

Washington County

Community Health Improvement Plan
2014



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Executive Summary

The Washington County Community Health Improvement Plan (CHIP) is a long-term, systematic effort to address public health priorities identified during the Community Health Assessment (CHA) and community health improvement processes. The CHIP will be used by the Department of Public Health and Environment (PHE) along with our community partners to set priorities, coordinate resources, develop policies, and define actions to target efforts that protect and promote health.

Beginning in the spring of 2013, members of *Living Healthy In Washington County (LHWC)* Steering Committee, a diverse group of community partners, began the Community Health Assessment (CHA) process to systematically examine health status indicators for Washington County. A variety of tools and processes including key informant interviews, an online community health opinion survey and listening sessions were used to identify the following community health priorities and goals:

Community Health Priority	Health Improvement Goal
1. Obesity in children and adults due to poor nutrition and physical activity	Increase healthy weight in adults Increase healthy eating in youth Increase active living in youth
2. Premature death and disability from chronic diseases due to tobacco use	Decrease tobacco use and exposure in all ages
3. Behavioral health problems among children and adults due to substance abuse and mental illness	Reduce stigma related to behavioral health issues Increase access to county services among populations facing behavioral health issues

Within each priority, issues related to **health equity** and **access to health services** will be addressed by targeting vulnerable populations.

Over the next five years, PHE and LHWC Steering Committee will lead Washington County in the implementation of the CHIP. Efforts will be evaluated annually and updated as necessary to align with community resources and needs.

As a member of the community, we welcome your feedback and collaboration on future activities to achieve the goals set forth by the CHIP.



Lowell Johnson
 Director, Washington County Department of Public Health and Environment

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Acknowledgments

2014 Washington County Board of Commissioners

The Board of Commissioners serves as the Community Health Board for Washington County.

- District 1 – Fran Miron
- District 2 – Ted Bearth
- District 3 – Gary Kriesel, Vice Chair
- District 4 – Autumn Lehrke, Chair
- District 5 – Lisa Weik

Community Partners

This health improvement plan is possible because of the generous participation and input from the following organizations and groups. Thank you to all who contributed.*

- | | |
|--------------------------------------|--|
| Allina Health | Lakeview Health Parish Nurses |
| Canvas Health | National Alliance on Mental Illness (NAMI) – |
| Children’s Mental Health Partnership | Washington County Chapter |
| City of Hugo | New Heights Charter School |
| City of Woodbury | North St. Paul/Maplewood/Oakdale Schools |
| Community Thread | Our Community Kitchen |
| CONNECT Chemical Health Action | Polaris |
| Collaborative | Southside Community Health Clinic |
| East Metro Water Resource Education | South Washington County Schools |
| Program | South Washington County Watershed District |
| Fairview Lakes Medical Center | Stillwater Area School District |
| Faith-Based Health and Wellness | Twin Cities Medical Society |
| Network | Vital Aging Network |
| FamilyMeans | Washington County Community |
| Forest Lake Area Partnership for | Services |
| Families | Washington County Correctional Health |
| Forest Lake Area Public Schools | Washington County Public Works |
| Great Harvest Bread Company | Woodbury YMCA |
| HealthEast Care System | Youth Matters |
| Lakeview Health Foundation | Youth Service Bureau |

**Individuals representing each of the organizations and groups listed can be found in Appendix A.*

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Introduction

What is a Community Health Improvement Plan?

The 2014 Washington County Community Health Improvement Plan (CHIP) is a long-term, systematic effort to address public health priorities identified during the Community Health Assessment (CHA) and health improvement processes. The CHIP will be used by the Department of Public Health and Environment (PHE) along with

Public Health is what we, as a society, do collectively to assure the conditions in which people can be healthy.

– Health Resources and Services Administration (HRSA)

community partners to set priorities, coordinate resources, develop policies, and define actions to target efforts that protect and promote health.

A CHIP is developed through a collaborative process, and defines a vision for the health of the community. In Minnesota, plans are developed for the geographic regions covered by the local health department. Community

health improvement planning is a foundational practice of public health as well as a national standard for all public health departments. Since the passage of the Local Public Health Act in 1976, Minnesota local health departments have been required to engage in a community health improvement process, beginning with a CHA. As part of Minnesota’s Local Public Health Assessment and Planning process, every health department must submit a CHIP dated within five years to the Minnesota Department of Health.

A snapshot of people and place

Washington County is an area of abundant natural beauty, historical character and agricultural heritage located on the eastern edge of the Twin Cities Metropolitan Area. Washington County is composed of 423 square miles of land; it runs more than 40 miles in length north to south. While much of Washington County has retained its rural atmosphere, today it is considered a suburban county.

Washington County is the fifth most populous county in Minnesota, comprising 4.5 percent of Minnesota’s population. According to the 2010 Census, the county population is 238,136; by the year 2020, this number is projected to increase by over 30 percent. The population has become more diverse since 2000; in 2010 the portion of single-race white residents changed from 93.6 percent in 2000 to 88.5 percent.¹⁰ Approximately 3.5 percent are now of Hispanic or Latino ethnicity compared to 4.9 percent statewide.

Washington County's population of those 65 years and older is rapidly growing while the younger population has had little change. It is expected that by 2020, the older population will be just over 40,000, almost double the current population for the older age groups.⁶

The percent of people of all ages in the county living at or below 200 percent of poverty is 13.4 percent while the state is at 25.5 percent. The estimated median household income in 2011 was \$76,491, compared to \$58,500 for the state and \$52,800 for the U.S. In 2011, 5.4 percent of adults in Washington County were without health insurance, compared to 11.7 percent in the state.¹⁰ Locations of poverty identified within the county are in the northwest corner of the county, east central; west along the county border with Ramsey County; in mobile home communities; and lower income housing in the south part of the county.⁹

Washington County graduation rates are good, at 87.9 percent for all students when compared to state and national rates however variation persists among racial and ethnic groups, and students from low-income households. For example, the four-year graduation rate among black/non-Hispanic students was only 75.7 percent in 2012, and only 73.3 percent of students that are enrolled in the free/reduced-price lunch program graduated on time. Lack of a high school diploma puts individuals at greater risk for poor health, lower lifetime earnings, unemployment and welfare, and prison.²

Health status is a product of many conditions and factors, such as living conditions and social and economic opportunity. Assessing the population and environmental health of a community can reveal important information about quality of life, economic potential, and emerging needs among community members. Health inequities identified through the CHA include:

- Obesity is twice as common among those whose household income is less than 200 percent of the federal poverty level.
- Twelve percentage points separate graduation rates of Hispanic students and their white non-Hispanic peers.
- The current ratio of residents to mental health providers in the county is 924 residents for every provider, compared to 766-to-1 in Minnesota.
- One in five adults living at or below 200 percent of the federal poverty level reported meeting the recommended daily intake of fruits and vegetables.
- About 72 percent of adult males were overweight or obese, compared with 50 percent of females. Seventy-two percent of those in the 200 percent poverty level or less were overweight or obese in 2010.
- Almost 18 percent of adults living at or below 200 percent of the federal poverty level currently smoke.

Given these challenges and the dynamic nature of the people and places within Washington County, we must be prepared to address issues affecting our health to ensure that current and future Washington County residents have a great place to live, work and play.

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Community Health Improvement Planning Process

Organize

The CHIP is the link between assessment and action; it will be used by PHE along with our community partners to define how we will work together to improve the health of the community. The CHIP outlines goals, objectives and strategies that PHE and its partners will address beginning in 2014, for the next five years. The plan also includes activities and measures to ensure progress towards these goals. The CHA and CHIP play an important role in local health department voluntary accreditation through the Public Health Accreditation Process (PHAB). The goal of the public health accreditation program is to promote and protect the health of the public by advancing the quality and performance of all health departments.

Stakeholder engagement

Living Health Washington County Steering Committee

Community engagement is essential to creating a CHIP that ensures effective, sustainable solutions. By leveraging existing public and private partnerships, a diverse group of community partners collaborated to convene the *Living Healthy in Washington County Steering Committee* (LHWC) Steering Committee. Sectors represented on LHWC include local hospitals and health care organizations, local government, community based organizations, social service organizations, and schools. The group's shared vision as of February 28, 2013, is "Washington County: A community committed to active, healthy lifestyles." Their mission is "to inspire and support residents to live longer, healthier lives through actions that increase opportunities for physical activity, healthier food options and decreased tobacco use and exposure." The focus of their work has been on making policy, system and environmental changes that support the mission.

In early 2013, the members of the LHWC Steering Committee agreed to expand their membership to natural resource and environmental organizations and integrate Washington County's Community Health Assessment with existing steering committee activities for the remainder of the year. The LHWC Steering Committee participated in the Community Health Assessment by:

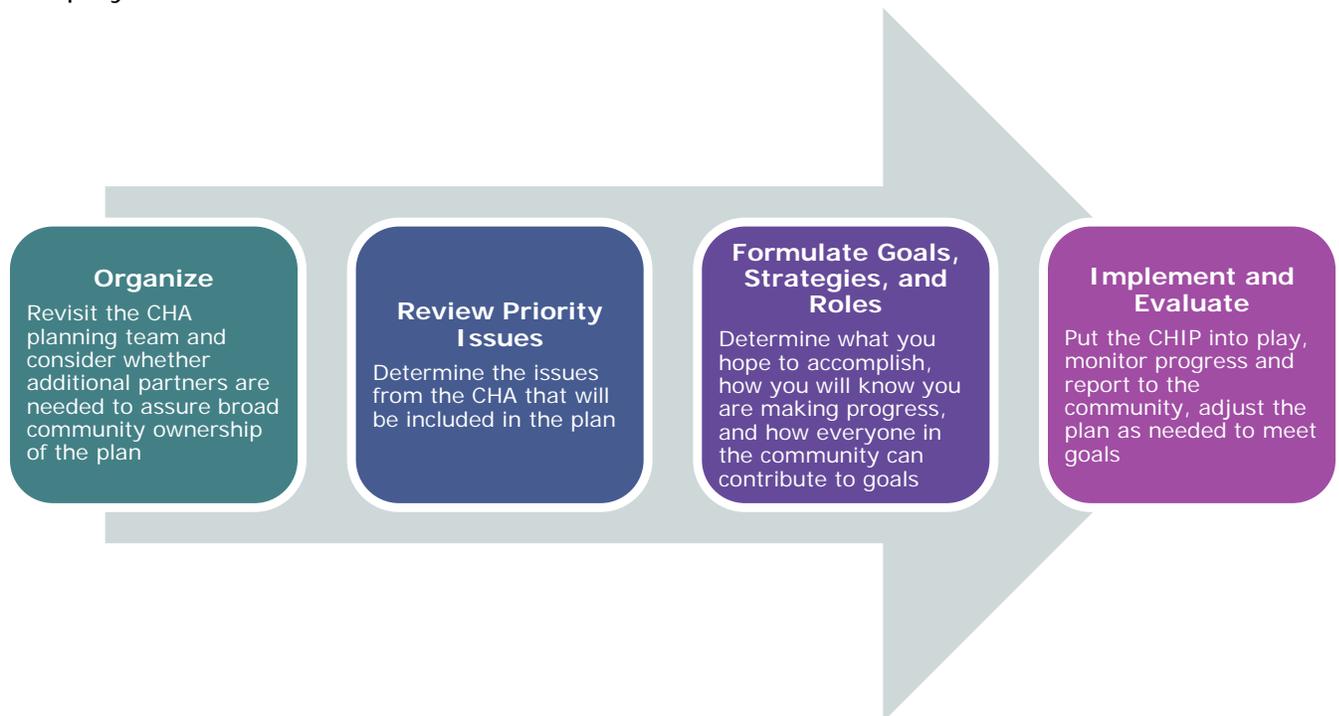
- serving as Advisory Committee to the CHA and CHIP;
- establishing the Vision for Living Healthy in Washington County;
- becoming familiar with the CHA process and requirements;
- reviewing statistics, survey data, and other information about the county;

- using CHA data to identify and prioritize health issues; and
- acting as advocates for the community health assessment and improvement planning process in the county.

A list of the LHWC member organizations can be found in Acknowledgments, page i. Individual names of people who participated in the assessment process are located in Appendix A.

Planning framework

To conduct the CHA, the LHWC Steering Committee applied elements of the *Mobilizing for Action Through Planning and Partnerships* (MAPP) framework in combination with the Minnesota Department of Health (MDH) community health improvement planning process. MAPP is a community-driven strategic planning process for improving public health.⁷ The framework provided a structure and best practices to help the steering committee prioritize public health issues, identify resources for addressing them, and take action. Upon identification of the community health priorities, the MDH community health improvement planning process (outlined below) was applied. As the steering committee transitioned from the assessment to the planning phase, the following process was used to develop goals and strategies, assign roles, and take the necessary actions to put the CHIP into play.



Project timeline

Below are the major project milestones.

Timeline of Events
2009 – 2013
LHWC Steering Committee Formation and Action
2013
<u>May</u>
<ul style="list-style-type: none">• Project Kickoff• LHWC Steering Committee expanded to include environmental health representation
<u>June</u>
<ul style="list-style-type: none">• Review for alignment of partner plans from hospitals, schools and environmental health partners including the Washington County Groundwater Protection Plan completed
<u>July</u>
<ul style="list-style-type: none">• Online community health opinion survey administered• Secondary data collection began
<u>August</u>
<ul style="list-style-type: none">• Youth survey completed• Focus groups and key informant interviews prepared
<u>September</u>
<ul style="list-style-type: none">• Key informant interviews and focus groups completed
<u>October</u>
<ul style="list-style-type: none">• Primary and secondary data organized and analyzed• Prioritization process completed
<u>November</u>
<ul style="list-style-type: none">• Community health priorities selected• Strengths and gaps to address priorities identified
2014
<u>January</u>
<ul style="list-style-type: none">• SHIP funding and community engagement began
<u>March</u>
<ul style="list-style-type: none">• Behavioral Health Action Workgroup convened
<u>May</u>
<ul style="list-style-type: none">• CHA and CHIP completed

Data collection

Primary and secondary data from a variety of sources was used to complete the CHA.

