CentraCare Health

Community Health Needs Assessment
2015-2016

Assessment Summary

CentraCare Health

CentraCare Health, a not-for-profit integrated health care delivery system, operates six hospitals in Central Minnesota. Its flagship hospital, St. Cloud Hospital was being founded by the Sisters of the Order of St. Benedict in 1886, has grown from a small, community hospital to a comprehensive, high-quality regional medical center. CentraCare Health was formed in 1995 and has subsequently acquired or been asked to operate five additional hospitals in Central Minnesota including:

- CentraCare Health – Melrose
- CentraCare Health – Long Prairie
- CentraCare Health – Sauk Centre
- CentraCare Health – Paynesville
- CentraCare Health – Monticello.

OUR MISSION

"Our mission works to improve the health of every patient, every day."

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As the largest, integrated health care provider in the region, CentraCare offers a full spectrum of inpatient and outpatient services in addition to long-term care and senior housing.

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Cancer Care
Children's Services
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Direct Access Testing
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Senior Services
Sleep Medicine
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Stroke Care
Surgery
Trauma Services
Weight Management
Women's Services
Wound Care

In addition to its full-spectrum inpatient and outpatient care, CentraCare strives to improve community health by implementing a diverse range of *community benefit programs.*

CentraCare continues to evaluate and expand upon its role in promoting community health. Guiding this effort is the conviction that in order to advance the common good, special attention should be given to individuals who live at the margins of society – the poor and disadvantaged – and are more likely to encounter barriers to good health and wellness. This directive informs the organization's community benefit programs and the health needs assessment.

Affordable Care Act Mandate

CentraCare Health's Community Health Need Assessment and Action Plan, 2015-2016 was completed pursuant to the March 2010 mandate established by the Patient Protection and Affordable Care Act (PPACA). In order to qualify for status as nonprofit, tax-exempt hospitals under Internal Revenue Code section 501(r), CentraCare Health must "conduct a community health needs assessment (CHNA) and adopt [an] implementation strategy at least once every three years. (These CHNA requirements are effective for tax years beginning after March 23, 2012)."[1] Compliance with this new regulation is reported to the Internal Revenue Service, which has issued guidelines on how assessments are to be documented.

In fiscal year 2012-2013, CentraCare Health completed a community health needs assessment which revealed six community health issues and proposed a comprehensive strategy to address each one of the six issues. Having cycled through its first three-year period, CentraCare has reevaluated the community health needs in fiscal year 2015-2016 and adopted an action plan that will similarly promote community health in the subsequent three-year cycle. Above all, the assessment process, both now and in years past, has opened doors for greater collaboration among community partners by strengthening relationships and promoting a more efficient use of resources in monitoring and improving community health.

THE CHNA Process

Conducting a health needs assessment is a multifaceted process that requires ample preparation, effective use of resources, sound methodology, and collaboration on behalf of all stakeholders. With that in mind, the assessment process was organized into five main phases, which were further broken down into a series of interconnected components:

- Formation of System-Wide Working Group and Definition of Service Areas
- Data Collection and Analysis (April-June 2015)
- Initial Prioritization (July-August 2015)
- Evaluation and Assessment of Community Members (September-October 2015)
- Final Prioritization (November-December 2015)

Although the process moved in this chronological order, the complexity of the assessment process necessitated a fluid movement between each phase. Indeed, key to a thorough and comprehensive assessment is the ability to examine and re-examine each component of the process in light of what is learned in later phases of assessment.

[1] For a fuller discussion of the new requirements under 501(r), see http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act

CentraCare's Systemic Approach

CentraCare Health takes pride in its level of involvement in the community and its receptiveness to the community's health care needs. Therefore, system administration considered it both reasonable and appropriate that staff and leaders within CentraCare Health be charged with the task of conducting the assessment, rather than contract with a third party removed from the community itself. An internal team called the CHNA Working Group was assembled, comprised of individuals with diverse knowledge and expertise in health care delivery, administration, planning and development, marketing, community and government relations, among other departments (see Figure 1). This group, which consists of individuals from across the CentraCare Health system, is indicative of the collaborative nature of the CHNA process and a testament, more generally, of the mutual support among the system's hospitals. Additionally, hospital board members and executives were engaged in the assessment process at an early stage.

It should be noted that, although a system-wide approach was adopted for parts of the CHNA, each hospital is ultimately responsible for identifying specific health needs in the community that it serves and developing an implementation strategy (community benefit plan) to address these needs, all of which were reported (and can be found) in each hospital's respective CHNA summary. In the initial stages of data analysis and prioritization, all working group members were presented with data broken down by county in order to indicate most clearly those issues that were prevalent throughout the CentraCare service and those issues unique to each hospital service area. Furthermore, each member of the working group participated in the prioritization process so that the final set of community health needs might accurately reflect genuine issues that are prevalent within the broader CentraCare service area. However, each hospital within CentraCare Health developed an implementation strategy, specific to the needs of the corresponding hospital service area, in response to the findings of the collaborative assessment process.

Figure 1. Community Health Needs Assessment Working Group, 2015-2016

Name	Title	Affiliation
Amina Ahmed	Community Health Worker	CentraCare Clinic
Anita Arceneau	Specialist, Communications & Marketing	CCH – Regional Sites
Melinda Bemis	Director, Strategic Planning & Business Development	CentraCare Health
David Borgert, MBA	Director, Community & Government Relations	CentraCare Health
Craig Broman, MHA	President	CCH – St. Cloud Hospital
Dianne Buschena-Brenna, RN	Director, CentraCare Health Plaza	CentraCare Health
Delano Christianson	Administrator	CCH – Sauk Centre
Lori Eiynck	Specialist, Planning	CentraCare Health
Tom Feldhege	Chief Financial Officer	CentraCare Clinic
Jodi Gertken	Director, Wellness	CentraCare Health
Gerry Gilbertson	Administrator	CCH – Melrose
Joseph Hellie, MHA	Vice President, Strategy & Network Development	CentraCare Health
Janice Johnson	Director, Population Health	CentraCare Health
Paul Knutson	Specialist, Mission Development	CCH – St. Cloud Hospital
Dennis Miley	Administrator	CCH – Paynesville
George Morris, MD	Medical Director	CentraCare Clinic
Mark Murphy	Vice President, Operations	CentraCare Clinic
Rosemond Owens	Specialist, Health Literacy & Cultural Competence	CentraCare Health
Stephen Pareja	Director, Clinical Services	CCH – Monticello
Kathy Parsons, MHA	Director, Managed Care & Revenue Cycle	CCH – St. Cloud Hospital
Joni Pawelk	Director, Marketing	CCH – Monticello
Bret Reuter	Director, Spiritual Care	CCH – St. Cloud Hospital
Jodi Sanders	Coordinator, Regulation & Reimbursement	CCH – St. Cloud Hospital
John Schnettler	Director, Marketing	CentraCare Health
Todd Steinke	Director, Development	CCH Foundation
Dan Swenson	Administrator	CCH – Long Prairie
David Tilstra, MD	President	CentraCare Clinic
Mary Ellen Wells	Administrator	CCH – Monticello
Sonja Zitur	Director, Accounting	CentraCare Health
Kally Kruchten	Administrative Assistant	CentraCare Health
Benjamin Sehnert	Intern, Community & Government Relations	CentraCare Health

CentraCare Service Area

CentraCare Health provides comprehensive, high quality care to people throughout Central Minnesota. Our network is comprised of:

- 6 hospitals
- 6 nursing homes
- 18 clinics
- 4 pharmacies
- A variety of senior living facilities in 6+ communities

Figure 2. CentraCare Hospital Service Areas

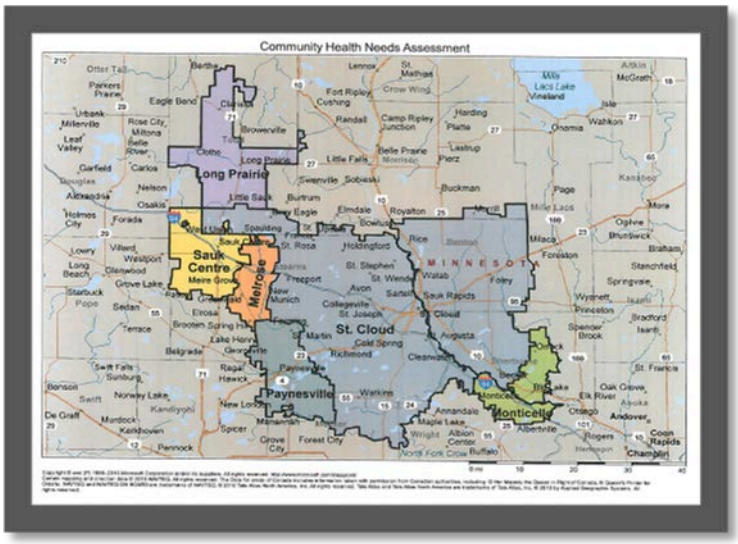

Figure 3. CentraCare HSA Zip Codes

Long Prairie Hospital	56440, 56347
Melrose Hospital	56335, 56352
Monticello Hospital	55309, 55362
Paynesville Hospital	55329, 56362, 56376
Saint Cloud Hospital	56307, 56310, 55308, 55319, 55320, 56320, 56321, 56329, 56331, 56333, 56336, 56340, 55353, 56356, 56357, 56367, 56368, 56369, 56371, 56301, 56302, 56303, 56304, 56372, 56393, 56395, 56396, 56397, 56398, 56399, 56374, 56375, 55377, 56377, 56379, 55380, 55382, 56387, 56388, 55389
Sauk Centre Hospital	56378

In determining the size of its service area, CentraCare Health has adopted the geographical demarcations put out by the Dartmouth Atlas of Health Care, which employs zip codes as the primary units in tabulating the extent of Hospital Service Areas (HSAs). Each zip code has been assigned to its corresponding hospital service area on the basis of where the greatest proportion of its Medicare residents were hospitalized (see Figure 3). When translated to the county level, the zip codes that constitute CentraCare's service area are located within Benton, Sherburne, Stearns, Todd, and Wright Counties in addition to the northern edge of Meeker County. The service area of CentraCare St. Cloud Hospital consists primarily of Benton, Sherburne and Stearns Counties, located in Central Minnesota. According to 2013 U. S. Census Bureau estimates, the St. Cloud Metro Area has a population of 210,978.

