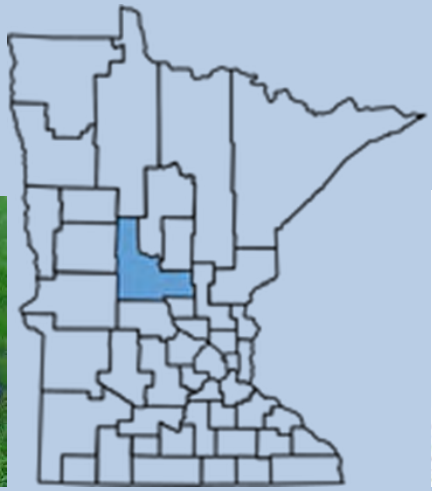
Morrison-Todd-Wadena Community Health Board

Community Health Improvement Plan

October 2014



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Executive Summary

The mission of the Morrison-Todd-Wadena-Community Health Board (CHB) is "By working together, the Morrison-Todd-Wadena Community Health Board prevents illness and injury, and promotes and protects the health of our communities."

Since the passage of the Community Health Services Act (now called the Local Public Health Act) in 1976, Minnesota Community Health Boards (CHBs) have been required to engage in a community health improvement process. The Morrison-Todd-Wadena Community Health Board worked collaboratively with the community and local organizations to develop a health improvement plan that reflects the community's health needs. The purpose of the community health improvement plan or CHIP is to outline how local public health, community partners and stakeholders in Morrison, Todd, and Wadena Counties will prioritize and address community health issues from 2015-2019. This CHIP is based on a community health needs assessment that was completed in 2013-2014.

What is a Community Health Improvement Plan (CHIP)?

A community health improvement plan (CHIP) describes long-term, collaborative efforts to address public health issues identified through a community health assessment. This plan describes how the Morrison-Todd-Wadena Community Health Board, community partners and stakeholders will work together to address the main community health needs in our region. In Minnesota, community health improvement plans are required to be submitted by community health boards to the Minnesota Department of Health every five years.

Methods

Morrison County Public Health, Todd County Health & Human Services, and Wadena County Public Health in collaboration with Tri-County Health Care, Lakewood Health System, and St. Gabriel's Hospital completed a community health need assessment that gathered data and information on the health of the population including a broad range of factors that impact health on the population level as well as existing assets and resources to address health issues.

Todd and Wadena Counties followed the MAPP (Mobilizing for Action through Planning and Partnerships) process.[1] The MAPP process is a community-driven strategic planning tool that includes community visioning, conducting four assessments (community themes and strengths, organization capacity and performance, community health, and forces of change), prioritizing issues, selecting goals and strategies, and developing an action plan.

[1] National Association of County & City Health Officials, Mobilizing for Action through Planning and Partnerships, 2014, http://www.naccho.org/topics/infrastructure/mapp/

Prioritization

Teams of Public Health and Hospital staff spent several months looking at the data gathered from the MTWC Community Health Survey, County Data Tables, Minnesota Student Surveys, and other sources. Using state-wide indicators provided by the Minnesota Department of Health, trending behavioral patterns and commonalities began to materialize. The community health assessment teams discussed this information and identified ten community health priority areas.

- Access to Health Care – affordable care, perception of importance, prevention care
- Aging Demographic – rising elderly dependency rate and increasing numbers
- ATOD - alcohol, tobacco, other drugs
- Cancer - screening and early detection
- Chronic Disease - diabetes, heart disease, stroke, high cholesterol, hypertension
- Mental Health - depression, anxiety, suicide, stress
- Adult & Childhood Obesity- poor nutrition and physical inactivity
- Parenting - injury prevention, immunizations, etc.
- Social Determinants of Health - poverty, housing, employment, environment, etc.
- Unintended Injury- motor vehicle accidents, etc.

Through additional discussion the top three priorities- adult and childhood obesity, mental health, and social determinants of health- were identified based on their significance, prevalence,

and alignment with current agency capacity. The hospital systems had chosen their top three priorities prior to finalization of the community improvement plan top priorities; and this was a factor in the final priorities chosen by the participating partners.

Public health staff developed action plans for each community health priority. Action plans included identifying specific goals, strategies and performance measures. As well as outlining specific activities, timelines, potential partners, and outputs for each intervention. A community stakeholder meeting was held to review the draft action plans and to discuss existing community assets, resources, and projects. Additionally, future strategies were identified and ranked based on cost and impact to determine how best to prioritize activities.

