BELTRAMI COUNTY

MEETING AGENDA

Beltrami County Community Health Board
October 21, 2025
2:00 p.m.

Meeting to be held in the County Board Room
County Administration Building, 701 Minnesota Avenue NW
Bemidji, MN

Minutes can be located on the County Website.

1. **Call to Order and Roll Call** - *2:00 p.m.*
2. **Approval of the Agenda** *(Additions/Corrections/Deletions) – 2:00 p.m.*
3. **Approval of July 15, 2025, Meeting Minutes** – *2:05 p.m.* Pg. 1
4. **Community Health Board Programs and Services Update** – *2:10 p.m.* Pg. 5
5. **Presentation from Minnesota Office of Addiction and Recovery** – *2:30 p.m.* Pg. 41
6. **Commissioners' comments and agenda additions for next meeting** – *2:50 p.m.*
7. **Adjourn** – *2:55 p.m.*

est. 1866
BELTRAMI county

Date: October 21, 2025
Beltrami County
Community Health Board

AGENDA BILL

SUBJECT: Approval of the Minutes

RECOMMENDATIONS: Approval, as presented

DEPARTMENT OF ORIGIN: HHS, Public Health Division

CONTACT PERSON (Name and Phone Number): Amy Bowles, CHS Administrator, 333-8116

DATE SUBMITTED: October 16, 2025

CLEARANCES: N/A

BUDGET IMPACT: N/A

EXHIBITS: Minutes from July 15, 2025

SUMMARY STATEMENT:

Copies of the minutes of past meetings are presented for the review and approval of the Community Health Board.

MINUTES OF THE PROCEEDINGS
OF THE BELTRAMI COUNTY COMMUNITY HEALTH BOARD
July 15, 2025

The Beltrami County Community Health Board met in regular session on July 15, 2025, at the County Board Room, County Administration Building, Bemidji, Minnesota.

CALL TO ORDER

Chair Craig Gaasvig, called the meeting to order at 2:00 p.m. Board Members John Carlson, Tim Sumner, and Scott Winger were present. Board Member Joe Gould was absent.

GENERAL COMMENTS - BOARD CHAIR

None.

APPROVAL OF AGENDA

No additions or corrections were made to the agenda.

GENERAL BUSINESS

Approved Agenda and Amendments

A motion to approve the agenda with no amendments was made by Board Member Sumner, seconded by Board Member Carlson, and unanimously carried.

Approved Minutes

A motion was made by Board Member Carlson, and seconded by Board Member Winger, to approve the April 15, 2025, Community Health Board Minutes. Unanimously carried.

REGULAR AGENDA

Programs & Services

Community Health System Administrator, Amy Bowles, updated the Board on the current staffing status of the Public Health Department. There are currently two open positions: 1) Public Health Nurse and 2) Public Health Program Manager.

Program updates:

WIC

WIC Program Coordinator Sheila Johnson and Registered Dietitian Krista Boyer updated the Board on the participation and activities

of the WIC Nutrition Program. This program services residents all across northern Minnesota and is not limited to just Beltrami County. The program is funded by the MN State WIC Grant.

Krista Boyer discussed the supports and services around the Breastfeeding. This includes:

- Breastfeeding consultation
- The Baby Café – drop-in group
- Bemidji Area Breastfeeding Coalition
- The Rock and Rest Tent
- WIC Breastfeeding Classes
- Beltrami County Public Health Milk Depot

Families First Program

Becky Berquist, representative to the Families First Collaborative; a partnership working together to help families and improve access and coordination of care for women during pregnancy. This program is operating on a 4-year grant that will expire in August of this year.

While they are working on another Federal grant to continue and expand their work, the collaborative has many services and processes in place that will be sustainable.

Community Health Assessment and Community Health Improvement Plan (CHA/CHIP)

Ms. Bowles presented the Final 2025-2030 CHA CHIP for approval for community publication, printing, and submission to the MN Department of Health. This Report will guide community health planning efforts through the next five-year cycle.

A motion was made by Board Member Carlson, and seconded by Board Member Sumner, to formally adopt the 2025-2030 CHA CHIP Report, approve publication, printing, and submission to the MN Department of Health. Unanimously approved.

Board Member Comments and Agenda Additions
None.

Next regular meeting of the County Board will be October 15, 2025, in the Board Room of the County Administration Building.

MEETING ADJOURNMENT

The Community Health Board meeting was adjourned at 2:54 p.m. Motion by Board Member Carlson, and seconded by Board Member Winger. Unanimously carried.

Craig Gaasvig, Chair

7/16/2025
Amy Bowles, Community Health System Administrator

est. 1866
BELTRAMI county

Meeting Date: October 21, 2025
Beltrami County
Community Health Board

AGENDA BILL

SUBJECT: **Community Health Board Program and Services**

RECOMMENDATIONS: Informational

DEPARTMENT OF ORIGIN: HHS, Public Health Division

CONTACT PERSON: Amy Bowles, CHS Administrator #8116

DATE SUBMITTED: 10/21/2025.

CLEARANCES: Anne Lindseth, HHS Director

BUDGET IMPACT: none

EXHIBITS: Power point and MDH Reports

SUMMARY STATEMENT: The Community Health Board will receive an overview from the Community Health Services (CHS) Administrator and Public Health Staff, highlighting key accomplishments from the past year as well as insights gained from recent trainings and conferences.

Where We've Been
Where We Are
Where We're Going

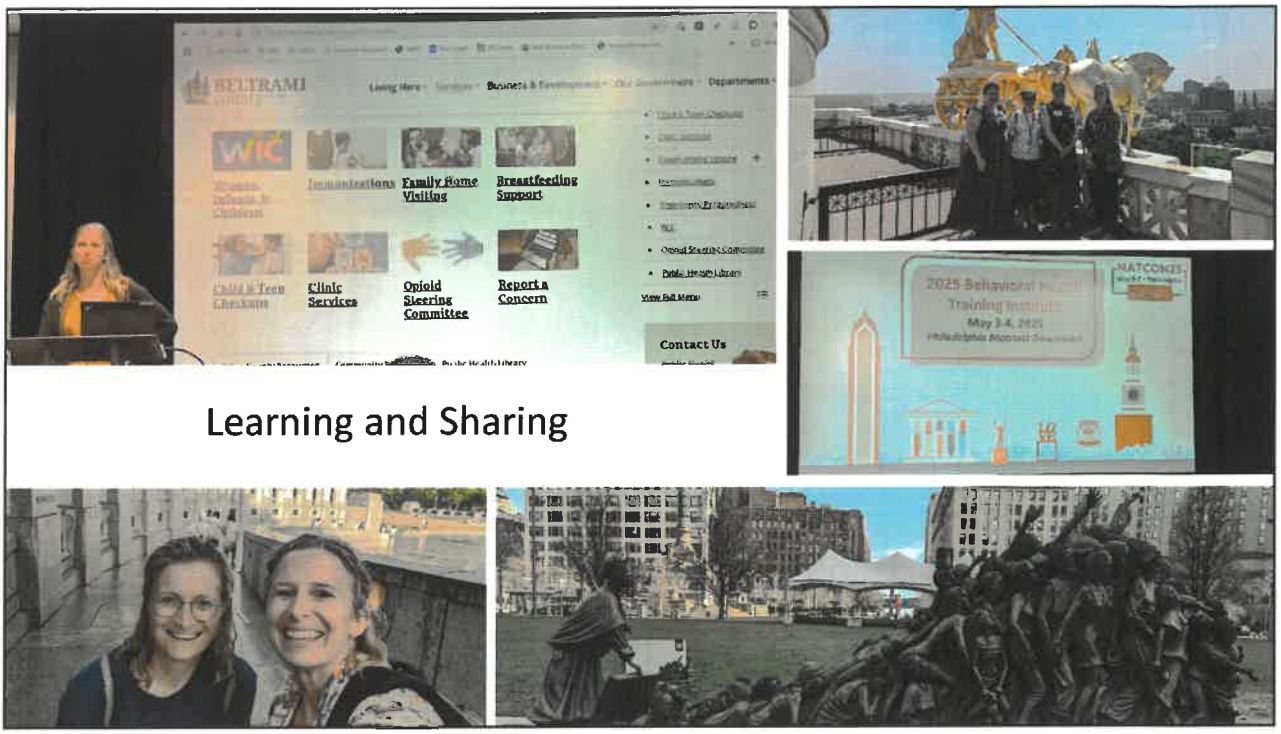
BELTRAMI COUNTY
Community Health Board

Amy Bowles MSN, BSN, RN, PHN
Community Health Services Administrator
October 21, 2025

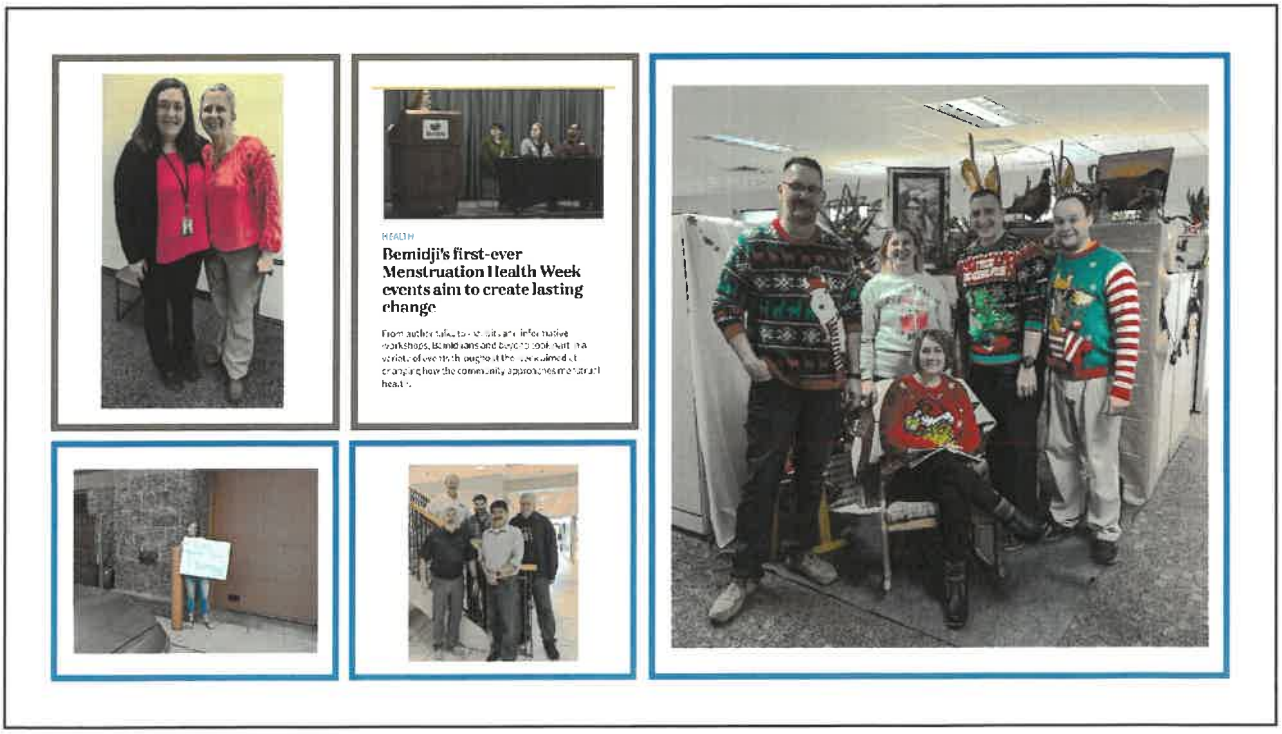
1

The Public Health Team: Our Baker's Dozen, Plus One

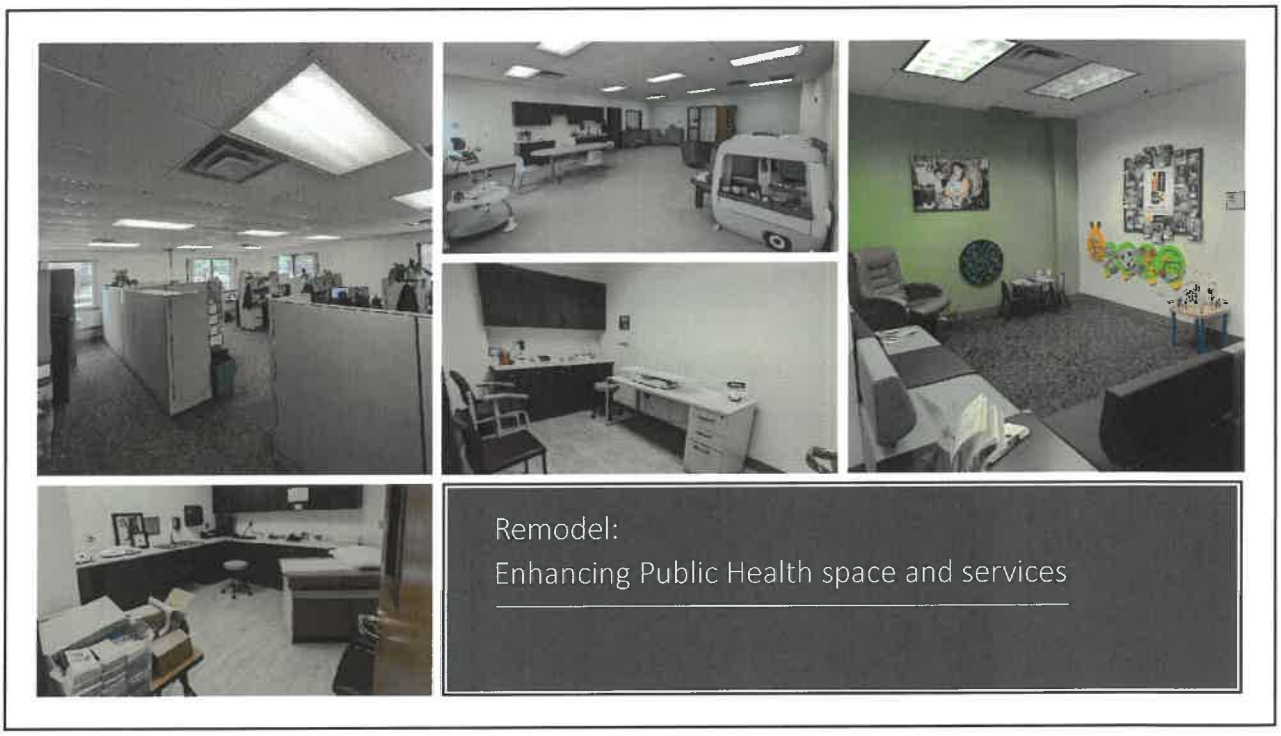
2


BELTRAMI
WIC
Immunizations
Family Home Visiting
Breastfeeding Support
Clinic Services
Opioid Steering Committee
Report a Concern
Contact Us
2025 Behavioral Health Training Institute
May 3-4, 2025
NATCONES
Learning and Sharing

3


HEALTH
Bemidji's first-ever Menstruation Health Week events aim to create lasting change

4


Remodel:
Enhancing Public Health space and services

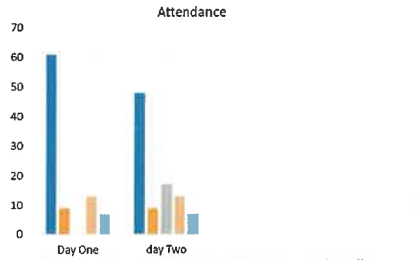
5


Wellness
and Team
Building

6

Outreach Partnerships Education

7



Partnerships in Emergency Response:

Shelter Training

Train to Prepare, Prepare to Respond, Respond to Recover

8


FamiliesFirstMinnesota.org
WIC
How does WIC help families?
Visibility and Connection

9


We are Ready, are You?
Who are Your Partners?

10


June 21, 2025

11


You Called
We Responded
BELTRAMI
WIC
BELTRAMI
BELTRAMI COUNTY

12


BELTRAMI
POST-STORM
RESOURCE CENTER
OPEN DAILY: JUNE 27 – JULY 2, 2025
Hours: 11:00 AM – 6:00 PM
SNAP / MFIP FOOD BENEFIT REPLACEMENT
HOT MEAL TIMES
WHAT'S AVAILABLE
BELTRAMI
EMERGENCY DISASTER SERVICE

13


WIC
IVE UNITE
FIRST
DAY
OF
SCHOOL
We Recovered

14


Beltrami County
2025-2030
Community Health
Assessment
Community Health
Improvement Plan
EMERGENCY MANAGEMENT
BELTRAMI
EM
BELTRAMI
COUNTY
Community Health Board
Partnerships in Emergency Response: Shelter Training
Train to Prepare, Prepare to Respond, Respond to Recover

15

DEPARTMENT OF HEALTH

Community health improvement plan review: Beltrami County

FALL 2025

Process

Strengths:

- Great engagement with partners from various sectors.
- CHA data is very visible throughout the CHIP, with clear connections between assessment and plan.
- CHIP format is engaging—consistent colors, visuals, and easy to navigate information.
- Populations at higher health risks are clearly represented.
- Community survey participation exceeded expectations, demonstrating broad input.

