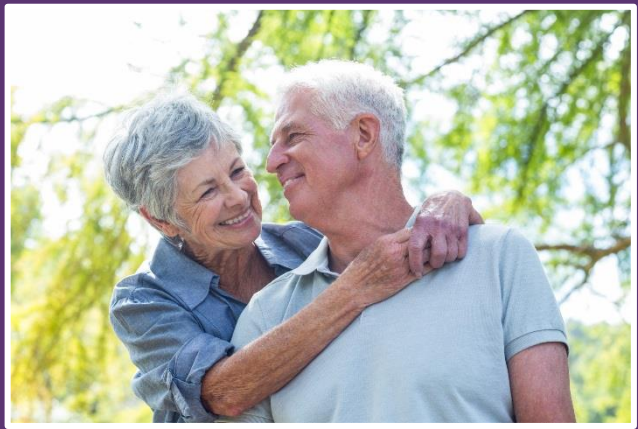
Olmsted County, Minnesota

Community Health Improvement Plan

2018 - 2020








Making the Healthy Choice the Easy Choice

A Collaborative Community Effort Led by: Olmsted County Public Health Services, Olmsted Medical Center and Mayo Clinic

January 2018

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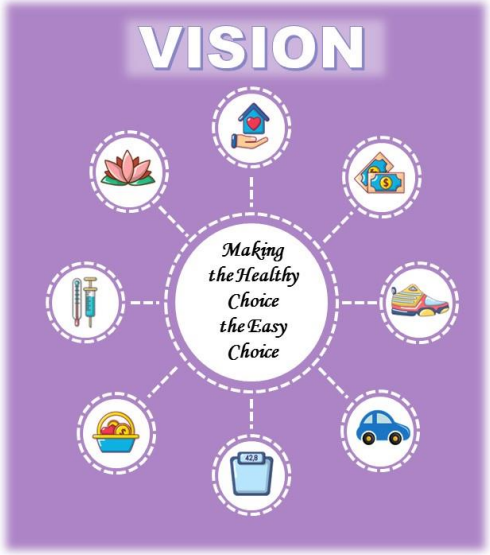
Executive Summary
2018 - 2020

A Collaborative Community Effort Led by: Olmsted County Public Health Services, Olmsted Medical Center and Mayo Clinic



Community Health Assessment & Planning Process

Core Values

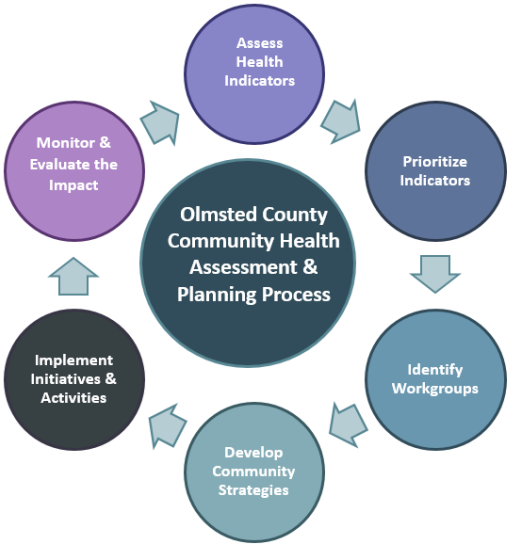
Data Driven ◆ Community Focus

Actionable & Sustainable

Collaboration ◆ Health Equity

Overarching Goals

- **Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death**
- **Promote quality of life, healthy development, and healthy behaviors across all life stages**
- **Create social and physical environments that promote good health for all**
- **Achieve health equity, eliminate disparities, and improve health of all groups**



Community Health Improvement Plan Priorities & Goals

Motor Vehicle Injury Prevention

Reduce the percent of Olmsted County residents reporting distracted driving behaviors

Vaccine Preventable Diseases

Reduce the incidence of vaccine preventable diseases in Olmsted County

Overweight/Obesity

Reduce overweight and obesity rates amongst Olmsted County residents

Mental Health

Every Olmsted County resident will have optimal mental health

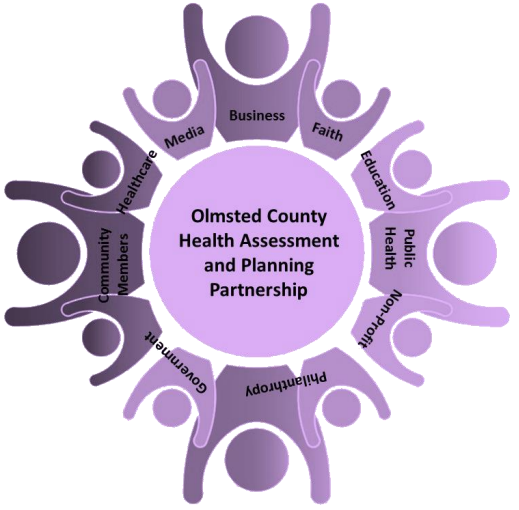
Financial Stress

Reduce the percentage of Olmsted County residents experiencing financial stress

For CHIP strategies and objectives, refer to the full CHIP document on Olmsted County Public Health Services' website.

Health Assessment & Planning Partnership Purpose

The purpose of the Health Assessment & Planning Partnership is to engage and inspire all sectors of the community to continually improve our community's health through assessment, planning and implementation efforts.



Contributing Organizations

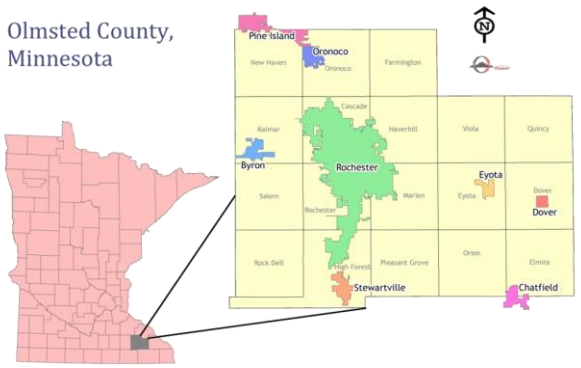
The Olmsted County Community Health Improvement Plan is a collaborative community effort led by Olmsted County Public Health Services, Olmsted Medical Center and Mayo Clinic. Several community organizations and partnerships have helped further develop and implement the Community Health Assessment and Planning (CHAP) process. Many thanks go to the organizations listed below and to any partnerships or coalition that support these efforts.

Agency	CCHI	CHAP Core Group	CHAP Data Subgroup	CHIP Workgroup Lead	HAPP	Community Health Integration Specialist Funding Agency
Diversity Council				X		
Family Services Rochester			X		X	
Mayo Clinic	X	X	X	X	X	X
National Alliance of Mental Illness (NAMI) of SE MN				X	X	
Olmsted County Community Services	X		X	X	X	
Olmsted County Public Health Services	X	X	X	X	X	X
Olmsted Medical Center	X	X	X	X	X	X
Rochester Area Foundation	X				X	X
Rochester Epidemiology Project, Mayo Clinic			X		X	
University of Minnesota Extension				X		
United Way of Olmsted County	X	X	X		X	X

CHAP – Community Health Assessment and Plan
CHIP – Community Health Improvement Plan
CCHI – Coalition of Community Health Integration
HAPP – Health Assessment and Planning Partnership

Refer to the Supplemental Document, Appendix E for a full list of organizations involved in coalition or partnership.

OLMSTED COUNTY, MINNESOTA
BY THE NUMBERS



Demographics

2015 Population
151,436

19%
Minority Population

12.9%
Population >5 years speak a language other than English in home

Geography

8th
largest county in Minnesota

8 Cities
18 townships

Byron Eyota Dover Oronoco Rochester Stewartville
Parts of: Chatfield Pine Island

Growth since 2000

22%
Overall population

108%
Minority population

62%
Adults 65 & older

51% female
49% male

74% population lives in Rochester

83%
Students graduate high school on time

Income

$70,000
Median Household Income

2015 – 2016 School Year

35%
students receiving free & reduced lunch

25%
under age 18

36.7
median age

13%
65 and older

Data Sources: U.S. Census Bureau, Decennial Census and Population Estimates, Minnesota State Demographic Center; Minnesota Department of Education

Olmsted County Community

Collaborative Nature

Olmsted County Public Health Services, Olmsted Medical Center, and Mayo Clinic have a strong, symbiotic relationship. They have collaborated with each other and other community partners for many years to serve the health needs of the residents in Olmsted County, Minnesota.

