Community Health Improvement Plan 2023-2027

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Horizon Public Health

Douglas, Grant, Pope, Stevens, and Traverse Counties

Approved by the Horizon Public Health Community Health Board
March 13, 2023

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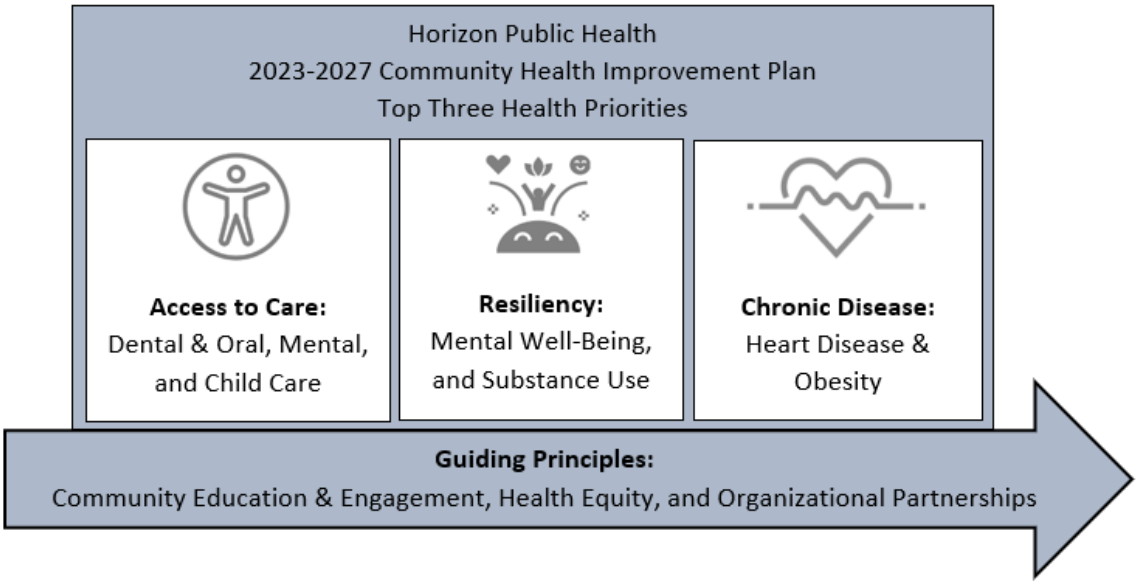
EXECUTIVE SUMMARY

Local public health in Minnesota seeks to improve the health of the people living in its jurisdiction through community health assessments and community health improvement plans. Horizon Public Health realizes that planning process and plans related to the community, need to engage the community intentionally and authentically.

Horizon Public Health convened a Community Partner Leadership Team (CLT) consisting of a wide representation of community sectors to ensure a community-infused assessment and planning process. The CLT used the Mobilizing for Action through Planning and Partnerships framework to complete a Community Health Assessment (CHA) which assisted in identifying health priorities to complete a Community Health Improvement Plan (CHIP). The CLT identified the following as the top health priority areas for 2023-2027 CHIP:



This CHIP guides the community in the development of initiatives, strategies, and polices aimed at addressing the top three priority areas. Over the past five years, workgroups and partners implemented strategies from the 2019-2022 CHIP. They achieved successes and developed strong partnerships even in the face of the COVID-19 pandemic. The 2023-2027 CHIP builds on these community achievements and challenges.

The CLT's role does not end with the drafting of this plan. This team will implement, monitor, and update the CHIP as well as ensure alignment with other local plans to better address the many factors that influence health. The CHIP relies on strong partnerships and highlights the critical role of community partners in improving health outcomes in the communities that Horizon Public Health serves.

The National Public Health Accreditation Board (PHAB) standards require local public health agencies to participate in or lead a collaborative process that engages community to produce a CHA and a CHIP. MN Statute 145A also requires local public health agencies in Minnesota to update and revise such a plan at least every five years.

If you have any questions, please contact:

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Horizon Public Health Mission Statement

Work in partnership with individuals and communities in creating an environment that promotes the health and improves the well-being of all people in Douglas, Grant, Pope, Stevens, and Traverse Counties.

Horizon Public Health

OVERVIEW AND VISION

Horizon Public Health serves the rural counties of Douglas, Grant, Pope, Stevens, and Traverse in West Central Minnesota which spans 2,987 square miles. The area is largely agricultural, rural, and with its lakes, is a recreational gem.

2022 Estimated Population by Age Group						
	Douglas	**Grant**	**Pope**	**Stevens**	**Traverse**	**Horizon**
TOTAL Population	**39,238**	**6,153**	**11,403**	**9,700**	**3,286**	**69,780**
% Change 2010-2020	7.7%	0.9%	2.6%	-0.5%	-5.9%	+5.2%
% Projected +/- 2030	*+2.8%*	*-2.8%*	*-1.1%*	*+0.4%*	*-12.5%*	*+1.1%*

Source: U.S. Census Bureau, Population

Key Demographic Data Points & Trends:

- Horizon Public Health's population is growing slower than the state overall population (3% compared to 7% respectively),
- Over the next three decades, Douglas County is expected to have the largest increase in population growth and Traverse County will experience the most significant decrease in population rates,
- Residents ages 65 and older will continue to become a larger share of the population, growing to nearly 30% of the total population by 2030,
- Four counties (Douglas, Grant, Pope, and Traverse) have a higher percentage of Veterans residents than the state average, and
- While not as culturally diverse as the state of Minnesota, the region is home to a growing Hispanic population, particularly in Stevens County.

Community Health Improvement Planning:

The purpose of the Horizon Public Health Community Partner Leadership Team (CLT) is to leverage community strengths, resources, and lived experiences to improve the health and quality of life for all Douglas, Grant, Pope, Stevens, and Traverse counties. The CLT serves as a steering committee for the Community Health Assessment and the Community Health Improvement Plan. The CLT team members:

- Assess community needs and advise on strategic priorities for project implementation,
- Include and engage at-risk populations to form solutions that address health disparities,
- Cultivate and attract new partners, create organizational strategic partnerships, and support collaborative efforts for efficiency, effectiveness, and reach,
- Explore and utilize data-driven solutions to create sustainable policy, systems, and environmental changes,
- Share best practices and advocate for equitable health opportunities in the community, and
- Promote awareness of project impacts and accomplishments.

How can different community sectors and individuals use the CHIP?

Healthcare (Hospitals, Health Centers, and Private Physicians) can:

- Understand the priority health issues, remove barriers, and assist with the implementation of strategies or interventions,
- Assist in coordinating programs to reduce redundancy or duplication of efforts,
- Share evaluation data on programs that are addressing the prioritized health issues, and
- Assist with the evaluation of strategies.