Opportunities for growth:

- Some pages are dense, with small font and technical language. You may want to consider simplifying language for community members who may not be familiar with some of the terminology as well as ensure the document is accessible.
- You may want to consider adding more information about your prioritization process for greater transparency. Currently, the CHIP states that the 4 priorities came from community survey rankings, but more explanation (e.g., prioritization matrix, corroborating data) would be helpful to strengthen justification.
- Equity considerations were mentioned in the implementation of your CHIP but you may want to share how it influenced the process as well.

Plan

Strengths:

- Four health priorities are clearly defined (chemical dependency, housing, safety & security, transportation).
- Pages 22–23 present well-structured goals, strategies, metrics, policy recommendations, and responsible partners.
- Many strategies include SMART goals, and metrics are linked to measurable outcomes.
- The plan includes short and long-term strategies which is helpful to see how priorities will be addressed over time.
- A comprehensive list of community and volunteer resources is provided at the end, making the CHIP a useful tool for both the public and partners.
- Annual review and mid-term evaluation processes are built in, ensuring continuous improvement.

Opportunities for growth:

- You may want to consider including baseline data for each metric to enable progress tracking.
- Stronger linkages between policy recommendations and measurable outcomes would strengthen evaluation.
- Consider aligning strategies with Healthy People 2030 or Minnesota state health priorities for broader consistency.

Community Engagement

Strengths:

- Multiple partners acknowledged (p.3) and clearly integrated into implementation roles (p.22–23).
- Outreach for the CHA survey was extensive, using face-to-face, online, and community events to increase response rates.
- CHIP highlights Tribal traditions and community connections, with inclusion of Tribal partners in both assessment and planning.
- Youth engagement (Youth Advisory Committee) is a notable strength, demonstrating commitment to future leadership.

Opportunities for growth:

- You may want to consider providing additional details on how residents will remain engaged throughout implementation and evaluation, beyond survey participation.
- Consider adding advisory groups or feedback loops for elders, people in recovery, or low-income families, similar to the youth-focused strategy.

Health Equity

Strengths:

- Acknowledges Native American presence and history (p.5) and integrates Tribal perspectives throughout the plan.
- Housing strategies address inequities by including sober living residences and supportive services, recognizing challenges faced by individuals in recovery.
- Transportation strategies include subsidies for low-income residents and expansion to underserved areas.
- Safety & Security plan includes an emphasis on equitable access for underserved communities.

Opportunities for growth:

- You may want to consider including an "equity impact" component to your plan for each priority to show how strategies will lead to more equitable outcomes.
- If possible, having disaggregated baseline data (by race, income, geography) consistently presented would help to better track disparities over time.
- Consider adopting an equity impact assessment tool to review future policies and programs.

DEPARTMENT OF HEALTH

State Community Health Services Advisory Committee

Building a Strong Foundation for a Healthier Minnesota: 2024 Community Health Board and MDH Report on Foundational Public Health Responsibilities

SCHSAC PERFORMANCE MEASUREMENT WORKGROUP REPORT

Governmental public health plays a vital role in keeping our communities healthy every day. It's why we can trust the food we eat, the water we drink, the air we breathe. Public health creates the conditions for all of us to live, work, and age safely.

This everyday protection is only possible when we have a coordinated governmental public health system – made up of state, local, and Tribal health departments. To guide and strengthen that system, we use the Foundational Public Health Responsibilities (FPHR) Framework, which defines the foundational responsibilities that must be in place everywhere for public health to work anywhere.

In 2024, all 51 community health boards and MDH reported on 46 national measures related to foundational responsibilities. A list of the 46 measures is included in Appendix B of this report.

This workgroup report summarizes the results, key takeaways, and observations from performance measurement data reported by community health boards and MDH for calendar year 2024. It does not include data from Tribal nations.

To meet community needs, we need a strong foundation. Both community-specific priorities and foundational responsibilities are essential. At this time, the Performance Measurement Workgroup is focused on measures related to the foundational responsibilities, since these reflect what must be in place everywhere and enables public health to effectively address community priorities.

Self-assessment is a common practice in public health

This report reflects self-assessment by community health boards and MDH. While self-assessment carries some subjectivity (e.g., some might rate themselves more strictly or by different reference points), it is a well-established and valuable method of public health evaluation.

Self-assessment captures lived experience and local knowledge that cannot always be measured through numbers alone.

See the limitations section on page x for more information.

What's in this report

- **Community health board results and key findings, including:**
  - **System progress is real.**
    - Figure 1: Percentage of overall performance measures met by Minnesota's community health boards
    - Figure 2: Number of measures met by community health board size (population served)
  - **There are notable areas of strengths and challenges across the system.**
    - Figure 3: Percentage of performance measures by capability
    - Figure 4: Community health boards' ability to meet emergency preparedness and response-related measures
    - Figure 5: Community health boards' ability to meet accountability and performance management-related measures
  - **Community health boards tend to show more strength where there is dedicated attention and funding**
  - **Next steps: Strengthen our public health system through funding, collaboration, and data sharing.**
- **Minnesota Department of Health results and key findings**
- **Limitations**
- **Appendix A: Additional graphs, including:**
  - Figures 6-11: Community health boards' ability to meet measures by foundational capabilities
  - Figures 12-17: Community health boards' ability to meet measures by foundational areas
  - Figure 18: Percent of 46 national measures met by community health board size (population served)
  - Figure 19: Percent of 46 national measures met by SCHSAC regions
  - Figure 20-21: Total number of Statewide Health Improvement Partnership sites by context and setting
  - Table 1: Number of emergency preparedness and response community partnerships by sector as of Sept. 30, 2024
  - Figure 22: Emergency preparedness and response activities with community partners
- **Appendix B: About performance measurement**
- **Appendix C: Workgroup charge and membership**

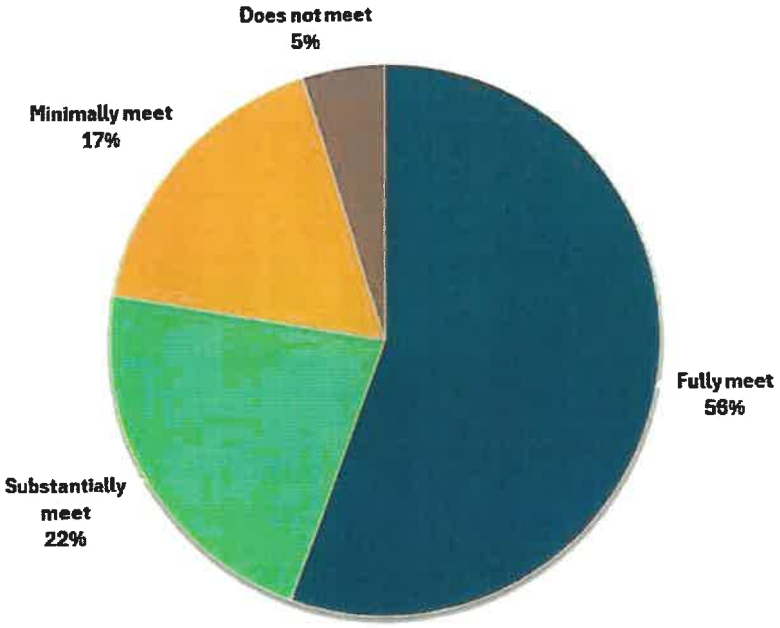
Community health board results and key findings

System progress is real.

We are seeing more measures fully or substantially met, a hopeful sign of forward movement despite ongoing pressures on public health. Disparities still exist, particularly among community health boards serving smaller populations.

In 2024, community health boards in Minnesota fully or substantially met 78% of overall performance measures. In 2023, community health boards fully or substantially met 71% of overall performance measures. Community health boards fully met 56% of overall performance measures.

Figure 1: Percentage of overall performance measures met by Minnesota's community health boards

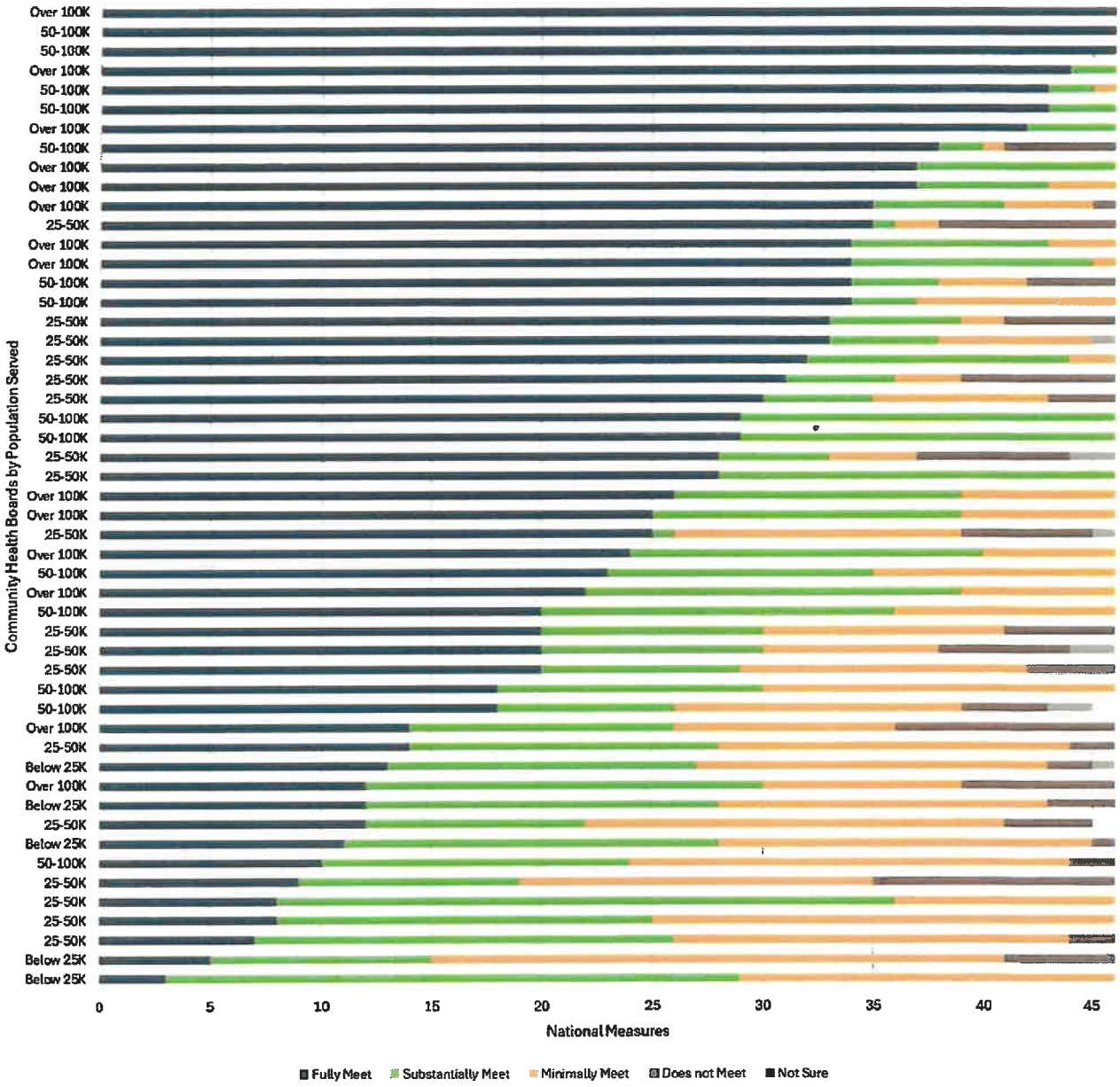


Half of community health boards (50%) can fully meet at least half of the measures, a pattern consistent with findings from previous assessments, suggesting a persistent variation in capacity.

24% of community health boards (12 out of 51) reported they cannot meet 5 or more measures.

Smaller community health boards (<50K population) are disproportionately represented in this group (75%), with only a few large, multi-county boards experiencing similar challenges.

Figure 2: Number of measures met by CHB size (population served)



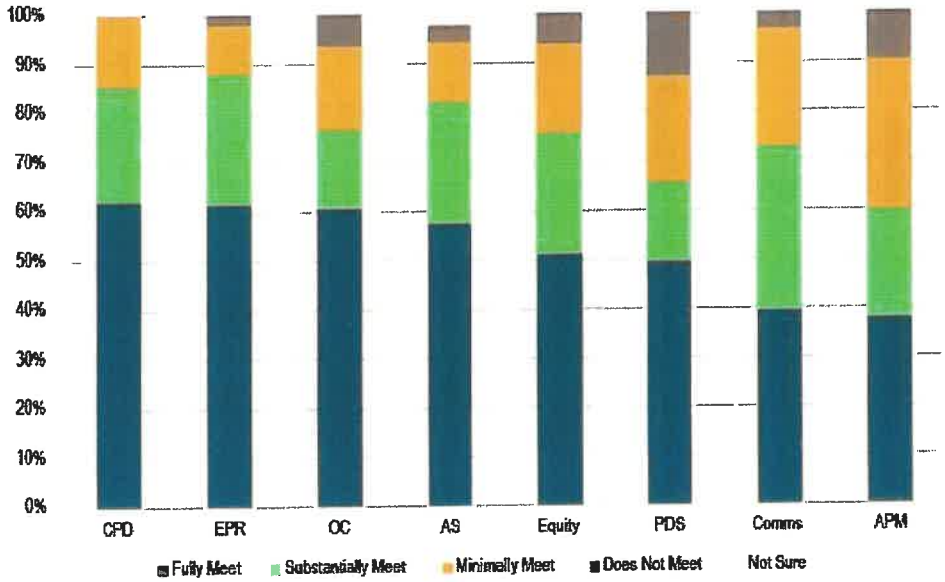
In the coming weeks, we will add a line with MDH data. We are also missing data on two measures from two CHBs that will be added once we receive it.

Workgroup reflection: **The data does not tell a one-size-fits all story. Patterns don't always align with community health board size or region.**

There are notable areas of strengths and challenges across the system.

Community health boards are doing well in the areas of community partnership development, emergency preparedness and response, and organizational competencies. Many community health boards have challenges with accountability and performance management and communication capabilities.

Figure 3: Percentage of performance measures by capability



CPD: Community Partnership Development; EPR: Emergency Preparedness and Response; OC: Organizational Competencies; AS: Assessment and Surveillance; PDS: Policy Development and Support; Comms: Communications; APM: Accountability and Performance Management

STRENGTHS

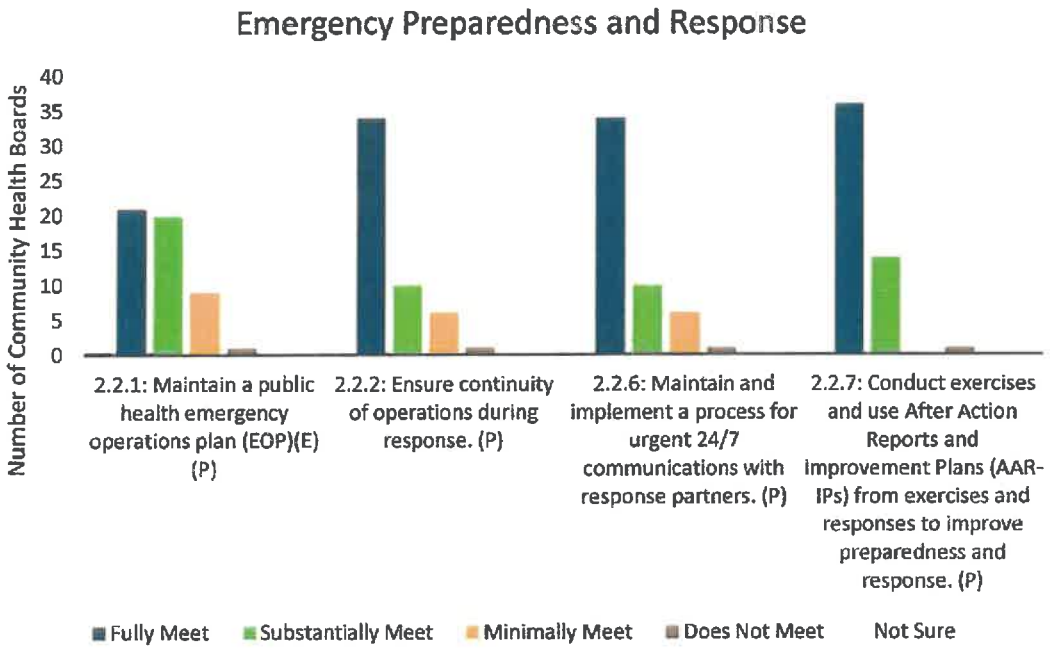
Community partnership development: Nearly all (96%) of community health boards fully or substantially meet the measure for participating in community health coalitions that promote health equity (4.1.2). Additionally, 86% of community health boards fully or substantially meet the measure for engaging community members to address public health issues and promote health (4.1.3).

