

KANABEC-PINE COMMUNITY HEALTH

COMMUNITY HEALTH IMPROVEMENT PLAN

2010-2015



Public Health
Prevent. Promote. Protect.

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INTRODUCTION

In 2010, the Kanabec-Pine Community Assessment and Planning process was initiated for the 2010-2014 assessment and planning cycle. Assessment data was gathered to determine the community health issues for Kanabec and Pine counties. Sixteen issues were identified through the assessment process. In 2011, the prioritization process was completed. Community stakeholders were a valuable asset in the assessment and planning process as they provided valuable input and ongoing feedback and ownership for the work that was operationalized through the health departments. The Community Health Improvement Plan identifies four of the top ten priority issues that exemplify engagement of the public health system and the community in identifying and addressing health problems through collaborative processes. The following jurisdiction descriptions were utilized during the initial assessment process to inform the work of the community stakeholders.

DESCRIPTION OF JURISDICTIONS

Kanabec County:

The current population estimate for Kanabec County is 16,005 persons for 2012 compared to the 2005 population of 16,215 and the size is 525 square miles. According to the 2012 Census, the population per square mile is 30.5 compared to the state population per square mile of 67.6. The largest communities in Kanabec County include Mora and Ogilvie; smaller communities include Brunswick, Grasston, and Quamba. Industries that employ Kanabec county residents consist of county/city government, factory, construction, small business, health care and farming.

Kanabec County is an economically depressed area with a 2009-2013 per capita income of \$22,291 compared to the state per capita income of \$30,913. In 2009-2013, 14.2% of people were in poverty. An estimated 20% of Kanabec County children under 18 were below the poverty level (as compared to 10% statewide). 9% of Kanabec County residents were people 65 years old and over. An estimated 10% of all families and 37% of families with a female householder and no husband present had incomes below the poverty level. The Minnesota Department of Employment and Economic Development indicate that the 2014 annual average unemployment rate for Kanabec County is 8.6% compared to 4.1% statewide. Kanabec County is low-ranked 83rd out of Minnesota's 87 counties in social and economic factors.

Approximately 3,987 (24.9%) of Kanabec County residents are between the ages of 0-19 years old. Of those 2,277 are enrolled in the Mora and Ogilvie School Districts, which are 8 miles apart. The Mora school district #332 has a 2013-14 enrollment of 1,773 students and is comprised of three schools; Fairview Elementary, Trailview Middle School and Mora High School. Ogilvie School District #333 consists of one school that enrolls 509 students kindergarten through 12th grade. All schools are the center of community activity, in which dances, funerals, 4-H, Boys Scouts, Girls Scouts, Brownies and other community activities are held. In Kanabec County, 46.1% of the children enrolled in school, participate in the free or reduced lunch program compared to 38.5% statewide (2013-2014 school year).

In 2009-2013 an estimated 23 percent of the population was under 18 years and 17 percent was 65 years and older. The Bureau of Census indicates that 17.7% of the population in Kanabec County is over

the age of 65 compared to the state percent of 13.5 (2013). In 2013, the total age dependency ratio was 57.1 compared to the 2006 ratio of 48.4. In 2013, the state ratio was 50.6 compared to 46.5 in 2006.

Pine County:

Pine County with an estimated 2012 population of 29,218 compared to the 2006 population of 27,996 and covering 1,411 square miles is located on the Wisconsin border approximately 80 miles north of the twin cities. The population per square mile is 20.7 compared to the state population per square mile of 67.6. The 35W corridor runs through Pine County making tourism one of Pine County's industries. Also, bringing more travelers is the Hinckley casino. The largest communities in Pine County include the county seat of Pine City, Hinckley, Moose Lake, and Sandstone. Smaller communities include Askov, Beroun, Brook Park, Bruno, Finlayson, Henriette, Kerrick, Rock Creek, Rutledge, Sturgeon Lake, and Willow River.

Outside of tourism, industries that make up the community include: local county/city government, school districts, factory, construction, logging, small business, health care, and farming.

The total school enrollment in Pine County in 2013-2014 was 3,966 students across 4 school districts and one private academy. There is a total of thirteen schools in Pine County. The percentage of children receiving free and reduced lunches during the 2013-2014 school year was 49.9% compared to 38.5% statewide.

In 2013, 17.5% of the Pine County population is over the age of 65 years compared to the state percentage of 13.5. The total age dependency ratio (2013) is 54.3 compared to the 2006 rate of 48.1. The 2013 MN state age dependency ratio is 50.6. An estimated 22 percent of the population was under 18 years and 17 percent was 65 years and older.

The per capita income in 2013 was \$31,341 compared to the 2004 per capita income of \$24,189; this is compared to the MN state per capita incomes of \$47,500 and \$36,184 respectively. Pine County is low-ranked at 82nd out of Minnesota's 87 counties in social and economic factors. The Minnesota Department of Employment and Economic Development indicate that the 2014 annual average unemployment rate for Pine County is 6.7% compared to 4.1% statewide. In 2013, the percent of people in poverty was 15.7% in Pine County compared to 11.2% in MN. An estimated 19 percent of related children under 18 were below the poverty level, compared with 10 percent of people 65 years old and over. An estimated 11 percent of all families and 34 percent of families with a female householder and no husband present had incomes below the poverty level.

Minorities make up 6% of the total population (2012). 3% are American Indian, 2% African American, and 1% Asian.

HEALTH INEQUITIES

Health Inequities in the jurisdiction for which this plan was created:

While there are disparities in the health of the populations of color, we know that the greatest health disparities exist among those with low socioeconomic status. According to the Minnesota Department of Health (MDH) County Health Tables¹, more than 37% of people in the area are living at or below 200% of poverty level (compared to the State at 26.1%). Residents of low socioeconomic status are dispersed throughout the entire 1,933 square mile area. We can identify some low-income housing and mobile home parks that have more concentrated populations of low-income households, but many are in the less densely populated and isolated areas of the counties. The table below shows the outcomes of the County Health Rankings for the counties served. Counties are ranked from 1 – 87 with 1 being the healthiest and 87 the least healthy based on numerous factors.

County	Overall Rank	Health Factor Ranking	Health Behaviors Rank	Social/Economic Factor Rank
Kanabec	48	80	59	83
Pine	71	83	20	82

When you look further into the County Health Rankings, the Health Factor rankings are very poor for our area when compared to the majority of Minnesota counties. Health Factors include Health Behaviors (smoking, obesity, inactivity) Clinic Care (uninsured, access to care and screenings), Social & Economic Factors (education attainment, child poverty, single parent households) and Physical Environment (air quality, water quality access to health foods and recreational facilities). The county Health Rankings support the fact that low socioeconomic status, smoking, obesity and inactivity are problems in the counties we serve and that these issues need to be addressed in the entire population.

Process used to complete planning:

The joint Kanabec-Pine Accreditation Steering Team (AST) met to determine the process for creating the CHIP. Accreditation Coordinators from each county's Public Health agency then drafted the plan, using the MDH CHIP Checklist and the Public Health Accreditation Board (PHAB) Standard 5.2 requirements. AST met to review the plan and recommend changes. The plan was then finalized by the Accreditation Coordinators and signed by the Directors. Click [here](#) to view the action plan.

Community Stakeholders who participated in the process:

Kanabec-Pine Community Health is fortunate to work with multiple community groups. These groups are described in further detail in the sections addressing the specific priority issues. They include the Statewide Health Improvement Program (SHIP) Community Leadership Team, Kanabec-Pine Community Health Services Advisory Committee, Substance Abuse Coalition of Kanabec County, Pine County Meth Task Force and local community Emergency Preparedness Advisory Committees. The Community stakeholders provide a broad range of perspectives, represent a variety of groups, sectors, and activities within the community, and bring both resources and enthusiasm to the table. This broad community

participation ensures that the Community Health Assessment and Community Health Improvement Plan results are driven and owned by the community.

Community Health Assessment (CHA) information shared with participants:

A nineteen page Community Health Assessment document was utilized and shared with participants during the initial identification of community health issues. Click [here](#) to view the document.

PRIORITIZATION PROCESS

Prioritization process used to identify the primary issues from the CHA included in the CHIP:

The Kanabec-Pine Community Health Services (CHS) Advisory Committee is responsible for priority setting, program planning, participating in the analysis of health data, and serving as a liaison between the community and the Kanabec-Pine Community Health Board. The Advisory Committee is made up of eight members, four represent Kanabec County and four represent Pine County. Members have a variety of expertise that includes community leadership, health care experience, community knowledge, social conditions, and health consumerism.

The Kanabec-Pine CHS Advisory Committee met a minimum of three times per year during the 2010-2015 planning cycle. The Advisory Committee reviewed legislation governing local public health, reviewed the previous Community Health Services Plan, utilized current health data to identify new and ongoing local health issues, and prioritized those health issues. The prioritization process was completed by utilizing a worksheet on problem importance. After the list of problems was identified, the Advisory Committee ranked the health issues using an anonymous rating system by polling their responses during a PowerPoint presentation. A total of sixteen problem areas were identified. The rating system provided a score that determined problem importance.

The same presentation was completed with agency staff from Pine County and agency staff with Kanabec County. The CHS Administrator met with staff to review the previous plan, to determine if the new issues that the Advisory Committee members identified were indeed the issues that staff encountered. Staff made recommendations on priorities based on program activities, funding changes, and outcomes based on the previous plan. The prioritized list gives a sense of direction for Kanabec-Pine Community Health.

The Advisory Committee made the final determination of problem importance by reviewing the results of the staff rankings. The results were very similar among all groups verifying the process of scoring by utilizing the principles of public health. The principles of public health that were utilized in this process included making primary prevention a priority; providing the greatest good for the greatest number of people; placing energy where the community is motivated for change; taking into consideration the years of potential life lost; and also consideration for quality of life. The table below reflects the top 16 priorities selected and the five priorities to address in the Community Health Improvement Plan. The priorities that were selected for the Community Health Improvement Plan were determined by

identifying those programs that spanned across the multi-county jurisdiction and those that had significant community stakeholder participation.

PRIORITIES

Priorities

CHS Advisory KCPH

PCPH

CHIP

		CHS Advisory	KCPH	PCPH	CHIP
A	Inadequate Prenatal Care	11	12	9	x
B	Increased adolescent pregnancy	8	13	10	x
C	Premature morbidity due to lifestyle choices	3	3	1	
D	Tick-borne diseases	16	16	14	
E	Sexually transmitted diseases	15	10	15	
F	Unintended injury and death	12	11	5	
G	Violence & Bullying among youth	14	15	13	
H	Lack of psychiatric services and mental health access for children	9	7	2	
I	Increased obesity due to lifestyle choices	1	1	3	x
J	Long term care for elderly and disabled	10	6	8	
K	Lack of adequate funding to provide essential Public Health services	5	8	6	
L	Health disparities among residents of Kanabec and Pine Counties due to poverty levels	7	2	7	
M	Inappropriate use of alcohol, tobacco, illegal and prescription drugs	4	5	11	x
N	Emergency events i.e... Natural disaster, infectious disease outbreak, or chemical event	6	4	12	x
O	Health risks due to environmental exposures, i.e... High radon levels, high lead levels, etc.	13	14	16	
P	Developmental delays, undetected health issues and/or diagnosed conditions in ongoing number of children	2	9	4	

PRIORITY DESCRIPTIONS

The following sections detail the characteristics of each of the priorities.

PRIORITY ISSUE: INADEQUATE PRENATAL CARE

Kanabec-Pine Community Health is a recipient of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program grant through the MN Department of Health. The strategy that addresses this priority issue is the Family Home Visiting Program complemented with the Nurse-Family Partnerships (NFP) and Healthy Families America (HFA) Models.

What data helped to identify this priority?

Kanabec-Pine has higher rates compared to the state of several demographic indicators, including as presented in the [Population Characteristics Table¹](#), Medical Assistance (MA) eligibility and teen birth rates. Our region also has higher number of births to unmarried mothers and lower secondary education levels than the state. In 2010, Kanabec County's birth % to unmarried mothers was 41.7%, Pine County's was 49.2% compared to the state % of 33.1.4 Education is a social health determinant that negatively impacts health in our region. In 2010, Kanabec County's indicator for over 3 years of college for birthing mothers was 14.8%, Pine County's was 20.5% compared to the state average in Minnesota of 39.9%.¹ The Family Home Visiting Program benefits these women.

FAMILY HOME VISITING

Strategy: Family Home Visiting Program

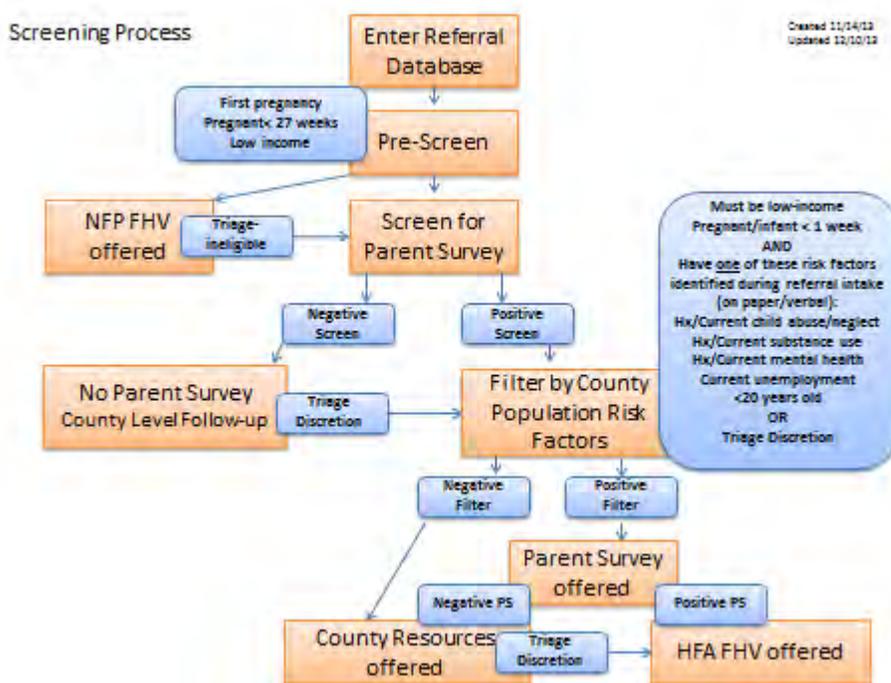
Family Home Visiting has experienced, Registered Nurses who schedule visits with expectant and new mothers and babies. Our goal is to foster healthy beginnings, improve pregnancy outcomes, promote school readiness, prevent child abuse/neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency for children and families. Kanabec-Pine Community Health serves two high risk populations of identified need with the MIECHV funding. The population focus is adolescent and young adult, first time parents. Overall, both counties have high-poverty geographic areas and both models serve low income mothers and families. The HFA model serves low resource parents, not necessarily first time parents and/or those mothers who have a history of child abuse or neglect or have had interactions with child welfare services. Both models prioritize families with a history of substance abuse or need substance abuse treatment; and those that currently use tobacco products in the home. NFP's maternal health model introduces vulnerable first-time parents to caring maternal and child health nurses. It allows nurses to deliver the support first-time moms need to have a healthy pregnancy, become knowledgeable and responsible parents, and provide their babies with the best possible start in life.

FHV BEST PRACTICES

Evidence-based or promising practices used to address the strategy included:

Kanabec-Pine Community Health Family Home Visiting Program became an NFP Model Implementing Agency in December of 2012 and has a Healthy Families America Model affiliation since February of 2013. Kanabec-Pine Community Health works to enhance child and family health outcomes to further serve the needs of children and families. Our nurses provide an assessment during an initial home visit and ongoing visits are offered. Supporting healthy parent-child relationships is a key component to the visits. Families receive support for infant care, child growth and development, lactation support, assisting families with Special Needs Children, Child and Teen Checkups and immunizations. Further information for parenting approaches, disease prevention, preventing exposure to environmental hazards and support services available in the community is also offered.

Additionally, efforts were made to establish stronger communication and information exchanges between community partners that are serving specific children and families. The goal is to enhance relationships between the primary care provider, MFIP staff, social services staff, child protection workers, the early intervention team, Head Start program staff, and any mental health providers serving the family. Collaboration occurs with each community partner as appropriate to meet client needs. Kanabec-Pine Community Health initiated an outreach tracking system to monitor efforts and ensure consistent contact with referrals' partners. In addition, a central referral intake system was created for Kanabec-Pine Community Health to manage incoming referrals. Each referral is put into the referral screening process in order to ensure engagement of individual women in a timely manner and to ensure that qualifying women have access to MIECHV programs. The goal is to have the nurse who completes the initial outreach to the family to be the Nurse Home Visitor for that family in order to ensure continuity of care with a strong nurse/family relationship. Kanabec-Pine Community Health has the promising practice of a consistent intake process for all referrals for home visiting with NFP home visiting as the first level, and HFA as the second level for program match eligibility. Below is a table illustrating the referral intake system:



FHV GUIDANCE

State-of-the-art guidance used included:

There is extensive training for the Family Home Visiting Nurses offered through the Minnesota Department of Health. Kanabec-Pine Community Health values professional growth. Our Program Nurses are trained in Motivational Interviewing with Extended Practice Enhancement, Parent Survey, Integrated Strategies, Smoking Cessation Support, Nutrition Support, Growing Great Kids, and Partners in Parenting Education to name just a few. There is also an MDH Reflective Practice Consultant (RPC) that collaborates with the Program Supervisor to identify a licensed mental health professional (LMHP) and provide training and mentoring of the identified LMHP, including assessment of infant mental health competencies and accompaniment through the infant mental health endorsement process as needed.

FHV POLICY CHANGES

Policy changes that were needed to accomplish these health objectives included:

Kanabec-Pine Community Health developed many examples of infrastructure changes. There are policies and practices in place that will allow nurses to accommodate clients' needs such as:

Both counties provide basic safety education for Home Visitors.

Both counties allow staff to use county cars for home visits if available.

Both counties accommodate mobile site office space for visits if home safety is a concern.

Home Visitors have a county cell phone, and a laptop computer with internet access.

Home Visitors are allowed to attend trainings and/or in-services related to Family Home Visiting.

FHV RESPONSIBLE PARTY

Individuals and organizations, in addition to public health, responsible for the strategy implementation included:

The Kanabec-Pine Community Health Advisory Group (CAG) advises the program's work plan and strategies for community outreach efforts. CAG is comprised of committed individuals and organizations who share a passion for the NFP and HFA programs and whose expertise can advise, support, and sustain the programs over time. A goal of the leadership for this program is for families to receive complementary services and perceive a seamless coordination of care between providers. A large amount of community engagement has been needed to ensure that appropriate referrals are coming in to the program in a timely manner.