Secondary data

Secondary data, or data not collected directly by Washington County, include: federal, state, and local data; hospitals and health care providers; local schools; academic institutions; other departments of government; and nonprofit organizations. Many sources of data for this health assessment are government agencies, such as the Minnesota Department of Health. Other data originate from nonprofit research organizations such as Wilder Research, and other public and private data such as Minnesota Hospital Association data. The categories of secondary data used include:

Opportunity for Health

1. Education and employment
2. Income and poverty
3. Housing and home ownership
4. Indoor and outdoor environments
5. Social connectedness
6. Communication and personal safety
7. Access to health care

Healthy Living

1. A healthy start for children
2. Physical activity and nutrition
3. Use of alcohol, tobacco and other drugs

Primary data

Washington County collects primary data for the purpose of incorporating the values and priorities of county residents into health improvement decisions. Sources of data used during this health assessment include:

- Metro Adult Health Survey (MAHS), 2010;
- Minnesota Student Survey (MSS), 2010 and 2013;
- Washington County Residential Survey, February 2013;
- Washington County Community Health Opinion Survey, July-August 2013;
- Community Health Key Informant Interviews, August-September 2013;
- Community Health Adult Listening Sessions, August-September 2013; and
- Community Health Youth Listening Sessions, August-September 2013.

Community input was collected as part of the CHA process between July and September 2013 in an effort to create a picture of the community's beliefs and perceptions regarding health in the community. A special emphasis was made to reach out to community members from across the county to hear health concerns directly from them. The goals of collecting community input were to:

- gather broad, representative perspectives regarding current health issues in Washington County;
- discover resident information both about what is healthy and what is unhealthy in their community;
- provide a variety of options for input; and
- engage traditionally under-represented groups.

Listening sessions

Adult Listening Sessions were conducted by PHE staff to collect knowledge from those who live and work in the county about health issues from a community standpoint. The participants were asked a set of prescribed questions, and voluntary, anonymous responses were collected. Eighty-eight individuals attended the various meetings, provided ideas, and participated in the discussion.

Conversations were held with:

- adult English learners;
- food shelf clients;
- low income individuals;
- older adults;
- people with disabilities;
- pregnant and parenting young adults;
- racially and ethnically diverse populations;
- unemployed individuals;
- Women, Infants and Children (WIC) participants; and
- General Educational Development (GED) students.

Youth Listening Sessions were also conducted by PHE staff using the same methods outlined above to collect knowledge about health issues from a youth standpoint; 102 youth participated in eleven conversations. Conversations were held with youth at:

- Fitness and community centers: Woodbury YMCA, Forest Lake Teen Center (Family Pathways), Landfall Teen Center (FamilyMeans), Cimarron Teen Center (FamilyMeans);
- Learning centers and schools: Alternative Learning Center Stillwater, Youth Open Minds group at Forest Lake High School;

- Woodbury Youth Service Bureau;
- Lake Area Youth Service Bureau (Forest Lake);
- 4H Youth Ambassadors;
- Park Grove Library (Cottage Grove);

Key Informant interviews

In-depth key informant interviews with select individuals based on their specific knowledge or experience with health issues in Washington County were conducted in-person and over the phone. An option to fill out an online questionnaire was also offered. All responses collected were voluntary and confidential. Participants provided a unique perspective about current and emerging health issues in the communities they work with. Key Informant Interviews were conducted with twenty-nine individuals from the following settings:

- non-governmental community organization, groups or coalitions (including food shelves, homeless services, non-profits, minority groups, disabled, and senior services);
- clinical professional (including hospital administrators, dentists, pediatricians, pharmacists, and nurses);
- professionals working with or serving youth;
- business professionals; and
- governmental administrators or representatives from city or county services (including law enforcement, veterans services, workforce center, advisory committees and elected officials).

Community Health Opinion Survey

The online community health opinion survey was a countywide effort to reach people who live or work in Washington County. The survey content was developed collaboratively with Ramsey, Dakota, and Anoka counties. It included 94 questions about 11 health topics. The survey was available for public participation from July 9 through August 30, 2013. It was promoted through local newspapers, newsletters, the Washington County website, social media, emails to key contacts and collaboratives, and promotional postcards distributed through county service locations and libraries. Paper and Spanish language versions of the survey were available on request. There were 1,042 respondents who completed the survey.

Over 1,150 community members provided input through the online Community Health Survey, Listening Sessions, and Key Informant Interviews. Key themes that emerged from the Listening Sessions, Key Informant interviews and Online Opinion Survey for both Youth and Adults and are ranked in order of top concern in Appendix C.

The CHA and its findings were shared broadly with participants and distributed to partner organizations through various routes of communication ranging from newsletters and announcements to formal presentations. The assessment was also made available to the population for which the plan was written via publication on the Washington County website.

Review of priority issues

LHWC Steering Committee members met on November 21, 2013 and used the CHA results to identify community health priorities in Washington County. Community health priorities are those issues critical to achieving the vision of the CHIP. Steering Committee members completed a scoring exercise for ten categories of health issues:

- Obesity; Nutrition and Physical Activity;
- Chronic Disease and Conditions;
- Mental Health;
- Substance Abuse;
- Tobacco Use;
- Injury and Violence;
- Environmental Health;
- Access to Health Services;
- Maternal and Child Health; and
- Infectious Diseases.

Participants represented various sectors of community health including environmental health, community services, schools, hospital partners, and for profit and nonprofit partners.

The following community health priorities identified, in order, were:

1. **Obesity** in children and adults due to poor nutrition and physical inactivity.
2. Premature death and disability from **chronic diseases** due to tobacco use.
3. **Behavioral health problems** among children and adults due to substance abuse and mental illness.

Additionally, the committee decided to address **Health Equity and Access to Health Services** across all three priority health issues.



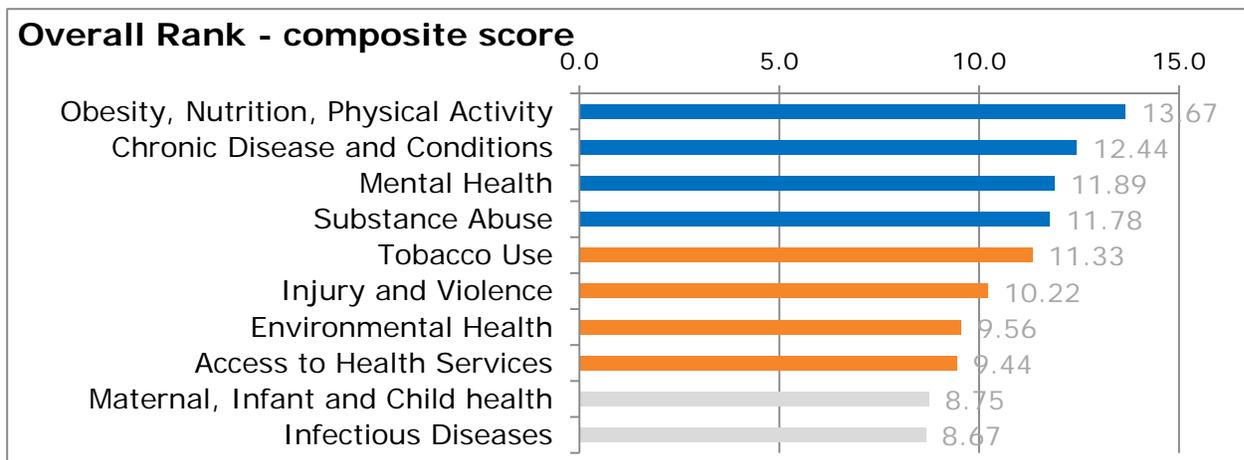
Steps of the prioritization process included:

- shared visioning and overlap of existing plans;
- scoring of ten health categories across five scoring measures: 1) Portion of population at risk or affected; 2) Quality of life impact; 3) Economic impact; 4) Health equity impact; and 5) Existing priority level;
- dot voting on community capacity and readiness to address health improvement for each category. Additional detail on the prioritization process including community capacity and readiness to address issues can be found in Appendix C; and
- an assessment of tangible and intangible community assets and resources was summarized as strengths and gaps for each health topic. Assets included people, physical structures, relationships, and organizations. More detail can be found in Appendix D.



In order to reach committee consensus on which issues to go forward with for shared community action Steering Committee participants and public health staff then completed a second simple ranking of the 10 health issues based on current individual knowledge.

- All groups agreed on the Top 4 health issues, not necessarily in the same order (**Blue**): Obesity, Chronic disease, Mental health, Substance abuse.
- All groups agreed on the Bottom 2 health issues (**Gray**): Maternal and child health, Infectious disease.
- Scoring varied significantly across issues ranked #5-8 (**Orange**): Tobacco use, Environmental health, Access to health services, Injury and violence.



Formulate goals and strategies

Once the steering committee identified top priorities, the group moved forward with formulating goals and strategies for each. Consistent with the MDH planning process, the steering committee revisited information from the CHA and assessed the need to involve additional partners to assure broad community ownership of the CHIP. For the priority issues #1 and #2 (**obesity and chronic disease and tobacco use**), the steering committee and PHE staff were able to align CHIP goals with the Statewide Health Improvement Program (SHIP) goals and activities, and will continue to work through LHWC. For priority issue #3 **behavioral health**, the steering committee determined that additional guidance was needed to identify community assets and resources, and recommend goals, objectives and strategies for inclusion in the CHIP. Across all priority issues, goals and strategies were created with both national and state goals in mind, and will use evidence-based strategies for implementation.

Obesity and chronic disease – taking action through SHIP

SHIP was established in 2009 by the Minnesota Legislature as part of the state's Health Care Reform Initiative. SHIP succeeds by encouraging and supporting healthy living and addressing health disparities through community engagement, local decision-making and sustainable, evidence based strategies.⁵ Initially, all local health departments in the state received two years of significant funding to address obesity and tobacco use. After those first two years, funding was greatly reduced and only a few local health departments continued with funding. PHE did not receive those funds but continued to work with the LHWC Steering Committee and to make progress on policy, environmental and system changes as much as possible.

In 2013, the Minnesota Legislature restored the funding and PHE has been awarded funding through 2015. SHIP will provide funding to the county and partners to implement CHIP work related to obesity and tobacco use. PHE and partners will emphasize work with lower income and under-represented groups, as identified in 'target populations' section of the action and evaluation plans found in Appendix F. For example, for school-related goals, an emphasis will be put on working with schools identified with higher rates for free and reduced lunch.

Behavioral health – new commitments to collaboration

Existing community chemical health and mental partnerships have had a strong commitment to addressing behavioral health with varying levels of resources over many years. County, private, and non-profit agencies provide behavioral health and advocacy services to consumers, but there is a lack of shared knowledge about services, access, and information. Inconsistent funding streams and the breadth of

related health issues are among current barriers to adopting a common vision for shared action.

The LHWC steering committee requested additional guidance for action strategies to address the #3 priority health issue, behavioral health. In response, PHE convened an ad hoc workgroup to develop strategy recommendations for behavioral health improvement in Washington County. The Behavioral Health Action Workgroup (BHAWG) met three times in March and April of 2014. The workgroup included 28 participants (see Appendix A) representing the following organizations and sectors:

- Washington County programs: Public Health, WIC, Correctional Health, Community Corrections, Community Services;
- Health care: Fairview Lakes, Lakeview Health, Southside, HealthEast;
- Schools: Stillwater Area Public Schools, Forest Lake Area Schools, ISD 622, Century College;
- Faith communities: St. Croix Valley Parish Nurse Association, Faith-Based Health and Wellness Network;
- Providers: Community Thread, Family Means, Youth Service Bureau;
- The National Alliance on Mental Illness (NAMI) – Washington County Chapter; and
- Coalitions: CONNECT (Chemical Health Action Collaborative), Children’s Mental Health Partnership

The workgroup completed the following activities:

- Meeting 1: Convened a collaborative group, reviewed assessment progress to date, looked at current data, discussed agency/collaborative goals and actions, defined behavioral health to include chemical health and mental health;
- Meeting 2: Reviewed group assets, formulated a goal, discussed gaps; and
- Meeting 3: Reviewed a framework for improvement, adopted shared goal and recommendations for future work.

The BHAWG process identified the greatest improvement needs in the areas of reducing stigma of behavioral health problems and improving access to health resources for those facing behavioral health problems. BHAWG strategy recommendations involve “re-thinking” the way community partners and existing coalitions engage behavioral health together. Refer to Appendix E for a complete listing of the multiple partners working on behavioral health and their respective networks. The recommendations also introduce the need to examine evidence-based solutions to reducing stigma, such as improving social and family connectedness and measuring overall wellbeing. Much of the recommended strategies will be new and therefore involve beginning steps such as *convening*, *assessing*, and *establishing new coordination practices*.

Community Health Priorities

The LHWC Steering Committee identified the following community healthy priorities:

Community Health Priority
1. Obesity in children and adults due to poor nutrition and physical activity
2. Premature death and disability from chronic diseases due to tobacco use
3. Behavioral health problems among children and adults due to substance abuse and mental illness

Additionally, the committee decided to address **Health Equity and Access to Health Services** across all three community health priorities.