- **Why this matters:** Community partnerships foster trust, leverages diverse perspectives and resources, and ensures that public health initiatives are responsive to the unique needs of the community. Strong partnerships enable more effective, equitable, and sustainable health outcomes.
- **The Statewide Health Improvement Partnership (SHIP)** illustrates how partnership and collaboration drives impact. In 2024 alone, local public health agencies worked with nearly 2,000

partner sites across the state. These partnerships have led to success on policy, system, and environmental changes to improve physical and mental wellbeing for Minnesotans.

Emergency preparedness and response: Community health boards fully or substantially met 88% of all the measures related to emergency preparedness and response.

Figure 4: Community health boards' ability to meet emergency preparedness and response related measures



Remove P's

- Community health boards demonstrate strong capacity in emergency preparedness and response through intentional partnerships and community engagement. In 2024, 27 community health boards used Response Sustainability Grant funding to expand or develop over 100 cross-sector partnerships, while another 20 improved community engagement through listening sessions, focus groups, and 1:1 meetings. These efforts show that boards are building trusted, proactive relationships for effective coordination and rapid response when emergencies arise. See table x and figure x in Appendix B for a summary of these community partnerships and activities.

Organizational Competencies: Community health boards fully or substantially met 78% of all the measures related to organizational competencies, demonstrating overall strength for this capability. The measure related to workforce development was an exception, with 65% of boards reporting they minimally or could not meet workforce development planning and the implementation of strategies.

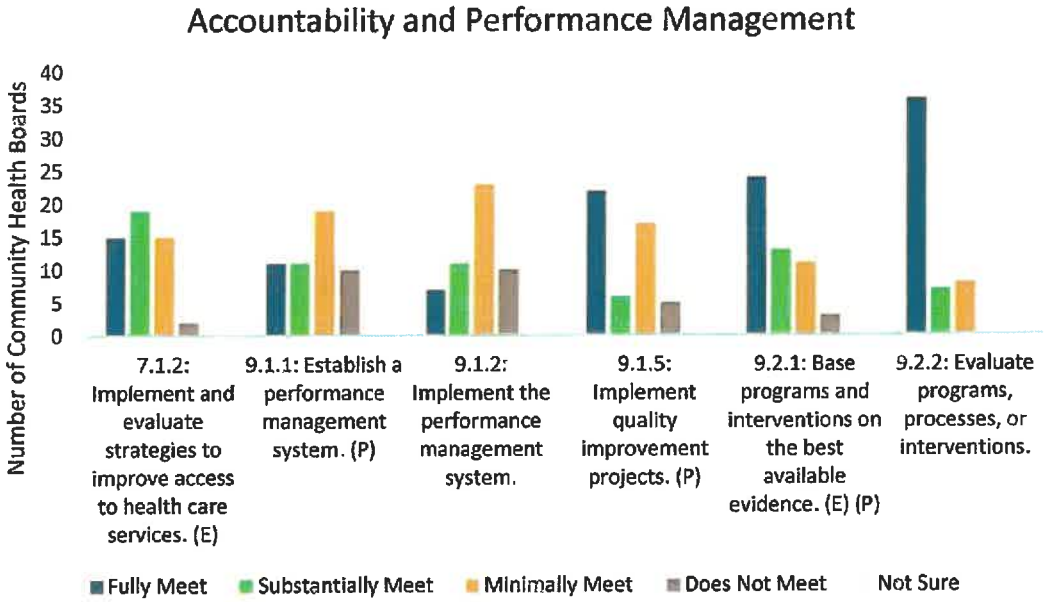
- **Why it matters:** Organizational competencies include leadership and governance, information technology, financial management, legal services, and workforce development. Having strong organizational competencies help agencies function effectively and respond to community needs.

CHALLENGES

Accountability and performance management: Less than half of community health boards, only 43%, fully or substantially meet the measure for establishing a performance management system (9.1.1). Even fewer, 35%, are fully or substantially implementing these systems (9.1.2). This gap highlights ongoing challenges such as limited staff capacity and expertise that can hinder progress.

Performance management is important because it makes public health work visible, measurable, and impactful. It provides the information needed for effective decision-making and drives continuous improvement across all parts of public health practice.

Figure 5: Community health boards' ability to meet accountability and performance management-related measures



Remove P's and E's above

- **Yes, but:** Many community health boards are working to improve, with over half planning to use FPHR Grant funds to strengthen accountability and performance management systems. Many community health boards are already engaging with MDH experts on this work.

Communications: Nearly a third (31%) of community health boards reported minimally or not meeting communication measures related to maintaining risk communication plans and processes for urgent communication with response partners (2.2.5) and procedures for ongoing, non-emergency communication outside the health department (3.1.1).

- **Yes, and:** At the same time, 80% of boards reported fully or substantially meeting the measure related to implementing communication strategies to encourage actions to promote health (3.2.2).

This strength demonstrates the system's capacity to engage communities in proactive health promotion.

- **MDH's rural communications assessment** (2025) found that rural agencies with dedicated staff had greater capacity and could take a more strategic approach, while those without relied on reactive communication.

Workgroup reflections: Community health boards are still rebuilding capacity after pandemic-related strain. Additionally, boards, particularly small ones, may face difficulty sustaining specialized roles (e.g., communications) due to workload scope and resource limitations.

Community health boards tend to show more strength where there is dedicated attention and funding.

For example, capabilities funded by the State Infrastructure (Innovation) Grant and the Foundational Public Health Responsibilities Grant boost capacity.

Positive impacts of funding include: These need review and approval from agencies

- Improved communication with communities, including more tailored public health campaigns.

  Infrastructure Fund example: The St. Paul–Ramsey County Public Health Trusted Messenger Initiative is strengthening partnerships with cultural communities to co-create and share vital health information in multiple languages and culturally meaningful ways. This ensures that everyone has access to the knowledge they need to live their healthiest lives. Fueled by infrastructure funding, the initiative's success is now inspiring expansion across other Ramsey County departments, showcasing the powerful ripple effect of innovation and community collaboration.

  FPHR example: The FPHR grant enabled the Meeker, McLeod, and Sibley Community Health Board to create a long-needed communications position, transforming how they connect with partners and the community. No longer limited to patchwork solutions, the CHB can now take a strategic approach to communication. This new capacity has led to clearer, more consistent messaging, stronger relationships with partners, and a professional, trusted presence in the community.

- Better data collection, interpretation, and use for decision-making.

  Infrastructure Fund example: The Northwest Eight (Polk, Norman, and Mahnomen CHB and Quin CHB) began by collaborating on data work for community health assessments and planning processes and has since expanded into piloting an innovative model for regional data services. This included the development of a shared data team to improve data collection, interpretation, and use, supporting better-informed decision-making across the region.

  FPHR example: For Sherburne County Community Health Board, the grant provided for the addition of a dedicated planner, critical for assessment and surveillance work. It's allowed them to prioritize the CHNA process and strengthen data-focused collaboration across partners. By merging two local data groups, engaging SHIP staff, and leveraging AmeriCorps support, they've deepened partner engagement and advanced shared understanding of Health in All Policies and social determinants of health.

- Regional coordination, shared staffing, and higher education partnerships increase capacity without requiring each community health board to hire dedicated staff.

Infrastructure Fund example: The Collaborative for Rural Public Health Innovation (CRPHI) is dedicated to advancing public health in rural communities and includes membership of local public health leaders representing 25 counties in South Central and Southwest Minnesota, representatives from Minnesota State University, Mankato, and representatives from MDH.

FPHR example: need example, Olmsted Regional data model?

- Some accredited agencies were already meeting measures, but these grants strengthened their efforts.

  Infrastructure Fund example: Hennepin County's Health Trends Across Communities innovation project is improving access to timely, medical-record data. This project is enhancing statewide capacity. Community health boards across the state now have access to richer, real-time data, strengthening their ability to understand community needs and enhancing the quality and relevance of the information available for planning and decision-making.

  FPHR example: Horizon hired a Population Health Supervisor to work on several foundational capabilities. They significantly increased their capacity to assist their local communities with policy development at a time when it was particularly crucial, given cannabis legalization.

Workgroup reflection: Sustainability is a concern from community health boards. Improvements made from grant-funded staff or initiatives risk plateauing without continued or increased funding.

Next steps: Strengthen our public health system through funding, collaboration, and data sharing.

Flexible funding, regional and cross-sector partnerships, and better coordination between local and state efforts will drive system improvements and ensure communities are better set up to thrive.

Flexible funding: Our public health system depends on flexible funding to stay strong and responsive. Sustaining and strengthening our system requires dedicated and flexible funding, including tax levy dollars. Current funding models are insufficient to meet system needs, and funding in part through tax levy provides the flexibility needed for community health boards to meet the needs of their community.

Collaboration: This report emphasizes the value of collaboration. Community health boards should continue to focus on strengthening regional collaboration to share work across geography and encourage innovative partnerships, such as those with universities, to continue building expertise and capacity.

Strengthen the foundation and drive innovation: Sustaining progress on the public health foundation requires ongoing and increased investment. At the same time, supporting innovation is essential to finding better ways of doing public health work. Community health boards are embracing creativity and moving beyond "the way it's always been done," but resources are needed to fuel and sustain this transformation.

System-level coordination: It's important to continue work toward system-level coordination, such as clarifying which practices are best led by locals versus MDH, improving communication and coordination

between them, and leveraging MDH data systems alongside local data to reduce redundancies and fill gaps.

Minnesota Department of Health results and key findings

As of oct 2, we are waiting on responses on 3 measures. We have met with all domain leads and subject matter experts.

Limitations

Several limitations and contextual factors should be considered when interpreting the data.

Scope: The data presented here includes that of local public health and the Minnesota Department of Health. It does not include Tribal Nations, which are important partners of our public health system. The sovereignty of Minnesota's Tribal Nations is affirmed and their authority over their own public health data, which remains under their control and ownership is acknowledged.

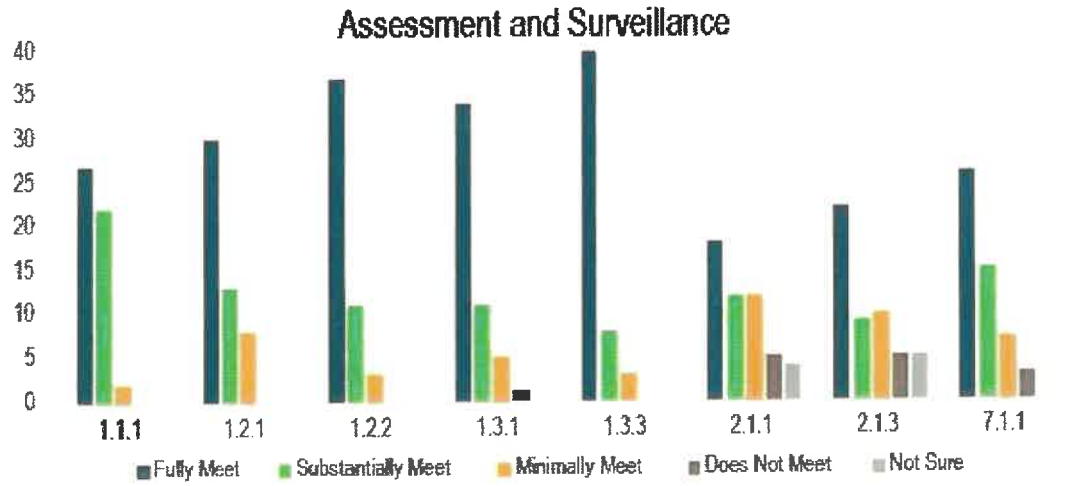
Self-reporting: Self-reporting is a widely used method for collecting data in public health. It comes with limitations, including less objectivity which can impact data quality. In 2023, effort was made to standardize response options to improve objectivity and consistency in reporting across the state.

Differences across counties: Reporting was done by community health boards. For multi-county community health boards (operating more than one health department), there may be differences between ability to meet by the counties the CHB governs not captured in the data. Multi-county community health boards were asked to report based on the lowest ability to meet of member health departments to reveal system strengths and gaps.

Community needs and impact are not measured: The measures assess how well community health boards can perform public health capabilities. However, they do not show if community health boards have what they need to meet the specific needs of their communities since community needs are not measured. This means that even if a larger community health board can carry out core public health capabilities, it does not necessarily mean they have enough resources to address their community's actual needs – or that they are better equipped than smaller community health boards to meet those needs.

Appendix A: Additional graphs

Figures 6-11: Community health boards' ability to meet measures by foundational capabilities[1]



