Cook County

COMMUNITY HEALTH ASSESSMENT AND IMPROVEMENT PLAN

2017-2022

Public Health and Human Services

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Executive Summary

This Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) represent a long-term effort to bring together partnering agencies and individuals who are dedicated to understanding and improving the health of the people who live, work, and play in Cook County. Together we prioritized a set of shared community health goals to work toward. Cook County's Public Health and Human Services Department (PHHS) facilitated this process with the vision of fostering continued collaboration and creating a means by which to focus our collective efforts on creating a more vibrant, healthy community.

The process included a series of eight community meetings held between 10/2017 and 4/2019. Participants reviewed a comprehensive set of health indicators for the county, prioritized health areas in need of attention, reviewed the results of a local community health survey, thought critically about those people most affected by each priority health area, created goals to work toward, analyzed dynamics affecting each goal, brainstormed who is already working toward these goals in the community, and finally, drafted and prioritized strategies that correspond with each goal.

Here are the priority health areas and corresponding goals the group created:

Priority Health Area	Goal
Behavioral Health	People Can Access Behavioral Health Services When They Need Them
	People Who Have Experienced Substance Abuse Have Support to Move Toward Recovery
Healthy Living Access	All Community Members Have Safe and Stable Housing
	Community Members of all Ages and Abilities Can Access Specialty Services
	Elders Experience Support to Age in Our Community
	Families with Young Children Experience Community Support

The CHIP takes these goals and links them to specific objectives, strategies, and activities that will guide our work over the next several years. The group of community partners will reconvene every six months to review progress toward these goals—making any modifications necessary to keep our vision on track and to keep us accountable to ourselves and to the public.

We invite your feedback and your participation in this process.

Acknowledgements

We thank the individuals and agencies that participated in this process for offering their voices and perspectives in the interest of creating a well-informed roadmap to improving our community's health.

Alison McIntyre	Cook County Public Health and Human Services
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Bev Green	Cook County Senior Center
Carla LaPointe	Cook County PHHS Advisory Committee
Cecelia Bloomquist	Human Development Center
Dave Mills	Cook County Commissioner
Diane Booth	Cook County Community Center
Eddie Hertzberg	Cook County PHHS Advisory Committee
Frank Ceo	Cook County PHHS Advisory Committee
Frankie Jarchow	Cook County PHHS Advisory Committee
Ginny Storlie	Cook County Commissioner
Grace Bushard	Cook County Public Health and Human Services
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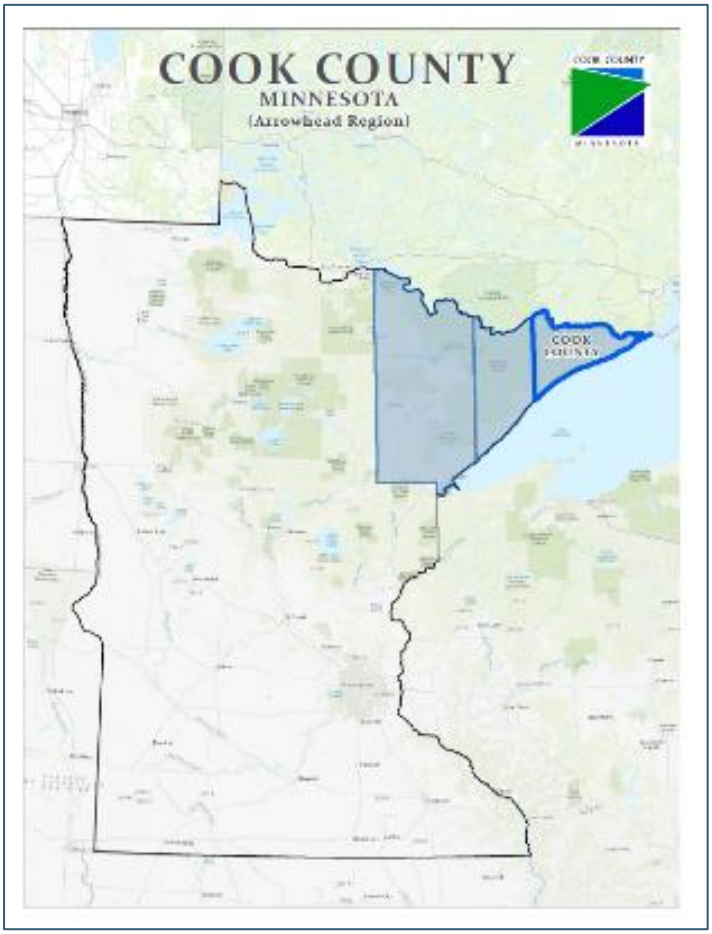
Jan Sivertson	Cook County Commissioner
Janelle Lambert	Minnesota Department of Health
Jay Arrowsmith DeCoux	Mayor, City of Grand Marais
Jeff Caldwell	Cook County Administrator
Jerry Lilja	Cook County PHHS Advisory Board/North Shore Health Care Foundation
Jodi Yuhasey	Violence Prevention Center
Joni Kristenson	Cook County Public Health and Human Services
Karl Hansen	North Shore Health Care Foundation
Kate Surbaugh	Sawtooth Mountain Clinic
Kay Grindland	Care Partners
Kimber Wraalstad	North Shore Health
Louise Anderson	Cook-Lake-Carlton-St. Louis Community Health Board
Mary Curry	Cook County YMCA
Mike Roth	City of Grand Marais Administrator
Pat Campanaro	Cook County PHHS Advisory Committee, Small Business Development Center
Patrick Knight	City of Grand Marais Communications Director
Paula Schaefbauer	Acting Programs Administrator: Grand Portage Reservation and Director of Grand Portage Health Services
Rachel Liechty	Independent School District 166
Rita Plourde	Sawtooth Mountain Clinic
Roger Linehan	Cook County PHHS Advisory Committee
Sadie Sigford	Independent Community Midwife (LM, CPM)
Tim Nelson	Cook County Land Services
Wendy Hansen	Cook County PHHS Advisory Committee

