Stronger Together

COMMUNITY HEALTH INITIATIVE OF
FARIBAULT & MARTIN COUNTIES

Inspire healthy, resilient communities through partnership and collaboration.

Community Health Improvement Plan 2020-2030

Approved and adopted by Human Services of Faribault & Martin Counties Human Services Board
03/24/2020

Human Services of Faribault & Martin Counties Community Health Board

Human Services of Faribault and Martin Counties govern the overall policy direction, operations and fiscal management of the Community Health Board of Faribault & Martin Counties. The CHB is comprised of 12 members, all county commissioners elected to serve within Faribault and Martin Counties plus two community representatives who are appointed to the Community Health Board.

Human Services Community Health Board of Faribault and Martin Counties - 2023
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Credits & Acknowledgements

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Community Health Leadership Coalition: Stronger Together – Updated 2024

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Executive Summary

The Community Health Improvement Plan (CHIP) is a product of Stronger Together, a community health leadership coalition that formed to oversee the development and implementation of the Community Health Improvement Plan. The CHIP is a long-term plan that identifies health priorities based on an extensive community health assessment and community engagement process. The intent of this plan is to develop initiatives, strategies and policies that are aimed at improving the health of the residents in Faribault and Martin Counties.

The CHIP planning process was initiated in 2018 after Human Services Community Health Services, Mayo Clinic Health System-Fairmont, and United Hospital District began a partnership to identify ways to better work together and share information among the entities. The community health assessment and CHIP process was quickly identified as a common deliverable among all three entities, so the decision was made to partner on this effort to reduce duplication and provide a greater impact towards improving health outcomes. The three entities began the process of completing a comprehensive community health assessment, a collaborative process involving the systematic collection and analysis of data and information to provide a sound basis for decision-making and action.

A variety of tools and processes were utilized to identify the priority health issues that were impacting the health of the community. Our communities indicated that Adverse Childhood Experiences (ACEs), Mental Health, Substance Use, Chronic Disease, and Access to Care (Health and Dental) were the highest priority issues to address.

Upon identifying the top health priorities, the partnership worked to develop a multi-sector community health leadership coalition – called Stronger Together. The goal in creating the coalition was to help guide the work of developing the CHIP, to help community organizations better connect for greater resource allocation and awareness, to develop initiatives, strategies, and action steps towards improving the health of the community and ultimately, serving as a hub for community health work happening across Faribault and Martin Counties.

This plan details the community health assessment process used and community engagement efforts taken in developing a response to our communities' priority health issues. Each work plan was developed by a group of community members and organizational representatives ensuring a focus on health equity and improved access to services was a priority in development of strategies and action steps. Over the next three years, the Stronger Together Coalition will work to implement this plan based on the intended timeframes in each action plan. This coalition will also monitor implementation efforts on a quarterly basis and revise this plan as needed.

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What is a Community Health Improvement Plan?

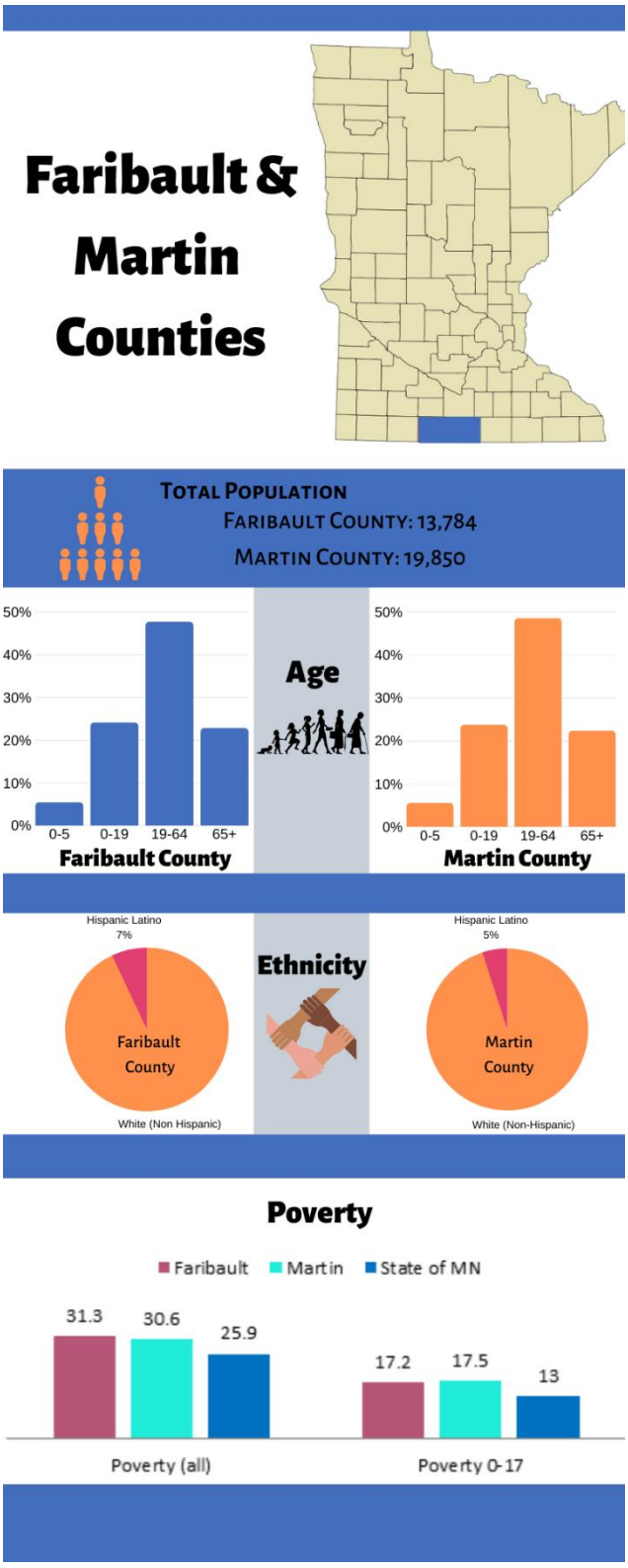
Beginning in 2017, Human Services of Faribault & Martin Counties convened stakeholders from the two local non-profit hospital systems to participate in a newly convened Health Care Coalition. The goal was to develop a stronger working relationship between the three entities – United Hospital District, Mayo Clinic Health System – Fairmont, and local Public Health. This collaboration began an ongoing effort to partner on the community health improvement planning process. Together, the three entities worked to complete a Community Health Assessment (CHA) and subsequently develop a joint Community Health Improvement Plan (CHIP).

Data Collection → Analysis → Input from Community → Set Priorities → Develop Action Plans

The 2020 Community Health Improvement Plan is a comprehensive, long-term plan that addresses the top priorities identified through the community health assessment process. The CHIP is collectively developed and implemented by community partners to ensure the goals, objectives, and strategies are effective and achievable. The process relies heavily on community input to ensure the plan meets the needs of the residents impacted by the CHIP.

This CHIP was originally developed and adopted by the Community Health Board in 2020. Regular monitoring and updates are completed annually. Data is collected and reviewed for trends at least every three years, starting in 2019. This plan is an active, living document that is updated annually based on the newest data and information. The health priorities are reviewed every three years for relevancy based on data, funding and community impacts, such as COVID-19.

The service area impacted by the CHIP includes Faribault and Martin Counties in South Central Minnesota. The area is considered rural with a total service population is 33,684. The county seat in Faribault County is the city of Blue Earth and in Martin County, the city of Fairmont.



Health Inequities as a Result of Social Determinants of Health

Health inequities are defined as the differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work, and age.

According to the World Health Organization, "There is ample evidence that social factors, including education, employment status, income level, gender and ethnicity have a marked influence on how healthy a person is. In all countries – whether low-, middle- or high-income – there are wide disparities in the health status of different social groups. The lower an individual's socio-economic position, the higher their risk of poor health. Health inequities are systematic differences in the health status of different population groups. These inequities have significant social and economic costs both to individuals and societies."

The root causes of health inequity can include structural inequality of resource allocation or the role of living conditions, such as land use, housing, transportation, and environmental pollutants. They can be related to economics and work environment and include employment and wage, occupational hazards, and poverty. Root causes can also be based on the social environment and include income inequality, chronic stress, and social isolation. Other social factors which play a role include access to health care, food insecurity and access to healthy foods, education availability, and availability of social services.

Through our health assessment process, key informants and community members identified factors which they felt may create health inequalities within Faribault and Martin Counties. These include race and ethnicity, having an aging population, limited access to care (health or dental), poverty, and transportation challenges.

Race & Ethnicity

Approximately 94% of the service area identifies white. Pockets of Hispanic populations across both Faribault and Martin Counties heighten awareness of potential health inequities.

Aging Population

Approximately 23% of the population in Faribault and Martin Counties is over the age of 65, which is significantly higher than the state average of 15%.

Access to Care (Health & Dental)

Approximately 25% of adults within Faribault and Martin Counties delayed or refused to access health care services within the past 12 months. For dental care, 22% of adults who felt they needed dental care did not get it or delayed treatment within the past 12 months. Additionally, 70% of Minnesota Health Care Program enrollees did not use dental services. Cost, affordability, and availability were cited as reasons for delaying or not seeking services.

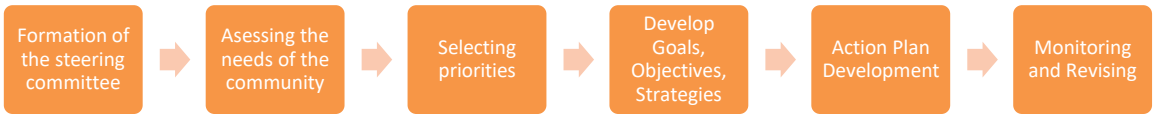
Poverty

31.3% of the population in Faribault County and 30.6% of the population in Martin County is living in poverty, which is higher than the state average of 25.9%.

Transportation

Community members noted the lack of adequate public transportation interferes with meeting basic personal needs and access to health care. This is especially true for clients who need transportation to non-emergent appointments in distant communities.

Community Health Improvement Planning Process



The Community Health Improvement Process will provide guidance to Human Services of Faribault & Martin Counties, our community partners, and stakeholders to improve the health of the population within Faribault and Martin Counties for the next 3-5 years.

Step 1

Formation of the steering committee

In 2018, representatives from Human Services of Faribault & Martin Counties (Community Health), Mayo Clinic Health System – Fairmont, and United Hospital District formed a Health Care Coalition with the goal of identifying opportunities for partnership and improved information sharing.

Soon after convening, the coalition members identified the value in partnering to complete the county community health assessment and planning process. Partnering with this project would reduce duplication and redundancy and would allow greater impact with implementation efforts. Prior to 2019, the three entities had completed their community assessment and planning process individually, within their required timeframes. Minnesota State Statute requires Community Health Boards to complete a community health assessment and planning process every five years, whereas the Internal Revenue Service (IRS) requires 501(c) 3 hospitals to complete a similar process every three years.

The members of the Health Care Coalition oversaw the community health improvement planning process from steps 1 through step 3. After completion of the health assessment, the coalition began the process of expanding membership and transforming the existing Health Care Coalition into what is now referred to as the Community Health Leadership Coalition (CHLC).

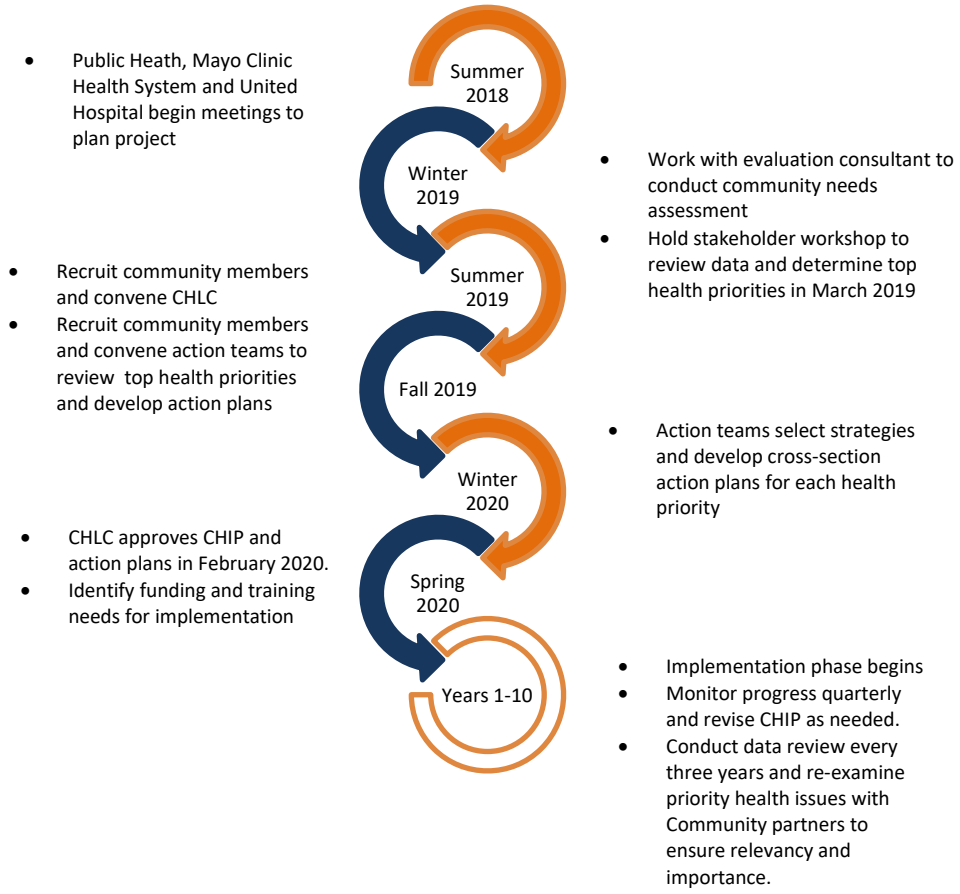
Goals for the CHLC include:

- Guide work in developing the bi-county Community Health Improvement Plan (by February 2020). This will include developing a CHIP that incorporates evidence-

based strategies, which can be done across sectors to improve health outcomes. The CHIP will focus on creating action plans addressing the following priority areas.

- Connect existing work happening in our communities.
- Implement action plans and monitor progress.
- Identify funding or collaboration opportunities to support plan implementation.
- Review county health data annually and recommend additional/further needs for consideration.
- Become a 'hub' for community health work happening across Faribault and Martin Counties.

Timeline for Implementation



Step 2

Assessing the needs of the community

The Health Care Coalition (HCC) utilized the evidence-based model Mobilizing for Action through Planning and Partnership (MAPP) framework for the planning process.

Data Collection Process

The HCC utilized an independent evaluator to assist with data collection and analysis. Primary and secondary data from a variety of sources were used to complete the CHA, which includes both quantitative and qualitative data. The data collection process took place between June 2018 and March 2019.

Primary Data:

The HCC collects primary data for the purpose of incorporating the values and priorities of county residents into health improvement decisions. Sources include:

- 2016 Adult Health Status Assessment for the South-Central MN Region – This was a random sample survey completed across a nine-county geographic area. A separate sample was drawn from each county. Address-based sampling was used so that all households had an equal chance of being sampled for the survey. Faribault County had a 31% response rate. Martin County had a 26.9% response rate. The survey addresses the health status of adults, examining chronic disease diagnosis, health behaviors, and social factors for which promote health.

- Community input was also collected as a part of the CHA. Goals of the input where to:
  - Gather broad viewpoints across both counties.
  - Provide a variety of options for input.
  - Involve under-represented groups.

- *Key Informant Interviews 2019*
  Eight community people were interviewed in the community, each serving a different population – for example, the Latino population, the aging population, young families, people receiving home visiting services, and chemical health services. Interviewees were asked to rate several health topics as to how big of a health concern the issue is in the community.

- *Community Values, Themes and Strengths Assessment 2019*
  Two hundred and ten community members responded to an online community values, themes, and strengths assessment. The survey respondents were mostly white,

married, and female. 65% lived in the city limits. 39% were from Faribault County and 58% were from Martin County. There was good representation across all age groups, and so this survey was more successful at reaching younger residents than other surveys we've done in the past. There was also a pretty good distribution of income levels within survey respondents, ranging from under $10K to over $200K. The most relevant survey items related to this study are the first three questions. Survey respondents were asked to pick the three most important factors for a Healthy Community, the three most important health problems in our community, and the three most important risky behaviors in the community.

Faribault & Martin Counties Community Values

Access to Health Care	•Community where quality health care is accessible to all residents.
Good Jobs and Healthy Economy	•Availability of industry and economic development which promotes healthy, sustainable communities and attracts young professionals to the community.
Good Schools	•Educational opportunities for all children to grow and reach their full potential. Education that prepares children for adulthood.
Safe Communities	•Communities that commit to allocating resources needed to foster safe environments for all.
Access to Community Resources and Services	•Resources are available to support happy, healthy, active lives. Resources and services which support parenting, aging in place, diversity, and ability for each resident to live their life to the fullest with equal opportunity for all. This includes access to healthy food, social services and recreation, and personal enrichment.

- *Community Event Dot Voting*
  Community members were asked to participate in dot voting to identify the most important health issues out of a list of 10 issues. Data was collected in spring and

summer 2018 in places like the Martin County Fair, Kiester Days, and school district entrance conferences and sporting events. Community members were given two dots and asked to rate the top health priorities for themselves, their families, or their community. 1,199 community members participated in the dot voting events.

