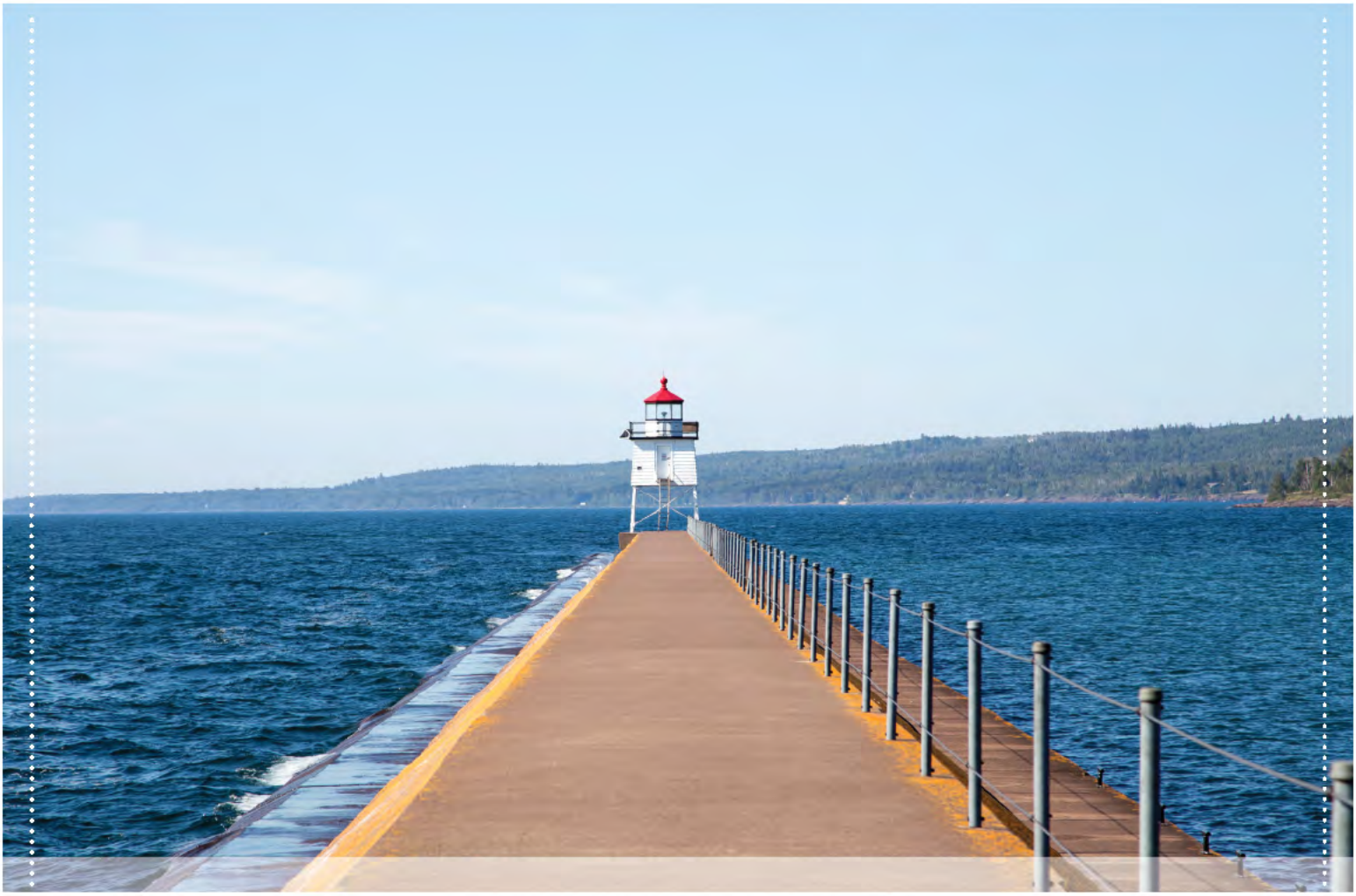
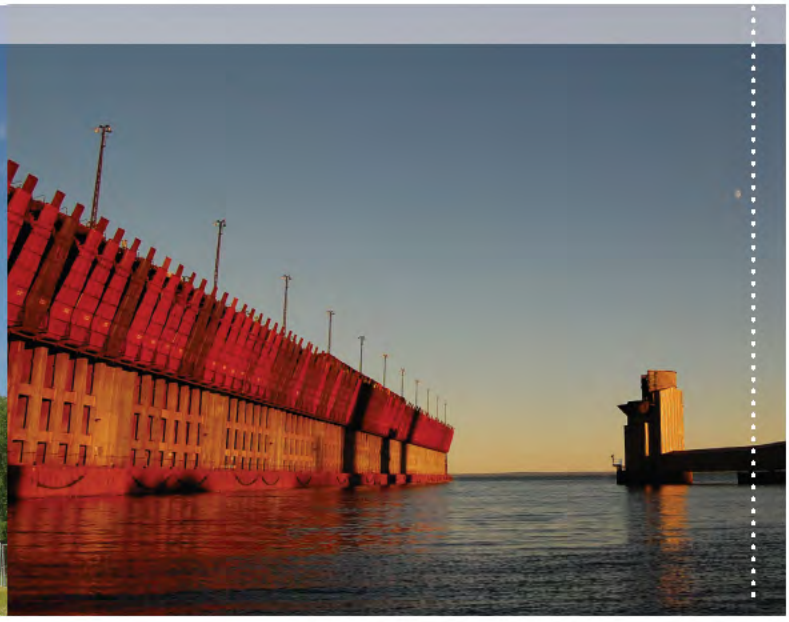


2016

# Lake View Community Health Needs Assessment



To facilitate true collaboration among health care systems, public health, human services and the nonprofit sector in our community, a community health needs assessment process was developed and conducted within Lake County. These organizations have aligned their resources, skills, expertise and interests to collaborate towards a healthier Lake County.

**CONTENTS**

**Lake View Memorial Hospital, Inc. (Lake View)** is part of the St. Luke's system, a comprehensive regional health care system. The St. Luke's system offers a comprehensive continuum of care serving the 17-county region of northeastern Minnesota, northwestern Wisconsin and the Upper Peninsula of Michigan. The system includes St. Luke's Hospital in Duluth, Minnesota, Lake View Hospital, Clinic and Urgent Care in Two Harbors, Minnesota, plus 14 primary and 27 specialty clinics, six urgent care locations and two retail express care clinics. Primary care clinics are located in Duluth, Hermantown, Hibbing, Two Harbors, Mountain Iron and Silver Bay, Minnesota, and Ashland and Superior, Wisconsin. In addition, Urgent Care and Q Care express medical services are available. St. Luke's is verified by the American College of Surgeons and the state of Minnesota Department of Health as a Level II trauma center.