Click [here](#) for the CAG member list.

FHV MEASURABLE OUTCOMES

Measurable health outcomes or indicators of progress include:

Kanabec-Pine Community Health provides quarterly data to MDH to illustrate the progress made to-date to enroll and retain the expected number of clients from the targeted high risk population served, e.g., number of clients enrolled, the number of clients lost to services, and reasons clients were lost to services. Kanabec-Pine Community Health also participates in the following aspects of the CEED evaluation: site and phone visits/interviews, focus groups, home visiting staff surveys, and reflective practice mentoring observations and/or videotaping.

As guided by the Family Home Visiting (FHV) Evaluation Benchmark Plan, Kanabec-Pine also reports on these 6 benchmarks:

Improved Maternal and Newborn Health

Child Injuries, Abuse, Neglect or Maltreatment and Reduction of Emergency Department Visits

Improvements in School Readiness and Achievement

Domestic Violence

Family Economic Self-Sufficiency

Coordination of Referral for Other Community Resources and Supports

FHV NATIONAL PRIORITIES

Alignment with national priorities in implementing this strategy:

The alignment with national priorities in implementing strategies to address inadequate prenatal care, inadequate nutrition, smoking, teenage pregnancy and a high percentage of births born to mothers in poverty is shown through alignment with Healthy People 2020, Maternal, Infant and Child Health Objectives (MICH):

MICH-9 Reduce preterm births²

MICH-10 Increase the proportion of pregnant women who receive early and adequate prenatal care²

MICH-11 Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women²

MICH-21 Increase the proportion of infants who are breastfed²

FHV COMMUNITY ASSETS

Existing community assets and resources available to implement the strategy included:

Name of Agency-Brief List of Relevant Services Provided by Agency

Pregnancy Resource Center-Pregnancy testing; education; low cost items

WINDOWS-Support for victims of violence

Food Shelf – Pine City; Mora-Food shelf

Ruby’s Pantry-Pine City, Ogilvie-Food Distribution with Fee

Family Pathways-Sandstone & Hinckley-Food shelf

Head Start-Families and children development and assistance

ECFE-Early Childhood Family Education

St. Croix River Education District (SCRED)-Child growth and development screenings

Rum River Special Ed Co-op (RRSEC)-Child growth and development screenings

Pine Technical College-Workforce Development

Teen Focus/Adult-Chemical Dependency treatment

Social Services-Supportive services: MA; Food Support; Daycare provider list; housing list

Therapeutic Services Agency-Mental and Chemical Health

New Pathways-Homeless Shelter

Child Care Resource and Referral-Free referral service

The Refuge-Domestic Violence/Shelter

Cambridge Medical Center-Prenatal/FP primary care/ Ob/GYN services; hospital

FirstLight Medical System-Prenatal/FP primary care/ Ob/GYN services; hospital

Fairview Health System-Prenatal/FP primary care/ Ob/GYN services; hospital

Gateway Family Health Clinic-Prenatal/FP primary care

Duluth Clinic-Prenatal/FP primary care

Essentia Health-Hospital

Outlook Clinic (Family Planning Clinic)-Pregnancy testing; birth control; STI/STD testing

Kanabec County Public Health and Pine County Public Health services-WIC, FHV, MCH programs, Child & Teen Checkups Outreach/Provider, Follow Along Program, Immunization program, and Car Seat program

Kanabec County Family Services and Pine County Social Services-Child Protection Services, Mental Health services, income maintenance, family advocates and social workers

Kanabec and Pine County School-based services (6 districts):-Early intervention (b-3); preschool (3-5yr); ECFE; ECS

Multiple Faith-based services-Church programs; preschool

¹Source: [NFP Population Characteristics Source List](#).

²Department of Health and Human Services, Centers for Disease Control and Prevention, Office of Disease Prevention and Health Promotion. Healthy People 2020. Topic: Maternal, Infant and Child Health. Retrieved from: [Healthy People 2020 - maternal infant and child health](#)

PRIORITY ISSUE: INCREASE IN OBESITY RELATED TO LIFESTYLE CHOICES

Strategies chosen to address obesity were: 1) Increase access to and consumption of healthy and affordable foods throughout the region, 2) Increase the number of children and adults who meet physical activity guidelines.

What data helped to identify this priority?

Two out of every three Minnesotans are overweight or obese—caused by insufficient physical activity and unhealthy eating—increasing risk for heart disease and diabetes, among other chronic illnesses. Obesity is one of the leading causes of death. In Minnesota, medical expenses due to obesity were approximately \$2.8 billion (2006). For the priority of addressing obesity, we serve the Kanabec and Pine counties, which encompass 1,933 square miles. The two counties have a combined population of 45,223; 93.95% White, 1.55% Black, 2.31% American Indian/Alaskan Native, 0.50% Asian/Pacific Islander, 1.69% two or more races, and 2.15% Hispanic. Pine County has a racial diversity with 3% of their population identifying as American Indian/Alaskan Native. Overall, American Indians experience: shorter life spans, higher rates of infant mortality, higher incidence of diabetes, heart disease, cancer, and other diseases; and poorer general health. While there are disparities in the health of the populations of color, we know that the greatest health disparities exist among those with low socioeconomic status. According to the MDH County Health Tables¹, more than 37% of people in the area are living at or below 200% of poverty level (compared to the State at 26.1%). Residents of low socioeconomic status are dispersed throughout the entire 1,933 square mile area. We can identify some low-income housing and mobile home parks that have more concentrated populations of low-income households, but many are in the less densely populated and isolated areas of the counties. The table below shows the outcomes of the County Health Rankings for the counties served. Counties are ranked from 1 – 87 with 1 being the healthiest and 87 the least healthy based on numerous factors.

County	Overall Rank	Health Factor Ranking	Health Behaviors Rank	Social/Economic Factor Rank
Kanabec	48	80	59	83
Pine	71	83	20	82

When you look further into the County Health Rankings, the Health Factors rankings are very poor for our area when compared to the majority of Minnesota counties. Health Factors include Health Behaviors (smoking, obesity, inactivity) Clinic Care (uninsured, access to care and screenings), Social & Economic Factors (education attainment, child poverty, single parent households) and Physical Environment (air quality, water quality access to health foods and recreational facilities). The county Health Rankings support that low socioeconomic status, smoking, obesity and inactivity are problems in the counties we serve and that these issues need to be addressed in the entire population.

The table below captures the percentages for overweight and obese individuals in Kanabec and Pine as compared to the state of Minnesota taken from Kanabec-Pine Community Health Services Community Health Assessment.

Behavioral Risk Factor Percentages				
Overweight	2006	2007	2008	2009
Kanabec	37.7%	36.2%	37.9%	38.8%
Pine	38.1%	36.3%	38.8%	39.0%
State	37.8%	35.8%	37.8%	39.1%
Obese	2006	2007	2008	2009
Kanabec	34.5%	26.0%	25.2%	25.2%
Pine	24.5%	26.0%	25.0%	25.0%
State	24.5%	25.9%	24.9%	24.7%
Current Smokers	2006	2007	2008	2009
Kanabec	17.8%	16.2%	17.1%	16.2%
Pine	17.7%	16.3%	17.2%	16.3%
State	18.3%	16.5%	17.5%	16.8%
Acute Drinking	2006	2007	2008	2009
Kanabec	17.1%	13.8%	19.0%	19.0%
Pine	17.4%	14.1%	19.4%	19.5%
State	17.6%	14.3%	19.7%	20.2%
Chronic Drinking	2006	2007	2008	2009
Kanabec	3.7%	3.6%	4.7%	5.0%
Pine	3.8%	3.6%	4.7%	4.9%
State	3.9%	3.8%	4.7%	5.0%



SHIP-INCREASE ACCESS FOR HEALTHY FOODS

Strategy One: Increase access to and consumption of healthy and affordable foods throughout the region.

One strategy to address obesity is to increase access to and consumption of healthy and affordable foods throughout the region through Public Health Staff and The Community Leadership Team of Partners in Healthy Living². Kanabec-Pine Community Health applied for and received funds through the

Statewide Health Improvement Program (SHIP). Partners in Healthy Living Coordinators work with community partners and the Community Leadership Team to implement SHIP strategies and approaches. The percent of public school students eligible for Free/Reduced Price Lunch (FRPL) Grades K-12 for Kanabec county is 45.9% and for Pine county, 49.8% as compared to Minnesota’s percentage of 38.5% in 2013-2014. With these percentages in mind, it is important for Partners in Healthy Living to work with our communities to increase access to and consumption of fruits and vegetables that are also affordable through farmers markets, schools, and other community-based healthy eating efforts such as childcares. Partners in Healthy Living Coordinators provide technical assistance, networking and training.

SHIP PROMISING PRACTICES

Evidence-based or promising practices used to address the strategy included:



The Strategic Prevention Framework model is used to continually assess the community; not only to identify the problem of obesity but also the related conditions and consequences that contribute to obesity. Information is collected about obesity and the availability of resources to support prevention efforts. Then community readiness to address obesity is evaluated. Based on the assessment, priorities are determined. Strategies¹ across the Kanabec-Pine area include the promising practice of the Farm to School program. By improving the offerings of fresh fruits and vegetables, Farm to School programs will help make the healthy choice the easy choice for students and school staff. Kids eat more of fresh, local foods and learn about where their food comes from -- all while supporting local farmers. By connecting farms and schools, children, schools and farmers all benefit. “Let’s Move Childcare” training helps daycare providers to promote evidence-based best practices for healthy eating in child care settings. Farmer’s Markets and Community Supported Agriculture are increasing the availability of healthy foods to our communities as a result of SHIP’s assistance in marketing and sustainability.

The tables below reflect examples of the work plans in the strategies of Community Healthy Foods, Healthy School Foods, Childcare and Worksite Wellness.

Worksite Wellness
Goal: Increase a culture of health within the workplace.
#1 Objective/Milestone: Worksite partners engaged, relationships established
#2 Objective/Milestone: Worksite partner commitments secured
#3 Objective/Milestone: Progress on Collaborative meetings
#4 Objective/Milestone: Baseline assessments completed
#5 Objective/Milestone: Worksite action plan, including a PSE component is created and implemented
#6 Objective/Milestone: Policy(ies) adopted
#7 Objective/Milestone: Efforts are sustained

<i>Community Healthy Eating</i>
Goal: Increase access to healthy foods to everyone in the region.
#1 Objective/Milestone: Stakeholder team(s) formed or if already existing reconvened
#2 Objective/Milestone: Assessment done of current community nutrition environment with focus on availability of fruits and vegetables, sodium, saturated fat and added sugars
#3 Objective/Milestone: Assessment results reviewed by stakeholder team and specific food outlets are targeted for improvement in access to fruits and vegetables and/or decreased access to sodium, saturated fat, added sugars
#4 Objective/Milestone: Additional stakeholders added to team according to food outlets targeted; Establish a Food Hub
#6 Objective/Milestone: Healthy Community Food professionals receive training if needed
#7 Objective/Milestone: Action plan, including PSE is implemented to increase access to fruits and vegetables and/or decrease access to sodium, saturated fat, added sugars
#8 Objective/Milestone: Efforts are sustained and/or regionalized

<i>Healthy School Foods</i>
Goal: Increase access to healthy foods to all students in schools.
#1 Objective/Milestone: School Health Council is formed or School Health Council is verified or reconvened.
#2 Objective/Milestone: School Health Council reviews current school wellness policy
#3 Objective/Milestone: School Health Council will conduct and review School Health Index
#4 Objective/Milestone: Continued progress on PSE within the identified strategies
#5 Objective/Milestone: A policy is written or re-written from an improved implementation and/or enforcement of an existing policy and presented to the school board
#6 Objective/Milestone: School staff, teachers and other community partners will receive communications and appropriate trainings
#7 Objective/Milestone: Efforts are sustained

Childcare
Goal: Increase access to and consumption of healthy and affordable foods throughout the region, and Increase the number of children and adults who meet physical activity guidelines.
#1 Objective/Milestone: Attendance at webinar provided by MDH, reviewing Minnesota child care and CACFP regulations
#2 Objective/Milestone: Meeting(s) conducted with child care providers, center directors, parents and other stakeholders
#3 Objective/Milestone: Dissemination plan for provider trainings created (logistics, curriculum and training materials, and recruitment)
#4 Objective/Milestone: Participating providers and centers recruited
#5.1 Objective/Milestone: Assessment of current food and nutrition practices and policies by providers or in centers
#5.2 Objective/Milestone: Action plan created for implementing practices on nutrition
#6.1 Objective/Milestone: Assessment of current breastfeeding support practices and policies by providers or in centers
#6.2 Objective/Milestone: Action plan created for implementing practices on breastfeeding support
#7.1 Objective/Milestone: Assessment of current physical activity practices and policies by providers or in centers
#7.2 Objective/Milestone: Action plan created for implementing practices on physical activity
#8 Objective/Milestone: Trainings conducted by master trainers
#9.1 Objective/Milestone: Practices in nutrition changed by providers or centers
#9.2 Objective/Milestone: Policies in nutrition adopted by providers or centers
#10.1 Objective/Milestone: Practices in breastfeeding support changed by providers or centers
#10.2 Objective/Milestone: Policies in breastfeeding support adopted by providers or centers
#11.1 Objective/Milestone: Practices in physical activity changed by providers or centers
#11.2 Objective/Milestone: Policies in physical activity adopted by providers or centers
#12 Objective/Milestone: Efforts are sustained

SHIP GUIDANCE

State-of-the-art guidance used included:

Kanabec-Pine Community Health applied for and received funds through the Statewide Health Improvement Program (SHIP). SHIP succeeds by encouraging and supporting community engagement in each of the strategies, through local decision-making and sustainable, evidence-based strategies. SHIP provides guidance through regional trainings, webinars and “Basecamp”, the web-based resource tool. The Minnesota Student Survey and MDH evaluation tools were also utilized to assist in gathering data.

SHIP POLICY CHANGE

Policy changes that were needed to accomplish these health objectives included:

In order for policies to be reformed to accomplish addressing obesity, technical assistance and community engagement is included in the work plan. Health literacy for institutional decision makers is accomplished through training and communication on nutrition standards, and technical assistance offered throughout planning and implementation of strategies. For instance, strategies that will decrease the availability of snacks high in sodium, saturated fats, and added sugars include implementing policies that encourage non-food rewards in the classrooms and daycares, improving the nutritional value and pricing structures in a la carte lines, removing vending machines, and adding healthier snacks to concession stands. There is a focus on the Smart Snacks in School nutrition standards (USDA). Numerous partnerships with schools are established to encourage and support school wellness policies, implementation of active classrooms/after school programs, and the creation of healthy snack carts.

SHIP RESPONSIBLE PARTY

Individuals and organizations, in addition to public health, responsible for the strategy

implementation included the SHIP Partners in Healthy Living Community Leadership Team. Members of the team are included in the link at the end of this section. The purpose of the SHIP Partners in Healthy Living Community Leadership Team is to establish, and grow community support within four SHIP strategy areas: school, community, workplace, and healthcare. Some of their work includes:

Act in an advisory capacity.

Assist in mapping community assets.

Identify decision makers related to SHIP Projects.

Identify potential priorities.

Assist in setting priorities.

Identify and engage local champions who can help move the work forward.

Ensure health inequities are being addressed.

Work together to share resources and build successful initiatives

Provide expertise

Be an Agent & Ambassador

SHIP MEASURABLE OUTCOMES

Measurable health outcomes or indicators of progress include:

Examples of indicators of progress of the goal of increased access to and consumption of healthy and affordable foods throughout the region include:

- Completion of assessments, policies, and practices
- A comparison of food offerings at baseline and follow-up
- Percentage of healthy food items served in school lunch program, daycares and farmers markets
- The number of trainings provided to school, daycare and farmers markets staff
- Increases in health literacy using baseline and follow-up
- The number and scope of policy, systems, and environmental changes that occur within each school, daycare and farmers markets

SHIP NATIONAL PRIORITIES

Alignment with national priorities in implementing this strategy:

The alignment with national priorities in implementing strategies to address obesity is shown through alignment with Healthy People 2020, Nutrition and Weight Status and Educational and Community Based Programs Objectives (NWS and ECBP):

NWS-17 Reduce consumption of calories from solid fats and added sugars in the population aged 2 years and older³

ECBP-10.8 Increase the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services nutrition⁴

ECBP-8.2 (Developmental) Increase the proportion of worksites with 50 or more employees that offer an employee health promotion program to their employees.⁴

SHIP COMMUNITY ASSETS

Existing community assets and resources available to implement the strategy included:

By connecting farms and schools, children, schools and farmers all benefit.

Cambridge-Isanti Public Schools

Rush City Public Schools

Chisago Lakes Public Schools

Care a Lot Home Daycare

Mora Public Schools

Debby's Giggles & Wiggles Child Care

North Branch Public Schools

Kids Choice Learn & Play Family Daycare

Ogilvie Public Schools

Marlene Marohn's Child Care

Onamia Public Schools

Kind Hearts Daycare

Pine City Public Schools

Sturgeon Lake Clubhouse Daycare

Princeton Public Schools

Chisago City Farmers Market

Lindstrom Community Garden
Isanti Family Farmers' Market
Onamia Farmers' Market
Pine City Farmers' Market
Kanabec County

Pine County
Isanti County
Mille Lacs County
Chisago County



INCREASE PHYSICAL ACTIVITY

Strategy Two: Increase the number of children and adults who meet physical activity guidelines.

Another strategy to address obesity is to increase the number of children and adults who meet physical activity guidelines through Public Health Staff and The Community Leadership Team of Partners in Healthy Living. Kanabec-Pine Community Health applied for and received funds through the Statewide Health Improvement Program (SHIP). Partners in Healthy Living Coordinators work with community partners and the Community Leadership Team to implement SHIP strategies and approaches. Partners in Healthy Living work with our communities to increase the number of children and adults who meet physical activity guidelines through schools, partnerships with city and county engineering departments and other community-based healthy eating efforts such as childcares by providing technical assistance, networking and training.



SHIP PROMISING PRACTICE

Evidence-based or promising practices used to address the strategy included:

The Strategic Prevention Framework model is used to continually assess the community; not only to identify the problem of obesity but also the related conditions and consequences that contribute to obesity. Information is collected about obesity, the availability of resources to support prevention efforts, and community readiness to address obesity is evaluated. Based on the assessment, priorities are determined. Strategies across the Kanabec-Pine area include the promising practice of creating master walk and bike plans; updating municipal plans to include “complete streets” with sidewalks and crosswalks; increasing access to connected walking and bicycling networks; connecting and promoting trail systems; and collaborating on projects that improve walkability and bikeability in communities. The tables below reflect examples of work plans from the strategies of Active Living, Active School Day and Healthcare.

