Stronger Together

COMMUNITY HEALTH INITIATIVE OF
FARIBAULT & MARTIN COUNTIES

Inspire healthy, resilient communities through partnership and collaboration.

Community Health Improvement Plan 2019-2022

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.

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Acknowledgements

We wish to thank all those involved for their invaluable collaboration and dedication to this work. A special thank you to Elizabeth Radel Freeman for her help in creating our Community Health Assessment, which was instrumental in developing this plan.

Table of Contents

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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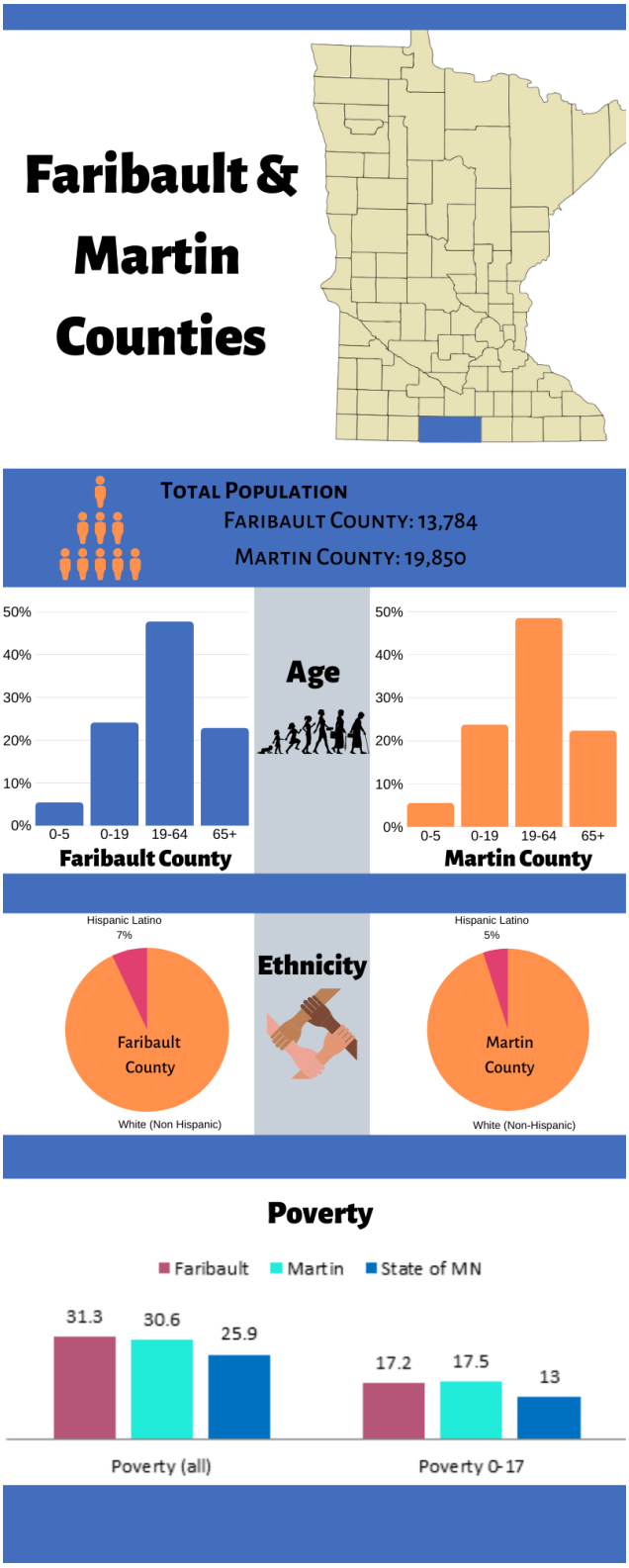
What is a Community Health Improvement Plan?

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 in order 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.

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.

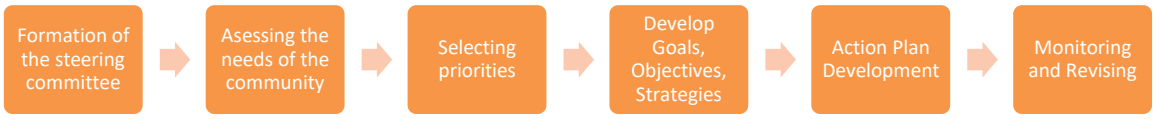
Poverty

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 on 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).