The health priorities identified as top concerns through the community data gathering process included mental health, substance abuse, dental, chronic disease/cancer, overweight/obesity, aging problems, physical exercise, nutrition, and access to health care services.

- *Local Public Health System Assessment*
  Human Services of Faribault & Martin Counties participate annually in an assessment of the capabilities and capacity of the local public health agency. This includes an assessment of how the ten essential public health services are being provided within the community, and public health performance management and quality improvement efforts.

Secondary Data:
Secondary data, or data that is not collected directly by Human Services of Faribault & Martin Counties, include: federal, state and local data; hospitals and health care providers; local schools; other governmental departments; and nonprofit organizations. Sources include:
• U.S. Census
• U.S. Department of Commerce
• USDA Food Access Research
• Centers for Disease and Control Prevention (CDC)
• Behavioral Risk Factor Survey
• Minnesota Department of Health County Health Tables
• Minnesota Student Survey
• Minnesota County Health Rankings
• Minnesota Department of Employment and Economic Development
• Minnesota Department of Health

The Community Health Assessment conclusions were shared widely with partner organizations through various means of communication including presentations and announcements.

Step 3
Selecting priorites

In March 2019, 50 community members representing multiple sectors and demographics attended a Community Health Status Workshop to review CHA data and provide feedback. The goals of the workshop were to:

1- Develop a community vision and common values of a healthy community,
2- Review the community health assessment data and identify observations from community stakeholders,
3- Select health priorities for inclusion in the CHIP for Faribault & Martin Counties,
4- Brainstorm ways to positively impact change,
5- Identify the community work already in place to build on existing momentum.

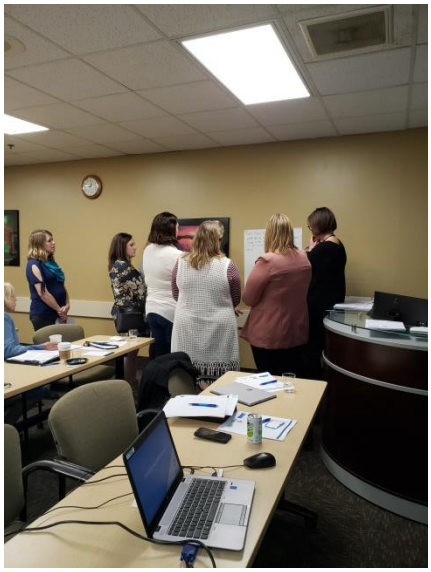
The group was given five guidelines for consideration when choosing health priorities. These included ensuring the health priorities are reflective of what the community wants and identifying the severity, importance, cost, and existing resources available to address the health priority area.

Upon review of the data indicators and community input, workshop participants were asked to vote on the top three health priorities they felt our community should work to address in the CHIP over the next three to five years.

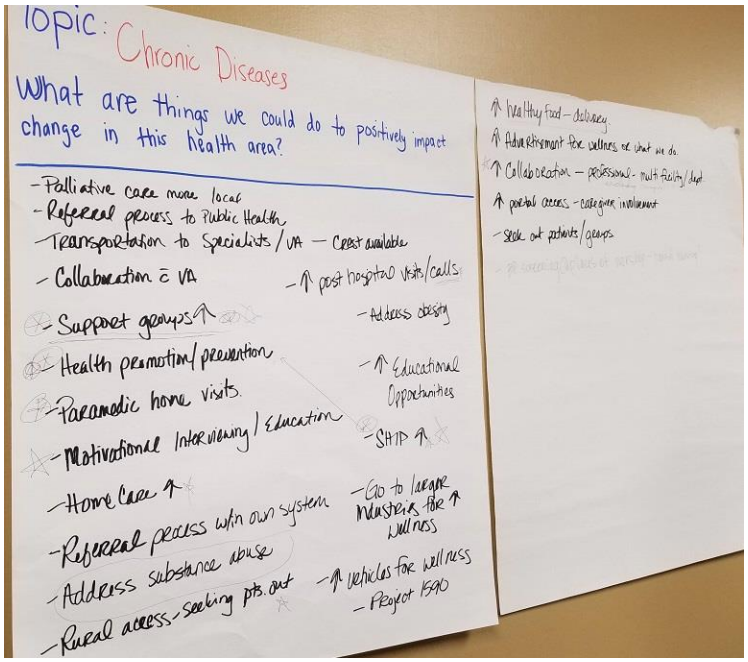
The following were prioritized as the top health priorities for inclusion in the CHIP, in order of importance:

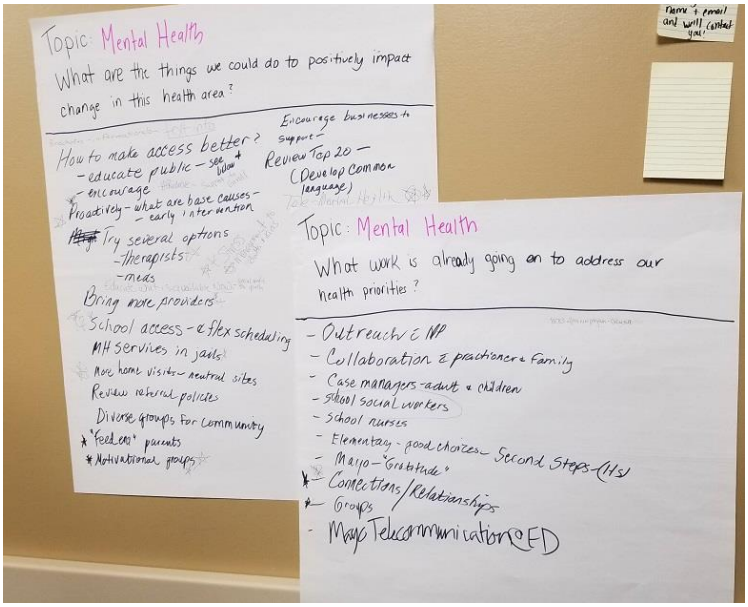
- Adverse Childhood Experiences (ACEs)
- Mental Health & Wellness
- Substance Abuse
- Chronic Disease
- Access to Care (Health & Dental)

After selection of the top priorities was made by community stakeholders, facilitators led small group discussions with participants to learn more about the work happening in these priority areas and to brainstorm ideas and resources we could capitalize on as we move forward development and implementation of the CHIP. Two discussion questions were posed in the small group sessions: 1) What are the things we could do to positively impact change in this priority health area, and 2) What work is already going on to address this health priority?



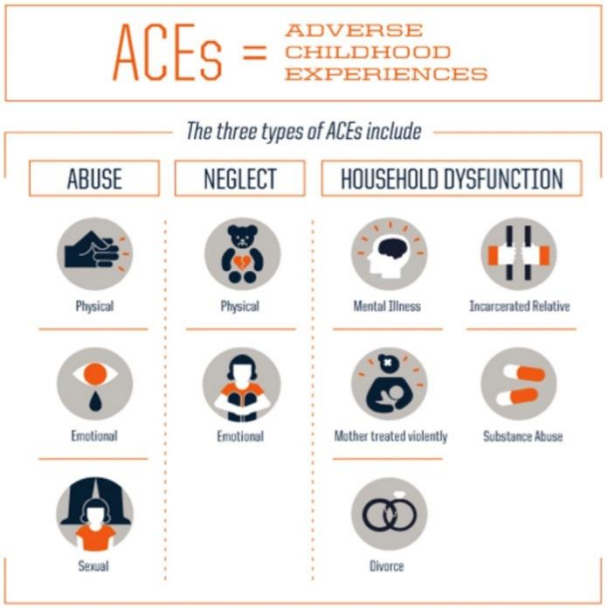
After the small group sessions concluded, each workshop participant was asked to visit each group topic area to review information that had been brainstormed and contribute any additional ideas, comments or questions that may have not yet been captured. Finally, workshop participants were asked to indicate interest in working on a coalition to oversee development and implementation of the CHIP.





Priority Health Issue: Adverse Childhood Experiences (ACEs)

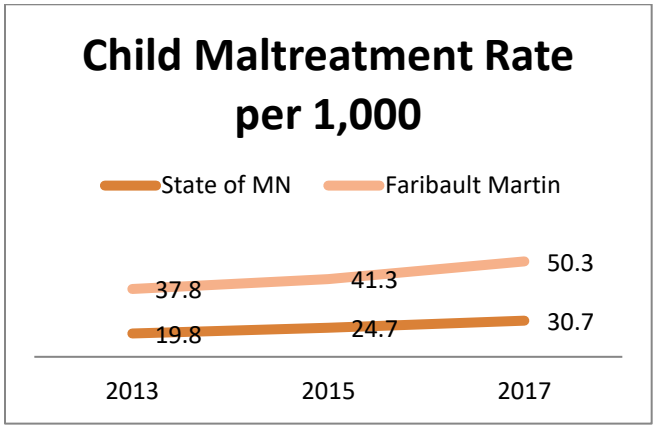
Adverse Childhood Experiences (ACEs) was selected as the top priority for inclusion in the CHIP by workshop participants. Adverse Childhood Experiences are potentially traumatic events that occur in a child's life:

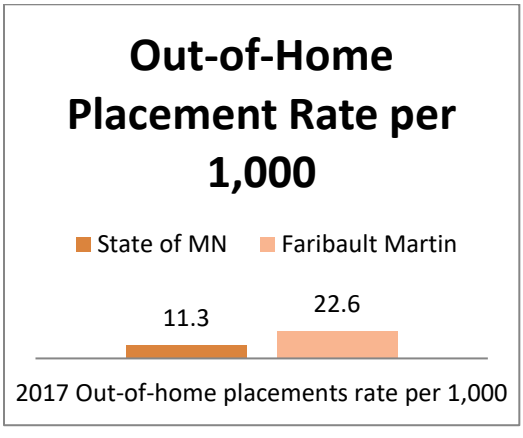


- Physical abuse
- Emotional abuse
- Sexual abuse
- Domestic violence in the home
- Parental substance abuse
- Living in a home with someone who has a mental illness
- Having had an incarcerated parent
- Parental divorce or separation

When children experience adverse events in childhood (ACEs), they are more likely to have poor mental health later in life and suffer from illnesses such as depression and anxiety. Children with ACEs are also more likely to use alcohol, tobacco and other drugs, and develop chronic disease later in life.

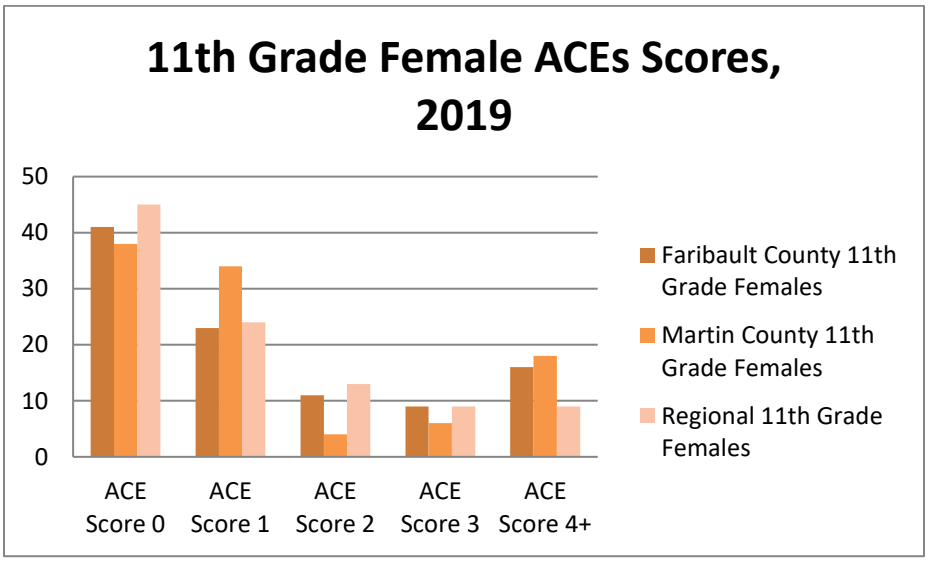
Over the past five years, Faribault and Martin Counties saw increases in the rate of children per 1,000 who sustained child maltreatment. The rate is also considerably higher than the state. Out of home placement rates were substantially higher in Faribault and Martin Counties than compared to the State of Minnesota.

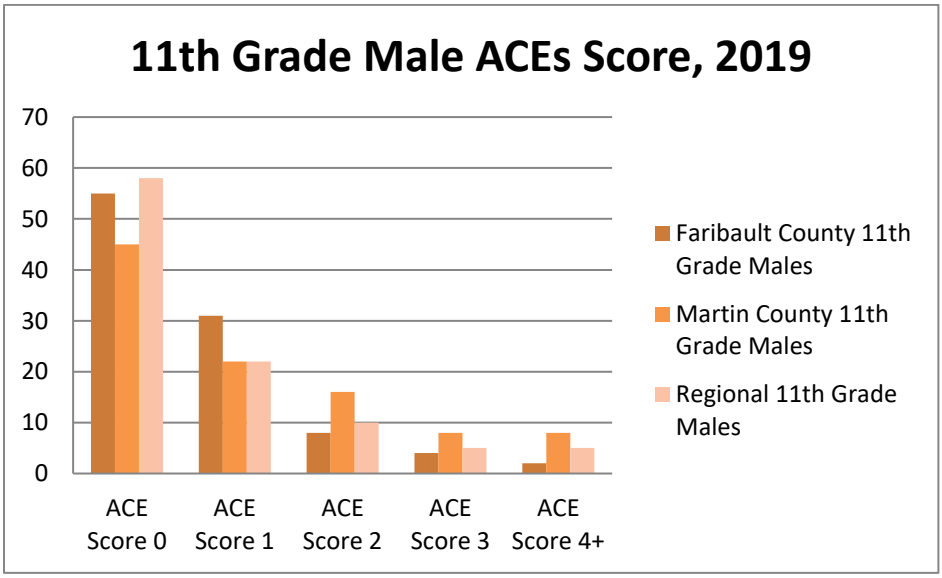




According to newly released data from the 2019 Minnesota Student Survey data, 59% of 11th grade females in Faribault County and 62% of 11th grade females in Martin County reported experiencing at least one ACE, with 16% of females in Faribault County and 18% of females in Martin County reporting four or more ACEs. Regionally, 55% of 11th grade females reported having one or more ACEs and 9% of 11th grade females reported four or more ACEs.

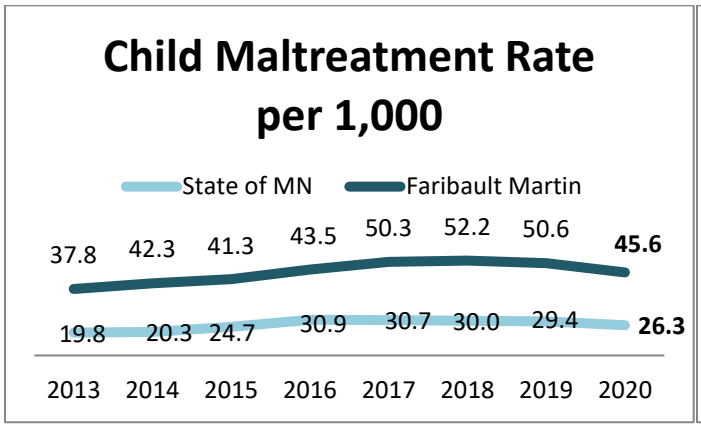
Similarly to the females, 45% of 11th grade males in Faribault County and 55% of 11th grade males in Martin County reported having one or more ACEs. 2% of Faribault County 11th grade males and 8% of Martin County 11th grade males reported having four or more ACEs. Regionally, 42% of males reported having one or more ACEs and 5% of 11th grade males reported having four or more ACEs.

