Washington County

Community Health Improvement Plan 2019

Executive Summary

The 2019 Washington County Community Health Improvement Plan (CHIP) is a long term, systematic effort for Washington County and its partners to address the top health priorities for community action, as identified in the Community Health Assessment (CHA).

The Local Public Health Act of 2003 (MN Statues 145A.10, Subd. 5a) requires Community Health Boards to set public health priorities based on a community health assessment conducted every five years. The five-member elected Board of County Commissioners is the governing body of the county that serves as the local Community Health Board (CHB).

In 2018, Washington County Public Health and Environment (PHE) partnered with Lakeview Hospital to conduct our Community Health Assessment, in tandem with their Community Health Needs Assessment. A variety of tools and processes were utilized to develop the assessment, including review of primary and secondary data, a provider survey, a community survey, and listening sessions. A health equity lens was used to consider how different populations are impacted by the factors considered and how the priorities impact people with different needs. Themes from this quantitative and qualitative analysis were presented and reviewed in a facilitated discussion of more than 40 community leaders and members. The resulting priorities that are addressed in this CHIP include:

- **Access to Care**
- **Access to Health**
- **Environmental Conditions that Promote Health**
- **Mental Health and Well-being**
- **Nutrition and Physical Activity**
- **Substance Abuse**

Over the next five years, PHE and our partners will lead the county in implementation of this CHIP. Efforts will be evaluated annually and updated as community needs change, and as new data becomes available.

Our department does not do this work alone. We depend on partnerships from all sectors of the community: other governmental agencies and county departments; business and industry; medical and health care; public and private education; nonprofit and faith communities; and most importantly from individuals like you! I would encourage each of you to consider how you might contribute to the health of your community.

Best wishes and be well!

Lowell R. Johnson
Director, Washington County Public Health and Environment

Credits and Acknowledgements

Washington County Board of Commissioners

The board of Commissioners serves at the Community Health Board for Washington County.

District 1 – Fran Miron
District 2 – Stan Karwoski
District 3 – Gary Kriesel
District 4 – Wayne A. Johnson
District 5 – Lisa Weik

The following Washington County staff members were instrumental in producing the Community Health Assessment and Implementation Plan:

Stephanie Souter
David Brummel
Kim Ball
Alena DeGrado
Caitlin Suginaka
Smita Rakshit
Alex Elizabeth
Maureen Hoffman

Community Partners

The health assessment and improvement plan is possible because of the generous participation from many individuals and groups. Thank you to all who contributed.

About this report

Washington County Public Health and Environment prepares a comprehensive assessment of the health of its residents every five years, and an accompanying Community Health Improvement Plan (CHIP). Health data is updated periodically within the Health Assessment cycle, through Community Health Profiles. The Community Health Assessment and related profiles can be found on the Washington County website at: www.co.washington.mn.us/CHA. Additional reports and data about Washington County can be found at: https://www.co.washington.mn.us/1211/Health-Data. The CHIP document, along with annual progress reports, will be available at https://www.co.washington.mn.us/1212/Plans.

For additional information, please contact us by e-mail PHE@co.washington.mn.us or by phone 651-430-6655.

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Introduction

The 2019 Washington County Community Health Improvement Plan (CHIP) is a long term, systematic effort for Washington County and its partners to address the top health priorities for community action, as identified in the Community Health Assessment (CHA).

The Local Public Health Act of 2003 (MN Statues 145A.10, Subd. 5a) requires Community Health Boards to set public health priorities based on a community health assessment conducted every five years. The five-member elected Board of County Commissioners is the governing body of the county that serves as the local Community Health Board (CHB).

The CHIP is also a requirement to maintain accreditation for the Washington County Department of Public Health and Environment (PHE). Under Domain 5 of the Public Health Accreditation Board (PHAB) requirements, it states that we must develop a community health improvement plan as the result of a planning process.

A snapshot of people and place

Washington County was created October 27, 1849, in the Territory of Minnesota. Minnesota was admitted to the United States as the 32nd state on May 11, 1858. As one of Minnesota's original nine counties, Washington County is on the eastern edge of the Twin Cities Metropolitan area, composed of 423 square miles of land, and possessing a distinct set of landscapes and resources. It runs more than 40 miles in length north to south and encompasses 468 lakes of 10 acres or more in area. The county seat is in Stillwater, Minnesota, along the St. Croix River.

The geography of Washington County is diverse and includes prairies, bluffs, forests, lakes, and rivers. County residents share an appreciation for the beauty of their natural surroundings and the resources of their communities.

While much of Washington County has retained its rural atmosphere, today it is considered a suburban county. Scenic beauty, historic significance, recreational amenities, and proximity to the growing Twin Cities Metropolitan Area have made Washington County a popular recreation and tourism destination, as well as a desirable place to live. These qualities also explain the county's continued popularity for residential and commercial development. The county vision statement is "A great place to live, work and play, today and tomorrow."

Washington County is the fifth most populous county in Minnesota, comprising 4.5% of the population of Minnesota. The total population in Washington County as of 2018 is 256,905. The county is growing, with an additional 75,000 new residents expected by 2040.

