

# Partnership 4 Health Community Health Board

**Community Health Improvement Plan**  
Becker, Clay, Otter Tail, Wilkin Counties

**2015-2019**

## Executive Summary

Beginning in 2011, the four counties of Becker, Clay, Otter Tail and Wilkin began meeting to pursue a joint Community Health Board. The Public Health Directors reviewed and compared programs and services to determine efficiencies in merging as a CHB. The Directors then invited local officials to join planning and discussion on forming a multi county CHB. The committee was comprised of a commissioner from each county and county administrators and a lay person from each county. Each county board passed resolutions to form Partnership4Health Community Health Board. The timing of this new CHB coincides with the new Community Health Assessment and Improvement Plan, Strategic Plan, Quality Improvement cycle due in 2015. These requirements were divided between the four Directors for completion.

The Community Health Improvement Plan (CHIP) is a long-term systematic effort to address health problems on the basis of the Community Health Assessment Activities and a Community Health improvement process. This plan is used by health and other governmental education and human service agencies in collaboration with community partners to set priorities, coordinate and target resources. A CHIP is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community. It should be done in a timely way as part of Minnesota's Local Public Health Assessment and Planning Process. Every Minnesota CHB must submit its CHIP to MDH by March 31, 2015. The timeline for the CHIP is 2015 – 2019. The process is outlined as organize, review priority issues, formulate goals, strategies, roles and implement and evaluate the CHIP. The CHIP provides guidance to the health department and partners and stakeholders on improving the health of the population within the local jurisdictions. The CHIP should be regarded as a working document during the reporting cycle.

The Partnership4Health communities of Becker, Clay, Otter Tail and Wilkin met with local stakeholders and hospitals to complete a Community Health Needs Assessment to identify top health priorities. The counties also utilized an online survey developed by Sanford Health Systems. In addition, Otter Tail County used the MAPP process to capture additional information through focus groups.

The four counties then contracted with the Center For Small Towns through the University of Minnesota, Morris to compile the data for the Community Health Assessment for the forming Partnership4Health CHB. This document can be referenced on each county's website.

This report gives a brief summary of each county's assessment information and partnerships and then identifies the common priority issues for the Partnership4Health CHB.

**Process used to complete planning**

One county utilized the Mobilizing for Action through Planning and Partnerships (MAPP) process for their planning. The other counties designed their own process.



County	Community Stakeholders Involved	Top Issues and Themes Identified
Becker	Becker County Community Health, Sanford Clinics, Essentia Hospital/Clinic, Detroit Lakes Community and Cultural Center, U of M Extension Service, Mahube-Otwa Community Action Council, school officials, public health staff	<ul style="list-style-type: none"> <li>*Obesity, Physical inactivity, and poor nutrition as risk factors for chronic disease.</li> <li>*Access to enhances health care</li> <li>*Tobacco use primary prevention/cessation</li> </ul>
Clay	Clay County Public Health, Sanford Health, Essentia Health, United Way of Cass-Clay, Dakota Medical Foundation, North Dakota State University, Fargo Cass Public Health, Family HealthCare Center, Urban Indian Health and Wellness Center, Center for Rural Health at UND, Southeast Human Services Center, two mayors, five county commissioners.	<ul style="list-style-type: none"> <li>* cost of health insurance, healthcare and prescription drugs;</li> <li>*physical and mental health including obesity, poor nutrition, eating habits and inactivity or lack of exercise;</li> <li>*cancer and chronic disease. *Other concerns were the aging population, safety issues in the community and children and youth (childcare, bullying issues, etc.)</li> </ul>
Otter Tail	Lake Region Healthcare Hospital/Clinic, Perham Health hospital/clinic, Otter Tail Family Services Collaborative involving 8 schools, mental health, United Way, County Attorney, Probation, Human Services, five County Commissioners, Special Education Cooperative’s, Lakes Country Service Cooperative, Mahube-Otwa Community Action Council; Emergency Preparedness Advisory Committee involving funeral director, law enforcement, ambulance service, city administrator, highway department, emergency management; Senior Services Network involving nursing home, foster care, assisted living, and home care providers; customers of public health and human services; employees of many of the agencies listed above.	<ul style="list-style-type: none"> <li>*Chronic health conditions</li> <li>*Lifestyle behaviors related to nutrition, physical activity, and tobacco use</li> <li>*Adverse childhood experiences</li> <li>*Fragmented mental health services</li> <li>*Access to specialized health services.</li> </ul>
Wilkin	Wilkin County Public Health, St. Francis Medical Center, Essentia HealthCare, Sanford Health Care, North Dakota State College of Science and Richland County Public Health.	<ul style="list-style-type: none"> <li>*Obesity:</li> <li>* Nutrition and Physical Activity;</li> <li>* Substance Abuse</li> <li>*Mental Health</li> <li>*Cancer</li> </ul>

**Prioritization process**

Healthy People 2020 provides a comprehensive set of 10-year, national goals and objectives for improving the health of all Americans. Healthy People 2020 contains 42 topic areas with over 1,200 objectives. A smaller set of Healthy People 2020 objectives, called Leading Health Indicators, has been selected to communicate high-priority health issues and actions that can be taken to address them.<sup>1</sup>

The issues and themes identified from community conversations, focus groups, key informant interviews, and multiple surveys were mapped to the Healthy People 2020 Leading Health Indicators. In addition local health indicators were added to the list to be examined. Mapping the issues allowed the P4HCHB to identify issues in common across all four counties.