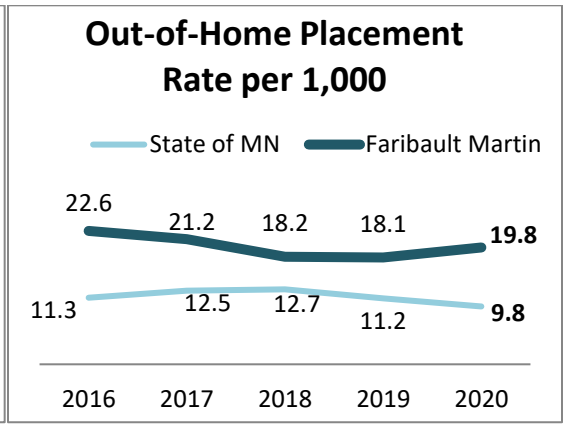




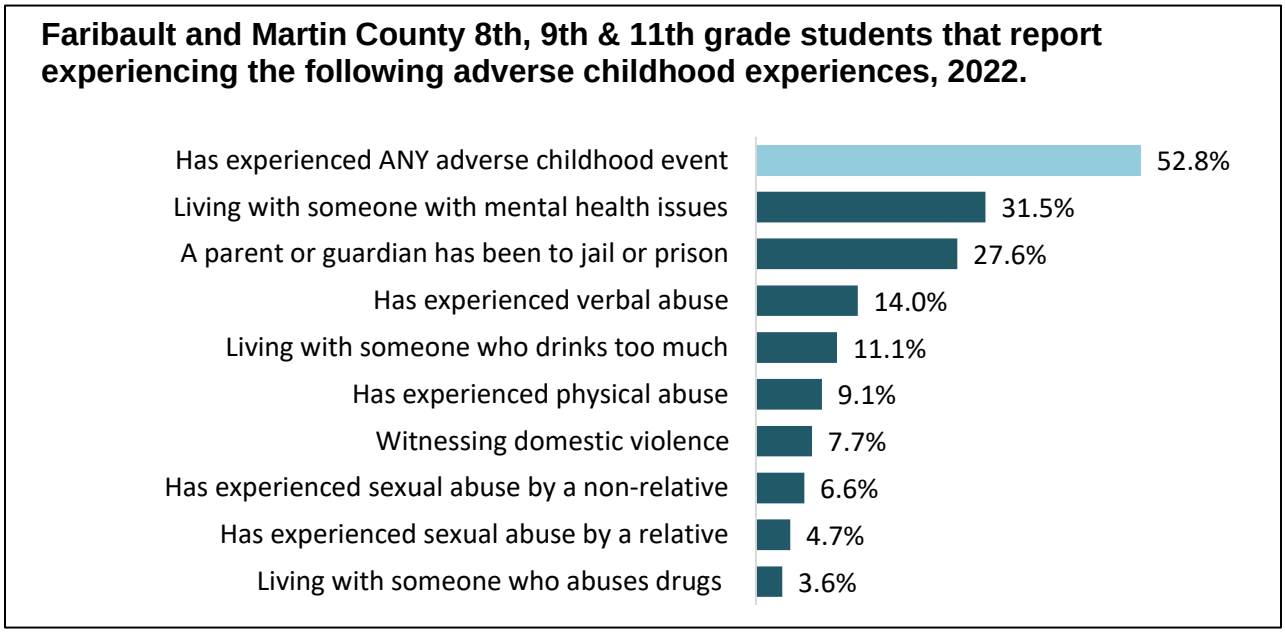
Adverse Childhood Experiences Data Update (June 2023)

Data from the Department of Human Services shows that Faribault and Martin Counties have had a decline in child maltreatment reports (total alleged victims) from its peak of 52.2 reports per 1,000 children in 2018 to 45.6 per 1,000 children in 2020. Additionally, the out-of-home placement rate declined slightly from 22.6 per 1,000 children in 2016 to 19.8 per 1,000 children in 2020. Despite the overall declines, Faribault and Martin Counties have a higher rate of child maltreatment reports and children in out-of-home placement compared with the State of Minnesota overall.





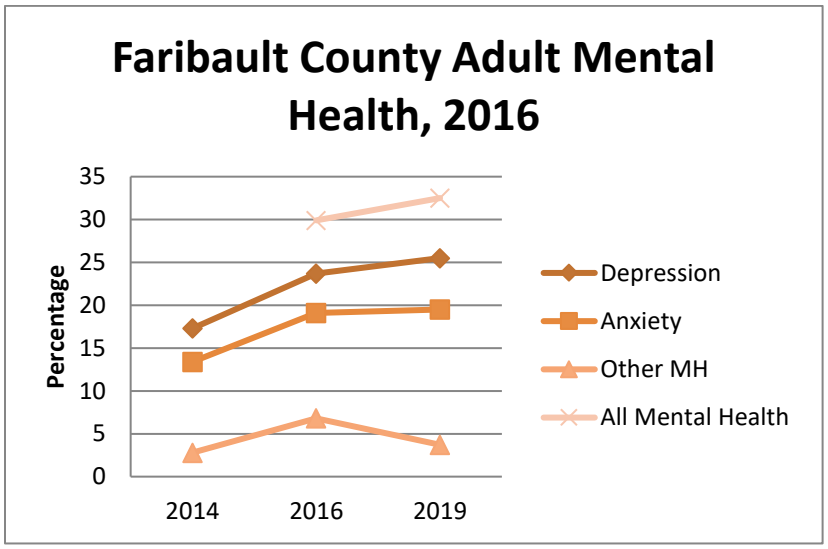
Data from the 2022 Minnesota Student Survey show that Faribault and Martin County students continue to be impacted by impacted by adverse childhood experiences (ACEs). In 2022, 52.8% of 8th, 9th and 11th graders experienced at least one ACE, compared with 52.9% of students in 2019. Nearly one in three students (31.5%) have lived with a parent or guardian who has depression or other mental health issues, and more than one in four students (27.6%) has experienced a parent or guardian in prison or jail.

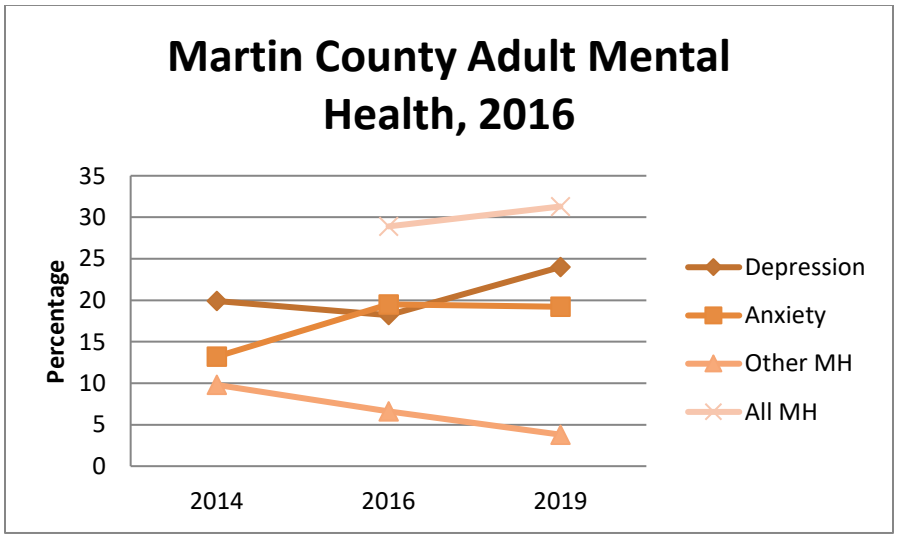


Priority Health Issue: Mental Health

Mental health plays a major role in people's ability to maintain good physical health. Mental illness, such as depression and anxiety affect people's ability to participate in health-promoting behaviors and affect how people cope with the everyday demands of life. Mental disorders are the most common cause of disability.

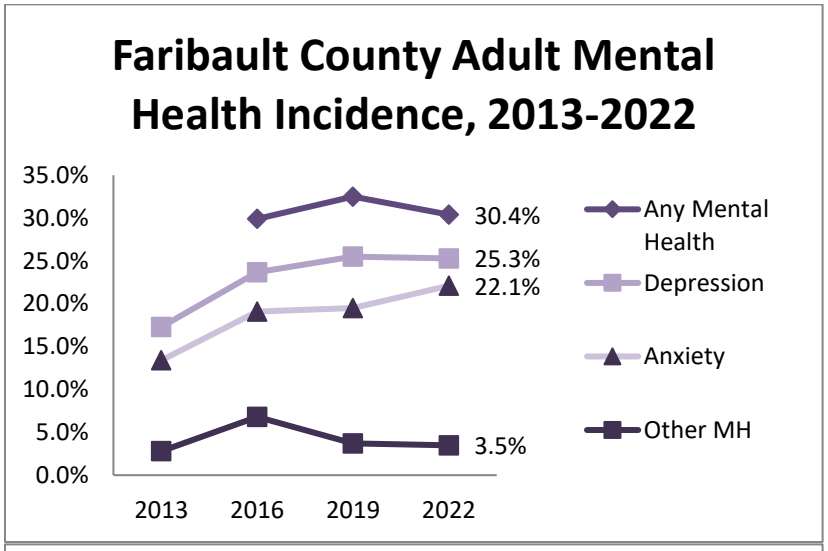
In Faribault County, 29.9% of adults reported having been diagnosed with any mental health problem in 2016. In Martin County, the percentage was 28.9%. Access to mental health care services was also identified as barrier for treatment and prevention. The percentage of adults reporting having delayed or not sought out mental health care services was 16% for Faribault County and 14.7% in Martin County.

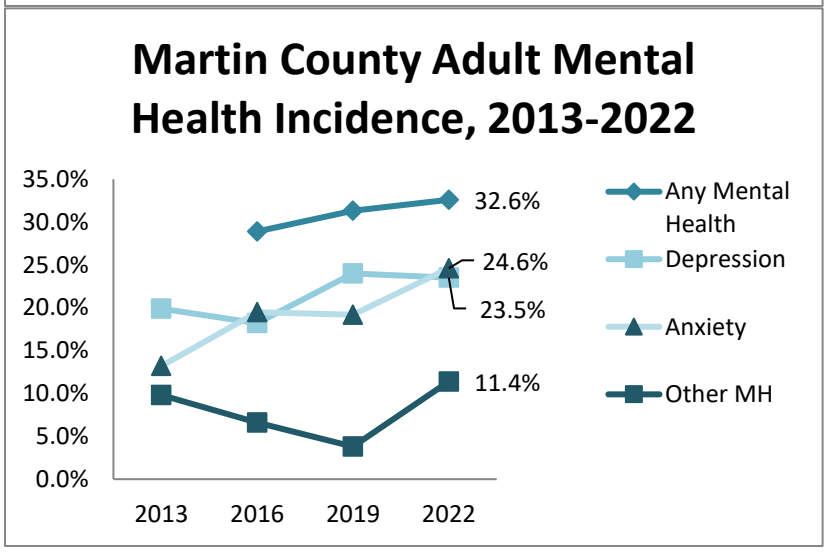




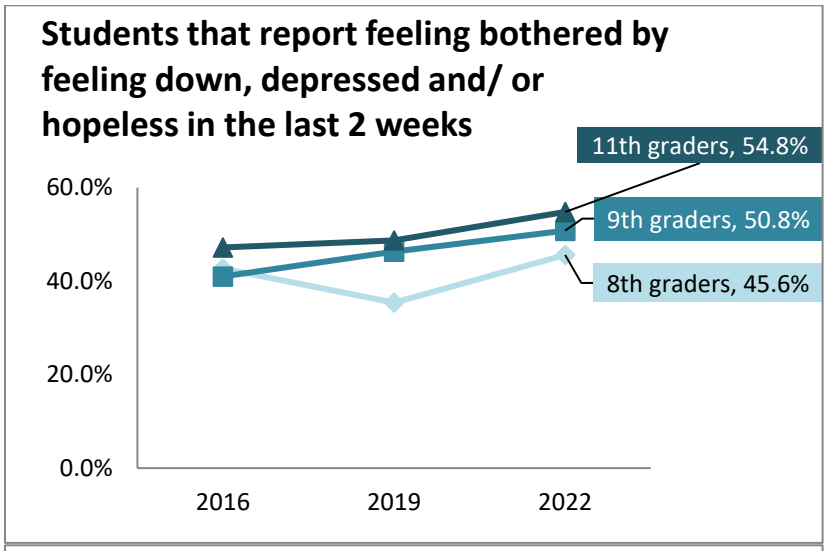
Mental Health Data Update (June 2023)

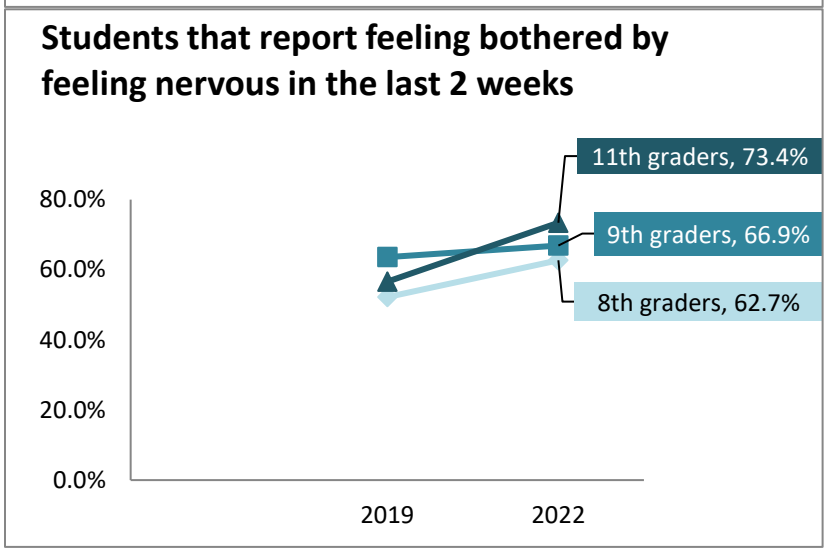
Mental health remains a key priority area for the counties. In 2022, 32.6% of Martin County adult residents and 30.4% of Faribault County adult residents reported experiencing a mental health condition. Anxiety and panic disorders increased the most between 2013 and 2022 in both Faribault and Martin Counties.





Mental health concerns are also common in youth. In 2022, one in two students reported feeling bothered by feeling down, depressed and hopeless in the past two weeks. Two out of three students reported feeling bothered by nervous, anxious or on edge in the past two weeks.





Priority Health Issue: Substance Abuse

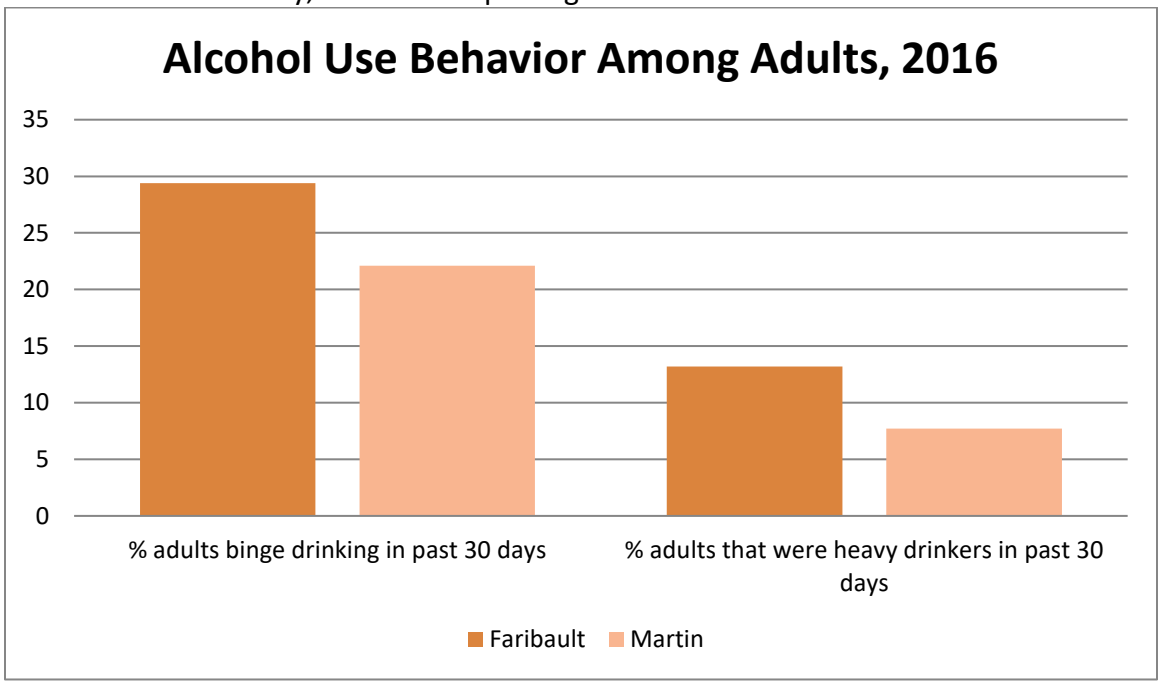
Drug misuse and abuse has many negative health consequences including unintentional injury, violence, unintended pregnancy, sexually transmitted infections, birth defects, and chronic diseases including cancer and cardiovascular disease.

Substance abuse, primarily methamphetamine use is a large contributing factor to child maltreatment and neglect, resulting in out-of-home placement within Faribault and Martin Counties. In 2016, approximately 60% of the out-of-home placements were due to substance abuse.

In trending data over time, we have seen improvements in the percentages of youth reporting substance use; however, percentages are still higher than the state average. Both counties have active Substance Abuse Prevention Coalitions in place to address youth substance use.

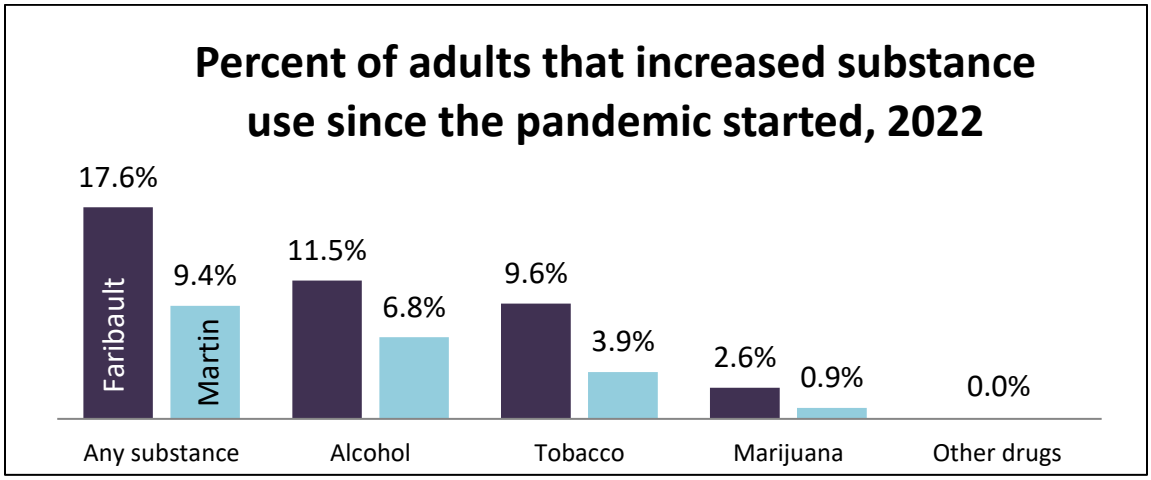
In Faribault County, 29.4% of adults reported binge drinking alcohol in the past 30 days. Slightly less of Martin County adults, 22.1%, reported binge drinking in the past 30 days. In Faribault County, more adults reported heavy drinking over the past 30 days (13.2%) than in Martin County (7.7%).