Social Determinants of Health and Health Equity

It is important to recognize that multiple factors affect health, including the environment, social and community networks, education, housing, and lifestyle factors. Where and how we live, work, play, and learn are interconnected factors that are critical to consider when assessing a community's health. Achieving health equity requires valuing everyone with focused and ongoing societal efforts to address avoidable inequalities, historical and present injustices, and the elimination of health disparities and health care disparities.

Health disparity: A population-based difference in health outcomes (e.g., women have more breast cancer than men).

Health inequity: A health disparity based in inequitable, socially-determined circumstances (for example, American Indians have higher rates of diabetes due to the disruption of their way of life and replacement of traditional foods with unhealthy commodity foods). Because health inequities are socially-determined, change is possible.

Health equity: When every person has the opportunity to realize their health potential without limits imposed by structural inequities. Health equity means achieving the conditions in which all people have the opportunity to attain their highest possible level of health.

Determinants of health: Health is determined through the interaction of individual behaviors and social, economic, genetic and environmental factors. Health is also determined by the systems, policies, and processes encountered in everyday life. Examples of determinants of health include job opportunities, wages, transportation options, the quality of housing and neighborhoods, the food supply, access to health care, the quality of public schools and opportunities for higher education, racism and discrimination, civic engagement, and the availability of networks of social support.[2]

[2] Minnesota Department of Health, Health Equity Terminology

Community Health Priorities

The Morrison-Todd-Wadena Community Health Board and community partners identified the following community health priorities:

Community Health Priorities
1. **Obesity in Children and Adults**
2. **Mental Health**
3. **Social Determinants of Health**

Priority Areas: Goals and Strategies Overview

Action Plan 1: Obesity
Goal: Prevent and reduce obesity in adults and children by increasing physical activity and healthy eating opportunities

Strategy 1: Increase healthy food access, availability, and consumption
Strategy 2: Increase access to physical activity opportunities (various settings)

Action Plan 2: Mental Health
Goal: Increase access to high quality mental health prevention and intervention services

Strategy 1: Increase awareness of mental health issues; develop a campaign to increase utilization of mental health system and resources on how to seek help to mental health services

Action Plan 3: Social Determinants of Health
Goal: Assure that the opportunity to be healthy is available everywhere for everyone

Strategy 1: Increase community knowledge, skills, and partnerships in the understanding and utilization of social determinants of health (SDOH)

Priority 1: Obesity

GOAL:
Prevent and reduce obesity in adults and children by increasing physical activity and healthy eating opportunities

Healthy Eating Opportunities:

According to the 2013 Morrison-Todd-Wadena (MTW) Community Health Survey and the 2013 Minnesota Student Survey:

- Less than one third (32.4%) of MTW adults consume five or more servings of fruits and vegetables daily
- Less than one-quarter of MTW adolescents report consuming fruits at least two times per day (21%) or vegetables at least two times per day (19%)
- About one-third (32.1%) of MTW adults consume at least one or more sugar-sweetened beverages daily
- Almost one-half (48%) of MTW adolescents report drinking at least one can, bottle, or glass of pop/soda daily
- 69.5% of MTW adults are overweight or obese, according to Body Mass Index (BMI)
- 29% of MTW adolescents are overweight or obese, according to Body Mass Index (BMI)
- 81% of 2013 MTW Community Health Survey respondents reported obesity among adults as a moderate or serious problem
- 69.7% of 2013 MTW Community Health Survey respondents reported obesity among children as a moderate or serious problem in their community

Physical Activity Opportunities:

According to the 2013 Morrison-Todd-Wadena (MTW) Community Health Survey and 2013 Minnesota Student Survey:

- Less than half (44.7%) of MTW adults meet the Physical Activity Guidelines for Americans, issued by the U. S Department of Health and Human Services (at least 2.5 hours of moderate- or vigorous-intensity aerobic physical activity per week/30 minutes, 5 days per week)

- Only one quarter (26%) of MTW adolescents meet the Physical Activity Guidelines for Americans, issued by the U. S Department of Health and Human Services (at least 60 minutes or more of physical activity daily)

STRATEGY 1:
Increase healthy food access, availability, and consumption

Background:

Good nutrition is vital to the growth and development of children. A healthy diet also helps reduce risks for many health conditions, including but not limited to: overweight and obesity, malnutrition, iron-deficiency anemia, heart disease, high blood pressure, type 2 diabetes, and some cancers. The goal of promoting healthful diets and healthy weight is not only to reduce chronic disease but to increase household food security and eliminate hunger. Food security means having enough to eat and being able to make healthy food choices. Adequate nutrition is particularly important for children, as it affects their cognitive and behavioral development. Children from food insecure, low-income households are more likely to experience irritability, fatigue, and difficulty concentrating on tasks, especially in school, when compared to other children.