Public Health Professionals/Government Agencies can:

- Use this document in preventative and educational efforts,
- Work and collaborate with healthcare partners to update strategies for each health issue,
- Evaluate strategies, outcomes, and outputs, and
- Share relevant and local public health data with partners.

Community and Faith-Based Organizations can:

- Understand the prioritized health issues, and get involved in supporting strategies that improve community health,
- Advocate with members of your organization about the importance of overall wellness and local community health improvement efforts,
- Identify opportunities within your organization/agency to support and encourage participation in the prioritized strategies and interventions, and
- Provide information or evaluation data on efforts of strategies implemented to the steering committee describing how the program or intervention is working in your organization.

Academia (Schools & Colleges) can:

- Understand the prioritized health issues identified in the county, and help by addressing them in school or college program curriculum planning,
- Create a healthier academic environment by aligning the CHIP strategies in wellness plans or policies, and
- Assist in the promotion or creation of resources that promote community health.

Businesses can:

- Use the recommended strategies to make your business a healthy place to work, and
- Provide opportunities for wellness and healthy eating for your employees.

Residents can:

- Get involved in improving community health by volunteering to be part of an initiative or program targeting one of the health issues identified through a community or faith-based organization, and
- Take an active role in your health and well-being by eating healthy and getting the proper exercise and preventative screenings.

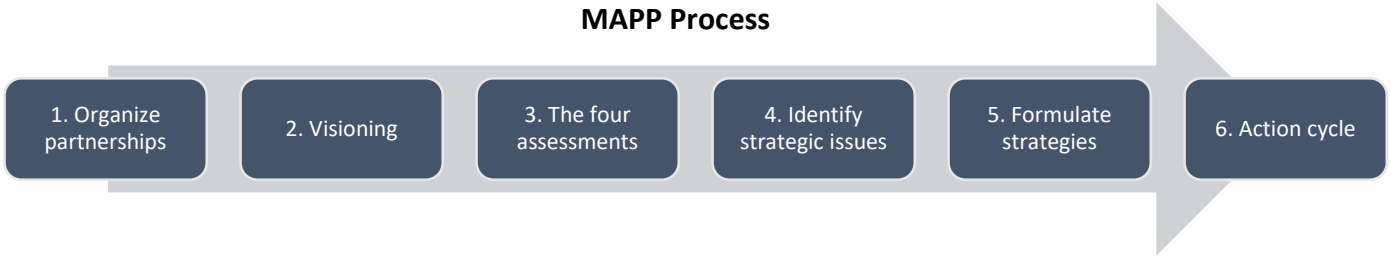
Horizon Public Health

PLANNING PROCESS

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-wide strategic planning process for improving public health. This framework helps communities prioritize public health issues, identify resources to address them, and take action to improve conditions that support healthy living.

Horizon Public Health, together with the CLT, took a modified MAPP approach to 'right-size' the process due to our unique population as well as due to the COVID-19 pandemic. Much of this process was being conducted as our communities were continuing to respond to the COVID-19 pandemic.

MAPP Process



Community Input Process

From the summer of 2020 through the first few months of 2022, Horizon Public Health worked to collect data to describe the health status and key health concerns of the residents who reside in Douglas, Grant, Pope, Stevens, and Traverse counties.

The input and information gathered during the process were analyzed and presented back to the CLT for prioritization. This process was used to gear alignment on shared priorities and sets the foundation for the implementation plan of the CHIP.

Community Health Assessment development…

- *July 2020:*
  The CLT met virtually to lay out the preliminary process for the next CHA-CHIP cycle. This meeting included an opportunity for the CLT to determine the data needed, individuals and agencies that will be involved, and a proposed timeline of the process. *Note: as the vaccine for COVID-19 became available and many of the agencies responding to the pandemic were also a part of the CLT, the process of data collection was paused.*

- *June 2021 - February 2022:*
  Comprehensive data collection began throughout the five counties to collect quantitative and qualitative data. Community conversations and focus groups were held to collect qualitative data. Additional online surveys using the Community Health Status Assessment and the Local Public Health System Assessments were completed.

- *March-May 2022:*
  Final data was gathered and compiled into our draft CHA document.

- *June 2022:*
  Seven CLT meetings were held to review the data sections of the CHA utilizing the ORID framework (Objective, Reflective, Interpretive, and Decisional). From these meetings a one-page introduction was created for each data section; Key Data Points & Trends, Strengths of the Community, Insights from the Data, and Considerations for Action to help identify, develop, and target CHIP initiatives.

- *August 2022:*
  Final version of CHA was approved by the Horizon Community Health Board. Data from this document was used to identify and develop the CHIP.

Community Health Improvement Plan Development…

- *September – November 2022:*
  Three data prioritization meetings were held in partnership with the CLT to help identify the CHIP priority areas. To make the process as accessible as possible, multiple methods of feedback and input were available for these meetings. This included offering online engagement, giving people time to provide feedback between meetings, and connecting with partners outside of meetings to gather input and feedback. Throughout this process, more than 3,000 voices were heard across the community through surveys, focus groups, community conversations, and community meetings. Based on these meetings, and additional input received, three priority areas were identified to focus the collaborative work over the next five years.

Participation breakdown of the CLT			
Health	31%	Law Enforcement	8%
Government – County	23%	Education K-12th	5%
Non-Profit	15%	Other	5%
Health – Hospital	10%	Education – Post Secondary	3%
Education – Early Childhood	8%	Health – Long Term Care	3%
Government - State	8%		

Prioritization Meeting #1: Prior to the first meeting, a survey was emailed to all the CLT members to ask them to rank and rate all (50+) health topic categories that are in the CHA (by level of community need and seriousness of the issue). The topics were sorted into three categories to present the data: Health Conditions, Health Behaviors, and Factors Influencing Health. A virtual meeting was held to review the responses and receive input to determine which topics carried to the next round of prioritization.

