Water Quality**

Clean air and safe water are prerequisites for health. Poor air or water quality can be particularly detrimental to vulnerable populations such as the very young, the elderly, and those with chronic health conditions.

Why is this important?

Clean air and water support healthy brain and body function, growth, and development. Air pollutants such as fine particulate matter, ground-level ozone, sulfur oxides, nitrogen oxides, carbon monoxide, and greenhouse gases can harm our health and the environment. Excess nitrogen and phosphorus run-off, medicines, chemicals, lead and pesticides in water also pose threats to well-being and quality of life.

More than 1 in 8 Americans have been diagnosed with asthma. **Air pollution is associated with increased asthma rates, and can aggravate asthma, emphysema, chronic bronchitis, and other lung diseases.** Damaged airways and lungs, and premature death from heart or lung disease are also caused by air pollution.

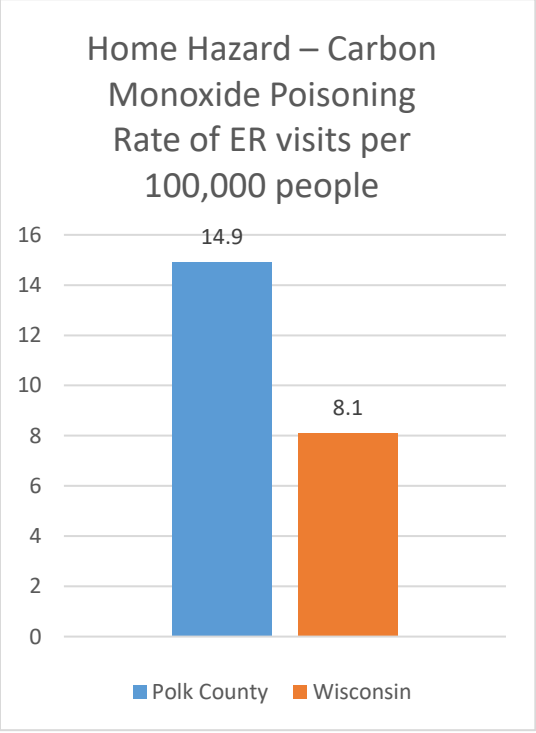
Contaminants in drinking water sicken more than 1 million people a year. Improper medicine disposal, and chemical, pesticide, and microbiological contaminants in water can lead to poisoning, gastro-intestinal illnesses, eye infections, increased cancer risk, and other health problems.

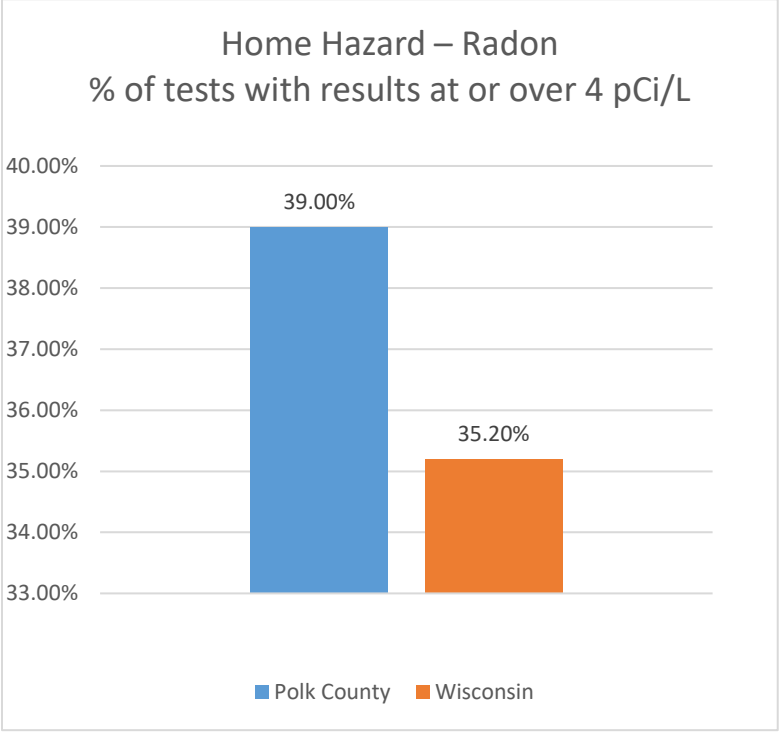
Poor surface water quality can also make lakes unsafe for swimming and wild fish unsafe for consumption. Nitrogen pollution and harmful algae blooms create toxins in water, which can lead to rashes, stomach or liver illness, respiratory problems, and neurological effects when people ingest or encounter polluted water.

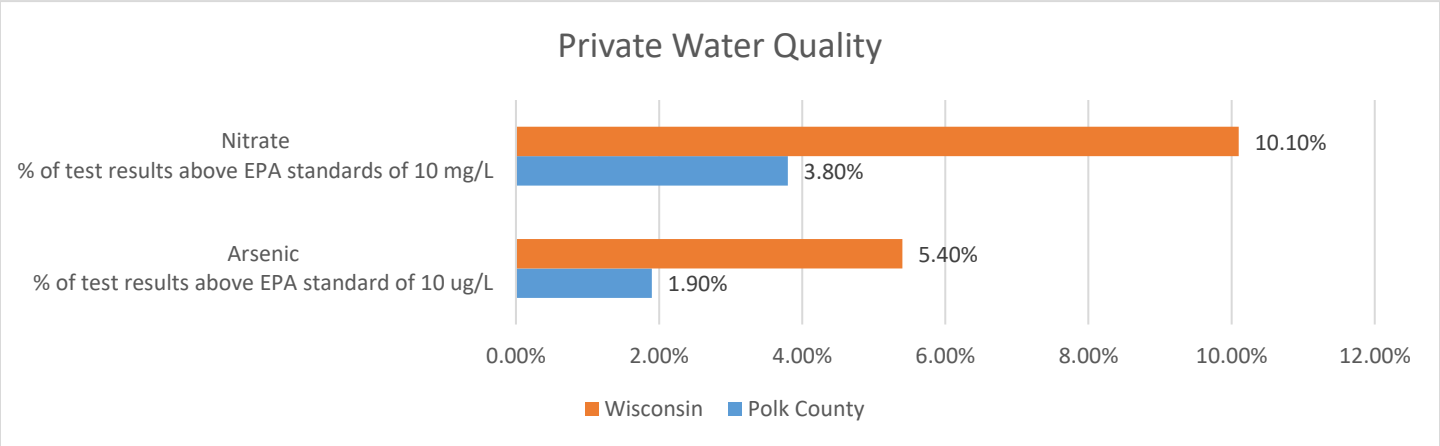
County Health Rankings, 2021; Environmental Protection Agency. Learn about air. Last reviewed December 4, 2018. Accessed March 14, 2019; Environmental Protection Agency. Learn about water. Last reviewed December 4, 2018. Accessed March 14, 2019; Centers for Disease Control and Prevention. Asthma: 2016 National Health Interview Survey. Last reviewed May 18, 2018. Accessed March 14, 2019; Centers for Disease Control and Prevention. Outdoor Air: Health Impacts of Fine Particles in Air. Last reviewed August 2, 2018. Accessed March 14, 2019; Lambertini E, et al. Risk of Viral Acute Gastrointestinal Illness from Non-Disinfected Drinking Water Distribution Systems. Environ. Sci. Technol. 2012; 46 (17):9299–9307.

	Chisago	Polk	Burnett	
Air pollution – particulate matter	7.6	7.5	6.7	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).
Drinking water violations	No	Yes	No	Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.

County Health Rankings, 2021; CDC's National Environmental Public Health Tracking Network, 2018; Safe Drinking Water Information System (SDWIS), 2020.







2021 County Environmental Health Profile

HEALTH FACTORS > PHYSICAL ENVIRONMENT > **Housing and Transit**

The housing options and transit systems that shape our communities' built environment affect where we live and how we get from place to place. The opportunities underlying these choices also affect our health.

Why is this important?

Our homes and those of our neighbors play a critical role in shaping our health and the health of the whole community. Safety and quality are important. For example, exposure to lead from pipes and paint can irreversibly harm brain and nervous system development. Improper insulation can expose occupants to extreme temperatures associated with increased mortality, especially among the very young, old, or sick. Asthma can be exacerbated by indoor allergens such as mold and dust, and residential crowding has been linked to physical illness and psychological distress.

The affordability and stability of housing also plays a role. Housing is a substantial expense with some 40 million families spending 30-50% of their income on housing. For low-income families, this decreases their ability to pay utility bills, have regular medical care or buy food or prescribed medicines. It also increases the likelihood of housing instability and homelessness which is associated with poor health outcomes such as psychological distress, increased alcohol use, and suicide.

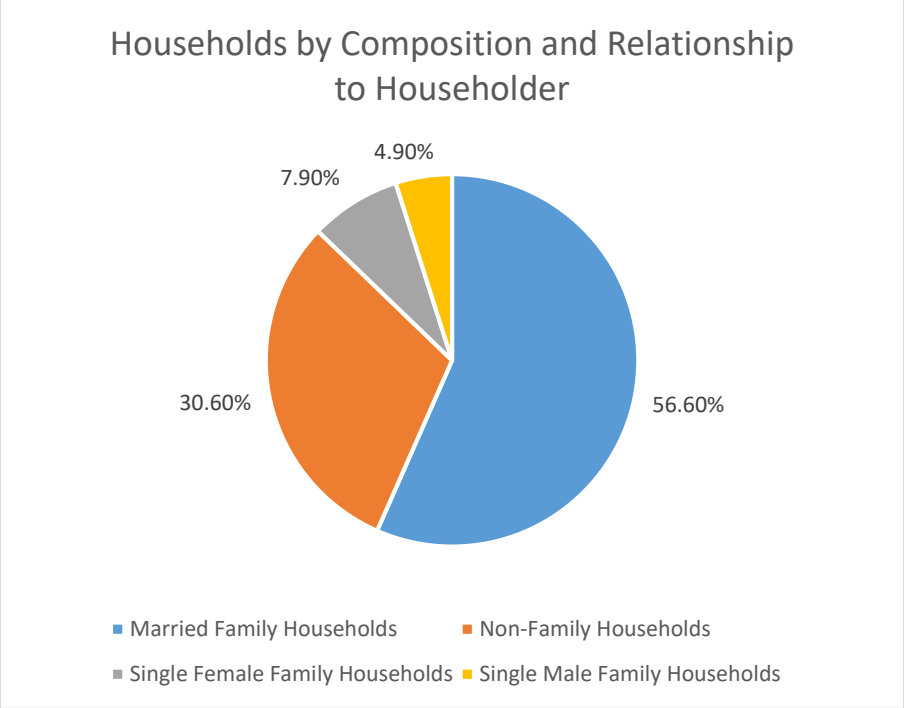
Lastly, **the neighborhoods where we live impact our health if they lack resources such as public transportation, grocery stores, and safe spaces to exercise**. A neighborhood's social characteristics can affect health as well.
Transit includes buses, of course, and also cars, bikes, sidewalks, streets, bike paths, and highways. Together, this varied and complex system connects people to each other, and to the places where they live, learn, work, and play.

