Meeker-McLeod-Sibley Healthy Communities

Collective Action Plan

May 2017

Community Health Assessment

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Background

History of CLT

The Meeker McLeod Sibley Healthy Communities Leadership Team (MMS HCLT) is a coalition of community members that has been in existence over fifteen years.

MMS HC is a collaboration of organizations and individuals partnering together to promote health and well-being within our communities. Created in January of 1995, the MMS HCC is supported by the Healthy Communities Leadership Team (HCLT), which meets on a quarterly basis and who's commitment is " to improve the health of our community."

Currently there are four subcommittees in the Healthy Communities Collaborative:

- Emergency Preparedness
- Obesity Prevention
- Mental Health and
- Prevention/Wellness

This coalition also serves as the Community Leadership Team for MMS CHS's Statewide Health Improvement Program (SHIP) grant, from the Minnesota Department of Health.

The mission of the CLT is to advance healthy living within our three counties.

The vision of the CLT is to partner with communities to encourage and support efforts to impact environmental change and enhance healthful living.

MMS Healthy Communities Collaborative History

Created in January of 1995, the MMS HCC workgroup has had a specific focus since 1996

- 1996 and 1997 focus was Chemical Health (Alcohol, Tobacco and Other Drugs)
- 1998 focus was Child Passenger Safety
- 1999 focus was "Our Time Their Future" (ATOD, Gun Safety and Self Esteem)
- 2000 focus was "Lighten Up Stress Less"
- 2001 focus was "Its Never too Late to Feel Great – Eat Smart, Stay Active."
- 2002 focus was "The Smoke Around You – Will You Want to Breathe it?"
- 2003 focus was "Type 2 Diabetes..A Growing Epidemic."
- 2004 focus was "Eat Smart PlayHard"
- 2005 focus was "Do Groove" with My Pyramid
- 2006 was "Put a Rainbow on Your Plate"
- 2007 was "Let's Take a Walk"
- 2008 to present " Healthy Communities Collaborative" and it's success stories.

CHA/CHNA workshop June 2nd- summary

On June 2nd, 2016, a Community Health Assessment meeting was held with CLT members and community members. The objectives of the meeting were to get a better understanding of what creates health, to use population health data to start a conversation on what we see and know about our communities overall health, and to recognize how we play a role in improving the community's health.

Population data was given to participants using a health indicator prevalence comparison. The data is from almost ten different sources, with a large portion being from the MMS Community Health Survey and a large statewide survey from 2014. Both state and local survey data was analyzed to be representative of the entire population in each geography; margin of error, analyzed using STATA, and the Minnesota Student Survey. The comparability of the data varied. Questions are sometimes asked differently between local and state surveys and different data collection modes are used. The indicator prevalence comparison also included additional demographic breakdowns by county, age, gender, education level, and income. The local MMS Community Health survey underrepresented the Hispanic/Latino population across the three counties. The data from the local survey was also self-reported and therefore subject to some biases such as exaggerated response and inaccurate recall. This comparison highlighted the areas where MMS ranked better than the MN rate, where there was notable difference between MMS and MN, and where MMS rate was worse than the MN rate. The data was organized by categories including who, behavior, access, and outcomes.

The data analysis

During the overview of MMS data presentation, the data highlighted as significant was elderly and child dependency ratio, exercise habits, binge drinking, and access to healthcare, dental care, and mental health care. Other important indicators were high rates in diabetes, heart trouble, cholesterol, and low rates in shingles vaccinations. After discussing the data, attendees made a list of over 20 health topics they deemed significant for the three counties. After participants voted on three topics they believe need to be most prioritized.

The final list of topics were

- Access to care
- Obesity
- Choice/behavior/culture
- Mental Health

- Senior Health
- Binge Drinking

Each table generated a discussion on what is currently being done to combat the issue, what strategies could be used to address the problem, and what challenges are faced to overcome implementing strategies for the issue. Participants were able to move to 3 tables during the brainstorming session.

Below is a summary of what was discussed at each topic:

Access to care

- Getting transportation- current transportation not user friendly
- Dental services for children (Meeker)
- Dental care-not affordable for many
- Does everyone in the community know the information?
- Stigma services-ex. Mental health
- Not enough mental health providers

Obesity

- Culturally acceptable
- Addressing school lunches
- Working with schools regarding physical activity
- How to motivate people
- Take advantage of what MMS already offers
- High impact of technology on families at home

Choice/behavior/culture

- Resources- human and money
- Connecting the public
- How to get people to participate
- Maybe start at the workplace
- Incentives with insurance?

Mental health

- Access to resources
- Get people to the right care

- Break the stigma held by mental illness
- Bring the community together
- Huge lack of providers
- Insurance coverage

Senior health

- Focus culture on embracing aging
- Transportation to events and appointments for seniors
- Stigma for asking for help
- Not taking advantage of the resources they quality for
- Understand barriers to access for healthcare
- Partner with resource organizations

Binge drinking

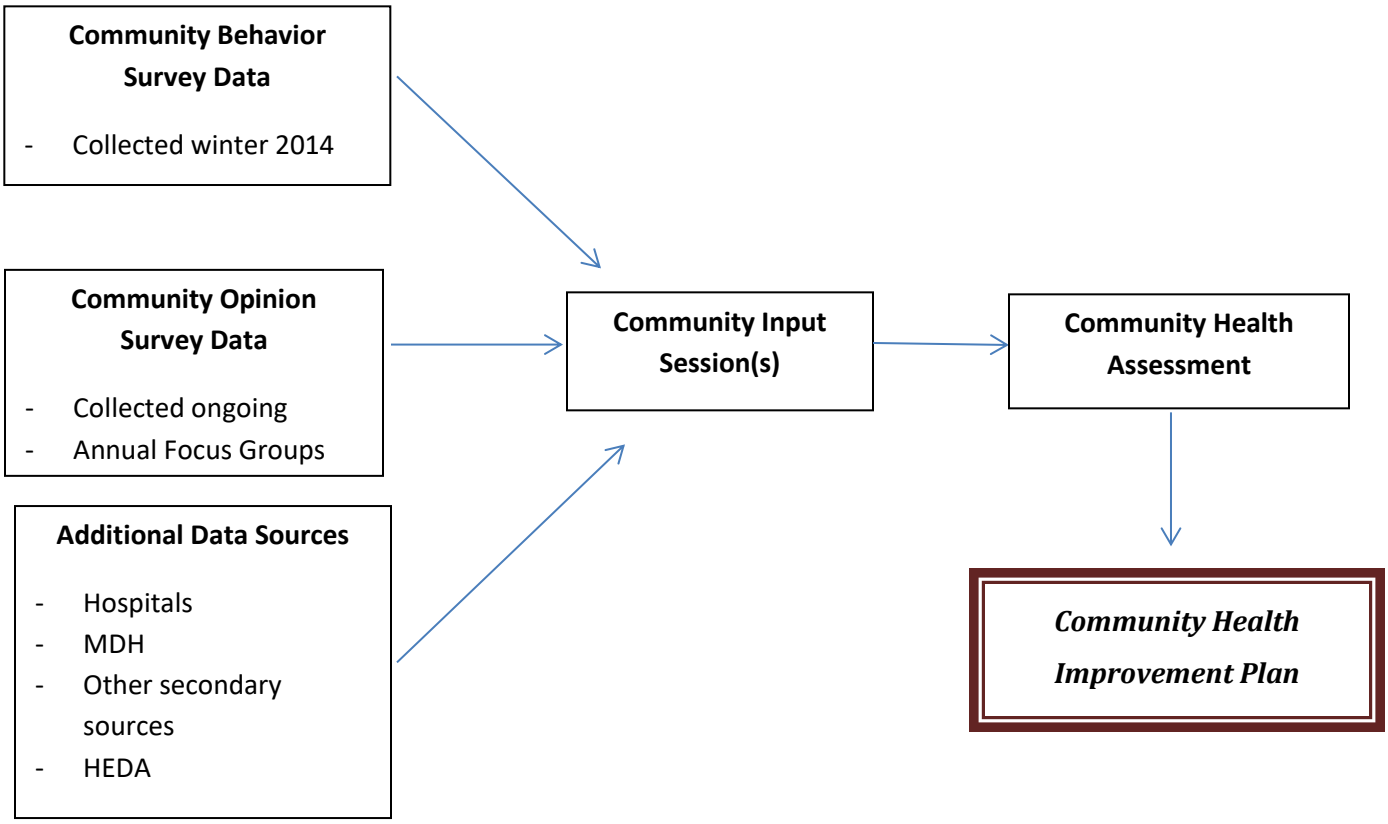
- Attitudes of adults
- The culture surrounding drinking
- Not a good understanding of what binge drinking is
- Not always seen as a issue
- Binge drinking is seen as accepted in certain situations
- Not a stigma around having a DUI
- Community events centered on alcohol (ex. Winstock)

After the World Café activity of table discussions, a large group session was held to discuss next steps and where to focus the energy in moving forward. The discussion focused on two main areas-access and choice behavior education.

Access- Throughout the morning, a common theme at each table was transportation as a barrier and discussion was held if that is what needs to be focused on, especially in regards to access to healthcare. Other barrier to accessing healthcare could be a stigma held for individuals needing service.

Choice behavior- In discussion it was evident a lot of health behaviors are based on the culture surrounding an individuals. The prevention and wellness committee is to look at how choice behavior meshes with the culture. From there, the subcommittee and partners could research ways to provide education and awareness to the community. For example, how could we change culture around binge drinking and how to educate community members on the effects of binge drinking.

