Community Health Improvement Plan

JULY 1, 2025 - JUNE 30, 2028

Benton County Wisconsin | CentraCare | Sherburne County | Stearns County Minnesota

Message to the Community

To be more effective in meeting the needs of the community, Public Health in the counties of Benton, Sherburne, and Stearns, along with CentraCare, have developed a partnership called the Central MN Alliance.

Every three years, CentraCare is required to complete a Community Health Needs Assessment and develop a Community Health Improvement Plan to address identified needs. At the same time, all Local Public Health Agencies in Minnesota are required to complete this same type of assessment and improvement plan every five years. Effective July 1, 2019, Local Public Health will align with CentraCare and complete this work, as a region, every three years.

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

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

Danielle Protivinsky
CentraCare

Jaclyn Litfin
Benton County
Public Health

Nicole Ruhoff
Sherburne County
Public Health

Janet Goligowski
Stearns County
Public Health

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

Legal Requirements

This document provides documentation of the following legal requirements.

The Minnesota Community Health Services Act (Minn. Stat. § 145A) of 1976, which was subsequently revised in 1987 and 2003, is now called the Local Public Health Act. This document describes the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHIP). Citations in this document: MN145A. In 2023, MN adopted Foundational Public Health Responsibilities and Framework to align with national efforts to transform the public health system. The framework represents the work governmental public health must do, and the important work governmental public health does, to meet the unique needs of communities across the state. These responsibilities are crucial to achieving population health goals. https://www.health.state.mn.us/communities/practice/systemtransformation/docs/headlinesactivities.pdf

The United States Patient Protection and Affordable Care Act of 2010 (PPACA) imposed reporting requirements under new Internal Revenue Code (IRC) § 501(r) for charitable hospitals regarding the fulfillment of their charitable purpose as tax-exempt organizations starting in 2011. This document describes the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan. Citations in this document: IRC501r.

Americans with Disabilities Act Advisory:

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

CLAS Standards:

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

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

COMMUNITY HEALTH IMPROVEMENT PLAN

CHIP Table of Contents

Executive Summary

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

> The Central MN Alliance Vision: In Central MN, every voice counts, every need is important, every culture respected, and everyone is involved in building a better community life with equitable services for all.

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

The Central MN Alliance used the MAPP (Mobilizing Action through Planning and Partnerships) 2.0 Framework to conduct the community health assessment and identify top community priorities within which to concentrate efforts to improve community health. The Implementation Phase of this CHIP is July 1, 2025, through June 30, 2028. Documentation for the Community Health Needs Assessment that was conducted resulting in this CHIP can be found in Appendix 2 of this document.

This is the third CHIP on which the Central MN Alliance partners have collaborated. The infrastructure from the previous process was maintained to identify the top two community priorities of Building Families and Mental Well-Being and the guiding principles of community collaboration, equity, resilience, education, awareness, and health organizations.

MAPP Framework: Mobilizing for Action through Planning & Partnerships

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

Top Community Priorities

Community Connection

Mental health, social connection, belonging, substance use

- Increase overall mental wellbeing among Benton, Sherburne, and Stearns County residents.
- Reduce drug use among Benton, Sherburne, and Stearns County residents.

Community Stability

Housing, financial insecurity, childcare, food insecurity

- Support the development & implementation of Family Resource Centers.
- Identify, discuss, & promote use and analysis of data to increase understanding of root causes prioritizing communities/groups most impacted.

Community Access

Healthcare access, such as: location, transportation, insurance

- Promote the importance of Prevention.
- Enhance and expand mobile clinic offerings in rural and underserved areas for acute care, primary care, screenings, and vaccinations.

The Community's Plan

Working Towards Community Health Improvement

The 2025-2028 Community Health Improvement Plan (CHIP) builds upon the foundation established by the 2019-2022 CHIP and further developed through the 2023-2025 CHIP. While the earlier CHIP cycles emphasized partner engagement and health equity, this new iteration integrates the lessons learned from previous collaborations and ongoing community needs.

The COVID-19 pandemic, which emerged during the 2019-2022 CHIP, significantly influenced public health priorities. Many planned strategies were temporarily paused as local health organizations, clinics, and hospitals shifted their focus to pandemic response. However, this period reinforced the importance of partner engagement, equitable access, and community-centered health initiatives. It also highlighted the need for data-driven decision-making and enhanced communication strategies to reach all community members effectively.

Throughout the pandemic, Central MN Alliance (CMA) partners continued to uphold the CHIP's guiding principles, emphasizing collaboration, equity, and resilience. They played a key role in community outreach, education, and resource coordination, ensuring that individuals and families remained informed and connected to essential services. Health organizations also deepened their efforts in data collection, surveillance, and service provision, strengthening their ability to address both immediate and long-term health challenges.

The 2025-2028 CHIP carries forward this momentum, reinforcing community-driven strategies that reflect ongoing and new partner engagement. The goal of this CHIP is to be The Community's Plan—one that truly represents the voices, needs, and priorities of the people it serves. While CMA staff will support the necessary tracking and reporting for compliance with state and federal requirements, the overarching vision is for the community to see themselves actively involved in both the document and the initiatives it outlines.

This CHIP will remain a living document, accessible on all CMA partner websites for transparency and ease of use. The initial version will provide a framework for monitoring progress, with specific partner agencies and strategies to be identified through continued engagement beyond the initial implementation phase. By fostering collaboration, adaptability, and community ownership, the 2025-2028 CHIP aims to drive meaningful, sustainable improvements in the health and well-being of Central Minnesota residents.

According to statute and law, all persons in the community share responsibility to be engaged, monitor, and revise the CHIP. If you wish to get involved or have any questions or concerns regarding the CHIP, would like to attend any Central MN Alliance (CMA) meetings, or would like CMA staff to attend any of your meetings, please reach out to any of the contacts listed in this document.

Goals and Activities

Community Connection: Mental Health, Connection and Substance Use

Goal 1: Increase overall mental wellbeing among Benton, Sherburne, and Stearns County residents
Baseline and Target goals will be determined in 2025.

Activities	Outputs	Persons Responsible
Connection Goal 1, Activity 1: Expand community partnerships on shared definitions of social capital and metrics to discuss social infrastructure and social connection leveraging the existing St Cloud Area Social Capital Survey	# Community organizations or partners involved # GIS Map features # (amount invested) in social infrastructure # Economic Development representatives involved in CC	CMA Regional Coordinator Designated Process Manager at each Partner Agency

Community Connection: Mental Health, Connection and Substance Use

Goal 1: Increase overall mental wellbeing among Benton, Sherburne, and Stearns County residents
Baseline and Target goals will be determined in 2025.

Activities	Outputs	Persons Responsible
Connection Goal 1, Activity 2: Develop a social infrastructure mapping tool for 3-county region to outline spaces both hard (buildings, roads, parks) and soft (support groups, community gatherings, youth groups) to display gaps and opportunities for growth in social capital and social connections, identify and create awareness around opportunities around social connection. GIS Map [+CS Goal 8: Asset mapping of food access across region]	# Community organizations or partners involved # GIS Map features # (amount invested) in social infrastructure # Economic Development representatives involved in CC	CMA Regional Coordinator Designated Process Manager at each Partner Agency

Community Connection: Mental Health, Connection and Substance Use

Goal 2: Reduce drug use among Benton, Sherburne, and Stearns County residents.
Baseline and Target goals will be determined in 2025.

Activities	Outputs	Persons Responsible
Connection Goal 2, Activity 1: Develop share parameter metrics across region for use when speaking to substance use challenges-regional dashboard metric	# metrics agreed to track (overdose, Minnesota Student Survey, current adult use) # joint activities planned # joint activities implemented	CMA Regional Coordinator Designated Process Manager at each Partner Agency
Connection Goal 2, Activity 2: Explore three-county/city joint Substance Use Prevention program(s) development (First Steps Central MN model)		CMA Regional Coordinator Designated Process Manager at each Partner Agency

Community Stability: Housing, Financial Insecurity, Child Care, Food Insecurity

Goal 1: Support the development & implementation of Family Resource Centers Baseline and Target goals will be determined in 2025.

Activities	Outputs	Persons Responsible
Stability Goal 1, Activity 1: Support development and implementation of community-led Family Resource Centers (FRC)/Community School (CRC) models	# FRC Parent Advisory Committees developed #Standards training completed #Food resources available at FRC/CRC/Community Schools #FRC/CRC/Community Schools	CMA Regional Coordinator Designated Process Manager at each Partner Agency
Stability Goal1, Activity 2: Promoting Food access opportunities at or through Family Resource Centers (FRC)/ Community Schools (CRC)		CMA Regional Coordinator Designated Process Manager at each Partner Agency

Community Stability: Housing, Financial Insecurity, Child Care, Food Insecurity

Goal 2: Identify, discuss, & promote use and analysis of data to increase understanding of root causes prioritizing communities/groups most impacted Baseline and Target goals will be determined in 2025.

Activities	Outputs	Persons Responsible
Stability Goal 2, Activity 1: Release Granite Table-Central MN Alliance dashboard	# Community/Partner requests regarding dashboard presentations # Data Walks	CMA Regional Coordinator Designated Process Manager at each Partner Agency
Stability Goal 2, Activity 2: Develop “Data Walk” event(s)		CMA Regional Coordinator Designated Process Manager at each Partner Agency

Community Stability: Healthcare Access such as Location, Insurance, Transportation.

Goal 1: Promote the importance of Prevention
Baseline and Target goals will be determined in 2025.

Activities	Outputs	Persons Responsible
Access Goal 1, Activity 1: Routine Return on Investment information shared in community (ROI)	#Return on Investment documents created # CMA Agency partner presentations	CMA Regional Coordinator Designated Process Manager at each Partner Agency
Access Goal 1, Activity 2: “What creates Health” campaigns: outreach/materials/presentations		CMA Regional Coordinator Designated Process Manager at each Partner Agency

Community Stability: Healthcare Access such as Location, Insurance, Transportation.

Goal 2: Enhance and expand mobile clinic offerings in rural and underserved areas for acute care, primary care, screenings, and vaccinations
Baseline and Target goals will be determined in 2025.

Activities	Outputs	Persons Responsible
Access Goal 2, Activity 1: Expansion of Project HEAL along with healthcare partners	#Project HEAL events # employers engaged that have shift-work environments	CMA Regional Coordinator Designated Process Manager at each Partner Agency
Access Goal 2, Activity 2: Employer led employee health initiatives (CentraCare Occupational Health, TriWellness at Work, Greater St. Cloud Development Corporation, One Community Alliance)		CMA Regional Coordinator Designated Process Manager at each Partner Agency

Population Measures

2025-2028 Community Health Improvement Plan (CHIP)

Population measures to be tracked include:

- Housing Ownership: Owner Occupied %
- Median Income
- Unemployment Rate

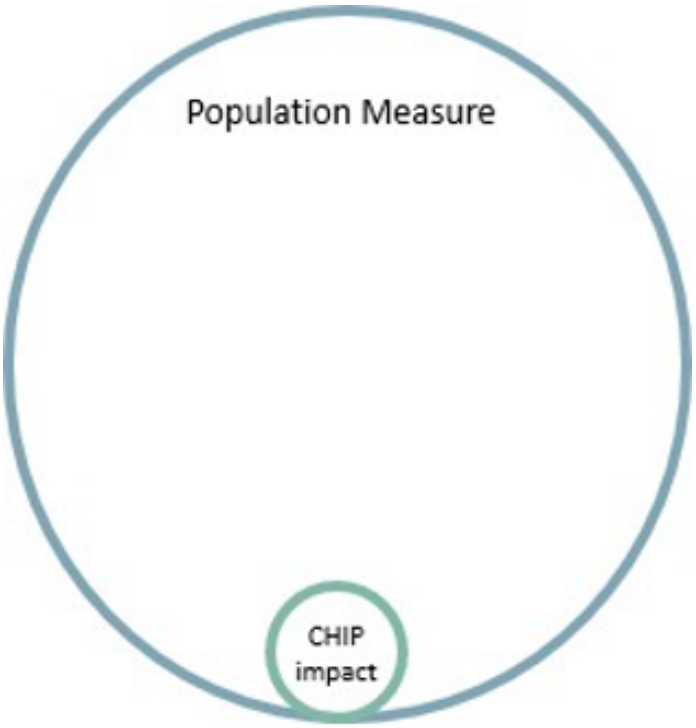
When contemplating the population measures to track for the 2025-2028 Central Minnesota Alliance (CMA) Community Health Improvement Plan (CHIP), the Top Community Priorities and the availability of data were considered. The population measures that were identified are all economically related as it was identified that the all the community priorities can be impacted by increasing the amount of income and wealth to which an individual and family have access. These population measures do not change much from year to year and while it is recognized that they are best examined by disaggregation, we are only including the primary data trends in this report.

We do so by also recognizing that it is our goal to continue to examine these data by multiple variables of disaggregation. We have included one example with the Percent of Owner-Occupied Housing dataset. There is a parallel data project occurring in the St. Cloud Area, Central Minnesota Communities of Excellence alumni cohort – Granite Table, which includes examining data at the census tract level. CMA members are involved in this project and the CMA CHIP population measures are being analyzed along with other community indicators.

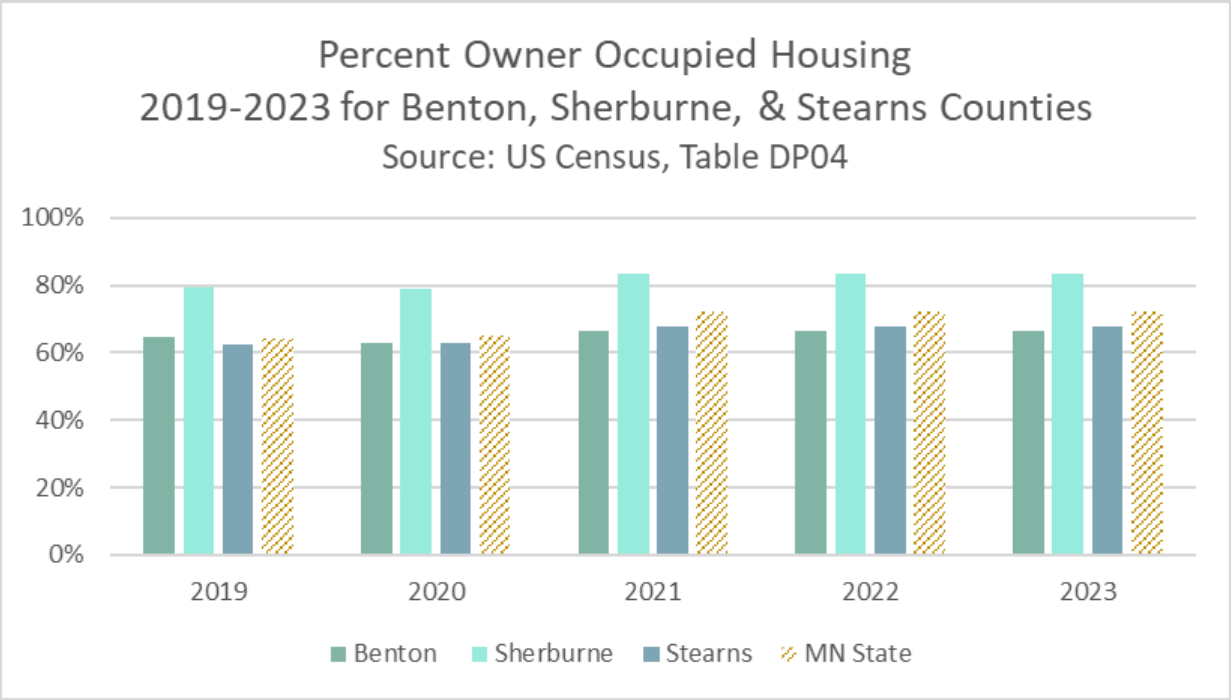
There was a May 2024 Report released by 247WallSt.com that ranked St. Cloud as the second worst city in the United States for Black Americans. They looked at the following data indicators by race: median income, unemployment, homeownership rates, and high school attainment rates. Presenting the CMA CHIP population measures by race was considered. Upon consultation with our local data resource regarding data from DEED (the MN Department of Employment and Economic Development), due to the margins of error when looking at smaller geographies, the decision was made to not provide these CHIP population measures by race.

It is recognized that wealth is not the only way for an individual or community to increase power. Economic data indicators are the most available data currently.

Finally, it is additionally recognized that the work that is completed in this CHIP by CMA members and community partners is a portion of the myriads of projects, policies, and programs that impact these measures. Despite that, reasons for using these measures include: the data are easily accessible, they are used to judge our community by outside entities, and others are familiar with these data as indicators.



2025-2028 CHIP: Percent Owner Occupied Housing by County



Notes about data: See US Census Table DP04. Desired trend is upward.

Key Data Points: Benton and Stearns Counties have similar percent owner occupied housing rates as the State.

	Benton	Sherburne	Stearns	MN State
2019	65%	79%	63%	64%
2020	63%	79%	63%	65%
2021	67%	83%	68%	72%
2022	67%	83%	68%	72%
2023	67%	83%	68%	72%

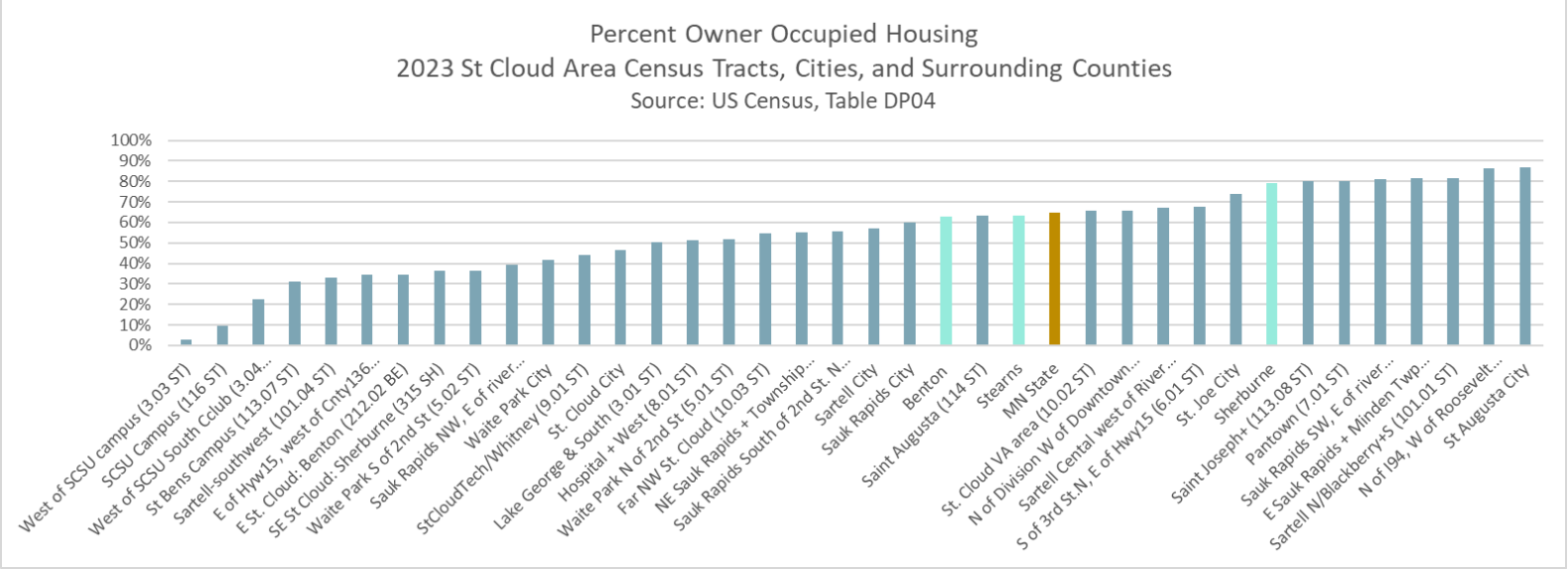
Equity Analysis Goals: To review these data by race, ethnicity, and smaller geographies such as Census Tract and City. Have conversations with individuals and partners regarding the data.

Trend Discussion: These data are fairly stable over this five-year period.

2025-2028 CHIP: Percent Owner Occupied Housing by County - Disaggregation Example

Notes about the data: Parenthetical coding within geographic names: (CensusTract #, ST= Stearns, BE=Benton, SH=Sherburne). The desired trend is upward.

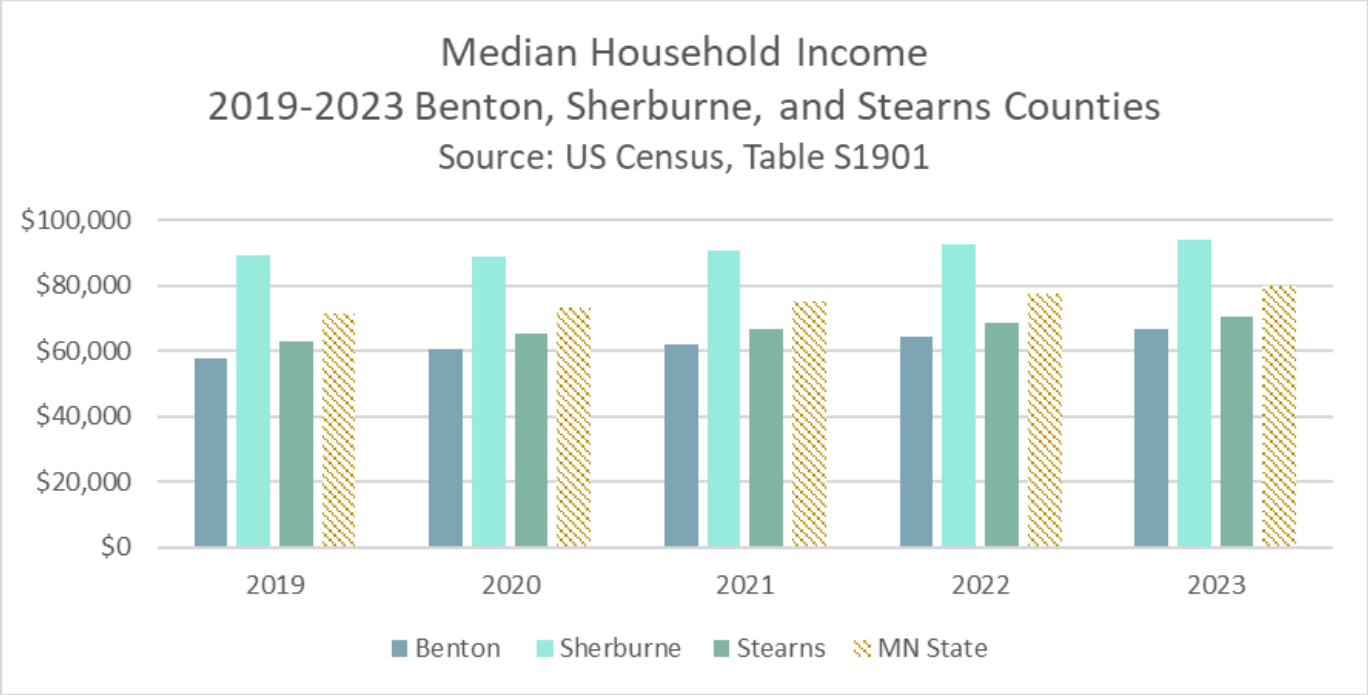
Key Data Points: More nuances can be seen in the data by looking at the Census Tract.



Equity Analysis Goals: have conversations with persons living in these neighborhoods about the data.

Trend Discussion: The goal is to look at these data over time. The number of Census tracts changes at the decennial census. These are baseline data.

2025-2028 CHIP Median Income



Notes about data: See US Census Table S1901. Desired trend is upward.

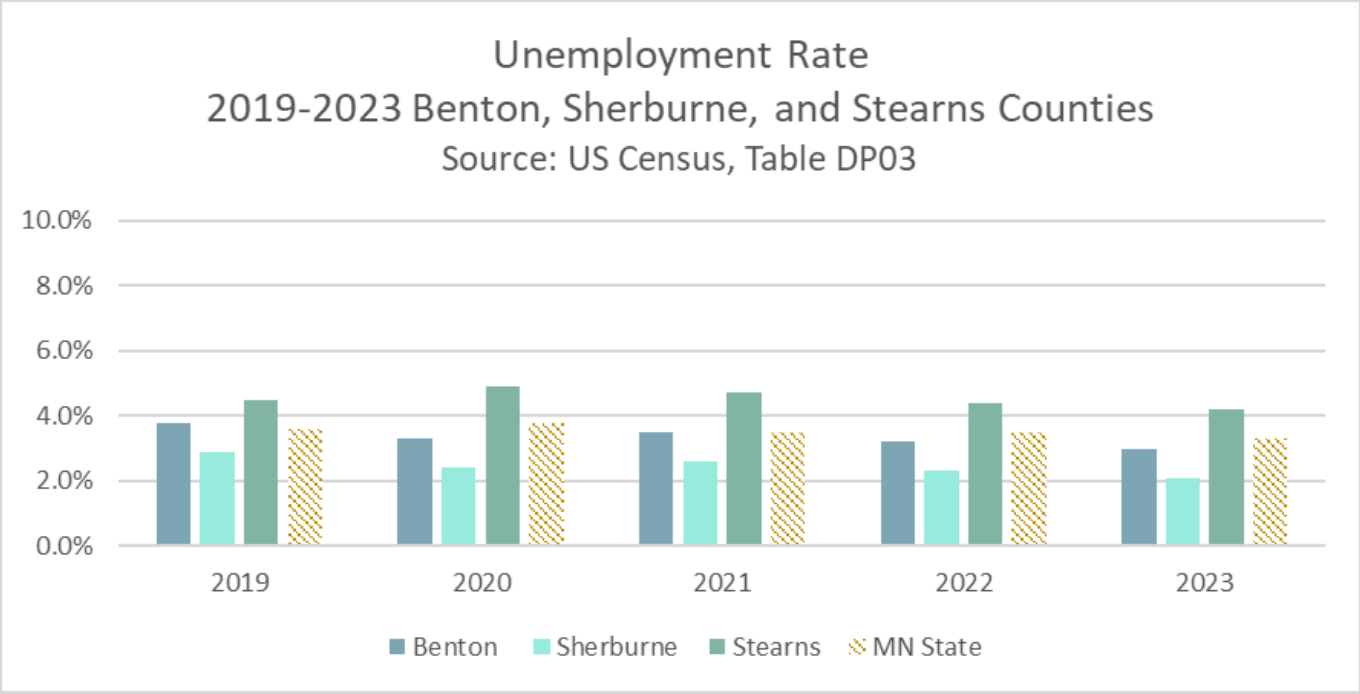
Key Data Points: Benton and Stearns Counties are below the State Median Income.

	Benton	Sherburne	Stearns	MN State
2019	$57,715	$89,250	$62,789	$71,306
2020	$60,564	$88,671	$65,244	$73,382
2021	$62,000	$90,500	$66,800	$75,000
2022	$64,200	$92,300	$68,500	$77,500
2023	$66,500	$94,000	$70,200	$79,800

Equity Analysis Goals: To review these data by race, ethnicity, and smaller geographies such as Census Tract and City. Have conversations with individuals and partners regarding the data. Compare these data to inflation, cost of living, food costs, and housing costs.

Trend Discussion: From 2021 to 2023, there is a general upward trend of these data.

2025-2028 CHIP: Unemployment Rate



Notes about data: See US Census Table DP03. Desired trend is downward.

Key Data Points: Generally, the unemployment rate has gone down for all three counties over the course of the five years. One exception is Stearns County in 2020.

	Benton	Sherburne	Stearns	MN State
2019	3.8%	2.9%	4.5%	3.6%
2020	3.3%	2.4%	4.9%	3.8%
2021	3.5%	2.6%	4.7%	3.5%
2022	3.2%	2.3%	4.4%	3.5%
2023	3.0%	2.1%	4.2%	3.3%

Equity Analysis Goals: Explore disaggregating these data by race, gender, ethnicity, or other characteristics identified by additional conversation about these data with partners and individuals in the three counties.

Trend Discussion: From 2021 to 2023, there is a general downward trend of these data.

Benton, Sherburne, & Stearns Counties Anticipated Impacts

Community Connection: Mental Health, Connection and Substance Use

- Identifying common language, metrics, and mapped social capital infrastructure will improve our ability to understand the social infrastructure in the 3-county area.
- Regional dashboard will highlight areas of strength and gaps for the region, with partner agencies working collaboratively to impact the impacts of drug use.

Impacts expected:
Reduced rates of depression, anxiety, and suicide
Lower substance use and overdose rates
Stronger social support networks, which are protective against chronic disease
Improved cognitive health in older adults
Higher life satisfaction and quality of life

Community Stability: Housing, Financial Insecurity, Child Care, Food Insecurity

- Family resource centers will serve as community-based hubs of support that are low or no cost and can offer a variety of services, as identified by the community. Services can include parenting supports, child development activities, and connection to resources.
- Family resource centers will prioritize food access and resources to address various food related concerns.

Impacts expected:
Lower rates of chronic diseases rates
Improved child development and long-term educational outcomes
Decreased hospitalization and emergency care use
Increased life expectancy, especially in underserved populations
Better pregnancy outcomes and reduced infant mortality
Higher economic productivity due to better health and fewer missed workdays
Reduced healthcare costs system-wide

Community Stability: Healthcare Access such as Location, Insurance, Transportation.

- Information that clearly supports the cost effectiveness of prevention will impact the need for deep end services and costly health care.
- Broadening the understanding of “What creates Health” will bring multiple sectors together to ensure health is considered in policy making.

Impact Expected:
Earlier diagnosis and treatment of preventable and manageable conditions
Increased use of preventive care (vaccines, screenings)
Reduced health disparities across race, class, and geography
Lower healthcare costs due to fewer emergency visits and complications
Establishment of relationship with primary provider and local resources

All 3 priority areas together will affect life expectancy rates. With attention to communities that have most barriers to healthy living, the collaborative efforts would show improvement across the region as a whole with no zip code “left behind”. While we understand this is a lofty goal and likely won’t be achieved in 3 years, it will build the foundation for ongoing Community Health Improvement Planning.

CentraCare Summary

Hospitals included: St. Cloud, Melrose, Sauk Centre, Paynesville, Long Prairie, Monticello, Benson, Redwood Falls, and Rice Memorial Hospital.

CentraCare is dedicated to fostering partnerships throughout the communities we serve, addressing their evolving health needs. As we continue to prioritize the well-being of our patients and communities, our initiatives will remain strategically aligned across the entire system. Below are the goals and strategies that support our collective impact and are aligned with the key drivers of our work.

- CentraCare will continue to share data with local partners to highlight population health measures that impact the overall health of the communities we serve.
- The Population Health Leadership Team will apply an equity lens when analyzing data to inform system-wide priorities and strategies.
- The Community Health Improvement (CHI) team will collaborate with local partners to coordinate and provide health education, prevention, and intervention strategies.
- CHI will serve as a pillar of support to all CentraCare hospitals, driving population health measures through education, promotion, mental well-being initiatives, prevention strategies, and strengthened community collaborations.
- CHI will work across communities to increase access to preventive services and primary care connections, with a goal of improving health outcomes, expanding access, and reducing emergency department utilization.
- CHI will expand Project H.E.A.L. mobile outreach to increase access to services in rural communities.
- Regional CentraCare sites will explore and expand on the development of walk-in clinics to provide same-day care options in underserved areas.
- CentraCare will maintain Healthcare Homes certification for 26 clinics, with recertification targeted for 2028.
- CentraCare will enhance referral workflows to identify and respond to Social Drivers of Health (SDoH), with a focus on outreach and resource connection in all regions.
- Health Hub repository available system-wide for any team member to connect patients with local, state and nationally available resources.
- CentraCare will continue to address food insecurity in high-need areas, such as distributing Emergency Food Bags, supporting local Farmers Markets, supporting *Backpack Attack* programs, maintaining Blessing Boxes and exploring the implementation of Food Rx program with the support of community partners.

- Referrals to the PEARLS program will be increased to support older adults experiencing depression, through both clinical and community-based partnerships.
- CentraCare will provide education for both the community and healthcare providers on suicide prevention and early intervention strategies.
- CHI will engage with community stakeholders on suicide prevention and mental health awareness initiatives.
- CentraCare will advance initiatives focused on the Treatment & Prevention of Harm Reduction & Education by supporting harm reduction strategies, enhancing substance use prevention efforts, and improving care and education for individuals impacted by substance use.
- CentraCare will enhance the quality of healthcare within correctional facilities to promote better public health outcomes, reduce recidivism, and aid in community reintegration, ultimately creating a healthier community.
- CHI will deliver the Health Equity 101 education series to CentraCare's ambulatory and specialty care sites.
- CentraCare will embed equity-focused interventions across all Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) implementation efforts.
- CHI will enhance connection with Faith Community Nurses and Spiritual Care to provide a unique blend of nursing and ministry for whole person care while addressing the need for accessible, efficient, and patient-centered, especially in situations where in-person visits are challenging or unnecessary while providing continuity of care cost effectively.
- CHI will collaborate with the Spiritual Care team to advance whole-person care, addressing both emotional and spiritual well-being.
- CentraCare will expand outreach and education around Advance Care Planning and work to increase the number of completed health care directives.
- CentraCare will advance the Perinatal Substance Use initiative to improve health outcomes for mothers and infants through early intervention and coordinated care.
- CentraCare will continue to support the Green Initiative to promote environmentally sustainable healthcare practices across the system.
- CHI will support community health and wellness events, such as local run/walk events, community health fairs, and Bike Rodeos.

- CentraCare will continue to make healthcare more accessible, efficient, and patient-centered, especially in situations where in-person visits are challenging or unnecessary while providing continuity of care cost effectively using telehealth or the expansion of technology services.
- CHI will improve access to care in underserved areas by expanding community health nursing outreach services.
- CHI will promote and share mental health resources and educational resources on CentraCare's website "Healthy Minds, Healthy Bodies" with community stakeholders such as schools and public health.
- CentraCare will advance health equity by providing internal cultural awareness presentations and Safe Space trainings to foster an inclusive, respectful, and culturally responsive environment.
- CHI will partner with community coalitions, such as the Age Flourishing Task Force and Camino Contigo, to address mental health, social isolation and loneliness.
- Over 15 clinic sites implement the Reach Out and Read Program. National non-profit initiative to promote literacy in children by incorporating education and book distribution in the pediatric care environment.
- CHI will collaborate with local public health agencies and community organizations to promote childhood immunizations through culturally sensitive outreach, education, and support tailored to the diverse needs of the community.
- CentraCare will partner with local communities to support Bounce Back Project and expand resiliency awareness.
- CHI will continue to offer Bounce Back Project Train the Trainer sessions to empower Community Champions, thereby increasing capacity and broadening impact.
- CHI will partner with RSVP to foster multi-generational social connections and engagement among older adults and expand the Happiness in Action initiative to area school districts.
- CC Community paramedics will consider and share when appropriate a virtual connection to mental health service within the scope of their wrap around services.