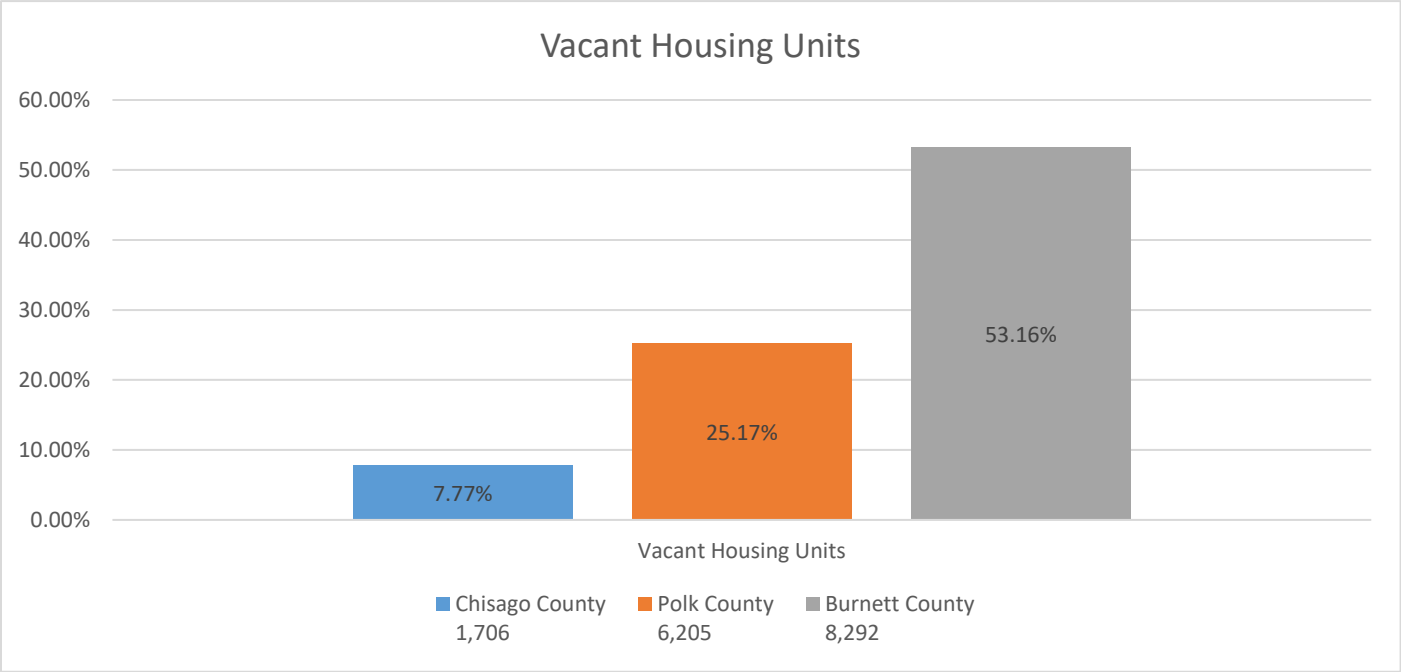
Local transit options can support active, energy-efficient travel and open up opportunities. **Too often, though, neighborhoods lack sidewalks and safe crossings, and our heavy reliance on cars can be problematic.** With the average American driving more than 10,000 miles a year and most of our nation's workers get to work in a car, this dependence on driving leads to 40,000 traffic-related deaths annually, exposes us to air pollution, and contributes to physical inactivity and obesity.

County Health Rankings, 2021; Braveman P, Dekker M, Egerter S, Sadegh-Nobari T. Housing and health. Princeton: Robert Wood Johnson Foundation (RWJF); 2011. Exploring the Social Determinants of Health Issue Brief No. 7; U.S. Department of Transportation, Federal Highway Administration. Summary of Travel Trends: 2009 National Household Travel Survey. Report No. FHWA-PL-ll-022 June 2011; Robert Wood Johnson Foundation (RWJF). How does transportation impact health? Princeton: Robert Wood Johnson Foundation (RWJF); 2012. Health Policy Snapshot Public Health and Prevention Issue Brief.

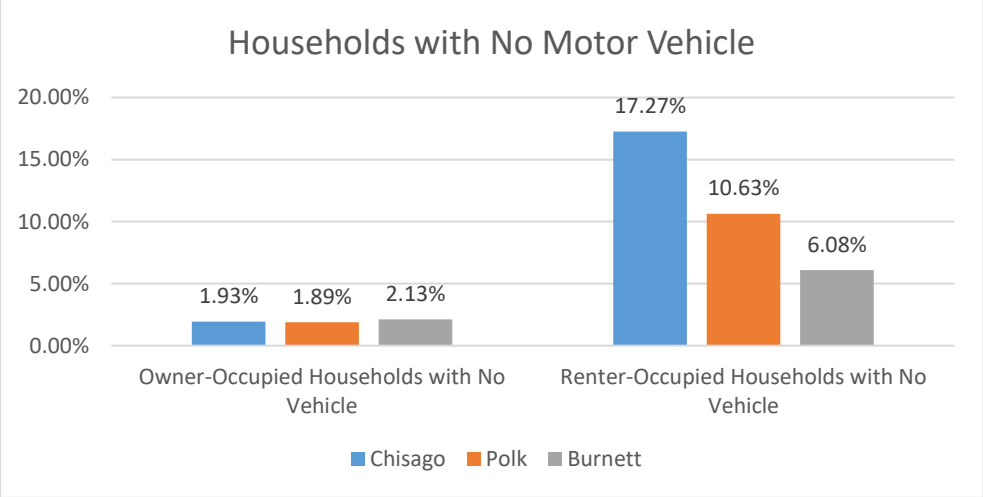
	Chisago	Polk	Burnett	
Severe housing problems	10%	12%	13%	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.
Driving alone to work	80%	83%	79%	Percentage of the workforce that drive alone to work.
Long commute – driving alone	53%	45%	40%	Among workers who commute in their car alone, the percentage that commute more than 30 minutes.
Traffic volume	114	30	22	Average traffic volume per meter of major roadways in the county.
Homeownership	86%	80%	83%	Percentage of owner-occupied housing units.
Severe housing cost burden	9%	11%	10%	Percentage of households that spend 50% or more of their household income on housing.
Housing cost burden	22.54%	25.56%	24.12%	Percentage of households that spend 30% or more of their household income on housing.
Broadband access	89%	80%	79%	Percentage of households with broadband internet connection.

County Health Rankings, 2021; Comprehensive Housing Affordability Strategy (CHAS) data, 2014-2018; American Community Survey, 5-year estimates, 2016-2020; Environmental Justice Screening and Mapping Tool (EJSCREEN), 2019; American Community Survey, 5-year estimates, 2015-2019.

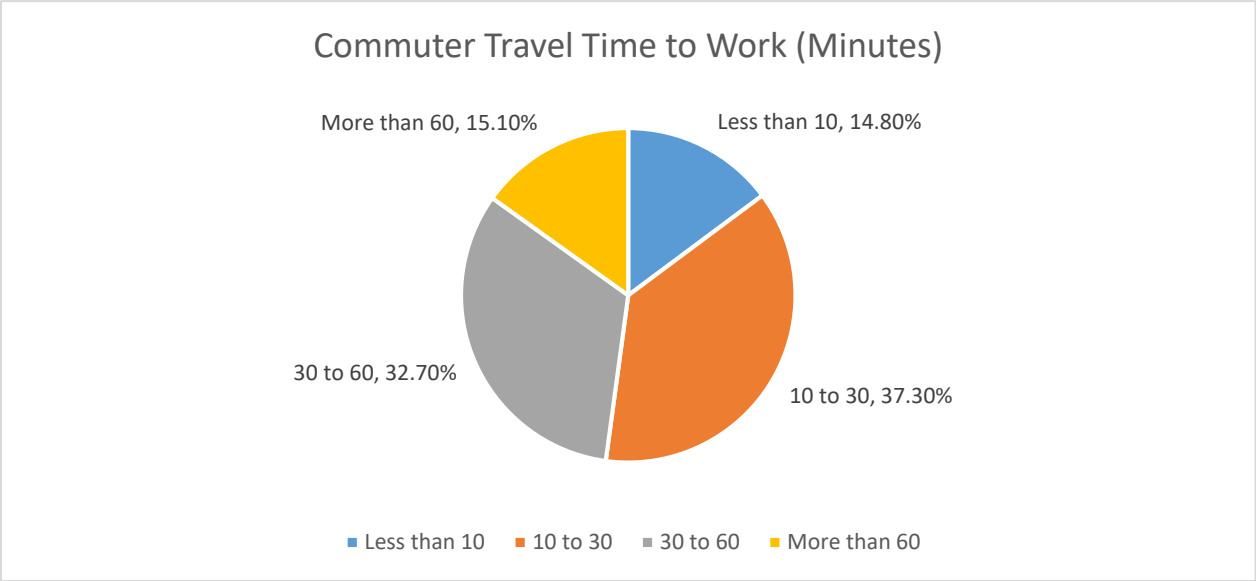




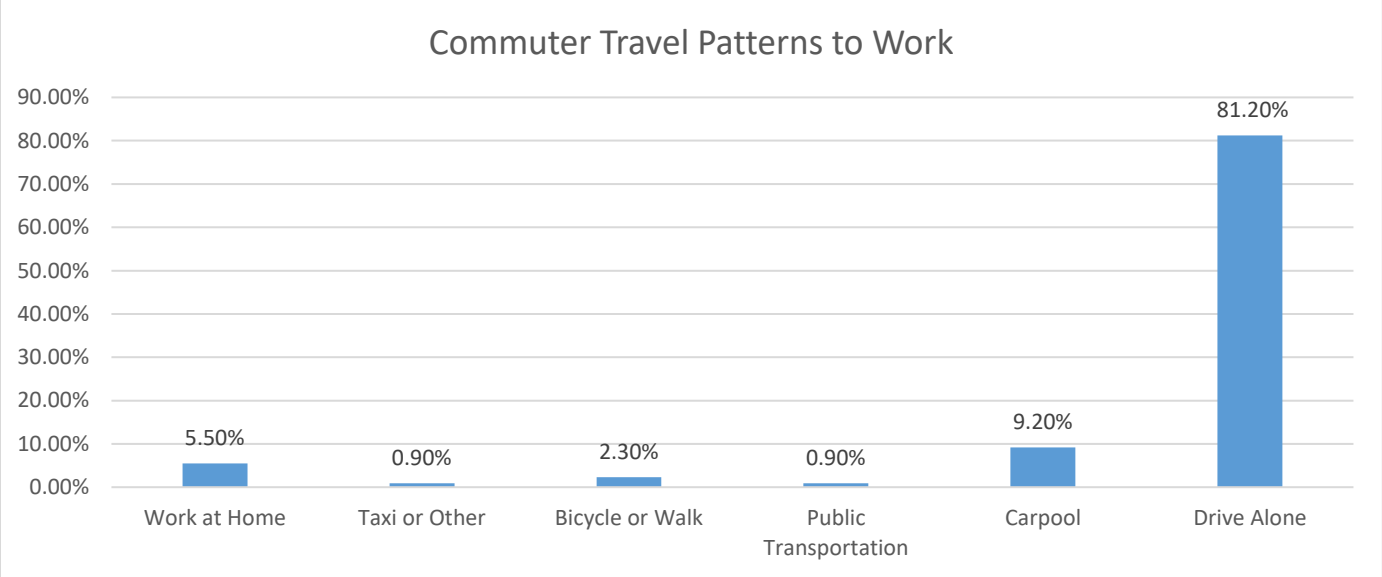
US Census Bureau, American Community Survey, 2015-19.