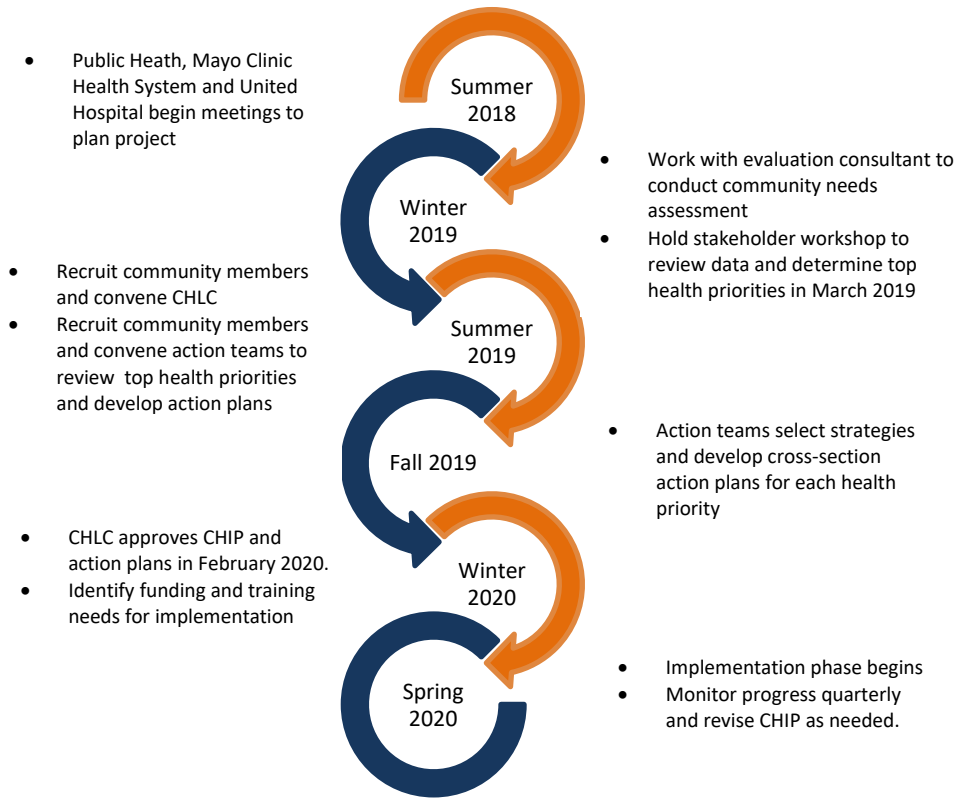
Goals for the CHLC include:

- 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 of 2018 and March of 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 Southcentral 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*
  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 a number of health topics as to how big of a health concern the issue is in the community.

- *Community Values, Themes and Strengths Assessment*
  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 particular 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 communications 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.

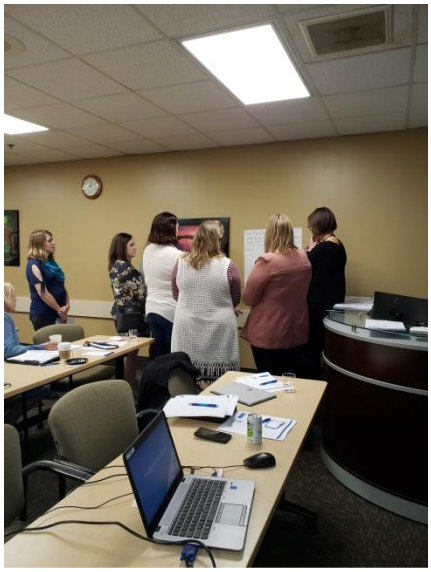
The group was given five guidelines for consideration when choosing health priorities. These included ensuring the health priorities are reflective of what the community wants and identifying the severity, importance, cost, and existing resources available to address the health priority area.

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.

