2020-2022

Wright County Community Health Needs Assessment Plan

CentraCare Monticello

WCCA Wright County Community Action

Wright County Public Health

Allina Health Buffalo Hospital

TABLE OF CONTENTS

EXECUTIVE SUMMARY

To better understand health issues facing the communities of Wright County, Buffalo Hospital, part of Allina Health, CentraCare – Monticello, Wright County Public Health and Wright County Community Action partnered to develop and conduct a Community Health Needs Assessment (CHNA). In early 2017, the organizations formed Wright County Community Health Collaborative in an effort to collect and prioritize data from various sources, and develop a joint community health implementation plan. The purpose of the collaborative group is to systematically identify and analyze health issues in the community and create a plan for how to address them. The group includes all Wright County organizations who are encouraged or required to complete a Community Health Needs Assessment (CHNA). The collaborative employed the Mobilizing for Action through Planning and Partnership (MAPP) framework which emphasizes collaboration of health care entities, public health and community organizations and is centered upon community engagement.

The CHNA utilized a variety of information sources and community input to analyze and prioritize community health issues. This information was used to develop the health improvement action plan to address the identified issues. Important activities in the CHNA process are outlined in this document, as well as roles and responsibilities among the partners in the collaborative.

The CHNA process was based on the partnership between four organizations: Buffalo Hospital, part of Allina Health, CentraCare – Monticello, Wright County Public Health and Wright County Community Action. Major CHNA decisions were based on consensus and open dialogue between the partners, as well as community input. The collaborative agreed that the definition of health encompasses a broad range of conditions, not just health in terms of healthcare. Improving health is no longer about treating and preventing medical conditions; it is the improvement of complete physical, mental, spiritual and social well-being.

Representatives from partnering organizations met regularly from September 2017 to July 2019 for progress updates, discussion on upcoming CHNA activities and event planning. All core partners in the collaborative contributed to the completion of the process to the best of their ability and utilized the strengths and capacity of various group members.

The partnership adopted the MAPP model for assessment and planning. MAPP is a community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is not an agency-focused assessment process; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems. Community ownership is a key component of MAPP. Participation from the broader community leads to collective thinking and sustainable solutions to complex problems.

Mapp Process Model

This effort included: (1) completion of a CHNA to systematically identify and analyze health priorities in the community, and (2) development of a plan to address these priorities as a collaborative and in partnership with others. Through this process, the collaborative engaged with community stakeholders to better understand the health needs of the communities it serves, identified internal and external resources for health promotion and created an implementation plan that leverages those resources to improve community health.

In 2018, community members, community organizations, public health and hospital/health system staff participated in a process that identified the following priority areas for community health in the communities served by the collaborative:

1) **Mental Health and Wellness**
2) **Dental Care**
3) **Substance Use and Abuse**

In 2018-19, staff solicited community input, assessed existing resources and developed a community health improvement plan for 2020-2022 in order to address these priorities. This implementation plan includes the following goals, each of which is supported by multiple strategies and will be implemented through a variety of activities monitored for progress and outcomes over time.

Mental Health and Wellness goal: Reduce the rate of mental health care delay and the number of "not good" mental health days in Wright County.

Dental Care goal: Reduce the rate of dental care delay in Wright County.

Substance Use and Abuse goal: Support local prevention efforts and advocate for policy changes to address substance abuse in Wright County.

INTRODUCTION

Wright County Community Health Collaborative was formed in order to systematically identify and analyze health issues in the community and create a plan for how to address them. The group includes Wright County organizations who are encouraged or required to complete a Community Health Needs Assessment (CHNA). The Internal Revenue Service provides guidelines for hospitals in this process as part of meeting obligations under the Patient Protection and Affordable Care Act, which requires 501(c)(3) non-profit hospitals to conduct an assessment at least every three years. Every five years all Minnesota community health boards must participate in assessment and planning to determine local public health priorities and focus local resources. Wright County Community Action (WCCA) is required to complete a Community Needs Assessment every three years as mandated through State and Federal funding streams.

In 2016, Wright County Public Health made a decision to align its local public health CHNA cycle with the two large healthcare systems operating in the community – Buffalo Hospital, part of Allina Health, and CentraCare - Monticello. WCCA was included to better understand the specific health needs within low-income populations and enable all participating organizations to work together in conducting data collection, data analysis and prioritization process. WCCA plans to conduct a joint assessment every three years.

Local Public Health System Structure

Through this process, the collaborative aims to:

• Better understand the health status and needs of the communities it serves by considering the most recent health and demographic data as well as gathering direct input from community members.

• Gather perspectives from individuals representing the interests of the community, including those who have knowledge or expertise in public health and those who experience health inequity or are low-income and/or minority members of the community.

• Identify community resources and organizations that the collaborative can partner with and support in the priority areas for that community.

• Create a strategic implementation plan based on information gathered through the needs assessment.

• Monitor and revise the plan as needed over the next three years.

The purpose of this report is to share the current assessment of community health needs most relevant to the communities served by the collaborative and its community health improvement plan to address these 2020-22 needs.

WRIGHT COUNTY COMMUNITY HEALTH COLLABORATIVE SERVICE AREA

Wright County Community Health Collaborative

COMMUNITY HEALTH VISION

On October 25, 2017 almost 50 stakeholders from across Wright County met to have a conversation about shaping a vision for a healthier community and providing direction for the next community health assessment and health improvement process. Numerous community organizations were present: mental health providers, schools, businesses, health care providers, government officials, community non-profit organizations and community members. As a result of this comprehensive workshop, the group framed the Community Health Vision.

Community Health Vision

As community members, we will commit to:
• Engagement: increase community ability to make a healthy choice an easy choice and inspire individual lifestyle change

• Collaboration: create successful partnerships and build leadership support through effective communication, respect and wise use of available resources

• Accessibility: streamline, expand and raise awareness of community resources and opportunities to improve the health of residents

• Connection: create inclusive and innovative solutions to help everyone feel socially connected, safe, supported and happy

MEMBER DESCRIPTIONS

Buffalo Hospital, part of Allina Health

Buffalo Hospital is a non-profit regional medical center committed to providing quality, patient-centered and comprehensive care to patients in and around Wright County. The hospital provides a full range of inpatient, outpatient and emergency care services and many specialty services. It has been nationally and locally recognized for its quality of care—particularly its safety philosophy, Community Benefit practices and emergency care. Buffalo

Hospital was also the first hospital in the state of Minnesota to be awarded the Pathway to Excellence American Nurse Credentialing designation and also received an award from the Minnesota Business magazine for developing wellness programs. Clinics affiliated with Buffalo Hospital include: Stellis Health clinics in Albertville, Buffalo and Monticello and Allina Health Clinics in Annandale, Buffalo, Cokato and St. Michael. The hospital also has a long history of working to improve the health of the communities it serves through charitable giving by the Buffalo Hospital Foundation and direct community health-improvement programming.

Buffalo Hospital is proud to be selected as a 2019 Watson Health Top 100 Small Community Hospital in the nation. The Watson Health 100 Hospitals study, formerly the Truven Health Analytics® study, identifies 100 top-performing hospitals based on publicly available data and a balanced look at clinical, operational and financial metrics. Watson Health 100 Top Hospitals leaders demonstrate that quality care and operational efficiency can be achieved simultaneously, thereby delivering greater value to their communities.

CentraCare – Monticello

CentraCare - Monticello delivers comprehensive services to help you take charge of your health and enjoy each day to the fullest including a modern birth center with OB/GYNs and midwives, state-of the-art Monticello Cancer Center, five-star rated Care Center, individualized diabetes education, skilled Emergency Department and Level IV Trauma Center, advanced life support ambulance service, comprehensive orthopedic care, inpatient and outpatient surgical services and wound care and hyperbaric medicine services. In addition, we support community health and wellness initiatives including Monticello and Big Lake Farmers' Markets, the annual Bike Rodeo and Helmet Sale, Safe Communities, Just Drive and Project H.E.A.L. Our dedication to ensuring access to enhanced health care services and supporting healthy choices in our community demonstrates our commitment to caring for every patient, every day. Because a healthy community feels good for everyone!