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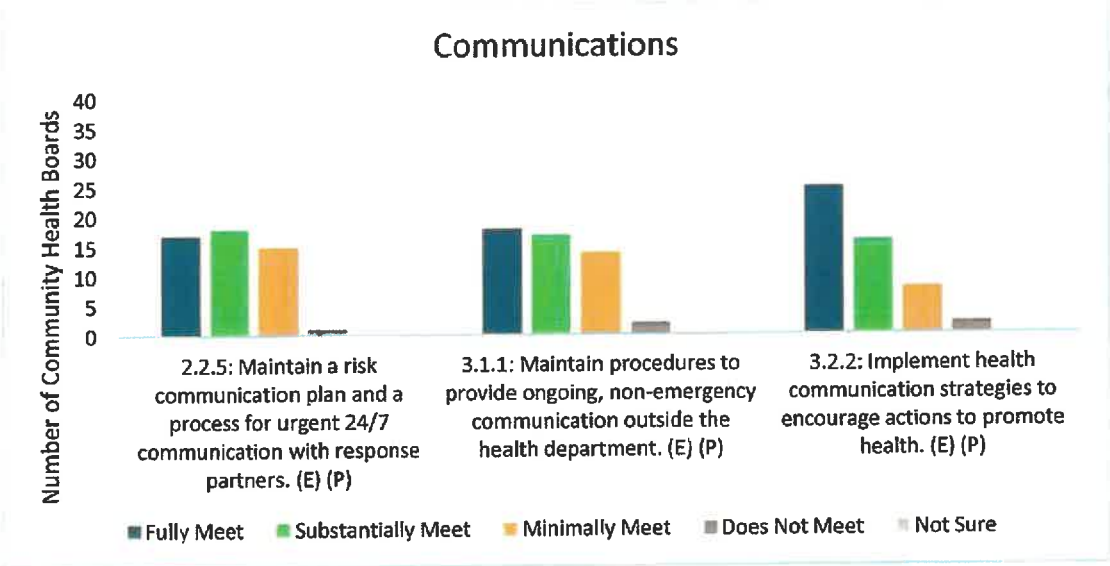
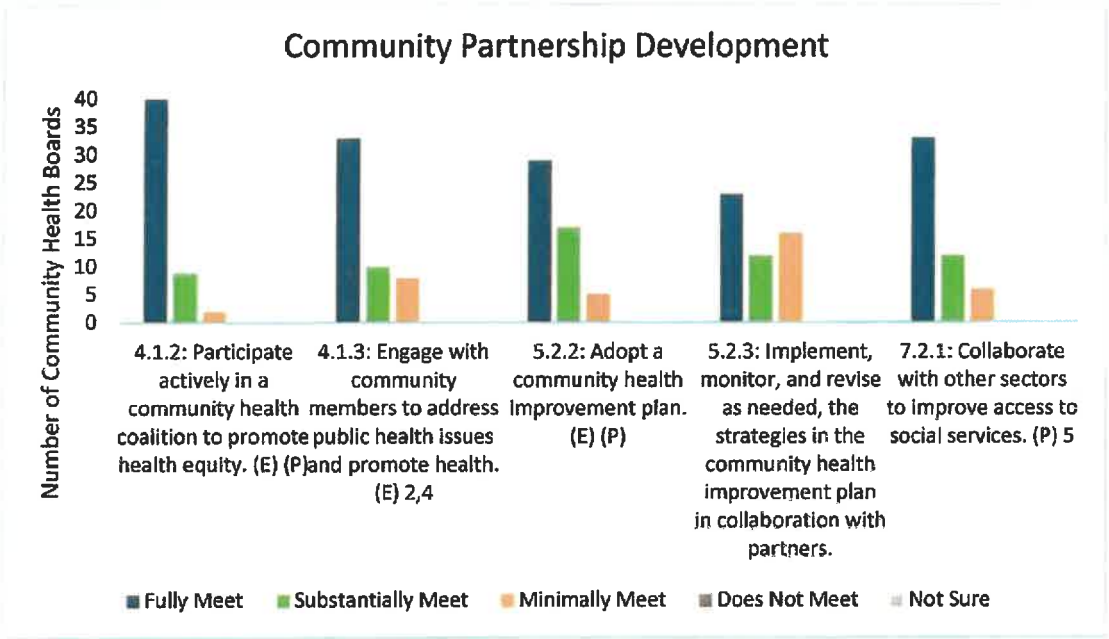
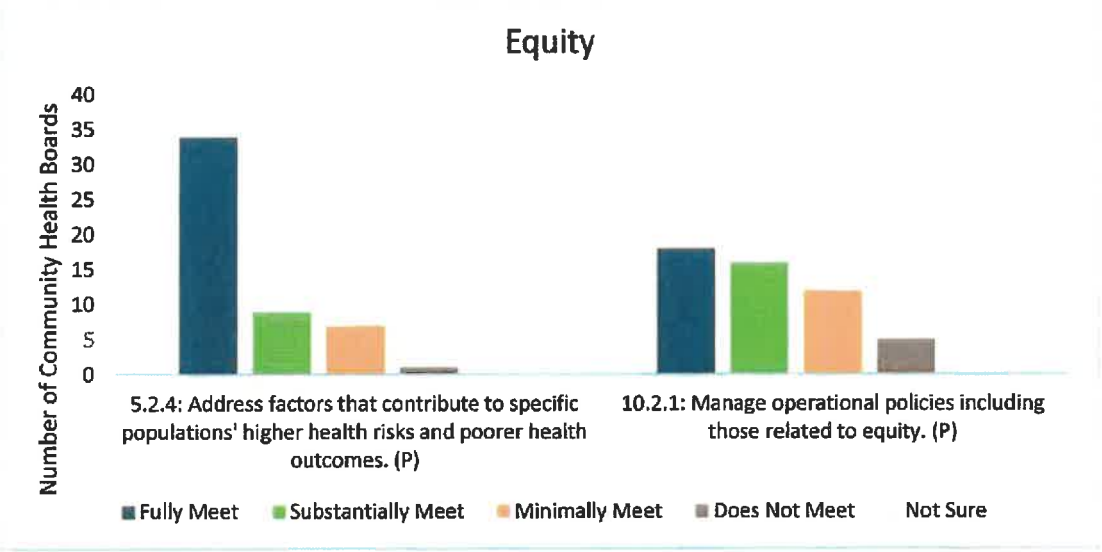
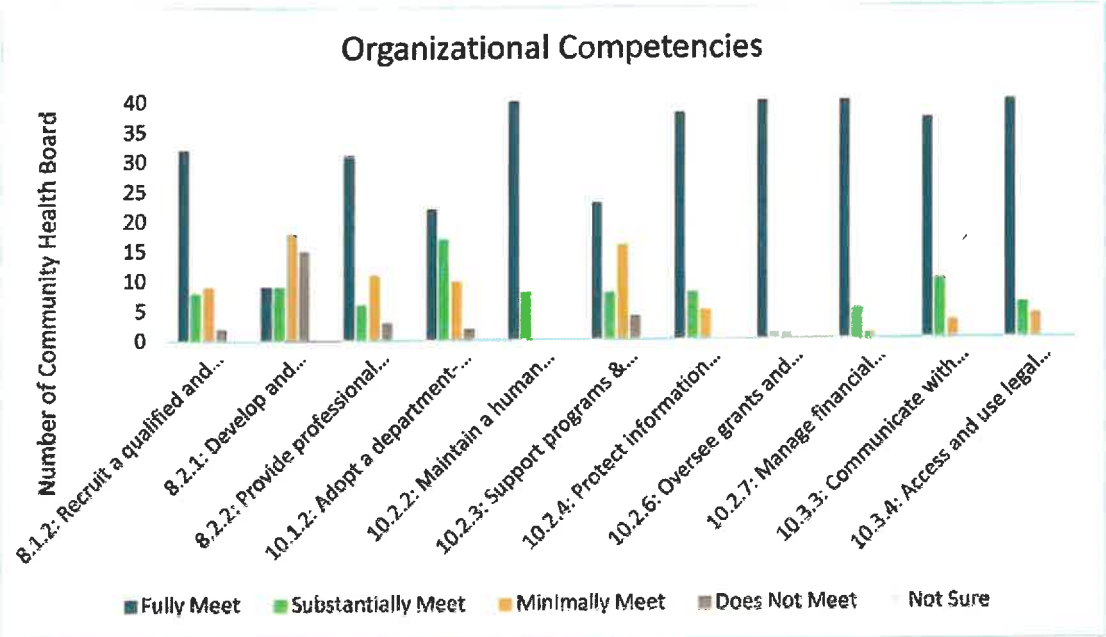
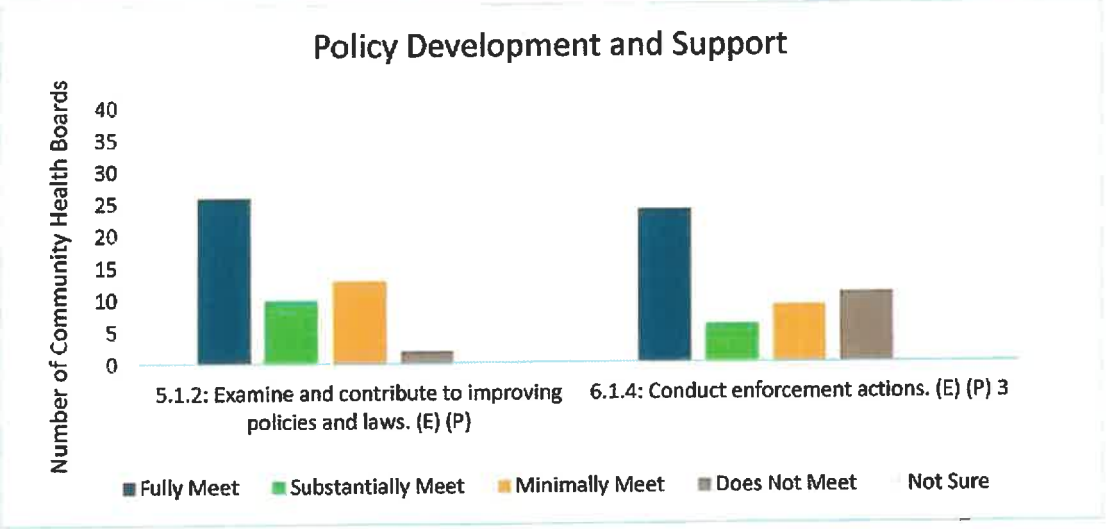


[1] Within the Foundational Public Health Responsibilities Framework, the foundational capabilities represent the foundation: Using the metaphor of a house, all houses need a strong foundation for the rest of the house to function properly. All public health's work is undergirded by a strong foundation, built of these capabilities, across all areas of work.

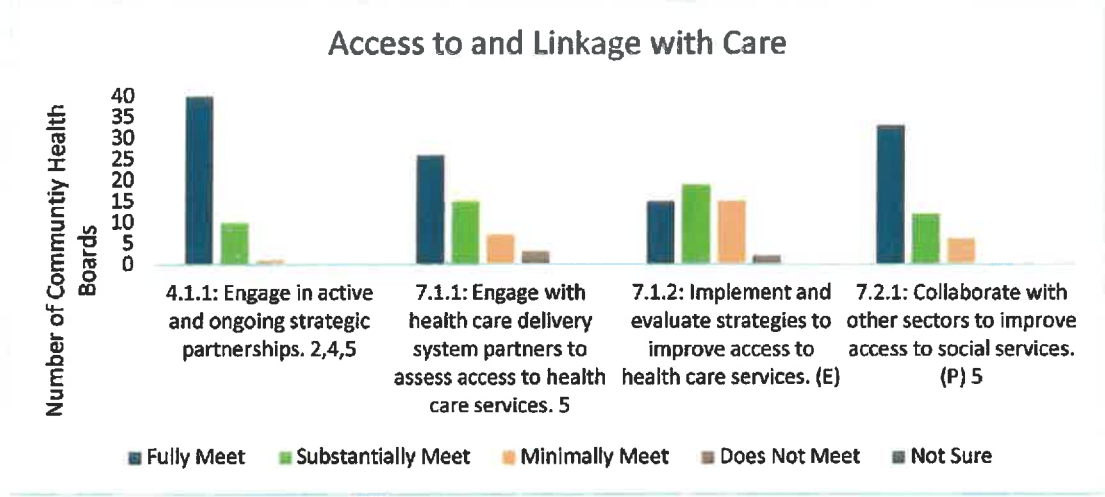

Community Partnership Development
Number of Community Health Boards
40
35
30
25
20
15
10
5
0
4.1.2: Participate actively in a community health coalition to promote health equity. (E) (P)
4.1.3: Engage with community members to address public health issues and promote health. (E) 2,4
5.2.2: Adopt a community health Improvement plan. (E) (P)
5.2.3: Implement, monitor, and revise as needed, the strategies in the community health improvement plan in collaboration with partners.
7.2.1: Collaborate with other sectors to improve access to social services. (P) 5
Fully Meet
Substantially Meet
Minimally Meet
Does Not Meet
Not Sure

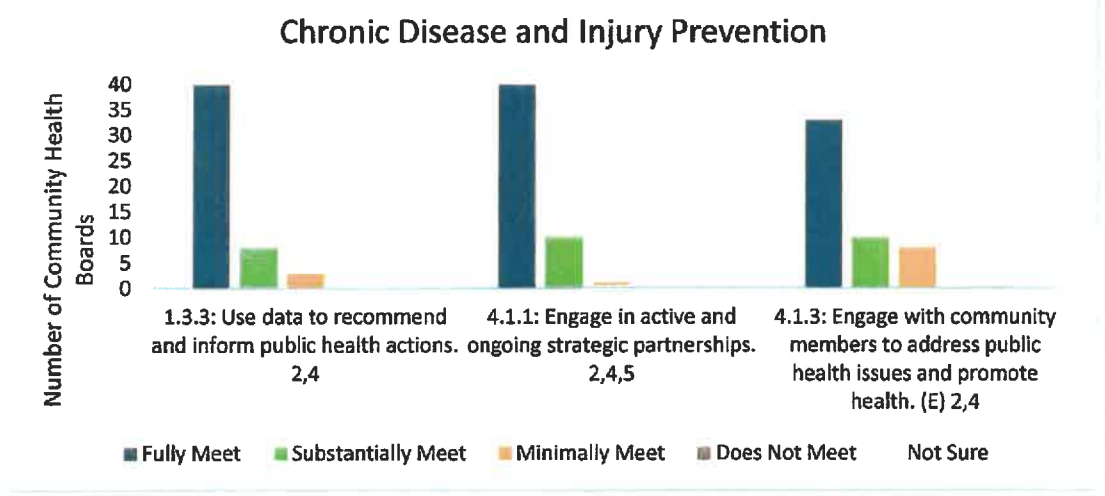

Equity
Number of Community Health Boards
40
35
30
25
20
15
10
5
0
5.2.4: Address factors that contribute to specific populations' higher health risks and poorer health outcomes. (P)
10.2.1: Manage operational policies including those related to equity. (P)
Fully Meet
Substantially Meet
Minimally Meet
Does Not Meet
Not Sure


Organizational Competencies
Number of Community Health Board
40
35
30
25
20
15
10
5
0
8.1.2: Recruit a qualified and...
8.2.1: Develop and...
8.2.2: Provide professional...
10.1.2: Adopt a department-...
10.2.2: Maintain a human...
10.2.3: Support programs &...
10.2.4: Protect information...
10.2.6: Oversee grants and...
10.2.7: Manage financial...
10.3.3: Communicate with...
10.3.4: Access and use legal...
Fully Meet
Substantially Meet
Minimally Meet
Does Not Meet
Not Sure

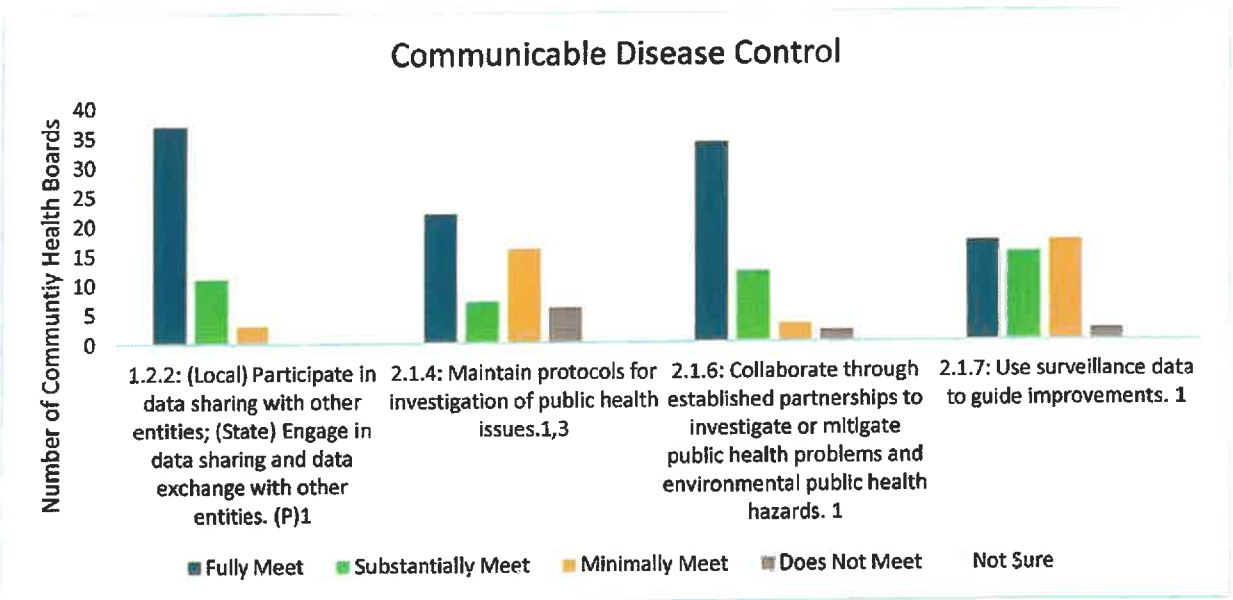

Policy Development and Support
Number of Community Health Boards
40
35
30
25
20
15
10
5
0
5.1.2: Examine and contribute to improving policies and laws. (E) (P)
6.1.4: Conduct enforcement actions. (E) (P) 3
Fully Meet
Substantially Meet
Minimally Meet
Does Not Meet
Not Sure

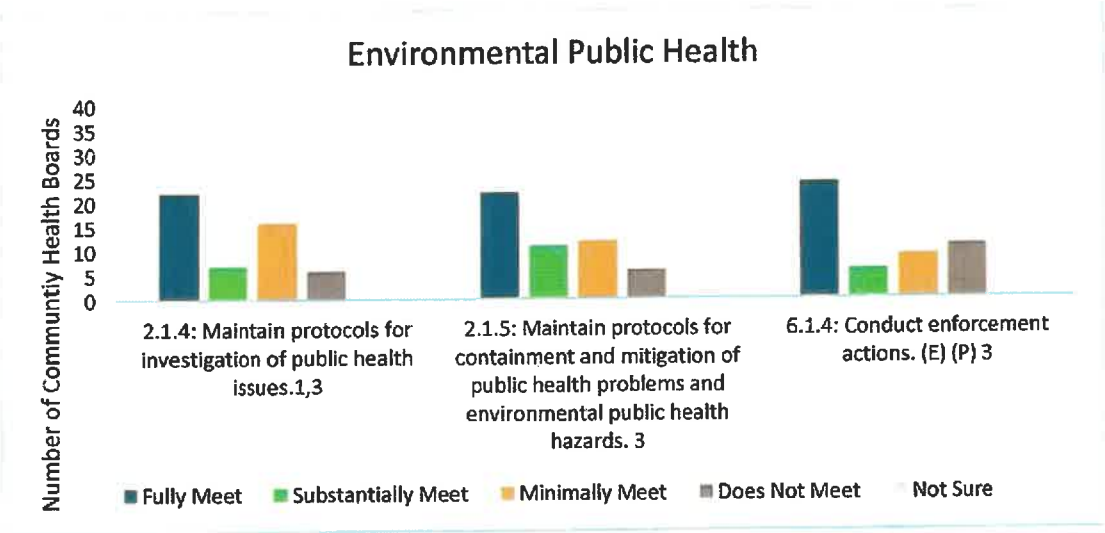
Figures 12-17: Community health boards' ability to meet measures by foundational areas[2]





[2] Within the Foundational Public Health Responsibilities Framework, foundational areas represent the rooms of our "house": There are some parts of a house that are universal--we expect houses all have a kitchen, bathroom, bedrooms, etc. In the same way, Minnesotans should see public health working in their jurisdictions in these five areas of work, no matter where they live. *NOTE: The measures reported on by community health boards for the foundational areas are national measures from PHAB, but PHAB does not identify them as tied to specific areas. The workgroup applied its discretion in aligning measures with areas, based on where community health boards would reasonably draw examples to demonstrate meeting the measure for accreditation purposes.*