In addition to family medicine, other specialties include cardiology, cardiac surgery, oncology, OB/GYN, plastic surgery, pulmonary medicine, allergy, neurosurgery, dermatology, endocrinology, gastroenterology, infectious disease, internal medicine, surgery, occupational health, orthopedics & sports medicine, pediatrics, physical medicine and rehab, rheumatology, psychiatry and urology. St. Luke's Home Care and Hospice Duluth provide services to patients within a 30-mile radius of Lake View Hospital.

Also, in collaboration with the University of Minnesota Medical School, Duluth campus, St. Luke's is involved with clinical research activities in the areas of cancer, lung and heart disease through the Whiteside Institute for Clinical Research.

Lake View is dedicated to improving the health of the communities it serves. Lake View will continue to seek opportunities to have the greatest impact in our community with the resources available to our hospital system. We will continue to support those efforts of community-based organizations whose goals and activities are compatible with our own mission, vision and values and the identified health priorities of our community.

## Mission

The Patient Above All Else

**Vision Statement**

To be the provider and partner of choice for the region.

**Values**

These values provide the foundation for our culture as we pursue our Mission and Vision:

The patient comes first
Quality is our expectation
People make it happen
Everyone is treated with respect

**Progress to Date on 2013 Community Health Needs Assessment**

Lake View's 2013 Community Health Needs Assessment included these top priorities:

| | |
|---|---|
| **Priority 1** | Obesity, physical activity, and nutrition |
| **Priority 2** | Smoking cessation |

A full progress report on actions taken to date and their impact can be found in Appendix A.

## 2016 Community Health Needs Assessment

### Objectives

In conducting the 2016 Community Health Needs Assessment, Lake View collaborated with community partners to work towards a healthy Lake County and embraced these guiding principles:

- *Seek to create and sustain a united approach to improving health and wellness in our community and surrounding area;*
- *Seek collaboration towards solutions with multiple stakeholders (e.g. schools, work sites, medical centers, public health) to improve engagement and commitment focused on improving community health; and*
- *Seek to prioritize evidence-based efforts around the greatest community good that can be achieved through our available resources.*

The goals of the 2016 Community Health Needs Assessment were to:

1. Assess the health needs, disparities, assets and forces of change in the hospitals' shared service area.
2. Prioritize health needs based on community input and feedback.
3. Design a collective impact-based implementation strategy focusing on a multi-sector collaborative approach.
4. Engage community partners and stakeholders in all aspects of the Community Health Needs Assessment process.

### Assessment Partners

The Community Health Needs Assessment (CHNA) was conducted by Lake View and St. Luke's. Assessment partners included stakeholders from community organizations working to improve health outcomes and reduce inequities. These partners assisted in developing the community-centered process and community dialogues as well as prioritizing community needs. They also will help build the implementation plan through a collective impact model.

Lake View partnered with Generations Healthcare Initiatives and a large number of other stakeholders across Northeast Minnesota and Northwest Wisconsin to conduct the Bridge to Health Survey to provide local and regional data utilized in this needs assessment.

**PROCESS OVERVIEW**

The community health needs assessment was conducted in four stages: assessment, prioritization, design and finalization. Through each phase of the assessment process, a collaborative community assessment team was asked to review the data, prioritization and results of community focus groups to maximize the relevance of the assessment. This group included representation from Lake View, St. Luke's, Lake County Public Health and Human Services, the Carlton-Cook-Lake-St. Louis Community Health Board, Lake Superior School District and non-profit organizations that work with underserved communities in Lake County or in the area served by Lake View Hospital.

Lake View started the process in May 2016 and completed it in October 2016. The Community Health Needs Assessment will be presented to Lake View executive team and the Board of Directors in October 2016.

## Assessment Process

**PHASE 1: ASSESSMENT**

The first phase in the process included the collection and review of data in order to provide stakeholders with a systematic review of the health of community members. This process fosters a deeper understanding of the demographics and health status of Lake County as compared to the rest of the region, state and nation. This process also was designed to assist stakeholders in focusing on data-driven opportunities for improvement in the identified priorities.

Throughout this assessment, it was imperative to view the health needs of the community through the lens of the social determinants of health. The social conditions in which we live, work and play have more of an impact on our life expectancy and total health than the medical care we receive. The model by the University of Wisconsin Population Health Institute, Figure 1, estimates that social and economic factors may have a larger impact (40%) than either clinical care (20%) or individual behavior (30%). The themes in this assessment directly reflect the community's definition of health as it relates to their whole lives, not the medical care they receive within our healthcare system.

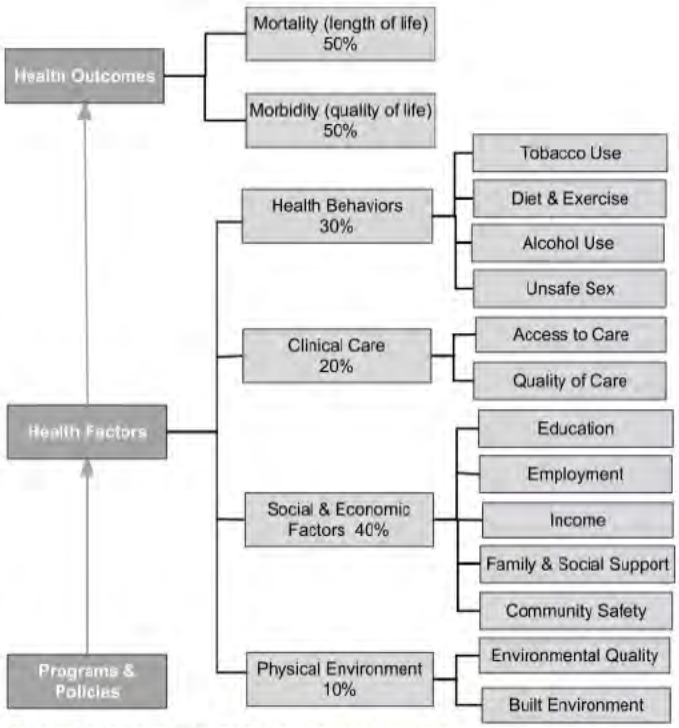



FIGURE 1

**DESCRIPTION OF COMMUNITY SERVED BY LAKE VIEW HOSPITAL**

Throughout the assessment and implementation strategy for the Community Health Needs Assessment a special emphasis is placed on populations facing the highest disparities in health outcomes.