Wright County Public Health

Wright County Public Health (WCPH), a division of Wright County Health & Human Services (WCHHS), has been working to promote health and safety, prevent illness, and protect our community since 1951. Wright County Public Health has a long history of looking "upstream" to identify the root causes of poor health and informing, engaging and activating the community to address those causes. Public health focuses on the health needs of the population as a whole and gives priority to preventing problems over the treatment of health problems. By focusing on the greatest good for the greatest number of people, public health organizes community resources to meet health needs and takes positive action to address community health issues.

Wright County Public Health, with partners, creates environments that promote well-being and reduces health disparities through empowerment, collaboration and service. We have 32 staff members led by a Public Health Director and three supervisors. Services are based on the Areas of Public Health Responsibility: assure an adequate local public health infrastructure, promote healthy communities and healthy behaviors, prevent the spread of infectious disease, protect against environmental health hazards, prepare for and respond to disasters and assure the quality and accessibility of health services.

We use data to monitor health status, engage with the community to develop solutions and take action, and work with a wide range of partners to create policies and plans that ensure the health of all.

Wright County Community Action

Wright County Community Action is an agency focused on creating opportunities where low-income individuals can thrive and build economic,

social and community assets. Our mission is "to work in partnership with the community to empower residents to improve their physical, social, and economic wellbeing". WCCA does this through its myriad of programs and services which provide both crisis intervention and prevention efforts for those experiencing, or are at risk of falling into, the scope of poverty. WCCA utilizes a multi-generational approach to providing services which allows us to serve clients from birth to beyond retirement, and provides each client with comprehensive agency support across all programs, leading to greater outcomes. Programs that are housed out of our agency include Head Start, Early Head Start, Energy Assistance, Weatherization, Homebuyer Training, Foreclosure Prevention, WIC (Women, Infants & Children), MNsure Navigation, Tax Preparation, and the Aging Alliance program. Our Food Shelf location in Waverly, MN houses all of our food security efforts including a Mobile Food Shelf, Emergency Food Box Network, BackPack program and Food Rescue initiative. The last few years has allowed WCCA to go through a rebirth in which the agency is no longer a "hidden gem", rather a cornerstone for collaboration and innovative solutions to community concerns. Through all of its efforts, WCCA aligns well with the Wright County Community Collaborative vision by providing basic needs, prevention services and encouraging community health regardless of economic standing.

DEMOGRAPHICS

Wright County is located in Central Minnesota, slightly northwest of the Twin Cities. Wright County covers 716 square miles and with a population of 131,130 is Minnesota's tenth most populous county. The following key indicators provide a brief overview of the region. Additional information about Wright County can be found through the U.S. Census Bureau.

POPULATION

Indicator	Result	Source
Median Income	$77,953	U.S. Census Bureau, American Community Survey (ACS), 2013-2017, 5-year estimates
Residents in households with income below poverty line	5.56%	US Census Bureau, American Community Survey. 2012-16
Median age	36.0	U.S. Census Bureau, American Community Survey (ACS), 2012-2016, 5-year estimates
Residents under age 18	37,455	US Census Bureau, American Community Survey. 2012-16
Residents age 65 or older	13,855	US Census Bureau, American Community Survey. 2012-16
Residents with limited English proficiency	1.4%	US Census Bureau, American Community Survey. 2013-17
Foreign born residents	2.9%	US Census Bureau, American Community Survey. 2013-17

RACE AND ETHNICITY
U.S. Census Bureau, Decennial Census and Population Estimates, 2017

Indicator	Result	Source
White alone	93%	U.S. Census Bureau, Decennial Census and Population Estimates - 2017
Black or African American alone	1.4%	U.S. Census Bureau, Decennial Census and Population Estimates - 2017
Asian alone	1.2%	U.S. Census Bureau, Decennial Census and Population Estimates - 2017
Two or More Races	1.2%	U.S. Census Bureau, Decennial Census and Population Estimates - 2017
Hispanic or Latino	2.8%	U.S. Census Bureau, Decennial Census and Population Estimates - 2017

HEALTH INDICATORS
Wright County Community Health Survey, 2018

Indicator	Result	Source
Delayed or did not get needed medical care during past 12 months	20.2%	Wright County Community Health Survey, 2018
Adults reporting drinking any alcohol in past month	72.8%	Wright County Community Health Survey, 2018
Adults who are overweight or obese	68.2%	Wright County Community Health Survey, 2018
Adults reporting fair or poor general health	7.1%	Wright County Community Health Survey, 2018
Delayed or did not get needed dental care during the past 12 months	23.7%	Wright County Community Health Survey, 2018
Delayed or did not get needed mental health care during the past 12 months	12%	Wright County Community Health Survey, 2018

Wright County Community Collaborative members at the visioning event

EVALUATION OF 2017-2019 COMMUNITY HEALTH NEEDS ASSESSMENT

Buffalo Hospital, part of Allina Health

Goal one: Support mental wellness in Wright County by identifying and expanding the offering of community mental health and wellness and addiction resources and strengthening social connections and relationships.

Much of the work in Wright County* to promote mental wellness and provide mental health resources was done through Bounce Back Project and Change to Chill program. Through Bounce Back Project, Buffalo Hospital provided series of classes in several area middle and high schools and implemented various tools and campaigns throughout the year to promote gratitude, social connections, random acts of kindness, three good things, mindfulness and self-care. In the last two years, the project expanded its reach from Buffalo to other parts of Northwest Region by creating community teams in Annandale and Cokato. Three existing teams consist of employees of Allina Health and community members and are tasked to develop, roll out and support many community-based mental health and wellness initiatives for people of all ages. Offerings include group book reads, game days for multigenerational interaction, social connection programs and speakers for community gatherings.

Change to Chill (CTC) ™

Change to Chill is a free, online Allina Health resource that provides stress reduction tips, life balance techniques and health education services for teens. More than 30,000 unique users visit the CTC website each year, including teachers, teens and parents. Through Change to Chill, hospital wellness specialists worked with students in the classroom and provided train-the-trainer sessions to adults. From 2017 through 2019, Buffalo hospital staff provided Change to Chill (CTC) curriculum to more than 2,400 students in area schools.

Additionally, to support a culture of mental well-being in local high schools, Allina Health launched the Change to Chill School Partnership (CTCSP) during the 2018–2019 school year. Buffalo Hospital supported Maple Lake High School as the first Change to Chill School Partnership in the Northwest Region. The partnership included focus groups with students, peer mentoring, messages for parents, train-the-trainer sessions for staff and a designated space called a "Chill Zone" for students and staff to practice self-care.

Hospital staff also continued to support *Be the Change,* an internal campaign to eliminate stigma around mental health conditions and addiction and ensure that all patients receive consistent, exceptional care. Volunteer *Be the Change* Champions attended trainings. Additional resources were provided through meetings, webinars and posters to reinforce the message of reducing mental health stigma.

Buffalo Hospital also provides financial support and in-kind support to community leaders working to improve mental wellness in Wright County. For example, the hospital has been the site for the Minnesota Department of Health monthly Mental Well-Being and Resilience Learning Community for Wright County. Ten times per year members of the community gather to hear learnings from implementing public health projects in Minnesota. Local groups then discuss the possibility of using these learnings in the local community setting and applying best practices for advancing the work around community health improvement.

Annually, Buffalo Hospital provides charitable contributions to be the main sponsor for Emotions In Motion 5K in Buffalo. The event is hosted by SAVE (Suicide Awareness Voices of Education), a nonprofit resource for those affected by suicide. Buffalo Hospital also co-hosted and organized a 'Let's Talk About It'-event in collaboration with SAVE. The event was held at Buffalo High School and included a meal, resource fair, main speaker and youth and adult panels with local people who

• *Northwest Region of Allina Health service area*

have been impacted by suicide. Over 450 people attended this event. Buffalo Hospital created a partnership with the Dassel- Cokato A to Z organization and supporting the efforts to provide resources for students/individuals going into the field of mental health and wellness.

