INTRODUCTION

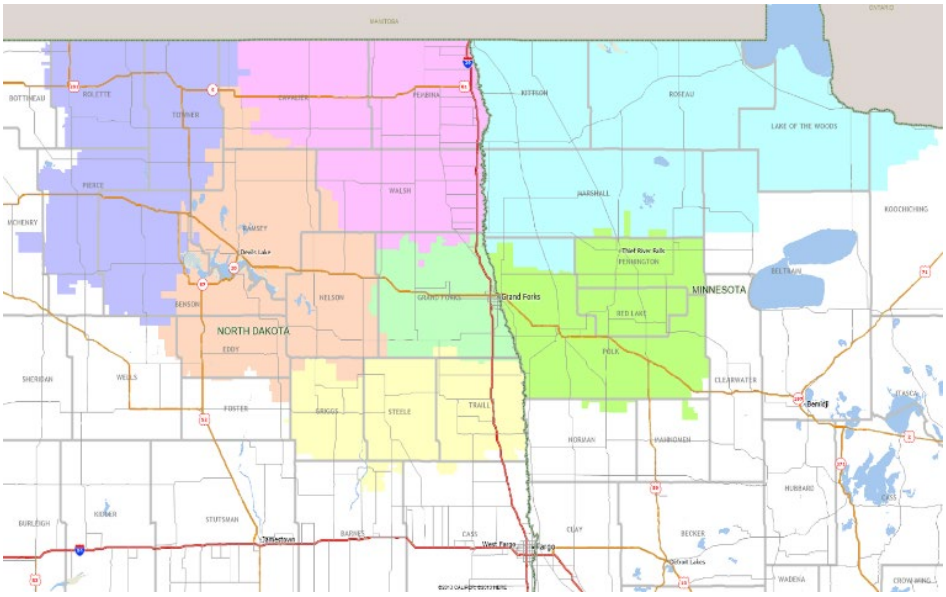
The 2022 Community Health Assessment was a joint effort led by Altru Health System and Grand Forks Public Health and was approved by our governing bodies and published in December and January, respectively. Our two organizations have a history of collaboration to improve community health. Together, we engaged multiple community stakeholders to conduct the assessment which provided robust information on health issues, status, and areas for improvement. Our assessment work provides the backbone for our Community Health Improvement Plan & Implementation Strategy Report.

ALTRU HEALTH SYSTEM

Altru Health System is a community-owned, integrated system with an acute care hospital, more than a dozen clinics in Grand Forks and the region, and large home care and outreach therapy networks. Employing more than 300 physicians and advanced practice providers and about 3,600 staff, we serve the approximately 229,000 residents in northeastern North Dakota and northwestern Minnesota as shown in the map below.

The passage of the Affordable Care Act in 2010 requires not-for-profit hospitals to conduct a community health assessment every three years. While Altru is required to conduct the project, it represents a great opportunity to partner with the community to gain a broader understanding of challenges and barriers to well-being.

The 2022 assessment process represents Altru's fourth cycle of work, conducting previous assessments in 2013, 2016 and 2019. Over the years, we have benefited from the involvement of many people and gained valuable information about the community we are privileged to serve.