County Health Rankings were examined and compared across the four counties of the CHB. The findings from the community assessment and community input aligned with priority areas in the County Health Rankings.

The Community Health Status Indicators published by the Centers for Disease Control provides a graphic depiction of factors that impact health. Ratings are based upon the scale of better, moderate, or worse than counties of similar size.

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<sup>1</sup> [Healthy People.gov/2020/leading health indicators](https://www.healthypeople.gov/2020/leading-health-indicators)




2020 Leading Health Indicators	Community Assessment Priorities									
	Partnership4 Health CHB	Becker County	Clay County	Otter Tail County	Wilkin County	Essentia Becker	Sanford Clay	Lake Region Healthcare Otter Tail	Perham Memorial Otter Tail	St Francis Wilkin
<b><i>Access to Health Services</i></b>										
Persons with Medical Insurance										
Persons with a primary care provider										
<b><i>Clinical Preventive Services</i></b>										
Colorectal cancer Screening										
Blood pressure controlled										
A1c value greater than 9%										
Children with recommended doses of vaccine										
<b><i>Environmental Quality</i></b>										
Air Quality Index										
Children exposed to secondhand smoke										
<b><i>Injury and Violence</i></b>										
Fatal Injuries (seatbelts and car safety)	Xxx	Xxx	Xxx	Xxx					xxx	
Homicides										
<b><i>Maternal, infant and Child Health</i></b>										
Infant deaths										
Preterm births										
<b><i>Mental Health</i></b>	Xxx	Xxx	Xxx	xxx			xxx		xxx	
Suicides										
Adolescents with major depressive episodes										
<b><i>Nutrition, Physical Activity, and Obesity</i></b>	xxx	xxx	xxx	xxx		xxx		xxx		
Meeting Physical Activity Guidelines	xxx	xxx	xxx	xxx						xxx
Obesity rates of adults	xxx	xxx	xxx	xxx			xxx	xxx	xxx	xxx
Obesity rates of children and adolescents	xxx	xxx	xxx	xxx			xxx	xxx	xxx	xxx
Vegetable intake of persons aged 2 or older										

2020 Leading Health Indicators	Community Assessment Priorities									
	Partnership4 Health CHB	Becker County	Clay County	Otter Tail County	Wilkin County	Essentia Becker	Sanford Clay	Lake Region Healthcare Otter Tail	Perham Memorial Otter Tail	St Francis Wilkin
<b>Oral Health</b>										
Use of oral health care system in past 12 mos.										
<b>Reproductive and Sexual Health</b>										
Sexually active females receipt of reproductive health services	Xxx	Xxx	Xxx	xxx						
Persons with HIV who know their sero-status										
<b>Social Determinants</b>										
Graduation rates										
<b>Substance Abuse</b>	xxx	xxx	xxx	xxx						xxx
Adolescent use of alcohol or illicit drugs										
Adult binge drinking										
<b>Tobacco</b>	xxx	xxx	xxx	xxx		xxx				
Adult smokers										
Adolescent use of cigarettes										
<b>Local Health Indicators</b>	<b>Community Assessment Priorities</b>									
<b>Chronic Health Conditions</b>	xxx	xxx	xxx	xxx				xxx		
Cancer rates								xxx		
Diabetes prevalence	xxx	xxx	xxx	xxx						
<b>Access to enhanced care</b>						xxx				
<b>People Living in Poverty</b>	xxx	xxx	xxx	xxx	xxx					
<b>Influenza Vaccinations &amp; Hospitalizations</b>	Xxx	Xxx	Xxx	xxx						
<b>Maternal Care and Birth Consequences 1st trimester care &amp; smoking</b>	Xxx	Xxx	Xxx	Xxx	xxx					
<b>Chlamydia</b>		xxx	xxx	xxx						
<b>Immunizations across the lifespan</b>	Xxx	xxx	xxx	xxx						
<b>Emerging Contaminants in Water Supply</b>	xxx	xxx	xxx	xxx						
<b>End of Life Care</b>	xxx	xxx	xxx	xxx						



## Becker County, MN

The following Summary Comparison Report provides an "at a glance" summary of how the selected county compares with peer counties on the full set of Primary Indicators. Peer county values for each indicator were ranked and then divided into quartiles.




	Better  (most favorable quartile)	Moderate  (middle two quartiles)	Worse  (least favorable quartile)
Mortality	<u>Coronary heart disease deaths</u>	<u>Alzheimer's disease deaths</u> <u>Cancer deaths</u> <u>Chronic kidney disease deaths</u> <u>Chronic lower respiratory disease (CLRD) deaths</u> <u>Diabetes deaths</u> <u>Female life expectancy</u> <u>Male life expectancy</u> <u>Motor vehicle deaths</u> <u>Unintentional injury (including motor vehicle)</u>	<u>Stroke deaths</u>
Morbidity	<u>Adult overall health status</u> <u>Alzheimer's diseases/dementia</u> <u>Gonorrhea</u> <u>Preterm births</u> <u>Syphilis</u>	<u>Adult diabetes</u> <u>Older adult asthma</u>	<u>Adult obesity</u> <u>Older adult depression</u>
Health Care Access and Quality	<u>Primary care provider access</u>	<u>Older adult preventable hospitalizations</u> <u>Uninsured</u>	
Health Behaviors	<u>Adult female routine pap tests</u> <u>Adult physical inactivity</u> <u>Adult smoking</u>	<u>Teen Births</u>	<u>Adult binge drinking</u>
Social Factors	<u>High housing costs</u> <u>Unemployment</u> <u>Violent crime</u>	<u>Children in single-parent households</u> <u>On time high school graduation</u> <u>Poverty</u>	<u>Inadequate social support</u>
Physical Environment	<u>Drinking water violations</u> <u>Housing stress</u>	<u>Access to parks</u> <u>Annual average PM2.5 concentration</u>	<u>Limited access to healthy food</u> <u>Living near highways</u>