To further foster collaboration, Buffalo Hospital holds a monthly mental health committee meeting consisting of representatives from Buffalo Hospital, area clinics, law enforcement, mental health professionals, Wright County Health and Human Services and the four-county crisis team. The goal of the committee is to bring together organizations working with mental health concerns to develop county-wide collaborative solutions.

Buffalo also has several initiatives to increase access to mental health support in the community. The hospital is a host for an annual retreat for women in treatment or surviving cancer. The event provides variety of tools to help deal with stress and anxiety, including yoga, creativity projects, laughter, healthy eating, and social connections. Additionally, the hospital hired a mental health professional to work half time in the clinic and half time in the emergency department to assist with mental health needs and provide timely mental health resources for patients who come to the emergency room in crisis. The hospital provides ongoing individual and group behavioral modification health coaching and the 'Let's Talk Wellness' program for community groups free of charge. Topics for group sessions include mindfulness, meditation, relaxation, music therapy, and stress management and have been provided at work places and local mental health counseling centers for staff and patients. Finally, in May of 2018, Buffalo Hospital introduced tele psychiatry to the patients in our emergency department, along with continuous promotion of the 24/7 mental health and addiction resource phone number at many of our community events and gatherings.

Goal two: Reduce or maintain the level of obesity and increase physical activity among the population of Wright County through programming, activities, and policies that promote and support a healthy lifestyle.

Ongoing classes and resources have been provided by Buffalo Hospital wellness staff to youth and families through Health Powered Kids (HPK), a free community education program featuring 60+ lessons and activities designed to empower children ages three to 14 years to make healthier choices about eating, exercise, keeping clean and managing stress. Additionally, yoga and Tai Chi classes were offered at worksites and group events such as the Connect Retreat for women dealing with cancer.

Buffalo Hospital also provides financial support to community leaders working in this area. For example, the hospital provides charitable contributions through the Allina Health Market Buck program to improve access to local fitness facilities and affordable healthy food. Additionally, from 2017 through 2019, Buffalo Hospital provided $90,000 in grants through the Neighborhood Health Connection™ (NHC) program to support programs such as Tai Chi offerings, group fitness classes and a community bike program, among others. NHC is a community grant program that aims to improve health by building social connections through healthy eating and physical activity. In-kind support is provided by Buffalo Hospital employees who are actively involved in local groups such as Live Wright with the focus on obesity, Walk/Bike Coalition and Crow River Food Council.

Finally, Northwest region clinics and wellness staff have been an active part of the Accountable Health Community (AHC) model. Because social conditions such as food and housing instability inhibit access to care and contribute to chronic diseases such as mental health conditions and obesity, Allina Health implemented the Accountable Health Communities (AHC) model through a cooperative agreement from the Centers for Medicare & Medicaid Services. Care teams in 78 Allina Health sites screen eligible patients for five health-related social needs:

housing instability, food insecurity, transportation barriers, difficulty paying for heat, electricity or other utilities; and concerns about interpersonal violence. When patients identify needs, the care team provides a list of community resources tailored to their needs. Some high-risk patients receive assistance navigating the resources.

Goal three: Support community access to clinical and non-clinical services in Wright County by engaging providers and community partners in collaborative network and resource sharing.

Buffalo Hospital focused on the social determinants of health in Northwest Region with a priority on healthy food access. Specifically, the work involved addressing access to healthier food and physical activity offerings for low-income and food insecure populations. Key activities included supporting local organizations already working on the issue of food insecurity and access through charitable contributions, creating opportunities and encouraging Allina employees to volunteer at local events, providing classes on nutrition and healthy eating and linking Wright County citizens to local growers.

Additionally, Buffalo Hospital provided programs and wellness offerings free of charge and open to anyone in the community. Two of the featured classes are Healthy Eating for Better Health, a four week series, and Diabetes Prevention Program, a yearlong program. Both address basic nutrition and fundamentals of healthy eating and developing exercise programs. Buffalo Hospital also provided Let's Talk Wellness series that can be customized to groups of any size. The topics for the series are chosen from an extensive list of options. Wellness Coaching is available, also free of charge, and targets behavioral modification while providing ongoing support through goal setting.

Allina Health employees also collaborated with teachers for family dinner nights at our local Alternative Learning Center, provided cooking demos and grocery store tours to many individuals and groups in the community. Buffalo Hospital hosts and maintains an on-site straw bale garden. Produce grown in the garden is used for local cooking demonstrations and nutrition and produce education. In addition, exercise classes have been provided to community groups and work sites.

Charitable contributions were provide by the Allina Health Market Bucks program to Fare For All (FFA), local Power of Produce (POP) programs and local food shelves. Neighborhood Health Connection grants provided assistance to local programs promoting healthy eating and physical activity.

In 2018, the Allina Health Bucks program served 294 families with $2,940 worth of produce purchased! The 'bucks' are used just like cash, and are given by Allina Health doctors, care managers and public health nurses to patients who are food insecure. Buffalo employees have also volunteered over 375 hours with the Food Group's Fare For All program in Wright County which has grown to be the largest in the state. Fare for All is a community program offering fresh produce and frozen meat packs at 40 percent off retail prices, or $10 and $25, respectively.

Connecting the dots is an important part of the work Buffalo Hospital does in the community, both between community partners and with our patients, employees and care providers. Buffalo Hospital hosts quarterly meetings with community leaders to identify needs and locate much needed resources; facilitates bi-monthly meetings with regional Allina Health leaders, and attends local chambers and rotary groups.

These community-driven programs and initiatives are making a difference. Survey data from 2015 to 2018 demonstrated significant increase in the consumption of fruits and vegetables, decrease in high blood pressure and cholesterol, no increase in BMI and 14 percent increase in food security among all respondents. All these changes and positive impact is attributed largely to the collaborative effort between all community partners to address the health needs in Wright County!

CentraCare – Monticello

In 2016, CentraCare Health System shared the top 10 priority health indicators with their five regional hospitals. CentraCare - Monticello was asked to consider the indicators and narrow the scope of work for their staff. The top four priority areas that emerged from this process were: ***Obesity and Inactivity, Mental Wellness, Primary Care Access and Distracted Driving.*** Staff worked to identify potential strategies that would address each priority area. An implementation plan was developed which included goals, activities related to goal, lead contacts, anticipated outcomes or results and progress on each activity. This implementation plan was designed to serve as a starting point to guide collective action. The plan was routinely monitored, evaluated, and progress noted as the process evolved.

For **Obesity and Inactivity**, several activities focused on continued partnerships with local school districts and community partners to promote healthy eating initiatives, active living and healthy lifestyles and wellness communication. This strategic work occurred through education to school staff, Safe Routes to School planning grant involvement, community activities promoting safe biking and family engagement in active lifestyles and installation of digital signage relaying health and wellness information and events.

Mental Wellness work focused on promoting community resiliency, awareness of services, participating in collaborative efforts around mental wellness and implementing a small group high school pilot program incorporating resiliency tools. The majority of this strategic work was accomplished utilizing CentraCare - Monticello's program the Bounce Back Project, whose tagline is Promoting Health Through Happiness. The Bounce Back Project team gave multiple resilience presentations, hosted booths at community events, helped sponsor school related service projects, community book reads, and hosted events and activities promoting self-care. The team also piloted a six-week resiliency curriculum in Monticello High School's alternative learning program. A social worker was also added to the team at Project H.E.A.L., which is a monthly free health screening offered in two local communities, to provide access and referral information related to mental wellness.

Actions in the area of **Primary Care Access** focused on the continued recruitment of primary care providers, adding two by the end of fiscal year 2017. Project H.E.A.L. was expanded to its second location and midwifery services were added on campus. Staff attended several wellness fairs and provided lunch-and-learn presentations to promote the addition of these primary care access opportunities.

Finally, concentrated efforts to bring awareness to **Distracted Driving** were undertaken. A CentraCare - Monticello representative joined the Safe Communities of Wright County Board. We sponsored and participated in our local *Just Drive Day* annually. We increased distracted driving awareness at local farmer's markets, health fairs, and expos. We also applied for and were awarded funds to purchase a "driving simulator" to educate students and adults about distracted or impaired driving. We also approved a CentraCare - Monticello employee policy on safe driving, requiring elimination of all distractions while driving for work, driving a company vehicle, or driving while being reimbursed for work-related mileage.