The following sections describe each community health priority, including:

Why do we care?

Describes the issue at hand and links to state and national priorities.

What do we know?

Provides relevant health data from Washington County on each priority.*

Where do we want to be?

Describes the goals, objectives and strategies.

What needs to happen?

Discusses potential policy, system or environmental changes. Additional policy changes may be identified over time.

*Data, resources and citations are included in the [2013 Washington County Community Health Assessment](#).

It is important to note that while the CHIP will guide important work related to these community health priorities, PHE will continue to work both internally and with partners on other public health and environmental health issues as need arises, and as part of our state mandated work. This includes, but is not limited to, disease prevention and control work on rising cases of sexually transmitted diseases and tick borne illnesses, as well as environmental health issues related to groundwater protection, and hazardous and solid waste management.

Obesity, Nutrition, and Physical Activity

Why do we care?

The most serious health problem identified through the 2013 Washington County Community Health Assessment (as well as in 2008) was overweight and obese children and adults due to poor nutrition and physical inactivity. County and state data also indicate that obesity has a disproportionate effect on lower income residents.

There are many factors contributing to the statewide and national epidemic of obesity. Lifestyle factors include low consumption of fruits and vegetables and other unhealthy food choices, sedentary lifestyles and lower rates of breastfeeding.

Washington County efforts to address obesity, nutrition and physical activity align with state priorities identified in Healthy Minnesota 2020: Chronic Disease & Injury Plan, including 1) increasing fruit and vegetable consumption, 2) increasing physical activity 3) reducing obesity.³ This priority is also in line with the national Healthy People 2020¹² goals to increase physical activity in adults and youth and the National Prevention Strategy.¹³

Obesity is associated with many diseases and conditions including hypertension, high cholesterol, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems, depression and some cancers.

What do we know?

- Four obesity-related conditions - heart disease, stroke, cancer and diabetes, accounted for nearly 51 percent of all deaths in Washington County in 2009;
- Currently, 61 percent of adults in the county, as in the state, are overweight or obese based on their calculated Body Mass Index (BMI) from self-reported height and weight. While youth overweight and obesity rates are slightly lower in Washington County than in the state, they remain a serious health concern.
- In 2010, approximately 17 percent of 9th graders and 16 percent of 12th graders were either overweight or obese.
- In Washington County, obesity is twice as common among those whose household income is less than 200 percent of the federal poverty level.

Where do we want to be?

Goal: Increase healthy weight in adults

Objective: Increase the number of adults who are a healthy weight from 39 percent to 47 percent by 2020.

Strategy 1: Healthy Food in the Community

Support ongoing and new partnerships and efforts to increase access to fruits and vegetables and decrease access to foods high in sodium, added sugar and saturated fat. Promote small scale food production and county-wide availability.

Strategy 2: Active Living

Support policies and practices that create safe, active communities by increasing opportunities for walking and biking and access to community recreation facilities for all ages.

Strategy 3: Worksite Wellness

Support the implementation of comprehensive employee wellness initiatives that encourage healthy lifestyle behaviors such as adequate physical activity, healthy eating, reduced tobacco use and exposure and support for nursing moms.

Strategy 4: Clinical-Community Linkages

Develop relationships among health care providers and community organizations. Build partnerships to implement evidence based clinical chronic disease guidelines and referral systems, and increase access to lifestyle change, prevention or chronic disease self-management programs.

Goal: Increase healthy eating in youth

Objective: Increase in the prevalence of youth who eat the recommended number of fruits and vegetables daily from 21 percent to 30 percent by 2020.

Strategy 1: Healthy School Food*

Partner with local school districts to implement nutrition initiatives such as healthy breakfast promotion, healthy lunch and snacks, alternatives to classroom celebrations, incentives, and fundraising, healthy choice concessions or vending, school gardens and Farm-To-School initiatives.

Strategy 2: Child Care

Provide training and resources to develop policies and practices to improve healthy eating, physical activity and support for breastfeeding or nursing moms in licensed childcare centers and pre-school settings.

* For school-related goals, an emphasis will be put on working with schools identified with higher rates for free and reduced lunch.

Goal: Increase active living in youth

Objective: Increase the prevalence of youth meeting moderate physical activity guidelines from 74 percent of boys and 68 percent of girls to 92 percent of boys and 89 percent of girls by 2020.

Strategy 1: Active School Day

Partner with local districts to work toward policies and practices that create opportunities for physical activity throughout the school day such as: Safe Routes to School, enhanced physical education, active classrooms, and before or after school activity options.

Strategy 2: Active Living

Support policies and practices that create safe, active communities by increasing opportunities for walking and biking and access to community recreation facilities for all ages.

Strategy 3: Child Care

Provide training and resources to develop policies and practices to improve healthy eating, physical activity and support for breastfeeding moms in licensed childcare centers and pre-school settings.

Strategy 4: Clinical-Community Linkages

Develop relationships among health care providers and community organizations. Build partnerships to implement evidence based clinical chronic disease guidelines and referral systems, and increase access to lifestyle change, prevention or self-management programs.

What needs to happen?

Potential policy changes related to obesity include:

- school nutrition policies to increase fruits and vegetables, decreasing sodium, saturated fat, and added sugar;
- track and revise convenience store, food program and city and county concession stand policies to increase fruits and vegetables, decreasing sodium, saturated fat, and added sugar;
- physical activity policies to address increasing activity throughout the day;
- school and city policies to increase walking/biking opportunities for all ages
- child care nutrition, breastfeeding, and active living policies to improve food options, support breastfeeding, and increase children's activity,
- worksite wellness policies addressing nutrition, tobacco, physical activity and breastfeeding support; and
- policies to support improved access to evidence-based lifestyle change programs, breastfeeding support, referrals, and healthy lifestyle guidelines.

Chronic Disease and Tobacco Use

Why do we care?

Chronic diseases, ranked second in the prioritization process, can cause illness, disability and death. Seven out of ten deaths among Americans each year are from chronic diseases.

Tobacco use, including cigarettes, cigars and smokeless tobacco, is the single leading preventable cause of death in the U.S., resulting in 443,000 premature deaths every year.

Addressing chronic disease and tobacco use aligns with the State's Healthy Minnesota 2020: Chronic Disease and Injury Plan³ as well as the national Health People 2020¹² goals related to tobacco use.

A **chronic disease** is one lasting three months or more, as defined by the U.S. National Center for Health Statistics. The most common types of chronic diseases are heart disease, cancer, stroke, diabetes, and arthritis.

What do we know?

- In Washington County, the leading causes of death in 2010 were cancer, heart disease, Alzheimer's disease, and stroke. Increased risk of chronic disease is caused primarily by behaviors such as inactivity, poor diet, smoking and excessive alcohol use.
- Nearly 25 percent of adults in Washington County have high blood cholesterol. Nineteen percent of adults in the county have been told by a health professional that they have high blood pressure. An additional 16 percent have been told they have borderline high blood pressure.
- Nearly 7 percent of adults in the county report being told they have diabetes. An additional 6 percent of adults have been told that they have pre or borderline diabetes.
- While the percent of women who smoked during pregnancy has been consistently below statewide percentages for the past decade, in recent years there has been a significant increase in smoking rates among pregnant women.
- Consistent with state trends, cancer has been the leading cause of death in Washington County for over a decade. The percent in 2010 was just over 27 percent, or 1,265 deaths. The most prevalent type of cancer-related death for both men and women is lung cancer. Trachea, bronchus and lung cancer accounted for nearly 29 percent of all deaths attributable to cancer for Washington County residents in 2010.

Where do we want to be?

Goal: Decrease tobacco use and exposure in all ages

Objective: Decrease in 12th graders under 18 years old who smoke from 17 percent to 12 percent by 2020.

Strategy 1: Other Tobacco Work

Develop relationships with tobacco vendors and clerks, high school and college health services staff and administrators, law enforcement, and city and county administration. Build partnerships to promote new tobacco policies and offer resources for, education, cessation, compliance, and enforcement.

Objective: Decrease in young adults (18-24) who smoke from 27.8 percent to 18.6 percent by 2020.

Strategy 1: Clinical-Community Linkages

Develop relationships among health care providers and community organizations. Build partnerships, conduct assessments for implementation of clinical chronic disease guidelines and referral systems, and increase access to evidence based lifestyle change, prevention or self-management programs.

Strategy 2: Other Tobacco Work

Develop relationships with tobacco vendors and clerks, high school and college health services staff and administrators, law enforcement, and city and county administration. Build partnerships to promote new tobacco policies and offer resources for, education, cessation, compliance, and enforcement.

Objective: Decrease secondhand smoke exposure of renters living in multi-unit housing from 30 percent to 20 percent by 2020.

Strategy 1: Smoke-Free Housing

Provide technical assistance to support multi-unit housing owners voluntarily working on ways to decrease tobacco use and exposure through cessation resources, environmental supports, and practices within their facilities.

Objective: Increase the percent of worksites with tobacco free grounds policies in place from 37 percent in 2012 to 45 percent in 2020.

Strategy 1: Worksite Wellness

Support the implementation of comprehensive employee wellness initiatives that encourage healthy lifestyle behaviors such as reducing tobacco use and exposure.

What needs to happen?

Potential policy changes related to chronic disease and tobacco use include:

- smoke-free housing policies in multi-unit housing complexes with a large number of diverse or low-income residents;
- comprehensive worksite wellness policies such as smoke free campuses, offering tobacco cessation programs and including cessation support as an insurance benefit;
- revise local tobacco ordinance as state laws change, in particular, those related to e-cigarettes;
- expand availability of local tobacco cessation programs and support; and
- tobacco vendors uphold laws and do not sell tobacco products to minors.

Behavioral Health

Why do we care?

The term “behavioral health” refers both to mental health and substance use, and recognizes that the two are often interrelated. Preventing, treating, and reclaiming individual health from these problems is essential for communities to be healthy, safe, and successful.

Mental health is as important as physical health. Mental health plays a major role in people’s ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people’s ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person’s ability to participate in treatment and recovery. As a result, mental health disorders are the leading cause of disability in the United States and Canada, accounting for 25 percent of all years of life lost to disability and premature mortality.

Behavioral health problems include chemical dependency and mental illness. These problems contribute to twenty-five percent of life lost to disability and premature death in the United States.

The steering committee identified mental health and chemical health (under the title “alcohol and other drug use”) as the third and fourth ranked priority issues respectively. The group then combined the two issues to become the overall #3 priority health issue in Washington County. The Minnesota Department of Health has identified mental health as a priority area, in part through the State Community Health Services Advisory Committee (SCHSAC). A report from the SCHSAC mental health workgroup recommends leadership at the state and local level, facilitating access to mental health resources, and implementing strategies for the prevention and early identification of mental illnesses.⁸ This priority also aligns with the Healthy People 2020 objectives around mental health and substance abuse.¹²

Addressing behavioral health collaboratively is a new initiative for the county and the plan is still in the early stages of development.

What do we know?

- Hospital discharge rates for mental health disorders in Washington County average 7 per 1000 over the last four years.
- The county suicide rate per 100,000 is 10.2 (up 21 percent in the past decade) compared to the state rate of 11.1.

- In 2010, 43 percent of 12th graders reported using alcohol in the past month.
- The 2010 chronic drinking estimate for Washington County adults is 3.2 percent approximately 1.5 percent lower than the state rate.
- The 2010 acute drinking estimate for Washington County adults is 22.5 percent approximately 5 percent higher than the state rate.
- While binge drinking among 12th graders decreased by 26 percent between 1998 and 2010, one out of every four (25 percent) reported consuming five or more drinks in a row in the past two weeks.
- Across Minnesota, the use of pain relievers for non-medical purposes increased among adults between 2003 and 2008.
- In 2010, about 6 percent of Washington County 12th graders and 4 percent of 9th graders reported using pain relievers and ADHD/ADD drugs.
- One in five 12th grade students reported using marijuana in 2010.

Where do we want to be?

Goal: Increase access to health services for people facing behavioral health issues

Washington County can be proud of the overall availability and quality of behavioral health services. However, consumers and their families, social service agencies and referral source personnel often cannot get clear, basic information such as treatment options, the full range of available services, payment mechanisms, and how to access the services. Additionally, basic information, communications, and linkage systems are lacking, particularly for individuals that are uninsured or have Medicaid or Medicare.

Objectives

- *Reduce Washington County suicide rate to from 10.2 per 100,000 to 9.2 per 100,000 by 2020*
- *Reduce hospitalization rate for mental health disorders from 7.4 per 1,000 to 6.7 per 1,000 by 2020*
- *Establish a baseline to measure the portion of adults who wanted behavioral health help during the past year but delayed or did not get it and reduce that portion by 2020*
- *Establish a baseline to measure the portion of adults exceeding a self-reported past 30 days poor mental health threshold and reduce that portion by 2020*
- *Establish a baseline to measure the portion of drug offenders who re-enter the criminal corrections system and reduce 10 percent by 2020*

Strategy 1: Coordinate cross-departmental county services

Coordinate continuity of county services influencing behavioral health. Develop a united front internally to county operations to improve common messaging, referral, and access to county services. Develop processes for connecting

consumers with resources for reclaiming health. Secure leadership support to sustain.

Strategy 2: Rethink the collaborative “landscape”

Implement a series of conversations among existing partnerships and collaboratives in the county to assess capacity and opportunity for shared work. Complete an environmental scan of programs, services, and initiatives in the county. Determine shared messaging to promote awareness of the inventory.

Strategy 3: Establish a shared communication plan

Develop common messages around behavioral health issues in order to close gaps in awareness and improve access to services. All members adopt and implement the plan.