Healthcare Clinical Community Linkages
Goal: Prevention of chronic disease and impact health care costs.
#1 Objective/Milestone: Relationships with partners established
#2 Objective/Milestone: Assessment or environmental scan of what evidence-based community programs are available
#3 Objective/Milestone: Assessment of the Screening, counsel, referral and follow-up process related to tobacco and obesity
#4 Objective/Milestone: Training provided
#5 Objective/Milestone: Action plan developed and implemented
#6 Objective/Milestone: Efforts are sustained

Active Living
Goal: Increase the access and opportunity for physical activity among everyone in the community.
#1 Objective/Milestone: Review of existing community planning documents is done
#2 Objective/Milestone: Assess the need of forming an Active Living Advisory Group
#3 Objective/Milestone: Community assessment or environmental scan is performed
#4 Objective/Milestone: Active Community action plan, including a PSE component is created and implemented
#5 Objective/Milestone: Continued progress on PSE within the identified strategies
#6 Objective/Milestone: Training provided to appropriate key stakeholders and decision-makers
#7 Objective/Milestone: Strategic promotion activities conducted
#8 Objective/Milestone: Efforts sustained

Healthcare-Advance Community Linkages with State and Federal Health Reform Initiatives
Goal: Prevention of chronic disease and impact health care costs.
#1 Objective/Milestone: Relationships with partners established
#2 Objective/Milestone: Community Health Assessment is completed
#3 Objective/Milestone: Action plan created with partners to address evidence-based programs, and/or referrals to those programs healthy lifestyle guidelines, clinical breastfeeding support within the health reform initiatives
#4 Objective/Milestone: Training provided
#5 Objective/Milestone: Action plan implemented
#6 Objective/Milestone: Efforts are sustained

Active School Day
Goal: Increase the access and opportunity for physical activity among all students in schools.
#1 Objective/Milestone: School Health Council is formed or School Health Council is verified or reconvened.
#2 Objective/Milestone: School Health Council reviews current school wellness policy
#3 Objective/Milestone: School Health Council will conduct and review School Health Index
#4 Objective/Milestone: Continued progress on PSE within the identified strategies
#5 Objective/Milestone: A policy is written or re-written from an improved implementation and/or enforcement of an existing policy and presented to the school board
#6 Objective/Milestone: School staff, teachers and other community partners will receive communications and appropriate trainings
#7 Objective/Milestone: Efforts are sustained

SHIP GUIDANCE

State-of-the-art guidance used included:

Kanabec-Pine Community Health applied for and received funds through the Statewide Health Improvement Program (SHIP). SHIP succeeds by encouraging and supporting community engagement in each of the strategies, through local decision-making and sustainable, evidence-based strategies. SHIP provides guidance through regional trainings, webinars and “Basecamp”, the web-based resource tool. The Minnesota Student Survey and MDH evaluation tools were also utilized to assist in gathering data.

SHIP POLICY CHANGE

Policy changes that were needed to accomplish these health objectives included:

In order for policies to be reformed to accomplish addressing obesity, technical assistance and community engagement must be included in the work plan. Technical assistance is offered throughout planning and implementation of strategies. For instance, counties and cities that are working on their comprehensive plan will create sidewalk and non-motorized transportation policies that coincide with street improvements, encourage use, and assure safety of individuals. For those cities that have an infrastructure grant for Safe Routes to School (SRTS), SHIP staff will provide technical assistance during the process of planning and implementing the necessary infrastructure work. Policies at the city and county level that increase the amount of trails in the area will increase opportunities for safe walking and biking.

SHIP RESPONSIBLE PARTY

Individuals and organizations, in addition to public health, responsible for the strategy

implementation included the SHIP Partners in Healthy Living Community Leadership Team. Members of the team are included in the link at the end of this section. The purpose of the SHIP Partners in Healthy Living Community Leadership Team is to establish, and grow community support for four SHIP strategy areas: school, community, workplace, and healthcare. Some of their work includes:

Act in an advisory capacity.

Assist in mapping community assets.

Identify decision makers related to SHIP Projects.

Identify potential priorities.

Assist in setting priorities.

Identify and engage local champions who can help move the work forward.

Ensure health inequities are being addressed.

Work together to share resources and build successful initiatives

Provide expertise

Be an Agent & Ambassador

SHIP INDICATORS OF PROGRESS

Measurable health outcomes or indicators of progress include:

Examples of measurable health outcomes or indicators of progress of the goal to increase the number of children and adults who meet physical activity guidelines include:

- Number of comprehensive plans staff have contributed to
- Number and scope of policies written into plans
- Miles of new walking/biking trails
- Number of Safe Route to School programs
- Increase in bike/walk traffic on trails
- Increase in biking/walking in community

SHIP NATIONAL PRIORITIES

Alignment with national priorities in implementing this strategy:

The alignment with national priorities in implementing strategies to increase the number of children and adults who meet physical activity guidelines is shown through alignment with Healthy People 2020, Educational and Community-based Programs and Physical Activity Objectives (ECBP):

ECBP-10.9 Increase the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services physical activity⁴

PA-3 Increase the proportion of adolescents who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity⁵

SHIP COMMUNITY ASSETS

Existing community assets and resources available to implement the strategy included:

Chisago County Senior Center	Chisago County
County of Isanti	Isanti County
City of Lindstrom	Kanabec County
City of North Branch	Lakes and Pines Community Action Council
City of Pine City	Mille Lacs County
City of Princeton	Pine Technical College
City of Rush City	Pine County
Anoka Ramsey Community College	

¹Center for Health Statistics, Minnesota Department of Health, 2009-15, retrieved from: [Retrieved from: County Health Tables - MDH](#)

² [Community Leadership Team members](#), 2015.

³Department of Health and Human Services, Centers for Disease Control and Prevention, Office of Disease Prevention and Health Promotion. *Healthy People 2020*. Topic: Nutrition and Weight Status. Retrieved from [Healthy People 2020 nutrition and weight status](#)

⁴Department of Health and Human Services, Centers for Disease Control and Prevention, Office of Disease Prevention and Health Promotion. *Healthy People 2020*. Topic: Educational and Community based Programs Retrieved from: [Healthy People 2020 Education and Community Based Programs](#)

Department of Health and Human Services, Centers for Disease Control and Prevention, Office of Disease Prevention and Health Promotion. *Healthy People 2020*. Topic: Physical Activity Retrieved from: [Healthy People 2020 Physical Activity](#)

PRIORITY ISSUE: INAPPROPRIATE USE OF ALCOHOL, TOBACCO AND OTHER DRUGS

Strategies chosen to address alcohol, tobacco and other drugs were to increase community collaboration and reduce youth substance abuse.

What data helped to identify this priority?

The Minnesota Departments of Education, Health, and Human Services administer the Minnesota Student Survey (MSS) every three years. The MSS is a census, meaning that all students in grades 5, 8, 9, and 11 are asked to participate. The survey measures past 30-day use of alcohol, tobacco, marijuana or prescription drugs; perception of risk/harm of use; perception of parental disapproval of use; and perception of peer disapproval of use; as well as measures of school climate, physical activity, violence and safety; connections with school and family; health; and other topics.

The 2013 Minnesota Student Survey data¹ highlights some of the concerns in Kanabec and Pine Counties. Students were asked if they had used any alcohol, tobacco, marijuana, or prescription drugs in the past 30 days. Kanabec County and Pine County youth in 11th grade reported using all four substances at a higher rate than the Minnesota state average with the exception of Pine County 11th grade male tobacco use at 22.5%. Data in Table 1 below indicates:

- Alcohol is the drug of choice for youth in Kanabec County, Pine County and Minnesota. A larger percentage of 11th grade females than males reported using alcohol in Kanabec County.
- Tobacco is the second most commonly used drug among 11th grade youth in Kanabec County and Pine County. The percentage of 11th grade females who reported using tobacco in Kanabec County is more than twice that of the Minnesota state average (31% vs. 13%).
- Marijuana is the third drug of choice among 11th grade youth in Kanabec County and Pine County. The gender differences in Kanabec County are similar to those on average in Minnesota; however, a larger percentage of 11th grade youth in Kanabec County reported using marijuana than the Minnesota state average.
- Prescription drugs are the fourth most commonly used drug among 11th grade youth in Kanabec County and Pine County.

In 2013, significant changes were made to the MSS survey. Prior to 2013, students in grades 6, 9, and 12 were surveyed. In addition, some questions were changed to be more consistent with national surveys. For these reasons, trend data in is only available for students in grade 9 and for questions that remain unchanged. No questions on past 30 day use of prescription drugs remained the same from 2010 to 2013, so no trend data is available. Data indicates that rates of alcohol and tobacco use decreased among 9th grade students in Kanabec County and Pine County between 2007 and 2013. The percentage of 9th grade females in Kanabec County that reported tobacco use in 2013 (6%) is less than half the percentage that reported tobacco use in 2007 (14%). However, the percentage of Kanabec County

students in grade 9 that reported marijuana use in the past 30 days more than doubled for males from 6% in 2007 to 20% in 2013.

Students in grade 9 reporting any use of alcohol, tobacco, marijuana, or prescription drugs in the past 30 days (Minnesota Student Survey, 2013).

Kanabec	2007		2010		2013	
	Male	Female	Male	Female	Male	Female
Alcohol	23%	22%	26%	39%	20%	17%
Tobacco	17%	14%	24%	21%	14%	6%
Marijuana	6%	8%	22%	17%	20%	10%
Prescription	*	*	*	*	8%	13%

Students in grade 9 reporting any use of alcohol, tobacco, marijuana, or prescription drugs in the past 30 days (Minnesota Student Survey, 2013).

Pine	2007		2010		2013	
	Male	Female	Male	Female	Male	Female
Alcohol	31.90%	36.80%	28.80%	31.10%	25.50%	31.60%
Tobacco	20%	14%	15%	18%	9.10%	11.20%
Marijuana	17%	8%	15%	10%	10%	9.70%
Prescription	*	*	*	*	4.50%	7.50%

ATOD COMMUNITY COLLABORATION

Strategy One: Enhance Community Collaboration:

In 2006, members of the Kanabec County Methamphetamine Community Action Group broadened the Group’s mission to address all substance abuse among youth and adults. The Group changed its name to the Substance Abuse Coalition of Kanabec County (SACK)² to reflect this new mission. Recruitment and retention efforts are critical to maintain and grow the coalition’s capacity. The coalition has collaborated with individuals and organizations in many sectors of the community, including Youth and Young Adults, Parents, High-risk Sub-populations, Business, Media, Schools, Youth-serving Organizations, Law Enforcement, Justice/Corrections, Religious Organizations, Civic/Volunteer Groups, Healthcare Professionals, State/Local/Tribal Government Agency with Expertise in Substance Abuse or

Public Health and Other Organizations Involved in Reducing Substance Abuse. The nature of the collaboration and the organization with whom the coalition collaborates depends upon the project.

There are representatives from SACK that are also members of the Pine County Methamphetamine Task Force³ which was established in 2003. In a small community, everyone involved strives to minimize duplication of services while collaborating to accomplish shared goals for a healthier and safer community across Kanabec and Pine Counties.

ATOD EVIDENCE-BASED PRACTICE

Evidence-based or promising practices used to address the strategy included:



The Strategic Prevention Framework model is used to continually assess the community; not only to identify the problem of inappropriate use of alcohol, tobacco and other drugs but also the related conditions and consequences that contribute to inappropriate use of alcohol, tobacco and other drugs. Information is collected; the availability of resources to support prevention efforts, and community readiness to address each problem is evaluated. Based on the assessment, priorities are determined. Activities related to those priorities across the Kanabec-Pine Community Health service area include attendance at local chamber and Ministerial Association meetings, submission of monthly columns to the local newspaper; development of a monthly meeting structure for existing local youth groups; participation in a nationally recognized school district campaign; and meetings of local collaborative substance abuse prevention groups. At local chamber and ministerial meetings, information is provided on substance abuse in the community and on SACK's current prevention efforts. The local newspaper, the 'Kanabec County Times' is provided monthly columns to increase awareness of youth substance abuse and to promote SACK's efforts in the community. Existing local youth groups including 'Mora Above the Influence' (MATI) and Ogilvie's group 'We Own It' participants come together to discuss youth engagement activities and opportunities for collaboration. The Pine County Methamphetamine Task Force provides grant funds to seven local schools in Pine County to supplement their drug education programs as well as providing funds for community events. The goal of the task force is to reach all ages – young, middle age, and adults with educational materials. And finally, the two school districts in Kanabec County also implement the evidence-based 'Above the Influence' campaign, a national effort that helps teens stand up to the

negative pressures and influences of marijuana use and has been shown to reduce marijuana use among teens.

The table below reflects examples from the [Drug-Free Communities Work plan](#).⁴

Priority Issue: Inappropriate use of alcohol, tobacco and other drugs.
Goal: Increase community collaboration.
#1 Objective: Increase the number of active coalition members of SACK by 10% by September 29, 2015.
Develop a structure for member recruitment.
Strengthen collaboration with business and faith sector representatives in the community.
Consistently provide structured meeting agendas and training schedules.
Expand opportunities for members to participate in workgroups.
Strengthen collaboration among existing youth groups in Kanabec County.

ATOD GUIDANCE

State-of-the-art guidance used included:

Trainings are offered statewide by the Minnesota Prevention Resource Center or nationally by the Community Anti-Drug Coalitions of America (CADCA) and The United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention. More than 40 active SACK members have many opportunities to attend trainings and conferences every year. Some are offered as part of a coalition meeting. For example, the coalition has sponsored presentations and trainings on social media, grassroots advocacy, and the culture of poverty. Coalition members and staff who attend trainings outside of the community are required to present what they learn at a coalition meeting when they return. These trainings equip coalition members with the knowledge and skills of prevention programs, practices, and policies. There are representatives from SACK that are also members of the Pine Meth Task Force which was established in 2003. In a small community, everyone involved strives to minimize duplication of services while collaborating to accomplish shared goals for a healthier and safer community across Kanabec and Pine Counties. They return to their community with an increased understanding, ability, and commitment to implement evidence-based and environmental prevention strategies. The Minnesota Student Survey and MDH evaluation tools were also utilized to assist in gathering data.

ATOD POLICY CHANGE

Policy changes that were needed to accomplish these health objectives included:

Public Health has worked with local government to pass a number of ordinances and policies. The Kanabec County Board of Commissioners passed a social host ordinance in 2010 and revised its liquor ordinance to require responsible beverage server training as a condition for establishments to obtain a liquor license in 2013. The City of Mora’s Council also passed a social host ordinance in 2010 and a tobacco-free parks policy in 2011. The Cities of Pine City and Hinckley passed tobacco-free and tobacco-

restricted parks policies in 2010. The Pine County Board of Commissioners passed an ordinance declaring the cleanup of clandestine drug lab sites as a chemical investigation site as a Public Health Nuisance in 2004.

ATOD RESPONSIBLE PARTY

Individuals and organizations, in addition to public health, responsible for the strategy implementation included:

The Substance Abuse Coalition of Kanabec County (SACK) provides innovative programs and services that help keep Kanabec County residents strong and resilient against alcohol, tobacco and other drugs (ATOD). The mission of SACK is to promote healthy choices in the community through prevention and collaborative partnerships for the reduction of alcohol, tobacco and other drug abuse among youth and residents. Whereas much time and resources were once spent implementing “programs,” the whole community now collaborates to achieve policy, systems, and environmental change. Today, SACK remains a community-based entity with more than 40 active members and approximately 20 organizations committed to reducing youth substance use in Kanabec County. This is significant for a small, rural county with only 3,571 residents living in the largest city, two school districts, one law enforcement agency, and a few large employers.

In Pine County the Methamphetamine Task Force meets quarterly to discuss action steps to reduce methamphetamine and other illegal drug use and manufacture in Pine County. This committee is comprised of commissioners, court representation, fire department personnel, and citizens from each district, local businesses, school personnel, county staff, and the Mille Lacs Band of Ojibway Indians.

The Task Force duties include:

Identification of the scope of methamphetamine use and manufacture in Pine County and the costs of dealing with it, for the individual and for local governments. They discuss questions such as, who does it impact? What local government departments must deal with it? What costs can be quantified?

Education of citizens, landlords, schools and government officials on the nature and impact of methamphetamine and its costs.

Development of a cooperative framework necessary to pursue grants for reducing methamphetamine use and manufacture, for abatement of property, for organization of concerned citizen groups within the county or for education of the public.

Research on the feasibility of county ordinances regarding methamphetamine manufacture in housing units or on property (if directed by the Board of Commissioners).

The Pine County Methamphetamine Task Force provides grant funds to seven local schools to supplement their drug education programs as well as providing funds for community events. The goal is to reach all ages – young, middle age, and adults.

ATOD MEASURABLE OUTCOMES

Measurable health outcomes or indicators of progress include:

Goal: Increase community collaboration

Objective 1: Increase the number of active SACK members by 10% by September 29, 2015.

Objective 2: Increase active SACK members' attendance at meetings, participation in workgroups and trainings by 25% by September 29, 2015.

Method of measurement: Community Involvement Agreements (CIAs) for 12 community sectors, Coalition meeting attendance sheets and in-kind tracking, Coalition Functioning Survey and Survey of coalition member interests

ATOD NATIONAL PRIORITY

Alignment with national priorities in implementing this strategy is:

The alignment with national priorities in implementing strategies to address inappropriate use of alcohol, tobacco and other drugs is shown through alignment with Healthy People 2020, Educational and Community-based Programs objectives (ECBP):

ECBP-10.5 Increase the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services substance abuse.⁵

ATOD COMMUNITY ASSETS

Existing community assets and resources available to implement the strategy included:

Mora Public Schools

Kanabec County Human Services

Lakes & Pines CAC

Pine County Human Services

Minnesota Teen Challenge

Central MN Jobs & Training Services

Ogilvie Public Schools

L and R Accounting

True Vine Lutheran Church

FirstLight Health System

Juettner Marketing

The Refuge Network

Family Pathways

Essentia Health

Pine County School Districts

Pine County Sheriff Department

Kanabec County Sheriff Department

Pilot Outreach Jail Ministry

REDUCE YOUTH SUBSTANCE ABUSE

Strategy Two: Reduce Youth Substance abuse:

Reduction in youth substance abuse and sustainability of reductions occurs when a prevention system becomes a community norm. This is most often achieved through capacity building and policy, systems, and environmental change. Members of SACK are trained to apply the SPF model to identify the community's priority problems and evidence-based strategies to address these problems. They also created logic models in order to identify the problems, intervening variables, local conditions in order to select strategies.