Lake View serves all of Lake County and beyond; for the purpose of the community health needs assessment, the community served is defined as Lake County. Lake County includes the following zip codes:

| City | Zip Code |
|---|---|
| Beaver Bay | 55601 |
| Finland | 55603 |
| Isabella | 55607 |
| Knife River | 55609 |
| Silver Bay | 55614 |
| Two Harbors | 55616 |

| Population Characteristics | | |
|---|---|---|
| | **Lake County** | **Minnesota** |
| Population | 10,866 | 5,303,925 |
| Median household income | $46,850 | $60,828 |
| Persons in poverty | 10.5% | 11.5% |
| High School Graduate (or GED) | 94.3% | 92.3% |
| Persons 65 years and over | 22.3% | 12.9% |
| Female persons | 49.6% | 50.4% |
| Persons white alone | 97.7% | 85.3% |
| Persons black or African American alone | 0.1% | 5.2% |
| Persons American Indian or Alaska Native alone | 0.5% | 1.1% |
| Data Source: U.S. Census Bureau, Quick Facts (based on 2010 Census) | | |

Poverty, education, age and race are all factors contributing to the inequitable health outcomes in Lake County. According to the Minnesota Department of Health's (MDH) White Paper on Income and Health, "Poverty in Minnesota is not evenly distributed across racial/ethnic groups, ages or educational levels. Poverty is concentrated among populations of color, children, people with less education, female-headed households and rural Minnesotans[1]."

People in Minnesota with lower incomes are more likely to:

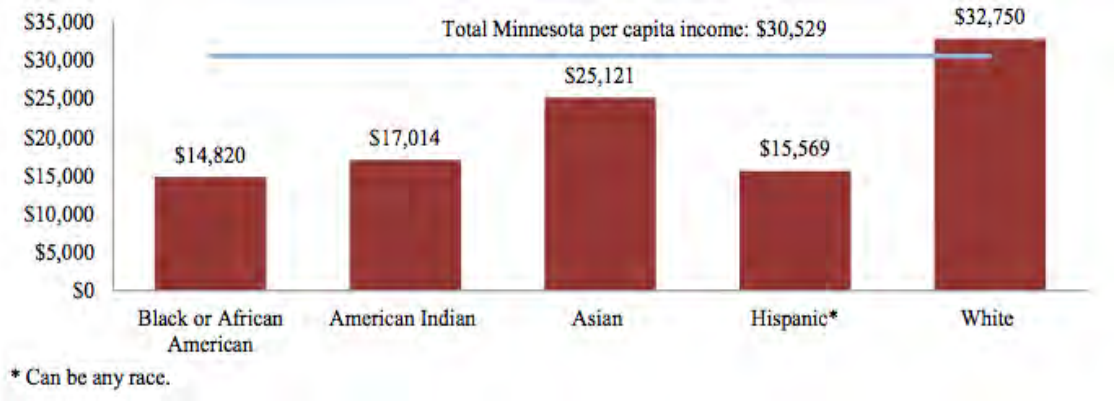
- Have an infant die in the first year of life
- Report that their health is fair or poor
- Report having diabetes
- Report having seriously considered attempting suicide

Additional information on the health disparities faced by minority populations in Lake County has been incorporated into this assessment. According to the Minnesota Department of Health's "Advancing

[1] Minnesota Department of Health, White Paper on Income and Health, March 3, 2014 http://www.health.state.mn.us/divs/opa/2014incomeandhealth.pdf

Health Equity" report[2] to the legislators on February 1, 2014: "American Indians and African-Americans in Minnesota experience substantially higher mortality rates at earlier ages.[3]"

The MDH "Advancing Health Equity" report to the legislators also cites that, "African-American, American Indian and Hispanic/Latino populations have household incomes that are almost half that of Asian and white populations." This is clearly illustrated in this graph depicting the per capita income of Minnesota residents from the past 12 months in 2012[4].




Limitations exist in reviewing health outcomes of specific sub-populations (low-income, people of color, Native Americans) due to the region's rural nature and the data for populations smaller than county level frequently being unavailable or of limited value. Therefore, much of the assessment data are presented at the county and state level to ensure stability of the estimates. When available, ZIP code or U.S. Census tract level data will supplement the county-level information to provide a deeper understanding of the health needs of the community.

**Data Collection and Review**

Lake View did not directly collect primary data, but partnered with many other stakeholders on the regional 2015 Bridge to Health Survey. The hospital collected, reviewed and evaluated existing public health data to support key indicators focused on aspects of health, wellness and the social determinants of health. These datasets included information from:

**United States Census Bureau**

This dataset provided internal and external stakeholders with the basic demographics of Lake County. Data utilized included:

- Demographic breakdown of Lake County: age, gender, race
- Socio-economic status: income, education

**Minnesota County-Level Indicators for Community Health Assessment**

[2] http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf
[3] Mortality disparity ratio is calculated by dividing the rate for a given population by the White rate. Source: MDH, Center for Health Statistics.
[4] Source: 2012 Census ACS 1 year, B19301 (race alone)

This Minnesota Department of Health dataset consists of data related to multiple indicators from several MDH sources to assist local health departments and community health boards with their community health assessments and community health improvement planning processes. These datasets are a standard set of indicators to compare across the Arrowhead Region of Minnesota. Data was reviewed from:

- Minnesota Student Survey Selected Single Year Results
- 2011 Minnesota County Health Tables
- 1991-2010 Minnesota Vital Statistics State, County and CHB Trends
- Minnesota Public Health Data Access

**CDC Behavioral Risk Factor Surveillance System (BRFSS)**

This dataset provided an opportunity for comparison of the health outcomes and health status in Lake County from local surveys to state and national averages for the same questions.