Data Collection and Analysis

Secondary data was chiefly extracted from the Community Health Status Indicators (CHSI) 2015 online web application made available by the Centers for Disease Control and Prevention. The selection of these indicators by the CDC was preceded by a review of both previously employed health indicators and the 2013 CDC monograph Community Health Assessment for Population Health Improvement: Most Frequently Recommended Health Metrics, which aims to inform the standardization of community health assessment work.[2] Inasmuch as we have sought to find reliable indicators that conform to national standards of community health evaluation, we heavily relied upon the CHSI 2015 indicators and topic areas in defining the framework of our own analysis.

The CHSI 2015 report utilizes a peer-county ranking system in which county values for each indicator were 1) ranked against the values of a grouping of peer counties (i.e. counties with similar demographics) and 2) divided into four

[2] To access an online PDF, visit http://www.cdc.gov/CommunityHealth/PDF/Final_CHAforPHI_508.pdf

quartiles. In the identification of possible community health needs, our data analysis focused on those values from Benton, Sherburne, Stearns, Todd and Wright.

Counties in the lowest three quartiles (as opposed to values in the first or "better" quartile). Data from Meeker County was consulted but did not play a decisive role in the selection of an initial set of health indicators. In the preliminary stages of data collection and analysis, we decided to include an indicator on our initial list of community health needs if any county value for that indicator either:

- fell within the fourth quartile
  OR
- fell within the second or third quartiles but was worse than the state average.

This standard was adopted as a mechanism for identifying those indicators in which the five-county area performed particularly poorly against state benchmarks and/or averages. All indicators for values in the fourth quartile were automatically added to our initial list of health needs (e.g. living near highways, coronary heart disease deaths, etc.) without further qualification. As noted, we determined to extract from the second and third quartiles only those values that fall below the Minnesota state average. Therefore, those values from the second or third quartiles in which the county performs better than the state were not included on our initial list. The CHSI 2015 report itself does not provide state averages for any indicators; we accordingly consulted the databases that the CHSI report employs to tabulate county values and subsequently identified the Minnesota state averages from the same data sets which had produced the county values for each indicator. These databases included (but were not limited to):

- National Vital Statistics System
- Behavioral Risk Factors Surveillance System
- American Community Survey
- American Health Resource File
- National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention Atlas
- National Environmental Public Health Tracking Network

Upon completion of the data collection and analysis phase, we had included 32 out of a possible 42 health indicators on the initial list of community health needs for the CentraCare Health service area. To this number were added three areas of concern among health care professionals within the CentraCare system: mental health provider access, severe head injuries, and transportation for non-English-speaking (e.g. Somali) patients. Thus, by the end of the data collection and analysis phase, the list of potential health priorities included 35 indicators which represented those needs which either had been identified by CentraCare personnel as areas of concern or in which the CentraCare service area performed poorly vis-à-vis the state.

Table 4. Data Collection and Analysis Components

Selection of Secondary Data Sources
• Review of CHSI Methodology • Familiarization with CHSI 2015 Indicators and Topic Areas
Extraction of Relevant Data
• Identification of County Values in Fourth Quartile • Identification of County Values in Second/Third Quartiles Below Minnesota State Average
Formation of Initial Health Indicators List
• Selection of 32 Health Indicators from CHSI 2015 • Addition of 3 Health Indicators by CentraCare Staff

Initial Prioritization

In order to prioritize the 35 health indicators, the CHNA Working Group reevaluated the set of five ranking criteria employed in St. Cloud Hospital's community health needs assessment of the previous cycle. Of these five, four were selected for inclusion in the 2015-2016 prioritization process. The criteria that were used, and their corresponding description are listed below:

- **Mission Relevancy:** the health issue falls within the hospital's overall mission and core competencies
- **Community Impact:** the prevalence and severity of the health issue
- **Resource Availability:** the availability of CentraCare's time, human, and strategic resources necessary to address the issue
- **Estimated Expense:** the expense (both internal and external) of addressing the issue

The prioritization process itself was divided into the two stages. The first stage consisted in rating each health indicator according to mission relevancy alone. Each CHNA Working Group member was sent a survey in which he or she either selected "yes" or "no" in response to the question, "Is each respective course of action relevant to CentraCare Health's mission and core competencies?" After a review of the responses to the survey, nine indicators, which had received less than 25% of the "yes" vote, were discarded from further consideration as priorities.

Because the indicators eliminated were indicators related to social determinants of health determined to be outside of the mission or core competencies of CentraCare Health does not mean that they are unimportant to CentraCare and those it serves. CentraCare remains active in community efforts to address these social determinants of health but does not include them among the determinants that can be directly addressed by the health care system.

The second stage of the process consisted in the prioritization of the remaining 26 indicators according to community impact, resource availability, and estimated expense.

From the list of 26 indicators, 10 determined to be most pressing and actionable were selected as system priorities and each system hospital was asked to address the 10 priorities in its action plan to be developed out of the needs assessment process.

The top 10 priorities were reviewed in comparison to data gathered in CentraCare's on-going, collaborative effort with area counties' Public Health Departments to complete their Health Needs Assessments. No data from the County Health Assessments contradicted the choice of the top priorities from the CentraCare Health Community Health Needs Assessments.

(It should be noted that the Top 10 Health Issues were modified for CentraCare Health – Long Prairie, CentraCare Health – Paynesville and CentraCare Health – Monticello due to their locations being in different counties with different profiles. The issues for those hospitals are included in this document after the listing of CentraCare's Top 10 Health Issues.)

Finally, the ranked issues were presented to each hospital's operating committees, boards, medical staffs and leadership group for feedback and clarification. Each hospital was asked to address all 10 ranked issues for their communities but focus on 3-5 issues that they felt they could take a leadership role in for their communities. Action plans will be developed for each hospital organization and community.

Health Care Issues Identified by the CentraCare Health Community Health Needs Assessment for CentraCare Health

Adult Obesity* – *The percentage of adults 20 years and older who report of BMI >=30

Adult Diabetes* – *The percent of adults living with diagnosed diabetes.

Older Adult Preventable Hospitalizations* – *The older adult preventable hospitalizations rate per 1,000.

Stroke Deaths* – *The age adjusted stroke death rate per 100,000

Coronary heart disease deaths* – *Coronary heart disease death rate

Cancer Deaths* – *Overall cancer death rate

Diabetes Deaths* – *The age adjusted diabetes death rate

Mental Health Access* – *Percentage of adults reporting a need for mental health services but not able to access services

Adult Smoking* – *The percent of adults who report smoking

Adult Physical Inactivity* – *The percent of adults who report no leisure time physical activity.

Health Care Issues Identified by the CentraCare Health Community Health Needs Assessment for CentraCare Health – Long Prairie

In addition to CCH Top 10 ranked issues:

Cost as a barrier to health care access* - *The percentage of adults who needed to see a doctor but did not due to cost

Access to healthy foods* – *the percentage of the population who are low income and do not live close to a grocery store

Health Care Issues Identified by the CentraCare Health Community Health Needs Assessment for CentraCare Health – Paynesville

Adult Obesity* – *The percentage of adults 20 years and older who report of BMI >=30

Adult Diabetes* – *The percent of adults living with diagnosed diabetes.

Adult Physical Inactivity – *The percent of adults who report no leisure time physical activity.*

Adult binge drinking - *The percent of adults who report binge drinking.*

Older Adult Preventable Hospitalizations – *The older adult preventable hospitalizations rate per 1,000.*

Pre-term Births – *The rate per 1,000 of births to females aged 15-19*

Teen Births - *The rate per 1,000 of births to females aged 15-19*

Stroke Deaths – *The age adjusted stroke death rate per 100,000.*

Adult smoking – *The percent of adults who report smoking*

Adult female PAP Test - *The percent of adult females who have had a PAP test in the past 2 years*

Health Care Issues Identified by the CentraCare Health Community Health Needs Assessment for CentraCare Health – Monticello

Adult binge drinking - *The percent of adults who report binge drinking.*

Adult smoking – *The percent of adults who report smoking*

Primary care physician access – *The rate of primary care providers per 100,000*

Adult female PAP Test - *The percent of adult females who have had a PAP test in the past 2 years*

Deaths from Alzheimer's disease – *Alzheimer's disease death rate per 100,000*

Deaths from cancer – *Overall cancer death rate*

Deaths from chronic kidney disease - *The age adjusted chronic kidney disease death rate*

Adult Diabetes – *The percent of adults living with diagnosed diabetes.*

Adult Obesity – *The percentage of adult obesity.*

Adult Physical Inactivity – *The percent of adults who report no leisure time physical activity.*

Cost as a barrier to health care access - *The percentage of adults who needed to see a doctor but did not due to cost*

CentraCare

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

The CHNAs for CentraCare's six hospitals as of January 1, 2016, were presented individually for each hospital. The Implementation Strategies focused heavily on health metrics as defined by the Community Health Status Indicators (CHSI) 2015 online web application made available by the Centers for Disease Control and Prevention. Throughout the last three years, each hospital has been gaining progress on their respective strategies and a report out will be conducted internally within CentraCare on the progress. A high-level overview of progress from Paynesville, Sauk Centre, Melrose and St Cloud hospitals can be seen in the table below. This list is in no way inclusive but provides an update on some of the work that our regional hospitals have been executing.