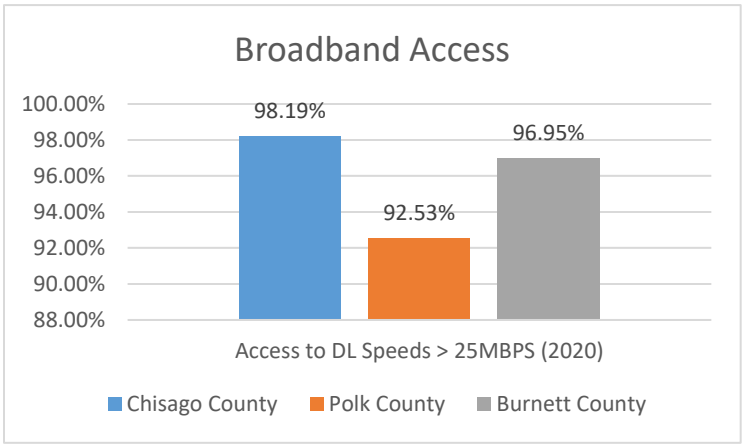
US Census Bureau, American Community Survey, 2015-19.

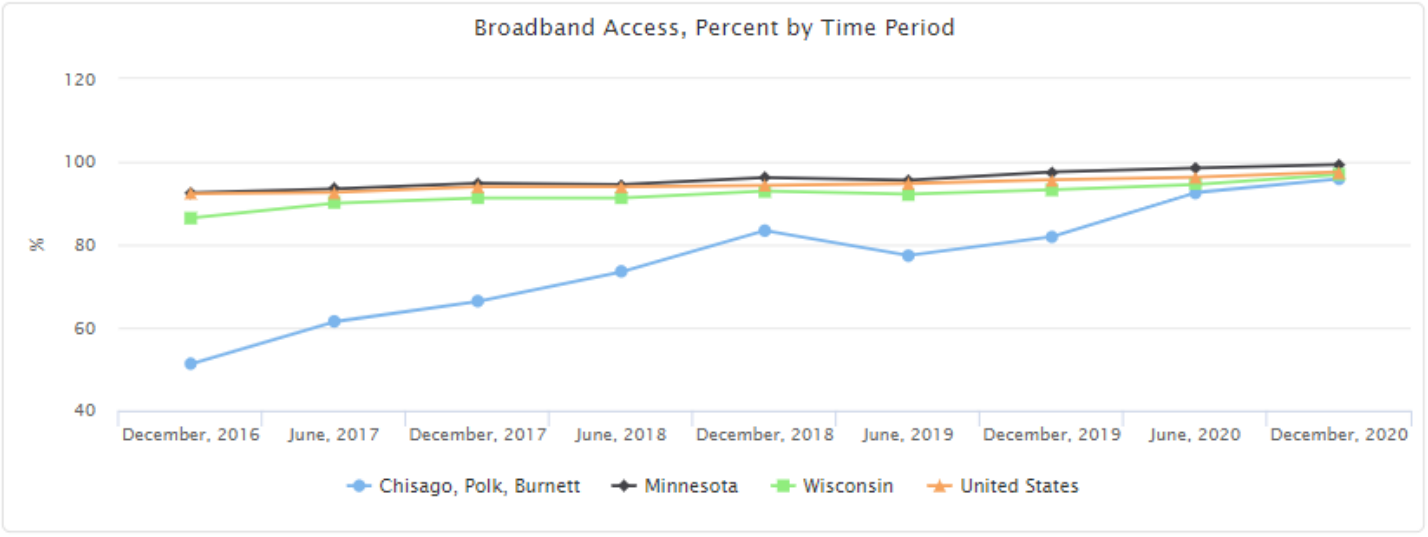


US Census Bureau, American Community Survey, 2015-19.

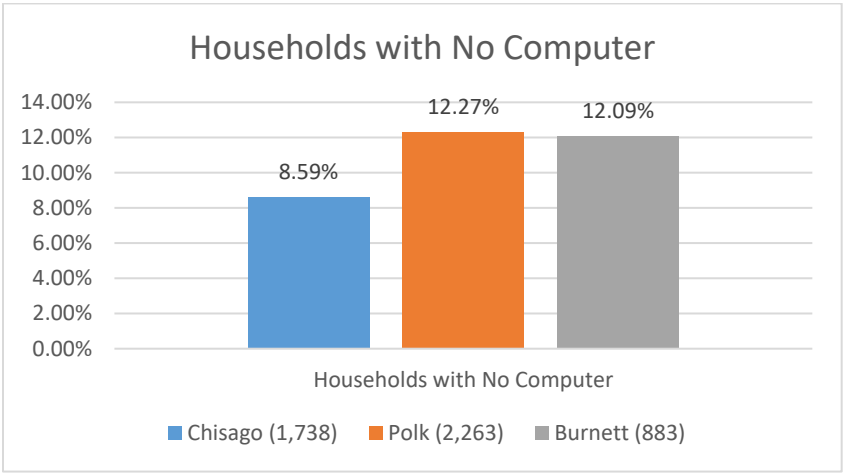


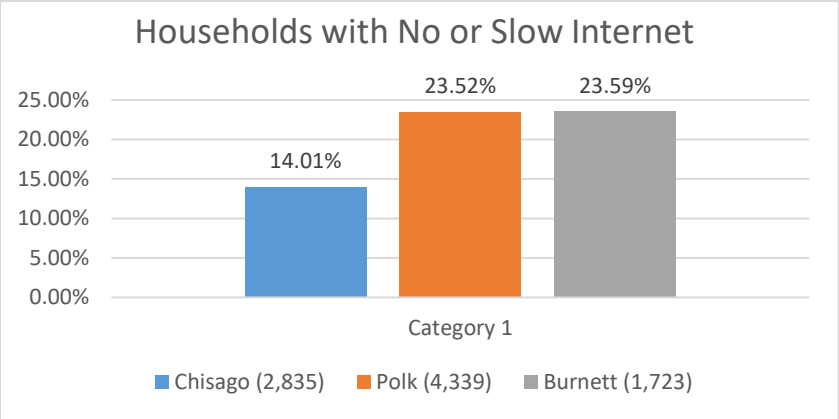
US Census Bureau, American Community Survey, 2015-19.

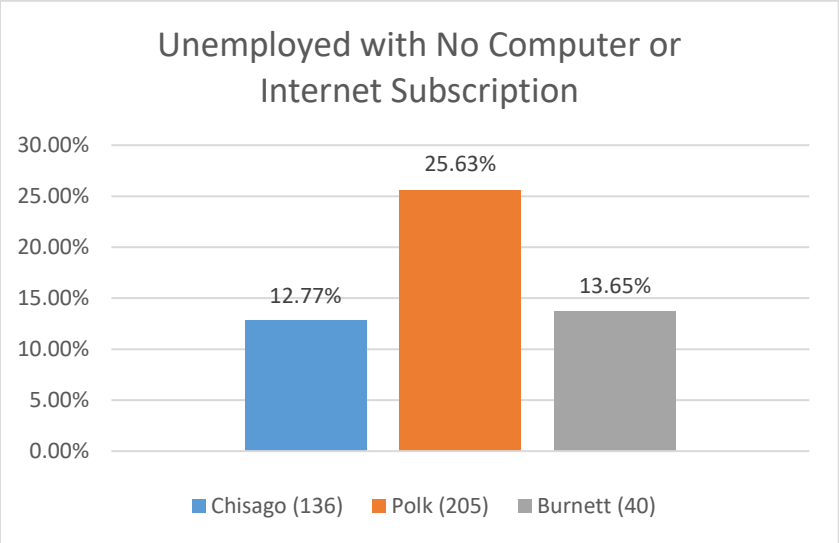




National Broadband Map, Dec 2020.



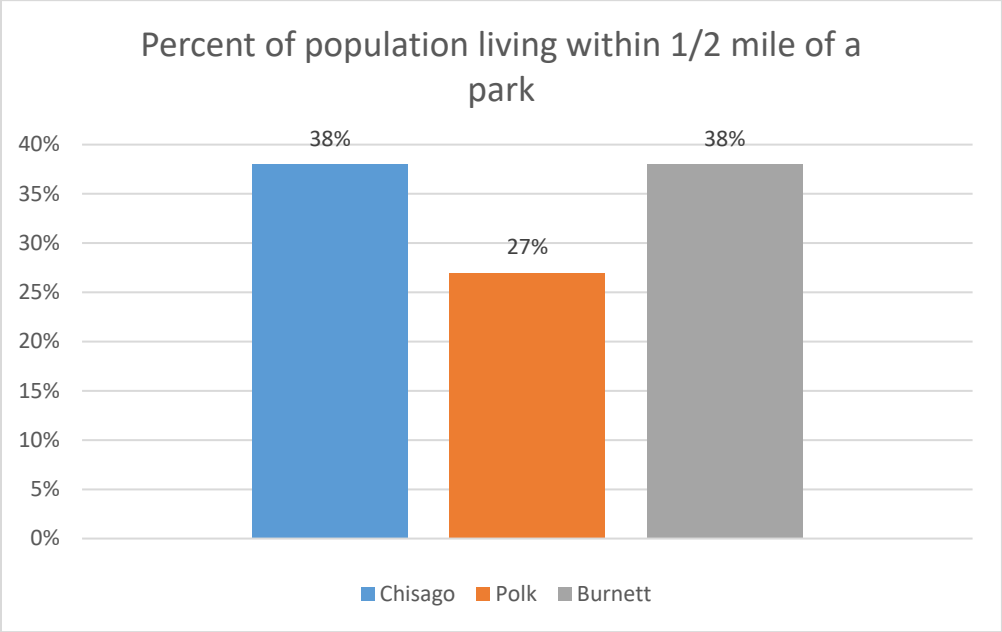




US Census Bureau, American Community Survey, 2015-19.