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## Clay County, MN

The following Summary Comparison Report provides an "at a glance" summary of how the selected county compares with peer counties on the full set of Primary Indicators. Peer county values for each indicator were ranked and then divided into quartiles.

	Better  (most favorable quartile)	Moderate  (middle two quartiles)	Worse  (least favorable quartile)
Mortality	Alzheimer's disease deaths Cancer deaths Chronic lower respiratory disease (CLRD) deaths Diabetes deaths Male life expectancy Motor vehicle deaths	Chronic kidney disease deaths Coronary heart disease deaths Female life expectancy Stroke deaths Unintentional injury (including motor vehicle)	
Morbidity	HIV Syphilis	Adult diabetes Adult obesity Adult overall health status Alzheimer's diseases/dementia Gonorrhea Older adult asthma Preterm births	Older adult depression
Health Care Access and Quality	Cost barrier to care Older adult preventable hospitalizations Uninsured		Primary care provider access
Health Behaviors	Adult female routine pap tests Teen Births	Adult physical inactivity Adult smoking	Adult binge drinking
Social Factors	Unemployment Violent crime	Children in single-parent households Inadequate social support Poverty	High housing costs On time high school graduation
Physical Environment	Access to parks Drinking water violations	Annual average PM2.5 concentration Housing stress Limited access to healthy food Living near highways	




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## Otter Tail County, MN

The following Summary Comparison Report provides an "at a glance" summary of how the selected county compares with peer counties on the full set of Primary Indicators. Peer county values for each indicator were ranked and then divided into quartiles.


	Better  (most favorable quartile)	Moderate  (middle two quartiles)	Worse  (least favorable quartile)
Mortality	Cancer deaths Chronic kidney disease deaths Chronic lower respiratory disease (CLRD) deaths Female life expectancy Male life expectancy Motor vehicle deaths Unintentional injury (including motor vehicle)	Alzheimer's disease deaths Coronary heart disease deaths Diabetes deaths Stroke deaths	
Morbidity	Adult diabetes Adult overall health status Preterm births Syphilis	Adult obesity Alzheimer's diseases/dementia Gonorrhea Older adult asthma Older adult depression	
Health Care Access and Quality	Cost barrier to care Uninsured	Older adult preventable hospitalizations Primary care provider access	
Health Behaviors	Adult smoking Teen Births	Adult female routine pap tests Adult physical inactivity	Adult binge drinking
Social Factors	Children in single-parent households High housing costs Inadequate social support Poverty Unemployment Violent crime	On time high school graduation	
Physical Environment	Access to parks Drinking water violations	Annual average PM2.5 concentration Housing stress Limited access to healthy food Living near highways	

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## Wilkin County, MN

The following Summary Comparison Report provides an "at a glance" summary of how the selected county compares with peer counties on the full set of Primary Indicators. Peer county values for each indicator were ranked and then divided into quartiles.

	Better  (most favorable quartile)	Moderate  (middle two quartiles)	Worse  (least favorable quartile)
Mortality	Cancer deaths Female life expectancy Male life expectancy	Alzheimer's disease deaths Chronic lower respiratory disease (CLRD) deaths	Coronary heart disease deaths Stroke deaths
Morbidity	Alzheimer's diseases/dementia Preterm births Syphilis	Gonorrhea Older adult depression	Older adult asthma
Health Care Access and Quality	Older adult preventable hospitalizations Uninsured	Primary care provider access	
Health Behaviors	Adult physical inactivity Teen Births		Adult binge drinking Adult smoking
Social Factors		Children in single-parent households High housing costs On-time high school graduation Poverty Unemployment Violent crime	
Physical Environment	Living near highways	Access to parks Annual average PM2.5 concentration Drinking water violations Housing stress Limited access to healthy food	

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## **Becker County**

In Becker County a series of Town Hall meetings were held with multiple partners including Becker County Community Health, Sanford and Essentia Hospital and Clinic providers, Detroit Lakes Community and Cultural Center, University of Minnesota Extension Office, Mahube-Otwa Community Action Council, local school officials and representatives from the Statewide Health Improvement Project. The online survey was sent out to key informants in the county.