Components of the Community Health Assessment Process



Collective Action

MMS Healthy Communities CLT has agreed to use a collective action framework in order to increase efficiencies and decrease duplication. Collective action occurs when organizations agree to coordinate activities in pursuit of shared objectives. (Mays, 2010). While community partners are active and engaged with community level initiatives there are still internal agency priorities. A challenge arises when balancing agency resources and staff capacity between internal and external priorities. Another challenge is the multifactorial root causes of the identified priority areas. A collective action framework attempts to address both of these challenges. The collective action approach requires collaboration and partnerships to work on overarching goals to address the priority areas, while each agency continues to utilize local agency data and work on interventions specific to their agency. Collectively, all the agency interventions contribute to the overall common goal. Diagram A represents a visual of the collective action approach created by The Centers for Disease Prevention and Control (CDC).

Diagram A

This approach will allow each partnering agency to identify their contribution (if any) towards the identified priority areas. This will allow agencies to share information, resources and coordination of services that will result on a larger impact on the community. (Mays, 2010).

Obesity

In 2013, 25.5 percent of MN adults were obese, and 35.6 percent were overweight. Obesity is a significant contributor to chronic conditions like diabetes, heart disease, stroke and cancer, which often lead to premature death and raise health care costs for both individuals and the state. Strategies that improve nutrition and increase physical activity through policy, systems and environmental change are fundamental to reducing obesity rates in children and adults.

Data

National Data:

- The Centers for Disease Control National Center for Health Statistics (NCHS) reported that in 2014, 36.5% of U.S. adults have obesity (Centers for Disease Control).
- Non-Hispanic blacks have the highest age-adjusted rates of obesity (48.1%) followed by Hispanics (42.5%), non-Hispanic whites (34.5%), and non-Hispanic Asians (11.7%). (CDC)
- Obesity is higher among middle age adults age 40-59 years (40.2%) and older adults age 60 and over (37.0%) than among younger adults age 20–39 (32.3%). Obesity can also be affected by socioeconomic status (CDC).

State Data:

- 2014 Minnesota data that showed 27.6% of all Minnesotans are obese (MN Dept. of Health).

Local Data:

- In 2014, 33.6% of Meeker-McLeod-Sibley adult residents self-reported (by submitting their height and weight) that they were obese(MMS Community Health Survey, 2014).

  MMS Community Health survey results show that 33.7% of Females are obese and 33.5% of men are obese. The highest age group of adults with obesity is ages 45-54 at 45.7%. MMS survey data shows that the lower of an education that a person has, the higher the percentage of obesity is. 42.9% of obese people reported having less than a high school education. 24.4% of people with a bachelor's degree or higher

reported being obese. This data also shows that MMS residents with median household income have the highest rate of obesity at 37.7%. Splitting up the three counties, Meeker County has the highest percent of obese residents at 37.2%, followed by Sibley with 35.4%, and with McLeod County with the lowest percent of obese residents at 30.5% making a total of 33.6% of MMS residents reporting they are considered obese (MMS Healthy Community Survey, 2014).

- Meeker McLeod Sibley and Minnesota Health Indicator Prevalence Comparison

	MMS - 2014		MN – 2014 [i]		
Indicator	**Rate**	**95% CI**	**Rate**	**95% CI**	**Notes**
Participated in any physical activities in the last month (Yes)	78.4%	(75.2-81.5)	79.8%	(79.0-80.5)	
Total servings of fruit and vegetables eating yesterday					
• **0 servings**	**6.7%**				
• **1-2 servings**	**28.2%**				
• **3-4 servings**	**29.2%**				
• **5-9 servings**	**32.2%**				
• **10 or more servings**	**3.7%**				
Eat out or order out a meal from a fast food place during an average week	**56.6%**				
Purchase or get food from a Farmers Market/Fruit stand/Vegetable stand	**42.9%**				
Use walking trails in your community (Yes)	**41.3%**				

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Senior Health

Health care reform is evolving at the state and federal levels. Local health departments are in a position to be key strategists to implement changes that reduce chronic health conditions, control health care expenditures, and improve population health. Public health and health care providers are challenged to collaborate to address policy, systems and environmental changes and to enhance care coordination with Accountable Care Organizations (ACOs)/Integrated Health Partnerships (IHPs) and other reform initiatives. Local health departments should be at the center of planning the local reform agenda as these agencies lead Community Health Assessment and Community Health Improvement Plan processes to advance long-term, systematic efforts to address public health problems in a community.

A population-based approach is critical to health reform and system innovation, and there is a key role for local government. County-based health care purchasing, ACOs, and IHPs provide an opportunity to build a prevention-focused, community-based local care system that optimizes health while controlling costs for the Medical Assistance population.

Data

National Data:

- In 2012, 40.5 of males and 42.5% of females aged 65 years and older were up to date on a core set of clinical preventive services (Healthy People, 2020).

State Data:

*Note: Will insert table reflecting Minnesota state data from the All Payers Claims Database. Data will include numbers on chronic diseases, prevalence/rates, and costs for the 65 and older population.

Local Data:

- According to the 2014 Meeker-McLeod-Sibley Community Health Survey data, the elderly dependency ratio (65+ years) in MMS is 27.4% compared to the 2014 Minnesota state average of 21% (MMS Community Health Survey).

Collective Action Plan: Table 1

QUESTION	MMS 65+	MMS ALL
26e. During an average week, how many times do you eat a home cooked meal?		
0 times	1.0%	0.5%
1-2 times	5.3%	8.2%
3-4 times	13.6%	14.7%
5-6 times	24.9%	29.3%
7 or more times	55.1%	47.2%
33j. Please indicate whether you use the following resources and facilities in your community: Physical activity classes or activities through Community Education		
I use this	8.4%	10.7%
I do not use this	84.7%	83.8%
My community does not have this	6.9%	5.5%
34. Overall, how would you rate your neighborhood as a place to walk?		
Very pleasant	58.0%	54.8%
Somewhat pleasant	35.7%	36.6%
Not very pleasant	4.2%	6.3%
Not at all pleasant	2.1%	2.4%
76e. In your opinion, how much of a problem is each of these issues in your county? Stray animals		
No problem	52.0%	45.4%
Minor problem	36.2%	42.3%
Moderate problem	10.4%	11.0%
Serious problem	1.5%	1.4%

Collective Action Plan: Table 2

	2014		
QUESTION	MMS 65+	MMS ALL	MN [ii] ALL
3. What kind of place do you usually go to when you are sick of need advice about your health?			
Doctor's office	51.4%	36.8%	
Clinic	54.6%	59.2%	
Some other health center	0.4%	0.3%	
Emergency room	5.8%	2.4%	
Urgent care clinic	5.6%	4.3%	
No usual place	1.2%	5.9%	
Other place	3.5%	3.9%	
8. During the past 12 months, have you seen a doctor, nurse or other health professional about your own health?			
Yes	92.9%	77.9%	69.8%
No	7.1%	22.1%	30.2%
10. During the past 12 months, was there a time when you thought you needed medical care but did not get			

it or delayed getting it?		
Yes	11.6%	23.7%
No	88.4%	76.3%
11. Why did you not get or delay getting the medical care you thought you needed? (Mark all that apply.)		
I could not get an appointment	7.6%	5.6%
I did not think it was serious enough	64.1%	46.6%
I had transportation problems	2.7%	1.4%
It cost too much	19.2%	40.9%
I did not have insurance	0.8%	11.9%
My insurance did not cover it	7.0%	13.4%
Other	10.7%	14.6%
12. During the past 12 months, was there a time when you thought you needed dental care but did not get it or delayed getting it?		
Yes	13.4%	20.6%
No	86.6%	79.4%
13. Why did you get or delay getting the dental care you thought you needed? (Mark all that apply.)		
I could not get an appointment	1.8%	4.0%
I was too nervous or afraid	5.0%	14.5%
I had transportation problems	0.7%	1.9%
It cost too much	58.3%	67.2%
I did not have insurance	45.8%	39.0%
The dentist wouldn't accept my insurance	5.9%	5.4%
I did not know where to go	4.1%	4.5%
Other	11.4%	14.6%
15. During the past 12 months, did you talk with or seek help from a health professional about mental health issues such as stress, depression, excessive worrying, troubling thoughts, or emotional problems?		
Yes	5.7%	10.6%
No	94.3%	89.4%

16. About how many days did you have to wait for an appointment with a mental health professional?	**n=35**	**n=126**
0-3 days	74.3%	48.9%
4-6 days	5.7%	15.4%
7-14 days	2.9%	17.6%
15-28 days	2.9%	6.8%
29-45 days	8.6%	7.9%
More than 45 days	2.9%	3.4%
17. How far did you have to travel to get to the appointments?	**n=36**	**n=129**
0-9 miles	63.9%	50.2%
10-29 miles	22.2%	27.6%
30-49 miles	11.1%	15.8%
50 miles or more	2.8%	6.5%
20. In the past 6 months, which statement best describes medications prescribed for you?		
I had no medications prescribed for me	13.2%	41.0%

I had medications prescribed or me and I filled ALL of the prescriptions	85.1%	55.3%	
I had medications prescribed for me and I did not fill at least one of them	1.7%	3.8%	
22. Currently insured			
Yes	99.95%	98.2%	92.7%
No	.05%	1.8%	7.3%
28. During the past 12 months, how often did you worry that your food would run out before you had money to buy more?			
Often	1.1%	3.7%	
Sometimes	6.0%	8.0%	
Rarely	3.7%	11.7%	
Never	89.2%	76.7%	
29. During the past 12 months, have you used a community food shelf program?			
Yes	3.5%	5.7%	
No	96.5%	94.3%	
56. Do you have access to at least one working car or other vehicle to use when you need to?			
Yes	93.7%	97.2%	
No	6.3%	2.8%	
57. Do you ever use public transportation such as Trailblazer Transit or Meeker County Transit?			
Yes	7.8%	7.5%	
No	92.2%	92.5%	