HEALTH FACTORS > PHYSICAL ENVIRONMENT > **Community Design/Park Access**

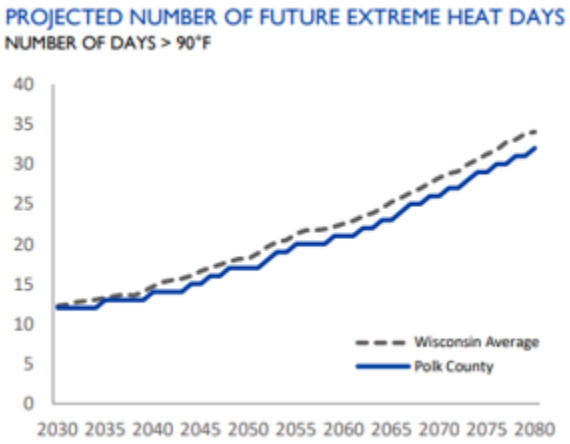
Although not mentioned in the County Health Ranking Model, an important component of the physical environment is park access. Outdoor recreation encourages physical activity and other healthy behaviors.

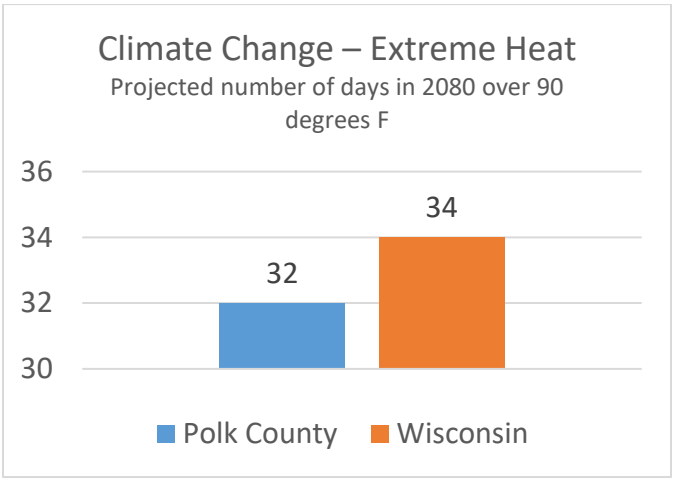


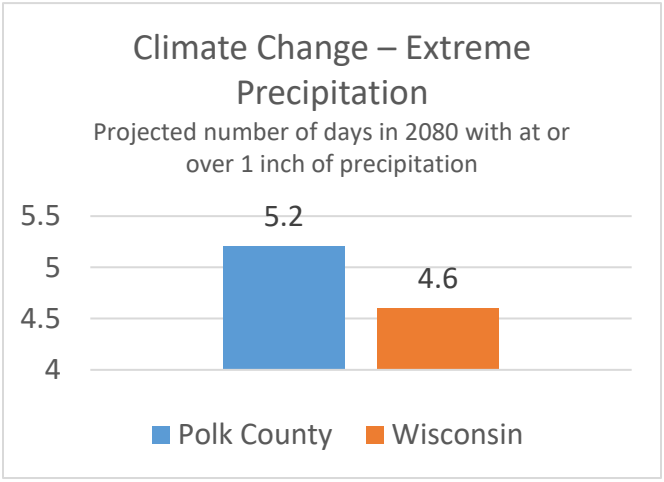
Center for Disease Control and Prevention,
CDC – National Environmental Public Health Tracking Network, 2015.

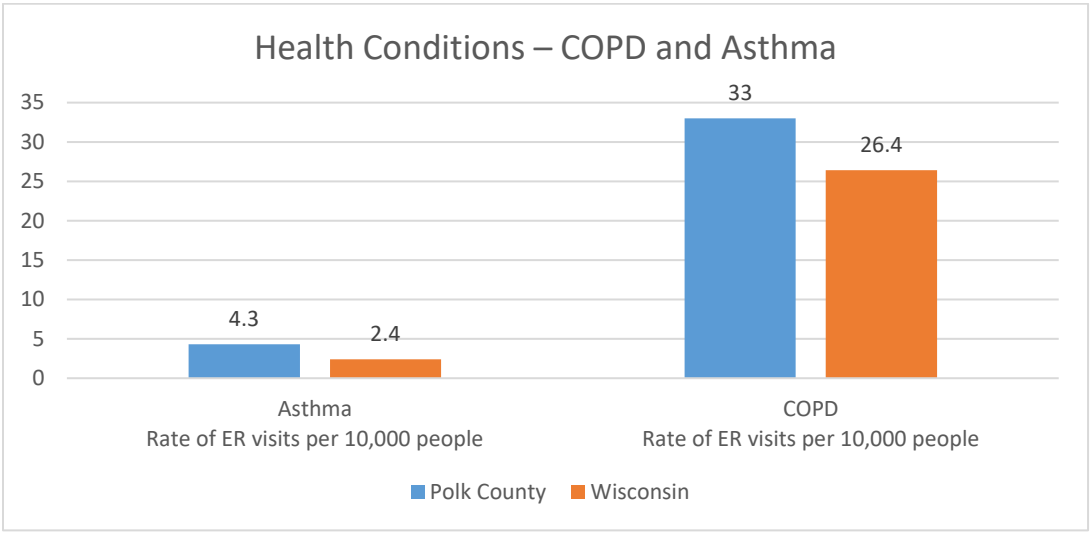
HEALTH FACTORS > PHYSICAL ENVIRONMENT > **Climate Change and Health Conditions**

Also, not yet part of the County Health Ranking Model is climate change. Climate change is an important factor and plays a contributing role in affecting certain health conditions.



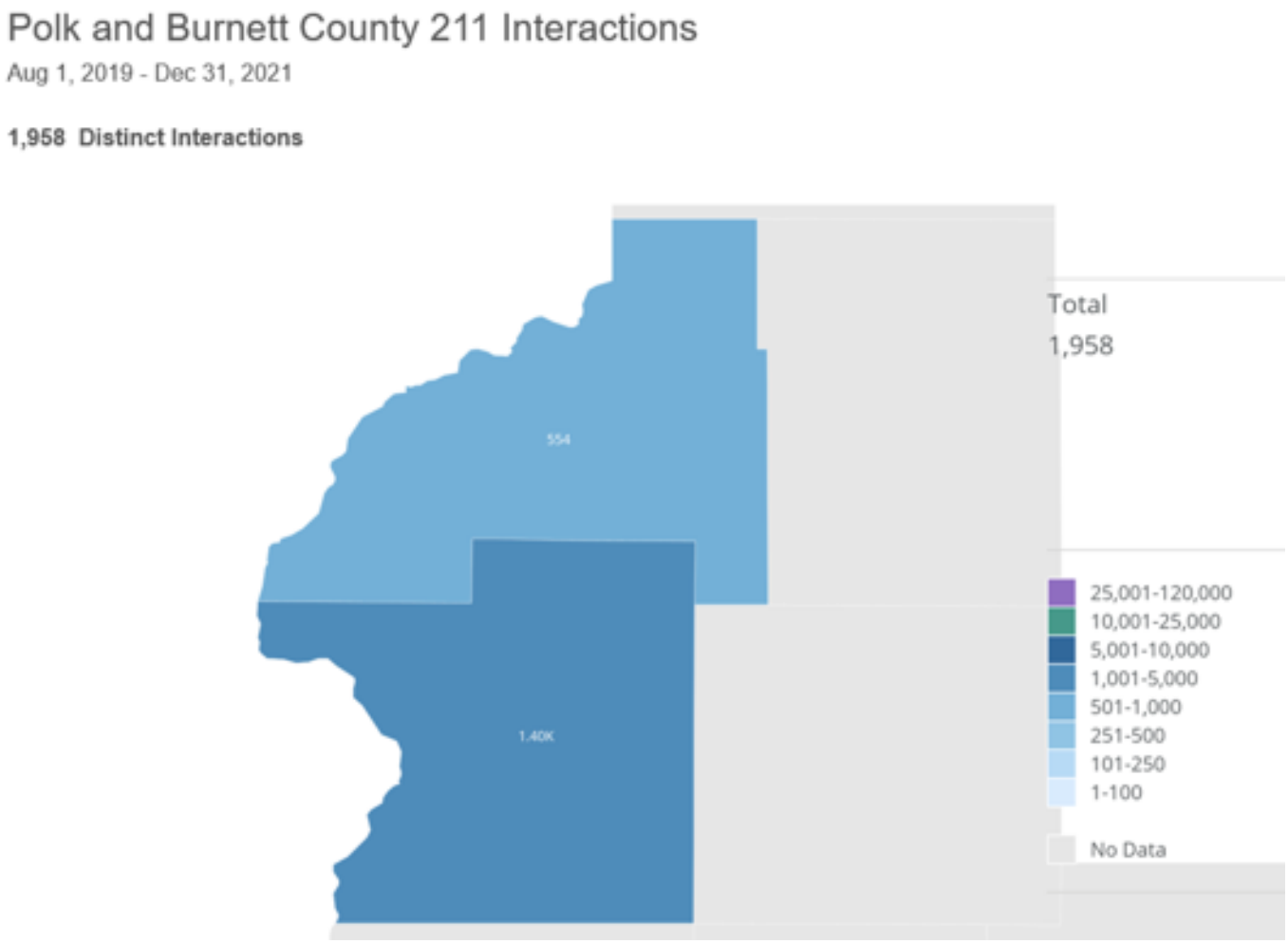




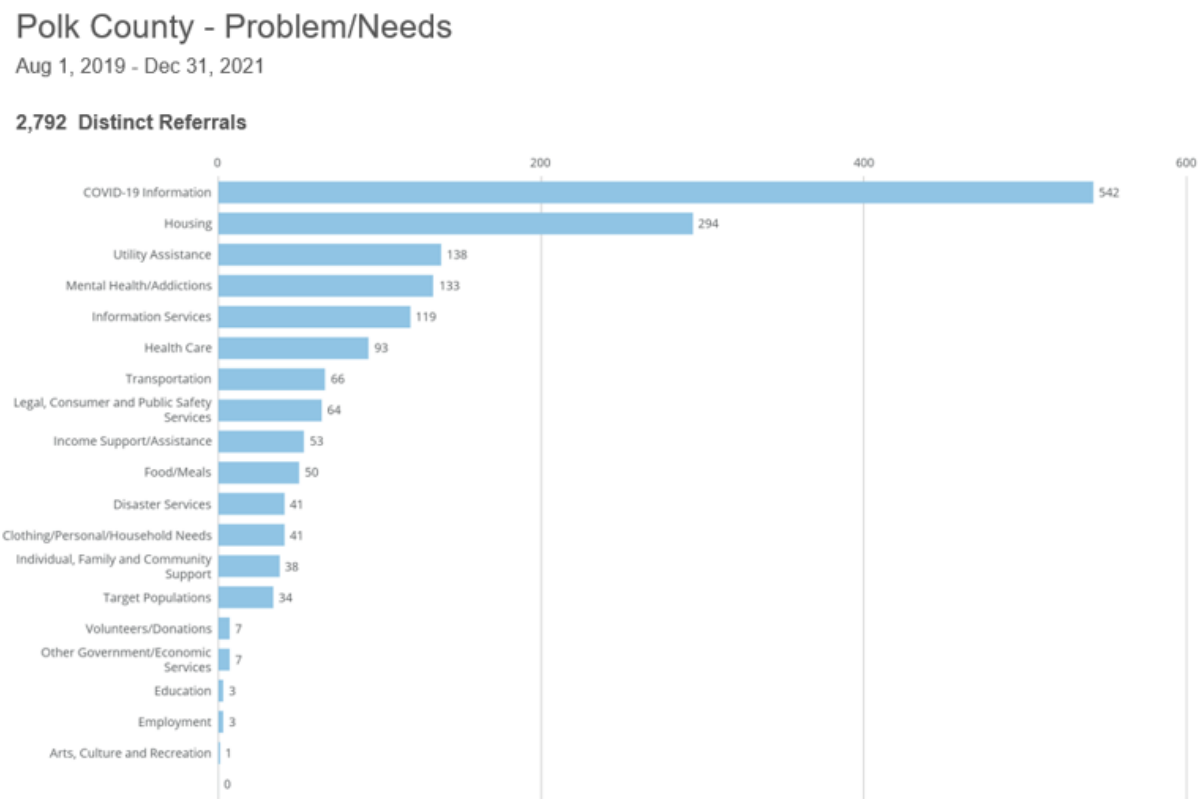


County Environmental Health Profile, Wisconsin Department of Health Services, 2021.