GRAND FORKS PUBLIC HEALTH

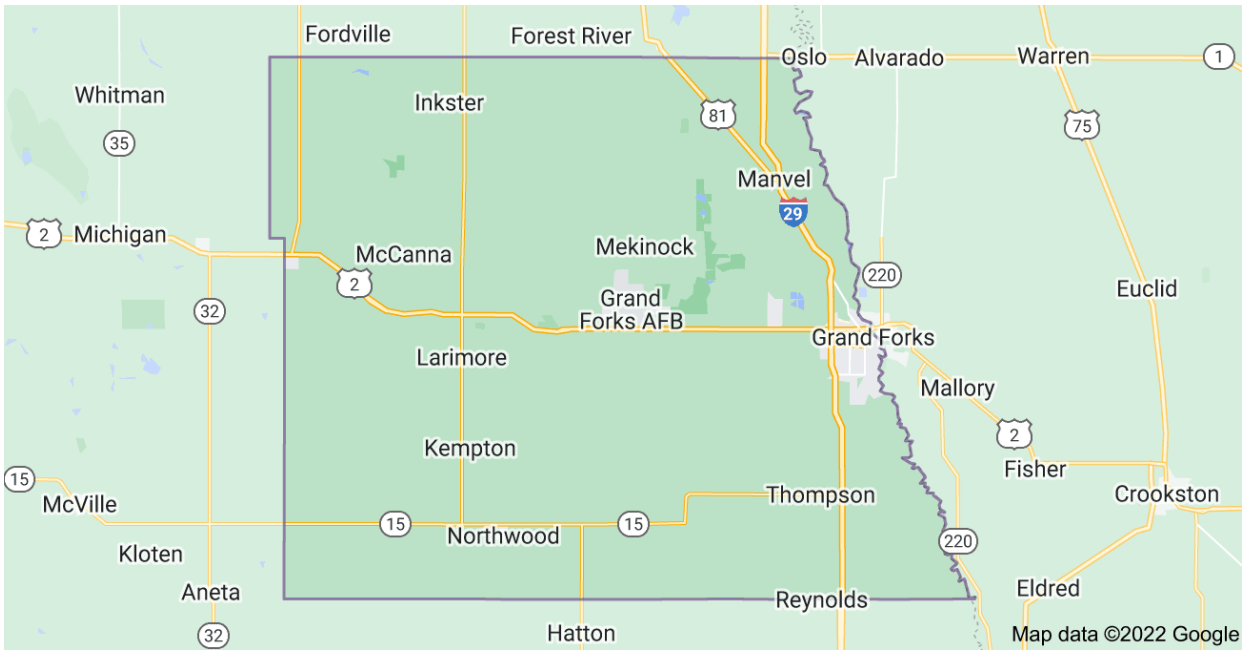
Grand Forks Public Health provides services to the City and County of Grand Forks, North Dakota. We believe in creating a culture in which all people have the means and the opportunity to make choices that lead to the healthiest lives possible. We facilitate policy, system and environmental changes that are supported by businesses, government, individuals, and organizations all working together to foster healthy communities and lifestyles.

Grand Forks Public Health is committed to:

- » Promoting healthy environments and lifestyles
- » Preventing disease
- » Building community resilience through preparedness
- » Assuring access to health services

Grand Forks Public Health is required to conduct an assessment as part of our pursuit to be an accredited public health department. The process also meets our goals for improving population health in our service area.

GRAND FORKS PUBLIC HEALTH SERVICE AREA

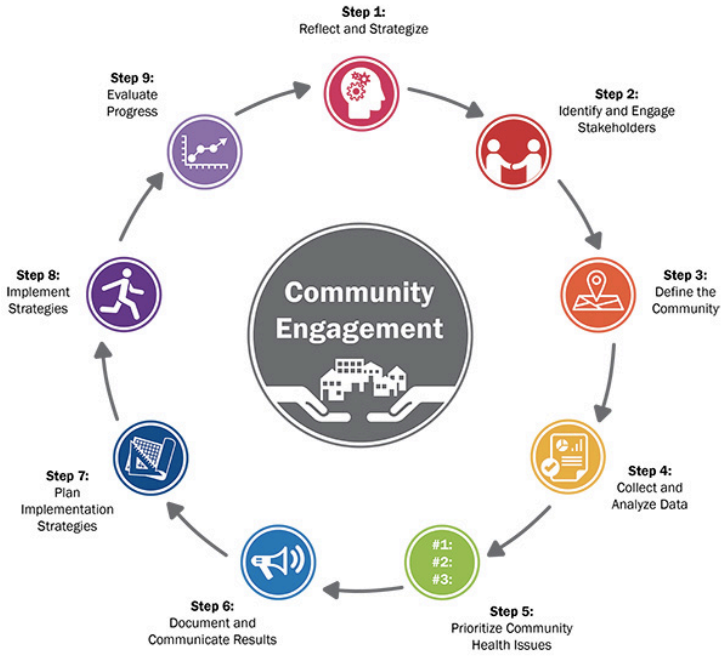


Working together, Altru Health System and Grand Forks Public Health are able to meet both of our respective requirements and develop a deeper understanding of the needs in our community.