Wright County Public Health

Priority issue – Obesity

The ongoing financial support provided by being a grantee of the Statewide Health Improvement Partnership has allowed Wright County Public Health (WCPH) and its community partners to implement a variety of efforts that promote healthier choices to bend the curve of obesity. The Live Wright Collaborative is the local coalition supporting these countywide efforts. Strong community partnerships have allowed WCPH to be comprehensive in the tactics to promote healthy eating and active living. We have worked with farmers markets to start Power of Produce kids' clubs, supported schools to make healthy choices an easier choice and are involved in the Crow River

Food Council. We have worked to increase physical activity through active recess in schools, conducting walkable community workshops and safe routes to school planning. This work is guided by evidence-based approaches that focus on policy, systems and environmental changes.

Goal 1: Increase healthy eating among youth and adults

Increase the prevalence of adults who eat recommended number of fruits and vegetables daily from 35% to 50% by December 31, 2018. The 2019 Minnesota Student Survey results were not available at the time of this document being completed. 2018 Survey Findings: 41.6% Adults reported eating recommended number of fruits and vegetables.

Goal 2: Increase active living among youth and adults

Increase the prevalence of adults meeting physical activity guidelines from 25% to 51% by December 31, 2018. (2015 – 5 or more days of 30 + minutes moderate activity). The 2019 Minnesota Student Survey results were not available at the time of this document being completed.2018 Survey Findings: 27.7% of adults reported 5-7 days of 30+ minutes of moderate physical activity.

Priority issue – Mental Well-Being

Overall, WCPH approach in addressing mental well-being is completely different from what was proposed in the 2015-2019 Community Health Improvement Plan (CHIP). The challenges for public health are to identify risk factors, increase awareness about mental disorders and the effectiveness of treatment, remove the stigma associated with receiving treatment, eliminate health disparities, and improve access to mental health services for all persons, particularly among populations in Wright County that are disproportionately affected. We worked in the last 2 years to incorporate mental health promotion into chronic disease prevention efforts, conduct surveillance and research the landscape of services available to improve understanding and outreach efforts to promote mental well-being, and collaborated with partners to develop more comprehensive mental health plans to enhance care and eliminate gaps. The progress we made as a department and community cannot be described in strategies, goals or objectives developed. The progress can be measured in the different approach WCPH is taking, in the discussions the organization have had internally and externally to learn more about mental illness and mental well-being, charting organization's path for the next CHNA, which has led to the identification of specific strategies and goals/SMART Objectives for the next improvement plan cycle.

Priority issue – Use and Abuse of Alcohol, Tobacco and Other Drugs

People's use and abuse of drugs continue to take a toll on our communities. Over the last five years we have seen subtle shifts in the rate of use and substances of use. This has required WCPH to be nimble in planning and implementing the efforts to address specific problems; youth use of electronic cigarettes and the misuse of opioids among our adult population. The media attention given to this issues also creates an opportunity for the organization to elevate key messages and work to change specific policy, systems and environments to curb the accessibility and use of substances.

Goal 1: Reduced use and impact of alcohol, tobacco, illegal drugs and the misuse of prescription medications through work with the drug prevention coalition of Wright County—Mentorship Education and Drug Awareness (MEADA).

Increase active coalition meeting participation by at least 25 percent by December 31, 2018. (8 representatives on average attend quarterly meetings). Status: We have increased membership sporadically however, the biggest thing we have done around the activity of the coalition is that it now meets every other month. We did increase the average number of coalition members attending meetings to 10 at every meeting during 2018.
By December 31, 2018, the MEADA membership will constitute a countywide representation of individuals and organizations with personal and

professional experience in Alcohol, Tobacco and Other Drugs (ATOD) prevention and use. Status: For this objective we have seen an improvement in representation when it comes to the personal and professional experience, however we still lacking in the geographic location side of it. Membership spans fields of work such as, law enforcement, school staff, hospital staff, treatment providers, drug court, community members, public health officials and county commissioners. However, membership is still largely representatives from Buffalo area, Howard Lake, Monticello, Cokato and St. Michael-Albertville.

Wright County Community Action

In 2017, Wright County Community Action underwent a strategic planning process utilizing community stakeholder conversations and insight. Several key priority areas influenced strategic goals, objectives, and strategies that will lead the agency toward growth and increased client outcomes. The following programmatic focuses are key elements of those strategies and contribute to the community's health.

FOOD INSECURITY

Under the nutrition segments of our agency, we set three strategies: evaluate space needs and opportunities, consistently evaluate new opportunities to provide comprehensive nutrition services and improve Food Shelf operations.

In late 2016, we transitioned the Food Shelf to a 'client choice model', which gave clients greater freedom to meet their specific needs. In order to fulfill our expanded service capacity, we involved Second Harvest Heartland and other food distribution services. We also expanded our business hours to 35 hours a week by including longer evening hours. Prior to 2017, our refrigeration infrastructure reduced our client's ability of choice due to limited space. By the spring of 2017, we were able to leverage local grant funding to purchase two modular coolers and a commercial freezer. We have also made significant building improvements to maximize service capacity and dry storage space.

We also recognized that our remote location in Waverly provided a challenge to potential clients with limited transportation. To address this need and gaps in the hours of availability and service, we launched the Wright County Emergency Food Box (EFB) program in the summer of 2017. This program consists of containers holding thirty-pounds of non-perishable foods at a satellite partner. More importantly, each box also provides specific educational resources, including the hours and locations of all area food shelves, with the intention of informing the client about their next step in resolving their food insecurity. Host sites receive training on the distribution of both the food and the resources, allowing our clients to receive counseling about their situation, as well as materials, from a trusted member of the community.

In September 2017, we continued our Food Shelf programming expansion by launching our Mobile Food Shelf program in order to serve homebound seniors. By collaborating with senior living communities, we expanded food access directly to our clients' doorsteps. Clients select items they need from a menu and have access to a volunteer Enrollment Specialist. Then, dedicated volunteers pack and deliver the items.

Building off the success of the Back Pack Food Program, which launched in 2016 for Head Start/Early Head Start families, the Howard Lake-Waverly-Winsted school district approached us in the fall of 2017. The school district requested we expand our operations to serve the needs of their low-income students. After extensive logistics planning and execution, we are proud that our relationship continues today. Furthermore, we also expanded our Back Pack program to serve Meeker & Wright Special Education Cooperative (MAWSECO).

Overall, our strategies and innovative programming have increased the clients served by over 200%.

Always working to reduce our overhead through thrifty design, in the winter of 2018 WCCA entered into a Food Rescue partnership with a local grocer. This program will engage volunteers in giving back to the community, further creating capacity within our agency, provide partner tax incentives and overall reducing edible waste from our local grocers.

HEAD START/EARLY HEAD START

As a part of federal performance standards, Head Start (HS) and Early Head Start (EHS) must conduct a Needs Assessment every five years alongside an annual self-assessment. This allows program leadership to monitor progress on their goals. Current key goals of the program include improving the quality of programming, increasing family outcomes and strengthening school district partnerships.

In 2017, HS was able to extend the hours of programming for a limited number of centers. Two more centers will be following extended hours in the 2019–2020 school year. By increasing hours of operation, we are meeting the needs of family schedules, as well as engaging the children in an improved educational structure and curriculum. To improve the quality of programming and staff development, HS/EHS also implemented Reflective Supervision. This process allows teachers to reflect on difficult situations they encounter in a healthy and productive way. This increases the teachers' mental well-being to increase service to the children in their care. Furthermore, our increased partnerships with mental health providers have moved us from an observation-based assessment to an interactive evaluation.

Also in 2017, the program piloted a new staff position called Family Advocate in order to provide a liaison between the classroom and caregivers. This role supports the entire family by providing home visits, referrals, and increased conversation around goals with parents and caregivers. Due to the pilot's success since implementing this model, we increased capacity for Family Advocates and now employs four positions to support various centers throughout the county. This concentrated effort on a 2Gen/Whole Family approach has led to greater family outcomes.