Individuals with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.

- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol and limit caloric intake to meet caloric needs

In addition, breastfeeding is a vital component of good nutrition. Breastfeeding conveys important protective factors for infants, such as boosting immune system response and

preventing obesity. Children who are breastfed are less likely to develop diabetes than those who were fed formula or introduced early to solid foods. Breastfeeding also promotes the development of healthy relationships through maternal-infant bonding, has health benefits for the mother, decreases absenteeism for both mother and child, and reduces health care costs.

OBJECTIVE: By 2019, increase consumption of fruits and vegetables and decrease consumption of sugar sweetened beverages by MTW residents by 5%.

Action Plan

Activity	Target Date	Potential Partners/Roles	Output
Continue to improve availability and access to healthier food and beverage choices by working with local growers, restaurants, businesses, grocery/convenience stores	Ongoing	Local Growers Grocery and Convenience Stores UMN Extension Worksites	Increased offerings of healthier foods
Increase breastfeeding support and messaging through collaboration with local partners	Ongoing	West Central Breastfeeding Coalition Healthcare Public Health	Consistent breastfeeding messages
Continue to provide support to schools on implementing USDA guidelines and additional initiatives to increase student's consumption of fruits, vegetables, and decrease consumption of saturated fats, sugar, and salt	Ongoing	Schools MDH	Trainings, equipment provided, policies updated
Provide support to worksites on healthy eating strategies and policies through the initiation of a worksite wellness collaborative	Ongoing	Worksites	Completion of worksite wellness collaborative; updated policies

Continue to implement and develop a referral system for evidence based chronic disease prevention programs (including nutrition emphasis) with local healthcare systems that includes education, counseling, and follow-up	Ongoing	Healthcare systems Community organizations UMN Extension	Referrals to community based programs
Work with childcare providers to increase breastfeeding support and promote healthy eating strategies – implement trainings, provide technical assistance, and policy support	Ongoing	Child care providers Child Care Aware Trainers	Trainings provided, updated policies and procedures

Alignment with State/National Priorities:

The HealthyPeople 2020 goal for nutrition is to "promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights" and 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.

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.

National Prevention Strategy: Healthy Eating is one of the seven priorities

Sources:

MTW 2013 Community Health Survey

2013 Minnesota Student Survey

U.S Department of Health and Human Services

HealthyPeople 2020

Healthy Minnesota 2020

STRATEGY 2:
Increase access to physical activity opportunities across various settings

Background:

Evidence-based information and recommendations related to physical activity as stated by HealthyPeople 2020, are listed below and are included as activities in our community health improvement plan for increasing physical activity:

1) "Worksite programs intended to improve diet and/or physical activity behaviors are recommended to improve employee weight status. This is based on strong evidence of their effectiveness for reducing weight among employees (worksite wellness collaborative)."

2) "Urban design and land use policies and practices that support physical activity in small geographic areas are recommended based on sufficient evidence of their effectiveness in increasing physical activity (active transportation and pedestrian plans; safe routes to school)."

3) "Implementing programs that increase the length of, or activity levels in, school-based physical education classes is recommended based on strong evidence of their effectiveness in improving both physical activity levels and physical fitness among school-aged children and adolescents (active schools)."

4) "Implementing efforts made in community settings to provide social support for increasing physical activity are recommended based on strong evidence of their effectiveness in increasing physical activity and improving physical fitness among adults. Social support interventions focus on changing physical activity behavior through building, strengthening, and maintaining social networks that provide supportive relationships for behavior change (exercise classes for seniors; collaboratives)."

5) HealthyPeople 2020 also provides evidence-based best practices in physical activity, screen time, and nutrition for early child care and education settings, including centers and home-based operations (child care trainings and collaborative).