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

Potential Partners

Potential Partners for Community Connection:

- ABE Classes
- 180 Degrees Emergency Youth Center – St. Cloud
- AccentCare
- Acquire Mental Health Clinic
- ACT (Assertive Community treatment) and IRTS (Intensive Residential Treatment Services) through the Central MN Mental Health Center
- Adult & Teen Challenge Minnesota
- Advancing Together with Morgan Tate
- Affinity Psychological Services, P.C.
- AL-ANON
- Alcoholics Anonymous
- Alzheimer's Support Group for Caregivers
- Anger Management, Domestic Violence, and Co-Parenting Support Groups, Trauma Informed Support Groups at the Village Family Services
- Anna Marie's domestic
- Apollo Counseling Inc.
- Assisted living activities
- Baby Café
- Bark Park Program
- Better Mental Health PLLC
- Block parties
- Bounce Back Project
- CAMHI (CommUNITY Adult Mental Health Initiative) Adult Mental Health Resource Guide
- CAMHI (CommUNITY Adult Mental Health Initiative) website [MNMentalHealth.org]
- Car Seat Training
- Career center gathering with the community
- Center for Family Counseling
- Center for Psychological Services
- Center for Victims of Torture (Waite Park)
- CentraCare Addiction Services
- Central Minnesota Mental Health Center
- Central MN Breastfeeding Coalition
- Central MN Community Empowerment Organization
- Central MN Council on Aging
- Central MN Mental Health Center
- Central MN Suicide Prevention Coalition
- Church Organizations
- Church/School Mentors
- Circle of Parents
- Circle of Security, trauma-informed curricula training sponsored by THRIVE
- Clara's House, partial hospitalization program for children with mental illness
- Coalition to End Social Isolation and Loneliness (CESIL)
- Community ACT Team
- Community Centers / Community Ed

- Community Events - movie in the park, summertime by George, etc.
- Community Garden
- Community groups
- Community Outpost (COP House)
- Community walks/5K / NAMI walk
- Cook Counseling Service LLC
- Dog parks / Splash Pads / walking paths
- ECFE Classes
- Effective Living Center
- ESL Classes
- Faith in Action
- Family Counseling
- Family Services Collaborative
- Farmers Market
- Fe y Justicia
- First Steps Collaborative of Central MN
- Follow Along program
- Foster Grand Parent Program
- Fraser
- Gearing Up for Action: Mental Health Workforce Plan for Minnesota Report from the Minnesota Health Workforce Steering Committee
- Granite City Counseling
- Greater St. Cloud Area Thrive
- Habitat for Humanity
- Healthy Families America
- Higher Ground
- Home visits as follow up to hospital stays
- Horizon Psychiatry
- In-home educators
- Intensive home visiting programs (Early Head Start, Healthy Families America, Nurse-Family Partnership)
- Intensive home visiting programs (Healthy Families America, Nurse-Family Partnership)
- Interpreter/Translation Services
- KidStop
- Library - book clubs,events
- Make It OK Campaign
- Mental Health First Aid
- Mental Health providers offering Circle of Security, a relationship based early intervention program
- Mental Health Providers offering Circle of Security, a relationship based early intervention program for parentsand children
- Minnesota Fatherhoodand Family Services Summit
- Mom groups
- Multicultural Care Center
- Neighborhood organizations - promise neighborhood • Nurse-Family Partnership
- Nystrom & Associates
- One Community Alliance-Building Equity
- Parent Aware
- Partners for Student Success, St. Cloud School District (#742)

- Pathways for Youth
- Preschool Programs
- Profound Therapy LLC
- Project Heal
- Psychotherapeutic Resources
- Public Health Division programs: WIC and Child and Teen Checkups
- Reach out and read
- Reach Up, Inc, Head Start
- School District programs (Early Childhood Family Education, Family Literacy, Special Ed)
- School District school counselors
- Scouts program
- SCSUP (Sherburne County Substance Use Prevention Coalition)-Sherburne County
- Sharing & Caring Hands
- SHIP (Statewide Health Improvement Partnership)
- Social Media groups • St. Cloud Feeding Area Children Together (FACT)
- Solutions Counseling
- St. Cloud Area Crisis Response Initiative
- St. Cloud Area Human Service Council
- STIR (Stronger Together Inspiring Resilience) – Sherburne County
- Strengthening Father Involvement Coparenting, trauma informed curricula training through THRIVE
- Support groups for parents
- Terabinth Refuge
- The Village Family Service Center
- Thumbs Up
- TriCounty Opioid Committee
- United Way 2-1-1
- United Way Success by Six
- Video Conferencing for schools
- Violence Crisis Hotline
- Walk In Counseling Center
- Whitney Center
- WIC

Potential Partners for Community Stability:

- ABE Classes
- 180 Degrees Emergency Youth Center – St. Cloud
- 180 Degrees St. Cloud Youth Shelter
- ACT (Assertive Community treatment) and IRTS (Intensive Residential Treatment Services) through the Central MN Mental Health Center
- ACT on Alzheimer's
- Affordable housing
- Al Loehr Veterans & Community Apartments
- AL-ANON
- Alcoholics Anonymous
- Assisted living activities
- Baby Café
- Car Seat Training
- Career center gathering with the community
- Catholic Charities
- Center City Housing Corp
- CentraCare Hospital Breast Milk Depot
- Central Minnesota Habitat for Humanity
- Central Minnesota Housing Partnership
- Central MN Breastfeeding Coalition
- Central MN Community Empowerment Organization
- Central MN Council on Aging
- Clara's House, partial hospitalization program for children with mental illness
- Community ACT Team
- Community Angel
- Community Garden
- Community Outpost (COP House)
- Conflict Resolutions Center (Mediation)
- Connectability of MN
- Credent Care
- DHS - health, Childcare, SNAP/EBT
- Evidence-based programs for seniors (Falls prevention)
- Family Counseling
- Family Services Collaborative
- Fare-For-All
- Farmers Market
- Fe y Justicia
- Financial Assistance programs
- First Steps Collaborative of Central MN
- Follow Along program
- Goodwill Easter Seals - Father Project
- Greater St. Cloud Area Thrive
- Habitat for Humanity
- Healthy Families America
- Help Me Connect
- Higher Ground
- Home Stretch Homebuyer Education
- Homehelp LLC
- Housing and Redevelopment Authority of St. Cloud, MN

- Housing Benefits 101
- Housing Link
- Immigrant family resources
- Independent Lifestyles, Inc.
- Intensive home visiting programs (Healthy Families America, Nurse-Family Partnership)
- Interpreter/Translation Services
- JD Home Healthcare
- La Cruz Community
- Landlords and Tenants: Rights and Responsibilities
- Legal aid accessibilityto undocumented families
- Lutheran Social Services (Refugee Resettlement Services Resiliency Program for Children)
- Madison/North Elementary/Discoveryschools - Feeding areachildren together
- Meals on wheels
- Milestones
- Minnesota Child Care Assistance Program
- Minnesota Council on Disability
- Minnesota Housing: Find Housing Help
- MN Depot of Human Service: Housing Programs and Services
- Multicultural Care Center
- Neighborhood organizations - promise neighborhood • Nurse-Family Partnership
- Oak Tree Support Services
- One Community Alliance-Buiding Equity through Action
- PACER Center
- Parent Aware
- Pathway4Youth
- Pathways for Youth
- Place of Hope
- Preschool Programs
- Private Pay respite care
- Public Health Division programs: WIC and Child and Teen Checkups
- Re-location Services (County & Lutheran Social Services)
- Ruby's Pantry
- School District programs (Early Childhood Family Education, Family Literacy, Special Ed)
- School District school counselors
- Senior linkage line
- Sharing & Caring Hands
- SHIP (Statewide Health Improvement Partnership)
- Simple Health Services
- SNAP
- St. Cloud Area Crisis Nursery
- St. Cloud Area Crisis Response Initiative
- St. Cloud Salvation Army
- St. Cloud Shines
- STIR (Stronger Together Inspiring Resilience) – Sherburne County
- Terabinth Refuge
- TriCap
- United Way 2-1-1
- United Way Success by Six
- VA Homeless Program
- Washington Place
- WIC
- Workforce Center

- Fraser
- Foley CROSS Center
- Hagen Center
- Living Waters Lutheran Church
- Minnesota Supplemental Aid (MSA)
- Murphy's Board and Care Home
- North Home Healthcare, LLC
- Nouis Home
- Presbyterian Family Foundation
- Professional Guardian Service MN
- River Crest
- SISU Living LLC
- St. Cloud Area Farmers Market
- St. Cloud Stand Down
- We Care Adult Day Services
- WeCare

Potential Partners for Community Access:

- ACT on Alzheimer's
- ACT (Assertive Community treatment) and IRTS (Intensive Residential Treatment Services) through the Central MN Mental Health Center
- AL-ANON
- Alcoholics Anonymous
- Baby Café
- Birth to 5 screenings, services, and referrals
- CAMHI (CommUNITY Adult Mental Health Initiative) Adult Mental Health Resource Guide
- CAMHI (CommUNITY Adult Mental Health Initiative) website [MNMentalHealth.org]
- Center for Victims of Torture (Waite Park)
- CentraCare Hospital Breast Milk Depot
- CentraCare Integrated Behavioral Health
- Central MN Council on Aging
- Central MN Mental Health Center
- Child and Teen Checkups
- Childbirth, Prenatal Classes
- Children's Mental Health Collaboratives
- Clara's House, partial hospitalization program for children with mental illness
- Clinics in the 3-county region
- Community ACT Team
- Community Outpost (COP House)
- Connectability of MN
- Crisis Line
- DHS - health, Childcare, SNAP/EBT
- Dial-a-ride
- East Side COP House-10-10
- Family Services Collaborative
- Fe y Justicia
- Financial Assistance programs
- First Steps Collaborative of Central MN
- Follow Along program
- Gearing Up for Action: Mental Health Workforce Plan for Minnesota Report from the Minnesota Health Workforce Steering Committee
- Greater St. Cloud Area Thrive
- Healthy Families America
- Help Me Connect
- Help me Grow Program
- Home visits as follow up to hospital stays
- Immigrant family resources
- Intensive home visiting programs (Early Head Start, Healthy Families America, Nurse-Family Partnership)
- Intensive home visiting programs (Healthy Families America, Nurse-Family Partnership) MESCH
- Interpreter/Translation Services
- Legal aid accessibilityto undocumented families

- Lutheran Social Services (Refugee Resettlement Services Resiliency Program for Children)
- Mental Health Programs - county
- Mental Health providers offering Circle of Security, a relationship based early intervention program
- Minnesota Statewide Suicide Prevention Plan
- Mobile crisis team
- Odom Medical Group
- One Community Alliance-Building Equity
- PACER Center
- Pathways for Youth
- Private Pay respite care
- Project Heal
- Project Know, Understanding Addiction – Behavior Section
- Public Health Division programs: WIC and Child and Teen Checkups
- Report and recommendation on Strengthening Minnesota's Health Care workforce from the Legislative Health Care Workforce Commission
- Resource navigators
- School District school counselors
- Senior Linkage Line
- SHIP (Statewide Health Improvement Partnership)
- St. Cloud Area Crisis Response Initiative
- St. Cloud Shines
- Stepping Stones Program (Birthline)
- STIR (Stronger Together Inspiring Resilience) – Sherburne County
- Telehealth
- Thumbs Up
- United Way 2-1-1
- WIC
- Young Parent Program (YPP)
- Professional Guardian Service MN
- Care Cab
- Disability Hub MN
- Elite Transport Specialized Care
- Mileage and Access Services
- Minnesota Non-Emergency Medical Transportation
- Resource Training and Solutions
- Schumacher Transportation LLC (Schu-Tran LLC)

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

Leadership & Monitoring

Leadership System & Process for Monitoring and Revision

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

[Lead Agency]: Strategy	Target Date	Person (see contact Info on last page)	Anticipated Outcome/ Result	Progress Notes
1. Central MN Alliance: Annual Report to the Community	Ongoing	CMA Leadership Group and Process Managers	One Annual Report to be developed each year. Partners will be engaged to identify how best to share the information: may be via written format, electronic/virtual, or in-person. Topics to discuss include CHNA, CHIP, and performance and population measures.	
2. Central MN Alliance: Quarterly Leadership Group meetings	Ongoing	CMA Leadership Group and Process Managers	Central MN Alliance agencies will remain up to date on CHIP Goal progress.	
3. Central MN Alliance: Delegated Authorities / Boards will receive at least annual updates	Ongoing	CMA Partner Agency Leadership	Delegated Authorities will remain up to date on CHIP Goal progress.	
4. Central MN Alliance: Data Group will meet at least monthly	Ongoing	CMA Data Group	Data surveillance will take place on a regional level.	

[Lead Agency]: Strategy	Target Date	Person (see contact Info on last page)	Anticipated Outcome/ Result	Progress Notes
5. Central MN Alliance: Process Managers will meet at least monthly.	Ongoing	CMA Process Managers	This CHIP document will be kept up to date and the next formal CHNA will begin July 2027.	
6. Central MN Alliance: Educate Policy Makers and all key community stakeholders on issues/emerging issues in the community	Ongoing	CMA Partner Agency Leadership and Community Action Work Group Leaders Central MN Communities of Excellence	Policy makers and key community stakeholders will be aware of this CHIP and progress being made.	
7. CentraCare: IRS reporting on CHNA process	Every third year after CHNA completion	Danielle Protivinsky, Senior Director - Health Equity & Community Health Improvement, CentraCare	Information will be provided for the IRS Report tax form describing CHNA components, prioritization process, partners, and how input from the community was utilized.	
8. Central MN Alliance Maintain CHIP as a living document. Stored on CentraCare website and other members link to the document.	At east monthly the links will be checked.	CMA Process Managers	A process is in place to allow for the CHIP to be a Living Document while still ensuring access on all member websites.	

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

Created On: 4/15/2025

Approved By:

Benton County Board: TBD

CentraCare- Melrose Hospital Advisory Board: 5/28/2025

CentraCare- Paynesville Hospital Advisory Board: 6/24/2025

CentraCare- Sauk Centre Hospital Advisory Board: 5/27/2025

CentraCare- St. Cloud Hospital Advisory Board: 4/23/2025

Sherburne County Board: 5/20/25

Stearns County Board: TBD

What is a revision? The CHIP is a living document, the posted document will be updated annually or as determined by the Process Managers.

Revised On:

Date	Description

Contact Information

Benton County	
Name	**Email**
Emma Hanson	ehanson@co.benton.mn.us
Jaclyn Litfin	jlitfin@co.benton.mn.us
Kayla Roelofs	kroelofs@co.benton.mn.us
Mariah Klein	mklein@co.benton.mn.us

Sherburne County	
Name	**Email**
Alison Miller	alison.miller@co.sherburne.mn.us
Cody Engelhaupt	cody.engelhaupt@co.sherburne.mn.us
Kara Zoller	kara.zoller@co.sherburne.mn.us
Nicole Ruhoff	Nicole.ruhoff@co.sherburne.mn.us
Peggy Sammons	Peggy.Sammons@co.sherburne.mn.us
Tammy Seifert	tammy.seifert@co.sherburne.mn.us
Somadee Cheam	somadee.cheam@co.sherburne.mn.us

Stearns County	
Name	**Email**
Corrine Dahl	corinne.dahl@stearnscountymn.gov
Janet Goligowsski	janet.goligowski@stearnscountymn.gov
Jannell Boeckermann	jannell.boeckermann@stearnscountymn.gov
Mike Matanich	Michael.matanich@stearnscountymn.gov

CentraCare	
Name	**Email**
Charlotte Merchlewicz	Charlotte.Merchlewicz@centracare.com
Danielle Protivinsky	Danielle.Protivinsky@centracare.com
Kimberly Tjaden	kimberly.tjaden@centracare.com
Melissa Pribyl	pribylm@centracare.com
Michelle Kiefer	michelle.kiefer@centracare.com
Brittany Pfannenstein	Brittany.Pfannenstein@centracare.com
Sylvia Amlie	Syliva.Amlie@centracare.com
Anessa Petersen	Anessa.Petersen@centracare.com
Madison Springer	Madison.Springer@centracare.com

MN Department of Health	
Name	**Email**
Melissa Michels, Assessment and Planning Planner	melissa.michels@state.mn.us
Bob Kuziej, Senior Research Scientist	bob.kuziej@state.mn.us

Process Managers

Benton County	
Jaclyn Litfin	jlitfin@co.benton.mn.us
Mariah Klien	mklein@co.benton.mn.us
Sherburne County	
Nicole Ruhoff	Nicole.ruhoff@co.sherburne.mn.us
Peggy Sammons	Peggy.Sammons@co.sherburne.mn.us
Stearns County	
Mike Matanich	Michael.matanich@stearnscountymn.gov
CentraCare	
Danielle Protivinsky	Danielle.Protivinsky@centracare.com
Brittany Pfannenstein	Brittany.Pfannenstein@centracare.com

Partner Agency Website Addresses

Agency	Website Address
Benton County	https://www.co.benton.mn.us/
Sherburne County	https://www.co.sherburne.mn.us/
Stearns County	https://co.stearns.mn.us/
CentraCare	https://www.centracare.com/

CHIP Appendices

Appendix 1: Public Comments Received for Community Health Improvement Plan (CHIP)

Appendix 1: Public comments Received for Community Health Improvement Plan The Community Priorities/Goals/Activities for July 2025 through June 2028 were shared via email and partner discussions for public comment from 3/26/2025 through 4/7/2025.

The link for public comment was shared by all CMN Members: Benton, Sherburne, and Stearns Counties, as well as CentraCare.

Twenty-one were returned with eighteen of narrative comment. The narrative responses are below. All responses were considered when completing the final draft of this document.

Survey Summary Statistics:

- Are you responding as a representative from an Agency (18) or as an Individual (3)?
- What county do you represent? Mark all that apply. Benton (10), Sherburne (14), Stearns (13), Other (4).
- Please provide feedback on the three Top Community Priorities: Community Connections (17), Community Stability (16), Community Access (17).
- Is there anything confusing or unclear about these priorities/goals/activities? Response (16), Blank (5).
- Do you have any other general comments you'd like to add? Response (13), Blank (8).
- Will your agency work on any of these priorities/goals/activities in the next three years? Yes (19), Maybe (2), No (0).
- Would you like to be contacted regarding your responses? Yes (4), No (17).
- Would you like to be added to a list for continued engagement in this process? Yes (10), No (11).

Narrative Responses

Date: 3/24/2025

Agency or Individual: Agency

County/ies: Benton, Sherburne, Stearns

Comment about Community Connections (CA): I like the top three priority areas, but there are almost too many "sub priorities" listed underneath. The Connection Goals under this category are fairly wordy and a little hard to understand.

Comment about Community Stability (CS): What is a 'data walk'?

Comment about Community Access (CA): I like the idea of expanding mobile health work, especially to more rural areas.

General Comment: Overall, it seems like too much information. It's really easy to get lost reading through this document and not understand it (i.e., what is a 'data walk). I think shortening some of the information underneath the goal descriptions would be helpful. This overview page seems a little overcomplicated for its intended purpose.

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes
Would you like to be contacted regarding your responses? No
Would you like to be added to a slist for continued engagement in this process? No

Narrative Responses

Date: 3/24/2025

Agency or Individual: Agency

County/ies: Benton, Sherburne, Stearns

Comment about Community Connections (CA): Goal 1: The two activities are very specific and involve creating a baseline and measurement process, which is very important. I do think 'next steps' need to be added regarding activities actually aimed at 'increasing overall mental wellbeing..."

These goals seem to be centered around St. Cloud. Are there any initiatives planned for the more rural areas?

In Goal 2 change 'reduce drug use' to 'reduce illicit drug use.'

Comment about Community Stability (CS): Define 'Data Walk'

Comment about Community Access (CA): Goal 1: should 'prevention' be 'preventative care'? "Prevention" sounds a lot like the substance use prevention goal above.

Goal 2, Activity 2: What are you doing with these initiatives? Expanding them? Creating more? Identifying more employers?

General Comment: These might be too detailed for someone with no background knowledge or investment in the CHNA CHIP process to digest.

Also, I think adding the survey data that led to these goals is very important to include.

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes
Would you like to be contacted regarding your responses? No
Would you like to be added to a list for continued engagement in this process? No

Narrative Responses

Date: 3/24/2025

Agency or Individual: Agency

County/ies: Benton, Sherburne, Stearns, other (Wright)

Comment about Community Connections (CA): I appreciate that "Belonging" and "Connection" are part of "Community Connections" (which directly influence one's mental health). I am unsure of how the second goal (Drug Abuse) fits within "Community Connections" other than as an indirect impact could be correlated with how connected one is to their community. In my mind, it is on par with something like suicide prevention (a secondary component).

Comment about Community Stability (CS): I appreciate Goal 2 of this section, as it allows the community to rally around a shared language and understanding, and then explore more deeply methods of collective impact that contribute to the shift in data. The first goal's activities seem to report, "Support what others are doing..." (without a more defined response to HOW). I also wonder if the activities for Goal 1 (FRCs and CRCs) would fit more within Community Access (because that's why/how they exist, right?).

Comment about Community Access (CA): I can see evidence that the second goal is directly related to increasing access.

General Comment: See comments for each specific priority above.

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes
Would you like to be contacted regarding your responses? No
Would you like to be added to a list for continued engagement in this process? No

Narrative Responses

Date: 3/25/2025

Agency or Individual: Agency

County/ies: Benton, Sherburne, Stearns

Comment about Community Connections (CA): It is important to include older adults in the community connections. The Central MN Council on Aging would be an integral partner. Utilize the Senior LinkAge Line as a resource & education piece to support older adults in these communities.

Comment about Community Stability (CS): Food insecurity is a challenge more than ever in these communities due to decrease funding. Older adults should also be included in promoting food access & support. Affordable housing is a challenge for all areas.

Comment about Community Access (CA): Senior LinkAge Line has presentations available to the community on a variety of topics. Mobile clinics are great & could expand to include assistance in completing applications in those underserved areas for people who don't have access to a computer & require in-person assistance.

General Comment: Appears older adults have not been included in these priorities.

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes
Would you like to be contacted regarding your responses? No
Would you like to be added to a list for continued engagement in this process? No

Narrative Responses

Date: 3/25/2025

Agency or Individual: Agency

County/ies: Benton, Sherburne, Stearns, other (Wright)

Comment about Community Connections (CA): I would ask if you have a way to track virtual space capabilities that are available in your area, to be included in the "Connection Goal 1, Activity 2:" space. I believe that there are some opportunities that might live out there such as virtual bookclubs, virtual crafting clubs, etc. Although we want to promote in-person engagement, our virtual tools can still be incredibly helpful to engage people who might be without transportation or they're uncomfortable in large in-person crowds.

Comment about Community Stability (CS): I think this is a wonderful vision! I personally don't have a lot of knowledge though as to what a "Data Walk" would include.

Comment about Community Access (CA): This is a wonderful focus! I am just wondering if it would be worthwhile to think about including Postvention into this effort as well perhaps uplifting efforts community members have made to overcome various health challenges.

General Comment: The only thing unclear from my perspective is what would be included as part of a "Data Walk".

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes
Would you like to be contacted regarding your responses? Yes
Would you like to be added to a list for continued engagement in this process? Yes

Narrative Responses

Date: 3/25/2025

Agency or Individual: Agency

County/ies: Benton, Sherburne, Stearns

Comment about Community Connections (CA): Connection goal 1, activity 2 is great. ANYTHING that promotes and encourages offline connection is a positive. Sherburne Co. SUP has been doing wonderful work in the substance use prevention space for a long time and is a great example of what can be done in different communities.

Comment about Community Stability (CS): None.

Comment about Community Access (CA): Finding creative ways to serve rural MN and remove as many barriers as possible is always a good endeavor. Same with any focus on eating disorders.

Curious to see the marketing approach for "What creates Health?"

General Comment: No.

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes
Would you like to be contacted regarding your responses? No
Would you like to be added to a list for continued engagement in this process? Yes

Narrative Responses

Date: 3/25/2025

Agency or Individual: Individual

County/ies: Stearns

Comment about Community Connections (CA): I think the goals in this section are good. I would also like to see more about mental health promotion (not just providing information on where to find resources). It would be great if the lead agencies (Stearns, Benton, Sherburne and CentraCare) had a major focus on health promotion activities.

Comment about Community Stability (CS): I think these goals are good, but I would like to see more of a role for the lead organizations to promote stability in the community. While there is talk of supporting community organizations, it isn't clear what this support might look like.

Comment about Community Access (CA):

General Comment:

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes
Would you like to be contacted regarding your responses? No
Would you like to be added to a list for continued engagement in this process? Yes

Date: 3/26/2025

Agency or Individual: Agency

County/ies: Stearns

Comment about Community Connections (CA): The priority of Community Connections seems right on target, and the goals of 1) increasing overall mental well being, and 2) reducing drug use by residents of of the 3 counties are both highly desirable and entirely appropriate. The activities for both goals seem appropriate, but I think it would benefit the plan to have activities that link more obviously to the goal.

Narrative Responses

For example, the Goal 2, Activity 2 regarding developing a substance abuse prevention plan modeled on First Steps Central MN, is clearly linked to Goal 2. On the other hand, the two activities for Goal 1, while both highly desirable, are less clear about how they increase overall mental wellbeing, and making this linkage more clear would probably facilitate implementing a plan that increased well-being.

Comment about Community Stability (CS): This priority of Community Stability is great. Goal 1 and the two activities listed are also great, with the goal clearly in line with the priority, and the activities clearly directed at achieving the goal. For goal 2, might I suggest an addition to the wording of the goal to make it very clearly linked to Community Stability. Here is my suggestion for an addition: "Identify, discuss, & promote use and analysis of data to increase understanding of root causes prioritizing communities/groups most impacted BY INSTABILITY."

Comment about Community Access (CA): This priority of Community Stability is great. Goal 1 and the two activities listed are also great, with the goal clearly in line with the priority, and the activities clearly directed at achieving the goal. For goal 2, might I suggest an addition to the wording of the goal to make it very clearly linked to Community Stability. Here is my suggestion for an addition: "Identify, discuss, & promote use and analysis of data to increase understanding of root causes prioritizing communities/groups most impacted BY INSTABILITY."

General Comment: The terminology in the activities for Goal 1 under the priority of Community Connections (e.g., social capitol, social infrastructure, metrics, parameters) is probably not familiar to much of the general public in our three counties, and if we could express these activities with our terminology, it would help make our plan easier to communicate to all of our residents--enhancing transparency and buy-in.

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes
Would you like to be contacted regarding your responses? Yes
Would you like to be added to a list for continued engagement in this process? Yes

Narrative Responses

Date: 3/26/2025

Agency or Individual: Agency

County/ies: Sherburne

Comment about Community Connections (CA): Community connections are absolutely vital to the success of our residents and businesses throughout Sherburne County. Starting with the first goal of mental health/ mental well-being is very important for our communities. It would be interesting to be a part of the social infrastructure mapping. There are multiple business groups I'd want to help add into that social mapping.

Comment about Community Stability (CS): Community Stability is incredibly important for our communities and I'm glad to see it as an identified category. Even harkening back to Maslow's Hierarchy of Needs proves the value of ensuring stability (in multiple arenas) for our communities. The FRC's are very exciting. I look forward to seeing their positive impact throughout our county. In addition to promoting food access through FRC, I'd love to see the FRC's work with community partners (economic development, workforce agencies, etc.) to provide workforce opportunities and career help to our families, to help on this stability side of the house. And yes, I look forward to learning more from the data of Granite Table. This data could be critical in earning more grants/funding opportunities to further develop the stability of our communities.

Comment about Community Access (CA): To be honest, I'm more unfamiliar with this category. My gut reaction is to say that since I am not a healthcare worker, nor have been very involved in that industry, I'm not sure if I can have much feedback here. However, I'm curious if that is the whole point? I could see the argument that everyone, including me, should be more aware of various healthcare initiatives, opportunities, and events happening throughout the county. Further, there are interesting opportunities for cross-departmental partnerships in regards to health outcomes.

General Comment: I guess my only concern is that society is like a giant bowl of spaghetti. In general, every arena of our society (be it mental health, housing, income/job stability, food access, etc.) greatly impacts every other arena. I fully agree with segmenting out particular categories to focus on (e.g., connections, stability, and access as the CHIP does); however, a continual "zooming out" to the holistic picture of our communities is also important. There is never enough funding, attention, support, or resources to solve all of our societal problems, this is true. As a society, we are like a hull of a boat with multiple leaking sections. We can only combat so many of the leaks at a time. But, through this same analogy, we must step back routinely to reassess our boat's holes. Are there any we've ignored? Have any gotten bigger to the point where they deserve our resources? I imagine that is what this CHIP reassessment is attempting to do, so bravo to all of you doing this noble work!

Narrative Responses

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes
Would you like to be contacted regarding your responses? Yes
Would you like to be added to a list for continued engagement in this process? Yes

Date: 3/26/2025

Agency or Individual: Individual

County/ies: Sherburne

Comment about Community Connections (CA): I like the goals and how you will show progress.

Comment about Community Stability (CS): The goals are good and good "outputs". I don't know what a "data walk" is though.

Comment about Community Access (CA): I like the goal and outputs. Is there a reason why you are only looking at shift-work environments? Does that mean factories and healthcare mostly?

General Comment: I like the color coding as it is easier to "group" in my mind.

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Maybe

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Maybe
Would you like to be contacted regarding your responses? No
Would you like to be added to a list for continued engagement in this process? No

Narrative Responses

Date: 3/26/2025

Agency or Individual: Agency

County/ies: Benton, Sherburne, Stearns

Comment about Community Connections (CA): The overall goal and goal 1 are very important, and I was glad to see it listed. I see mental health and mental well-being as a major factor affecting the lives of those in our communities, particularly older adults, who I work with. Social isolation, lack of sense of belonging, lack of family support, solo seniors and those with mental health diagnoses all could use more support. A common issue raised for older adults is financial barrier to services. Many older adults are on a fixed income and there is a lack of affordable options for support, whether formal or informal, and if there are options, transportation is a barrier. I have seen a lack of support from neighbors even, people seem to not be as supportive or friendly to older adults these days, even afraid to ask for help from them as they don't know them. Connection/Belonging/Mental Well-being is a great goal.

Comment about Community Stability (CS): Family Resource Centers sound like they would be a great benefit to the community if able to have all resources in community collaborate, vs. being spread out silos. I hope that older adults are also considered when offering resources. There are grandparents providing caregiving for grandchildren, who are at different stages of life with different needs and resources. I hope also that seniors will be included in option for food access, many are food insecure, but do not qualify for meals or SNAP benefits, and if they do the SNAP benefits are not high enough to be of much assistance with the cost of groceries. Please remember older adults as part of a valued part of our community, who need support as well.

Comment about Community Access (CA): What creates health campaign is a great idea, promoting information earlier in life and consistently throughout life would hopefully impact the health of people living in our communities. Might "financial health" also be included in this as later in life, without proper saving for retirement, finances are a huge stress that affects many older adults. Stress is correlated to health and well-being. Older adults on fixed income that rely solely on social security struggle with paying for rent, debt, food, medical bills, transportation, etc.. Housing is another huge issue for those on fixed income solely relying on social security, as landlords want 1.5x-2.5x income! Mobile clinic offerings in rural areas sound like another benefit, just making sure that the word gets out to those who would be in need of these services. Reaching out to local FM and AM radio stations and not just online information as many older adults also do not access internet, either through choice or availability.

Narrative Responses

General Comment:

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Maybe

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Maybe
Would you like to be contacted regarding your responses? No
Would you like to be added to a list for continued engagement in this process? No

Date: 3/26/2025

Agency or Individual: Agency

County/ies: Benton, Stearns

Comment about Community Connections (CA): I agree with the idea but wish that there was a more impactful way to measure other than #'s served or # of organizations/agencies. The APO has some great mapping tools that can be layered and interactive and could be brought in to the conversation for much of the mapping work.

There is always a need for prevention work, so any efforts are beneficial.

Comment about Community Stability (CS): I am excited to finally see the Granite Table Dashboard. I would like to see how ALICE data matches up with the information on the dashboard.

Comment about Community Access (CA): Any additional resources that we can assist employers with is a benefit.

General Comment:

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes
Would you like to be contacted regarding your responses? No
Would you like to be added to a list for continued engagement in this process? No

Narrative Responses

Date: 3/28/2025

Agency or Individual: Agency

County/ies: Sherburne

Comment about Community Connections (CA): 100 cups of coffee is an initiative supported by More Resilient MN that supports the children's mental health collaborative in all 3 counties. It is a process of having community conversations with partners to identify gaps and needs for mental health services and supports. The Benton/Stearns Collaborative does this and Sherburne County wants to begin. This could be a good activity to incorporate in addressing this priority.

Comment about Community Stability (CS): Love the inclusion of FRC's!!!!!

Comment about Community Access (CA):

General Comment: They appear clear and achievable.

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes
Would you like to be contacted regarding your responses? Yes
Would you like to be added to a list for continued engagement in this process? Yes

Date: 3/28/2025

Agency or Individual: Agency

County/ies: Other (Wright)

Comment about Community Connections (CA): As a community, the main concern is to have health insurance

Comment about Community Stability (CS): As a community, the main concern is to have health insurance

Narrative Responses

Comment about Community Access (CA): More information is missing to know the resources we can use.

General Comment: There is no confusion. What is missing is dissemination and knowledge of resources.

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes
Would you like to be contacted regarding your responses? Yes
Would you like to be added to a list for continued engagement in this process? Yes

Date: 3/28/2025

Agency or Individual: Individual

County/ies: Sherburne

Comment about Community Connections (CA):

Comment about Community Stability (CS):

Comment about Community Access (CA): Sherburne County public nurses were helpful in connecting and guiding our school to set up a partnership with CentraCare Clinics to provide vaccine access to our school during our open house. Follow up and follow through was completed and we feel it was successful year 1. We would like to do this again for next school year.

General Comment:

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes
Would you like to be contacted regarding your responses? No
Would you like to be added to a list for continued engagement in this process? No

Narrative Responses

Date: 3/28/2025

Agency or Individual: Agency

County/ies: Sherburne

Comment about Community Connections (CA): Goal 1 - Activity 1 - That activity seems vague. I'm not sure what the implementation may look like.
Goal 1 - Activity 2 - I really like the idea of mapping hard and soft spaces. I hope the outcomes will be shared with the community, to increase awareness of what is available.
Goal 2 - makes sense. :-)

Comment about Community Stability (CS): Goal 1 - I fully support both identified Activities. Goal 2 - Doesn't mean a lot to me but hopefully is meaningful for those who are closely involved.

Comment about Community Access (CA): Goal 1 - I think both Activities bring value. I really like the idea of the campaigns. Goal 2 - I support those activities.

General Comment: The verbiage is definitely higher level which seems to be directed to those who are most intimately involved in the Ctrl MN Alliance. Hopefully when Activities are implemented at the community level, they will be worded in ways that will be more easily understood by community members.

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes
Would you like to be contacted regarding your responses? No
Would you like to be added to a list for continued engagement in this process? No

Narrative Responses

Date: 4/5/2025

Agency or Individual: Agency

County/ies: Benton, Sherburne, Stearns, other (Morrison, Wright)

Comment about Community Connections (CA): Families/parents are indicating higher needs of support in their role as parents and managing the stress that comes along with isolation while parenting young children.

It feels like a lot of communities and partners in the area have identified similar needs/goals. How can be more collaborative instead of duplicating efforts?