WCCA collaborates extensively with the Monticello School District in Wright County. There are four classrooms in Monticello School where HS funded and district funded child slots are in the same rooms. These classrooms are referred to as "blended" because observers would not be able to tell which children were funded by HS, and which children were in the district funded preschool program. This model helps improve social connectedness amongst children of varying economic classes.

AGING ALLIANCE

During the 2017 strategic planning process, WCCA specifically called out the following strategies for the Aging Alliance program: (1) Implement services that meet the needs of aging adults in Wright County, (2) Evaluate how WCCA programs can help aging adults live longer in their own homes and (3) Foster strong partnerships with the county, healthcare facilities, and local nonprofit organizations. WCCA's Aging Alliance launched in 2018 and focuses on providing services for older adults with the intention of helping them live longer in their own homes. The program premiered in early spring by providing Assisted Transportation, which removes the barrier of access to basic needs such as grocery stores, medical appointments, pharmacy runs and social services appointments. The program grew rapidly throughout the year with the help of a qualified and passionate Dispatcher, who takes special care to connect the volunteer driver with the right client. This attention to detail allows the program to have an additional element of social and emotional support as the drivers and clients spend hours on the road together sharing company and reducing the risk of senior isolation.

By 2018, WCCA launched homemaker/housekeeping services with the mission of allowing older residents to be able to live

in a safe and healthy environment and reduce the risk of slips, falls and accidents while maintaining their home. The success of these two services, partnered by the county's great need for senior-focused services, allowed the agency to be awarded a Live Well at Home grant through Minnesota Department of Human Services alongside Title III funding through Central MN Council on Aging. Soon after, the agency was able to launch core services alongside their housekeeping program and begin coordinated efforts to reduce senior isolation through social events and volunteerism.

By May 2019, WCCA was serving 16 seniors on a weekly or biweekly basis through its housekeeping and chore program and over 72 seniors with Assisted Transportation. A pipeline of clients demonstrates the increasing need for these services throughout Wright County. This pipeline will continue to grow as Baby Boomers continue to age further into retirement.

2020-2022 CHNA PROCESS AND TIMELINE

The Wright County Community Health Collaborative designed a process that engaged community stakeholders throughout and included both review of existing secondary data and collection of primary data through local survey, Electronic Medical Records (EMR) data analysis, community dialogues and focus groups.

Staff of each organization provided leadership for the process designed to identify unique needs and develop localized action plans, while also identifying common themes for action community-wide.

Organizing and Partnership Development: **August–September 2017**

a. Establish the Core Committee: Buffalo Hospital, part of Allina Health, CentraCare – Monticello, Wright County Public Health and Wright County Community Action representatives.
b. Develop the MAPP Steering Committee: representatives from non-profit organizations, healthcare, schools, diverse cultural communities, businesses/chambers of commerce, law enforcement, city and county officials, subject matter experts, and other leaders in the community. This group will serve an important role as community representatives and issue experts. The MAPP Committee will be convened during several key phases of the CHNA process; including visioning, data review, and health issue prioritization. Community Benefit Advisory Council (CBAC) will serve as a base group for the MAPP Steering Committee.

Visioning: **October–December 2017**

a. Hold a Vision and Values session with the MAPP Steering Committee, facilitated by the Core Committee and external facilitator. This will produce a shared Vision and Values which will guide the work of the collaborative. This is also an opportunity to increase visibility of the partnership, build relationships, and advocate for the importance of improving community health.
b. Draft Vision and Values statements from the Visioning session and share with the MAPP Steering Committee. Collect feedback and finalize Vision and Values statement by the end of December 2017.

Data Gathering and Analysis: **October 2017-December 2018**

a. Develop and deploy local Wright County Public Health survey – develop and revise survey **April-May 2018**, send survey in **August 2018**, data analysis **November-December 2018**
b. Local Public Health System Assessment – **January 1, 2017-December 31 2017**
c. Forces of Change Assessment and Assets discussion – **May 7, 2018**
d. Gather publicly available data that can inform health issue prioritization and planning – **October 2017-August 2018**

e. Wright County Public Health: Health Equity Data Analysis – **October 2017-April 2018**
f. Gather local health indicators through Electronic Medical Records (Buffalo Hospital, part of Allina Health and CentraCare – Monticello) – **April –August 2018**
g. Wright County Community Action Community Needs Assessment – **January – August 2018**
h. Gather community anecdotal data (Wright County Fair) – **July 18-22, 2018**

Prioritize Health Issues:

August 2018- January 2019

a. Convene MAPP Committee in a data review session and start prioritization of health issues – **August 13, 2018**
b. Gather community input through dialogues and focus groups in the community
c. Analyze data to identify the top 3 priorities to become the focus of future CHNA planning work.

Develop Action Plans: **January-May 2019**

a. Collaborative produces joint action (implementation plan) focusing on top 3 chosen priorities and joint tactics/activities to address those priorities.
b. Conduct Community Action Summit to share results of Community Needs Assessment and develop the tactics to address social determinants of health – **May 30, 2019**
c. Met with local coalitions, advisory groups and task forces to align activities and build relationships with community partners.

Implementation and Monitoring of Action Plans:

2020 – 2022

a. Celebrate successes - final MAPP Committee meeting and/or communication to review action plans and celebrate accomplishments thus far.
b. Begin implementation of 2020-2022 plans.
c. Regular meetings to further implementation and monitor progress.

DATA COLLECTION AND COMPARATIVE ANALYSIS

Wright County Community Collaborative utilized a variety of information and data sources along with gathering community input to analyze and prioritize community health issues. The data sources included:

- **Minnesota Student Survey**
- **US Census Bureau (demographic data)**
- **Feeding America (food insecurity)**
- **US Department of Education**
- **CDC and US Department of Health and Human Services data**
- **US Department of Agriculture statistics**
- **US Department of Labor**
- **County Health Rankings**
- **US Department of Health and Human Services**
- **Dartmouth College Institute for Health Policy and Clinical Practice (chronic conditions data)**
- **Electronic Medical Records (EMR) data from local healthcare providers**
- **Data gathered from local focus groups, community dialogues, visioning and community events**

The challenges of analyzing the data from above mentioned sources included lack of consistency in interpretation of the data, applicability of the data in relation to the health issues the county was facing, time related concerns (in many cases, most recent data available was two or three years old) and most important, lack of unbiased, consistent, measurable information collected directly from the community the collaborative group served.

In early 2015, the idea of conducting a local, current health survey was introduced by Wright County Public Health. With the support of local healthcare systems (Buffalo Hospital, part of Allina Health, and CentraCare Health—Monticello), the survey was administered to Wright County residents in 2015, and again in 2018, when Wright County Community Action joined the collaborative.

2018 COMMUNITY HEALTH SURVEY RESULTS

BACKGROUND:

- The paper survey was mailed to 8,000 people; 1,600 in each of the five commissioner districts.
- Probability sample; by address and adult with most recent birthday.
- Two copies of survey sent with postcard reminder in between.
- In 2015, the survey had 2089 completions – 26.1% response rate.
- In 2018, the survey had 2039 completions - 25.5% response rate.
- Data statistically weighted to account for sample design and differential response by gender and age.
- Funding for the survey was received from Minnesota Department of Health (SHIP program), CentraCare – Monticello and Buffalo Hospital, part of Allina Health. Due to limited funding, in 2018 the survey was shortened from six to four pages. However, the questions used for comparative analysis were not changed to help ensure consistency and comparability.