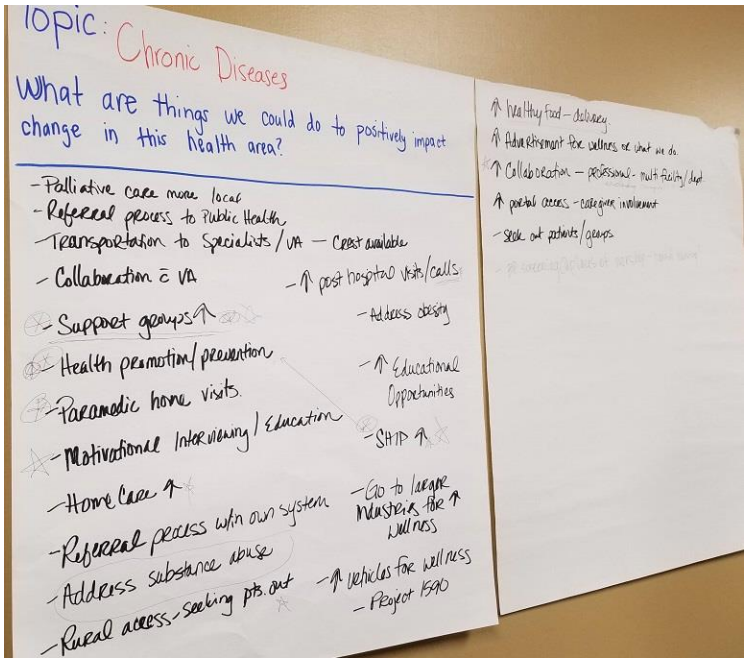
The following were prioritized as the top health priorities for inclusion in the CHIP, in order of importance:

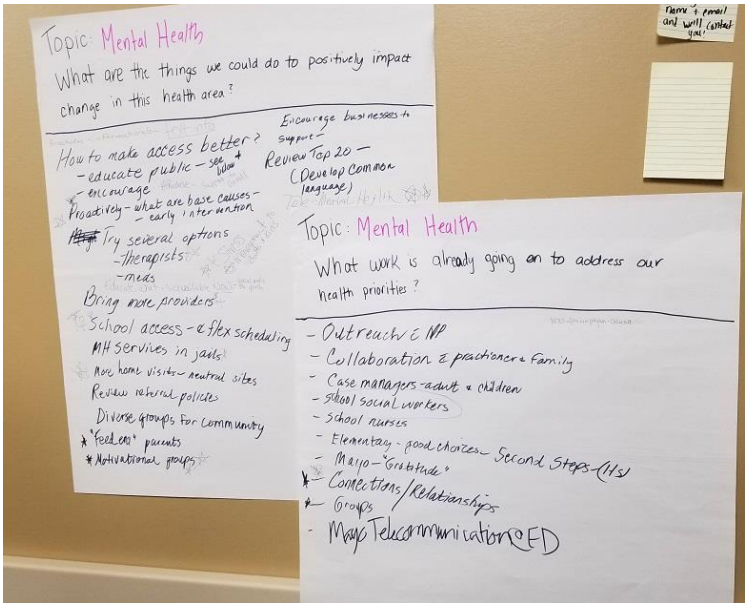
- Adverse Childhood Experiences (ACEs)
- Mental Health & Wellness
- Substance Abuse
- Chronic Disease
- Access to Care (Health & Dental)

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?



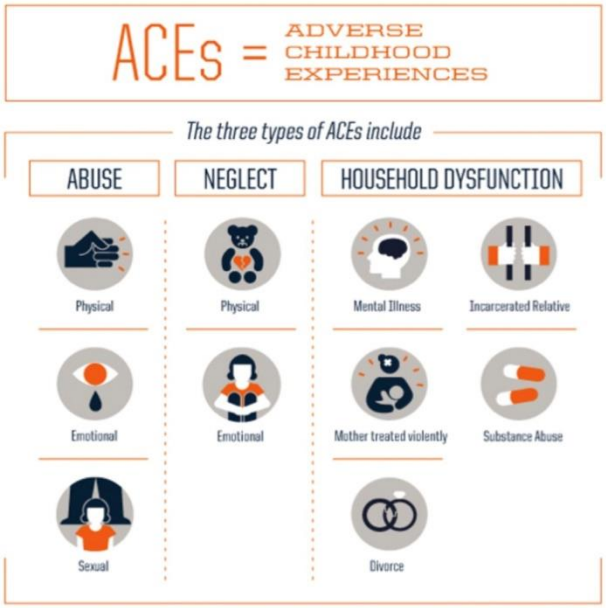
After the small group sessions concluded, each workshop participant was asked to visit each group topic area to review information that had been brainstormed and contribute any additional ideas, comments or questions that may have not yet been captured. Finally, workshop participants were asked to indicate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