A unique first example of community collaboration in Olmsted County dates back to the late 1800's. In 1883, the 'Great Tornado' swept through Rochester, killing 26 people and destroying much of the north side of town. In the wake of that terrifying experience, Sister Mary Alfred, a Franciscan Sister teaching in Rochester, approached the 'country doctor' to discuss the need for a hospital. The Sisters of St. Francis offered to build and maintain a hospital if the good doctor would provide the medical staff. The humanitarian spirit of a Franciscan Sister combined with the professional dedication of a small-town physician named William Worrall Mayo, and his more famous sons Will and Charlie, formed the foundation that continues today.

The humble dedication and practice of sharing information and knowledge of past and present leaders has created a culture where *prevention, resiliency,* and *foresight* are the fabric of our community's existence. Since these early beginnings, the community has taken **positive and proactive actions** to lay a foundation for a culture of health with its residents through the development of public health policies and practices dating back to 1866 when the first health ordinance was enacted. This culture of foundation continues to be embedded in many aspects of our community today.

Olmsted County is small enough where people know each other, yet large enough to bring resources together to respond to problems, and furthermore, prevent them. The spirit of community collaboration and 'group practice' stems back to the Mayo brothers and it continues to shape and form the way current community leaders approach several challenges related to health, safety, and social conditions in our neighborhoods, cities, and county. While the 'Great Tornado' could be cited as the original catalyst for collaboration in our community, a series of more recent initiatives, events, decisions and partnerships serve as additional motivation and influence. These consist of: healthcare collaborations, housing initiatives, improved nutrition and physical activity programs, and tobacco-free living ordinances and policies.

These well-established relationships and past initiatives and projects provided a natural 'stepping stone' to establish the joint community health assessment and planning (CHAP) process in 2012. One joint community process has galvanized leadership from key sectors to be part of the solution to address the conditions and factors that impede optimal health.

The above synopsis of the community's collaborative nature was summarized from Olmsted County's Robert Wood Johnson Foundation's Culture of Health Prize Phase I application.

Community Health Improvement Plan Context

Purpose

In early 2012, discussions began between Olmsted County Public Health Services, Olmsted Medical Center, and Mayo Clinic on the opportunity to work together on a collective health assessment and planning process to produce a joint community health needs assessment (CHNA) and community health improvement plan (CHIP). Olmsted County Public Health Services has conducted community health assessments and developed improvement plans since the enactment of the Local Public Health Act in 1976 (Minnesota State Statute 145A). However, new requirements for local public health agencies in Minnesota and non-profit hospitals provided a unique opportunity to conduct ***one*** community health assessment and planning process for Olmsted County.

Local public health agencies in Minnesota are required to develop a plan with, and for the community. This requirement is evident within the Minnesota Local Public Health Assessment and Planning Process. This state-wide process integrates and aligns local public health deliverables with the national accreditation standards and measures (Public Health Accreditation Board - PHAB). PHAB requires local public health agencies to (1) participate in or lead a collaborative process resulting in a comprehensive community health assessment and (2) conduct a comprehensive planning process resulting in a CHIP.

In addition to the requirements for local public health agencies, a requirement in the Patient Protection and Affordable Care Act (PPACA) requires non-profit hospitals to conduct a CHNA every three years to maintain their tax-exempt status. Within Olmsted County, two organizations fit this PPACA requirement: Olmsted Medical Center and Mayo Clinic.

Olmsted County continues to look above and beyond these state and federal requirements and focuses efforts on the true value and benefits of community collaboration. Because of the numerous past collaborations and partnerships within Olmsted County - and specifically between Olmsted County Public Health Services, Olmsted Medical Center, and Mayo Clinic - one joint CHAP process has been identified as the best strategy for all three organizations and ultimately, the entire community. **This is the right thing to do!**

The purpose and true intent of the current CHIP is to provide guidance to the full community on improving the current CHIP health priorities. The CHIP is grounded in results from the 2016 Community Health Needs Assessment, has been developed collaboratively with community members, and is one process to address and improve community needs. Specifically, the CHIP:

- Describes the CHAP process, including partners involved
- Outlines the five community health priorities, along with the prioritization process used
- Identifies community-level strategies with measurable and time-framed objectives
- Describes future implementation, monitoring and evaluation activities

For a complete description of the organizational requirements, please refer to Appendix B in the supplemental document.

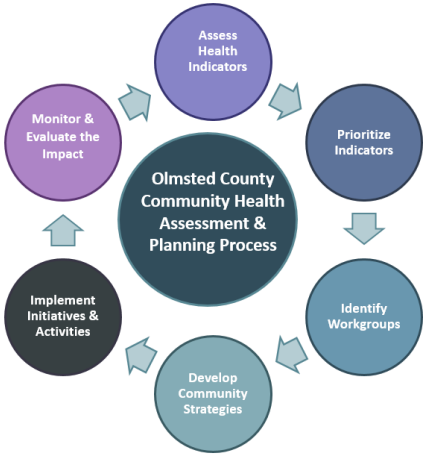
Community Health Improvement Plan Context

Framework

Several best practice frameworks and models influence and guide Olmsted County's CHAP process. The CHAP process does not follow one specific framework or model in its entirety; however, the combination of all frameworks steered the innovative collaborative nature of the overall community-driven CHAP process.

Steps and/or phases of the following frameworks/models were used throughout Olmsted County's CHAP process:

- Collective Impact
- Core Public Health Functions and Essential Services
- County Health Rankings and Roadmaps
- Health Impact Pyramid
- Minnesota Local Public Health Assessment and Planning Process
- Mobilizing for Action through Planning and Partnerships
- Precede-Proceed Model
- Social Determinants of Health Framework



For a complete description and listing of the guiding frameworks used in the community health assessment and planning process, please refer to Appendix C in the supplemental document.

Process

Assess Health Indicators

With guidance and leadership from the CHAP Data Subgroup and Core Group, a comprehensive community health needs assessment (CHNA) was completed in late 2016. The assessment process integrated a variety of steps, including: identifying potential health indicators; collecting and analyzing relevant information, including data from a community survey and community listening sessions; and the assembly and dissemination of the final document.

For a further defined CHNA process, please refer to Olmsted County's 2016 Community Health Needs Assessment: Olmsted County Community Health Needs Assessment.

Prioritize Health Indicators

A process to prioritize the health issues of Olmsted County was developed and implemented in Spring 2016. Local data on each issue (i.e. objective factors) was presented and shared with community groups which in turn contributed subjective scores/factors to the full prioritization process *(refer to CHAP Prioritization Process, page 21)*.

Identify Workgroups

Establishing workgroups and leads has allowed for more thoughtful planning for the 2018 CHIP. In mid-2016 the community health integration (CHI) specialist was hired and her primary focus was to help the workgroups establish foundational components to support the implementation of the 2018 CHIP. Established workgroups also allowed for greater participation in the development of strategies for each CHIP priority. Learning from the previous CHIP, a small planning group was established for motor vehicle injury prevention to assist with the creation of the data profile and strategy selection. (cont.)

For a list of community priority workgroup leads, refer to Appendix D in the supplemental document.

Community Health Improvement Plan Context

Process (cont.)

Develop Community Strategies

Data Profiles

Data profiles were created for every priority to provide a deeper dive into each of the CHIP priorities to assist with strategy selection and action planning. The profiles include both quantitative and qualitative data that was collected through various data sources to better understand each priority in Olmsted County. Each profile also includes contributing factors (local conditions) and an asset and gaps map.

All data profiles and executive summaries can be found on Olmsted County Public Health Services' website: Olmsted County CHIP

Planning Summit

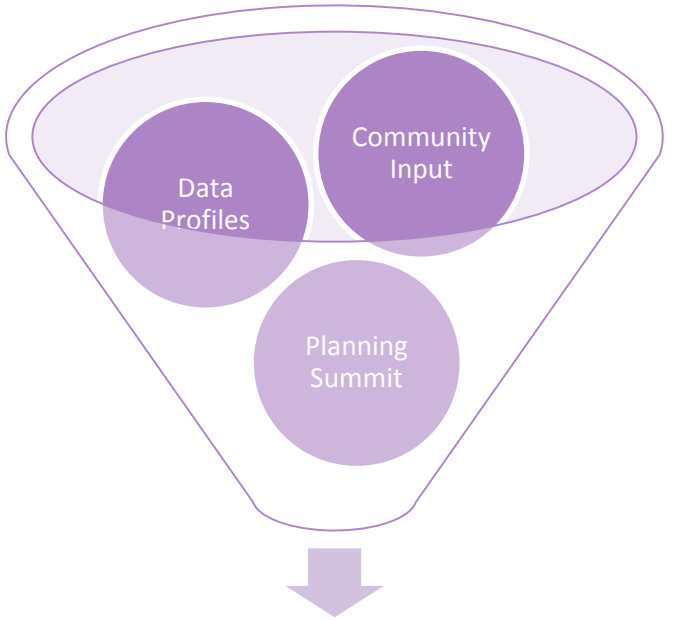
In October 2017, the CHIP workgroup leads and members from the CHAP Core Group held a day-long planning summit. The summit allowed workgroup leads to select strategies and develop work plans and evaluation plans.