ASSESSMENT METHODOLOGY

Leadership from Altru and Grand Forks Public Health agreed to adopt the updated process from the Association for Community Health Improvement (an American Hospital Association affiliated group) for our community health assessment. The diagram shows the steps that comprise the process.

The Community Health Assessment report documents steps 1 through 6 of this process. This report will address steps 7 and 8.



PRIORITIES

As noted in our Community Health Assessment, we worked with a Community Advisory Committee to conduct the assessment; this group was instrumental in every step of the assessment process. (See Attachment One for a list of organizations represented by this group.) The Committee members approved the following criteria to guide priority setting:

- The burden, scope, severity, or urgency of the health need
- The estimated feasibility and effectiveness of possible interventions
- The health disparities associated with the need
- The importance the community places on addressing the need
- The community resources already allocated to addressing the need
- The connection to the purpose of the assessment developed by the Advisory Committee: *Improve the overall health of the community by focusing on factors that promote health and wellness.*

After reviewing primary and secondary data and considering the priority setting criteria, the Committee agreed to the following priority areas for improvement:

Mental Health - Improve the mental well-being of all residents and build resilience.
Workforce - Collaborate across sectors to expand the available workforce.
Access to Care - Increase access to primary, specialty, behavioral, and oral health care with a focus on reducing barriers.
Substance Use - Reduce the prevalence of substance use including alcohol, tobacco, and other drugs.
Child Care - Develop strategies to meet the childcare needs of the region with a focus on access and affordability.
Obesity - Reduce the prevalence of obesity in the population through increased access to supportive services and reduced cost burden.

IMPROVEMENT PLANNING/IMPLEMENTATION STRATEGY DEVELOPMENT

Upon approval of the priorities by the governing bodies, a small workgroup of community stakeholders was assembled to develop the frame for improvement over the next three years. These stakeholders represented Altru Health System, Grand Forks Public Health, Spectra Health, Mental Health Matters, Blue Zones Project Grand Forks and Grand Forks Region Economic Development Corporation.

With this assessment/improvement cycle, stakeholder conversations changed to reflect the very different dynamics in the community and region post pandemic. The influence of mental health factors across all priorities, the focus on health equity and the lingering impacts of the pandemic are impacting how we view community well-being and how we need to respond with improvement initiatives. In addition, there are new and different community resources at play that will be important to this work and how it is sustained.

The overarching strategies to address the priorities identified are directed toward community infrastructure to address social determinants of health and community building through healthy connections. The strategies, proposed partners, potential tactics and outcomes we hope to achieve are discussed on the following pages. Note that the workgroup strived to be as inclusive as possible during this initial planning phase; the work will likely condense and be refined by the stakeholders who are engaged going forward.

(See Attachment Two for definitions of key terms.)

STRATEGY 1: Leverage community infrastructure to address social determinants of health to improve health equity.

Any improvement activity demands infrastructure, including resources, to initiate and sustain the changes. A targeted effort by community partners will be required to truly impact overall wellbeing and improvements in the priority areas identified.

This strategy requires a broad view as we seek to impact social determinants of health and ultimately health equity across the community. The work is foundational to subsequent improvement activities.

The Greater Grand Forks area has several entities that are already engaged in community health improvement work. Leadership and an accountability structure will be important to ensure tactics are implemented and that existing resources are leveraged and connected appropriately. Often the biggest hurdle is the lack of awareness of what's available to support those in need among the various professionals and agencies with which they are interacting. Creating awareness of and connections across resources seems simple but can be challenging at the same time.

The following information outlines the preliminary partners, tactics and outcomes we seek to achieve in working on this strategy.

OBJECTIVE: Build sustainable infrastructure through community partnerships.