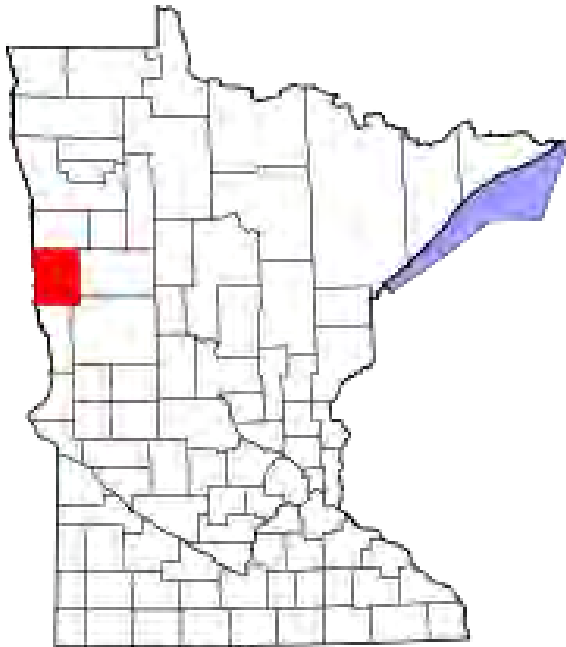
This is in line with the work being done through our PartnerSHIP 4 Health project over **all four** counties involving policy, systems and environmental change related to obesity, physical activity, nutrition and smoking cessation.

The strategy implemented by St. Mary's Essentia Health includes a National Diabetes Prevention Program (NDPP) addressing the highest priority health need as well as preparatory activities for building system-wide population health improvement capacity in the future. Steps to system wide capacity include training a Master NDPP who will train other Lifestyle Coaches. Acquiring Certified Diabetes Educator/Registered Nurse, Institute of Rural Health to serve as system coordinator and Master Trainer staff members to be part of diabetes intervention work group.

### **The three highest priority health issues for Becker County were:**

- \* Obesity, physical inactivity and poor nutrition as risk factors for chronic diseases such as type 2 Diabetes
- \* Access to Healthcare, defined as enhanced healthcare for the local population
- \* Tobacco use primary prevention/cessation

### **The first intervention and improvement activity was to focus on type 2 Diabetes**



## Clay County

The Health Needs Assessment Collaboration convened a breakfast meeting of community leaders which served as an opportunity for discussion of the resident population's health and the prevalence of disease and health issues within the community. Survey data was collected from the leaders which offers important insight and should be interpreted as anecdotal narrative. The community leaders' findings are not generalizable to the community.

Among health and wellness concerns, both community leaders' and residents' top concerns for Clay County were: cost of health insurance, healthcare and prescription drugs; physical and mental health including obesity, poor nutrition, eating habits and inactivity or lack of exercise; cancer and chronic disease. Other concerns

were the aging population, safety issues in the community and children and youth (childcare, bullying issues, etc.) Clay County has a large Latino and Somali population.

### **Clay County partners in the Community Assessment were:**

- \* Center for Rural Health at the University of North Dakota and Southeast Human Services Center
- \* Clay County Public Health
- \* Dakota Medical Foundation
- \* Essentia Health
- \* Family HealthCare Center
- \* Fargo Cass Public Health
- \* North Dakota State University Urban Indian Health and Wellness Center
- \* Sanford Health
- \* United Way of Cass-Clay
- \* Two mayors and five City Council/Commission members

**These partners met several times to discuss the Community Needs and priority issues. Two surveys were conducted, one of which was a generalizable survey of residents and the second was a community leader survey**

Clay County's Implementation Strategy is to address obesity, poor nutrition and inactivity issues through the PartnerSHIP4Health project which focuses on Policy, Systems and Environmental Changes. There is also a Cass (ND) and Clay (MN) Healthy People Initiative funded by Dakota Medical Foundation with a

goal to reduce obesity in children age 19 and younger by 20% by the year 2020. Another community collaborative is the Cass Clay Food Systems Initiative with a purpose to assure that residents have access to safe, nutritious and affordable foods. There is also an initiative called “Let’s Eat Local” which was started with the purpose to impact all levels of our community food systems. The aim was to improve the production, distribution, sales and consumption of healthy, locally grown foods within our region.

<p style="text-align: center;"><b><u>SHIP 1.0</u></b></p> <p><b>Strategy:</b>          *To implement comprehensive nutrition policies supporting USDA school menu regulations for breakfast and lunch          *Promoting healthy snacks including snack carts, vending, a la carte, school store, food rewards and fundraising          *Supporting Farm to School programs such as school gardens, orchards and cafeteria salad bars</p>	<p style="text-align: center;"><b><u>SHIP 2.0</u></b></p> <p style="text-align: center;"><b>The emphasis went away from school menus since schools had to abide by USDA regulations to get extra federal funding</b></p> <p><b>Focus:</b>          *Farm to School efforts          *Healthy School Food Options          Outside of the USDA Reimbursable School Meal Program including:          *A la carte options offered during school meal service that are also known as competitive foods which includes, snack carts, school stores, concessions, vending machines, food rewards, food as fundraisers, food at celebrations and parties</p>	<p style="text-align: center;"><b><u>SHIP 3.0</u></b></p> <p style="text-align: center;"><b>Must have components of access, health literacy for institutional decision-makers and policy</b></p> <p><b>Examples:</b>          *Competitive foods          *Salad bars          *Farm To School</p>
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It is the goal of this strategy, Healthy School Food Options, to increase fruit and vegetables and decrease sodium, saturated fat, added sugars in foods available during the school day on school campuses. Evidence-based strategies to reach these goals include Farm to Fork, nutrition literacy components, establishing and implementing standards for all foods sold on school grounds within the school wellness policy.