ATOD EVIDENCE BASED PRACTICES

Evidence-based or promising practices used to address the strategy included:



The SPF model is used to continually assess the community; not only to identify the problem of inappropriate use of alcohol, tobacco and other drugs but also the related conditions and consequences that contribute to inappropriate use of alcohol, tobacco and other drugs. Information is collected; the availability of resources to support prevention efforts, and community readiness to address each problem is evaluated. Based on the assessment, priorities are determined. Strategies across the Kanabec-Pine area include the promising practice of conducting regular compliance checks, providing Responsible Beverage Service Training, participating in the National Take-Back Initiative. The Pine County Methamphetamine Task Force provides grant funds to seven local schools in Pine County to supplement their drug education programs as well as providing funds for community events. The goal of the task force is to reach all ages – young, middle age, and adults with educational materials. The two school districts in Kanabec County implement the evidence-based “Above the Influence” campaign, which is a national campaign that helps teens stand up to the negative pressures and influences of marijuana use and has been shown to reduce marijuana use among teens.

The table below reflects examples from the [Drug-Free Communities Work plan](#).⁴

Priority Issue: Inappropriate use of alcohol, tobacco and other drugs. Goal: Reduce Youth substance abuse. ¹
#1 Objective: Decrease marijuana use by 5% in Kanabec County among 8th, 9th and 11th grade students by May 1, 2016 and By May 1, 2016 decrease tobacco use by 10% among Kanabec County 8th, 9th and 11th grade students.
Status: In progress
Strengthen current drug policies at Mora Schools and Ogilvie Schools.
Implement evidence-based “Above the Influence” campaign, which is a national campaign that helps teens stand up to the negative pressures and influences of marijuana use and has been shown to reduce marijuana use among teens.
Conduct quarterly tobacco compliance checks using best practices.
Pass tobacco-free policy in Ogilvie Community Park and in area surrounding Mora High School.
Implement evidence-based Tobacco-Free Kids campaign aimed at reducing youth tobacco use.

ATOD GUIDANCE

State-of-the-art guidance used included:

Trainings are offered statewide by the Minnesota Prevention Resource Center or nationally by CADCA and SAMHSA. More than 40 active SACK members have many opportunities to attend trainings and conferences every year. Some are offered as part of a coalition meeting. For example, the coalition has sponsored presentations and trainings on social media, grassroots advocacy, and the culture of poverty. Coalition members and staff who attend trainings outside of the community are required to present what they learn at a coalition meeting when they return. These trainings equip coalition members with the knowledge and skills to implement prevention programs, practices, and policies.

ATOD POLICY CHANGES

Policy changes that were needed to accomplish these health objectives included:

Public Health has worked with local government to pass a number of ordinances and policies. The Kanabec County Board of Commissioners passed a social host ordinance in 2010 and revised its liquor ordinance to require responsible beverage server training as a condition for establishments to obtain a liquor license in 2013. The City of Mora’s Council also passed a social host ordinance in 2010 and a tobacco-free parks policy in 2011. The Cities of Pine City and Hinckley passed tobacco-free and tobacco-restricted parks policies in 2010. The Pine County Board of Commissioners passed an ordinance declaring the cleanup of clandestine drug lab sites as a chemical investigation site as a Public Health Nuisance in 2004.

ATOD RESPONSIBLE PARTY

Individuals and organizations, in addition to public health, responsible for the strategy implementation included:

SACK provides innovative programs and services that help keep Kanabec County residents strong and resilient against alcohol, tobacco and other drugs. The mission of SACK is to promote healthy choices in

the community through prevention and collaborative partnerships for the reduction of alcohol, tobacco and other drug abuse among youth and residents. Whereas much time and resources were once spent implementing “programs,” the whole community now collaborates to achieve policy, systems, and environmental change. Today, SACK remains a community-based entity with more than 40 active members and approximately 20 organizations committed to reducing youth substance use in Kanabec County. This is significant for a small, rural county with only 3,571 residents living in the largest city, two school districts, one law enforcement agency, and a few large employers.

The Pine County Meth Task Force meets quarterly to discuss action steps to reduce methamphetamine and other illegal drug use and manufacture in Pine County. This committee is comprised of commissioners, court representation, fire department personnel, and citizens from each district, local businesses, school personnel, county staff, and the Mille Lacs Band of Ojibway Indians.

The Task Force duties include:

Identification of the scope of methamphetamine use and manufacture in Pine County and the costs of dealing with it, for the individual and for local governments. They discuss questions such as, who does it impact? What local government departments must deal with it? What costs can be quantified?

Education of citizens, landlords, schools and government officials on the nature and impact of methamphetamine and its costs.

Development of a cooperative framework necessary to pursue grants for reducing methamphetamine use and manufacture, for abatement of property, for organization of concerned citizen groups within the county or for education of the public.

Research on the feasibility of county ordinances regarding methamphetamine manufacture in housing units or on property (if directed by the Board of Commissioners).

The Pine County Methamphetamine Task Force provides grant funds to seven local schools to supplement their drug education programs as well as providing funds for community events. The goal is to reach all ages – young, middle age, and adults.

ATOD MEASURABLE OUTCOMES

Measurable health outcomes or indicators of progress include:

Goal: Reduce Youth Substance Use

Objective 1: Decrease in past 30-day binge drinking among 18-25 year olds.

Objective 2: Decrease in past two week binge drinking among 9th and 11th graders.

Objective 3: Decrease in past 30 day alcohol use among 5th, 8th, 9th and 11th graders.

Objective 4: Decrease tobacco use among 8th, 9th, and 11th grade students in Kanabec County by 10% by May 1, 2016.

Objective 5: Decrease marijuana use among 8th, 9th, and 11th grade students in Kanabec County by 5% by May 1, 2016.

Method of Measurement: Minnesota Student Survey, Drug Free Communities Survey developed by University of Minnesota

ATOD NATIONAL PRIORITIES

Alignment with national priorities in implementing this strategy:

The alignment with national priorities in implementing strategies to address Alcohol, Tobacco and other Drugs is shown through alignment with Healthy People 2020, Substance Abuse and Tobacco Use Objectives:

SA-2 Increase the proportion of adolescents never using substances

SA-3 Increase the proportion of adolescents who disapprove of substance abuse

SA-4 Increase the proportion of adolescents who perceive great risk associated with substance abuse

TU-2 Reduce tobacco use by adolescents

ATOD COMMUNITY ASSETS

Existing community assets and resources available to implement the strategy included:

Mora Public Schools

Lakes & Pines CAC

Minnesota Teen Challenge

Ogilvie Public Schools

True Vine Lutheran Church

Juettner Marketing

Family Pathways

Mora Public Schools

Kanabec County

Pilot Outreach Jail Ministry

Kanabec County/ Commissioner

Central MN Jobs & Training Services

L and R Accounting

FirstLight Health System

The Refuge Network

Kanabec County

¹ Minnesota Department of Human Services, Substance Use in Minnesota, 2008-15. Retrieved from [SUMN Data](#)

² [SACK Coalition Members](#)

³ [Pine Meth Task Force Members](#)

⁴ [Full Workplan, Drug-Free Communities 2014-2015](#)

⁵ Department of Health and Human Services, Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies. *Healthy People 2020*. Topic Substance Abuse. Retrieved from [Healthy People 2020 substance abuse](#)

PRIORITY ISSUE: PUBLIC HEALTH EMERGENCY PREPAREDNESS

The goal of Public Health Emergency Preparedness is to improve the readiness of our jurisdiction for public health emergencies through planning, training and exercises. Strategies chosen to address this priority were: 1) Utilize a practical inventory management system for mass dispense reporting; 2) Create an Essential Services Plan for isolated and quarantined individuals; and 3) Enhance the current Security Plan for Mass Dispensing.

STRATEGY 1

Strategy Description 1: **Utilize a practical inventory management system for mass dispense reporting.**

Utilizing a practical inventory management system for mass dispense reporting refers to the tracking of supplies and equipment used during a medical countermeasure dispensing operation. Vaccines, medicines, ancillary supplies and/or equipment may be requested prior to and during a mass dispense clinic. A nationally recognized system would create an efficient and effective method for tracking those assets and sending status reports to the state health department.



EP PROMISING PRACTICE

The promising practice chosen to implement the strategy is the Inventory Management Tracking System (IMATS). As a result of gaps recognized during the 2009 pandemic, the Centers for Disease Control and Prevention (CDC) Division of Strategic National Stockpile partnered with the Countermeasure Tracking System (CTS) program in the CDC Division of Health Informatics and Surveillance, to build the nationwide CDC Inventory Management and Tracking System. The vision of IMATS is to increase the capacity of all levels of public health to track and manage inventory of medical and non-medical countermeasures during daily operations or an event requiring emergency response.

EP GUIDANCE

State-of-the-art guidance used to implement this strategy was the national online IMATS training. A WebEx training by MDH was conducted in January 2015 which was attended by four staff – two from Pine County and two from Kanabec County. This training is now available online and can be completed by other staff when needed.

EP POLICY CHANGE

A policy change that was needed to accomplish this training was the inclusion of the training objective in our Kanabec-Pine Public Health Emergency Preparedness Work Plan for the 2014-2015 grant years. This component of the work plan was required by the Minnesota Department of Health (MDH) as a grant duty under CDC 'Capability 9: Medical Materiel Management and Distribution'¹ and was approved by the local public health director and the MDH Regional Public Health Preparedness Consultant.

EP RESPONSIBLE PARTY

In addition to local public health Logistics Team staff in charge of supplies, it may be possible that MN Responds (Medical Reserve Corps) volunteers would need to participate in the tracking system during an event. However, at present, the responsibility for implementing the strategy lies with local public health staff, who have recently completed the training, and with the Minnesota Department of Health (MDH) and the CDC IMATS training staff, who are available for guidance.

EP HEALTH OUTCOME

A health outcome for the development of the IMATS includes the ability of the local health department to track and provide real time inventory status to CDC. See Action Plan chart below for specific measurable outcomes.

EP COMMUNITY ASSETS

Existing community assets and resources available to implement the strategy include computers with the capability to access the training, staff to complete it; and state health department and CDC IMATS staff to provide training, guidance and assistance.

EP NATIONAL PRIORITIES

Alignment with national priorities in implementing this strategy is demonstrated through the fulfillment of CDC 'Capability 9: Medical Materiel Management and Distribution', Function 3: "Maintain updated inventory management and reporting system."¹ This document aligns with the Department of Homeland Security's National Preparedness Goal which includes Presidential Policy Directive 8⁴. The directive describes the nation's approach to preparing for the threats and hazards that pose the greatest risk to the security of the United States. It also aligns with the Health People 2020 national initiative, topic 'Preparedness'⁵.

ACTION PLAN

Priority Issue: Emergency Preparedness

Goal: Improve preparedness of Kanabec and Pine Counties for public health emergencies through planning, training and exercises

#1 Objective: Develop the ability to track and provide real time inventory status for mass dispense supplies and equipment to MDH and CDC by June 30, 2015

Priority Issue: Emergency Preparedness
Goal: Improve preparedness of Kanabec and Pine Counties for public health emergencies through planning, training and exercises
Establish a local Inventory Management Tracking System (IMATS) account with CDC
Preparedness Coordinator completes IMATS training
Logistics Team staff complete IMATS training

¹U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Office of Public Health Preparedness and Response. 2011. *Public Health Preparedness Capabilities: National Standards for State and Local Planning*. p. 86. Retrieved from [CDC Preparedness capabilities](#)

STRATEGY 2

Strategy Description 2: Create an Essential Services Plan. Creating an Essential Services Plan for isolated or quarantined individuals includes the planning for provision of basic needs such as food, water, and medicine. In the event that a local resident needs to be quarantined and does not have the resources or the assistance from family or friends to access these essential services, local public health has the responsibility to meet those needs.



EP PROMISING PRACTICE

A promising practice chosen to implement the strategy is the writing of the plan itself with guidance from MDH. Components of the plan include utilization of local resources such as grocery stores, medical supply stores, etc. that could help meet the essential needs of quarantined and isolated individuals. The plan also includes the identification of personnel responsible to transport supplies and to coordinate and report activities to MDH.

EP GUIDANCE

State-of-the-art guidance used to address the strategy included three documents developed in July 2014 by the Minnesota Department of Health. These documents include: 'Isolation and Quarantine Essential Services Plans for Local Public Health: Basic Checklist,' 'Isolation and Quarantine Essential Services Plans for Local Public Health: FAQ,' and the 'Isolation and Quarantine Essential Services Request and Tracking Form.' The three documents provide a template for local public health to create their own Essential Services Plan.

EP POLICY CHANGE

A policy change that was needed to accomplish the writing of this plan was the inclusion of the plan objective in the Kanabec-Pine Public Health Emergency Preparedness Work Plan for the 2014-2015 grant year. This component of the work plan was required by the Minnesota Department of Health (MDH) as a grant duty under CDC 'Capability 11: Non-Pharmaceutical Interventions'² and was approved by the local public health director and the MDH Regional Public Health Preparedness Consultant.

EP RESPONSIBLE PARTY

Individuals and organizations, in addition to public health, responsible for the strategy implementation include the County Preparedness Advisory Council to review and discuss the plan and resources available for fulfilling essential services. The Council consists of public health and human services personnel; representatives from county Emergency Management, health facilities, and ambulance service; as well as other community organizations. Local ambulance service would provide transport to a medical facility if needed; local county Emergency Management could assist with resources not available locally; human services personnel could provide behavioral health services. In addition to these, the Minnesota Department of Health conducts monitoring of quarantined residents to assess their needs, and officially makes requests to local public health to address the specific needs of those quarantined individuals.

EP HEALTH OUTCOME

A health outcome for this strategy is the fulfillment of basic needs for isolated or quarantined individuals in our jurisdiction. See Action Plan chart below for specific measurable outcomes.

EP COMMUNITY ASSETS

Existing community assets and resources available to implement the strategy include the MDH essential services plan documents, public health staff, local suppliers of food and medicine, local ambulance service, local human services agency staff and local emergency management personnel.

EP NATIONAL PRIORITIES

Alignment with national priorities in implementing this strategy is demonstrated through the fulfillment of the CDC Capability document 'Capability 11: Non-Pharmaceutical Interventions, Function 3, Resource Element P1': "Written plans should include agreements with health care coalitions and other community partners to coordinate support services to individuals during isolation or quarantine scenarios."² This document aligns with the Department of Homeland Security's National Preparedness Goal which includes Presidential Policy Directive 8⁴. The directive describes the nation's approach to

preparing for the threats and hazards that pose the greatest risk to the security of the United States. It also aligns with the Health People 2020 national initiative, topic ‘Preparedness’⁵.

ACTION PLAN

<p>Priority Issue: Emergency Preparedness Goal: Improve preparedness of Kanabec and Pine Counties for public health emergencies through planning, training and exercises</p>
<p>#2 Objective: Create an Essential Services Plan for isolated or quarantined individuals in Pine and Kanabec Counties by June 30, 2015</p>
<p>Review guidance from MDH regarding components of a plan</p>
<p>Write draft of Essential Services Plan</p>
<p>Review Plan with other Emergency Preparedness Staff and Public Health Director; edit</p>
<p>Present Plan to all Public Health Staff and to Preparedness Advisory Council</p>

² U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Office of Public Health Preparedness and Response. 2011. *Public Health Preparedness Capabilities: National Standards for State and Local Planning*. p. 106. Retrieved from [CDC Preparedness Capabilities](#)

STRATEGY 3

Strategy Description 3: Enhance the existing Security Plan for Mass Dispensing. The existing Security Plan included in the ‘County Strategic National Stockpile and Medical Countermeasure (SNS/MCM) Dispensing Plan’ includes general procedures for securing and transporting assets; controlling entry to and exit from a facility used for mass dispensing; and for operating a traffic control post, roadblock and checkpoint. Gaps to the plan include training security personnel on the plan specifics; site vulnerability assessment; evacuation and security breach plans; badging procedures and training; handling of spontaneous volunteers; protecting dispensing site personnel; and collaborating with Emergency Management. All of the components, including the existing ones, need to be made site-specific for each potential mass dispense site.



EP EVIDENCE-BASED PRACTICE

Evidence-based or promising practices used to address the strategy include the '2011 CDC Public Health Capabilities: National Standards for State and Local Planning' document, 'Capability 8: Medical Countermeasure Dispensing'; 'Capability 9: Medical Materiel Management and Distribution,'³; and the document: CDC's Division of Strategic National Stockpile *Local Technical Assistance Review(LTAR)* tool.

EP GUIDANCE

State-of-the-art guidance used included the two resources referred to in the previous paragraph, as well as assistance from MDH personnel to review current plans and assess gaps. Capabilities 8 (Medical Countermeasure Dispensing) and 9 (Medical Materiel Management and Distribution) in the CDC document mentioned above include the resource elements which address security measures required at the mass dispensing site as well as during the acquisition, storage and distribution process. In addition, MDH staff periodically visit local county public health agencies in Minnesota to assess the completeness of Mass Dispensing Plans and to give guidance.

EP POLICY CHANGES

A policy change that was needed to accomplish the writing of this plan was the inclusion of the plan objective in the Kanabec-Pine Public Health Emergency Preparedness Work Plan for the 2014-2015 grant years. This component of the work plan was required by the Minnesota Department of Health (MDH) as a grant duty under 'Capability 8: Medical Countermeasure Dispensing' and 'Capability 9: Medical Materiel Management and Distribution'³ and was approved by the local public health supervisor and director and the MDH Regional Public Health Preparedness Consultant.

EP RESPONSIBLE PARTY

Individuals and organizations, in addition to public health, responsible for the strategy implementation include the local law enforcement agency in each county -- the Pine County Sheriff's Office and the Kanabec County Sheriff's Office. In 2008, Pine County Sheriff's Office upper management staff and Public Health were involved in the creation of the security plan component of the Medical Countermeasure Dispensing Plan and will also update the plan with the additional items that were identified. Collaboration between local public health and law enforcement will ensure identified components are completed satisfactorily to fulfill the Capability elements.

EP HEALTH OUTCOME

The health outcomes of implementing this strategy are written plans for the secure transport of medical materiel and a safe environment in which the local health department dispenses medical countermeasures. See Action Plan chart below for specific measurable outcomes.

EP COMMUNITY ASSETS

Existing community assets and resources available to implement the security strategy included the CDC’s LTAR tool and Capabilities documents, local law enforcement staff, and the local emergency preparedness advisory council in Pine County.