Foundational Partners

- Altru Health System
- Altru Health Foundation
- Blue Zones Project Grand Forks
- Grand Forks Public Health
- Spectra Health

Potential Additional Community Partners

- Community leaders of underserved groups, e.g. LGBTQ+, New Americans
- City and county officials
- Educational leadership
- Faith community leadership
- Grand Forks Region Economic Development Corporation
- Military community leadership
- Other healthcare providers
- Other local nonprofits
- University of North Dakota
- Other stakeholders as identified

Potential Tactics

- Share CHIP and resource plan with community leaders to create awareness and generate support for infrastructure needs.
- Build a community dashboard on Health Equity that utilizes data to highlight the health disparities within our community.
- Provide increased education opportunities on Health Equity and Social Determinants of Health.
- Identify capacity of various community partners to support infrastructure development work – via funding or in-kind support.
- Conduct community campaign to educate on social determinants of health and the impact on health outcomes.
- Explore and pursue available funding opportunities that build sustainability for Health Equity.
- Engage people with lived experience in the conversations on how to address social determinants of health.
- Development of a community coalition on Health Equity.
- Create a community-level Health Equity Plan.
- Other tactics as identified by working team.

Outcomes

- Sustain the number of community partners involved in the community health assessment to be part of the implementation work.

- » Increase the reach of community health assessment survey for next cycle to include representation of high-risk populations.
- » Increase the awareness of the community health assessment process and increase in survey respondents for the next cycle.
- » Increase the number of coalitions or workgroups that adopt health equity into their work.
- » Generate data to inform community stakeholders in decision making.
- » Establish connections with other organizations who are investing in like-type work.

Resources

https://www.bcbsnd.com/content/dam/bcbsnd/documents/brochures/caring-foundation/BCBSCF2023_FinalReport.pdf

https://www.barhii.org/enlarged-framework

https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/sdoh-workbook.pdf

https://racialequityalliance.org/wp-content/uploads/2015/10/GARE-Racial_Equity_Toolkit.pdf

https://www.grandforksgov.com/home/showpublisheddocument/46104/638070572641370000

https://www.hhs.nd.gov/sites/www/files/documents/DOH%20Legacy/Community%20Engagement/Community_Engagement_Strategic_Plan_3-17-2023.pdf

OBJECTIVE: Generate community investments to sustain health and wellness improvement efforts over the next three years.

Foundational Partners

- » Altru Health System
- » Altru Health Foundation
- » Blue Zones Project Grand Forks
- » Community Foundation
- » Grand Forks Public Health
- » North Dakota Department of Health and Human Services

Potential Additional Community Partners

- » City and county officials
- » Community leaders of underserved groups, e.g. LGBTQ+, New Americans
- » Grand Forks Region Economic Development Corporation
- » Educational leadership

- Faith community leadership
- Military community leadership
- Other local nonprofits
- Other healthcare providers
- Spectra Health
- University of North Dakota
- Other stakeholders as identified

Potential Tactics

- Share CHIP and resource plan with community leaders to create awareness and generate support for infrastructure needs.
- Identify capacity of various community partners to support infrastructure development work – via funding or in-kind support.
- Explore and pursue funding opportunities available that build sustainability for Health Equity.
- Other tactics as identified by working team.

Outcomes

- Increased funding into the community to support health improvement.
- Establish connections with other organizations who are investing in like-type work.

Resources

https://www.bcbsnd.com/content/dam/bcbsnd/documents/brochures/caring-foundation/BCBSCF2023_FinalReport.pdf

https://www.barhii.org/enlarged-framework

https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/sdoh-workbook.pdf

https://racialequityalliance.org/wp-content/uploads/2015/10/GARE-Racial_Equity_Toolkit.pdf

STRATEGY 2: Empower community building among individuals through healthy connections and neighborhood networks.

This strategy relates to the importance of social connection and feelings of belonging. In the wake of the COVID-19 pandemic, the value of social relationships has been elevated and there is an increased need to support social connections in our community. Feelings of connection and belonging play an important part in health and well-being.