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In the area of Mental Health, Clay County’s plan is to work in collaboration with community partners for the prevention and early detection of mental health issues. This ReThink Mental Health group is a strategic planning collaborative with a mission to improve Mental Health/Behavioral Health needs through innovative, community wide problem solving processes. Goals for this group include improved policies, practices, systems, partnership, environmental and community support.



## Otter Tail County

In an effort to reduce Adverse Childhood Events, all four counties will provide Healthy Families America and Nurse Family Partnership evidence based home visiting models.

The Otter Tail Family Services Collaborative partners, the Emergency preparedness Advisory Committee and the Senior Services Network met to gather information from focus groups. In addition, a survey was distributed to a convenient sample of county and hospital staff and whomever they invited to complete the survey. It was also promoted via the media which resulted in one request for a copy of the survey

to be mailed to an individual. Short surveys were developed to be used at two community events; within the waiting rooms of public health and human services and mailed to all families with children enrolled in the Child & Teen Check Up program.

Otter Tail county has hospitals in both Fergus Falls (Lake Region) and Perham. Otter Tail has a large Somali population

**The Lake Region Health Care planning group identified their implementation strategy . The plan is as follows.**

- to sustain and develop new community wellness programs that will benefit the community and to respond to other identified community health needs.
- to utilize the term “community wellness” as it promotes an active and proactive approach to meeting the health needs of the community.
- Lake Region Takes Roots Community Garden distributes the produce to the WIC program, food shelves and the Salvation Army Food Kitchen.
- Public Health and the hospital are partnering to create an accountable community for health within the service area of Lake Region Healthcare.

### **Lake Region identified priority issues as:**

- \*Nutrition
- \*Physical Activity
- \*Obesity as they relates to Chronic Health Conditions



**Perham identified priority issues as:**

- \*Obesity and implications to other chronic health conditions
- \*Fragmented or minimal rural mental health services
- \*Access to specialized health care services

**The Perham Hospital planning group identified their implementation strategies in three year plans.**

**For Obesity, the plan is as follows:**

- \*Expand Medical Home model of care for wellness/prevention and health accountability
- \*Promote Health Care Team to use “Behavioral/Motivational Health” Interview Model
- \*Continue and/or expand school/hospital/community partnerships with Minnesota SHIP initiatives
- \*Expand community partnerships to make environmental adaptations to encourage active lifestyles
- \*Community education to impact Baby/Early Childhood nutrition habits
- \*Develop a Medication Adherence Program
- \*Expand nutrition education at health facilities and in the community

**The strategy for Mental Health is as follows:**

- \*Partner with Sanford Health for expansion of Behavioral Health outreach
- \*Partner with Minnesota Consortium for Advanced Rural Psychology Training (MCARPT)
- \*Research feasibility of tele-mental health services
- \*Maintain active role in Minnesota Hospital Association Mental Health Task Force to partner in solutions to address limited mental health services for rural areas
- \* Increase collaborative role with local, county and regional mental health service providers

**The strategy for Access to Specialized Health Care Services plan is:**

- \*Research feasibility of offering dialysis locally
- \*Research feasibility of offering chemotherapy locally
- \*Secure outreach visits from specialists; (nephrology, orthopedic surgery)



## Wilkin County

Wilkin County Public Health working with their partners, St. Francis Medical Center, Essentia Health Care, Sanford Health Care, North Dakota State College of Science and Richland County Public Health did an on line survey and a paper community survey and held focus group interviews. The survey results were compiled by Dr. Stephen Pickard of the North Dakota Department of Health and Center for Disease Control. Dr. Pickard presented the results of the Community Needs Assessment at a community meeting held August 27, 2013. The priority issues identified were 1) Nutrition and Physical Activity; 2) Obesity; 3) Substance Abuse

Wilkin identified these issues but also have programs in place to deal with them. The local clinics have obesity management programs in place to address this issue with their patients through the primary care physicians. Nutrition consultation is available at both clinics, through the Public Health Department and at St. Francis Campus. The Southern Valley Health Watch promotes active living events. The Breckenridge Active Living Committee has been involved in developing community structure and policy to promote sidewalk and trail development, safe routes to school and numerous other activities through the Statewide Health Improvement Project. Work is being done in the local schools as well.

The strategy for substance use/abuse, Wilkin County has a very active Youth Community Prevention Coalition that is well established as well as a Tobacco Coalition. The local college, NDSCS has an active ATOD coalition. The schools in the county have an active SADD program.

In the area of mental health, one full time psychiatrist is on staff at the Hope Unit at St. Francis and two psychologists that work with children's mental health clients.

Wilkin County established an ACTIVE Task Force to address obesity and physical activity with the charge as follows:

### **ACTIVE Task Force Goals**

**Purpose:** The purpose of the ACTIVE Task Force is to develop a comprehensive and consistent approach to obesity management in the Richland and Wilkin County community, thus reducing the incidence of adult obesity.

### **Long Term Goal**

To reduce the incidence of adult obesity in Richland and Wilkin Counties by 5% by 2025. (County Health Rankings)



**Short Term Goal #1:** To engage community members in healthier lifestyle activities and choices in the following subset areas – Seniors, Work Sites, and Youth.