Collective Action Plan: Table 3

		2014			
Indicator		**MMS 65+**	**MMS ALL**	**MN [iii] ALL**	**Notes**
Overall health status					
	Excellent	4.5%	10.7%	20.2%	
	Very good	30.9%	45.9%	37.5%	
	Good	45.7%	33.8%	30.3%	
	Fair	17.1%	8.6%	9.3%	
	Poor	1.8%	1.0%	2.7%	
Ever told by doctor, nurses	**Adults who have been told they have high blood pressure**	65.4%	33.1%	27.0%	MMS includes pre-hypertension so likely MN rate would be higher if it included pre-hypertension. MN rate is from 2013 (not asked in 2014)
	Diabetes or prediabetes (non-pregnancy related)	27.1%	15.3%	9.5%	
	Overweight	36.2%	34.2%		This is based on being ever told by doctor and is lower than when calculated from self-reported height and weight. (see 2nd last row)
	Cancer	22.4%	8.1%		In BRSS, cancer is asked in two separate

	Skin cancer or other cancer (calculated)			10.4%	questions: *ever told you had skin cancer* or *ever told you had any other cancer*. Because they are not asked the same way, MMS and MN rate are not directly comparable. MN rate calculated from BRFSS for those who answered "Yes" to either question.
	Chronic lung disease	12.0%	5.1%	4.3%	MN rate is from 2013. In MMS survey asked as: *Ever told you have chronic lung disease (including COPD, chronic bronchitis or emphysema)?* In BRFSS asked as: *Ever told you have COPD?*
	Heart trouble or angina **Angina or coronary heart disease or heart attack (calculated)**	21.5%	7.3%	5.5%	In BRSS, heart troubles is asked in two separate questions: *ever told you had angina or coronary heart disease* or *ever told you had a heart attack*. Because they are not asked the same way, they are not directly comparable. MN rate calculated from BRFSS for those who answered "Yes" to either question.
	Stroke or stroke related health problems	6.9%	2.3%	2.2%	
	High cholesterol	51.1%	29.5%	33.6%	MN rate is from 2013.
	Arthritis	49.5%	23.3%	21.8%	
	Depression	14.5%	18.6%	18.2%	
	Anxiety or panic attacks	11.9%	14.8%		
	Other mental health problems	2.7%	3.2%		
	Obesity	13.1%	12.4%		This is based on being told by doctor and is much lower than when calculated from self-reported height and weight. (see last row)
	Asthma	9.3%	11.8%	11.8%	
Adults 65+ who have had a flu shot within the past year		77.4%	77.4%	64.3%	

Visited the dentist or dental clinic within the past year for any reason	71.8%	74.2%	72.6%	In MMS: dental exam or teeth cleaned within the past year
Hearing test				
Within the past year	28.7%	25.2%		
Within the past 2 years	12.5%	12.2%		
2 years or more	32.1%	48.3%		
Never	26.9%	14.3%		
Eye exam				In BRFSS asked as: *When was the last time you had an eye exam in which the pupils were dilated?*
Within the past year	75.1%	61.2%	76.8%	
Within the past 2 years	16.2%	19.7%	13.7%	
2 years or more	8.2%	17.9%	5.6%	MN rate is from 2013.
Never	0.5%	1.2%	3.5%	
Blood pressure checked				
Within the past year	96.8%	87.1%		
Within the past 2 years	2.8%	9.3%		
2 years or more	0.5%	3.3%		
Never	0.0%	0.3%		
Blood cholesterol				MN rate is from 2013.
Within the past year	85.1%	61.7%	57.2%	
Within the past 2 years	8.7%	15.1%	12.5%	
2 years or more	4.7%	11.7%	11.0%	
Never	1.4%	11.5%	19.4%	
Blood sugar checked				In BRFSS asked as: *Have you had a test for high blood sugar or diabetes within the past three years?*
Within the past year	83.0%	58.2%		
Within the past 2 years	6.9%	13.4%		
2 years or more	4.5%	14.4%		
Within the past 3 years			47.4%	
Never	5.6%	14.1%		
Any screening for skin cancer				
Within the past year	33.1%	17.4%		
Within the past 2 years	7.9%	8.8%		
2 years or more	14.5%	14.6%		
Never	44.5%	59.2%		
Any screening for colon cancer		(45+)	(50+)	In BRFSS asked as: *How long has it been since you had your last sigmoidoscopy or colonoscopy?*
Within the past year	23.4%	22.9%	16.4%	
Within the past 2 years	20.6%	16.4%	12.6%	
Within the past 5 years	27.3%	21.1%	26.3%	MN only asked of those 50+
5 years or more	18.6%	14.0%	18.5%	Age data in MMS survey was gathered as categories (45-54, 55-65, etc.) so cannot be calculated at age 50.
Never	10.1%	25.7%	26.2%	

Men who have had a prostate exam within the past two years	89.9%	61.5% (45+)	36.7% (40+)	MMS survey asks about prostate exam, BRFSS asks about PSA test, therefore these cannot be compared.
Women aged 18+ who have had a pap test	37.7%	66.1%	76.6%	MMS rate is for those who had pap in past two years. MN rate is for those who had pap in past three years; MMS survey did not include past three years as an option.
Women aged 45+ who have had a mammogram in the past two years	79.6%	79.2%	73.4%	Age data in MMS survey was gathered as categories (45-54, 55-65, etc.) so cannot be calculated at age 40.
Visited a doctor for a routine checkup within the past year	82.0%	66.5%	69.8%	In MMS survey asked as: *When was the last time you had a general health exam?* In BRFSS asked as*: About how long has it been since you last visited a doctor for a routine checkup?*
If you have not had a general health exam within the past 1 to 2 years, why not?				Sample size for 65+ is very small (n=31) so data has limited precision and should be interpreted with caution.
Could not get an appt	0.0%	1.3%		
Transportation problems	1.2%	0.5%		
Cost too much	10.5%	8.5%		
Did not have insurance	3.5%	16.7%		
Insurance did not cover	5.6%	4.5%		
Other	79.2%	68.5%		
Adults 65+ ever had a pneumonia shot	71.1%		72.6%	
Shingles vaccine	59.9%	17.3%	27.9%	
Number of days mental health was not good				
0 days	72.4%	53.9%	69.0%	
1-9 days	23.2%	33.4%	20.3%	
10-19 days	1.9%	7.1%	5.0%	
20-29 days	1.5%	3.9%	2.1%	
All 30 days	1.1%	1.8%	3.3%	
Delayed getting mental health care	2.7%	9.6%		
In past six months:				
No meds prescribed	13.2%	41.0%		
Meds prescribed, filled	85.1%	55.3%		
Meds prescribed, not ALL filled	1.7%	3.8%		
Participated in any physical activities in the last month (Yes)	74.4%	78.4%	79.8%	
Number of days of at least 30 minutes of moderate physical activity				

0-4 days **5-7 days**	69.8% 30.2%	76.0% 24.1%		
Number of days of at least 20 minutes of vigorous physical activity **0-2 days** **3-7 days**	80.1% 19.9%	74.6% 25.4%		
Overweight	44.3%	40.9%	36.5%	Calculated based on self-reported height and weight.
Obesity	33.1%	33.6%	27.6%	Calculated based on self-reported height and weight.

Mental Health

Mental and chemical health promotion can improve quality of life and physical health, and early intervention services can lessen the burden of both. Unrecognized and untreated mental and chemical health conditions can disrupt development across the lifespan, social connections, family life, education, employment and economic stability, and full community participation. Early intervention and support for families can prevent child and parent mental and chemical health problems and promote overall health and resiliency at all stages of life. When left untreated, mental and chemical health conditions can worsen and become disabling or less amenable to treatment.

Data

National Data:

- In 2014, there were an estimated 43.6 million adults aged 18 or older in the United States with any mental illness in the past year. This number represented 18.1% of all U.S. adults (SAMHSA)
- In 2015, an estimated 16.1 million adults aged 18 and older in the United States had at least one major depressive episode in the past year. This number represents 6.7% of all U.S. adults (National Institute of Mental Illness).

State Data:

Local Data:

Source: MMS Community Health Behavior Survey

- In 2014, 26.4% of Meeker, McLeod, and Sibley residents reported that they had mental health concerns (depression, anxiety/panic attacks, or other mental health problems), compared to Minnesota at 18.1% (MMS Community Health Survey).
- 10.6% of MMS residents reported that they were seeking mental health care in 2014 (MMS Community Health Survey).
- 9.6% of MMS residents reported that there "was a time when you wanted to talk with or seek help from a health professional about mental health issues but did not g, or delayed talking to someone (MMS Community Health Behavior Survey).