**Carlton-Cook-Lake-St. Louis County Community Health Board Community Health Improvement Plan (CHIP)**

In 2012, the Carlton-Cook-Lake-St. Louis County Community Health Board gathered diverse data sources and conducted community assessment meetings, which included prioritization, to shape a shared vision for a healthy region. This collaborative effort identified priority areas needing attention across the Community Health Board's geographical region and built a foundation for future collaborative work amongst community partners. The Community Health Improvement Plan serves as a guide for Carlton-Cook-Lake-St. Louis County Community Health Board on how local health boards, hospitals, health plans, clinics and other community organizations will focus and align their work to improve the health of the population and communities they jointly serve. Priorities identified through this process included:

1. Obesity
2. Mental Health

The Carlton-Cook-Lake-St. Louis County Community Health Board CHIP also includes an additional focus on health inequity and the opportunities to work with communities experiencing greater health inequity as related to the higher burden of both obesity and mental health issues. The 2012 CHIP can be found in Appendix B.

**2015 Bridge to Health Survey**

Based on the 2015 Bridge to Health Survey[5], families living at 200% of poverty or less have a self-reported lower perceived health status, report higher rates of mental health problems, report a higher incidence of rarely to never getting the social and emotional support they need, have higher obesity rates, eat less fruits and vegetables, exercise less, have higher tobacco use rates and often worry that food would run out.

[5] Kjos, S.A., Kinney, A.M., Finch, M.D., Peterson, J.M., *Bridge to Health Collaborative (2015). Bridge to Health Survey 2015: Northeastern Minnesota and Northwestern Wisconsin Regional Health Status Survey.* April 2016.

The following table of indicators represents the specific health needs of the community:

| Condition or outcome | Indicator | Bridge to Health Survey Result (2015) | Minnesota (Years of Data) | National (Years of Data) |
|---|---|---|---|---|
| Obesity | % obese according to BMI from self-reported height and weight | 32.1% | 25.5% (2013 BRFSS) | 29.4% (2013 BRFSS) |
| Tobacco use | % reporting smoking ≥ 100 cigarettes and currently smoking | 13.1% | 18.0% (2013 BRFSS) | 19.0% (2013 BRFSS) |
| Physical activity | % that meet either moderate or vigorous physical activity guidelines of ≥ 5 days/week of ≥ 30 min. moderate OR ≥ 3 days/week of ≥ 20 min. vigorous | 29.0% | 52.7% (2013 BRFSS) | 50.8% (2013 BRFSS) |
| Diet | % consuming ≥ 5 servings/day of fruits and vegetables combined | 28.6% | 21.9% (2009 BRFSS) | 23.4% (2009 BRFSS) |
| Mental health | Average number of mentally unhealthy days reported in past 30 days | 8.4 | 2.9 (2013 BRFSS) | 3.7 (2013 BRFSS) |
| Physical health | % reporting fair OR poor health | 13.1% | 12.4% (2013) | 16.7% (2013) |
| Alcohol use | % reporting either binge OR heavy drinking | 33.2% Binge | 21.6% Binge 7.1% Heavy Drinking (2013 BRFSS) | 17.4% Binge 6.2% Heavy Drinking (2013) |

**Written Comments from 2013 Community Health Needs Assessment**

Neither Lake View or St. Luke's received any comments on their previous Community Health Needs Assessment. Any comments would have been taken into consideration in the development of this report.

**Current Community Health Assets in Lake County**

Lake County is a community with a vibrant array of work taking place in regards to improving the community's health. The implementation plan developed collaboratively will center on the opportunity for partnership with work already being done by organizations in the community.

The interactive map on Healthy Northland[6] provides an opportunity for review of other assets, including opportunities for recreation, physical activity, healthy food, tobacco-free living resources and overall health and wellness resources. A continued partnership with Healthy Northland and the coalitions they work with is vital in addressing the needs of our community's health. The resources outlined in this asset map highlight the existing resources within the community that are available to respond to the health needs of the community. Additional partners and stakeholders will be added to this list as the implementation plan is developed to address community priorities.

In designing the implementation strategy for this report, further analysis will be done of existing internal and external resources to improve the health of the community.

## PHASE 2: PRIORITIZATION

The assessment follows an iterative process that uses data from a wide range of sources and then solicits feedback from a broad group of stakeholders. The process began with a comprehensive review of local demographic and health data to identify health status, health disparities and inequities that contribute to poorer health outcomes. This included a review of the data available for common risk factors that contribute to poor health, including obesity, physical inactivity and tobacco use.

The data showed that across multiple measures of health, wellness, and disease prevalence, residents of color and residents with lower levels of income have poorer health outcomes. Therefore, a health equity focus is needed to ensure that any strategies developed to improve the health and well-being of all patients are also effective in reducing health inequities between populations based on race, income and place.

The collaboration placed a heavy emphasis on taking into account input from persons who represent the broad interests of the community, specifically individuals from low-income, medically underserved or

[6] Healthy Northland, http://www.healthynorthland.org/index_split.aspx?w=424&r=/index_simple.aspx^id=32~pv=78~pvq=subdivision_name=%27Duluth%27~pvc=5000~rnd=zGLa3&l=/active_arrowhead/menu_panel.aspx^cal=26~prop=11~tow=12, July 2016.

minority populations and those with a special knowledge or expertise in public health. The collaboration conducted focus groups in community locations at various times of the day throughout the months of March and April 2016. A total of 12 focus groups were held with more than 300 total participants. A full list of organizations represented at the community focus groups can be found in Appendix C.

Participants at the focus groups were presented with background details on the social determinants of health and information from the 2015 Bridge to Health Survey. They were asked to share their feedback on these questions:

- *What makes you feel healthy in your neighborhood?*
- *What is working for health in Lake County?*
- *What is not working for health in Lake County?*

Participants were then asked to share what they believed were the top three biggest challenges to achieving health in Lake County by writing them on post-it notes. These topics were then placed on a wall within the room and grouped into common themes (e.g. obesity, mental health, access to dental care). Participants were then asked to prioritize using the dot-voting method based on these criteria:

- *What is most important to the community?*
- *What will have the greatest burden on the community if the problem is not addressed?*
- *What impacts certain subgroups/populations more than others?*

A focus group was held with staff members from Lake County Public Health and Human Services in order to ensure strong representation from those with knowledge or expertise of public health in our community.