The population in the county is changing. The elderly population expected to continue to grow and the county is also becoming more racially diverse.

Washington County is the third most affluent county in Minnesota based on 2015 household income, after Scott and Carver Counties. Median household income for the county increased 5.8 percent from $79,109 in 2010 to an estimated $83,706 in 2015. Minnesota's median household income increased 7.4 percent from $57,243 in 2010 to $61,492 in 2015.

Community Assets and Resources

Washington County has many organizations that are committed to improving community health and well-being. In addition, there are a number of resources and assets available within the county that can be enhanced or mobilized to address health priorities in the community. An inventory was created using data collected from partnership connections and other existing plans (e.g. County Comprehensive Plan). Many of the organizations and coalitions identified were directly involved in the CHA and prioritization process (described further in the next section). Others were engaged in subsequent in discussions around implementation. Refer to **Appendix A** for detailed descriptions of partnerships and community coalitions, and additional information on government agencies, funding, natural and built environment, and business and industries. This listing is not intended to be exhaustive.

Planning Process

Planning framework

Mobilizing for Action through Planning and Partnerships (MAPP) is a framework for a community health assessment and health improvement planning developed by the National Association of County and City Health Officials (NACCHO). Washington County PHE chose to adapt parts of the MAPP model as the guiding structure for the 2019 Community Health Assessment. In addition, Washington County PHE integrated the community health assessment framework outlined by the Minnesota Department of Health to assure compliance with state law.

The MAPP framework uses traditional strategic planning concepts as a basis for improving community health. The framework focuses on systems thinking, helps develop partnerships and collaboration, and emphasizes data-driven decision making. These assessment frameworks result in the identification of priorities for community action.

A summary is provided here, with more details found in the CHA document and its appendix.

Data Collection

Washington County collects primary data for the purpose of incorporating the values and priorities of county residents into health improvement decisions. Sources of data used during the assessment and planning process include:

- Survey of the Health of All Populations and Environments (SHAPE), 2014
- Targeted 2014 SHAPE sample
- Minnesota Student Survey (MSS), 2016
- Health Equity Data Analysis (HEDA), 2017
- Community Health Survey, 2018 (in partnership with Lakeview Hospital)

Secondary data, or data not collected directly by Washington County, include: federal, state, and local data; hospitals and health care providers; local schools; academic institutions; other departments of government; and nonprofit organizations. Many sources of data for this health assessment are government agencies, such as the Minnesota Department of Health. Examples of secondary data include Census and communicable disease reporting. Other data originate from nonprofit research organizations such as Wilder Research, and other public and private data such as Minnesota Hospital Association data. Both primary and secondary data was utilized during the CHA and CHIP development.

Community Themes and Strengths

In the summer of 2018, Washington County administered a community health survey in partnership with Lakeview Hospital. The goal of the survey was to better understand what impacts the health of residents, their families, and their community. The questions were developed and administered previously by Ramsey County for their own community health survey. The primary method of collection was an online survey shared through several channels, such as Staying in Touch (the county newsletter), the county website, and email. In addition, Lakeview Hospital shared the link with their internal employees. Finally, a small number of surveys were completed by hand at community locations and entered into the database. The responses were compiled and shared with ACET, Inc., a contracted evaluation firm, for analysis. The data was reviewed by the ACET team for common ideas and themes and then coded using key word and phrase searches. Following the initial analysis, the data was then analyzed to identify key themes by question and demographic. To read the Community Health Survey Report, see the Community Health Assessment, Appendix D.

Forces of Change

The Center for Community Health (CCH), a collaborative between public health agencies, non-profit health plans and not-for-profit hospital/health systems in the seven-county Twin Cities metropolitan area, hosted a dialogue for community leaders on Wednesday, October 25, 2017, Forces of Change Affecting Community Health. Sixty participants contributed to insights and exchanged ideas. For a complete summary of the event, see the Community Health Assessment, Appendix H.

The event facilitated a community dialogue to identify and discuss factors that influence the health of people in our local communities and the Twin Cities region. The participant group explored questions such as: “What is occurring that might affect the health of our community?” and “What specific threats or opportunities are present?”

Community Health Status Assessment

The Community Health Status Assessment looks at community health and quality of life by reviewing health data to get a better sense of what the current state of health is in our community. Washington County PHE used data to guide decision-making during the 2019 community health assessment process. Throughout the CHA process, an equity lens was used to consider how different populations are impacted by the factors we considered and how the priorities impact people with different needs. This includes considering factors such as race, ethnicity, age, gender identity, socioeconomic status, and education levels when setting priorities and developing implementation plans.

After assessing all identified priorities, Washington County PHE ranked health indicators with their associated Hanlon Scores. While a rigorous methodology, the Hanlon method limits scoring to indicators with morbidity and mortality data. Therefore, several indicators have not been scored via the Hanlon method, such as Food Insecurity, Built Environment, Immunizations, or Social Connectedness. All indicators remain essential to community health. For a complete overview of our prioritization process using the Hanlon Method, see the Community Health Assessment, Appendix E.

Stakeholder engagement

A number of organizations and individuals were engaged in the development of the CHA/CHIP. This occurred in several different formats.