Communicable Disease Control
Number of Communtiy Health Boards
40
35
30
25
20
15
10
5
0
1.2.2: (Local) Participate in data sharing with other entities; (State) Engage in data sharing and data exchange with other entities. (P)1
2.1.4: Maintain protocols for investigation of public health issues.1,3
2.1.6: Collaborate through established partnerships to investigate or mitigate public health problems and environmental public health hazards. 1
2.1.7: Use surveillance data to guide improvements. 1
Fully Meet
Substantially Meet
Minimally Meet
Does Not Meet
Not Sure


Environmental Public Health
Number of Communtiy Health Boards
40
35
30
25
20
15
10
5
0
2.1.4: Maintain protocols for investigation of public health issues.1,3
2.1.5: Maintain protocols for containment and mitigation of public health problems and environmental public health hazards. 3
6.1.4: Conduct enforcement actions. (E) (P) 3
Fully Meet
Substantially Meet
Minimally Meet
Does Not Meet
Not Sure

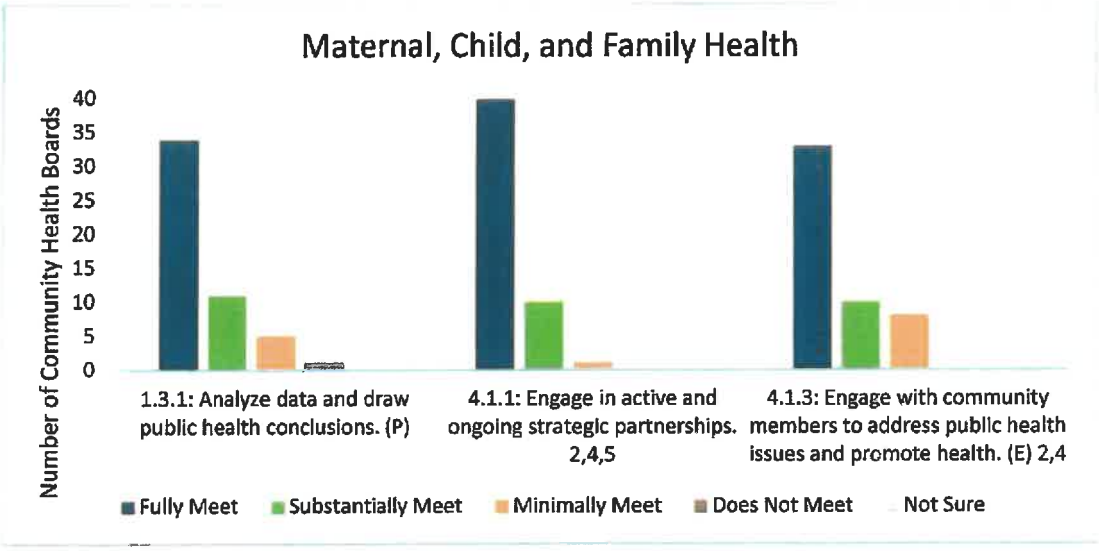


Figure 18: Percent of 46 national measures met by community health board size (population served)

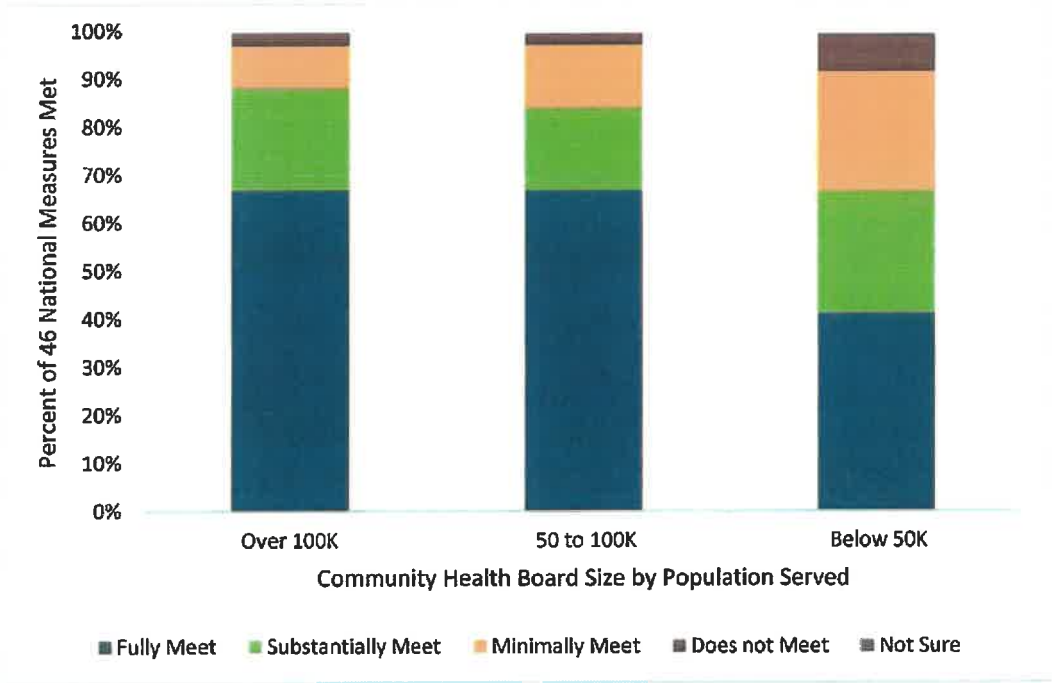


Figure 19: Percent of 46 national measures met by SCHSAC regions

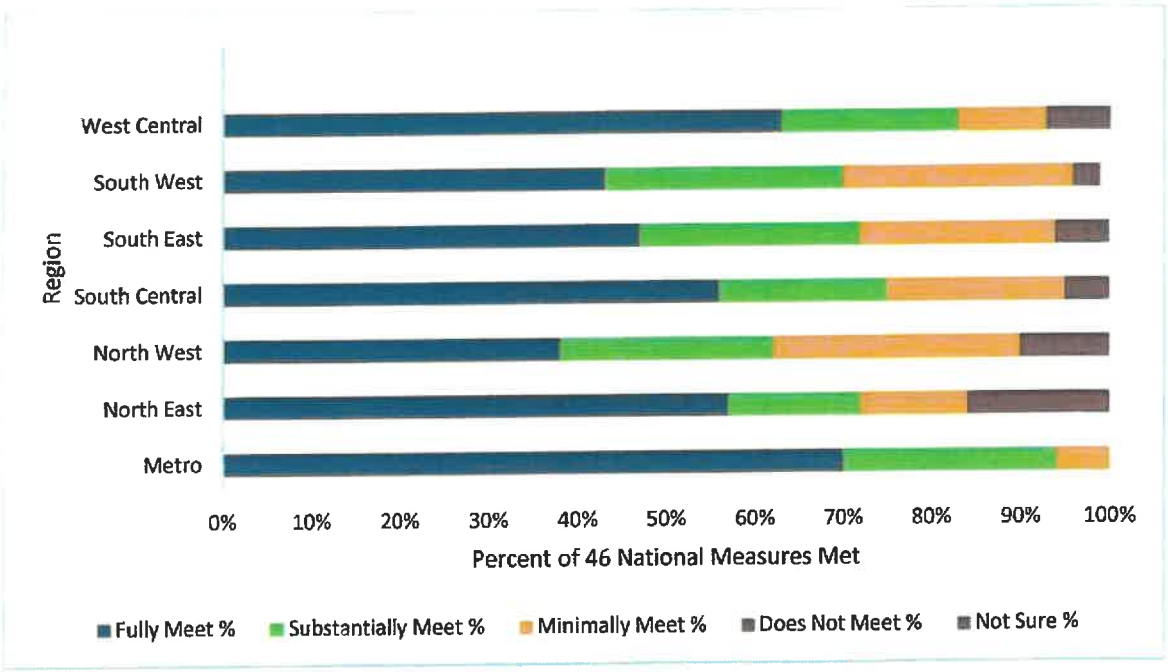
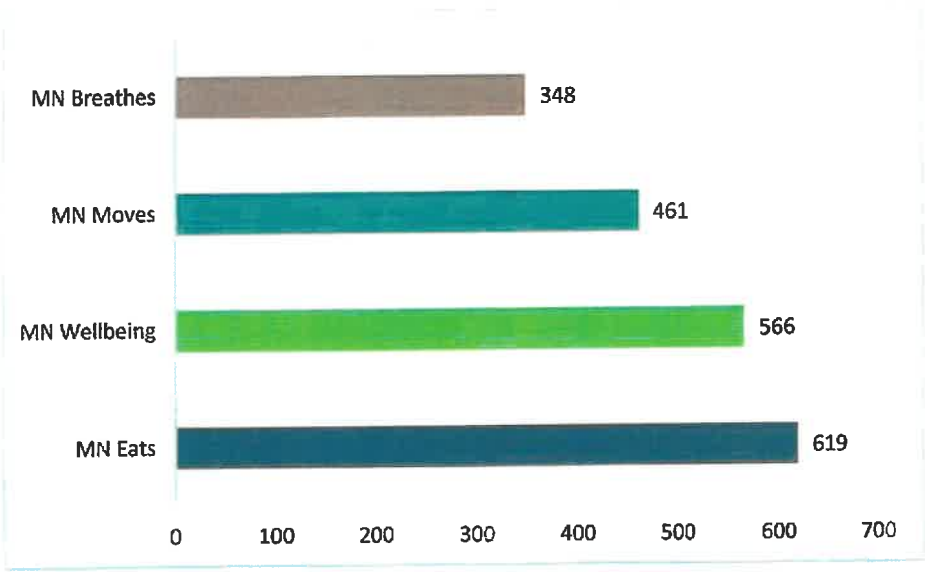


Figure 20-21: Total number of Statewide Health Improvement Partnership sites (1,994), by context and setting



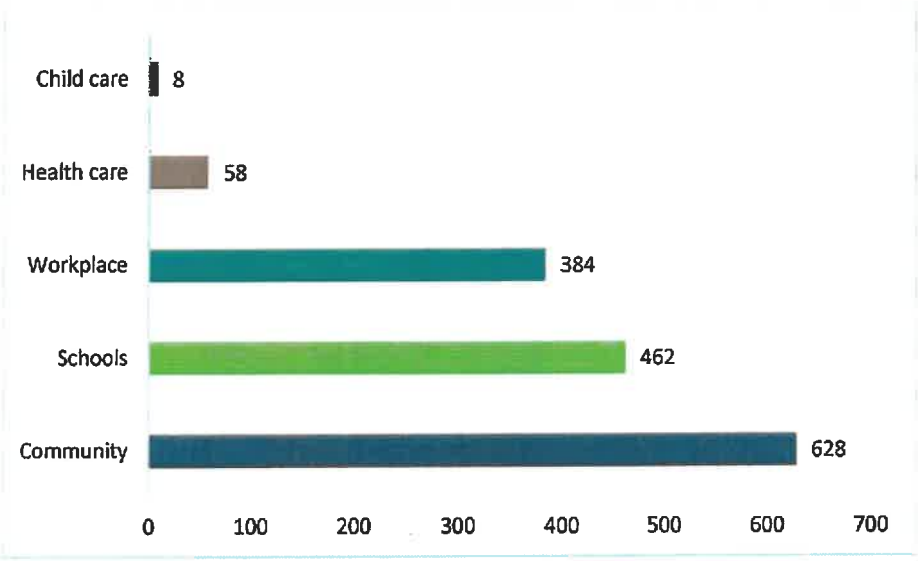
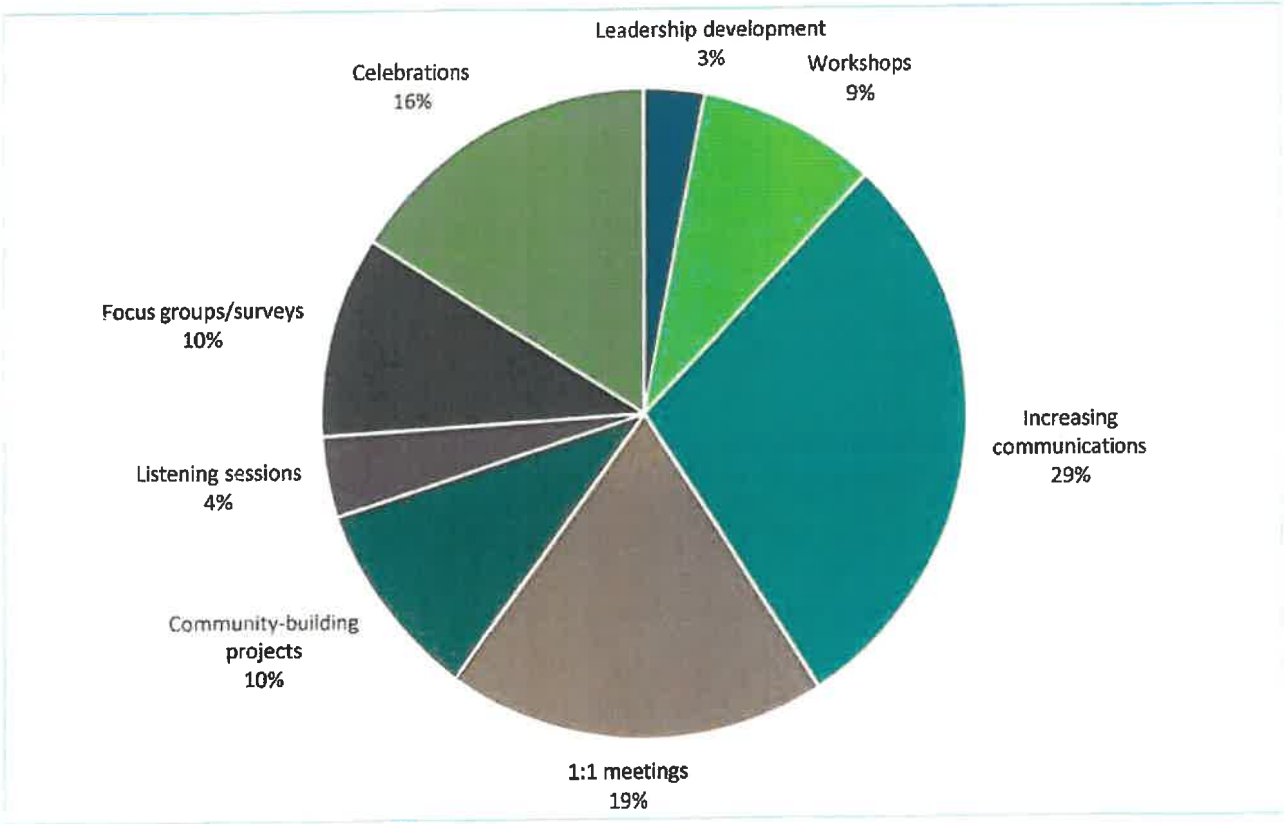


Table 1: Number of emergency preparedness and response community partnerships by sector as of Sept. 30, 2024

Sector	Number engaged
Health care (hospitals/clinics)	23
Public safety and emergency management	20
cultural and faith-based groups	19
Education and childcare settings	16
Local government	16
Social services	13
Community leadership	11
LTC, assisted living, other senior services	10
Voluntary organizations active in disasters and non-profits	8
Housing and sheltering	6

Sector	Number engaged
Mental/behavioral health	5
Media	5
Business/worksites/agri-business	4
Coroner, medical examiner, funeral homes	4
Total	**160**

Figure 22: Emergency preparedness and response activities with community partners



Appendix B: About performance measurement

What was measured

The performance measures for calendar year 2024 correspond with the Foundational Public Health Responsibilities. The 46 national measures are a subset of Public Health Accreditation Board measures and align with foundational responsibilities. In Minnesota, community health boards are not required to become accredited; however, these national measures represent best practices for governmental public health work. This set of measures is used to assess local and state ability to meet the national standards using a standardized scale, which allows continuity of monitoring the performance.

The (E) after some of the measures denotes there is an equity component directly related to that measure.

The (P) denotes measures from PHABs Pathways Recognition Program.