Priority Health Issue: Adverse Childhood Experiences (ACEs)

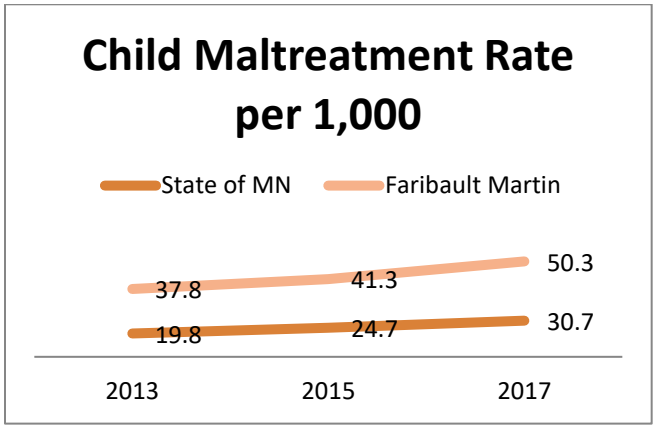
Adverse Childhood Experiences (ACEs) was selected as the top priority for inclusion in the CHIP by workshop participants. Adverse Childhood Experiences are potentially traumatic events that occur in a child's life:

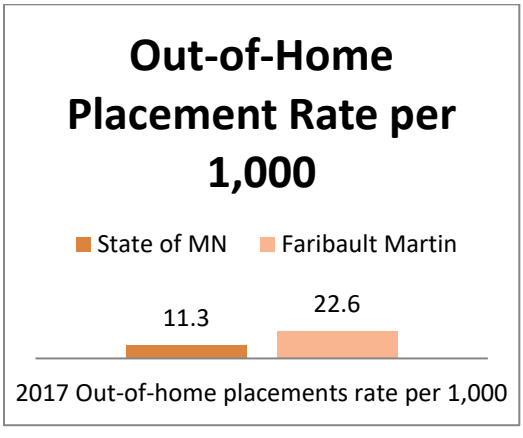


- Physical abuse
- Emotional abuse
- Sexual abuse
- Domestic violence in the home
- Parental substance abuse
- Living in a home with someone who has a mental illness
- Having had an incarcerated parent
- Parental divorce or separation

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.

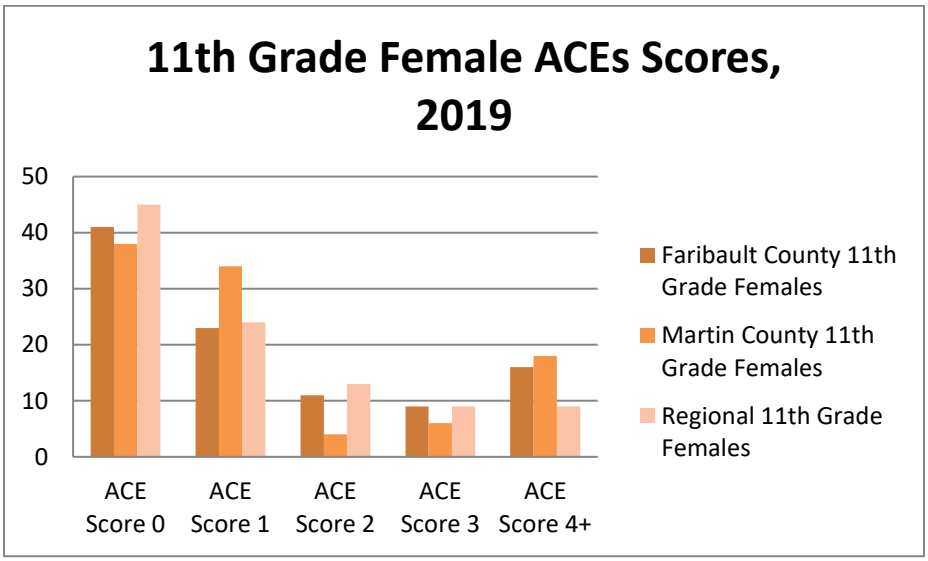
Over the past five years, Faribault and Martin Counties saw increases in the rate of children per 1,000 who sustained child maltreatment. The rate is also considerably higher than the state. Out of home placement rates were substantially higher in Faribault and Martin Counties than compared to the State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