CHIP Topic Prioritization: Survey #1 Results

Health Conditions	#	%
Mental Health/ Depression	39	100%
Overweight/ Obesity	31	79%
Cancer (all types)	26	67%
Diabetes/ Pre-Diabetes	18	46%
Suicide	18	46%
Heart Disease	14	36%
Alzheimer's	12	31%
High Blood Pressure	9	23%
COVID-19	6	15%
High Cholesterol	3	8%
STD	3	7%
Unintentional Injury	3	8%
COPD	2	5%
Other	2	5%
Parkinson's	1	3%
Stroke	1	3%
CLRD	0	0%
Influenza/ Pneumonia	0	0%
59 Individuals invited to participate		
39 responses received (66% response rate)		

Health Behaviors	#	%
Alcohol & Drug Use/ Adults	32	82%
Physical Inactivity	29	74%
Screen Time	29	74%
Alcohol & Drug Use/ Youth	26	67%
Unhealthy Eating	25	64%
Tobacco & E-cig/ Youth	21	54%
Tobacco & E-cig/ Adults	10	26%
Unsafe Driving Habits	9	23%
Prenatal Care (lack of)	4	10%
Breastfeeding (low rates)	1	3%
Teenage Pregnancy	1	3%
Other	1	3%
59 Individuals invited to participate		
39 responses received (66% response rate)		

Factors Influencing Health	#	%
Adverse Childhood Experiences	36	92%
Poverty	30	77%
Child Care	26	67%
Housing/ Renting	26	67%
Transportation	25	64%
Health Care Access/ Quality	17	44%
Child Maltreatment	11	28%
Broadband Access	8	21%
Educational Access/ Quality	6	16%
Immunizations	3	8%
Radon	1	3%
Other	1	3%
Arsenic	0	0%
Lead	0	0%
Nitrate	0	0%
Vector Disease	0	0%
59 Individuals invited to participate		
39 responses received (66% response rate)		

The topics which had more than 25% of the CLT vote were carried to next round of prioritization and are noted here:

CHIP Topic Prioritization, Community Partner Leadership Team Top 25%

Health Conditions:

- Mental Health and Mental Illness
- Overweight and Obesity
- Cancer (all types)
- Diabetes and Pre-Diabetes
- Suicide
- Heart Disease
- Alzheimer's and other Dementia

Health Behaviors:

- Alcohol and Drug Use/Adults
- Physical Inactivity
- Screen Time
- Alcohol and Drug Use/Youth
- Unhealthy Eating
- Tobacco and E-cig/Youth
- Tobacco and E-cig/Adults

Factors Influencing Health:

- Adverse Childhood Experiences
- Poverty
- Child Care
- Housing and Renting
- Transportation
- Health Care Access and Quality
- Broadband Access

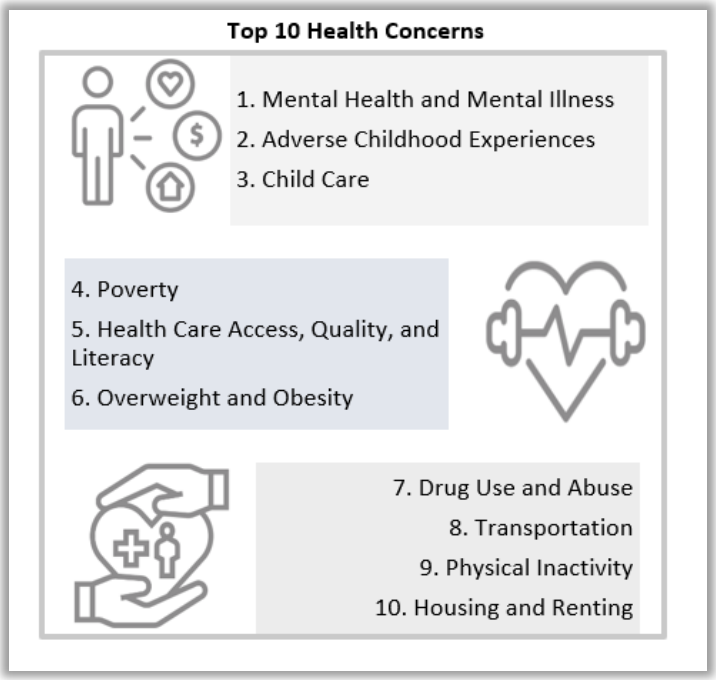
Prioritization Meeting #2: Prior to the second meeting, the CLT was surveyed and voted again to consider explicitly defined criteria and feasibility factors for the 21 health topics prioritized during the first meeting. The survey asked CLT members to use a 1 to 5 scale to rate each health topic on five criteria: potential impact, ability to address disparities, feasibility, and passion to act. 53% of the CLT participated in the second online survey. Using the survey results, average scores and a summary score, which placed greater emphasis on impact (weighted x3) and ability to address disparities (weighted x2), were calculated for each topic. The results are noted on the table below.

During the second meeting, which was virtual, the topic prioritization table was discussed using the ORID framework (Observation, Reflective, Implication, and Decision/Action), which was also used early on in the CHA process. The CLT was given the opportunity to apply a qualitative approach to the results to be able to then group and combine to identify the top three health priority areas.

CHIP Topic Prioritization Table, meeting #2

TOPIC	Impact	Address Inequities	Passion	Feasibility	Summary Score
Mental Health and Mental Illness	4.7	4.3	4.2	3.9	28.5
Adverse Childhood Experiences (ACEs)	4.5	4.2	3.9	3.6	27.2
Child Care	4.6	4	3.3	3.6	26.7
Poverty	4.5	4.5	3.4	3.1	26.5
Health Care Access, Quality, and Literacy	4.3	4.4	3.4	3.8	26.5
Overweight and Obesity	4.4	4.1	3.3	3.8	26.4
Drug Use and Abuse	4.4	4	3.2	3.8	26.2
Transportation	4.3	4.5	2.9	3.5	25.8
Physical Inactivity	4.3	3.8	3.2	3.8	25.7
Housing and Renting	4.3	4.4	3	3.1	25.4
Suicide	4.1	3.5	3.3	3.5	24.6
Unhealthy Eating	4	3.9	3.2	3.4	24.5
Diabetes and Pre-Diabetes	4	3.6	2.9	3.7	24.2
English Language Learner	3.6	4.5	2.8	3.8	23.9
Alcohol Use and Abuse	4	3.2	3.1	3.4	23.7
Broadband Access	3.8	4	2.5	3.7	23.6
Heart Disease	3.8	3.5	2.7	3.6	23.2
Cancers (all types)	3.9	3.3	2.7	3.4	23.1
Dementia and Alzheimer's Disease	3.7	3.1	2.9	3.2	22.3
Tobacco and Electronic Cigarette Use	3.7	3.1	2.4	3.3	21.9
Screen Time	3.6	3	2.5	3.1	21.4

Prioritization Meeting #3: the final data prioritization meeting was held in a hybrid format. At this meeting, the CLT applied the framework of Results Based Accountability (RBA) to sections of the identified 2023-2027 Priority Areas. Moving to an RBA model is a way to ensure accountability so the whole community, public and private, must share responsibility for results.



RBA involves a process that can help direct the work of creating a strategy for improving the well-being of a population or subpopulation in a geographic area.