Community Input

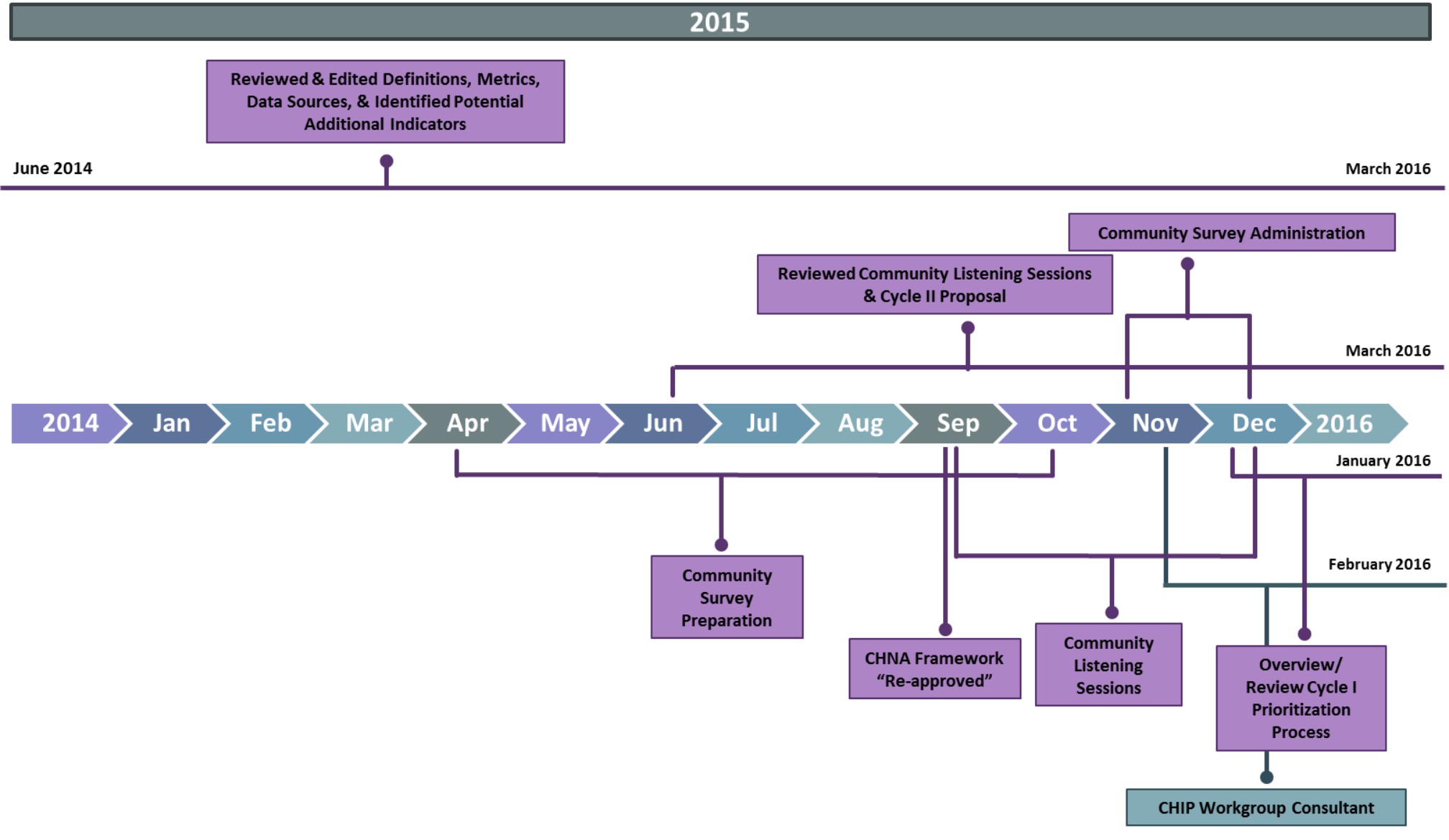
In 2016, quarterly community health forums were established to bring community members together to learn and network and to promote a healthier community. The November 2017 community health forum provided a venue for community members to provide feedback on the strategies developed by the workgroups for each CHIP strategy. Additionally, members of the Public Health Services Advisory Board provided input for each CHIP strategy. All feedback provided by community members was incorporated into the final work plans for each strategy.

Health Assessment and Planning Partnership Support

The CHIP strategies were presented to the Health Assessment and Planning Partnership (HAPP) to solicit final input and ask for support of the proposed strategies.



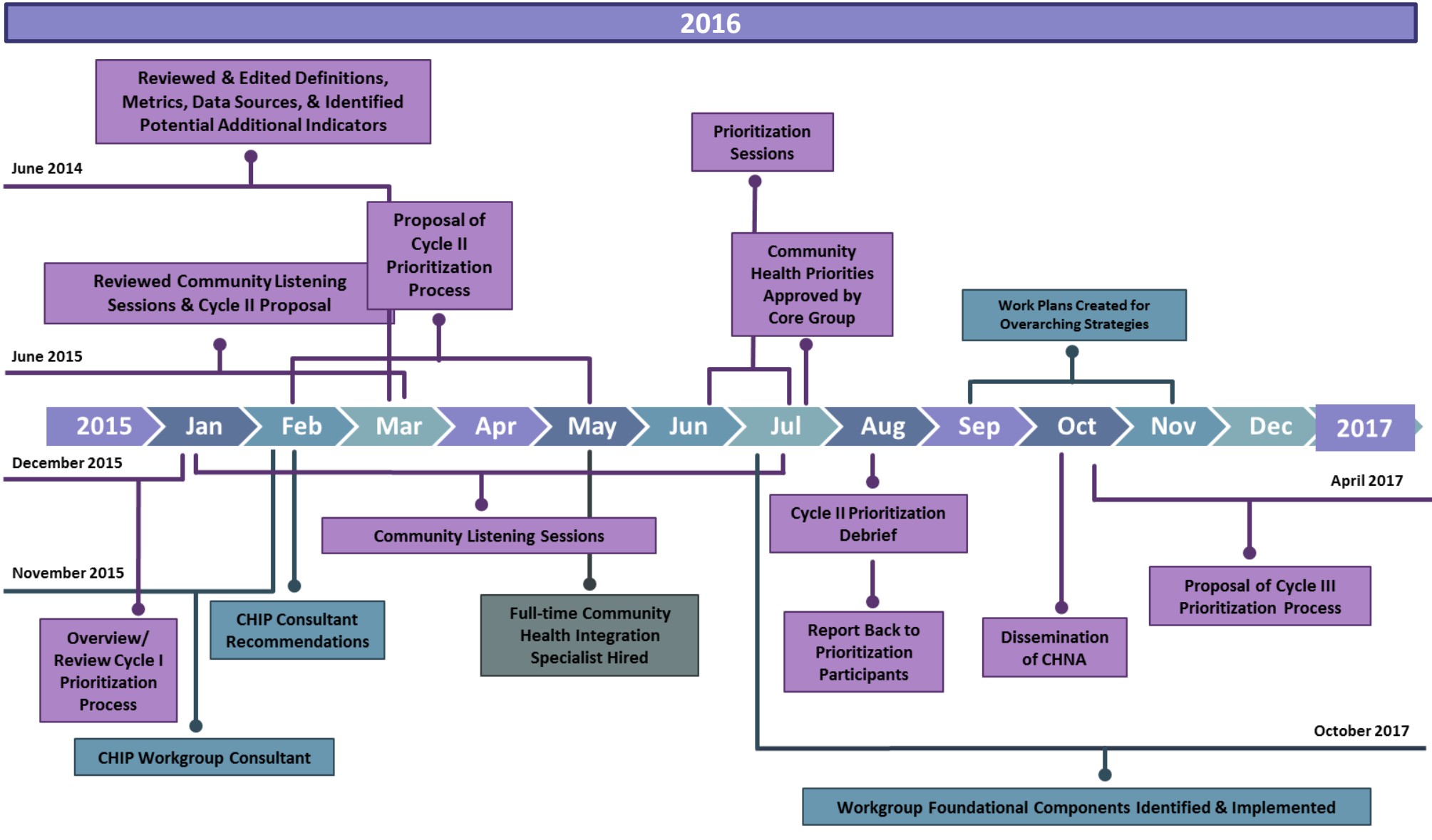
Community Health Assessment and Planning Process
2015 - 2017 Timeline