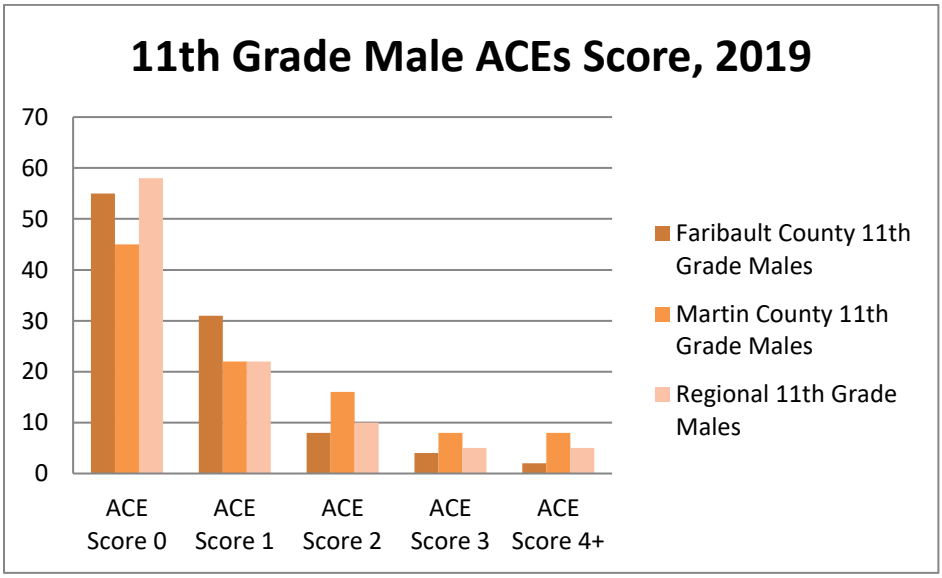




According to newly released data from the 2019 Minnesota Student Survey data, 59% of 11th grade females in Faribault County and 62% of 11th grade females in Martin County reported experiencing at least one ACE, with 16% of females in Faribault County and 18% of females in Martin County reporting four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