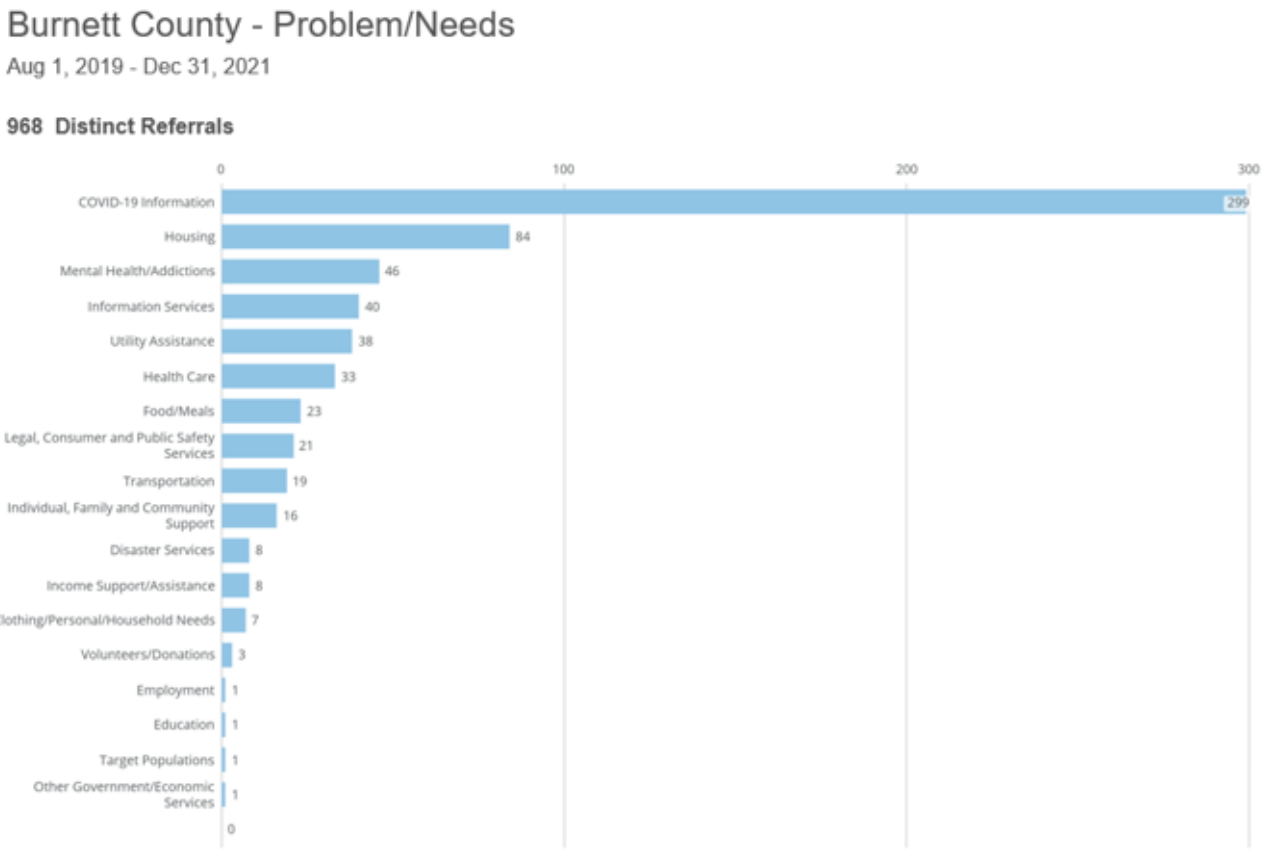
iii. 211 Interactions and Distinct Referrals



United Way St. Croix Valley, 2021



United Way St. Croix Valley, 2021



United Way St. Croix Valley, 2021

5. PRIORITIZATION OF HEALTH NEEDS

Once primary and secondary data were compiled and analyzed, discussions about the interpretation of the data were discussed in 90-minute increments with community partners every week for six weeks. The following criteria guided the discussion:

- Burden, scope, severity, or urgency of the health need.
- Estimated feasibility and effectiveness of possible interventions.
- Health disparities associated with the need.
- Importance the community places on addressing the need.

It was clear that mental health and substance use were at the top of list. Then, after reviewing Maslow's Hierarchy of Needs Pyramid, the Health Impact Pyramid, and the Socio-Ecological Model, it became apparent that the areas of greatest need and impact led to targeting SDOH. How could we help those with SDOH concerns and what health outcomes would we push to improve that the community was passionate about?

The **significant health needs identified** could be broken down into six main categories.

1. Basic needs and safety needs, that make up the deficiency portion of Maslow's Hierarchy of Needs Pyramid, are not being met.
    a. Basic needs - food, housing; safety needs - income, employment, education, transportation, childcare, financial security, broadband.
2. There is a lack of a comprehensive "community support system."
    a. This includes a lack of strong social and support networks, coordinated and comprehensive care, resources or resource capacity, volunteer opportunities.
3. Access to care, services, and opportunities is not equitable.
    a. Medical appointments, transportation, social opportunities, early childhood development, income, employment, education, broadband, inclusion, diversity, health equity.
4. It is imperative to address mental/behavioral health and substance use/chemical dependency/addiction.
5. Community leaders do not effectively collaborate at a strategic level and work as "one team."
6. Communication is not consistent.
    a. It is not easy to know where to go to get help and clear direction.
    b. Residents and leaders do not have a one-stop site to obtain information.

Since all six concerns cross over one another, SCRMC is choosing to address all six concerns over the next three years.

When determining how to present the health priorities in a language easily understood by our employees and community, the SCRMC CHNA and Implementation Strategy Steering Team chose to condense the six categories into three categories. We started our path selecting 1) access to services, 2) family and social support, and 3) health equity, diversity, and inclusion.

Following much discussion and trying to figure out what people could remember easily, we voted and selected to condense the three priorities even further. Since the word "access" adopted a broader meaning during this CHNA than in previous years, we chose to simplify it further. Instead of "access to services" we moved to one word, "access."

We also voted to move away from the phrase "family and social support" to "support." Since community experts and members used the term "support" in a broad perspective, we felt it was a good *fit*. It was simple to remember and reflected the essence of helping people and making it easier for them to get the help they need.

Lastly, “health equity, diversity, and inclusion” is a new phrase to many in our area. We wanted to be sure not to have anyone overwhelmed with three meanings in one priority area so we, again, voted to simplify the phrase to one word, “inclusion.” “Inclusion” was chosen because during the CHNA data collection process, we heard the word “belonging” enter many conversations. “Belonging,” which we interpret as another word for “inclusion,” encompasses the idea of both “health equity” and “diversity.” One is not likely to feel that “health equity” and acceptance of “diversity” is strong without feeling a sense of “belonging.” Therefore, “health equity, diversity, and inclusion” moved to “inclusion.”

Mental/behavioral health and substance use/chemical dependency/addiction, strategic integration, and communication, although they will not have their own category, will be intertwined into the access, support, and inclusion implementation strategies. SCRMC will use behavioral health and substance use health outcomes to measure the success of the access, support, and inclusion implementation strategies.

6. POTENTIAL RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

The main goal of the CHNA is to understand the needs of a community and the overall challenges they face while planning for future change. Community-level challenges can resonate through the needs of the individual, the organization, the neighborhood, or city/town/village. Within communities, various resources exist, including organizations, people, policies, and physical spaces among others, that elevate the quality of life of a community.

As each person has unique needs within the community, what an asset or resource is to one may not be for another. Homeless shelters, food pantries, clinics, financial assistance programs, and recreational centers are all examples of community resources that may be used by different community members. Identifying the resources that are available in the community and actively used are important factors as it can help ensure public awareness of available resources and demonstrate what models work well within a community and what can be done to fill in existing gaps.

There are hundreds of quality resources and programs that could help address significant health needs. In an effort to simplify, we condensed and categorized some of the available resources. For example, there are multiple "food pantries" in Polk County, yet you will only see "food pantries" listed one time below. For larger programs and resources, like 211, there are hundreds of basic needs and safety needs addressed within that one resource.

In primary data collection, it was clear that there are many quality resources available. The main issue lies in connecting those individuals with the correct resources. For people or families that have one basic need concern, for example food insecurity, they may also have concerns in other areas such as housing or paying for utilities. It is in the best interest of the community to be able to connect these resources and not send people or families from one phone number (or website) to the next. Having that link between organizations will make it easier for people to get help. To note, though, programs like 211 are only as strong as the organizations that put their information into them. For example, if there is a resource available, but they did not give 211 their information, they will not be listed in that database.