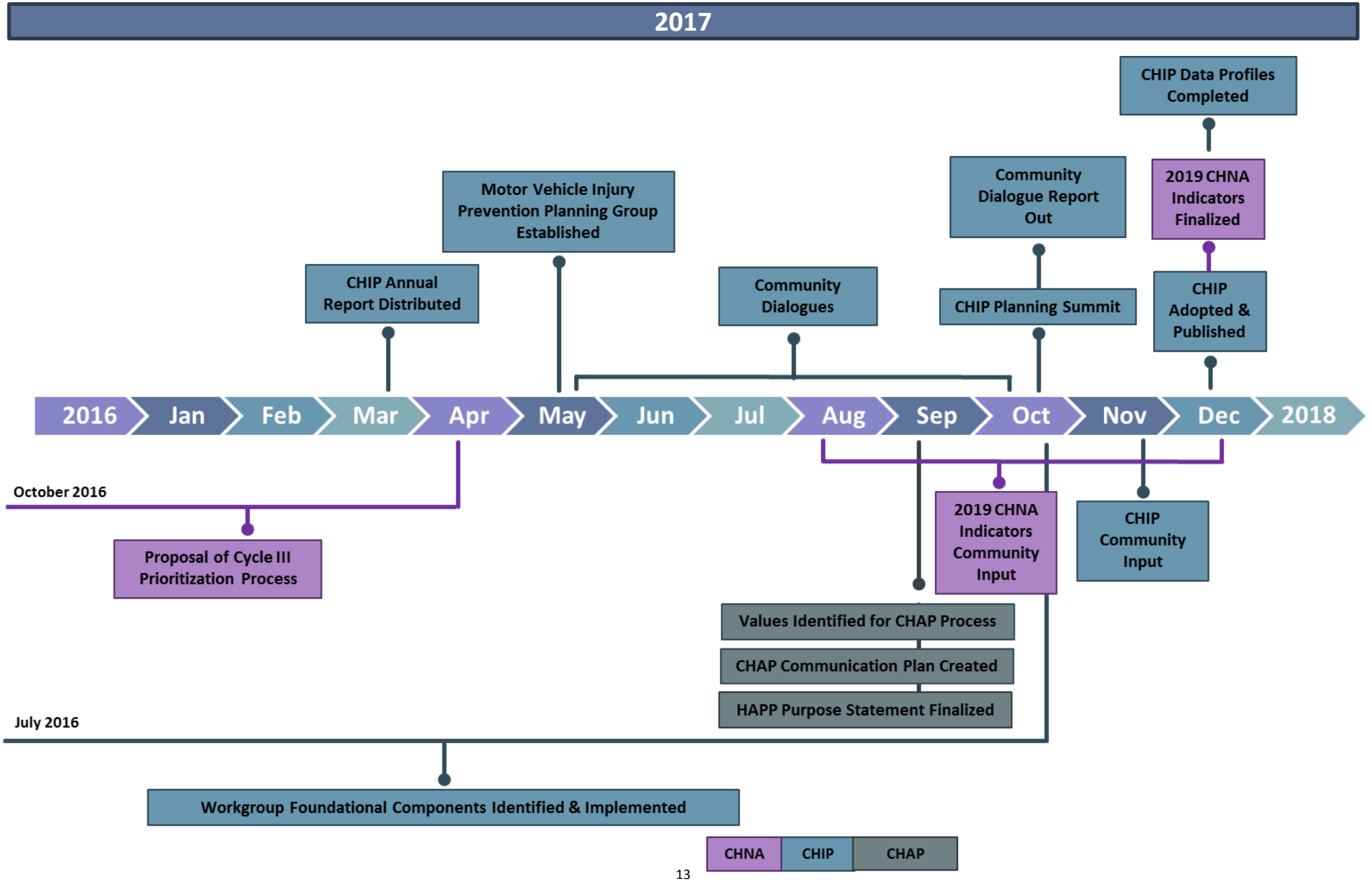
Refer to page 14 for listing of recurring meetings

CHNA | CHIP | CHAP

Community Health Assessment and Planning Process 2015 - 2017 Timeline



Community Health Assessment and Planning Process
2015 - 2017 Timeline



Community Health Assessment and Planning Process 2015 - 2017 Timeline

Recurring Meetings

Biweekly	Quarterly
University of Minnesota Rochester Community Collaboratory	Health Assessment & Planning Partnership
Monthly	Community Health Forums (started October 2016)
Coalition for Community Health Integration (CCHI)	CHIP Leads Meeting (started July 2016)
CHAP Core Group	**Three Times a Year**
CHAP Data Subgroup	CHIP Financial Stress Workgroup
CHIP Mental Health Workgroup	CHIP Vaccine Preventable Diseases Workgroup
Making it Better: Obesity Coalition (CHIP Workgroup)	
Public Health Services Advisory Board	

Health Assessment and Planning Partnership

Health Assessment and Planning Partnership Overview

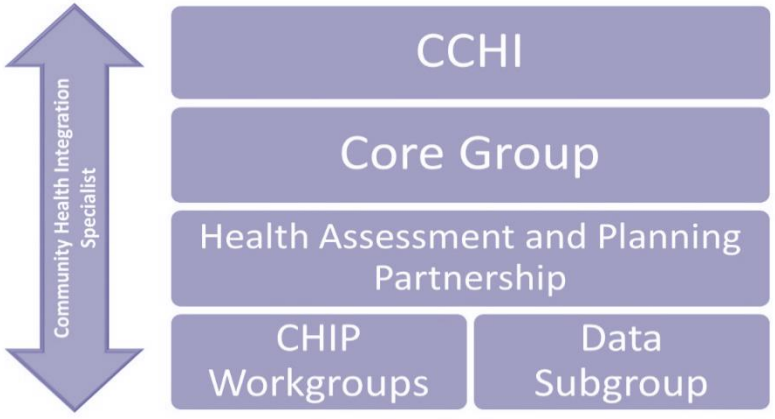
Several groups contribute to the CHAP process. The Health Assessment and Planning Partnership (HAPP) is a quarterly community-based meeting that is designed to:

- Provide opportunities for participants to offer input and feedback on the CHAP process
- Provide relevant updates on the CHNA and CHIP
- Foster networking opportunities

Health Assessment and Planning Partnership Purpose

The purpose of the Health Assessment and Planning Partnership is to engage and inspire all sectors of the community to continually improve our community's health through assessment, planning and implementation efforts.