Description of Cook County



Geography

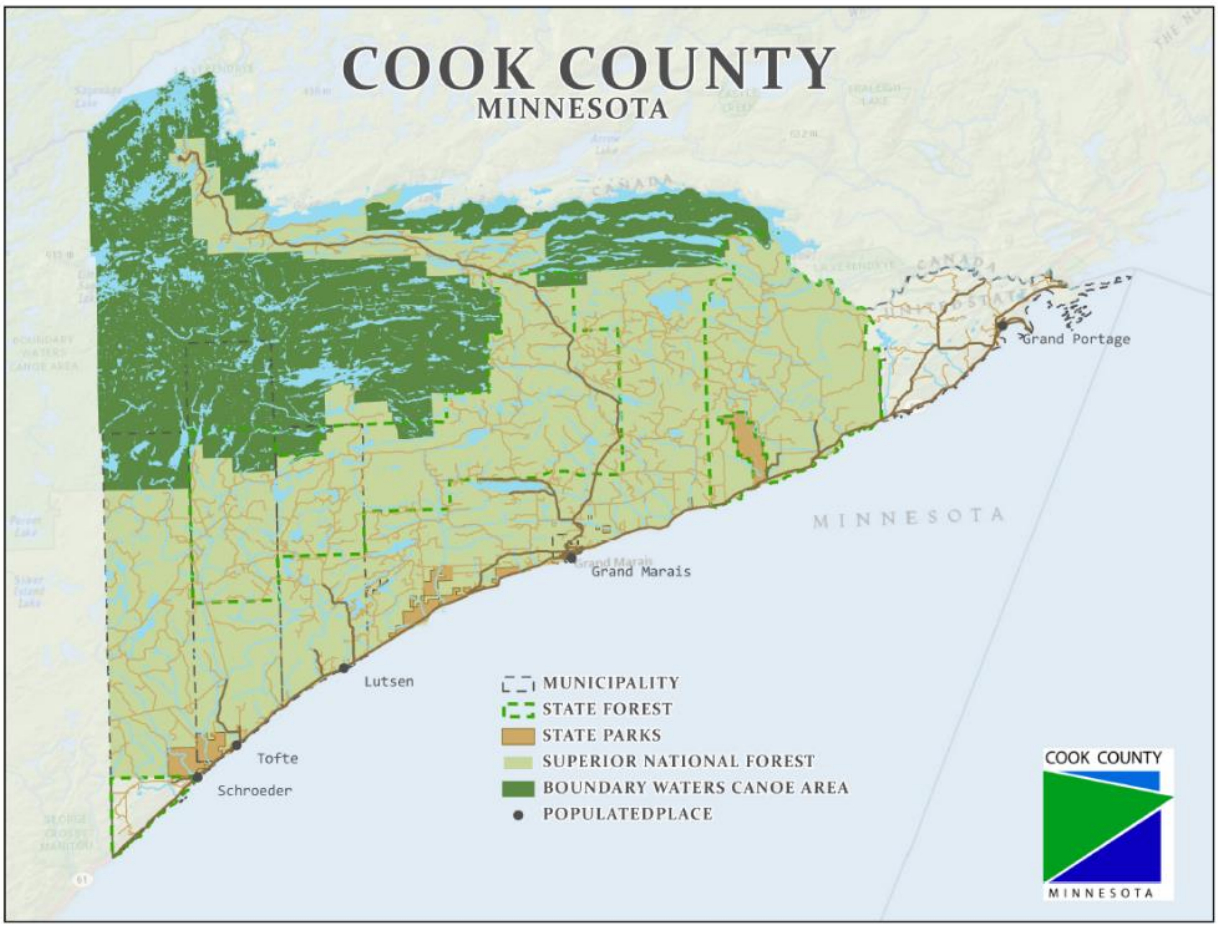
Cook County is the northeastern tip of the state of Minnesota and part of its Arrowhead region. The county borders Ontario, Canada to the north; Lake County, Minnesota to the west; and Lake Superior to the south and east. The county has a total area of 1,452 square miles, making it the twelfth largest county in Minnesota by total area[1]. Much of this land (70%) is federally owned and the majority is within the Superior National Forest (including the Boundary Waters Canoe Area Wilderness). 56% of this land (1887 square miles) is covered by water, including 812 lakes, and three major river systems (Poplar, Brule, and Pigeon Rivers) that flow into Lake Superior[2].

Population and Economy

According to 2018 U.S. Census estimates, Cook County has a population of 5,393, making it the sixth least populous county in the state of Minnesota[3]. This creates a population density of 3.6 people per square mile[4]. The county seat and only city in Cook County is Grand Marais, with a population of 1,351. The County includes three townships (Lutsen, pop. 415; Schroeder, pop. 205; and Tofte, pop. 249), three unorganized territories, and Grand Portage Reservation (pop. 565). The Minnesota State Demographic Center estimates that the County's population will increase by 5% between 2015 and 2045[5].

As a year-round tourist destination, the number of people in Cook County on any given day fluctuates, reaching up to an estimated 75,000 during the height of tourist season[6]. Cook County's economy is highly dependent on tourism, with over 40% of jobs in the county in the Leisure and Hospitality industry[7]. The median household income in Cook County is $51,903 (compared to Minnesota's average household income of $68,388), and 13% of Cook County residents live below the poverty line (compared to 9.5% of all Minnesota's residents)[8].

The racial and ethnic breakdown of Cook County residents is 85.4% White, 1.1% Black/African American, 8.3% American Indian/Alaska Native, 2.7% two or more races, and 2.5% Hispanic/Latino[9]. In terms of age, 15.9% of Cook County residents are under the age of 17, 56.7% are 18-64 years old, and 27.4% are 65 and older[10].



Community Assets and Resources

In terms of health services, within Cook County, there is one hospital (North Shore Health), two clinics (Grand Portage Health Services and Sawtooth Mountain Clinic), one dental practice (Grand Marais Family Dentistry), three acupuncturists, three chiropractors, one Licensed Alcohol and Drug Counselor (Wilderness Outpatient), one Certified Professional Midwife, one pharmacy (Grand Marais Pharmacy). Mental health professionals work through Accend Services, through the County Public Health and Human Services Department, within Sawtooth Mountain Clinic, Grand Portage Human Services and in private practice. Cook County Public Health and Human Services also offers a variety of social support programming, assistance enrolling in public benefits, and leadership in the six key areas of public health per state statute[1]. North Shore Health also

[1] Minn. State Statute. 145.A.04, 1) Assure and adequate public health infrastructure, 2) Promote healthy communities and healthy behavior, 3) Prevent the spread of communicable diseases, 4) Protect against environmental health hazards, 5) Prepare and respond to emergencies, and 6) Assure health services.

provides ambulance, home care, long-term care, and emergency room services. The county is also home to various nonprofit agencies[2] that work to improve health and well-being within the community. These include:

- AEOA: is a regional non-profit Community Action Program (CAP) that provides employment and training services in Cook County. AEOA also provides housing case management services, senior services including Meals on Wheels and transit services through Dial-a-Ride and the Volunteer Driver Program.
- Care Partners: Supports the Cook County community to navigate aging, chronic illness, and end-of-life
- The Hub: Serves as a gathering space for seniors and their families, offering a variety of programs and services
- The North Shore Healthcare Foundation is a private, non-profit grantmaking organization that supports local health care organizations in Cook County
- Oral Health Taskforce: Provides dental education and sliding scale dental services from the prenatal period to age 26.
- The Violence Prevention Center: Serves those affected by domestic and sexual violence in Cook County, helps people build healthy relationships, works toward a community without violence
- The YMCA offers fitness facilities, child care, educational programs for community members

Other assets that support community well-being include a vibrant local arts community and numerous opportunities for outdoor recreation and wilderness exploration in the area.

In the first community meeting, participants answered the question "What makes you proudest of your community?" voicing a variety of responses that point to the intangible human assets present in the Cook County Community. Responses included:

- People care about each other
- Breadth of talents and willingness to pitch in for the community
- Partnerships—we work together and help each other
- Independent, creative people
- Coming together for solutions
- Willingness to fix what isn't working

[2] Sawtooth Mountain Clinic, our community Federally Qualified Health Center, is a non-profit as well

Defining the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP)

Local health departments and/or Community Health Boards are responsible under state statue (Minn. Stat. Ch.145A) to assess the health of their communities, and to create a plan to improve the health of the population living within their jurisdictions. Each of these processes occurs on a five-year cycle. A **Community Health Assessment (CHA)** refers to the process of systematically collecting and analyzing health-related data, as well as defining the priority health areas in a community. A **Community Health Improvement Plan (CHIP)** guides a health department and its partners to improve population health in accordance with the priorities defined in the CHA. A CHIP includes community-wide health goals, measurable objectives, and activities to achieve them. It also uses health indicators (regularly collected health-related datapoints) to gauge the progress a community is making toward achieving its self-defined goals.

Local jurisdictions aren't the only bodies to use the CHA and CHIP processes to improve population health. Similar processes occur at both a state and national level. As a state, Minnesota completed its last CHA in 2017, using it for the foundation for Healthy Minnesota 2022: Statewide Health Improvement Framework. Healthy Minnesota organizes its three core priorities around the vision that all people in Minnesota enjoy healthy lives and healthy communities.