A community focus group provided the opportunity for community members, business leaders, healthcare professionals, public health professionals, minority groups, teachers and community-based organizations to share their input on the overarching health needs of the community. Lake View compiled the feedback to discussion questions and the results of prioritization and reviewed to determine if the needs that emerged aligned with Lake View's mission. The needs were prioritized as follows:

1. Mental Health
2. Alcohol, tobacco and other drugs
3. Socio-economic disparities based on race and neighborhood
4. Obesity, including lack of access to healthy foods and physical inactivity

Each priority area has multiple aspects in which the hospital will work with community partners and stakeholders to address. By adopting a collective impact model to improve overall health and wellness in our community, not all issues will be directly addressed by the hospital, but through a multi-sector coalition-based approach.

While the following two themes were frequently discussed topics at the community focus groups, based on resources available and lack of expertise in the area, the needs that the hospital will not be addressing include:

1. Housing
2. Transportation

Lake View will work to bring visibility to these issues and share findings with local subject matter experts.

### PHASE 3: DESIGN OF STRATEGY AND IMPLEMENTATION PLAN

The hospital will work together to design an implementation strategy with internal stakeholders as well as external partners and stakeholders who represent the existing healthcare facilities and resources within the community that are available to respond to the health needs of the community as identified in this assessment. This implementation strategy will be reviewed and approved by Lake View's board of directors prior to April 15, 2017.

Lake View and St. Luke's continually review how the resources are best allocated to address the priorities identified in the Community Health Needs Assessment.

### CONCLUSION

As part of a nonprofit health system, Lake View is committed to improving the health of our community. This needs assessment and implementation plan illustrate the importance of collaboration between our hospital and our community partners. By working collaboratively, we can have a positive impact on the identified health needs of our community during each hospital's individual Fiscal Years 2017-2019. There are other ways in which the hospitals will indirectly address local health needs, including the provision of charity care, the support of Medicare and Medicaid programs, discounts to the uninsured and others.

Over the next three years, this collaboration will continue to work with the community to ensure that this implementation plan is relevant and effective and will make modifications as needed.

# APPENDIX A

**Lake View Hospital**

**Progress to Date on 2013 Community Health Needs Assessment**

**Community Health Needs Assessment Implementation Plan Progress Report**

## Priority 1: Obesity, physical activity, and nutrition

Lake View Hospital engaged in numerous initiatives to positively impact obesity, physical activity, and nutrition in Lake County.

- Lake View Hospital sponsored the 11th Annual Walking By Water wellness event in 2013. This event featured non-competitive walking routes of one, three, and five miles on the Two Harbors walking trail system to encourage lifelong physical activity for people of all ages. This event also included a 100-mile challenge during the summer months to promote physical activity and training for the event in September. Participants were asked to record their miles walked (or equivalent exercise) each month and they were entered into a drawing at the event if they achieved a total of 100 miles or more. Lake View also offered blood sugar and cholesterol screenings for Walking By Water wellness event participants. General education was provided on these two health topics.
- Lake View Hospital continues to participate in various health fairs across our communities. These include the Lake County Employee Health Fair, Cooperative Light & Power Health Fair, and the Stanley LaBounty Employee Health Fair. Blood sugar, cholesterol, and balance assessments are provided to participants free of charge by Lake View. A registered dietitian is available at these events to provide nutrition information and answer client questions. Lake View offered free fitness center memberships to Lake View Fitness Center as door prizes and silent auction items to various community fundraisers and community events in Two Harbors and Silver Bay. These events included the Two Harbors Youth Basketball Program golf fundraiser event, Community Partners annual dinner fundraiser and caregiver event, Silver Bay After-Prom event, and the Voyager Snowmobile Club. The goals of these donation programs were to financially support other community events and to promote general physical activity and wellness in our communities.
- Lake View Hospital leased a portion of its clinic property free of charge to the Two Harbors Youth Soccer Club in 2016 to promote increased physical activity and prevention of childhood obesity. This partnership will provide more opportunities for the children in our community to benefit from physical activity and exercise.
- Lake View's Physical Therapy and Fitness Center location in the William Kelley High School in Silver Bay continues to provide access to a variety of high-quality exercise equipment to the community, school students, athletes, staff, and coaching personnel. The staffing and supervision of the fitness center is covered by Lake View Hospital.
- Lake View offers free, one-time consultations with a physical therapist or exercise physiologist to set up independent exercise programs in the fitness center. This program is tailored to ensure that individuals are performing safe and appropriate exercise regimens to increase physical activity and prevent obesity. The focus of the consultation is to individualize a fitness program to help the client reach their personal goals, including improved fitness and/or weight loss.

- Lake View hosts free fitness classes. A strength and flexibility class, led by trained community volunteers, is held on Tuesdays and Thursdays. A yoga class, led by a Lake View physical therapist who focuses on flexibility and balance training, is held on Tuesdays. Lake View has offered these classes for the past 5 years.
- In 2013 – 2014 as a participant in a Community Transformation Grant (CTG) and a State-wide Health Improvement Program (SHIP) grant, Lake View Medical Clinic developed scripting and processes to capture patients' Body Mass Index measurements. Appropriate educational resources and referrals are provided as needed.
- Lake View contracts with AEOA to provide Meals on Wheels and Senior Dining programs to area seniors. Lake View's registered dietitian prepares the balanced meals that adhere to the USDA Dietary Guidelines.
- Lake View's registered dietitian participates in local health-related events and serves as a guest speaker on nutrition-related topics. Most recently, she spoke at the Aging Mastery Program (a program co-facilitated by Lake County Public Health and ISD 381 Community Education) and at the Mobile Resource Center in Finland, Minnesota.
- A registered dietitian in the hospital provides nutrition assessment and education/counseling to inpatients and their families and/or caregivers. Group nutrition classes are held on a regular basis in the cardiac rehab clinic to provide general information on a variety of pertinent nutrition topics, and individual consultation is also encouraged for those who could benefit from more in-depth nutrition therapy.
- Lake View contracts with the Lake County WIC program to provide nutrition education to targeted groups, with priority placed on clients who meet high-risk criteria including being overweight/obese.