Strategy 4: Strengthen clinical-community linkages

Strengthen relationships among health care providers and community organizations. Build partnerships to support evidence-based clinical behavioral health practices and referral systems, and increase access to lifestyle change, prevention or self-management programs.

Goal: Reduce stigma related to behavioral health issues

Throughout the community health assessment and planning process, community members and collaborators repeatedly stated how difficult it is for individuals affected by behavioral health problems to talk about it.

Objective:

- *Reduce past year suicide attempts among 9th grade students from 4 percent to 3.8 percent by 2020*
- *Increase the portion of youth who experience social and emotional support from adults at school from 42 percent to 45 percent by 2020*
- *Reduce the portion of adults who experience inadequate social support from 12 percent to 10.8 percent by 2020*

Strategy 1: Coordinate cross-departmental county services

Coordinate continuity of county services influencing behavioral health. Develop a united front internally to county operations to improve common messaging, referral, and access to county services. Develop processes for connecting consumers with resources for reclaiming health. Secure leadership support to sustain.

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Strategy 4: Strengthen clinical-community linkages

Strengthen relationships among health care providers and community organizations. Build partnerships to support evidence-based clinical behavioral health practices and referral systems, and increase access to lifestyle change, prevention or self-management programs.

Goal: Increase social and emotional wellbeing

Evidence-based research supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Prevention Framework suggests that initiatives that improve overall social and emotional wellbeing reduce the incidence of behavioral health problems.

Objective:

- *Establish a baseline for month community involvement among adults (2014 MetroSHAPE) and increase 5 percent by 2020*
- *Increase the portion of youth who experience social and emotional support from adults at school from 42 percent to 45 percent by 2020*
- *Reduce past month poor mental health days among adults from 2.3 to 2.1 by 2020*

Strategy 1: Explore ways to integrate behavioral health into school wellness programs

Strengthen relationships between behavioral health staff and new School Health Councils (SHC) formed to address priorities #1 and #2.

Strategy 2: Establish a shared communication plan

Develop common messages around behavioral health issues that explore “upstream” way to increase capacity for resilience for individuals, neighborhoods, communities. Promote community awareness that connectedness and social support makes everyone better off.

Strategy 3: Explore ways to strengthen social support and involvement among adults

Begin discussions among community partners about how to measure and improve social support and community involvement among adults. Make decisions about how to assess these data and who is willing to get involved in the process. This strategy may involve assessment, strategic planning, and further narrowing of target populations.

What needs to happen?

Potential policy changes related to behavioral health include:

- Follow legislative and industry standards
- Research and implement evidence-based practices for behavioral health improvement

Health Equity and Access to Services

Why do we care?

Health is a state of complete physical, social, and mental well-being and not merely the absence of disease or infirmity. Health is created in the community through social, economic and environmental factors as well as individual behaviors and biology. Improving health equity and access to services can reduce barriers to health.

MDH, in their 2014 report *Advancing Health Equity in Minnesota* identifies the need across the state to address health disparities and health inequity.¹ Similarly, state and national goals from Healthy Minnesota 2020 and Healthy People 2020, respectively, highlight the need for improving access to services.

Health equity is a state of where all persons, regardless of race, income, creed, sexual orientation, gender identification, age or gender have the opportunity to be as health as they can.¹

The federal Affordable Care Act (ACA) includes requirements that will potentially impact access to services by maximizing enrollment for those eligible for public or private coverage, including evaluation of coverage needs and options for the population with incomes between 138 and 200% Federal Poverty Level (FPL); reviewing strategies for Minnesotans to easily learn and get answers about coverage and care options, including links with the Health Insurance Exchange; and assessing the strength of the safety net to serve the newly covered and meet the needs of those who will not be covered in 2014. It will be important to monitor and evaluate the impact of the ACA over time.

While the primary care physician to patient ratio in Washington County is above state and national levels, the CHA and CHIP processes revealed gaps with regards to health and access to services, particularly for lower income and underserved populations, as well as in regards to mental health service access.

Although the diverse populations in Washington County are growing and are predicted to continue to grow, PHE has had limited relationships providing direct programs or community based prevention efforts to these groups. Individuals identified for receiving public health services (such as WIC or Nursing Services) are the primary contacts for diverse populations. PHE does however have relationships with organizations who work directly with diverse populations such as schools, non-profits, Washington County Community Services, the County Jail, and health care providers. Specific efforts will be made as part of obesity and chronic disease implementation (through SHIP) to identify the level of need and interest with diverse populations.

What do we know?

- Obesity in the county is twice as common among those whose household income is less than 200 percent of the federal poverty level.
- The percent of the county population that is uninsured hovered between 6 and seven percent in recent years.
- While Washington County remains well below state and national uninsured rates, access to health services was identified in the 2012 needs assessment document from Lakeview Health.
- Transportation can be substantial barrier to maintaining health, especially regarding the ability to access primary care services. About 3.4 percent of all Washington County households had no vehicle access.
- Survey responses from Washington County residents in the 2013 Residential Survey listed “Ease of travel by public transit in Washington County” as the most significant potential problem, followed by taxes, foreclosed properties and traffic congestion.
- The current ratio of residents to mental health providers in the county is 924-to-1, compared to 766-to-1 in Minnesota.

Where do we want to be?

Goals related to healthy equity and access to services are addressed across the three community health priorities of obesity, chronic disease and tobacco use, and behavioral health.

What needs to happen?

Policy changes related to healthy equity and access to services are addressed across the three community health priorities of obesity, chronic disease and tobacco use, and behavioral health.

Implement and Evaluate

Action and evaluation plans have been developed for each community health priority goal and objective, and are found in Appendix F. These priorities cannot be addressed by the county alone, but require the work and commitment of community partners. The action and evaluation plans include:

- the goal, objective and strategy (including data tracking and indicators);
- target population;
- performance measures;
- milestones;
- partners; and
- expected timeframe.

Leadership, implementation, and action for the community health priorities of **obesity** and **chronic disease and tobacco use**, will continue through the LHWC Community Leadership Team (CLT). The CLT consists of members of the LHWC Steering Committee along with others who will narrow their focus to the implementation of the SHIP grant. SHIP is helping communities prioritize healthy living. Local public health agencies chose from a menu of evidence-based strategies to match their local needs. **Behavioral health** work will continue under the Behavioral Health Action Workgroup (BHAWG).

Partners working toward health improvement in Washington County will continually assess the value of measures and indicators utilized by stakeholders in the CHIP. The PHE Performance Management System will serve as a framework for the monitoring and evaluation of population indicators and performance measures to drive improvements. Performance Management is the practice of using data for decision-making by establishing results and standards; measuring, monitoring and communicating progress toward those results; and engaging in quality improvement activities when desired progress is not being made. The use of performance management facilitates the achievement of improved community and environmental health outcomes and also builds accountability and transparency into processes and operations.

Selection of indicators will be guided by the following criteria:

- Communication Power Does the indicator communicate to a broad range of audiences?
- Proxy Power Does the indicator say something of central importance about the result?
- Data Power Quality data available on a timely basis.

Decisions to change measures will rely heavily on empirical evidence and community input. This process of *measure maintenance* will be facilitated by PHE staff and advised by subject matter experts. Measure maintenance will be included in the CHIP evaluation process, resulting in periodic recommendations for each measure. Recommendations may include:

- continue a measure without change;
- perform additional examination of a measure via ad-hoc review;
- transition a measure to monitoring; or
- retire a measure.

PHE will prepare an annual progress update (as well as a 6 month update for 2014) on progress towards meeting the goals and objectives identified in the CHIP.

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Appendix A: Community Health Improvement Plan Participants

Many thanks to our community partners for the time and attention they gave to this community health improvement process. This work would not be possible without them.

Community Collaborators – Includes LHWC, CLT and BHAWG

Jennifer Anderson, Twin Cities Medical Society
Nicole Anderson, Washington County Correctional Health*
Heidi Bardwell, Woodbury YMCA
Karla Bataglia, Community Thread*
Ann Bellows, Family Means/Stillwater School Wellness Program *
Heidi Benson, Southside Community Health Clinic
Kathy Bystrom, Fairview Lakes and Forest Lakes Area Partnership for Families
Marna Canterbury, Lakeview Health*
Carolyn Carr-Latady, Forest Lake Area Public Schools
Ren Clinton, Washington County Community Corrections*
Kara Coppinger, Canvas Health*
Tara Dahliger, South Washington County Schools*
Colleen Danford, Youth Matters
Maggie Domski, Washington County PHE/ Women Infants and Children’s Clinic*
Nancy Elias, Forest Lake Area Public Schools *
Natasha Fleishman, Great Harvest Bread Company
Dana Gabor, St. Croix Valley Parish Nurses*
Jodie Glewwe, Washington County Correctional Health*
Kathy Grafsgaard, South Washington County Schools
Angie Hong, East Metro Water Resource Education Program
Lisa Hoogheem, North St. Paul/Maplewood/Oakdale Schools
Pam Johnson, Canvas Health/Children’s Mental Health Partnership*
Becky Knighton, Washington County Community Services
Rachel Larson, Stillwater Area Public Schools*
Yvonne LeMieux, Canvas Health*
Dee Lindblom, Faith-Based Health and Wellness Network*
Matt Moore, South Washington Watershed District
Katie Pape, Canvas Health
Dan Parnell, National Alliance on Mental Illness – Washington County Chapter*
Joan Pennington, HealthEast Care System
Mary Planten-Krell, Youth Service Bureau and CONNECT*
Ann Pung-Terwedo, Washington County Public Works
Sue Schultz, Community Thread*
Jennifer Stella, Polaris
Traci Thompson, Washington County Community Services*
Ann Turnbull, Century Community College*
Sheri Vrieze, Canvas Health*
Lisa Warner, Canvas Health*

*Indicates membership of the Behavioral Health Action Workgroup

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Appendix B: Community Input Issues and Themes

YOUTH SURVEY - KEY THEMES

Listening Sessions	Key Informant Interviews	Online Opinion Survey
<i>11 Conversations with 102 Youth</i>	<i>29 Interviews with Adults that serve Youth</i>	<i>74 youth Under Age 18 Completed the Survey</i>
<ol style="list-style-type: none"> 1. Substance use and abuse (drugs, alcohol, and tobacco) 2. Mental health (bullying, depression, self-harm) 3. Healthy living and weight (healthy food and physical activity) 4. Adverse behaviors (texting while driving, theft, breaking curfew) 5. Youth-directed programming (activities and education) 	<ol style="list-style-type: none"> 1. Mental health (reducing stigma, increasing access to services) 2. Parenting and role modeling 3. Collaboration on youth health issues across sectors/between government and non-government entities 4. Substance use and abuse (drugs, alcohol, and tobacco) 5. Resources (low-cost services, activities, public health education, transportation) 	<ol style="list-style-type: none"> 1. Distracted driving (cell phone texting) 2. Unemployment 3. Obesity (overweight among children) 4. Driving under the influence of alcohol or other drugs 5. Obesity (overweight) among adults 6. Teen Pregnancy

ADULT SURVEY - KEY THEMES

Listening Sessions	Key Informant Interviews	Online Opinion Survey
<i>12 Conversations with 88 Participants</i>	<i>29 Interviews with Adults</i>	<i>1,042 Individuals from Teens to Age 85+</i>
<ol style="list-style-type: none"> 1. A healthy natural environment 2. Healthy living/weight (diet and exercise) 3. Social infrastructure (social services, public health initiatives, schools, etc.) 4. Substance abuse (alcohol, drugs, tobacco) 5. Mental health (access to care, stigma) 	<ol style="list-style-type: none"> 1. Physical activity (access and utilization) 2. Youth issues (substance use and abuse and mental health) 3. Diet and healthy food (access and consumption) 4. Mental health (access to care, stigma) 5. Increase awareness (public health education and initiatives) 	<ol style="list-style-type: none"> 1. Distracted driving (cell phone texting) 2. Driving under the influence of alcohol or other drugs 3. Tobacco use by youth 4. Obesity (overweight) among children 5. Alcohol use by underage youth

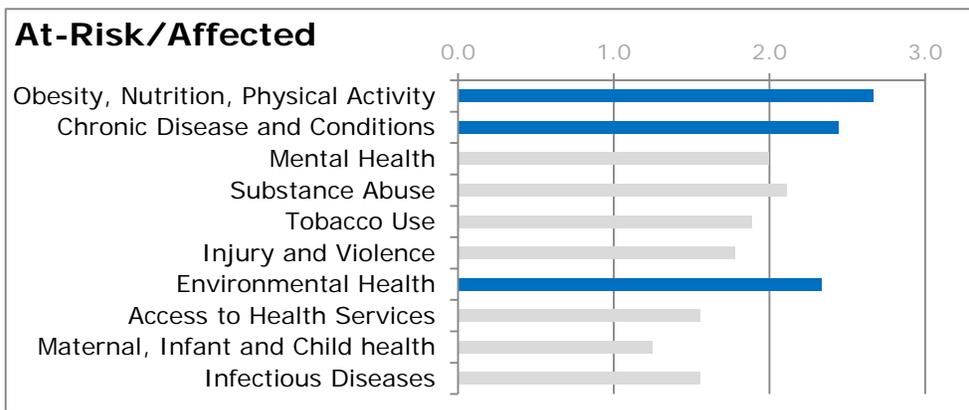
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Appendix C: Community Capacity and Readiness to Address Issues

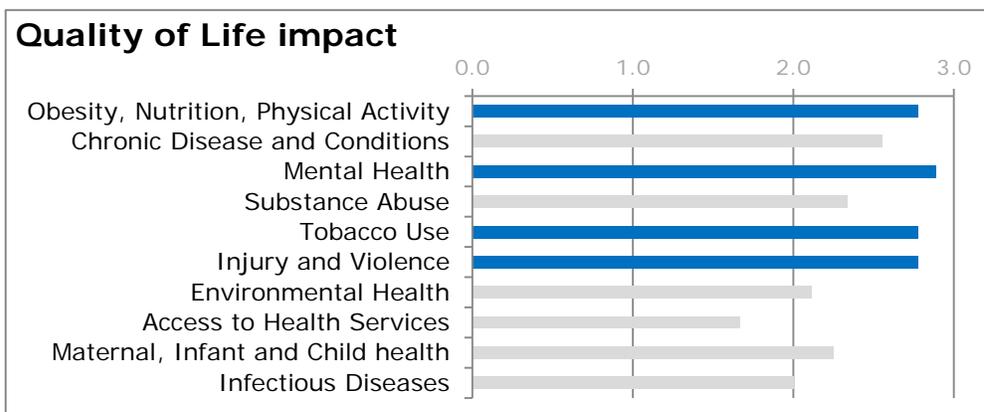
An assessment of community capacity and readiness was conducted by LHWC on November 21, 2013. Health impact of the 10 issues was scored across 5 measures.