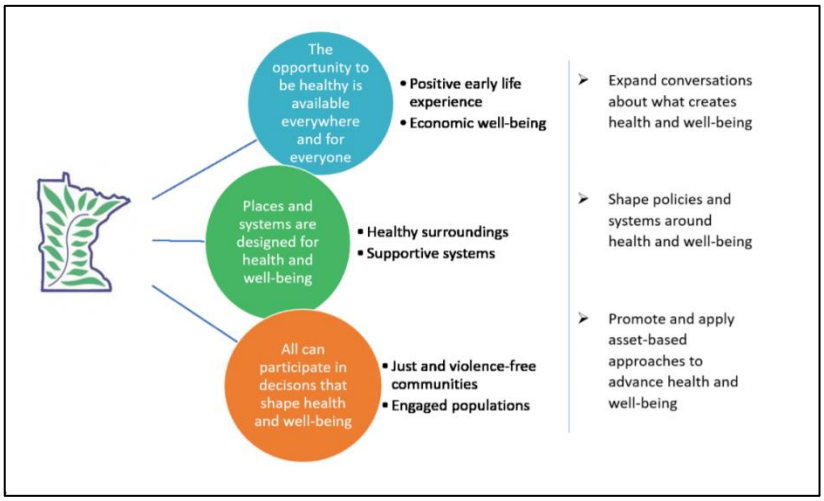


Figure 1: Priorities, Key Conditions, and Strategic Activities from Healthy Minnesota 2022

Nationally, the Office of Disease Prevention and Health Promotion (ODPHP) has an analogous resource, titled Healthy People 2020, with its own set of goals and objectives for improving the heatlh of all Americans.

At times, data and goals from Cook County will be placed aside state or national data, to show where synergies exist within multiple levels of government working toward a similar vision.

Methods Used

The process of creating a CHA and CHIP within Cook County used tools from two different approaches:

1) Mobilizing for Action through Planning and Partnerships (MAPP): A six-stage process that includes developing partnerships, visioning, collecting/analyzing data, identifying strategic issues, forming goals/strategies, and moving toward action

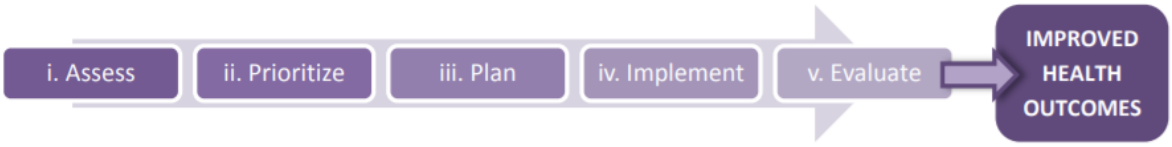
2) The Results-Based Accountability Approach (RBA): Starts with the desired results a group wishes to achieve and works backward to figure out how to proceed. It describes itself as action-oriented, common sense, and data-driven

Local Community Engagement Process

Cook County Public Health and Human Services worked with a diverse group of community partners throughout the process of developing the CHA and CHIP. Participants represented local nonprofits, a local foundation, the school district, Sawtooth Mountain Clinic, North Shore Health, Grand Portage Health and Human Services, as well as city and county employees and officials. Over 30 community members attended at least one meeting, with many attending all eight community meetings that occurred between 2017 and 2018. The number of participants grew organically over time, by posing the question at meetings, "who else should be at the table?" and then inviting those not present to become part of the process.

Because the CHA and CHIP are inherently collaborative, living documents to guide future work in our community, cultivating strong participation from many people with many different perspectives is of foundational importance.

The meetings community members attended are represented by the following diagram:



Here is a chronological breakdown of activities during community meetings in Cook County:

1) Describing the vision of a healthy community
2) Reviewing local health data
3) Prioritizing priority health areas for the community
4) Distributing and analyzing results from a community health survey in Cook County
5) Exploring health inequities within Cook County
6) Creating problem statements and goals to work toward
7) Defining indicators to attach to each goal
8) Exploring the stories behind health issues in the community, and partners already working in these areas
9) Brainstorming and prioritizing solutions and strategies for change

Looking at the data

In assessing the health of our Cook County community, the stakeholder group considered key heath indicators from a variety of sources (including the Minnesota Student Survey[3], the Bridge to Health Survey, and US Census Data—accessed primarily through Minnesota Compass). Additionally, we surveyed adults throughout the county to better understand how the people who live and work here experience health in their daily lives.

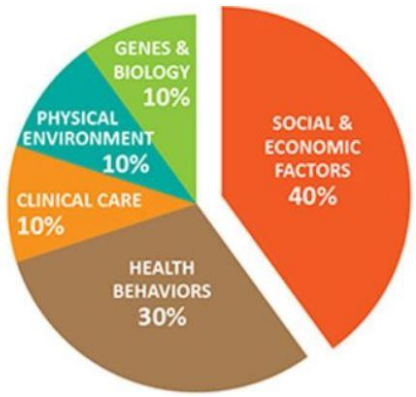


Figure 2: What creates health?
(Image from Grantmakers in Health, 2017)

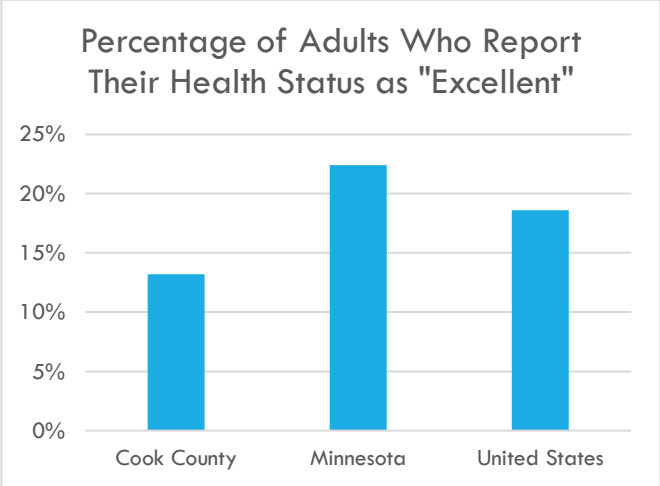
While most of the data we report is based on traditional measures of health, the county also recognizes that the conditions in which Cook County residents are born, live, work, and age have a large and measurable effect on an individual's health.

Whenever possible, we have illustrated the inequities in health that exist in our county. However, it was not always possible to find data that links individual measures of health to a respondent's race/ethnicity, household income, or other variables that could help illustrate a more nuanced picture of health. We also compare county-specific outcomes to regional, state, and national outcomes as the data allows.

Health in Cook County

Self-reported health status

Overall, 13.2% of Cook County residents report their health as excellent. Looking more deeply, only 8.5% Cook County adults living under 200% of the federal poverty line (FPL) self-report that they are in excellent health, while 14.8% those living above 200% FPL report excellent health[11].

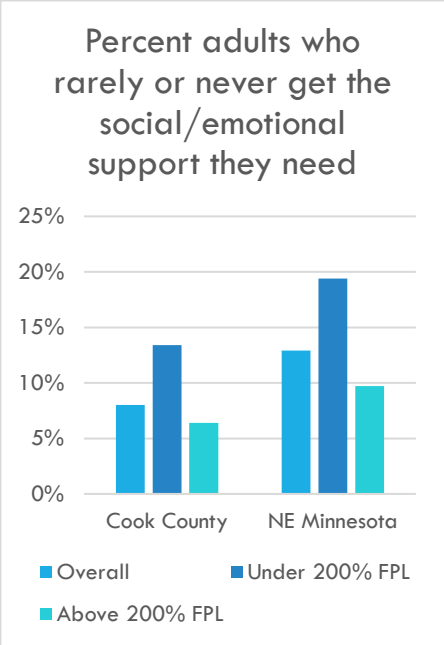


Mental Health

In Cook County, the ratio of mental health providers to residents (1:1,080) is significantly lower than it is for the State of Minnesota (1:430)[12].

