2014

WABASHA COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN

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Wabasha County Public Health
Wabasha, MN
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To be the healthiest communities in which to live, learn, work, and play.

The Wabasha County Community Health Improvement Plan is posted online at www.co.wabasha.mn.us

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CORE TEAM MEMBERS

2013-2014 Core Team Members

Fit City of Wabasha/Kellogg- Carol Scott

St. Elizabeth Medical Center- Jenny Schlagenhaft

Wabasha County Human Services- Terry Smith

Wabasha County Public Health- Judy Barton, Jodi Johnson

Wabasha County Advisory Committee- Rita Fox

The development of this community health improvement plan was led by core team members. This plan would not have been possible without input and guidance from the community members and partners identified on the next page.

Wabash County and St. Elizabeth Medical Center would like to thank the following organizations and participants for being part of the planning sessions that led to the community health priorities as outlined in this report.

Becky Rietmann-Health and Human Services Advisory Committee
Colleen Hansen-Three Rivers Community Action Council
Terry Smith- Wabasha County Social Services
Rita Fox- Community Volunteer, Health and Human Services Advisory Co.
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Kim Scanlan-Three Rivers Community Action Council
Tammy Fiedler- Wabasha County Public Health
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Maureen Nelson-United Way of Goodhue/Wabasha/Pierce
Cea Grass-South Country Health Alliance
Mary Orban- Minnesota Department of Health
Pastor -Faith Lutheran Church
Kim McCoy- Stratus Health

Wabasha County

This Community Health Improvement Plan encompasses the geographic area of Wabasha County which is located in South East Minnesota. Wabasha County has 550 square miles and a population of 21,676 residents, 8,277 households, and 5,876 families. This is a 2.7% decrease in population from the previous census done in 2000. The population density is 41 people per square mile. The racial makeup of the county is 97.97% White, 0.25% Black or African American, 0.27 %Native American, 0.43% Asian, 0.62% from other race, and 0.45% from two or more races. 1.68% of the population is Hispanic or Latino of any race.

The county is made up of several small and rural communities with the county seat located in the city of Wabasha. Other incorporated towns include, Plainview, Lake City, Mazeppa, Hammond, Millville, Kellogg, Weaver, Theilman, Zumbro Falls, Bellchester, Oak Center and Reads Landing. Due to the proximity to the city of Rochester and the number of Wabasha County residents who work, shop, and seek their entertainment and recreation in Rochester, Wabasha County is consider a Metropolitan Statistical Area of Rochester. Within Wabasha County agriculture and agri-businesses are the primary sources of employment

Wabasha County has an aging population with the percent of people 65 and older at 17%, the state average is 12.9%. 0ur 65 and older dependency ration per 100 population of 15-64 is 26.6% compared to the state average of 19.2%. Of the elderly 28.9% live alone.

6.1% of our population are children under 5 and 25.5% of our population are children are 0-19. Wabasha County's Child dependency ration under age 15/100 ages 15-64 is 29.5% compared to the state average of 29.9%. We have a higher than state percentage of births to unmarried mothers and births to teen Moms ages 18-19, however a lower than state average of births to Moms under the age of 18.

Wabasha County total dependency age ratio is 56.1%, which is 5 % higher than the state average, and a 6% increase from 2006. 10.7% of our children below the age of 18 are living in poverty and 25.3% of our total population is living at or below 200% poverty. Educational attainment of the population 25 plus who live in poverty is: 25% have less than a high school degree, 34% have a high school diploma or GED, 30% have some college or Associates Degree, and 11% have a Bachelors Degree or higher.

The percentage of Wabasha County residents with no insurance is 11%, compared with 9.1% state average. Another 12% of Wabasha County residents report they are underinsured. Availability of providers to our residents shows that primary care physicians (841.1 residents/ physician), dentists (3,618 residents/dentist) and mental health providers (21,873 to 1) is well below the state average for all three provider types.

Leading causes of death to Wabasha County residents are:

- Heart Disease- 24%
- Cancer - 23.5%
- Unintentional Injury- 8%

According to the 2012 County Health Rankings 12 % of our adult population consider themselves in poor/fair health (National is 10% and state is 11%), 3.7 % consider themselves in poor physical health (National is 2.6% and state is 3%) and 4% of our adult population reported having poor mental health (National 2.3% and state 2.7%)

The Wabasha County Community Health Needs Assessment process began in the summer of 2013 with the establishment of a leadership team. Team members included:

- Jenny Schlagenhaft, Director of Community Relations, Saint Elizabeth's Medical Center. Jenny has been employed with Saint Elizabeth's for 10 years. She has worked in health care public relations and communications for more than 32 years. She is actively involved in community partnerships that emphasize community health and promote wellness and prevention.
- Kim McCoy, MPH, MS, Program Manager,Stratis Health
  Kim provides leadership on public health and health care quality initiatives throughout Minnesota. She works with communities to facilitate collaborative assessment and planning. Kim brings together people from different settings and disciplines to develop innovative ideas and implement evidence-based best practices to improve health and health care. Kim holds an M.S. in Health Services Research and an M.P.H. in Public Health Administration from the University of Minnesota.
  Stratis Health has the expertise and experience with a wide array of health care improvement services. They are well-integrated with the Minnesota health care community to facilitate improvements for people and communities especially in reducing health disparities among vulnerable populations. Stratis Health knows the rural community and has led rural health quality work aimed at improving rural care delivery to assist critical access hospitals in addressing their unique challenges and opportunities.
- Mary Orban, Regional Consultant, Minnesota Department of Health
  Mary has more than 28 years working in public health at the local and state levels. Mary has worked for local public health departments in Rice and Mower counties and in Michigan for a variety of program areas, including providing home visiting services to families. During the past 11 years, Mary has worked for MDH as the public health nurse consultant for the Southeast and part of South Central regions.
- Judy Barton, RN, PHN, Director of Wabasha County Public Health Department
  Judy has been a registered nurse for 38 years with 34 of those years in public health. She has been a public health director/community health administrator responsible for Community Health Needs Assessment and planning for the past 30 years. She has served on several state-wide public health committees throughout her career.