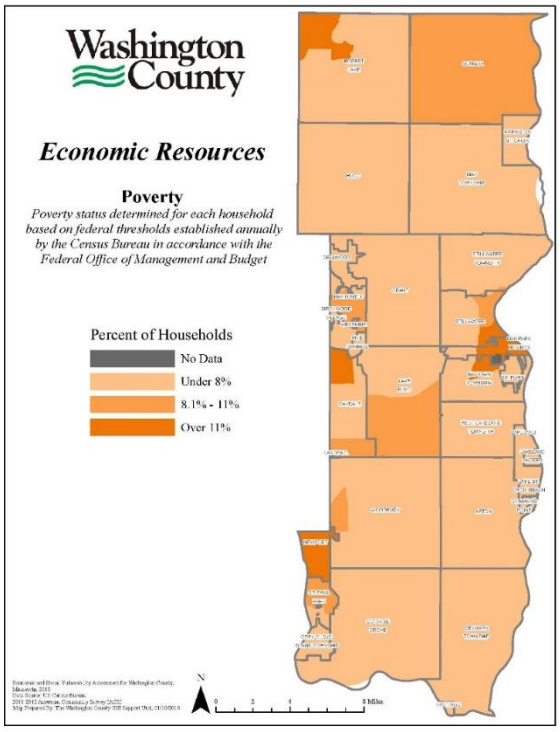
- ***Subject Matter Advisor Input:*** Local subject matter advisors reviewed indicator data to ensure accuracy and share emerging insights. See Community Health Assessment, Appendix B for data review instructions and a complete list of subject matter advisors.
- ***Washington County Community Dialogues:*** In 2018, Washington County PHE actively partnered with Lakeview Hospital to facilitate community dialogues.
    - *The Community Health Action Team* meets to discuss and address unmet health needs in the area through action, networking and educational opportunities. Members represent local public health, local businesses, education, nonprofits, social services agencies and community members.
    - *The Lakeview Health and Wellness Advisory Committee* serves as the eyes and ears for Lakeview Health Foundation and provides resources and services to meet the health and well-being needs of the community.
    - *The Community Leadership Team* is a collaborative which provides guidance for the Washington County's Statewide Health Improvement Partnership grantee, Living Healthy in Washington County. Members represent organizations from the north, central and south parts of the county who represent community organizations, health care, schools, and worksites.
- ***Provider survey:*** In 2018, HealthPartners surveyed health care providers to understand their perceptions of leading health needs and community resources available to help their patients. The survey also asked providers to identify barriers they face in addressing health needs and the resources they need to better serve their patients. 23 health care providers completed the survey, including seven who practice at Lakeview Hospital.
- ***Implementation discussions:*** In 2019, a number of internal and external partners were engaged in discussions focused around implementation. This is described further in the Formulate Goals and Strategies section.

Equity Lens

Although Washington County consistently ranks as one of the healthiest counties in Minnesota, some residents in the county are still affected by poor health. The health outcomes of populations within the county can be starkly different depending on a variety of factors, including race, education, income, and geographic locations. The difference in health outcomes are especially concerning, given that one's health is largely the result of external influences rather than personal health behaviors. The full CHA sought to highlight these differences to give a stronger understanding of the challenges that all populations in Washington County may be facing.

A key method of analyzing health disparities within the county is through the Washington County SHAPE Targeted survey. This survey used a convenience sampling where the majority of respondents fell below the median household income of $81,540. Of this sampling a little under 50% of these individuals made $23,000 or less per year. Below are some key data points that underscore health inequities in the county:

- Adult tobacco use within the targeted 2014 SHAPE sample is 21.6 %, almost 4 times higher than county average of 5.9%.
- While the county average for adults at a healthy weight (41.4%) exceeds state goals, lower income residents do not (25.10%).
- Housing cost burden (defined as spending more than 30% of income on housing) is 44.6% for renters, compared with 17.8% for owners.
- Over 50% of respondents to the 2014 targeted SHAPE sample indicated that they often or sometimes are worried about food running out before they have money, compared with 5.8% for the county average.
- Rates of mental illness are highest in low income communities. Nearly one-third of adults in low income households reported having an anxiety or depression diagnosis.



In an effort to acknowledge and call attention to health equity in the CHA/CHIP development, Washington County PHE chose to modify the Hanlon Method, the tool used to examine health indicators.

The traditional Hanlon Method considers four criteria of individual health problems: size of the problem, seriousness of the problem, estimated effectiveness of the solution, and the PEARL factors (propriety, economic feasibility, acceptability, resource availability, and legality). For the modified method, there is a focus only on the first two criteria (size and seriousness). Morbidity, mortality, and health equity were deemed to be the values that drive seriousness. Of the values, health equity was weighted most heavily. These designations allowed health equity to be incorporated into all future decisions throughout the process, assuring that vulnerable populations and communities receive the attention they need in order to be healthy. The Hanlon scoring methodology is listed as:

Value	Criteria
Morbidity (3pts)	Does the condition reduce an individual's quality of life?
	Does the condition cost more than $300 annually in medical expenses?
	Does the condition cost more than $1000 annually in all related costs?
Mortality (2pts)	Does the condition contribute to early death in Washington County? (1pt)
	Is it one of the identified top 15 rankable causes of death in Washington County? (1-5 rank = 2pts, 6-15 = 0.5pts)
Health Equity (4pts)	Is the condition more prevalent in marginalized populations? (2pts)
	Is the morbidity burden greater in marginalized populations? (1pt)
	Are marginalized populations more likely to die of this condition? (1pt)
Comparability (1pt)	Relative to data available for other geographies (state or national), is Washington County better (0 pts), equivalent (0.5 pts), or worse (1pt)?