Comment about Community Stability (CS): It has been helpful to have presentations about the FRC to a collaborative of early childhood agencies and professionals. These professionals are known to be collaborative and they will and have been sharing this information out with others.

I am not familiar with Granite Table-Central MN Alliance dashboard. Is that something we can access? share information with?

Comment about Community Access (CA): Our current political climate is impacting these efforts, especially in rural areas. We have seen less children getting medical care, attending school, pulling away from Head Start, WIC, SNAP, and other resources as they fear ICE and deportation. How can we help families feel safe accessing the supports?

General Comment: How will "root causes" continue to be re-assessed or reviewed as the political climate continues to change and impact the causes? I feel like the causes of some of these challenges are much different than they were 3 years ago.

There are many concerns about funding being lost to nonprofits and other agencies that are also supporting these families and community members. Are there ways we can help make sure that there is funding and support for the nonprofit partners?

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes
Would you like to be contacted regarding your responses? No
Would you like to be added to a list for continued engagement in this process? Yes

Narrative Responses

Date: 4/7/2025

Agency or Individual: Agency

County/ies: Stearns

Comment about Community Connections (CA): Social Connection continues to be a challenge for ALL ages. Will specific work or marketing be done to build Community Connections beyond the mapping?

Comment about Community Stability (CS): Will the Family Resource Centers reach ALL ages, not leaving out an age group?

Comment about Community Access (CA): I do not have any changes. I agree with the expansion of Project HEAL. Is there a way to find funding that could support the efforts of community-based organizations? It would also be great to see a renewed effort around employee wellness. I feel this was put on hold during COVID-19.

General Comment: Individuals may not understand what the Family Resource Center and Community School Models are. Maybe link the survey to a one-page handout on explaining the concepts?

Will you or your agency work on any of these drivers, goals, or activities in the next three years? Yes

Are there other goals and activities that you or your agency will be working on that support the drivers/influences in the next three years? Yes
Would you like to be contacted regarding your responses? No
Would you like to be added to a list for continued engagement in this process? Yes

Community Health Needs Assessment

CONDUCTED JULY 2024 - JANUARY 2025

Benton County Wellness | CentraCare | Sherburne County | Stearns County Minnesota

Legal Requirements

This document provides documentation of the following legal requirements.

The Minnesota Community Health Services Act (Minn. Stat. § 145A) of 1976, which was subsequently revised in 1987 and 2003, is now called the Local Public Health Act. This document describes the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHIP). Citations in this document: MN145A.

The United States Patient Protection and Affordable Care Act of 2010 (PPACA) imposed reporting requirements under new Internal Revenue Code (IRC) § 501(r) for charitable hospitals regarding the fulfillment of their charitable purpose as tax-exempt organizations starting in 2011. This document describes the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan. Citations in this document: IRC501r.

Americans with Disabilities Act Advisory:

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

CLAS Standards:

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

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

CHNA Table of Contents

Executive Summary

Vision, structure of process, Priorities, Guiding Principles, and Top Community Priorities

> The Central MN Alliance Vision: In Central MN, every voice counts, every need is important, every culture respected, and everyone is involved in building a better community life with equitable services for all.

This Community Health Needs Assessment (CHNA) is a guide map that informs the Community Health Improvement Plan (CHIP).

The Central MN Alliance used the NACCHO (National Association of County and City Health Officials) MAPP (Mobilizing Action through Planning and Partnerships) 2.0 Framework to conduct the community health needs assessment, identify root cause areas and top community priorities within which to concentrate efforts to improve community health. This CHNA informed the CHIP Implementation Phase of July 1, 2025, through June 30, 2028.

This is the third CHNA and CHIP on which the Central MN Alliance partners have collaborated.

MAPP Framework: Mobilizing for Action through Planning & Partnerships

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

Top Community Priorities and Goals

Community Connection

Goal 1: Increase overall mental wellbeing among Benton, Sherburne, and Stearns County residents.

Goal 2: Reduce drug use among Benton, Sherburne, and Stearns County residents.

Community Stability

Goal 1: Support the development & implementation of Family Resources Centers.

Goal 2: Identify, discuss, and promote use and analysis of data to increase understanding of root causes prioritizing communities/groups most impacted.

Community Access

Goal 1: Promote the importance of Prevention.

Goal 2: Enhance and expand mobile clinic offerings in rural and underserved areas for acute care, primary care, screenings, and vaccinations.

A. Regional Collaboration

Central MN Alliance

In April 2018, the first meeting of the Central Minnesota Alliance was held. The members of this partnership include Benton County, Public Health; CentraCare; Sherburne County Health and Human Services, Public Health Division; and Stearns County Human Services, Public Health Division.

These relationships have been building over time and as a result, a commitment to join community planning was solidified. The group collectively decided to use the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 process and to follow the hospital IRS requirement of a 3-year timeframe for each CHNA cycle. A MAPP framework was also utilized for the previous two planning cycles.

In February 2021, the National Association of County and City Health Officials (NACCHO) announced a MAPP Evolution. In December 2022, the MAPP 2.0 tools became available. The Central MN Aliance sent one staff member to Washington DC in January of 2024 to learn how to use the new handbooks and tools. The Community Health Needs Assessment is about Telling the Community Story utilizing three assessments.

- Resources
- Policy
- Data access/capacity
- Community alliances
- Workforce
- Leadership
- Health equity capacity
- Community power and engagement

- Health outcomes
- Risk factors
- SDOH
- Root Causes
- Health Inequities

- Lived experience
- Strengths, assets, culture
- Built environment
- Historical context
- Structural racism

Three assessments were conducted to complete the Community Health Needs Assessment: Community Status Assessment, Community Context Assessment, and Community Partners Assessment. All four CMA member agencies had staff involved in each of the assessment committees.

The structure of the CMA partnership involves layers of groups of people from each agency with differing levels of involvement. In 2024, the CMA also created an Assessment Design Team that involved members from Community Partners.

Key Authorities:

Key Authorities have the ultimate statutory responsibility for completion of the CHNA and CHIP.

Benton County Board of Commissioners
Scott Johnson, First District Ed Popp, Second District Steve Heinen, Third District Jared J. Gapinski, Fourth District Pam Benoit, Fifth District
Sherburne County Board of Commissioners
Andrew Hulse, First District Raeanne Danielowski, Second District Gregg Felber, Third District Gary Gray, Fourth District Brad Schumacher, Fifth District
Stearns County Board of Commissioners
Tarryl Clark, First District Joe Perske, Second District Jeff Bertram, Third District Leigh Lenzmeier, Fourth District Steve Notch, Fifth District

CentraCare

St. Cloud Hospital Advisory Board

Joe Bergstrom - Chief Financial Officer, Preferred Credit, Inc.
Shannon Cabrera, MD - Ophthalmologist, CentraCare Eye Center
Denise Christie, DNP - CRNA, CentraCare
Shonda Craft, PhD - Dean of School of Health and Human Services, SCSU
Ryan Daniel, MBA, WSO-CSE - Chief Executive Officer, St. Cloud Metro Bus
Eileen Dauer, MD - Chief of Staff, CentraCare - St. Cloud Hospital
Jacob Eiler, MD - Anesthesiologist, CentraCare Clinic Anesthesiology
Renee Frauendienst, RN - Retired Public Health Division Director
Mary Jepperson - Professor, College of St. Benedict / St. John's University
Sister Judy Kramer - Retired Teacher, College of St. Benedict / St. John's University
Joe Mercuri, MD - Hospitalist, CentraCare - St. Cloud Hospital
Joy Plamann, DNP, MBA - Executive Vice President & Chief Operating Officer, CentraCare
Coleen Quinlivan, OSB - Leadership Team/ Community Secretary, Sisters of the Order of St. Benedict
John Schmitz, MD - Psychiatrist, CentraCare; Physician Director, Behavioral Health
Bob Thueringer - Retired COO Coborns, Inc.

CentraCare - Melrose Advisory Board

John Baste - Owner, Famo Feeds Freeport
Patrick Heller, MD - Family Medicine, CentraCare - Melrose
Sheila Hellermann - Community Development Director, City of Melrose
Vicky Herkenhoff - Vice President, Administration & Finance, Stearns Electric Association
Carig Maus - Chief of Police, City of Melrose
Jes Schlichting - State Farm Insurance Representative
Jennifer Tschida - President, CentraCare - Melrose

CentraCare - Paynesville Advisory Board

Kurt Habben, MD - Ex Officio, Chief of Staff, CentraCare - Paynseville
Craig Henneman - Ex Officio/Secretary
Chelsey Mueller - Appointed Community Member
Steve Peterson - Appointed Community Member
Joy Plamann, DNP, MBA - Chief Operating Officer, CentraCare
Daniel Rea - Vice Chairperson, Appointed Community Member
Josh Reitmeier - Appointed Community Member
Bruce Stang - Appointed Community Member

CentraCare- Sauk Centre Operating Committee
Sara Abel - Abel Chiropractic Associates Tim Borgmann, CPA - Board Vice Chair Benedict Haeg, MD - Family Medicine, CentraCare - Sauk Centre Chrissy Hokanson - Vice President & Controller, Dan Welle's Southtown Carolyn Koglin - Senior Director, Ambulatory Care, CentraCare - Sauk Centre Neil Linscheid - Board Chair, Community Member Adam Paulson - President, CentraCare - Sauk Centre Mike Traeger - COO / Chief Lending Officer & Market President, Minnesota National Bank Jean Yarke - Retire Registered Nurse

CMA Member Directors:

Member Directors set major timelines, monitor the progress, and give updates to the Key Authorities.

Benton County
Jaclyn Liftin, Public Health Director, CHS Administrator
Sherburne County
Nicole Ruhoff, Manager, Public Health Manager, CHS Administrator
Stearns County
Janet Goligowski, Human Services Director
CentraCare
Danielle Protivinsky, Senior Director - Health Equity & Community Health Improvement

Steering Committee: *group of stakeholders directing MAPP. The stakeholders represent the community's populations and organizations. The steering committee includes people with resources, community members, and critical public health sectors. (MAPP Handbook).*

Steering Committee
Jaclyn Litfin, Public Health Director, Benton County **Mariah Klein**, Community Health Specialist, Benton County **Nicole Ruhoff**, Public Health Manager, Sherburne County **Peggy Sammons**, Public Health Planner, Sherburne County **Mike Matanich**, Community Health Supervisor, Stearns County **Dani Protivinsky**, Senior Director – Health Equity & Community Health Improvement, CentraCare B**rittany Pfannenstein**, Community Health Improvement Manager, CentraCare

Assessment Design Team: *a team that representative of the community, responsible for coordinating the design, application, and interpretation of the assessments. (MAPP Handbook).*

Assessment Design Team
CMA ADT Members Jaclyn Litfin, Public Health Director, Benton County Peggy Sammons, Public Health Planner, Sherburne County Briana Angstman, Public Health Coordinator, Stearns County Dani Protivinsky, Senior Director – Health Equity & Community Health Improvement, CentraCare **Community Partner ADT Members** Mohamed Goni, Senior Refugee Specialist, Lutheran Social Service of Minnesota Paula Woischke, Senior Director, Whitney Senior Center Sang Maxwell, Director of Partnerships for Student Success, St. Cloud Area School District 742 Shirwa Adan, Chief Executive Officer, Credent Care Stef Rothstein, Director of Education Partnerships, United Way Steve Vincent, Director of Behavioral Health Services, CentraCare

Leadership Committee: *guides the development, implementation, and evaluation, ensuring alignment community priorities and health equity goals.*

Benton County
Jaclyn Liftin, PH Director, Community Health Services Administrator Emma Hanson, Community Health Specialist Mariah Klein, Community Health Specialist Kayla Roelofs, Community Health Specialist
Sherburne County
Nicole Ruhoff, Community Health Services Administrator Tammy Seifert, Public Health Supervisor-Healthy Families Kara Zoller, Public Health Supervisor-Healthy Communities Peggy Sammons, Public Health Planner Cody Engelhaupt, Lead Community Health Coordinator Allison Miller, Community Health Coordinator Somadee Cheam, Public Health Supervisor-WIC
Stearns County
Janet Goligowski, Director, Human Services Director Mike Matanich, Human Services Supervisor, Public Health (Process Manager) Corinne Dahl, Human Services Supervisor, Public Health Janelle Boeckermann, Human Services Supervisor, Finance & Technology
CentraCare
Danielle Protivinsky, Senior Director - Health Equity & Community Health Improvement Brittany Pfannenstein, Community Health Improvement Manager Hani Jacobson, Community Health Nurse Kim Tjaden, MD, Medical Director Liz D. Vicente, Community Health Nurse Melissa Pribyl, Community Health Nurse Michelle Kiefer, Community Health Specialist II Charlotte Merchlewicz, Community Health Specialist II Angelica Hight, Community Health Nurse Sylvia Amlie, Regional Community Health Specialist Madison Springer, Regional Community Health Specialist Anessa Petersen, Regional Community Health Specialist

Minnesota Department of Health
Bob Kuziej, Senior Research Scientist Ann March, Public Health Assessment Planner

Other CentraCare Regional Collaborations:

Other CentraCare locations also execute community-driven strategic planning with local public health and community partners. This section gives a summary of those partnerships.

CentraCare: Benson
Countryside Public Health serves a five-county area and partners with agencies- Swift, Chippewa ,Lac qui Parle, Yellow Medicine, and Big Stone counties.

CentraCare: Long Prairie
The Todd-Morrison-Wadena CHNA Collaborative includes seven local organizations: CentraCare- Long Prairie, Lakewood Health System, Tri-County Health Care, CHI St. Gabriel's Health, and Morrison-Todd-Wadena Community Health Board.

CentraCare: Monticello
The Wright County Community Health Collaborative includes four local organizations: CentraCare – Monticello, Buffalo Hospital- Allina Health, Wright County Community Action, and Wright County Public Health.

CentraCare: Redwood
Southwest Health and Human Services (SWHHS) serves Lincoln, Lyon, Murray, Pipestone, Redwood, and Rock counties in southwestern Minnesota

CentraCare: Rice Memorial
Supported by a joint effort from Kandiyohi Public Health and Renville County Public Health

B. Definition of Community to be Served

The table below shows service area zip codes within each county that are part of Central MN Alliance. County zip codes were identified using Randy Majors Research Hub Minnesota ZIP Codes Map.

Benton County	55371, 56333,56367, 56377, 56379,56357, 56329, 56304, 56330, 56373
Sherburne County	55309, 55308, 55330,55398, 55319, 56304, 55371, 55377, 56379
Stearns County	55353, 56307, 56310,56312, 56316, 56320, 56321, 56325, 56340,56352, 56335, 56356, 56331, 56362, 56368,56369, 56371, 56374, 56375, 56376, 56377,56378, 56387, 56301, 56303, 55329, 55382,55320, 55389, 56388, 56399

Languages spoken in the three counties:
To discuss languages spoken in the counties, we are using two data sources. The MN Compass data uses 2018-2022 5-year American Community Survey estimates identifying a percent of the population 5 years and older that speak a language other than English (2022 US Census). The second dataset is from the Minnesota Department of Education that identifies the count of enrolled students by the Primary Language Spoken at Home as of October 2024 (2024 MDE). The full list of languages can be found in the Community Status Assessment Committee Report.
Benton: According to 2022 US Census, 6.6% of the Benton County population, 5 years old and older, speak a language other than English. According to 2024 MDE data, 98% of enrolled students have English as their Primary Language Spoken at Home. The largest number of the other 14 languages spoken in Benton County homes of enrolled students; the two largest groups being Somali and Spanish.
Sherburne: According to 2022 US Census, 4.5% of the Sherburne County population, 5 years old and older, speak a language other than English. According to 2024 MDE data, 93% of enrolled students have English as their Primary Language Spoken at Home. There are 78 other languages spoken in Sherburne County homes of enrolled students; the three largest groups being Hmong, Russian, and Spanish.
Stearns: According to 2022 US Census, 10.3% of the Stearns County population, 5 years old and older, speak a language other than English. According to 2024 MDE data, 78% of enrolled students have English as their Primary Language Spoken at Home, 13% have Somali, and 7% have Spanish. There are 65 other languages spoken in Stearns County homes of enrolled students; the four largest groups being Anuak, Arabic, French, and Vietnamese.

Benton County, Minnesota:

Located in Central Minnesota, Benton County is part of the St. Cloud Metropolitan Statistical Area. Benton County is one hour north of the Twin Cities and one hour south of premier lake and resort areas. Most of the County's larger communities (St. Cloud, Sauk Rapids, Sartell, and Rice) are located on its Western edge. The center of the County is the City of Foley, the County Seat, home to 2,685 residents, a relatively significant decrease from 2,711. The largest city is Sauk Rapids, which has 13,851 residents, an 11 digit decrease from 13,862 residents from previous recordings. The part of St. Cloud that is located in Benton County includes 7,072 residents, a significant increase from 6,669 residents in previous recordings. Benton County's portion of Sartell includes 2,283 people, a relatively slight decrease from 2,462 residents in previous recordings. Rice, with a population of 1,998, is located on the northwestern edge of the County and underwent a slight increase from 1,975 from previous recordings. The total Benton County population is 41,600, part of a trend of increasing populations from 41,458, and before that 41,375 and 38,575 from previous recordings. Approximately 61% of our population is between the ages of 18-64, with the biggest population cohort being a draw between 10-19 years of age and 30-39 years of age. The gender ratio in Benton County is equal, with 50% male and 50% female.

Approximately 87.2% of our population in Benton County identifies as white non-Hispanic, 5.5% as black, 3.1% as Hispanic, 1% as Asian Pacific Islander, and 2.7% as multiracial. Additionally, 12.8% identify as people of color. The median home value is $247,100, with 68% owner-occupied homes, an increase from 62.7%. Residents have a median household income of $71,480, a significant increase from $60,564. The percentage of residents living under the poverty line is about 9.8%, impacting roughly 10% of our residents aged 65 years old and older and 9% of children under the age of 18. We have a high school graduation rate of about 92.3%, a significant increase from 85% from previous findings. Additionally, 24.5% of our population holds a bachelor's degree or higher. Our disabled population is about 11.1%. The majority of adults in Benton County take 10-19 minutes a day to travel to work and the mean travel time to arrive to work is 22.7 minutes. We have 17,664 people employed in jobs, a relatively slight significant increase from 17,201, and 1,057 total businesses/employer establishments, a relatively slight increase from 1,018. these numbers are significantly increased from 15,505 and 968, respectively. The unemployment rate is about 3.8%.

Data sources used for these statistics were MN Compass (2018-2022 ACS Estimates), Census Reporter (ACS 2023 5-year unless noted), U.S. Census QuickFacts (2022), and the MN Department of Employment and Economic Development (2020-2023).

Sherburne County, Minnesota:

Sherburne County is located in East Central Minnesota between two growing and economically healthy metropolitan areas - the Minneapolis-St. Paul and St. Cloud Metropolitan Statistical Areas. Sherburne County is triangular in shape with the Mississippi River forming the southwestern boundary. The county seat in Sherburne County is Elk River, which is also the largest city, with 26,367 residents: a relatively slight increase from 25,835 residents from previous recordings. Sherburne County is home to seven communities that are located along the major roadway arteries of U.S. Highways 10 and 169.

The total population of Sherburne County is 102,206 people, a relatively slight increase of 5.2% from 97,183 residents from previous recordings. Approximately 61% of the population is between the ages of 18-64, a slight dip from 62% from previous recordings, and the biggest population cohort is a tie between 10-19 years of age and 30-39 years of age, a relatively slight dip from the 45–54-year-old age range from previous recordings. The gender distribution is 51% males and 49% females. Approximately 87.8% of our population identifies as white non-Hispanic, 12.2% as people of color, 3.2% as black, 3% Hispanic, 1.3% Asian or Pacific Islander, 3.9% as multiracial, less than 1% Native American or Alaska Native, less than 1% other race. The median home/house value is $332,700, a significant step up from $244,700, with 85% owner-occupied homes, a relatively slight jump from 79% owner occupied homes from previous recordings. Residents have a median household income of $101,214, a significant increase from an $88,671 median household income from previous recordings.
The percentage of residents living under the poverty line is about 4.4%, a slight dip from 5% from previous recordings, impacting our populations of 65 years and over at 8%, another slight decrease from 9%. Additionally, poverty in Stearns County affects roughly 3% of children under the age of 18. Sherburne County has a high-school graduation rate of 96% overall, a relatively slight increase from 87%. Additionally, 29.9% of our population holds a bachelor's degree or higher. The disabled population is about
9.5%, a small dip from 10% on previous records. The majority of adults in Sherburne County take over 30 minutes a day to travel to work and the mean travel time is 31.3 minutes. Sherburne County has 27,603 people employed in jobs, a relatively significant increase from 26,005 people employed from previous recordings, and has 2,439 businesses/employers' establishments, a relatively slight increase from 2,242 from previous recordings. The unemployment rate is 3%.

Data sources used for these statistics were MN Compass (2018-2022 ACS Estimates), Census Reporter (ACS 2023 5-year unless noted), the MN Department of Employment and Economic Development (2020-2023), and US Census Quick Facts (2022).

Stearns County, Minnesota:

Stearns County is home to 30 cities. The smallest is St. Rosa and the largest is St. Cloud with a total population of 160,977, a relatively slight increase from 158,292, from previous recordings. St. Cloud also serves as the County Seat and portions of St. Cloud also lie in Benton County and Sherburne County, which accounts for the above population; the Stearns County portion of St. Cloud has a population of 55,515. The total population of Stearns County is the aforementioned 160,977, a relatively slight increase from 159,788, and before that, 158,292 residents, from previous recordings.

Approximately 65% of the population is between the ages of 18- 64, with the biggest population cohort being in the 20–29-year-old range. The gender distribution is 51% males and 49% females. Approximately 83% of our population identifies as white, 17% as people of color, and 3.8% as Hispanic. Additionally, 8% identify as black or African American, less than 1% identify as Native American or Alaska native, 1.9% identify as Asian or Pacific Islander, and 2.9% identify as multiracial. The median home/house value is $256,500, with 69% owner-occupied homes, a slight increase from 63% in previous recordings. Residents have a median household income of $74,709, a relatively significant increase from $65,244 from previous recordings. The percentage of residents living under the poverty line is about 11.2%, a slight dip from 12% from previous recordings, impacting 13% of our populations under the age of 18 and 12% of our population aged 65 and over. Stearns County has a high-school graduation rate of 94.2%, a relatively significant increase from 83% high school graduation rate from previous recordings. Additionally, 30.2% of Stearns County's residents hold a bachelor's degree or higher. The disabled population is about 11.2%. The majority of adults in Stearns County take 10-19 minutes a day to travel to work and the Mean travel time to get to work is 23.2 minutes. Stearns County has 85,999 people employed in jobs, an uptick from 82,677 and 82,331 before that, and 4,666 total employers establishments/businesses, an uptick from 4,474, and 4,421 before that, from previous recordings. The unemployment rate is about 4.5%, a relatively small decrease from 5% from previous recordings.

Data sources used for these statistics were MN Compass (2018-2022 ACS Estimates), Census Reporter (ACS 2023 5-year unless noted) US Census Quick Facts (2022), and the MN Bureau of Employment and Economic Development (2020-2023).

Data sources used for these statistics were MN Compass, U.S. Census 2020 ACS Estimates, US Census QuickFacts, the MN Department of Employment and Economic Development, and Census Reporter.

Table: County Demographic Data Indicators

Benton County	County Seat	Foley
	Largest City	Sauk Rapids
	Population	41,600
	Population Growth (2020-2023)	34%
	Median Household Income	$71,480
	Poverty Rate	9%
	Unemployment Rate	3.8%
Sherburne County	County Seat	Elk River
	Largest City	Elk River
	Population	102,206
	Population Growth (2020-2023)	5.16%
	Median Household Income	$101,214
	Poverty Rate	4.4%
	Unemployment Rate	3%
Stearns County	County Seat	St. Cloud
	Largest City	St. Cloud
	Population	160,977
	Population Growth (2020-2023)	74%
	Median Household Income	$74,709
	Poverty Rate	11.2%
	Unemployment Rate	4.5%

Sources: Census Reporter, MN Compass, MN Bureau of Employment and Economic Development

Stearns' old population: 159,788
Sherburne's old population: 97,183
Benton's old population: 41,379, 41,458.

CentraCare

CentraCare works to improve the health of every patient, every day by providing high quality, comprehensive care to the residents of Central Minnesota. The parent corporation of CentraCare was formed in 1995 by a merger of St. Cloud Hospital and the St. Cloud Clinic of Internal Medicine.

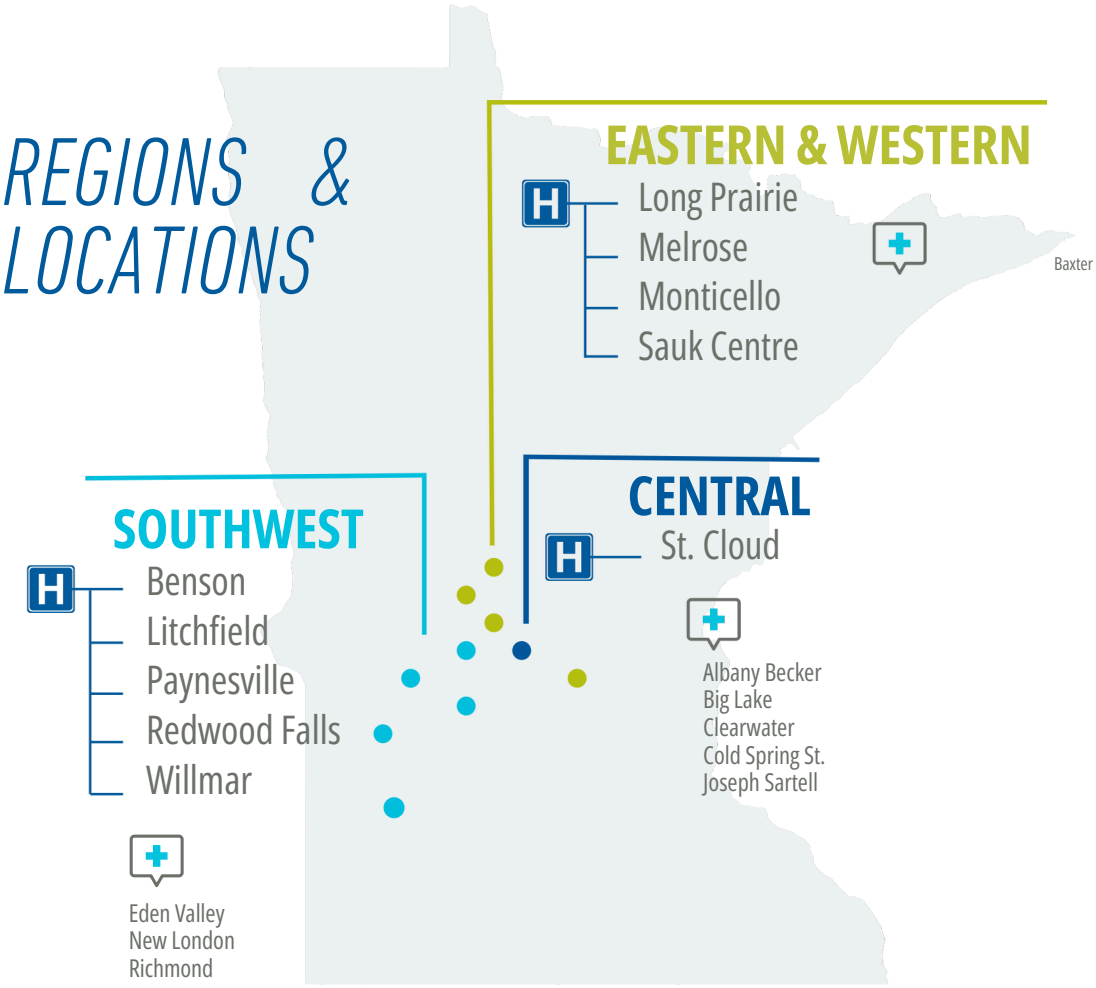
Over the last twenty-three years, the organization has grown to include not only St. Cloud Hospital and CentraCare Clinics, but hospitals and clinics, in the communities of Long Prairie, Melrose, Sauk Centre, Redwood, Monticello, Benson, Willmar and Paynesville. This wide service area allows us to care for patients in urban, suburban, and rural locations and includes beneficiaries that are underserved. CentraCare began operating the wholly owned subsidiary of Carris Health, which expanded our service area to West Central and Southwest Minnesota.

St. Cloud Hospital	• Catholic, not-for-profit regional hospital • 489 licensed beds • Largest health care facility in the Region • Magnet-designated hospital since 2004 • Hospital service area consists primarily of Benton, Sherburne, and Stearns Counties
CentraCare Clinics	• 26 CentraCare Primary Care clinics that have achieved Level 3 Health Care Homes certification through the Minnesota Department of Health (MDH).
CentraCare-Melrose	• Not-for-profit • 25-bed critical access hospital, Level IV trauma center, and clinic • Service area primarily consists of western Stearns County
CentraCare-Paynesville	• 36 bed Level-4 trauma & Critical Access not-for-profit hospital, three family medicine clinics: Eden Valley, Richmond, and Paynesville clinics • Walk-in care option available • Service area primarily consists of the southwestern corner of Stearns County

CentraCare - Sauk Centre	• Not-for-profit • 25-bed critical access hospital, Level IV trauma center, and clinic • Service area primarily consists of the northwestern corner of Stearns County
CentraCare - Redwood Falls	• 25-bed Level IV Trauma Center and Critical Access Hospital • Not-for-profit. Rural health clinic • Service area primarily Redwood County with neighboring counties in SW Minnesota
CentraCare - Willmar Rice Memorial	• A wholly-owned subsidiary of CentraCare. Not-for-profit. • Comprised of a partnership between CentraCare, Rice Memorial Hospital in Willmar, Redwood Area Hospital in Redwood Falls, and ACMC Health- including 10 clinics in SW Region of the State
CentraCare- Monticello	• Not-for-profit • Critical access hospital, clinic, cancer center and specialty care services • Service area primarily in Wright and Sherburne Counties
CentraCare - Long Prairie	• Not-for-profit • 25-bed critical access hospital, Level IV trauma center, clinic, and walk-in clinic • Attached Vitality Wellness Center - facility includes a pool, gym, and studio utilized by CentraCare specialty care, staff, and community members • Primary service area located in the middle of Todd County
CentraCare - Benson	• 21 bed Critical Access not-for-profit Hospital and Rural Health Clinic • Walk-in care clinic option available • Located in Swift County

CentraCare Health

REGIONS & LOCATIONS



AT A GLANCE

Calendar Year 2024

10 HOSPITALS[1]

30+ CLINICS

160+ OUTREACH LOCATIONS

ONE MEDICAL SCHOOL[2]

PATIENT CARE

Calendar Year 2024

356K	537K	57K	128K	63K
Unique patients	Hospital admissions	Surgeries performed	ER visits	Virtual (Video) visits

CAREGIVERS

As of 12/31/24

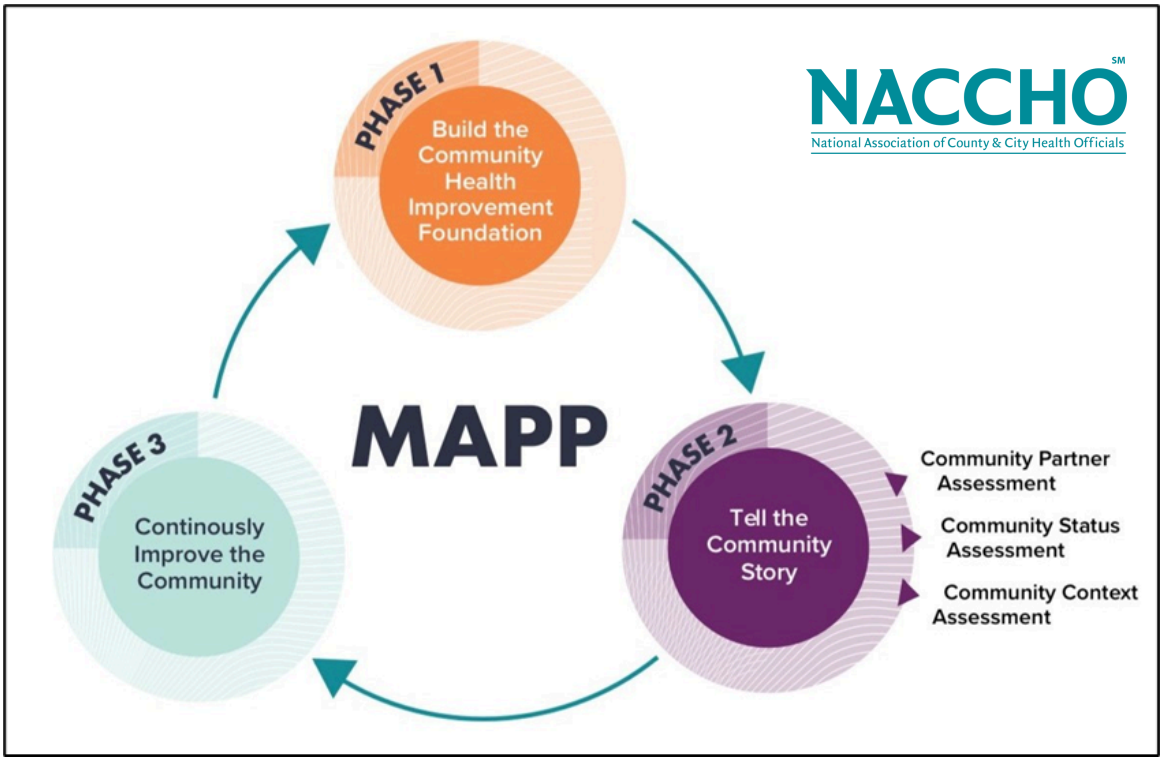
11.6K Employees

950+	3.4K	975+
Physicians & APPs	Nurses (LPN, RNA, RNs)	Volunteers

C. Process and Methods to Conduct the CHNA

The Central MN Alliance (CMA) agreed to utilize the MAPP (Mobilizing for Action through Planning and Partnerships) 2.0 Framework process to conduct the Community Health Needs Assessment (CHNA) and prepare the Community Health Improvement Plan (CHIP). MAPP 2.0 consists of three phases outlined in detail in this section: Build upon the community health improvement infrastructure, tell the community story,and continuously improvecommunity health. The CHNA largely encompasses the first two phases and identifies the priorities, goals, and activities for the third, ongoing phase.

While this document is a static document describing the process employed from July 2024 through January 2025, community assessment is also a continuous task.



Build on the Community Health Improvement (CHI) Infrastructure

As described in the section titled Regional Collaboration, the partnership development for the creation of the Central MN Alliance was formalized with the first meeting of the Central MN Alliance in April 2018. At a June 29, 2021, meeting, the CMA members agreed to continue the partnership for the July 2022 through June 2025 CHIP. At a February 21, 2024, meeting, the CMA members agreed to continue the partnership for the July 2025 through June 2028 CHIP. The CMA members also agreed to:

- Utilize the MAPP 2.0 framework.
- Conduct the three MAPP Assessments consecutively: Partner, Status, then Context
- Have the Process Managers be the MAPP Steering Committee, supported by intentional community input gathered from the Building Equity Through Action-Action Teams, Granite Table, and the United Way of Central MN Health Committee
- Maintain the Vision

The Vision

The Central Minnesota Alliance (CMA) Vision was formalized in July 2021 and continued in this CHNA cycle. The CMA agrees that the statement is a living statement, and any member can ask to revisit the Vision to make changes at any time.