- Work with seniors in our community to develop and/or enhance policies and programs that promote healthy lifestyles that meet their needs
- Survey the senior population in our community to determine what activities and choices they are interested in
- Match current opportunities to see what is available and what gaps exist
- Determine the existing barriers that hamper seniors' efforts to be healthier
- Identify and implement solutions to barriers, to include policies and programs
  
- Work with local work sites to develop and implement a comprehensive worksite wellness policy that promotes healthy lifestyle choices
- Identify two work sites in Richland County and 2 work sites in Wilkin County
- Identify current opportunities to improve wellness at those work sites
- Work with the companies to develop and/or enhance their current policies and programs
  
- Work with local schools to develop and implement a comprehensive school wellness policy that promotes lifelong healthy lifestyle choices
- Survey all local schools to determine what healthy lifestyle policies and programs are already in existence
- Identify gaps in current policies and/or programs
- Determine barriers that hamper adoption of a comprehensive policy and acceptance/participation in the programs
- Work with schools to identify and implement solutions to the barriers
- Work with local day care providers to develop a comprehensive approach to promote healthy lifestyles
- Identify two day care providers in Richland County and two day care providers in Wilkin County
- Identify current wellness opportunities at those day care sites
- Work with the day care providers to develop and/or enhance their current programs so as to encourage healthy eating and physical activity

**Short Term Goal #2:** Increase community awareness and knowledge of healthy lifestyle opportunities and events.

- Develop a method(s) of communicating community events that focus on physical activity opportunities to increase awareness. (i.e. website, Chamber of Commerce, etc.)
- Develop a communication tool (Facebook, website, newspaper column, etc.) to share nutrition information, recipes, etc. (i.e. fruit or vegetable of the month)
- Work with local restaurants, fast-food eateries, convenience stores, vending machines, etc. to develop ways for sharing the nutritional data for their food selections

The partners have met recently to begin work on Mental Health. In the area of mental health, The Hope Unit has one full time psychiatrist and two psychologists that work with adults and children.

Health Equity Partners identified:

<b>Organization</b>	<b>Service provided</b>
<b>A Place to Belong, Fergus Falls</b>	Social club for individuals with a serious mental illness
<b>A Place to Belong, Detroit Lakes</b>	Social club for individuals with a serious mental illness
<b>Access of the Red River Valley</b>	Services for individuals with disabilities
<b>Boys and Girls Club of Detroit Lakes</b>	After school & summer programs for youth
<b>Boys and Girls Club of Perham</b>	After school & summer programs for youth
<b>Clay Co Adult Mental Health LAC</b>	Advisory committee
<b>Churches United for the Homeless</b>	Homeless shelter
<b>Clay County Social Services</b>	Human services
<b>Compassion House</b>	Shelter for homeless
<b>CCRI</b>	Services for individuals with disabilities
<b>Dorothy Day House</b>	Shelter for homeless
<b>Farm in the Dell</b>	Home and workplace for individuals with disabilities
<b>Head Start (Lakes &amp; Prairies)</b>	Promotes the school readiness of children ages birth to five from low-income families
<b>Lake Region Halfway Homes</b>	Drug and alcohol treatment center
<b>Lakeland Mental Health Center, Detroit Lakes</b>	Behavioral healthcare services
<b>Lakeland Mental Health Center, Fergus Falls</b>	Behavioral healthcare services
<b>Lakeland Mental Health Center, Moorhead</b>	Behavioral healthcare services
<b>Lakes Crisis &amp; Resource Center</b>	Shelter, Mental Health Services, Crime Victim Advocacy
<b>Mahube-Otwa</b>	Services for low income and elderly person

<b>Organization</b>	<b>Service provided</b>
<b>Moorhead Public Housing</b>	Housing for low income families and individuals
<b>Rewind, Inc.</b>	Drug and alcohol treatment center
<b>REACH</b>	Human services, food pantry, counseling
<b>Social Connection</b>	Social club for people with a serious mental illness
<b>The Village Family Service Center</b>	Human services
<b>WCRJC</b>	Juvenile detention

**Potential Future Partners identified:**

<b>Organization</b>	<b>Service provided</b>
<b>A Place 4 Friends</b>	Social club for individuals with a serious mental illness
<b>Blue Sky, Inc.</b>	Services for individuals with disabilities
<b>Boys and Girls Club of Moorhead</b>	After school & summer programs for youth
<b>Community Behavioral Health Hospital</b>	Behavioral health
<b>Gull Harbor</b>	Addiction treatment
<b>Lakeland Mental Health Center, Perham</b>	Behavioral health services
<b>Matthew House</b>	
<b>Productive Alternatives</b>	Vocational services for persons with disabilities
<b>Red River Recovery</b>	Chemical and drug rehab
<b>ShareHouse Wellness Center</b>	Substance abuse services
<b>Solutions, Inc.</b>	Behavioral health services
<b>Someplace Safe</b>	Crisis prevention center
<b>Stepping Stones</b>	Safe environment for young people
<b>Valley Lake Boys Home</b>	Residential treatment facility to boys ages 12 to 18

# Implementation Strategy

The **Partnership4Health Community Health Board** has identified the common top three priorities as:

- 1) **Obesity**
- 2) **Mental Health**
- 3) **Decrease Adverse Childhood Events**

Our Implementation Strategy is to address **nutrition and physical activity** issues through the PartnerSHIP 4 Health project focusing on Policy, System and Environmental Changes to reduce obesity.