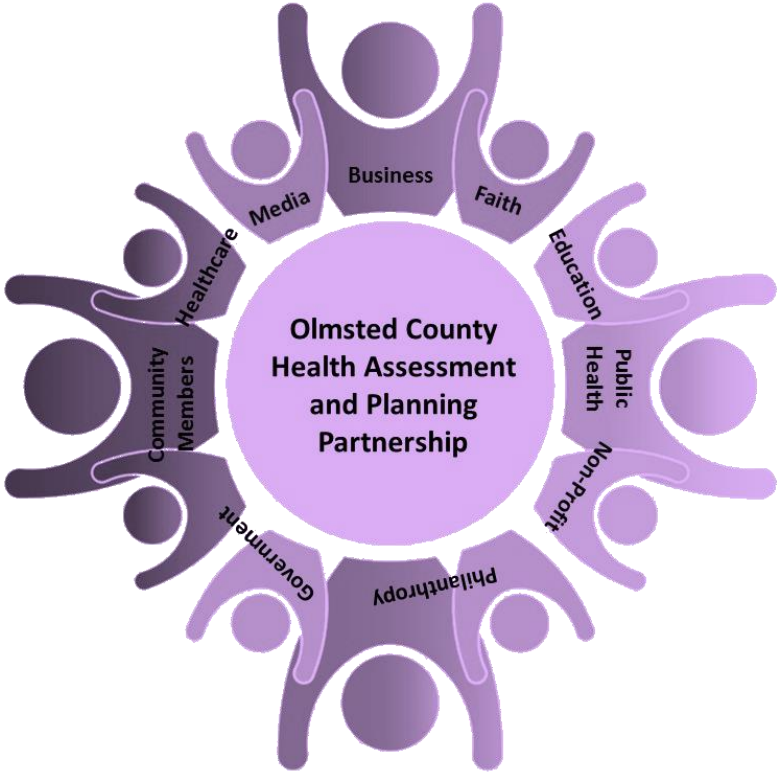
CHAP Organizational Chart



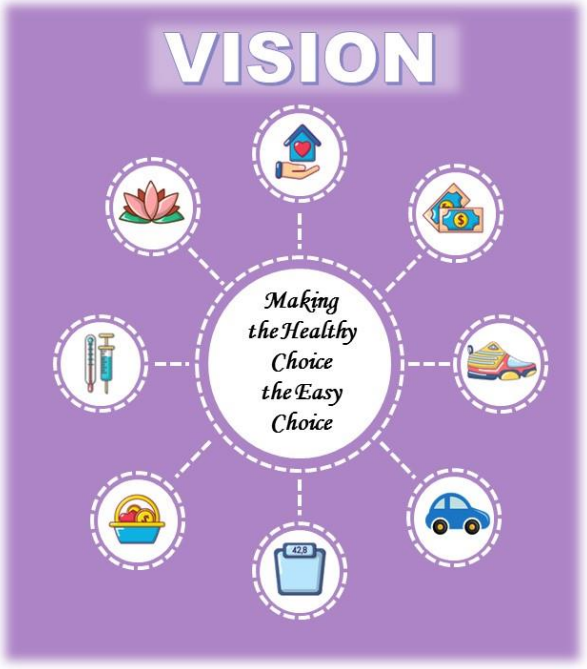
For a full listing of HAPP organizations please refer to Appendix E in the supplemental document.

Partnership Representation

The CHAP process strives to have membership, involvement and participation from all walks of life. HAPP has multi-sector representation, and includes a variety of individuals and organizations throughout the Olmsted County community.



Community Health Assessment and Planning Process Vision, Values and Goals



Core Values

In 2017, core values were developed for the entire CHAP process. The core values serve as guiding principles and provide a foundation for the entire process. The core values were identified by workgroup leads, the CHAP Data Subgroup and Core Group. The health assessment and planning partnership members provided input for the definitions of the core values.

Cross-cutting strategies were identified for each value that was outside the scope of the workgroups. These strategies are essential to successful implementation of the CHIP and will help advance community efforts. Specific activities around each of the strategies were identified by the CHAP Core Group and CHIP workgroup leads.

The CHIP core values share the same issue statement, goal and outcome objectives:

- **Issue Statement:** Olmsted County's CHAP process created core values in the Fall of 2017 without clear action steps or linkages to the CHIP priorities.
- **Goal:** Integrate core values into the CHAP process.
- **Outcome Objective:** By 2023, all CHIP priority strategies will reflect and embed the CHAP core values.

For definitions, strategies and objectives for the CHAP values please refer to pages 18 and 19.

Overarching Goals

Throughout the CHAP process, and explicitly seen within the CHIP, is alignment with national initiatives, specifically with Healthy People 2020. With this alignment, all CHAP process groups agreed upon adhering and supporting the following all-encompassing CHAP goals:

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death
- Promote quality of life, healthy development, and healthy behaviors across all life stages
- Create social and physical environments that promote good health for all
- Achieve health equity, eliminate disparities, and improve health of all groups

For a listing of state and national priorities, refer to Appendix H in the supplemental document.

Community Health Assessment & Planning Process Core Values

- ✓ Data Driven
- ✓ Community Focus
- ✓ Actionable & Sustainable
- ✓ Collaboration
- ✓ Health Equity

Community Health Assessment and Planning Process Core Values

Data Driven

The CHAP process uses multiple valid and timely data approaches, including both qualitative and quantitative, to ensure there are no gaps in understanding our community's needs.

Strategies and Objectives

Strategy 1: Develop and implement a systematic way to evaluate the CHAP process

- **By Q4 2020, implement a fully comprehensive evaluation plan that includes process and outcome metrics**

Strategy 2: Turn data into information

- **Through 2020, a CHIP evaluation report will be published annually**
- **By Q4 2019, the CHNA will display data in additional ways, including a health disparity index and relevant maps**

Community Focus

The CHAP process brings together a broad community voice through deliberate and authentic community engagement and ensures that all efforts are being implemented with community input.

Strategies and Objectives

Strategy 1: Develop and enhance marketing and communication

- **By Q4 2020, implement a marketing and communications plan for the CHAP process**

Strategy 2: Expand community involvement in the CHAP process

- **By Q4 2020, create a process to ensure all community voices are represented**

Collaboration

The CHAP process aims to work with multiple partners across all sectors in our community, in a deliberate and transparent way, to achieve our shared goals.

Strategies and Objectives

Strategy 1: Expand the CHAP Core Group to include major stakeholders

- **By Q4 2019, all identified major stakeholders will be active members of the CHAP Core Group**

Strategy 2: Enhance meaningful interactions between all CHAP process groups

- **By Q4 2020, increase satisfaction and engagement of all CHAP process groups (baseline to be determined in 2018)**

Community Health Assessment and Planning Process Core Values

Actionable and Sustainable

The CHAP process fosters a culture of continuous improvement and all efforts are adequately resourced and measurable.

Strategies and Objectives

Strategy 1: Ensure diverse and adequate funding for the CHAP process

- **By Q2 2018, a funding commitment by the Coalition for Community Health Integration (CCHI) will be determined for the CHAP process**
- **By Q4 2018, research best practices and incorporate a minimum of two traditional and non-traditional funding sources**
- **By Q4 2020, apply for a minimum of two competitive grants to assist with CHIP implementation**

Strategy 2: Clarify roles and responsibilities of all organizations involved in the CHAP process

- **By Q4 2018, all organizations will have a signed memorandum of understanding (MOU) that clearly identifies their roles and responsibilities**

Health Equity

The CHAP process is committed to continuously understanding, identifying and addressing inequities across our community.

Strategies and Objectives

Strategy 1: Develop and share a community-wide definition of health equity

- **By Q4 2018, develop a community-wide definition of health equity**
- **By Q4 2020, develop a method to assess the community's knowledge and understanding of health equity**

Strategy 2: Identify and address health disparities

- **By Q2 2019, each CHIP workgroup will identify at least one activity to address health equity**
- **By Q4 2020, the CHAP process will enhance the use of health disparities data through CHNA mapping and health disparity indices**

Community Health Priorities and Strategies

Prioritization Process

The 2016 prioritization process included two sets of data: objective and subjective. Objective (affected, premature risk and trend) and subjective (community's perception and ability to impact) scores were combined for an overall score for each indicator. Additionally, at the end of each session, participants were asked to provide their individual input on the current indicators, as well as suggesting missing or emerging indicators.

For the 2016 prioritization process, an effort was made to involve more groups and community members in the subjective prioritization process. Along with the organizations that participated in 2013, seven additional organizations/groups participated. This resulted in a total of 244 people participating in the prioritization process.

The objective and subjective each accounted for 50% of the final score. The results from the eleven subjective prioritizations were then compiled with the objective scores to determine an overall numerical ranking of the health indicators. The top ten indicators with the highest community ranking were:

- Injury Prevention
- Immunizations
- Overweight/Obesity
- Physical Activity
- Mental Health
- Financial Stress
- Binge Drinking
- Senior Tsunami
- Diabetes
- Multiple Chronic Conditions

After a lengthy process, the CHAP Core Group identified five priorities to be the focus of the next CHIP. The top five priorities identified were:

- Injury Prevention
- Overweight and Obesity
- Immunizations
- Financial Stress
- Mental Health

For a complete description and listing of the subjective and objective factors used in the prioritization process and information about who participated in the prioritization process, please refer to Appendix G in the supplemental document.

Olmsted County, Minnesota
Community Health Needs Assessment
2016

MOTOR VEHICLE INJURY PREVENTION

20% of OC youth and adolescents do not always wear a seatbelt while driving or riding in the front seat

50% of OC youth and adolescents read incoming texts or e-mails and **43%** send texts or e-mails while driving

IMMUNIZATIONS

18% of OC children ages 24-35 months are not fully vaccinated with the recommended immunization series

44% of OC residents are not vaccinated against seasonal influenza

OVERWEIGHT/ OBESITY

41% of OC adults are overweight

28% of OC adults are obese

18% OC youth and adolescents are overweight

MENTAL HEALTH

7% of OC youth and adolescents have been diagnosed with depression

16% of OC adults have been diagnosed with depression

FINANCIAL STRESS

21% of OC homeowners and **46%** of renters are paying over 30% of their income for housing

29% of OC adults are worried or stressed about having enough money to pay their bills

TOP 5 COMMUNITY HEALTH PRIORITIES

A Collaborative Community Effort Led by: Olmsted County Public Health Services, Olmsted Medical Center and Mayo Clinic

Community Health Priorities and Strategies

Community Health Priorities

The next several pages are devoted to the top five community's priorities. This section will focus on a summary of why the health issue is a community priority and community-level strategies to ultimately improve the status of the issue in Olmsted County.