2016 Action Plan Goals	Hospital/Region	Actions Conducted since 2016
Goal: Decrease stroke deaths	St. Cloud Hospital	• SCH Stroke Center received the Get with the Guidelines- Stroke Silver Quality Achievement Award • Tele-stroke Program implemented • CentraCare website expanded to include stroke signs and risk factors • Stroke and blood vessel screening services expanded to new locations
	Melrose	• Tele-Stroke Program implemented • Designated as a Stroke-Ready-Hospital by MN Dept. of Health 4/2017
	Sauk Centre	• Added the Tele-stroke services for follow up care with stroke patients. • Have had 17 patients that have qualified for the post stroke visit, and 65% completed their post-stroke follow up via telehealth.
Goal: Decrease deaths resulting from Coronary Heart Disease	St. Cloud Hospital	• Mission: Lifeline STEMI transfer program implemented • SCH received AHA recognition at Silver Level
	Sauk Centre	• Sauk Centre refers patients with heart specific issues to the Cardiac Rehab program; over 100% of the patients had an increase in their overall Quality of Life Scores upon completion of the program.
Goal: Increase Awareness of Cancer risk factors and need for early intervention	St. Cloud Hospital	• Colorectal Cancer Risk Assessment Tool added to CentraNet along with other links with info about causes and prevention
	Sauk Centre	• Colorectal Cancer Screening began 6/2017; goal was 71.6%, now at 74.4% • Updated Infusion Center and expanded to 5 days per week • Added Tele-Oncology • Planning to update software to have 3D mammography

2016 Action Plan Goals	Hospital/Region	Actions Conducted since 2016
Goal: Decrease disease burden of Diabetes and improve well-being of those living with Diabetes	St. Cloud Hospital	• Education, screening, and decision-making tools surrounding Diabetes added to Centracare website
	Melrose	• Hired new staff through Accountable Communities for Health Grant to address Diabetes in Hispanic Population • Partnered with Catholic Charities to offer 6-week classes certified by the American Diabetes Association on Diabetes Self-Management • Continued partnership with Project H.E.A.L.
	Paynesville	• ICAN program established for diabetes support/education • The BASICS education program from International Diabetes Center was implemented by campus Dietician • Quarterly community-wide pre-diabetes education imployed 9/2016 • Annual Lunch and Learn education has included topics such as Diabetes on a Budget and Optimizing Medication/Treatment Goals
	Sauk Centre	• Diabetes Center now comes to Sauk Centre twice a month • Staff participated in 2-day training session with the IDC to provide improved care for our diabetic patients as well as a 90-day action plan to improve A1C in diabetic population
Goal: Decrease preventable hospital admissions for older adults	St. Cloud Hospital	• Community Paramedic Program expanded to additional regional sites
	Melrose	• Offered fall education at Melrose Spring Expo 4/2017 • Held an 'Aging Safely at Home' educational/community event 5/2018 • Started a Heart Failure Support Group 11/2017
	Paynesville	• CCH-P has participated in the Paynesville and Cold Spring Community EXPOs promoting healthy lifestyles
	Sauk Centre	• Utilized 'Health Care Home' to create a partnership between patient, family, provider, care coordinator, etc.
Goal: Increase Mental Health Care Access	St. Cloud Hospital	• Expanded Integrated Behavioral Health access to additional primary care clinics throughout the region • Expanded Adverse Childhood Events (ACEs) awareness resources in Trauma Informed Care
	Sauk Centre	• Sauk Centre clinic implemented SBIRT for patients with addictions to drugs and alcohol. This allows for screening and early intervention • Implemented Integrated Behavioral Health 3 days a week in Hospital Specialty Services effective 5/2017 • Implemented Tele-Behavioral health in the Emergency Room
	Melrose	• Met with Superintendent of Melrose Area School District to support and help pass referendum to build a more accessible footprint for exercise, including a new community Center • Collaborated with BLEND (now Feeling Good MN) and Chamber of Commerce to start local farmer's market in Melrose
	Paynesville	• Fare for All began providing food packs to the community 12/2016 • The CCH-P Farmer's Market completed its third year in 2018 • Two additional courses surrounding weight-related topics were added to CCH-P Lunch & Learn program in 2018-19 through Lifestyle Health • CCH Weight Management program extended to Paynesville 11/2017 • Campus Dietician has expanded services to Medicare and other insurance members for 1-to-1 weight management support
	Sauk Centre	• Yearly education on the NuVal food grading system at Coborn's takes place yearly at health fair

2016 Action Plan Goals	Hospital/Region	Actions Conducted since 2016
Goal: Decrease percentage of adults who report smoking	St. Cloud Hospital	• Implemented a tobacco treatment program allowing for both internal and external referrals • Now has 14 Tobacco Treatment Specialists that are available to see patients within an average of 4 miles of all primary care clinics • Feeling Good MN was created in 2/2018 from "Crave the Change" to decrease youth tobacco use rates and exposure to secondhand smoke • Supported 32 local policies raising age to purchase tobacco to 21 • Represents CentraCare on Sherburne Counties Federally Funded Drug-Free Communities Grant, exclusively working on the prevention of youth electronic cigarette use. • Annually participates in the legislative session; lobbying elected officials for tobacco prevention and control efforts.
	Paynesville	• Two Paynesville providers have been certified in tobacco cessation
	Sauk Centre	• Effective 7/2017 Tobacco Treatment appointments offered in Sauk Centre
Goal: Increase percentage of adults who report regular physical activity	St. Cloud Hospital	• CentraCare Wellness Website created to provide education, awareness, and resource directory centered around wellness
	Melrose	• Promote and encourage Melrose Riverfest 1K/5K Run & Walk; have had increased participation each year since 2017
	Paynesville	• CCH-P Co-sponsored 5K/10K runs annually in Coldspring, Richmond and Paynesville • Lunch and Learn opportunities have focused on health lifestyles including topics such as The Benefits of Mobility/Exercise. • CCH-P employee survey was completed, and results were shared with Paynesville Community Education to assist in identifying community opportunities to increase physical activity
	Sauk Centre	• Offers Silver Sneakers classes on site 3 days per week • Collaborates with Sauk Centre Chamber of Commerce to host an annual "Walk Your Sauks Off" fun walk; worked with Chamber to have 5K race during Sinclair Lewis Days 2017 • Working to bring BLEND program into schools • Created 'Women's Night Out' to promote community wellness

With the formation of the Central MN Alliance, the CHNA process and prioritization of community health issues is broadly focused on community issues rather than disease conditions specifically. The new framework relies on a mixture of national, state, and local data. The responsibility of coordinating the CHNA process for CentraCare now lies with the population health leadership team (PHLT). The team was formed in early 2017 dedicated to provides direction for all risk- based contracts and identify opportunities to increase value, improve quality, improve access, and decrease cost of care for patients.

CentraCare's health condition focus areas in 2019 include the following: diabetes, asthma, hypertension, depression, cardiovascular care (including preventive care and management of Congestive Heart Failure), and preventive care and health screenings (colorectal cancer screening, breast cancer screening, cervical cancer screening, and immunizations). These health condition focus areas will be used as population measures within the Community Health Improvement Plan with appropriate priorities.

CentraCare Health Community Health Needs Assessment Action Plans Summary
CentraCare Health – Long Prairie – Responsible Party – Dan Swenson

Priorities	Action Plan Description	Assigned to	Progress Summary	Status (c) Complete (I) In Progress (N) Not started
Obesity / Assess to Health Foods	Educating the community about the NuVal food grading system at Coborns and the ability to easily make healthier food choices by using NuVal system in the stores.	Clara Vancura	No longer using this system at Coborns	C
	Access to health Foods. Revitalizing the local Farmers Market on CCH-LP property every Friday May – October.	Misty Lemke		C
	CSA Shares for families that qualify. CSA Shares will continue through the winter months.	Katie Gruber		C
	Continue to collaborate with the Todd County extension office.			I
	Teaching health cooking/food choices at the school.	Clara Vancura	Provide nutrition and gardening classes in the	Complete and ongoing
	Fare For All. Food available to all at a discounted rate.	Katie Gruber		
Adult Diabetes/ Diabetic Deaths	Diabetes Center comes to CCH-LP twice a month to better serve our patients. The Diabetes Center offers a team approach to incorporate diabetes care into a patient's lifestyle to improve their health.	Julia Draxten Jodi Hillmer	We now have a chronic disease management RN, we continue to work with the Diabetes Center, as well as with Trish on same day	Complete
	Evaluate transition to our staff manager outreach clinic.	Julia Draxten		
	Monthly Diabetic Support Group	Clara Vancura	Continues monthly with variable attendance of community members.	Complete and ongoing
	Reviewed at weekly Case Review (Team Based Care)	Julia Draxten	*In progress, we meet bi-weekly to review diabetic*	*Complete*

Older Adult Preventable Hospitalization	Utilize Health Care Home to create a partnership between the patient, family, provider, care coordinator, and others designated for the patient care plan. The care coordinator is available to coordinate the patient care and improve the quality of life and health outcomes for those individuals with complex health conditions or disabilities	Julia Draxten	*TCM calls are fully activated. And care coordination fully engaged.*	*Complete*
	Continue to explore community paramedic program.	Jodi Hillmer	Community paramedic available 2 days a week	C
	Community Chronic Disease Management classes			
	Research telehealth services in our new Assisted Living	Jodi Hillmer Lisa Udy		N
Stroke Deaths	Telestroke has been implemented in our emergency room to improve the stroke outcomes of those patients receiving treatment. Telestroke uses a video communication to allow a neurologist to assess a patient as quickly as possible. Teleneurology appointments are scheduled for 30 days after their event, for qualified patients, to ensure additional follow up care is provided.	Jodi Hillmer	Implementation complete	C
Coronary Heart Disease Deaths	Long Prairie refers patients with heart specific issues to the Cardiac Rehab program. This program focuses on the lifestyle change, education, exercise, weight management and diet adjustments.	Jodi Hillmer	Program continues to be a success	C
Cancer Deaths	CCH Marketing Focus is currently Colon Cancer and Breast Cancer.	CentraCare Health Marketing		C

Mental Health Access	Goal is to pursue Telemental Health.	Jodi Hillmer Julia Draxten	IBH telehealth grant goes live in LP in June 2019.	In Progress
	The DIAMOND initiative is Depression Improvement across Minnesota that was launched in 2008 to improve depression care throughout the state. The Long Prairie Clinic is a certified DIAMOND site for patients with depression.	Julia Draxten	We are live with Diamond it is part of our health care home work.	C
	Research grant for pain management related to mental health, ie: Healing Touch	Julia Draxten Nicole Bjerke	A meeting with Ryan Engdahl is scheduled for 2/26/2019 to learn about CCH Integrated Behavior Health model. One CCH-LP-specific grant that is identified in mental health is through Sourcewell. This grant application is due in May 2019. We have not fully vetted this opportunity. CCH-LP has not determined if this funding is a good fit yet.	In Progress
Wellness	Annual Career Fair for High School students held in the fall with the community businesses, Schools, Military, etc.	Misty Lemke		C
	Silver and Fit exercises for seniors	Lisa Udy		C
	Wellness Coalition Committee working to promote wellness to the community.	Ben Dehn		C
Adult Smoking	2 certified providers to teach Smoking Cessation.	Tricia Shoutz Carol Klimek		C
Cost as a Barrier to health care access	Offer aide to patients for free Legal Aid services	Julia Draxten	Legal aid staff support patients once weekly.	C
	Medical Legal Partnership	Julia Draxten	Attorney on site one day per	C
	Having billing staff on site to answer patient questions.	Sarah Shutter	Staff now available	C