RBA uses data-driven, decision-making processes to help communities organize and move problems into action. Horizon Public Health staff guided the CLT through a 'turn the curve' exercise by answering four questions about the top three identified priority areas:

1. How are we doing?
2. What is the story behind the curve?
3. Who are the partners who have a role to play in turning the curve?
4. What works to turn the curve?

Development of CHIP Action Plans:

Following the planning and strategy meetings, the CLT worked to identify the 2023-2027 goals, objectives, and action plan for each priority area.

Priority Area #1 Access to Care:

Access to care is of vital importance to maintain optimal health, increase life expectancy, and improve quality of life. Access to care was selected as a significant health need to be addressed due to its impact on individual health outcomes, as well as the economic vitality of the community. The pandemic led to delays in care and continues to have an impact on mental health. Multiple strategies are needed to address rural workforce shortage gaps potentially exacerbated by the COVID-19 pandemic.

Dental and Oral Health Care: To improve access to health care there is a need to recruit more providers and specialists to care for the elderly and young children. A strategy to increase access to dental care for older adults with Medicaid coverage, particularly those in long-term care facilities or with transportation barriers is necessary. Ongoing education to parents about preventative services and care prior to children getting their first tooth and permanent teeth is another important strategy.

Mental Health Access: Over one-third of residents (36-46%) reported experiencing poor mental health one or more days in the past month with 14-23% of adults having experienced depression or anxiety. Mental health is a critical component of overall health and multiple strategies are needed to ensure individuals experiencing challenges can connect with others easily for support and treatment. Local actions may focus on increasing access for youth and residents who have experienced trauma or other Adverse Childhood Experiences (ACEs).

Child Care Access: The lack of child care access is continuing to negatively impact our community through employment, income, and community vitality. Reductions in child care options present challenges for working parents and require creative strategies.

Priority Area #2 Community Resilience:

Breaking the cycle of adversity and trauma must include building hope and resilience for children and families. Adverse Childhood Experiences (ACEs) can increase a person's risk for chronic stress and use of adverse coping mechanisms can result in lifelong chronic illness such as depression, heart disease, obesity, and substance abuse. Mental health and substance use disorders are the leading disease burden in the United States.

In the Horizon Public Health counties, over one-third of residents reported experiencing poor mental health for one or more days in the past month with 14-23% of adults having experienced depression or anxiety. Data showed notable changes in self-reported mental health conditions and drug overdoses between 2016 and 2020. COVID-19 continues to have an impact on the prevalence of anxiety and depression, contributing to poor mental health.

Priority Area #3: Chronic Disease:

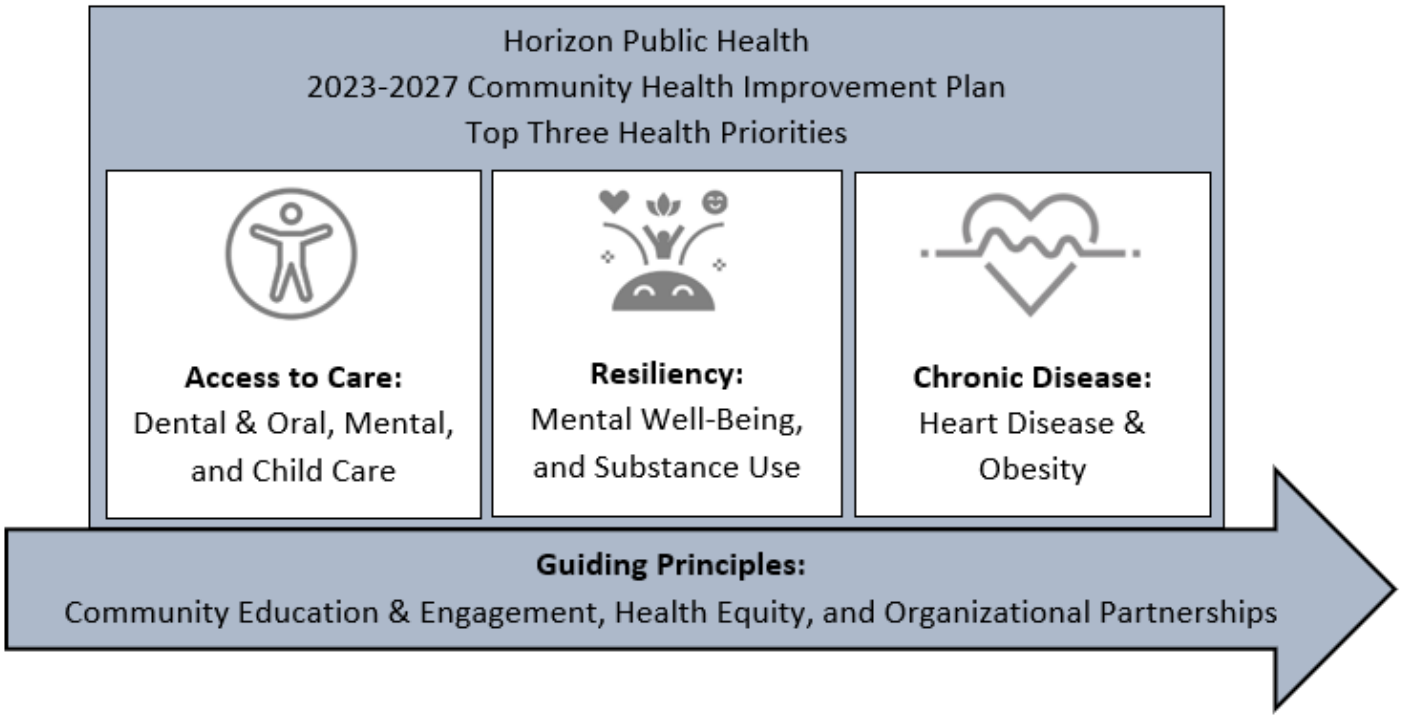
Heart disease is the leading cause of death in Horizon Public Health counties. The percentage of adults with high blood pressure is higher in each county than the statewide average, while diabetes rates are higher than the state average in all but Stevens County. With heart disease as the leading cause of death and high blood pressure rates higher than the statewide average, a combination of strategies needs to be considered to encourage heart health.

The rising obesity trend is one of the multiple factors contributing to poor heart health. Behaviors such as excessive eating and physical inactivity can affect a person's weight. However, outside influences such as the absence of health education, food insecurity, and one's environment can also be factors.

Increasing opportunities for physical activity and access to healthy foods can help establish healthy behaviors to reduce obesity rates. Greater access to affordable, healthy food and access to physical activity options can help residents make good choices that result in lower rates of chronic disease and better weight control.