**Priority 2: Smoking Cessation**

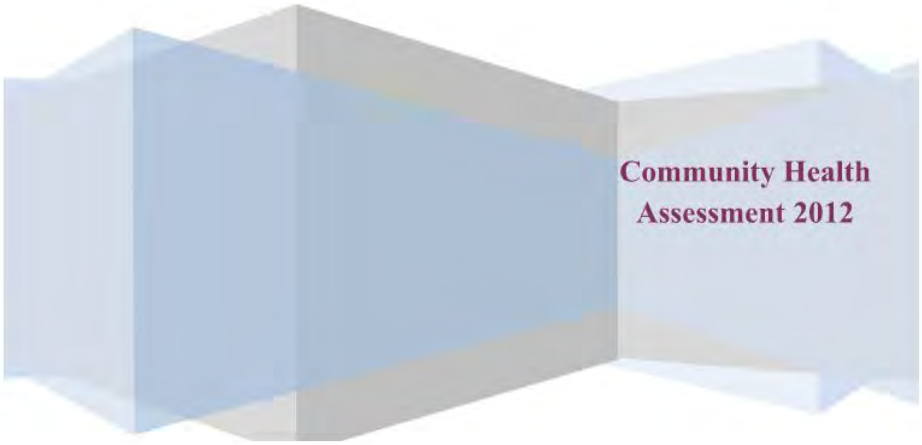
- Lake View Medical Clinic participated in a CTG/SHIP grant in 2013-2014 that assisted in the development of processes to provide smoking cessation resources through the Call It Quits FAX Referral Program. Referral letters and information were created and integrated into the eClinical Works electronic health record used in the clinic setting.
- Lake View Medical Clinic staff participated in area health fairs and provided smoking cessation materials.

# APPENDIX B

**2012 Carlton-Cook-Lake-St. Louis County**
**Community Health Improvement Plan**

Public Health
Prevent. Promote. Protect.

## Carlton-Cook-Lake-St. Louis Community Health Board (CCLStL CHB)



## Overview:

The Minnesota County-level Indicators for Community Health Assessment is a listing of indicators across multiple public health categories and from various data sources. This list of indicators has been gathered together to assist Minnesota's community health boards (CHB) in their community health assessment and community health improvement planning processes.

**Community Health Assessment is:**

1. Collecting, analyzing and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve the public's health; and
2. The systematic collection and analysis of data in order to provide a basis for decision making.

A thorough and valid Community Health Assessment is a customary practice and core function of public health, and also is a national standard for all public health departments. Since the passage of the Local Public Health Act in 1976, Minnesota CHBs have been required to engage in a community health improvement process, beginning with a Community Health Assessment. As part of Minnesota's Local Public Health Assessment and Planning process, every Minnesota CHB must submit its Ten Most Important Community Health Issues (based on the Community Health Assessment) to the Minnesota Department of Health (MDH) by **February 15, 2015.**

### Phase 1: Initial Planning Meetings

An initial planning committee comprised of Sue Erzar, AIK CHB, Jenny Peterson, Generations Healthcare Initiative, Julie Myhre, CCLStL CHB, Marie Margitan, MDH Nurse Consultant completed a cross walk between MDH Statewide Assessment and the MDH's basic set of indicators (compiled by Epidemiologists Kinney and Edelman) and assembled an initial set of data indicators.

The core planning committee continued to meet throughout the summer providing direction to a student intern who inputted data sets into an excel document.

In early September, a diverse set of stakeholders met to review the initial set of data indicators as well as suggest additional data sets:

Facilitators: Jenny Peterson, Marie Margitan, Julie Myhre and Annie Harala.

Attendees: Integrity Health; Barb Westberg, Essentia; JoAnn Hoag, St. Luke's; Mavis Breehm, Lake Superior Community Health Center; Amy Westbrook, MDH; Guy Peterson, St. Louis County; Michelle MacDonald, St. Louis County; Terri Allen, Carlton County; Michelle Backes-Fogelberg; Carol Berg, UCare.

Key Data Sources included:

- Bridge to Health (2000, 2005, 2010)
- Minnesota Student Survey (2004, 2007, 2010)
- Minnesota Department of Health Statistics
- Minnesota Department of Human Services
- Census

The Data Profile was organized into sections similar to the format used by the Minnesota Department of Health in its MN Statewide Health Assessment - 2012:

| | | |
|---|---|---|
| *People and Place | *Opportunity for Health | * Chronic Disease and Conditions |
| *Healthy Living | * Injuries and Violence | |

### Phase 2: Opinion Survey September – November 2012

Over 1,000 residents completed a convenience sample opinion survey either online link or by paper. Questions were taken from surveys developed by Ann Kinney, Epidemiologist at the Minnesota Department of Health. The purpose of the survey was to provide a snapshot of the community's perceptions and opinions regarding health issues which would not only engage additional people in the assessment process but also help inform the prioritization process. Data profile is available on the CHB's website at www.communityhealthboard.org under "Health Data" tab.

### Phase 3: Community Assessment Meetings - Fall 2012

Community meetings were held throughout the fall in locations across the four counties.
Facilitators for these meetings: Jenny Peterson, Marie Margitan and Julie Myhre

The guiding principles of the assessment process and community meeting were as follows:

- Data-driven from respected sources
- Input from diverse stakeholders participate
- Locally driven
- Assessment would meet requirements (public health, hospitals, etc.)
- Diverse view and opinions welcomed
- Serve as a catalyst for individual and collaborative efforts

The community assessment meetings all followed the same format:

A total of three rounds of initial prioritization occurred in the following areas:

* "People and Place" and "Healthy Living"
* "Opportunity for Health" and "Injuries and Violence"
* Chronic Disease and Conditions

Followed by small group discussion

Resulting in the small group identification of initial set of prioritized issues for each section

The group also reviewed results from each county's collated opinion surveys to help inform the prioritization process.

A final prioritization process occurred at the end of the meeting where participants were given a number of dots to vote with on their top priority health issues. They were asked to consider the following:

- What issue can we best impact?
- Is there energy around the issue?
- Will addressing the issue improve the health of all?

This final prioritization process provided a ranking of the health issues with their corresponding votes. By the end of the meeting, the top 10 health issues for each meeting were identified.

## County Based Meeting: Dates and Stakeholder Attendance

County based meetings were held across the four counties and included input from a broad and diverse stakeholder group including representatives from healthcare, social services, community agencies, education, public health, tribal reservations, faith communities, county advisory committee members, policy makers, etc.