- 211
- Aging and Disability Resource Centers
- Amery Hospital and Clinic
- Birth to Three
- Burnett County Health Department
- Businesses
- Children & Families Polk County
- Chisago County Health Department
- Commodity Supplemental Food Program
- Community Referral Agency
- Economic Development Association/Authority
- Family Resource Center
- Feeding Wisconsin/Second Harvest Heartland
- Food Pantries
- FoodShare
- Head Start/Early Head Start/CESA
- HealthPartners
- Higher Education
- Independent Living Center
- Interfaith Caregivers
- Law Enforcement
- M Health Fairview
- Mental Health Task Force
- Municipalities
- Northwoods Homeless Shelter
- Osceola Medical Center
- People Loving People
- Polk County Health Department
- Salvation Army
- School Districts
- Seniors Farmers Market Nutrition Program
- St. Croix Regional Medical Center
- St. Croix Valley Food Bank
- Success by Six
- Supplemental Nutrition Program for Women, Infants and Children
- Temporary Emergency Food Assistance Program
- United Way St. Croix Valley
- Well Badger Resource Center

7. PRIOR CHNA AND IMPLEMENTATION PLAN RESULTS

The priority areas for the July 1, 2019 – June 30, 2022 CHNA and implementation plan were as follows:

- Mental Health
- Substance Abuse
- Nutrition and Physical Activity
- Access to Care

Actions taken by SCRMC to improve these areas:

Mental Health First Aid Training

- National skills-based training course that teaches participants about mental health and substance-use issues.
- 32 employees trained; 93% of triage nurses; 100% of Athletic Trainers prior to pandemic.
- Community Partner: United Way St. Croix Valley

Annual Make It OK Campaign

- Internal communication and external social media campaign to reduce the stigma associated with mental illness.
- Weekly campaign promotion in May (Mental Health Month) each year
- Community Partners: HealthPartners, United Way St. Croix Valley

Community Garden Class

- A curriculum approved class, "Muddy Feet and Healthy Eats," was offered in conjunction with the St. Croix Falls school district to help kids learn how to tend a garden while learning about growing healthy food, the benefits of eating healthy, and the importance of caring for the environment.
- 11 students enrolled in class; community garden created; 4.64/5.00 Experience Rating; 100% Likelihood to Recommend
- Community Partner: St. Croix Falls School District

Power of Produce

- St. Croix Falls primary care providers participated in a pilot initiative in collaboration with community partners to promote fresh, healthy fruits and vegetables to children. Select SCRMC providers handed out a "coupon" at well child visits with the intent for the child, and their family, to redeem it any of the local farmers markets for a $2 Power of Produce token. The token could then be redeemed with any of the onsite farmers.
- Redemption rate: poor (less than 10)
- Community partners: Amery Farmers' Market, Amery Medical Center, Osceola Medical Center, Osceola Farmers' Market, Polk County Public Health, St. Croix Falls Farmers' Market, United Way St. Croix, University of Wisconsin-Extension

Healthy or Transparent Food Options

- Nutritional values added to cafeteria items (State Street Café)
- Continue to offer gluten-free and vegetarian options and use whole grains whenever possible.
- Weekly drop off and pick up site for CSA (Community Supported Agriculture) program. Community members would buy food shares through CSA program, Steady Hand Farm would deliver produce, community members had local destination to pick it up
- Garden planted and maintained by nutrition services staff. Produce grown used in meals.

- Sponsored local farmers market.

Fresh Food Vending

- Opportunity for all shifts to have access to healthy options.
- Working with vendor to honor their commitment to "healthy options" and keeping items stocked
- Community Partner: Midwest Vending

Wellness Center(s)

- Over thirty fitness classes offered weekly to the public at Lindstrom Wellness Center (located in the Lindstrom Clinic) and Webster Wellness Center (located in the Webster Health Center) until shutdown due to pandemic in March 2020.
- Monthly workshops offered and planned/staffed through 2021. Workshops targeted healthy eating, chronic disease prevention, stress management, and physical activity. Terminated these offerings in lieu of pandemic.

Healthy Habits and Programming Enhancements

- Implemented employee wellbeing platform with associated incentives in 2021; paid out $79,950 in 2021
- Added myStrength as an activity option in late 2021, a comprehensive digital program with proven tools and activities for stress, depression, sleep and more.
- Changed Employee Assistance Program (EAP) vendor in 2021 and integrated EAP into online wellbeing platform in 2022.
- Wellbeats app added for utilization convenience. Wellbeats has virtual fitness, nutrition, and mindfulness classes for every age, interest, and ability level.
- Added Computerized Cognitive Behavior Therapy (cCBT) to EAP to help decrease stress.
- Added pre-diabetes and pre-hypertension diagnoses to Omada program.
- Community Partners: HealthPartners, Omada, Livongo

Healthier Together Moment/Mindful Moment

- The purpose is to take an intentional pause, a moment to help one relax, renew, and restore during the day. It can be as simple as an ice breaker activity, a stretch, or just taking a few deep breaths.
- Guide created and on MyWellness intranet site; incorporated into Monthly Power Point and encouraged to be used at monthly meetings (new suggestion/recommendation each month.
- Community Partner: HealthPartners

Culture of Health Systems Design Approach; Research/Education

- SCRMC was selected and participated in a Total Worker Health research pilot project with HealthPartners and the Harvard T.H. Chan School of Public Health. Total Worker Health strategies integrate safety and wellbeing functions in a coordinated team effort to drive health improvement. It shifts the focus from behavior change to addressing working conditions through policies, practices and procedures. Total Worker Health targets root causes.
- Published Research Article from study: Journal of Occupational and Environmental Medicine (May 2021, Vol 63, Issue 5, pp:411-421) titled "Building Capacity for Integrated Occupational Safety, Health, and Well-Being Initiatives Using Guidelines for Total Worker Health Approaches."
- SCRMC served as a co-presenter at the national Health Enhancement Research Organization (HERO) conference in collaboration with the HealthPartners Chief Science Officer/President of HealthPartners Institute, Adjunct Professor at Harvard T.H. Chan School of Public Health, and co-chair of the U.S. Secretary of Health and Human Services' Advisory Committee on National Health

Promotion and Disease Prevention objectives for 2030 (aka Health People 2030). The session was titled "Integrating Safety and Wellbeing to Drive Improvement."

Reach Out and Read (part of Little Moments Count initiative)

- Age-appropriate book distribution at well child visits. Eighty percent of a child's brain is formed between birth and age three. Also linked with well child visit compliance.
- Primary Care providers trained and program is implemented at Lindstrom Clinic; applied for all Wisconsin clinics, as well, but they were at maximum capacity and could not execute.
- Community Partners: HealthPartners, Allina Health, Sanford Health, Hennepin Health, Children's MN, The People's Center, Bethel University

Dental Clinic

- Opened Dental Clinic at Webster Health Center in Webster, WI, in July 2019.
- As of May 2022, SCRMC has had 5,658 total visits (almost 1,500 unique patients) with new patients being added each month; 20% of total visits have been to support the MA population.

Give Kids A Smile Event

- Annual dental event helping underserved children.
- 2022 – 9 children treated, $3,462 in cleanings, sealants, exams, fillings, and an extraction
- Community Partners: American Dental Association

Telehealth

- Expedited telehealth services in lieu of pandemic to continue offering care while keeping providers, staff, and community members safe. Began April 2020. SCRMC continues to utilize this service for patients and plans to provide enhancements in the near future.

Respiratory Clinic

- When COVID testing began, St. Croix Regional Medical Center responded with drive-through testing at our St. Croix Falls location. The first version of the drive-through was held outdoors to help prevent exposure to staff and other patients. As weather became a challenge, the drive-through added the capability for patients to be tested and screened indoors in a sectioned off area of the hospital. The demand to address a more long-term response to this type of testing became obvious. To respond to this need, SCRMC planned, built, and opened the Respiratory Illness Clinic on the St. Croix Falls campus to replace the drive-through. The Respiratory Illness Clinic offers patients a safe place to be seen for symptoms including fever, cough, sore throat, congestion, muscle/body aches, runny nose, loss of smell, and fatigue; symptoms associated with COVID, but also other highly contagious viruses. The Clinic, which opened in November 2020, offers a separate entrance for patients experiencing virus and flu-like symptoms to limit exposure. It also has a separate air handling system independent of the rest of the St. Croix Falls Clinic to restrict any airborne illnesses from being transported throughout the building.
- Beginning in January of 2021, SCRMC was one of the few medical centers in the area offering monoclonal antibodies treatment for COIVD-19. The FDA authorized the use of monoclonal antibodies that are given by IV infusion. These antibodies can attach to parts of the coronavirus and can help the immune system recognize and respond more effectively to the virus.

Overall impact evaluation: While all efforts listed above were noble and took a tremendous amount of teamwork and effort, without addressing physiological and safety needs at the base of what we do, long-term impact is difficult.

8. THE IMPLEMENTATION STRATEGY

A community implementation strategy is an action-oriented strategic plan that outlines priority health issues for a defined community, states how the issues will be addressed, and delineates indicators for measurement to ultimately improve the health of the community.

SCRMC's Mission, Vision, Values, and Standards of Behavior:

Mission: We help people live healthier, happier, and longer lives.

Vision: To transform from quality sick care to quality well care that is sustainable and affordable.

Values:

People Centered: We are committed to collaborate, coordinate, and provide accessible and affordable care that is based on shared decision-making between patients, consumers, their families, and care teams. We respect their preferences, values, cultural traditions, and socio-economic situations.

Trust: We are committed to act in the best interest of our patients, their families, our colleagues, and the communities we serve. We are thoughtful, consistent, and purposeful in all our actions. We trust others will perform at their best.

Innovation: We are committed to drive innovation by implementing products, services, processes, and business models that aim to improve quality, affordability, integration, and sustainability for our patients, consumers, and communities. We utilize technology to innovate and change the way people buy and use health care, and create business models that integrate the delivery of care between health care organizations or activities.

Growth: We are committed to invest in growth strategies independently or through partnerships and alliances to enhance services driven by customer need or demand that optimize revenue and opportunities for future expansion.

Standards of Behavior:

Service *Care with compassion*

I strive to make every interaction a positive one. I will promote a patient-centered and patient-safe environment by serving others to the best of my abilities.

Communication *Go the extra mile*

I listen attentively to guests and coworkers in order to fully understand and meet their needs while ensuring they feel valued and heard.

Teamwork *One team*

I represent the team and the organization in everything I do. How we perform together, directly impacts SCRMC's success and whether we are a desired place to work, to give and receive care.

Accountability *Own it*

I am accountable for my behavior and I take pride in the work I do at SCRMC.

Character *Walk the Talk*

I understand the impact that my character has on everyone around me.

Excellence *Lead by Learning*

I strive to be the best I can be at all times by learning, growing, and improving myself. I am dedicated to professional care.