Within the health issue summary, the following will be described:

- **Community Health Importance**
  A description of why the issue is important to the health of the general community.
- **Local Conditions in Olmsted County (i.e. Obesity in Olmsted County)**
  This section includes select local, current data from the recent CHNA (2016) and local conditions (associations, correlations) for each priority. Also included are themes and quotes from community dialogues that took place in 2017.
- **Community Perception of the Health Issue**
  The community's perception of the health issue from the prioritization sessions.

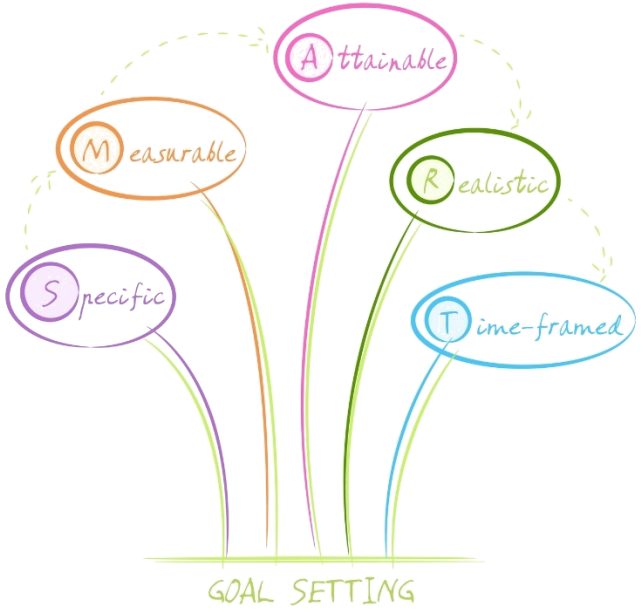
Not included in this document is Community Strengths (a broad portrayal of current community assets and resources, including current community programming, partnerships and/or resources).

For *Community Strengths, please refer to Appendix F in the supplemental document.*

For the CHIP to be truly actionable, action plans are needed to identify activities and measurements for each priority and overarching strategy. The CHIP workgroups developed action plans for each CHIP priority based on the resources available, the capacity of the workgroups and the current community context. The action plans are meant to be flexible and dynamic.

The action plans are on the following pages. Each plan includes:

- **Issue Statement**: represents underlying challenges that need to be addressed, which lead to improvement of health conditions.
- **Population Goal:** desired long-term result for the community priority.
- **Population Outcome Objective:** overall long-term effect from strategies (by 2023).
- **Strategy:** depicts the identified broad community-based strategy.
- **Objectives:** identifies what is trying to be accomplished and are written as SMART (specific, measurable, achievable, relevant and time bound). Process and outcome objectives are included.



For implementation plans, please refer to the CHIP Implementation Plan: Olmsted County CHIP Implementation Plan .

For a list of data sources related to the local conditions sections, please refer to Appendix I in the supplemental document.

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Impaired Driving
Drugs
Education
Prevention
Cell Phones
Seat Belts
Behaviors
Teens
Distracted Driving
Eating
Driver
Motor Vehicle
Texting
Passenger
Bystander
E-mailing
DWI
Injury Prevention
Visual Distractions
Older Adults
Laws
Traffic Crashes
Cognitive Distractions
Alcohol
Manual Distractions

Community Health Priority: Motor Vehicle Injury Prevention

Community Health Importance and Impact

Traffic crashes are the leading cause of death for American youth and adolescents. When it comes to distracted driving, young people are among the most likely to text and talk behind the wheel. All distractions endanger driver, passenger, and bystander safety; but because text messaging requires visual, manual and cognitive attention from the driver, it is by far the most dangerous distraction.

Local Conditions of Motor Vehicle Injury in Olmsted County

In 2014, nationwide, 3,179 people were killed, and 431,000 were injured in motor vehicles crashes involving distracted drivers. The National Highway Traffic Safety Administration reports that 10% of all drivers ages 15 to 19 involved in fatal crashes were reported as distracted at the time of the crashes. According to the 2016 Minnesota Student Survey, **37%** of Olmsted County youth and adolescents send or read texts or e-mails while driving.

From 2012 to 2014

36%

of traffic fatalities & severe injuries were related to vehicle occupants not wearing a seat belt

Men are

10%

less likely to wear a seatbelt than women

"Feel like you're taking advantage of people [when you ask for a ride]"

"Teen drivers are not the only ones texting and driving"

More Males

3.2 per 100,000

were killed in crashes involving a drunk driver in Minnesota than females

1.2 per 100,000

From 2012 to 2014

18%

of traffic fatalities & severe injuries were related to driver inattentiveness

From 2012 to 2014

23%

of traffic fatalities & severe injuries were speed related

Adult Ages

18-34

are less likely to wear a seatbelt than adults over 35

"Consequences don't sink in until closer to home"

Community Dialogue Themes

- Driving is Independence
- Driving Distractions
- What Would it Take to Change or Stop?

Community Perception

Level of Threat

Slight → Moderate → Significant → Severe/Extreme

10% of prioritization participants feel injury prevention is one of the top health issues impacting Olmsted County residents

Community Health Priority: Motor Vehicle Injury Prevention

Issue Statement

Distracted driving is a leading factor in crashes in Minnesota. From 2011 - 2015, more than 86,000 crashes were distracted driving-related, contributing to one in four crashes in Minnesota.

Population Goal and Objective

Goal

Reduce the percent of Olmsted County residents reporting distracted driving behaviors

Outcome Objective

- **By 2023, reduce the percentage of Olmsted County youth and adolescents reporting reading and sending e-mail and text messages while driving from 38% to 31%**
- **By 2023, include an additional question in the 2019 CHNA survey regarding adult distracted driving behaviors**

CHIP Strategies and Objectives

Strategy 1: Explore state, local, and organizational policy changes to address distracted driving

- **By Q2 2018, identify at least five possible state or local organizational policy changes that address cell phone use while driving**
- **By Q4 2020, collaboratively pass or amend three state or local organizational policies that address cell phone use while driving**

Strategy 2: Enhance collaboration between existing traffic safety groups to create unified messaging

- **By Q2 2018, convene four joint meetings with Fatal Review Committee members, Toward Zero Deaths Safe Roads Coalition members, and the Motor Vehicle Injury Prevention CHIP workgroup members to identify common goals and opportunities for collaboration**
- **By Q2 2018, ensure representatives from the 4 E's (enforcement, education, engineering, and emergency medical services) are present when developing unified messaging**
- **By Q4 2020, implement at least nine unified social media campaigns where three or more partner agencies utilize and share the materials created**

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Emerging Threats
Meningococcal
Anti-Vaccine
Influenza
HPV
Polio Td
DTaP
MMR
Infectious Disease
Vaccine Hesitancy
Immunizations
Varicella
Outbreaks
Disability
Hepatitis B
PVC
Hib

Vaccine Preventable Diseases

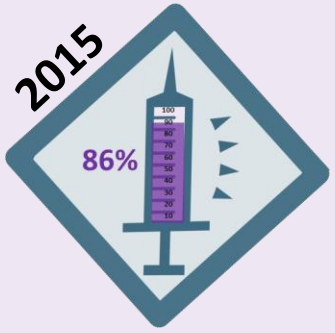
Community Health Priority: Vaccine Preventable Diseases

Community Health Importance and Impact

Vaccinations allow protection from several infectious diseases. With increased vaccination rates, some infectious diseases (small pox) or cancers (cervical cancer) can be eliminated or eradicated.