In Faribault County, 5% of adults reported currently using marijuana. The percentage was lower in Martin County, with 3.8% reporting current use.

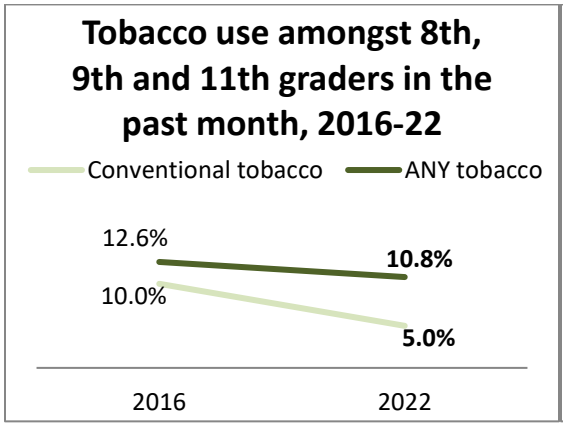


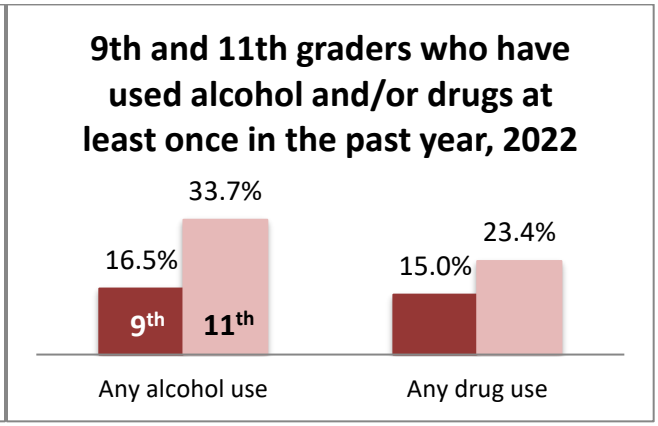
Substance Abuse Data Update (June 2023)

In the 2022 COVID-19 Impact and Adult Health Survey, 17.6% of Faribault County residents and 9.4% of Martin County residents reported that their substance use has increased since the beginning of the pandemic. In both counties, residents were most likely to report that their alcohol use increased, followed by tobacco and marijuana. None of the survey respondents reported that other drug use increased during the pandemic.



Tobacco use has decreased among Faribault and Martin County students from 2016 to 2022. However, substance use remains a problem. In 2022, one in 10 students (in 8th, 9th, and 11th grades) had used some tobacco product in the last month. Additionally, one in three 11th grade students (33.7%) had used alcohol in the past year, and one in four 11th grade students (23.4%) had used marijuana or other drugs in the past year.





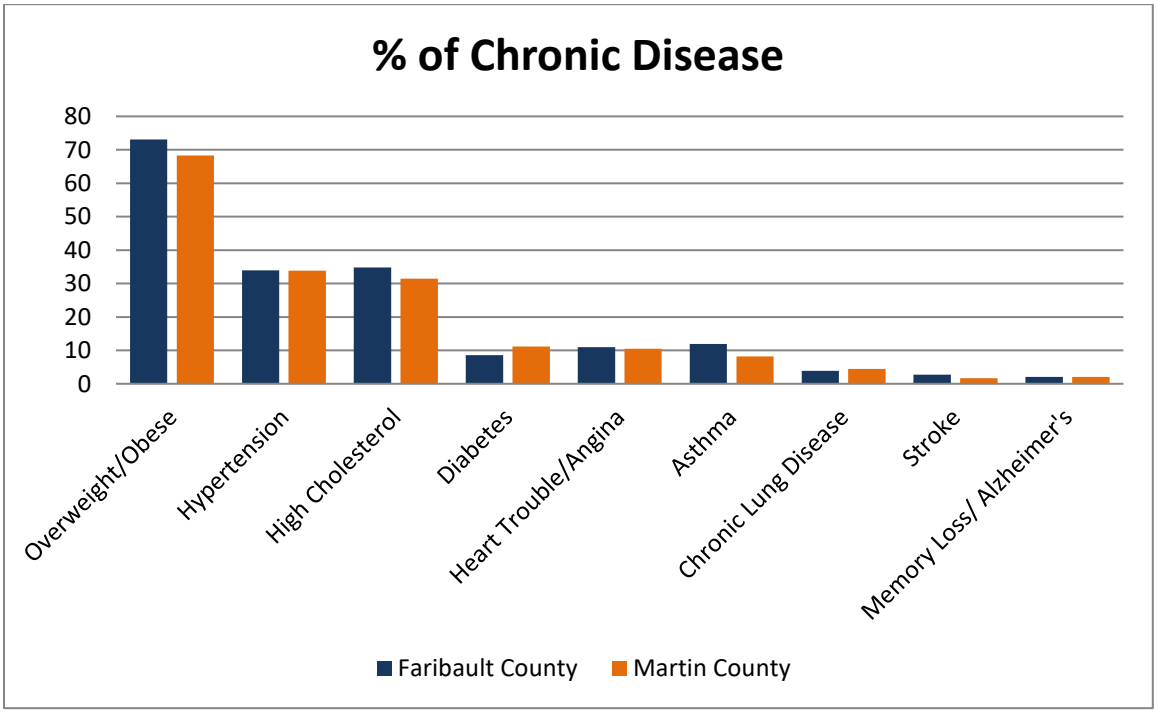
Priority Health Issue: Chronic Disease

Chronic diseases are defined broadly as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both. Chronic diseases such as heart disease, diabetes, and cancer are the leading causes of death and disability in the United States. They are also leading drivers of health care costs.

Many chronic diseases are caused by a short list of risk behaviors:

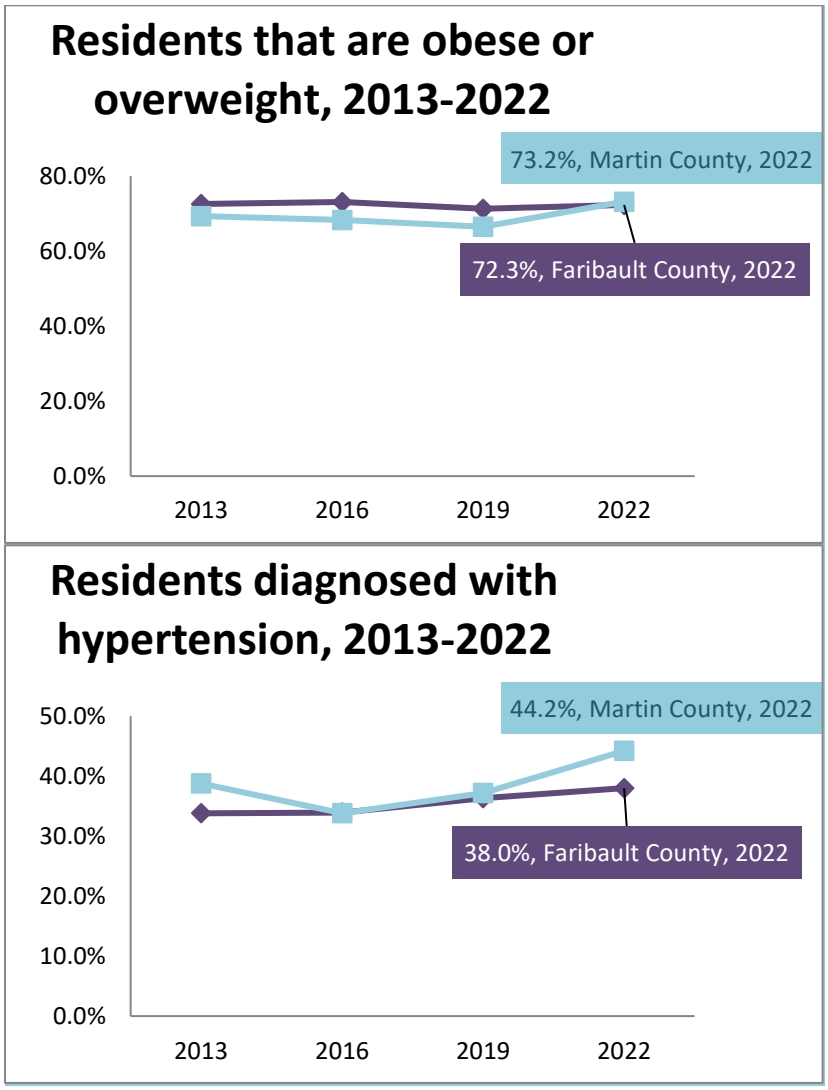
- Tobacco use and exposure to secondhand smoke
- Poor nutrition, including diets low in fruits and vegetables and high in sodium and saturated fats
- Lack of physical activity
- Excessive alcohol use

In Faribault County, 73.1% of adults are overweight or obese according to body mass index. In Martin County, that percentage is 68.3%. On average, 61% of adults in Faribault and Martin Counties do not meet the guidelines for physical activity. Over 33% of the adults in Faribault and Martin Counties reported a diagnosis of high blood pressure. Approximately 33% of adults also report a diagnosis of high cholesterol or triglycerides. Approximately 10% of adults report a diagnosis of diabetes.



Chronic Disease Data Update (June 2023)

Overweight and obesity and hypertension remain health conditions for many adult residents in Faribault and Martin Counties. In 2022, 72.3% of Faribault County residents and 73.2% of Martin County residents were overweight or obese according to body mass index. More than one in three adults were diagnosed with hypertension in 2022, with 44.2% of Martin County residents and 38.0% of Faribault County residents diagnosed with hypertension.



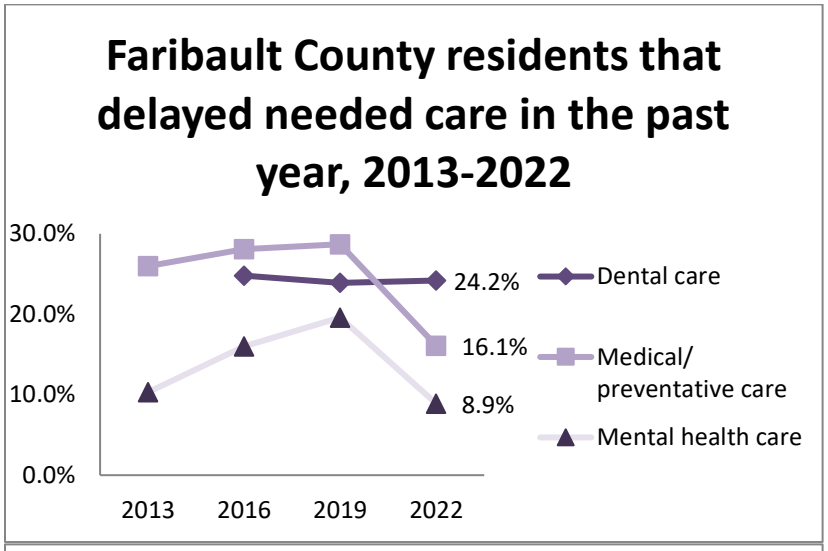
Priority Health Issue: Access to Care (Medical and Dental)

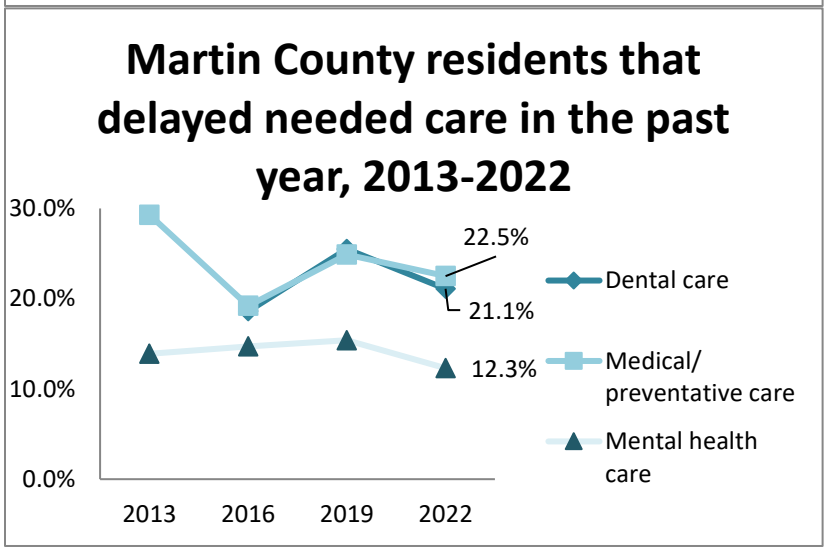
Accessing health care resources in rural communities with an aging population can be challenging. A lack of adequate and affordable transportation options, dental providers who accept medical assistance, and the availability of mental health providers are all concerns prompting selection of this CHIP strategy.

Recent data from the 2019 Adult Health Survey demonstrates low rates of uninsured population, however rising rates of individuals who are not seeking preventative health care services. Dental care access is particularly challenging when dental providers are unable to accept medical assistance. In Faribault County, nearly 25% of adults reported delaying or never obtaining needed dental care and in Martin County, 19%.

Access to Care Data Update (June 2023)

Compared with 2019, fewer residents in 2022 reported delaying needed mental health care, or delaying medical and preventative care. Yet, many residents are still delaying or foregoing needed care. In 2022, about one in four Faribault County residents and one in five Martin County residents delayed needed dental care.





Step 4
Developing Goals, Objectives and Strategies

After the CHIP health priorities were selected at the CHA Workshop in March of 2019, recruitment efforts began to form the Community Health Leadership Coalition (CHLC). The first meeting of the CHLC was held in July 2019 and includes representation from early childhood, K-12 education, public health, human services, county elected officials, law enforcement, local nonprofits, health care, public transportation, faith community, chamber of commerce, state government, and community.

The CHLC developed goals and objectives for each health priority with the ability to measure progress towards achievement over time. The CHLC is charged with developing and monitoring implementation of the CHIP across both counties. To carry out this work, three action teams were convened: 1) Community Resiliency Action Team, 2) Healthier Together- Chronic Disease Action Team and 3) Access to Care Action Team. Membership on the action teams comprises community members who have a vested interest in the work of the action team. Each team is comprised of members from the CHLC, who act as the liaison between the work of the action team and the work of the CHLC.

Each action planning team is working to develop a bi-county approach to addressing the CHIP health priorities areas. Each action plan will identify the goals, objectives, and proposed strategies to impact community outcomes. The result will be a livable work plan that is continuously monitored and revised as opportunities arise and community needs evolve.

The action teams were able to capitalize on the brainstorming done by the community at the March 20 CHA Data Workshop. This allowed each team to have a starting point with ideas and strategies and also allowed CHIP facilitators to identify potential stakeholders to involve in the work.

Step 5
Action Plan Development

Utilizing the data from the CHA and a list of community assets and resources identified at the March 2019 Community Health Status Workshop, each action planning team worked to develop their action plan for the identified health priority areas. An action plan acts as a blueprint for addressing these health priorities. The action plans include goals, objectives, target population, performance measures, strategies, milestones, partners, and timeframes. For each health priority area, the CHLC has identified both long and short-term outcome indicators, which will serve as the primary measures on which to base program evaluation.

Adverse Childhood Experiences /Building Community Resiliency Action Plan

Issue Statement
The Centers for Disease Control, in partnership with Kaiser Permanente, led one of the largest investigations of childhood abuse and neglect and later-life health and well-being, referred to as the Adverse Childhood Experiences (ACEs) Study. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan. According to Faribault and Martin County residents, ACE scores are a significant factor contributing to lifelong health and opportunity.

Goal
Decrease the incidence of Adverse Childhood Experiences (ACEs) and increase resiliency among residents in Faribault and Martin Counties.

Population Outcomes Measures
Decrease in the percentage of adults who report feelings of hopelessness, anxiety, or loss of interest in things they used to enjoy within the past 12 months between 2016 and 2022. Baseline: 28.2% in Faribault County and 24.1% in Martin County reported in the regional 2016 Adult Health Survey.
Decrease in the percentage of adults reporting being diagnosed with any mental health problem between 2016 and 2022. Baseline: 29.9% in Faribault County and 28.9% in Martin County from 2016 to 2023 as reported in the regional Adult Health Survey
Decrease in the rate of child maltreatment reports between 2017 and 2022. Baseline: 50.3 reports per 1,000 children in Faribault and Martin Counties in 2017.
Decrease the rate of children in out of home care per 1,000 children between 2017 and 2022. Baseline: 21.2 per 1,000 children in 2017.
Decrease the rate of child maltreatment for neglect per 1,000 children between 2017 and 2022. Baseline: 34.7 per 1,000 children in 2017.
Decrease the percentage of 11th grade students who report an ACE score of one or more. Baseline: 59% Faribault County 11th grade females, 62% Martin County 11th grade females, 45% Faribault County 11th grade males, and 55% Martin County 11th grade males in the 2019 Minnesota Student Survey.
Decrease the percentage of 9th and 11th grade students who report using alcohol, tobacco, and other drugs from 2016 to 2022. Baseline data identified from the Minnesota Student Survey.
Decrease the percentage of adults who report heavy drinking in the past 30 days from 2013 to 2022. Baseline data 8.3% in Faribault County and 7.8% in Martin County from the 2013 Adult Health Survey.
Decrease the percentage of adults who report binge drinking in the past 30 days from 2013 to 2022. Baseline data 27.7% in Faribault County and 24.8% in Martin County from the 2013 Adult Health Survey.