There are also references for several of the measures to indicate that it was also prioritized as a measure of foundational areas:

[1] Communicable Disease Control

[2] Chronic Disease and Injury Prevention

[3] Environmental Public Health

[4] Maternal, Child, and Family Health

[5] Access to and Linkage with Care

Foundational responsibility	National measures
Assessment and surveillance	1.1.1: Develop a community health assessment. (E) (P)
	1.2.1: Collect non-surveillance population health data. (P)
	1.2.2: (Local) Participate in data sharing with other entities; (State) Engage in data sharing and data exchange with other entities. (P)[1]
	1.3.1: Analyze data and draw public health conclusions. (P)
	1.3.3: Use data to recommend and inform public health actions. [2,4]
	2.1.1: Maintain Surveillance systems. (E) (P)
	2.1.3: Ensure 24/7 access to resources for rapid detection, investigation, containment, and mitigation of health problems and environmental public health hazards. (P)
	7.1.1: Engage with health care delivery system partners to assess access to health care services. [5]
Community Partnership Development	4.1.2: Participate actively in a community health coalition to promote health equity. (E) (P)
	4.1.3: Engage with community members to address public health issues and promote health. (E) [2,4]
	5.2.2: Adopt a community health improvement plan. (E) (P)
	5.2.3: Implement, monitor, and revise as needed, the strategies in the community health improvement plan in collaboration with partners.
	7.2.1: Collaborate with other sectors to improve access to social services. (P) [5]

Foundational responsibility	National measures
Communications	2.2.5: Maintain a risk communication plan and a process for urgent 24/7 communication with response partners. (E) (P)
	3.1.1: Maintain procedures to provide ongoing, non-emergency communication outside the health department. (E) (P)
	3.2.2: Implement health communication strategies to encourage actions to promote health. (E) (P)
Equity	5.2.4: Address factors that contribute to specific populations' higher health risks and poorer health outcomes. (P)
	10.2.1: Manage operational policies including those related to equity. (P)
Organizational Competencies	8.1.2: Recruit a qualified and diverse health department workforce. (E) (P)
	8.2.1: Develop and implement a workforce development plan and strategies. (E) (P)
	8.2.2: Provide professional and career development opportunities for all staff. (P)
	10.1.2: Adopt a department-wide strategic plan. (P)
	10.2.2: Maintain a human resource function. (P)
	10.2.3: Support programs & operations through an information management infrastructure. (P)
	10.2.4: Protect information and data systems through security and confidentiality policies. (P)
	10.2.6: Oversee grants and contracts. (P)
	10.2.7: Manage financial systems. (P)
	10.3.3: Communicate with governance routinely and on an as-needed basis. (P)
	10.3.4: Access and use legal services in planning, implementing, and enforcing public health initiatives. (P)
Policy Development and Support	5.1.2: Examine and contribute to improving policies and laws. (E) (P)
	6.1.4: Conduct enforcement actions. (E) (P)[3]
Accountability and Performance Management	9.1.1: Establish a performance management system. (P)
	9.1.2: Implement the performance management system.
	9.1.5: Implement quality improvement projects. (P)
	9.2.1: Base programs and interventions on the best available evidence. (E) (P)
	9.2.2: Evaluate programs, processes, or interventions.
	7.1.2: Implement and evaluate strategies to improve access to health care services. (E)

Foundational responsibility	National measures
Emergency Preparedness and Response	2.2.1: Maintain a public health emergency operations plan (EOP)(E) (P)
	2.2.2: Ensure continuity of operations during response. (P)
	2.2.6: Maintain and implement a process for urgent 24/7 communications with response partners. (P)
	2.2.7: Conduct exercises and use After Action Reports and Improvement Plans (AAR-IPs) from exercises and responses to improve preparedness and response. (P)
Measures connected to foundational areas	2.1.4: Maintain protocols for investigation of public health issues.[1,3]
	2.1.5: Maintain protocols for containment and mitigation of public health problems and environmental public health hazards.[3]
	2.1.6: Collaborate through established partnerships to investigate or mitigate public health problems and environmental public health hazards.[1]
	2.1.7: Use surveillance data to guide improvements.[1]
	4.1.1: Engage in active and ongoing strategic partnerships.[2,4,5]

Reporting guidance for Community Health Boards

Community health boards were asked to engage key staff in reviewing the 46 measures and consider the requirements and related elements for each measure. In an effort for consistency in reporting, the measures with several requirements and elements were numbered, and the number accomplished used to consider the response selection. Community health boards were asked to consider thoroughness and quality in selecting their response. They were not required to submit any documentation.

Community health boards selected from the following response options:

- Fully meet
- Substantially meet
- Minimally meet
- Cannot meet

Multi-county community health boards (operating more than one health department) were asked to report on the lowest level of capacity of member health departments to reveal strengths and gaps. That is, if two of three health departments in a multi-county community health board can fully meet a measure, but the third can only minimally meet, the entire community health board should report minimally meet. If the third cannot meet the measure at all, the entire community health board should report cannot meet (see example).

Example for multi-county community health boards:

1.1.1 Develop a Community Health Assessment	Health dept 1	Health dept 2	Health dept 3	CHB (select the lowest level of capacity)
Fully meets	X		X	

1.1.1 Develop a Community Health Assessment	Health dept 1	Health dept 2	Health dept 3	CHB (select the lowest level of capacity)
Substantially meets				
Minimally meets		X		X
Does not meet				

Minnesota Department of Health Reporting

MDH based its responses on findings from the 2024 reaccreditation readiness assessment, supplemented by measure reviews with accreditation domain leads and subject matter experts.

Data from major grant programs

The performance measurement workgroup reviewed existing data currently reported by community health boards related to grants Statewide Health Improvement Partnership (SHIP) and Emergency Preparedness and Response for incorporation into this report.

From SHIP reporting, the following system-level data was considered:

- Policy, systems, and environment changes in childcare, community, healthcare, school, and workplace settings.
- Stage of policy, systems, and environment work with partner sites.

From the Response Sustainability Grant (RSG) and Public Health Emergency Preparedness (PHEP) reporting, the following system-level data was considered:

- Training for emergency preparedness (RSG)
- New, revised, or reviewed memorandum of understandings, memorandum of agreements, and mutual aid agreements (RSG)
- Health equity assessment of plans, policies, procedures (RSG)
- Engagement of communities disproportionately impacted in exercises and after-action report/improvement plans. (PHEP)

Appendix C: Workgroup charge and membership

The Performance Measurement Workgroup leads efforts to measure and assess the performance of Minnesota's governmental public health system and its capacity to carry out public health responsibilities.

As part of this work, the workgroup analyzes performance data from local public health annual reporting. By reflecting on this data, we can uncover our system's strengths, identify its gaps, and assess the effectiveness of our efforts. This insight allows us to see the big picture, revealing how local health challenges connect to larger systemic issues.

This workgroup report summarizes the results and key takeaways gleaned from local public health annual reporting data from 2023. For the full workgroup charge, please visit: Standing and active SCHSAC workgroups - MN Dept. of Health.

Chairs

Chera Sevcik, Faribault-Martin
Amy Bowles, Beltrami

Members

Amy Bowles, Beltrami County Public Health
Susan Michels, Carlton, Cook, Lake, St. Louis Community Health Board
Angie Hasbrouck, Horizon Public Health
Janet Goligowski, Stearns County Health and Human Services
Amina Abdullahi, City of Bloomington Public Health
Michelle Ebbers, DesMoines Valley Health and Human Services
Chera Sevcik, Health and Human Services, Faribault and Martin Counties
Meaghan Sherden, Olmsted County Public Health
Rodney Peterson, Dodge County Commissioner
Mark Dehen, Nicollet County Commissioner
Chris Brueske, Minnesota Department of Health, Office of Data Strategy and Interoperability
Kristin Osiecki, Minnesota Department of Health, Center for Health Equity
Ann Zukoski, Minnesota Department of Health, Health Promotion and Chronic Disease Division, Center for Health Promotion
Mary Orban, Minnesota Department of Health, Public Health Strategy and Partnership Division, Center for Public Health Practice

Workgroup MDH Staff

Ghazaleh Dadres, Data analyst
Ann March, Planner

Minnesota Department of Health
State Health Community Services Advisory Committee
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Saint Paul, MN 55164-0975
651-201-3880
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www.health.state.mn.us

09/04/2025
To obtain this information in a different format, call: 651-201-3880

est. 1866
BELTRAMI county

Meeting Date: October 21, 2025
Beltrami County
Community Health Board

AGENDA BILL

SUBJECT: Presentation from Minnesota Office of Addiction and Recovery

RECOMMENDATIONS: Informational

DEPARTMENT OF ORIGIN: HHS, Public Health Division

CONTACT PERSON: Amy Bowles, Community Health Systems Administrator #8116

DATE SUBMITTED: 10/21/2025.

CLEARANCES: Anne Lindseth, Health and Human Services Director

BUDGET IMPACT: None

EXHIBITS: Power point

SUMMARY STATEMENT: Jeremy Drucker, director of the Minnesota Office of Addition and Recovery (OAR) will provide the CHB with an overview of the office's core functions and initiatives and provide an update on progress toward the state's goal for reducing opioid related overdoes. OAR will also share key takeaways from the current opioid epidemic data and trends that are informing strategic priorities.

Beltrami County Community Health Board

Jeremy Drucker | Office of Addiction and Recovery

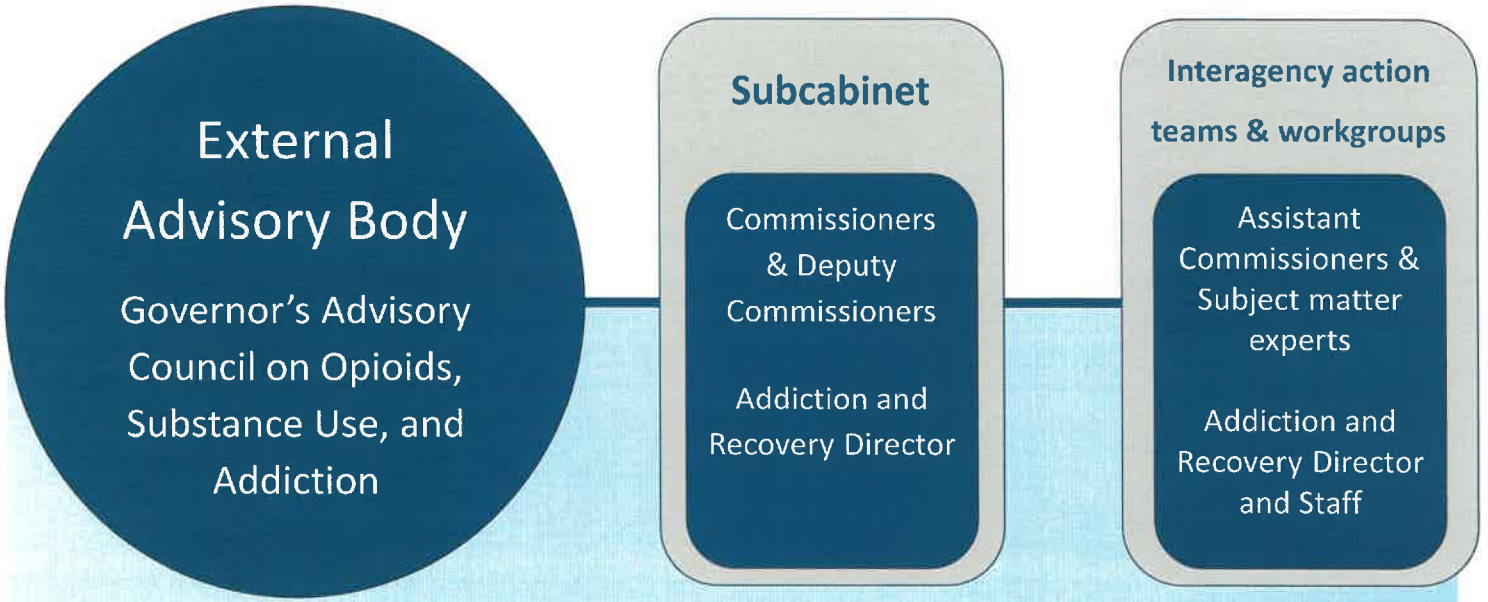
Subcabinet on Opioids, Substance Use, and Addiction

Created in 2022 by the legislature and Governor Walz to improve outcomes for Minnesotans experiencing substance use disorder, their families, and their communities by working across state government.

Chaired by the Addiction and Recovery Director and consisting of 12 state agencies:

- Human Services
- Children, Youth, and Families
- Health
- Education
- Higher Education
- Public Safety
- Corrections
- Commerce
- Management and Budget
- Direct Care and Treatment
- Cannabis Management
- Interagency Council on Homelessness

Governance structures



Office of Addiction and Recovery supports the work of these entities. It also helps coordinate and align work across the enterprise.

Key State Initiatives

- DHS 1115 SUD Reform Waiver
- DHS/DOC 1115 Reentry Waiver
- MDH Comprehensive Overdose Morbidity and Prevention Action
- MDH Cannabis/SUD Prevention Grants
- MDE Statewide Health Standards
- Naloxone Saturation
- Recovery Friendly Workplaces

Last Updated: July 2025

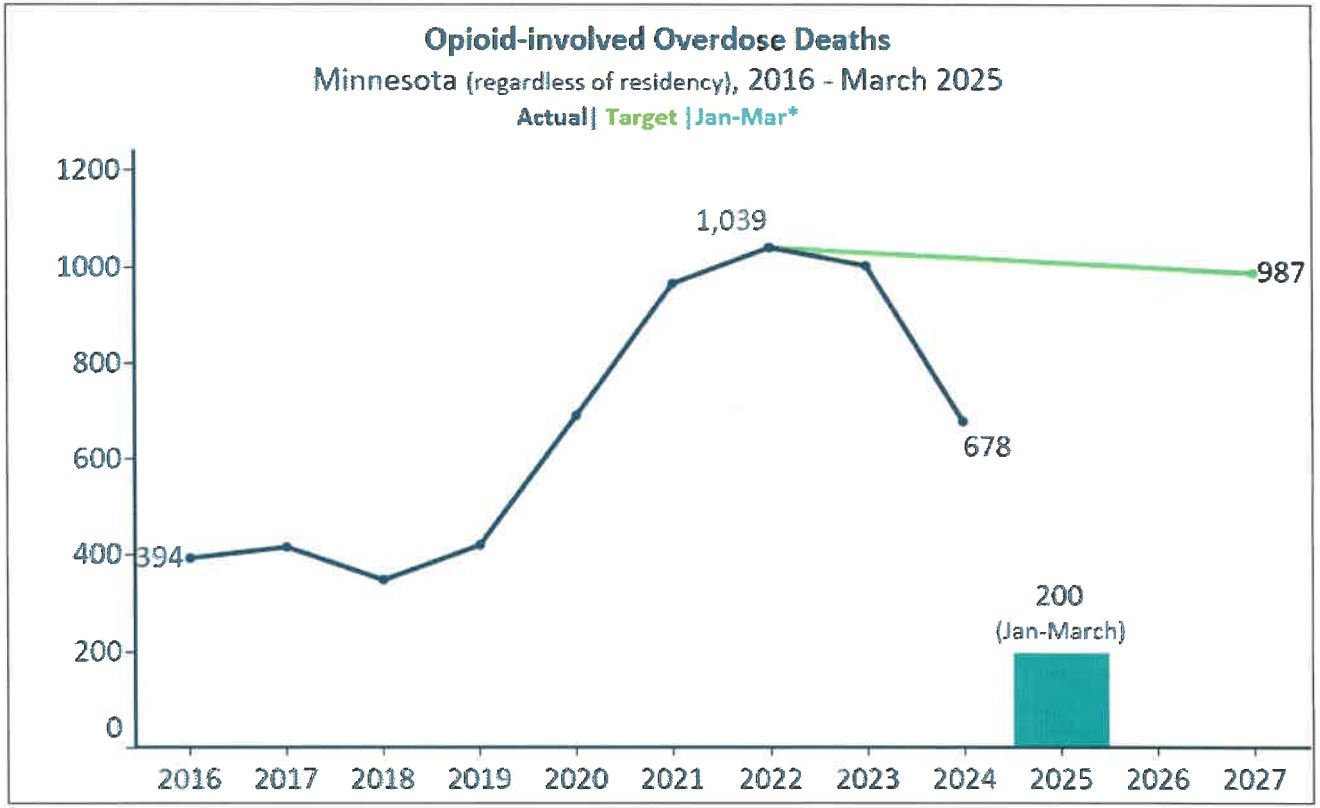
Next Update: ~October 2025

Three-Year Goal – Reduce Opioid related overdose deaths

- 2024 had a 32.3% decrease from 2023.
- This decrease was experienced across all populations.
- While the first quarter in 2025 suggests a slight uptick from 2024, the numbers remain below 2022 overdose deaths.

	Annual Total			
# of people	2022	2023	2024	
White	600	505	384	
Black	249	280	178	
American Indian	139	141	81	
Total	1,039	1,001	678	

	Quarter 1 (Jan-Mar)			
# of people	2022	2023	2024	2025*
White	157	124	106	118
Black	54	73	48	46
American Indian	28	37	39	27
Total	252	256	195	200



* Data for 2025 is preliminary and likely to change as cases are finalized.