Washington County PHE also engaged in a Health Equity Data Analysis. This process identifies differences in health outcomes between population groups and describes the broader policy and systems factors that contribute to the inequalities. A series of focus groups were conducted with community members with the intent of assessing the impact income has on mental health and physical activity. The goal of the focus groups was to hear from individuals who may be experiencing disparities in these areas and initiate a conversation on the conditions, causes, and potential pathways towards health equity. The results of this analysis will help provide direction for actions to reduce and eliminate these health inequalities in Washington County. The data collected in this project was utilized in the CHA/CHIP.

Review and selection of priority areas

Washington County PHE partnered with Lakeview Hospital in August 2018 for *a Community Prioritization Dialogue*. At this meeting, participants were asked to score and theme all quantitative and qualitative data collected. The themes generated were presented to a diverse group of more than 40 community leaders and members. A facilitated discussion allowed participants to indicate their top priorities. These priorities and perspectives were a key contributor to the development of CHIP priorities. A list of the organizations that participated in that dialogue can be found in **Appendix B**. Additional details about the dialogue were included in the Community Health Assessment, Appendix F.

Formulate goals and strategies

The resulting priority areas are described in the next section of this plan. It should be noted that these priorities are also shared with Lakeview Health/Health Partners. Though these priorities represent more than the standard two or three that are often included in Community Health Improvement Plans. Both community partners and PHE staff felt that the identified priorities all warranted inclusion in this planning process, as drivers of our work and partnerships.

Once priority areas were established through the joint CHA/CHNA process with Lakeview Health, a core team of PHE staff developed a facilitation plan and conducted outreach to both internal and external stakeholders in the spring of 2019. The purpose of these conversations was to further develop strategy areas and initial action steps for the CHIP. This decentralized approach allowed for flexibility in strategy development, while also recognizing that there are many efforts underway already to address these important community issues. Specific community groups and/or county departments and agencies where implementation conversations were held are listed below. Descriptions of these coalitions or partnerships, some of which include representatives from many different types of organizations, can be found in Appendix A.

- Community Leadership Team (Living Healthy in Washington County)
- Community Health Action Team (Lakeview Health/Health Partners)
- CONNECT
- Washington County Community Development Agency
- Washington County Community Services
- Washington County Public Works
- Internal PHE programs: Family Health Nursing, Disease Prevention and Control, Environmental Protection, Healthy Communities

For some areas, like Nutrition and Physical Activity, there are existing coalitions carrying out work, like Living Healthy in Washington County, which utilizes funding from the Statewide Health Improvement Partnership (SHIP). In the area of Access to Health – Transportation, the county, under leadership from the Department of Community Services, has developed a committee structure and work groups to lead prioritization and strategy development. For other areas where PHE has not been as actively engaged in conversations or issues, like housing, partnerships between PHE and others are in a much earlier stage. The CHA and CHIP presented an opportunity to engage on topics that public health staff have not typically engaged in, in the past. In initiating conversations, county staff focused on 1) *what is already occurring that moves us towards our goals* and 2) *where are the gaps*? Based on those conversations, and an internal work group, strategy language was developed and described in the following sections. Additional partners will be engaged as CHIP implementation occurs.

In the development of objectives and targets for population health indicators, we utilized state and national targets, including Healthy People 2020 and Healthy Minnesota 2020. These frameworks provide important state and national context and targets for a variety of population health indicators. Indicators were also chosen to align with recommendations from the Center for Community Health, a coalition of metro hospital systems and public health agencies, which are seeking to align efforts around assessment work. In some cases, Washington County is meeting or exceeding national or state objectives for population health. However, data from our 2014 targeted low income SHAPE, shows that not all residents are able to achieve the same health outcomes. As National frameworks are updated, like Healthy People 2030, targets will be revised accordingly.

Priority Areas

In this section, each priority is described. This description includes selected population-level indicators which describe the **current state** (baseline) and the **target** we are seeking (the target or objective). Each priority includes the following:

Priority: Health Issue identified during the CHA/CHIP process

Definition: How do we define this priority?

Why do we care? How does this area impact the health of our community? What key data are available? This is only a snapshot of information on this area, with more data available in the CHA, and the department's Health Data Profiles available online.

Result: Defined as a condition of well-being for children, adults, families, or communities.

Indicator(s): A measure that helps quantify the achievement of a Result. Grounded in current and available data and bound by the target or objective we are seeking**.** Targets line up with state and national frameworks, such as Healthy People 2020 and Healthy Minnesota 2020.