Guiding Principles; (Community Education & Engagement, Health Equity, and Organizational Partnerships):

Through the planning and development of the CHIP, Horizon Public Health has been intentional to include community education and engagement, health equity and organizational partnerships as guiding principles within the action plans. These principles will be applied to all priority areas to help guide and lead the work.



The process used to track the status and results of the Horizon Public Health Community Health Improvement Plan will be documented by using Clear Impact Scorecard™. This online tool was created to initiate, sustain, and reinforce the work of results-based accountability. The scorecard has the ability to foster collaboration between partners, easily share data, and track trends.

The Horizon Public Health Community Health Strategist/Accreditation Coordinator will maintain this scorecard and share the status through the Horizon Public Health website and other online resources. The scorecard will assist by improving efforts to develop and communicate a shared vision, define clear measures of progress, share data internally, share data with community partners, and simplify the way data is collected, monitored, and reported.

In addition to monitoring and evaluating the progress of the CHIP, Horizon Public Health will also collect and maintain up-to-date data. One area we are lacking is good countywide data on youth for several measurements. The great potential for youth data is the Minnesota Student Survey, which is conducted every three years. However, we at times have gaps in data. We anticipate conducting targeted data collection on CHIP implementation activities for some of the goal areas (both youth and adults) as another method for informing and monitoring our CHIP action steps.

Sustainability is an important consideration in plan development. Sustaining implementation efforts of the CHIP have been built into this plan by:

1. Supporting a strong local public health system by maintaining and developing community partnerships. These partnerships create a platform for ongoing community health improvement,
2. Utilizing a coordinated health improvement effort that broadens and builds upon successful local initiatives and engaging partners to align efforts and resources to address identified priorities,
3. Keeping the strategies and actions realistic and manageable for the community and its partners,
4. Identifying and implementing policy, systems, and environmental change strategies for sustainable solutions,
5. Reinforcing that the CHIP is a living document that will be revised as resources, environments, and situations evolve, and
6. Communicating data and reports for the public will be made available via the health department's website and other social media platforms so community members and stakeholders can stay informed and monitor progress.

Horizon Public Health and its partners are committed to working to implement, monitor, and document the strategies outlined in this Community Health Improvement Plan. The Horizon Community Partner Leadership Team will continue to work to improve and maintain the capacity and infrastructure present in the Horizon Public Health service area. This plan will be used as a guide to work collectively in engaging key stakeholders and community members to take ownership, participate in, and document strategies identified to meet the objectives outlined in this plan.

Horizon Public Health extends gratitude to the partners who participated in the development of the CHIP. This plan represents the commitments of partners to improve the health well-being of our community. We look forward to working together to realize our collective goals for a safe, healthy, and bright future together.

Horizon Public Health

ACKNOWLEDGMENTS

Horizon Community Health Board

Chair: Larry Lindor, Pope County Commissioner
Vice: Charlie Meyer, Douglas County Commissioner

Douglas County Commissioners:
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Grant County Commissioners:
Doyle Sperr, Dwight Walvatne

Medical Consultant:
Dr. Allison Juba

Pope County Commissioner:
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Stevens County Commissioners:
Jeanne Ennen, Bob Kopitzke

Traverse County Commissioners:
Dwight Nelson, Kayla Schmidt

Community Representatives:
Deb Hengel, Dennis Thompson

Horizon Community Partner Leadership Team

Stephanie Aasness	Dancing Sky Area Agency on Aging
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Kesha Anderson	Region IV South Mental Health
Tara Bitzan	Alexandria Chamber of Commerce
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Joanna Curry	Glacial Ridge Health System
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Kristin Erickson	Minnesota Department of Health
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Connie Fields	Early Childhood Initiative Douglas County
Dona Greiner	Stevens County Emergency Manager
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Betsy Hills	Horizon Public Health
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Marty Lanter	Wheaton School
Tina Lindquist	Grant County Emergency Manager
Diane Lopez	Douglas County Seniors
Whitney Lund	Horizon Public Health
Sara Lundquist	Morris Chamber of Commerce
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Kerry Michael	University of Minnesota Morris
Jeannie Pederson	Pope County Family Collaborative, Early Childhood Initiative
Jackie Peters	Alexandria YMCA
Kelsey Peterson	Horizon Public Health
Jessica Peterson	Horizon Public Health
Denise Pikarski	Browns Valley School
Amy Reineke	Horizon Public Health
Rim Riley	Pope County Sheriff
Amber Rousu	West Central MN Communities Action
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Molly Westerman	Stevens County Social Services
Darcy Zirbes	Alexandria Police

Equity Terms

Equity is a core value of public health practice and is essential to ensuring communities have access to the resources, services, and opportunities to thrive.

Cultural Sensitivity	Multicultural knowledge, awareness, and skills that support a person's ability to work and be effective with individuals who are from cultural identities different from one's self.
Diversity	The characteristics and experiences, both seen and unseen, that make everyone unique.
Downstream	Downstream interventions are designed to improve health at the individual level, for example, preventative care or disease management.
Factors Influencing Health	The conditions in the environments where people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks, commonly referred to as the social determinants of health.
Health Disparities	Refers to a higher burden of illness, injury, disability, or mortality experienced by one group relative to another. The term is linked to economic, social, or environmental disadvantage.
Health Equity	The state in which everyone has a fair and just opportunity to attain their highest level of health.
Health Equity Lens	Intentionally looking at the positive and negative impacts of proposed messages or interventions; this approach may include getting input from intended audiences.
Health Literacy	The ability of individuals to locate, understand, interpret, and apply health information to guide their decisions and behaviors.
Implicit Bias	The unconscious way our minds categorize information; unconsciously assigning attitudes, perceptions, and stereotypes to people with various identities.
Inclusion	The actions that are taken to understand, embrace, and leverage the unique identities and perspectives of all individuals so that all feel welcomed, valued, and respected.

Equity Terms

CONTINUED

Structural Vulnerability	The ways in which various institutions and practices designed to offer care and assistance can also, at times unintentionally, contribute to health risks and poor health outcomes.
Upstream	Upstream interventions continuously identify and address the root causes of health inequities; improving community conditions through system-level changes.
Vulnerable Populations	Populations who are at a greater risk of having poor health outcomes due to multiple factors and/or barriers they experience.
Equity Considerations	We embrace and acknowledge multiple dimensions of diversity and cultural identities such as, but not limited to: age, color, disability, ethnicity, gender, gender identity, mental health, national origin, physical health, pregnancy, race, religion, religious beliefs, rural, sexual orientation, socioeconomic status, urban, and/or veteran status.

**Several documents and definitions were reviewed to compile this list. The definitions above have been adapted to meet our community's needs.*
**All HPH staff and select partners had a chance to give input and provide guidance using a survey tool between January and March 2023.*

References:

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This list will be modified as needed. Developed March 2023.