Per the Blue Zone Project, research from the original Blue Zones communities has shown that feelings of connection can increase longevity. In addition, connection improves quality of life by boosting self-esteem and fostering a sense of purpose, security and belonging. Specifically linking social connection to our priority area of substance use, the impact of peer-to-peer support has been demonstrated to promote positive impacts in the recovery and treatment community.

While having social connections leads to more positive outcomes, research has long demonstrated that the opposite is also true: a lack of social connection has been shown to lead to worse outcomes. A recent document from the Administration for Community Living states that social isolation is as bad for health as smoking 15 cigarettes a day. There is significant research spanning across decades on the negative impacts of social isolation on the homebound and elderly. Research has shown the link between cognitive decline and an increase in neurological conditions with social isolation, such as dementia. Studies now can link social isolation and loneliness with increased morbidity and mortality across the life span as well as increased risk and likelihood of:

- Acute illness
- Behavioral and mental health, e.g., anxiety, depression, substance use disorder
- Chronic disease, e.g., heart disease, type 2 diabetes
- Infectious disease
- Inadequate nutrition
- Inadequate sleep
- Increased health care utilization
- Premature mortality, including death by suicide and all causes
- Reduced physical activity

It is easy to understand the importance of social connection at an individual level, but there is also benefit at the community level. Adults who feel connected to their community are more likely to contribute to their workplace, engage in civic opportunities such as volunteering, and care for those around them, including family, friends, and neighbors. Social connection plays an important part in creating vibrant neighborhoods and economic stability in our community. By building community and neighborhood networks, the focus of this strategy will be primary prevention—work that will promote health and wellness before a significant health concern develops.

The following information outlines the preliminary partners, tactics and outcomes we seek to achieve through this strategy.

Objective: Increase the community capacity for generating connections among individuals and neighborhoods

Foundational Partners

- Altru Health System
- Altru Health Foundation
- Blue Zones Project Grand Forks
- Grand Forks Public Health
- Mental Health Matters
- Spectra Health

Potential Additional Community Partners

- Business community leaders
- Civic engagement groups
- East Grand Forks Park District
- Grand Forks Region Economic Development Corporation
- Grand Forks Park District
- Grand Forks Senior Center
- Live Well Grand Cities
- Global Friends Coalition
- Grand Forks Air Force Base
- Grand Forks Public Schools
- Substance Abuse Prevention Coalition
- University of North Dakota
- Other stakeholders as identified

Potential Tactics

- Develop a coalition (or leverage existing one) focused on increasing social connectedness in the community.
- Develop a toolkit to help individuals build community connections within their neighborhoods.
- Increase targeted outreach to engage neighborhoods/families most in need.
- Implement screening for community belonging and food insecurity in primary care visits.
- Increase sports programming for youth that is accessible to all and includes a variety of options
- Support mini longest table events focused on neighborhoods.
- Promote neighborhood gardens that are accessible to all.
- Promote neighborhood schools as community resource hubs.
- Organize social events promoting connections in a specific population (e.g., neighbors, 55+, youth).
- Implement a community landing page through Mental Health Matters to house community resources.
- Develop a comprehensive database for connecting people to volunteer opportunities across the community.

- » Create intentional connections between workforce and youth, e.g. mentorship programs.
- » Other tactics as identified by the working team.

Outcomes

- » Increased community well-being index (BZ Real Age Test)
- » Increased Real Age Test outcomes related to belonging (BZ Real Age Test)
- » Increased positive responses to the question "I feel a strong connection to the community" (CHA community survey)
- » Increased positive responses to the question "People in the community are inclusive and welcoming to all" (CHA community survey)
- » Decreased rate of misuse of alcohol, marijuana, and cigarettes by students (Grand Forks and Polk County Youth Surveys)
- » Decreased rate of misuse of alcohol and other drugs by adults
- » Decreased number of poor mental health days (CHR&R)
- » Decreased rate of obesity
- » Decreased number of opioid related EMS response calls
- » Decreased number of deaths by suicide
- » Decreased reported frequent mental distress
- » Increased Health Factors rank (CHR&R)
- » Decreased number of adults reporting physical inactivity
- » Increased access to exercise opportunities