The leadership team then invited more than 400 community members representing a broad spectrum of the county to participate in a Wabasha County Health Needs Assessment titled: "Call for Action & Collaboration" a two-part workshop series. Attendees included representatives from the following organizations:
Wabasha County Public Health, Wabasha County Social Services, Wabasha County, City of Wabasha, Three Rivers Community Action, Saint Elizabeth's Medical Center, United Way, Dental Clinics, Wabasha County Public Health Advisory Committee, Hospice, Elder Network, Churches, Senior Advocacy, South Country Health Alliance, Common Closet, Wellness Center, Lake City Medical Center, Health Partners, MN Department of Health, and Stratus Health

Additional outreach activities that served to broaden the scope of the assessment process Included discussions with providers and public health officials in Goodhue County, Minnesota, and Pepin and Buffalo Counties in Wisconsin, all neighboring counties.

The Assessment Process- Process Overview

The leadership team agreed to adopt and follow the Minnesota Department of Health Community Health Assessment Model as a framework for evaluating and analyzing county health needs.

Organize and Plan

Face-to-face meetings and conference calls were used to establish the structure, time frames and responsibilities for leadership team members. Minnesota Department of Health and Stratis Health representatives served in a consulting capacity, which local public health and hospital leaders took direct action to gather and analyze county data.

Data Gather and Analysis

- Once the basic work plan was established, team members launched a thorough process of collecting and analyzing critical data sets and health indicators categorized under six primary themes:
  1. People and Place
  2. Opportunity for Health
  3. Healthy Living
  4. Chronic Disease and Conditions
  5. Infectious Disease
  6. Injury and violence
- The evaluation of the data gathered resulted in the creation of two summary reports:
  1. Wabasha County Profile: People and Place (Appendix A)
  2. Call for community Action and Collaboration: Key Health Findings (Appendix B

A formal presentation of these resources and data sets was shared with key stakeholders during the two Community Health Needs Assessment workshops to engage community leaders, providers and citizens in a rigorous process of gaining feedback and prioritizing county-specific health needs.

Following the formal presentation of data and findings, workshop participants were engaged in large-group and small-group discussions facilitated by a Stratis Health consultant. Using standard quality improvement tools, including the Minnesota Technology of Participation facilitation process, Affinity Diagram, Nominal Group Technique and the Decision Matrix,

participants offered feedback and rankings that resulted in the development of the following:

A vision for a healthy community
The top 11 health needs based on data presented
A preliminary list of community resources and assets
The prioritization of the top four health needs in Wabasha County
A jump start of the implementation process by identifying preliminary strategies under each broad theme that can be taken to improve community health

Following the workshops, a progress report and invitation to participate as an implementation plan work team member were created and disseminated to workshop participants and all key stakeholders within the county. This report was also publicized in our local weekly newspapers.

Community Assets Identified

Prior to the identification of health needs, workshop participants were guided through a large group visioning process. Members were asked to envision a "healthy community." The vision exercise was a precursor to the identification of existing community assets. This listing was categorized to fully understand the diversity of skills, abilities, talents, and resources.

- Individual Talents/Skills within our communities:
  Advocates, health educators, coach, dispenser of information, information and referral resources, team builder, story teller, listener, organizer, socialization, problem solver, proof reading, research, research translator, finance analysis, project planner, small scale farmer, swimming and gymnastics instructor, quilter, grant writer, nursing
- Organizational Resources:
  Fundraising, staffing, facilities, leadership, experience, grant funding, community planning, education/support for seniors, aging in place resources and facilities, caring for the sick and elderly, social hub for community, opportunities for volunteers, resources for fulfilling immediate needs for people in the community, access/knowledge of community resources, government programs, strong focus on prevention and wellness, food shelf, access to health, schools, government agencies, civic groups, faith communities, hospitals, nursing homes, dental offices, fitness center, libraries, service organizations, funding agents, non-profits, fire/police/ambulance, businesses, providers, insurers, Chamber of Commerce, and health relation associations
- Other Partners/Resources:
  Mentorship Program, physicians, chiropractors, Mayo Clinic Health System, Area Agency on Aging, mental health providers, law enforcement, Catholic charities, emergency medical services, city/county officials, day care providers, media, pharmacies, clergy, senior dining, consumers, housing authorities, food shelves, libraries, transportation, and sexual assault services

Top 10 Health Needs Identified

Higher Percentage than the state average of Older Adults

The aging population is rising resulting in a greater number of seniors living alone. Statistics find an increasing prevalence of age-related issues such as arthritis, disability and mobility limitations, dementia, Alzheimer's disease, falls, and medication

management issues. A growing demand for family caregiver supports, affordable independent senior housing and in home assistance was noted.

Insufficient access to Mental Health services, especially specialty mental health prescribers.

The population is experiencing a higher number of mentally unhealthy days. Teen girls have a high level of suicidal thoughts and seniors have a rising depression rate. There is a high level of risky behaviors reported by teens, such as cutting/intentional injuries and bullying.

Declining immunization rate & reemergence of vaccine preventable Infectious Diseases

Declining immunization rates among older children has been found as well as an increasing prevalence of re-emerging communicable diseases, such as pertussis (Whooping Cough).

Unique Environmental Health risks

There is a higher than state average level of radon and lead in homes and nitrate levels in ground water.

Lack of access to Oral Health

Lack of access to dental services for the low-income population and many dentists don't accept Medicaid patients. One of the top health issues among children is prevalence of cavities. More children and adults need an annual dental exam and cleaning.