TOP 5 HEALTH ISSUES FACING WRIGHT COUNTY

Top five issues identified in the 2018 survey are the same as those identified in 2015 -
People's attitudes are shifting to serious problem as responses for top 5 issues facing Wright County

2018	Moderate/Serious Problem
1. Distracted Driving	**83%**
2. Obesity	**66%**
3. Lack of Physical Activity	**65%**
4. Illegal drug use among teens	**63%**
5. Illegal drug use among adults	**59%**

Obesity	**According to height and weight status that respondents provided in their survey, it shows that 29% are considered obese. The overweight and/or obese survey respondents represent 2 in 3 adults.** **- 42% reported consuming 5 or more servings of fruits/vegetables day yesterday** **- 28% reported 30 minutes or more of moderate exercise 5-7 days per week**

Utilization of Health Care during past 12 months and "Foregone Care"	**20% delayed or did not get needed Medical Care** **- Most common reason: Not serious enough (48%)** **24% delayed or did not get needed Dental Care** **- Most common reason: Cost too much (59%)** **12% delayed or did not get needed Mental Health Care** **- Most common reason: Not serious enough (41%)**

General Health Status and Behaviors	**- 93% of adults report their health as good/very good/excellent** **- 11% of adults report being smokers** **- 73% of adults report any alcohol use in the past 30 days** **- 27% report ever being told by a doctor that they had any mental health problem** **- 33% reported at least one day of not good mental health in the past 30 days** **- 16% of adults reported that they worried about food running out during the past 12 months**

Distracted Driving	**People feel that distracted driving is a problem/an issue in their community, yet many continue to acknowledge they engage in distracting activities while driving;** **- 42% report reading or sending texts (often and sometimes)** **- 85% report making or answering a phone call (often and sometimes)** **- 44% report they eat, shave or put on make-up, do other activities (often and sometimes)**

Better	2015	2018
High blood pressure/hypertension	26.3%	23.9%
High cholesterol or triglycerides	28.9%	27.6%
0 not good physical health days in the last 30 days	58.1%	66.4%
0 not good mental health days in the last 30 days	64.4%	67.2%
0 servings vegetables yesterday	14.5%	11.0%
0 servings fruit/fruit juice yesterday	17.4%	15.3%
0 servings fruits/vegetables yesterday	6.5%	3.7%
5+ servings fruits/vegetables yesterday	35.8%	41.6%
"Never" worried about food running out during the past 12 months	70.3%	84.4%
Participate in any physical activity during the past 30 days	82.9%	86.0%
Moderate exercise 5-7 days per week	25.0%	27.7%
Vigorous exercise 3-7 days per week	25.7%	30.6%
Current cigarette smoking	11.5%	10.6%
Any alcohol drinking in past 30 days	76.3%	72.8%

Worse	2015	2018
Asthma	9.6%	12.0%
Anxiety or panic attacks	15.9%	18.0%
Delayed dental care during the past 12 months	19.9%	23.7%
Current smokers who tried to quit during the past 12 months	48.2%	44.9%
Drivers who make or answer a phone call "often" while driving	18.1%	20.8%

DATA REVIEW AND ISSUE PRIORITIZATION

Approximately 150 stakeholders representing broad interests of the community and 40 community organizations participated in key informant interviews and/or attended at least one of several meetings between October 2017 and March 2019 to review and discuss the above data and help identify three priority health issues. Agencies represented at these meetings include:

Allina Health Clinics
Buffalo-Hanover-Montrose School District
Buffalo Hospital Foundation
Buffalo Hospital, part of Allina Health
Buffalo Rotary
Catholic Charities
CentraCare Clinic
CentraCare Health - Monticello
Central MN Council On Aging
Central MN Mental Health Center
Community members
Crisis Nursery
Crow River Food Council
Dassel-Cokato Early Childhood Education
DBT® and EMDR® Specialists
Forgotten Harvest
Family Youth Community Connections
Howard Lake-Winsted-Waverly School District
Integriprint Printing
Love INC
Minnesota Department of Health
Marion O'Neill, MN House of Representatives
Monticello Help Center
Rivers of Hope
Safe Communities of Wright County
Solutions Counseling
STRIVE Therapy
Timber Bay
Virginia Piper Cancer Institute, Buffalo Hospital
Wright County Sheriff's Office
Wright Choice
Wright County Commissioner
Wright County Community Action
Wright County Health and Human Services
Wright County Historical Society
Wright County Public Health
Wright County Public Health Task Force
Wright County Area United Way
Youth First

The review process included a formal prioritization tool known as the Hanlon method, which includes ranking health priorities based on three primary criteria: the size of the problem, including projection of future trends; the seriousness of the problem, including disparate health burdens within the population; and the effectiveness and feasibility of interventions on the part of health care.

FINAL PRIORITIES

Through this process, three priorities were identified for action in 2020-2022:

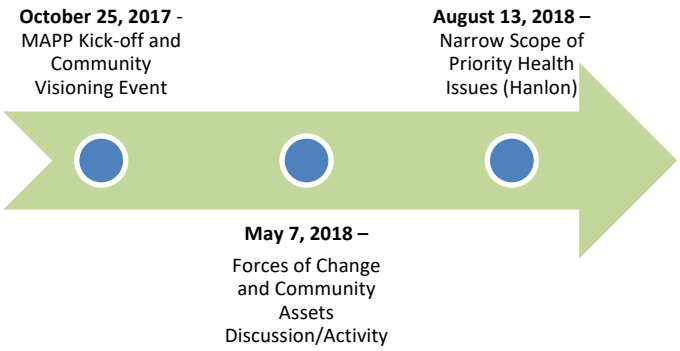
1. Mental Health and Wellness
2. Dental Care
3. Substance Use and Abuse

COMMUNITY INPUT

Informal conversations over coffee is where our journey started and was ultimately nurtured by a two day training opportunity in May of 2017 on Mobilizing for Action through Planning and Partnership (MAPP). All organizations involved in the Wright County Community Health Collaborative were able to attend. Shortly after this training in one of our meeting we all agreed upon that it made sense to use the MAPP model and committed to each other we were in this journey together.

MAPP Prioritization Meeting

A group of health professionals in Wright County are working together to roll out a new approach to how we assess health in our communities and implement a community driven process for improving health. Representatives from Allina Health—Buffalo Hospital, CentraCare - Monticello, Wright County Community Action and Wright County Public Health began meeting in the summer of 2016, to set the stage for completion of a community wide health assessment and health improvement process to be completed by the summer of 2019.



Developing a healthy community does not just happen; it requires a conscious and careful approach. The model we have chosen to use is MAPP; National Association of County and City Health Officials (NACCHO) states that "this framework helps communities prioritize public health issues, identify resources for addressing them and take action to improve conditions that support healthy living. MAPP is generally led by one or more organizations and is completed with the input and participation of many organizations and the individuals who work, learn, live and play in the community."

On October 25, 2017, the collaborative conducted a Community Visioning event. The goal of the event was to help advance collaborative work on the Community Health Needs Assessment in Wright County by identifying gaps, challenges, creating potential partnerships and developing a community vision. Fifty representatives from various community organizations and groups attended the event and helped the collaborative frame the community health vision and create common understanding of what a healthier community would look like in years to come.

MAPP Prioritization Meeting

Community Conversation – May 7, 2018
As part of the overall assessment process, the collaborative conducted a conversation with community partners to share data on specific topics, facilitate small group discussion and gather input that would further define potential priority health issues. Data was gathered from a variety of sources and shared with the large group before breaking into smaller groups. The collaborative core group members facilitated Forces of Change Assessment among the attendees.

Forces of Change Assessment identifies all the forces, associated opportunities and threats that can affect, either now or in the future, the community and local public health system.

Areas included in Forces of Change discussion:
Economic
Technological
Social
Environmental

Question posed with each one of the forces discussed: How does this force of change pose a threat or opportunity to the health of our community?

The collaborative also assessed Community Assets as strengths in the community the group collectively serves. The group gathered input from the participants on the following areas:

- Skills, Talents and Experience of Community Members
- Neighborhood Associations and other Social Groups
- Sense of History
- Community Pride
- Community Reputation

Narrow scope of community priority issues
On August 13, 2018, the collaborative conducted a targeted prioritization session involving Community Benefit Advisory Council (CBAC) and Wright County Task Force members to better understand which issues are rising to the top as major health concerns in Wright County. The session utilized the Hanlon method.