CCH-P Community Health Needs Assessment Update through Q2 FY2018
Action Plan Summary

Priorities	Action Plan Description	Assigned to:	Progress Summary	Timeline
Adult Obesity	Contact community partners to explore mutually beneficial healthy food choices.	Marketing/ HR	Fare for All began providing food packs to the community 12/2016. Program continues with 1923 packs sold through 12/2018. The CCH-P Farmer's Market completed its third year in 2018. Expanded to weekly markets in 2019. Project Heal was demonstrated during 2017 and was discontinued due to lack of participants. CCH-P has been leading by example by increasing healthy options in vending machines to 75%. In 2018 beverages con- taining sugar were removed from all campus vending.	Three-year plan ends FY 2019
	Provide community wide education on Obesity Prevention.	Marketing, Dietician, Clinic	Weight related topics have been part of the CCH-P Lunch and Learn program for the past three years. Two additional educational courses were added in 2018-19 to the community through Lifestyle Health called Eat, Drink and be Mindful--a six course series. Social media focus on weight management has included the Paynesville area community.	Three-year plan ends FY 2019
	Explore weight loss options with an internal (CCH) and external (service area) weight loss program.	Director of Patient Care and Clinic Services	Biometric screenings offer an incentive for CCH employees related to insurance premiums. CCH Weight Management was extended to Paynesville 11/2017. The program includes a telehealth component. Since the program started 93 program participants have been seen from the Paynesville service area. The campus dietitian has expanded services to Medicare and other insurance members for 1-to-1 weight management support where their BMI is greater than 30.	Three-year plan ends FY 2019
	Evaluate feasibility of an ICAN program in Paynesville.	Director of Finance, Dietician	ICAN was explored and established for diabetes support/education. Moved to Adult Diabetes area of Community Health Needs Assessment work plan under community education.	Three-year plan ends FY 2019
Adult Diabetes	Quarterly community-wide Prediabetes education done by dietician	Dietician	Quarterly community-wide pre-diabetes education has been completed since September 2016 and will continue going forward.	Three-year plan ends FY 2019
	Explore additional education options beyond quarterly prediabetes education	Clinical Staff: Clinic, hospital, CDE	The BASICS education program from International Diabetes Center was implemented by campus dietician for support of new diabetics including medication changes and annual reviews.	Three-year plan ends FY 2019
	Increase the overall D5 rate (Non Tobacco Use, BP <140/90, Aspirin Use, A1C <8, Statin Use, Foot & Eye Exam, Microalbumin, A1C last 12 months) in our patient population.	Physician Quality Champion, Director of Clinic	The baseline score for D5 rate on 9/30/2016 was 28.6%. The D5 rate on 12/31/2018 was 46.5%. Clinic leadership, staff and providers continue to focus on this area as a community measure.	Three-year plan ends FY 2019
	Increase diabetes community education including health fairs and lunch-and-learns.	Dietician/Marketing	ICAN was established for diabetes education in the Paynesville service area. Education through ICAN involved training of the campus dietician and one community member along with the College of St. Benedict. This is an ongoing effort. Annual Lunch and Learn education has included topics such as Diabetes on a Budget and Optimizing Medication/Treatment Goals. Two Paynesville providers have been certified in tobacco cessation to support work around diabetes. CCH-P has participated in the Paynesville and Cold Spring Community EXPOs promoting healthy lifestyles.	Three-year plan ends FY 2019
Adult Physical Inactivity	Explore relationships with other partners to create opportunities for physical activity (walk-a-thons, bike-a-thons).	Foundation, Administration	CCH-P has co-sponsored 5K and/or 10K runs annually in Coldspring, Richmond, and Paynesville. The campus continues to explore partnering opportunities with area community education departments to support joint iniatives related to healthy lifestyles.	Three-year plan ends FY 2019
	Explore a community partnership (school, Rose Center) to encourage the use of the school facility for physical activity.	Administrator	Lunch and Learn opportunities have focused on health lifestyles including topics such as The Benefits of Mobility/Exercise.	Three-year plan ends FY 2019
	Survey employees to solicit ideas for increasing physical activity within our communities.	Senior Services Director	The employee survey was completed with 129 respondants. Results were shared with Paynesville Community Education to assist in identifying community opportunities to increase physical activity.	Three-year plan ends FY 2019

Priority Area: Mortality: Stroke Deaths			
Goal: Implement policies and process the decrease the number of residents that die as a result of strokes			
ACTION PLAN			
Activity	**Lead Person/Contact**	**Anticipated Outcome or result**	**Progress/Notes**
Continue TeleStroke Program locally: Patients who access CentraCare Health – Melrose have TeleStroke connect in real time with an interventional neurologist from St. Cloud Hospital Stroke Center	Trista Klaphake	Speed decisions, which will improve patient outcomes.	Telestroke Map Current Locations
Teleneurology: Provides better access to neurological care at CentraCare Health – Melrose.	Sara Zastrow	Keeps recovering stroke patients closer to home, for follow-up appointments	
Designation of a Stroke Ready Hospital			Designated as a Stroke Ready Hospital by Minnesota Department of Health in April 2017.
Stroke Signs & Risk Factors on CentraCare Health website: Includes FAST assessment and downloadable link to the Stroke Education packet		Education and Awareness	Stroke Care - CentraCare Health, Central Minnesota
RESOURCES			
CDC Division for Heart Disease and Stroke Prevention	Evaluation Resources Educational Materials Data & Statistical Tools	Program Planning and Evaluation	Division for Heart Disease and Stroke Prevention-DHDSP|Home Page|CDC
National Institute of Neurological Disorders and Stroke		Public Information Research Programs Diversity Enhancement	NINDS | Preventing Stroke | Brain Basics
Community Tool Box -- Tools and Resources For building healthier communities --			Community Tool Box

Priority Area: Teen Births: The rate per 1,000 of births to females aged 15-19

Goal:
Continue to monitor this health status indicator but plan to focus on higher priority issues over the next three years.

ACTION PLAN

Activity	Lead Person/Contact	Anticipated Outcome or result	Progress/Notes
Collected data to understand and monitor the Melrose teen birth rate. FY2013 was an unusually high number but has since declined. Will continue to monitor.	????		Will continue to look at data to understand what occurred in FY 2013. Did school curriculum/sexual education change that year which resulted in a higher number of teen births? Held meeting on 11/6/17 to discuss.

RESOURCES

Priority Area: Mortality & Morbidity Diabetes: *The percentage of adults living with diagnosed diabetes.*			
Goal: Implement policies and process the decrease the disease burden of diabetes and improve the well- being of those living with diabetes.			
ACTION PLAN			
Activity	**Lead Person/Contact**	**Anticipated Outcome or result**	**Progress/Notes**
Accountable Communities for Health Grant to address Diabetes in Hispanic Population -- Use of Emerging Professions Community Health Workers. Hire Jonathan Walz, CHW, as a CCH-Melrose employee.	Julia Draxten Rachael Lesch LeschR@centracare.com	Decrease disparities in diabetes care and disease burden	Hired Jonathan Walz, CHW, as a CCH-Melrose employee to work with the Hispanic population.
Diabetes Self-Management Education certified by the American Diabetes Association -- Classes are offered in both individual sessions and a group setting.	Julia Draxten	Diabetes Self-Management	Partnered with Catholic Charities to offer a group 6-week class. 13 community members signed up. Classes held 9/15/17-10/20/17.
Continue partnership with Project H.E.A.L. – a program of the CentraCare Family Medicine Center that provides health screenings at social service organizations to meet the needs of those who are otherwise unable to access health care.	Julia Draxten		Monthly Melrose service offered by one of our family medicine providers.
Health Care Home coordinators more involved in diabetes patients; providing more education on what it is, how to manage, etc.	Julia Draxten		Brainstorm the implementation of the year long I CAN prevent diabetes program.
RESOURCES			
American Diabetes Association Diabetes Pro – Professional Resources Online			American Diabetes Association
CDC: Preventing Diabetes			Preventing Diabetes | Basics | Diabetes | CDC
National Institute of Diabetes and Digestive and Kidney Diseases NIH			National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
The Guide to Community Preventive Services: Diabetes Prevention and Control			http://www.thecommunityguide.org/diabetes/index.html

Priority Area: Healthcare Access and Quality: Older Adult Prevention of Hospitalization			
Goal: Implement policies and process the decrease the number of preventable admissions for Older Adults			
ACTION PLAN			
Activity	**Lead Person/Contact**	**Anticipated Outcome or result**	**Progress/Notes**
Expanded Programs for Fall Prevention: Stepping On Program in collaboration with Central Minnesota Council on Aging and MDH --	Eileen Maus Melissa Hjelle—Injury Prevention Specialist	Increase Awareness, Improve confidence and physical activity, Education on reducing fall risk	Fall education at the Melrose Spring Expo, 4/8/17.
Expand Home Safety Assessments – Occupational Therapy home visits after patient is discharged	Summer Erdmann	Falls are the most frequent cause of preventable admissions – Increase awareness and decrease hazards in home living environment	Held an 'Aging safely at home' educational/community event May 16, 2018 to increase awareness and decrease hazards in home living environment.
Expand Community outreach services	Lori Klinkhammer	Educate and support patients dealing with heart failure on healthy eating and resources needed to stay healthy.	Started a Heart Failure Support Group Nov. 9, 2017.
RESOURCES			
Minnesota Falls Prevention: STEADI (Stopping Elderly Accidents, Deaths & Injuries) Toolkit			Minnesota Falls Prevention
National Council on Aging Program Summary: A Matter of Balance			A Matter of Balance - Falls Prevention Program | NCOA
Community Tool Box -- Tools and Resources For building healthier communities --			Community Tool Box
CDC: Older Adult Falls Program – Publications and Resources			Older Adult Falls | Home and Recreational Safety | CDC Injury Center