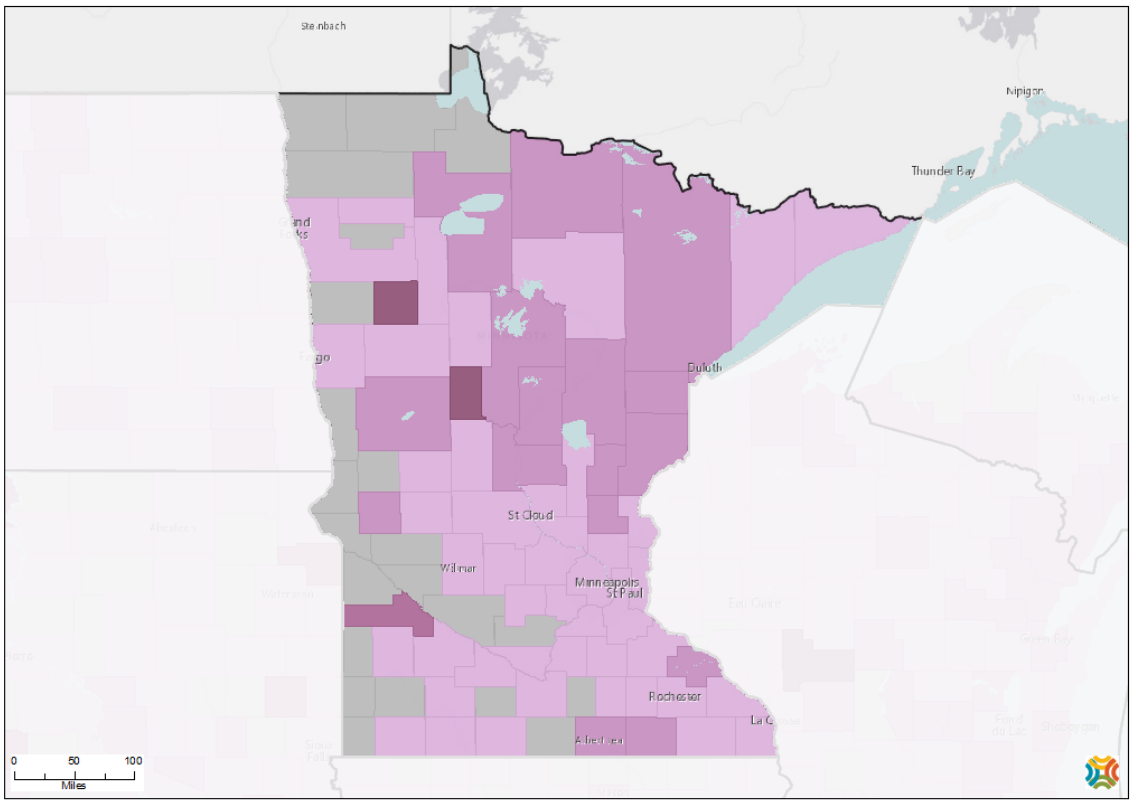
Source: South Country Health Alliance and PrimeWest

Placeholder to add table

Source: Hospitals/Clinics

Placeholder to add table

Minnesota Mental Unhealthy Days



Map Legend

Mentally Unhealthy Days, Average per Month by County, BRFSS 2006-12

- Over 5.0
- 4.1 - 5.0
- 3.1 - 4.0
- Under 3.0
- No Data or Data Suppressed

Community Commons, 10/21/2016

Access to Care

Health care reform is evolving at the state and federal levels. Local health departments are in a position to be key strategists to implement changes that reduce chronic health conditions, control health care expenditures, and improve population health. Public health and health care providers are challenged to collaborate to address policy, systems and environmental changes and to enhance care coordination with Accountable Care Organizations (ACOs)/Integrated Health Partnerships (IHPs) and other reform initiatives. Local health departments should be at the center of planning the local reform agenda as these agencies lead Community Health Assessment and Community Health Improvement Plan processes to advance long-term, systematic efforts to address public health problems in a community.

An individual health insurance coverage mandate now applies in Minnesota under the Affordable Care Act, but there will still remain a percentage of uninsured and underinsured individuals in the state.

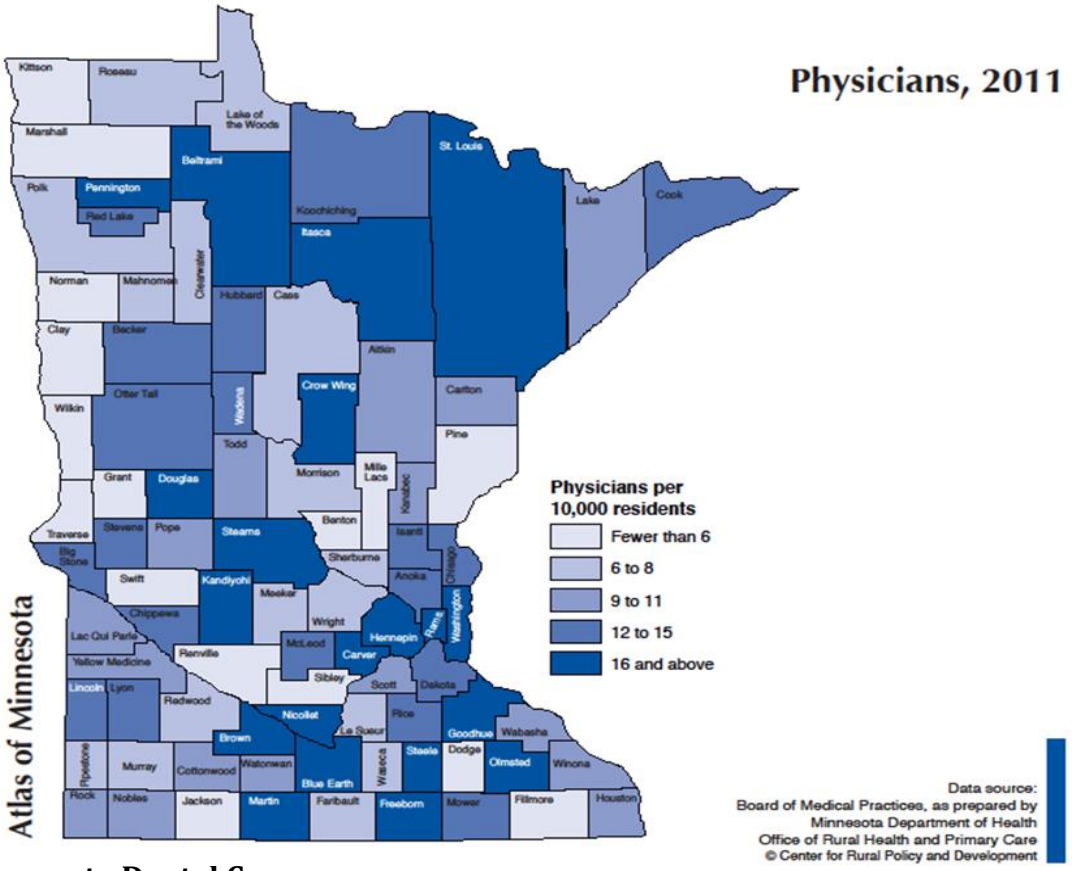
Federal legislation was passed in 2009 for parity between mental health and physical health services within health insurance coverage. Minnesota has not developed an adequate system for either insured or uninsured persons to receive care for mental health issues.

Access to dental care is limited due to the lack of a sustainable, statewide model of care for persons on public programs. This is influenced by a shortage of dental health care workers and reimbursement practices for persons on government health programs.

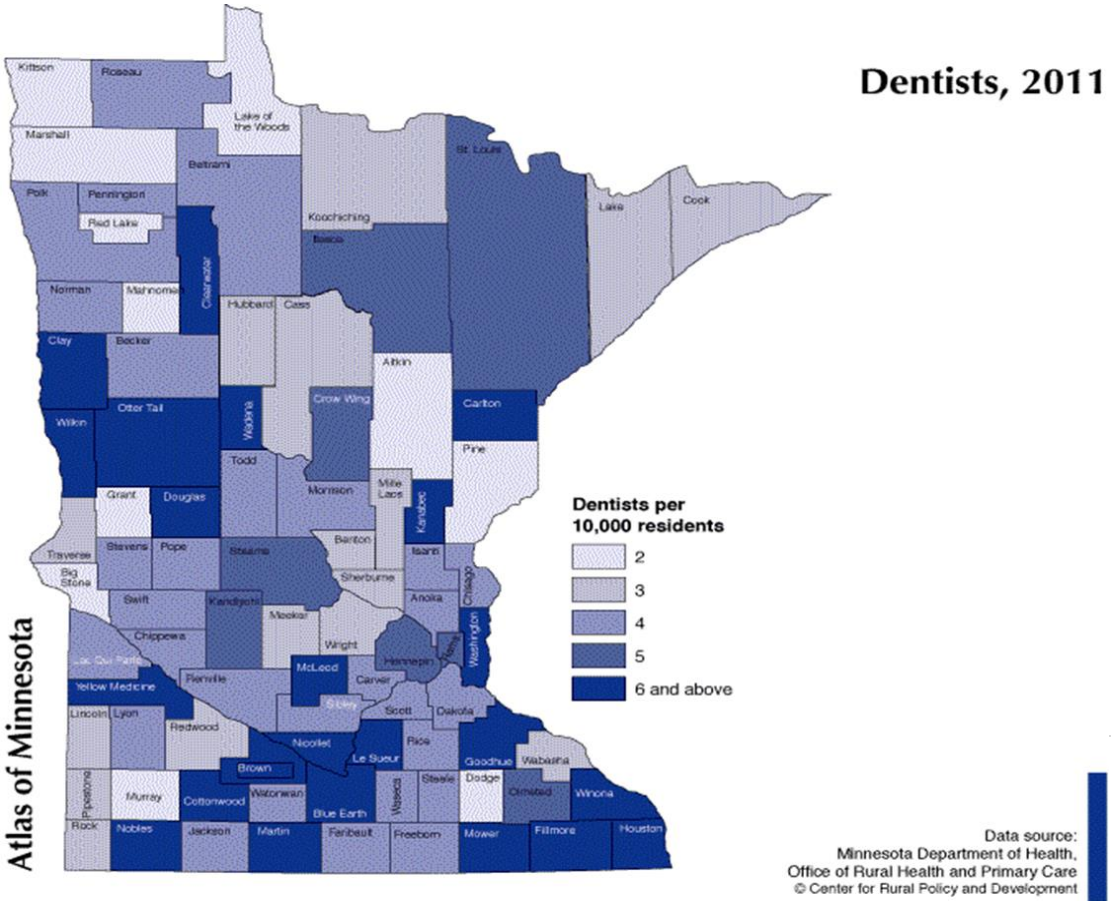
Data

State Data:

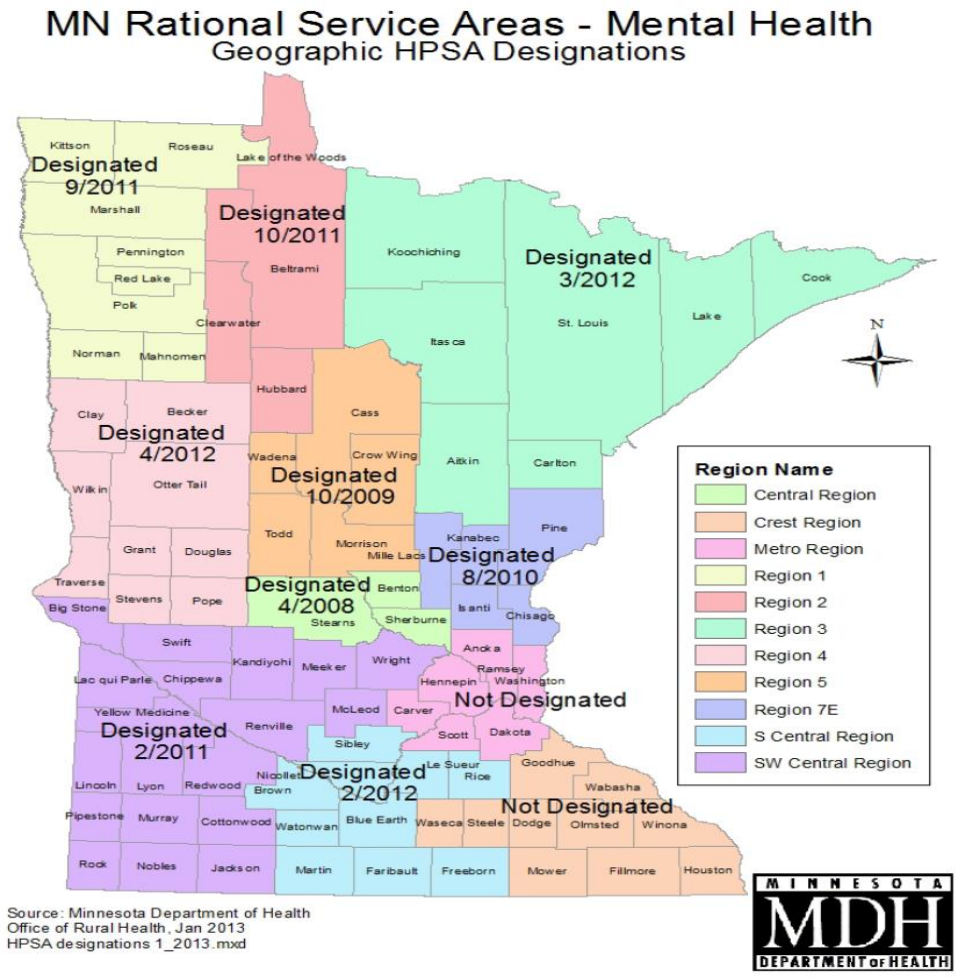
Access to Health Care



Access to Dental Care



Access to Mental Health Care



Binge Drinking

Alcohol use is reported by over half of all adults in the United States and is the most widely used drug in MN—even more prevalent than tobacco. Excessive alcohol consumption contributes to a number of negative consequences, including unintentional injuries, violent acts, chronic diseases and unintended or unhealthy pregnancies.

The economic costs associated with alcohol use in MN are estimated at over $5 billion annually—17 times greater than the tax revenues collected from alcohol sales.[iv] Increasing the price of alcohol through a small tax increase has been shown to reduce excessive drinking and alcohol related injuries.

Data

National Data:

- In 2014, 9,967 people were killed in alcohol-impaired driving crashes, accounting for nearly one-third (31%) of all traffic-related deaths in the United States (CDC).
- One in six U.S. adults binge drinks about four times a month, consuming about eight drinks per binge (CDC).

State Data:

- In 2015, there were 137 alcohol related traffic deaths in Minnesota and 25,027 DWI incidents (Minnesota Dept. of Public Safety).

Local Data:

- 30.7% of MMS residents reported binge drinking (four or more drinks on any one occasion for females and five or more drinks on any one occasion for males), compared to Minnesota as a whole at 19.5% of adults who are binge drinking (MMS Community Health Survey).
- 18% of MMS students in grades 8, 9, and 11 reported that they used alcohol in the past year (2016 Minnesota Student Survey).
- 2.2% of MMS students in grades 8,9, and 11 reported that they frequently binge drank in the past year (typically drake 5 or more drinks at a time and drank on 10 or more occasions during the past year), (2016 Minnesota Student Survey).
- In 2015, there were 295 DWI incidents within Meeker, McLeod, and Sibley Counties (MN Dept. of Public Safety).
- In 2015, 5 alcohol related traffic deaths occurred within Meeker, McLeod, and Sibley Counties (MN Dept. of Public Safety).

Choice/Behavior/Culture

Health Equity argues that being healthy is not always a choice or behavior, but rather a part of the Social Determinants of Health.

Serious health inequities exist between populations of color, persons living in poverty, and the rest of Minnesota's population. Life expectancy within Minnesota varies by zip code. African American and American Indian babies die in the first year of life at twice the rate of white babies.[i] Populations of color in Minnesota are at greater risk of many leading causes of death including cancer, heart disease, diabetes, homicide, suicide, unintentional injury and HIV/AIDS.

Social and economic conditions that are strong predictors of health outcomes are not favorable for populations that experience health disparities. Unemployment is highest among populations of color, American Indians, and people who live in rural Minnesota, as well as individuals with disabilities. American Indian, Hispanic/Latino, and African American youth in Minnesota have the lowest rates of on-time graduation.[i] Prolonged poverty is generally the leading cause associated with health inequities. Inequities are caused by a variety of other social conditions including racial and cultural barriers to care, disparate access to preventive health resources, unemployment, the lack of a livable wage, and unsafe and unstable housing.

Social Determinants of Health:

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as "place."5 In addition to the more material attributes of "place," the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins (Healthy People, 2020).

Health Equity:

When every person has the opportunity to realize their health potential — the highest level of health possible for that person — without limits imposed by structural inequities. Health equity means achieving the conditions in which all people have the opportunity to attain their highest possible level of health (Minnesota Department of Health).

Data

National Data:

- In November 2016, 4.4% of U.S. residents were unemployed (MN Employment & Economic Development).

State Data:

- In November 2016, 3.2% of Minnesota residents were unemployed (MN Employment & Economic Development).
- The graduation rate for all of Minnesota was 81.9% in 2015 (MN Dept. of Education).

Local Data:

- In November 2016, unemployment rates for Meeker-McLeod-Sibley averaged 3.3% (MN Employment & Economic Development).
- In 2015, the graduation rate for Meeker-McLeod-Sibley averaged 86.1% (MN Dept. of Education).

Meeker-McLeod-Sibley Community Health Behavior Survey, 2014

Question 76c – In your opinion, how much of a problem is each of these issues in your county? **Poor sidewalk conditions**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	36.0%	40.6%	18.8%	4.6%

Question 34 – Overall, how would you rate your neighborhood as a place to walk?

	Very Pleasant	Somewhat pleasant	Not very pleasant	Not at all pleasant
All 3 counties combined	54.8%	36.6%	6.3%	2.4%

Question 26e – During an average week, how many times do you do the following? Eat a home cooked meal

	0 times	1-2 times	3-4 times	5-6 times	7 or more
All 3 counties combined	0.5	8.2%	14.7%	29.3%	47.2%

Question 33j – Please indicate whether you use the following resources and facilities in your community. Physical activity classes or activates through Community Education

	I use this	I do not use This	My community Does not have this
All 3 counties combined	10.7%	83.8%	5.5%

Will add HEDA data summary when available

Appendix 1

Partners from the follow organizations were at the table for the June 2nd, 2016 Community Health Assessment workshop:

Minnesota Department of Health
University of Minnesota Extension

Blue Cross/Blue Shield
Mental Health Professionals
Hutchinson Health
Meeker Memorial Hospital
Glencoe Regional Health Services
Ridgeview Sibley Medical Center
Community Members
Tri-Valley Migrant Head Start
City of Hutchinson
Glencoe Silver Lake School District
Sibley East School District
Ecumen
Sibley County Public Health and Human Services
Meeker McLeod Sibley Community Health Services

Appendix 2

Table Notes from Community Health Assessment Workshop

June 2nd, 2016

Table 1

Access

Group 1

1. When you look at the data about access what jumped out at you?
    a. Not clear if it is a problem from the data
    b. Getting transportation is however an issue
        i. Not available for medical appointments
    c. Mental health providers are not available timely
    d. Limited crisis MH intervention access
    e. MH use ER instead of more appropriate crisis settings
2. What is missing from the data?
    a. Transportation is not user friendly (limited places/times/hours)
    b. No dental providers for children, have "bandaid"ed the problem with mobile clinics, but not addressed the root of the problem
    c. MH and Dental providers can no longer serve patients who miss 3 appointments
3. Does the broader community know this information?
    a. Yes it is a problem, but no one offered how to improve or that there were any ways to improve.
    b. But because it does not affect the majority of the community, not great concern/motivation to change... it's the poor person's problem
    c. Legislature aware of mental health limitations, providers aware of limited # of mental
        i. Health providers
4. What can we do?
    a. Simple answer? No
    b. Need mental health providers for children
    c. Mental health crisis
    d. Equal access policies at the state level? Difficult but lasting effects
5. What challenges?
    a. Funding to providers

Group 2

1. What jumps out at you regarding the data?

    a. We do not have a lot of providers per resident…. Especially in Sibley
    b. Cost-people are delaying care because of costs, or not getting care
    c. Transportation is an issue, How does it affect the population that uses it? Who uses it? Why do they use it? Can it be better coordinated to meet the population's needs?
    d. Lack of information about the transportation issues
    e. Meeker has no dental providers for children