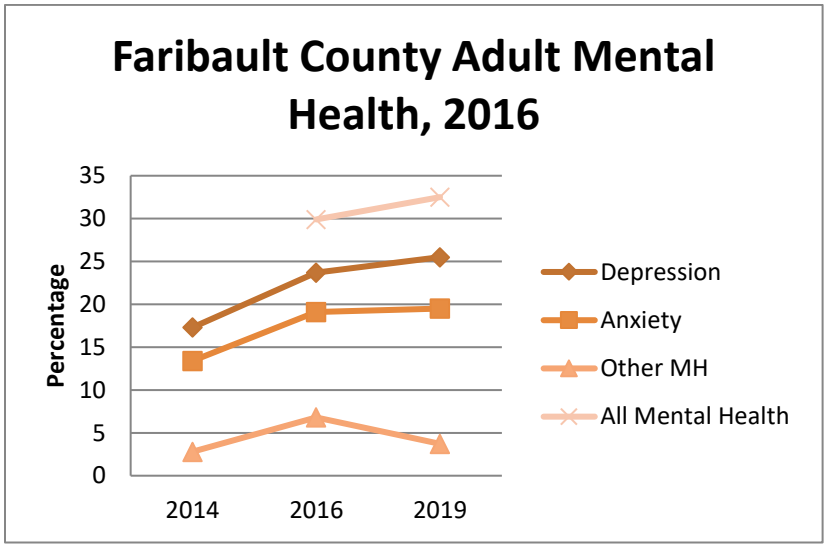


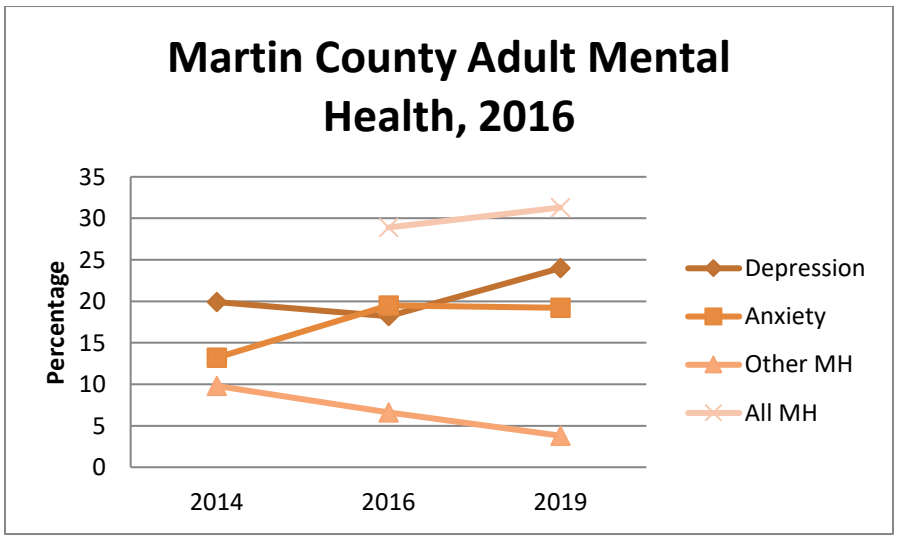


Priority Health Issue: Mental Health

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.





Priority Health Issue: Substance Abuse

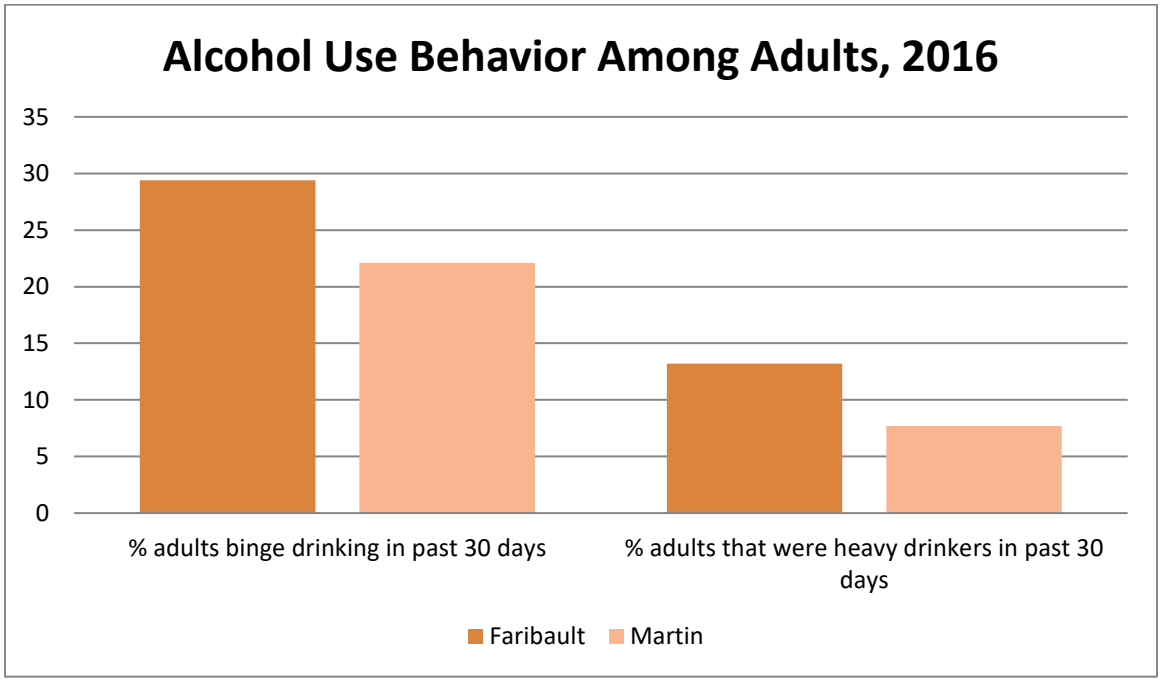
Drug misuse and abuse has many negative health consequences including unintentional injury, violence, unintended pregnancy, sexually transmitted infections, birth defects, and chronic diseases including cancer and cardiovascular disease.

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.