Health Issues Scored across 5 Measures

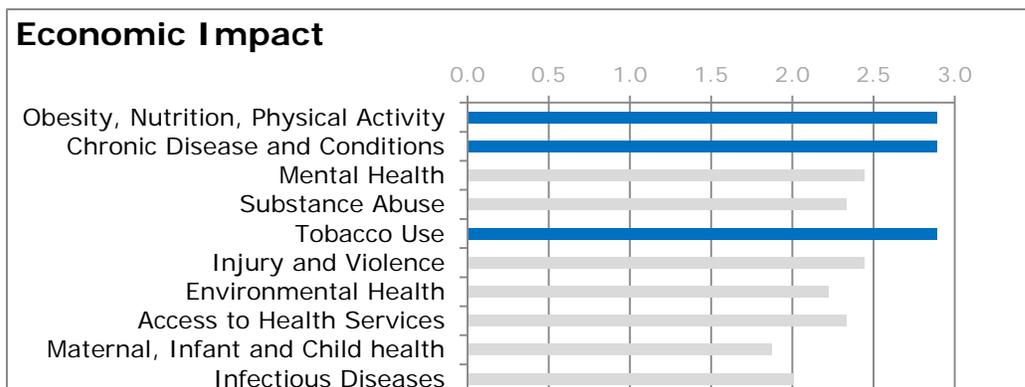
1. Portion of population at risk or affected: number and percentage of county residents directly impacted by this health problem. The highest-scoring health concerns in this category were Obesity, Chronic Diseases and Conditions, and Environmental Health.



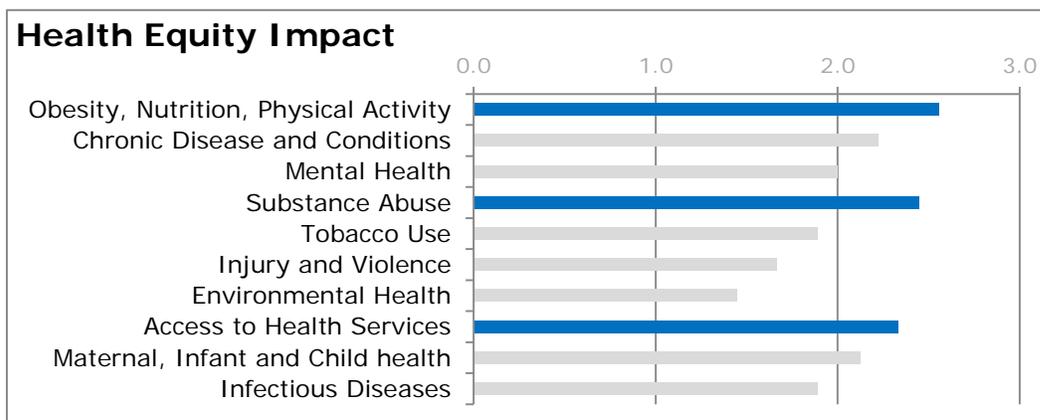
2. Quality of life impact: measure of health effects and hardship, including hospitalizations, death, long-/short-term disability, displacement from home, ability to participate in recreation.



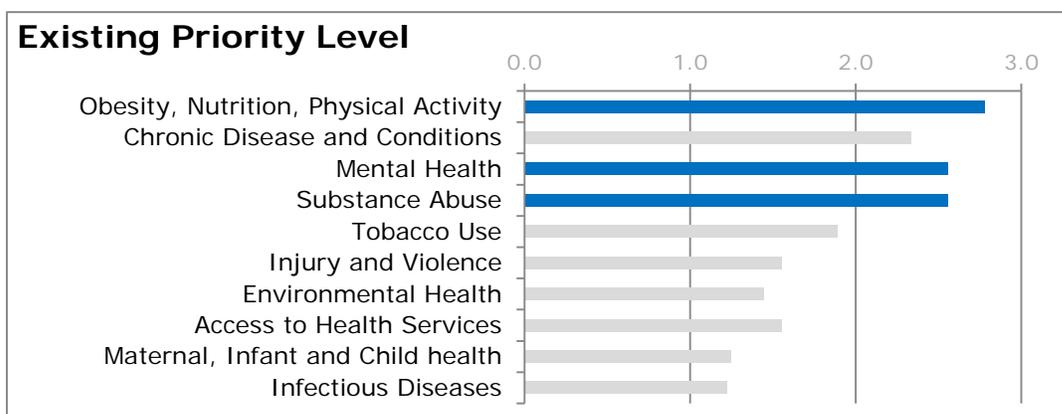
3. Economic impact: long- or short-term costs to the public and to families and individuals.



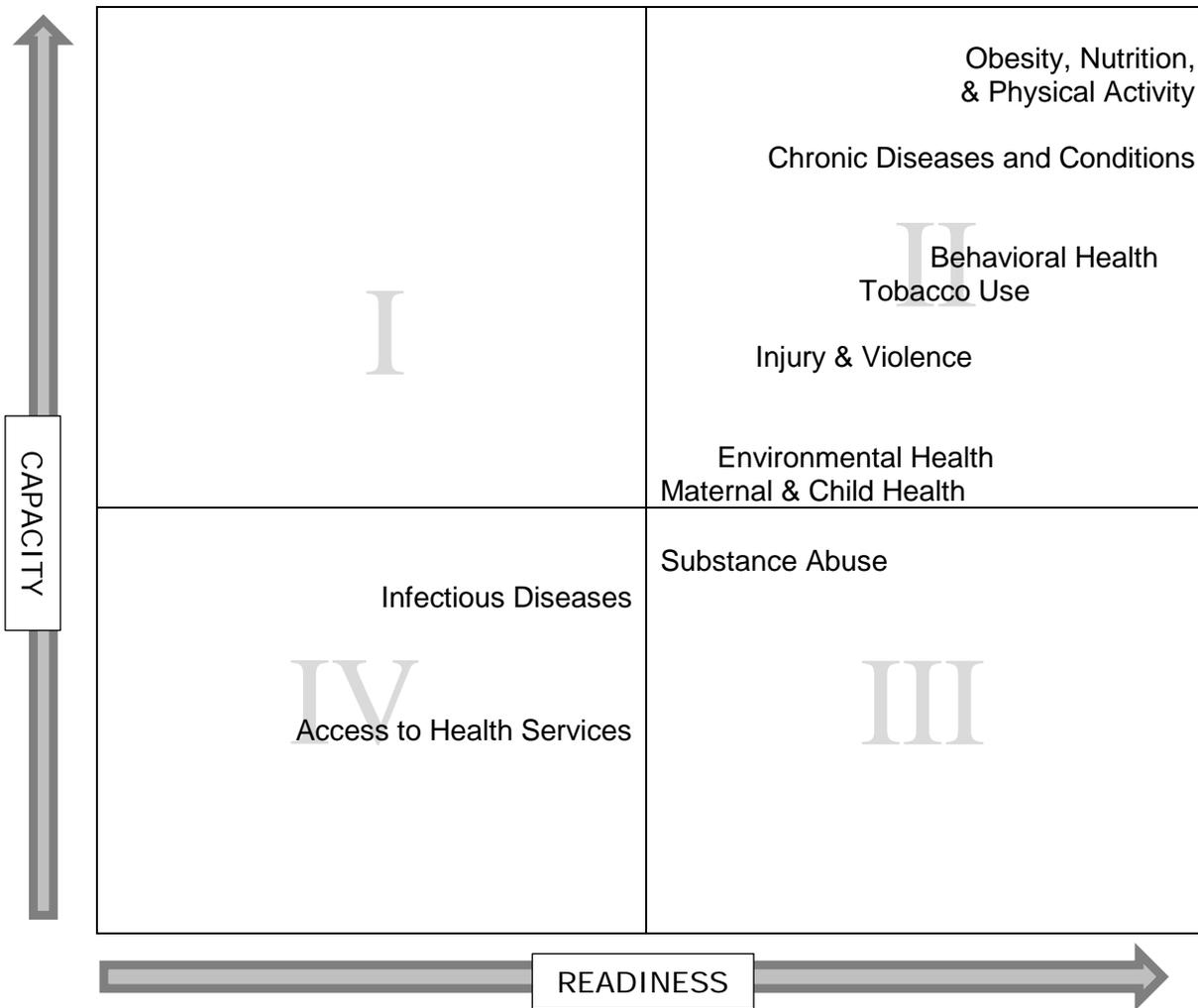
4. Health equity impact: measure of this health issue affecting different demographics or populations differently (children, elderly, people in poverty).



5. Existing priority level among stakeholders: measure of current priority level among county residents, community partners, and health providers.



Living Healthy in Washington County (LHWC) steering committee members completed a voting exercise to identify community capacity and readiness to address current health issues in Washington County.



Capacity: resources, people, strengths or momentum to make change
Readiness: interest from the community to act on the health topic

(I) **PROMOTE:** High capacity, low community readiness
 (II) **COLLABORATE:** High capacity, high community readiness
 (III) **DEVELOP:** Low capacity, high community readiness
 (IV) **EVALUATE:** Low capacity, low community readiness

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Appendix D: Community Assets and Resources

A community asset and resource exercise was conducted by LHWC on November 21, 2013. Assets included people, physical structures, relationships, and organizations. The group looked at strengths and gaps across all 10 health issues.

Strengths

Gaps

	Strengths	Gaps
Obesity	<ul style="list-style-type: none"> School food options Power-up YMCA- ways to wellness Insurance Health care- Gym memberships SHIP funding Walking/biking trails- parks CDC: obesity rate level/decrease Creative Initiatives- fresh green bucks Local Policies- Healthy Eating Farmer Markets- Community Gardens CSAs 	<ul style="list-style-type: none"> Food Costs – access Daycare- priority Physical Ed- in schools Health Care/School Challenging to change Lack of coverage for insurance members Trail connections Food Desserts/Lack of Access Density of fast food restaurants Lack of nutrition education in schools Food social norms hard to change: cultural emotional beliefs
Chronic Disease	<ul style="list-style-type: none"> Healthcare Providers- prevention focus Education Screenings ACA providing preventative care Relationship with tobacco, obesity, nutrition & P. A. This will remain on the radar of MN 	<ul style="list-style-type: none"> Cost (not covered by insurances) Underserved populations don't get early interventions access Health impacts of groundwater contamination Screening (access & cost)- e.g. colon cancer, dental, mammogram & prostate Awareness around chronic Disease/Education
Tobacco	<ul style="list-style-type: none"> SHIP work & continuation Overarching policies- Freedom to Breathe Continued downward trend- chew incl.? Taxing- Minnesota not afraid to tax Insurance benefit Primary care Physicians- Still part of practice Education with cessation 	<ul style="list-style-type: none"> E-Cigs: Health impact Smoking in cars Data on chewing tobacco trend up or down Cancer treatments? Education- healing from surgeries with tobacco use
Mental Health	<ul style="list-style-type: none"> Excellent Providers School Bullying Awareness Mental/Physical: Multi-apt. options in 1 bldg. Campaigns (Facebook etc.) Regionalization-crisis mental health Social workers On the RADAR for communities Visibility is increasing 	<ul style="list-style-type: none"> Wait time to access Limited skills by kids, staff in schools, etc. Low awareness Integrated county-wide strategy Stigma Affordability (Co-pays) Community Services for persistent mental illness School counselor-to-student ration is very low Lacking school MH services & personnel Lack of resources (financial)