OBJECTIVE: By 2019, increase the number of MTW residents who met the recommended guidelines for physical activity by 5%.

Action Plan

Activity	Target Date	Potential Partners	Output
Work with targeted MTW schools to implement and evaluate at least one of the following active school strategies: quality physical education (more active time and longer class sessions); active classrooms, active recess, recess offered before lunch, or before/after school physical activity opportunities	2015	MDH School Partners MNAHPERD UMN Extension	Number of active school strategy workshops that are conducted for targeted schools Number of active schools strategies that are implemented for each school
Continue to provide support to the elementary schools participating in the Active Schools pilot study (Menahga, Sebeka, Upsala, Swanville, and Long Prairie-Grey Eagle)	2016	MDH School admin, P.E. and health teachers at Menagha, Sebeka, Upsala, Swanville, and Long Prairie-Grey Eagle UMN Extension	Number of specific active school strategy workshops that are conducted for each school Number of active schools strategies that are implemented for each school
Provide worksite wellness support to local businesses through the initiation of a worksite wellness collaborative	2014	Long Prairie and Wadena worksites	Initiation of a worksite wellness collaborative in both Wadena and Long Prairie that focuses on nutrition, physical activity, and weight management Number of worksites that join the collaborative

Continue working with Region 5 Development Commission and targeted schools and cities to discuss and implement Active Transportation and Pedestrian Plans related to Safe Routes to School	2017	R5DC MNDOT MDH Bike MN Targeted schools and cities	Number of trainings provided and number of schools participating Number of schools implementing Minnesota Bike Walk Fun! Bike/Ped Safety Curriculum Parent and student surveys are completed for each participating site Walking and biking audits are completed for each participating community Number of schools completing SRTS plans Number of schools and communities implementing Safe Routes to Schools and Active Transportation/ Pedestrian Plans Number of students participating in active transportation to and from school
Plan and develop a referral system for evidence-based chronic disease prevention programs (including physical activity emphasis) with local healthcare systems that includes education, counseling, and follow-up	2016	Healthcare systems and clinics Wellness, exercise, senior, community centers	Increase linkages to physical activity community resources for patients
Provide support in the initiation and continuation of a child care collaborative with physical activity as a major focus	2014	Twist and Sprout, Providers Choice Child care providers	Participating child care providers have been trained in physical activity strategies for children Child care collaborative meets monthly
Improve physical activity opportunities and classes for seniors	2015	Senior centers Classroom instructors, home health nurses aids	Number of seniors that attend exercise sessions

Alignment with State/National Priorities:

The HealthyPeople 2020 goal for physical activity is to "improve health, fitness, and quality of life through daily physical activity" and includes objectives focused on increasing access to physical activity opportunities across a wide-range of settings. These objectives highlight policies targeting physical activity in childcare settings and recess and physical education in schools, increasing the proportion of adults who engage in aerobic physical activity of moderate intensity for at least 150 minutes/week (30 minutes per day, five days per week), increasing the proportion of physician office visits that include counseling or education related to physical activity, and changing the built environment to increase the access and availability of physical activity opportunities (Safe Routes to School and Active Transportation/Pedestrian Plans)

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 that "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 a 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."

National Prevention Strategy: Active Living is one of the seven priority areas

Sources:

MTW 2013 Community Health Survey

2013 Minnesota Student Survey

U.S Department of Health and Human Services

HealthyPeople 2020

Healthy Minnesota 2020

2013 Minnesota Student Survey

National Prevention Strategy

How We Will Know We Are Making A Difference:

Performance Measures		
Short Term Indicators	**Source**	**Frequency**
By 2019, increase the number of adults that engage in 30 minutes of moderate physical activity five days or more per week from 44.7% to 49%.	Community Health Survey	Every 3 years
By 2019, increase the number of adults who consume five or more servings of fruits and vegetables from 32.4% to 37%.	Community Health Survey	Every 3 years
By 2019, increase the percentage of WIC infants ever breastfed	WIC	Annual
By 2019, decrease the number of adults who consume at least 1 or more sugar-sweetened beverages daily from 32.1% to 27%.	Community Health Survey	Every 3 years
By 2019, increase the number of adolescents that engage in 60 minutes of moderate physical activity, 7 days per week from 26% to 31%.	MN Student Survey (5th, 8th, 9th, & 11th grade students)	Every 3 years
By 2019, increase the number of adolescents who consume fruits at least two times per day from 21% to 26%.	MN Student Survey (5th, 8th, 9th, & 11th grade students)	Every 3 years
By 2019, increase the number of adolescents who consume vegetables at least two times per day from 19% to 24%.	MN Student Survey (5th, 8th, 9th, & 11th grade students)	Every 3 years
By 2019, decrease the number of children who consume daily at least 1 or more cans, bottles, or glasses of pop/soda from 48% to 43%.	MN Student Survey (5th, 8th, 9th, & 11th grade students	Every 3 years