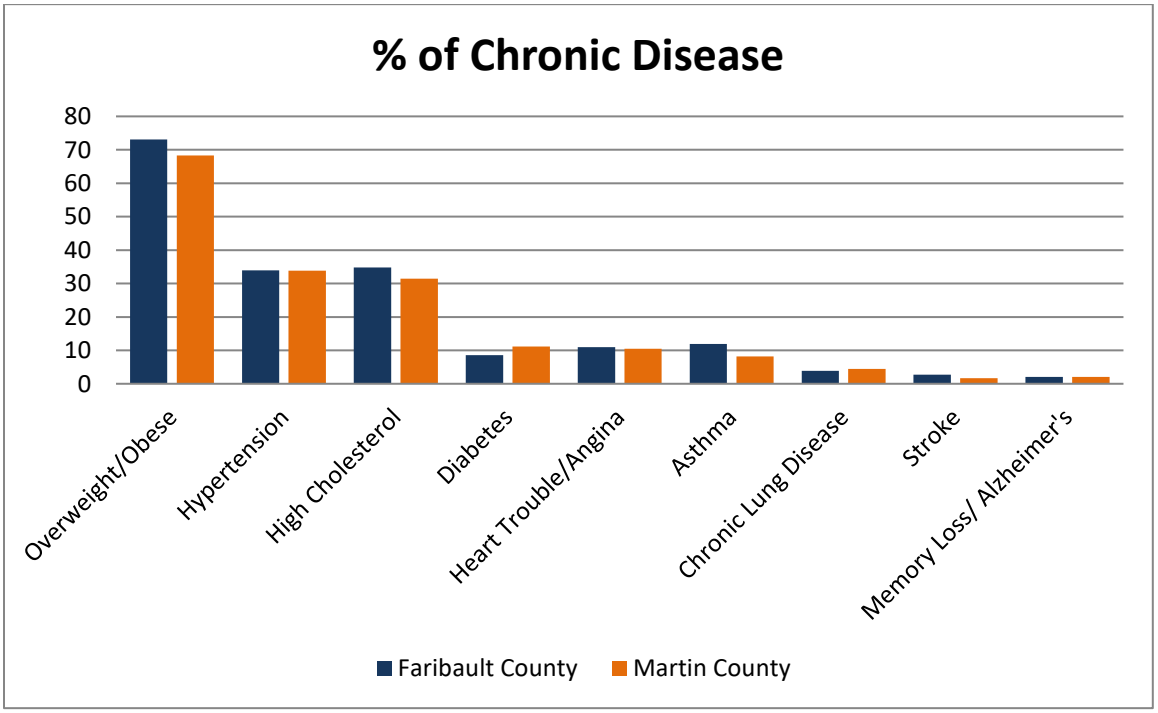
Priority Health Issue: Chronic Disease

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.



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%.

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) 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 end 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 Partners	*indicates CHLC member

- 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?
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

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
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.
Identify shareable media and developing posting plan among partner organizations.	Community Resiliency Team Members	31-Mar-20 – review plan quarterly.
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.
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.
Promote referral and connection between organizations – utilizing tools like Aunt Bertha for collection of community resources and support.	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
• 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?
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
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 75 families who meet risk factors and program criteria.	Chera Sevcik, Community Health	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.	Lynn Smithwick, Human Services of Faribault & Martin Counties	Ongoing- report on status of program availability quarterly.
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	Caroline McCourt, SHIP	September 30, 2020. Ongoing implementation efforts after training.

as part of curriculum across all grade levels. Identified options include: A Thousand Pedals, Mindful Education Curriculum, Change to Chill		
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.
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.
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.
Offer Bridges Out of Poverty training to community members in Faribault and Martin Counties.	Chera Sevcik	Offer training by September 1, 2020.
Identify and offer training on trauma and resiliency to mentors enrolling in Kinship, Stars, or BEAM mentorship programs.	Katy Gonzalez	By May 31, 2021
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.
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 Brooke Pierce	December 31, 2021
Support development of strong communication between law enforcement, human services, medical providers, and	Lynn Smithwick, Debbie Mosloski	Ongoing- report on status of program availability quarterly.