[3] Minnesota Student Survey data is an invaluable resource to community, however, due to the small population of our community the number of students in a grade is very small (in this survey, 29 8th grade students, 38 9th grade students, and 27 11th grade students reported). Given the small sample size, each answer has a strong and measurable effect on the overall survey results.

Adults[13]



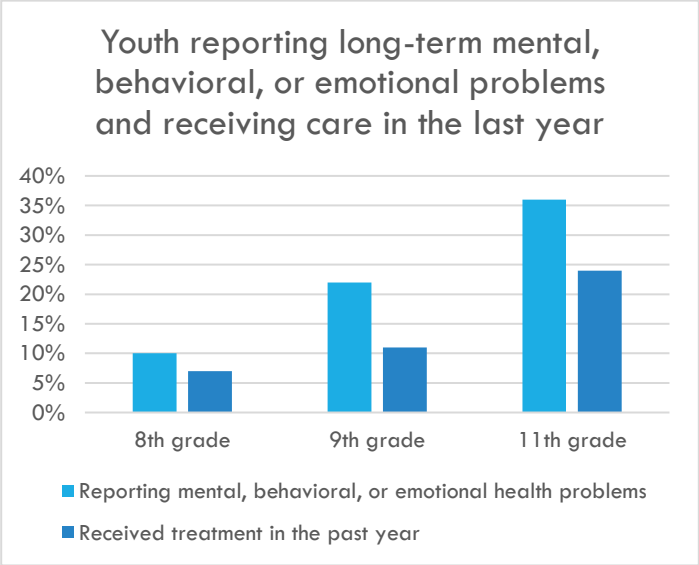
11.5% of men and 4.4% of women living in Cook County report rarely/never getting the social and emotional support that they need. The overall percent (including both males and female adults) of people who report rarely/never getting the social and emotional support that they need (8%) also varies between those living under 200% FPL (13.4%) and those living above 200% FPL (6.4%).

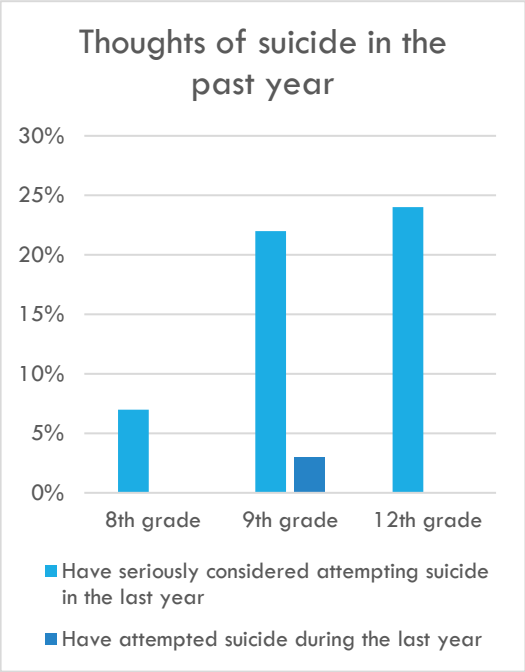
Nearly one in four adults in Cook County (24%) has been formally diagnosed with depression, 22% have been diagnosed with anxiety or panic attacks, and 9% report a diagnosis of other mental health problems.

Cook County adults living in poverty (under 200% FPL) are more likely to report stress, depression, or emotional difficulties for two weeks or more in the past month than adults who are not living in poverty (14% vs 10%). Those living in poverty are also more likely to delay seeking mental health care than those who are not living in poverty (19% vs 10%).

Youth[14]

Among Cook County students, over the past 2 weeks, 18% of 8th grade students, 48% of 9th grade students, and 46% of 11th grade students report feeling down, depressed or hopeless for several days or more.





10% of 8th grade, 22% of 9th grade, and 36% of 11th grade students report having long-term mental health, behavioral, or emotional problems (defined as lasting six months or more), yet only 7% of 8th grade, 11% of 9th grade, and 24% of 11th grade students have been treated for these problems over the past year.

In the past year 7% of 8th grade, 22% of 9th grade, and 24% of 11th grade students report seriously considering attempting suicide.

Alcohol, Tobacco, and Other Drug Use

Adults[15]

21.6% of Cook County adults are current commercial tobacco smokers, compared to 18.8% of the adult population across Northeastern Minnesota and 17.6% of adults nationally. Of Cook County adults who smoke, 51.2% attempted to quit within the last year. Within Cook County, subgroups of the population that smoke tobacco at the highest rate are adults aged 18-34 (57.3%) and those living under 200% FPL (34.5%).

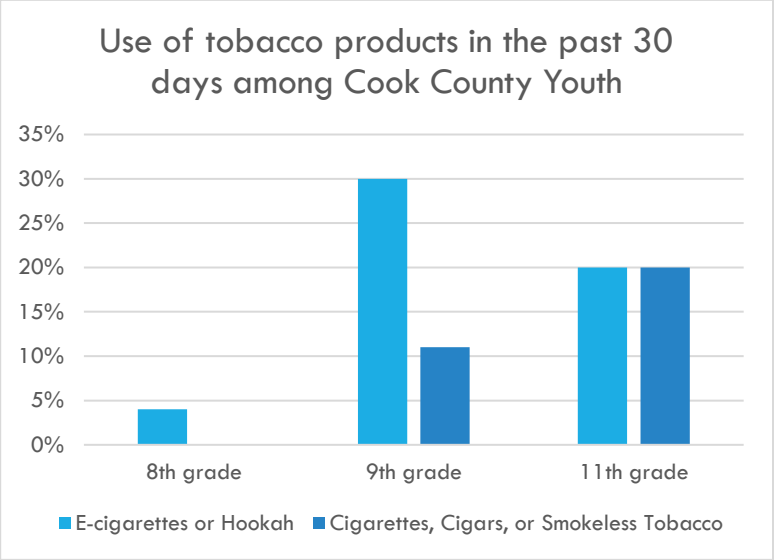
Within Cook County, 25.1% of the adult population report binge drinking in the past month (defined as 5+ drinks on one occasion for men, and 4+ drinks on one occasion for women). This is slightly lower than the binge drinking rate for Northeastern Minnesota (32.3%), but higher than the state and national rates (21.0% and 16.8% respectively). Within Cook County rates of binge drinking are highest among the 18-34 year (50.3%) and 35-44 year (35.8%) age groups.

In 2017, 57 people from Cook County were admitted to a Minnesota Treatment Facility for substance abuse/addiction. Of these admissions, 43.9% were admitted for alcohol use, 35.1% were admitted for methamphetamine use, and 10.5% were admitted for opioid use Of those referred to a Treatment Facility, 17 were referred by their family, self, or friends; 14 were referred by the criminal justice system, and 8 were referred by a health professional. Please note that this data has some gaps because if less than 5 people are represented by a substance or referral source, the data is suppressed for confidentiality.[16]

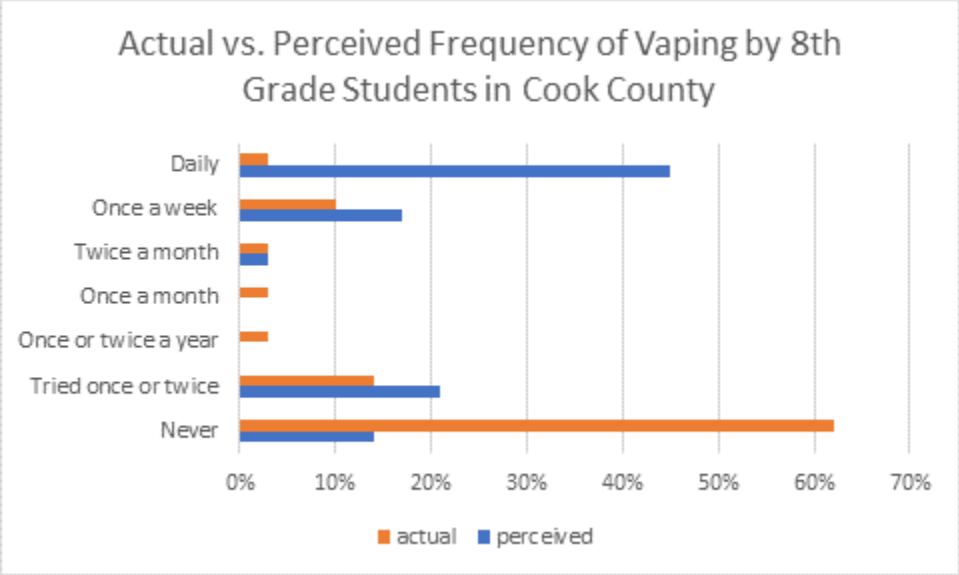
Youth[17]