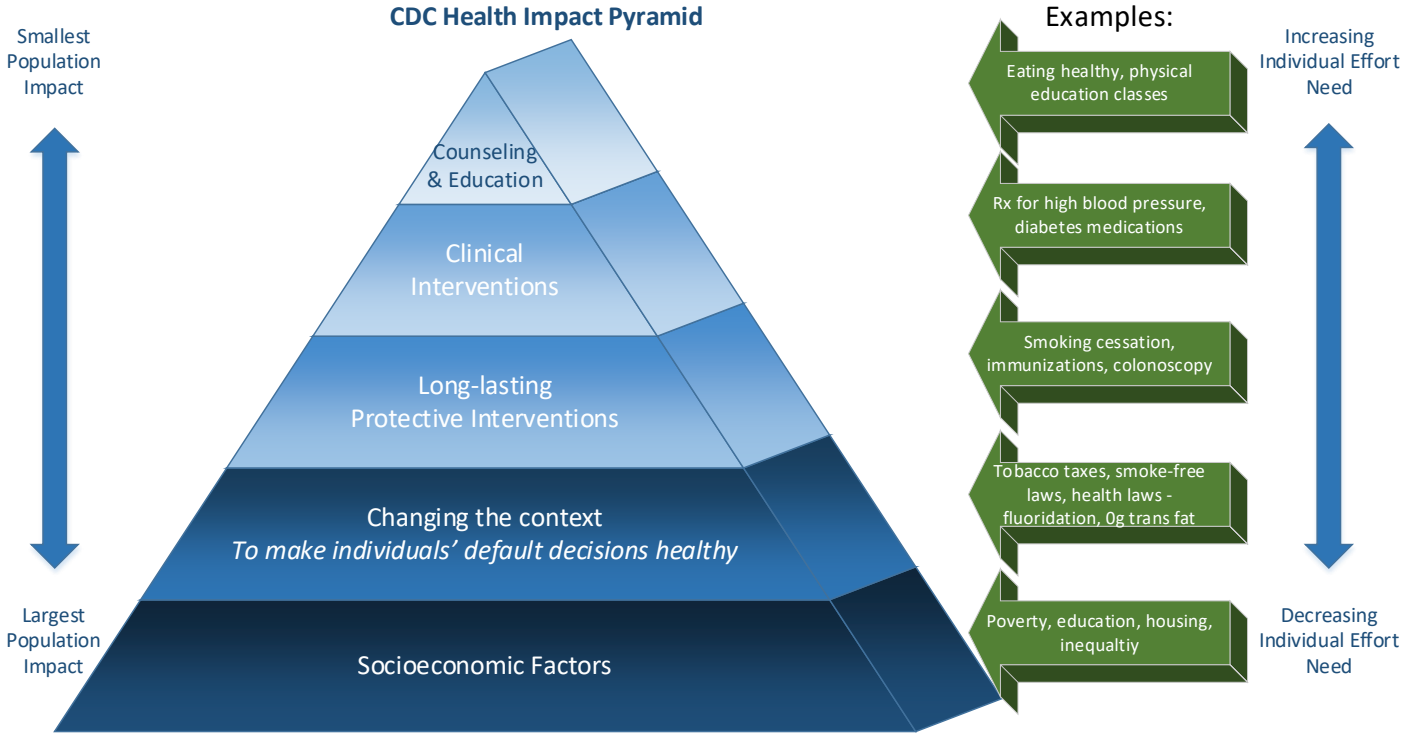
Health Concerns and Priority Focus Areas

When determining priority areas and intervention strategies, it was important to note that the two most commonly cited **concerns** surrounding diagnoses encompassed **mental health** and **substance use**.

With past CHNA priorities and implementation strategies, the areas of concern ended up being the chosen health priorities. This method has had a tendency to lack root cause analysis. In the past, once the community determined the priority areas, everyone jumped right into work groups and solutions. In an attempt to avoid duplication of unsuccessful efforts, the team focused on root cause analysis and on what might be the best way to move forward collaboratively. We focused on community assets and where the intervention or service disconnect became apparent, while staying grounded in theory. After many lengthy discussions, conversations, and interviews, the answer became clear. To keep it as simple as possible, this is the **problem** that emerged:

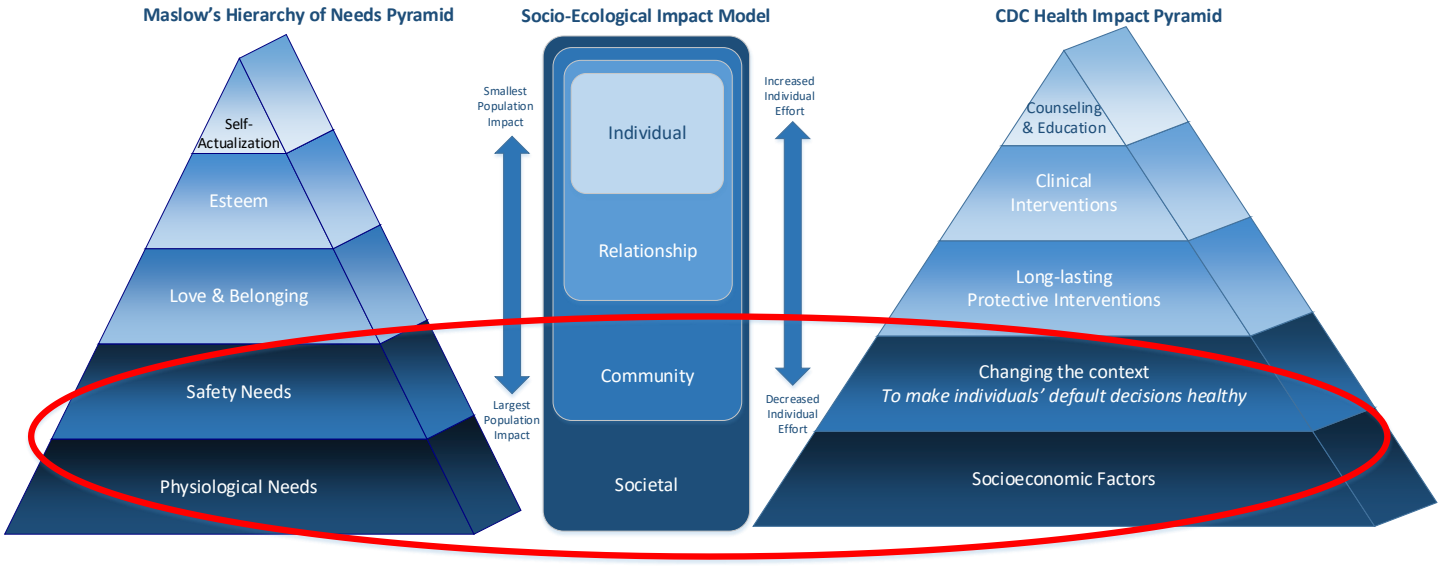
There is unequal accessibility with a "community health system" that does not consistently address socioeconomic factors, is difficult to navigate, and lacks smooth transitions.

The health impact pyramid identified below falls directly in line with the concerns and priority areas identified in the 2022 CHNA. Attention needs to be directed toward the base of the pyramid where impact will be the largest. As a healthcare system, SCRMC is well versed in the top three tiers. In moving toward the goal of transitioning from quality sick care to quality well care that is sustainable and affordable, focus needs to take hold at the root of the problem. SDOH and health disparities (upstream efforts) must be addressed collaboratively to create a solid foundation to build upon.



Frieden, T. A Framework for Public Health Action: The Health Impact Pyramid. Am J Public Health. 2010; April; 100(4): 590-595

Below is a brief visual review of the three models, from earlier in the report, that helped build the foundation of the July 1, 2022 – June 30, 2025 community implementation strategy.



SCRMC's **July 1, 2022 – June 30, 2025 Community Health Priorities** are:

1. **Access**
2. **Support**
3. **Inclusion**

SCRMC is passionate about delivering our community the care and services they need (**access**), with the help that they deserve (**support**), in an environment where they feel they belong (**inclusion**). We will work together **fluidly** to acquire, promote, and protect wellbeing across the lifespan. Our overarching strategy will be to **build systemic community infrastructure that drives health equity and social justice for all**. SCRMC will focus on multi-sectoral policy and action, integrated services, and empowering people and communities through collaboration.

OVERALL INDICTORS

Effect on mental health and substance use.

The following indicator(s) will serve the purpose of measuring if the health priority implementation strategies selected has an overarching effect on **mental health** and **substance use** from the IRS reporting period of July 1, 2022 to June 30, 2025.

1

INDICATOR: Decrease the percentage of adults self-reporting **fair or poor health status** (respondents who reported their general health status as "excellent," "very good," "good," "fair," or "poor").
Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. PLACES Data [online]. 2021 [accessed May 31, 2022]. URL: https://www.cdc.gov/PLACES. *Other: Behavioral Risk Factor Surveillance System(BRFSS), 2019.*
Baseline/Current Metric: 15%
Target Metric:

MEASURE	DATA TYPE	United States 2019 Population Estimate: 328,239,523	Chisago 2019 Population Estimate: 56,579	Polk County 2019 Population Estimate: 43,783	Burnett County 2019 Population Estimate: 15,414
Fair or poor self-rated health status among adults	Crude prevalence %	18.6	14.7	16.2	18.5
	Age-adjusted prevalence %	17.8	13.7	14.4	15.7
			Average age-adjusted prevalence = 14.6%		

Healthy People 2030 objective OHM-8: Respondent-assess health status - in good or better health. (Summary Mortality and Health tier).
Source: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People 2030: Overall Health and Well-Being Measures. Accessed July 30, 2021. https://health.gov/healthypeople/objectives-and-data/overall-health-and-well-being-measuresexternal icon.

2

INDICATOR: Decrease the percentage of adults reporting **mental health not good** for 14 or more days per month.
Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. PLACES Data [online]. 2021 [accessed May 31, 2022]. URL: https://www.cdc.gov/PLACES.
Baseline/Current Metric: 14%
Target Metric:

MEASURE	DATA TYPE	United States 2019 Population Estimate:	Chisago 2019 Population Estimate: 56,579	Polk County 2019 Population Estimate: 43,783	Burnett County 2019 Population Estimate: 15,414
Mental health not good for 14 or more days per month among adults	Crude prevalence %	14%	12%	13%	13%
	Age-adjusted prevalence %	14%	13%	14%	15%
			Average age-adjusted prevalence = 14%		

Healthy People 2020 objective HRQOL/WB-1.2: Increase the proportion of adults who self-report good or better mental health.
Source: National Health Interview Survey (NHIS), CDC/NCHS. Accessed May 2, 2022. https://www.healthypeople.gov/2020/topics-objectives/objective/hrqolwb-12

3

INDICATOR: Decrease the percentage of students who intentionally self-harm without intending to die (past 12 months).
Source: Youth Risk Behavior Survey - Polk County, 2019
Baseline/Current Metric: 20%
Target Metric:

	All Students	Female	Male	6th Grade	7th Grade	8th Grade	9th Grade	10th Grade	11th Grade	12th Grade
Anxiety Student who had experienced significant problems with anxiety (past 12 months).	49%	59%	39%	46%	56%	49%	44%	46%	50%	49%
Depression Students who experience prolonged, disruptive sadness (past 12 months). Specifically, it asked whether students had felt "so sad or hopeless almost every day for two weeks or more in a that [they] stopped doing some usual activities" within the past 12 months.	28%	37%	20%	23%	30%	33%	21%	25%	32%	27%
Self-Harm Students who intentionally self-harmed without intending to die (past 12 months)	20%	27%	13%	16%	22%	23%	16%	20%	21%	18%

In general, self-reported rates of anxiety and depression were high for students who:
1. had a low sense of school belonging
2. had experienced bullying, violence or trauma
3. had low grades
4. had anything else that set them apart from their peers, including race, class, sexual orientation and disability

Strategy specific action steps and plan to evaluate

ACCESS	Access to care, services, and opportunities is equitable for all community members (regardless of socioeconomic status).
POTENTIAL FUTURE INDICATOR: Increase the use of telehealth to improve access to health services - AHS-R02 SOURCE: Healthy People 2030 - Research POTENTIAL FUTURE INDICATOR: Increase the proportion of people with a usual primary care provider - AHS-07 SOURCE: Healthy People 2030 - Baseline only POTENTIAL FUTURE INDICATOR: Increase the proportion of adolescents who had a preventive health care visit in the past year - AH-01 SOURCE: Healthy People 2030 - Baseline only	