Community Resiliency Team Members 2019
• Abbey Smith, Martin County West Schools • Amy Becker, Fairmont Schools • Anna Garbers, Human Services of Faribault & Martin Counties- Mental Health • Autumn Welcome, Martin County West Schools • Caroline McCourt, Human Services of Faribault & Martin Counties – SHIP • Conan Schaffer, Blue Earth Area Schools • Dar Holmseth, Blue Earth Area Schools – Community Education • Debra Mosloski, Human Services of Faribault & Martin Counties – Child Protection • Doug Storbeck, Granada Huntley East Chain Schools • Greg Brolsma, Fairmont Kinship* • Jennifer Crawford, United South Central Schools • Kathy Smith, Martin County Commissioner • Katy Gonzales, Fairmont Kinship • Kayt Klemek, United South Central Schools • Kelly Bleess, Blue Earth Area Schools • Lynn Smithwick, Human Services of Faribault & Martin Counties – Social Services • Melissa Haugh, United South Central Schools • Michelle Rosen, Fairmont Area Schools • Molly Weinberger, Counseling Services of Southern Minnesota* • Pastor Richard Abel • Brooke Pierce, Mayo Clinic Health System • Shea Ripley, Building Blocks Child Care • Steph Johnson, Martin County Substance Abuse Prevention Coalition • Tracy Henning, Drug Court • Ryan Murphy, School Resource Officer • Mike Gormley, Faribault County Sheriff • Ann Crofton, Blue Earth Area School

Alignment with State and National Priorities
Healthy Minnesota 2022: Priority 1: The opportunity to be healthy is available everywhere and for everyone. **National Prevention Strategy:** *Mental & Emotional Well-Being:* Recommendation 1: Promote positive early childhood development, including positive parenting and violence-free homes. Recommendation 2: Facilitate social connectedness and community engagement across the lifespan. Recommendation 3: Provide individuals and families with the support necessary to maintain positive mental well-being.

Adverse Childhood Experiences /Building Community Resiliency Strategies and Objectives

Strategy 1:
Increase the knowledge of ACEs among community members and partners and their effect on the health of our community.

Outcome Objectives
• By March, 31, 2020, share local data and inform community members about the prevalence of ACEs, Mental Health and Substance Abuse issues. • By February 28, 2020, offer social media training to coalition membership. • By March, 31, 2020, develop a communications plan for 2020 to inform and educate the community about resiliency. Ensure plan directly corresponds to coalition activities under Community Resiliency Strategy 2. • By September 30, 2023, develop shareable success stories to highlight the positive impacts of area organizations.

Key Activities	Who is responsible?	By When?	2023 Status Review
Develop a high-level summary of community health assessment findings of ACEs, SA and MH related to Faribault and Martin Counties	Chera Sevcik - Public Health	31-Mar-20	Completed. Modify strategy

Identify and offer social media training by February 28, 2020 to ensure best practices when developing communications strategy moving forward.	Caroline McCourt – Public Health/SHIP	28-Feb-20	Remove. No longer relevant.
Create and/or identify communication materials, scripts and templates to share, including: printed materials, social media, videos and visuals.	Community Resiliency Team Members	31-Mar-20 – review materials at each meeting for use.	Continue in action plan for 2023. Updated who is responsible and timelines.
Identify shareable media and developing posting plan among partner organizations.	Community Resiliency Team Members	31-Mar-20 – review plan quarterly.	Continue in action plan for 2023.
Capitalize on Community Events to provide education, information and sharing about coalition activities. Utilize community calendars and health observances to promote messaging that support resiliency.	Community Resiliency Team Members	Ongoing – review upcoming events at regular meetings to develop plan for participation or information dissemination.	Update strategy. Updated who is responsible and timelines. Continue in action plan for 2023.
Identify strength-based messages about partner organizations and community resources that promote or support resiliency (Drug Court, Healthy Families, ECFE, CER, CPS, Mentoring, Law Enforcement etc.) in an effort to normalize community utilization of support services.	Community Resiliency Team Partner Organizations	Ongoing – develop a plan to develop messages on a quarterly basis.	Continue in action plan for 2023. Updated who is responsible and timelines.
Promote referral and connection between organizations – utilizing tools for collection of community resources and support.	Community Resiliency Team Partner Organizations	Ongoing	Continue in action plan for 2023.

Strategy 2:
Build resiliency in individuals, families, and in the community through the development and implementation of policies and practices.

Outcome Objectives
• Coalition will stay current with best practices for building community resiliency, promoting mental wellbeing, and reducing substance abuse by identifying and sharing information quarterly. • By 2023, increase resiliency in Faribault and Martin Counties by identifying and implementing at least 10 strategies/programs/policies or practices.

Key Activities	Who is responsible?	By When?	2023 Status Review
Research what other communities are doing to effectively promote community resilience. Bring back those ideas, modify if needed and replicate in our community. Examples include: Yellow Zone Toolkit from Stearns County.	Community Resiliency Team Members	Ongoing- standing agenda item to review recent learnings between meetings	Continue in action plan for 2023.
Monitor legislation, funding, and reform changes occurring at the national or state level that may impact our work happening locally. Monitor Families First and Substance Use Reform.	Community Resiliency Team Members	Ongoing- standing agenda item to review recent learnings between meetings	Continue in action plan for 2023.
Support implementation and referral to Healthy Families America home visiting program among 60 families who meet risk factors and program criteria.	Chera Sevcik, Community Health	Ongoing- report on status of program availability quarterly.	Continue in action plan for 2023.

Support implementation and referral to the Parent Support Outreach Program to families at-risk of Child Protection involvement.	Lynn Smithwick, Human Services of Faribault & Martin Counties	Ongoing- report on status of program availability quarterly.	Continue in action plan for 2023. Updated who is responsible.
Identify and offer training to at least three E-12 school or childcare settings and adopt promotion of mental wellness, emotional capacity building/coping skills and resilience as part of curriculum across all grade levels. Identified options include: A Thousand Pedals, Mindful Education Curriculum, Change to Chill	Caroline McCourt, SHIP	September 30, 2020. Ongoing implementation efforts after training.	Continue in action plan for 2023. Develop additional strategy to coordinate work with the trauma informed collaborative started in 2023.
Identify and refer at-risk clients to trauma informed therapy programs to support resiliency.	Counseling Services of Southern Minnesota Molly Weinberger	Ongoing- report on status of program availability quarterly.	Continue in action plan for 2023.
Support implementation of school linked mental health services by sharing examples of existing partnerships and resources available.	Community Resiliency Team Members	Ongoing- report on status of program availability quarterly.	Continue in action plan for 2023. Develop additional strategy to complete assessment of school-based mental health services.
Support training and implementation of the Mental Health First Aid program. Offer at least three trainings annually. Continue to pursue MHFA Youth Train the Trainer trainings.	Lynn Smithwick	Training for Adult MHFA by December 31, 2019. Offer 3 trainings minimum annually.	Discontinue.
Offer Bridges Out of Poverty training to community members in Faribault and Martin Counties.	Chera Sevcik	Offer training by September 1, 2020.	Completed. Add additional strategies to support ongoing training and implementation of the Bridges out of Poverty model.

Identify and offer training on trauma and resiliency to mentors enrolling in Kinship, Stars, or BEAM mentorship programs.	Katy Gonzalez	By May 31, 2021	Continue in action plan for 2023. Update timeframes.
Support and refer participants (adults and youth) to mentorship programs.	Katy Gonzalez Kinship, BEAM, Star Mentoring Program Coordinators	Ongoing- report on status of program availability quarterly.	Continue in action plan for 2023.
Offer motivational interviewing training to all helping professions working in our communities to better engage patients/clients in conversations about ACEs, MH, and SA. (Resources might include Dr. Sood, People Incorporated Training Network).	Caroline McCourt	December 31, 2021	In progress. Continue in action plan for 2023.
Support development of strong communication between law enforcement, human services, medical providers, and educational systems, especially in regards to supporting children who have experienced a traumatic event. Utilize Child Protection Team meetings to communicate timely information about situations between partners. Explore partnership with the school to alert professionals about situations that might impact the child.	Lynn Smithwick, Debbie Mosloski	Ongoing- report on status of program availability quarterly.	Continue in action plan for 2023. Updated who is responsible.
Utilize the Mayo Clinic Road to Resilience Tool kits- explore ways to promote the toolkit and implement within the medical community.	Mayo Clinic Fairmont Brooke Pierce	December 31, 2020	Continue in action plan for 2023.

Utilize the Statewide Health Improvement Partnership (SHIP) to promote positive mental health through comprehensive worksite wellness programs.	Kaley Hernandez	October 31, 2020	Continue in action plan for 2023. Update timeframes.
Partner youth groups to promote stress management/resiliency in regards to youth substance use.	Steph Johnson, Kayt Klemek, Michelle Thompson MCSAP, FariCARES, ALA Teen Group	Ongoing- report on status of program activities quarterly.	Continue in action plan for 2023. Updated who is responsible and timeframes.
Support training and implementation of the Celebrating Families program.	Tracy Henning, Michelle Rosen	Training by December 31, 2019. Implementation starts January 22, 2020.	Continue in action plan for 2023. Updated who is responsible and timeframes. Update strategy to reflect seeking funds to support.
Support Substance Abuse Prevention Coalitions work plan implementation across Faribault and Martin Counties.	Steph Johnson, Kayt Klemek MCSAP, FariCARES,	Ongoing- report on status of program activities quarterly.	Continue in action plan for 2023. Updated who is responsible and timeframes.
Support county wide implementation of substance abuse prevention activities through the Drug Free Communities Grant in Faribault County	Kayt Klemek	By December 31, 2021.	Continue in action plan for 2023. Updated who is responsible and timeframes.

Chronic Disease Prevention Action Plan

Issue Statement
According to the National Institute of Health, tobacco use, overweight/obesity, and hypertension are the leading causes of preventable death in the United States. A significant percentage of adults in Faribault and Martin Counties report having a diagnosis of hypertension and diabetes, or are overweight, or use tobacco.

Goal
Decrease the incidence of chronic disease, obesity and tobacco use in Faribault and Martin Counties by implementing policies, programs, and systemic changes that promote opportunities for healthy lifestyles among all residents.

Population Outcomes Measures
Decrease the percentage of adults who report using tobacco products from 2013 to 2022. Baseline data 22.9% Faribault County and 11.3% Martin County from the 2016 Adult Health Survey.
Decrease the percentage of 11th grade youth who report using tobacco products (including e-cigarettes) from 2013 to 2022. Baseline data identified from the Minnesota Student Survey.
Decrease the percent of adults diagnosed with high blood pressure or hypertension. Baseline data is 33.9% in Faribault County and 33.8% in Martin County from the 2016 Adult Health Survey.
Decrease the percent of adults diagnosed with high cholesterol or triglycerides. Baseline data is 34.8% in Faribault County and 31.4% in Martin County from the 2016 Adult Health Survey.
Decrease the percent of adults diagnosed with cancer. Baseline data is 12.9% in Faribault County and 10.5% in Martin County from the 2016 Adult Health Survey.
Decrease the percent of adults diagnosed with heart trouble or angina. Baseline data is 11% in Faribault County and 10.5% in Martin County from the 2016 Adult Health Survey.
Decrease the percent of adults diagnosed with diabetes. Baseline data is 8.6% in Faribault County and 11.1% in Martin County from the 2016 Adult Health Survey.
Decrease the percent of adults diagnosed with asthma. Baseline data is 11.9% in Faribault County and 8.9% in Martin County from the 2016 Adult Health Survey.
Decrease the percent of 9th graders who are overweight or obese according to BMI. Baseline is 21.2% among youth in Faribault and Martin Counties from the 2016 Minnesota Student Survey.
Decrease the percent of 11th graders who are overweight or obese according to BMI. Baseline is 28.7% among youth in Faribault and Martin Counties from the 2016 Minnesota Student Survey.

Decrease the percentage of adults who are overweight or obese according to BMI. Baseline is 73.1% in Faribault County and 68.3% in Martin County from the 2016 Adult Health Survey.

Community Partners

- Allison Amy, Mayo Clinic Health System
- Caroline McCourt, Human Services of Faribault & Martin Counties – SHIP
- John Roper, Faribault County Commissioner
- Tom Mahoney, Martin County Commissioner
- Mary Ellen Rigby, United Hospital District
- Deb Barnes, Lakeview Methodist Senior Living
- Ned Koppen, Fairmont Chamber of Directors
- Roni Dauer, Fairmont Community Education & Recreation
- Beth Labenz, University of Minnesota Extension
- Jessica Meyer, Mayo Clinic Health System
- John Huisman, Blue Earth City Council
- Dar Holmseth, Blue Earth Area Community Education
- Kelly McDonough, Minnesota Area Agency on Aging
- Lisa Hunwardsen, Mayo Clinic Health System
- Loria Rebuffoni, Faribault County
- Sandy Lorenz, Community Member Faribault County
- Darla Nelson Phillip, Mayo Clinic Health System
- Carolyn Kryzer, United Hospital District

Alignment with State and National Priorities

Healthy Minnesota 2022:

Priority 1: The opportunity to be healthy is available everywhere and for everyone.

Chronic Disease Strategies and Objectives

Strategy 1:
Increase access to evidence-based prevention programs aimed at reducing the onset of chronic disease.

Outcome Objective
• Community Leadership Team will develop Lifestyle Rx resource list by Oct 2020. • Develop partnerships through Community Leadership Team to increase number of referrals between providers and chronic disease management programs by Jan 2021. • SHIP will provide 4 Motivational Interviewing trainings to area providers May 2020-Jan 2021. • CLT will work to establish Food Rx program utilized by area providers by Jan 2021. • Identify plan to offer chronic disease screenings in communities and workplaces by OCT 2020.

Key Activities	Who is responsible?	By When?	2023 Status Review
Share information about classes available	Darla Nelson-Phillip, Mayo Mary Ellen Rigby, UHD Kelly McDonough, MNRAAA	July 2020 Ongoing	Continue in action plan for 2023
Create resource list of available services for those living with chronic disease [Lifestyle Rx]	Kelly McDonough, MNRAAA Caroline McCourt, SHIP Roni Dauer, Dar Holmseth, Community Education	Ongoing OCT 2020	Continue in action plan for 2023
Identify gaps in programs aimed at prevention and maintenance of chronic disease, and identify next steps for acquiring.	Darla Nelson-Phillip, Mayo Mary Ellen Rigby, UHD Kelly McDonough, MNRAAA Caroline McCourt, SHIP Roni Dauer, CREST	OCT 2020	Continue in action plan for 2023
Develop robust referral network between medical providers and available programs and resources for managing chronic illness.	Caroline McCourt, SHIP Darla Nelson-Phillip, Mayo Mary Ellen Rigby, UHD Kelly McDonough, MNRAAA	Jan 2021	Continue in action plan for 2023
Provide motivational interviewing training for health care providers to increase comfortability in	Caroline McCourt, SHIP Darla Nelson-Phillip, Mayo Mary Ellen Rigby, UHD	OCT 2021	Completed.

addressing health behaviors and chronic disease management, and improve referral to community resources.	Dulcimer		
Utilize medical provider model to encourage consumption of produce and increased access to healthy foods. (Food RX)	Caroline McCourt, SHIP Jessica Meyer, MAYO Mary Ellen Rigby, Winnebago Treatment Facility	Dec 2021	Continue in action plan for 2023
Offer opportunities for chronic disease screening in the community	Albert Lea/Fairmont YMCA Caroline McCourt, SHIP Darla Nelson Phillip, MAYO Mary Ellen Rigby, UHD	Dec 2021	Continue in action plan for 2023

Strategy 2:
Implement evidence-based strategies to promote breastfeeding for all new mothers in Faribault and Martin Counties.

Outcome Objective
• Provide Baby Café in Faribault Co in Wells and Blue Earth through ECFE/ WIC Clinic by DEC 2021 • By June, 2021 offer Certified Lactation Counselor Training in Fairmont, MN. • Increase WIC referral from providers by June 2021. • Increase breastfeeding home visits with Maternal Child Health Program by June 2021

Key Activities	Who is responsible?	By When?	2023 Status Review
Expand Baby Café program into Faribault County through ECFE in Blue Earth and WIC clinic in Wells at USC. Promote the Baby Café Program in Martin County.	Caroline McCourt, SHIP Lauren Schofield/Patti Kasper, Public Health Carolyn Kryzer, UHD BEA & USC ECFE/Community Education	DEC 2021	Complete. Maintain programming in 2023 action plan.
Promote WIC program with all prenatal women.	WIC Public Health	Ongoing	Continue in 2023 action plan.