EP NATIONAL PRIORITIES

Alignment with national priorities in implementing this strategy is shown through the fulfillment of the CDC Capability document, ‘Capability 8: Medical Countermeasure Dispensing, Function 3, P3’: “Written plans should include security measures, processes and protocols for dispensing sites”; and ‘Capability 9: Medical Materiel Management and Distribution, Function 4, P1’: “Written plans should include processes and protocols that address the maintenance of physical security of medical countermeasures throughout acquisition, storage, and distribution...”³ This document aligns with the Department of Homeland Security’s National Preparedness Goal which includes Presidential Policy Directive 8⁴. The directive describes the nation’s approach to preparing for the threats and hazards that pose the greatest risk to the security of the United States. It also aligns with the Health People 2020 national initiative, topic ‘Preparedness’⁵.

ACTION PLAN

Priority Issue: Emergency Preparedness Goal: Improve preparedness of Kanabec and Pine Counties for public health emergencies through planning, training and exercises
#3 Objective: Enhance the existing Security Plan for Mass Dispensing by June 30, 2015
Review CDC guidance documents for the Security Plan with Sheriff’s Office
Sheriff’s Office write draft of plan and review with Public Health Preparedness Coordinator
Review plan with Preparedness staff and Public Health Director and edit for final inclusion in SNS/MCM Plan

³ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Office of Public Health Preparedness and Response. 2011. *Public Health Preparedness Capabilities: National Standards for State and Local Planning*. pp. 76, 88. Retrieved from [CDC Preparedness Capabilities](#)

⁴ U.S. Department of Homeland Security. 2011. *National Preparedness Goal, First Edition*. Retrieved from [FEMA National Preparedness Goal](#)

⁵ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Office of the Assistant Secretary for Preparedness and Response. *Healthy People 2020*. Topic Preparedness. Retrieved from [Healthy People 2020 Preparedness](#)

Appendix:

COMMUNITY HEALTH ASSESSMENT

People and Place Demographic Description

Kanabec County: The current population estimate for Kanabec County is 16,005 persons for 2012 compared to the 2005 population of 16,215 and the size is 525 square miles. According to the 2012 Census, the population per square mile is 30.5 compared to the state population per square mile of 67.6. The largest communities in Kanabec County include Mora and Ogilvie; smaller communities include Brunswick, Grasston, and Quamba. Industries that employ Kanabec county residents consist of county/city government, factory, construction, small business, health care and farming.

Kanabec County is an economically depressed area with a 2009-2013 per capita income of \$22,291 compared to the state per capita income of \$30,913. In 2009-2013, 14.2% of people were in poverty. An estimated 20% of Kanabec County children under 18 were below the poverty level (as compared to 10% statewide). 9% of Kanabec County residents were people 65 years old and over. An estimated 10% of all families and 37% of families with a female householder and no husband present had incomes below the poverty level. The Minnesota Department of Employment and Economic Development indicate that the 2014 annual average unemployment rate for Kanabec County is 8.6% compared to 4.1% statewide. Kanabec County is low-ranked 83rd out of Minnesota's 87 counties in social and economic factors.

Approximately 3,987 (24.9%) of Kanabec County residents are between the ages of 0-19 years old. Of those 2,277 are enrolled in the Mora and Ogilvie School Districts, which are 8 miles apart. The Mora school district #332 has a 2013-14 enrollment of 1,773 students and is comprised of three schools; Fairview Elementary, Trailview Middle School and Mora High School. Ogilvie School District #333 consists of one school that enrolls 509 students kindergarten through 12th grade. All schools are the center of community activity, in which dances, funerals, 4-H, Boys Scouts, Girls Scouts, Brownies and other community activities are held. In Kanabec County, 46.1% of the children enrolled in school, participate in the free or reduced lunch program compared to 38.5% statewide (2013-2014 school year).

In 2009-2013 an estimated 23 percent of the population was under 18 years and 17 percent was 65 years and older. The Bureau of Census indicates that 17.7% of the population in Kanabec County is over the age of 65 compared to the state percent of 13.5 (2013). In 2013, the total age dependency ratio was 57.1 compared to the 2006 ratio of 48.4. In 2013, the state ratio was 50.6 compared to 46.5 in 2006.

Pine County:

Pine County with an estimated 2012 population of 29,218 compared to the 2006 population of 27,996 and covering 1,411 square miles is located on the Wisconsin border approximately 80 miles north of the twin cities. The population per square mile is 20.7 compared to the state population per square mile of 67.6. The 35W corridor runs through Pine County making tourism one of Pine County's industries. Also, bringing more travelers is the Hinckley casino. The largest communities in Pine County include the county seat of Pine City, Hinckley, Moose Lake, and Sandstone. Smaller communities include Askov, Beroun, Brook Park, Bruno, Finlayson, Henriette, Kerrick, Rock Creek, Rutledge, Sturgeon Lake, and Willow River.

Outside of tourism, industries that make up the community include: local county/city government, school districts, factory, construction, logging, small business, health care, and farming.

The total school enrollment in Pine County in 2013-2014 was 3,966 students across 4 school districts and one private academy. There is a total of thirteen schools in Pine County. The percentage of children receiving free and reduced lunches during the 2013-2014 school year was 49.9% compared to 38.5% statewide.

In 2013, 17.5% of the Pine County population is over the age of 65 years compared to the state percentage of 13.5. The total age dependency ratio (2013) is 54.3 compared to the 2006 rate of 48.1. The 2013 MN state age dependency ratio is 50.6. An estimated 22 percent of the population was under 18 years and 17 percent was 65 years and older.

The per capita income in 2013 was \$31,341 compared to the 2004 per capita income of \$24,189; this is compared to the MN state per capita incomes of \$47,500 and \$36,184 respectively. Pine County is low-ranked at 82nd out of Minnesota's 87 counties in social and economic factors. The Minnesota Department of Employment and Economic Development indicate that the 2014 annual average unemployment rate for Pine County is 6.7% compared to 4.1% statewide. In 2013, the percent of people in poverty was 15.7% in Pine County compared to 11.2% in MN. An estimated 19 percent of related children under 18 were below the poverty level, compared with 10 percent of people 65 years old and over. An estimated 11 percent of all families and 34 percent of families with a female householder and no husband present had incomes below the poverty level.

Minorities make up 6% of the total population (2012). 3% are American Indian, 2% African American, and 1% Asian.

DEMOGRAPHICS

Ages (Years)		2006		2007		2008		2009		2010		2011		2012	
		total	%	total	%										
MN	Total	5,167,101		5,197,621		5,220,393		5,266,214		5,303,925		5,344,861		5,379,139	
	0-17*	1,257,264	24.3	1,260,282	24.2	1,254,644	24	1,260,795	23.9	1,284,063	24.2	1,277,526	23.9%	1,424,771	26.5%
	18-64*	3,282,443	63.5	3,301,123	63.5	3,315,230	63.5	3,334,362	63.3	3,336,741	62.9	3,365,567	63.0%	3,224,601	59.9%
	65+	627,396	12.1	636,216	12.2	650,519	12.5	671,055	12.7	683,121	12.9	701,768	13.1%	729,767	13.6%
CHB	Total	44,695		44,254		44,388		44,267		45,989		45,773		45,223	
	0-17*	9,898	22.1	9,895	22.4	9,656	21.8	9,880	22.3	10,495	22.8	10,140	22.2%	10,843	24.0%
	18-64*	28,096	62.9	27,595	62.3	27,844	62.7	27,211	61.5	27,979	60.8	27,997	61.2%	26,418	58.4%
	65+	6,701	15	6,764	15.3	6,888	15.5	7,176	16.2	7,515	16.4	7,636	16.7%	7,962	17.6%
Kanabec	Total	16,276		16,090		16,091		15,899		16,239		16,169		16,005	
	0-17*	3,697	22.7	3,705	23	3,616	22.5	3,766	23.7	3,896	24	3,763	23.3%	3,987	24.9%
	18-64*	10,237	62.9	10,017	62.3	10,061	62.5	9,638	60.6	9,684	59.6	9,704	60.0%	9,179	57.4%
	65+	2,342	14.4	2,368	14.7	2,414	15	2,495	15.7	2,659	16.4	2,702	16.7%	2,839	17.7%
Pine	Total	28,419		28,164		28,297		28,368		29,750		29,604		29,218	
	0-17*	6,201	21.9	6,190	22	6,040	21.3	6,114	21.6	6,599	22.2	6,377	21.5%	6,856	23.5%
	18-64*	17,859	62.8	17,578	62.4	17,783	62.9	17,573	61.9	18,295	61.5	18,293	61.8%	17,239	59.0%
	65+	4,359	15.3	4,396	15.6	4,474	15.8	4,681	16.5	4,856	16.3	4,934	16.7%	5,123	17.5%

*Note change in 2012 in age range 0-19 and 20-64

Source: U.S. Census [Census](#) local source MN Center for Health statistics, MN County Health Tables, Demographics Section

[County Health Tables - MDH](#)

		Race and Ethnicity									
		2008		2009		2010		2011		2012	
		total	%	total	%	total	%	total	%	total	%
MN	Total	5,220,393		5,266,214		5,303,925		5,344,861		5,379,139	
	White	4,648,528	89	4,664,703	88.6	4,524,062	85	4,645,546	86.9%	4,654,134	86.5%
	American Indian/ Alaskan Native	64,503	1.2	66,640	1.3	60,916	1.1	68,412	1.3%	68,961	1.3%
	Black/African American	238,531	4.6	249,909	4.7	274,412	5.2	286,301	5.4%	297,962	5.5%
	Asian/Pacific Islander	188,340	3.6	202,143	3.8	216,390	4	228,506	4.3%	238,326	4.4%
	Two or more races	80,491	1.5	82,819	1.6	125,145	2.4	116,096	2.2%	119,756	2.2%
	Ethnicity - Hispanic/Latino	216,574	4.1	226,384	4.3	250,258	4.7	259,297	4.9%	264,359	4.9%
CHB	Total	44,388		44,267		45,989		45,773		45,223	
	White	42,053	94.7	41,870	94.6	43,101	93.7	43,012	94.0%	42,485	93.9%
	American Indian/ Alaskan Native	1,081	2.4	1,092	2.5	1,011	2.2	1,031	2.3%	1,043	2.3%
	Black/African American	525	1.2	586	1.3	652	1.4	715	1.6%	701	1.6%
	Asian/Pacific Islander	247	0.6	214	0.5	195	0.4	218	0.5%	228	0.5%
	Two or more races	482	1.1	505	1.1	808	1.8	797	1.7%	766	1.7%
	Ethnicity -Hispanic/Latino	829	1.9	881	2	937	2	973	2.1%	974	2.2%
		Race and Ethnicity									
		2008		2009		2010		2011		2012	
		total	%	total	%	total	%	total	%	total	%
Kanabec	Total	16,091		15,899		16,239		16,169		16,005	
	White	15,558	96.7	15,379	96.7	15,754	97	15,691	97.0%	15,537	97.1%
	American Indian/ Alaskan Native	202	1.3	184	1.2	90	0.6	98	0.6%	99	0.6%
	Black/African American	34	0.2	51	0.3	55	0.3	60	0.4%	73	0.5%
	Asian/Pacific Islander	113	0.7	94	0.6	56	0.3	69	0.4%	61	0.4%
	Two or more races	184	1.1	191	1.2	250	1.5	251	1.6%	235	1.5%
	Ethnicity - Hispanic/Latino	182	1.1	195	1.2	214	1.3	246	1.5%	249	1.6%
Pine	Total	28,297		28,368		29,750		29,604		29,218	
	White	26,495	93.6	26,491	93.4	27,347	91.9	27,321	92.3%	26,948	92.2%
	American Indian/ Alaskan Native	879	3.1	908	3.2	921	3.1	933	3.2%	944	3.2%
	Black/African American	491	1.7	535	1.9	597	2	655	2.2%	628	2.1%
	Asian/Pacific Islander	134	0.5	120	0.4	139	0.5	149	0.5%	167	0.6%
	Two or more races	298	1.1	314	1.1	558	1.9	546	1.8%	531	1.8%
	Ethnicity - Hispanic/Latino	647	2.3	686	2.4	723	2.4	727	2.5%	725	2.5%

Source: U.S. Census [Census](#) local source MN Center for Health statistics, MN County Health Tables, Demographics Section [County health Tables - MDH](#)

Demographics and Socioeconomics

Total Population	2009	2010	2011	2012	2013
State of Minnesota	5,266,214	5,303,925	5,344,861	5,379,139	5,420,380
Kanabec County	15,899	16,239	16,169	16,005	15,996
Pine County	28,368	29,750	29,604	29,218	29,104
Kanabec- Pine CHB	44,267	45,989	45,773	45,223	45,100

Estimated Number of Households	2009	2010	2011	2012	2013
State of Minnesota	2,108,843	2,087,227	2,101,295	2,110,877	2,132,670
Kanabec County	6,427	6,413	6,419	6,382	6,375
Pine County	11,014	11,373	11,369	11,295	11,281
Kanabec- Pine CHB	17,441	17,786	17,788	17,677	17,656

Unemployed-Annual Average (%)	2009	2010	2011	2012	2013
State of Minnesota	8.1	7.3	6.4	5.6	5.1
Kanabec County	13.5	12.1	11.1	9.8	9.2
Pine County	11.6	10.3	9.3	8.1	7.5
Kanabec- Pine CHB	12.3	11.0	9.9	8.7	8.1

Food Stamp Utilization (Avg. monthly household)	2009	2010	2011	2012	2013
State of Minnesota	169,711	134,859	237,132	251,642	259,246
Kanabec County	651	522	943	941	919
Pine County	1,199	929	1,711	1,792	1,865
Kanabec- Pine CHB	1,850	1,451	2,654	2,734	2,784

Per Capita Income (adjusted to 2013 dollars)	2009	2010	2011	2012	2013
State of Minnesota	\$44,770	\$45,481	\$46,832	\$48,071	\$47,500
Kanabec County	\$31,562	\$32,133	\$32,884	\$33,947	\$34,263
Pine County	\$29,837	\$30,311	\$30,672	\$31,151	\$31,341
Kanabec- Pine CHB	\$30,448	\$30,955	\$31,455	\$32,141	\$32,377

Median Household Income (adjusted to 2013 dollars)	2009	2010	2011	2012	2013
State of Minnesota	\$60,397	\$59,209	\$58,974	\$59,690	\$60,664
Kanabec County	\$49,909	\$45,657	\$46,284	\$44,877	\$46,940

Pine County	\$42,684	\$44,907	\$43,960	\$46,616	\$43,026
Kanabec- Pine CHB	NA	NA	NA	NA	\$0

In Poverty All Ages	2009	2010	2011	2012	2013
State of Minnesota	10.9	11.5	11.8	11.4	11.2
Kanabec County	11.1	13.6	14.4	14.6	14.2
Pine County	18.9	15.2	15.9	13.4	15.7
Kanabec- Pine CHB	16.0	14.6	15.3	13.8	15.1

In Poverty Age 0-17 (%)	2009	2010	2011	2012	2013
State of Minnesota	13.9	15.0	15.3	14.6	14.0
Kanabec County	17.6	20.4	22.0	21.7	21.6
Pine County	25.7	21.7	24.0	20.8	23.2
Kanabec- Pine CHB	22.6	21.2	23.3	21.1	22.6

Elderly Dependency Ratio	2009	2010	2011	2012	2013
(# of people over 64 per 100 people over 15-64)					

State of Minnesota	18.9	19.2	19.6	20.3	21.0
Kanabec County	24.0	25.5	26.0	27.8	28.5
Pine County	24.9	24.9	25.4	27.1	27.8
Kanabec- Pine CHB	24.6	25.1	25.6	27.3	28.1

Child Dependency Ratio (# of people under 15 years old per 100 people 15-64)	2009	2010	2011	2012	2013
State of Minnesota	29.9	29.6	29.6	29.6	29.6
Kanabec County	30.3	29.6	28.8	28.8	28.7
Pine County	27.8	27.2	27.4	27.4	26.5
Kanabec- Pine CHB	28.6	28.1	27.9	27.9	27.2

Total Dependency Ratio	2009	2010	2011	2012	2013
State of Minnesota	48.4	49.1	49.2	49.9	50.6
Kanabec County	53.2	55.8	55.6	56.5	57.1
Pine County	51.2	52.7	52.7	54.4	54.3
Kanabec- Pine CHB	51.9	53.8	53.7	55.2	55.3

SCHOOLS

School Enrollment PreK-12	2010-11	2011-12	2012-13	2013-14
State of Minnesota	837,640	839,426	845,177	850,763
Kanabec County	2,403	2,342	2,338	2,277
Pine County	3,910	3,878	3,884	3,866
Kanabec- Pine CHB	6,313	6,220	6,222	6,143

	2010-11	2011-12	2012-13	2013-14
Students Eligible (%)				
Free and Reduced Meals				
State of Minnesota	36.6	37.2	38.3	38.5
Kanabec County	47.6	46.0	47.0	46.1
Pine County	49.7	49.0	51.0	49.9
Kanabec- Pine CHB	48.9	47.9	49.5	48.5

Students who Receive	2010-11	2011-12	2012-13	2013-14
Special Education (%)				
State of Minnesota	14.8	14.9	14.9	14.9
Kanabec County	14.1	15.6	15.2	14.3

Pine County	12.3	12.7	13.1	13.1
Kanabec- Pine CHB	13.0	13.8	13.9	13.5

Maternal-Child Health

Number of Births	1994-1998	1999-2003	2004-2008	2009-2013
State of Minnesota	320,916	338,111	361,106	345,406
Kanabec County	777	845	955	779
Pine County	1,302	1,566	1,673	1,508
Kanabec- Pine CHB	2,079	2,411	2,628	2,287

Birthrate per 1,000 population	1994-1998	1999-2003	2004-2008	2009-2013
State of Minnesota	13.8	13.7	14.0	12.9
Kanabec County	11.2	11.1	11.8	9.7
Pine County	11.2	11.7	11.8	10.3
Kanabec- Pine CHB	11.2	11.5	11.8	10.1

Low Birth Weight, single births	1994-1998	1999-2003	2004-2008	2009-2013
(%) (less than 2,500 grams)				

State of Minnesota	4.4	4.6	4.9	4.8
Kanabec County	5.6	4.3	3.3	4.1
Pine County	4.5	4.9	4.9	5.0
Kanabec- Pine CHB	4.9	4.7	4.3	4.7

Premature Births (%) (less than 37 weeks gestation)	1994-1998	1999-2003	2004-2008	2009-2013
State of Minnesota	7.4	7.7	8.4	8.0
Kanabec County	7.5	6.9	7.6	8.5
Pine County	6.9	8.1	9.9	9.0
Kanabec- Pine CHB	7.1	7.7	9.2	8.8