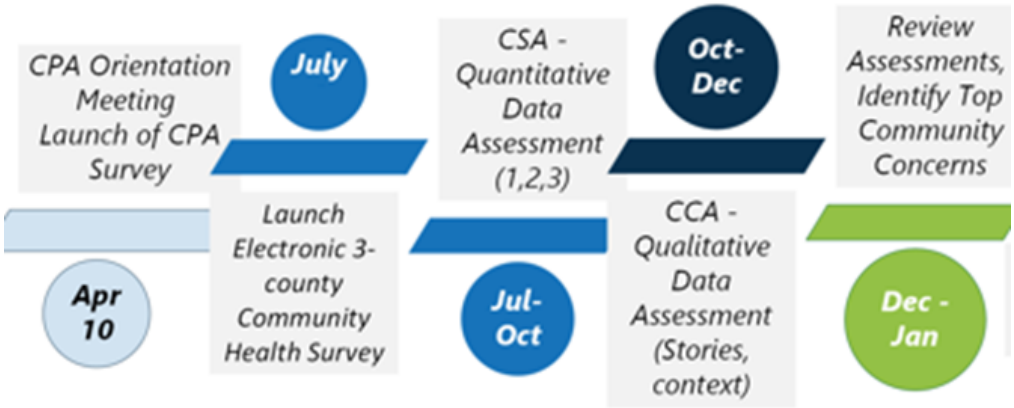
CMA Vision

In Central MN, every voice counts, every need is important, every culture respected, and everyone is involved in building a better community life with equitable services for all.

Telling the Community Story & Identifying Root Causes of Inequities

Three assessments were completed consecutively July 2024 through January 2025: Community Partners, Community Status, and Community Context. It was a goal to impart more emphasis on what resulted from the Community Partners and Community Context assessments than from the quantitative data within the Community Status assessment.

In December 2022, NACCHO launched the MAPP 2.0 tools. In January of 2024, one staff member from the Central MN Alliance participated in a MAPP 2.0 training course in Washington DC. The recommendation was to complete the three assessments consecutively rather than concurrently, and the CMA, upon consensus, agreed to conduct the assessments in the following order: Community Partner Assessment, Community Status Assessment, and Community Context Assessment. Also, by suggestion within the MAPP 2.0 Framework, an Assessment Design Team (ADT) was initiated.



Several community partners who also are required to conduct a community health assessment, agreed to join a small group of CMA leaders on the ADT. The ADT included one member from each of the CMA agencies plus one person from each of the following partner agencies: Central MN Community Empowerment Organization (CMCEO), City of St. Cloud / Whitney Senior Center, Independent School District 742 (St. Cloud), Credent Care Home Care Services, United Way of Central MN, and the Stearns County Public Health Task Force. The ADT met monthly from June 2024 to December 2024. Most of the ADT members also participated in the January 2025 Assessment Triangulation process.

Each Assessment was conducted by an Assessment Committee made up of people from each of the four CMA members.

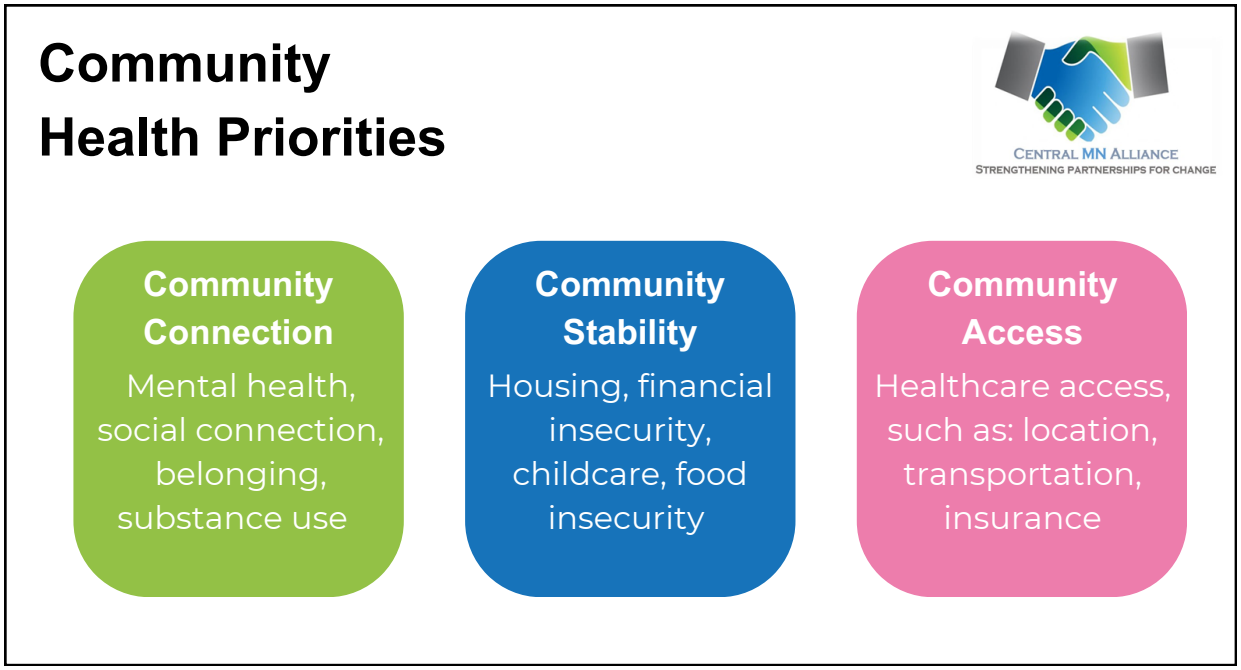
At a January 2025 CMA Leadership Group meeting, a MAPP 2.0 Assessment Triangulation Process was completed. This meeting was attended by the CMA Leadership Group, ADT members, as well as a few other invited partners: St. Cloud State University Center for Health Outcomes and Policy Research (CHOPR) researchers, CMA Local Public Health Medical Directors, Minnesota Department of Health Public Health System Consultant, and the Granite Table Board, which includes the following partners: Granite Table Executive Director, Central MN Community Foundation, St. Cloud State University Office of the Provost, and the Communities of Excellence 2026 Granite Table Mentor. Each Assessment Committee shared the Assessment findings and recommendations.

After the Assessment Committees had shared the findings and recommendations, the hybrid January 2025 meeting attendees participated in a Mentimeter activity for them to share what they were seeing as cross cutting themes across all three Assessments. Those qualitative data were exported from Mentimeter and ChatGPT was used to identify the top themes within the data. From what ChatGPT provided, nine priority themes were rated by attendees by level of concern as a top community priority. The resulting ranked list included: mental health, social determinants of health, housing, financial instability, social connections & belonging, childcare, food security, equity, and access to healthcare.

These priorities were discussed further at the late January CMA Steering Committee meeting. It was discussed that social determinants of health and equity are foundationally addressed in all that we do. The following three groupings were discussed:

1. Mental Health, Connection, Belonging, Substance Use
2. Financial Instability, Housing, Childcare, Food Insecurity
3. Access to Healthcare

The Process Managers created a Brainstorming worksheet to identify names for the groupings. At a February 12th CMA Steering Committee meeting, the Top 3 Community Health Priorities were identified as: Community Connection, Community Stability, and Community Access, or simply: Connection, Stability, Access.



Community Partner Assessment Committee

Please see Appendix A for the report of activities conducted by the Community Partner Assessment Committee.

Community Partner Assessment Committee Recommendations

- Show why partnerships are key to improving community health and how to strengthen them:
  - Highlight the wide variety of organizations and resources in CMA to showcase the value of collaboration in addressing health needs.
- Clarify partner roles in supporting public health and addressing inequities:
  - Raise awareness among partners about their positive role in supporting community health to enhance their engagement and impact.
- Assess the skills and strengths of partners to advance health and equity goals:
  - Evaluate existing resources and capacities within CMA to identify areas where collaboration can drive health and equity improvements
- Map existing partners to identify strengths and areas for growth:
  - Document CMA’s current network to uncover strengths and pinpoint opportunities for expanding partnerships or addressing gaps.
- Identify new partners and ways to improve collaboration and community engagement:
  - Promote a unified, community-centric approach to funding and resource utilization, ensuring collective efforts address health inequities and foster meaningful partnerships.

Community Status Assessment Committee

Please see Appendix B for the report of activities conducted by the Community Context Assessment Committee.

Community Status Assessment Committee Recommendations

- Provide data in more accessible ways for partners and community residents.
- Review more deeply the reasons for delay of care.
- Explore the differences in the data by different demographics.

Community Context Assessment Committee

Please see Appendix C for the report of activities conducted by the Community Context Assessment Committee.

Community Context Assessment Committee Recommendations

Forces of Change

- Focus on the effective communication strategies, finding common goals and co-creating solutions.
- Active listening and understanding diverse perspectives, fostering open dialogue, utilizing collaborative decision-making processes, promoting cultural competency.
- “A rising tide lifts all boats”

Community Context Assessment Committee Recommendations

Built Environment

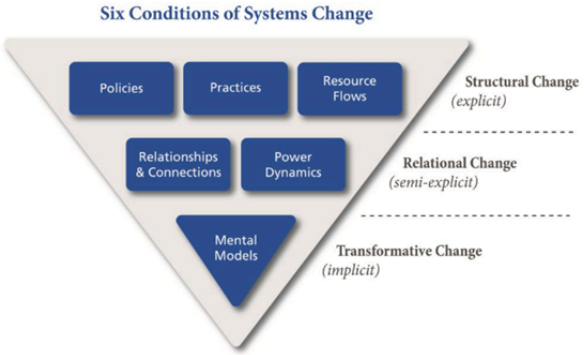
- Infrastructure projects should consider prioritizing areas that have been under resourced
- Expansion of broadband has been a priority
- Housing affordability and quality focus

Community Strengths and Assets

- Promote collaborative governments and non-profits, connection to rich healthcare resources, support the strong education system and partnerships
- Central MN Alliance approach - aligning resources and expertise across the region for collective impact on Health Outcomes

Identify Goals and Action Steps

After the Top Community Health Priorities were identified, the CMA Process Managers started work on developing potential Goals and Activities that would fit under each priority. Members of the Leadership Group used a Goals and Action Steps Worksheet stored on Microsoft Teams to collaboratively prepare a list of goals and activities. After creation of the list, partners utilized the “Six Conditions of Systems Change” to identify where the goals aligned with this framework. Ultimately, our group agreed that for transformational change the shifting of mental models will be key.



To keep the CHIP at a workable level, it was decided that we would try to identify two goals with activities for each priority to include in the CHIP. In early March, a Mentimeter scaling survey was used to prioritize the brainstormed goals. At a Process Managers meeting in mid-March, the goals and activities were identified to put into the CHIP document for public comment. A great list of goals and activities was brainstormed; just because a goal was not included in the CHIP, does not mean that the CMA will not work on it. The Process Managers have discussed that the goal brainstorming worksheet will be reviewed annually.
It is the intention of the CMA members that the CHIP will be a living document and as more conversations take place with community partners, the goals and activities may change. The changes to the document will be reported at least annually when local public health is required to report on CHIP work.

Implementation Phase

While continuous improvement is the goal, administratively, the implementation phase of the CHIP that results from this CHNA will be for three years from July 1, 2025, through June 30, 2028.

D. Similarities to National, State, and Other Local Planning Processes

Organizations with similar 501C3 processes within our community reflect the alignment and partnerships of the health priorities outlined.

National, State, Local, or Other Planning Process	
Local: Anna Marie's Alliance, https://annamaries.org/programs/ Priority Alignment: • Community Connection • Community Stability • Community Access	Provides a safe place for women and children who experience domestic violence and creates systems change that reduces violence. Community advocacy programs offer criminal justice advocacy, connection to community resources and specialized advocacy with a Latino/a Advocate, an East African Immigrant Advocate and an LGBTQ advocate. Prevention services work in schools to promote social-emotional learning and healthy relationship skills for children in grades K-12.
Local: Arc Midstate, https://arcminnesota.org/about/why-the-arc/ Priority Alignment: • Community Connection • Community Stability • Community Access	The Arc promotes and protects the human rights of people with intellectual and developmental disabilities, actively supporting them and their families in a lifetime of full inclusion and participation in their communities. People with intellectual and developmental disabilities and their families trust Advocates at The Arc for help in addressing issues that affect their lives. Advocates provide personalized information, navigation, and referrals on disability issues and systems throughout the lifespan. The Arc engages people in public policy advocacy to protect and promote the human rights of people with disabilities.
Local: Center for the Victims of Torture, https://www.cvt.org/about-us/ Priority Alignment: • Community Connection • Community Stability • Community Access	Parenting.

Local: Central MN Council on Aging, annualreport_2023fnl.pdf. Priority Alignment: • Community Connection • Community Stability • Community Access	Age-Friendly and Dementia Friendly community support, Social Communication Engagement, Suicide Prevention Coalition participation.
Local: Granite Table-Central MN Communities of Excellence, About Central MN Community Foundations | Nonprofits • Community Connection • Community Stability • Community Access	Mission: Enriching lives in Central MN through intentional, collaborative, and equitable action. Vision: Central MN is recognized as a community of inclusion where people thrive and feel a sense of belonging. Values: Engage Community, Create Equity, Welcome All
Local: Initiative Foundation, 2023 Annual Impact Report — Initiative Foundation • Community Connection • Community Stability	High quality, affordable childcare in Central MN.
Local: Reach-Up Head Start, Annual Report - Reach-Up Head Start • Community Connection • Community Stability • Community Access	Children who have been in the Reach-Up Head Start program all year will demonstrate developmental progress in the five domains (Social Emotional Development, Language and Literacy, Approaches to Learning, Cognitive and General Knowledge, Physical Development and Health). 85% of families who set housing, financial, or health goals (and have follow-up) will meet at least one goal. A minimum of 200 Reach-Up families will demonstrate parent participation/education (e.g., parent meetings, parent education classes, socializations, conferences/referral visits).
Local: Building Equity Through Action • Community Connection • Community Stability • Community Access	Hosts Dine & DialoguesAlso has 5 action groups: Community Engagement, Education, Employment and Economy, Healthcare, and Housing.

Local: Central Minnesota Community Foundation Central Minnesota Community Foundation - CommunityGiving • Community Connection • Community Stability • Community Access	Engaging People. Connecting Resources. Building Community
Local: Thriving Young Minds THRIVE https://thrivecentralmn.org/ • Community Connection	Embeds early childhood social-emotional development & mental health into existing services. Provides high quality, relevant training on issues of early childhood mental health. Raises awareness of the vital importance of social emotional development. Develops family focused, integrated service delivery systems. Help families access knowledge and encouragement to be successful in infant and child mental health through ongoing reflective practices. A whole family approach is taken across all disciplines.
Local: United Way of Central MN https://www.unitedwayhelps.org/ • Community Connection • Community Stability • Community Access	Access to ongoing quality learning and literacy services for families with children, birth through 3rd grade. Youths should have at least one caring mentor supporting and guiding them in development of positive life skills. Access to emergency, transitional or permanent housing with a special focus on youth and families with children. Connecting individuals with resources to stabilize living conditions, maintain independence and lessen dependency. Build knowledge and skills related to cost-effective food choices, food preparation, safe food storage and nutrition. Connecting individuals to free & confidential resources they need that build support and safe environments for families around mental health.
Local: United Way of Sherburne County, Home - Sherburne County Area United Way. • Community Connection • Community Stability	Non-profit connections, Imagination Library
National: Center for Disease Control Mental Health for Children & Parents, About Children's Mental Health | Children's Mental Health | CDC. • Community Connection • Community Access	CDC works with partner agencies to better understand mental health and mental health conditions and their impact on children.

National: National Prevention Strategy, Healthy People 2030, Objectives and Data - Healthy People 2030 | odphp.health.gov • Community Connection • Community Stability • Community Access	5 Topic areas: Health Conditions-20 goals, Health Behaviors-14 goals, Populations-10 goals, Settings & Systems 13 goals, SDOH-5 goals.
State: Early Childhood Family Education (ECFE), Early Childhood Family Education. • Community Connection	Early Childhood Family Education. Early Childhood Family Education (ECFE) is a program for all Minnesota families with children between the ages of birth to 48 months. ECFE's goal is to enhance the ability of all families to provide the best possible environment for their child's learning and growth.
State: Minnesota Statewide Health Improvement Framework, Healthy Minnesota Partnership Statewide Health Improvement Framework - MN Dept. of Health. • Community Connection • Community Stability • Community Access	NA
State: Minnesota Statewide Health Assessment, Minnesota Statewide Health Assessment - MN Dept. of Health. • Community Connection • Community Stability • Community Access	The MN statewide health assessment provides a snapshot of health and wellbeing across MN and within our communities. The assessment provides data, opportunities in communities, partners, and stories/ community context. This assessment is the result of a collaboration led by the Healthy Minnesota Partnership and supported by the Minnesota Department of Health (MDH).
State: Minnesota Association of County Social Service Administrators (MACSSA) Position Statement for the 2025 Session, Welcome to MACSSA. • Community Connection • Community Stability • Community Access	NA

Minnesota Climate Action Framework Community Stability Community Access	https://climate.state.mn.us/minnesotas-climate-action-framework https://climate.state.mn.us/protecting-healthy-lives-communities Grant funding has the following focus areas: [1] Funding and supporting community-led initiatives across Minnesota that address health risks from climate change and improve health outcomes. And [2] Providing proactive health services and delivering culturally appropriate, affordable, and responsive healthcare and mental health services to protect public health and create a foundation for climate resiliency.

E. Existing Community Resources

- ABE Classes
- 180 Degrees Emergency Youth Center – St. Cloud
- AccentCare
- Acquire Mental Health Clinic
- ACT (Assertive Community treatment) and IRTS (Intensive Residential Treatment Services) through the Central MN Mental Health Center
- Adult & Teen Challenge Minnesota
- Advancing Together with Morgan Tate
- Affinity Psychological Services, P.C.
- AL-ANON
- Alcoholics Anonymous
- Alzheimer's Support Group for Caregivers
- Anger Management, Domestic Violence, and Co-Parenting Support Groups, Trauma Informed Support Groups at the Village Family Services
- Anna Marie's domestic
- Apollo Counseling Inc.
- Assisted living activities
- Baby Café
- Bark Park Program
- Better Mental Health PLLC
- Block parties
- Bounce Back Project
- CAMHI (CommUNITY Adult Mental Health Initiative) Adult Mental Health Resource Guide
- CAMHI (CommUNITY Adult Mental Health Initiative) website [MNMentalHealth.org]
- Car Seat Training
- Career center gathering with the community
- Center for Family Counseling
- Center for Psychological Services
- Center for Victims of Torture (Waite Park)
- CentraCare Addiction Services
- Central Minnesota Mental Health Center
- Central MN Breastfeeding Coalition
- Central MN Community Empowerment Organization
- Central MN Council on Aging
- Central MN Mental Health Center
- Central MN Suicide Prevention Coalition
- Church Organizations
- Church/School Mentors
- Circle of Parents
- Circle of Security, trauma-informed curricula training sponsored by THRIVE
- Clara's House, partial hospitalization program for children with mental illness
- Coalition to End Social Isolation and Loneliness (CESIL)
- Community ACT Team
- Community Centers / Community Ed

- Community Events - movie in the park, summertime by George, etc.
- Community Garden
- Community groups
- Community Outpost (COP House)
- Community walks/5K / NAMI walk
- Cook Counseling Service LLC
- Dog parks / Splash Pads / walking paths
- ECFE Classes
- Effective Living Center
- ESL Classes
- Faith in Action
- Family Counseling
- Family Services Collaborative
- Farmers Market
- Fe y Justicia
- First Steps Collaborative of Central MN
- Follow Along program
- Foster Grand Parent Program
- Fraser
- Gearing Up for Action: Mental Health Workforce Plan for Minnesota Report from the Minnesota Health Workforce Steering Committee
- Granite City Counseling
- Greater St. Cloud Area Thrive
- Habitat for Humanity
- Healthy Families America
- Higher Ground
- Home visits as follow up to hospital stays
- Horizon Psychiatry
- In-home educators
- Intensive home visiting programs (Early Head Start, Healthy Families America, Nurse-Family Partnership)
- Intensive home visiting programs (Healthy Families America, Nurse-Family Partnership)
- Interpreter/Translation Services
- KidStop
- Library - book clubs,events
- Make It OK Campaign
- Mental Health First Aid
- Mental Health providers offering Circle of Security, a relationship based early intervention program
- Mental Health Providers offering Circle of Security, a relationship based early intervention program for parentsand children
- Minnesota Fatherhoodand Family Services Summit
- Mom groups
- Multicultural Care Center
- Neighborhood organizations - promise neighborhood • Nurse-Family Partnership
- Nystrom & Associates
- One Community Alliance-Building Equity
- Parent Aware
- Partners for Student Success, St. Cloud School District (#742)

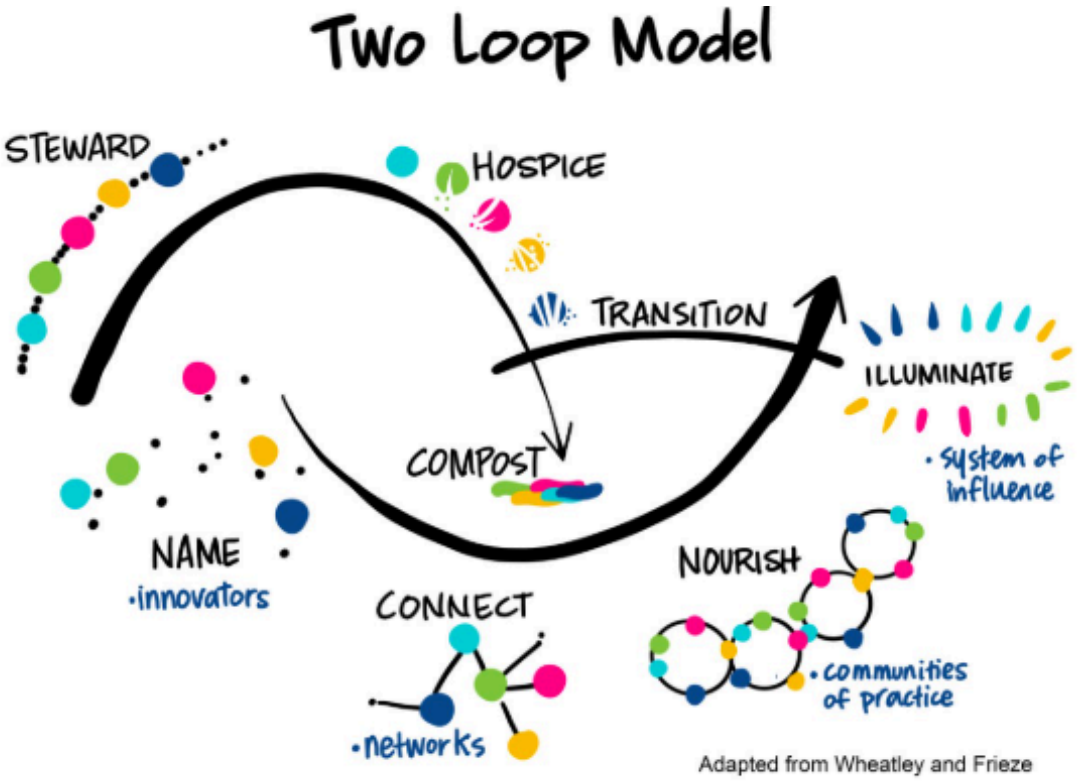
- Pathways for Youth
- Preschool Programs
- Profound Therapy LLC
- Project Heal
- Psychotherapeutic Resources
- Public Health Division programs: WIC and Child and Teen Checkups
- Reach out and read
- Reach Up, Inc, Head Start
- School District programs (Early Childhood Family Education, Family Literacy, Special Ed)
- School District school counselors
- Scouts program
- SCSUP (Sherburne County Substance Use Prevention Coalition)-Sherburne County
- Sharing & Caring Hands
- SHIP (Statewide Health Improvement Partnership)
- Social Media groups • St. Cloud Feeding Area Children Together (FACT)
- Solutions Counseling
- St. Cloud Area Crisis Response Initiative
- St. Cloud Area Human Service Council
- STIR (Stronger Together Inspiring Resilience) – Sherburne County
- Strengthening Father Involvement Coparenting, trauma informed curricula training through THRIVE
- Support groups for parents
- Terabinth Refuge
- The Village Family Service Center
- Thumbs Up
- TriCounty Opioid Committee
- United Way 2-1-1
- United Way Success by Six
- Video Conferencing for schools
- Violence Crisis Hotline
- Walk In Counseling Center
- Whitney Center
- WIC

Note: We intend to have community-driven strategies that encompass all sectors. These lists are in no way meant to be exhaustive. They are meant to be used as considerations when working on community initiatives and identifying gap areas of inclusion. If you would like another resource added to these lists, contact any member of the Process Managers or Leadership Group.

F. Evaluation of Actions Conducted Since the Previous CHNA Process

Since the completion of the previous Community Health Needs Assessment (CHNA), the Central MN Alliance has implemented a variety of strategies and initiatives aimed at addressing the priority health needs identified in our communities. Each of the partner agencies support this work both independently and collaboratively. We are able to focus on specific community needs as well as the overall impact to Central MN.

All four CMA Agencies provide programs, technical assistance and leadership in creating healthy communities. The Community Health Improvement Plan is one of the ways we do this work. As it relates to how we support and conduct the work of the goals within the CHIP, we employ the Berkana Institute's Two Loops Model and act in the areas of Naming (identifying), Connecting (networking), Nourishing (communities of practice), and Illuminating.



Benton County Report on 7/1/22-6/30/25 CHIP Goals

Data Access & Systems

Benton County Public Health (BCPH) made significant strides in data sharing and outreach efforts through various platforms and collaborations. Digital media was leveraged to share important data points, particularly through online platforms and communications tools. Content was strategically aligned with awareness months via coordinated efforts among our Central Minnesota Alliance. This included engagement in hot-topic content and graphics. This synergy helped raise awareness on key issues, including broadband access.

Broadband access efforts were another priority, with a focus on expanding connectivity and digital access. The team developed a Broadband Access Toolkit, which was made publicly available and shared during outreach and community partner meetings. The toolkit was designed to better understand broadband impacts on health and resources for improved broadband access. Additionally, at the County level, Benton County conducted a Broadband Access project, significantly bringing broadband to rural community most impacted, aiming to enhance internet infrastructure and access across the County.

Data within presentations, education, and community engagement were integral parts of outreach. The department conducted presentations focusing on County Health Rankings, covering crucial topics impactful to building families and the mental well-being of our community. Alongside presentations, data briefs were distributed, including both 2-pagers and 4-pagers coordinated within CMA, offering essential insights into local health information regarding our CMA work. Collaborative efforts extended to the mental health sector, where the team engaged with various groups to develop a toolkit that could support ongoing initiatives and awareness around mental health access and mental health impacts on health as related to the CHIP goals.

Further efforts were directed toward infographics aimed at improving public awareness on mental health access and broadband, with specific data components incorporated to make the information more accessible and actionable. BCPH also participated in various committees and coalitions, such as the Status Committee of CMA, and worked to implement a coordinated CMA data calendar for consistent monthly social media posts and outreach efforts. Additionally, support was provided to the East St. Cloud workgroup in evaluating Benton’s western parts of the county and specific needs and priorities.

Structural Racism

A key component has been a focus on staff development, community engagement, and policy initiatives. Staff and Community training efforts were a part of this, including the Public Health Nurse (PHN) Residency program participation and the Tri-Wellness at Work employer staff development initiative around equity.
Engagement with the community was tailored to specific populations driven by data.

Health education was central to these efforts, with the department partnering with local schools as well as implementing food access initiatives to address the broader determinants of health in the community.

Lastly, participation in the “Building Equity through Action” group on various committees and respective outreach; outreach materials were also translated and interpreted to ensure accessibility for diverse populations, ensuring that language barriers did not prevent individuals from accessing necessary services.

Lived Experience

BCPH’s efforts to improve mental health and resilience were centered around lived experience and the importance of social and emotional learning (SEL). Training sessions focused to a trauma-informed approach, Adverse Childhood Experiences (ACEs), and educator self-care, and were offered to childcare providers, equipping them with the knowledge to support the emotional well-being of children, especially due to impacts from COVID. Collaboration with local schools and partners also played a vital role in building developmental assets and offering training opportunities aimed at supporting emotional resilience within the educational setting, including supporting guest speakers around resiliency and mental health, mental health provider reflective supervision, mental health spaces, and an initial start of an outdoor classroom environment within a school setting.

Mental health outreach continued to be a priority, with efforts to raise awareness about mental health resources and support. The department distributed “Mental Health Matters” bags, which contained valuable resources, and promoted the 988-suicide prevention hotline through tabling at events such as the Rox Games and the Foley Youth Expo. In addition, digital media campaigns were launched to raise awareness of mental health resources.

The "What Creates Health" campaign was another major initiative, with presentations aimed at educating leadership and partners on County health rankings and the various factors influencing health. Internal education efforts ensured that leadership and staff were well-versed in the Community Health Improvement Plan (CHIP), which guided the department's strategic initiatives. Community communication was also enhanced through videos, social media, and educational materials, further amplifying the department's messages about health and well-being.

The department's commitment to community engagement was an area of focus. Its participation in events such as local expos and ongoing outreach efforts and collaborative work was expanded.

BCPH actively supported commercial tobacco policy development and initiatives aimed to protect the health of our youth and further impact mental health and building of families.

The department also implemented a public health approach to Human Trafficking and Healthy Relationships, focusing on prevention through education, youth engagement, and family resilience. By recognizing human trafficking as a public health issue, staff coordinated closely with local partners and coalitions to develop strategies that address root causes and risk factors.

These partnerships extended to local schools, medical providers, county departments, and community-based committees, creating a network of support and shared responsibility. Staff development initiatives were also prioritized, equipping public health professionals with training to recognize signs of trafficking and respond effectively. Through these efforts, the department worked to foster safe, informed communities and promote healthy relationships, particularly among youth and vulnerable populations.

Historical Context

Historical context educational resources were gathered and shared among CMA to increase awareness and foster an environment that acknowledges and addresses the impacts of past on current health outcomes.

Next Steps

Next steps for our Department include ongoing implementation of efforts and activities as we transition into a new Community Health Improvement Plan cycle with our Regional Partners.

Sherburne County Report on 7/1/22-6/30/25 CHIP Goals

Data Access

- Two Loops Model Focus: Name, Connect, & Nourish
- Data Sharing Initiatives:
  - Shared 2021 Local Survey Data. St. Cloud Live media article (June 2023).
  - 2024 Community Health survey Data Highlights (October 2024).
  - County Board and Administration education/sharing
- Data Literacy & Engagement:
  - “Data Parties” (1/2/24 & 9/10/24) to promote data understanding.
  - Expanded partnerships with BRIDGES collaborative, Mainstreet Family Services, ISD728, STIR, and Sherburne Economic Development.
- Program & Grant Support:
  - 2024 survey data supported a Good Food Access Program grant.
  - Expanded collaboration with Building Equity through Action, Economic Development, SCSU, and United Way.

Broadband Access

- Two Loops Model Focus: Nourish & Illuminate
- Policy Advocacy & Community Support:
  - Engaged USDA (8/27/24) and LPHA Conference (2023) on broadband expansion.
  - Promoted broadband-health connection with community leaders (Oct & Nov 2024).
- Broadband Access Toolkit:
  - Toolkit Link (2023) AmeriCorps Project. Shared on website.
- Infrastructure Investment:
  - ARPA & CARES funds expanded broadband access, reaching 1,497 properties (38.7% gap reduction, 2019-2024).

Structural Racism

- Two Loops Model Focus: Connect, Nourish, & Illuminate
- Inclusive Workforce Initiatives:
  - Sherburne County achieved I-WE Certification (6/27/24) for inclusive employment practices through the County DEIB Committee work.
- Building Equity & Community Engagement:
  - Developed St. Cloud Equity Toolkit; TriWellness cohort (Nov 2024).
  - Supported food equity in a food desert, aiding a USDA grant app.
- County-Level Commitment:
  - Contracted with Culture Brokers (Oct 2023-Jan 2025) for workforce diversification.
  - Integrated equity into Sherburne County United Way initiatives.

Lived Experience

- Two Loops Model Focus: Name, Connect, & Nourish
- Community Conversations on Health & Equity:
  - Dine & Dialogue events 4/13/24, 7/13/24 BIPOC Mental Health Month, and 12/5/24 (Access to Healthy Food). Four scheduled for 2025.
  - Conversations on Race in St. Cloud (2023 & 2024).
- Public Health Awareness & Education:
  - PH 101 Presentations: Sherburne Economic Development (2024), Active Central MN (2025).
  - Health in All Policies (HIAP): Engaged county planning/zoning officials, Community Health Board and Administration.
- Adverse Childhood Experiences (ACEs) Awareness:
  - 9/17/24 Training & Development Event: Ellison Center presentation.
  - May 2025 Gathering: Growing Resilient Communities Initiative.
- Digital Outreach:
  - CMA Brand Social Drivers of Health infographics, HHS/PH/CHB website updates (Q3 2024).

Historical Context

- Two Loops Model Focus: Nourish & Illuminate
- Recognition of Indigenous History & Contributions:
  - MDH Discussions on evolving Land Acknowledgments.
  - OneCommunity Alliance Land Acknowledgments in community meetings.
- Cultural Education & Awareness Efforts:
  - Indigenous History Presentations: St. Cloud Indigenous Learning Program (12/24).
  - Field Trip to Two Inlets (Sept 2024): Public Health Division training on Indigenous health.
- Incorporation of Indigenous Perspectives:
  - Updated Sherburne County Comprehensive Plan & Website (2023) to reflect Indigenous heritage. See: Two Inlets at Bdé Heḣáka [*Dakota*] - Omashkooz Zaaga’igaans [*Ojibwe*] Regional Park.
  - November 2023: "What Matters: Indigenous Peoples’ Heritage Month" materials shared.

Stearns County Report on 7/1/22-6/30/25 CHIP Goals

Stearns update Data Access and System

Stearns County made progress in improving public access to health data through strategic outreach and communication. Collaborating through the Central Minnesota Alliance (CMA), the county utilized digital platforms and coordinated campaigns around key community-based identified topics and other national awareness months to increase visibility on priority topics such as broadband access impact on health and mental health.

Alongside presentations, data briefs were distributed, including both 2-pagers and 4-pagers coordinated within CMA, offering essential insights into local health information regarding our CMA work. Collaborative efforts extended to the mental health sector, where the team engaged with various groups to develop a toolkit that could support ongoing initiatives and awareness around mental health access and mental health impacts on health as related to the CHIP goals.

A Broadband Access Toolkit was developed by the CMA collaboration and shared at community events and partner meetings to help residents understand the connection between broadband and health. Other broadband expansion initiatives also took place across Stearns County, working to improve internet infrastructure in rural communities, enhancing digital equity for those most impacted.