Performance Measures		
Long Term Indicators	**Source**	**Frequency**
By 2019, decrease the percentage of overweight adults from 37.4% to 35%.	Community Health Survey	Every 3 years
By 2019, decrease the percentage of obese adults from 32.1% to 30%.	Community Health Survey	Every 3 years
By 2019, decrease the percentage of overweight adolescents from 16% to 14%.	MN Student Survey (8th, 9th, & 11th grade students)	Every 3 years
By 2019, decrease the percentage of obese adolescents from 13% to 11%.	MN Student Survey (8th, 9th, & 11th grade students)	Every 3 years

Priority 2: Mental Health

GOAL:
Increase access to high quality mental health prevention and intervention services

Mental Health:

According to the 2013 Morrison-Todd-Wadena (MTW) Community Health Survey:

- 18.3% reported they felt sad, blue or depressed 10 or more days in a month
- 73.2% stated they have a high or medium stress level
- 13.3% reported they had delayed receiving mental health care in the past 12 months; of those who delayed care 51.7% did not think it was serious enough, 26.4% thought it cost too much, and 21% did not know where to go to receive mental health services
- 57.2% view mental health, depression, anxiety as a serious or moderate problem
- 69% view parents with inadequate or poor parenting skill as a serious or moderate problem

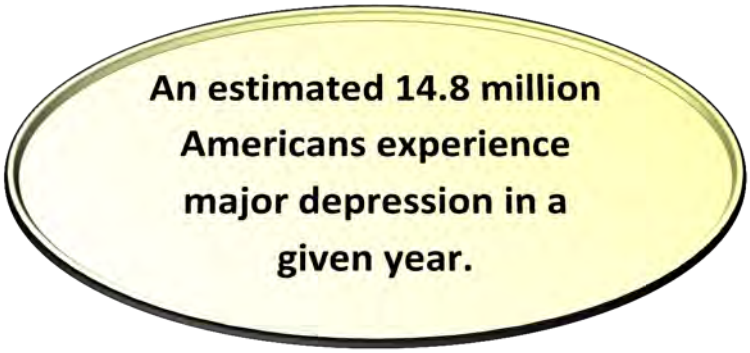
STRATEGY 1:
Increase awareness of mental health issues; develop a campaign to increase utilization of mental health system and resources on how to seek help for mental health services

Background:

Mental health disorders are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning. These disorders have a significant impact on community vitality not only from the cost to treat the illness but from income loss due to

unemployment, expenses for social support, and indirect costs, such as workers' compensation, short-and long-term disability, productivity, and absenteeism.

A combination of well-targeted treatment and prevention programs in the field of mental health, within overall public strategies, could avoid years lived with disability and deaths, reduce the stigma attached to mental disorders, help reduce poverty and promote a country's development. Studies provide examples of effective programs targeted at different age groups – from prenatal and early infancy programs, through adolescence to old age – and different situations, such as post-traumatic stress following accidents; marital stress; work-related stress; and depression or anxiety due to job loss, widowhood, or adjustment to retirement. Many more studies need to be conducted in this area, particularly in low- and middle-income countries. There is strong evidence to show that successful interventions for schizophrenia, depression and other mental disorders are not only available, but are also affordable and cost-effective. Yet there is an enormous gap between the need for treatment of mental disorders and the resources available. In developed countries with well-organized health care systems, between 44% and 70% of patients with mental disorders do not receive treatment. In developing countries the figures are even more startling, with the treatment gap being close to 90%" (World Health Organization).



OBJECTIVE 1: By October 31, 2015, increase awareness of Region Five Mental Health services and use of the crisis line.