Program: A Program, agency, or service system responsible for helping reach the stated Results.

The word "program" is used to describe the work needed to address community priorities. Use of this language matches our performance scorecard which will be used for performance measurement, as described later on in this document. These program statements are written to provide flexibility in implementation, and were developed with stakeholders in the spring of 2019. As new needs arise in the community, or from within the department, program strategies and subsequent action steps may be modified, removed, or new ones added.

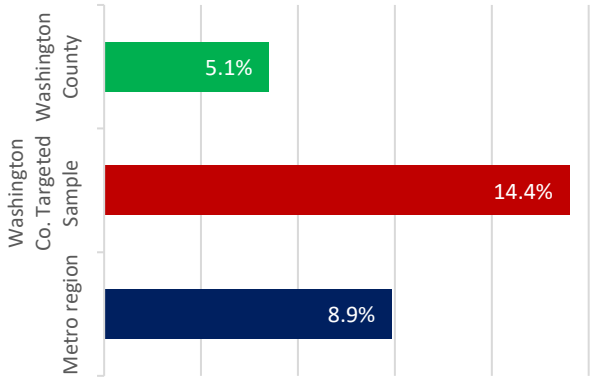
Access to Care

Definition: Access to care refers to having equitable access to appropriate, convenient and affordable health care. This includes factors such as proximity to care, access to providers, cost, insurance coverage, medical transportation, care coordination within the health care system, and cultural sensitivity and responsiveness.

Why is this important?

When people cannot afford to pay for insurance or other health care costs, they are less likely to get the care they need. Even if people are able to get the care they need, managing their health through medication can be a major cost burden. In the past 12 months, about 5% of adults in Washington County have skipped a dose of medication because they could not afford it.

Percentage of adults who skipped a dose of medication because they could not afford it in the past 12 months
Source: Metro SHAPE, 2014



When we look at Washington County's low income population, over 14% of these residents said they skipped a dose of their medication due to cost. Nearly 60% of adults in our community who delayed or did not receive medical care did so because of cost or lack of insurance. More than half of adults who needed mental health care said cost was the reason they did not get the care they needed.

Another aspect of access to care is access to preventative health services. According to the CDC, preventive care includes health services like screenings, check-ups, and patient counseling that are used to prevent illnesses, disease, and other health problems, or to detect illness at an early stage when treatment is likely to work best. Immunizations are often provided at checkups, particularly for children. Getting recommended preventive services and making healthy lifestyle choices are key steps to good health and well-being. Preventive services also lower the costs of health care overall.

Where do we want to be?

R Increase utilization of preventive services, including immunization services.

I Increase immunization rates for children aged 19 to 35 months who receive recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (PCV) from **75%** to **80%** (Healthy People 2020)

P Support and explore expanded options for dental services.

P Increase utilization of Child and Teen Checkup (C&TC) services for those that are eligible.

P Continue and expand outreach on the importance of immunizations in children, adolescents, and adults.

R Support and explore options for health care services for residents who are under or uninsured.

I Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care from 16.2% to 4.2% (Healthy People 2020).

I Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary prescription medicines from 5.1% to 2.8% (Healthy People 2020).
2016 SHAPE low income respondents: 14.4%

P Increase transportation options that connect residents with health care services (see Access to Health).

P Develop alternative options for sexually transmitted infection testing and treatment.

P Continue to offer immunization clinics for under and uninsured residents.

P Continue to explore options for development of community clinic that serves under and uninsured residents.

What needs to happen?

Policy and system level changes that might occur under this priority area include:

- Continued and increased funding from the Local Public Health Grant, a core funding source for local health departments.
- Exploration of a community clinic or alternative model to meet the needs of under or uninsured residents.

Access to Health

Definition: Access to health refers to the social and environmental conditions that directly and indirectly affect people's health such as housing, income, employment, education, and more. These factors, also referred to as social determinants of health, disproportionately impact low income communities and communities of color.

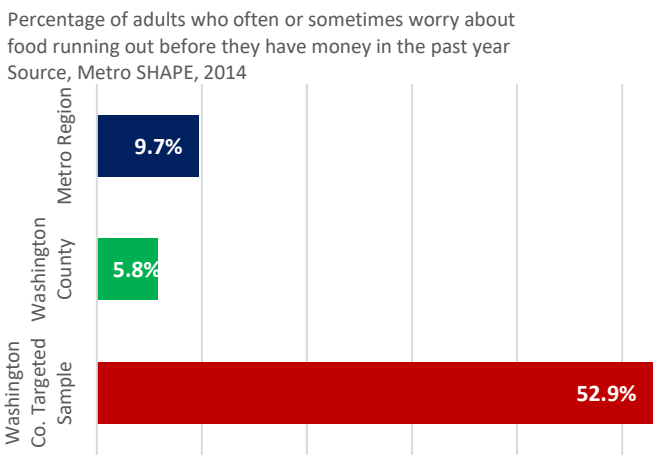
Why is this important?

A person's opportunity to be healthy goes far beyond health care. Healthy People 2020 defines social determinants of health as conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. For the CHIP, the focus in this area is related to transportation, housing, health equity (including food insecurity), and early child brain development.