Other health data from community conversation and other sources played a central role in community education, including two joint projects with the Community Foundation and Stearns County Emergency Management that included presentations and video education created in three languages. These materials supported efforts related to sever weather, fire safety family, well-being and mental health awareness. These videos were shaped by community input. After listening sessions, we developed narratives based on what we heard and invited community members to present the information themselves on camera. This process and information align with our broader CHIP.

Structural Racism

Equity remains a foundational principle of Stearns County's h efforts. Staff development has been a key part of emphasizing culturally responsive care and workforce diversity.

Stearns County has significantly expanded its on-the-ground engagement through coordinated public health and human services outreach. Public Health staff, often working alongside other department staff, have been embedded in community spaces such as homeless shelters, local libraries, schools, domestic violence shelters, places of worship and food shelves. Our presence at these sites has helped forge deeper relationships with residents of Stearns County experiencing instability, connecting them to vital resources and services.

Through mobile services like Neighborhood WIC Clinics in areas such as Sauk Centre and Paynesville, and community vaccination clinics we have extended health access into community. Or our four county Home Visiting program meeting families where there at to build health families through coordinated outreach efforts, with additional support offered to help overcome access barriers like lack of transportation or a medical home.

Community outreach driven by data and focused on populations with identified disparities. Partnerships with local schools and nonprofits supported education and access to food, while collaboration with the Building Equity Through Action / One Community Alliance initiative enhanced the county's equity infrastructure. To reduce barriers, materials were translated and interpreted, ensuring broader community access to key services and messages.

Lived Experience

Stearns County significantly expanded its presence in community spaces by utilizing staff in high-need locations identified with focus groups and conversations with those with lived experience. As a result, in person service delivery was provided right where it was needed to remove barriers that could prevent individuals from accessing necessary services in partnership with groups like:

- Place of Hope (adult and family shelters)
- Anna Marie's Shelter (domestic violence)
- Catholic Charities and Project Connect
- Neighborhood WIC clinics in Sauk Centre and Paynesville
- Fe Y Justicia
- St. Cloud Great River Regional Library
- East African food shelf
- Collaborations with Somali-led organizations such as CAIRO.
- Meetings with Sauk Centre community leaders (churches, schools, senior centers)
- Participation in local events (Project Connect, PRIDE in the Park, Hispanic Heritage Day, Senior Center visits)
- Public health promotion at the Somali Independence Day celebration
- Collaborations with CMCEO, Somali Radio / TV, and other organizations

Historical Context

In collaboration with CMA partners, Stearns County supported the collection and distribution of educational materials highlighting the historical context of health disparities. These tools were used to raise awareness among staff and community leaders about how systemic and generational inequities continue to affect current health outcomes.

Next Steps

As the current CHIP cycle progresses, Stearns County will continue to evaluate and adapt strategies in partnership with its regional collaborators. Future work will focus on:

- Strengthening relationships with underserved populations
- Expanding culturally responsive programming
- Sharing data and results with community partners
- Supporting sustainable, equity-driven public health approaches
- The next phase of CHIP planning will build on lessons learned and emerging needs, ensuring a responsive and community-informed path forward.

CentraCare Report on 7/1/22-6/30/25 CHIP Goals

Since the completion of the previous Community Health Needs Assessment (CHNA), CentraCare has implemented a variety of strategies and initiatives aimed at addressing the priority health needs identified in our communities. CentraCare has a rich history of partnering in Central Minnesota, assessing the changing needs of our communities since the early 1990s. With the formalization of CHNA processes through the Patient Protection and Affordable Care Act (PPACA), these efforts have been more structured and coordinated across CentraCare hospitals. The PPACA mandates that not-for-profit hospitals conduct a CHNA every three years and adopt an implementation strategy to address identified community health concerns. This section provides an evaluation of the actions taken and progress made.

Community Collaboration

- Community Health Nursing Services: Weekly health services are provided at the Community Outpost, addressing critical care gaps for Somali- and Spanish-speaking populations who experience significant barriers to healthcare access.
- Project H.E.A.L. Clinics: Established at multiple locations across the community to deliver essential healthcare services to individuals facing challenges in accessing traditional medical care.
- Electronic referral to First Steps of Central MN: Connecting families to family home visiting
- Housing Summit and Childcare Summits were held to increase community connections and collaborations. The Housing Engagement Summit continues to gain traction in the areas of Policy, Home Builders, Government and Education. The Childcare Summit addressed the needs that families and employers face with childcare shortages and how it affects staffing with examples of creative employer solutions.
- Addressing SDOH with partnerships throughout Stearns, Benton and Sherburne Co with activities that address food insecurity such as Blessing Boxes and Emergency Food Bags.

Advancing Equity

- Data-Driven Insights: Monthly reporting on health equity metrics to assess and improve Population Health Measures.
- Health Equity Training: Implementation of the Health Equity 101 training series across all CentraCare clinics, equipping staff with the knowledge and tools to provide equitable care.

- Gender-Affirming Care: System-wide integration of gender-affirming services within primary care settings to ensure inclusive, patient-centered care for all individuals. This included Safe Space training at each primary care site.
- Comprehensive Wrap-Around Services: Patients receive holistic support through a multidisciplinary team, including Community Health Workers, Social Workers, Integrated Behavioral Health providers, Community Paramedics, Community Faith Based Nurses, Care Management professionals, and Community Health Improvement specialists.
- Social Drivers of Health (SDoH) Screening: Standardized screening conducted across all Ambulatory and Inpatient Departments to identify and address social determinants impacting health. An expansion is being explored for the St. Cloud Hospital Emergency Trauma Center.
- Cultural Awareness Education: Bi-monthly cultural awareness presentations on Somali, Hispanic, and LGBTQ+ populations are provided to all CentraCare staff to enhance cultural competence and improve patient care experiences.

Awareness

- Suicide Prevention Initiatives: Training and education programs implemented both within CentraCare and throughout the broader community to enhance suicide awareness and prevention efforts.
- Mental Health Resource Development: Creation, dissemination, and promotion of the Healthy Minds Support Healthy Bodies resource to provide education and support for mental well-being.

Resilience

- Bounce Back Project: Resilience-building presentations are delivered across the healthcare system and in the community. Train-the-Trainer sessions occur biannually to expand program reach and impact. Social media is utilized for continued promotion and education.
- School-Based Resilience Education: The Bounce Back Project collaborates with RSVP to provide resilience education within schools, equipping students with tools to support mental and emotional well-being.
- CentraCare ACE’s Workgroup is an established interdisciplinary team that is increasing the awareness of ACE’s and resources throughout the system.

Education

- Reach Out and Read: Implemented at all CentraCare clinic locations, fostering early literacy development and strengthening family connections through pediatric care settings
- Help Me Grow: “Screen at 3” bookmarks are added to all 3-year-old Reach Out and Read books to promote early developmental screenings.
- Milestone & Developmental Wheels: Provided at all 9-month visits, offering parents tools to track and support their child’s developmental progress.
- Advance Care Planning education provided to patients seeking a great understanding of the document to achieve a higher level of completion rates at clinic sites.

Next Steps

CentraCare’s hospitals have worked diligently to implement strategies based on the most recent CHNA findings. The CHNAs for CentraCare’s four hospitals (Paynesville, Sauk Centre, Melrose, and St. Cloud) prior to June 30, 2025, were presented individually.

Stakeholder groups at each of CentraCare’s four hospitals have been identified and will meet quarterly. Building on the new priority areas, CentraCare will continue to refine strategies based on community feedback and emerging health trends. Future actions will emphasize culturally competent care, strengthening collaborative partnerships, and leveraging innovative solutions to address health disparities across our service areas.

By evaluating and adapting our initiatives, CentraCare remains committed to improving the health and well-being of the communities we serve through sustainable, equity-driven approaches.

Annual CHIP updates for each of CentraCare’s four hospitals will be provided to each hospital Advisory Board.

Appendix A:

Community Partner Assessment Committee Report

CENTRAL MN ALLIANCE
STRENGTHENING PARTNERSHIPS FOR CHANGE

Community Partner Assessment Report

2024

Overview of MAPP

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is not an agency-focused assessment process; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems.

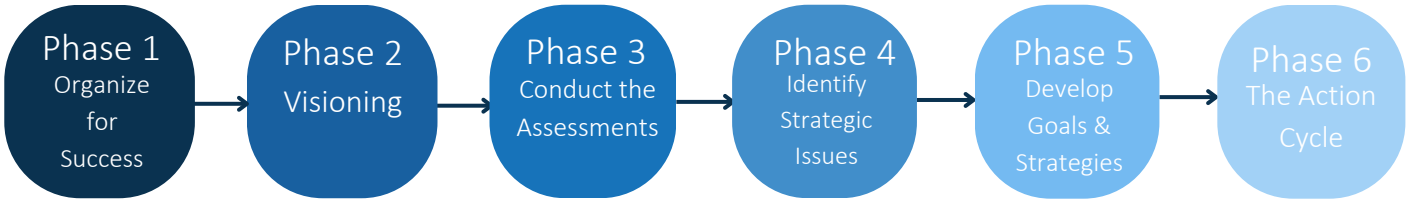
In 2019, the National Association of County and City Health Officials (NACCHO) began a redesign the MAPP process. This redesign was focused on the following principles:

- Equity
- Inclusion
- Trusted Relationships Community Power
- Strategic Collaboration and Alignment
- Data and Community Informed Action
- Full Spectrum Actions
- Flexible
- Continuous

In 2024, a Central MN Alliance member was selected to participate in the MAPP 2.0 Pilot Training. They were 1 of 35 participants.

More information about MAPP and the redesign process can be found in NACCHO's MAPP Evolution Blueprint Executive Summary.

Original MAPP Framework



MAPP 2.0 Framework

MAPP Guiding Questions

- What are the sub-populations within our community that have higher health risk or poorer health outcomes?
- What structural and social factors contribute to higher health risks or poorer health outcomes of certain populations within our community?
- How are various types of community partners impacting health inequities in the community or contributing to the health and wellness of community members?

Community Partner Assessment: Goals & Intentions

The CPA is an assessment process that allows all of the community partners involved in MAPP to critically look at 1) their own individual systems, processes and capacities and 2) their collective capacity as a network/across all community partners to address health inequities. This tool helps identify the range of actions that are currently being taken and could be taken moving forward to address health inequity at the individual to systemic and structural levels.

CPA Goals

The goals of the Community Partner Assessment are to:

- Describe why community partnerships are critical to community health improvement (CHI) and how to build or strengthen relationships with community partners and organizations
- Name the specific roles of each community partner to support the local public health system and engage communities experiencing inequities produced by systems
- Assess each MAPP partner's capacities, skills, and strengths to improve community health, health equity, and advance MAPP goals
- Document the landscape of MAPP community partners, including grassroots and community power building organizations, to summarize collective strengths and opportunities for improvement
- Identify who else to involve in MAPP moving forward, along with ways to improve community partnerships, engagement, and community power-building

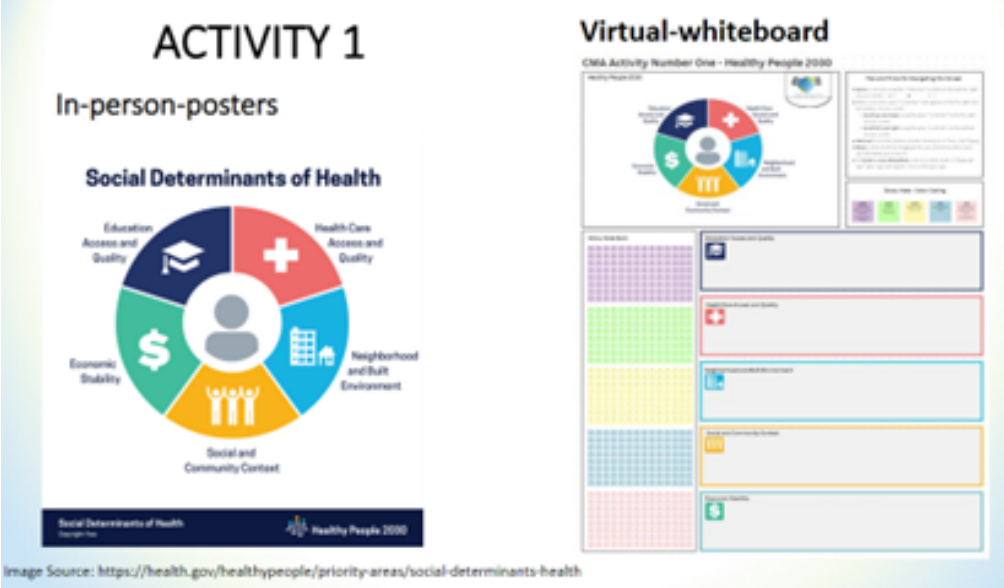
Methods

The CPA consisted of an online survey available April through August and a community partner meeting in April 2024. More than 35 organizations participated in the CPA in some way. Some participated in the survey, some attended the meeting, and others participated in both.

Partner Orientation Meeting

The Partner orientation meeting was held in a hybrid format on April 10, 2024. 12 partner organizations participated in-person with 23 virtually.
The meeting consisted of an overview of the Central MN Alliance, MAPP and CHNA (Community Health Needs Assessment) process overview and two activities.
This meeting supported building connections and learning about what is needed in the CMA region to address health inequities and improve community health.

The Social Determinants of Health



Education Access and Quality

Themes from partners:

- Educational Programs
- Cultural Outreach
- School Coordination
- Workforce Training

Neighborhood and Built Environment

Themes from partners:

- Housing & Infrastructure
- Health & Safety
- Community Engagement
- Environmental Sustainability
- Diversity & Inclusion

Healthcare Access and Quality

Themes from partners:

- Equitable Access
- Maternal & Child Health
- Mental Health
- Chronic Disease
- SDoH
- Infectious Disease
- Public Health Partners
- Health Advocacy

Social and Community Context

Themes from partners:

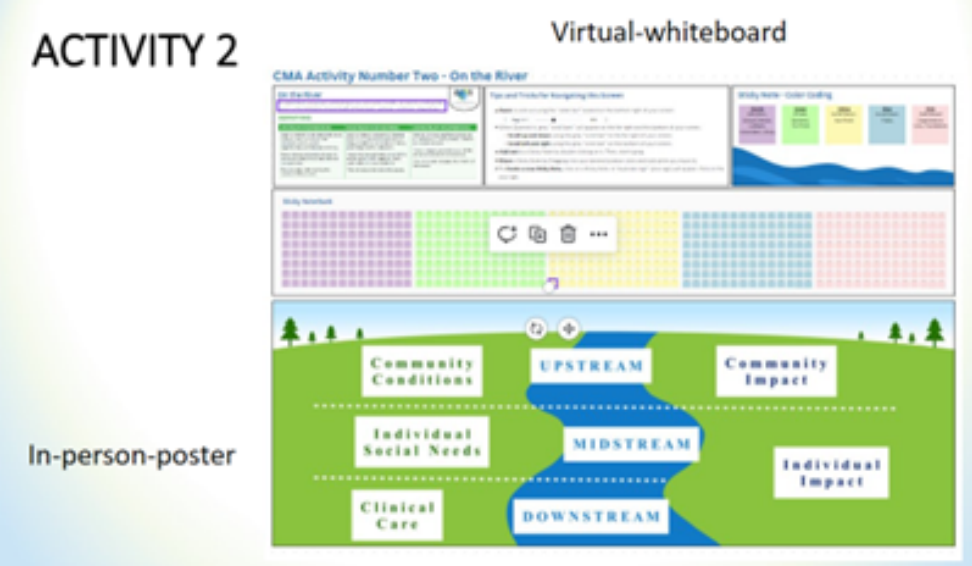
- Community Engagement
- Education & Awareness
- Social Support
- Workplace Wellness
- Access & Inclusion
- Youth Development

Economic Stability

Themes from partners:

- Workforce Growth
- Financial Assistance
- Essential Services
- Community Engagement

On the River



Clinical Care

Themes from partners:

- Childhood Immunizations
- HealthCare Delivery and Access
- Chronic Disease Management
- Advance Care Planning
- Mental Health Services and Supports
- Social Determinants of Health
- Community Partnership
- Cultural Competency
- Health Equity

Community Conditions

Themes from partners:

- Neighborhood
- Senior Care
- Education
- Basic Needs/SDOH
- Faith Based Services
- Cultural Competency
- Advocacy
- Mental Health
- Recreation
- Dental

Community Impact

Themes from partners:

- Healthcare Policy
- Health Education
- Professional Training
- Medical School
- Workforce Development
- Economic Stability
- Accessible Programs
- Transportation
- Dental Access
- Active Transport
- Funding Projects
- Community Partners
- Outreach
- Crisis Services
- Continuum Care
- Interpreter Services
- Recreation
- Safe Routes

Individual Social Needs

Themes from partners:

- Senior Care
- Mental Health
- Substance Use
- LPH
- Early Childhood
- Employment
- Parks
- Transportation
- Social Skills
- Youth Mentoring
- Cultural Competency

Individual Impact

Themes from partners:

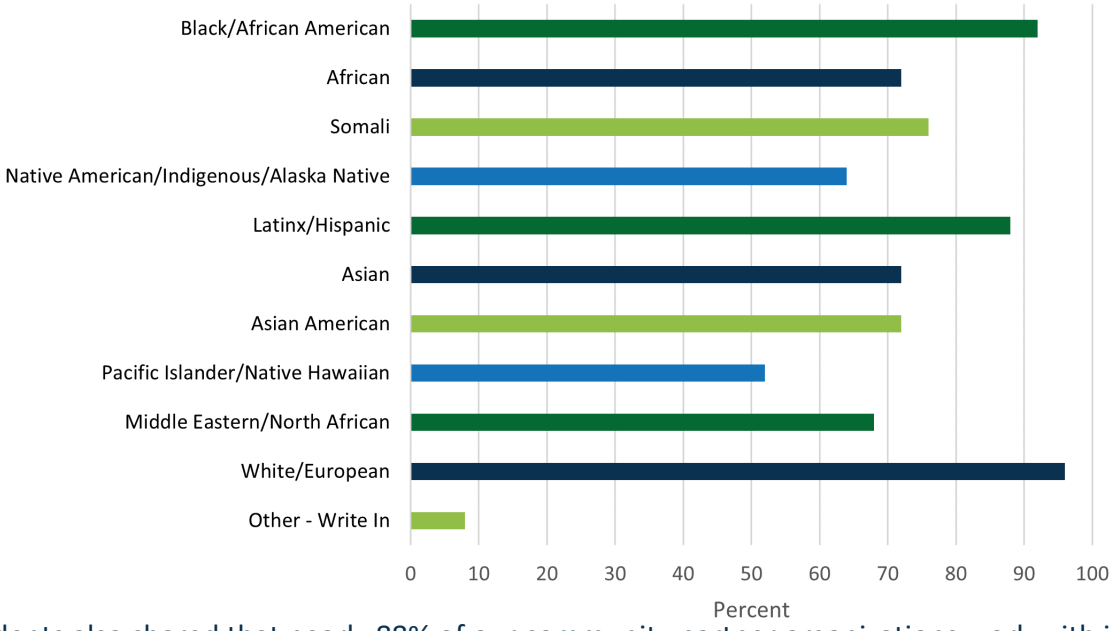
- Neighborhood
- Continuing Education
- Basic Needs/SDOH
- Health Literacy
- Insurance
- Community Resources
- LPH
- Preventative Screening
- Young Adults

Survey

19 partner organizations participated in the CPA Survey from April to August 2024. The CPA survey consisted of sixty-three questions on the following topics: about the organization, interest in participating in the community health improvement process, demographics of people served, topic area focuses, organizational commitment to equity, who the organization is accountable to, capacities as they relate to the 10 Essential Public Health Services, general capacities and strategies, data access and systems, community engagement practices, policy, advocacy, and communication.

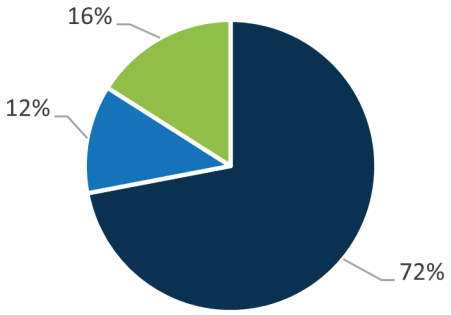
About Our Community Partner Organizations

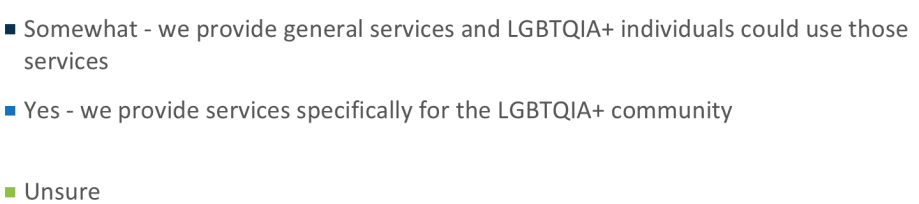
Over 86% of organizations work with racial/ethic groups



Respondents also shared that nearly 88% of our community partner organizations work with immigrants, refugees, asylum seekers, and other populations that speak English as a second language.

Does your organization offer services for transgender, nonbinary, and other members of the LGBTQIA+ community?





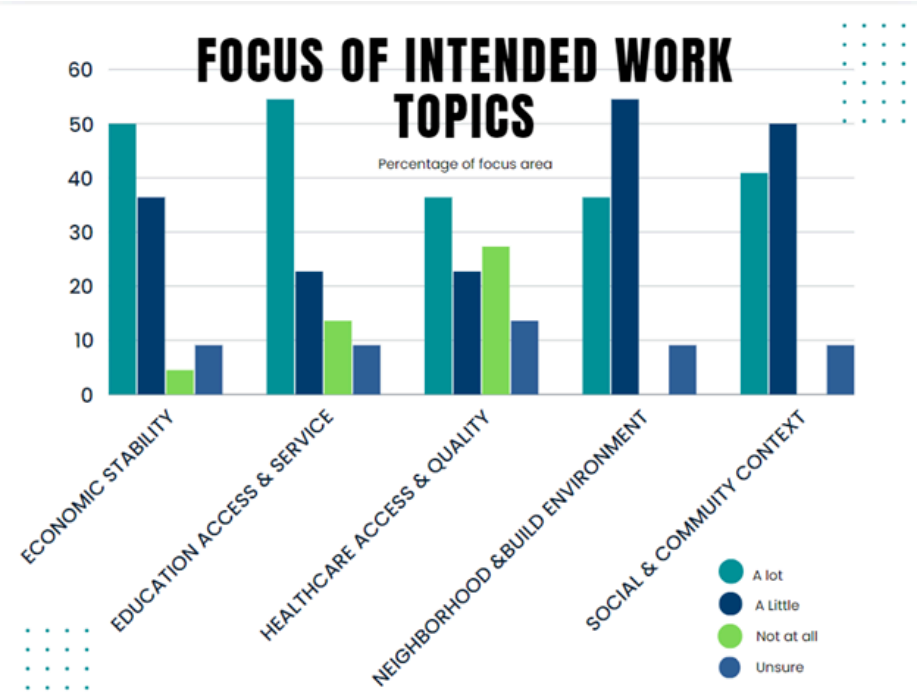
Other population groups served by partner organizations

Families, older adults and individuals that are low-income are among those served by many of the partner organizations.

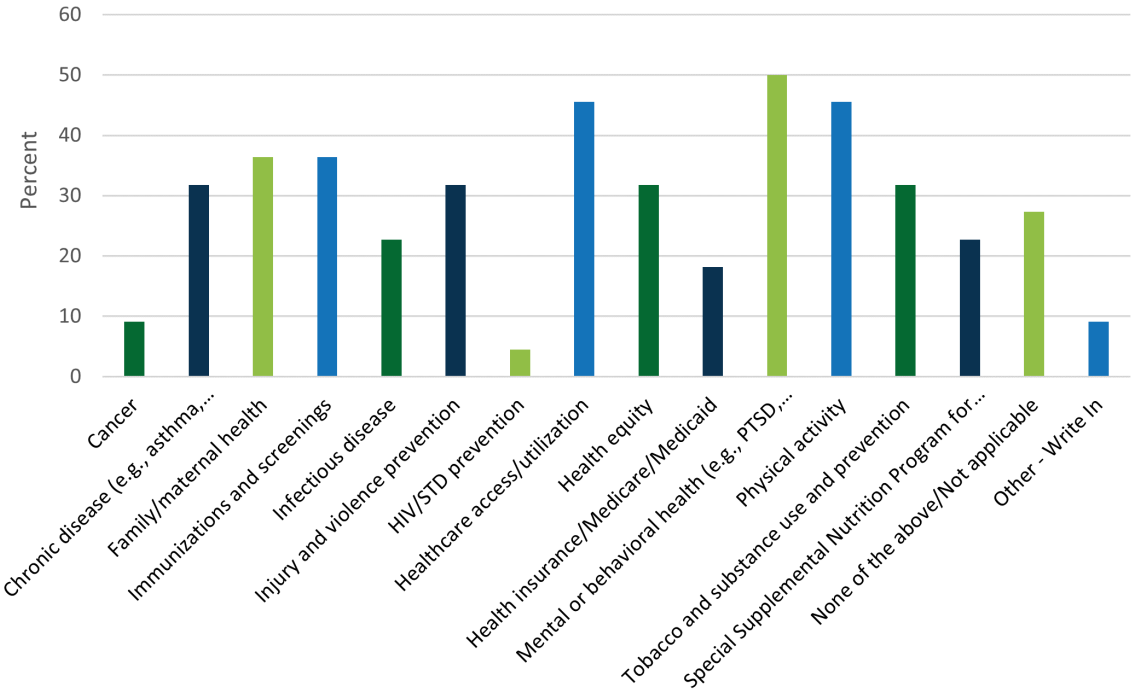
Organizational Focus on Social Determinants of Health

Healthy People 2030 defines social drivers of health as "the conditions in the environments where people are born, live, work, play, worship, and age that affect a wide range of health, functioning and quality of life outcomes and risk based on 22 participant responses.

Most organizations present responded as focusing their intended work as “a lot” or “a little” on these topics.



Organizational Focus on Health Issues

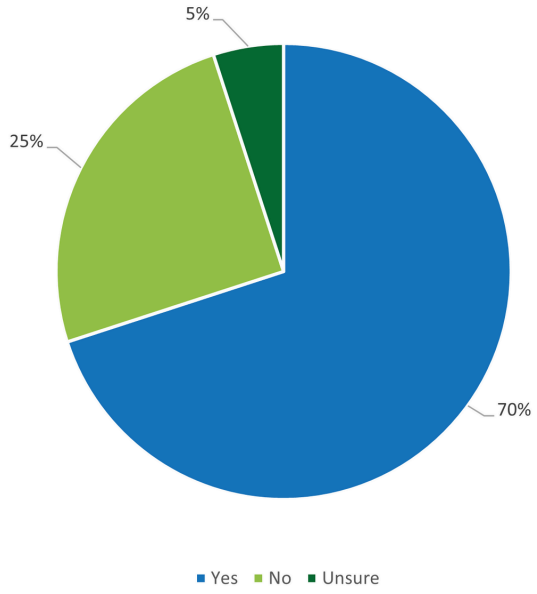


While our partners work on a variety of health issues the top five focus areas of our partners include Mental or Behavioral Health, Physical Activity, Healthcare Access & Utilization, Immunizations & Screenings, and Family/Maternal Health.

Please review the following statements regarding diversity, equity and inclusion in your organization. For each one, select a) Agee, b) Disagree, or c) Unsure.

	Agree	Disagree	Unsure	Responses
We have at least one person in our organization dedicated to addressing diversity, equity, inclusion, and belonging internally in our organization. Count Row %	11 50.0%	6 27.3%	5 22.7%	22
We have at least one person in our organization dedicated to addressing inequities externally in our community. Count Row %	9 40.9%	8 36.4%	5 22.7%	22
We have a team dedicated to advancing equity/addressing inequities in our organization. Count Row %	13 61.9%	5 23.8%	3 14.3%	21
Advancing equity/addressing inequities is included in all or most staff job requirements. Count Row %	11 50.0%	8 36.4%	3 13.6%	22
Totals Total Responses				22

Does your organization have an advisory board of community members, stakeholders, youth, or others who are impacted by your organization?



Partner Demographic Reflection

Approximately four out of every ten partner organizations have leadership that reflects the demographics of the community they serve.

Partner Capacity

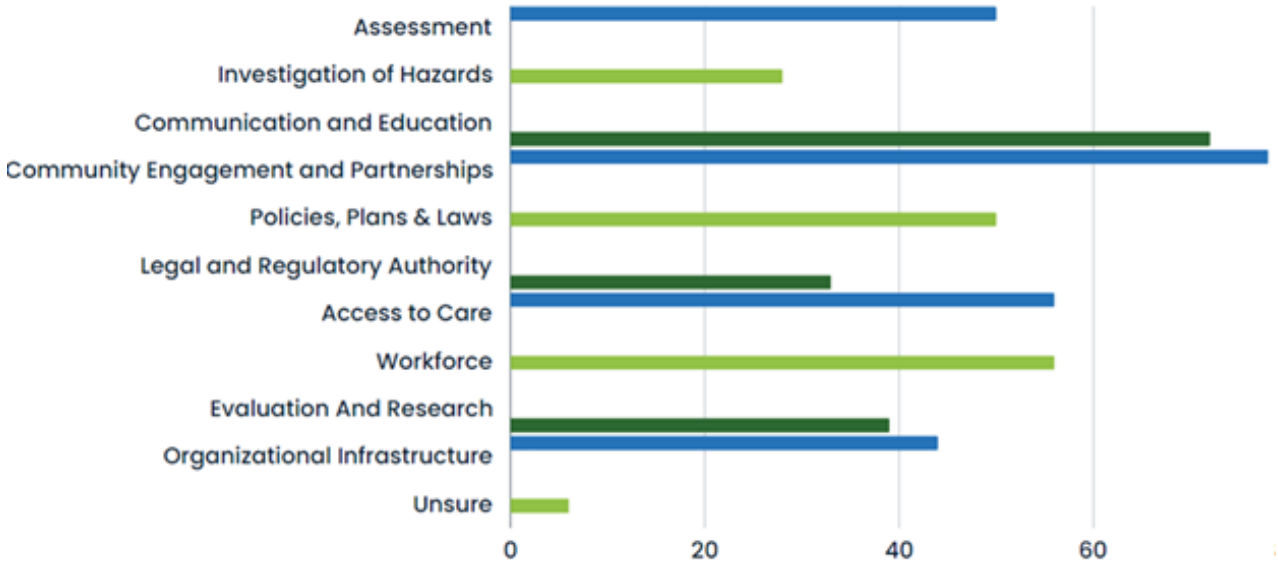
20% Partners that have sufficient capacity to support their work

The 10 Essential Public Health Services

The 10 Essential Public Health Services describe the public health activities that all communities should undertake. They are:

- Assess and monitor population health status, factors that influence health, and community needs and assets
- Investigate, diagnose, and address health problems and hazards affecting the population
- Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it
- Strengthen, support, and mobilize communities and partnerships to improve health
- Create, champion, and implement policies, plans, and laws that impact health
- Utilize legal and regulatory actions designed to improve and protect the public's health
- Assure an effective system that enables equitable access to the individual services and care needed to be healthy
- Build and support a diverse and skilled public health workforce
- Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement
- Build and maintain a strong organizational infrastructure for public health

The public health system in the Central MN Alliance geography is a network of entities with different roles, relationships, and interactions that all contribute to the delivery of the 10 Essential Public Health Services, and to the community's health and well-being.

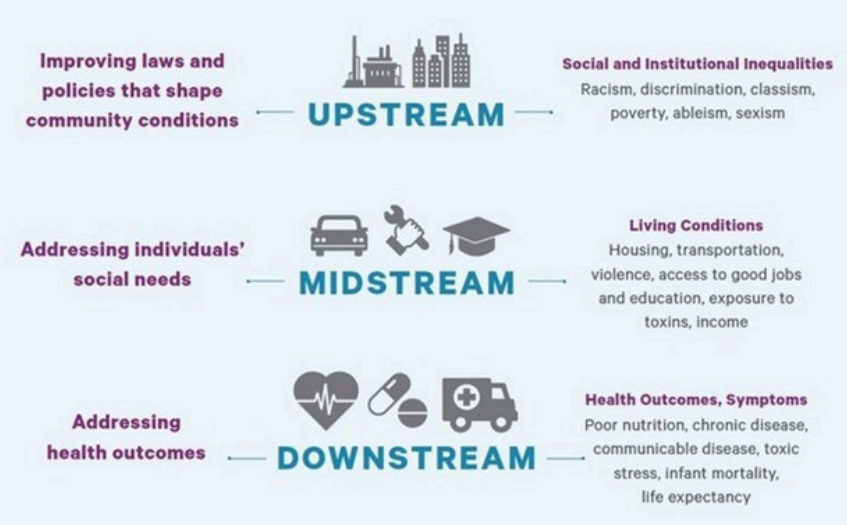


This graph illustrates how respondents viewed their organization's activities and efforts align to with and support the improvement of public health. It highlights areas such as the assessment of living and working conditions, the investigation of health hazards, and the effectiveness of communication and education on health topics. The graph also reflects the role of community engagement and partnerships, policies, and legal authority in enhancing health outcomes. It can show how organizations are addressing access to care, workforce development, and the implementation of policies that impact health, while also emphasizing efforts in research, evaluation, and building a strong organizational infrastructure.

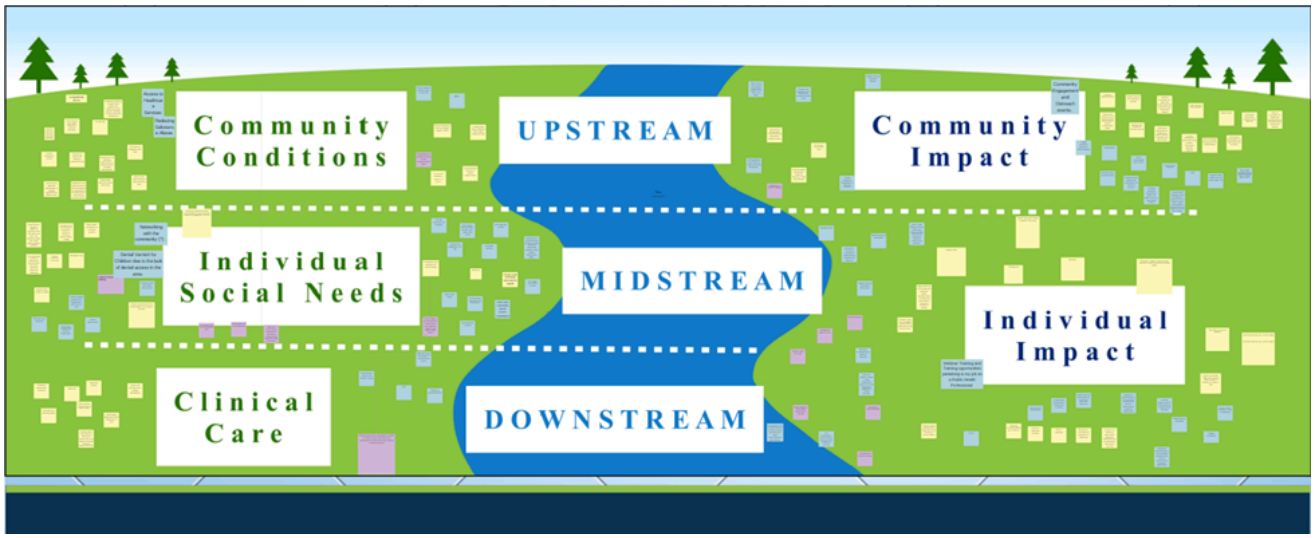
Social determinants (otherwise known as social drivers) of health (SDOH) refer to the conditions in the environments where individuals are born, grow, live, work, play, and age, which influence a broad spectrum of health outcomes, functioning, and overall quality of life. These factors significantly impact health and well-being, and they contribute to disparities in health status and inequities across different populations.