## Phase 4: Health Priorities

Health Issues Refined

Presentation of Top 10 Health Issues to Community Health Board

### Obesity

There are increased rates of overweight and obesity among adults and children. Obesity leads to long term health issues (e.g. heart disease, diabetes, arthritis, etc.). In the CHB area, 49.5 % of the people are considered obese or overweight (BTH). The percentage of Cook and Lake 12$^{th}$ graders who are overweight almost doubled from 2007 to 2010 (MSS).

### Mental Health

There are increased rates of untreated or undiagnosed mental health issues (e.g. anxiety, depression, stress) being reported by both youth and adults. In 2010, 14% of ninth grade students had suicidal thoughts and 3% of ninth grade students attempted suicide (MSS). In the CHB area 17.4% of the people reported that they delayed seeking mental health care due to cost (BTH).

### Alcohol, Tobacco & Drug Use

There are high rates of alcohol, tobacco, and marijuana use in youth and high rates of binge drinking in adults and adolescents. In the previous 30 days, 44% of twelfth grade students in the CHB area used alcohol and 22% of St. Louis County adults use tobacco. In the CHB area 13.9% of the people are current smokers (MSS).

### Poverty

Poverty has a negative impact on health (e.g. poor diet, substance use, lack of access to health care, higher stress, lack of exercise, etc.) Single parent homes are at an even greater risk to live in poverty. In Northeastern Minnesota, people with income of ≤200% of poverty reported a higher incidence of obesity, depression, and food insecurity (BTH).

### Priority: Adolescent Sexual Activity

Sexual activity among teens continues to be a concern. According the MSS, there is an increasing number of youth engaged in sexual activity with decreased use of preventive methods. In the CHB area 59% of twelfth graders have had sexual intercourse. Among those sexually active, 40% do not use birth control (MSS).

### Access to Dental Care

There is limited access to dental care for low income adults and children, even if covered by a MN Health Care Program. In the CHB area 61.3% either delayed or did not receive dental care because it cost too much and 42.5% stated they delayed or did not receive dental care because they did not have insurance (BTH).

### Uninsured & Underinsured

Both adults and children reported that a lack of insurance or being underinsured was the reason they delayed seeking care when needed. There is also a lack of information related to the availability of health services and options for payment of those services. In the CHB area 8.1% of the people are currently uninsured (BTH).

### Lack of Preventive Services

Adults and children are not getting preventative screenings and immunizations. In the CHB area (2010) 29.9% adults have never had a colon screening and 13.3% have never had a cholesterol screening. In addition, 10.2% of women have never had a mammogram (BTH). Reported participation rates for complete child and teen checkups were in 2009- 72%, 2010- 73% and 2011- 70% (DHS).

### Lack of Physical Activity

Adults and adolescents are less active than recommended for optimal health. Higher participation levels of physical activity are needed to impact overall health. In 2010, 29.5% of the adults in the CHB area reported they participated in vigorous activity 3 or more times per week and 42.3% in moderate activity 5 days a week (BTH). In 2010, the percentages of adolescents who reported as physically active for at least 30 minutes on at least 5 of the last 7 days were $6^{th}$ - 47%, $9^{th}$ graders- 57% and $12^{th}$ graders- 46% (MSS).

### Food Insecurity

Increased rates for food assistance and support programs indicate food insecurity which results in a negative impact on overall health. Food insecurity limits access to healthy foods. In the CHB area 7.6% of BTH respondents reported they had used the food shelf. In addition, 39.3% of students were eligible for free or reduced lunch (MSS).

**In attendance:**

## Lake County – September 24, 2012

| | |
|---|---|
| Lakeview Memorial Hospital: | JoAnn Hoag |
| Lakeview Clinic Manager: | Brad Alm |
| Lake Superior Community Education Director: | Chris Langenbrunner |
| Lake County Medical Consultant: | Dr. Leppink |
| Lake County Commissioner | Dr. Tom Clifford |
| Lake County Human Services Director | Vickie Thompson |
| Lake County Public Health Supervisor | Michelle Backes-Fogelberg |
| Lake County Public Health Advisory Committee member: | Nancy Christenson |
| Two Harbors Area Partners Director: | Kristen Cruikshank |
| Lake County SHIP Coordinator: | Forrest Johnson |

## Cook County – October 22, 2012

Cook County North Sore Hospital and Care Center – Administrator: Kimber Wraalstad

| | |
|---|---|
| North Shore Hospital Board: | Tom Spence |
| Sawtooth Mountain Clinic: | Rita Plourde |
| Cook County PH & HS: | Sue Futterer, Joni Kristenson, Grace Buschard, Allison Heeren |
| Cook County PH & HS Advisory Committee: | Diane Pearson |
| Cook Co Rep on Community Health Board: | Diane Pearson |
| Cook County Community Center and Extension Service: | Diane Booth |
| Care Partners: | Kay Olson |
| North Shore Health Care Foundation: | Karl Hansen |
| Cook County Board of Commissioners: | Sue Hakes |

## St. Louis County – Northern Site (Mountain Iron) October 26, 2012

| | |
|---|---|
| Fairview Range Hospital | David Hohl |
| Northern St. Louis Family Services Collaborative: | Edie Carr |
| Salvation Army: | Debbie Stahl |
| AEOA Planning: | Lorrie Janatopulos |
| AEOA HeadStart: | Chuck Neil |
| Laurentian Clinic: | Todd Scaia |
| Virginia Medical Center: | Michelle Flemming |
| Ely Community Member: | Wendy Nelson |
| Ely Community Resource Agency: | Julie Hingel |
| School Nurse: | Wendy Newcomb |
| St. Louis County Public Health: | Guy Peterson |
| St. Louis Co. PH & HS Advisory Committee Member: | Tony Cuso |
| Cook Hospital: | Mike Holmes |
| St. Luke's | Todd Scaia |
| Essentia Health-Northern Pines: | Cindy Loe |
| Essentia Health – Virginia: | Dan Milbridge |

### Carlton County – November 5, 2012

| | |
|---|---|
| Community Memorial Hospital: | Rick Bruer and Nancy Taggert |
| Mercy Hospital: | Jason Douglas |
| Carlton County PH & HS: | Dave Lee, Terri Allen, Pam Brumfeldt, Joanne Erspamer, Meghann Condit |
| Carlton Co. Children & Family Services Collaborative: | Donna Lekander |
| Veteran's Services Director: | Duane Brownie |
| Public Health Advisory Committee: | Loren Bergstedt |
| PH Advis Committee and CHB Board: | Barb Little |
| Carlton County Volunteeer Services | Jill Hatfield |
| Villa Vista Nursing Home & Moose Lake School Board: | Julie Peterson |
| Carlton County Human Services Advisory Board: | Jerry Pederson |
| Sunnyside Nursing Home: | Wendy Lonetto |
| Fond du Lac College: | Mary Monsen |
| Residents from Cromwell: | Liz Thom |
| Fond du Lac Reservation: | Nate Sandman |
| U of M Extension Nutrition Program: | Janet Adkins |