Developed by J.J. Hanlon, the Hanlon Method for Prioritizing Health Problems is a well-respected technique which objectively takes into consideration explicitly defined criteria and feasibility factors. Though a complex method, the Hanlon Method is advantageous when the desired outcome is an objective list of health priorities based on baseline data and numerical values. Hanlon helps prioritize the issues in terms of the identified areas, yet still emphasizes that feasibility should be considered when choosing what area to tackle. The prevalence (size of problem) and severity (seriousness to those impacted) help to ensure that a range of issues is explored when prioritizing, but the third element of feasibility really determines the path that makes the most sense.

As a result of the prioritization session, the collaborative arrived at 10 top health priorities facing the population of Wright County.

FINDINGS FROM KEY STAKEHOLDER GROUPS

After collecting extensive feedback and conducting community conversations and dialogues, the collaborative arrived at top 10 priorities, which were then reviewed by each organizations' stakeholder groups. Each group consisted of key stakeholders, including senior leaders and managers. All four groups focused on defining what health priorities are the most relevant to the population each organization serves, and how the population is affected by the gaps identified in the CHNA process.

Each group arrived at their own prioritized list of health issues facing Wright County. The lists were then combined by the core group and issues were again prioritized based on the rankings from individual organizations. The core group focused on the issues facing the majority of the population served and the severity and magnitude of the health

concerns. The collaborative chose the top three priorities based on true community need, versus just the ability to provide interventions. The collaborative believes that part of the solution is starting the conversation around the topics that have not yet been addressed, and engaging community partners and other organizations to assist in implementation planning and development of tactics/activities to address those priorities.

NEEDS IDENTIFIED BUT NOT INCLUDED IN THE CHNA:

Going into the Hanlon Prioritization on August 13th, 2018, the core group had a list of 20 identified health issues that needed to be discussed and arranged according to the weight of its size, seriousness and effectiveness. After all the health issues were ranked, the core group realized there were several identified issues that could be combined with top priorities. For example, Suicide Awareness and Prevention can be combined with one of the top priorities of Mental Health and Wellness. Other issues that were identified included Stress, Lack of Physical Activity and Social Connectedness/Isolation. While the core group understands that all of these issues are important and need concentrated efforts in order to resolve, they will be consciously discussed and naturally addressed in the strategies and tactics each organization creates.

While topics such as distracted driving ranked as a high need in Wright County, there are currently many groups already working on this issue and actively pursuing interventions around this concern (Safe Communities of Wright County, Highway 55 coalition, Highway 12 coalition and I94 West Chamber of Commerce).

Some of the priorities identified in 2017–2019 Implementation Plan are still relevant to the work of the collaborative (food insecurity, obesity, physical activity, access to care). The collaborative made significant strides in addressing those priorities and will continue to support the efforts around these initiatives through current workflows and service models.

IMPLEMENTATION PLAN

After confirming the top three priorities and gathering community ideas for action, Wright County Community Health Collaborative developed an implementation plan based on the input. This plan outlines the set of actions that the collaborative will take to respond to the identified community needs. Following the community dialogues and focus groups, a core group of staff from four organizations participating in collaboration worked through email, phone and in-person meetings to review and discuss the data and to draft goals and strategies for the 2020-2022 implementation plan. The three priorities and their respective goals and strategies were communicated to Community Benefit Advisory Council, hospital boards and leadership groups in the participative organizations, as well as any other interested community members.

Action sessions were then convened to develop specific objectives and evidence-based activities to support each of the goals during the three-year implementation phase.

The following implementation plan is a three-year plan depicting the overall work that the collaborative will conduct to address the priority areas. Existing resources to address each issue are also listed so as to reduce duplication and identify possible partners. Detailed objectives including timelines and measures of success will be developed in detail by the workgroups that will convene over the course of the implementation period.

The members of the collaborative will maintain organization specific work plans and commit to working as a group on at least one collective impact tactic for each identified priority over the course of the implementation period. Shared collective impact tactics will have measurable outcomes and

involve mutually reinforcing activities with the backbone support of participating organizations. The collaborative is committed to continuous communication over the course of implementation period to implement collective impact tactics.

Priority 1: Mental Health and Wellness
Resources: Currently, many partners exist in the community that have expertise in and work to support mental health initiatives, such as community mental health providers, clinics, Bounce Back Project, Mental Health Advisory Council, Community Adult Mental Health Initiative, Central MN Mental Health.

Goal: Reduce the rate of mental health care delay and the number of "not good" mental health days in Wright County

Strategies:

- Strategy 1: Address all aspects of the mental wellness continuum, including well-being maintenance, prevention of disease and intervention
- Strategy 2: Increase social connectedness and combat isolation
- Strategy 3: Education around mental illness as a medical condition
- Strategy 4: Increase awareness about suicide related issues – suicide prevention

Collective impact tactic: Implement coordinated awareness campaign educating the community about mental illness as a medical condition.

Priority 2: Dental Care
Resources: Currently, many partners exist in the community that have expertise in and work to support mental health initiatives, such as 33 dental clinics in Wright County, Children's Dental Service, Operation Grace, Apple Tree Dental, Give Kids a Smile and Dental Health Work Group – part of the Public Health Task Force.

Goal: Reduce the rate of dental care delay in Wright County

Strategies:

- Strategy 1: Increase access to dental care for all with the focus on underserved population
- Strategy 2: Educate the community about the importance of regular dental care

Collective impact tactic: Each organization involved in Wright County Community Health Collaborative will have an active participant in the Dental Health Work Group – part of the Public Health Task Force to help advance the work around dental care access in Wright County.

Priority 3: Substance Use and Abuse
Resources: Currently, many partners exist in the community that have expertise in and work to support prevention of substance use and abuse, such as Mentorship Education and Drug Awareness (MEADA) Coalition of Wright County, Opioid Action Team, Drug Court, treatment and recovery services.

Goal: Support local prevention efforts and advocate for policy changes to address substance abuse in Wright County

Strategies:

- Strategy 1: Reduce stigma related to diagnosis and treatment of addictions and substance abuse disorders, and the possible connection to mental health conditions
- Strategy 2: Provide education and address tobacco and e-cig use and access
- Strategy 3: Identify and create better linkage to appropriate available resources

Collective impact tactic: Engage in policy, system and environmental changes that reduce access to e-cigarettes among youth and adults.

The members of the collaborative are committed to working in alignment with community coalitions, task force or advisory boards whose work is already focused on these priority health issues (Mentorship Education and Drug Awareness (MEADA) Coalition of Wright County, Mental Health Advisory Committee and Dental Health Work Group – part of the Public Health Task Force).

The collaborative will work to support current intervention efforts and prevent duplication while building new or strengthening existing relationships across the community. The collaborative believes coordinated approach will have the greatest impact on addressing these priority health issues.

RESOURCE COMMITMENTS

Wright County Community Health Collaborative, through its member organizations, will commit resources during 2020-2022 to ensure effective implementation of its planned activities to meet the goals and objectives identified. Resources may include specific programs and services, charitable contributions and employee volunteerism offered by individual organizations and staff time devoted to advancing collective work.

Although each organization participating in the collaborative will commit to its' own set of tactics and activities (appropriately aligned with the mission and defined organizational purpose of each member of the collaborative), the group will collectively work on at least one common tactic/activity under each of three defined priorities and commit to measurable outcomes for those tactics at the end of the three year implementation cycle.

The group will meet in-person, via phone or web-based services on a regular basis (no less than monthly) to track progress, identify gaps and work towards successful resolution of the identified challenges.

EVALUATION OF OBJECTIVES

Throughout the implementation phase, specific metrics will be tracked to document progress toward meeting goals and objectives and make adjustments to the implementation plan as needed. Specific evaluation plans will be established or continued for programs and initiatives as appropriate. Monitoring of population-level metrics and system-wide metrics will also provide context for the health status of the communities Wright County Community Collaborative serves and the work of the collaborative group overall.

Some of the evaluation sources include but not limited to the Minnesota student survey, local Wright County survey (comparative data will be analyzed; the collaborative will strive to deploy new survey in 2021), treatment admissions, Electronic Medical Record (EMR) data, number of people reached through educational efforts and community presentations.