Action Plan

Activity	Target Date	Potential Partners/Roles	Output
1. Develop communication team to develop campaign materials and messages	2014	Public Health Mental Health providers	6-10 Team members identified
2. Identify and pilot campaign messages with diverse sample of community members; identify best communication methods (i.e., website, social media, print, peer messaging)	2015	Public Health Human Services Mental Health providers Region Five+ Mental Health Initiative	3-5 messages piloted and approved
3. At least bi-monthly, provide public with information via e-newsletter, radio, print, social media, and website updates	2015	Public Health Mental Health providers Region Five+ Mental Health Initiative Media partners	Materials distributed
4. Develop local survey and evaluation plan to determine campaign effectiveness	2015	Public Health Region Five+ Mental Health Initiative	Survey developed
5. Distribute survey to random sample of clients and community members	2015	Public Health Region Five+ Mental Health Initiative	Survey completed
6. Utilize survey results to adapt campaign messages and inform stakeholders of campaign success	2015	Public Health Region Five+ Mental Health Initiative	Survey results shared

OBJECTIVE 2: By October 31, 2015, improve processes for depression screening and follow up for women of reproductive age and increase knowledge of ACE and importance of childhood protective factors (e.g., maternal-infant attachment)

Action Plan

Activity	Target Date	Potential Partners/Roles	Output
1. Conduct infant mental health training on childhood protective factors for early childhood partners and providers at two different geographical sites in Region Five. Evaluate training to determine usefulness of information and next steps.	2015	Public Health Behavioral Health Health Care Early Childhood School Human Services MN Department of Human Service (DHS) Prevent Child Abuse MN (PCAMN) MN Department of Health (MDH) Family Service Collaboratives	Two trainings completed Evaluation completed
2. Provide Adverse Childhood Experience (ACE) trainings at three different geographical sites in Region Five for community partners. Evaluate training to determine usefulness of information and next steps.	2015	Public Health Behavioral Health Health Care Early Childhood School Human Services MN DHS PCAMN	Three trainings completed Evaluation completed

		MDH	
3. Regionally assess current practice of partners related to depression screening tools, intervals for completion and follow up for women of reproductive age.	2015	Public Health Behavioral Health Health Care Human Services	Current practice identified
4. Regionally determine steps to streamline depression screening, intervals for completion and follow-up for women of reproductive age.	2015	Public Health Behavioral Health Health Care Human Services	Refined process
5. Develop a consent form to release client health information related to screening and follow up between agencies providing care throughout the region.	2015	Public Health Behavioral Health Health Care Human Services	Health Information Exchange Consent Form

OBJECTIVE 3: By October 31, 2015, increase the number of chronic disease and mental health prevention programs and referrals (e.g., I CAN Prevent Diabetes, Wellness in Recovery Action Plan) available in Region Five.

Action Plan

Activity	Target Date	Potential Partners/Roles	Output
1. Collaborate with regional health care partners to assess the	2014	Public Health	Programs and referral system

Action Plan

availability of evidence-based chronic disease and mental health prevention programs; identify current referral practices		Health Care Human Services Region Five+ Mental Health Initiative	documented
2. Identify ways to implement new or expand existing programs; identify effective referral systems and tracking tools	2015	Public Health Health Care Human Services Region Five+ Mental Health Initiative	Referral process identified and communicated
3. Provide training and information on the co-occurrence of chronic disease and mental health for providers and community stakeholders. Evaluate training to determine usefulness of information and next steps.	2015	Public Health Health Care Human Services Region Five+ Mental Health Initiative	Training and evaluation completed
4. Implement new programs and referral systems with community partners	2015	Public Health Health Care Human Services Region Five+ Mental Health Initiative	Programs and referral systems implemented consistently
5. Track referrals and program completion rates	2015	Public Health Health Care Human Services Region Five+ Mental Health Initiative	Referrals tracked and documented consistently

Alignment with State/National Priorities:

- Healthy People 2020 Mental Health Goal: 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.
- Guide to Community Preventive Services: Mental Health is a priority area: collaborative care for the management of depressive orders is a key, evidenced-based strategy for improving mental health care in a community.