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.		
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
Utilize the Statewide Health Improvement Partnership (SHIP) to promote positive mental health through comprehensive worksite wellness programs.	Caroline McCourt	October 31, 2020
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.
Support training and implementation of the Celebrating Families program with families involved in drug treatment court.	Tracy Henning, Michelle Rosen	Training by December 31, 2019. Implementation starts January 22, 2020.
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.
Support county wide implementation of substance abuse prevention activities through the Drug Free Communities Grant in Faribault County	Kayt Klemek	By December 31, 2021.

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

- 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*

*indicates CHLC member

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?
Share information about classes available	Darla Nelson-Phillip, Mayo Mary Ellen Rigby, UHD Kelly McDonough, MNRAAA	July 2020 Ongoing
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
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
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
Provide motivational interviewing training for health care providers to increase	Caroline McCourt, SHIP Darla Nelson-Phillip, Mayo	OCT 2021

comfortability in addressing health behaviors and chronic disease management, and improve referral to community resources.	Mary Ellen Rigby, UHD 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
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

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 by DEC 2020. • By June, 2020 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?
Expand Baby Café program into Faribault County. Promote the Baby Café Program in Martin County.	Caroline McCourt, SHIP Lauren Schofield/Patti Kasper, Public Health Carolyn Kryzer, UHD Dar Holmseth, ECFE/Community Education	DEC 2020
Promote WIC program with all prenatal women.	WIC Public Health Jessica Meyer, MAYO Carolyn Kryzer/ Rick Ash, UHD	Ongoing
Promote breastfeeding home visits with	WIC	Ongoing

maternal child health program in Public Health.	Public Health Jessica Meyer, MAYO Carolyn Kryzer/ Rick Ash, UHD	
Increase access to breastfeeding support services within Faribault and Martin Counties by offering Certified Lactation Consultant Training.	Caroline McCourt, SHIP	JUNE 2020

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?
Partner with area food support programs (food shelves, etc.) to improve access to healthy foods.	Kaley Hernandez, SHIP Jessica Meyer, MAYO Carolyn Kryzer, UHD Kelly McDonough/Krista Eichhorst, MNRAAA CREST Home Healthcare Agencies	Ongoing

	Prairie Transit	
Partner with area restaurants and corner stores to offer healthy menu and food options.	Kaley Hernandez, SHIP Carolyn Kryzer, UHD	DEC 2020
Develop or expand opportunities for community gardens.	SHIP Staff Darla Nelson Phillip, MAYO Mary Ellen Rigby, UHD	March 2021
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
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
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
Utilizing a collaborative approach, partner with area worksites to offer comprehensive wellness policies and practices addressing physical activity, healthy eating, tobacco cessation, breastfeeding support, and stress management.	SHIP Staff	FEB 2020 Ongoing
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

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.

Community Partners
• 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 • Lauren Schofield, Human Services of Faribault & Martin Counties– Community Health • Jeani Tennyson, Human Services of Faribault & Martin Counties- Developmental Disabilities Services and Adult Protection *indicates CHLC member

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 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
• 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* • Jeani Tennyson, Human Services of Faribault & Martin Counties – Developmental Disabilities Services and Adult Protection • Lauren Schofield – Human Services of Faribault & Martin Counties – Community Health *indicates CHLC member

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?
Partner with Appletree Dental to establish a clinic site in Martin County in an effort to increase dental services for indiviudals in service area who have medical assistance.	Amy Long -Mayo Health System	January, 2021
Develop a Faribault County dental network. Research other successful models and reach out to the Southern Minnesota Initiative	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.

Foundation (SMIF) to explore opportunities for starting a network in Faribault County.		
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 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)
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.
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.
Explore ways to increase access to tele-health mental health services in Faribault & Martin Counties.	Greta Dahlberg, Behavioral Health Manager – Human Services	Ongoing
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
Partner with Community Resiliency Team on mental health educational campaign – Promoting positive mental wellness and	Deb Barnes	See Community Resiliency Team Work Plan.

#makeitok to reduce the stigma of mental illness. Increase access to trainings for Mental Health First Aid		

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 Care Team	Ongoing – look at ways to promote ease of scheduling and reminder systems to increase patient utilization of preventative services.
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.
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 to 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 liveable, 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 in regards to 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.

Appendix A

See attachment: Faribault and Martin Counties Public Health Data Tables

Appendix B

See Attachment: Minnesota Student Survey 2016 vs 2019