	Jessica Meyer, MAYO Carolyn Kryzer/ Rick Ash, UHD		
Promote breastfeeding home visits with maternal child health program in Public Health.	WIC Public Health Jessica Meyer, MAYO Carolyn Kryzer/ Rick Ash, UHD	Ongoing	Continue in 2023 action plan.
Increase access to breastfeeding support services within Faribault and Martin Counties by offering Certified Lactation Consultant Training.	Caroline McCourt, SHIP	JUNE 2021 Online training hosted; in-person training rescheduled to May 2021	Completed. Add in the WIC Peer breastfeeding program and increased access to CLC staff.

Strategy 3:
Implement evidence-based strategies to reduce chronic disease, obesity and tobacco use across Faribault and Martin Counties.

Outcome Objective
• Increase awareness of safe walking and biking opportunities through social media, bike education in schools, worksite wellness programs by May 2020. • Decrease the percentage of 11th graders who are overweight or obese according to BMI by 3% by AUG 2022. • Decrease the percentage of adults who are overweight or obese according to BMI by 5% by AUG 2022. • Decrease youth tobacco usage by 10% by AUG 2022. • Offer bike safety education [bike rodeo] at all schools in both counties 1x per year by AUG 2022. • Increase food insecure screened clients served by area food shelves through referrals from providers through use of Aunt Bertha resources and SDoH screening tools by OCT 2020. • Implement 2 new community garden sites by March 2022. • Increase all area districts participation in Walk/Bike to school days 2x per year by AUG 2021.

Key Activities	Who is responsible?	By When?	2023 Status Review
Partner with area food support programs (food shelves, etc.) to improve access to healthy foods.	Kaley Hernandez, SHIP Jessica Meyer, MAYO Carolyn Kryzer, UHD	Ongoing	Continue in action plan for 2023

	Kelly McDonough/Krista Eichhorst, MNRAAA CREST Home Healthcare Agencies Prairie Transit		
Partner with area restaurants and corner stores to offer healthy menu and food options.	Kaley Hernandez, SHIP Carolyn Kryzer, UHD	DEC 2020	Continue in action plan for 2023
Develop or expand opportunities for community gardens.	SHIP Staff Darla Nelson Phillip, MAYO Mary Ellen Rigby, UHD	March 2021	Continue in action plan for 2023
Partner with Farmer's Markets to promote and encourage use within the community.	SHIP Staff Faribault & Martin Community Food Partnerships Diabetes Educators, UHD & MAYO Clinic Managers- Jessica Meyer, MAYO Ned Koepen, Chamber of Commerce	March 2020 Ongoing	Continue in action plan for 2023
Partner with active living coalitions to promote safe and accessible walking and biking.	Active Living Coalitions Faribault & Martin Co Caroline McCourt, SHIP	APRIL 2020 Ongoing	Continue in action plan for 2023
Partner with coalitions/schools to promote Safe Routes to School.	Active Living Coalitions Faribault & Martin Co Caroline McCourt, SHIP School Partners Community Education Kiwanis	APRIL 2020 Ongoing	Continue in action plan for 2023
Utilizing a collaborative approach, partner with area worksites to offer comprehensive wellness policies and practices addressing physical activity, healthy eating, tobacco	SHIP Staff	FEB 2020 Ongoing	Continue in action plan for 2023

cessation, breastfeeding support, and stress management.			
Partner with school districts to offer comprehensive school wellness policies and practices aimed at improving access to heathy foods, physical activity, stress management, and tobacco prevention.	Caroline McCourt, SHIP Darla Nelson-Phillip, MAYO UHD School Partners	FEB 2020 Ongoing	Continue in action plan for 2023

Access to Health Care Action Plan

Issue Statement
With the implementation of the Affordable Care Act (ACA), rates of uninsured adults and children living in Faribault and Martin Counties has decreased over time (3.9% Faribault County and 2.8% Martin County, 2016 Adult Health Survey), however more people are reporting delaying medical or dental care. Respondents to the survey indicated the top reasons for delaying medical, dental, or mental health care included cost, inability to obtain an appointment, not feeling the medical issue was serious enough, not having insurance coverage for their health issue, transportation issues, unsure where to go. or feeling nervous or afraid. Delaying medical or dental care can result in lifelong morbidity and shortened life span.

Goal
Increase access to health care, dental, and behavioral health care in Faribault and Martin Counties.

Population Outcome Measures
Decrease the percentage of adults who have not had a general health exam within the past year. Baseline: 31.7% in Faribault County and 31.2% in Martin County, 2016 Adult Health Survey.
Decrease the percentage of adults who thought they needed medical care but did not get it, or delayed getting it, in the past 12 months. Baseline: 28.1% in Faribault County and 19.2% in Martin County, 2016 Adult Health Survey
Decrease the percentage of adults that thought they needed dental care but did not get it, or delayed getting it, in the past 12 months. Baseline: 24.8% in Faribault County and 18.6% in Martin County, 2016 Adult Health Survey.
Decrease the percentage of Minnesota Health Care program enrollees who do not use dental services. Baseline: 70.5% in Faribault County and 70.7% in Martin County, 2017 Oral Health Data, Minnesota Public Health Data Access, Minnesota Department of Health.

Decrease the percentage of children aged 20 and under who are eligible for Child & Teen Check-Up and did NOT use preventative dental services. Baseline: 69.7% in Faribault County and 67.9% in Martin County, 2017 Oral Health Data, Minnesota Public Health Data Access, Minnesota Department of Health.
Increase the total number of eligible children who receive at least one CTC screening annually. Baseline: 41% in Faribault County and 39% in Martin County, DHS Line 10 Participation Report https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6793I-ENG

Community Partners
• Allison Amy, Mayo Clinic Health System • Rick Ash, United Hospital District • Greta Dahlberg, United Hospital District • William Groskreutz Jr., Faribault County Commissioner • Amy Long, Mayo Clinic Health System • Jeremy Monahan, Prairie Lakes Transit • Deb Barnes, Lakeview Methodist Senior Living • Dan Woodring, Interfaith Caregivers • Nicole Worlds, Human Services of Faribault & Martin Counties – Financial Assistance • Patti Kasper, Human Services of Faribault & Martin Counties – Community Health • Chera Sevcik, Human Services of Faribault & Martin Counties • Lauren Schofield – Human Services of Faribault & Martin Counties – Community Health

Alignment with State and National Priorities
Healthy Minnesota 2022: Priority 1: The opportunity to be healthy is available everywhere and for everyone. Priority 2: Places and systems are designed for health and well-being.

Access to Care Strategies and Objectives

Strategy 1:
Improve access to culturally and linguistically appropriate medical, dental and mental health care for all residents of Faribault and Martin Counties.

Outcome Objectives
1. By December 31, 2021 increase the number of providers offering dental services for individuals on medical assistance through partnership with Appletree Dental. 2. Establish a dental network in Faribault County by December 21, 2021. 3. By December 31, 2020, contracts will be executed between UHD/Mayo Health System – Fairmont/ Wells – and Prairie Express Transit. 4. Increase the number of mobile dental clinics offered to residents in Faribault and Martin Counties. 5. Increase awareness of health and dental care access issues among elected officials. 6. Increase partnerships and awareness of mental health services available to residents of Faribault & Martin Counties. 7. Improve access to tele-health mental health services to residents in Faribault & Martin Counties.

Key Activities	Who is responsible?	By When?	2023 Status Review
Partner with Appletree Dental to establish a clinic site in Martin County to increase dental services for individuals in service area who have medical assistance.	Amy Long -Mayo Health System	January, 2021	Completed.
Develop a Faribault County dental network. Research other successful models and reach out to the Southern Minnesota Initiative Foundation (SMIF) to explore opportunities for starting a network in Faribault County.	Greta Dahlberg, United Hospital District	By July 2020, reach out to SMIF and begin exploring possibilities for development of a dental network in Faribault County.	Continue in 2023 action plan.
Develop a contractual agreement between Prairie Lakes Transit and local health care providers (Mayo and UHD) to offer no-cost transportation for patients utilizing public transit to medical appointments.	Jeremey Monahan, Prairie Lakes Transit	By February 1, compile and analyze data regarding patient ridership in 2018/2019. February – March – hold meetings with UHD and Mayo to determine feasibility and explore contract options. Goal, by July 1, 2020 finalize contracts between PL Transit and UHD and	Continue in 2023 action plan. Add a transportation access assessment.

		Mayo Clinic Health System to offer patient transportation.	
Identify funding options to secure mobile dental clinics in Faribault & Martin Counties – and promote those opportunities.	Access to Care Team	Ongoing – identify possible local or state funding sources (Managed Care Organization, local foundations)	Continue in 2023 action plan.
Advocate for higher medical assistance reimbursement for dental providers.	Access to Care Team	On an annual basis, identify community needs and advocate with state and federal legislators. Members will report on activities quarterly.	Legislation passed to increase MA reimbursement rates.
Utilize common resource guide for primary care, mental health and (i.e. Aunt Bertha) to inventory and promote existing services available in Faribault & Martin Counties. Develop brochures or promotional materials for use by providers with patients.	Access to Care Team	Review and submit resources by December 31, 2020 and update annually or as needed.	Continue in action plan. Aunt Bertha has been transitioned to "Find Help"
Explore ways to increase access to tele-health mental health services in Faribault & Martin Counties.	Greta Dahlberg, Behavioral Health Manager – Human Services	Ongoing	Continue in 2023 action plan.
Coordinate with the South Central Community Based Initiative (SCCBI) and other metal health providers to stay informed of regional activities to improve services for mental health.	Chera Sevcik – Human Services of Faribault & Martin Counties BH Manager – Human Services of Faribault & Martin Counties	Ongoing- Chera will report out to committee of regional SCCBI activities	Continue in 2023 action plan.
Partner with Community Resiliency Team on mental health educational campaign – Promoting positive mental wellness and #makeitok to reduce the stigma of mental illness.	Deb Barnes	See Community Resiliency Team Work Plan.	Continue in 2023 action plan

Strategy 2:
Increase the percentage of adults and children who receive annual preventative health care services.

Outcome Objectives
1. Identify or develop system changes that promote ease of scheduling to increase patient utilization of preventative services. 2. Implement coordinated patient education and awareness campaign to promote preventative health services. 3. Complete outreach with medical and dental providers to promote child and teen check-ups.

Key Activities	Who is responsible?	By When?	2023 Status Review
Explore opportunities to reduce barriers to scheduling preventative examinations. This includes, scheduling next preventative exams prior to leaving appointment and utilizing technology to remind patients to schedule appointments.	Access to Care Team	Ongoing – look at ways to promote ease of scheduling and reminder systems to increase patient utilization of preventative services.	Continue in action plan for 2023
Develop and implement streamlined patient education campaigns among all participating health care organizations to increase awareness and encourage use of and normalize preventative health care services. Ensure all communications/promotional materials developed are inclusive of English and Spanish language and culturally appropriate for local community.	Access to Care Team – Rick Ash, Amy Long, Natanael Moreno	By December, 31, 2020 – develop a planned communications/marketing campaign to promote utilization of prevention services for 2021.	Continue in action plan for 2023
Promote Child & Teen Check-Up services to all children. Work with local providers to identify ways to encourage annual C&TC exams among.	Lauren Schofield, Public Health	Provide outreach to all medical and dental clinics within Faribault & Martin Counties annually.	

Step 6
Monitoring and Revising

The Stronger Together Coalition is a large, cross-sector coalition which represents multiple sectors and community organizations. The coalition developed three action teams to oversee development and implementation of the CHIP strategies and key activities. These plans were developed over the course of seven months, with community partners identifying roles and responsibilities with implementation of each strategy. Each action team has a designated leader to convene meetings and develop agendas. After the development of the action plan, each action team will meet bi-monthly to implement key action steps and update on the progress of the strategies. Regular meetings will ensure the action teams remain accountable for implementing and monitoring the plan. A summary of action plan progress made by each of the coalition action teams will be provided at the quarterly Stronger Together Coalition meetings.

The Stronger Together Community Health Leadership Coalition is responsible for recommending approval of the CHIP to the Community Health Board. The coalition will also be responsible for monitoring and revising the CHIP throughout the implementation phase. The coalition will meet quarterly to review progress towards strategy implementation and provide updates to the Community Health Board and to the community. The CHIP, as a live able, workable document, will continue to be updated quarterly and the most recent update will be available on the Human Services of Faribault & Martin Counties website and the coalition Facebook page. The coalition expects changes will be made, especially to the key activities, as the work evolves throughout the plan timeframe. Resource availability and funding is always changing, which could significantly impact key activities.

The coalition will monitor the population outcome measures by monitoring data indicators every three years. Data available more frequently will be shared as available. Monitoring data will help inform coalition activities and needs regarding monitoring and revising data measures and for identifying new or emerging health priorities not identified at the time of the community health assessment. The coalition will monitor strategy objectives for each action plan strategy quarterly. Revisions will be made as new key activities are identified or as outcomes are met.

The coalition will develop a communications plan to ensure timely information sharing with the community at-large. Sharable information will be identified at the quarterly Stronger Together Coalition meeting to ensure the community is kept informed of coalition activities. This may be done through the coalition social media platforms, news releases, and meeting notes.

2023 Progress Update

The initial adoption of the CHIP was adopted in March of 2020. On March 15, 2020, the COVID-19 pandemic escalated and resulted in world-wide shutdowns as public health, health care and first responders worked to respond to the growing concern with COVID-19. The pandemic emergency declaration lasted for over three years and resulted in significant delays in plans to implement the CHIP within Faribault & Martin Counties. The pandemic also significantly changed resources and support available for the community members.

Throughout the pandemic, the three action teams and the full coalition continued to make progress on the initial action plans developed within the CHIP. (See annual community reports) While many of the original timelines were not met due to delays because of COVID-19, significant progress was made.

The annual adult health survey was scheduled to be repeated in 2022 to maintain the three-year schedule. The decision was made to develop a combined COVID-19 impact survey and adult health survey to continue to obtain trend data and learn more about the impacts of COVID-19 to community members. This assessment was completed using both random sampling and convenience methods, which focused on priority populations. Additionally, community events were utilized as opportunities to complete dot voting and learn more about the needs of the community. Additionally, the Minnesota Student Survey was also repeated in 2022 to allow for trending of youth data related to multiple health behaviors and outcomes. Upon completion, both data were analyzed by community members for trends and themes.

Review of the data demonstrated the need to maintain the priority health areas of ACEs, Mental Health, Substance Abuse, Chronic Disease and Access to Health Care and Dental as the primary focus on the CHIP moving forward. Additionally, funding available for response to the COVID impacts, the Statewide Health Improvement Partnership, as well as the Opioid Settlement Funds, allow the Coalition to have access to funding to implement programs, policies, systems, and environmental changes to improve the priority health areas outlined in the CHIP.

In 2023, the decision was made to combine the Healthier Together and Access to Care action teams, for overlap of committee members and better alignment of priorities. The new action team will be called Access to Health.

The full Stronger Together Community Health Leadership Coalition will function at the Community Leadership Team for the Statewide Health Improvement Partnership as well as the Task force providing recommendations on the use of the Opioid Settlement Funds. This will allow further partnership recruitment to the coalition, better alignment of community health priorities and initiatives and ensure the focus of the funding fulfills the CHIP priorities.

Within the three years between adoption of the initial CHIP and review of the data and progress, there were significant changes in community members participating in the work. There had been some significant turnover within the community which resulted in new leadership on the coalition. In 2023, we also reviewed membership of the coalition and action teams and updated as appropriate. In addition to reviewing membership, action teams also reviewed the action plans to celebrate the work that has been successfully completed, to revise timelines and deadlines for the work moving forward, and to add new initiatives, goals, and objectives for the next 3-5 years.

The Adverse Childhood Experiences and Building Resiliency Action Plan will continue to guide the work of the Community Resiliency Action Team. The Chronic Disease Prevention and Access to Care Action Plans will guide the work of the Access to Health Team.

Revised Action Plans - 2023

Adverse Childhood Experiences /Building Community Resiliency Action Plan

Issue Statement

The Centers for Disease Control, in partnership with Kaiser Permanente, led one of the largest investigations of childhood abuse and neglect and later-life health and well-being, referred to as the Adverse Childhood Experiences (ACEs) Study. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan. According to Faribault and Martin County residents, ACE scores are a significant factor contributing to lifelong health and opportunity.

Goal

Decrease the incidence of Adverse Childhood Experiences (ACEs) and increase resiliency among residents in Faribault and Martin Counties.

Population Outcome Measures	Population	Status	Most Recent Data	Baseline Data	2030 Target
Decrease in the percentage of adults reporting being diagnosed with any mental health problem.	Faribault County	Little or no detectable change	30.4%[1]	29.9%[3]	29.3%[A]
	Martin County	Getting worse	32.6%[1]	28.9%[3]	
Decrease in the percentage of adults who report feelings of hopelessness, anxiety, or loss of interest in things they used to enjoy within the past 12 months.	Faribault County	Little or no detectable change	29.9%[2]	28.2%[3]	25.8%[A]
	Martin County	Getting worse	34.6%[2]	24.1%[3]	
Decrease in the percentage of students reporting being bothered by feeling down, depressed or hopeless in the last 2 weeks	**Faribault and Martin County** 8th graders	Getting worse	45.6%[4]	42.7%[6]	42.7%[A]
	9th graders	Getting worse	50.8%[4]	41.0%[6]	41.0%[A]
	11th graders	Getting worse	54.8%[4]	47.2%[6]	47.2%[A]

Source 1: Faribault and Martin Counties COVID-19 Impact and Adult Health Survey, 2022.
Source 2: Faribault and Martin Counties Adult Health Survey, 2019.
Source 3: Faribault and Martin Counties Adult Health Survey, 2016.
Source 4: Minnesota Student Survey, 2022.
Source 5: Minnesota Student Survey, 2019.
Source 6: Minnesota Student Survey, 2016.