Chronic Disease/Nutrition/Physical Activity

The county mirrors the national epidemic with a rising prevalence of overweight and obesity in all populations. Lack of physical activity and healthy eating was reported among all populations.

Self reported substance abuse

Self-reported behaviors find a high binge drinking rate among teens and adults and increase use of alcohol among seniors. Rising rates of smoking among young adults was also among the findings.

Unintentional Injury and Violence

Wabasha County residents have a high prevalence of accidental falls, traumatic brain injuries (TBI) and poor motor vehicle behaviors (seat belt use, DWI/DUI, speed, and inattentive driving.

Adolescent Sexual Health

There is a high incidence of sexual intercourse among 9th and 12th grade students. A higher teenage birth rate was reported. The sexually-transmitted disease rate (Chlamydia) is also high.

Maternal/Infant Child Health issues

A high percentage of births to unmarried mothers have been recorded and a high number of grandparents are living with and responsible for grandchildren.

Access to Transportation

There are limited transit services in the Wabasha County but a growing need for transportation to medical appointments, services and job-seeking activities. Low-income people lack funds to pay for gas/and or car repairs.

Health Priorities

Upon a thorough review and discussion of key findings, the facilitator led key stakeholders through a prioritization and ranking process using a problem importance index with the following criteria: (See appendix C)

- Percent of the county residents that are impacted by this issue
- Practical/realistic to address issue
- Cost to address or cost of not addressing – cost/benefit relationship Available resources – including state, federal or local funding and staffing
- Severity of the impact of the issue
- Barriers to addressing the impact
- Level of community Support

Based on criteria, the following top four most critical health needs in Wabasha County were identified:

1. **SENIOR HEALTH**: Improving the health and well-being of aging population thus allowing them to remain in their own homes.
2. **PREVENTION & WELLNESS**: Reducing obesity and promoting healthy habits (nutrition and physical activity) to prevent and or mange chronic diseases.
3. **MENTAL HEALTH**: Improving access to mental health services
4. **ORAL HEALTH**: Improving oral health and access to affordable dental services

Developing the Community Health Improvement Plan

After the two Community Health Needs Assessment workshops and the prioritization of needs in Wabasha County the leadership team distributed a progress report to key stake holders and invited them to confirm the priorities and to offer feedback and input.

Following the solicitation of feedback and support from key stakeholders the leadership team put out a call to community organizations and citizens for workgroup members and team leaders for each of the four priority areas. The work teams were responsible to develop and implement a Wabasha County Community Health Needs Assessment Improvement plan in their priority area that would achieve county-wide health improvement.

The leadership team was able to recruit volunteers for all priority areas, except oral health. It was decided that initially the leadership team would move forward with the other 3 priority areas and attempt to recruit team members for the oral health priority in year 2 of the implementation phase.

Stratus health held two educational sessions with team leaders on goal setting, methods setting, evidence based practices, and how to move the team forward as progress is made.

Each priority area team then met, studied further data and narrowed their focus for initial goals and methods.

The Senior Needs team decided to focus first on fall prevention. Wabasha County has a higher percentage of their elderly residing in Nursing Facilities than the statewide average. In addition the number one reason for admission to our Nursing Facilities was injuries as a result of a fall.

The Prevention and Wellness team decided to initially focus on childhood obesity and reducing the incidence of Childhood Obesity in Wabasha County by implementing the 5-2-1-0- program in our schools, and expanding to other areas in the future.

The Mental Health team focused on access to Mental Health care, particularity mental health specialist who can prescribe. In addition the need for in home therapy for our high risk families was identified and will be address in year two of this 5 year plan.

Senior Needs Community Health Improvement Plan

Date Created: January 6, 2014 **Date Reviewed/Updated: 5/8/14, 9/5/14**

PRIORITY AREA: Senior Needs
GOAL: Improve the health, function and quality of life of older adults to keep them safely in their homes.

PERFORMANCE MEASURES **How We Will Know We are Making a Difference**		
Short Term Indicators	**Source**	**Frequency**
By end of 2014, attendees at fall/prevention educational program assessed with a risk of falls will have an individual action plan developed	*Count of action plans developed*	*At conclusion of each educational program*
By end of 2015, Number of individuals continuing to follow fall prevention action plan will be 50%	*Staff tracking of plan compliance*	*Annual*
By end of 2015, Increase the % of seniors who are actively engaged in programs/services that promote physical activity, balance improvement and fall reduction by 5%	*Attendance records*	*Annual*
By end 2014, Attendees at Living Well with Chronic Diseases series will have an individual action plan developed	*Count of action plans developed*	*At conclusion of series*
By end of 2015, Number of individuals continuing to follow action plan to manage chronic diseases will be 50%	*Staff tracking of plan compliance*	*Annual*
Long Term Indicators	**Source**	**Frequency**
By 2017, experience 5% fewer falls in Wabasha county in older adults	*MN Dept of Health*	*Annual*

OBJECTIVE #1: Increase awareness among seniors and their caregivers of fall risk factors, factors contributing to decline in physical mobility, importance of exercise and balance, and fall prevention strategies
BACKGROUND ON STRATEGY Source: Falls Free: Promoting a National Falls Prevention Action Plan by the National Council on the Aging Preventing Falls: How to Develop Community based Fall Prevention Programs for Older Adults by CDC and Healthy People 2020 **Evidence Base*:*** Yes **Policy Change (Y/N): N**