Local Conditions of Vaccine Preventable Diseases

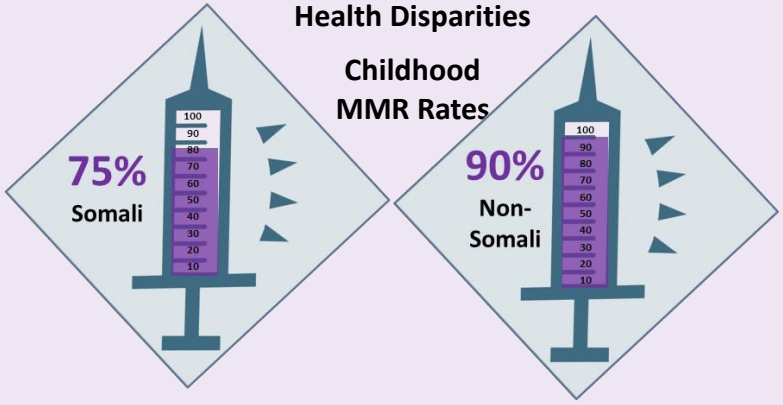
In 2015, 86% of Olmsted County children aged 24-35 months were up-to-date on their age-appropriate Measles, Mumps and Rubella (MMR) vaccine. The Olmsted County rate is high in comparison to Minnesota, with 78.5% of children aged 24-35 months immunized, however, the Healthy People 2020 goal calls for a 90% coverage rate. The majority (96%) of Olmsted County kindergarteners were update-to-date (2013-2016).



of children aged 24-35 months were up-to-date on age-appropriate MMR

Health Disparities

Childhood MMR Rates



"I know nothing about the effectiveness. I am not too worried about side effects, I don't think my kids are going to get autism, let's clear that up but I don't know if it works"

"Would like non-biased and non-monetary motivated sources of information"

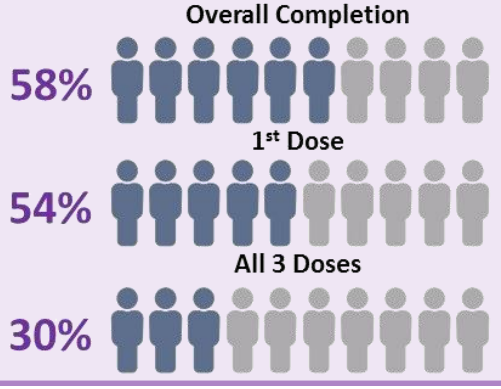
Community Perception

Level of Threat

Slight → Moderate → Significant → Severe/Extreme

16% of prioritization participants feel immunizations is one of the top health issues impacting Olmsted County residents

HPV Adolescent Immunization Rates 2013 - 2016



"Risk could only be one in a million but don't want that to be my own daughter"

Community Dialogue Themes

- Concerns about the Vaccine
- Lack of Knowledge about Vaccine
- Sources of Information
- Health Providers' Role

"I know I can call my health care provider but not everyone has that"

Community Health Priority: Vaccine Preventable Diseases

Issue Statement

Even though most infants and toddlers in Olmsted County have received all recommended vaccines by age two, many under-immunized children, adolescents and adults remain, leaving the potential for outbreak of disease

Population Goal and Objective

Goal

Reduce the incidence of vaccine preventable diseases in Olmsted County

Outcome Objective

- By 2023, increase the completion rate of the MMR series for Somali children in Olmsted County from 75% to 90%
- By 2023, increase the completion of the HPV series for adolescents in Olmsted County from 58% to 70%

CHIP Strategies and Objectives

Strategy 1: Implement education and engagement activities to decrease missed opportunities for vaccinations

- By Q4 2020, increase health providers using Minnesota Immunization Information Connection (MIIC) forecasting to identify vaccination opportunities (baseline to be identified in 2018)
- By Q4 2020, increase the availability of HPV vaccine in the clinical setting from 12 locations to 16 locations

Strategy 2: Implement education and engagement activities to dispel misinformation and concerns about MMR and HPV vaccines

- By Q4 2018, collaborate with the Somali Health Advisory Committee to identify two or more appropriate tactics to dispel misinformation and concerns about MMR in the Somali population
- By Q4 2020, work with health providers who administer the HPV vaccine to establish a community standard for dispelling misinformation and encouraging administration of the HPV vaccination

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Fast Food
Farm to Table
Cost of Medical Care
Lifestyle
School Gardens
Safe places to exercise
Physical Activity
BMI
Children
Parks and Trails
Physical Education

Active Transportation
Healthy Living
Adults
Heart Disease
Smart Snacks
Portion Control
Diabetes
School Breakfast Programs
Mental Health
Processed Foods
Hypertension
Active Recess
Body Fat
Weight
Sedentary

Overweight/Obesity

Safe Routes to School
Active Classrooms
Chronic Disease
Teens
Glucose
Competing priorities
Access to healthy foods

Community Health Priority: Overweight/Obesity

Community Health Importance and Impact

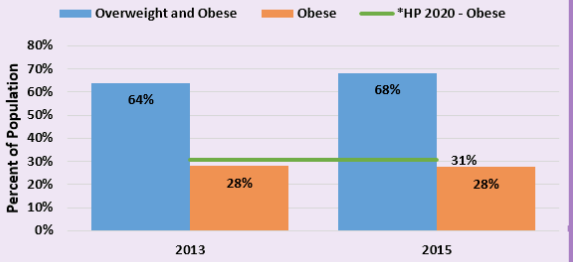
Obesity is associated with many health-related problems from diabetes, heart disease, hypertension, and premature mortality to mental health issues. In addition, obesity increases the overall cost of healthcare placed on society.

Local Conditions of Overweight/Obesity in Olmsted County

The 2015 CHNA survey shows that **41%** of Olmsted County adults are overweight and **28%** are obese (with a total of **68%** being overweight or obese).

According to body mass index (BMI) calculations from the 2016 Minnesota Student Survey, **14%** of adolescents are overweight and **8%** are obese.

Olmsted County Adult Weight Status



* HP 2020 target is for adults age 20 and older

Health Disparities - Adults

Adults are more likely to be overweight or obese if they:

- **were born in the U.S.**
- **are white, non-Hispanic**
- **rent their home**

"The financial aspect, could afford to pay rent or eat healthier"

Community Dialogue Themes

- Blending of Cultures
- Accessibility & Availability
- Family Dynamics
- Competing Priorities

"My family refuses to eat healthy"

Health Disparities - Adolescents

Highest rates of overweight or obesity

Hispanic 32%

Black 29%

46%

of adults eat 5 servings of fruits & vegetables daily

"Our culture, our extended family eats a lot"

50%

of adults meet national guidelines for physical activity

Residents worried about food running out

92.2%	2.4%	1.9%	2.7%	0.8%
0	1-3	4-6	7-15	25+

Number of Days in Month

"Family dynamics impact the food being prepared at home. If someone is always home, they can prepare meals"

Community Perception

Level of Threat

Slight → Moderate → Significant → Severe/Extreme

52% of prioritization participants feel overweight/obesity is one of the top health issues impacting Olmsted County residents

Community Health Priority: Overweight/Obesity

Issue Statement

According to Olmsted County residents, competing priorities are significant factors contributing to overweight and obesity

Population Goal and Objective

Goal

Reduce overweight and obesity rates amongst Olmsted County residents

Outcome Objective

- By 2023, reduce the percentage of Olmsted County adults who are overweight or obese from 68% to 65%
- By 2023, reduce the percentage of Olmsted County adolescents who are overweight or obese from 22% to 21%

CHIP Strategies and Objectives

Strategy 1: Utilize social capital within the Obesity Coalition membership to recruit specific community leaders to assist with implementation

- By Q1 2018, increase the coalition's capacity by recruiting up to 10-12 selected community leaders to assist with implementation of work plans

Strategy 2: Implement a county-wide campaign to provide local examples of what a healthy community looks like to increase healthy eating and physical activity that address competing priorities

- By Q4 2018, research at least 3 effective campaign strategies and begin initial implementation of a county-wide campaign around what healthy looks like, highlighting evidence-based strategies and local examples
- By Q4 2020, the marketing campaign will showcase at least eight local examples of what a healthy community looks like

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Mental Health

Chronic Illness
Sadness
Anxiety
Suicide
Stigma
Fear
Advocacy
Social Connectedness
Developmental
Eating Disorder
Resiliency
Coping
Panic
Trauma
Quality of Life
Dental Health
Stress
Isolation
Wellness Activities
Addictions
Emotional
Resources
Behavioral
Therapy
Depression
Self-Destruction
Stable Housing
Proper Diet
Access to Care
Support System
Worry
Physical Pain
Self-care

Community Health Priority: Mental Health

Community Health Importance and Impact

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships and the ability to contribute to community or society.

Local Conditions of Mental Health in Olmsted County

Local data shows that nearly one in three adults have ever had a mental health condition (29.2%). Currently 32% of adults are living in a household with at least one individual with a diagnosed mental health condition. Data from the Olmsted County CHNA Community Survey shows that **13.5**% of adults scored 50 or below on the World Health Organization's (WHO) well-being index which indicates low mood; of these, 29.4% scored 28 or lower, which indicates depression is likely.