In the past 30 days, 4% of 8th grade students, 30% of 9th grade students, and 20% of 12th grade students used e-cigarettes or hookah to consume tobacco. This is equal to or higher than the percentage of youth in those grades consuming cigarettes, cigars, or smokeless tobacco (0%, 11%, and 20% for 8th, 9th, and 11th grade students, respectively.

Among Cook County youth, 0% of 8th grade students, 11% of 11th grade students, and 36% of 12th grade students report binge drinking at least one day in the past month (defined as 5+ drinks on one occasion).



Middle and high school students in Cook County perceive a greater rate and frequency of substance use among their peers than the data shows is occurring. Below is one example that illustrates this phenomenon, related to the actual and perceived frequency of vaping among 8th grade students in Cook County.



Household Economics

Food Security

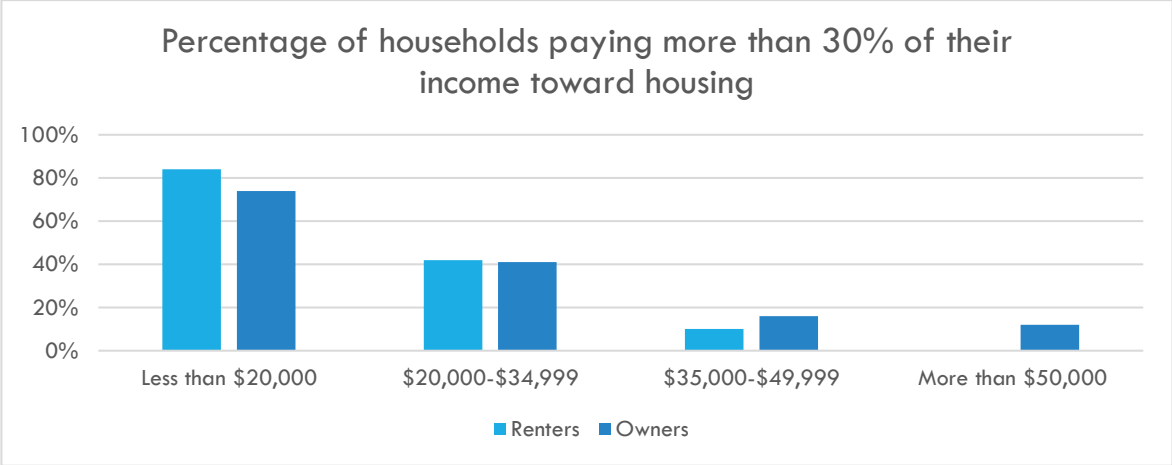
14.9% of Cook County residents reported that within the last 12 months they often or sometimes worried that food would run out before they had money to buy more. This rate was over double (36.2%) for residents living under 200% FPL[18].

Childhood and Parenting[19]

88.5% of children under the age of six who live in Cook County have both parents working; The average cost to have two children in full-time childcare is estimated to be $884/month.

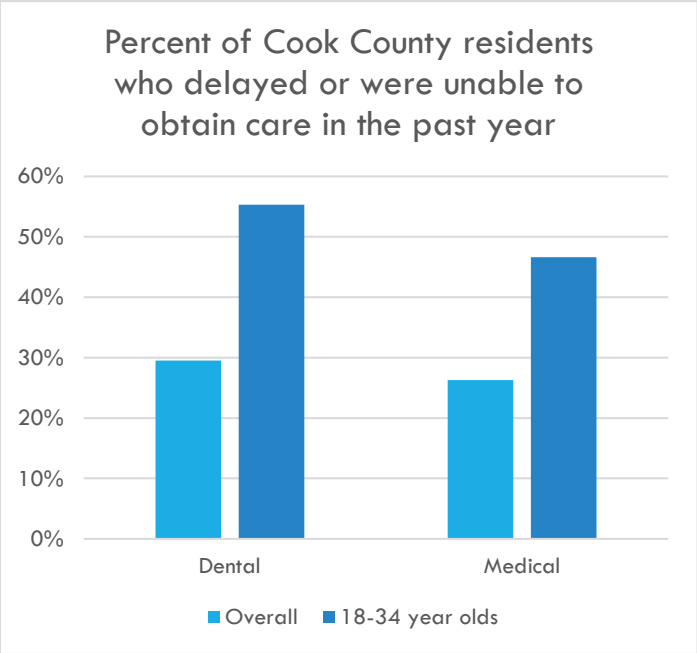
Housing[20]

There are approximately 2,627 households in Cook County. Of these, 588 are cost-burdened (paying more than 30% of their income toward housing)—including 139 senior households. As shown in the graph below, the percentage of cost-burdened household varies widely by household income.



Access to Healthcare[21]

Overall, 95.9% of Cook County residents have some type of health insurance. This is about the same as the rate of coverage throughout Northeastern Minnesota (96.1%), and significantly higher than the rate of insured people at both a state (92.1%) and national (85.6%) level.

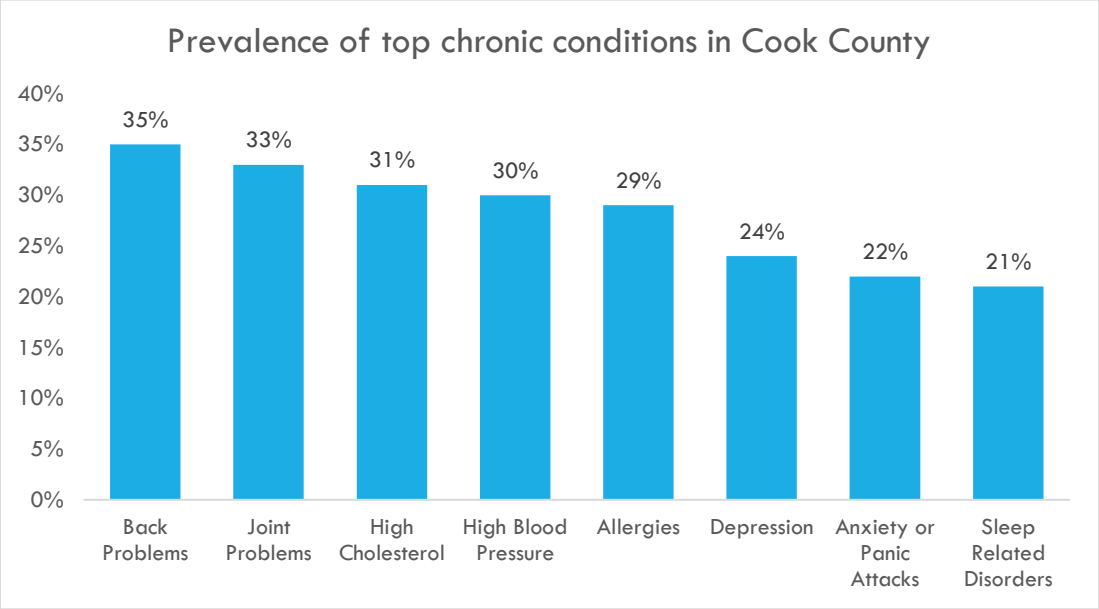


Despite relatively high rates of insurance coverage, a significant percentage of Cook County residents report being unable to obtain or having delayed medical (26.3%) or dental (29.5%) care in the past year. This percentage is highest among young adults, ages 18-34 (46.6% for medical and 55.3% for dental).