Lack of access to **transportation** can have an adverse impact on health. Navigating existing public, nonprofit, community, volunteer, for-profit, and client-based transportation options in Washington County, particularly for those who cannot, do not, or opt not to drive a personal vehicle, is challenging. Important local destinations, such as grocery stores, hospitals, community centers, farmer's markets, houses of worship, County service centers, and other human service organizations, are geographically scattered across the County's thirty-three cities and townships, with less than half of the County's thirty-three cities and townships served by regular scheduled transit services. No local fixed-route circulator services currently operate wholly within or between the County's communities. Access to regional destinations is similarly limited: Express routes start and end in only five of the County's cities with service offered exclusively on weekdays during traditional peak commuting periods (5 – 8 a.m., 4- 7 p.m.) with no mid-day options.

A critical component to a healthy and vibrant community is a diverse and balanced **housing** supply in good physical condition that includes a variety of price levels, housing types, and sizes. A mix of housing tenures, types, and rent and sales prices provides residents with a range of choices so that they can continue living in their community as their housing needs change through their lifetimes. The affordability of housing is especially important for all residents because it provides a stable foundation on which to build one's life.

Health equity is the attainment of the highest level of health possible for all people. Health inequity is a difference in health status between more and less socially and economically advantaged groups, caused by systemic differences in social conditions and processes that effectively determine health. Health inequities are avoidable, unjust and therefore actionable. Although Washington County consistently ranks as one of the healthiest counties in the state, some residents in the county are still affected by poor health. The health outcomes of populations within the county can be starkly different depending on a variety of factors, including race, education, income, and geographic locations.



People experiencing **food insecurity** do not have consistent access to healthy and adequate food. Expenses for food are one of the first reductions people make under economic stress. People who experience food insecurity may forego adequate food for other expenses such as housing and health care.

About 53% of Washington County's low income population often or sometimes worries about food running out before they have money within the past year.

Where do we want to be?

R Residents have improved mobility and transportation options that link them with a variety of health services and opportunities to be healthy.

I Reduce % of trip denials for Transit Link and Metro Mobility.

P Implement a One-stop for transportation information and referral.

P Increase awareness of the One-Stop and of existing transportation options through high-quality training and outreach events.

P Provide twenty high-quality travel orientation events that support greater mobility for persons with disabilities and older adults.

P Sustain the involvement of both external and internal partners in increasing awareness and improving opportunities for mobility for those who cannot, do not, or opt not to drive.

P Advocate and promote long-term investments in transit to provide reliable and efficient transit services.

R Residents have affordable and accessible housing options.

I Reduce/maintain the percentage of households that are considered housing cost burdened
% of households spending 30% or more of their income on housing costs.
2017 ACS: Renter: 45% Owner: 18%

I Reduce the number of people experiencing homelessness.
2018 HOST Face to face contacts: 466

I Increase % of affordable studio/one bedroom apartments.
2018 ACS: 6%

P Promote a diverse housing supply to provide residents with a range of housing options, including affordable housing.

P Strengthen existing and explore new community partnerships to address housing and homelessness in Washington County.

R Washington County promotes health equity concepts both within county departments, and with external stakeholders.

I The percentage of households that experience food insecurity should be at or below 5.8% (Healthy People 2020)
2016 SHAPE response: 5.4%
2016 SHAPE low income respondents: 52.9%

P Continue and expand Health Equity efforts within PHE.

P Strengthen existing and explore new community partnerships to address healthy equity.

P Continue and expand efforts to address food insecurity.

R Promote early child brain development.

I 3rd grade reading level: % of 3rd graders passing Minnesota Comprehensive Assessment (MCA)
2018 MCA results for county: 62 %

P Nurture child development through intensive-targeted (Healthy Families America) home visiting and work to increase the engagement and retention of more families in services.

P Incorporate early childhood resources into clinics and community.

What needs to happen?

Potential policy and system level changes vary by topic. Examples include:

- Development of the One-Stop information center for residents seeking transportation assistance.
- Expanded circulator loops within and even between communities.
- Development of additional transit stops or centers in the county.
- Planning, design, and building of transit corridors. (e.g. Gold Line)
- New construction of general occupancy rental homes at all affordability levels, and preservation of publicly subsidized housing.

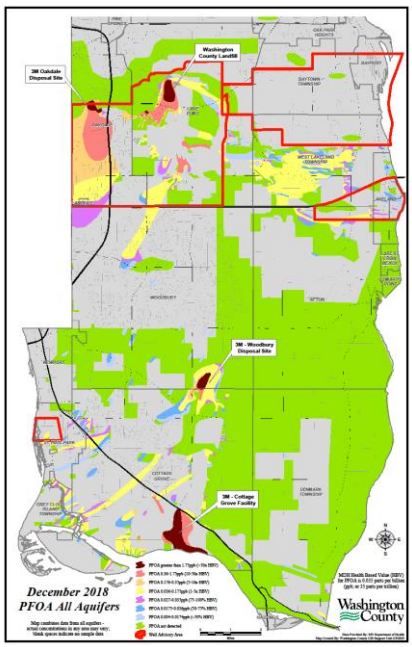
- Exploration of shelter options for homeless residents and families, including determining what shelter model will best serve our community, the operational costs of the proposed model, possible location(s) for shelter.
- Coordinating across health care systems, public health, and schools to incorporate early childhood resources in the community.
- Assess social determinants of health in county services and practices.