71%

are living in socially connected neighborhoods

88%

feel that people in their neighborhood can be trusted

Health Disparities

Adults are more likely to score below 50 on the WHO well-being index if they are:

- **white, non-Hispanic**
- **in fair or poor health**
- **financially stressed**
- **living in household earning less than $35,000 annually**

Adults are more likely to be socially connected if they are:

- **white, non-Hispanic**
- **in good, very good or excellent health**
- **born in the United States**
- **living in higher income household**
- **own their home**

85%

of neighbors are willing to help each other

Community Dialogue Themes

- **Lack of Social Connectedness**
- **Barriers to Optimal Mental Health**
- **Stigma**

Community Perception

Level of Threat

Slight → **Moderate** → **Significant** → **Severe/Extreme**

67% of prioritization participants feel mental health is one of the top health issues impacting Olmsted County residents

"Mental health vs. mental illness, knowing the difference goes a long way"

"Stigma is huge, realize all humans suffer from same thing in different degrees"

"Normalcy of limited contact with neighbors"

75%

of neighbors know each other

Community Health Priority: Mental Health

Issue Statement

According to the Substance Abuse and Mental Health Services Administration, recovery, or a return to optimal mental health, encompasses four dimensions - health, home, purpose and community. Olmsted County residents have indicated that stigma, disconnectedness and a fragmented service delivery system negativity impact these core dimensions of mental wellness

Population Goal and Objective

Goal

Every Olmsted County resident will have optimal mental health

Outcome Objective

- By 2023, increase the percentage of Olmsted County residents reporting they reside in a socially connected neighborhood from 71% to 76%

CHIP Strategies and Objectives

Strategy 1: Co-create a pilot project to impact social connectedness in neighborhoods in Olmsted County

- By Q4 2019, engage two or more neighborhoods in pilot projects
- By Q4 2020, develop and distribute a summary of best practices on how to build social connectedness within neighborhoods

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Physical Health

Worry

Food

Violence

Safety

Education

Unemployment

Insecurity

Depression

Medical

Insurance

Stress

Basic Needs

Financial Stress

Homelessness

Childcare

Unhealthy Coping Behaviors

Poverty

Mental Health

Vulnerability

Relationships

Housing

Crime

Social Support System

Utility Bills

Medications

Anxiety

Community Health Priority: Financial Stress

Community Health Importance and Impact

Finances are one of the leading causes of stress in America. With less money in the budget, people tend to cut corners in areas of healthcare to pay for basic necessities (i.e. deciding to pay for groceries and not having enough money for prescription medicine), which can lead to more serious health issues.

Local Conditions of Financial Stress

According to The United States Census data (2009-2013), **21%** of Olmsted County homeowners and **46%** of renters are paying more than 30% of their income for housing [mortgage/rent] alone.

Data from the Olmsted County CHNA Community Survey shows that **28.7%** of Olmsted County adults are currently financially stressed - or are worried or stressed about not having enough money to pay their bills. Of those that are financially stressed, over half (58.2%) are worried about money six or more months out of the year.

"If you can't find affordable childcare you can't work. It is a vicious cycle"

2015 CHNA Community Health Survey

Which of the following were you worried or stressed about not being able to pay for?

Community Dialogue Themes

- Importance of Quality Childcare
- Worker Shortage (Childcare)
- Affordability & Accessibility
- Current barriers (Housing)
- Aspects not being Focused on (Housing)
- Collaboration is Needed (Housing)

"They [childcare workers] get paid a low wage too, which places a stress on their families too"

Community Perception

Level of Threat

Slight → Moderate → Significant → Severe/Extreme

31% of prioritization participants feel financial stress is one of the top health issues impacting Olmsted County residents

29%

of adults are financially stressed

"We can be in different boats but need to be paddling in the same direction" **(housing)**

"How our system is set up to pay for childcare. Have to pay as you go and creates a financial stress"

"There are people around us who don't want to hear the [housing] issue"

"Low income seniors and soon to be seniors, could have another subgroup for just senior housing"

Community Health Priority: Financial Stress

Issue Statement

There are many efforts in Olmsted County addressing contributors to financial stress, but there is a need to qualify and index the efforts and increase collaboration

Population Goal and Objective

Goal

Reduce the percentage of Olmsted County residents burdened by financial stress

Outcome Objective

- By 2023, reduce the percentage of Olmsted County residents who report experiencing financial stress due to housing and childcare expenses from 60% to 55%

CHIP Strategies and Objectives

Strategy 1: Support efforts aimed at identifying and understanding current assets and gaps in our community related to financial stress

- By Q3 2018, assist in conducting an environmental scan that identifies strengths, weaknesses, opportunities and threats of current efforts addressing housing in Olmsted County
- By Q4 2019, assist in conducting an environmental scan that identifies strengths, weaknesses, opportunities and threats of current efforts addressing childcare in Olmsted County

Strategy 2: Act as a convener to support current efforts addressing financial stress issues in Olmsted County

- By Q4 2020, host at least four community forums that focus on housing issues in Olmsted County
- By Q4 2020, host at least four community forums that focus on childcare issues in Olmsted County

Our Future: From Planning to Action

Implementation

CHIP workgroups and the CHAP Core Group developed their implementation plans based on how to best achieve their objectives. Each strategy (priority and CHAP values) uses the same work plan template to outline activities, who is responsible and resources needed. The work plans are meant to be dynamic and will be updated to reflect the current work.

Monitoring and Evaluation

Monitoring and evaluation considerations were developed in tandem with action plans for the CHIP priorities and CHAP values. Like the action plans, the monitoring and evaluation plans are meant to be flexible and dynamic and capture the resources needed to conduct monitoring and evaluation activities. The monitoring and evaluation plans uses both logic model concepts and Results Based Accountability to simplify the terminology.

For work plans and monitoring and evaluation plans, please refer to the CHIP Implementation Plan: Olmsted County CHIP Implementation Plan .

Logic Model

The CHAP logic model provides a high-level look at how the CHAP value strategies and CHIP priorities are connected and essential to improving the health of our community. The logic model pulls out high-level outputs and outcomes developed for each strategy and priority to provide a visual representation of the work related to the CHIP that is being done. The inputs reflect resources and support that is needed to reach the long-term goals. Strategies include the overarching strategies and priorities identified in the CHIP. Outputs answer "How much do we do?", while the short term and intermediate outcomes focus on answering "How well did we do it?" and "Is anyone better off?". Long-term outcomes reflect the population measures associated with the CHIP priorities. Logic models for both the CHIP strategies and CHAP values can be found in the CHIP Implementation Document: Olmsted County CHIP Implementation Plan .

Our Future: From Planning to Action

Sustainability

The current CHIP reflects a coordinated health improvement effort that will last multiple cycles; and ultimately, many years. In alignment with other initiatives, the Olmsted County community will follow a three-year cyclic community health assessment and planning process. Such aligned community initiatives include:

- Olmsted County Public Health Services' commitment and compliance to the Minnesota Local Public Health Assessment and Planning Process
- Olmsted County Public Health Services' efforts to maintain national public health accreditation through the Public Health Accreditation Board
- Mayo Clinic and Olmsted Medical Center's observing the Affordable Care Act requirements
- Commitment and charge of the CHAP Core Group to continually improve the CHAP process, and continued outreach and inclusion of all in the community

In addition to the above mentioned aligned efforts, the following will serve to further support sustained action:

- Joint community funded community health integration specialist position, with the goal of helping to sustain the community health assessment and planning efforts
- Dedication and engagement from community organizations and individuals to consistently serve on the CHAP Data Subgroup and CHIP workgroups
- Quarterly Health Assessment and Planning Partnership meetings - conveyed, coordinated and facilitated by Olmsted County Public Health Services
- Commitment and charge of the Coalition for Community Health Integration
- Quarterly community health forums

Record of Changes and Updates

Date	Changes/Updates Summary	Responsible Person(s)

List of Appendices

See CHIP supplemental document for appendices, which include:

A. Assessment and Planning Requirements

B. Guiding Frameworks

C. Community Health Improvement Plan Priority Workgroup Leads

D. Contributing Organizations

E. Community Strengths

F. Prioritization Process

G. Community Health Priorities: Alignment with State and National Priorities

H. Data Sources

Thank you

A special thank-you to all the individuals, organizations and partners that have been involved throughout the community health assessment and planning process.

The development of the CHAP process would not have been feasible without LEADERSHIP, GUIDANCE and DIRECTION from the:

Health Assessment and Planning Partnership
CHAP Core Group
Coalition for Community Health Integration
Workgroup Lead Organizations
CHAP Data Subgroup

Questions regarding the Community Health Improvement Plan document or process can be directed to:

Olmsted County Public Health Services
Health Assessment and Planning Division
507-328-7500