STRATEGY	ACTION STEPS	PLAN TO EVALUATE
Increase convenient opportunities to visit a health care provider.	Hire Family Practice Physician(s) and add appointment slots.	1. Successful onboarding of a Family Practice Physician with Obstetrics for St. Croix Falls and Webster Clinics. 2. Successful onboarding of Family Practice physician for Unity Clinic. 3. Increase visit capacity by two patient slots per provider due to improved efficiency and standardization of workflows.
Increase technology utilization to improve patient engagement and self-care.	Promote and educate providers/patients on MyChart ease of use and capabilities.	1. Number of providers (and/or patients) who use technology to communicate with and care for patients.
Anticipated **IMPACT:** Patients are empowered to help themselves live a healthier, happier, and longer life.		
RESOURCES SCRMC plans to commit: Admin/leadership, provider, staff time.		
Community **PARTNERS:** Allina		

STRATEGY	ACTION STEPS	PLAN TO EVALUATE
Create personalized professional development plan for every employee.	Research best practices for learning environments (physical and virtual) that promote innovation and learning.	1. Best practice learning environment report complete. 2. Environment best practices are built into new construction and rennovation build outs.
Create clear pathways for employee growth and development.	Create job architecture structure with a roadmap to promotional opportunities.	1. Job architecture is complete. 2. Located on SCRMC intranet site.
Create local workforce opportunities to support socioeconomic efforts (employment/income, family/social support).	Create a cutting edge education facility that has a regional simulation lab in operation with local peer mentorship programming.	1. Innovation Learning Center build out is complete at Unity Clinic. 2. Simulation lab in operation. 3. Peer mentorship program active.
Reduce barriers to job opportunities by providing supportive childcare options.	Offer employees childcare support.	1. Childcare services are offered to employees. 2. Track utilization rate.
Anticipated **IMPACT:** Families can stay, or come, to this area while earning a liveable wage, having access to affordable childcare, with opportunities for growth and development.		
RESOURCES SCRMC plans to commit: Admin/leadership, provider, staff time.		
Community **PARTNERS:** Regional Economic Development Agencies		

STRATEGY	ACTION STEPS	PLAN TO EVALUATE
Develop plan to create new, visionary physical structure.	Explore land opportunities and secure a land option for a new build.	1. Contract signed. 2. Initial plan for build complete.
Anticipated **IMPACT:** Promote growth, service, community integration, and provision of state of the art healthcare.		
RESOURCES SCRMC plans to commit: Admin/leadership, provider, staff time.		
Community **PARTNERS:** Regional community leaders, economic development groups		

SUPPORT	Community leaders work together to align strategic efforts and create a "community health system" that is easy to use, creates seamless transitions, and is built around supporting community members' ability to live healthier, happier, and longer lives (regardless of socioeconomic status).

INDICATOR: Decrease hospitalizations for preventable conditions from 2,161 to _____
SOURCE: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2020

INDICATOR: Decrease child food insecurity rate/# of food insecure children (Chisago: 10.4%; 15.8%; Burnett 20.8%)
Source: Feeding America, Map the Meal Gap, 2019

POTENTIAL FUTURE INDICATOR: Increase the proportion of adults whose health care provider checked their understanding – HC/HIT-01 or
INDICATOR: Decrease the proportion of adults who report poor communication with their health care provider – HC/HIT-02
SOURCE: Healthy People 2030 – Baseline Only

POTENTIAL FUTURE INDICATOR: Increase the proportion of people with substance use and mental health disorders who get treatment for both – MHMD-07
SOURCE: Healthy People 2030 – Baseline Only

STRATEGY	ACTION STEPS	PLAN TO EVALUATE
Establish and strengthen relationships with other community sectors.	Improve "crisis" intervention process with community partners (exp. law enforcement, public health, other social service agencies).	1. Clear process is in place with community partners. Quarterly meetings for evaluation and improvement.
	Create dedicated community relations team member.	1. Dedicated community relations team member has been successfully onboarded.
	Reach out to community partners and share an organizational overview in an effort to align strategically.	1. Engage with 25% of indentified partners across all four sectors (business, charitable, education, government).
Anticipated **IMPACT:** Community partners are aligning strategically and creating clear role delineation in multi-sector care.		
RESOURCES SCRMC plans to commit: Admin/leadership, provider, staff time.		
Community **PARTNERS:** Law Enforcement, Community Care Agencies		

STRATEGY	ACTION STEPS	PLAN TO EVALUATE
Become a community partnership leader.	Align social needs and health equity data with community partners.	1. Data collection methods are consistent. SCRMC and the community are using consistent terminology. 2. Data is being shared between sectors. Dashboard is created.
	Create and execute employee community engagement initiative.	1. Community volunteer opportunities are located on the SCRMC intranet and it is easy to sign-up to volunteer. 2. Financial resources are allocated in FY2023 forecast for paid time for all employees to participate in individual community engagement. 3. 100% of all employees have completed community engagement orientation.
Anticipated **IMPACT:** 1. Success is being measured consistently with community partners. 2. Employees are proud to be an active part of the community. Mental health will improve because employees are helping others and feel good about giving back to the community. SCRMC is a role model in supporting the community.		
RESOURCES SCRMC plans to commit: Admin/leadership, provider, staff time.		
Community **PARTNERS:** Community Care Agencies		

STRATEGY	ACTION STEPS	PLAN TO EVALUATE
Increase resource referrals for patients with unmet social needs.	Integrate socio economic screening questions into electronic health record (EHR) and create clear referral protocols and pathways.	1. Seamless referral pathways are created with community partners, and providers/staff are educated. 2. Questions are selected, uploaded into EHR, and providers/staff are educated. 3. Referrals tracked.
Anticipated **IMPACT:** SCRMC is actively identifying patients/community members with hardships. By asking the right questions, we can get people/families the help they need and deserve.		
RESOURCES SCRMC plans to commit: Admin/leadership, provider, staff time.		
Community **PARTNERS:** Allina, Community Care Agencies		

STRATEGY	ACTION STEPS	PLAN TO EVALUATE
Connect vulnerable populations to community resources.	Integrate Community Health Worker (CHW) into "community health system" that targets low-income youth and families.	1. CHW onboarding is successful. 2. Referrals tracked. 3. Likelihood to Recommend
	Create comprehensive community resource site for providers/staff to help patients/community members.	1. Community resources are located in one area on the SCRMC intranet.
Anticipated **IMPACT:** Patients/community members/families are getting the help they need, when they need it. Basic needs are being met. People are thriving.		
RESOURCES SCRMC plans to commit: Admin/leadership, provider, staff time.		
Community **PARTNERS:** Allina, Community Care Agencies, Public Health, University of Wisconsin-Madison		

STRATEGY	ACTION STEPS	PLAN TO EVALUATE
Provide patients with reliable and affordable transportation options.	Create short-term transportation plan until county-wide transit program is in place.	1. A short-term transportation plan is in place (12-36 months) and active. 2. Referrals tracked.
	Work with key stakeholders to create a sustainable and affordable long-term community transportation plan.	1. Transportation advisory group in place and SCRMC is at the table (minimum - one county). 2. Initial plan is developed with key stakeholders.
Anticipated **IMPACT:** Our patients/community members are getting the care, services, and resources they need to live healthier, happier, and longer lives.		
RESOURCES SCRMC plans to commit: Admin/leadership, provider, staff time.		
Community **PARTNERS:** Allina, Community Care Agencies		

STRATEGY	ACTION STEPS	PLAN TO EVALUATE
Provide support in navigating the health care system.	Create integrative support process for patients/community members.	1. Integrate one care team navigator for every five full-time Primary Care Physicians to assist patients with care coordination. 2. Likelihood to Recommend
Anticipated **IMPACT:** Getting patients/community members the care they need is easy.		
RESOURCES SCRMC plans to commit: Admin/leadership, provider, staff time.		
Community **PARTNERS:** Allina, Community Care Agencies		

INCLUSION	Community members feel "belonging" and are empowered to help themselves and each other live healthier, happier, and longer lives (regardless of socioeconomic status).

INDICATOR: Decrease the Area Deprivation Index (ADI) average
SOURCE: Area Deprivation Index; University of Wisconsin-Madison School of Medicine and Public Health, Neighborhood Atlas, 2019
Chisago, Polk, Burnett: 49 (1 is the least disadvantaged, 100 is the host disadvantaged)

INDICATOR: Prevent Social Vulnerability Index from increasing.
SOURCE: Social Vulnerability Index; Centers for Disease Control and Prevention and the National Center for Health Statistic, CDC - GRASP, 2018
Chisago, Polk, Burnett: .08 (1.0 is highest vulnerability, 0.0 is lowest vulnerability)

STRATEGY	ACTION STEPS	PLAN TO EVALUATE
Decrease stigma associated with getting mental health support.	Select and implement community-wide campaign in collaboration with community partners.	1. Campaign is rolled out annually.
Anticipated **IMPACT:** People don't feel ashamed talking about mental health. They get the help they need.		
RESOURCES SCRMC plans to commit: Admin/leadership, provider, staff time.		
Community **PARTNERS:** HealthPartners, Polk United, Mental Health Task Force, Polk County Public Health, Amery Hospital & Clinic, Osceola Medical Center		

STRATEGY	ACTION STEPS	PLAN TO EVALUATE
Promote a culture of "belonging" by increasing awareness in health equity, diversity, and inclusion.	Select or create a health equity, diversity, and inclusion curriculum. Roll out to employees annually.	1. Health equity, diversity, and inclusion education requirements have been completed by 100 % of employees.
Anticipated **IMPACT:** Employees/providers create a culture where our patients/community members feel welcome, included, and understood.		
RESOURCES SCRMC plans to commit: Admin/leadership time, provider time, staff time.		
Community **PARTNERS:** University of Wisconsin-Madison, Robert Wood Johnson Foundation, Mental Health Task Force		

STRATEGY	ACTION STEPS	PLAN TO EVALUATE
Create opportunities to increase the voice of the patient/community members.	Organize internal patient advisory committee and create charter.	1. Patient advisory charter complete. 2. Ten patients/community members have been recruited and have attended at least one meeting. 3. One patient/community member has attended a Board meeting to voice their experience journey.
Anticipated **IMPACT:** SCRMC understands the changing needs of the community.		
RESOURCES SCRMC plans to commit: Admin/leadership time, provider time, staff time.		
Community **PARTNERS:** Community Members, Patients, Community Care Agencies.		

9. ADOPTION OF COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGY

On June 28, 2022 the Governing Board of St. Croix Regional Medical Center, met to discuss the 2022 Community Health Needs Assessment (CHNA) and the July 1, 2022 – June 30, 2025 Implementation Strategy for addressing the community health needs. Upon review, the Board approved the CHNA and the Implementation Strategy.

Signature: _____ Date: 6/28/2022

Governing Board Chair