Target Setting Methods
A: Maintain Baseline.
B: Statewide Average.
C: Percentage Point Decrease.

Population Outcome Measures	Population	Status	Most Recent Data	Baseline Data	2030 Target
Decrease the percentage of students who report at least one adverse childhood experience (ACE score of one or more).	**Faribault and Martin County** 8th graders	Little or no detectable change	48.1%[4]	46.6%[5]	45.1% [B]
	9th graders	Improving	51.9%[4]	57.1%[5]	47.1% [B]
	11th graders	Getting worse	59.5%[4]	55.1%[5]	50.4% [B]
Decrease the percentage of students who report four or more adverse childhood experiences (ACE score of four or more).	**Faribault and Martin County** 8th graders	Improving	6.4%[4]	9.8%[5]	6.4% [B]
	9th graders	Little or no detectable change	9.4%[4]	9.7%[5]	6.9% [B]
	11th graders	Little or no detectable change	9.7%[4]	10.6%[5]	7.6% [B]
Decrease in the rate of child maltreatment reports per 1,000 children.	Faribault and Martin Counties	Little or no detectable change	45.6 reports per 1,000 children[7]	50.3 reports per 1,000 children[8]	26.3 reports per 1,000 children[B]
Decrease the rate of children in out-of-home care per 1,000 children.	Faribault and Martin Counties	Little or no detectable change	19.8 per 1,000 children[9]	21.2 per 1,000 children[10]	9.8 per 1,000 children[B]
Decrease the rate of child maltreatment for neglect reports per 1,000 children.	Faribault and Martin Counties	Little or no detectable change	33.5 reports per 1,000 children[7]	34.7 reports per 1,000 children[8]	16.1 per 1,000 children[B]

Source 4: Minnesota Student Survey, 2022.
Source 5: Minnesota Student Survey, 2019.
Source 6: Minnesota Student Survey, 2016.
Source 7: Minnesota's Child Maltreatment Report, 2020, DHS-5408M. Minnesota Department of Human Services.
Source 8: Minnesota's Child Maltreatment Report, 2017, DHS-5408J. Minnesota Department of Human Services.
Source 9: Minnesota Out-of-home Care and Permanency Report, 2020, DHS-5408MA. Minnesota Department of Human Services.
Source 10: Minnesota Out-of-home Care and Permanency Report, 2017, DHS-5408JA. Minnesota Department of Human Services.

Target Setting Methods
A: Maintain Baseline.
B: Statewide Average.
C: Percentage Point Decrease.

Population Outcome Measures	Population	Status	Most Recent Data	Baseline Data	2030 Target
Decrease the percentage of students who report using conventional tobacco products in the past 30 days.	**Faribault and Martin County** 8th graders	Improving	2.9%[4]	5.0%[6]	2.3%[B]
	9th graders	Improving	3.3%[4]	7.4%[6]	2.7%[B]
	11th graders	Improving	9.8%[4]	19.7%[6]	4.7%[B]
Decrease the percentage of students who report using any tobacco products, including e-cigarettes, in the past 30 days.	**Faribault and Martin County** 8th graders	Little or no detectable change	7.1%[4]	8.0%[6]	6.4%[B]
	9th graders	Improving	7.4%[4]	10.6%[6]	8.2%[B]
	11th graders	Little or no detectable change	19.7%[4]	21.2%[6]	14.9%[B]
Decrease the percentage of students who report using alcohol in the past year.	**Faribault and Martin County** 8th graders	Improving	10.1%[4]	16.2%[6]	10.2%[B]
	9th graders	Improving	16.5%[4]	21.4%[6]	14.4%[B]
	11th graders	Improving	33.7%[4]	48.2%[6]	29.1%[B]
Decrease the percentage of 9th and 11th grade students who report any use of marijuana and/or other drugs in the past year.	**Faribault and Martin County** 9th graders	Baseline only	15.0%[4]	-	10.0%[C]
	11th graders	Baseline only	23.4%[4]	-	18.4%[C]

Source 4: Minnesota Student Survey, 2022.
Source 5: Minnesota Student Survey, 2019.
Source 6: Minnesota Student Survey, 2016.

Target Setting Methods
A: Maintain Baseline.
B: Statewide Average.
C: Percentage Point Decrease.

Population Outcome Measures	Population	Status	Most Recent Data	Baseline Data	2030 Target
Decrease the percentage of adults who report using tobacco products.	Faribault County	Getting worse	24.6%[2]	22.9%[3]	16.1%[A]
	Martin County	Getting worse	18.5%[2]	11.3%[3]	
Decrease the percentage of adults who report heavy drinking in the past 30 days.	Faribault County	Little or no detectable change	12.1%[2]	13.2%[3]	8.0%[C]
	Martin County	Little or no detectable change	9.3%[2]	7.7%[3]	
Decrease the percentage of adults who report binge drinking in the past 30 days.	Faribault County	Improving	27.5%[2]	29.4%[3]	22.1%[C]
	Martin County	Little or no detectable change	22.1%[2]	22.1%[3]	

Source 1: Faribault and Martin Counties COVID-19 Impact and Adult Health Survey, 2022.
Source 2: Faribault and Martin Counties Adult Health Survey, 2019.
Source 3: Faribault and Martin Counties Adult Health Survey, 2016.

Target Setting Methods
A: Maintain Baseline.
B: Statewide Average.
C: Percentage Point Decrease.

Community Partners - Community Resiliency Team
• Amy Becker, Fairmont Schools • Ann Crofton, Blue Earth Area School • Anna Garbers, Human Services of Faribault & Martin Counties- Mental Health • Autumn Welcome, Martin County West Schools • Brooke Pierce, Mayo Clinic Health System • Caroline McCourt, Human Services of Faribault & Martin Counties • Chris Gerhardt, Martin County Sherriff Department / GHEC SRO • Conan Schaffer, Blue Earth Area Schools • Courtney Logwood, Fairmont Kinship • Darla Nelson-Phillip, Mayo Clinic Health System Fairmont • Debra Mosloski, Human Services of Faribault & Martin Counties – Child Protection • Doug Storbeck, Granada Huntley East Chain Schools • Emily Fett, Fairmont Area Schools • Jamie Bleess, Martin County Commissioner • Jennifer Crawford, United South Central Schools • Kaley Hernandez, Human Services of Faribault & Martin Counties • Kathy Smith, Martin County Commissioner • Katy Gonzales, Fairmont Kinship • Kayt Klemek, United South Central Schools • Kelly Bleess, Blue Earth Area Schools • Liz Heimer, Human Services of Faribault & Martin Counties • Melissa Haugh, United South Central Schools • Michelle Rosen, Fairmont Area Schools • Molly Weinberger, Counseling Services of Southern Minnesota • Nicole Anderson, Human Services of Faribault & Martin Counties • Pastor Richard Abel, • Shea Ripley, Building Blocks Child Care • Shelly Larsen, Martin County Substance Abuse Prevention Coalition • Stephanie Dyslin, Human Services of Faribault & Martin Counties

- Tracy Henning, Drug Court
- Val Malchow, Dept of Corrections

Alignment with State and National Priorities
Healthy Minnesota 2022: Priority 1: The opportunity to be healthy is available everywhere and for everyone. **National Prevention Strategy:** *Mental & Emotional Well-Being:* Recommendation 1: Promote positive early childhood development, including positive parenting and violence-free homes. Recommendation 2: Facilitate social connectedness and community engagement across the lifespan. Recommendation 3: Provide individuals and families with the support necessary to maintain positive mental well-being.

Adverse Childhood Experiences /Building Community Resiliency

Strategies and Objectives

Strategy 1:
Increase the knowledge of ACEs among community members and partners and their effect on the health of our community.

Outcome Objectives
• By September 1, 2023 develop a communications plan about to share information about ACEs data and to promote strength based services to prevent ACEs. • Develop and disseminate one success story per month to highlight work happening within the community regarding ACEs that can be shared by coalition members in their networks.

Key Activities	Who is responsible?	By When?
Publicize community health assessment data on www.fmchs.com website for community partner use.	Chera Sevcik	1-Dec-23
Share best practices among coalition membership for utilizing social media as a communication tool to support strategy work.	Communications Planner	Ongoing
Create and/or identify communication materials, scripts and templates to share, including: printed materials, social media, videos and visuals.	Communications Planner	Monthly - Social media/print media promotion materials shared with coalition monthly.
Identify shareable media and developing posting plan among partner organizations.	Communications Planner	Monthly- Social media/print media promotion materials shared with coalition monthly.
Promote community events to provide education, information and sharing about coalition activities. Utilize community calendars and health observances to promote messaging that support resiliency.	Communications Planner & Coalition Membership	Each meeting - Review community events at each meeting and identify opportunities to partner.
Identify strength-based messages about partner organizations and community resources that promote or support resiliency (Drug Court, Healthy Families, ECFE, CER, CPS, Mentoring, Law Enforcement etc.) in an effort to normalize community utilization of support services.	Communications Planner & Coalition Membership	Monthly – highlight different organizations o programs within the community
Promote referral and connection between community partners and organizations. Look at different mechanisms (referrals forms, help me connect, etc. to support clients.)	Community Resiliency Team Partner Organizations	Ongoing

Strategy 2:
Build resiliency in individuals, families, and in the community through the development and implementation of policies and practices.

Outcome Objectives
• Quarterly, provide presentations and information updates to Community Resiliency Action Team members on evidence-based, evidence-informed, or innovative strategies or ideas to increase resiliency among residents of Faribault & Martin Counties. • By December 2024, develop an inventory of existing mental health and substance use resources and identify gaps in services. • Working across sectors, implement multiple (at least 10) strategies that foster and build resilience among community members of multiple ages.

Key Activities	Who is responsible?	By When?
Research what other communities are doing to effectively promote community resilience. Bring back those ideas, modify if needed and replicate in our community. Examples include: Yellow Zone Toolkit from Stearns County.	Caroline McCourt, Kaley Hernandez & Coalition membership	Ongoing- standing agenda item to review recent learnings between meetings. Provide presentations at CRT meetings on different programs or services.
Monitor legislation, funding, and reform changes occurring at the national or state level that may impact our work happening locally. Monitor Families First and Substance Use Reform.	Community Resiliency Team Members	Ongoing- standing agenda item to review recent learnings between meetings
Support implementation and referral to Healthy Families America home visiting program among 60 families who meet risk factors and program criteria.	Liz Heimer, Alyssa Johnson	Ongoing- report on status of program availability quarterly.

Support implementation and referral to the Parent Support Outreach Program to families at-risk of Child Protection involvement.	Jackie Auringer	Ongoing- report on status of program availability quarterly.
Implement a trauma informed collaborative to support schools, worksites, and community partners in adopting trauma informed strategies, policies, and practices within their settings.	Caroline McCourt, Kaley Hernandez	Ongoing- report on status of program availability quarterly.
Conduct a baseline assessment of school-based mental health resources to summarize current service delivery and identify gaps in service.	Caroline McCourt	Complete assessment by December 2023.
Identify and refer at-risk clients to trauma informed therapy programs to support resiliency.	Counseling Services of Southern Minnesota Molly Weinberger	Ongoing- report on status of program availability quarterly.
Work towards becoming a Bridges out of Poverty Community. - Support a Community of Practice to encourage schools, community, worksites, etc. to adopt policies and practices that support financial resilience. - Identify individuals and send to a train the trainer to provide the program Getting Ahead in a Just Getting by World. - Offer BOP foundational training to community partners. - Explore offering additional training for Emotional Poverty, etc.		Develop a community of practice by December 2023 Complete train the trainer by December 2023 Send individuals to train for Getting By Training by June 2024. Offer Bridges out of Poverty training ongoing to community organizations.
Identify and offer training on trauma and resiliency to mentors enrolling in Kinship, Stars, or BEAM mentorship programs.	Katy Gonzalez, Courtney Logwood BEAM/STARS Rep	Ongoing- report on status of program availability quarterly.

Implement motivational interviewing within helping professionals as part of the Families First Prevention Services Act legislative requirements.	Jackie Auringer Human Services of Faribault & Martin Counties	By December 31, 2023
Offer motivational interviewing training to all helping professions working in our communities to better engage patients/clients in conversations about ACEs, MH, and SA. (Resources might include Dr. Sood, People Incorporated Training Network).	Caroline McCourt Darla Nelson Phillip	Ongoing- report on status of program availability quarterly.
Support development of strong communication between law enforcement, human services, medical providers, and educational systems, especially in regards to supporting children who have experienced a traumatic event. Utilize Child Protection Team meetings to communicate timely information about situations between partners. Explore partnership with the school to alert professionals about situations that might impact the child.	Debbie Mosloski, Jackie Auringer Human Services of Faribault & Martin Counties	Ongoing- report on status of program availability quarterly.
NEW 2023: Provide Recovery Specialist case management services to support families involved in family preservation with chemical use issues.	Jackie Auringer Human Services of Faribault & Martin Counties	Ongoing- report on status of program availability quarterly.
Explore discharge planning and supports for incarcerated individuals with mental health and substance abuse concerns.	Anna Garbers Human Services of Faribault & Martin Counties	Ongoing- report on status quarterly.
Utilize the Mayo Clinic Road to Resilience Tool kits- explore ways to promote the toolkit and implement within the medical community.	Darla Nelson Phillip	Ongoing- report on status of program activities quarterly.
Utilize the Statewide Health Improvement Partnership (SHIP) to promote positive	Kaley Hernandez	Ongoing- report on status of program activities quarterly.

mental health through comprehensive worksite wellness programs.		
Partner youth groups to promote stress management/resiliency in regard to youth substance use.	Steph Johnson, Kayt Klemek, Michelle Thompson MCSAP, FariCARES, ALA Teen Group	Ongoing- report on status of program activities quarterly.
Identify funding to support ongoing implementation of the Celebrating Families Program withing FM Counties.	Tracy Henning, Amy Becker	Ongoing- report on status of program activities quarterly.
Support Substance Abuse Prevention Coalitions work plan implementation across Faribault and Martin Counties.	Shelly Larsen, Nathan Goette MCSAP, FariCARES,	Ongoing- report on status of program activities quarterly.
Engage community in planning process for utilizing the Opioid Settlement funding - convene subcommittee to review the needs and determine strategies that support the community health improvement plan.	Public Health/Human Services Coalition Membership	Beginning July 2023.

Chronic Disease Prevention Action Plan

Issue Statement
According to the National Institute of Health, tobacco use, overweight/obesity, and hypertension are the leading causes of preventable death in the United States. A significant percentage of adults in Faribault and Martin Counties report having a diagnosis of hypertension and diabetes, or are overweight, or use tobacco.

Goal

Decrease the incidence of chronic disease, obesity and tobacco use in Faribault and Martin Counties by implementing policies, programs, and systemic changes that promote opportunities for healthy lifestyles among all residents.

Population Outcomes Measures
Decrease the percentage of adults who report using tobacco products from 2013 to 2022. Baseline data 22.9% Faribault County and 11.3% Martin County from the 2016 Adult Health Survey.
Decrease the percentage of 11th grade youth who report using tobacco products (including e-cigarettes) from 2013 to 2022. Baseline data identified from the Minnesota Student Survey.
Decrease the percent of adults diagnosed with high blood pressure or hypertension. Baseline data is 33.9% in Faribault County and 33.8% in Martin County from the 2016 Adult Health Survey.
Decrease the percent of adults diagnosed with high cholesterol or triglycerides. Baseline data is 34.8% in Faribault County and 31.4% in Martin County from the 2016 Adult Health Survey.
Decrease the percent of adults diagnosed with cancer. Baseline data is 12.9% in Faribault County and 10.5% in Martin County from the 2016 Adult Health Survey.
Decrease the percent of adults diagnosed with heart trouble or angina. Baseline data is 11% in Faribault County and 10.5% in Martin County from the 2016 Adult Health Survey.
Decrease the percent of adults diagnosed with diabetes. Baseline data is 8.6% in Faribault County and 11.1% in Martin County from the 2016 Adult Health Survey.
Decrease the percent of adults diagnosed with asthma. Baseline data is 11.9% in Faribault County and 8.9% in Martin County from the 2016 Adult Health Survey.
Decrease the percent of 9th graders who are overweight or obese according to BMI. Baseline is 21.2% among youth in Faribault and Martin Counties from the 2016 Minnesota Student Survey.
Decrease the percent of 11th graders who are overweight or obese according to BMI. Baseline is 28.7% among youth in Faribault and Martin Counties from the 2016 Minnesota Student Survey.
Decrease the percentage of adults who are overweight or obese according to BMI. Baseline is 73.1% in Faribault County and 68.3% in Martin County from the 2016 Adult Health Survey.