Upstream vs. Downstream Work

In public health, there is the concept of "upstream" and "downstream" health interventions. The analogy of the river is used to describe how polices, and social and institutional inequities have a profound impact on health outcomes. Upstream work focuses on improving the structures that influence health, whereas downstream work addresses individual health outcomes and symptoms.



In the Central MN Alliance geographical area, partner organizations shared key areas of community health interest for upstream and midstream work to create a healthier community environment downstream. This activity demonstrated current needs, interests, and opportunities for projects with the support of more funding, capacity, and targeted programming.



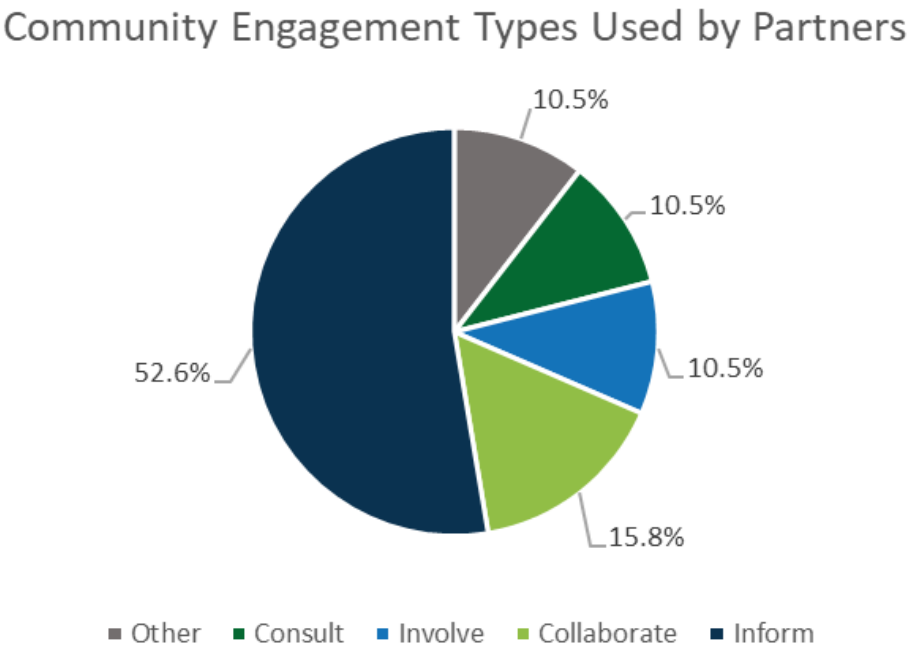
Partner organizations participated in an activity where they put the main activities their organizations participate in on the river. This helped create a visual representation of the health work being done throughout the region. This was done both in person and virtually.

Community Engagement

Engaging the community is a cornerstone of public health initiatives, ensuring that all voices are heard. The Central Minnesota Alliance (CMA) partners actively engage their communities through various methods, fostering collaboration and trust.

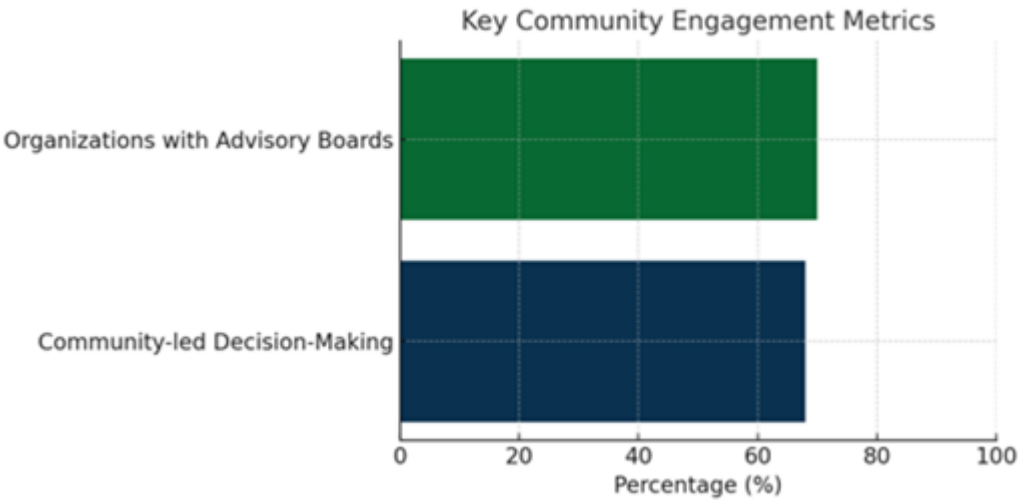
Engagement Types

A large portion of CMA partners (52.6%) primarily focus on informing the community. 15.8% focus on collaboration, while others consult or involve the community to varying degrees.



Key Engagement Metrics

68% of organizations participate in community-led decision-making around policies and programs. 70% of organizations maintain advisory boards that ensure diverse community representation.



Partner organizations are participating in the community health initiative for a variety of reasons. The top reasons include connections, access to data and improving conditions for members/constituents. Connections were by far the most important to our partners.

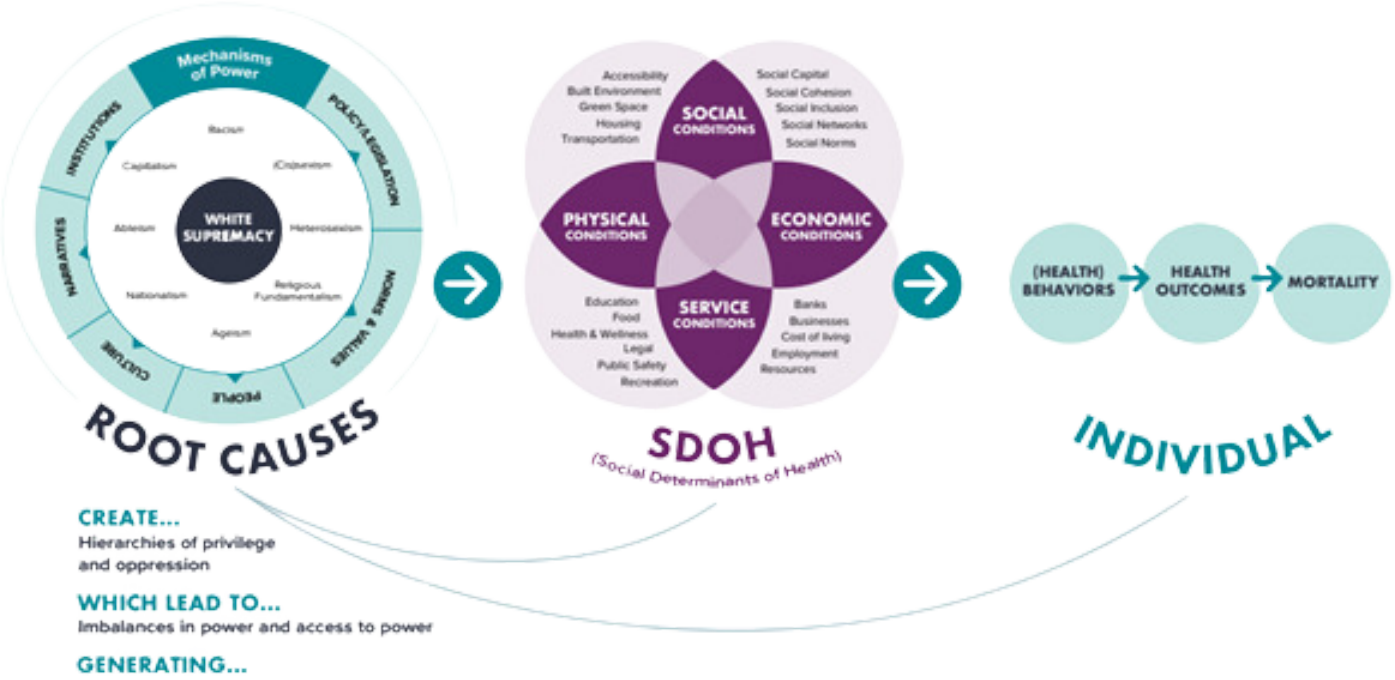
Next Steps

CMA partners are committed to deepening engagement with underrepresented groups, focusing on providing resources and fostering collaboration to build resilient communities.

Health Equity-DRIVERS OF INEQUITIES (ROOT CAUSES)

Data Access & Systems (DAS)	• Public Policies will use an equity lens to impact disparities • All persons will have to broadband
Structural Racism (SR) / Community Power	• All community members will have ability to influence agenda setting, resource distribution, and be included in process
Lived Experience (LE) & Historical Context (HC)	• Communities participate in shaping programs • Systems recognize the strengths & assets of communities served • Systems prioritize community needs expressed by communities

Health Equity-DRIVERS OF INEQUITIES (ROOT CAUSES) Models



Health Equity Action Spectrum - Image source: Appendix J Mapp Handbook p. 91

	ROOT CAUSES (STRUCTURAL)	ROOT CAUSES (INSTITUTIONAL)	SDOH	INDIVIDUAL
WHAT?	This level specifies actions that address the underlying structural – social, political and economic – systems that lead to hierarchies of privilege and oppression, imbalances in power and resultant social injustices throughout society.	This level specifies actions that address an organization or institution's culture, practices, policies and processes that lead to health inequities at the community and individual levels.	This level specifies actions taken within a community to address that community's conditions and resources that impact community member's ability to optimize health.	This level specifies actions that address different populations' access to, and quality of, care to alleviate risk of/and health outcomes at the individual level.
IMPACT?	**Shifts social ideologies, norms, beliefs, values and culture**	**Shifts POWER from institutions to comunities.**	**Increases access to care and resources (reactive); builds whole, healthful, and sustained infrastructure (preventive) in a community**	**Increases access to care (reactive), information and resources (preventive)**

Advancing Health Equity

The goal of CMA is to achieve health equity. Health equity is the assurance of conditions to achieve optimal health.

Health inequities are differences in outcomes that are unjust, unfair, and actionable.

Health outcomes are driven, in part, by the conditions in which people live. Part of public health's role is to improve these conditions to ensure people can achieve optimal health.

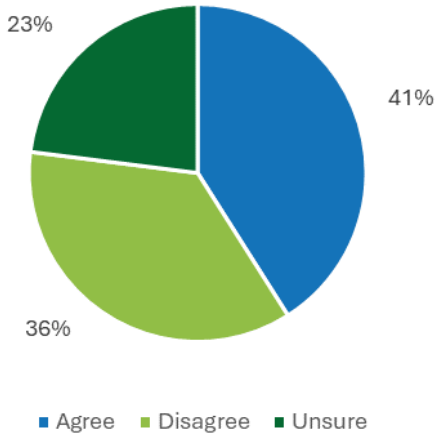
Differences in the quality of the social drivers of health (like the conditions in which people live and work) are driven by unequal distribution of power and resources. We must address these root causes of inequity to see sustainable change in health inequities.

Community members and populations experiencing inequities must be included at each step of the CHNA/CHIP process.

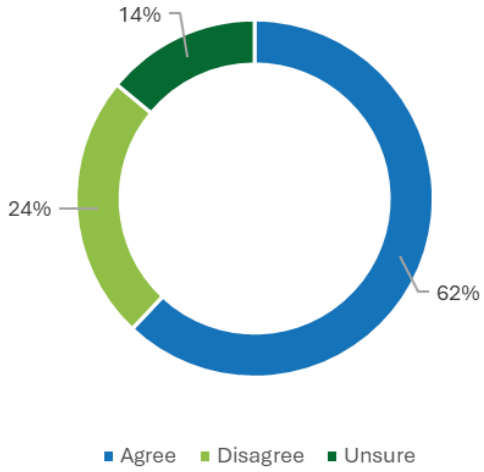
Addressing health inequities requires gathering sufficient and effective data to understand them.

To improve population health and advance health equity, we must address both the social determinants of health and the factors that drive their unequal distribution.

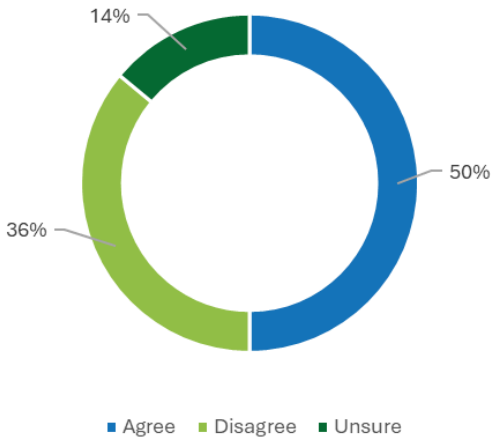
We have at least one person in our organization dedicated to addressing inequities externally in our community



We have a team dedicated to advancing equity/addressing inequities in our organization



Advancing equity/addressing inequities is included in all or most staff job requirements



Lessons Learned

Community Strengths

The Central MN Alliance region is filled with a variety of people and organizations that are supporting community health and well-being. There is a strong desire among partners to collaborate and learn from each other to continue to improve. Many organizations are engaged in health equity work and others express a desire to begin this work. The Central MN Alliance region has partners working in all SDOH areas of Healthy People 2030, all areas of the 10 Essential Public Health Services, and the top ten health issues identified through the Community Health Needs Assessment.

Organizational Capacities

Many of the organizations struggle with capacity and that prevents them from doing the upstream work that they would like to do. However, partners recognize that collaboration, networking, and resource promotion can help expand capacity to continue to address health inequities within the community.

Promote Growth and Learning

Partners recognize that there is still a long way to go to address systems of power in the community. Power imbalances in the community and within organizations exist and the need for representation at all levels. Organizations need to continue to work on their internal culture, in order to make changes throughout the community. Promoting growth and learning are important to communities health and partners is needed to continue to move forward to breakdown barriers and improve equity.

Health Behaviors & Health Outcomes

SDOH (Social Determinants/Drivers of Health) concepts are crucial to communities because they significantly influence a population's health and well-being by encompassing non-medical factors like income, education, housing, access to food, and neighborhood safety, which can have a larger impact on health outcomes than healthcare access alone, ultimately contributing to health disparities if not addressed effectively; essentially, understanding and addressing SDOH allows communities to work towards improving overall health equity by tackling the root causes of health issues rather than just treating symptoms.

Impact on health disparities:
SDOH can create significant health inequities between different populations due to unequal access to resources like quality housing, nutritious food, and education, leading to poorer health outcomes for marginalized communities.

Holistic approach to health:
By considering SDOH, healthcare providers and community leaders can take a more comprehensive approach to health, addressing factors beyond just medical treatment to promote overall well-being.

Preventative care:
Addressing SDOH can enable proactive interventions to prevent health issues from developing in the first place, such as promoting healthy food access in food deserts or improving access to quality education to increase employment opportunities.

Community-level interventions:
SDOH information can guide community-based programs and policies designed to improve social conditions and address underlying health disparities.

Addressing the challenges our communities face today and the challenges they will face in the future requires a high level of commitment among leaders across sectors and generations to take a systems approach to improving the conditions, outcomes, and resilience of their community.

Additional Lessons - Leverage "Debrief and notes"

- CMA has a wide variety of organizations and resources to collaborate with
- Partners don't realize the positive role they have in supporting community health
- Funding needs to be community centric
- No organization works in a bubble
- A unified approach to addressing health issues will be important to ensure we leverage resources in a meaningful way

Next Steps

As the Central MN Alliance moves into Phase 3 of the MAPP 2.0 process, continuously improve the community, the information gathered in the Community Partner Assessment will help identify organizations to connect with to address the top health issues, gather further data, and advance health equity. Additionally, the CPA advances community connections and collaboration to further improve the community's health.

Acknowledgements

Participating Partners

- Sherburne County
- SWCD
- Boys and Girls Club Central MN
- Too Much Talent
- Elk River School District
- Fey y Justicia
- Health Partners
- UMN Education
- UCare
- City of Melrose
- Medica
- Canvas Health
- St. Cloud APO
- Central MN Mental Health Center
- M Health Fairview
- Benton County
- Sherburne County
- Stearns County
- Benton County Public Health
- Sherburne County Health & Human Services
- Stearns County Human Services
- CentraCare
- Sauk Rapids School District
- Central MN D-CAN
- Central MN United Way
- Central MN Council On Aging
- Whitney Senior Center
- Sherburne United Way
- City of Sartell
- Rocori School District
- City of St. Cloud
- Big Lake Food Shelf

Community Health Assessment Core Group

Jaclyn Litfin, Benton County Public Health
Nicole Ruhoff, Sherburne County Health and Human Services
Peggy Sammons, Sherburne County Health and Human Services
Mike Matanich, Stearns County Human Services
Janet Goligowski, Stearns County Human Services
Dani Protivinsky, CentraCare
Brittany Pfannenstein, CentraCare

Community Partner Assessment Facilitators

Lead Facilitators: Peggy Sammons, Dani Protivinsky
Assistant Facilitators: Brittany Pfannenstein, Jaclyn Litfin, Mike Matanich

Central MN Alliance
Community Partner Assessment Orientation Meeting
4/10/24, 9a-noon, Sauk Rapids Government Center

Today's Agenda

9:00 am	Welcome, Introductions
9:15 am	Introduction to Central MN Alliance (CMA), MAPP, CHNA MAPP = Mobilizing for Action through Partnerships and Planning CHNA (pronounced CHINA) = Community Health Needs Assessment
9:40 am	Activity: Healthy People 2030 Social Determinants of Health Fill out Sticky Notes
9:50 am	BREAK & put sticky notes on 5 Healthy People 2030 Posters
10:05 am	Count off by 5's Move to Healthy People 2030 Posters by number
10:40 am	Debrief
10:55 am	Activity: On the River
11:05 am	BREAK & put sticky notes On the River Poster, categorize, review
11:25 am	Debrief
11:40 am	Next Actions
11:45 am	Thank you and Evaluation

THE 10 ESSENTIAL PUBLIC HEALTH SERVICES

To protect and promote the health of all people in all communities

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve equity, the Essential Public Health Services actively promote policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities. Such barriers include poverty, racism, gender discrimination, ableism, and other forms of oppression. Everyone should have a fair and just opportunity to achieve optimal health and well-being.

Created 2020

ESSENTIAL PUBLIC HEALTH SERVICE #1
Assess and monitor population health status, factors that influence health, and community needs and assets

ESSENTIAL PUBLIC HEALTH SERVICE #2
Investigate, diagnose, and address health problems and hazards affecting the population

ESSENTIAL PUBLIC HEALTH SERVICE #3
Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it

ESSENTIAL PUBLIC HEALTH SERVICE #4
Strengthen, support, and mobilize communities and partnerships to improve health

ESSENTIAL PUBLIC HEALTH SERVICE #5
Create, champion, and implement policies, plans, and laws that impact health

ESSENTIAL PUBLIC HEALTH SERVICE #6
Utilize legal and regulatory actions designed to improve and protect the public's health

ESSENTIAL PUBLIC HEALTH SERVICE #7
Assure an effective system that enables equitable access to the individual services and care needed to be healthy

ESSENTIAL PUBLIC HEALTH SERVICE #8
Build and support a diverse and skilled public health workforce

ESSENTIAL PUBLIC HEALTH SERVICE #9
Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement

ESSENTIAL PUBLIC HEALTH SERVICE #10
Build and maintain a strong organizational infrastructure for public health

Social Determinants of Health

Social Determinants of Health
Copyright-free

Healthy People 2030

CMA Community Partner Assessment Orientation Meeting, 4/10/24

On the River

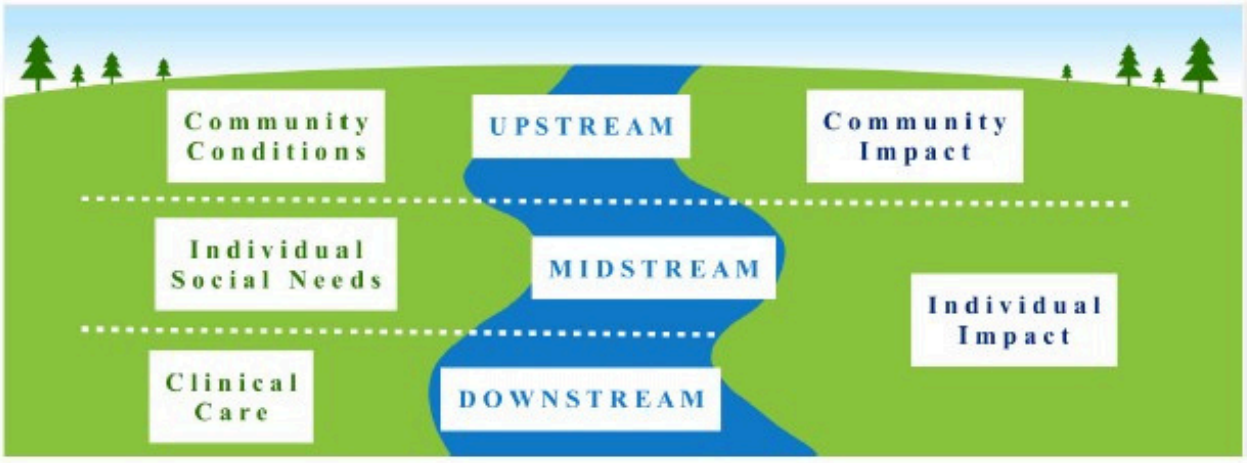
All organizations and groups contributing to our community's health, can work to create greater fairness in the distribution of good health at three levels: upstream, midstream, downstream.

DEFINITIONS

UPSTREAM INTERVENTIONS	MIDSTREAM INTERVENTIONS	DOWNSTREAM INTERVENTIONS
Seek to reform the fundamental social and economic structures that distribute wealth, power, opportunities, and decision-making. These changes generally happen at the macro policy level: national and transnational. They are about diminishing the causes-of-the-causes.	Seek to reduce exposure to hazards by improving material working and living conditions, or to reduce risk by promoting healthy behaviors. These changes generally occur at the micro-policy level: regional, local, community, or organizational. They are about changing the causes.	Seek to increase equitable access, at an individual or family level, to health and social services. These changes generally occur at the service or access to service level. They are about changing the effects of the causes.

The purpose of this activity is to encourage communities to talk about how we can move upstream in the ways we listen, decide what to speak up about, schedule our time and other resources, and set priorities for our local, regional and provincial organizations. An important question is, how can we develop a habit of looking upstream, to the causes-of-the-causes of poor health, whether we work in direct service, community engagement, administration, or advocacy for policy change?

Evidence is mounting that an upstream approach to health—one that addresses people's access to the determinants of health—will benefit everyone.



CMA CPA Orientation Meeting Evaluation

Thank you for your time that you have spent with us today. We appreciate your time!

We've combined these two sets of questions for ease of your response, but we will separate any identifying information (Name, Email) from the evaluation responses prior to analysis. Thank you for your time in filling out these questions. You can also use the QR code if you'd like.

1. Do you provide your permission to share your contact information with people who attended this meeting?
   - ❑ Yes
   - ❑ No

2. Name: _____

3. Email: _____

1. How comfortable are you with identifying ways in which your agency contributes to the health of the community? (Put an X along the line)

Not comfortable at all _____ Very comfortable

2. Is there anything else you'd like to share with us about the meeting today?

THANK YOU!!

Appendix B:

Community Status Assessment Committee Report

CENTRAL MN ALLIANCE
STRENGTHENING PARTNERSHIPS FOR CHANGE

Community Status Assessment Report

2024

Overview of MAPP

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is not an agency-focused assessment process; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems.

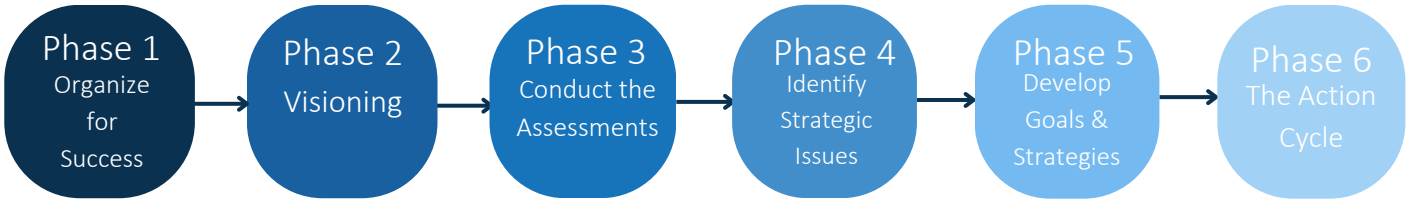
In 2019, the National Association of County and City Health Officials (NACCHO) began a redesign the MAPP process. This redesign is focused on the following principles and is called MAPP 2.0:

- Equity
- Inclusion
- Trusted Relationships Community Power
- Strategic Collaboration and Alignment
- Data and Community Informed Action
- Full Spectrum Actions
- Flexible
- Continuous

In January 2024, a Central MN Alliance member was selected to participate in the NACCHO MAPP 2.0 Pilot Training. They were 1 of 35 participants.

More information about MAPP 2.0 can be found at this link.

Original MAPP Framework



MAPP 2.0 Framework

CMA Prioritized, MAPP Guiding Questions

- What are the sub-populations within our community that have higher health risk or poorer health outcomes?
- What structural and social factors contribute to higher health risks or poorer health outcomes of certain populations within our community?
- How are various types of community partners impacting health inequities in the community or contributing to the health and wellness of community members?

Community Status Assessment: Overview

The CSA is about quantitative data. It collects "the numbers" on the status of our community such as demographics, health status, and differences in health outcomes. The CSA helps a community move "upstream" and identify health differences beyond health behaviors and outcomes, including their association with social drivers of health, systems, and institution policies and processes. The CSA is a community-driven assessment to help tell the community's story. (NACCHO MAPP 2.0 CSA Handbook, p. 4)

Image source: pixabay geralt

The CSA seeks to understand the following:

- What does the status of your community look like, including health, socioeconomic, environmental, and quality-of-life outcomes?
- What populations experience differences in their health outcomes across health, socioeconomic, environmental, and quality-of-life outcomes?
- How do systems influence outcomes?

CSA - General Process Followed

- Primary Data Collected via the Central MN Adult Community Health Survey. In the field 8/14/24 through 10/6/24. A Data Highlights document was created.
- The Joint CMA/ Granite Table Data Committee met 10 times between May 2024 and January 2025.
- Many Secondary Datasets were reviewed: Minnesota Student Survey, US Census, MN Compass, CDC, MN Community Measurement, MDH, MN DHS, SAHMSA, MN Public Health Data Access, Wilder Foundation, U of MN, Feeding America, Health Trends Across Communities (HTAC).
- The Greater St. Cloud Equity Dashboard funded and hosted by the Morgan Family Foundation was reviewed.
- Input from Family Home Visiting Public Health Nurses from the First Steps Central MN, December 2023, input gathering session was reviewed and used to validate other trends we were seeing.
- Data and Research Articles were reviewed.
- Members of the Data Committee attended United Way of Central MN Youth Opportunities and Financial Security Convenings.
- Through the Granite Table partnership, a supplementary Framework to MAPP 2.0 is the Baldridge-based Communities of Excellence 2026 Framework and supporting materials of suggested key indicators and cascading measures were reviewed.

Arriving at the Areas of Opportunities

- Reviewed sources
- Reviewed meeting notes of data discussed
- As Data Committee CMA and Granite Table data subject matter experts - identified our top quantitative community concerns.
- Looked at all our top lists and identified the final list that was shared at the January 2025 Assessment Triangulation Meeting.

CSA Committee Report Executive Summary

Top Quantitative Data Themes (no particular order)

Areas of Opportunity

- Mental Health / Mental Wellbeing / Connection (Chemical Health, Substance Use, Deaths of Despair)
- Access to Child Care
- Housing
- Disparities in Health Outcomes (HTAC - Health Trends Across Communities)
- Financial Insecurity (Dental, Food, Poverty)

Key Supporting Article Data

- Unaffordable rents are linked to premature death. An individual paying 50% of their income toward rent in 2000 was 9% more likely to die over the next 20 years compared with someone paying 30% of their income toward rent, the researchers found.
- Worst Cities for Black Americans by 24/7 Wallstreet.com. St. Cloud, MN is #2 on this list. (supporting data points: median household income, homeownership rate, unemployment rate, Total Black population)

CSA Committee Recommendations

- Provide data in more accessible way for partners and residents.
- Review more deeply the reasons for delay of care.
- Explore the differences in the data by different demographics.

Process Outline and Details

Local primary data were collected via the Central MN Adult Community Health Survey. The survey instrument was developed by the 2024 Central MN Community Health Survey Instrument Committee. Please find the committee members in the Acknowledgements section of this report. The Instrument Committee met from June 18, 2024 through August 6, 2024. The survey was in the field from August 6, 2024 through October 6, 2024. Wright County participated in the Instrument Committee and they had a similar survey in the field for a similar time period.

Stearns County supported the Instrument electronic development in ArcGIS Survey123. The survey was translated into Spanish and Somali. Stearns County created a dashboard for us to use to track responses and conduct additional outreach as needed.

We had a goal of sharing the data at a couple community events in mid- and late-October. We had a community partner ask if we could leave the survey open through October 6 to reach more of the target populations.

The Benton, Sherburne, and Stearns County AmeriCorps members were very involved in the community outreach for the survey. There were 548 instances of outreach documented in the Survey Distribution Tracker. We learned that posters with QR codes were less effective than emails sent to partners with with we had a relationship.

We are very grateful for the 893 responses that were received! 814 were received from the three-county region. We are honored that people trusted us with their responses.

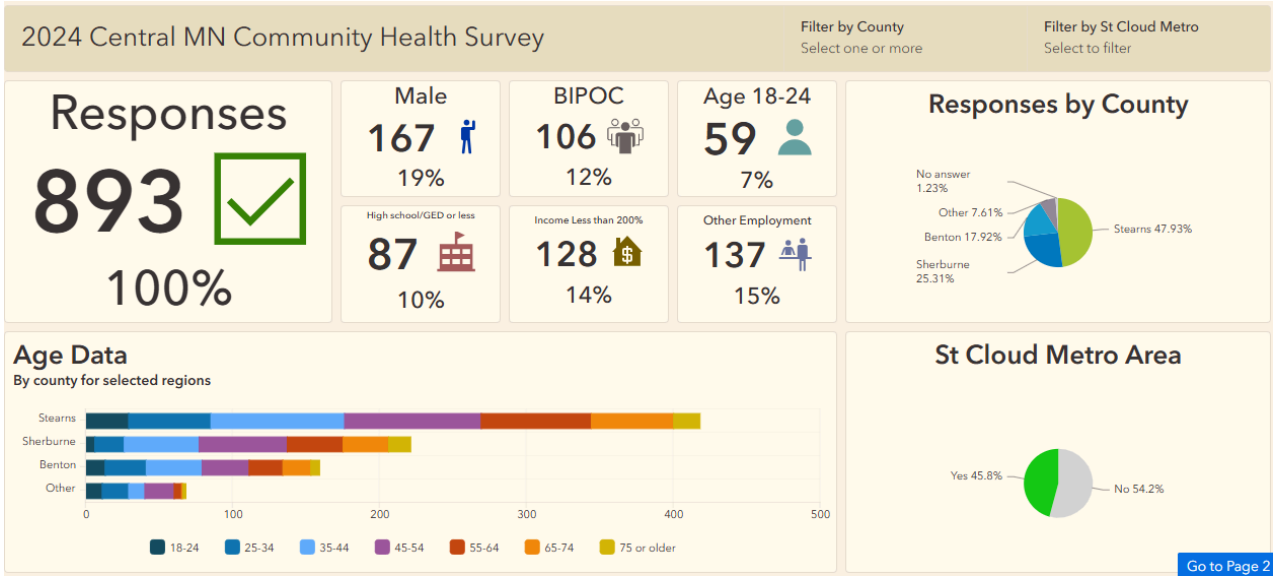


Image: Dashboard Page 1

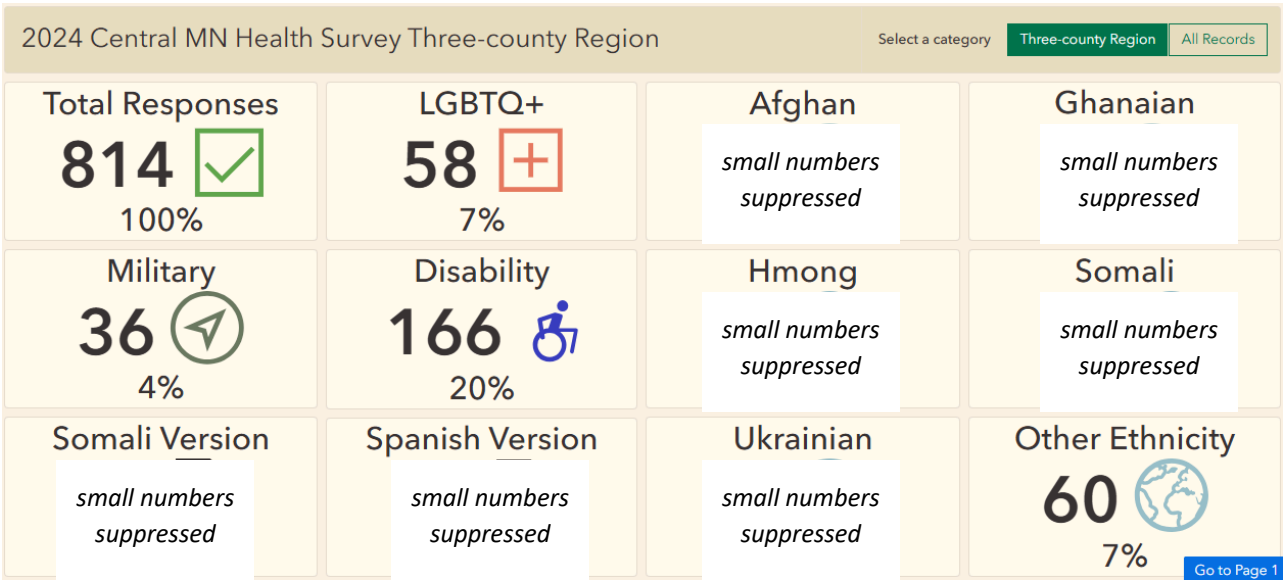


Image: Dashboard Page 2

The Survey Instrument can be seen in Appendix A of this report. If you would like to see the Spanish or Somali version of the survey, please contact peggy.sammons@co.sherburne.mn.us.