In the area of **Mental Health** our plan is to work in collaboration with community partners for the prevention and early detection of mental health issues.

In an effort to reduce **Adverse Childhood Events**, all four counties will provide Healthy Families America and Nurse Family Partnership evidenced based home visiting models.

## Obesity

### Rationale:

Becker has an obesity rate of 5%  
Otter Tail has an obesity rate of 4%  
Wilkin has an obesity rate of 5%

*These rates are at or above the state average of 4%*

Clay County has an obesity rate of 3%

(MDH 2013)

**Goal:** create communities where everyone can attain and maintain a healthy weight by increasing access to healthy foods and physical activity opportunities

**Objective 1:** Increase access to healthy and affordable foods in communities. (Food Hub)

**Strategy:** Work with food outlets such as convenience stores and fringe stores to improve the selection of fresh fruits and vegetables available for purchase

**Measure:** Decrease in the percent of census tracts that lack access to healthy food outlets (food deserts) and food swamps

**Objective 2:** Continue to support organizational and programmatic nutrition standards and policies and improve the quality of foods served at worksites, organizations and schools

**Strategy:** Work with schools in the counties to implement recommended school food nutrition standards

**Measure:** Increase in number of schools implementing nutrition standards

**Objective 3:** Facilitate access to safe, accessible and affordable places for physical activity. Support workplace policies and programs that increase physical activity

**Strategy:** Implement evidence based adapted behavior change programs such as worksite wellness programs

**Measure:** Percentage of adults who have access to such programs provided as a work benefit

**Objective 4:** Encourage Community Design and development that supports physical activity

**Strategy:** Expansion of Complete Streets Work, Walking School Bus programs, Walkable/Bikable friendly communities

**Measure:** Increase percentage of communities that have adopted Complete Streets ordinances

**Objective 5:** Promote breastfeeding through policies and programs to increase the number of infants who breastfeed at birth and the proportion still breastfeeding at six months

**Strategy:** Increase the percent of worksites with Lactation Support policies and programs

**Measure:** Increase in percent of breastfeeding initiation rates and employers who model lactation support policies or programs

Problem: Nutrition & Physical Activity

Evidence-base: The Minnesota Department of Health State Health Improvement Program requires the implementation of strategies that address policy, system, and environmental changes within communities, health care systems, schools, and worksites.

Partnership4Health will be continuing to utilize this approach by providing technical assistance and practice facilitation within the community, healthcare, school, and worksite settings. Health equity partners include providers who serve clients with disabilities, low income, social/emotional diagnosis, or at risk youth.

**Alignment with State/National  
Priorities**

Healthy MN 2020 Nutrition  
Indicators include:

**\*By 2020, more Minnesota  
children are exclusively breastfed  
for six months.**

**\*By 2020, fewer Minnesota  
households experience food  
insecurity.**

One of the top 12 leading objectives  
of Healthy Minnesota 2020 is to

increase physical activity, using the number of adults and youth meeting the physical activity guidelines as the lead indicators. Healthy Minnesota 2020 states:

*“Physical activity is a public health priority and impacts nearly every aspect of health. Lack of physical activity combined with a poor diet is the second leading cause of preventable death and disease and poses a huge economic burden on Minnesota. Physical inactivity is associated with an increased risk of obesity, heart disease, stroke, diabetes, cancer, falls, arthritis and depression.”*

(HealthyPeople 2020, Healthy Minnesota 2020)

**The 2020 Obesity HealthyPeople goal:**

*To “promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights”*

-this includes objectives focused on efforts to address individual behaviors as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations and communities

## Mental Health

**Goal:** Increase awareness and early identification and intervention of mental illness

**Problem:** Improving Mental Health and Addressing Mental Illness

### Rationale:

The 9<sup>th</sup> Grade Student Survey revealed the following percentage of students that were worried or upset in each county:

Becker 16%

Clay 13%

Otter Tail 13%

Wilkin 18%

(Minnesota Student Survey 2013)

**Objective 1 :** Promote integration of behavioral health services into primary care settings and with community partners

**Strategy:** Community outreach using existing social structures and partners

**Measure:** Increased awareness and access to mental health services and increase in providers

**Objective 2:** Develop efforts to demonstrate strong cross sector collaboration and support

**Strategy:** Enhance emotional wellness by improving education, planning and community capacity

**Measure:** Enhanced coordination and provision of services

**Evidence-base:** The Community Preventive Services Task Force recommends collaborative care for the management of depressive disorders based on strong evidence of effectiveness in improving depressive symptoms, adherence to treatment, response to treatment, and remission and recovery from depression.

Collaborative care compared to usual care shows the following favorable outcomes:

- Fewer depression symptoms
- Adherence to prescribed treatment
- Response to treatment
- Remission or recovery of symptoms
- Improved quality of life
- Higher satisfaction with treatment.



Partnership4Health will be continuing to utilize depression screening tools and care coordination for the clients served for intensive family home visiting and long term care to reach the populations of adults age 20-64 and older adults 65 years and older.