Receiving Prenatal Care 1st Trimester, (%)	1994-1998	1999-2003	2004-2008	2009-2013
State of Minnesota	83.8	85.2	86.1	84.8
Kanabec County	81.3	81.2	85.5	83.2
Pine County	74.5	80.4	80.0	82.2
Kanabec- Pine CHB	77.1	80.7	82.0	82.5

Mothers Who Smoked During Pregnancy (%)	1994-1998	1999-2003	2004-2008	2009-2013
State of Minnesota	13.1	10.9	9.7	10.8
Kanabec County	27.1	25.7	24.6	25.8
Pine County	25.0	26.6	25.7	28.4
Kanabec- Pine CHB	25.8	26.3	25.3	27.5

	1994-1998	1999-2003	2004-2008	2009-2013
Births to Unmarried Women				
State of Minnesota	24.8	26.5	31.3	33.1
Kanabec County	34.0	37.0	37.5	42.2
Pine County	33.9	38.3	41.7	46.3
Kanabec- Pine CHB	34.0	37.9	40.1	44.9

Teen Birth Rate (per 1,000 15-19 years old)	1994-1998	1999-2003	2004-2008	2009-2013

State of Minnesota	32.3	28.1	27.3	20.3
Kanabec County	37.4	35.6	34.0	23.1
Pine County	40.5	43.3	38.4	31.4
Kanabec- Pine CHB	39.3	40.3	36.8	28.2

Number of Infant Deaths by Birth year	1993-1997	1998-2002	2003-2007	2008-2012
State of Minnesota	2,113	1,867	1,798	1,721
Kanabec County	7	4	3	3
Pine County	11	9	10	15
Kanabec- Pine CHB	18	13	13	18

Causes of Death

Number of Deaths	1994-1998	1999-2003	2004-2008	2009-2013
State of Minnesota	184,966	189,613	186,990	197,458
Kanabec County	630	637	656	714
Pine County	1,159	1,226	1,237	1,235
Kanabec- Pine CHB	1,789	1,863	1,893	1,949

Crude Death Rate (per 100,000 population)	1994-1998	1999-2003	2004-2008	2009-2013
State of Minnesota	795.4	765.8	724.2	739.1
Kanabec County	910.3	838.1	812.6	889.1
Pine County	998.2	919.7	874.3	845.6
Kanabec- Pine CHB	0.0	0.0	0.0	0.0

Age-adjusted Death Rate (per 100,000 population)	1994-1998	1999-2003	2004-2008	2009-2013
State of Minnesota	797.5	748.2	674.9	653.1
Kanabec County	824.8	780.1	707.2	717.9
Pine County	837.6	800.1	718.7	676.8
Kanabec- Pine CHB	832.0	790.0	713.0	691.0

Age-adjusted Death Rate/Female (per 100,000 population)	1994-1998	1999-2003	2004-2008	2009-2013
State of Minnesota	654.3	628.2	572.5	555.9
Kanabec County	694.9	634.9	587.7	573.0

Pine County	648.2	654.1	602.6	545.6
Kanabec- Pine CHB	663.3	644.5	596.1	554.1

Age-adjusted Death Rate/Male (per 100,000 population)	1994-1998	1999-2003	2004-2008	2009-2013
State of Minnesota	998.5	910.0	808.6	775.2
Kanabec County	957.4	975.8	846.5	899.2
Pine County	1,055.1	972.8	851.6	823.5
Kanabec- Pine CHB	1,019.4	970.5	847.8	848.3

Cancer (Age-adjusted Death Rate)	1994-1998	1999-2003	2004-2008	2009-2013
State of Minnesota	193.2	185.3	171.1	161.3
Kanabec County	182.8	196.8	195.2	166.0
Pine County	212.7	197.7	210.9	161.4
Kanabec- Pine CHB	202.1	196.8	205.3	163.0

Heart Disease (Age-adjusted Death Rate)	1994-1998	1999-2003	2004-2008	2009-2013
State of Minnesota	212.8	171.0	135.5	118.9
Kanabec County	201.8	170.8	138.2	150.3
Pine County	243.7	221.9	162.9	121.2
Kanabec- Pine CHB	229.0	203.3	153.4	131.2

Original source U.S. Census ([Census](#))

Local source MN Center for Health Statistics (Vital Statistics Trend Report)

www.health.state.mn.us/divs/chs/trends/index.html

Selected Mortality Indicators

Leading Causes of Death	Kanabec						Pine						State					
	2005	2008	2009	2010	2011	2012	2005	2008	2009	2010	2011	2012	2005	2008	2009	2010	2011	2012
Cancer	29.9%	26.7%	30.0%	21.9%	33.6%	28.6%	27.6%	27.4%	25.2%	27.4%	32.6%	35%	23.5%	24.5%	25.3%	31%	31%	31%
Heart Disease	25.5%	14.6%	23.3%	28.9%	27.7%	25.5%	25.6%	21.1%	20.5%	25.8%	26.8%	20%	21.1%	19.3%	19.1%	23%	24%	25%
Chronic Lower Respiratory Disease	3.6%	2.5%	8.0%	7.0%	4.2%	7.1%	3.6%	6.3%	8.1%	6.3%	11.6%	6%	5.2%	5.3%	5.2%	6%	7%	7%
Stroke	2.9%	5.7%	4.7%	13.2%	7.6%	8.2%	6.5%	5.1%	8.5%	6.8%	5.8%	8%	6.3%	5.4%	5.4%	7%	7%	7%
Unintentional Injury	10.9%	8.9%	2.0%	5.3%	7.6%	10.2%	5.6%	3.9%	6.4%	11.1%	8.4%	10%	5.1%	5.2%	5.4%	7%	8%	8%
Diabetes	1.4%	2.5%	1.3%	1.8%	2.5%	3.1%	3.6%	4.3%	1.3%	4.2%	2.1%	5%	3.3%	2.8%	2.7%	3%	4%	4%
Alzheimer's Disease	70.0%	1.9%	2.7%	4.4%	2.5%	1.0%	2.0%	1.1%	0.9%	4.2%	2.1%	2%	3.5%	3.4%	3.6%	5%	5%	5%
Suicide	70.0%	1.9%	1.3%	3.5%	2.5%	3.1%	40.0%	1.9%	1.7%	3.7%	1.6%	2%	1.4%	1.5%	1.5%	2%	2%	2%
Nephritis	2.9%	3.1%	2.0%	5.3%	2.5%	6.1%	2.0%	3.5%	1.7%	2.1%	0.5%	2%	1.7%	2.1%	2.1%	3%	2%	2%
Hypertension	--	1.9%	0.0%	0.0%	1.7%	3.1%	40.0%	70.0%	0.9%	3.7%	4.7%	1%	1.4%	1.3%	1.2%	1%	2%	2%
Other	16.0%	24.2%	16.7%	--	--	--	17.0%	19.1%	17.1%	--	--	--	21.4%	23.2%	23.5%	--	--	--

Source: MN Center for Health statistics, MN County Health Tables, Mortality Section [County Health Tables - MDH](#)

Infectious Disease

Selected Infectious Disease Indicators							
Lyme disease, number of new cases	2006	2007	2008	2009	2010	2011	2012
Kanabec	7	12	8	7	8	5	4
Pine	25	41	22	35	33	33	17
State	913	1239	1050	1065	1293	1201	912
Human Anaplasmosis	2006	2007	2008	2009	2010	2011	2012
Kanabec	1	3	5	4	14	11	4
Pine	5	12	6	18	25	30	16
State	176	322	278	317	720	782	507
West Nile Virus	2006	2007	2008	2009	2010	2011	2012
Kanabec	-	0	0	0	0	0	0
Pine	-	0	0	0	0	0	0
State	-	101	10	4	8	2	70
Giardiasis	2006	2007	2008	2009	2010	2011	2012
Kanabec	1	2	0	1	0	0	0
Pine	2	1	2	0	3	1	1
State	1105	904	756	678	846	686	633
Campylobacteriosis	2006	2007	2008	2009	2010	2011	2012
Kanabec	3	3	2	1	3	6	0
Pine	2	3	4	3	10	7	3
State	899	907	885	919	1007	1235	954
Salmonellosis	2006	2007	2008	2009	2010	2011	2012
Kanabec	0	0	0	2	3	0	0
Pine	2	5	3	1	2	0	3
State	725	711	756	578	695	701	786
Tuberculosis	2006	2007	2008	2009	2010	2011	2012
Kanabec	0	0	0	0	0	0	0
Pine	1	1	0	0	0	0	0
State	217	238	211	161	135	137	162

Source: Minnesota Department of Health, Acute Disease Epidemiology

[County Health Tables - MDH](#)

Vaccine Preventable Disease Indicators

Vaccine Preventable Disease Indicators						
Mumps	2006	2007	2008	2009	2010	2011
Kanabec	0	0	0	0	0	*
Pine	4	0	0	0	0	*
State	180	28	34	6	6	*
Pertussis	2006	2007	2008	2009	2010	2011
Kanabec	0	0	0	9	0	0
Pine	0	0	0	3	0	2
State	320	393	1034	1134	1142	661
Hepatitis A	2006	2007	2008	2009	2010	2011
Kanabec	0	0	0	0	0	0
Pine	0	0	0	0	0	1
State	31	94	49	30	37	29
Hepatitis B	2006	2007	2008	2009	2010	2011
Kanabec	0	0	0	0	0	0
Pine	0	0	0	0	0	0
State	32	25	24	39	24	17

Source: Minnesota Department of Health - Immunization, TB & International Health Section [County Health Tables - MDH](#)

Sexually Transmitted Diseases

Number of Cases of Chlamydia, Gonorrhea, Syphilis, HIV (All Stages) 2006-2013								
Chlamydia	2006	2007	2008	2009	2010	2011	2012	2013
Minnesota	12,975	13,480	14,414	14,369	15,509	16,898	18,048	18,724
Kanabec	16	11	26	26	22	23	14	25
Pine	30	48	34	41	37	42	58	74
Gonorrhea	2006	2007	2008	2009	2010	2011	2012	2013
Minnesota	3,316	3,479	3,054	2,328	2,149	2,283	3,082	3,872
Kanabec	0	0	0	3	1	1	0	1
Pine	1	2	2	1	0	0	1	7
Syphilis All Stages	2006	2007	2008	2009	2010	2011	2012	2013
Minnesota	190	186	263	214	347	366	335	*
Kanabec	0	0	0	0	0	0	0	*
Pine	0	0	0	1	0	1	0	*
HIV (AIDS)	2006	2007	2008	2009	2010	2011	2012	2013
Minnesota	318	325	326	372	331	292	314	301
Kanabec	0	0	0	0	1	0	1	1
Pine	0	0	0	1	2	1	1	2

Source: Minnesota Department of Health, STD Statistics and Reports

<http://www.health.state.mn.us/divs/idepc/dtopics/stds/stats/2013/stdsurvrpts2013.html#archive>

Injuries

Unintentional Injuries and Falls (Fatal)					
Unintentional Injuries Fatal (#) under 20 years old	2006	2007	2008	2009	2010
Kanabec	0	0	1	0	0
Pine	1	2	0	1	2
State	168	149	132	122	132
Unintentional Injuries Fatal (#) 20 years and above	2006	2007	2008	2009	2010
Kanabec	5	4	13	3	6
Pine	13	12	10	14	19
State	1746	1914	1870	1912	1955
Falls Fatal (#) under 20 years old	2006	2007	2008	2009	2010
Kanabec	0	0	0	0	0
Pine	0	0	0	0	0
State	4	4	3	4	2
Falls Fatal (#) 20 years and above	2006	2007	2008	2009	2010
Kanabec	2	1	2	0	1
Pine	2	4	3	4	4
State	588	681	698	743	784

Traumatic brain injury rate (per 100,000 population)	2006	2007	2008	2009	2010	2011
Kanabec	*	162.3	120.5	*	*	*
Pine	124.3	107.8	119.3	135.1	134.6	147.3
State	93.4	93	91.5	95.9	92.1	92.6
Spinal Cord Injury Events	2006	2007	2008	2009	2010	2011
Kanabec	0	1	0	1	0	0
Pine	3	2	4	1	1	0
State		296	271	262	255	298

Source: Minnesota Department of Health, Center for Health Statistics

[County Health Tables - MDH](#)

Motor Vehicle Injuries by Severity	Kanabec						Pine						State					
	2005	2008	2009	2010	2011	2012	2005	2008	2009	2010	2011	2012	2005	2008	2009	2010	2011	2012
Severe	7	4	3	5	8	5	19	8	7	12	6	13	2,019	1,553	1,271	1,191	1,159	1,268
Moderate	31	19	17	29	15	18	101	56	51	48	85	57	10,453	8,334	7,714	7,445	7,110	6,902
Minor	89	58	52	47	50	35	142	141	102	110	128	119	25,212	23,492	22,089	22,540	22,026	21,144
Killed	9	4	1	2	2	0	13	7	3	8	6	14	559	455	421	411	368	395
Unhurt	370	196	239	308	250	240	599	452	452	366	642	524	183,590	158,401	149,354	151,085	144,920	138,965
Total	506	281	312	391	325	298	874	664	615	544	867	727	221,833	192,235	180,849	182,672	175,583	168,674

Sources: Minnesota Department of Public Safety

[County Health Tables - MDH](#)

Youth Substance Use

Alcohol is the most frequently used drug nationally and statewide, and is associated with a number of adverse health consequences. Reported use of alcohol, tobacco, marijuana and prescription drugs in the past 30 days is a common measure of recent use. Marijuana is the number one illicit used drug among youth state and countywide. In 2013, a new question was added to the Minnesota Student Survey asking about student's past month misuse of any prescription drugs (use of prescription drugs not prescribed for them). Prescription drugs can have dangerous health consequences if used incorrectly, or if used by someone other than for whom they were intended.

Students in grade 9 reporting any use of alcohol, tobacco, marijuana, or prescription drugs in the past 30 days (Minnesota Student Survey, 2013).

Kanabec	2007		2010		2013	
	Male	Female	Male	Female	Male	Female
Alcohol	23%	22%	26%	39%	20%	17%
Tobacco	17%	14%	24%	21%	14%	6%
Marijuana	6%	8%	22%	17%	20%	10%
Prescription	*	*	*	*	8%	13%

Students in grade 9 reporting any use of alcohol, tobacco, marijuana, or prescription drugs in the past 30 days (Minnesota Student Survey, 2013).

Pine	2007		2010		2013	
	Male	Female	Male	Female	Male	Female
Alcohol	31.90%	36.80%	28.80%	31.10%	25.50%	31.60%
Tobacco	20%	14%	15%	18%	9.10%	11.20%
Marijuana	17%	8%	15%	10%	10%	9.70%

Prescription * * * * 4.50% 7.50%

Alcohol-Related Motor Vehicle Crashes and Fatalities and other Consequences

As a depressant, alcohol use interferes with coordination, judgment and reaction time and can have fatal consequences. Impaired behavior around motor vehicles puts drivers, pedestrians, passengers and others at risk.

Dollars of Cost Per Capita of Alcohol Related Traffic Crashes, Fatalities and Injuries, 2006 - 2013: by County

	2006	2007	2008	2009	2010	2011	2012	2013
Minnesota	\$53	\$60	\$50	\$49	\$45	\$49	\$49	\$43
Kanabec County	\$17	\$98	\$14	\$16	\$15	\$18	\$13	\$10
Pine County	\$107	\$104	\$60	\$60	\$200	\$165	\$121	\$117

Number of Driving While Intoxicated by County of Residence, 2006 - 2013

	2006	2007	2008	2009	2010	2011	2012	2013
Minnesota	41,951.00	36,989.00	34,216.00	31,352.00	28,716.00	28,316.00	27,475.00	24,834.00
Kanabec County	113	132	106	74	96	75	91	80
Pine County	290	218	210	176	160	162	153	125

Percent of Alcohol-Related Motor Vehicle Crashes (Defined as Alcohol-related if BAC is at a .01 level or higher), 2006 - 2013: by County

	2006	2007	2008	2009	2010	2011	2012	2013
Minnesota	6.00%	5.40%	5.40%	5.30%	5.10%	5.00%	5.50%	4.70%
Kanabec County	7.60%	12.20%	5.20%	6.40%	6.90%	8.90%	8.70%	6.60%
Pine County	6.60%	6.50%	7.70%	7.90%	9.50%	7.90%	7.80%	5.30%

Number of Alcohol-Related Motor Vehicle Fatalities (Defined as Alcohol-related if BAC is at a .01 level or higher), 2006 - 2013: by County

	2006	2007	2008	2009	2010	2011	2012	2013
Minnesota	166	190	163	141	219	136	131	117
Kanabec County	0	1	0	0	0	0	0	0
Pine County	2	2	1	1	4	3	2	2

Sources: Office of Traffic Safety, MN Department of Public Safety

SUMN Web Site: [SUMN](#)

2009-2013 Crash Statistics by County

	DWI	Crash	All Death	Alcohol Related Death
Minnesota	146,985	366,629	1,982	656
Kanabec County	478	652	5	0
Pine County	898	1,672	38	12

Source: MN Department of Public Safety

[MN Department of Public Safety - Crash Facts](#)

Drinking alcohol is a risk factor for many causes of death in Minnesota. It is estimated that 40% of liver cirrhosis deaths, among both males and females in the United States, are alcohol-related.

Rate per 10,000 Pop of Cirrhosis Deaths, 2006 - 2013: by County

	2006	2007	2008	2009	2010	2011	2012	2013
Minnesota	0.6	0.7	0.7	0.3	0.3	0.4	0.9	1
Kanabec County	1.2	1.9	1.2	0.6	0.6	0	1.3	1.3
Pine County	1.1	0	0.4	0.7	0.4	0.7	2.4	0.3

Smoking is a risk factor for many causes of death in Minnesota. The statistics reported include lung, bronchus and trachea cancer deaths from all causes—not just smoking-related deaths. It is estimated that 90% of lung cancer deaths among males and 79% of lung cancer deaths among females in the United States are smoking-related.

Rate Per 10,000 Pop of Deaths from Lung, Bronchus and Trachea Cancer -- all causes, 2006 - 2013: by County								
	2006	2007	2008	2009	2010	2011	2012	2013
Minnesota	4.5	4.6	4.6	4.5	5	4.3	4.3	4.4
Kanabec County	6.8	5.6	8.1	6.8	4.4	2.5	5	6.9
Pine County	8.1	7.1	8.1	6	4.6	5.7	6.8	8.2

Mental Health

Drinking alcohol is a risk factor for many causes of death in Minnesota. It is estimated that 23% of suicides, among both males and females in the United States, are alcohol-related.