2. What is going well?
    a. Meeker and Kandiyohi and Renville counties now merged transportation services
    b. Sibley's mobile dental clinic… all ages, but this clinic is hard to get into because everyone is trying to get into
    c. New Sibley mobile medical van too.
    d. Sibley has dental varnishing for children available to all homes, daycares and schools now.
3. Needs?
    a. Transportation may not go to county where service is available… if you live in a different county.
    b. Mental health now taking up jail beds/ER beds/ mental health beds in hospitals in distance areas
    c. Do we have any mental health clinics in 3 county areas that are low cost? Sibley has open door.
    d. Dental is a health equity issue
    e. Why can't we have a dentist in our schools? We already have therapists, counselors
4. What can we do
    a. Increase MA dental providers, how to get dental providers to buy into the community's needs?
    b. Increase providers in the schools.
5. Easy solutions?
    a. No
    b. Dental colleges, dental technicians in the school
    c. State mandated % of providers must take M.A. for dental? Like they have for medical
    d. Hygiene education and supplies like toothbrushes/floss
    e. Dental care is not very affordable for many, especially low income, then it cannot be a priority
    f. Need affordable dental care… not equitable
    g. Education

Group 3

1. What pops out to you regarding the data?
    a. Mental health needs
    b. Many choose not to go to providers
        i. Why?
            1. Stigma
            2. Not that bad
    c. Regarding food
        i. Number of people utilizing fast food/vending machines vs. farmers markets CSA's

ii. Healthy options not as available or not as convenient… but maybe could be healthier? Or it is the culture/a routine/a norm
    1. Would be ideal that eating healthy is the norm instead of snacks that are a bargain (3 cookies for a $1)
    2. More appealing options of choices (cut apples vs. whole apples)
iii. Non healthy options as available
iv. Belief that healthy foods are more expensive. Healthy foods do take time, require storage, and require preparation and planning.
v. Unhealthy snacks available at schools through lunch account negate the healthy lunch options that are required.
vi. Do the responsible adults know what is healthy and how to be healthy and how to prepare foods those children like if you cut up an apple they will eat it.
vii. Education to parents? Support?

d. Culture around healthy eating

2. What can we do to address this issue?
    a. Easy-No
    b. Simple-No
    c. Access to healthy foods--- starts with the responsible adults that are providing the food and modeling the behavior regarding healthy choices
    d. Nutrition education for low income. Currently only one person for McLeod and Wright
    e. More people need to educate others
    f. Seniors- is everyone aware of all available services to those they serve?
        i. Is SNAP connected to mental health and to transportation to other services that will help this person connect to what they need? To make it easier.
    g. Current disconnect between what the nutritional professionals are doing and what the majority of people are taught… on the internet or at school…. And what is available.

Table 2

Obesity

Group 1

1. "What part of the data jumps out at you?"

    - Lack of exercise

- Percent of the people overweight
- 5% higher than the state average
- Eating habits
- Lack of exercise in general
- Seasonal barriers, i.e. winter
- Number of people that go out to eat
- Intake of fruits and vegetables are higher than state average

2. "What do you observe in the community?"

    - Young people over weight (in their teens and 20s)
    - School aged children and younger that are overweight
    - Often times this is mirrored by parents being overweight
    - Lack of intake of fruits and vegetables
    - Eating healthy costs more

3. "Is there a story that is not being told?"

    - Mental health connection
    - Link to other health indicators
    - Cost issues i.e. gym membership
    - Strength: McLeod county trail and sidewalk accessibility
    - Strength: Number of parks in Hutchinson
    - Strength: Community engagement – farmers markets
    - Challenges: culture – people do not necessarily care about this
    - Challenge: Community events around unhealthy menus, i.e. pancake breakfast, fish fry
    - Challenge: limited menus at restaurants, i.e. burgers and fries

4. "What would have the most impact?"

    - Making healthy options more available, healthy choices
    - Culture of health
    - Starting young
    - Parents modeling behavior
    - Education

5. "Main theme?"

    - Access to activities
    - Access to healthy food
    - Access to low cost healthy food
    - Culture of health

Group 2

1. "What data jumped out at you?"

    - Rate of obesity is high – even considering self-reporting
    - What we've done has not made a difference
    - Cultural stuff

2. "What do you observe in the community?"

    - Senior population focus on trips, buffets, ride the bus, sit some more, is cultural
    - Starting at a younger age. 3-5 year olds are overweight.
    - No discussion of life style choices. Conversation is shut down.
    - Small subgroup is healthy and active, a large group is unhealthy. How do you close the gap?
    - Electronic devices are a barrier. Used by parents as a sitter.
    - Real impact of technology
    - Lack of physical activity among kids
    - Taking away recess
    - Heart rate needs to be elevated to be exercise

3. "What is not being told by the data?"

    - People do not know how to prepare food
    - Healthy food is less convenient
    - It tastes different and people have different feelings about healthy food
    - Young age – reaching people at a young age.
    - List of snack foods suggested by schools should not include teddy grahams, i.e. and should include more healthy snacks.

4. "What can we do that would have the most impact?"

    - Food systems in school – bread with melted cheese served as a main course/protein is not acceptable.
    - Reach out to children – they are formed by their parents
    - Lunch room reform – the push back after the Michelle Obama efforts. Kids bringing their own bottle of ranch for their lockers
    - Understanding satiety. Do not need to feel full like thanksgiving dinner after each meal.
    - Rewards in school are focused on food rewards such as a cookie, Dairy Queen coupon, pizza or hot dog party.
    - Implementing healthy fundraisers
    - Time is an issue
    - Not only limited income but limited skills.
    - How did we get here? We need to go back.
    - Culture in Europe is a better example

- Imply negative connotation that to be overweight is bad/not normal
- Obese is an offensive word. Doctors using other language. "Less than ideal weight."
- Take smaller steps to motivate
- Social acceptance. Obesity is culturally acceptable.
- Obesity tied to mental health issues.

5. "What is the main focus?"

    - Kids
    - Schools
    - Culture
    - Language

Group 3

1. "What part of the data jumps out at you?"

    - Rate of physical activity
    - Disparity from 9th grade to adult. What changes here? Driver's license, going out to eat more often, making their own choices?
    - No trending data. Data is from one point in time.
    - The number that delayed medical care – could affect obesity
    - No access to city vs county data
    - Healthy food costs more
    - Healthy food weighs more. If they take the bus, how many bags will they buy, processed food is lighter.

2. "Are there parts of the story not being told?"

    - Access to trails, gyms, and the utilization of these
    - What are the alternate choices that are being made?
    - Example of average size getting larger: Family trip to Disneyland to the original Mr. Toad's Wild Ride. The rails guiding guests waiting in line are very narrow. Would not accommodate the average person. This is an indicator of change of size of average person.
    - What normal is this change?
    - What's an unhealthy weight
    - Chik-a-filet made $6 billion last year. This is an indicator of its popularity
    - Why are people eating out?
    - People are tired – on the highway, kids in activities, working full time. They are tired.
    - It is possible to make healthy choices at fast food restaurants.

3. "What are the successes?"

- SHIP –
- The state is "pumping a lot of money" in to this program
- Low income programs – SNAP at farmer's markets
- Partnerships
- Weakness: Transportation

4. "What could make the most impact?"

- More power if employers make healthy choices more convenient
- Healthy meal before work
- Working on policies – food policies
- Insurance discounts for those who have an annual physical
- Working with school regarding physical education, recess, snacks, lunches, and education

5. "What are the main themes?"

- Kids
- Schools
- Nutrition campaign
- Reach low income who are high risk
- Health disparities "causes" health risks

Table 3

Choice/behavior/culture

Group 1

1. What jumped out at you in the data we reviewed for this issue?
    - How do we get public to connect?
    - Delay of medical care and the top two reasons why we weren't getting medical or dental care?
    - Drinking and the students and the large amount of adults. Adults are setting the example.
    - Shingles vaccine- age and access from point a to point b. We are rural so is the transportation an issue as in cost
    - High deductibles in medical costs
    - Prioritizing correctly as a culture

2. What do you observe in your community around this issue?

    Knowledge as to resources out there

    - Culture – fear in coming in

- Need of a resource person to get out the information

3. What is going well in our community around this issue?
    - Health focus: is out there (runs, playgrounds, trails, farmers markets, farm share,)
    - Cooking classes
    - Coalitions for underage drinking
    - Joyride – rides for those that have been drinking and need a ride (Meeker)

4. Challenges
    - Town festivals
    - Rewards for races etc. as the rewards are unhealthy (alcohol)
    - Resources- Human and money

5. What are the easiest/simplest things that we can do to address this issue?
    - Tricounty-dricounty
    - Environment
    - Increase awareness to what is available
    - Promote healthy behaviors and lifestyles and reward them for it
        - Rewards for healthy choices
        - Healthy food access
        - Farmers market
        - Community engagement – to show the benefit (cost is challenges)
    - Promote the ideas to start young with healthy lifestyles

Group 2

1. What jump out to you in the data we reviewed for this issue?
    - Amount of Drinking in 9th graders
    - Lack of exercise
    - Lifestyle contributes a lot to our choices – one leads to the other

2. What do you observe in your community that supports the data reviewed?
    - Jail full of people around (Winstock)

3. What is missing from the conversation thus far?
    - Provider questions: asking individuals that don't seek out medical help until it is needed- not preventative
    - Access to trails, healthy foods etc. are they using them
    - What are the areas and barriers to why they are not participating

4. Strengths in our communities
    - More community involvement
    - Parks, trails, activity free classes

- Partnering with other groups
- Safety
- Community gardens in schools
- Awareness is a big part – you can eat healthy, you can go for a walk

5. What challenges exist in our community around these issues?
    - Getting public to participate
    - Optional phy-ed in high schools, lesser minutes of activity in elementary – kids could get in the habit of more physical activity to make a healthier choice when they are adults.
    - Perception with having alcohol at graduations, etc. or that kids have always drank – we did

6. What are easiest/simplest things that we can do to address this issue?
    - Start early to focus on the positive messages
    - Behavioral change
    - Starts at home with habits – workplace wellness – encourage parents to be active at work and have them bring it home. And have the kids work on healthy behavior at schools
        - Rewards don't have to be candy, or unhealthy choices
        - School gardens – kids work at the garden and they use the food from the garden for school lunches.
    - Start at school – home – work. City level and what people have access to.
        - As an example look what happened with smoking – at first it was a big deal and now no one says much as it is now the norm. Positive peer pressure as to this is what we do here and what we don't do. Policies also help.