### St. Louis County – Southern Site (Duluth) – November 7, 2012

| | |
|---|---|
| Lake Superior College - Nursing Program: | |
| Arrowhead Parish Nurse Association: | Pam Franklin |
| Essentia: | Dr. Tim Zager and Dr. Nancy Beery |
| Essentia: | Barb Westberg |
| American Lung Association: | Jill Rogers |
| Integrity Health: | Bruce Penner |
| Lake Superior Healthcare Center: | Mavis Beehm, Dr. Jacob Prunuske |
| Area Agency on Aging: | Catherine Sampson |
| Community Action Duluth: | Angie Miller |
| Institute for Sustainable Futures: | Jamie Harvie |
| St. Luke's Hospital: | Dr. Mary Boylan |
| CHUM Agency: | Shari Flesness |
| LISC Director: | Pam Kramer |
| Gloria Dei Lutheran Church: | Patti Maguire |
| United Way: | Emily Way |
| UMD Medical School: | Dr. Jacob Prunuske |
| Ely Bloomenson Hospital: | Nancy Andrea |

### Phase 5: Next Steps

- Complete an environmental scan identifying current activities, community partners and gaps in services.
- Develop a Community Improvement Plan to address the top prioritized health issue.

The CHB will develop a collective four County Community Health Improvement Plan to address the top health issues.

# APPENDIX C

## Community Organizations Represented in Focus Groups

### Community Organizations Represented at August 2016 Focus Groups*

| Organization Name | Area of Focus | Organization Name | Area of Focus |
|---|---|---|---|
| Lake View Hospital and Clinic | Health care | St. Luke's Hospital | Health care |
| Lake County Public Health | Public Health | Community Partners | Senior Care |
| Lake Superior School District | Education | City of Two Harbors | Government |
| Human Development Center | Behavioral Health | | |
| | | | |
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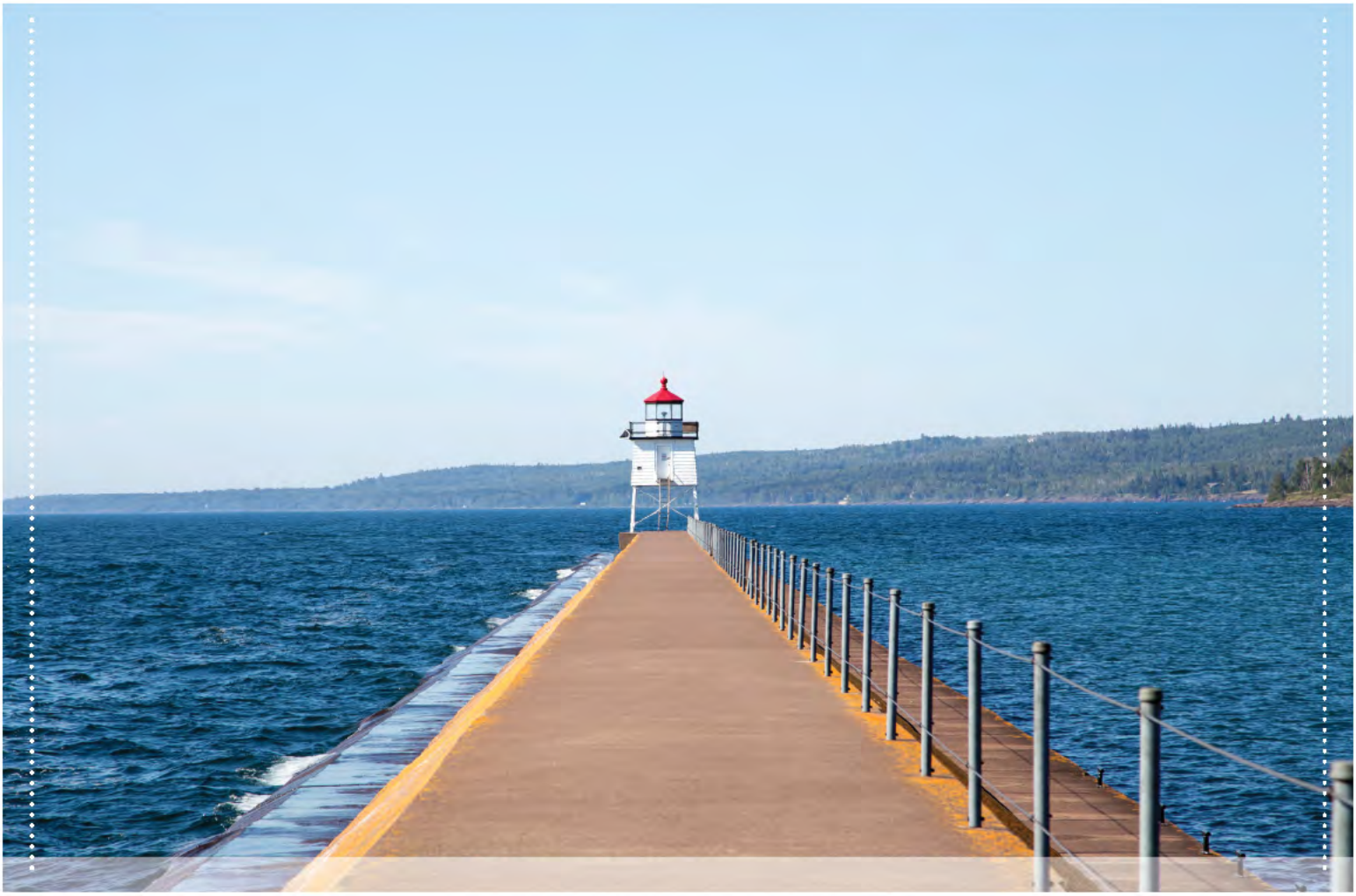
***Full rosters with names available upon request.**

Additionally, community residents attended the majority of the focus groups, providing representation and input from the community at large.



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