ACTION PLAN					
Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**	**Progress Notes**
Develop education program for seniors to address fall risk factors, factors contributing to decline in physical mobility, importance of exercise and balance, and fall prevention strategies	June 2014	Staff time Volunteer time	Jodi Johnson, WCPH Rita Fox, SEMC	Increased awareness of fall risk factors, factors contributing to decline in physical mobility, importance of exercise and balance, and fall prevention strategies	
Develop a pre and post test for participants in educational programs to measure increased awareness	June 2014	Staff time Volunteer time	Jodi Johnson, WCPH Rita Fox, SEMC	Post test will show increased awareness over pre test of risk factors, factors contributing to decline in physical mobility, importance of exercise and balance and of fall prevention strategies	
Present educational program to seniors and their caregivers at three different sites where seniors gather in Wabasha County	January 2015	Staff time Volunteer time Lap top with LCD Information packets	Jodi Johnson, WCPH Rita Fox, SEMC	Increased awareness of fall risk factors, factors contributing to decline in physical mobility, importance of exercise and balance, and fall prevention strategies	

OBJECTIVE #2: Assess individual seniors for risk of falls

BACKGROUND ON STRATEGY
Source: Falls Free: Promoting a National Falls Prevention Action Plan by the National Council on the Aging
Preventing Falls: How to Develop Community based Fall Prevention Programs for Older Adults by CDC and
Healthy People 2020
Evidence Base:
Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Research and select assessment tools for self assessment of fall risk, balance and mobility	May 2014	Staff time Volunteer time	Jodi Johnson, WCPH Rita Fox, SEMC	Identification of seniors at risk for falls	
Research and select tool for individual goal/action planning	May 2014	Staff time Volunteer time	Jodi Johnson, WCPH Rita Fox, SEMC	Tools track compliance with action plan	
Conduct assessments with seniors at the educational programs	January 2015	Staff time Volunteer time	Jodi Johnson, WCPH Rita Fox, SEMC	Identification of seniors at risk for falls	
Meet with seniors with assessment scores showing any risk of falls to provide education on interventions to prevent falls, on available resources and to develop their own action plan	January 2015	Staff time Volunteer time	Jodi Johnson, WCPH Rita Fox, SEMC	*Increased awareness of resources *Actions plans developed	
Develop plan for follow up with seniors who initiated an action plan	January 2015	Staff time Volunteer time	Jodi Johnson, WCPH Rita Fox, SEMC	Participation and progress toward goals	

OBJECTIVE #3: Increase the % of seniors who are actively engaged in programs/services that promote physical activity, balance improvement and fall reduction

BACKGROUND ON STRATEGY
Source: : Falls Free: Promoting a National Falls Prevention Action Plan by the National Council on the Aging
Preventing Falls: How to Develop Community based Fall Prevention Programs for Older Adults by CDC and Healthy People 2020
Evidence Base: Matter of Balance workshops for the elderly
Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Develop list of local resources/services for improving exercise, mobility and balance	May 2014	Staff time Volunteer time	Jodi Johnson, WCPH Rita Fox, SEMC	*Increased awareness of resources *Use of resources in action plans	
Host one "Matter of Balance" workshop with trained outside facilitators	October 2014	Staff time Volunteer time Facilitator expenses Laptop with LCD	Jodi Johnson, WCPH Rita Fox, SEMC	Increased participation in programs and services to improve balance	

OBJECTIVE #4: Provide one Living with Chronic Disease Series

BACKGROUND ON STRATEGY
Source: : Falls Free: Promoting a National Falls Prevention Action Plan by the National Council on the Aging
Preventing Falls: How to Develop Community based Fall Prevention Programs for Older Adults by CDC and Healthy People 2020
Evidence Base: Stanford University Chronic Disease Self-management Program
Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Sponsor facilitator training for two individuals for Living with Chronic Disease	Date of next facilitator training	Staff time Volunteer time Mileage	Jodi Johnson, WCPH Rita Fox, SEMC	Ability to host Living Well series	

		Training expenses			
Host one six week series of Living Well with Chronic Disease	December 2014	Staff time Volunteer time Informational handouts Room rental	Jodi Johnson, WCPH Rita Fox, SEMC Facilitators	*Increase awareness of benefits of self management of chronic disease *Action plans track progress	

Prevention & Wellness Community Health Improvement Plan

Date Created: November 1, 2013 **Date Reviewed/Updated: May 2014**

PRIORITY AREA: Prevention & Wellness
GOALS: Help children and families eat healthier and be more active through the implementation of 5-2-1-0 Let's Go!

PERFORMANCE MEASURES **How We Will Know We are Making a Difference**		
Short Term Indicators	**Source**	**Frequency**
5= By 2015, increase the number of children and adults eating at least 5 servings of fruits and vegetables daily by 5%.	*Student Survey* *BRFS*	*Annual*
2= By 2015, increase the proportion of children/adolescents who view television, videos or play video games for no more than 2 hours a day.	*Student Survey* *BRFS*	*Annual*
1= By 2015, increase the proportion of children and adults who meet current Federal physical activity guidelines for aerobic physical activity by 5%.	*Student Survey* *BRFS*	*Annual*
0=Increase access to water and low-fat milk in schools, childcare and homes; limit or eliminate sugary beverages		
Long Term Indicators	**Source**	**Frequency**
By 2017, experience no increase in the percentage of overweight children/adolescents.	*Student Survey*	*Annual*
By 2017, experience no increase in the percentage of overweight adult.	*BRFS*	*Annual*