An additional option offered for this survey was spoken videos in English, Spanish, and Somali via YouTube. The videos did not receive much traffic, but our team learned a lot from the process. This work was conducted by a team that is recognized in the Acknowledgements section of this report.

The Survey came out of the field on October 6 and we wanted to share data about it on October 17th. The 2024 Central MN Community Health Survey Cleaning Committee and the Analysis Team net daily, worked hard, and prepared a Survey Highlights document that was shared at the October 17th event. The Committee membership can be found in the Acknowledgements Section of this report. The Highlights document can be seen in Appendix B of this report. With the exception of the sex (Male/Female) composition of respondents, we are pleased with the representation of the convenience sample.

Re: Male representation. It took extra outreach to obtain the 19% that responded. We knew from survey research that males are less likely to take surveys. For the first few weeks while in the field, the numbers sat around 7-9%. Additional thanks to the AmeriCorps members for all the work they did to notify the community of the survey opportunity.

Secondary Data

- The Joint CMA/ Granite Table Data Committee met 10 times between May 2024 and January 2025. See the full membership of the Data Committee in the Acknowledgement Section of this Report.

- Many Secondary Datasets were reviewed: Minnesota Student Survey, US Census, MN Compass, CDC, MN Community Measurement, MDH, MN DHS, SAHMSA, MN Public Health Data Access, Wilder Foundation, U of MN, Feeding America, Health Trends Across Communities (HTAC). A full list of data sets that CMA staff regularly access is listed in Appendix C of this report.

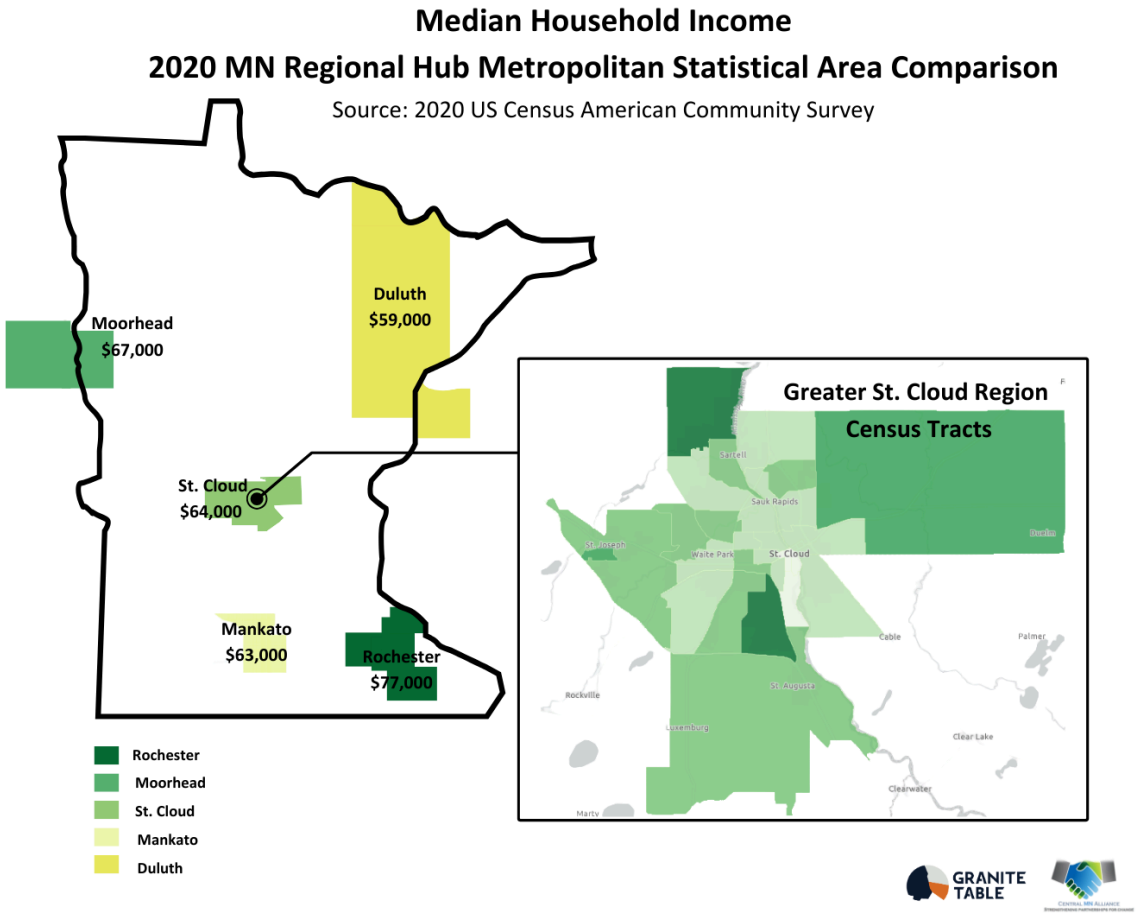


Image: Screenshot compilation from the Granite Table ArcGIS Hub. 2020 US Census ACS data.

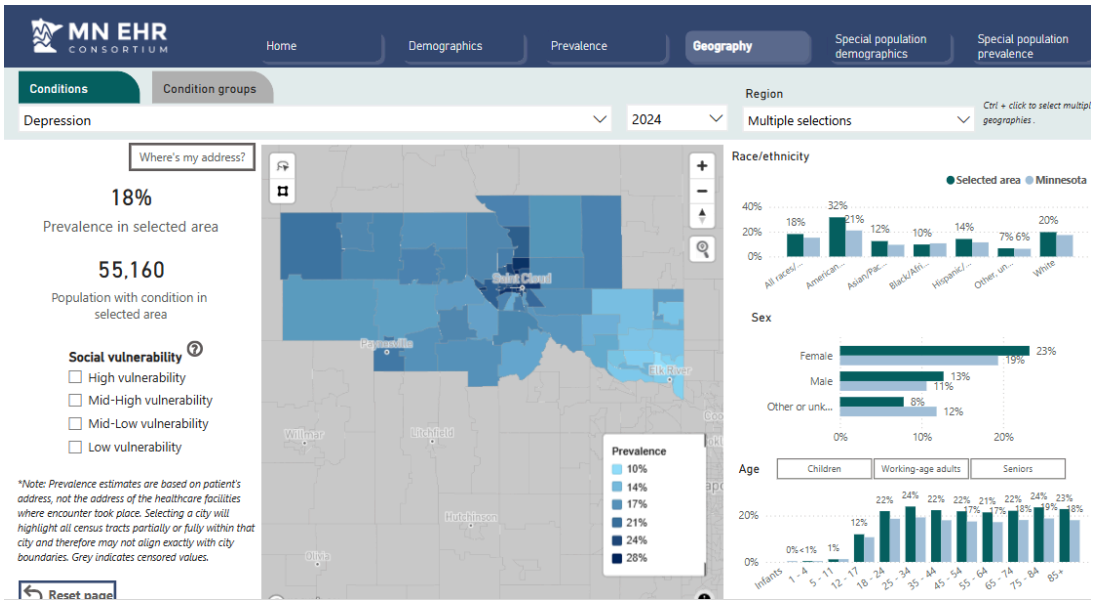


Image: Screenshot of HTAC, 2024 Depression prevalence in the 3-county region. The State Prevalence is 15%.

- There are a growing number of data sources that are providing data mapped at the Census Tract level. We made Census Tract lists to aligned with the County Commissioner District boundaries and looked a data by different types of geographies. MN Compass and HTAC maps were reviewed at these levels. MN Compass has a great feature called: Build Your Own Custom Profile that we've been using a lot.

- The CSA Committee was responsible for reviewing the data on languages spoken in each of the three counties. The Minnesota Department of Education has data on students for Primary Language Spoken in the home by enrolled student. The data are effective October of each school year. Please see Appendix D of this report for the list of languages spoken in Benton, Sherburne, and Stearns Counties. Analyzing these data is recommended by PHAB (Public Health Accreditation Board) standards. These lists are also helpful as they help us understand the population better and can assist the counties in planning for interpreter and translation needs.

- The Greater St. Cloud Equity Dashboard funded and hosted by the Morgan Family Foundation was reviewed.

- Input from Family Home Visiting Public Health Nurses from the First Steps Central MN, December 2023, input gathering session was reviewed and used to validate other trends we were seeing. The challenges that the nurses were seeing for families included: transportation, lack of resources, culturally appropriate resources, language needs, housing options, mental health resources, child care, navigating the health care system, cost of food, insurance, employment.

- From May 2024 through January 2025, as Committee members found Data and Research Articles, they were shared and reviewed with the committee.

- Members of the Data Committee attended United Way of Central MN Youth Opportunities and Financial Security Convenings. The CMA CHIP contributes to the United Way of Central MN #KnowYourNumber campaign to increase the number of youth who are on the way to economic mobility by 2,030 children by 2030.

- Through the Granite Table partnership, a supplementary Framework to MAPP 2.0 is the Baldridge-based Communities of Excellence 2026 Framework and supporting materials of suggested key indicators and cascading measures were reviewed.

Health	Life Expectancy
Education	HS Graduation Rate
Economy	Median Household Income
Quality of Life: Social and Community	Adults with 14+ "Not Good" Mental Health Days Per Month
Quality of Life: Housing	Homes with Suboptimal Conditions

Image: Communities of Excellence 2026 Key Indicators

CSA Committee Report Key Take-Aways

Top Quantitative Data Themes (no particular order)

Areas of Opportunity

- Mental Health / Mental Wellbeing / Connection (Chemical Health, Substance Use, Deaths of Despair)
- Access to Child Care
- Housing
- Disparities in Health Outcomes (HTAC - Health Trends Across Communities)
- Financial Insecurity (Dental, Food, Poverty)

Key Supporting Article Data

- Unaffordable rents are linked to premature death. An individual paying 50% of their income toward rent in 2000 was 9% more likely to die over the next 20 years compared with someone paying 30% of their income toward rent, the researchers found.
- Worst Cities for Black Americans by 24/7 Wallstreet.com. St. Cloud, MN is #2 on this list. (supporting data points: median household income, homeownership rate, unemployment rate, Total Black population)

CSA Committee Recommendations

- Provide data in more accessible way for partners and residents.
- Review more deeply the reasons for delay of care.
- Explore the differences in the data by different demographics.

CSA Committee Report Appendices
Table of Contents

CENTRAL MINNESOTA COMMUNITY HEALTH SURVEY

Instructions: This survey is for adults (age 18 and over). All questions in this survey are optional.

1. In general, would you say that your health is:
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

2. During the past 12 months, was there a time when you thought you needed medical care but did not get it or delayed getting it?
   - ☐ Yes
   - ☐ No (skip to question 4)

3. If Yes; Why did you not get or delay getting the medical care you thought you needed? (Mark ALL that apply)
   - ☐ The care I needed cost too much
   - ☐ My insurance did not cover it
   - ☐ I did not have insurance
   - ☐ I could not get an appointment
   - ☐ I did not have access to telehealth or a virtual visit
   - ☐ I had transportation problems
   - ☐ I did not think it was serious enough
   - ☐ I was too nervous or afraid
   - ☐ I don't trust the health care system
   - ☐ Other reason (please specify): _____

4. During the past 12 months, was there a time when you thought you needed dental care but did not get it or delayed getting it?
   - ☐ Yes
   - ☐ No (skip to question 6)

5. If Yes; Why did you not get or delay getting the dental care you thought you needed? (Mark ALL that apply)
   - ☐ The care I needed cost too much
   - ☐ My insurance did not cover it
   - ☐ I did not have insurance
   - ☐ I could not get an appointment
   - ☐ I did not have access to telehealth or a virtual visit
   - ☐ I had transportation problems
   - ☐ I did not think it was serious enough
   - ☐ I was too nervous or afraid ☐ I don't trust the health care system ☐ Other reason (please specify): _____

6. During the past 12 months, was there a time when you thought you needed mental health care but did not get it or delayed getting it?
   - ☐ Yes
   - ☐ No (skip to question 8)

7. If Yes; Why did you not get or delay getting the mental health care you thought you needed? (Mark ALL that apply)
   - ☐ The care I needed cost too much
   - ☐ My insurance did not cover it
   - ☐ I did not have insurance
   - ☐ I could not get an appointment
   - ☐ I did not have access to telehealth or a virtual visit
   - ☐ I had transportation problems
   - ☐ I did not think it was serious enough
   - ☐ I was too nervous or afraid
   - ☐ I was afraid someone I know would see me
   - ☐ I don't trust the health care system
   - ☐ Other reason _____

8. During the past 30 days, for about how many days did you feel stressed, worried, or concerned? _____

9. During the past 30 days, for about how many days have you felt sad, blue, or depressed? _____

10. How often would you say that you feel a lack of companionship?
    - ☐ Hardly ever
    - ☐ Some of the time
    - ☐ Often

11. How often do you feel left out?
    - ☐ Hardly ever
    - ☐ Some of the time
    - ☐ Often

12. How often do you feel isolated from others?
    - ☐ Hardly ever
    - ☐ Some of the time
    - ☐ Often

13. During the past 12 months, have you used a community food shelf program or a community food box program?
    - ☐ Yes
    - ☐ No

14. How often do you or others in your household buy or get food from the following places?

	Never or less than 1 time per month	About 1 time per month	About 2 or 3 times per month	About 1 time per week	2 or more times per week
Supermarket or large grocery store	☐	☐	☐	☐	☐
Small grocery store	☐	☐	☐	☐	☐
Convenience store or gas station	☐	☐	☐	☐	☐
Food shelf, food pantry, or community food box program	☐	☐	☐	☐	☐
Some other place (please specify):	☐	☐	☐	☐	☐

15. During the past 12 months, how often did you worry that your food would run out before you had money to buy more?
    - ☐ Often
    - ☐ Sometimes
    - ☐ Rarely
    - ☐ Never

16. How often do you use any of the following commercial tobacco products?

	Every Day	Some Days	Not At All
Non-menthol cigarettes	☐	☐	☐
Menthol cigarettes	☐	☐	☐
Cigars, cigarillos, little cigars	☐	☐	☐
Pipes	☐	☐	☐
Snuff, snus, chewing tobacco	☐	☐	☐
E-cigarettes or vaping devices that contain nicotine (do not include marijuana or THC products)	☐	☐	☐
A hookah water pipe	☐	☐	☐
Dissolvable tobacco products (lozenges, strips, or sticks)	☐	☐	☐
Any other type of commerciat tobacco products (please specify):			

17. How often do you use any of the following marijuana products (also called weed, pot, or cannabis)? Do not count medical marijuana prescribed by a doctor or CBD-only or hemp products.

	Every Day	Some Days	Not At All
Plant/flower (joints, pipes, bongs, blunts, or hookahs)	☐	☐	☐
Edibles (beverages or food)	☐	☐	☐
E-cigarettes or vaping devices that contain marijuana or THC	☐	☐	☐
Extracts or concentrates (shatter, wax, budder, hash, or honey oil)	☐	☐	☐
Any other type of marijuana product (please specify):			

18. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit?
    - ☐ Yes
    - ☐ No

19. Do you have reliable access to the internet in your home?
    - ☐ I only access the internet somewhere other than home (skip to question 21)
    - ☐ Yes, I have reliable internet access at home
    - ☐ No, I do not have reliable internet access at home
    - ☐ Don't know

20. Why is it that you do not have reliable internet access at home?
    - ☐ Internet services are not provided in my area
    - ☐ I cannot afford it
    - ☐ I am not interested in using it
    - ☐ Something else
    - ☐ Don't know

21. What type of device do you typically use to access the internet? (Mark ALL that apply)
- ☐ Smartphone
- ☐ Another device, like a tablet or computer
- ☐ I do not use the internet

22. Consider your living situation, do you:

    - ☐ Rent
    - ☐ Own
    - ☐ Neither

23. During the past 12 months, have you experienced any issues obtaining housing? (Mark ALL that apply)
    - ☐ I did not have any issues
    - ☐ Upfront rent and security deposit
    - ☐ Criminal record
    - ☐ Previous rental history (eviction, unlawful detainer)
    - ☐ Poor credit or lack of rental history
    - ☐ History of unpaid utility payments
    - ☐ Difficulty finding a place that accepts pets
    - ☐ Lack of available affordable housing
    - ☐ Lease requirements (number of months required)
    - ☐ Could not get a mortgage
    - ☐ Difficulty finding a place near public transportation
    - ☐ Other (please specify): _____

24. During the past 12 months, have you experienced any issues keeping your housing? (Mark ALL that apply)

- ☐ I did not have any issues keeping housing
- ☐ Issues with landlord
- ☐ Issues with neighbors
- ☐ Cost of utility payments
- ☐ Lost income
- ☐ Could not afford rent or mortgage
- ☐ Poor or substandard conditions
- ☐ Change in family or household situation (health issues, aging out, roommate left, etc.)
- ☐ Other (please specify): _____

25. During the past 12 months, were you treated unfairly or discriminated against in the following situations?

	Yes	No
Applying or working at a job	☐	☐
Getting medical, mental, or dental care	☐	☐
Finding a place to live, either renting or buying	☐	☐
Applying for social services or public assistance	☐	☐
Interacting with law enforcement	☐	☐
While out in public	☐	☐
Other (please specify):	☐	☐

26. How satisfied are you with the way your community addresses the following concerns?

	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very
Affordable housing	☐	☐	☐	☐	☐
Access to healthcare services (medical, dental, or mental health)	☐	☐	☐	☐	☐
Accommodations/Services for people with a disability	☐	☐	☐	☐	☐
Accommodations/Services for people with autism or other neurodiversity	☐	☐	☐	☐	☐
Support for parents	☐	☐	☐	☐	☐
Alcohol use by adults	☐	☐	☐	☐	☐
Alcohol use by youth	☐	☐	☐	☐	☐
Anxiety/stress	☐	☐	☐	☐	☐
Bullying	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Chronic diseases like asthma, diabetes, arthritis	☐	☐	☐	☐	☐
Depression among youth	☐	☐	☐	☐	☐
Depression among adults	☐	☐	☐	☐	☐
Domestic violence	☐	☐	☐	☐	☐

	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very
Discrimination or harassment	☐	☐	☐	☐	☐
Distracted driving	☐	☐	☐	☐	☐
Impaired driving	☐	☐	☐	☐	☐
Families experiencing financial stress	☐	☐	☐	☐	☐
Firearm injuries	☐	☐	☐	☐	☐
Access to affordable, healthy food	☐	☐	☐	☐	☐
Human trafficking	☐	☐	☐	☐	☐
Lack of childcare	☐	☐	☐	☐	☐
Opioid/other drug use	☐	☐	☐	☐	☐
Recreational marijuana use	☐	☐	☐	☐	☐
Isolation and/or loneliness	☐	☐	☐	☐	☐
Smoke or vaping tobacco	☐	☐	☐	☐	☐
Suicide	☐	☐	☐	☐	☐
Other (please specify):	☐				

27. Which county do you live in?
    - ☐ Benton
    - ☐ Sherburne
    - ☐ Stearns
    - ☐ Other (please specify) _____

28. What is your mailing city? The city you use for your mailing address. _____

29. What is your zip code? _____

30. What best describes your gender identity? (Mark ALL that apply)
    - ☐ Male
    - ☐ Female
    - ☐ Transgender Male
    - ☐ Transgender Female
    - ☐ Non-Binary
    - ☐ Questioning/Exploring
    - ☐ Gender Nonconforming
    - ☐ Genderfluid
    - ☐ Gender identity not listed above (please describe): _____
    - ☐ Prefer not to answer

31. What best describes your sexual orientation? (Mark ALL that apply)

☐ Straight/Heterosexual
☐ Gay
☐ Lesbian
☐ Bisexual
☐ Pansexual
☐ Queer
☐ Asexual
☐ Questioning
☐ Sexual orientation not listed above (please descibe): _____
☐ Prefer not to answer

32. Your age group:

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

33. How many adults age 18 or older (including you) live in your household? _____

34. How many children under age 18, live in your household? _____

35. Are you a member of the following ethic or cultural groups?

	Yes	No
Afghan	☐	☐
Ghanaian	☐	☐
Hmong	☐	☐
Somali	☐	☐
Ukrainian	☐	☐
Ethnic or cultural group not listed above (please descibe):	☐	☐

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

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Middle Eastern or North African
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Race not listed above (please describe): _____

37. Have you ever served in the military?
    - ☐ No, I have never served
    - ☐ No, but I completed part or all the initial/basic training
    - ☐ Yes, I have served in the military
    - ☐ Other (please specify): _____

38. Your education level:
    - ☐ Did not complete 8th grade
    - ☐ Did not complete high school
    - ☐ High school diploma/GED
    - ☐ Trade/Vocational school
    - ☐ Some college
    - ☐ Associate degree
    - ☐ Bachelor's degree
    - ☐ Graduate/Professional degree

39. What is your current employment status? (Mark ALL that apply)
    - ☐ Employed full time
    - ☐ Employed part time
    - ☐ Self-employed or farmer
    - ☐ Unemployed or out of work
    - ☐ A homemaker or stay at home parent
    - ☐ A student
    - ☐ Retired
    - ☐ Unable to work because of a disability
    - ☐ Employment status not listed above (please specify): _____

40. Are you deaf or hard of hearing?
    - ☐ Yes
    - ☐ No
    - ☐ Prefer not to disclose

41. Are you blind, visually impaired, or low vision?
    - ☐ Yes
    - ☐ No
    - ☐ Prefer not to disclose

42. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
    - ☐ Yes
    - ☐ No
    - ☐ Prefer not to disclose

43. Because of a physical, mental, or emotional condition, do you have serious difficulty walking or climbing stairs, dressing or bathing, or doing errands alone?
    - ☐ Yes
    - ☐ No
    - ☐ Prefer not to disclose

44. What was your household's total income from all earners and all sources in 2023?
    - ☐ $29,000 or less
    - ☐ $29,001 - $39,000
    - ☐ $39,001 - $49,000
    - ☐ $49,001 - $59,000
    - ☐ $59,001 – $69,000
    - ☐ $69,001 - $79,000
    - ☐ $79,001 - $89,000
    - ☐ $89,001 - $99,000
    - ☐ $99,001 - $109,000
    - ☐ $109,001 - $119,000
    - ☐ More than $119,001
    - ☐ Prefer not to answer

Thanks for your participation!

Your input will be used to assess the health of our community. Summary results from all the surveys collected will be shared with the community in late 2024 / early 2025. Thank you! Your time and input are greatly appreciated!

Central Minnesota Alliance

2024 Adult Community Health Survey Highlights

Fall 2024

Thank You!

Thank you to the 893 people who completed the survey! We are extremely grateful for contributing your valuable time, your honest information, and your thoughtful comments. Your feedback will help us identify the strengths and opportunities within our community. Thank you, also, to the partners who helped share the survey opportunity with others. If you missed the opportunity to take the survey, we intend on offering another survey next year.

Survey Methodology Overview

The electronic Central Minnesota Adult Community Health Survey was conducted between August 14 through October 6, 2024.

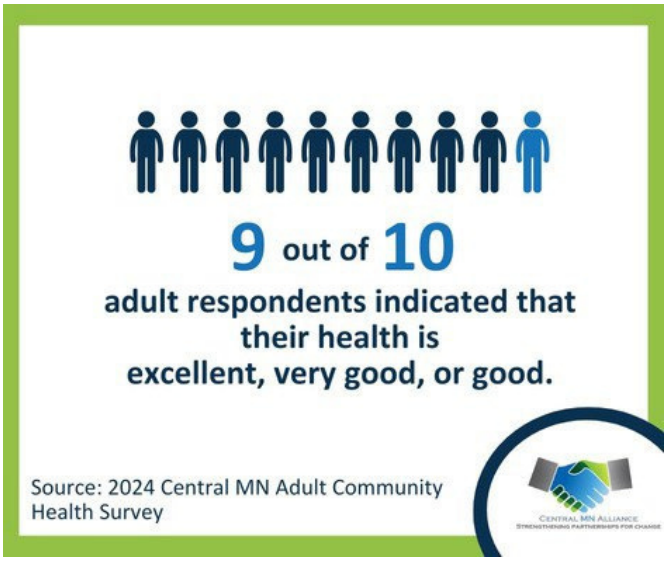
Survey Instrument

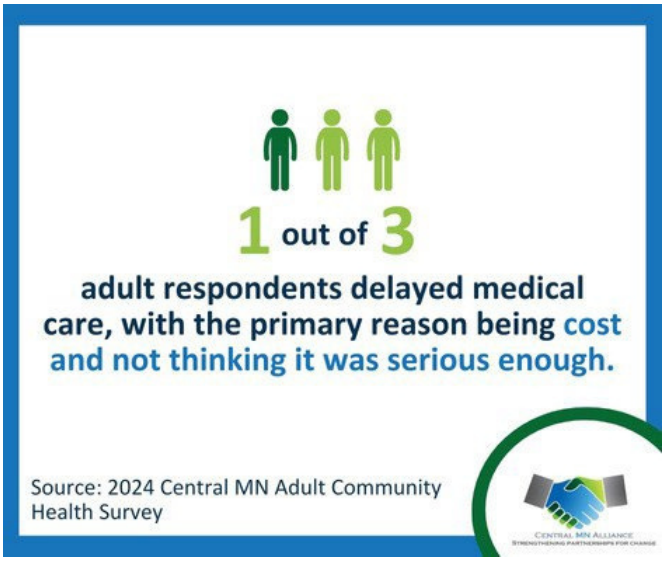
For this 2024 survey, a number of changes were made. The survey was shortened and only offered as a convenience sample. Staff from each of the participating public health agencies and CentraCare developed the questions with technical assistance from the Minnesota Department of Health Center for Health Statistics.

The survey instrument was translated into Somali and Spanish and built in ArcGIS Survey123 by the Stearns County GIS Department, resulting in a link that could be shared electronically.

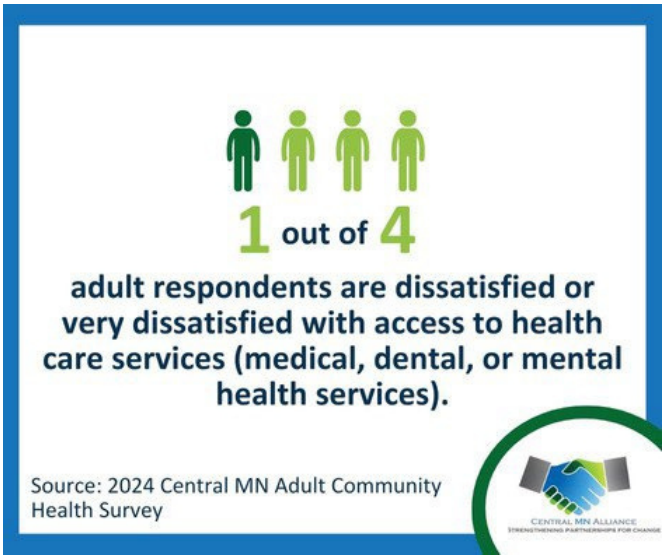
Survey Administration

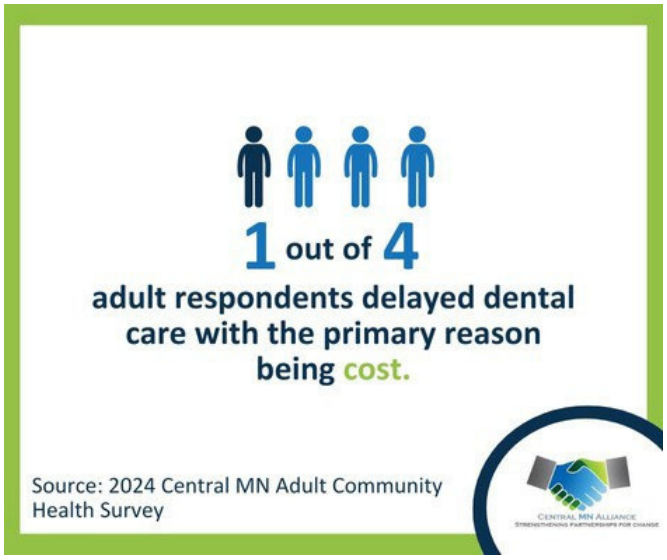
The electronic link to the survey was distributed by public health staff in Benton, Sherburne, and Stearns Counties, CentraCare staff, and community partners via email, social media, newsletters, and websites. The opportunity to take the survey was shared in meetings at which staff attended. A distribution list was maintained. Paper copies of the survey were available for Central Minnesota Alliance staff to share; paper copies were completed and manually entered by staff into the electronic link. Survey resources were also available on CMA agency websites with links to paper copies of the survey, posters to share about the survey, and videos where the survey was being read in English, Spanish, and Somali. The survey was distributed to people who live, work, play, and engage with communities in Benton, Sherburne, and Stearns counties.

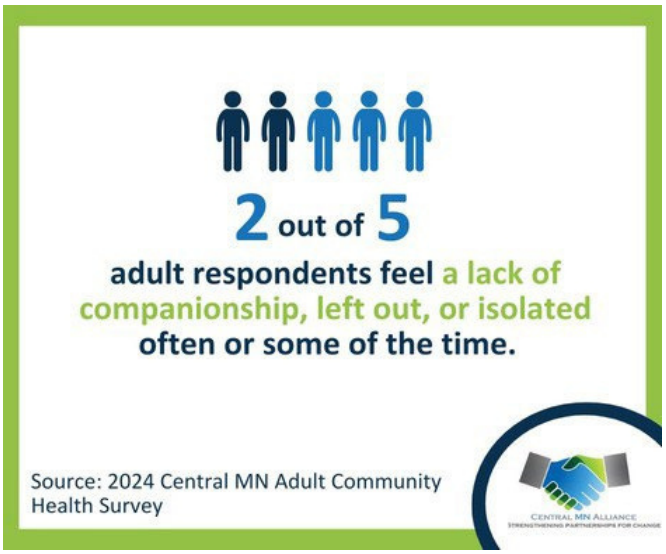


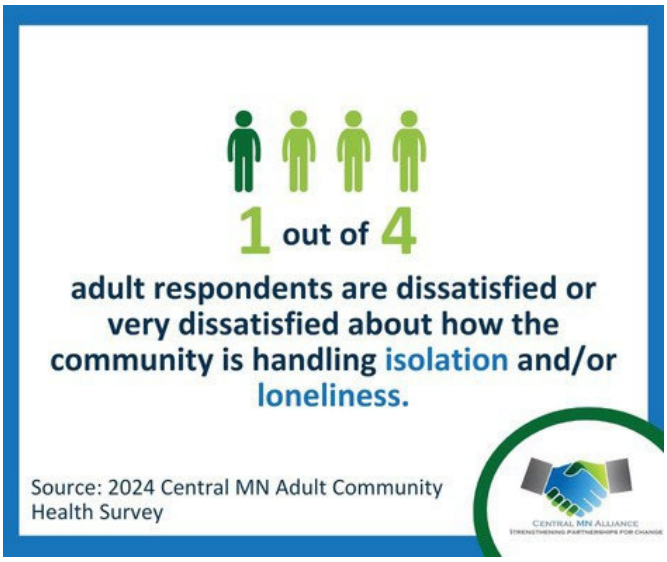


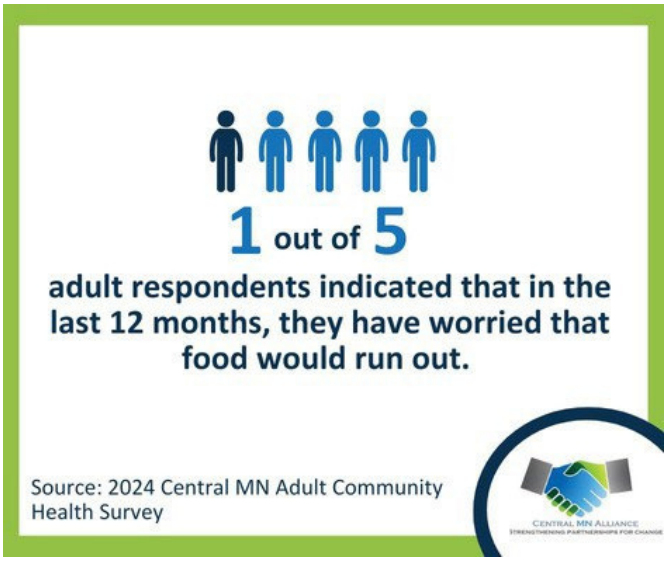
SURVEY HIGHLIGHTS

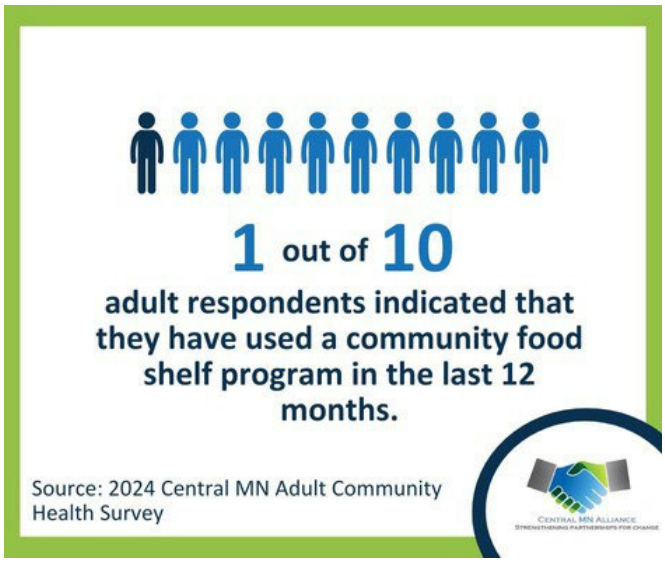


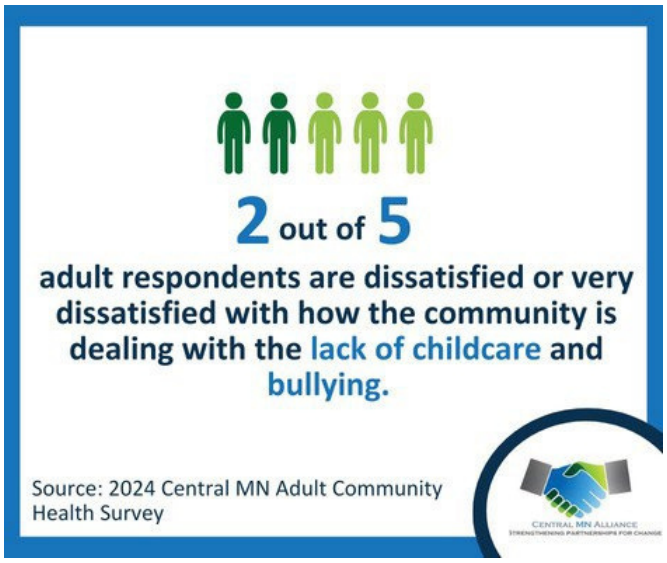



2 out of 5
adult respondents feel a lack of companionship, left out, or isolated often or some of the time.
Source: 2024 Central MN Adult Community Health Survey


1 out of 4
adult respondents are dissatisfied or very dissatisfied about how the community is handling isolation and/or loneliness.
Source: 2024 Central MN Adult Community Health Survey


1 out of 5
adult respondents indicated that in the last 12 months, they have worried that food would run out.
Source: 2024 Central MN Adult Community Health Survey


1 out of 10
adult respondents indicated that they have used a community food shelf program in the last 12 months.
Source: 2024 Central MN Adult Community Health Survey


2 out of 5
adult respondents are dissatisfied or very dissatisfied with how the community is dealing with the lack of childcare and bullying.
Source: 2024 Central MN Adult Community Health Survey


1 out of 3
adult respondents are dissatisfied or very dissatisfied with how the community is dealing with affordable housing, depression among youth, depression among adults, distracted driving, families experiencing financial stress, and opioid/other drug use.
Source: 2024 Central MN Adult Community Health Survey

Here is a comparison of how the survey respondents who live in Benton, Sherburne, and Stearns counties (approximately 800) look compared to the overall population of the three counties in 2020 (approximately 300,000).