Priority Area: Pre-term Births: The rate per 1,000 of births to females aged 15-19			
Goal: Continue to monitor this health status indicator but plan to focus on higher priority issues over the next three years.			
ACTION PLAN			
Activity	**Lead Person/Contact**	**Anticipated Outcome or result**	**Progress/Notes**
Compiled data for the Melrose area. Looking to take a deeper dive into the details of what is out of the norm, is it in a specific culture, smoking mothers, mothers using alcohol, etc..	?????		Currently studying and monitoring the numbers.
RESOURCES			

Priority Area: Morbidity: Adult Obesity – The percentage of adults 20 years and older who report BMI >=30			
Goal: Implement policies and process to decrease the percentage of adult residents with BMI >= 30			
ACTION PLAN			
Activity	**Lead Person/Contact**	**Anticipated Outcome or result**	**Progress/Notes**
Expand partnership with Melrose Area School District to create a healthier community by making healthy options automatic, affordable and accessible for everyone.	Gerry Gilbertson	Education, Support and Programming options	Met with Superintendent to support and help pass referendum to build a larger, more accessible footprint for exercise, wellness activities and community center. Referendum failed 2016. New superintendent in 2017. Gerry had brief meeting with him to discuss our interest and support to build something for the community.
Expand collaboration with CentraCare Health Foundation to educate the community and raise awareness of Coborn's Dietitian's Choice (previously called NuVal) and BLEND initiatives.	Julie Baum	Education, Support and Programming options	Julie continues to work with BLEND and the Chamber of Commerce to start local Farmer's Market to Melrose. 2018 Farmers Market successful with over 11 vendors and an average of 170 community members each Wednesday.
RESOURCES			
CDC: Overweight & Obesity			Overweight & Obesity | CDC Prevention Strategies & Guidelines | Overweight & Obesity | CDC
National Institutes of Health – Obesity			Obesity Health Problem, Healthy Weight Basics, NHLBI, NIH
Community Tool Box -- Tools and Resources For building healthier communities --			Community Tool Box

Priority Area: **Health Behaviors: Adult Binge Drinking – Percentage of adults who report binge drinking**			
Goal: Continue to monitor this health status indicator but plan to focus on higher priority issues over the next three years.			
ACTION PLAN			
Activity	**Lead Person/Contact**	**Anticipated Outcome or result**	**Progress/Notes**
We will consider the Stearns County Public Health Survey to see if there are any statistics in the 56352 Melrose zip code to understand how big of an issue it is.	????		Will monitor.
RESOURCES			

Priority Area: Health Behaviors: Adult Physical Inactivity: The percent of adults who report no leisure time physical activity			
Goal: Implement policies and process to increase the percent of adults who report regular physical activity			
ACTION PLAN			
Activity	**Lead Person/Contact**	**Anticipated Outcome or result**	**Progress/Notes**
Promote and encourage Melrose Riverfest 1K|5K Run & Walk	Anita Arceneau	Make the healthy choice, the easy choice -- opportunities for wellness activities	Successful 2017 5K event with 80 participants. Encourage the entire family to join. Will continue every year. Successful 2018 5K run and Kids 1K event with over 100 participants.
Expand partnership with Melrose Area School District to create a healthier community.	Gerry Gilbertson	Education, Support and Programming options	Continue to have discussions with school.
CentraCare Health Wellness Website	Lori Klinkhammer	Education, Awareness, Resource Directory	Wellness - CentraCare Health, Central Minnesota
RESOURCES			
The Guide to Community Preventive Services Increasing Physical Activity			The Community Guide - Increasing Physical Activity
CDC Guide to Strategies to Increase Physical Activity in the Community			Community Strategies | Physical Activity | CDC
Community Tool Box -- Tools and Resources For building healthier communities --			CHORC

Priority Area: Obesity and Inactivity

Goal: Educate and support local health and wellness activities that will promote healthy weight and increased activity among those we serve

ACTION PLAN

Activity	Lead Person/Contact	Anticipated Outcome or result	Progress/Notes
Continue partnerships with local school districts to provide health and nutrition education assistance among students	Heather Eidem eidemh@centracare.com	Education and Awareness	• August 2016; Nutrition education to STMA schools • October 2016; Food Allergies presentation to Monticello School District kitchen staff • November 2016; Diabetes education to Maple Lake schools
Continue the incorporation of BLEND (Better Living: Exercise and Nutrition Daily) principles and events at CentraCare Health – Monticello and in the communities we serve	Melissa Pribyl pribylm@centracare.com	Education on community resource for obesity reduction and healthy weight management	• BLEND collaboration on Monticello's Safe Routes to School planning grant application (& approval!)
Support community activities that promote healthy lifestyles	Heather Eidem eidemh@centracare.com Melissa Pribyl pribylm@centracare.com	Education and promotion of local health and wellness	• June-July 2017 Activity information and stretch bands at Farmer's Markets and Wellness in the Park • Bike Rodeo and Helmet Sale June 2017, June 2018 • Open Streets STMA May 2017, May 2018 • Open Streets Albertville Sept. 2017 (hula hoops) • Big Lake ECFE events • Bertram Blast sponsor • Timberdash sponsor and booth participant
Increase community health and wellness communication by sharing area events on	Melissa Pribyl pribylm@centracare.com	Community members, patients and employees	• Digital signage installed June 2017; various topics communicated

Community Health and Wellness electronic board		will have increased knowledge of area events related to health and wellness	
Explore efforts to increase participation in employee wellness program locally at CentraCare Health - Monticello and increase awareness of wellness opportunities throughout CentraCare	Melissa Pribyl pribylm@centracare.com	Increase employee participation in wellness activities; create wellness center with designated employee campaign funds	• Increased communication of events/programs with addition of educator Mackenzie Hauer • Wellness Fitness Center opened 10/2018 • Employee Wellness Coaching offered in Monticello • Yoga classes offered on campus • Community Supported Agriculture (CSA) offered for employees
Investigate the addition of an annual "Healthy BMI" challenge to CentraCare Health – Monticello employees; possibly challenge other businesses in the area we serve to do the same	Melissa Pribyl pribylm@centracare.com	Increase employee participation in wellness activities	
Explore a sponsorship/partnership project to promote walking, biking, and running in our community such as: install signage on area pathways to identify distances to popular destinations, sponsorship at the bike challenge course, extend campus walking path	Melissa Pribyl pribylm@centracare.com	Educate and promote health and wellness in community	• Collaborative team working on Safe Routes to School application for Monticello School District • Sponsored a bike repair station at local challenge bike course • Added bike hitches to redesigned main entrance

			• Participated in Big Lake's Bikeable Community Workshop 6/2018, member of "Bike Big Lake" Advisory Committee • Participated in Monticello's Downtown Area Study to encourage walkability/bikeability, member of "Monticello on the Move" committee
Explore working with the Health Promotion Coordinators at Wright and Sherburne County to implement Workplace Wellness strategies at CentraCare Health – Monticello	Melissa Pribyl pribylm@centracare.com	Increase employee participation in wellness activities	
Incorporate health and wellness activities/ promotions in our community interactions	Joni Pawelk pawelkj@centracare.com	Promotion of health and wellness in our community	• Kid-friendly pool noodle obstacle course added to hospital's Community Picnic August 2016 • Hula Hut at Community Picnic August 2017 • Ninja Warrior Course (teen-adult) and kid-friendly warrior course at Community Picnic August 2018 • Jump Ropes as parade handout • Sponsored Little Mountain Elementary's Color Run 2017, 2018

RESOURCES			
BLEND -Better Living: Exercise and Nutrition Daily	Educational website, Facts, and Initiatives	Public Information	blendcentralmn.org
Wright County Public Health	Local resource for assessment, referral, planning, and support		co. wright.mn.us
Sherburne County Public Health	Local resource for assessment, referral, planning, and support		co. sherburne.mn.us
Local school districts	Local resource for assessment, referral, planning, and support		monticello.k12.mn.us biglake.k12.mn.us becker.k12.mn.us isd728.org

Priority Area: Mental Wellness

Goal: Increase availability of mental health services, educate and increase awareness, and support local organizations that enhance mental wellness

ACTION PLAN

Activity	Lead Person/Contact	Anticipated Outcome or result	Progress/Notes
Continue partnership and support of the Bounce Back Project to promote health through happiness; Provide the community and employees tools to increase resiliency	Melissa Pribyl pribylm@centracare.com	Sponsor 3 Bounce Back Project community events each year	• Hosted "Wanna Come Out & Play" in January 2017 for 150 guests; January 2018 131 guests • Monticello's Downtown Block Party booth July 2017; Party in the Park July 2018 • Bounce Back booth at the Wright County Fair July 2017 – helped man booth; July 2018 • Magic of Self Care event March 2018 • Self-Care boxes shared at Monticello's Diversity event • FY2018: 57 Bounce Back resiliency presentations and 12 Self-Care presentations
Increase awareness of mental health/chemical dependency services for our residents who do not currently have access	Jennifer Smolen smolenj@centracare.com	Access and Referral information shared at Project H.E.A.L. and local faith organizations	• Social workers added to volunteers of Project HEAL • GBHU opened July 2017 • Project HEAL brochures shared with Tri-Valley Headstart group
Consider expanding the Healthy at Home offerings to include mental health follow up	Gordy Vosberg vosbergg@centracare.com	Service Enhancement	

Participate in community-based collaborative efforts around mental wellness	Dr. John Hering john.hering@centracare.com Melissa Pribyl pribylm@centracare.com	Education and promotion of wellness	• Facilitated and co-sponsored Screenagers film at 4 local school districts Spring 2017 • Sponsored Community Book Read ("Gifts of Imperfection"), shared 500 books • Bounce Back event: Magic of Self-Care March 3, 2018
Consider implementing a high school pilot program to introduce, instruct, and incorporate resiliency tools with students, including a pre- and post- resiliency survey	Melissa Pribyl pribylm@centracare.com	Education and Awareness; Develop ongoing curriculum to support students	• 6-week Bounce Back Resiliency curriculum facilitated at Monticello Alternative Learning Program Nov-Dec. 2017
RESOURCES			
Bounce Back Project	Educational website, Tools, and Event information	Public Information	bouncebackproject.org
Central MN Mental Health Center	Local resource for assessment, referral, planning, and support	Public Information	cmmhc.org
Wright County Health & Human Services	Local resource for assessment, referral, planning, and support	Public Information	co. wright.mn.us
Sherburne County Health & Human Services	Local resource for assessment, referral, planning, and support	Public Information	co. sherburne.mn.us
Local school districts	Local resource for assessment, referral, planning, and support		monticello.k12.mn.us biglake.k12.mn.us becker.k12.mn.us isd728.org