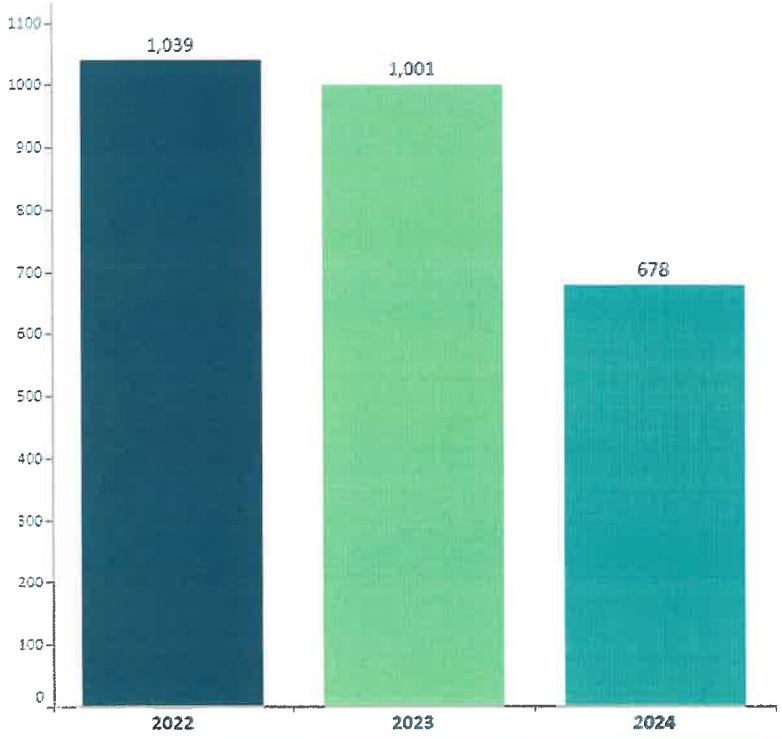
Source: Minnesota Death Certificates, Injury and Violence Prevention Section, MDH

Opioid-involved overdose deaths, yearly comparison

Count of opioid-involved overdose deaths in Minnesota from 2022-2024

The decreases from 2022 to 2024 are not equally experienced among all populations.

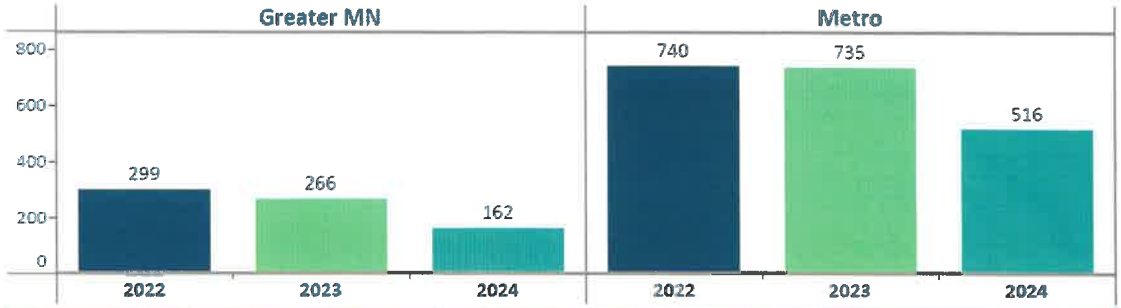
Total Count



In 2024, opioid-involved overdose deaths were **34.7% lower** than 2022.

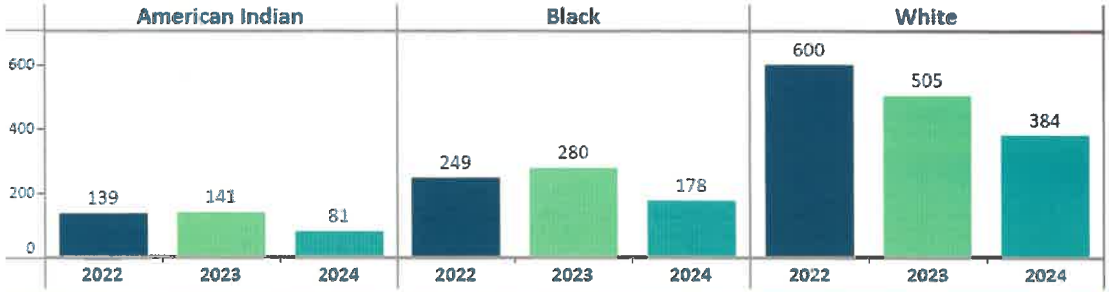
Source: Minnesota Death Certificates, Injury and Violence Prevention Section, MDH

Regional Count



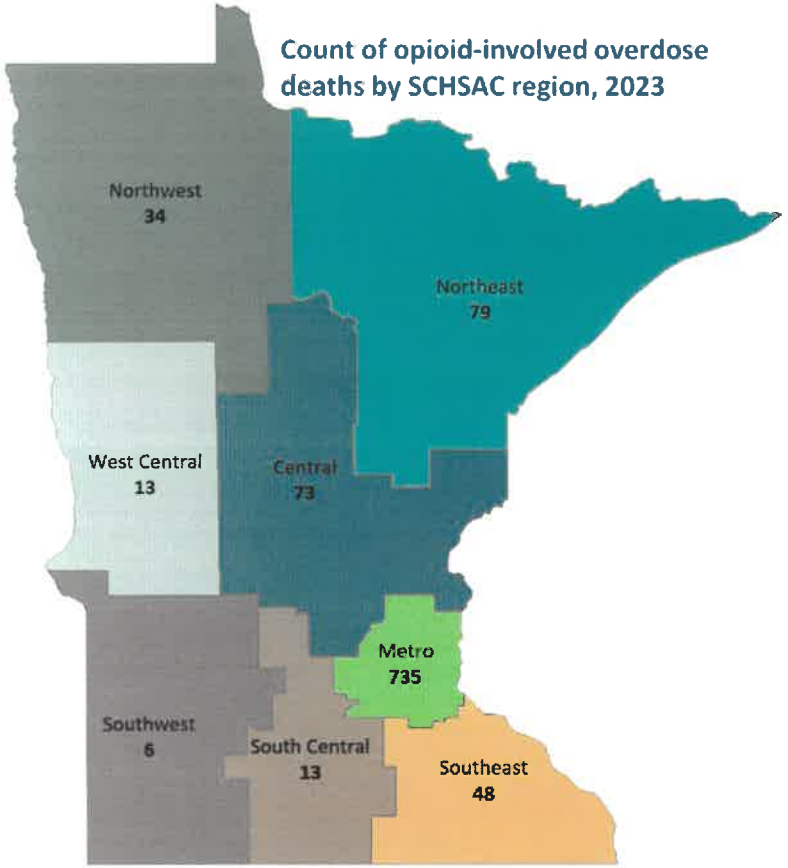
Overdose deaths decreased in **Greater MN by 46%** from 2022 to 2024.
The **Metro area** saw a much smaller **decrease of 30%** during that time.

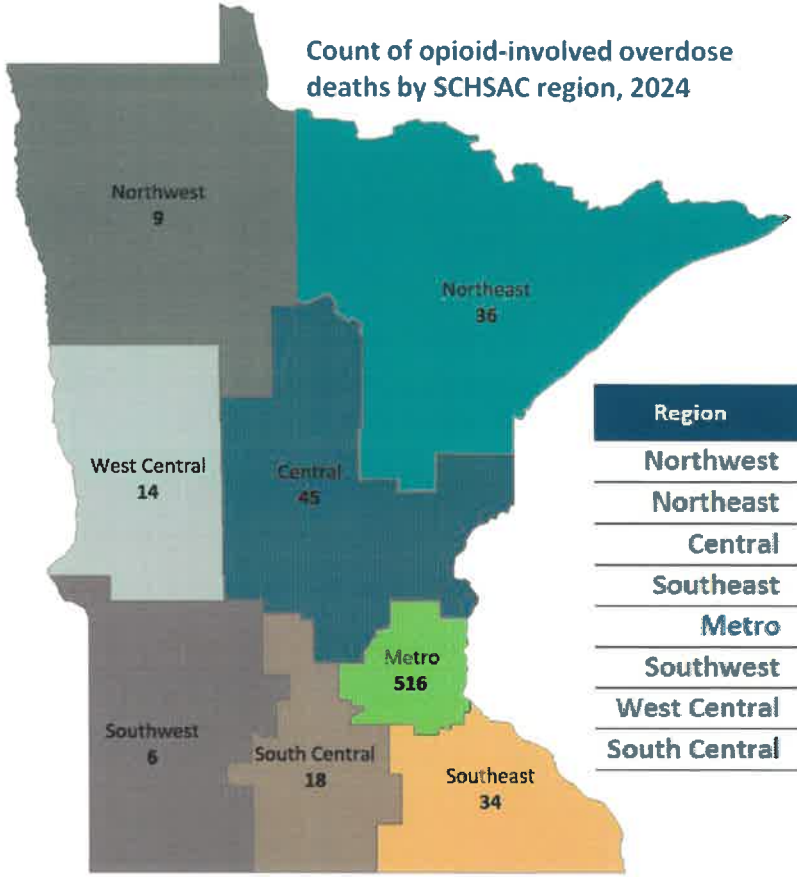
Race Count



American Indians had the greatest decrease from 2022 to 2014 from 2022 to 2024 at **41.7%**, compared to **Whites and Blacks decreasing by 35.8% and 28.5% respectively**.

Opioid-involved overdose deaths, by region





Region	2022	2023	2024	% change 2022-2024
Northwest	34	34	9	-73.5%
Northeast	68	79	36	-52.1%
Central	84	73	45	-47.1%
Southeast	71	48	34	-46.4%
Metro	740	735	516	-45.5%
Southwest	11	6	6	-30.3%
West Central	14	13	14	0.0%
South Central	17	13	18	5.9%

Source: Minnesota Death Certificates, Injury and Violence Prevention Section, MDH

Naloxone Portal by the numbers

Access to naloxone, a medication that reverses an opioid overdoses, may be a factor in the drop of deaths in recent years. The 2023 Minnesota Legislature mandated that select groups carry this medication. DHS operates a web portal to help supply kits.

Portal Funding

Total funding in portal:	**$7.2M**
Total spent in orders shipped:	**$5.1M**
Annual funding until Oct 2027:	**~$3.0M**

Portal Orders

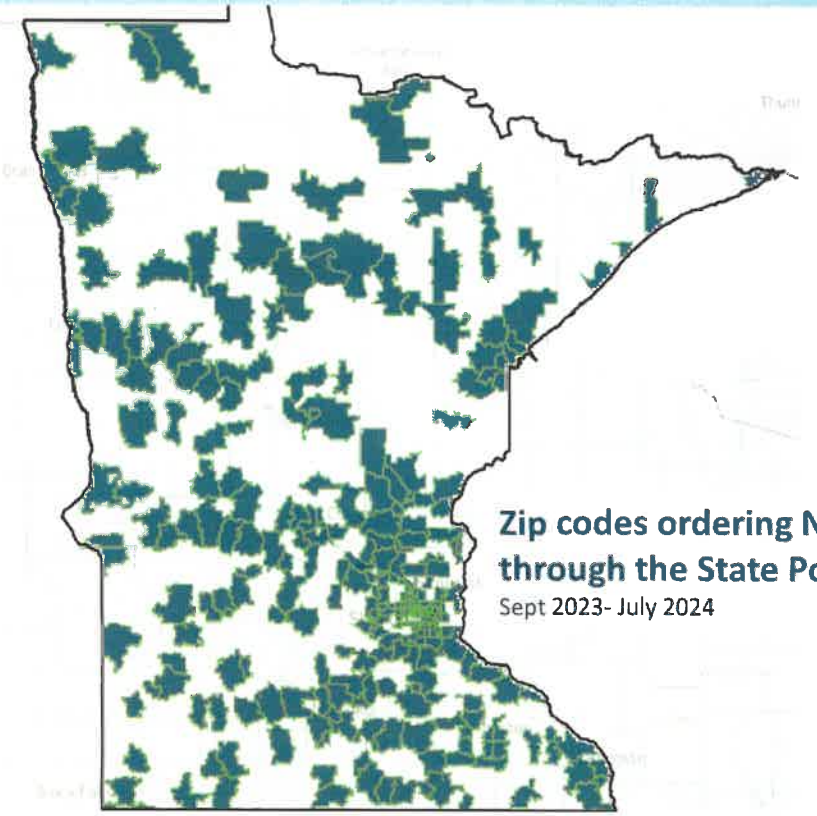
# of orders sent:	**1,461**
# of shipping zip codes:	**282**
# of organizations placed orders:	**731**
# of kits sent (2 dose box):	**146,616**

Portal Eligibility

Tier 1: Organizations directly serving individuals most at risk for overdose

Tier 2: Community organizations that serve people who use drugs or people in recovery

Tier 3: Organizations with legislative mandates to carry naloxone

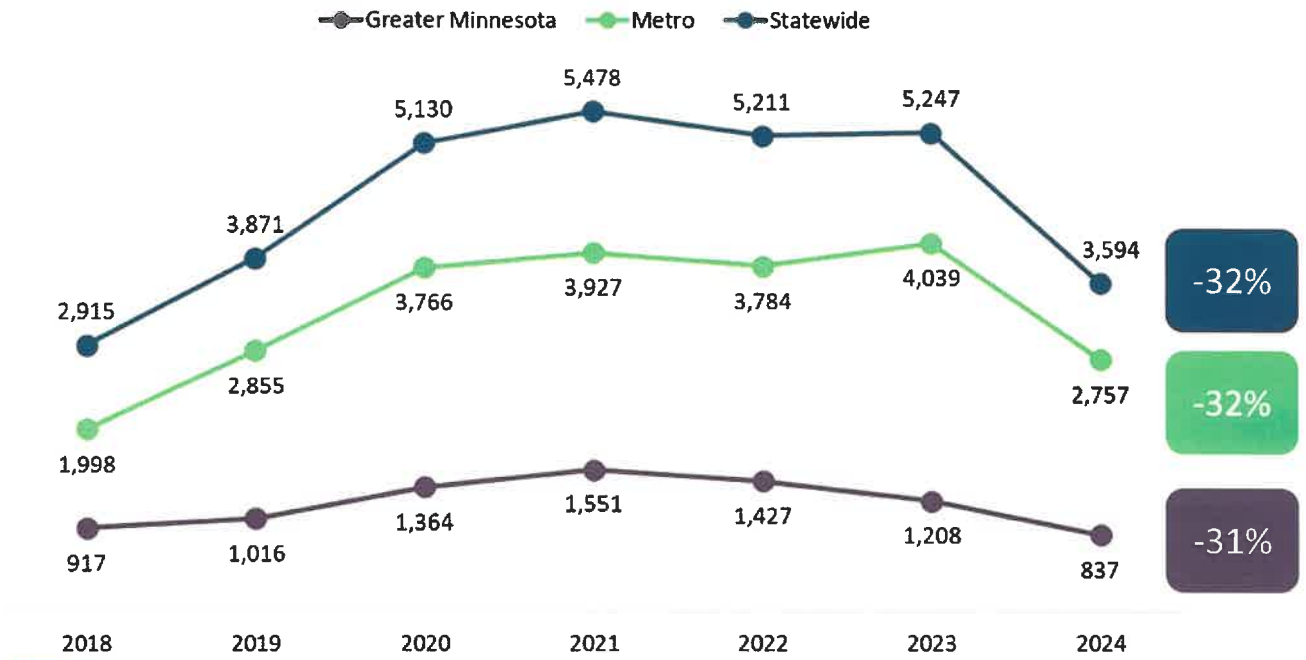


Zip codes ordering Naloxone through the State Portal
Sept 2023- July 2024

HOSPITAL DISCHARGE

Hospital-treated nonfatal opioid overdoses decreased statewide, with similar decreases seen in the Metro and Greater Minnesota.

Hospital-treated nonfatal opioid overdose
Metro vs. Greater Minnesota, Minnesota residents, 2018-2024



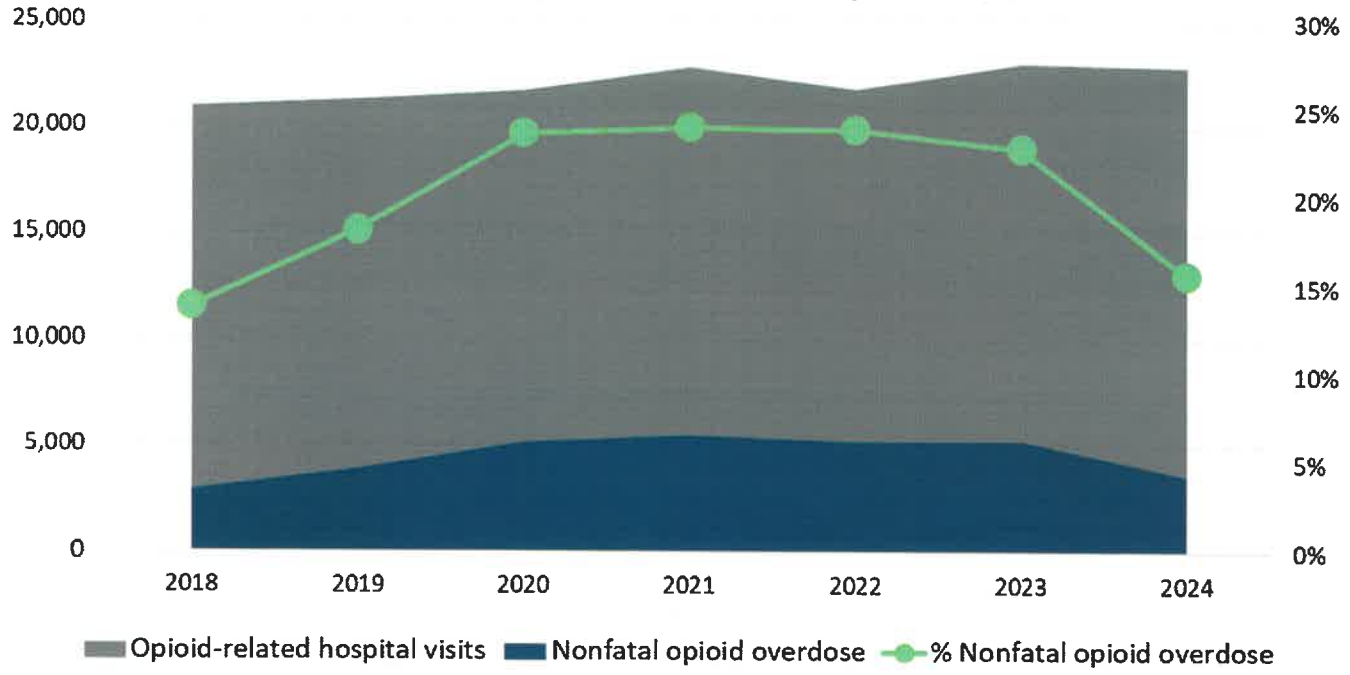
DEPARTMENT OF HEALTH

SOURCE: Hospital Discharge Data (2018-2024), Injury Prevention and Mental Health Division, Minnesota Department of Health.
NOTE: Includes nonfatal overdoses of unintentional/undetermined intent among Minnesota residents treated in Minnesota and North Dakota hospitals (excludes federally funded facilities). Drug categories are non-exclusive and based on ICD-10-CM diagnosis codes.