The top three reasons respondents gave when asked why they failed/delayed seeking care were: Didn't think it was serious enough (53%), high insurance deductible (33%), and cost of care (18%).

Chronic Disease

The most prevalent chronic conditions experienced by Cook County residents are as follows:

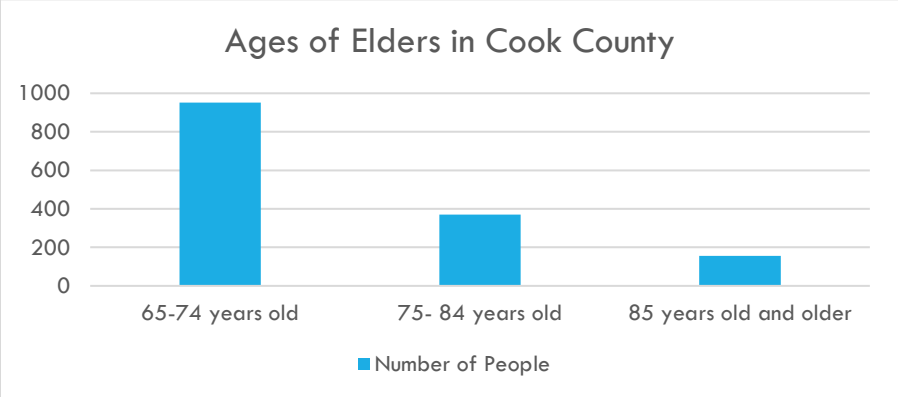


Diabetes

10% of adults in Cook County have been diagnosed with prediabetes, and 7% have been diagnosed with diabetes.

Aging

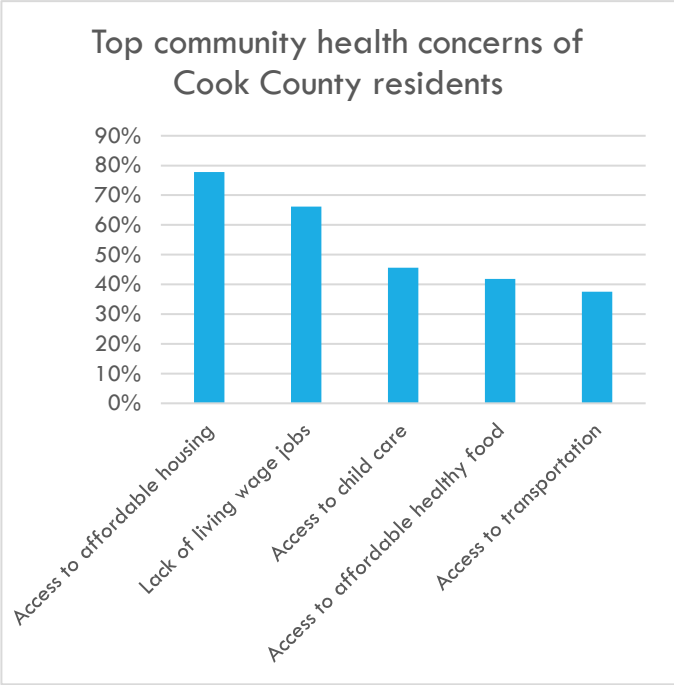
Cook County's elderly population (defined as people over the age of 65 is significantly higher as a percentage of the overall population, as compared to Minnesota overall. According to 2017 census estimates, 15.9% of Minnesota residents are over the age of 65 (compared to 27.4% in Cook County). By 2030, the percentage of Minnesota residents over the age of 65 is projected to be 21.10% (compared to 39.9% in Cook County).[22] Within Cook County, most people over 65 are concentrated in the 65-74 age range.



Primary Data: 2017 Cook County Community Survey

In 2017 Cook County Public Health and Human Services distributed a survey to residents with the goal of gaining additional insight into the ways in which residents view and prioritize health needs in the community. We received 145 responses.

Of these responses the following were the top five issues rated as "serious problems" in the community: Access to affordable housing, lack of living wage jobs, access to child care, access to affordable healthy food, and access to transportation.



Respondents also had the chance to reflect on those aspects of the community that help to create health and wellness for individuals and families. Common responses included nature/connection to the outdoors, community programming through local agencies, having a local clinic and hospital, and a sense of social connectedness.

Prioritizing Health Areas of Heath in Need of Improvement

Priority Health Areas

The community stakeholder group reviewed key health indicators from regional, state, and national datasets as well as from the Cook County Community Health Survey in its initial meetings. Subsequent meetings focused on discussion of how to create top health priority areas to improve throughout the county. These priority areas were set through a combination of what stakeholders perceived to be most important, and the data itself.

For the 2019-2024 Community Health Improvement Planning Cycle, Cook County's priority health areas are:

1) Behavioral Health
2) Healthy Living Access

Lenses that Guide our Work

In addition to these priority health areas, the community stakeholder decided to use a health equity as a lens through which to consider the goals, objectives, strategies, and activities the community undertakes to improve the health of its population. Practically, using health equity as a lens means asking questions such as:

- Who in our community suffers disproportionately?
- What causes disproportionate rates of illness and disease in certain segments of our population?
- How do the conditions in which community members are born, live, work, and age affect one's health?

The community stakeholder group also added prevention as a lens, indicating its commitment to continue to work upstream to prevent adverse health events and conditions before they occur.

Problem Statements and Goals

After forming priority health areas for the county, the community stakeholder group created a series of problem statements that embody core issues within each area. These problem statements were then re-worded to form six key goals:

1) People Can Access Behavioral Health Services When They Need Them
2) People Who Have Experienced Substance Abuse Have Support to Move Toward Recovery
3) All Community Members Have Safe and Stable Housing
4) Community Members of all Ages and Abilities Can Access Specialty Services
5) Elders Experience Support to Age in Our Community
6) Families with Young Children Experience Community Support

Based on these goals, the community stakeholder discussed a series of questions to move the process toward creating objectives, strategies, and activities for the CHIP. These questions were:

- How could we measure progress toward our goals?
- What is the story behind each of these goals?
- Who should be involved in helping the community reach these goals?
- What solutions might move us toward our goals?
- Which solutions should the community pursue and how?

Goals, Objectives, Strategies, and Activities

Goal 1: People Can Access Behavioral Health Services When They Need Them

While struggles with mental health are common, a combination of stigma surrounding mental illness and a limited number of local mental health providers can lead community members to face

challenges to seeking professional support services. Complex and fragmented mechanisms to fund mental health services cause gaps in the spectrum of mental health care available in our area.