Population Outcomes Measures	Population	Status	Most Recent Data	Baseline Data	2030 Target
Decrease the percent of adults diagnosed with high blood pressure or hypertension.	Faribault County	Getting worse	38.0%[1]	33.9%[3]	33.8%[A]
	Martin County	Getting worse	44.2%[1]	33.8%[3]	
Decrease the percent of adults diagnosed with high cholesterol or triglycerides.	Faribault County	Improving	29.1%[1]	34.8%[3]	29.8%[C]
	Martin County	Getting worse	36.1%[1]	31.4%[3]	
Decrease the percent of adults diagnosed with cancer.	Faribault County	Improving	10.7%[1]	12.9%[3]	9.5%[C]
	Martin County	Little or no detectable change	10.3%[1]	10.5%[3]	
Decrease the percent of adults diagnosed with heart trouble or angina.	Faribault County	Improving	9.7%[1]	11.0%[3]	10.7%[A]
	Martin County	Getting worse	12.5%[1]	10.5%[3]	
Decrease the percent of adults diagnosed with diabetes.	Faribault County	Getting worse	11.6%[1]	8.6%[3]	10.1%[A]
	Martin County	Getting worse	13.2%[1]	11.1%[3]	
Decrease the percent of adults diagnosed with asthma.	Faribault County	Little or no detectable change	11.0%[1]	11.9%[3]	9.7%[A]
	Martin County	Getting worse	11.7%[1]	8.2%[3]	
Decrease the percent of 9th and 11th graders who are overweight or obese according to BMI.	**Faribault and Martin Counties** 9th graders	Getting worse	27.7%[4]	21.2%[6]	21.2%[A]
	11th graders	Little or no detectable change	27.7%[4]	28.7%[6]	24.7%[C]
Decrease the percentage of adults who are overweight or obese according to BMI.	Faribault County	Little or no detectable change	72.3%[1]	73.1%[3]	70.3%[A]
	Martin County	Getting worse	73.2%[1]	68.3%[3]	

Source 1: Faribault and Martin Counties COVID-19 Impact and Adult Health Survey, 2022.
Source 2: Faribault and Martin Counties Adult Health Survey, 2019.
Source 3: Faribault and Martin Counties Adult Health Survey, 2016.
Source 4: Minnesota Student Survey, 2022.
Source 5: Minnesota Student Survey, 2019.
Source 6: Minnesota Student Survey, 2016.

Target Setting Methods
A: Maintain Baseline.
B: Statewide Average.
C: Percentage Point Decrease.

Community Partners – Access to Health Team
• Allison Amy, Mayo Clinic Health System • Alyssa Johnson, Human Services of Faribault & Martin Counties • Caroline McCourt, Human Services of Faribault & Martin Counties • John Roper, Faribault County Commissioner • Mary Ellen Rigby, United Hospital District • Deb Barnes, Lakeview Methodist Senior Living • Ned Koppen, Fairmont Chamber of Directors • Roni Dauer, Fairmont Community Education & Recreation • John Huisman, Blue Earth City Council • Ashley Hagen, Minnesota Area Agency on Aging • Darla Nelson Phillip, Mayo Clinic Health System • Carolyn Kryzer, United Hospital District • Nicole Worlds, Human Services of Faribault & Martin Counties • Karla Olson, Fairmont Area Schools • Louisa Trepero, University of Minnesota Extension • Shannon Swanson, BEA Community Education • Stephanie Busiahn, Fairmont Community Education • Amy Long, Mayo Clinic Health System • William Groskruetz, Jr., Faribault County Commissioner • Dan Woodring, Interfaith Caregivers • Jeremy Monahan, Prairie Lakes Transit • Sue Hassing, United Hospital District • Emily Fett, Fairmont Area Schools

Alignment with State and National Priorities
Healthy Minnesota 2022: Priority 1: The opportunity to be healthy is available everywhere and for everyone.

Chronic Disease Strategies and Objectives

Strategy 1:
Increase access to evidence-based prevention programs aimed at reducing the onset of chronic disease.

Outcome Objective
• Increase the availability of evidence-based chronic disease prevention programs (tobacco cessation, diabetes prevention, heart disease prevention, etc.) available within Faribault & Martin Counties by December 2025. • Increase referrals to programs providing chronic disease prevention programs by December 2025.

Key Activities	Who is responsible?	By When?
Create resource list of available services for those living with chronic disease [Lifestyle Rx]	Public Health/Human Services Mayo Clinic Health System United Hospital District	Identify list of current programs and services available by December 2024. Review and update annually.
Identify gaps in programs aimed at prevention and maintenance of chronic disease and identify next steps for acquiring.	Public Health/Human Services Mayo Clinic Health System United Hospital District	Review gaps and needs by July 2025.
Develop robust referral network between medical providers and available programs and resources for managing chronic illness.	Public Health/Human Services Mayo Clinic Health System United Hospital District Community organizations Community Education and Recreation	Outreach to providers to update current resource availability and referral process for programs by December 2025
Promote classes available to support management and prevention of chronic disease	Community Education and Recreation MNRAAA Interfaith Caregivers & other non-profit providers	Ongoing
Utilize medical provider model to encourage consumption of produce and increased access to healthy foods. (Food RX)	Public Health/Human Services Mayo Clinic Health System United Hospital District Local Food Shelves	Ongoing
Explore offering chronic disease screening at community events.	Public Health/Human Services Mayo Clinic Health System United Hospital District	Determine feasibility by June 2024.

Strategy 2:
Implement evidence-based strategies to promote breastfeeding for all new mothers in Faribault and Martin Counties.

Outcome Objective
• 100% of prenatal and postpartum WIC participants will be referred to lactation services (IBCLC, Peer Breastfeeding Program, Baby Café). • Increase initiation of breastfeeding among WIC participants (92% Faribault County, 74% Martin County).

Key Activities	Who is responsible?	By When?
Promote lactation services and programs to prenatal and postpartum women through referral to IBCLC and breastfeeding programs, breastfeeding classes, and community outreach.	Public Health/Human Services Mayo Clinic Health System United Hospital District	Ongoing
Provide ongoing lactation information and education to medical providers	Public Health/Human Services Mayo Clinic Health System United Hospital District	Bi-Annually
Provide peer breastfeeding program services to women enrolled in the WIC program.	Public Health/Human Services	Ongoing
Increase available of Baby Café Program within Faribault & Martin Counties by offering services in Fairmont, Blue Earth and Wells.	Public Health/Human Services ECFE Fairmont, Blue Earth and USC	Ongoing

Strategy 3:
Implement evidence-based strategies to reduce chronic disease, obesity and tobacco use across Faribault and Martin Counties.

Outcome Objective

Key Activities	Who is responsible?	By When?
Partner with area food shelves to implement the Super Shelves Program.	SHIP Staff Community Food Partnerships	September 2025
Partner with area restaurants and corner stores to offer healthy menu and food options.	SHIP Staff Community Food Partnerships	Ongoing
Develop or expand opportunities for community gardens.	SHIP Staff Community Food Partnerships Kinship of Martin County	Ongoing
Partner with Farmer's Markets to promote and encourage use within the community.	SHIP Staff Community Food Partnerships	Ongoing
Partner with active living coalitions to promote safe and accessible walking and biking by conducting walkable and/or bikeable communities' assessments with local Active Living Coalitions.	SHIP Staff Active Living Coalitions	Ongoing
Partner with Active Living Coalitions /schools to implement walk/bike education programs, quality physical education curriculum and active school day policies and practices.	SHIP Staff Area Schools Active Living Coalitions	Ongoing
Partner with area worksites to implement worksite wellness programs and policies addressing physical activity, healthy eating, tobacco cessation, breastfeeding support, trauma informed worksite and stress management.	SHIP Staff	Ongoing
Partner with school districts to offer comprehensive school AND employee wellness policies and practices aimed at improving access to heathy foods, physical	SHIP Staff	Ongoing

activity, stress management, and tobacco prevention.		

Access to Health Care Action Plan

Issue Statement
With the implementation of the Affordable Care Act (ACA), rates of uninsured adults and children living in Faribault and Martin Counties has decreased over time (3.9% Faribault County and 2.8% Martin County, 2016 Adult Health Survey), however more people are reporting delaying medical or dental care. Respondents to the survey indicated the top reasons for delaying medical, dental, or mental health care included cost, inability to obtain an appointment, not feeling the medical issue was serious enough, not having insurance coverage for their health issue, transportation issues, unsure where to go or feeling nervous or afraid. Delaying medical or dental care can result in lifelong morbidity and shortened life span.

Goal
Increase access to health care, dental, and behavioral health care in Faribault and Martin Counties.

Population Outcome Measures
Decrease the percentage of adults who have not had a general health exam within the past year. Baseline: 31.7% in Faribault County and 31.2% in Martin County, 2016 Adult Health Survey.
Decrease the percentage of adults who thought they needed medical care but did not get it, or delayed getting it, in the past 12 months. Baseline: 28.1% in Faribault County and 19.2% in Martin County, 2016 Adult Health Survey
Decrease the percentage of adults that thought they needed dental care but did not get it, or delayed getting it, in the past 12 months. Baseline: 24.8% in Faribault County and 18.6% in Martin County, 2016 Adult Health Survey.
Decrease the percentage of Minnesota Health Care program enrollees who do not use dental services. Baseline: 70.5% in Faribault County and 70.7% in Martin County, 2017 Oral Health Data, Minnesota Public Health Data Access, Minnesota Department of Health.
Decrease the percentage of children aged 20 and under who are eligible for Child & Teen Check-Up and did NOT use preventative dental services. Baseline: 69.7% in Faribault County and 67.9% in Martin County, 2017 Oral Health Data, Minnesota Public Health Data Access, Minnesota Department of Health.
Increase the total number of eligible children who receive at least one CTC screening annually. Baseline: 41% in Faribault County and 39% in Martin County, DHS Line 10 Participation Report https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6793I-ENG

Population Outcomes Measures	Population	Status	Most Recent Data	Baseline Data	2030 Target
Decrease the percentage of adults who have not had a general health exam within the past year.	Faribault County	Little or no detectable change	32.2%[1]	31.7%[3]	28.4%[C]
	Martin County	Improving	24.1%[1]	31.2%[3]	
Decrease the percentage of adults who thought they needed medical or preventative care but did not get it, or delayed getting it, in the past 12 months.	Faribault County	Improving	16.1%[1]	28.1%[3]	20.9%[C]
	Martin County	Getting worse	22.5%[1]	19.2%[3]	
Decrease the percentage of adults that thought they needed dental care but did not get it, or delayed getting it, in the past 12 months.	Faribault County	Little or no detectable change	24.2%[1]	24.8%[3]	21.1%[A]
	Martin County	Getting worse	21.1%[1]	18.6%[3]	
Decrease the percentage of adults that thought they needed mental health care but did not get it, or delayed getting it, in the past 12 months.	Faribault County	Improving	8.9%[1]	16.0%[3]	13.3%[C]
	Martin County	Improving	12.3%[1]	14.7%[3]	
Decrease the percentage of Minnesota Health Care program enrollees who do not use dental services.	Faribault County	Getting worse	72.8%[11]	70.5%[12]	70.6%[A]
	Martin County	Little or no detectable change	69.5%[11]	70.7%[12]	
Decrease the percentage of children aged 20 and under who are eligible for Child & Teen Check-Up and did NOT use preventative dental services.	Faribault County	Improving	67.7%[11]	69.7%[12]	66.9%[C]
	Martin County	Getting worse	70.4%[11]	68.1%[12]	
Increase the total number of eligible children who receive at least one CTC screening annually.	Faribault County	Improving	43%[13]	41%[14]	47%[C]
	Martin County	Improving	45%[13]	39%[14]	

Source 1: Faribault and Martin Counties COVID-19 Impact and Adult Health Survey, 2022.
Source 2: Faribault and Martin Counties Adult Health Survey, 2019.
Source 3: Faribault and Martin Counties Adult Health Survey, 2016.
Source 11: 2020 Oral Health Data, Minnesota Public Health Data Access, Minnesota Department of Health.
Source 12: 2017 Oral Health Data, Minnesota Public Health Data Access, Minnesota Department of Health.
Source 13: 2021 Minnesota Child and Teen Checkups Line 10 Participation Report, DHS-6793L-ENG, Minnesota Department of Human Services.
Source 14: 2018 Minnesota Child and Teen Checkups Line 10 Participation Report, DHS-6793I-ENG, Minnesota Department of Human Services.

Target Setting Methods
A: Maintain Baseline.
B: Statewide Average.
C: Percentage Point Decrease.

Community Partners - Access to Health Team

- Allison Amy, Mayo Clinic Health System
- Alyssa Johnson, Human Services of Faribault & Martin Counties
- Caroline McCourt, Human Services of Faribault & Martin Counties
- John Roper, Faribault County Commissioner
- Mary Ellen Rigby, United Hospital District
- Deb Barnes, Lakeview Methodist Senior Living
- Ned Koppen, Fairmont Chamber of Directors
- Roni Dauer, Fairmont Community Education & Recreation
- John Huisman, Blue Earth City Council
- Ashley Hagen, Minnesota Area Agency on Aging
- Darla Nelson Phillip, Mayo Clinic Health System
- Carolyn Kryzer, United Hospital District
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- Stephanie Busiahn, Fairmont Community Education
- Amy Long, Mayo Clinic Health System
- William Groskruetz, Jr., Faribault County Commissioner
- Dan Woodring, Interfaith Caregivers
- Jeremy Monahan, Prairie Lakes Transit
- Sue Hassing, United Hospital District
- Emily Fett, Fairmont Area Schools

Alignment with State and National Priorities

Healthy Minnesota 2022:

Priority 1: The opportunity to be healthy is available everywhere and for everyone.

Priority 2: Places and systems are designed for health and well-being.

Access to Care Strategies and Objectives

Strategy 1:
Improve access to culturally and linguistically appropriate medical, dental and mental health care for all residents of Faribault and Martin Counties.

Outcome Objectives
1. Establish a dental network in Faribault County by December 31, 2026. 2. Increase the percentage of children who are up to date with child and teen check-up and immunizations by December 2026. 3. Recruit mobile dental provider to provide services within Faribault & Martin counties by December 2026. 4. Increase partnerships and awareness of mental health services available to residents of Faribault & Martin Counties.

Key Activities	Who is responsible?	By When?
Maintain partnership with Appletree Dental to establish a clinic site in Martin County to increase dental services for individuals in service area who have medical assistance.	Mayo Clinic Health System	Ongoing
Provide outreach to residents of Faribault & Martin Counties on medical assistance and programs available for supporting health and dental needs.	Nicole Worlds, Human Services of Faribault & Martin Counties	Monthly through July 2024.
Develop a Faribault County dental network. Research other successful models and reach out to the Southern Minnesota Initiative Foundation (SMIF) to explore opportunities for starting a network in Faribault County.	United Hospital District Public Health Early Childhood Initiatives	By December 2024 reach out to SMIF and begin exploring possibilities for development of a dental network in Faribault County.
Conduct transportation access assessment to determine needs for transportation to and from medical appointments. Evaluate needs from assessment and provide outreach to communities on available services. Explore opportunities for partnership between Prairie	United Hospital District Mayo Clinic Health System Public Health/ Human Services	Complete assessment by December 2023.

Lakes Transit and other providers with health care providers.		
Identify funding options to secure mobile dental clinics in Faribault & Martin Counties – and promote those opportunities.	Access to Health Team Early Childhood Initiatives	On an annual basis, identify community needs and advocate with state and federal legislators. Members will report on activities quarterly.
Utilize common resource guide for primary care, mental health and (i.e. Find Help) to inventory and promote existing services available in Faribault & Martin Counties. Develop brochures or promotional materials for use by providers with patients.	Access to Health Team	By December 2024, develop unified referral network with comprehensive listing of resources for mental health, primary care and dental. Update annually.
Continue promoting and using tele-health mental health services in Faribault & Martin Counties. [KH1]	Access to Health Team	Ongoing
Coordinate with the South-Central Community Based Initiative (SCCBI) and other metal health providers to stay informed of regional activities and resources to improve services for mental health.	Chera Sevcik Anna Garbers	Report on activities SCCBI is completing at quarterly meeting.
Partner with Community Resiliency Team on mental health educational campaign – Promoting positive mental wellness and #makeitok to reduce the stigma of mental illness. [KH2]	Access to Health Team	Annually
Identify ongoing training opportunities for community partners on poverty and cultural humility. [KH3]	Access to Health Team	Annually

Strategy 2:
Increase the percentage of adults and children who receive annual preventative health care services.

Outcome Objectives
1. Identify or develop system changes that promote ease of scheduling to increase patient utilization of preventative services.

2. Implement coordinated patient education and awareness campaign to promote preventative health services.
3. Complete outreach with medical and dental providers to promote child and teen check-ups.

Key Activities	Who is responsible?	By When?
Explore opportunities to reduce barriers to scheduling preventative examinations. This includes, scheduling next preventative exams prior to leaving appointment and utilizing technology to remind patients to schedule appointments.	Access to Health Team	December 2026
Develop and implement streamlined patient education campaigns among all participating health care organizations to increase awareness and encourage use of and normalize preventative health care services. Ensure all communications/promotional materials developed are inclusive of English and Spanish language and culturally appropriate for local community.	Access to Health Team Public Health Mayo Clinic Health System United Hospital District	January 2024 and annually.
Promote Child & Teen Check-Up services to all children. Work with local providers to identify ways to encourage annual C&TC exams and immunizations.	Public Health Mayo Clinic Health System United Hospital District	January 2024 and annually.

Appendix A

See attachment: Faribault and Martin Counties Public Health Data Tables 2019

Appendix B

See Attachment: Faribault and Martin Counties Public Health Data Tables 2022

Appendix C

See Attachment: ACEs Trends 2013-2022