HOSPITAL DISCHARGE

Opioid-related hospital burden has stayed relatively stable, despite recent declines in nonfatal opioid overdoses.

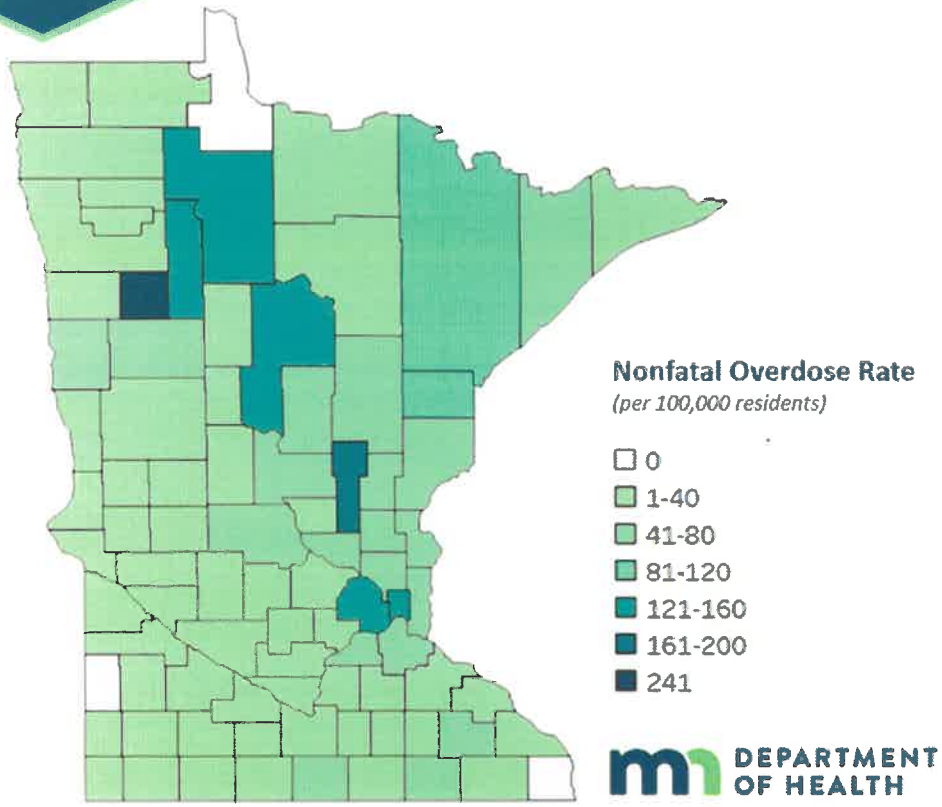
Nonfatal opioid overdoses represent only a portion of opioid-related hospital visits.

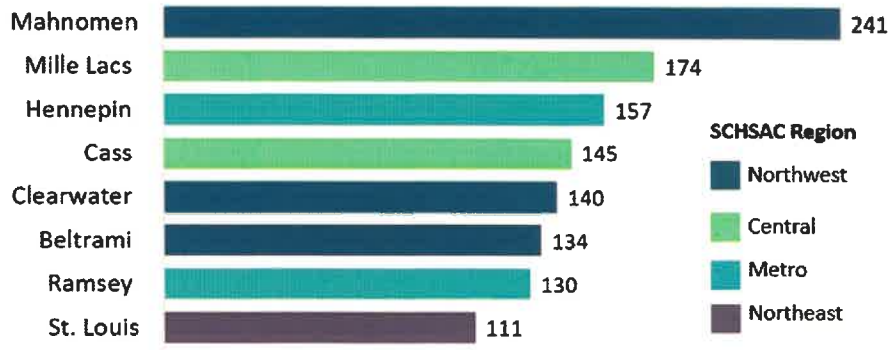


SOURCE: Hospital Discharge Data (2018-2024), Injury Prevention and Mental Health Division, Minnesota Department of Health.
NOTE: Includes opioid-related hospital visits with a discharge diagnosis for an opioid-related disorder (F11) or a nonfatal opioid overdose among Minnesota residents treated in Minnesota and North Dakota hospitals (excludes federally funded facilities). Drug categories are non-exclusive and based on ICD-10-CM diagnosis codes.

HOSPITAL DISCHARGE

Nonfatal opioid overdose rates vary across Minnesota. Beltrami is among eight counties exceeding the statewide rate.

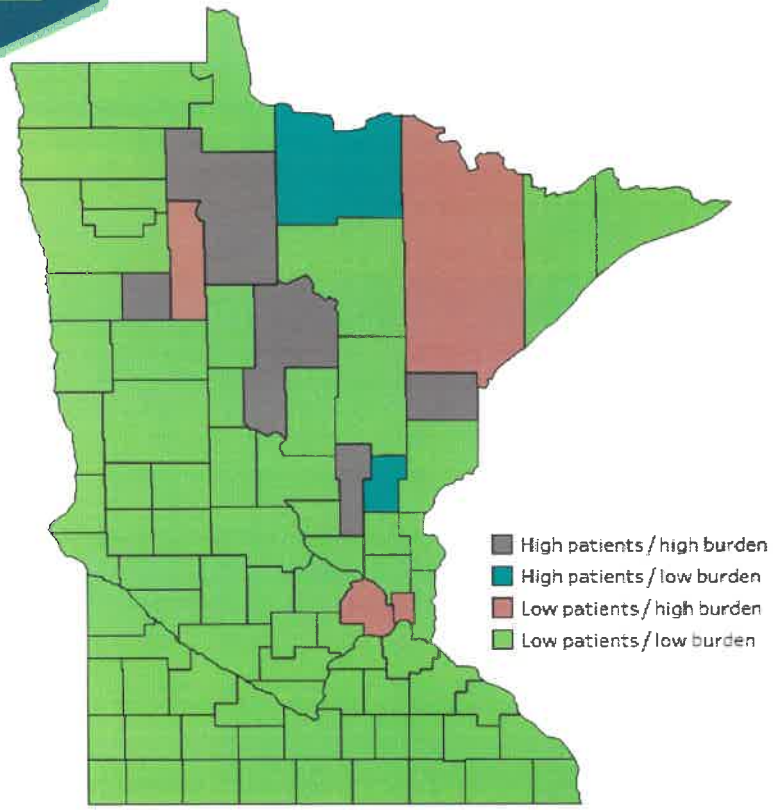




SOURCE: Hospital Discharge Data (2018-2024), Injury Prevention and Mental Health Division, Minnesota Department of Health.
NOTE: Includes nonfatal overdoses of unintentional/undetermined intent among Minnesota residents treated in Minnesota and North Dakota hospitals (excludes federally funded facilities). Drug categories are non-exclusive and based on ICD-10-CM diagnosis codes.

HOSPITAL DISCHARGE

Four counties show high nonfatal opioid overdose burden and relatively low rates of MOUD patients.



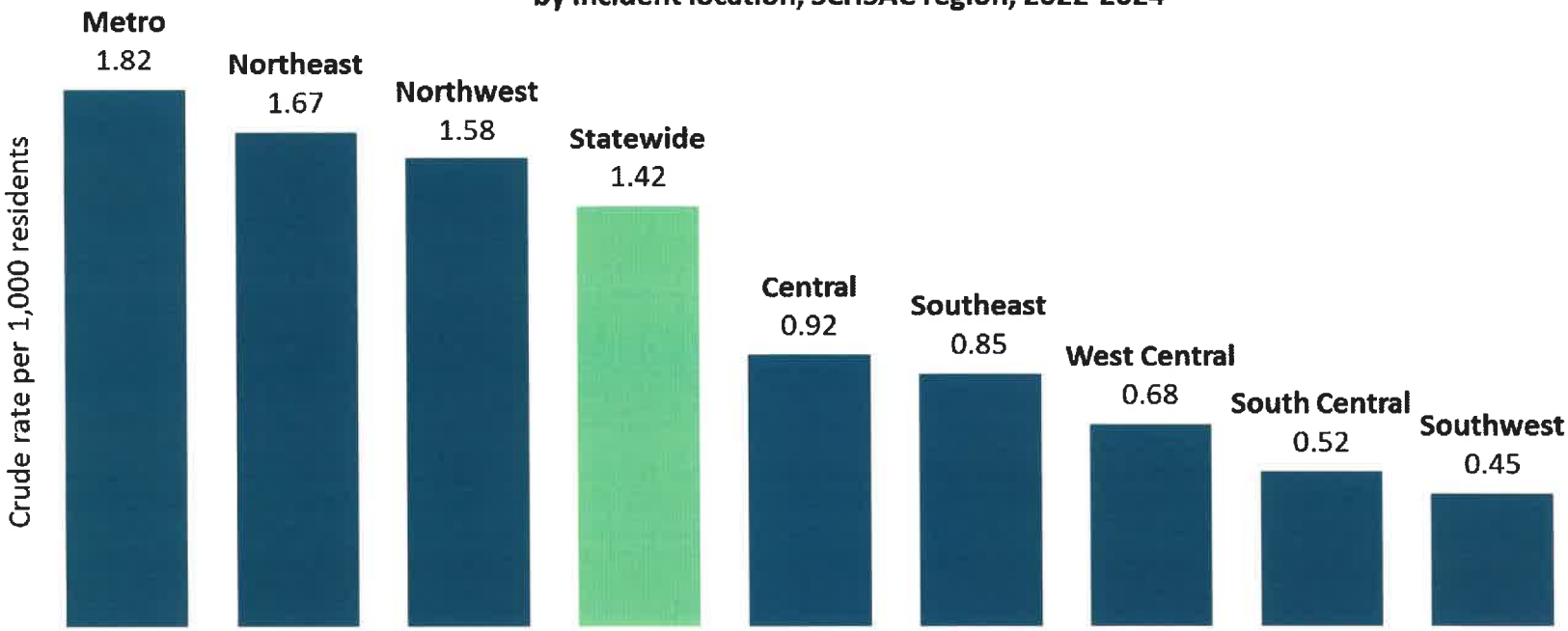
MOUD Patient Rate (per 1,000 residents) / Hospital-treated Nonfatal Opioid Overdose Rate, by county of residence, 2022-2024

County	MOUD patient rate (average)	MOUD patient rate compared to statewide	Hospital-treated nonfatal opioid overdose rate (crude)	Nonfatal opioid overdose rate compared to statewide
Hennepin	3.4	**Much lower** (0.0 to 3.7)	1.67	**Much higher** (1.2 or more)
Ramsey	4.4	**Lower** (3.7 to 6.3)	1.36	**Much higher** (1.2 or more)
Clearwater	6.1	**Lower** (3.7 to 6.3)	1.23	**Much higher** (1.2 or more)
Saint Louis	5.9	**Lower** (3.7 to 6.3)	1.07	**Higher** (0.8 to 1.1)
Statewide	6.3	-	0.82	-
Beltrami	10.6	**Much higher** (8.9 or more)	1.29	**Much higher** (1.2 or more)

NONFATAL OVERDOSE SOURCE: Minnesota Hospital Discharge Data (Nonfatal Overdose), Injury Prevention and Mental Health, 2022-2024.
MOUD SOURCE: Minnesota Prescription Monitoring Program Data (MOUD Patients), Minnesota Board of Pharmacy, 2022-2024. Analysis completed by MDH.

EMS-treated NFOD rate highest in the Metro, NE, and NW.

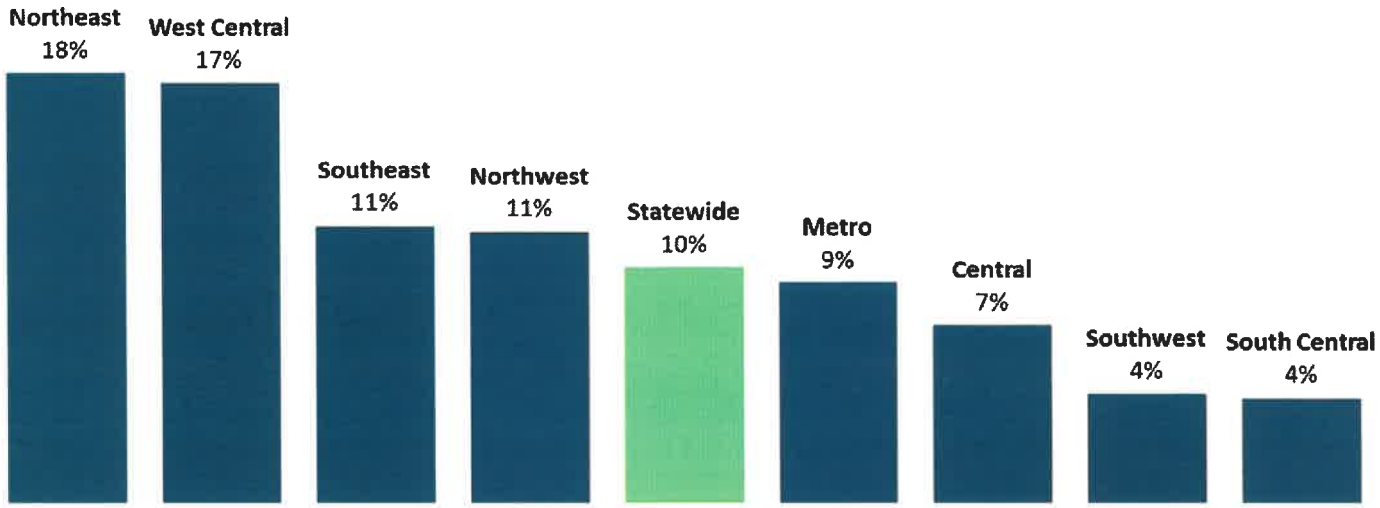
EMS runs for nonfatal opioid overdose by incident location, SCHSAC region, 2022-2024



SOURCE: Minnesota State Ambulance Reporting System (MNSTAR), Minnesota Office of EMS, 2022-2024.
NOTE: Analysis by the Minnesota Department of Health, Injury Prevention and Mental Health Division. Based on incident location for suspected opioid overdose event. Includes events meeting the EMS nonfatal opioid overdose case definitions adapted from Michigan and Rhode Island.

In Minnesota, 1 in 10 patients are not transported by EMS following a nonfatal opioid overdose event.

Proportion of EMS runs for nonfatal opioid overdose that are not transported to hospital, by SCHSAC region, 2022-2024



SOURCE: Minnesota State Ambulance Reporting System (MNSTAR), Minnesota Office of EMS, 2022-2024.
NOTE: Analysis by the Minnesota Department of Health, Injury Prevention and Mental Health Division. Based on incident location for suspected opioid overdose event. Includes events meeting the EMS nonfatal opioid overdose case definitions adapted from Michigan and Rhode Island.

Opioid Epidemic Key Takeaways

- Commonly prescribed opioids are no longer the major cause of opioid overdose deaths. Fentanyl is involved in over 90% of opioid overdose deaths
- The illicit drug landscape is changing and dynamic. People are increasingly unaware of what is in the drugs they consume. Significant amount of use is polysubstance
- Medications for Opioid Use Disorder (MOUD) are FDA-approved drugs that are proven to reduce substance use disorder for opioids. Most effectively used in combination with counseling and behavioral therapies
- Low Barrier MOUD access is reducing overdoses by increasing treatment and improving retention in care