Sources:

MTW 2013 Community Health Survey

U.S Department of Health and Human Services

HealthyPeople 2020

Centers for Disease Control and Prevention

Healthy Minnesota 2020

National Prevention Strategy

World Health Organization

National Institute of Mental Health

In the U.S., about one in four adults and one in five children have diagnosable mental disorders (National Institute of Mental Health)

How We Will Know We Are Making A Difference:

Performance Measures		
Short Term Indicators	**Source**	**Frequency**
Number of campaign messages and materials disseminated	Staff monitoring	Ongoing
Number of residents who are aware of mental health services and crisis line	Local survey	Annually
Percent of residents who view the campaign messages as useful	Local survey	Annually
Percent of training attendees who report training as valuable to their work	Training evaluation	Post-training
Percent of training attendees who identify specific steps to utilize the training information	Training evaluation	Post-training
Percent of clients of reproductive age receiving depression screening	PH-Doc, electronic medical record	Quarterly
Number of individuals referred to a chronic disease or mental health prevention program who attended at least 80% of classes	Referral form, electronic medical record	Quarterly
Long Term Indicators	**Source**	**Frequency**
By December 2015, increase use of the crisis line and referral service by 10%.	Crisis line phone records	Monthly
By December 2015, increase the percent of women of reproductive age receiving depression screening, consultation, and follow-up services.	PH-Doc, electronic medical record	Quarterly
By December 2015, increase the number of referral systems in place to provide chronic disease and mental health prevention programs in Region Five.	Staff monitoring	Quarterly
By December 2016, decrease the number of Morrison-Todd-Wadena adult residents reporting being diagnosed with depression and/or anxiety.	Community Health Survey	Every 3 years (2013, 2016, 2019)

Priority 3: Social Determinants of Health

GOAL:
Assure that the opportunity to be healthy is available everywhere for everyone.

Social Determinants Of Health:

According to the U.S Census Bureau:

- 18.7% of children live in poverty
- The median household income across the MTW CHB is much lower than the state of Minnesota
- The unemployment rate has increased steadily across all three counties, from 2005-2009
- 23% of home owners report spending more than 30% of their income on housing

STRATEGY 1:
Increase community knowledge, skills and partnerships in the understanding and utilization of social determinants of health (SDOH).

Background:

As stated by HealthyPeople 2020, "by working to establish policies that positively influence social and economic conditions and those that support changes in individual behavior, we can improve health for large numbers of people in ways that can be sustained over time. Improving the conditions in which we live, learn, work and play and the quality of our relationships will

create a healthier population, society and workforce." There is consensus that only a portion of our health is attributable to health care and the rest to other factors such as behavior, genetics, and social and environmental factors.

The ability to be healthy is often associated with factors such as social position, race, ethnicity, gender, religion, sexual identity, or disability. When these factors limit a person' ability to be healthy, it can lead to health inequity. Health inequities are caused by the uneven distribution of social determinants of healthy. Examples of social determinants include housing, education, access to transportation, employment opportunities, and the neighborhood environment.

OBJECTIVE 1: By 2018, increase the number of partner agencies who have adopted the SDOH guiding principles from 0 to 15; and by 2019 increase the number of partner agencies who have utilized the SDOH guiding principles from 0 to 9.

Action Plan

Activity	Target Date	Potential Partners/Roles	Output
Provide information and training to partners on SDOH	2015	Public Health Community, non-profits and faith-based organizations Schools	Number of trainings Number of attendees Knowledge gained
Clear definition of at risk population including enhanced data collection	2016	Public health and health lead, partners contribute	Definition and data related to at-risk population
Identify and map social determinants of health issues.	2016	Partnership involvement	Mapping and listing of current issues
Develop a listing of guiding principles to address SDOH	2016	Partnership involvement	Listing in place
Adopt list of guiding principles RE: SDOH	2018	Partnership involvement	Adopt by 15 partners

Action Plan			
Use of principles in decision making	2019	Partnership involvement	Examples by at least 3 agencies per county of use of principles in existing or new programming

OBJECTIVE 2-4: By 2018, conduct 10 healthy home assessments; and by 2019, increase the number of assessments by 5. By 2019, increase the number of active living policies by 3. By 2019, increase the number of smoke free policies multi-unit rental properties by 3.