The local goal of increasing access to services is in line with the national Healthy People 2020 goal to "improve mental health through prevention and by ensuring access to appropriate, quality mental health services."[23]. Healthy Minnesota names "supportive systems" as a key condition for health. In terms of behavioral health access, this condition would include for transportation systems to access care, and health care systems in which people feel a sense of safety, belonging, and can afford, "the right care at the right time, in a convenient location, with a caring provider and a positive outcome."[24]

Objective: The percentage of Cook County adults who report that they rarely or never get the social and emotional support they need will drop from 8%[25] to 5%

Strategies	Activities	Partners	Timeline
Adding behavioral health providers and support staff within the community	Add community skills workers for both adults and children	PHHS, Accend Services	Within PHHS, Community Support provider began in 7/2019
	Pursue ARMHS certification within PHHS	PHHS	Ongoing
Improving local crisis response efforts	Add locally based crisis responders	HDC, PHHS	Ongoing
	Improve information sharing and debriefing after incidents	HDC, PHHS, Law Enforcement, ER Staff, GP Human Services, VPC	Ongoing
	Learn about daytime crisis response options/obligations	MN DHS, PHHS, HDC	Summer 2019
	Increasing outreach for crisis response through the "Let's Talk" Campaign	Birch Grove, PHHS, ISD #166, North Shore Health, HDC	Ongoing
Increasing available mental health services through expanding telehealth	Create a physical space to accommodate telemedicine for mental health	SMC	2019-2020
	Create policies/procedures to facilitate telemedicine for mental health		
	Procure technical equipment for telehealth for mental health		
	Explore staffing options to facilitate telehealth for mental health		

Creating a trauma-aware and trauma-responsive community	Create a cohort of representatives from various community agencies through the County to operationalize how to address the effects of ACEs in the community Cohort meets regularly for both continuing education and peer support, facilitated by a professional ACES Trainer Cohort members develop trauma-responsive interventions within their agencies	SMC	2019-2020
Creating a regional mental health and well-being summit	Meet regularly with regional representatives to create content, outreach materials for day-long summit Spread the work locally about the summit and invite local agencies/individuals	PHHS, public health staff from other NE MN counties, MDH	2019
Developing local mental health advisory council (LMHAC)	Create application process for individuals interested in serving on LMHAC Outline the goals, duties, and meeting times for the LMHAC Support LMHAC in developing and working toward projects and/or recommendations for systems change	PHHS	2019
Providing education and awareness of behavioral health related topics and resources	Assess and respond to requests for additional training and/or awareness of resources	PHHS, local schools, SMC, Care Partners, North Shore Health, Grand Portage Human Services, LMHAC, Law Enforcement	Ongoing

Goal 2: People Who Have Experienced Substance Abuse Have Support to Move Toward Recovery

Substance abuse is a complex public health issue that strongly affects individuals, families, and communities through "a set of related conditions associated with the consumption of mind-and behavior-altering substances."[26] Substances range from alcohol, to commercial tobacco, to a wide range of illicit drugs. Rates of alcohol and tobacco use in Cook County are higher than state and national rates[27], and confronting substance abuse in general is a priority within our community.

Reducing substance abuse and tobacco use are also goals listed under Healthy People 2020. One challenge to this goal is the estimate that 95% of people struggling with substance use are considered unaware of their problem. The federal government highlights the importance of increasing prevention efforts and improving access to treatment for substance abuse and co-occurring disorders as important priorities[28]. Preventing substance abuse and supporting people in recovery also fit within the Healthy Minnesota 2022 priority that "places and systems are designed for health and well-being[29]." This priority challenges us to re-imagine how to substance abuse prevention and intervention efforts can be improved in systems of care and the places where people spend their time.

Objective: The percentage of adults who report binge drinking within the past month will decrease from 25.1%[30] to 20%

Strategies	Activities	Partners	Timeline
Educating the public about addiction	Propose a 0.5 FTE Health Educator within PHHS to focus on community substance abuse education	PHHS	2019-2020
	Create a community panel presentation on commercial tobacco use	PHHS, SMC, Grand Portage, ISD 166, ALA, law enforcement	Summer-Fall 2019
Addressing the rise in youth vaping	In-service trainings for ISD 166 staff on vaping	SMC, PHHS, ISD 166	Summer 2019
	Letter to ISD 166 families urging families to talk about vaping		
	Propose ordinance changes to County and City that raise the legal age to purchase commercial tobacco to 21	SMC, PHHS, PHHS Advisory Council, ISD 166, ALA	2019-2020
	Increase vaping outreach and education and school events like open house	SMC, PHHS, ISD 166, ALA	2019-2020
Supporting people in recovery	Propose a 0.5 FTE Treatment Coordinator within PHHS to support transitions into and out of treatment programs	PHHS	2019-2020

	Explore the idea of a "sober support network" modeled after the military's re-integration program as well as the feasibility of Peer Support Specialists working within the community	PHHS, Corrections, SMC, Higher Ed, AEOA, spiritual/faith communities, Recovery Alliance Duluth, Wilderness Outpatient	2020-2022
	Learn more about Substance Use Disorder (SUD) reform in Minnesota and how this could impact local support for people in recovery	PHHS, Wilderness Outpatient	Ongoing
Building a community coalition dedicated to substance abuse prevention	Continue to convene community partners regularly to discuss updates and strategies to prevent substance abuse	Corrections, PHHS, Law Enforcement, SMC, Wilderness Outpatient, VPC, ISD 166	Ongoing
	Explore mentorship models for rural youth to increase protective factors related to substance use	TBD	Ongoing
	Explore and pursue relevant funding opportunities to expand substance use prevention efforts	PHHS	2020-2022

Goal 3: All Community Members Have Safe and Stable Housing

The Cook County Community Health Survey Access ranked affordable housing as the number one most important health issue to the community. Housing is widely recognized as a social determinant of health; in other words—the places where people live during their life have a direct relationship to their health, safety, and sense of belonging. As a social determinant of health, there is no national public health goal related to access to safe, and stable housing (though the American Public Health Association does, "support innovative approaches to ensuring everyone has a healthy home.")[31]. Healthy Minnesota includes housing under its priority "the opportunity to be healthy is available everywhere and for everyone,"[32] considering health and wellbeing as greatly dependent on (among other factors), the opportunity to access quality housing.

Objective: The total number of cost-burdened households (paying more than 30% of their income toward housing costs) will decrease from 588[33] to 500

Strategies	Activities	Partners	Timeline

Mapping actors currently involved in local housing initiatives	Talk and record conversation about housing initiatives in Cook County	EDA, PHHS	2019
Documenting the history of local housing initiatives and studies	Gather documents and record conversations about recent housing initiatives	EDA, PHHS, City of Grand Marais	2019
Exploring funding and technical assistance opportunities to organizing efforts related to housing	Consider applying for Cross Sector Innovation Initiative	EDA, SMC, PHHS, City of Grand Marais	2019-2020

Goal 4: Community Members of all Ages and Abilities Can Access Specialty Services

While Cook County is fortunate to have both a clinic and hospital within its jurisdiction, there are certain specialty medical services that are not available locally. This results in community members travelling (often to Duluth or the Twin Cities) for certain services, and the need for coordination between local providers and specialists practicing out of the area. It also represents an opportunity for telemedicine to gain a greater presence within the local health care system.

Healthy People 2020 also lists "Access to Health Services" as a goal, breaking it down into three components: insurance coverage, health services, and timeliness of care[34]. Of these components, the geographic availability of services is the most relevant and challenging for our community at large. Under the Healthy Minnesota priorities, "places and systems are designed for health and well-being," would include conversations about how to increase access to specialty medical services in rural remote areas such as Cook County[35].