Environmental Conditions that Promote Health

Definition: Environmental conditions that promote and protect health refers to having a healthy and safe environment that enhances a person's quality of life. Access to environmental services and amenities can increase health and overall life satisfaction. Environmental conditions that impact health might include: surface and drinking water, air quality, changing weather conditions, and natural/built infrastructure.

Why do we care?

There are a number of environmental conditions that have the ability to impact one's health. One example in Washington County is drinking water.



Groundwater provides 100% of drinking water for county residents. There are several groundwater contamination plumes in the southern half of the county, and four special well construction areas. This includes a trichloroethylene (TCE) plume in West Lakeland and Baytown Townships.

In addition there is widespread contamination from per fluoro-alkyl substances (PFAS) that originated from four different sites in the county. PFOA, show on the map to the left, is one type of PFAS that is of health concern.

Between TCE and PFAS contamination, six municipal water supplies are affected, and either provide treatment or blending within their systems. Over 1,000 private wells have also been issued well advisories by MDH. Between public and private wells, the county estimates that nearly half of residents are impacted by groundwater contamination from PFAS or TCE. In 2018, the State of Minnesota reached a settlement with the 3M Company for $850 million. These funds will be used to ensure clean drinking water for residents of the southern half of Washington County.

Where do we want to be?

Residents have access to clean air, water, and land.

Work under this priority area is addressed through various other programming efforts that are underway within Washington County. There are two planning documents, both housed out of PHE, which support efforts to provide a safe and healthy environment for county residents. These two plans are the Waste Management Master Plan and the Groundwater Plan. Both of these plans were developed with extensive stakeholder engagement to develop strategies. Due to tracking and reporting already in place for these planning efforts, we do not include additional programs or strategies in this area, at this time. However, PHE and partners may develop program language in this priority area over time, to address emerging concerns or issues.

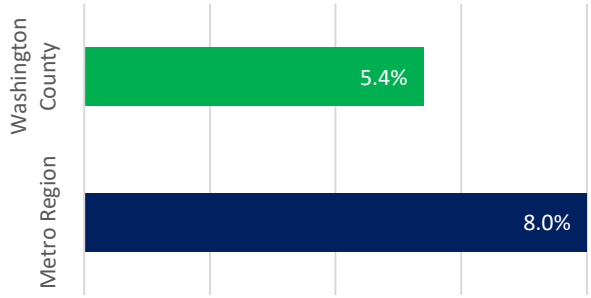
Mental Health and Well-being

Definition: Mental health and well-being refers to the interconnection between mental illness, mental health, mental well-being, and the associated stigma. Poor mental health is associated with poor quality of life, higher rates of chronic disease, and a shorter lifespan.

Why do we care?

Mental health is as important as physical health. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery. 5% of adults in Washington County report that they have poor mental health on 14 or more days in a month. This rate was even higher among low income residents.

Percentage of adults reported having 14 or more poor mental health days in the past 30 days
Source: Metro SHAPE, 2014



Many adults in our community say they have been diagnosed with a mental illness such as anxiety or depression. More than 1 in 5 adults in our community has been diagnosed with anxiety and 1 in 4 has been diagnosed with depression. Rates of mental illness are highest in low income communities. Nearly one-third of adults in low income households reported having an anxiety or depression diagnosis. Access to mental health care, as well as bullying, was mentioned as unhealthy aspects of the community in community surveys. Health care providers mentioned the growing prevalence of mental health issues as well as the need for more mental health treatment referrals.

Work related to mental health and well-being cross into multiple programs within county government, as well as many community partners. Washington County PHE actively participates in and serves on the leadership team for CONNECT, a mental and chemical health collaborative. The CONNECT leadership team includes Tubman, Family Means, Youth Service Bureau, Canvas Health, Hazelden Foundation, Washington County Community Services, and Canvas Health. Washington County PHE dedicates a portion of time from each of two community health specialist positions (totaling 1.0 FTE) to the work of mental and chemical health in the county and expand existing staff capacity within the department. This position focuses primarily on reducing stigma related to mental health and promoting increased protective factors/reduced risk factors to mental and chemical health.

Where do we want to be?

R All residents achieve optimal mental health and well-being.

I The percentage of adults reporting having poor mental health on 14 or more days in the past 30 days should be at or below 5.8% (Healthy People 2020).
2014 SHAPE response: 5.4%;
2014 SHAPE low income respondents: 27.7%

I Reduce % of adults that have been told by professional having anxiety and depression.
2014 SHAPE response: Depression-20.8%, anxiety-19.4%
2014 low income SHAPE respondents: Depression-31.9%, Anxiety-30.4%

I Reduce % of youth bothered by feeling down, depressed, or hopeless, in the past 30 days.
2016 MSS: Male- 28.5%, Female-49.6%

I Reduce suicide rates from 13.7 per 100,000 deaths to below 10.2 per 100,000 deaths (Healthy People 2020).