Rate per 10,000 Pop of Suicides, 2006 - 2013: by County

	2006	2007	2008	2009	2010	2011	2012	2013
Minnesota	1.1	1.1	1.1	1.1	1.1	1.3	1.2	1.3
Kanabec County	0	0.6	1.9	1.2	2.5	1.9	1.9	0.6
Pine County	2.1	0.7	1.8	1.4	2.5	1	1.4	2.1

Sources: Natality and Mortality data: Minnesota Center for Health Statistics

Alcohol-attributable fractions: Alcohol-Attributable Disease Impact (ARDI) SUMN Web Site: [SUMN](#)

Homocide (#) Under age 20	2006	2007	2008	2009	2010
Kanabec	0	0	0	0	0
Pine	0	0	0	0	0
State	30	22	27	25	29
Homocide (#) 20 years and above	2006	2007	2008	2009	2010
Kanabec	0	0	0	2	0
Pine	0	0	0	0	0
State	97	96	101	68	82

Behavioral Risk Factors

Behavioral Risk Factor Percentages				
Overweight	2006	2007	2008	2009
Kanabec	37.7%	36.2%	37.9%	38.8%
Pine	38.1%	36.3%	38.8%	39.0%
State	37.8%	35.8%	37.8%	39.1%
Obese	2006	2007	2008	2009
Kanabec	34.5%	26.0%	25.2%	25.2%
Pine	24.5%	26.0%	25.0%	25.0%
State	24.5%	25.9%	24.9%	24.7%
Current Smokers	2006	2007	2008	2009
Kanabec	17.8%	16.2%	17.1%	16.2%
Pine	17.7%	16.3%	17.2%	16.3%
State	18.3%	16.5%	17.5%	16.8%
Acute Drinking	2006	2007	2008	2009
Kanabec	17.1%	13.8%	19.0%	19.0%
Pine	17.4%	14.1%	19.4%	19.5%
State	17.6%	14.3%	19.7%	20.2%
Chronic Drinking	2006	2007	2008	2009
Kanabec	3.7%	3.6%	4.7%	5.0%
Pine	3.8%	3.6%	4.7%	4.9%
State	3.9%	3.8%	4.7%	5.0%

Behavioral Risk Factor Percentages		
Overweight*	2011	2012
Kanabec	37.7%	37.8%
Pine	38.1%	38.2%
State	36.9%	37.3%
Obese	2011	2012
Kanabec	26.5%	26.7%
Pine	26.5%	26.7%
State	25.7%	25.9%
Current Smokers	2011	2012
Kanabec	18.3%	18.0%
Pine	18.8%	18.4%
State	19.2%	18.8%
Acute Drinking	2011	2012
Kanabec	21.0%	20.5%
Pine	22.1%	21.5%
State	22.7%	22.1%
Chronic Drinking	2011	2012
Kanabec	7.7%	6.1%
Pine	7.9%	6.3%
State	8.1%	6.3%

Source: Minnesota Department of Health, Behavioral Risk Factor Surveillance System

*2011 & 2012 BRFSS data cannot be compared to previous years due to changes in survey methodology.

**Note: In previous County Health Tables, estimated percent of overweight included obesity.

[County Health Tables - MDH](#)

Quality of Life

Poor physical health days	2010	2011	2012	2013	2014
Minnesota	3.1	3.1	3	2.9	2.8
Kanabec	3.3	3.2	3.6	3.1	3
Pine	3.7	3.4	3.3	3.1	3.3
Poor mental health days	2010	2011	2012	2013	2014
Minnesota	2.8	2.8	2.7	2.7	2.6
Kanabec	3.4	4.4	4.1	3.6	4
Pine	2.5	2.7	2.5	2.9	3.3
Source: Robert Wood Johnson Foundation County Health Rankings					
Health Status, Fair or Poor	2006	2007	2008	2009	
Minnesota	10.8	11	11.4	10.2	
Kanabec	11.4	11.5	11.8	10.8	
Pine	11.4	11.6	11.8	10.8	
Reporting Limitations	2006	2007	2008	2009	
Minnesota	22.6	18.8	22.5	19.5	

Kanabec	22.8	19.7	23.1	20.8	
Pine	22.8	19.8	23	20.6	
No Exercise	2006	2007	2008	2009	
Minnesota	14.2	16.7	18.1	15.8	
Kanabec	14.2	17	18.4	16.3	
Pine	14.3	17.1	18.3	16.3	

Source: Minnesota Department of Health, Behavioral Risk Factor Surveillance System

[County Health Tables - MDH](#)

Community Health Improvement Plan

Goal: *To create a document to highlight the community's plan to improve health, (involving partners in processes of assessment, planning, and strategy development, as well as in strategy implementation.)*

#1 Objective:

Create a Community Health Improvement Plan Document

Status of Objective: In process

Action Steps/Activities/Deliverables	By When	Resources Needed	Lead Person	Status w/dates
Review the LPH planning and process	October- November 2014	Time to meet Coordinators to organize meeting Internet Input from county directors/administrators	PHAB Steering Team	Completed 10/29/14
Research MDH for examples of other CHIPs	October- November 2014	Time to meet Coordinators to organize meeting Internet Input from county directors/administrators	PHAB Steering Team	Completed 10/29/14
Review Community Health Improvement Plan Review Checklist and Public Health Accreditation Board standards and measures 5.2	October- November 2014	Time to meet Coordinators to organize meeting Internet	PHAB Steering Team	Completed 10/29/14

Action Steps/Activities/Deliverables	By When	Resources Needed	Lead Person	Status w/dates
		Input from county directors/administrators		
Draft a document that highlights existing programs that address the previously selected priority issues	October 2014	Coordinators time	Jeni, Pauline	1 st draft completed 10/29/14
Review and edit 1 st draft of CHIP	October 2014	Time to meet Coordinators to organize meeting Internet Input from county directors/administrators	PHAB Steering Team	Completed 10/29/14
Create a template to meet requirements	November 2014	Coordinators time	Jeni, Pauline	Completed
Research programs that address priority issues and review existing work-plans	November 2014	Coordinators time Meeting time with program leaders	Jeni, Pauline, program leaders	completed
Continued revisions to CHIP draft	November-December 2014	Coordinators time Meeting time with program leaders	Wendy, Jeni, Pauline, program leaders	Completed

Community Health Improvement Plan

Goal: To create a document to highlight the community's plan to improve health, (involving partners in processes of assessment, planning, and strategy development, as well as in strategy implementation.)

#1 Objective:

Create a Community Health Improvement Plan Document

Status of Objective: In process

Action Steps/Activities/Deliverables	By When	Resources Needed	Lead Person	Status w/dates
Continued review and edits of CHIP revisions	December 17, 2014	Time to meet Coordinators to organize meeting Internet Input from county directors/administrators	PHAB Steering Team	Due December 17 th completed
Community Health Services advisory committee to review and approve draft of CHIP document	December 2014 - January 2015	Time on agenda Facilitator/presenter	Wendy	Due December 31, 2014 completed
Make final edits to CHIP	November 2014 - February 2015	Coordinators time	Wendy, Jeni, Pauline	February 2015 completed
Submit to the Community Health board	March	Time on the agenda	Wendy	March 18

Continued review and edits of CHIP revisions	December 17, 2014	Time to meet Coordinators to organize meeting Internet Input from county directors/administrators	PHAB Steering Team	Due December 17 th completed
for review and approval	2015			
Submit document to MDH electronically	March 2015	Point person to submit	Wendy	March 2015

FAMILY HOME VISITING POPULATION

Population	MN	Kanabec	Pine	CHS
Total births ¹	68,407	163	293	456
Preterm births (<37 weeks gestation) as % of all births ²	8.1	7.0	7.3	7.2
Hispanic	7.5	2.5	2.5	2.5
Non-Hispanic White	74.8	98.2	91.8	94.1
Non-Hispanic Black	9.6	0.6	0.7	0.7
American Indian or Alaska Native	2.0	0	4.8	3.1
Asian or Pacific Islander	7.2	0.6	0.7	0.7
Low birth weight (<2500 g) as % of all births ²	4.8	1.3	5.3	3.9
Hispanic	--	--	--	--
Non-Hispanic White	--	--	--	--
Non-Hispanic Black	--	--	--	--
American Indian or Alaska Native	--	--	--	--
Asian or Pacific Islander	--	--	--	--
Maternal age < 21(%) (captured age 18-19) ⁴	4.3	8.0	9.2	NA

Total births ¹	68,407	163	293	456
Births to women receiving late or no prenatal care (%) GINDEX (% Inadequate/none) ⁵	3.1	2.3	5.2	4.1
Teen births ages 15-19 (per 1,000) ⁶	24.6	31.9	41.5	37.9
Infant mortality (per 1,000 live births) (counts due to small number) ⁷	309	0	1	1
Total deaths age 1-4 (per 100,000) (count due to small numbers; age category 0-4) ⁸	376	0	2	2
Incidence of child abuse and neglect (per 1,000) (determined) ⁹	3.5	2.1	4.8	3.8
Medicaid funded births (%) (2009 data) ¹⁰	40.7	54.8	52.6	NA
Income eligibility for pregnant women used to determine Medicaid eligibility (133-300% FPL) ¹¹	275%	275%	275%	275%
Income eligibility for pregnant women used to determine WIC eligibility (133-300% FPL) (under 275% with MA/other verified support; under 185% without MA) ¹²	275%/ 185%	275%/ 185%	275%/ 185%	275%/ 185%

Total births ¹	68,407	163	293	456
Population in poverty (% with incomes less than FPL) (2006-2010 census data) ¹³	10.6	12.5	14.0	NA

Population Characteristics Sources

Minnesota Department of Health (MDH). **Nativity Table 1: Selected Minnesota Natality Statistics by State and County, 2010.** Retrieved from [County Health Tables - MDH](#)

MDH. **Nativity Table 2: Prematurity and Low Birth Weight of Singleton Births in Minnesota by State and County, 2010.** Retrieved from [County Health Tables - MDH](#)

MDH. **Nativity Table 2: Prematurity and Low Birth Weight of Singleton Births in Minnesota by CHS Agency, 2010.** Retrieved from [County Health Tables - MDH](#)

Note: *This data represents all mothers including preterm/LBW.*

MDH. **Nativity Table 9: Race and Ethnicity of Mother in Minnesota by State and County, 2010.** Retrieved from [County Health Tables - MDH](#)

MDH. **Nativity Table 9: Race and Ethnicity of Mother in Minnesota by CHS Agency, 2010.** Retrieved from [County Health Tables - MDH](#)

MDH. **2010 Minnesota Health Statistics: Live Births: Live Births-Table 2: Selected Resident Natality Statistics By County and Selected City Minnesota, 2010.** Retrieved from [MDH - MN Health Statistics - Live Births](#)

MDH. **Nativity Table 4: Prenatal Care in Minnesota by State and County, 2010.** Retrieved from [County Health Tables - MDH](#)

MDH. **Nativity Table 4: Prenatal Care in Minnesota by CHS Agency, 2010.** Retrieved from [County Health Tables - MDH](#)

MDH. **Nativity Table 7: Minnesota Teen Birth and Pregnancy Rates by State and County, 2008-2010.** Retrieved from [County Health Tables - MDH](#)

MDH. **Nativity Table 7: Minnesota Teen Birth and Pregnancy Rates by CHS Agency, 2008-2010.** Retrieved from [County Health Tables - MDH](#)

MDH. **2010 Minnesota Health Statistics: Infant Mortality and Fetal Deaths: Infant Mortality and Fetal Deaths-Table 3 Infant, Neonatal, and Post neonatal Deaths By Race of Child and Fetal Deaths by Race of Mother By County and Selected City of Residence Minnesota, 2010.** Retrieved from [MDH Infant Mortality and Fetal Deaths](#)

MDH Center for Health Statistics. Death Queries. **Number of Deaths and Rate By Age Group and Year (all Ages, All Causes of Death, All Genders, All ethnicity, All Races, Year 2010.** Retrieved from [MDH causes of death](#)

MDH. **Demographics Table 10: 2010 Child Subjects of Maltreatment Reports per 1,000 in the Child Population (0-17 years old).** Retrieved from [County Health Tables - MDH](#)

Minnesota Department of Human Services. **Live Births to Minnesota Residents, 2009 By Mothers' County of Residence and Medicaid as Payer of Delivery or Birth Claims** [Internal memo].

CAG Members:

Christine Andres, DNP, PHN, RN, CLC ~ NFP and HFA Supervisor

Gwen Lewis, RN, PHN ~ HFA Program Manager

Janet Ashmore ~ Pine County Health and Human Services

Casey Comstock ~ The Refuge Network

Becky Foss ~ Pine County Health and Human Services

Kelly Kehr ~ Lakes and Pines Head Start

Dylan Kringstad ~ Family Pathways Teen Center

Maria Lourey-Bowen ~ MLB Outreach Services

Paula Nelson ~ Allina Health CMC

Heather O'Brien—Essentia Health,

Danielle Olson, DDS ~ Midwest Dental

Mandy Pierson ~ Kanabec County Sheriff's Department

Jill Pryor, LSN ~ Braham High School

Julie Ray ~ FirstLight Health System

Carrie Sell ~ More ECFE Office

Cheryl Smetana McHugh ~ Therapeutic Services Agency, Inc.

Cristy Thomas ~ Central MN Jobs & Training Services/Work Force Center

Julie Werner ~ Pine Community Food Shelf

Karen Wolner ~ St. Croix River Education District

Substance Abuse Coalition of Kanabec County (SACK)

Year 6 Action Plan for September 30, 2014 - September 29, 2015

DFC Goal 1: Increase community collaboration

Objective 1: Increase the number of active coalition members of SACK by 10% by September 29, 2015.

Strategy 1: Develop a structure for member recruitment.

ACTIVITY	RESPONSIBLE GROUP/PERSON	TARGET DATE (BY WHEN?)	PROGRESS
Submit monthly columns to Kanabec County Times to increase awareness of youth substance abuse and promote SACK's efforts in the community	SACK Coordinator SACK Members	10/1/14 - ongoing	Columns submitted: 11/6 Sydney P. (youth) – “Through Struggles You Are Not Alone” – youth empowerment sharing her experience of CADCA Mid-Year and being inspired to make a change within her community 12/4 Barb McFadden – “Buzzed Driving Can Lead to

ACTIVITY	RESPONSIBLE GROUP/PERSON	TARGET DATE (BY WHEN?)	PROGRESS
			DWI” – defining buzzed driving beyond alcohol.
Continue to distribute monthly e-newsletter to coalition members and community stakeholders	SACK Coordinator	10/1/14 - ongoing	Switched over from Constant Contacts to Mail Chimp which combines the monthly e-newsletter and weekly blogs to gain a wider audience by syncing the posts onto SACK’s social media sites. 10/1, 10/6, 10/8, 10/14, 10/15, 10/30 11/18, 11/19 12/16, 12/18, 12/19
Meet with local radio station quarterly to share local data on the scope and consequences of substance abuse among youth, and promote SACK’s current prevention efforts and campaigns	SACK Coordinator SACK Members	12/31/14, 03/31/15, 06/30/15, 09/29/15	
Update and expand recruitment packet for current SACK members to distribute among friends, colleagues, and community members	SACK Coordinator SACK Members	12/1/14	11/4 SACK meeting: Presentation and discussion on the results of the Kaizen Coalition Assessment

ACTIVITY	RESPONSIBLE GROUP/PERSON	TARGET DATE (BY WHEN?)	PROGRESS
			<p>previously administered by SSGT Brad Rekstad of the Minnesota National Guard Counterdrug Task Force in August. From this discussion, the coalition will evaluate the strengths and weakness of SACK and determine as a group what the priorities are moving forward.</p> <p>The priorities were identified as:</p> <p>New members should get an orientation with mentors. Extension of monthly meetings of 20 minutes for the Youth. Also have Youth participation in monthly updates. Active involvement by coalition members.</p> <p>The coalition will work on a “welcome wagon” group and packet in an upcoming workgroup meeting to create a system of meeting with new members and</p>

ACTIVITY	RESPONSIBLE GROUP/PERSON	TARGET DATE (BY WHEN?)	PROGRESS
			updating them on the coalition's work. At that workgroup, a new introduction packet will be created.
Participate in local community events to increase awareness of SACK (e.g. community expo booth, parent/teacher conferences, and school orientations)	SACK Coordinator SACK Members	09/29/15	

Strategy 2: Strengthen collaboration with business and faith sector representatives in the community.

ACTIVITY	RESPONSIBLE GROUP/PERSON	TARGET DATE (BY WHEN?)	PROGRESS
Meet with local business and faith representatives to increase knowledge of SACK's current prevention efforts	SACK Coordinator SACK Members	1/1/15	
Attend local chamber and Ministerial Association meetings to provide information regarding substance use among youth in the community and SACK's current prevention efforts and campaigns	SACK Coordinator SACK Members	2/1/15 - ongoing	
Invite individual business and faith representatives to attend a SACK meeting	SACK Coordinator SACK Members	3/1/15 - ongoing	

Objective 2: Increase current active members' attendance at meetings, workgroups, and trainings by 25% from previous year by September 29, 2015.

Strategy 1: Consistently provide structured meeting agendas and training schedules.