Strengths

Gaps

	Strengths	Gaps
Substance use/abuse	<ul style="list-style-type: none"> School awareness- desire/willingness to be involved Chemical dependency providers Multi-option clinics RX drop-off programs Chemical Health Action Collaborative Local Coalitions 	<ul style="list-style-type: none"> Availability (access to youth/adult substances) Gap in funding (chemical Health Action Collaborative) Knowledge/access to services (stigma/fear) Possible force of Legalizing Marijuana
Access to Health Services	<ul style="list-style-type: none"> Excellent quality providers Availability- Minute clinics, urgency room and clinic @ OPH Walmart Availability of navigators to enroll in new insurance Clinics have multiple services: MNsure, child dental Affordable Care Act 	<ul style="list-style-type: none"> Transportation Multi-lingual access Cost/Insurance/Under-insured Dental Care & Affordability <ul style="list-style-type: none"> No adult dental No tax credits Lack of awareness of changes Info about where services are available
Injury and Violence	<ul style="list-style-type: none"> Excellent Medical Care Distracted Driving awareness is higher Washington County local on stranger to stranger violence School district interventions high on safety in South Washington, Stillwater & Forest Lake MSS says youth largely feels safe at school RX drug disposal resources 	<ul style="list-style-type: none"> Emergency Personnel arrival times in rural areas Higher rate of falls Transportation network is behind Addressing higher middle-aged veteran suicides
Environmental Health	<ul style="list-style-type: none"> Network of agencies- working on issues Quality of work being done focus on public health and environment There <i>is</i> funding MN commitment to protecting our natural environment 	<ul style="list-style-type: none"> Connecting environmental and public health Public awareness of environmental health issues in the county Gap between state and local coordination Radon public awareness Awareness indoor/outdoor air quality Farm policies and trends are leading to more surface and groundwater pollution > no mechanism to stop this currently
Maternal Child Health	<ul style="list-style-type: none"> Medicaid allows more access to care Breast feeding coalition options & resources for adoption and family planning Teen Pregnancy rate down ACE (Adverse childhood Experience) study 	<ul style="list-style-type: none"> Lack of knowledge of Medicaid access No dental care for non-pregnant women Room for improvement in breast feeding Access to affordable daycare Lack of knowledge for breast feeding coalition options and resources Discussion & Concern- Post-partum depression issues (rural areas) ACE study & action around it
Infectious Disease	<ul style="list-style-type: none"> MDH, CDC on top of it and monitoring trends Local partnership between county (public health), CDC, State & Schools Youth- sex ed./prevention of STD's in school health curriculum Vaccinations exist and available 	<ul style="list-style-type: none"> STD's (Chlamydia) in age 15-24 group Awareness of Emerging Tick-borne diseases Severity of long term consequences not well-known/recognized Rates higher than state/comparable Are new immigrants bringing new infectious diseases Anti-vaccination movement

Appendix E: Behavioral Health Partners



Influence & Reach:

Behavioral Health partners in Washington County

Collaborators

Community Thread
National Alliance on Mental Illness (NAMI)
St. Croix Valley Parish Nurses
Faith Based Health and Wellness Network
Southside Community Health Clinic
Lakeview Health
HealthEast Foundation
Fairview Lakes
Washington County Correctional Health
Washington County Community Corrections
Washington County Public Health and Environment
Canvas Health
Family Means
Chemical Health Action Collaborative - CONNECT
Stillwater Area Public Schools
School District 622
Century College
Forest Lake Area Partnership for Families (FLAPF)
Children's Mental Health Partnership
Youth Service Bureau

Collaborators' Network

Mental Health Collaborative
Chemical Health Action Collaborative - CONNECT
Local Mental Health Advisory Council (LAC)
Canvas Health
Youth Service Bureau
PowerUp
Family Means
Demand the Change
Sexual Violence Prevention Network - MNCASA
Children's Mental Health Collaborative
Sexual Assault Response Team
South Washington County Schools Partnership
Forest Lake Area Partnership for Families (FLAPF)
FLAPF Suicide Prevention Collaborative
MOST Forest Lake
Youth Intervention Program Association
Community Health Action Team (CHAT)
Suicide Prevention Collaborative (SPC)
Youth Matters (formerly YADP)
Mental Wellness Initiative
Teen Health Fund
Washington County Senior Workers
MN Association of Senior Services
Community Collaborative Group
Metrics
Mental Health Alliance
Canvas Health SED team

Adapted from Behavioral Health Workgroup input. 3 March 2014.

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Appendix F: Action and Evaluation Plans

The following section includes action and evaluation plans related to community health priorities identified in through the community health assessment process. SHIP goals were aligned with health issues; progress on each goal will be monitored and reported according to the indicated timeframe. Each table has the following components:

Community Health Priority: health priority determined through the community health assessment process

Goal: goal related to strategic health issue

Objective: what we are trying to achieve; includes relevant state and national lead indicators and targets

Target Population: the individuals, groups and/or organizations that the intervention is being developed for

Performance Measure: a measure of how well the strategy is working

Strategy: what partners will do to contribute to goals

Milestone: key indicators of progress

Partners: those who have a role to play in advancing the goal with the support of the Community Leadership Team

Timeframe: expected implementation period

Community Health Priority	OBESITY		
Goal	Increase healthy weight in adults		
Objective	Target Population	Performance Measure	
Increase the number of adults who are a healthy weight from 39% to 47% by 2020. <i>Health Indicator:</i> Obesity Rate (Potential sources: BRFSS, Minnesota Obesity Plan, Healthy People 2020, Metro SHAPE)	Seniors, low-income families, those receiving WIC or SNAP benefits, diverse groups who live in areas with limited access to health foods and poor transportation options	<ul style="list-style-type: none"> • # of corner store projects • # of food shelf redesigns • # of Fresh Green Buck\$ locations • # of healthy concession programs • # of attendees at healthy concession training • # of other community food projects implemented 	
Strategy	Milestones	Partners	Timeframe
1. <u>Healthy Food in the Community</u> Support ongoing and new partnerships and efforts to increase access to fruits and vegetables and decrease access to foods high in sodium, added sugar and saturated fat. Promote small scale food production and county-wide availability.	<ul style="list-style-type: none"> • Stakeholder team(s) formed • Establish partner project process • Review of current community nutrition data • Action plan, including a policy component, is written by stakeholder team 	Washington County Staff, Community Leadership Team, food shelves, grocery and convenience stores, Washington County and City Parks	April 2014 – October 2015

Community Health Priority	OBESITY		
Goal	Increase healthy weight in adults		
Objective	Target Population	Performance Measure	
Increase the number of adults who are a healthy weight from 39% to 47% by 2020. <i>Health Indicator: Obesity Rate</i> (Potential sources: BRFSS, Minnesota Obesity Plan, Healthy People 2020, Metro SHAPE)	Residents age 60 and over and the organizations that serve them	<ul style="list-style-type: none"> • # of assessments completed • # of action plans developed, including policy statement/% of action plans implemented • # of promotion activities conducted 	
Strategy	Milestones	Partners	Timeframe
1. <u>Active Living</u> Support policies and practices that create safe, active communities by increasing opportunities for walking and biking and access to community recreation facilities for all ages.	<ul style="list-style-type: none"> • Formation of Active Living Advisory Group (or use existing stakeholder group) • Review community comprehensive plans and CHA • Active Community action plan, including policy statement is finalized • Training provided to appropriate institutional decision-makers • Establish Partner Project Process • Strategic promotion activities conducted • Active Community action plan implemented • Efforts sustained 	Washington County Staff, Public Works Staff, Senior groups, Schools, Community Leadership Team, City and County planners	April 2014 – October 2015

Community Health Priority	OBESITY		
Goal	Increase healthy weight in adults		
Objective	Target Population	Performance Measure	
<p>Increase the number of adults who are a healthy weight from 39% to 47% by 2020.</p> <p><i>Health Indicator:</i> Obesity Rate (Potential sources: BRFSS, Minnesota Obesity Plan, Healthy People 2020, Metro SHAPE)</p>	<p>Worksite health partnership Washington County employers and employees</p>	<ul style="list-style-type: none"> • # of worksite partner projects • # of assessments completed • # of actions plans developed/% of action plans implemented • # of smoke-free campus policies implemented • # of cessation programs offered • # of worksites engaged • # of employees impacted by policy or action plan (Reach) 	
Strategy	Milestones	Partners	Timeframe
<p>2. <u>Worksite Wellness</u> Support the implementation of comprehensive employee wellness initiatives that encourage healthy lifestyle behaviors such as adequate physical activity, healthy eating, reduced tobacco use and exposure and support for nursing moms.</p>	<ul style="list-style-type: none"> • Worksite partner commitments secured • Wellness coalition convened – redesign of WHP • Implementation trainings conducted • Establish Partner Project Process • Baseline assessments completed • Worksite action plan, including a sustainability component, is completed • Training for institutional decision-makers is conducted • Action plan is implemented • Sustainability plan adopted • Efforts are sustained 	<p>Consultant, PHE staff, Community Leadership Team</p>	<p>May 2014 – September 2015</p>

Community Health Priority	OBESITY		
Goal	Increase healthy weight in adults		
Objective	Target Population	Performance Measure	
Increase the number of adults who are a healthy weight from 39% to 47% by 2020. <i>Health Indicator: Obesity Rate</i> (Potential sources: BRFSS, Minnesota Obesity Plan, Healthy People 2020, Metro SHAPE)	Adults at risk for chronic disease, who use and/or are exposed to tobacco, who are uninsured or on Medicare, Medicaid or MNCare, who are pregnant or breastfeeding women, adults over the age of 60	<ul style="list-style-type: none"> • # of completed assessments • # of action plans developed • # of protocols developed for referral to prevention resources • # of referrals to tobacco resources 	
Strategy	Milestones	Partners	Timeframe
3. <u>Clinical-Community Linkages</u> Develop relationships among health care providers and community organizations. Build partnerships to implement evidence based clinical chronic disease guidelines and referral systems, and increase access to lifestyle change, prevention or self-management programs.	<ul style="list-style-type: none"> • Relationships with partners established • Review existing assessments with partners and community stakeholders with regard to identifying and improving access • Identify gaps in community and clinic based programs at individual clinics through assessment, survey and/or inventory • Infrastructure development for access to community resources • Action plan created with partners • Training provided • Action plan implemented • Efforts sustained 	Healthcare Clinics, Physicians, Home Care, Health Care Homes, Hospitals, St. Croix Family Medical Clinic, Washington County Correctional Health, Woodbury YMCA, Community Leadership Team, community organizations, community education	April 2014 – October 2015

Community Health Priority	OBESITY		
Goal	Increase healthy eating in youth		
Objective	Target Population	Performance Measure	
<p>Increase in the prevalence of youth who eat the recommended number of fruits and vegetables daily from 21% to 30% by 2020.</p> <p><i>Health Indicator:</i> Obesity Rate (Potential sources: BRFSS, MSS, Minnesota Obesity Plan, Healthy People 2020, Metro SHAPE)</p>	<p>All five WC school districts and interested public, private, and charter schools in the county. An emphasis will be put on working with schools identified with higher rates for free and reduced lunch</p>	<ul style="list-style-type: none"> • # of SCHs formed • % of SCHs that conduct a needs assessment • % of SCHs with written action plan (including a policy statement) to address needs • # of schools that update and implement wellness policies 	
Strategy	Milestones	Partners	Timeframe
<p>1. <u>Healthy School Food</u> Partner with local school districts to implement nutrition initiatives such as breakfast promotion, healthy lunch and snacks, alternatives to classroom celebrations, incentives, fundraising, healthy concessions and vending, school gardens and Farm-To-School initiatives.</p>	<ul style="list-style-type: none"> • School Health Council (SHC) is formed • SHC conducts needs assessment • SHC has conducted a more specific/approved or standard school environmental assessment that includes nutrition environment • Existing school nutrition policies and practices have been reviewed • Action plan, including a policy component, is written • School staff, teachers and other community partners have received training • Action plan, including a policy component is presented to stakeholders and implemented • Efforts are sustained 	<p>Washington County Staff, Community Leadership Team</p>	<p>April 2014 – October 2015</p>

Community Health Priority	OBESITY		
Goal	Increase healthy eating in youth		
Objective	Target Population	Performance Measure	
Increase in the prevalence of youth who eat the recommended number of fruits and vegetables daily from 21% to 30% by 2020. <i>Health Indicator:</i> Obesity Rate (Potential sources: BRFSS, MSS, Minnesota Obesity Plan, Healthy People 2020, Metro SHAPE)	Licensed childcare providers, Early Childhood Family Education, Head Start, home child care providers	<ul style="list-style-type: none"> • # of providers and centers participating in assessment • # of nutrition, physical activity and breastfeeding trainings offered • # of participants in trainings • # of providers and centers that develop and adopt policies related to trainings 	
Strategy	Milestones	Partners	Timeframe
1. <u>Child Care</u> Provide training and resources to develop policies and practices to improve healthy eating, physical activity and support for breastfeeding moms in licensed childcare centers and pre-school settings.	<ul style="list-style-type: none"> • Meeting(s) conducted with child care providers, center directors, parents and other stakeholders • Dissemination plan for provider trainings created • Participating providers and centers recruited • More specific/approved or child care standard assessment of current food and nutrition, breastfeeding support and physical activity practices and policies • Action plan created for implementing practices • Trainings conducted by master trainers • Action plans are implemented • Policies in nutrition, breastfeeding support and physical activity adopted by providers or centers • Efforts are sustained 	Washington County staff, Community Leadership Team, WC Child Care Council, WC Community Services licensing staff, daycare centers and preschools, and Parent Aware Program staff, WC Breastfeeding Coalition	April 2014 – October 2015