Priority Area: Primary Care Access

Goal: Supplement current services and expand services to increase access to care for those we serve

ACTION PLAN

Activity	Lead Person/Contact	Anticipated Outcome or result	Progress/Notes
Continue to recruit primary care providers to CentraCare Health – Monticello to support access to primary care services	Dr. John Hering john.hering@centracare.com	Add 2 new primary care providers by end of FY2017	• Dr. Teresa Divine - Stellis Health • Evan Dyce, CNP – Monticello Medical Group
Continue current partnership with Project H.E.A.L. and consider expansion within our service area	Melissa Pribyl pribylm@centracare.com	Service Enhancement, Screening and Referral; expansion of Project H.E.A.L. by FY2017	• Project HEAL started in Big Lake December 2016
Partner with local organizations to promote health education and awareness	Melissa Pribyl pribylm@centracare.com	Education and Awareness	• Wellness Fair -Monticello High School in 2017 and 2018 • Wellness Fair – City of Elk River Oct. 2017 • Bounce Back and Importance of Good Sleep Lunch & Learns – Bondhus • Wellness Fair – Cargill Feb. 2018 • Wellness Fair – Cornerstone Chevrolet June 2018
Continue to expand Women's Health services on campus	Dr. John Hering john.hering@centracare.com	Add midwifery services in FY2016 and increase births at CCHM by 50 in FY2017	• Midwife Diane Larson added August 2016 • Midwife Jessica Borgstrom added February 2017

			• Births increased from 245 to 250 in FY2017 • Perinatology Telehealth services added
Explore expanding the variety of education classes and support groups offered in the Monticello area and collaborate with other local organizations to share educational opportunities	Melissa Pribyl pribylm@centracare.com Heather Eidem eidemh@centracare.com	Education and Awareness	• Shared Mississippi Shores director's contact information with Central MN Council on Aging to bring EVB classes to site- "Matter of Balance"
Share contact information for available providers on Community Health and Wellness electronic board	Joni Pawelk pawelkj@centracare.com	Increase awareness and referral options shared in common space on hospital campus	• Digital Signage installed June 2017
Investigate the possibility of offering occupational health services to local business partners	Dr. John Hering john.hering@centracare.com	Determine feasibility by December 2016 and establish plan	
RESOURCES			

Priority Area: Distracted Driving

Goal: Increase public awareness to the practice of distracted driving and promote the pledge to stop driving distracted in our communities

ACTION PLAN

Activity	Lead Person/Contact	Anticipated Outcome or result	Progress/Notes
Partner with and support community efforts aimed at decreasing distracted driving	Melissa Pribyl pribylm@centracare.com	Partner with local law enforcement, public health, civic and non-profit organizations	• December 2016 Safe Communities of Wright County and Just Drive have joined forces to roll out campaign to increase distracted driving awareness • Helped to sponsor "Just Drive 2017" in April 2017; April 2018 • Partnered with Monticello and Becker schools to bring distracted driving simulator to their campus; DD lunch n learn at Monticello High School • Distracted driving info and awareness activity at Monticello Chamber golf tournament May 2017 • Distracted driving information shared at August 2017 Farmer's Markets • Distracted Driving segment shared in Foundation Breakfast video • Distracted Driving Lunch N Learn with Greg LaVallee Feb. 2018 • Distracted Driving banners displayed in lobbies of CCHM and Medical Group Feb-Mar 2018 • Distracted Driving Risk Wheel at Becker Expo March 3, 2018 • Distracted Driving on Facebook Live April 2018 • Awarded Foundation grant funds to purchase driving simulator; Simulator received July 2018

			• Participated in Annandale Advocate series on distracted driving • Participated in West Sherburne Tribune story on distracted driving
Explore utilization of CentraCare Health's Injury Prevention Specialist (IPS) to increase educational offerings/events	Melissa Pribyl pribylm@centracare.com Melissa Hjelle hjellem@centracare.com	Establish 2 injury prevention classes locally	• Obtained distracted driving simulator from HCMC with help from IPS to use at Monticello and Becker High Schools • Obtained impaired vision goggles from IPS for use in Monticello High School health classes • Pedal Car course at Monticello High School April 2018
Explore an agreement that all CentraCare Health – Monticello employees who request mileage reimbursement will sign a pledge that they will not drive distracted while on work time; investigate the possibility of taking this system-wide	Dr. John Hering john.hering@centracare.com	Increase awareness and safety of employees	• Mary Ellen Wells proposed initiative to CentraCare leadership January 2017; Policy drafted and shared May 2017; to Executive Council on July 27th; Safe Driving Policy in effect Nov. 2017
RESOURCES			
Safe Communities of Wright County	Educational website, Facts, Resources/Registration	Public Information	safecommunitiesofwrightcounty.org
End Distracted Driving	Educational website	Public Information	enddd.org

Law enforcement	Local resource for assessment, referral, planning, and support		co.wright.mn.us/214/sheriff co.sherburne.mn.us/sheriff
Local school districts	Local resource for assessment, referral, planning, and support		monticello.k12.mn.us biglake.k12.mn.us becker.k12.mn.us isd728.org
Local driving schools	Local resource for assessment, referral, planning, and support		wreck-lessdriving.com asanchez@sherbtel.net

CentraCare Health Community Health Needs Assessment Action Plans Summary
CentraCare Health – Sauk Centre – Responsible Party: Del Christianson

Priorities	Action Plan Description	Assigned to:	Progress Summary	Status
	Action Plan Description taken from Board-Approved CHNA Document	*Person(s) primarily responsible*	*Update on progress narrative*	(C) Complete (I) In Progress (N) Not Started
Adult Obesity	Educating the community about the NuVal food grading system at Coborns and the ability to easily make healthier food choices by using NuVal system in stores.	Luann Peterson & Todd Stordahl	Educating the community on NuVal is handled yearly at the health fair. Carly and Luann will work with the Wellness committee.	I
	Recruit more bariatric providers to allow for bariatric outreach services at CentraCare Health – Sauk Centre.	St. Cloud Human Resources	Bariatric is projected to begin late 2017.	N
Adult Diabetes	Diabetes Center now comes to Sauk Centre twice a month to better serve our patients. The Diabetes Center offers a team approach to incorporate diabetes care into a patient's lifestyle to improve their health.	Carolyn Koglin	Optimal Diabetes Care as of 6/30/17: Goal was 24.3% and we are 28.9%	I
	Providers and clinic nursing participated in a 2-day training session with the IDC to provide improved care for our diabetic patients.	Carolyn Koglin	The staff participated in a 2-day training session.	C
	The Sauk Centre clinic participated in the 90 Day Action Plan to improve A1C in our diabetic population.	Carolyn Koglin	The staff participated in the 90 Day Action Plan.	C
Older Adult Prev. Hospitalization	Utilize Health Care Home to create a partnership between the patient, family, provider, care coordinator and others designated for the patient's care plan. The	Lola Welle & Carolyn Koglin	Our goal was 109 and we are at 100. Goal is to enroll 10 more patients.	I

Older Adult Prev. Hospitalization (cont)	care coordinator is available to coordinate the patient care and improve the quality of life and health outcomes for those individuals with complex health conditions or disabilities.			
Stroke Deaths	Tele stroke has been implemented in our emergency room to improve the stroke outcomes of those patients receiving treatment. Tele stroke uses video communication to allow a neurologist to assess a patient as quickly as possible. Tele neurology appointments are scheduled for 30 days after their event, for qualified patients, to ensure additional follow up care is provided.	Patty Roth	We have done community education on stroke and treatments. We have added the Tele-stroke services for follow up care with stroke patients. We have had 17 patients that have qualified for the post stroke visit, and 65% completed their post-stroke follow up via telehealth. There was a 69% decrease in modified Rankin Scale (reflects the degree of disability) overall between enrollment and 6 months later. There was also an 8% increase in Quality of Life between enrollment and 6 months later.	I
Coronary Heart Disease Deaths	Sauk Centre refers patients with heart specific issues to the Cardiac Rehab program. This program focuses on lifestyle change, education, exercise, weight management and diet adjustments. The program is tailored to the individual patient's needs.	Mary Rasmussen & Patty Roth	In both Cardiac and Pulmonary Rehab, over 100% of the patients had an increase in their overall Quality of Life Scores upon completion of the program.	

CentraCare Health Community Health Needs Assessment Action Plans Summary

CentraCare Health – Sauk Centre – Responsible Party: Del Christianson

Cancer Deaths	The current focus for CentraCare Health Marketing is Colon Cancer Screening. In March, free drive-through colon cancer screening kits that could be done at home, were offered by the Coborn Cancer Center in recognition of Colon Cancer Awareness month. More than 120 adult residents of Central Minnesota are diagnosed and/or treated for colorectal cancer annually at the Coborn Cancer Center, St. Cloud Hospital or CentraCare Radiation Oncology in Alexandria, Minn.	CentraCare Health Marketing	Colorectal Cancer Screening effective 6/30/17, goal was 71.6%, we are at 74.4%. Updated Infusion Center and expanded to 5 days per week. Added Tele-Oncology Planning to update software to have 3D mammography.	
Diabetes Deaths	Diabetes Center now comes to Sauk Centre twice a month to better serve our patients. The Diabetes Center offers a team approach to incorporate diabetes care into a patient's lifestyle to improve their health.	Carolyn Koglin	Optimal Diabetes Care as of 6/30/17. Goal of 24.3%, we are at 28.9%.	I
	Providers and clinic nursing participated in a 2-day training session with the IDC to provide improved care for our diabetic patients.	Carolyn Koglin	The staff participated in a 2-day training session.	C
	The Sauk Centre clinic participated in the 90 Day Action Plan to improve A1C in our diabetic population.	Carolyn Koglin	The staff participated in the 90 Day Action Plan.	C
Mental Health Access	The Sauk Centre clinic implemented SBIRT this past year for our patients with addictions to drugs and alcohol. This allows for screening and early intervention with those patients that have issues with drugs and alcohol. Providers and nurses have been trained on the screening and intervention process.	Carolyn Koglin	Working on a report to identify number of positive screens and number of referrals to behavioral health.	I