ACTIVITY	RESPONSIBLE GROUP/PERSON	TARGET DATE (BY WHEN?)	PROGRESS
Assess current active members' attendance and participation	SACK Coordinator	10/1/14	<p>Had the Kaizen Assessment done in August by SSgt. Rekstad. Held a results presentation at the November 4th meeting, which revealed that the active involvement of the coalition is a priority issue.</p> <p>The leadership workgroup is visiting ideas on including more coalition members in activities, instead of the usual key members. Including, revisiting the workgroup members and participation to gain more involvement and interest; less coordinator involvement in the decision making and inclusive of coalition.</p>

ACTIVITY	RESPONSIBLE GROUP/PERSON	TARGET DATE (BY WHEN?)	PROGRESS
			<p>Joy created a spreadsheet to track members' attendance; she created CIAs to have members resign if they last signed over a year ago and for members that have attended several meetings and had not previously signed. The spreadsheet is updated after every meeting to monitor members' attendance and participation.</p>
<p>Provide detailed agendas to coalition members one week in advance of SACK and workgroup meetings</p>	<p>SACK Coordinator</p>	<p>10/1/14 – ongoing</p>	<p>E-mailed agendas to active members –</p> <p>October 2nd - meeting 10/7</p> <p>October 31st – meeting 11/4</p> <p>November 26th – meeting 12/2</p> <p>January 2nd – meeting 1/6</p>

ACTIVITY	RESPONSIBLE GROUP/PERSON	TARGET DATE (BY WHEN?)	PROGRESS
Convene coalition members at monthly SACK meetings	SACK Coordinator SACK Chair/Co-Chair	10/1/14 – ongoing	10/7, 11/4, 12/2, 1/6
Meet with Chair and Co-Chair monthly to review meeting minutes, training opportunities, agendas for upcoming meetings, and address any coalition needs	SACK Coordinator SACK Chair/Co-Chair	10/1/14 – ongoing	Confirmed agenda with Brent on 10/14 for the November coalition meeting. Due to schedule conflicts, emailed agenda to Brent on 11/25 for December meeting for final approval.
Create a calendar of monthly meetings, community events, and local, state and national training opportunities offered throughout the year	SACK Coordinator SACK Chair/Co-Chair	12/1/14	Calendar created on SACK website and linked to monthly newsletter, with listing of upcoming events. *Print calendar for meetings for announcement wall
Review current meeting structure and survey coalition members on the location, time, and duration of meetings to	SACK Coordinator	03/1/15	Surveyed the coalition via Survey Monkey on 9/23

ACTIVITY	RESPONSIBLE GROUP/PERSON	TARGET DATE (BY WHEN?)	PROGRESS
ensure that coalition needs are met			<p>and 60% of the coalition would not attend a meeting if it was after 5 pm, mostly due to their children's activities after school. 75% preferred to keep the meeting at its current time (8-10 a.m.) with 55% indicating that 3-5 p.m. works best. 95% of the members liked the current location of the jail training room and wanted it to remain there.</p> <p>*Will revisit times and the standing day of the meeting (received some feedback that the 1st Tuesday of the month is not a good day for all) in 6 months.</p>

Strategy 2: Expand opportunities for members to participate in workgroups.

ACTIVITY	RESPONSIBLE GROUP/PERSON	TARGET DATE (BY WHEN?)	PROGRESS
Assess current active members' attendance and participation in workgroups	SACK Coordinator	11/1/14	Kaizen Results workgroup – 10/14 (6 attendees plus Brad) One-on-one Interviews – 10/29 (8 plus Britt and Jen) Communications – 11/5 (5 plus Britt and Jen)
Survey active members to assess interest in current workgroups and explore the possibility of creating new workgroups based on identified coalition needs	SACK Coordinator SACK Chair/Co-Chair	12/1/14	
Develop and maintain an informational flyer for new and existing SACK members that outlines the dates/times of current workgroup meetings and trainings	SACK Coordinator	1/1/15 - ongoing	

Create an action plan for each workgroup	SACK Coordinator	1/31/15	
	SACK Chair/Co-Chair		
	SACK workgroup members		

Strategy 3: Strengthen collaboration among existing youth groups in Kanabec County.

ACTIVITY	RESPONSIBLE GROUP/PERSON	TARGET DATE (BY WHEN?)	PROGRESS
Develop a monthly meeting structure for existing local youth groups (e.g. SADD, Ogilvie “We Day” participants, 4-H) to come together and discuss youth engagement initiatives and opportunities for collaboration	SACK Coordinator SADD Youth Leader We Day Youth Leader 4-H Youth Leader	12/1/14	
Create calendar of monthly meetings, youth servings events, and leadership trainings for the upcoming year and distribute to existing youth groups	SACK Coordinator Youth Group Leaders	1/1/15	

DFC Goal 2: Reduce youth substance use

Objective 1: Decrease marijuana use by 5% in Kanabec County among 8th, 9th and 11th grade students by May 1, 2016.

Strategy 1: Strengthen current drug policies at Mora Schools and Ogilvie Schools.

ACTIVITY	RESPONSIBLE GROUP/PERSON	TARGET DATE (BY WHEN?)
Survey staff at Ogilvie and Mora schools regarding the effectiveness of current school drug policies and consequences	SACK Coordinator Ogilvie School Administration Mora School Administration	10/1/14
Share previously collected local data on the scope of alcohol, tobacco, marijuana, and other drug use among youth and facilitate a discussion with school administration on the survey results to identify each policy's strengths and areas that need improvement	SACK Coordinator Ogilvie School Administration Mora School Administration	12/1/14
Research model drug policies from other area schools	SACK Coordinator	1/1/15
Collaborate with Mora and Ogilvie Schools to strengthen and develop school drug assessment teams	SACK Coordinator Ogilvie School Administration	2/1/15
Present to the athletic directors at Mora and Ogilvie coaches meeting on the "Athlete's Wellness" handbook, which provides materials for coaches, parents, and athletes on the importance of overall wellness and promotes healthy choices by abstaining from drugs and alcohol	SACK Coordinator	3/1/15
Provide the coaching staff at Mora and Ogilvie with the "Athlete's Wellness" handbook at the beginning of each sports season	SACK Coordinator	3/1/15 8/1/15

Strategy 3: Implement evidence-based “Above the Influence” campaign, which is a national campaign that helps teens stand up to the negative pressures and influences of marijuana use and has been shown to reduce marijuana use among teens.

ACTIVITY	RESPONSIBLE GROUP/PERSON	TARGET DATE (BY WHEN?)
Present local data and national trends on the scope and consequences of marijuana use among youth in the community through monthly column in the local paper, social media and parent/teacher conferences at both Mora and Ogilvie schools	SACK Coordinator	12/1/15
Work with SADD and We Day youth groups to develop “Above the Influence” campaign materials, including an informational card/brochure, posters, flyers, advertisements, and other materials to post on social media outlets, print in the local paper, and hand out at school and local community events (e.g. county fair, parent/teacher conferences, annual ski race and marathon, prom, sporting events, theater productions)	SACK Coordinator SADD Youth Group We Day Youth Group	2/1/15
Work with health education teachers at Mora and Ogilvie schools to create lesson plans that incorporate “Above the Influence” activities, videos, and messaging	SACK Coordinator Mora Health Ed Teacher Ogilvie Health Ed Teacher	3/1/15
Work with school administration and staff at Ogilvie and Mora schools to present to elementary, middle and high school students on being “Above the Influence”	SACK Coordinator Ogilvie School Administration Mora School Administration	4/1/15

Partner with community healthcare providers, teen outlook clinic, and school nurses to pass out “Above the Influence” brochures and display campaign posters	SACK Coordinator Healthcare Representatives Mora School Nurse Ogilvie School Nurse Teen Clinic Representatives	5/1/15
In partnership with SADD and We Day youth groups, implement “Tag It,” which involves youth “tagging,” documenting, and publicizing the positive influences in their lives.	SACK Coordinator SADD Youth Group We Day Youth Group	9/29/15

DFC Goal 2: Reduce youth substance use

Objective 2: By May 1, 2016 decrease tobacco use by 10% among Kanabec County 8th, 9th and 11th grade students.

Strategy 1: Conduct quarterly tobacco compliance checks using best practices.

ACTIVITY	RESPONSIBLE GROUP/PERSON	TARGET DATE (BY WHEN?)	PROGRESS
Compile local data on compliance checks conducted by the Kanabec County Sherriff’s Office	SACK Coordinator Sheriff’s Office Representative	11/1/15	
Work with the Sheriff’s Office to identify a deputy to conduct the compliance checks	SACK Coordinator Sheriff’s Office Representative	1/1/15	Alex Gerhardson with conduct the 4 compliance checks – quarterly

ACTIVITY	RESPONSIBLE GROUP/PERSON	TARGET DATE (BY WHEN?)	PROGRESS
Offer compliance check refresher training to deputies, if needed	SACK Coordinator Sheriff's Office Representative	1/1/15	Not needed

Conduct quarterly compliance checks at all tobacco retailers	Sheriff's Office Deputy Youth Decoys	03/31/15, 06/30/15, 09/29/15
Provide feedback to tobacco retailers on the results of compliance checks conducted at their establishment	SACK Coordinator Sheriff's Office Representative	04/15/15, 07/15/15
Offer training to local retailers and their staff on the importance of compliance checks, how to properly check IDs, and reduce tobacco access to youth	SACK Coordinator Sheriff's Office Representative	6/1/15
Develop local tip line where youth and community members can report retailers and adults who provide tobacco sales to minors	SACK Coordinators SACK Tobacco Workgroup Sheriff's Office Representative	6/1/15
Advertise tip line and collaborate with Mora and Ogilvie schools, media outlets, and local businesses to educate youth, parents, and community members on utilizing the tip line	SACK Coordinators SACK Tobacco Workgroup Communications Consultant Sheriff's Office Representative	8/1/15
Monitor and evaluate the implementation of tobacco compliance checks	Sheriff's Office Representative	9/29/15

Strategy 2: Pass tobacco-free policy in Ogilvie Community Park and in area surrounding Mora High School.

ACTIVITY	RESPONSIBLE GROUP/PERSON	TARGET DATE (BY WHEN?)	PROGRESS
Review research on model tobacco-free policies and enforcement in surrounding communities	SACK Coordinator SACK Tobacco Workgroup	1/1/15	
Collaborate with local newspaper to run a community-wide survey to gauge interest in passing and enforcing tobacco-free policies	SACK Coordinator Media Outlet Editor	2/1/15	
Meet with Sheriff's Office to review current enforcement and consequences of tobacco-free policy violations in community	SACK Coordinator SACK Tobacco Workgroup	3/1/15	
Present community survey results and local data to the Ogilvie city council and advocate for a tobacco-free parks policy	SACK Coordinator SACK Tobacco Workgroup	5/1/15	
Work with Mora High School administration and the Mora City Council to expand current tobacco-free policy to include areas, including sidewalks, surrounding the school	SACK Coordinator Mora School Administration Mora City Council	6/1/15	

Strategy 3: Implement evidence-based Tobacco-Free Kids campaign aimed at reducing youth tobacco use.

ACTIVITY	RESPONSIBLE GROUP/PERSON	TARGET DATE (BY WHEN?)	PROGRESS
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<p>Work with outside evaluator and Mora and Ogilvie school administration to conduct a focus group on youth tobacco use with youth and parents</p>	<p>SACK Coordinator Wilder Research Mora School Administration Ogilvie School Administration</p>	<p>1/1/15</p>	
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Present results from the focus group along with local data and national trends on the scope and consequences of tobacco use among youth through monthly column in the local paper, social media and parent/teacher conferences at both Mora and Ogilvie schools	SACK Coordinator SACK Tobacco Workgroup	2/1/15
Coordinate with SADD and We Day youth groups to register for and participate in National Kick Butts Day to raise awareness of the tobacco use in Kanabec County and encourage youth to be tobacco-free	SACK Coordinator SADD Youth Group We Day Youth Group	2/1/15
Create National Kick Butts Day campaign materials such as posters and flyers that can be posted on social media outlets, printed in local paper, and distributed at local community events (e.g. county fair, parent/teacher conferences, annual ski race and marathon, prom, sporting events, etc.)	SACK Coordinator SADD Youth Group We Day Youth Group	3/15/15
Coordinate with SADD and We Day youth groups to submit a column in the newspaper on National Kick Butts Day activities and promote activities on local radio station	SACK Coordinator SACK Tobacco Workgroup	3/15/15
Work with County Tobacco Diversion Program to provide mental and emotional wellness training (e.g. positive coping skills, stress management) to youth offenders	SACK Coordinator Tobacco Diversion Trainer	4/1/15
Collaborate with youth groups to work with tobacco retailers on relocating tobacco products and e-cigarettes displays away from vantage point of youth and removing advertising directed towards youth	SACK Coordinator SADD Youth Group We Day Youth Group	6/1/15
Work with community swimming pool, County Fair Board, bowling alley, community parks, and Sheriff's Office to sponsor tobacco-free events and activities for youth during the summer	SACK Coordinator SACK Tobacco Group	6/15/15

Membership List for SACK:

🚫 CIA Ambrose Laura 01-14-14	1/15/2014 7:28 AM	Adobe Acrobat D...	613 KB
🚫 CIA Athey, Lucas 02-27-14	4/18/2014 12:44 PM	Adobe Acrobat D...	658 KB
🚫 CIA Bohlman, Megan 03-04-14	4/18/2014 12:44 PM	Adobe Acrobat D...	667 KB
🚫 CIA Bollenbeck, Michelle 03-01-14	8/7/2014 10:00 AM	Adobe Acrobat D...	650 KB
🚫 CIA Comstock, Casey 10-07-14	10/7/2014 4:15 PM	Adobe Acrobat D...	677 KB
🚫 CIA Faurie, Kirsten 03-06-14	8/7/2014 10:02 AM	Adobe Acrobat D...	622 KB
🚫 CIA Green, Jeremy 06-03-14	6/5/2014 3:49 PM	Adobe Acrobat D...	653 KB
🚫 CIA Hallberg, Kelly 02-19-14	4/18/2014 12:44 PM	Adobe Acrobat D...	644 KB
🚫 CIA Harris, Marlin 03-05-14	8/7/2014 10:01 AM	Adobe Acrobat D...	631 KB
🚫 CIA Jenkins, Haven 03-19-14	8/7/2014 9:57 AM	Adobe Acrobat D...	634 KB
🚫 CIA Juettner, Sandra 10-07-14	10/7/2014 4:14 PM	Adobe Acrobat D...	643 KB
🚫 CIA Kampfe, Janice 02-24-14	8/7/2014 10:00 AM	Adobe Acrobat D...	642 KB
🚫 CIA Martens, Lenore 10-07-14	10/7/2014 4:13 PM	Adobe Acrobat D...	663 KB
🚫 CIA McFadden, Barbara 10-07-14	10/7/2014 4:14 PM	Adobe Acrobat D...	657 KB
🚫 CIA Nelson, Brent 02-26-14	8/7/2014 9:58 AM	Adobe Acrobat D...	637 KB
🚫 CIA Nielsen, Les 10-07-14	10/7/2014 4:14 PM	Adobe Acrobat D...	654 KB
🚫 CIA Raverty, Katie 10-07-14	10/7/2014 4:15 PM	Adobe Acrobat D...	675 KB
🚫 CIA Sand, Christine 03-21-14	8/7/2014 10:02 AM	Adobe Acrobat D...	624 KB

Pine Meth Task Force Member List:

Amber Chase – Pine County Human Services
Beth J. Jarvis- Pine County Human Services
Bonnie M. Rediske Pine County Human Services
Curt Rossow –Pine County Commissioner
Denise A. Baran-Pine County
Don Faulkner –Community Member
James Johnson –Essentia Health
Janet Reisdorfer- Willow River Public Schools
Jeffrey J. Nelson –Pine County
Jenifer Rancour –Kanabec County Public Health
Jerry Olson- Community Member
Jessica Swan –Firstlight Healthsystems
Joe Newton –Essentia Health
Krista Martin –Trial Courts
Lori Swanson-Kanabec County Public Health
Lynette Kuzel –Teen Center
Matt W. Ludwig –Pine County Commissioner
Rebecca Foss –Pine County Health and Human Services
Reese Frederickson –Pine County Attorney
Sandy Korf-Hinckley-Finlayson Public Schools
Terry A. Arola –Pine County
Troy Anderson – Pine City Public Schools

EMERGENCY PREPAREDNESS ADVISORY COUNCIL

Bob-Benes-Lakes and Pines CAC
Brian-Smith-Kanabec County Sheriff's Office
Chad-Gramentz-Kanabec County Highway Department
Christine-Andres-Kanabec County Public Health
Chuck-Hurd-Kanabec County Family Services
Cindy-Teichroew-FirstLight Health System
Craig-Schultz-Mora Public Schools
Dan-Niedzielski-Ogilvie First Responders
David-Schlicher-FirstLight Ambulance
Ellen-Ryan-FirstLight Health System
Gary -Gauffin-Mora Public Schools
Hazel-Miller-American Red Cross
Helen-Pieper-Timber Trails Public Transit
Jack-L'Heureux-St Clare Living Community of Mora
James-Gilles-Kanabec County Highway Department
Jan -Lahtonen-East Central Electric
Janet-Hawkinson-Mora Public Schools
Joanne-Nelson-Jail Administrator
Joe-Heggernes-Mora Fire Department
Joel-Dhein-City of Mora
Karen-Amundson-Mora Area Chamber
Kate-Mestnik-Kanabec County Public Health
Kathi-Ellis-Kanabec County Board of Commissioners
Kathy -Belsheim-Ogilvie Public Schools
Kathy -Burski-Kanabec County Public Health
Ken-Broshofske-Amateur Radio
Kirsten-Faurie-Kanabec County Times
Larry -Butenhoff-St. Clare Living Community of Mora
Mark-Sharratt-Ogilvie Fire Department
Mark-Vizenor-FirstLight Health System
Nick-Bakke-Mora Public Schools
Patrick-Christopherson-Kanabec County Coordinator
Penny -Simonsen-East Central RDC
Randy-Ulseth-FirstLight Health System
Rita-Clasemann-Ministerial
Tony -Miller-DNR
Wendy-Thompson-Kanabec County Public Health

CLT Members:

Kathy Burrill- Lakes School District, Food Service Director
Tony Buttacavoli – Isanti County Public Health, Director

Abby Olson, Pine City- Pine City High School- Food Services Director
Cassie Casey- Lakes & Pines CAC, Head Start
Cecilia Coulter- Chisago City Farmers Market
Gayle Cupit- City Center Co-op, Cambridge
Michael Dahlheim- Mille Lacs Health System
Leona Dressel- Lakes and Pines Community Action Council
Barb Eller- Mille Lacs Area Food Network
Kathy George- City of Lindstrom
Nathan Johnson- City Planner, Pine City
Megan King- Isanti County-MN Extension SNAP-Ed and Nutrition Educator
Nikki Klanderud- Allina System, Community Engagement Manager
Nicole Laven- Mora, Fairview & Trailview Schools- Principal
Nicole Linder- Fairview, Integrative Health Specialist
Judy Nelson- Chisago County Senior Center
John Olinger- City Administrator – City of Lindstrom
Julie Powers- Cambridge Public Schools, Food Service Director, worksite wellness director
Darcy Rylander- Allina System, Wellness Program Coordinator
Kam Schroeder- Kanabec County, MN Extension SNAP-Ed and Nutrition Educator
Penny Simonson- East Central Senior Resource Center, Coordinator
Patrick Tepoorten- North Branch School District
Lisa Krahn- 7 County Senior Federation, Pine City Farmers Market
Laureen Williams- Program Coordinator of Student-Parent Support at Pine Technical College
Danna Woods -FirstLight Health System, Dietician
Josi Wood- Isanti County Farmer's Market, Manager
Deb Wright- FirstLight Health System, Wellness First Ambassador