Priority Area 1: Access to Care

Goal: Increase access to care in the Horizon Public Health service area.

1. Increase access to dental and oral health care, with a focus on underserved populations.
2. Increase access to mental health care services when needed.
3. Increase capacity of sustainable child care.

Problem/Issue Statement:

Access to care is of vital importance to maintain optimal health, increase life expectancy, and improve quality of life. Access to care was selected as a significant health need to be addressed due to its impact on individual health outcomes, as well as the economic vitality of the community. The pandemic led to delays in care and continues to have an impact on mental health. Multiple strategies are needed to address rural workforce shortage gaps potentially exacerbated by the COVID-19 pandemic.

Dental and Oral Health Care: To improve access to health care there is a need to recruit more providers and specialists to care for the elderly and young children. A strategy to increase access to dental care for older adults with Medicaid coverage, particularly those in long-term care facilities or with transportation barriers is necessary. Ongoing education to parents about preventative services and care prior to children getting their first tooth and permanent teeth is another important strategy.

Mental Health Access: Over one-third of residents (36-46%) reported experiencing poor mental health one or more days in the past month with 14-23% of adults having experienced depression or anxiety. Mental health is a critical component of overall health and multiple strategies are needed to ensure individuals experiencing challenges can connect with others easily for support and treatment. Local actions may focus on increasing access for youth and residents who have experienced trauma or other Adverse Childhood Experiences (ACEs).

Child Care Access: The lack of child care access is continuing to negatively impact our community through employment, income, and community vitality. Reductions in child care options present challenges for working parents and require creative strategies.

Short-Term Outcomes:

Increase awareness of specifically targeted access gaps, through data and public communication strategies.

Intermediate Outcomes:

An increase in individuals receiving care and attending (first) visits.

Long-Term Outcomes:

A reduction in reporting of delays in care. Individuals can receive the care they need.

Local Policy Recommendations:

- Mandatory fluoride varnish application policies
- Encourage mental health care into primary care practices
- Health system integration & collaboration agreements

Alignment with State and National Priorities:

- Minnesota State Oral Health Plan 2020-2030 (1)
- Recommendations on Strengthening Mental Health Care in Rural Minnesota (2)
- Rural Child Care Solutions: From the Ground Up (3)
- Mental Health First Aid (4)
- Make it OK (5)

Priority Area 1: Access to Care: Dental and Oral Health Care

Dental and Oral Care

Goal: Increase access to dental and oral health care, with a focus on underserved populations.

Strategy: Early Childhood Dental Network, PrimeWest Health, and Horizon Public Health will work to increase access to dental care by developing strategies to provide preventative care and dental treatment in clinical and non-traditional settings.

Outcome Objectives:

- By 2027, increase annual preventative dental screenings by 5% for those under the age of 5.
- By 2027, increase annual preventative dental screenings by 7% for those 65 and older on Medical Assistance.

Baseline Data/Source:

- Minnesota Department of Health, 2019 Annual Preventative visits 3-5 year old's: Douglas 49%, Grant 54%, Pope 48%, and Traverse 28%.
- Annual MN Healthcare plan benchmark goal for annual visits is 55%. Horizon Public Health, age 65+, PrimeWest range; Douglas 40% (high), Pope 32% (low)

Community Work Groups:

Early Childhood Dental Network, PrimeWest Health, Early Childhood Initiatives.

Action Steps:	**Lead Person/Agency Responsible:**
By December 31, 2023; Identify baseline data to identify gaps in care for children under the age of 5.	Early Childhood Dental Network
By December 31, 2023 and ongoing: Identify oral health educational materials for prioritized populations, including: parents who have children under the age of 5, immigrants, individuals over the age of 65 and their caretakers, and people with special health care needs.	Early Childhood Dental Network PrimeWest Health Horizon Public Health
By July 31, 2024 and annually :Collect data to monitor progress and identify best practice solutions. Share material and information through identified networks.	Horizon Public Health Supervisors Dental Health Coalitions
By December 31, 2024 and ongoing :Identify and implement best practice strategies to address prenatal care and oral health of children's first visit, to parents through WIC and Child and Teen Check Up visits.	Horizon Public Health
By March 31, 2024 and ongoing :Support and implement annual strategies identified by the Early Childhood Dental Network and PrimeWest Health to improve oral health for identified populations (under 5 and over 65 on MA).	Early Childhood Dental Network PrimeWest Health
By March 31, 2025 :Identify, support and promote oral health strategies in non-traditional settings such as; tele-dentistry in long-term care, head start, WIC clinics, correctional, early childhood center, schools, etc.	Early Childhood Dental Network PrimeWest Health
Ongoing; Support funding opportunities identifying barriers to improve oral health education, school sealant programs, and community water fluoridation for residents in Horizon Public Health counties.	Horizon Public Health Supervisors Horizon Public Health Administrators

Priority Area 1: Access to Care: Mental Health Care

Mental Health Care

Goal: Increase access to mental health services when needed.

Strategy: Identify and implement best practices aimed at reducing mental health stigma, increasing mental health awareness, and improving mental health status by increasing partnerships and awareness of mental health services through the communities.

Outcome Objectives:

- By 2027, decrease the average number of days that youth feel down, depressed, or hopeless in the past month.
- By 2027, decrease the percentage of adults who are reporting a delay in mental health care by 10%.

Baseline Data/Source:

- 2022 MN Student Survey: 8th graders reporting feeling down, depressed or hopeless more than half the days in a month ranged from 7% to 14%.
- 2020 SHIP Survey: 71% of adults reported a delay in mental health care (1. Didn't think it was serious, 2. Cost 3. COVID-19 pandemic related)

Community Work Groups:

Suicide Prevention Coalition (SCOPE), Mental Health Taskforces, Local Advisory Councils, Transportation Advisory Council, Stevens County Building Community Resilience, Lakes Area Age Friendly, Community Impact Coalition.