Resources

http://ccare.stanford.edu/uncategorized/connectedness-health-the-science-of-social-connection-infographic/

https://acl.gov/sites/default/files/committoconnect/CTC_SocialIsolationOverview_FINAL.pdf

https://committoconnect.org/our-work/

Social-Isolation-Fact-Sheet-5-10-Benefits-of-Social-Relationships_092121-1.pdf (committoconnect.org)

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6125010/

https://pubmed.ncbi.nlm.nih.gov/34646109/

https://store.samhsa.gov/sites/default/files/pep22-06-01-005.pdf

https://www.health.harvard.edu/blog/poverty-homelessness-and-social-stigma-make-addiction-more-deadly-202109282602

PRIORITIES ADDRESSED WITHIN THE COMMUNITY

The six priorities identified in the Community Health Assessment are complex and interwoven. This CHIP takes a different approach than previous improvement plans using the overarching community strategies that "live upstream" with a prevention focus and the potential to have impact across the priorities versus addressing each individually.

With this approach, the priority areas of workforce development and childcare will not be as directly impacted by the strategies and tactics identified here. There are considerable local and state resources addressing these areas, and the work group felt that we could defer to these other entities currently engaged to make improvements on these two topics.

Additionally, access to care has long been a priority of Altru, Grand Forks Public Health, and other community partners. The work group felt that the focus of these organizations will continue independent of this CHIP. The work identified here can supplement and support the valuable ground that has been gained.

NEXT STEPS

This CHIP will be approved by Altru Health System's Board of Directors during its meeting on April 24, 2023. After approval, it will be made available to the public via the Altru and Grand Forks Public Health websites.

Upon approval, the structure to implement the plan will be developed and launched. This CHIP will be a living document through the course of this assessment/improvement cycle and become better defined as the community stakeholders form workgroups and secure resources to achieve the strategies and objectives identified. The tactics and outcomes identified may change over time as new information emerges and leaders engage with the work.

ATTACHMENT ONE | COMMUNITY ADVISORY COMMITTEE ORGANIZATIONS

Alluma

Altru Family YMCA

Altru Health System

Chamber of Grand Forks and East Grand Forks

City of East Grand Forks

City of Grand Forks

Community Violence Intervention Center

East Grand Forks Public Schools

Global Friends Coalition

Grand Forks Air Force Base

Grand Forks Herald

Grand Forks Housing Authority

Grand Forks Parks and Recreation

Grand Forks Fire Department

Grand Forks Park District

Grand Forks Police Department

Grand Forks Public Schools

Grand Forks Senior Center

Grand Forks Economic Development Corporation

Korsmo Family Dentistry

Northeast Human Service Center

Northlands Rescue Mission

Polk County Public Health

Quality Health Associates

Safe Kids

ShareHouse

Spectra Health

Turtle River State Park

University of North Dakota Masters of Public Health Program

United Way

ATTACHMENT TWO | DEFINITIONS

HEALTH DISPARITIES

Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that have been disadvantaged by their social or economic status, geographic location, and environment. https://www.cdc.gov/healthequity/whatis/index.html

HEALTH EQUITY

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." ~ Robert Wood Johnson Foundation.
https://www.rwjf.org/en/insights/our-research/2017/05/what-is-health-equity-.html

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. https://www.cdc.gov/healthequity/whatis/index.html

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, racism, climate change and political systems. Centers for Disease Control and Prevention (CDC) has adopted this SDOH definition from the World Health Organization.
https://www.cdc.gov/about/sdoh/index.html

UNDERSERVED POPULATIONS/COMMUNITIES

Groups that have limited or no access to resources or that are otherwise disenfranchised. These groups may include people who are socioeconomically disadvantaged; people with limited English proficiency; geographically isolated or educationally disenfranchised people; people of color as well as those of ethnic and national origin minorities; women and children; individuals with disabilities and others with access and functional needs; and seniors.
https://www.fema.gov/about/glossary/u