MAPP Community Partners

To align with their system and other partners, Allina Health and CentraCare will pursue health priorities and activities in addition to those described in the Wright County Community Health Collaborative implementation plan.

ALLINA HEALTH SYSTEMWIDE ACTIVITIES

To support local CHNA efforts, Allina Health identifies community health needs consistent across its entire system and systemwide initiatives with which to address these needs. By developing systemwide initiatives, Allina Health ensures efficient use of resources across its service area and provides hospitals with programs they can adapt to meet their community's unique needs. Thus, as part of developing its implementation plan, Buffalo Hospital staff met in February and April 2019 with leaders from each of Allina Health's nine community engagement regions to discuss the results of each hospital's data review, prioritization and community input processes. Together, they identified mental health, including substance use, as a priority need in all Allina Health geographies. Additionally, all communities identified social determinants of health, particularly access to healthy food and stable housing, as key factors contributing to health. Obesity caused by physical inactivity and poor nutrition was identified as a priority need in most Allina Health communities.

Based on this process, Allina Health will pursue the following system-wide priorities in 2020-2022:

- **Mental health and substance use**
- **Social determinants of health**
- **Healthy eating and active living**

Below are the systemwide goals and strategies that Buffalo Hospital will pursue. Though obesity was not identified as a priority in the Wright County, Buffalo will address Allina Health's healthy eating and active living priority through its social determinants of health-work, particularly increasing access to healthy food. When implementing activities, consideration is given to how these activities can best support historically underserved communities and reduce health disparities.

Mental health and substance use
Goal 1: Increase resilience and healthy coping skills in our communities
Goal 2: Reduce barriers to mental health and substance use services for people in our communities.

Strategies:

- Increase resilience among school-age youth.
- Increase social connectedness and community resilience efforts.
- Decrease stigma associated with seeking help for mental health and substance use conditions, with a particular focus on the experiences of racial and ethnic minorities and other historically underserved communities.
- Increase support of policy and advocacy efforts aimed at improving access to adolescent mental health and substance use services.

Activities:

- Offer Change to Chill programming in at least one Wright County high school each year and continue to support current Change to Chill schools as requested.
- Enhance and promote Health Powered Kids mental health and wellness programming to Wright County schools.
- Support grassroots community-based efforts around resilience, including social-connectedness.
- Enhance mental health and substance use stigma elimination programming in the Change to Chill program.
- Promote stigma elimination education and messaging, particularly in May and October.
- Support and advocate for policies aimed at increasing number of and accessibility to mental health and substance use services.

Social Determinants of Health
Goal: Reduce social barriers to health for Allina Health patients and communities.

Strategies:

- Implement a sustainable, effective model to systematically identify and support patients in addressing their health-related social needs.
- Implement a sustainable network of trusted community partners who are able to support our patients in addressing their health-related social needs.
- Increase support of policy and advocacy efforts aimed at improving social conditions related to health.
- Improve access to healthy food in our communities.

Activities:

- Support the successful implementation and evaluation of the Accountable Health Communities model at participating sites.
- Champion development of and support transition to an Allina Health system-wide strategy and care model to identify and address the health-related social needs of our patients.
- Implement a process to identify key community partners and support their sustainability through financial contributions, exploration of reimbursement models, employee volunteerism and policy advocacy.
- In partnership with Allina Health and community stakeholders, design and implement a process to facilitate tracked referrals to connect patients to community resources.
- Participate in and support community coalitions aimed at improving access to transportation, housing and food, including connecting Allina Health resources, expertise and data to these groups as appropriate.
- Work with community organizations to improve access to healthy food in the communities we serve through grant-making, charitable contributions, employee volunteer opportunities and innovative community partnerships.

CENTRACARE CENTRAL MINNESOTA SYSTEMWIDE ACTIVITIES

To increase success in meeting the needs of the community, the public health agencies in the counties of Benton, Sherburne, and Stearns, along with CentraCare in those counties (including St. Cloud Hospital, CCH- Melrose, CCH- Paynesville, and CCH- Sauk Centre), have developed a partnership called the Central MN Alliance. With the formation of the Central MN Alliance, the CHNA process and prioritization of community health issues is broadly focused on community issues rather than the traditional disease conditions the hospitals previously focused on. The new framework relies on a mixture of national, state, and local data.

The Central MN Alliance agreed to utilize the MAPP (Mobilizing for Action through Planning and Partnerships) process to conduct the Community Health Needs Assessment and prepare the Implementation Strategy. The partnership agreed to follow the hospital IRS requirement of a 3-year timeframe. On April 24, 2018, the first meeting was held of the Central MN Alliance. The members of this partnership include Benton County Human Services, Public Health; CentraCare, Population Health; Sherburne County Health and Human Services, Public Health; and Stearns County Human Services, Public Health Division. These relationships have been building over time and as a result, a more formal structure of this community partnership was developed. To that end, all agencies had staff attend May 2017 training on the MAPP (Mobilizing for Action through Planning and Partnerships) process that was sponsored by NACCHO (National Association of County and City Health Officials). Several meetings were held between May 2017 and April 24, 2018 to create a unified Community Health Needs Assessment and Implementation Strategy.

The work of each of the four MAPP Assessment sub-groups resulted in four lists of 10 community priorities. The Core Support Team talked with their agency staff to identify any themes or commonalities amongst the four lists. They then came together and went through a facilitated

process using the Central MN Alliance Vision as a guide to finalize a top 10 list. A decision was made to focus on the top two priorities for the Implementation Strategy for 2019-2022. Although the priorities three through ten will not specifically be addressed through action planning or measurement, there are ways many of these priorities are being addressed either within the top two priorities or the community. In the future, the group will assess the capacity to expand the number of priorities being addressed and measured.

THE CENTRAL MN ALLIANCE PRIORITIES

	Priority	Examples
1	**Building Families**	Individual/family intervention, child well-being, parenting skills
2	**Mental Health**	Awareness, access, well-being, addiction
3	**Encouraging Social Connection**	Across the age spectrum, social connections, community intervention
4	**Adverse Childhood Experiences (ACEs)**	Awareness, cultural, preventative measures, leading to chronic disease
5	**Tobacco/Nicotine Use**	E-cigarettes, addiction
6	**Health Care**	Access, cost
7	**Risky Youth Behavior**	Education, trafficking, mental health, safety, homelessness, alcohol/tobacco/other drugs
8	**Financial Stress**	Living wage, unemployment, affordable living
9	**Trauma**	Across the lifespan
10	**Educating Policy Makers and Key Community Stakeholders**	Educating on emerging issues in the community

ACKNOWLEDGEMENTS

Wright County Community Health Collaborative would like to thank many partners who made this assessment and plan possible:

• Individual community members who offered their time and valuable insights;

• Partner organizations that met to review and prioritize data and develop implementation plans and the individuals who contributed their expertise and experience to ensure a thorough and effective outcome;

• Member organization's staff who provided knowledge, skills and leadership to bring the assessment and plan to fruition;

• Members of the CHNA steering team, representing the two hospitals, public health department and community action organization all serving the population of Wright County.

Wright County Community Health Collaborative members

CONCLUSION

Wright County Community Health Collaborative will work diligently to address the identified needs prioritized in this process by taking action on the goals and objectives outlined in this plan.
For questions about this plan or implementation progress, please contact a member of the CHNA core steering team:

Janna Netterfield, Buffalo Hospital, part of Allina Health – janna.netterfield@allina.com

Mona Volden, Buffalo Hospital, part of Allina Health – mona.volden@allina.com

Joel Torkelson, Wright County Public Health – Joel.Torkelson@co.wright.mn.us

Sarah Grosshuesch, Wright County Public Health - Sarah.Grosshuesch@co.wright.mn.us

Melissa Pribyl, CentraCare – Monticello - pribylm@centracare.com

Amy Kortisses, Wright County Community Action - AKortisses@wccaweb.com

Candice Zimmermann, Wright County Community Action - CZimmermann@wccaweb.com

Allina Health
BUFFALO HOSPITAL