CentraCare Health Community Health Needs Assessment Action Plans Summary

CentraCare Health – Sauk Centre – Responsible Party: Del Christianson

Mental Health Access (cont.)	The DIAMOND initiative is Depression Improvement across Minnesota that was launched in 2008 to improve depression care throughout the state. The Sauk Centre Clinic is a certified DIAMOND site for patients with depression.	Carolyn Koglin	The Diamond program has dissolved and we now focus on Depression Care. As of 6/30/17, we use PHQ9. Goal of 91.2@ and we are at 87%. Depression 6-month remission goal is 10.6% and we are at 10%.	I
	Bring Integrated Behavioral Health Services to the clinic with coordinated care delivered by Nicole Pohlman, MSW LICSW.	Carolyn Koglin	We have implemented Integrated Behavioral Health 3 days a week in Hospital Specialty Services effective May 2017.	Complete
	Explore a community health worker partnership and work model in the community of Sauk Centre.	Patty Roth		N
	Tele- Behavioral health in the Emergency Room	Patty Roth	We have implemented Tele-Behavioral health in the Emergency Room	C
Adult Smoking	Jane Jenc, PA-C attended Tobacco Treatment Training in February 2016. A plan will be explored to use the tools from the training to implement a program designed to help people stop smoking. Aspects of the program would include a weekly check in and access to free smoking cessation tools like nicotine patches and tic tacs at the weekly meetings. This will allow for additional group setting support in the quitting process. The current data indicates a 13% usage rate.	Jane Jenc, PA-C & Carolyn Koglin	Effective 7/1/17 we offer Tobacco Treatment appointments in Sauk Centre. We are working on a quality measure to track success with this new program.	I

CentraCare Health Community Health Needs Assessment Action Plans Summary

CentraCare Health – Sauk Centre – Responsible Party: Del Christianson

Adult Physical Inactivity	Sauk Centre offers Silver Sneakers classes on site 3 days per week. Silver Sneakers promotes increased activity in seniors in order to improve their overall well-being. Group fitness classes are taught by an instructor and offer a wide range of exercises designed to increase muscle strength, range of movement and can be customized for all experience levels. The group fitness environment also promotes social interaction.	Bill Larson & Patty Roth	Silver Sneakers will be moving to the Dining Room of Lake Shore Estates. This will encourage participation of the Lake Shore Estate residents and maintain the availability of the program on campus.	I
	CentraCare Health-Sauk Centre along with the Sauk Centre Chamber of Commerce host an annual "Walk Your Sauks Off" fun walk to promote activity in the Sauk Centre community.	Dennis Heinen & Anita Arceneau	CentraCare Health – Sauk Centre worked with the Chamber to have a 5k race during Sinclair Lewis Days 2017.	C
	The residents of the CentraCare Health – Sauk Centre Nursing Home enjoy the "Get Fit" program as part of their activity program. This encourages the residents to continue to move and exercise as much as they are able to in order to keep their range of motion and muscle strength.	Debbie Britz & Agnes Bearson	Get fit with the residents. Every Monday/ Thursday 1/2-hour exercise program with a smaller group. The focus is on arms, legs, and vocals. Exercises include tossing the ball, using stretch bands and laughing yoga. Tuesday and Fridays is a larger group which consist of 30 people. The focus is on cognitive, vocal and body exercise. We encourage music programs to have the residents sing, tap their toes and some even dance. We offer Silver Sneakers, that we currently have 2 residents involved in. Working on strength to decrease falls.	I

CentraCare Health Community Health Needs Assessment Action Plans Summary
CentraCare Health – Sauk Centre – Responsible Party: Del Christianson

Adult Physical Inactivity (cont,)	Explore a community partnership with the school to encourage the use of the school facility for physical activity.	Patty Roth	Paul Knutson working with Blend program to bring into the schools. Paul from Foundations is working on getting Fun Bins in the community to promote fitness. The Rotary is sponsoring one bin. Paul will be reaching out to the Lions to inquire about sponsoring a second bin.	I
	Explore opportunities at Ladies Night Out to promote community wellness.	Dennis Heinen & Anita Arceneau	2017 Ladies night out we collaborated with Snap Fitness to hand out 3 -1-month free memberships to snap fitness. We had a drawing for 2-$20.00 punch cards for Silver Sneakers. We handed out education material for 5K training plans for new runners.	C

Priority Area: Mortality: Stroke Deaths

Goal:
Sherburne, Stearns and Benton county will implement policies and process the decrease the number of residents that die as a result of strokes

ACTION PLAN

Activity	Lead Person/Contact	Anticipated Outcome or result	Progress/Notes
Participate in "Strides for Stoke" (MN Stoke Association	Melissa Freese FreeseM@centracare.com	Education Awareness	
"Strike Out Stroke" Day with the Rox" Semi-professional Baseball Team -- Screening and Prevention Information Presented	Melissa Freese FreeseM@centracare.com	Screening, Referral Education and Awareness	
Stroke Center Certification	Melissa Freese FreeseM@centracare.com	Research-based guidelines with the goal of speeding recovery and reducing death and disability	SCH Stroke Center received the Get With the Guidelines- Stroke Silver Quality achievement Award
Stroke Signs & Risk Factors on CentraCare Health Site : Includes FAST assessment and downloadable link to the Stroke Education packet	Melissa Freese FreeseM@centracare.com	Education and Awareness	Stroke Care - CentraCare Health, Central Minnesota
TeleStroke Program Patients who access a facility that has TeleStroke connect in real time with an interventional neurologist from St Cloud Hospital Stroke Center	Vamsi Dwaram Dwaramv@centracare.com Brandy Kramer KramerB@centracare.com	Speed decisions, which will improve patient outcomes.	Telestroke Map Current Locations
Stroke & Blood Vessel Screenings – Currently done Weekdays, Expand services and locations	Imaging Services @CentraCare Health Plaza 320-229-4986	Determine risk for stroke, peripheral vascular disease and abdominal aortic aneurysm	Stroke-and-Blood-Vessel-Screenings.pdf
Develop plan to expand Stroke Support Group to additional Communities	Melissa Freese FreeseM@centracare.com	Community resource for stroke survivors, family and friends	

RESOURCES			
CDC Division for Heart Disease and Stroke Prevention	Evaluation Resources Educational Materials Data & Statistical Tools	Program Planning and Evaluation	Division for Heart Disease and Stroke Prevention-DHDSP|Home Page|CDC
National Institute of Neurological Disorders and Stroke		Public Information Research Programs Diversity Enhancement	NINDS | Preventing Stroke | Brain Basics
Community Tool Box -- Tools and Resources For building healthier communities --			Community Tool Box

Priority Area: Mortality: Coronary Health Disease Deaths

Goal:
Sherburne, Stearns and Benton county will implement policies and process the decrease the number of residents that die as a result of Coronary Heart Disease

ACTION PLAN

Activity	Lead Person/Contact	Anticipated Outcome or result	Progress/Notes
Take Heart Program: provides the community: Free one-hour Bystander CPR/AED group trainings. Each group member gets hands-on practice with an inflatable manikin. Note: No certificate is issued. Information on and help in getting AEDs for buildings.	Susie Osaki Holm OsakiHolmS@centracare.com	Improve neurologically-intact survival rates for patients admitted to the hospital after cardiac arrest	
STEMI transfer program to fast-track care of patients with heart attack		One phone call from a partner hospital sets in motion a step-by-step protocol that results in the systematic treatment and transfer of patients from area hospitals across Minnesota	Mission: Lifeline Home Page
Get with the Guidelines : AHA Recognition at Silver Level			Get with the Guidelines Overview
Advanced Certification in Heart Failure (Joint Commission)		Advanced Certification in Heart Failure recognizes hospitals that have achieved high standards for treatment of heart failure patients, demonstrated by Bronze-level or higher performance in the Get With The Guidelines ®-Heart Failure program as well as compliance with The Joint Commission standards	

Heart Failure Support Group	Dona Anderson AndersonD@centracae.com	Community Resource for People Living with Heart Disease	
RESOURCES			
CDC Division for Heart Disease and Stroke Prevention	Evaluation Resources Educational Materials Data & Statistical Tools	Program Planning and Evaluation	Division for Heart Disease and Stroke Prevention-DHDSP|Home Page|CDC
National Institute of Neurological Disorders and Stroke		Public Information Research Programs Diversity Enhancement	NINDS | Preventing Stroke | Brain Basics
Community Tool Box -- Tools and Resources For building healthier communities --			Community Tool Box

Priority Area: Mortality: Deaths from Cancer – Overall death rate

Goal:
Through screening, and health education with a focus of prevention, Sherburne, Stearns and Benton county will increase awareness of risk factors and the need for early intervention when diagnosed.

ACTION PLAN

Activity	Lead Person/Contact	Anticipated Outcome or result	Progress/Notes
Community Outreach Program – Medical Oncologists schedule visits in 6 locations throughout the market area.		Increased Awareness /Knowledge of Community Primary Care Providers Screening and Early Detection Treatment close to home	
Member of the Mayo Clinic Cancer Care Network		Through Collaboration, improve all aspects of cancer care	
Survivorship Program -- *Wide Range of Programs that enhance life throughout the cancer experience.*		Connection to resources and support.	
Support Groups for Specific Types of Cancer		Specially trained volunteers facilitate group and individual support and share helpful information	
Colorectal Cancer Risk Assessment Tool on CentraNet along with other links with information about causes and prevention		Screening and Prevention	http://www.cancer.gov/colorectalcancerrisk/
Drive through Colon Cancer Screening: March Colon Cancer Awareness Month		Awareness, Screening, Prevention	
Zero Prostate Cancer Run/Walk		Information about screening and Shared decision making tool regarding prostate cancer screening and treatment	
Mobile Mammography Program *Dance for Hope Zumbathon fitness*		Extends prevention services and expert care to Women across Central Minnesota	

Participant in the Minnesota Department of Health Breast and Cervical Cancer Screening Sage program. This program provides free office visits for breast and cervical exams, as well as a screening mammogram and Pap smears for those who are eligible.		Screening and Prevention	
Radio Shows and PSA – October to Highlight Breast Cancer Awareness Month		Reach a broad sector of the community on importance of mammograms and screening as well as importance of lifestyle habits to reduce risk of breast cancer	
Cancer prevention through education: share with community through participation in health fairs, one-on-one sessions, events and group education sessions hosted by churches and employers		Education and Awareness	
RESOURCES			
American Cancer Society			American Cancer Society | Information and Resources for Cancer: Breast, Colon, Lung, Prostate, Skin
National Cancer Institute -- Cancer Prevention Overview for Health Professionals			Comprehensive Cancer Information - National Cancer Institute
CDC – National Comprehensive Cancer Control Program			CDC - Ongoing Work - National Comprehensive Cancer Control Program
CDC Cancer Prevention and Control			CDC - Cancer Prevention and Control
Community Tool Box -- Tools and Resources For building healthier communities –			Community Tool Box

Priority Area: Mortality & Morbidity Diabetes: *The percentage of adults living with diagnosed diabetes, and the age adjusted diabetes death rate.*

Goal:
Sherburne, Stearns and Benton county will implement policies and process the decrease the disease burden of diabetes and improve the well- being of those living with diabetes.