OBJECTIVE #1: Implement 5-2-1-0 Goes to School
BACKGROUND ON STRATEGY Source: Healthy People 2020 and 5-2-1-0 Let's Go! Evidence Base*:* 5-2-1-0 obesity prevention program Policy Change (Y/N): N
ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Sponsor 4-week 5210 campaign for k-5 graders at Wabasha-Kellogg and St. Felix School Sponsor 4-week 5210 campaign for k-5 graders at Plainview-Elgin-Millville School	March 2014 October 2014	School tool kit with student and parent packets Staff Time Volunteer Time	Julie Jacobs, SEMC Ashley Marx, W-K School Carrie Williams, St. Felix School Kim Ihrke, PEM School	• Increased awareness of 5210 messages • Logs track weekly participation and progress toward goals • Recognition and rewards for students who meet desired participation goals	
Develop 5210 maintenance program	May 2014	School tool kit with family resources Staff Time Volunteer Time	Julie Jacobs, SEMC Jenny Schlagenhaft, SEMC Parent/teacher organizations	• Maintenance program is developed • 5210 practices continue at home with leadership from parents	
In collaboration with school wellness committees, establish and revise school polices that promote System/Policy/Environment (SPE) changes that encourage 5210 practices	Oct 2014	School tool kit with SPE resources Staff Time	Julie Jacobs, SEMC Jenny Schlagenhaft, SEMC Ashley Marx, W-K School Carrie Williams, St. Felix School Kim Ihrke, PEM School	• A minimum of two SPE changes are approved and accepted by leadership	
OBJECTIVE #2: Implement 5-2-1-0 Health Care					
BACKGROUND ON STRATEGY Source: Healthy People 2020 and 5210 Let's Go Evidence Base: 5-2-1-0 program Policy Change (Y/N): Y, requires local medical clinics to incorporate the parent questionnaire into well-child visits.					
ACTION PLAN					

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
5210 Healthy Habits Questionnaires, which are distributed to every parent during well-child primary care clinic appointments at Wabasha Clinic, prompts discussion and education between provider and parents	Feb 2014	Healthcare tool kit with educational resources Staff Time	Jenny Schlagenhaft, SEMC Anna Arens, Wabasha Clinic	• Questionnaires are being distributed, completed and submitted to providers • Meaningful conversations and action planning takes place during clinic appointment • Action steps are tracked in patient record	
Distribute 5210 Healthy Habits Questionnaires to WIC clients and lead discussion and education between public health nurses and parents	March 2014	Healthcare tool kit with questionnaire and educational resources Staff Time	Jenny Schlagenhaft, SEMC Tammy Fiedler, WCPH WIC coordinator	• Questionnaires are being distributed, completed and submitted to providers • Meaningful conversations and action planning takes place during clinic appointment • Action steps are tracked in patient record	
Post 5210 posters with key messages in every exam room at Wabasha Clinic and WIC	February 2014	5210 Posters Staff Time	Anna Arens, Wabasha Clinic Tammy Fiedler, WCPH	•	
Investigate the clinic practices for measuring and calculating BMI at every well-child visit	February 2014	Staff Time	Anna Arensm Wabasha Clinic	• All providers are consistently calculating BMI and when score falls outside of desirable, a specific set of practices, recommend-ations and referrals are made/ followed to ensure BMI improvement.	

OBJECTIVE #3: Implement 5-2-1-0 Early Childhood					
BACKGROUND ON STRATEGY Source: Healthy People 2020 and 5210 Let's Go Evidence Base: 5-2-1-0 Policy Change (Y/N): Y					
ACTION PLAN					
Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**	**Progress Notes**
Introduce 5210 toolkit to all licensed childcare providers in Wabasha County	June 2014	Early childhood tool kit Staff Time Volunteer Time Printing Postage	Carol Scott, SEMC Shannan Bleed, Wabasha County Social Services	• Every licensed childcare provider receives a toolkit • A minimum of 50% of the providers complete an internal audit/assessment of their program. • A minimum of 25% of the providers implement at least two 5210 practices by end of 2014	
OBJECTIVE #4: Implement 5-2-1-0 Communities					
BACKGROUND ON STRATEGY Source: Healthy People 2020 and 5210 Let's Go Evidence Base: Policy Change (Y/N): N					
ACTION PLAN					
Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**	**Progress Notes**
Develop comprehensive communication plan across all sectors that builds awareness of the key messages of 5210: Tactics may include – social media, websites, posters, brochures, press releases, events, public service announcements, etc.	June 2014	5210 tool kits and resources Publicity/Media support Staff Time Volunteer Time	Jenny Schlagenhaft, SEMC Carol Scott, SEMC Fit City Collaborative	• Children and families are exposed to 5210 messages where they live, learn, work and play. • Community-	

				wide SPE changes encourage and reinforce 5210 practices	
Fit City Restaurant Challenge is sponsored and features the 5210 commitment	May 2014	Fit City Restaurant Challenge materials 5210 tool kits Staff Time Volunteer Time Media support	Fit City Collaborative	• At least 7 restaurants in Wabasha participate in Fit City 5210 Restaurant Challenge • At least 25% of patrons select the 5210 featured entrée and submit scoring	
In partnership with Scheel's grocery store in Wabasha, adopt 5210 messages in grocery store signage, recipes and advertising	February 2015	5210 tool kits Staff Time Volunteer Time	Julie Jacobs Bob Scheel and staff	• Store signage, advertising and recipes incorporate 5210 brand	

Mental Health Community Health Improvement Plan

Date Created: Nov 13, 2013 **Date Reviewed/Updated:** 3/6/14, 6/1/14

PRIORITY AREA: Mental Health		
GOAL: : Improve access to mental health services for all ages in Wabasha County		
PERFORMANCE MEASURES **How We Will Know We are Making a Difference**		
Short Term Indicators	**Source**	**Frequency**
Meetings will be held with Mental Health providers for discussion of issues and steps that need to be taken to address the issues	Meeting dates and attendance by county and mental health staff	Annually
Partnerships with neighboring counties with similar mental health access issues will be developed to address the shortage of mental health providers in our rural counties	Evidence of counties partnering, (ie partnership agreements, joint ventures, etc.)	Annually
Long Term Indicators	**Source**	**Frequency**
Increase access to specialty providers of mental health services with prescribing authority	Actual increase in numbers as evidenced by , community resources review.	Annually
Increased in Mental Health services available to children in Wabasha County	Actual increase as evidenced by community resources review	Annually
Improvement in response to Mental Health Crisis's in Wabasha County	Survey of Law Enforcement, local ER, and jail staff	Every other year.