**Alignment with State/National Priorities:**

**The HealthyPeople 2020 Mental Health goal:**

*To improve mental health through prevention and by ensuring access to appropriate quality mental health services*

National Prevention Strategy: Mental and Emotional well-being is one of the seven priorities. Promote early identification of mental health needs and access to quality services.

## Adverse Childhood Events

### Rationale:

New studies and emerging research regarding ACE scores and the impact of Evidence Based Home Visiting Programs indicate a positive outcome. Becker County Benchmark “Z” score was 10, which was in the top seven in the state of Minnesota. The percent of women receiving prenatal care in the first trimester by county was: Becker 78%, Clay 48%, Otter Tail 82% and Wilkin 92%.

(MDH 2013)

**Goal:** Improve pregnancy outcomes by increasing the number of women who plan pregnancies and receive prenatal care by targeting high risk populations

**Objective 1:** Increase health related self-efficacy among children and their young caregivers

**Strategy:**  
Implementation of Nurse Family Partnership and Healthy Families America evidence based models in communities

**Measure:** Families will experience healthy birth outcomes and positive parenting outcomes, keeping our children safe and in a nurturing relationship

**Objective 2:** Increased early prenatal care

**Strategy:** By enrolling early in the models, women will be encouraged to follow through with prenatal cares

**Measure:** Reduction in low birth weight babies

**Objective 3:** Reduce the number of preventable hospitalizations among children and adolescents

**Strategy:** Increase the proportion of children and adolescents who have had a wellness exam

**Measure:** The proportion of children/adolescents with wellness checkups including immunizations

### **Evidence-based practice for the CHIP plan**

**Problem:** Adverse Childhood Events

Evidence-base: The Community Preventive Services Task Force recommends early childhood home visitation programs based upon strong evidence of their effectiveness in reducing child maltreatment among high risk families. Programs delivered by professional visitors (i.e. nurses or mental health workers) seem more effective. Home visitation programs reviewed offered services to teen age parents, single mothers, families of low economic status, and families with very low birth weight infants, parents

previously investigated for child maltreatment, and parents with alcohol, drug, or mental health problems.

Programs try to decrease the likelihood of child maltreatment by:

1. Providing parents with guidance for and examples of caring and constructive interaction with their young children,
2. Facilitating the development of parental life skills,
3. Strengthening social support for parents, and
4. Linking families with social services.

Partnership4Health will be providing family home visiting utilizing the Nurse Family Partnership model for first time parents and the Healthy Families America model for first time and/or families with more than one child.

Three of the four counties have significant minority populations, Becker, Native American; Clay, Latino/Somali and Otter Tail Somali.

#### **Alignment with State/National Priorities**

**The HealthyPeople 2020 Adverse Childhood Event goal:**

*To capitalize on the opportunity to influence health in early childhood: assure all families can receive newborn home visits.*

**National Prevention Strategy:** Increase use of preconception and prenatal care, especially for low income and at-risk women. Promote positive early childhood development, including positive parenting and violence free homes.

(Healthy Minnesota 2020, National Prevention Strategy)

The Community Health Assessment is located on county specific websites and accessible to the general public. The Community Health Improvement Plan is also located on county specific websites and is a working document through the five year cycle 2015-2019.

The following is information regarding community perceptions from the survey to actual data. This summary was compiled by the Center for Small Towns.

Becker County: [www.co.becker.mn.us](http://www.co.becker.mn.us)

Clay County: [www.co.clay.mn.us](http://www.co.clay.mn.us)

Otter Tail County: [www.co.ottertail.mn.us](http://www.co.ottertail.mn.us)

Wilkin County: [www.co.wilkin.mn.us](http://www.co.wilkin.mn.us)

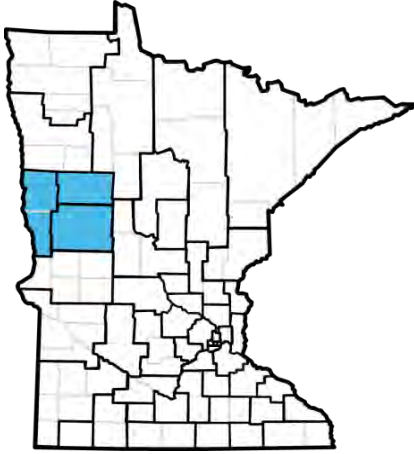
# Summary

By comparing the perceptions from the community members to the data, we can find areas where the community could be better educated on their health factors and outcomes.

County	Areas where perceptions and data disagree	
	Under-concerned	Over-concerned
Becker	Quality food access	Housing affordability Dropout rates and truancy*
Clay	Water quality Communicable diseases Dropout rates and truancy*	Availability of elder care
Otter Tail	Communicable diseases Poverty	Family Composition Mental health services
Wilkin	Physician availability Quality food access Grocery store access	Housing affordability
All counties	Air quality	Student inactivity
*indicates a slight difference in the perception and the reality from the data		

Overall, there are a lot of areas in of the health report data that support the perceptions the community members of Becker, Clay, Otter Tail, and Wilkin have of their health. However, there are also areas, where the perceptions of the community are not supported by the data. These are areas where the community health boards could focus their efforts to better inform the community or highlight strengths in health that the community members may be unaware of.





## Contact Information

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Quality Improvement Plan and Accreditation