Action Steps:	**Lead Person/Agency Responsible:**
By December 31, 2023: Work groups will be identified through existing coalitions, groups, and individuals with lived experiences to implement the proposed action steps below. Set schedules for reoccurring meetings.	Horizon Public Health Strategist
By December 31, 2023: Improve access to care by promoting innovative outreach strategies, including 988, mobile crisis, and peer-to-peer interventions.	Identified Coalition(s) HPH Communications Committee
By March 31, 2024 and ongoing: Support training and implementation of Mental Health First Aid programs at identified worksites.	Connected Communities Horizon Public Health
By March 31, 2024: Compile resources about mental health access availability for individuals and families. Post and share information for community access.	Identified Coalition(s) HPH Communications Committee
By December 31, 2024 and ongoing: Identify innovative strategies through data which can be shared to address gaps in services and mental health needs.	Identified Coalition(s)
By December 31, 2025: Identify innovative strategies such as; calm rooms, school well-being curriculum, and/or social connectedness initiatives to be incorporated at worksites, schools, and community buildings to improve non-traditional mental health services.	Identified Coalition(s)
Ongoing: Promote Child and Teen Check Up services to children. Work with local providers to identify innovative promotional strategies to encourage and increase annual exams. Support regional and local solutions for individuals and families experiencing mental health needs.	Horizon Public Health Strategist Horizon Public Health Supervisors Horizon Public Health Administrators

Priority Area 1: Access to Care: Quality Child Care

Quality Child Care
Goal: Increase capacity of sustainable child care.
Strategy: Working to understand child care needs across the region and implement solutions to increase the availability of child care.
*Horizon Public Health is supporting the work in the community to achieve the below objective.

Outcome Objectives:

- By 2027, increase the number of licensed child care providers in Horizon Public Health counties

Baseline Data/Source:

- 2020 MN Department of Human Services, West Central MN needs a 39% growth in licensed child care capacity to fill the shortfall.
- Between 2015 and 2020, West Central MN licensed child care availability decreased by almost 600.

Community Work Groups:
Stevens County Child Care Committee, Alexandria Area Child Care Committee, Early Childhood Initiatives.

Action Steps:	**Lead Person/Agency Responsible:**
By July 31, 2023 and ongoing: Support and engage with local innovative coalitions working to develop 'right-sized solutions' to increase the supply of high-quality child care in rural communities. Remain a part of the planning and implementation process.	Identified Child Care Coalitions Horizon Public Health Nurse
Ongoing: Attend meetings to support and drive innovative ideas. Identify local data (when available), community concerns, and ideas to engage and empower solutions.	Horizon Public Health Nurse Horizon Public Health Strategist
Ongoing: Identify and recruit community members, including those with lived experiences, and community business organizations to attend child care coalitions/ meetings to share their perspectives on issues, challenges, and identify solutions.	Identified Child Care Coalitions
Ongoing: Share information from the progress of the coalition(s) with identified community partners and leaders to ensure the success of the projects.	Identified Child Care Coalition Horizon Public Health Strategist
By December 2027: Implementation of strategies that were identified in the planning of the project.	Identified Child Care Coalitions

Priority Area 2: Community Resilience

Goal: Develop organizational and community capacity to implement a public health framework that focuses on factors influencing health in the Horizon Public Health service area.

1. Increase individual and community resilience.
2. Reduce substance use and substance use disorders.

Problem/Issue Statement:

Breaking the cycle of adversity and trauma must include building hope and resilience for children and families. Adverse Childhood Experiences (ACEs) can increase a person's risk for chronic stress and use of adverse coping mechanisms can result in lifelong chronic illness such as depression, heart disease, obesity, and substance abuse. Mental health and substance use disorders are the leading disease burden in the United States.

In the Horizon Public Health counties, over one-third of residents reported experiencing poor mental health for one or more days in the past month with 14-23% of adults having experienced depression or anxiety. Data showed notable changes in self-reported mental health conditions and drug overdoses between 2016 and 2020. COVID-19 continues to have an impact on the prevalence of anxiety and depression, contributing to poor mental health.

Short-Term Outcomes:

Increased awareness in community members about trauma informed care and Adverse Childhood Experiences (ACEs).

Intermediate Outcomes:

Community members recognize trauma and are able to assist others in getting help.

Long-Term Outcomes:

Communities have capacity to promote and protect mental health by adopting policies and/or procedures which are trauma informed.

Local Policy Recommendations:

- Policies that would provide more support for mental health and addiction services.
- Policies that would further destigmatize and decriminalize substance use disorders.

Alignment with State and National Priorities:

- ACEs Aware, ACE Training and Education (11)
- Resilience in Action (12)
- SAMHSA Trauma and Guidance for a Trauma-Informed Approach (13)
- Zero Suicide (14)
- Minnesota Department of Health, Thrive (15)
- National Association of Counties, Opioid (16)
- Colorado Health Institute, Opioid Crisis Blueprint (17)
- Substance Abuse and Mental Health Services (18)

Priority Area 2: Community Resilience: Mental Well-Being

Mental Well-Being

Goal: Increase Individual and community resilience.

Strategy: Build resilience in individuals, families, and in the community through the development and implementation of policies, practices and environmental changes.

Outcome Objectives:

- By 2027, increase youth reporting adults in the community care for them.
- By 2027, decrease days adults reported mental health problems.

Baseline Data/Source:

- 2022 MN Student Survey: 13-26% of 8th graders reported 2+ ACEs. 18-27% of 8th graders who reported that the community cared about them 'quite a bit'.
- 2020 SHIP Survey: 26% of adults reported mental health problems. 12% reported 10+ days a month their mental health was 'not good'.

Community Work Groups:

Suicide Prevention Coalition (SCOPE), Mental Health Taskforces, Local Advisory Councils, Transportation Advisory Council, Stevens County Building Community Resilience, Early Childhood Initiatives, Lakes Area Age Friendly, Community Impact Coalition, Connected Community, COPEWELL Project.

Action Steps:	**Lead Person/Agency Responsible:**
By December 31, 2023: Work groups will be identified through existing partnerships and coalitions to adopt proposed action steps. Reoccurring meetings will be scheduled.	Horizon Public Health Strategist Identified Coalition(s)
By December 31, 2023: Develop a high-level summary of new health assessment findings on the topics of ACEs reports, substance use and mental health data. Share with identified coalitions/work groups and partners.	Horizon Public Health Strategist
By March 31, 2024: Conduct surveys, focus groups, and/or conversations with youth and those adults age 65 and older to learn more about social isolation, adverse community environments and identified needs.	Community Resilience Work Group
By March 31, 2024 and ongoing: Identify and share local stories that promote mental well-being. Examples will highlight positive impacts of community/individuals/families/worksites, etc. Share stories to MN Thrive Network.	Community Resilience Work Group
By December 31, 2025: Promote referral and connection between organizations to expand 'Handle with Care' initiatives to increase supporting children and families experiencing trauma.	Community Resilience Work Group
By December 31, 2025: Support the implementation of school linked mental health services by sharing examples of existing partnerships and resources available.	Community Resilience Work Group
By December 31, 2025: Utilize SHIP to promote positive mental health throughout worksite wellness programs by implementing at least 5 best practice programs annually.	SHIP Coordinator
By December 31, 2027: Annually complete at least three ACEs community trainings to educate about Adverse Childhood Experiences.	ACE Trainers
Ongoing: Capitalize on community events to promote programs and strategies to increase resiliency.	Community Resilience Work Group

Priority Area 2: Community Resilience: Substance Use

Substance Use

Goal: Reduce substance use and substance use disorders.