OBJECTIVE #1: Increase access to Mental Health Specialist with prescribing authority

BACKGROUND ON STRATEGY Evidence shows mental health can be improved through prevention and by ensuring access to appropriate, quality mental health services.
Source: 2020 healthy people
Evidence Base*:* Y
Policy Change (Y/N): Y

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Meet with Local SS Directors and State Mental Health Consultant for the SE Regional Hub to look at way of improving access to Mental Health Specialist prescribers for residents of our SE Hub.	Jan-July 2014	County staff time, HVMHC staff time	Terry Smith-WCSS Judy Barton-WCPH	Collaboration of the SE Regional Hub resulting in increased access to mental health prescribers	
SE regional hub to develop a joint mental health prescriber team to serve all 5 counties with services both on site and via ITV.	Aug-Dec, 2014	Financial support from each of the counties to assist with administrative costs for HVMHC	Terry Smith-WCSS Judy Barton-WCPS County SS Directors from Houston, Fillmore, Winona, and Goodhue Counties	Addition of 3 mental health nurse practitioners or physician assistants. This staff would be employed by and housed at Hiawatha Valley Mental Health Center.	
Arrange for an ITV station in each county and at the base at the HVMHC in Winona and phase in use of ITV psychiatry/prescribing by county as funding becomes available.	Dec. 2014	County dollars to help support ITV equipment at each site.	Terry Smith-WCSS Judy Barton-WCPS County SS Directors from Houston, Fillmore, Winona, and Goodhue Counties	Ability to access via ITA a prescriber as needed from any of the five counties without resident needing to drive to Winona.	

OBJECTIVE #2: Increase mental health services to high risk children, risk can be due to psycho-social or health risk factors

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Develop a team of stakeholders to meet around the issue of	Jan. 2014	Stakeholders staff time	John Dahlstrom-WCSS	Identification of top needs and prioritization of	March 2014 3 meetings held. Top 3

Children's Mental Health			Judy Barton-WCPH	needs	priorities identified-
Committee to establish priority areas for improved service needs within our county	April 2014	Stakeholders staff time	John Dahlstrom-WCSS Judy Barton-WCPH	Top need identified for the committee to address	April 20104 Top need identified as in home family therapy
Establish an in home family therapy provider who will have a primary focus of Wabasha County residents	Dec. 2015	Children's Mental Health provider willing to come into Wabasha Co. Financial resources to assist a Mental Health provider to locate in our county County staff time for grant writing and bringing in a new provider	John Dahlstrom-WCSS Judy Barton-WCPH	In home family therapy provider available to high risk Wabasha County families	

OBJECTIVE #3: Develop an improved response to individuals in Mental Health Crisis in our County

BACKGROUND ON STRATEGY Evidence shows mental health can be improved through prevention and by ensuring access to appropriate, quality mental health services.
Source: 2020 healthy people

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Collaborate with SE Regional Hub to research opportunities to develop a 24/7 mobile crisis intervention team which would respond to an individual's mental health crisis. This would allow for more appropriate assessment and referral of the individual vs law enforcement handling these crisis's alone.	4/1/14	Staff Time	John Dahlstrom-WCSS Lynn Skinner-Regional MI consultant SE Hub Social Services Directors	SE Hub collaborative approach to Mental Health crisis .	
Research and apply for grant funding to develop and	12/31/14	Staff time to research and write grant for	Lynn Skinner	Grant approved for funding of a	

implement a mobile crisis intervention team for the SE Regional Hub.		crisis response team	County SS Directors	mobile crisis team.	
Implement Mobile Crisis Team in the SE Regional Hub service area as per grant requirements.	12/31/2015	Funding, able and willing mental health provider (center)	Lynn Skinner County SS Directors	Fully functioning mobile crisis team which will respond when requested anywhere within the SE Hub	

Appendix A- Wabasha County People and Place

Wabasha County People and Place

POPULATION STATISTICS

- 2010 Actual Census Population 21,676
- 2006 Estimated Population 22,286
- Percentage of population decrease from 2006 to 2010 2.7%
- State Averaged a 2.6% gain during this timeframe
- Neighboring counties growth or loss
  - Winona- 4% gain
  - Fillmore-1.5% loss
  - Houston-4% loss
  - Goodhue-.5% gain

Mothers and Children

Percent of Births to unmarried mothers

•2006-2010 Wabasha County 30.2%

•2001-2005 Wabasha County 26.2%

•2006-2010 State 32.9%

•2001-2005 27.9%

Teen Birth Rate -# of births /1000 females in the specific age group (2008-2010)

	15-17	18-19	15-19
•Wabasha County	*	52.6	22.2
•State of MN	11.5	43.6	24.6

Teen Pregnancy Rate -# of pregnancies /1000 females in the specific age group (2008-2010)

	15-17	18-19	15-19
•Wabasha County	*	61.1	26.0
•State of MN	16.0	58.1	33.2

Children Continued

School Enrollment PreK-12

•2010-2011 4491

•2007-2008 4601

•% loss of students in our schools 2.7%

Percentage of children under age 5

•Wabasha County (1,332) 6.1%

•State of MN (355,504) 6.7%

Percentage of children 0-19

•Wabasha County (5534) 25.5%

•State of MN (1,431,221) 27%

Child Dependancy Ratio under age 15/100 pop ages 15-64

•Wabasha County 2010 29.5%

•State of MN 2010 29.9%

OUR ELDERLY RESIDENTS

GENERAL STATISTICS AND FINANCIAL STATISTICS.