Objective: The percentage of people who report delaying medical care in the past year will decrease from 26.3%[36] to 20%

Strategies	Activities	Partners	Timeline
Getting more specialist providers to periodically practice in Cook County	Have discussions with local providers about which specialists to pursue and why	SMC, North Shore Health	2019-2020
	Contact leadership at Essentia and St. Lukes and request CEOs to visit North Shore Health and Sawtooth Mountain Clinic	North Shore Health	2020
	Maintain the range of current specialists who travel to the County to practice periodically	SMC, North Shore Health	Ongoing
	Map current specialists (Who is travelling here? Where are local providers	PHHS, SMC, North Shore Health	2019-2020

	sending patients for different specialty services?)		
Improving access to specialist providers via telehealth	Advocate for more support from regional health systems (St. Lukes and Essentia)	North Shore Health	Ongoing
	Work out logistics of offering on-site telehealth services locally	SMC, North Shore Health	
	Find local supporters who are supportive of telehealth and work with them to pilot specific services remotely	SMC, North Shore Health	
Supporting travel and lodging costs for residents who need to travel for specialty care	Explore pre-existing local and regional resources for medical travel and lodging assistance and identify gaps in service	North Shore Health Care Foundation, PHHS	2019-2020
Coordinating transitions of care between specialists and local providers	Connect with Care Coordinators (nurses, case managers, etc.) to learn more about struggles with transitions of care	PHHS, North Shore Health, SMC, Care Partners	2019-2020

Goal 5: Elders Experience Support to Age in Our Community

27.4% of Cook County residents are over 65 years of age[37]. The Minnesota Department of Human Services (DHS) estimates that the percentage of Cook County residents over the age of 65 will increase to 39.9% by 2030[38]. Given the projected increase in Cook County's population of elders, our stakeholder group chose to focus on how to help create an environment that supports the health and well-being of elders who are aging in our community.

Nationally, Healthy People 2020 also has a goal of, "Improving the health, function, and quality of life of older adults." This is in part due to national demographic trends related to growth in the elderly population, and, in part due to the higher risk of elders for living with chronic disease[39]. Certain priorities set by Healthy Minnesota ("the opportunity to be healthy is available everywhere and for everyone" and "all can participate in decisions that shape health and well-being") are inclusive of focusing on health and well-being in our elderly population[40].

Objective: The percentage of community members over the age of 65 perceive their health status to be "fair" or "poor" will drop from 9.8%[41] to 7.8%

Strategies	Activities	Partners	Timeline
Expand housing options for seniors	Re-open discussions between consulting firm and EDA on the	EDA	2019-2020

	feasibility of having an assisted living facility in Grand Marais		
Support workforce in serving elders	Identify in-demand occupations related to serving elders	PHHS, North Shore Health, Care Partners, The Hub, North Shore Healthcare Foundation	2020-2021
	Assess local vacancies and turnover rates in different types of positions, including factors relating to each		
Expand the geographic availability of services for seniors in Cook County	Map geographic program availability of different services/gaps	PHHS, North Shore Health, Care Partners, The Hub, North Shore Healthcare Foundation	2019-2020
	Identify areas (geographic or programmatic) for expansion of services and/or outreach		
Streamline collaboration among elder-serving agencies	Continue convening elder-serving agencies regularly	PHHS, North Shore Healthcare Foundation, Care Partners, The Hub	2019-2020
	Develop local Aging Taskforce with multi-agency representation		
	Streamline resource guides for elders into one resource		
	Survey volunteers and staff who work with local elders to better understand their needs and experiences	PHHS	
Support medically related travel and lodging	Identify current services available and gaps	North Shore Healthcare Foundation	Ongoing
	Research additional supports and funding options		
Expand outreach and education targeted to supporting elders and their families	Brainstorm ways to increase elders' knowledge of local resources	PHHS, North Shore Health, Care Partners, The Hub, North Shore	Ongoing

		Healthcare Foundation	
	Expand dementia-related educational offerings for families and the community at large	Care Partners	Ongoing
	Explore the idea and role of an "Aging Navigator"	PHHS, North Shore Health, Care Partners, The Hub, North Shore Healthcare Foundation	2020-2022

Goal 6: Families with Young Children Experience Community Support

The Cook County Community Health Survey ranked "access to childcare" as the third most important health issue to the community. The community stakeholder group discussed the value of investing resources in early learning and support for parents, given the positive lifelong effects of developing supportive relationship and experiences early in life (and, conversely, the lifelong negative effects of adverse childhood experiences).

Nationally, Healthy People 2020 also recognizes the importance of early and middle childhood and is working toward this goal by documenting and tracking key population-based health measures specific to this age group. Healthy Minnesota 2022 also lists "positive early life experience" as a key condition for health.

Objective: The percentage of Cook County residents who respond that childcare is a top area of need within the community will drop from 46%[42] to 30%

Strategies	Activities	Partners	Timeline
Expanding public education on secure attachment between children and caregivers	Continue to offer Circles of Security programming for Cook County families	ISD 166, PHHS, Cooperation Station	Ongoing
	Pilot Healthy Families America home visiting program	SMC	2019-2024
Assess needs of young families in Cook County	Gather and analyze surveys and focus groups with families that have given birth in the past three years	ISD 166, Rural Mamas Connect, SMC, PHHS	Spring-Fall 2019
	Host community and provider presentations to present results		Fall 2019
	Regularly convene an early intervention interagency	All area schools, PHHS, SMC, VPC	Ongoing

Consider splitting the Early Childhood Coalition into working groups	group to develop common forms and strengthen referral processes		
	Regularly convene an early learning group that elevates the perspective of childcare providers	Local childcare providers, ISD 166	2020-2022
	Create a strategic planning group that engages in assessing community needs, pursuing funding opportunities, and hosting community-wide events on topics of interest	PHHS, ISD 166, SMC, other interested community members	2020-2022
Support perinatal health and well-being for families	Follow-up and check-in on findings/recommendations of focus groups and surveys in the areas of promoting social connectedness, creating integrated systems of care, and supporting postpartum transitions to parenthood	Rural Mamas Connect, PHHS, SMC, local doulas/midwives	Ongoing
Increase capacity to provide breastfeeding support to local families	Connect with discharge staff at Essentia and St. Lukes on the possibility of IBCLC consultations using telemedicine	SMC, CHB, staff from Essentia and St. Lukes	2019-2020
	Curate and position a collection of resources related to returning to work and pumping	CHB and SMC	2019-2020
	Build local support network for lactation through interested community members and professionals	PHHS, training agencies, community members/professionals	2020-2022
Create facilitated, weekly social support/education groups for pregnant people and parents of young children	Brainstorm a structure for meeting dates, locations, and facilitators	PHHS, SMC, local MCH professionals, interested community members	2020
	Identify potential funding streams		
	Publicize program to the public		
	Pilot support groups		
Create online resource clearinghouse and hub for	Explore whether to transition Rural Mamas Connect website to a local	PHHS and Rural Mamas Connect	2020

information on local events and support	model and/or to explore alternative online platforms to house support resources and information		
Explore models of inter-generational support to connect elders and families with young children	Brainstorm program models and research existing programs that offer similar connection/service	PHHS and interested partner agencies	2020

Implementation Plan and Accountability

The community stakeholder group will meet every six months to review progress toward the goals, objectives, strategies, and activities listed in this Community Health Improvement Plan (CHIP). The group will also invite additional partners to participate in this process who are working in the priority health areas upon which this plan focuses. The CHIP is a living document and will be updated as some activities are completed, and others begin. This document will provide:

1) A way to record and remember the community's self-identified health goals
2) A tool to encourage communal accountability toward these goals
3) A guide to start broad-based community conversations about how to creatively and collectively work toward achieving the desired goals for community health

As new data becomes available (from the US Census, Bridge to Health, Minnesota Student Survey, and through community-based surveys/listening sessions/engagement events), this data will be incorporated into the community stakeholder meetings. PHHS will ask partner agencies to monitor and contribute any data that relates to how they are implementing CHIP activities at bi-annual stakeholder meetings.

Updated data, along with general group reflections on progress toward objectives, strategies, and activities, will provide the basis for any decisions on whether to modify the CHIP to be more relevant to changes in the community. The group may decide to modify the CHIP at a stakeholder meeting, with any participant making a motion—that is agreed to by the consensus of those present. Minutes of these meetings will be available to all stakeholders as a written record of both group decisions and any accompanying discussion.

In 2022, Cook County Public Health will begin its next cycle of Community Health Assessment and Community Health Improvement Planning. This will also be a time to reflect upon progress made in the current cycle, and to consider any changes in the dynamics affecting our community's health.

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