Group 3

1. What jumped out to you in the data?
    - Binge drinking
    - Rates of obesity
    - Choices in MA dental providers and lack of choice

2. What do you observe in your community that supports the data?
    - High deductible – lack of choice – seeking the medical care they need not preventative. Do they not know what they preventative choices are less expensive?
    - Preventative not checked could now turn into a high medical need.
    - Cultural difference in accessing care and misunderstandings
    - Is there a voucher to give as a part of insurance benefit – even though they still don't come in with these benefits? (CT&C) Do they choose to not know

what their health care covers? Culture of prevention? Change of culture? Shift and it is not being embraced

3. What is going well?
    - Incentives – they just need to be made available with the use - Outreach!!! Standardization in the clinic as to what is provided (EMR) Which of our providers is missing out on certain tests/ screenings

Barriers

- Catch the patient when they are in the clinic – for medical visit but the barrier is the time and the billing. Our system needs to change. Reimbursement doesn't support prevention

4. What is the easiest/simplest thing that we can do to address this issue
    - Nothing is easy or simple
    - Changing the culture (not easy though)
    - Perception and knowledge.
    - New abnormal.
    - Same as above for this question – they aren't easy either
    - School and work is a great place to start and then bring it home. What we offer in the cafeteria? Adding the calories to the food menu items.

Table 4

Mental Health

Group 1

- Access
    - County Breakdown, McLeod providers are full of those "flocking" from other areas (Meeker/Sibley) where service is lower
        - Data can be too simplistic, not looking at "next available appointment" or provider ratios that don't look at the definition of the provider (level of training/experience)
    - There should be more of a focus on utilizing Mental Health tools in Primary HealthCare settings
        - TeleHealth Options

        - Not successful for Glencoe Regional
    - How can the mix of mental health providers change the outcomes?
    - People traveling for specific services
        - Transportation is a barrier
- Biggest Challenge(s): Diagnosis specific rather than all encompassing
    - Ex. Happiness vs. Depression (Do you have depression as opposed to are you happy, how is your quality of life)
    - Focus on Mental Illness vs. Mental HEALTH/WELLNESS
- How can we be more creative at expanding provider utilization?
- The range of providers? Addressing mental health at ALL provider levels

Hutch Mental Health/Hutchinson Health

- Siloed

- Opportunities for greater outreach/education/INTEGRATION on how everyone can help as opposed to being depended on for all the answers
- Even the department may not take a focus on mental wellness

Energy in the Community

- We ALL need to be involved

    - Whether they want to or not/they need too, collaboration is key
    - Interaction between primary care providers and mental health providers needs improvement, cannot have the drop-off effect that seems to happen currently
    - Education, State, Healthcare, Mental Health providers, Law enforcement- where are they in this topic
        - The energy doesn't seem to be collaborative or appropriately skilled in the area (is law enforcement done with them once they get the patient to the ER?)
        - What are the capacities? Mental Wellness/Health
        - Increasing capacity for RESILIENCY
    - These resonate more with people

    - Bounce Back Program in Buffalo/Monticello

Group 2

1. What part of the story is missing:
    a. Stigma
        i. Lack of seeking/initiating services
    b. How do we over come the stigma?
    c. Starting in schools
        i. Helps children recognize mental health importance
        ii. Decreases stigma and helps open up people to the idea of mental health and its contribution to overall health
            1. Biophysical, psychosocial, etc as components of health
        iii. Benefit having a separate mental health (not just a school nurse)
2. Strengths
    a. Attempt to remove the stigma
        i. McLeod has a group that coordinates runs/walks
        ii. "Break the Stigma" Run, Name and affiliation group unknown (collaborative of several organizations)
    b. Providers available are of good quality
    c. Crisis intervention
        i. ER's seem to know where to send people (appropriately) following the initial visit (in crisis)

        ii. Grant money may be coming available to help providers address this Crisis Text/Phone

        Barriers to finding appropriately qualified practitioners to respond

    d. Starting to be on the radar
        i. State level initiatives
    e. Communities are aware-"we"(providers/county level-LAC) are aware and spreading this aware
    f. PACT4Familiescollaboratives
        i. Funding
        ii. Services
            1. School Based Services reduced socioeconomic burdens for families (less time off work, less missed school)
3. Challenges
    a. Lack of providers

        i. Turnover is great, seems like once people get established their provider leaves and its devastating for people to start opening up and the relationship breaks and they start all over

ii. Long Wait Times
    1. People need services now
iii. Possible distance for quality providers in some areas
iv. Children's/Adolescents are low, Infant services almost nonexistent in the 3 county area
v. The level of crisis services available is unacceptable
    1. The ER is the current source but not adequately trained to serve this need (DO SEE STRENGTHS FOR THIS AREA)

4. Current Players (refer to Jelly Bean Chart)
    a. Jail, Clinic, MHPractitioners, Schools, Public Health, Social Services, Healthcare (everyone truly has it, see below)
    b. Who is not actively engaged (by choice, disincluded, not fairly represented)
        i. Local Law Enforcement
            1. How well attended are trainings for MH crisis intervention
            2. Low population density and occurrence seems to hinder our participation in having groups of well trained staff
            3. Not a great system for identifying where patients in crisis go? Ex. 8 yr old was sent to Marshall, removed from family and added trauma
            4. Transitional planning needs are great and undermet
            5. Recycling, reoccurring problems
        ii. Clinics need a bigger capacity to screen more regularly or spend more time in this particular need
        iii. Hospitals, ER's - focus on treating physical and not mental health (goes back to utilizing)
        iv. Ramp up the energy of the players already involved
        v. Schools are not involved
            1. Lack of support (staff, funding)
        vi. Businesses-Maybe for the elderly or the disgruntled but not fully understood or well handled

Group 3

1. Where should our energies be focused
    a. Do we understand the definition of Mental Health?
    b. More and more stuff "diseased"
    c. Definitions are broadened to include more illness
    d. There are incentives to include more as a problem
        i. Drug coverage, Insurances coverage
        ii. Some people have unrealistic expectations of what mental illness is

iii. Even the wording of the questions to capture the information is very specific to type of illness, Underreported? Exaggerated?

e. Mental health is an underlying concern of a lot of healthcare visits •
f. Is there a difference between destigmatizing vs. normalizing
g. At what point did the healthcare system start screening for mental illness?
h. PHQ-9, What are the confounding factors? Can the scores be explained?
i. Eustress? Is it normal/expected or is it a pattern of illness?
j. Crisis services should be a focus, they should not end up in the ER
    i. We should divert a lot of people to more appropriate care
    ii. Hugelackofcrisisinterventionservices
    iii. Crisis hotlines not always available 24/7(that's a problem)
k. Opportunity for education with youth
    i. Self-esteem
    ii. Resiliency Skills/Coping Skills
    iii. "You're not alone" message
    iv. Safe place to talk
    v. Positive activities (outside of sports/academics)
        1. What are other things kids can do, together
        2. Will it impact other behaviors
    vi. Reduce risky behaviors
    vii. Increasing positive community norms

2. What are the most impactful things we can do?
    a. Teach coping skills (CBT tx)
    b. What challenges do we have to overcome
    c. Stigma
    d. Social media
        i. How to: raise your child right, feed your child, the different agendas people are pushing, constant pressures for parents rubbing off on children?
    e. Lack of service, sibley county so disparate
    f. Societal expectations have greatly increased over the years
    g. Culture of Stress
    h. Why was there more resiliency in the past?
    i. Lack of personal relationships and communications in person vs. texting
    j. Families that can/cannot participate in planned activities
        i. Gap widens
    k. Socioeconomic barriers continue to be a large struggle
    l. Communicating that everyone, even people with mental illness, have mental
    Health

m. Institutionalization's and that impact on stigma
n. Psychotropic use lower in Dutch communities
    i. Dutch People don't think we need to be happy all the time(MPR conversation)

Table 5

Senior Health

(all groups combined)

1. What jumped out to you in the data reviewed for this issue?

- The number of elderly who still work
- The rapid increase in population of senior citizens
- The rate of individuals with dementia/Alzheimer's
- Seniors are more likely to have diabetes and high blood pressure (chronic health issues)
- It seemed that dementia/Alzheimer's was under-reported
- Would have liked to see data related to number of service opportunities for seniors

2. What do you observe in your community related to senior health?

- Act on Alzheimer's grant in Sibley county
- A high need of caregiver support that is not being met
- Lack of adult daycares within all communities
- An increasing need of public transportation and volunteer drivers for the senior population
- Lack of access to social events and activities
- Lack of visibility/outreach of senior resources
- Nutrition education for low income individuals
- Lack of physical ability for senior citizens to prepare healthy meals
- Inability to afford healthy food and lack of healthy food options
- Seniors are not fully utilizing the food benefits that they qualify for
- Transportation can be expensive
- The affordable transportation can be difficult to schedule and some seniors may have to wait hours to get a ride
- Seniors need more assistance with coordination of services to increase the utilization of services

3. What are the strengths in our communities regarding these issues?

- Trailblazer Transit system
- Volunteer drivers
- AFC Silver Sneakers program in Hutchinson
- Lutheran Social Services caregiver support group in Hutchinson
- Senior Linkage Line
- Minnesota River Area Agency on Aging
- Senior Expo
- Care Event (Sibley)
- Farmer's market accepts SNAP
- Care access to HCP in nursing homes and assisted living
- Immunization offerings for senior populations
- Home safety assessments
- Community-based fall prevention programs to assess risk for falls and then referring based on the assessment results