Total dependancy ratio-(under 15, over 65)/100 pop of 15-64

•Wabasha County 2010	56.1%
•State of MN 2010	51.1%
•Wabasha County 2006	49.1%
•State of MN 2006	47.2%

Percent of 25+ yo with <or=to HS Education

Wabasha County (2005-2009)	50.2%
State of MN(2005-2009)	37.1%

Percent of under 18 years living in poverty

Wabasha County	10.7%
State of MN	13.9%

Percent of all people living at or below 200% Poverty

Wabasha County	25.3%
State of Mn	25.5%

Poverty Status of Families with children under 18 y.o in Wabasha County

•All families	7.2%
•Married Couple Families	3.6%
•Female household families (no husband present)	15.1%

Educational attainment of the population 25+ with poverty status in the last 12 months for Wabasha County residents.

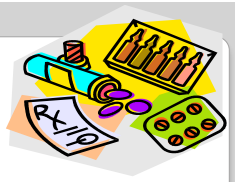
•Less than high school	25%
•High school grad or GED	34%
•Some college or Associates Degree	30%
•Bachelors Degree or higher	11%

•Median Income by Educational Attainment and Gender in 25+ population for Wabasha County residents

•Less Than high school graduate-	Male $26,475	Female $15,530
•High School or GED -	Male $33,137	Female $20,743
•Some College or Associate Degree -	Male $39,962	Female $27,030
•Bachelors Degree -	Male $51,489	Female $35,338
•Graduate or professional degree	Male $ 62,484	Female $51,245

Employment and Earnings

Access to Medical Care



Health Insurance:

Percent of county residents with no health insurance	11%
Percent of MN residents with no health iansurnce	9.1%
Percent of county residents under insured	12%
People with incomes $25,000-$37,999 who do not have Health insurance	13.8%

Health Care Providers in Wabasha County:

Primary Care Physicians	841:1	State is 636:1
Dentists	3,618:1	State is 2,126:1
Mental Health Providers	21,873:1	State is 1,306:1

HEALTH OF OUR PEOPLE

2010 LEADING CAUSES OF DEATH TO WABASHA COUNTY RESIDENTS

1. Heart Disease	24.0%
2. Cancer	23.5%
3. Unintentional Injury	8.0%

Years of Potential Life Lost Due to the 3 Leading Causes

	to age 65	**to age 75**
1. Heart Disease	90	250
2. Cancer	100	265.5
3. Unintentional injury	107.5	264

All causes of death Years of potential life lost

597.5	1,198

How do Wabasha County Residents view their health ??

According to the 2012 County Health Rankings:

- 12% of our adult population consider themselves in poor/fair health (National 10%, State 11%)
- 3.7% consider themselves in poor physical health (National 2.6%, State 3%)
- 4% of our adult population reported having poor mental health (National 2.3%, State2.7%)

Appendix B-Wabasha County CHIP

Help us Improve the Health of Wabasha County Residents…

A Call for Community Action and Collaboration.

KEY FINDINGS

The following list of themes, with specific needs, challenges, and health impacts, were identified during a preliminary assessment of county data and statistics collected from a variety of sources. Themes align with Healthy People 2020 topics and objectives.

THEME	DESCRIPTION OF NEEDS/CHALLENGES/ HEALTH IMPACTS	SUPPORTING DATA (COUNTY AND STATE SOURCES)
Older Adults	• Aging population is rising • High Elderly Age Dependency Ratio • Rising percent of seniors living alone • Increasing prevalence of arthritis, including disability and mobility limitations • Rising prevalence of dementia, including Alzheimer's disease • High prevalence of falls • Increase in medication management issues • Growing demand for family caregiver supports • Growing demand for affordable independent senior housing • Potential need for more healthcare workers (providers/mid-levels/other), which are difficult to recruit to rural areas • Growing need for in-home assistance (chore services, companionship, transportation) • Need for improved coordination of services	• Projected that number of seniors to double in next 20 years • **28.9% of seniors live alone.** • **Elderly Age Dependency ratio is 26%** • 32.9% of 65+ report having a disability • 21.3% of 65+ report ambulatory limitations • In MN, 827,000 adults have arthritis • 25% increase in Alzheimer's disease by 2025 • **Fatal falls rate in Wabasha County 84.8/100,000 (7 deaths due to falls in 2010)** • **Demand for 243 additional senior housing (market rate, affordable) units by 2016.** • **Demand for 86 congregate, 84 assisted living, and 75 memory care units by 2016** • **40% of Three Rivers Community Action (TRCA) respondents report needing help with personal care or household assistance so they can remain at home**. ***Statistics in bold are county/regional data**

Mental Health	• Higher number of mentally unhealthy days • High level of suicidal thoughts among teen girls • Rising depression rates among seniors • High level of risky behaviors reported by teens (cutting/intentional injuries, bullying) • Increasing need for better access to full continuum of mental health services	• **County rankings respondents report having four mentally unhealthy days in the last 30 (compared to 2.7 in state and 2.3 nationally)** • **23% of 9th grade females thought about killing themselves in last year; 7% of 9th grade females tried to kill themselves.** • **18% of 9th grade girls have hurt themselves through burns, cutting, or bruises.** • **44-55% of youth has bullied or has been bullied.** • **Total number of county residents receiving mental health services in 2010 – 304/10,000.** • **45.3% of TRCA respondents reported needing help reducing isolation and loneliness.**
Immunizations & Infectious Diseases	• Declining immunization rates among older children • Increase prevalence of emerging communicable diseases such as pertussis (Whooping Cough)	• **Reported Pertussis cases in 2011- 0 in 2012 – 10** • **Reported Pertussis cases in SE MN in 2011-55 in 2012- 407** • **MN state 13-17 yo vaccine rates do not reach the 2010 National goal of 90%. Varicella is 81.9, Tdap 82.5, Meningocacal 63.1, Female HPV 3 doses 34.8** • **2010 national adult average for Tdap vaccination is 6% yet the source infectant for infants who have gotten pertussis is Parent 47%, Siblings 20%, Grandparents 8%**
Environmental Health	• High level of radon and lead in homes High nitrate levels in ground water.	• **County average radon level 6.9 pCi/l, national average is 1.3.** • **56% of children under 3 tested for blood lead levels had an elevated rate, state average is 36%** • **See map for nitrate levels throughout the county.**
Oral Health	• Lack of access to dental services for low-income population • Many dentists don't accept Medicare/Medicaid patients • Lack of oral health prevention/education screening and services • More children and adults need annual dental exam	• **12 dentists per 10,000** • **78.8% of adults 18+ report visiting a dentist or dental clinic within the past year for any reason.** • **45.3% of TRCA respondents reported need for a nearby dentist to accept MA and MN Care.** • **Dental caries, or tooth decay, a preventable condition, remains the most common chronic**