Strategy: Create a resilient community that understands behavioral health issues, including the influence of trauma on mental health and substance use disorders.

Outcome Objectives:

- By 2027, reduce substance use among Horizon Public Health youth.
- By 2027, reduce substance use among Horizon Public Health adults.

Baseline Data/Source:

- 2022 MN Student Survey: 11th graders who reported using alcohol, marijuana and/or drugs in the past year range from 5-19%. 11th grader's perception of using alcohol, marijuana, and/or other drugs in the past year is higher than actual use.
- 2020 SHIP Survey: 10% of adults reported 'heavy drinking' and 24% reported 'binge drinking' in the past 30 days. 7% reported using marijuana, opioids, stimulants, or illegal substances in the past 30 days.

Community Work Groups:

Suicide Prevention Coalition (SCOPE), Mental Health Taskforces, Local Advisory Councils, Transportation Advisory Council, Stevens County Building Community Resilience, Lakes Area Age Friendly, Community Impact Coalition.

Action Steps:	**Lead Person/Agency Responsible:**
By June 30, 2023: Establish substance use work groups to steer the opioid settlement memorandum of understanding (MOU). Set schedules for regular ongoing meetings.	Horizon Public Health Strategist
By September 30, 2023: Develop a fair and transparent work plan and process for deciding where and how to spend the Opioid Settlement MOU by the identified work groups.	Horizon Public Health Strategist Identified Coalitions
By December 31, 2023 and ongoing: Identify and launch educational campaigns to address stigma, risk, harm reduction, and protective factors from substance use and misuse.	Identified Coalitions
By December 31, 2023 and ongoing: Partner with schools and youth groups to promote stress management and resiliency in regards to preventing youth substance use.	Drug Free Communities E-Cigarette Prevention Grant Identified Coalitions
By December 31, 2023 and ongoing: Identify and promote resources available for treatment and recovery for those in addiction and working on recovery.	Identified Coalition(s)
By December 31, 2027: Implement at least five best practice strategies, in identified at-risk settings/communities.	Identified Coalition(s)
Ongoing: Monitor legislation, funding, and reform changes occurring at the state and national level that may impact public health work happening locally.	Horizon Public Health Strategist Horizon Public Health Administrators

Priority Area 3: Chronic Disease

Goal: Decrease the incidence of chronic disease

Problem/Issue Statement:
Heart disease is the leading cause of death in Horizon Public Health counties. The percentage of adults with high blood pressure is higher in each county than the statewide average, while diabetes rates are higher than the state average in all but Stevens County. With heart disease as the leading cause of death and high blood pressure rates higher than the statewide average, a combination of strategies needs to be considered to encourage heart health.

The rising obesity trend is one of the multiple factors contributing to poor heart health. Behaviors such as excessive eating and physical inactivity can affect a person's weight. However, outside influences such as the absence of health education, food insecurity, and one's environment can also be factors.

Increasing opportunities for physical activity and access to healthy foods can help establish healthy behaviors to reduce obesity rates. Greater access to affordable, healthy food and access to physical activity options can help residents make good choices that result in lower rates of chronic disease and better weight control.

Short-Term Outcomes:
Improve cross-organization communication and collaboration to better serve communities.

Intermediate Outcomes:
Physical activity and healthy eating are being documented in electronic records.

Long-Term Outcomes:
Availability of prescriptions and community linkage for physical activity and healthy eating for patients with identified risk factors.

Local Policy Recommendations:

- Policies that implement Exercise is Medicine with Healthcare providers.
- Policies that implement Food Rx with Healthcare providers as a standardized screening and referral.

Alignment with State and National Priorities:

- Exercise is Medicine, American College of Sports Medicine (7)
- Healthy Food as Medicine (8)
- Park Rx (9)

Priority Area 3: Chronic Disease

Chronic Disease
Goal: Decrease the incidence of chronic disease.
Strategy: Increase access to evidence-based prevention programs aimed at reducing the onset of heart disease.

Outcome Objectives:

- By 2027, decrease the percentage of youth who are overweight or obese according to Body Mass Index (BMI) by 5%.
- By 2027, decrease the percentage of adults diagnosed with high blood pressure or hypertension by 5%.
- By 2027, decrease the percentage of adults who are overweight or obese according to Body Mass Index (BMI) by 5-7%.

Baseline Data/Source:

- 2022 MN Student Survey: 28-53% of 8th graders reported being overweight or obese, 14-24% reported being active 5 days/week for at least 60 min./ day.
- 2020 SHIP Survey Data: 32% of adults reported a diagnosis of high blood pressure/hypertension or pre-hypertension. 12% of adults reported a diagnosis diabetes or pre-diabetes. 70% of adults reported being overweight/obese. 84% of adults participate in physical activities or exercise during the past 30 days.

Community Work Groups:
Believers in Breastfeeding (BIB) Coalition, Healthcare providers, Food Banks, Food Shelf.

Action Steps:	**Lead Person/Agency Responsible:**
By December 31, 2023: Research, identify, and create a list of available services for those living with chronic disease. Identify partners to support and share information	SHIP Coordinator Horizon Public Health Strategist
By December 31, 2023: Identify local healthcare providers to implement Exercise is Medicine and Food Rx.	SHIP Coordinator
By December 31, 2023: Identify local data to create a dashboard (Clear Impact) to track chronic disease and heart disease strategies. Identify communication plans, methods, and partners to share information.	Horizon Public Health Strategist HPH Communications Committee
By December 31, 2025: Develop a referral network between medical providers and available programs and resources for managing chronic illness.	SHIP Coordinator
By June 30, 2024: Identify active transportation barriers in schools, housing, and/or neighborhoods to advocate for funding opportunities. Advertise bike and walking paths throughout communities.	SHIP Coordinator
By December 31, 2025: Implement a community linkage model to increase access to physical activity and increase consumption of healthy foods. (Exercise is Medicine and Food Rx)	SHIP Coordinator Healthcare Providers
By December 31, 2027: Educate pregnant and postpartum women about the benefits of breastfeeding and provide ongoing support. Promote nutrition education to encourage healthy eating habits early in life.	Horizon Public Health WIC
By December 31, 2027: Identify innovative strategies to grow the number and capacity of SHIP worksite policies to include physical activity and access to healthy eating.	SHIP Coordinator Worksite Wellness Coordinators

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7. Exercise is Medicine, American College of Sports Medicine. https://www.exerciseismedicine.org/
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