4. What are some of the areas within this broader topic where we should focus our energy?

- Determine barriers to access of resources
- Increasing education and activities for the population with dementia and Alzheimer's
- Increase outreach and awareness of the resources (i.e. tele-health services) available for the senior population
- Figure out a way to follow up with seniors to find out if they have accessed their resources that have been offered to him.
- Engage seniors in an activity or group that sparks their passion
- Educate seniors based on the gaps identified
- Senior counseling to prepare them for stages of aging

5. What are some simple things that we can implement to address senior health?

- Partner with resource organizations
    - Specifically determine who is responsible for outreach?
- Reach out to the senior population to ask them directly what they think are their greatest needs instead of assuming that we know what their needs are
- Reverse the stigma of aging and flip it to an acceptance of aging and prepare seniors for what to expect
- Providers should start the discussion of aging earlier in life
- Promote embracing aging instead of being ashamed of it

Table 6

Binge Drinking

(all groups are together)

1. What jumped out to you in the data we reviewed for this issue?

    Rate of MMS compared to statewide numbers. Adult vs. Adolescents

    Higher income has increased rate of daily ETOH use

    - Why is this? Stress, socially acceptable
    - 20 % of 9th graders are drinking
    - People are honest in answering this; may not understand what binge is drinking. People don't understand that 4 or more drinks is considered binge drinking.

2. What do you observe in your community around this issue?
    - Attitudes of adults
    - Culturally accepted
    - Attitude of alcohol being legal vs. "drugs"
    - Adolescents are getting the alcohol
    - Messaging doesn't match statistics
    - P & I grant to address binge drinking
    - Difference between having a glass of wine vs. a bottle; how is that message told/learned by adolescents
        - How are adult decisions influencing the youth?
    - People are drinking at home more than out socially – more availability
    - How does mental health feed into our binge drinking rates?
    - Need to dig deeper into the data
    - More education on what is considered Binge drinking.
    - The stigma around having a DUI is not prevalent in MN
    - The DARE program (4-5 grade) is effective for a reason- how can we shift some focus to ETOH use as well. Discuss binge drinking.
    - Increase ETOH programs/education in our schools – target younger grades
    - ETOH use is discussed in drivers training (one drink is not acceptable is the message)
    - County Newsletter – is the 30% of parents that binge drink reading it or giving the information/teaching their children

- Children as early age as 3-4 they have a concept of what drinking too much is (using a bowling pin as a wine bottle)
- Popularity of wine: increase in women's social drinking
- Trends are influencing our rates: craft beer and wine
- Support for events such as River Song gravitates towards liquor sales to fund the events. Other funding sources either don't exist or don't provide the level of funding
- Parents, schools, business community need to be more involved
    - Hard to see social media posts, but cannot do anything about it
    - ADA and alcoholic
- Business community culture- is ETOH use acceptable vs. not-acceptable
- People feel that they deserve "a break"
- People don't think twice about having 3 drinks when out for dinner
- Socially acceptable
- Community events having ETOH at the center of it
- Vary rarely there is an event where ETOH is not served or involved; especially in rural area
- It is "expected" that you have a drink at events
- Real definition of binge drinking is not accepted by our culture.
- Correlation of binge drinking and alcoholism
- Seeing one day a week as binge drinking as not a problem
- Adolescents access to ETHO. Where are they getting it?
- People are not aware of the health implications (dangers)? How it correlated to other health behaviors and risks.
- Need more education on the health implications of binge drinking with correlation to the frequency of binge drinking

3. What are the areas we should focus on?

- Education and Prevention
    - Parents participation in a DARE program
- Defining, with community involvement, what binge drinking is.
- Consistent messaging; binge drinking, excessive use, alcoholism

4. What are the strengths in our community around this issue?

- Media attention: Hutchinson Leader, local coalitions
- Sibley and Meeker county partnering and prevention
    - How do we sustain these efforts
    - LARP
- What are the needs in our community around this issue?

- How do we continue engagement
- How do we teach responsible drinking or abstinence
  - Drinking a small amount at dinner vs. binge drinking
  - What are other cultures doing?
- Increase key stakeholders participation so the conversation can sustain

5. What challenges will we have to overcome to implement some of the specific strategies in this area?

- Culture
  - If binge drinking is not seen as a problem, how do we address it
  - Need to get the whole community behind it
  - Children trust what the adults are doing
  - People's perception of drunk driving vs. binge drinking
- The perception is similar to when "smoking was cool" – binge drinking (>4 drinks in one setting) is accepted or seen as ok when going out.

Large Group Discussion

What next steps do we need to take to harness today's energy and move forward?

- Prevention and wellness committee – look at the choice behavior and mesh with culture
- Learning from other communities in resiliency is there something we can learn from
- Education and awareness (ex. binge drinking) how to get to them and how do you get them there to teach them – engage and educate
- More data as to how is transportation being the barrier. Is it a big issue? Are there health care access issues?
- Access and stigma – is the stigma what is a barrier to what is the impact on getting access
- How do we get to them partner with businesses, expand the partnership

[ii] Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015. [accessed March 3, 2017]. URL: http://www.cdc.gov/brfss/brfssprevalence/

[iii] Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015. [accessed March 3, 2017]. URL: http://www.cdc.gov/brfss/brfssprevalence/

Appendix 3

Meeker-McLeod-Sibley Community Health Behavior Survey, 2014

Question 27a – During the growing season, how often do you or others in your household buy or get food from the following places? Farmer's market, fruit/vegetable stand

	Never or less than 1 time/month	About one time/month	About 2-3 times/month	About 1 time/week	Two or more times/week
All 3 counties combined	42.9%	25.5%	18.3%	10.2%	3.1%

Question 33a – Please indicate whether you use the following resources and facilities in your community. Walking trails

	I use this	I do not use This	My community Does not have this
All 3 counties combined	41.3%	40.6%	18.1%

Question 33b – Please indicate whether you use the following resources and facilities in your community. Bicycle paths, shared use paths or bike lanes

	I use this	I do not use This	My community Does not have this
All 3 counties combined	31.6%	49.0%	19.4%

Question 33c - Please indicate whether you use the following resources and facilities in your community. Public swimming pools or water parks

	I use this	I do not use This	My community Does not have this
All 3 counties combined	17.8%	62.3%	19.9%

Question 33d – Please indicate whether you use the following resources and facilities in your community. Public recreation centers

	I use this	I do not use This	My community Does not have this
All 3 counties combined	20.5%	56.2%	23.3%

Question 33h – Please indicate whether you use the following resources and facilities in your community. Health club, fitness center, or gym

	I use this	I do not use This	My community Does not have this
All 3 counties combined	15.8%	73.1%	11.1%

Question 76a – In your opinion, how much of a problem is each of these issues in your county? **Lead contamination**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	47.1%	43.9%	8.5%	0.5%

Question 76b1 – In your opinion, how much of a problem is each of these issues in your county? **Radon**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	41.7%	38.9%	17.7%	1.8%

Question 76b2 – In your opinion, how much of a problem is each of these issues in your county? **Second hand smoke**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	32.8%	29.4%	29.6%	8.2%

Question 76b3 – In your opinion, how much of a problem is each of these issues in your county? **Carbon Monoxide**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	45.4%	41.2%	12.4%	1.1%

Question 76d1 – In your opinion, how much of a problem is each of these issues in your county? **Garbage/litter**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	47.0%	40.3%	10.8%	1.8%

Question 76d2 – In your opinion, how much of a problem is each of these issues in your county? **Public nuisances: pests**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	61.6%	34%	3.3%	1.2%

Question 76e – In your opinion, how much of a problem is each of these issues in your county? **Stray animals**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	45.4%	42.3%	11.0%	1.4%

Question 76f – In your opinion, how much of a problem is each of these issues in your county? **Garbage or Junk Houses**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	35.5%	47.2%	13.9%	3.5%

Question 76g – In your opinion, how much of a problem is each of these issues in your county? **Hoarding**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	45.5%	41.5%	11.2%	1.8%

Question 76h1 – In your opinion, how much of a problem is each of these issues in your county? **Mold in private housing**

	No problem	Minor problem	Moderate problem	Serious problem

All 3 counties combined	43.6%	45%	9.9%	1.6%

Question 76h2 – In your opinion, how much of a problem is each of these issues in your county? **Mold in rental housing**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	39.9%	42.2%	15.3%	2.5%

Question 76h3 – In your opinion, how much of a problem is each of these issues in your county? **Mold in businesses**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	52.8%	38.4%	7.0%	1.8%

Question 76h4 – In your opinion, how much of a problem is each of these issues in your county? **Mold in schools**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	55.5%	34.9%	7.1%	2.6%

Question 76i – In your opinion, how much of a problem is each of these issues in your county? **Sexually transmitted diseases**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	41.7%	43.1%	12.6%	2.6%

Question 76j – In your opinion, how much of a problem is each of these issues in your county? **Use of marijuana/other illegal drugs**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	18.2%	28.2%	39.3%	14.3%

Question 76k – In your opinion, how much of a problem is each of these issues in your county? **Abuse of over the counter or prescription drugs**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	23.0%	35.7%	33.0%	8.3%

Question 76l – In your opinion, how much of a problem is each of these issues in your county? **Difficulty obtaining alcohol/drug abuse treatment for youth**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	38.8%	36.0%	18.7%	6.5%

Question 76m – In your opinion, how much of a problem is each of these issues in your county? **Difficulty obtaining alcohol/drug abuse treatment for adults**

	No problem	Minor problem	Moderate problem	Serious problem
All 3 counties combined	41.5%	36.6%	17.0%	5.0%