	• One of the top health issues among children is prevalence of cavities	**disease of children ages 6 to 19. The national prevalence rate is 25% in children aged 6 to 11, and 59% in adolescents aged 12 to 19 years.** • **At 55%, Minnesota's third grade caries experience (history of dental caries) does not meet the Healthy People target of 42%.** • **About 18% of third grade students have untreated tooth decay.** • **The state average school sealant rate is 64%, however, WC schools do not offer sealant** • **62% of population lives in rural areas with private wells that most likely do not have the optimal amount of fluoride to prevent tooth decay in children.**
Chronic Disease/ Nutrition/Physical Activity/ Substance Abuse	• Rising prevalence of overweight and obesity in all populations • Lack of physical activity among all populations • Lack of healthy eating among all populations • High binge drinking rate among teens and adults • Increase use of alcohol among seniors • Rising rates of smoking among young adults	• **26% obesity rate in adults** • **63% adults obese or overweight** • **16% 9th graders overweight** • **16% 9th graders obese** • **20.2% of WIC children overweight and 14% obese** • **1 in 3 adults don't get enough physical activity** • **41% of 9th graders spend six or more hours per week –screen time** • **85% of Minnesotans do not eat enough fruits and vegetables to meet daily recommendations** • **37.7% of TRCA respondents with limited income said they need help on how to shop for well-balanced, nutritious meals** • **20% of MN adults report binge drinking** • **17% of 9th graders engaged in binge drinking in last two weeks.**
Unintentional Injury and Violence	• High prevalence of accidental falls • High rate of traumatic brain injuries (TBI) • Poor motor vehicle behaviors (seat belt use, DWI/DUI, speed, and inattentive driving)	• **Fatal falls rate in Wabasha County 84.8/100,000 (7 deaths due to falls in 2010)** • **TBI prevalence is 41 (rate 177/100,000) state rate is 92.1/100,000. Major causes of TBI in our county are falls (44.6%), struck by or against something (23%), Motor vehicle 10.5%), motorcycle (7%), ATV (3.5%)**

		• **Wabasha County higher than state average in fatal and serious injury MV accidents due to:** **Alcohol 79/100,000 state 35/100,000 Wabasha County highest in region,** **Inattentive driving 53/100,000 state40,** **No seat belt 61/100,000 state 28/100,000** **Speed 83/100,000 state 36/100,000**
Adolescent Health	• High incidence of sexual intercourse among 9th and 12th grade students • Higher teenage birth rate • Higher SDT rate (Chlamydia)	• **9th graders –23% males and 15% females have had sex one or more times.** • **12th graders – 67% males and 66% females have had sex one or more times.** • **9th graders – 30% never use condom** • **12th graders – 23% never use condom** • **Teen Birth Rate for 18-19 yrs 52.6, state 43.6** • **52 cases of Chlamydia reported in 2010**
Maternal/Infant Child Health	• High percentage of births to unmarried mothers • High number of grandparents living with and responsible for grandchildren	• **30.2% of births born to unmarried mothers** • **17.1%of children born with no father listed on birth certificate** • **12% of children born to mothers who smoked during pregnancy** • **199 grandparents in Wabasha County are living with/responsible for grandchildren**
Transportation ***(Health Determinant)***	• Limited transit services in county • Limited volunteer driver programs • Low-income lack funds to pay for gas and/or car repairs • Growing need for transportation to medical appointments, services, and job-seeking activities	• **75.2% of TRCA Community Partners survey respondents report need for transportation for adults to access services; 63.1% reported need for transportation to look for a job, maintain a job, or access training.**
Others (Audience Feedback)		

Summary of data sources: Minnesota Department of Health; Centers for Disease Control; Minnesota Department of Human Services; Student Survey; County Health Rankings; Three Rivers Community Action (TRCA) Needs Assessment; Saint Elizabeth's Medical Center; US Census; EPA, and WONDER.

Appendix C

Wabasha County Community Health Assessment and Planning
Decision-making

Criteria / Issues	*numbers of people affected*	*seriousness of issue*	*availability of community/financial resources to address need*	*impact on low-income population*	
Increasing prevalence of Alzheimer's					
Lack of services to meet elder care needs					
Lack of affordable, independent senior housing					
Increased alcohol abuse among seniors					
Increased births to single moms					
High prevalence of smoking during pregnancy					
High prevalence of grandparents raising grandchildren					
Lack of access to dental care					
Lack of transportation to medical appointments					
Lack of transportation to job seeking opportunities					
Low immunization rates for young adults and adults					
High rates of sexual activity by teens					
Low rates of condom use by teens					
High rates of teens who have been bullied or bullied others					

High rates of binge drinking among teens					
High rates of DUIs among teens					
High rates of suicidal intention among teens – esp girls					
High obesity rates among adults					
High obesity rates among children and teens					
Lack of physical activity by adults					
Inadequate nutrition among adults					
High mortality due to falls					
High prevalence of traumatic brain injury					
Lack of access to mental health care					