Demographic	3-County Region According to 2020 US Census	3-County Region 2024 Adult Respondents
Male	50%	15%
Female	50%	85%
Straight/heterosexual	90%	95%
LGBTQ+	10%	5%
Age 18-34	30%	20%
Age 35-44	20%	20%
Age 45-54	15%	25%
Age 55-64	15%	20%
Age 65-74	10%	10%
Age 75+	10%	5%
White	85%	85%
BIPOC	15%	15%
High school/GED or less	30%	10%
Some college +	35%	35%
Bachelors	25%	30%
Graduate/professional	10%	25%
Income: <Less than 200%	10%	15%
Income: >200% or more	90%	70%
Blank		15%

These quantitative data do not tell the whole story. We look forward to discussing these data as they relate to your

Benton, publichealth@co.benton.mn.us

CentraCare, communityhealthimprovement@centracare.com

Sherburne, public.health@co.sherburne.mn.us

Stearns, healthforall@co.stearns.mn.us

Appendix C: Most Used Data Sources

CMA maintains a document with Most Used Data Sources. The document file is open to all agencies to add to as we learn about new sources that we use. Included here is the list we have to date.

Principal = this data includes data specific to Benton, Sherburne, and Stearns Counties or sub-geographies within these three counties.

Subordinate = while an important dataset to consider, the geographies of the data are different than the county boundaries.

Profile = Yes, means that you can pull profiles at the county-level with this data source.

Data Source	**Principal / Subordinate**	**Profiles Offered**
**Minnesota Department of Health County-Level Indicators by Data Source: Resource for all to review. 17 page PDF	Principal	no
Census Poverty & Income by county [Small Area Income and Poverty Estimates (SAIPE) Program]	Principal	no
Minnesota Cancer Reporting System	Principal	no
Minnesota Compass	Principal	yes
Minnesota County Health Tables	Principal	no
Minnesota Department of Education Data Center	Principal	no
Minnesota Injury Data Access System (MIDAS)	Principal	no
Minnesota Kids Count Databook	Principal	yes
Minnesota Public Health Data Access Portal	Principal	yes
Minnesota Sexually Transmitted Diseases, including HIV	Principal	no

Data Source	Principal / Subordinate	Profiles Offered
MDH, Minnesota Student Survey, excluding substance use data	Principal	yes
MDE MSS Interactive Data Reports	Principal	no
Minnesota Vital Statistics Interactive Queries, Birth Queries by County require a password, contact healthstats@state.mn.us	Principal	no
Substance Use in Minnesota.org	Principal	yes
Behavioral Risk Factor Surveillance System (state level data)	Subordinate	no
Childhood Opportunity Index: The Geography of Child Opportunity: Why Neighborhoods Matter for Equity	Subordinate	yes
Minnesota Adult Tobacco Survey (state level data)	Subordinate	no
Greater St. Cloud Equity Dashboard (while much of the data are from St. Cloud, Sauk Rapids/Rice, Sartell-St. Stephen, it is applicable across the three counties)	Principal	yes
Central Minnesota Social Capital Survey (15 mile radius around St. Cloud)	Principal	no
County Health Rankings, Robert Wood Johnson Foundation, University of Wisconsin Population Health Institute (Note, this source will not be available after 2025)	Principal	yes
AARP Livability Index	Principal	yes
Minnesota's Community and Uninsured Profile, by State health Access Data Assistance Center (shadac).	Principal	yes
MN All Payer Claims Database (APCD) Public Use File Dashboards	Subordinate	no
Economic Profile System (Headwaters Economics out of Bozeman, Montana)	Principal	yes
CDC Social Vulnerability Index Interactive Maps	Principal	no
US Census Reporter	Principal	yes

Data Source	Principal / Subordinate	Profiles Offered
HTAC - Health Trends Across Communities	Principal	no
Environmental Public Health Tracking Heat & Health Tracker	Principal	yes
MDH Emergency Preparedness & Response Regional Profiles	Subordinate	yes
Granite Table ArcGIS Hub - currently with housing and income data (28 Census Tracts of the Greater St. Cloud Region)	Subordinate	no
Communities of Excellence 2026 Dashboard - Granite Table is the Central MN Alumni COE Cohort, which gives us access to this dashboard.	Principal	no
University of Minnesota Rural Health Information Hub.	Subordinate	yes
Minnesota Department of Health, Health Equity Resource Library	Subordinate	no
WIC Cultural Toolkit: Afghan, Arican American, American Indian, Hmong, Somali, Ukrainian	Subordinate	no
WIN (Wellbeing in the Nation) Network Measures	Principal	yes

Appendix D: Languages Spoken in the three counties

To discuss languages spoken in the counties, we are using two data sources. The MN Compass data uses 2018-2022 5-year American Community Survey estimates identifying a percent of the population 5 years and older that speak a language other than English (2022 US Census). The second dataset is from the Minnesota Department of Education that identifies the count of enrolled students by the Primary Language Spoken at Home as of October 2024 (2024 MDE).

Benton

According to 2022 US Census, 6.6% of the Benton County population, 5 years old and older, speak a language other than English. According to 2024 MDE data, 98% of 6,160 enrolled students have English as their Primary Language Spoken at Home. The remaining students speak 14 languages, which include (the starred languages have the largest numbers of the 14 language groups):

Afrikaans	Arabic	Hmong	Mandingo	Vietnamese
Amharic	Cheyenne	Khmer, Cambodian	Somali*	Wolof
Anuak	French	Lao, Laotian	Spanish*	

Sherburne

According to 2022 US Census, 4.5% of the Sherburne County population, 5 years old and older, speak a language other than English. According to 2024 MDE data, 93% of 21,195 enrolled students have English as their Primary Language Spoken at Home. The remaining students speak 78 languages, which include (the starred languages have the largest numbers of the 78 language groups):

Afrikaans	Edo	Hmong*	Moldovan	Swedish
Akan	Eleme	Igbo	Nepali	Tagalog
Amharic	English, Creolized	Italian	Norwegian	Tamil
Arabic	Ewe	Japanese	Oromo, Afan Oromo, Oromiffa	Telugu
Belorusan	Filipino, Pilipino	Kabyle	Ossetian	Thai
Bengali	Finnish	Karen	Pashto	Tigrinya
Bosnian	French	Khmer, Cambodian	Polish	Turkish
Burmese	Fulah	Kikuyu	Portuguese	Twi
Cantonese	German	Kom	Romanian	Ukrainian
Cebuano,	Gio	Korean	Russian*	Urdu
Chinese,	Grebo	Krahn	Shona	Uzbek
Mandarin	Gujarati	Kurdish	Sign Language, ASL	Vietnamese
Croatian	Haitian Creole	Lao, Laotian	Sinhala	Wolof
Czech	Hausa	Lingala	Somali	Yoruba
Danish	Hawaiian	Mandingo	Spanish*	Zulu
Dinka	Hindi	Marathi	Swahili, Kiswahili	

Stearns

According to 2022 US Census, 10.3% of the Stearns County population, 5 years old and older, speak a language other than English. According to 2024 MDE data,
78% of 24,617 enrolled students have English as their Primary Language Spoken at Home,
13% have Somali, and
7% have Spanish.
The remaining students speak 65 languages, which include (the starred languages have the largest numbers of the 78 language groups):

Acholi
Afrikaans
Amharic
Anuak*
Arabic*
Bengali
Burmese
Cantonese
Cebuano,
Cheyenne
Chinese, Mandarin
Cutchi-Swahili
Dari
English, Creolized
Ewe
Fanti
Farsi
Filipino, Pilipino
French*
French, Creolized
Ga
German
Grebo
Gujarati
Hindi
Hindustani
Hmong
Hungarian
Indonesian, Bahasa
Indonesian
Italian
Japanese
Karenni
Khmer, Cambodian
Korean
Krio
Kurdish
Lao, Laotian
Lingala
Mandingo
Nepali
Norwegian
Nuer
Oromo, Afan Oromo,
Oromiffa
Pashto
Polish
Portuguese
Portuguese -Creole
Punjabi
Quechua
Quichua
Russian
Shona
Sign Language, ASL
Swahili, Kiswahili
Tagalog
Turkish
Twi
Ukrainian
Urdu
Uzbek
Vietnamese*
Wolof
Xhosa
Yoruba
Zulu

Acknowledgements

Joint CMA GT Data Committee

The Joint Central MN Alliance (CMA) / Granite Table (GT) Data Committee acted as the Community Status Assessment Committee for the 2024-2025 Assessment phase. This is an ongoing committee that is scheduled to meet every two weeks and about 20% of the meetings get cancelled. Members of the Committee include:

- Peggy Sammons, Sherburne County - CSA Lead Facilitator
- Emma Hanson, Benton County
- Melissa Pribyl, CentraCare
- Dani Protivinsky, CentraCare
- Annika Peterson, Sherburne County AmeriCorps Member
- Madelyn Backes, Sherburne County AmeriCorps Member & Granite Table
- Mike Matanich, Stearns County
- Yasin Dubow, Stearns County AmeriCorps Member
- Nimo Jama, Stearns County AmeriCorps Member
- Mario Seaman, Stearns County AmeriCorps Member
- Dr. King Banaian, Granite Table, St. Cloud State University
- Gary Floss, Granite Table, Communities of Excellence 2026
- Clarinda Solberg, Granite Table, United Way of Central MN
- Dr. David Tilstra, Granite Table, CentraCare
- Dr. Sarah Sengupta, Center for Health Outcomes and Policy Research (CHOPR)
- Christopher Stanley, Center for Health Outcomes and Policy Research (CHOPR)

2024 Central MN Community Health Survey Instrument Committee

This committee met from 6/18/24 through 8/6/24. The ArcGIS Survey123 work went through 10/16/24.

- Peggy Sammons, Sherburne County - Committee Facilitator
- Mariah Klein, Benton County
- Melissa Pribyl, CentraCare
- Briana Angstman, Stearns County
- Sam Heskin, Stearns County
- Mike Matanich, Stearns County
- Brittany Spah, Stearns County
- Joel Torkelson, Wright County
- Bob Kuziej, Minnesota Department of Health
- Assistant Commissioner Dr. Robsan (Helkeno) Tura, Minnesota Department of Health (involved with updates only)

- Dan Schmitz, Stearns County, ArcGIS Survey123 Lead
- Eric Ini, Influencer Hotspot, Contractor for survey Spanish and Somali translation

2024 Central MN Community Health Survey YouTube Video Offer for Auditory Accessibility Team

This team conducted their work 8/8/24-9/23/24. All videos were posted by 9/23/24.

- Dave Unze, Sherburne County Communications Media Specialist - Lead
- Annika Peterson, Sherburne County AmeriCorps Member
- Tina Thao, Benton County AmeriCorps Member (English)
- Lilian Bonilla, Sherburne County Community Health Worker (Spanish)
- Yasin Dubow, Stearns County AmeriCorps Member (Somali)

2024 Central MN Community Health Survey Cleaning Committee
2024 Central MN Community Health Survey Analysis Team

This committee work was conducted 10/7/24 - 10/16/24.

- Peggy Sammons, Sherburne County - Committee Facilitator
- Emma Hanson, Benton County
- Mariah Klein, Benton County
- Jaclyn Litfin, Benton County
- Tara Wilbanks, Benton County AmeriCorps Member
- Sylvia Amlie, CentraCare
- Anessa Petersen, CentraCare
- Brittany Pfannenstein, CentraCare
- Dani Protivinsky, CentraCare
- Madelyn Backes, Sherburne County AmeriCorps Member & Granite Table
- Annika Peterson, Sherburne County AmeriCorps Member
- Nicole Ruhoff, Sherburne County
- Briana Angstman, Stearns County
- Mike Matanich, Stearns County
- Yasin Dubow, Stearns County AmeriCorps Member

2024 CSA Report format

- Tabitha Young, Benton County AmeriCorps Member

Appendix C:

Community Context Assessment Committee Report

CENTRAL MN ALLIANCE
STRENGTHENING PARTNERSHIPS FOR CHANGE

Community Context Assessment Report

2024

Overview of MAPP

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is not an agency-focused assessment process; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems.

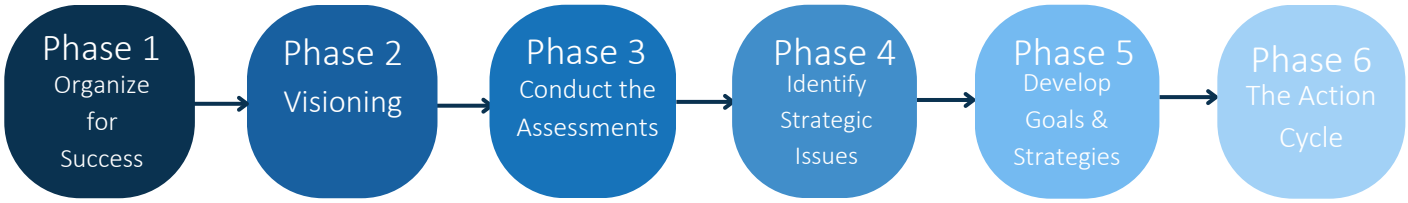
In 2019, the National Association of County and City Health Officials (NACCHO) began a redesign the MAPP process. This redesign was focused on the following principles:

- Equity
- Inclusion
- Trusted Relationships Community Power
- Strategic Collaboration and Alignment
- Data and Community Informed Action
- Full Spectrum Actions
- Flexible
- Continuous

In 2024, a Central MN Alliance member was selected to participate in the MAPP 2.0 Pilot Training. They were 1 of 35 participants.

More information about MAPP and the redesign process can be found in NACCHO's MAPP Evolution Blueprint Executive Summary.

Original MAPP Framework



MAPP 2.0 Framework

MAPP Guiding Questions

- What are the sub-populations within our community that have higher health risk or poorer health outcomes?
- What structural and social factors contribute to higher health risks or poorer health outcomes of certain populations within our community?
- How are various types of community partners impacting health inequities in the community or contributing to the health and wellness of community members?

Community Context Assessment: Overview

The CCA is a qualitative tool to assess and collect data. It collects the insights, expertise, and views of people and communities affected by social systems to improve the functioning and impact of those systems. The CCA moves beyond interventions that rely on perceived community needs to understand a community's strengths, assets, and culture. The CCA centers on people and communities with lived experiences and lived expertise. It focuses on the views, insights, values, cultures, and priorities of those experiencing avoidable gaps firsthand. All communities have a vibrancy that must be nurtured and supported in community improvement.

The CCA seeks to understand the following:

- What strengths and resources does the community have that support health and well-being?
- What current and historical forces of change locally, regionally, and globally shape political, economic, and social conditions for community members?
- What physical and cultural assets are in the built environment? How do those vary by neighborhood?
- What is the community doing to improve health outcomes? What solutions has the community identified to improve community health?

The CCA Domains:

There are three primary domains: Community Strengths and Assets, Built Environment, and Forces of Change. These seek to capture the lived experience and expertise of community members, particularly from communities that experience structural gaps, to lift untold or under-told realities, and to find solutions to health issues facing the community.

Domain 1: Forces of Change

What is occurring or might occur that affects the health of your community or local public health system? (These can be both things within your community and things in the larger societal and economic context of your community.)

- **Politics:** Political and governmental impact on health; Global politics and national priorities; Leadership and governance
- **Economy:** Inflation and cost of living; Income and employment; Housing and rent
- **Society:** Social issues and public policies; Diversity and inclusion; Mental health and well-being
- **Technology:** Digital media and information; Artificial intelligence (AI) and rapid growth; Role in consumerism and society
- **Environment:** Climate change and increase in natural disasters; Access to resources and basic needs; Sustainability and renewable energy
- **Law:** Legal and financial impacts of policy changes on health and safety; Economic inequality and legal protections; Law enforcement challenges and benefits

Which communities are disproportionately impacted by forces of change? How and why are they disproportionately impacted?

- **Low-income communities:** Financial struggles, health gaps, mental health challenges; Housing instability, food insecurity, and less access to resources.
- **People of color:** Avoidaable negative health outcomes and higher rates of chronic conditions, cycles of poverty; Structural racism and discriminatory practices cause unequal access and opportunity.
- **Immigrants and refugees:** Economic hardship, barriers to accessing services, education, and health care; Discriminatory practices and social exclusion.
- **Rural populations**: Limited access to health care, higher rates of economic insecurity, and fewer resources. Less access to stable employment, older housing, social exclusion.

Which communities are disproportionately impacted by forces of change? How and why are they disproportionately impacted?

Low-income communities*:* Financial struggles, health gaps, mental health challenges; Housing instability, food insecurity, and less access to resources.

People of color: There are avoidable gaps and higher rates of chronic conditions, cycles of poverty; Structural racism and discriminatory practices cause unequal access and opportunity.

I**mmigrants and refugees:** Economic hardship, barriers to accessing services, education, and health care; Discriminatory practices and social exclusion.

Rural populations: Limited access to health care, higher rates of economic insecurity, and fewer resources. Less access to stable employment, older housing, social exclusion.

How does historical and structural context shape the forces of change today, and who benefits from current conditions?

Historical and structure context within community such as broken treaties, displacement, and generational economic, social, and health outcomes are shaped by the forces of change identified and negatively impact and create health gaps within members of our community and have long-term and lasting impacts in regard to access to resources, education, healthcare, policy, and housing, for example.

Populations with fewer negative historical impacts and greater generational wealth see lesser negative impacts from forces of change and tend to have greater access to economic opportunities, quality education, healthcare, and property ownership.

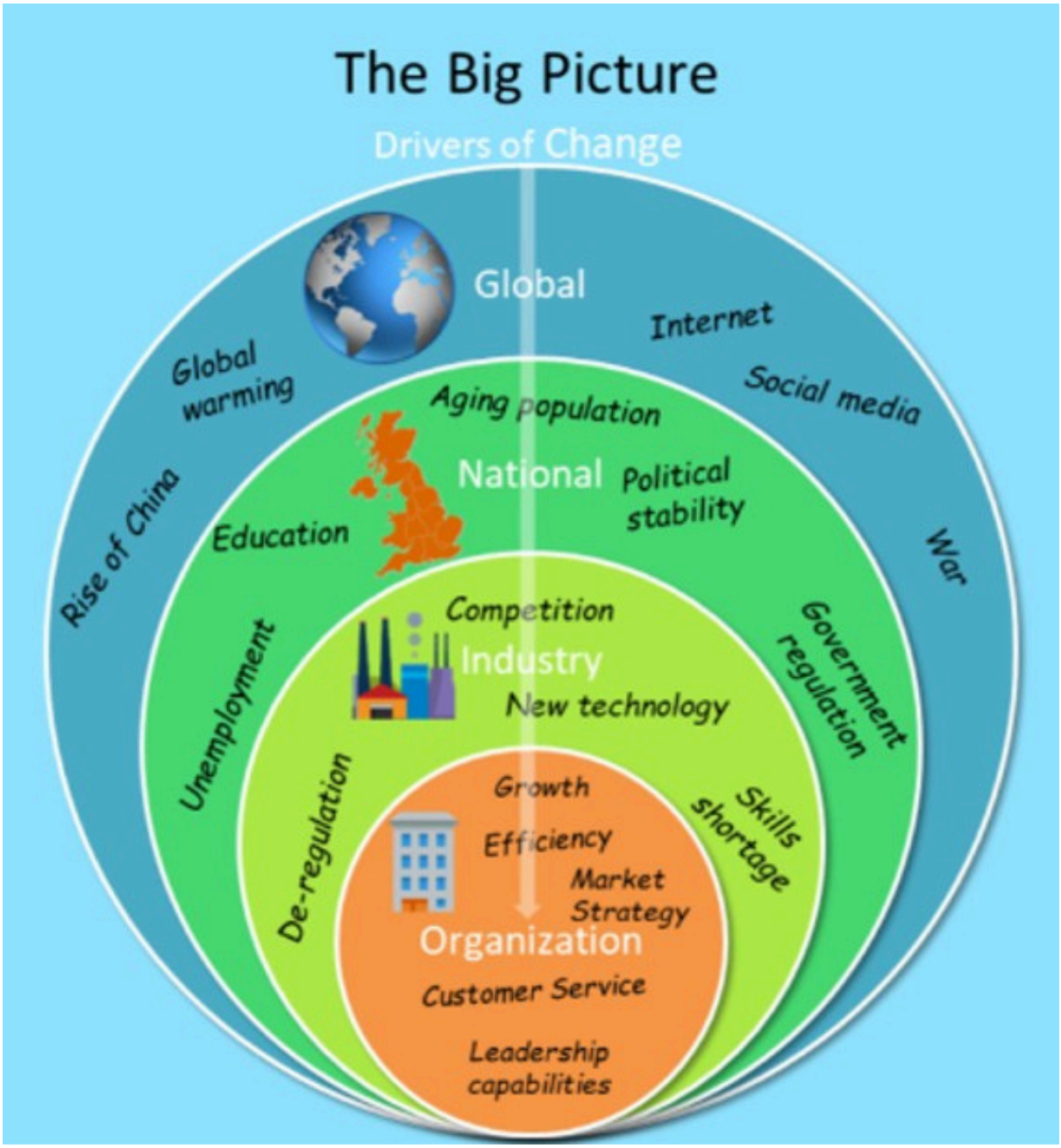
How have climate change and COVID-19 changed conditions in your community?

Climate change: More frequent and intense storms, floods, and heatwaves. Disruptions in local infrastructure, including healthcare, daily activities, and agriculture. Worsening air pollution can exacerbate respiratory illnesses such as asthma. Water quality issues such as runoff contamination or flooded wells can affect access to clean water. Fluctuation in agricultural yields, crop failure, food security concerns. Low-income and rural residents are more likely to live in housing that is poorly equipped to handle extreme heat or flooding.

COVID-19: Before the pandemic, childhood immunization rates in Minnesota had already been decreasing, partly due to growing vaccine hesitancy and concerns over vaccine safety. The COVID-19 pandemic exacerbated this issue. Many routine pediatric care visits were postponed or canceled during the height of the pandemic, further decreasing vaccination rates. rural and economically disadvantaged communities often have less access to healthcare providers, which can make it harder for parents to get their children vaccinated. Additionally, mistrust of government institutions and healthcare systems, compounded by socioeconomic barriers, can contribute to lower vaccination rates.

What have health departments done to help?

Health departments in Sherburne, Benton, and Stearns counties have been proactive in addressing public health challenges by engaging directly with community members, health care partners, and local organizations to understand the unique impacts of community issues. Through these conversations, they have brainstormed solutions and developed strategies to address and improve health outcomes. In addition to their own efforts, public health departments have supported grant applications for their departments and assisted other community partners with funding opportunities to strengthen public health initiatives. They have also utilized data-driven approaches, including the use of Social Vulnerability Index (SVI) and Social Drivers of Health (SDOH) data, to identify and prioritize high-risk communities, ensuring that resources and support are directed where they are needed most. To combat the pandemic, health departments have hosted COVID-19 vaccination clinics and led vaccination campaigns, including mobile vaccination units, to improve access for vulnerable and rural populations. These coordinated efforts have played a vital role in enhancing community resilience, supporting community recovery and addressing immediate public health needs.



https://5forcesofchange.com/power-big-picture/

Domain 2: Community Strengths and Assets

What strengths and assets do community members have?

- **Faith-based networks:** Churches, mosques, and community centers strengthen support.
- **Generational ties:** Strong family connections, mentorship, and shared knowledge.
- **Community event participation:** Festivals, markets, and programs like "Dine & Dialogue" create bonds.
- **Employment opportunities:** Strong sectors in healthcare, education, and industry.
- **Housing Initiatives:** Most residents are housed, though unhoused numbers are growing. Partners are collaborating and finding solutions that meet the need of various communities.

How do these community strengths and assets contribute to community health?

- ***Faith and culture:*** *Foster emotional well-being and resilience.*
- ***Community care:*** *Events and volunteering reduce isolation and build trust.*
- ***Education hubs****: Libraries and schools boost literacy and offer learning spaces.*
- ***Health initiatives:*** *Health fairs, local clinics, and partnerships improve access to care.*
- ***Creative outlets:*** *Art, festivals, and poetry encourage expression and healing.*

Which strengths and assets can be used and strengthened to address health inequities?

- **Resilience**: Increase mental health support programs rooted in community traditions and Indigenous healing practices.
- **Community Organizing:** Partner with faith leaders, non-profits and schools to amplify outreach on health education and services.
- **Community Care:** Expand mutual aid networks to provide affordable childcare and transportation for low-income families.
- **Economic:** Leverage job training programs and microlending initiatives to support economic resilience. ?Healthy workplaces
- **Well-being:** Implement more holistic health services (e.g., acupuncture and trauma counseling) through partnerships with local health centers.
- **Cultural:** Promote shared identity and cultural pride through cross-cultural events and increased access to translated materials in multiple languages

Domain 3: Built Environment

What physical assets and resources exist in the built environment of your community?

- Members in communities across the tri-county region have access to parks with a variety of features, including playground equipment and sports facilities. Trails and walking paths are also common in many areas. Some communities have specific recreational amenities such as skate parks, splash pads, pools and beaches for use in the summer and ice rinks to use in the winter.
- Many communities have places for individuals to gather, such as libraries, community centers, and downtown areas that include businesses, restaurants, and other amenities.
- Churches and other faith communities are also prevalent across our region and offer members a way to connect with others.
- Improvements to broadband services also help individuals stay connected to needed services, as well as each other.
- Schools play an important role in their community, providing a place for all members to learn, connect, and stay active. They also can offer support and safety, as well as connect students and their families to needed resources.
- Alternative care models have been noted in the region and provide options for uninsured or underinsured families. Mobile clinics, community-based services, and alternative pay models reduce barriers to care and offer a way for everyone to access the services they need.

How do these resources differ across neighborhoods, particularly in those experiencing the greatest health inequities?

- Equitable access to resources is a key concern noted across many communities in our region. Central locations often have better access to amenities like parks, community facilities, grocery stores, and broadband services, while outlying neighborhoods may lack such resources or have greater difficulty accessing these services. Some neighborhoods also lack basic infrastructure like sidewalks, trails, and adequate lighting, which limits accessibility for residents. In outlying areas, a lack of sidewalks or wide shoulders on busy roads limit a person's ability to safely participate in physical activity. Often, we see such amenities in a town center, leaving those in outer areas without the same access.
- While many communities are working to become a welcoming place for all, many areas lack inclusive signage or universal symbols to help limited English speakers. There is also a need for more wheelchair accessible amenities in public buildings and parks.
- Limited public transportation has also been noted to be a common issue, primarily affecting those in outlying areas. This may restrict access to jobs, services, and community activities and creates an additional barrier for people who do not drive.
- Access to childcare options that fit the needs of a family can also differ across communities. There was a lack of available care noted across the three counties, especially for infants, and care can be costly or available at times that do not align with work schedules.
- While broadband access has been improving, people who live outside of a town center may not have the same access to reliable internet, making it more difficult to stay connected with friends and family or accessing services such as telehealth care.

How do community members view and interact with their built environment?

- Members of a community interact with their built environment in various ways, such as utilizing parks and trails for recreation, attending community events, and supporting local businesses. Many communities provide a variety of recreation opportunities, such as playgrounds, basketball courts, tennis courts, and ice rinks.
- To help keep members connected and build relationships, several areas in our region hold events such as concerts, art fairs, and other local festivals to promote community. Social media also plays a role in relationship building, with neighborhoods using a variety of platforms to stay connected.
- The ways community members interact with their environment are influenced by the availability and accessibility of resources, as well as the sense of safety and inclusivity they experience in those spaces.

How do these interactions impact community members' health?

- Frequent use of parks, trails, and recreational facilities promotes physical activity. Access to these amenities encourages walking, running, biking, and other forms of exercise. By providing opportunities for outdoor recreation, the built environment within communities helps reduce sedentary lifestyles, encourages active living, and promotes connection to neighbors.
- The availability of community events fosters social connections and helps individuals feel more connected to their surroundings, which in turn decreases feelings of social isolation. Community centers and parks provide venues for social interaction that help positively affect mental health. Community spaces that focus on inclusivity help create a sense of belonging, especially for individuals across diverse backgrounds.

What key aspects of the built environment in our communities impact health inequities?

- Access to amenities and resources
- Safety and inclusivity
- Community engagement and social connection

How can these aspects be improved or addressed to improve community health?

- Infrastructure changes to increase access to sidewalks, parks, and other resources , as well as improving safety features on busy streets near schools and other places children and older adults frequent or in outlying neighborhoods, would benefit all community members, making it safer and easier to stay active and commute without a vehicle. More public transportation options may also help residents access the things they need to stay healthy. Helping communities access affordable, fresh foods in their neighborhoods can reduce the negative health outcomes associated with poor nutrition.
- By making community spaces more welcoming and accessible for all residents, individuals will have a place to go that feels safe and inviting. Improvements can include signage with universal symbols or additional languages, accessibility features for people with disabilities, and broad cultural representation through artwork, murals, and other cultural elements. This can help foster a sense of belonging and build a strong sense of community.

- Communities can work to increase community engagement by better promoting local events and gatherings and creating equitable access to amenities. They may also choose to use existing infrastructure such as parks, libraries, or community centers to create social hubs that work to decrease feelings of social isolation and build connectedness.

Image from MN Department of Health

Lessons Learned

Community Strengths

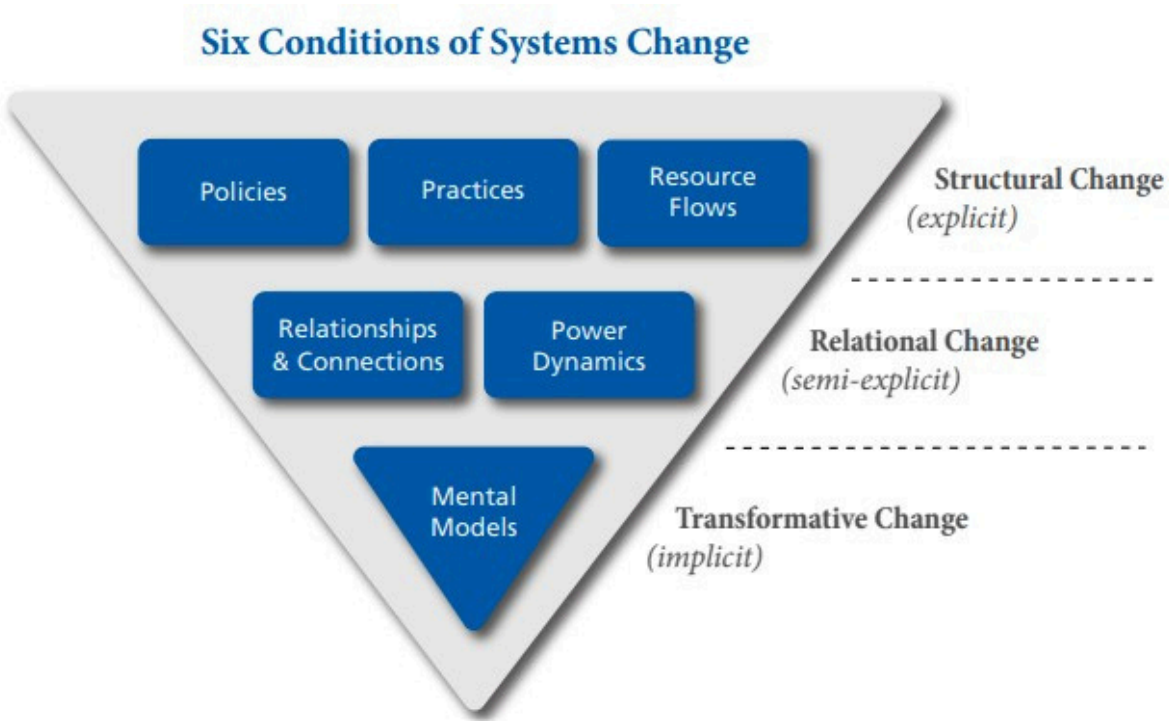
The Central MN Alliance region is filled with valuable assets in our built environment as well in the people who make up our communities. The CMA understands the importance of focusing on strengths but also will continue to illuminate disparities, work collaboratively with partners and advocate for priorities identified by the community.

Organizational Capacities

The region recognizes that collaboration, networking, and resource promotion can help expand capacity to continue to address health disparities within the community. This work needs a "Health in All Policies" approach to create impacts across sectors. It will be important for the CMA to develop strategies around increasing relationships with other sectors and aligning priorities. CMA should lead with shared values and outcomes that appeal to both progressive and conservative communities. The CMA should also revisit MAPP 2.0 CCA workbook to utilize additional Qualitative Research Methods, Considerations, and Resources identified in Table 1.

Promote Growth and Learning

Data and information collected during the Community Health Needs Assessment continues to illuminate disparities in a variety of factors, such as home ownership, employment and health outcomes. The CMA should continue to explore "The Water of SYstems Change". https://www.fsg.org/wp-content/uploads/2021/08/The-Water-of-Systems-Change_rc.pdf Systems change is about shifting the conditions that are holding the problems in place.



Health Behaviors & Health Outcomes

SDOH can create significant health disparities between different populations due to unequal access to resources like quality housing, nutritious food, and education, leading to poorer health outcomes for marginalized communities. SDOH information can guide community-based programs and policies designed to improve social conditions and address underlying health disparities. It will be important to continue to link the Built Environment to Health Behaviors & Health Outcomes.

Additional Lessons - Leverage "Debrief and notes"

- No sector works in isolation, there are many sectors that contribute to the development of a community
- A unified approach to addressing health issues will be important to ensure we leverage resources in a meaningful way

Next Steps

As the Central MN Alliance moves into Phase 3 of the MAPP 2.0 process, continuously improve the community, the information gathered in the Community Context Assessment will help focus on strengths and assets, understanding the context of our communities and advance health equity. Additionally, the CCA builds on the community connections and collaboration to further improve the community's health.

Acknowledgements

Participating Partners

- Sherburne County Substance Use Prevention Coalition
- Triwellness at Work 2024 Cohort
- Benton County
- Sherburne County
- Stearns County
- Benton County Public Health
- Sherburne County Health & Human Services
- Stearns County Human Services

Community Health Assessment Core Group

Jaclyn Litfin, Benton County Public Health
Nicole Ruhoff, Sherburne County Health and Human Services
Peggy Sammons, Sherburne County Health and Human Services
Mike Matanich, Stearns County Human Services
Janet Goligowski, Stearns County Human Services
Dani Protivinsky, CentraCare
Brittany Pfannenstein, CentraCare

Community Context Committee Facilitators

Lead Facilitators: Nicole Ruhoff and Mike Matanich