Community Health Priority		OBESITY	
Goal		Increase active living in youth	
Objective	Target Population	Performance Measure	
<p>Increase the prevalence of youth meeting moderate physical activity guidelines from 74% of boys and 68% of girls to 92% of boys and 89% of girls by 2020.</p> <p><i>Health Indicator:</i> Obesity Rate (Potential sources: BRFSS, MSS, Minnesota Obesity Plan, Healthy People 2020, Metro SHAPE)</p>	<p>All five school districts, and interested public, private and charter schools in the county. An emphasis will be put on working with schools identified with higher rates for free and reduced lunch</p>	<ul style="list-style-type: none"> • # of SCHs formed • % of SCHs that conduct a needs assessment • % of SCHs with written action plan (including a policy statement) to address needs • # of schools that update and implement wellness policies • # of schools with SRTS programs • # of students that participate in SRTS programs or events 	
Strategy	Milestones	Partners	Timeframe
<p>1. Active School Day Partner with local districts to work toward policies and practices that create opportunities for physical activity throughout the school day such as: Safe Routes to School, enhanced physical education, active classrooms, and before or after school activity options.</p>	<ul style="list-style-type: none"> • School Health Council is formed • School Health Council has conducted an approved or standard school health assessment • Existing physical activity policies have been reviewed • Comprehensive school physical activity program inventory completed • School staff, teachers and other community partners have received training • Action plan including policy component is written, presented to stakeholders and implemented • Efforts are sustained 	<p>Schools Administrators, transportation, health and physical education teachers, before and after-school childcare staff, SHCs, city planners, city parks and recreation, LHWC CLT, Washington County Public Works, Washington County PHE</p>	<p>April 2014 – October 2015</p>

Community Health Priority		OBESITY	
Goal		Increase active living in youth	
Objective	Target Population	Performance Measure	
<p>Increase the prevalence of youth meeting moderate physical activity guidelines from 74% of boys and 68% of girls to 92% of boys and 89% of girls by 2020.</p> <p><i>Health Indicator:</i> Obesity Rate (Potential sources: BRFSS, MSS, Minnesota Obesity Plan, Healthy People 2020, Metro SHAPE)</p>	<p>Organizations that serve youth such as city planners and parks and recreation staff, county parks, YMCA, Youth Service Bureau, schools and the families or individuals that use their facilities</p>	<ul style="list-style-type: none"> • # of assessments completed • # of action plans developed, including policy statement/% of action plans implemented • # of promotion activities conducted 	
Strategy	Milestones	Partners	Timeframe
<p>2. <u>Active Living</u> Support policies and practices that create safe, active communities by increasing opportunities for walking and biking and access to community recreation facilities for all ages.</p>	<ul style="list-style-type: none"> • Formation of Active Living Advisory Group (or use existing groups) • Review CHA, comprehensive plans or other assessments • Active Community action plan, including policy statement is finalized • Training provided to appropriate institutional decision-makers • Establish Partner Project Process • Strategic promotion activities conducted • Active Community action plan implemented • Efforts sustained 	<p>PHE Staff, Public Works Staff, Senior groups, Schools, Community Leadership Team, City and County planners</p>	<p>April 2014 – October 2015</p>

Community Health Priority		OBESITY	
Goal		Increase active living in youth	
Objective	Target Population	Performance Measure	
<p>Increase the prevalence of youth meeting moderate physical activity guidelines from 74% of boys and 68% of girls to 92% of boys and 89% of girls by 2020.</p> <p><i>Health Indicator:</i> Obesity Rate (Potential sources: BRFSS, MSS, Minnesota Obesity Plan, Healthy People 2020)</p>	Licensed childcare providers, Early Childhood Family Education, Head Start, home child care providers	<ul style="list-style-type: none"> # of providers and centers participating 	
Strategy	Milestones	Partners	Timeframe
<p>3. <u>Child Care</u> Provide training and resources to develop policies and practices to improve healthy eating, physical activity and support for breastfeeding moms in licensed childcare centers and pre-school settings.</p>	<ul style="list-style-type: none"> Meeting(s) conducted with child care providers, center directors, parents and other stakeholders Dissemination plan for provider trainings created Participating providers and centers recruited More specific/approved child care standard assessment of current food and nutrition, breastfeeding support and physical activity practices and policies Action plan created for implementing practices Trainings conducted Action plans are implemented Policies in nutrition, breastfeeding support and physical activity adopted by providers or centers Efforts are sustained 	Washington County staff, Community Leadership Team, WC Child Care Council, WC Community Services licensing staff, daycare centers and preschools, and Parent Aware Program staff, WC Breastfeeding Coalition	April 2014 – October 2015

Community Health Priority		OBESITY	
Goal		Increase active living in youth	
Objective	Target Population	Performance Measure	
<p>Increase the prevalence of youth meeting moderate physical activity guidelines from 74% of boys and 68% of girls to 92% of boys and 89% of girls by 2020.</p> <p><i>Health Indicator:</i> Obesity Rate (Potential sources: BRFSS, MSS, Minnesota Obesity Plan, Healthy People 2020)</p>	<p>Youth at risk for chronic disease, who use and/or are exposed to tobacco, who are uninsured or on Medicare, Medicaid or MNCare, or pregnant</p>	<ul style="list-style-type: none"> • # of completed assessments • # of action plans developed • # of protocols developed for referral to prevention resources • # of referrals to tobacco resources 	
Strategy	Milestones	Partners	Timeframe
<p>4. <u>Clinical-Community Linkages</u> Develop relationships among health care providers and community organizations. Build partnerships to implement evidence based clinical chronic disease guidelines and referral systems, and increase access to lifestyle change, prevention or self-management programs.</p>	<ul style="list-style-type: none"> • Relationships with partners established • Assessment or review of existing data done with partners and community stakeholders with regard to identifying and improving access • Identify gaps in community and clinic based programs at individual clinics through inventory or survey • Infrastructure development for access to community resources • Action plan created with partners • Training provided • Action plan implemented • Efforts sustained 	<p>Healthcare Clinics, Hospitals, Physicians, Home Care, St. Croix Family Medical Clinic, Washington County Correctional Health, Woodbury YMCA, CLT</p>	<p>April 2014 – October 2015</p>

Community Health Priority	CHRONIC DISEASE		
Goal	Decrease tobacco use and exposure in all ages		
Objective	Target Population	Performance Measure	
<p>Decrease in 12th graders under 18 years old who smoke from 17% to 12% by 2020.</p> <p><i>Health Indicator:</i> Smoking rate (Potential Sources: Minnesota Student Survey)</p>	Tobacco vendors, law enforcement, city administration and clerks, individuals and community organizations	<ul style="list-style-type: none"> • # of compliance checks completed by the city and county law enforcement • # of vendors who sold to underage youth • Identified police departments participating in compliance officer education meetings/trainings • # of vendors licensed to sell tobacco and nicotine delivery products • # of management and clerks participating in county-sponsored vendor trainings • #/list of cities who updated their tobacco ordinance • #/list of schools with a smoke-free campus policy 	
Strategy	Milestones	Partners	Timeframe
<p>1. <u>Other Tobacco Work</u> Develop relationships with tobacco vendors and clerks, high school and college health services staff and administrators, law enforcement, and city and county administration. Build partnerships to promote new tobacco policies and offer resources for, education, cessation, compliance, and enforcement.</p>	<ul style="list-style-type: none"> • Compliance checks documented • Vendor trainings for owners/managers and clerks • Tobacco ordinance review and revisions for cities and county • Law enforcement education on youth access and enforcement • City administration partnerships for enforcement and education • High School/College campuses with no tobacco use policy 	<p>American Lung Association, American Cancer Society, City and County, Law Enforcement, Fire Departments MN Department of Health MN Department of Alcohol and Gambling Enforcement</p>	<p>April 2014 – October 2015</p>

Community Health Priority	CHRONIC DISEASE		
Goal	Decrease tobacco use and exposure in all ages		
Objective	Target Population	Performance Measure	
Decrease in young adults (18-24) who smoke from 27.8% to 18.6% by 2020. <i>Health Indicator:</i> Smoking rate (Potential sources: BRFSS, Metro SHAPE, Healthy MN 2020, Healthy People 2020)	Healthcare clinics, Physicians, Home Care, Health Care Home Staff, patients at risk for chronic disease, patients who use and/or are exposed to tobacco, patients who are uninsured or on Medicare, Medicaid or MNCare, Pregnant or breastfeeding women, adults over the age of 60	<ul style="list-style-type: none"> • # of completed assessments • # of action plans developed • # of protocols developed for referral to prevention resources • # of referrals to tobacco cessation resources 	
Strategy	Milestones	Partners	Timeframe
1. <u>Clinical-Community Linkages</u> Develop relationships among health care providers and community leaders. Build partnerships, conduct assessments for implementation of evidence based clinical chronic disease guidelines and referral systems, and increase access to evidence based lifestyle change, prevention or self-management programs.	<ul style="list-style-type: none"> • Relationships with partners established • Assessment done with partners and community stakeholders with regard to identifying and improving access • Identify gaps in community and clinic based programs at individual clinics through assessment • Infrastructure development for access to community resources • Action plan created with partners • Training provided • Action plan implemented • Efforts sustained 	Healthcare Clinics, Hospitals, St. Croix Family Medical Clinic, Washington County Correctional Health, Woodbury YMCA, Community Leadership Team	April 2014 – October 2015

Community Health Priority	CHRONIC DISEASE		
Goal	Decrease tobacco use and exposure in all ages		
Objective	Target Population	Performance Measure	
<p>Decrease in young adults (18-24) who smoke from 27.8% to 18.6% by 2020.</p> <p><i>Health Indicator:</i> Smoking rate (Potential sources: BRFSS, Metro SHAPE, Healthy MN 2020, Healthy People 2020)</p>	<p>Tobacco vendors, law enforcement, city administration and clerks, individuals and community organizations.</p>	<ul style="list-style-type: none"> • # of compliance checks completed by the city and county law enforcement • # of vendors who sold to underage youth • Identified police departments participating in compliance officer education meetings/trainings • # of vendors licensed to sell tobacco and nicotine delivery products • # of management and clerks participating in county-sponsored vendor trainings • #/list of cities who updated their tobacco ordinance • #/list of schools with a smoke-free campus policy 	
Strategy	Milestones	Partners	Timeframe
<p>2. <u>Other Tobacco Work</u> Develop relationships with tobacco vendors and clerks, high school and college health services staff and administrators, law enforcement, and city and county administration. Build partnerships to promote new tobacco policies and offer resources for, education, cessation, compliance, and enforcement.</p>	<ul style="list-style-type: none"> • Compliance checks documented • Vendor trainings for owners/managers and clerks • Tobacco ordinance review and revisions for cities and county • Law enforcement education on youth access and enforcement • City administration partnerships for enforcement and education • High School/College campuses with no tobacco use policy 	<p>American Lung Association, American Cancer Society, City and County, Law Enforcement, Fire Departments MN Department of Health MN Department of Alcohol and Gambling Enforcement</p>	<p>April 2014 – October 2015</p>

Community Health Priority		CHRONIC DISEASE	
Goal		Decrease tobacco use and exposure in all ages	
Objective	Target Population	Performance Measure	
<p>Decrease secondhand smoke exposure of renters living in multiunit housing from 30% to 20% by 2020.</p> <p><i>Health Indicator:</i> Smoking rate (Potential Sources: Metro Area Survey of Apartment Renters)</p>	<p>Multi-unit housing owners and managers, tenants, Housing Redevelopment Authority, senior housing, foster care providers, treatment homes and other affordable housing, Community Services and PHE staff who conduct home visits.</p>	<ul style="list-style-type: none"> • # of multi-unit housing owners/managers instituting a new smoke-free policy (Target: 1) • # of affordable housing owners/managers offering education and cessation resources to residents (Target: 1) • # of housing owners/managers that complete housing assessments 	
Strategy	Milestones	Partners	Timeframe
<p>1. <u>Smoke-Free Housing</u> Provide technical assistance to support multi-unit housing owners interested in working on ways to decrease tobacco use and exposure through cessation resources, environmental supports, and practices within their facilities.</p>	<ul style="list-style-type: none"> • Community Housing Assessment Complete • Identify tobacco-related disparities in community • Determine housing targets/priorities • Assess landlord knowledge, readiness, and opinions • Communication with stakeholders • Develop landlord and community outreach plan • Survey tenants tobacco use, knowledge, readiness, and opinions (<u>before and after</u> policy implementation) • Implement outreach plan for policy and practices review and revision • Efforts monitored and sustained 	<p>Washington County PHE Staff, American Lung Association, American Cancer Society, Minnesota Department of Health, LHWC Community Leadership Team</p>	<p>April 2014 – October 2015</p>

Community Health Priority	CHRONIC DISEASE		
Goal	Decrease tobacco use and exposure in all ages		
Objective	Target Population	Performance Measure	
Increase the percent of worksites with tobacco free grounds policies in place from 37% in 2012 to 45% in 2020. <i>Health Indicator:</i> Smoking rate (Potential Sources: Minnesota Worksite Wellness Survey)	Worksite health partnership Washington County employers and employees	<ul style="list-style-type: none"> • # of partner projects • # of assessments completed • # of actions plans developed/% of action plans implemented • # of smoke-free campus policies implemented • # of cessation programs offered • # of worksites engaged • # of employees impacted by policy or action plan (reach) 	
Strategy	Milestones	Partners	Timeframe
1. <u>Worksite Wellness</u> Support the implementation of comprehensive employee wellness initiatives that encourage healthy lifestyle behaviors such as reducing tobacco use and exposure.	<ul style="list-style-type: none"> • Worksite partner commitments secured • Wellness coalition convened • Implementation trainings conducted • Partner Project Process established • Baseline assessments completed • Worksite action plan, including a sustainability component, is completed and adopted 	Consultant, Washington County staff, Community Leadership Team, Chambers of Commerce, Rotary Clubs	April 2014 – October 2015