Action Plan			
Activity	**Target Date**	**Potential Partners/Roles**	**Output**
Develop and pilot test a healthy home education campaign (including healthy home messages and checklist).	6/30/15	MDH/TA Seniors/Input Youth/Input Renters/Input Property Owners/Input Health Care Partners Human Service Agencies Public Health	Healthy Home Education Campaign
Implement a healthy home public education campaign.	1/31/16	Media/Message Delivery Health Care Partners/ Message Delivery	Healthy Home Messages Communicated

Action Plan

		Human Service Agencies/ Message Delivery Public Health/ Message Delivery	Resources
Advocate for tobacco free multi-unit rental housing.	10/31/14	MDH/TA Live Smoke-Free MN/TA Public Health Staff/Implementation	Policy
Assess built environment for safety and support of active living, and advance active living policies	11/30/14	MDH/TA Region V Development Commission/TA Public Health Staff/Implementation	Completed assessment Policies
Provide online healthy homes assessment training to identified public health staff	12/31/15	Public Health Staff/Participation National Center for Healthy Housing (online training)	Capacity Resources
Public Health Nurses conduct healthy home assessments.	4/30/16	Public Health Staff/Implementation	Increase healthy home practices
Develop a referral system for healthy home assessments to be done as part of home visits.	12/31/16	Public Health Staff/Input Human Service Agencies/Input Clinics/Hospitals/Input	Outreach plan for conducting healthy home assessments

Alignment with State/National Priorities:

Healthy People 2020: Social determinants of health is a new, yet important, topic area for HealthyPeople. This topic area focuses on a goal of creating social and physical environments that promote good health for all, which is one of the four overarching goals for the decade.

The Guide to Community Preventive Services: Low-income neighborhoods may lack resources that support safety and good health, including access to safe housing. Interventions can improve household safety.

Sources:

MTW 2013 Community Health Survey

U.S Department of Health and Human Services

HealthyPeople 2020

Healthy Minnesota 2020

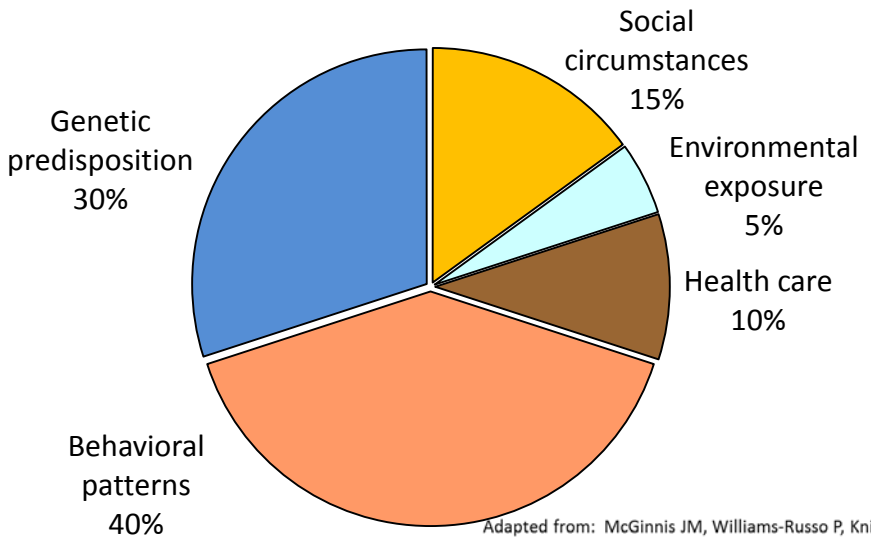
National Prevention and Strategy

World Health Organization

Minnesota Department of Health

The Guide to Community Preventive Services

Proportion contributed to premature death:



Adapted from: McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21(2):78-93

How We Will Know We Are Making A Difference:

Performance Measures		
Short Term Indicators	**Source**	**Frequency**
Number of partners engaged in developing local principles of social determinants of health	Sign In Sheets, Meeting Minutes	Reviewed One Time Annually
Number of healthy home assessments conducted	PH Doc	One Time Annually
Number of Healthy Home Campaign materials disseminated	Healthy Home Campaign Dissemination	One Time Annually
Long Term Indicators	**Source**	**Frequency**
Environmental Quality	County Health Rankings	One Time Annually
Partner survey related to knowledge of social determinants of health and incorporation of principles	Survey Monkey	One Time Annually
Poverty Rate	U.S. Census, Vital Statistics	One Time Annually
Client survey regarding knowledge of healthy home campaign and home assessment	Local Client Survey	One Time Annually
Assessment of policies that advance health	M-T-W Grant Reports	One Time Annually
Perception of safe and affordable homes	M-T-W Community Health Survey	Every 3-5 years