ACTION PLAN

Activity	Lead Person/Contact	Anticipated Outcome or result	Progress/Notes
Collaboration with the International Diabetes Center to develop standards of Care, Guidelines and Best Practice throughout the Region	Dr. Lynn McFarling mailto:mcfarlingl@centracare.com	Standardized Care which will lead to decreased complications and improved blood sugar control.	
Accountable Communities for Health Grant to address Diabetes in East African and Hispanic Population -- Use of Emerging Professions Community Health Workers	Rachael Lesch LeschR@centracare.com	Decrease disparities in diabetes care and disease burden	
Second Harvest Project – Food Insecurity *Analysis of the impact of food security programs on health care cost on patient with Diabetes and Cardiovascular Disease*	Janice Johnson Janice.Johnson@centracare.com	Improve engagement and self-management of Patients with Diabetes by addressing one of the social determinants	
Diabetes Prevention Class		Patients learn to identify risk factors for diabetes and understand the role of physical activity in prevention	
CentraCare.com Health Topics which include Prediabetes, Type 1 and 2 Diabetes, Taking Care of your Feet and Should I get an Insulin Pump	CentraCare Diabetes Center 320-202-7759	Education, Screening , Decision Making Tools,	Diabetes - CentraCare Health, Central Minnesota
Diabetes Self-Management Education certified by the American Diabetes Association -- Classes are offered in both individual sessions and a group setting across the region.	CentraCare Diabetes Center 320-202-7759	Diabetes Self-Management	

RESOURCES			
American Diabetes Association Diabetes Pro – Professional Resources Online			American Diabetes Association
CDC: Preventing Diabetes			Preventing Diabetes | Basics | Diabetes | CDC
National Institute of Diabetes and Digestive and Kidney Diseases NIH			National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
The Guide to Community Preventive Services: Diabetes Prevention and Control			http://www.thecommunityguide.org/diabetes/index.html
Community Tool Box -- Tools and Resources For building healthier communities --			Community Tool Box

Priority Area: Healthcare Access and Quality: Older Adult Prevention of Hospitalization			
Goal: Sherburne, Stearns and Benton county will implement policies and process the decrease the number of preventable admissions for Older Adults			
ACTION PLAN			
Activity	**Lead Person/Contact**	**Anticipated Outcome or result**	**Progress/Notes**
Community Paramedic Program started in St Cloud and Monticello	Gordon Vosberg VosbergG@centracare.com	Increase follow-up with PCP and appropriate community resources	Expand Program to Additional Regional Sites
Expanded Programs for Fall Prevention: Stepping On Program in collaboration with Central Minnesota Council on Aging and MDH --	Melissa Hjelle—Injury Prevention Specialist *HjelleM@centracare.com*	Increase Awareness, Improve confidence and physical activity, Education on reducing fall risk	
Expand Home Safety Assessments (Involve Community Paramedic Program) and Connection with Routine Home Modifications	Central Minnesota Falls Prevention and Home Safety Coalition (320) 255-7295	Falls are the most frequent cause of preventable admissions –Increase awareness and decrease hazards in home living environment	
RESOURCES			
Minnesota Falls Prevention: STEADI (Stopping Elderly Accidents, Deaths & Injuries) Toolkit			Minnesota Falls Prevention
National Council on Aging Program Summary: A Matter of Balance			A Matter of Balance - Falls Prevention Program | NCOA
Community Tool Box -- Tools and Resources For building healthier communities --			Community Tool Box
CDC: Older Adult Falls Program – Publications and Resources			Older Adult Falls | Home and Recreational Safety | CDC Injury Center

Priority Area: Healthcare Access and Quality: Mental Health Access			
Goal: Sherburne, Stearns, Benton and Wright counties will implement policies and process to increase access for residents with Mental Health Issues			
ACTION PLAN			
Activity	**Lead Person/Contact**	**Anticipated Outcome or result**	**Progress/Notes**
Integrated Behavioral Health Initiative: Imbedding Behavioral Health Personal in Primary Care Clinics	Dr. John Schmitz	Improved Access to BH provider. Resource for staff in screening and follow up care	Expand access to additional primary care clinics throughout the region.
Midtown Clinic: Imbed Primary Care Services in to a Mental Health Clinic (Central Minnesota Mental Health Center) SAMSHA grant -- Using a Team Based/Integrated Care Approach . Primary and Behavioral Health Care Integration (PBHI) grant	Nicole Zenk, APRN, CNP CentraCare Clinic-Midtown	"Whole Person" centered care addressing both physical and mental health concerns	Expand access to additional CMMHC sites throughout the region HI-CProgramBrochure_3.pdf
Child Advocacy Center Provides Trauma Informed Care to Children who are victims of trauma or abuse. Collaborative Program with Law Enforcement, Judicial System, Child Advocacy and Mental Health and Public Health		Adverse Childhood Events (ACEs) awareness – Develop Resiliency in families	Expand Resources to Central Minnesota in Trauma Informed Care Recent News and Press Releases | County News | Community | Stearns County, Minnesota
D.I.A.M.O.N.D. Program (Depression Improvement across Minnesota Offering a New Direction	Dr. John Schmitz	Team approach to treating depression – Improved management	
RESOURCES			
US Department of Health and Human Services Behavioral Health		Behavioral Health	
Healthy People 2020 CDC: Mental Health		Mental Health and Mental Disorders | Healthy People 2020 Mental Health - Home Page - CDC	
Community Tool Box -- Tools and Resources For building healthier communities --		Community Tool Box	

Priority Area: Morbidity: Adult Obesity – The percentage of adults 20 years and older who report BMI >=30			
Goal: Sherburne, Stearns and Benton county will implement policies and process to decrease the percentage of adult residents with BMI >= 30			
ACTION PLAN			
Activity	**Lead Person/Contact**	**Anticipated Outcome or result**	**Progress/Notes**
Medical Weight Management Program	weightlossinfo@centracare.com	Education, Support and Programming options for Weight Loss	
Culture of Health: Workplace Wellness Symposium *	CentraCare Heart & Vascular Center	Insights into the AHA Food & Beverage Toolkit	
Healthier Food Environments *	QLA Cohort 2		Expand Pilot Program to other sites
Healthy U	weightlossinfo@centracare.com	Group education to increase success with weight management	
RESOURCES			
CDC: Overweight & Obesity			Overweight & Obesity | CDC Prevention Strategies & Guidelines | Overweight & Obesity | CDC
National Institutes of Health – Obesity			Obesity Health Problem, Healthy Weight Basics, NHLBI, NIH
Community Tool Box -- Tools and Resources For building healthier communities --			Community Tool Box

Priority Area: Health Behaviors: Adult Smoking – Percentage of adults who report smoking			
Goal: Sherburne, Stearns and Benton county will implement policies and process to decrease the percentage of adult residents who smoke			
ACTION PLAN			
Activity	**Lead Person/Contact**	**Anticipated Outcome or result**	**Progress/Notes**
Crave the Change *		• Reduce exposure to secondhand smoke • Advocate for statewide legislative efforts • Engage communities to protect youth • Promote cessation services	Crave the Change –
Nicotine Dependence Program	320-251-2700 x 57448	Education, Support and Medication Therapy to successfully quit smoking	Additional Smoking Cessation Specialists trained throughout the region.
Tools and Interactive Decision guides available on Centracare.com		Readiness to quit assessment and suggestions for next steps	Interactive Tool: Are You Ready to Quit Smoking? - CentraCare Health, Central Minnesota
RESOURCES			
CDC: Smoking & Tobacco Use			CDC - Fact Sheet - Quitting Smoking - Smoking & Tobacco Use
The guide to Community Preventive Services "What Works to Promote Health"			The Community Guide - Reducing Tobacco Use and Secondhand Smoke Exposure

Priority Area: Health Behaviors: Adult Physical Inactivity: The percent of adults who report no leisure time physical activity			
Goal: Sherburne, Stearns and Benton county will implement policies and process to increase the percent of adults who report regular physical activity			
ACTION PLAN			
Activity	**Lead Person/Contact**	**Anticipated Outcome or result**	**Progress/Notes**
CentraCare Health Earth Day Run	Earth Day Run in St. Cloud, MN - From CentraCare Health	Make the healthy choice, the easy choice -- opportunities for wellness activities	
Health 101 for Everyone		Screening, Education, Awareness of Resources	
The L.I.F.E Program	320-654-3630 ext. 70291	Education, Awareness Support for Behavioral Change	
BLEND *			
CentraCare Health Wellness Website *		Education, Awareness, Resource Directory	Wellness - CentraCare Health, Central Minnesota
RESOURCES			
The Guide to Community Preventive Services Increasing Physical Activity			The Community Guide - Increasing Physical Activity
CDC Guide to Strategies to Increase Physical Activity in the Community			Community Strategies | Physical Activity | CDC
Community Tool Box -- Tools and Resources For building healthier communities --			CHORC

CentraCare Health has begun a multi-year, multi-million-dollar initiative to build community support for and implement strategies to improve the overall wellness of its service area in the St. Cloud Metro Area and, eventually, throughout CentraCare's service area. Topics included in that initiative, called Feeling Good MN (www.feelinggoodmn.org) are marked by an * in the above texts. Feeling Good MN will build upon past success in key health improvement activities and will be fueled by partnerships with employers, schools, public institutions, public health and human services and other health care providers to measurably improve the health status or our communities.