Community Health Priority		BEHAVIORIAL HEALTH	
Goal		Increase access to health services for people facing behavioral health issues	
Objective	Target Population	Performance Measure	
<p>Reduce Washington County suicide rate to from 10.2 per 100,000 to 9.2 per 100,000 by 2020</p> <p>Reduce hospitalization rate for mental health disorders from 7.4 per 1,000 to 6.7 per 1,000 by 2020</p> <p>Establish a baseline to measure the portion of adults who wanted behavioral health help during the past year but did not get it</p> <p>Establish a baseline to measure the portion of adults exceeding a self-reported past 30 days poor mental health threshold</p> <p>Establish a baseline to measure the portion of drug offenders who re-enter the criminal corrections system and reduce 10 percent by 2020</p> <p><i>Health Indicator:</i> Suicide rate, hospitalization rate (Potential Sources: Minnesota Hospital Association, MDH County Health Tables, MDH Center for Health Statistics)</p>	Adults and youth facing behavioral health problems	<ul style="list-style-type: none"> • # of county program clients receiving behavioral health resource information staff contact person • # offenders returning to jail within 3 months of release • # of county staff trained on processing and referring protocols • # of county programs adopting a resource sharing and referral policy 	
Strategy	Milestones	Partners	Timeframe
<p>1. <u>Coordinate Cross-Departmental Services</u> Coordinate continuity of county services influencing behavioral health. Develop a united front internally to county operations to improve common messaging, referral, and access to county services. Develop processes for connecting consumers with resources for reclaiming health. Secure leadership support to sustain.</p>	<ul style="list-style-type: none"> • Behavioral Health Coordination Council is formed • Council members have provided "orientation" summary to each other regarding existing programs and services • Council has conducted a needs assessment • Comprehensive resource inventory completed • County staff from participating programs have been identified and have received training on resource/referral/messaging • Action plan including department policy component is written, presented to stakeholders and implemented • Efforts are sustained 	Washington County: Public Health & Environment, Community Corrections, Community Services, Sheriff's Office, Correctional Health	May 2014 – December 2015

Community Health Priority	BEHAVIORIAL HEALTH		
Goal	Increase access to health services for people facing behavioral health issues		
Objective	Target Population	Performance Measure	
<p>Reduce Washington County suicide rate to from 10.2 per 100,000 to 9.2 per 100,000 by 2020</p> <p>Reduce hospitalization rate for mental health disorders from 7.4 per 1,000 to 6.7 per 1,000 by 2020</p> <p>Establish a baseline to measure the portion of adults who wanted behavioral health help during the past year but did not get it</p> <p>Establish a baseline to measure the portion of adults exceeding a self-reported past 30 days poor mental health threshold</p> <p>Establish a baseline to measure the portion of drug offenders who re-enter the criminal corrections system and reduce 10 percent by 2020</p> <p><i>Health Indicator:</i> Suicide rate, hospitalization rate (Potential Sources: Minnesota Hospital Association, MDH County Health Tables, MDH Center for Health Statistics)</p>	Adults and youth facing behavioral health problems	<ul style="list-style-type: none"> • # of community organizations/agencies committed to participating • # of existing coalitions participating • # of participating agencies/groups that conduct a shared assessment • # of participating agencies/groups that adopt changes as a result of assessment • # of participating agencies/groups that engage shared work with at least one other partner 	
Strategy	Milestones	Partners	Timeframe
<p>2. <u>Rethink the Collaborative “Landscape”</u> Implement a series of conversations among existing partnerships and collaboratives in the county to assess capacity and opportunity for shared work. Complete an environmental scan of programs, services, and initiatives in the county. Determine shared messaging to promote awareness of the inventory.</p>	<ul style="list-style-type: none"> • Relationships with partners established • Assessment done with partners and community stakeholders with regard to identifying and improving awareness of issues and services • Opportunities for collective and agency-level change are identified • Changes are adopted at agency/coalition level • Opportunities for shared work are identified • 2 or more participating members engage shared work • Efforts sustained 	<p>Washington County: PHE, Community Corrections, Community Services; CONNECT Chemical Health Action Collaborative, Lakeview Health, St. Croix Valley Parish Nurses, Canvas Health, Youth Service Bureau, National Alliance on Mental Health Issues (NAMI) Washington County Chapter</p>	<p>April 2014-December 2016</p>

Community Health Priority	BEHAVIORAL HEALTH		
Goal	Increase access to health services for people facing behavioral health issues		
Objective	Target Population	Performance Measure	
<p>Reduce Washington County suicide rate to from 10.2 per 100,000 to 9.2 per 100,000 by 2020</p> <p>Reduce hospitalization rate for mental health disorders from 7.4 per 1,000 to 6.7 per 1,000 by 2020</p> <p>Establish a baseline to measure the portion of adults who wanted behavioral health help during the past year but did not get it</p> <p>Establish a baseline to measure the portion of adults exceeding a self-reported past 30 days poor mental health threshold</p> <p>Establish a baseline to measure the portion of drug offenders who re-enter the criminal corrections system and reduce 10 percent by 2020</p> <p><i>Health Indicator:</i> Suicide rate, hospitalization rate (Potential Sources: Minnesota Hospital Association, MDH County Health Tables, MDH Center for Health Statistics)</p>	Adults and youth facing behavioral health problems	<ul style="list-style-type: none"> • # of community organizations/agencies who contribute to the communication plan • # of existing coalitions that contribute to the communication plan • # of participating agencies/groups that adopt a shared communication plan 	
Strategy	Milestones	Partners	Timeframe
<p>3. <u>Establish a Shared Communication Plan</u> Develop common messages around behavioral health issues in order to close gaps in awareness and improve access to services. All members adopt and implement the plan.</p>	<ul style="list-style-type: none"> • Relationships with partners established • Assessment done with partners and community stakeholders with regard to identifying and improving awareness of issues and services • Communication plan developed with partners • Training provided • Communication plan implemented • Efforts sustained 	Washington County: PHE, Community Corrections, Community Services; CONNECT Chemical Health Action Collaborative, Lakeview Health, St. Croix Valley Parish Nurses, Canvas Health, Youth Service Bureau, National Alliance on Mental Health Issues (NAMI) Washington County Chapter	April 2014-December 2016

Community Health Priority	BEHAVIORAL HEALTH		
Goal	Increase access to health services for people facing behavioral health issues		
Objective	Target Population	Performance Measure	
<p>Reduce Washington County suicide rate to from 10.2 per 100,000 to 9.2 per 100,000 by 2020</p> <p>Reduce hospitalization rate for mental health disorders from 7.4 per 1,000 to 6.7 per 1,000 by 2020</p> <p>Establish a baseline to measure the portion of adults who wanted behavioral health help during the past year but did not get it</p> <p>Establish a baseline to measure the portion of adults exceeding a self-reported past 30 days poor mental health threshold</p> <p><i>Health Indicator:</i> Suicide rate, hospitalization rate. (Potential Sources: Minnesota Hospital Association, MetroSHAPE survey)</p>	Adults and youth facing behavioral health problems	<ul style="list-style-type: none"> • # of providers providing input • # of discussions or presentations with partners to explore opportunities for evidence-based clinical practice • # of participating agencies/groups that adopt a shared communication plan 	
Strategy	Milestones	Partners	Timeframe
<p>4. <u>Strengthen Clinical-Community Linkages</u> Strengthen relationships among health care providers and community organizations. Build partnerships to support evidence-based clinical behavioral health practices and referral systems, and increase access to lifestyle change, prevention or self-management programs.</p>	<ul style="list-style-type: none"> • Relationships with partners established • Assessment done with partners and community stakeholders with regard to identifying and improving awareness of issues and services • Communication plan developed with partners • Training provided • Communication plan implemented • Efforts sustained 	Washington County PHE, Lakeview Health, Canvas Health, Youth Service Bureau	April 2014-December 2016

Community Health Priority	BEHAVIORAL HEALTH		
Goal	Reduce stigma related to behavioral health issues		
Objective	Target Population	Performance Measure	
<p>Reduce past year suicide attempts among 9th grade students from 4 percent to 3.8 percent by 2020</p> <p>Increase the portion of youth who experience social and emotional support from adults at school from 42 percent to 45 percent by 2020</p> <p>Reduce the portion of adults who experience inadequate social support from 12 percent to 10.8 percent by 2020</p> <p><i>Health Indicator:</i> Suicide rate, hosp. rate (Potential Sources: MN Hospital Association, MDH County Health Tables, MDH Center for Health Statistics, MetroSHAPE survey)</p>	County residents, policy makers, providers, law enforcement	<ul style="list-style-type: none"> • # of community organizations/agencies committed to participating • # of existing coalitions participating • # of participating agencies/groups that conduct a shared assessment • # of participating agencies/groups that adopt changes as a result of assessment • # of participating agencies/groups that engage shared work with at least one other partner 	
Strategy	Milestones	Partners	Timeframe
<p>1. <u>Rethink the Collaborative “Landscape”</u> Implement a series of conversations among existing partnerships and collaboratives in the county to assess capacity and opportunity for shared work. Complete an environmental scan of programs, services, and initiatives in the county. Determine shared messaging to promote awareness of the inventory.</p>	<ul style="list-style-type: none"> • Relationships established • Meeting and communication schedule established • Assessment done with partners and community stakeholders to identify and improve community awareness of behavioral health and tools to reduce stigma • Opportunities for collective and agency-level adoption of tools are identified • Tools adopted at appropriate level • Opportunities for measuring stigma reduction at a county or community level are identified 	<p>Wash. Co.: PHE, Comm. Corrections, Comm. Services; CONNECT Chemical Health Action Collaborative, Lakeview Health, St. Croix Valley Parish Nurses, Canvas Health, Youth Srvc. Bureau, NAMI</p>	<p>April 2014-December 2016</p>

Community Health Priority	BEHAVIORAL HEALTH		
Goal	Reduce stigma related to behavioral health issues		
Objective	Target Population	Performance Measure	
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Strategy	Milestones	Partners	Timeframe
<p>2. <u>Establish a Shared Communication Plan</u> Develop common messages around behavioral health issues in order to close gaps in awareness and improve access to services. All members adopt and implement the plan.</p>	<ul style="list-style-type: none"> • Relationships with partners established • Assessment done with partners and community stakeholders with regard to identifying and improving awareness of issues and services • Comm. plan developed with partners • Training provided • Communication plan implemented • Efforts sustained 	Wash. Co.: PHE, Comm. Corrections, Comm. Services; CONNECT Chemical Health Action Collaborative, Lakeview Health, St. Croix Valley Parish Nurses, Canvas Health, Youth Svc. Bureau, NAMI	April 2014-December 2016

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Strategy	Milestones	Partners	Timeframe
<p>3. <u>Strengthen Clinical-Community Linkages</u> Strengthen relationships among health care providers and community organizations. Build partnerships to support evidence-based clinical behavioral health practices and referral systems, and increase access to lifestyle change, prevention or self-management programs.</p>	<ul style="list-style-type: none"> • Relationships with partners established • Assessment done with partners and community stakeholders with regard to identifying and improving awareness of issues and services • Communication plan developed with partners • Training provided • Communication plan implemented • Efforts sustained 	Washington County Public Health & Environment, Lakeview Health, Canvas Health, Youth Service Bureau	April 2014-December 2016

Community Health Priority	BEHAVIORAL HEALTH		
Goal	Increase social and emotional wellbeing		
Objective	Target Population	Performance Measure	
<p>Establish a baseline for past month community involvement among adults (2014 MetroSHAPE) and increase 5 percent by 2020</p> <p>Increase the portion of youth who experience social and emotional support from adults at school from 42 percent to 45 percent by 2020</p> <p>Reduce past month poor mental health days among adults from 2.3 to 2.1 by 2020</p> <p><i>Health Indicator:</i> community involvement, social/emotional support, poor mental health (Potential Sources: MDH County Health Tables, MDH Center for Health Statistics, MetroSHAPE survey)</p>	School-aged youth	TBD	
Strategy	Milestones	Partners	Timeframe
<p>1. <u>Integrate Behavioral Health into School Wellness Programs</u> Strengthen relationships between behavioral health staff and new School Health Councils (SHC) formed to address priorities #1 and #2.</p>	<ul style="list-style-type: none"> • Feasibility discussions are facilitated with school personnel • Wellbeing data presented to school staff and partners who work with youth • Gap assessment completed contingent upon partner commitments to proceed 	Schools Administrators, before and after-school childcare staff, SHCs, Washington County PHE	April 2014-December 2016

Community Health Priority	BEHAVIORAL HEALTH		
Goal	Increase social and emotional wellbeing		
Objective	Target Population	Performance Measure	
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Strategy	Milestones	Partners	Timeframe
<p>2. <u>Establish a shared communication plan</u> Develop common messages around behavioral health issues that explore “upstream” way to increase capacity for resilience for individuals, neighborhoods, communities. Promote community awareness that connectedness and social support makes everyone better off.</p>	<ul style="list-style-type: none"> • Relationships with partners established • Assessment done with partners and community stakeholders with regard to identifying and improving awareness of issues and services • Comm. plan developed with partners • Training provided • Communication plan implemented • Efforts sustained 	<p>Washington County: PHE, Community Corrections, Community Services; CONNECT Chemical Health Action Collaborative, Lakeview Health, St. Croix Valley Parish Nurses, Canvas Health, Youth Service Bureau, NAMI</p>	<p>April 2014-December 2016</p>

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Strategy	Milestones	Partners	Timeframe
<p>3. <u>Explore ways to strengthen social support and involvement among adults</u> Begin discussions among community partners about how to measure and improve social support and community involvement among adults. Make decisions about how to assess these data and who is willing to get involved in the process. This strategy may involve assessment, strategic planning, and further narrowing of target populations.</p>	<ul style="list-style-type: none"> • Feasibility discussions are facilitated with community partners • Wellbeing data presented to partners • Gap assessment completed contingent upon partner commitments to proceed 	Washington County Public Health & Environment, Lakeview Health, Canvas Health, Youth Service Bureau	April 2014-December 2016