P Reduce Stigma surrounding mental illness.

P Increase access to education and resources around mental health and mental well-being.

P Improve timely access to mental health services.

P Build community resilience across the lifespan.

What needs to happen?

Potential policy changes related to mental health and well-being may include:

- Continued or increased access to funding for training programs that promote and support stigma reduction and community resilience.
- Research and implement evidence-based practices for mental health improvement.
- Expansion of treatment services to prevent lack of access to timely services.
- Continued support and/or expansion of crisis response services.

Nutrition and Physical Activity

Definition: Nutrition and physical activity refers to equitable access to nutrition, physical activity, and food and feeding choices. Poor nutrition and physical inactivity are major contributors to obesity and chronic diseases such as diabetes, heart disease, and stroke, which disproportionally impact low income communities and communities of color.

Why do we care?

A diet rich in fruits, vegetables, whole grains, and lean proteins is a key protective factor in preventing chronic disease. This is important for both children and adults. Providing our youngest generation access to healthy food and opportunities to move more will help them get a healthy start in life. Children spend more time in schools than in any other environment away from home, and healthy students come to school ready to learn. In addition, the majority of Minnesota families with children ages 12 and under regularly use some type of child care arrangement.

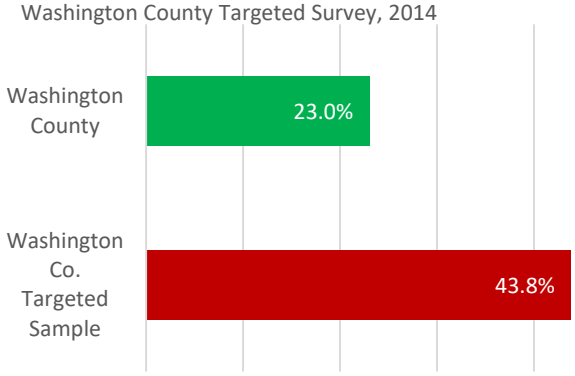
Schools that follow the national recommendations to offer healthy breakfast and lunch, and more opportunities to eat nutritious snacks through vending machines, classroom celebrations, concessions, or school stores helps students stay focused on academics. Youth who are physically active are stronger, have healthier bodies, experience reduced stress, and have increased self-esteem. Exercise can also help control weight and may enhance academic performance. The U.S. Department of Health and Human Services recommends that youth ages 6–17 participate in at least 60 minutes of daily activity. Schools can promote physical activity through comprehensive school physical education and sport programs, recess, walk/bike to school programs, active classrooms, and physical activity clubs and sports.

About half of youth eat one or more servings of fruit per day. Fewer than half of Washington County 9th grade students report eating at least one serving of vegetables per day. Despite these percentages being low, the rate in Washington County is similar to the Minnesota average. The recommendation for youth is to be active for 60 minutes or more at least five days a week. Compared to adults, far fewer youth in our community report getting the recommended amount. About half of youth in Washington County are getting the recommended amount of physical activity. County rates are similar to that of Minnesota.

For adults, the current recommendation for adults is to eat five or more servings of fruit and vegetables per day. Physical activity is defined as exercise and other activities that involve bodily movement. Types of physical activity include playing, working, active transportation, household chores, and recreational activities.

While Washington County typically meets or exceeds federal recommendations for nutrition and physical activity, results from our targeted sampling indicates that this is not the case for low income residents. We also see higher rates than national targets across the standard county population and our targeted sample, for high blood pressure and high cholesterol.

Percentage of adults who have ever been diagnosed with high blood pressure
Source: Metro SHAPE Survey, 2014; Washington County Targeted Survey, 2014



R Youth have increased access to and availability of healthy food and physical activity.

I 9th graders who are physically active for 60+ minutes or more at least 5 days a week.
2016 MSS: 92% for boys and 89% for girls

I % of youth who report eating at least 1 serving of fruits and veg per day should be 30% or greater. (Healthy Minnesota 2020)
2016 MSS: Fruit-53.2%, Veg-45.5%

I Reduce the percentage of 9th graders who report being overweight or obese from 19% to 16.1%. (Healthy Minnesota 2020)

P Support ongoing and new school partnerships and implementation efforts to increase access to physical activity and healthy food in school settings.

P Support ongoing and new childcare partnerships and implementation to increase physical activity and healthy food in childcare settings.

P Support and expand other partnerships that support healthy food and physical activity in youth.

R Increase access to and availability to healthy food and physical activity in the community (all ages).

I Proportion of adults who are obese is less than 27.8%. (Healthy Minnesota 2020)
2014 SHAPE: 23.5%
2014 SHAPE low income: 41.1%

I % of adults eating 2+ servings of fruits and 3+ servings of veg each day.
2014 SHAPE: Fruit- 57.9%; Veg-31.0%
2014 SHAPE low income: Fruit- 46.2%; Veg- 20.9%

I 75% or more of adults report 150 or more minutes of physical activity per week. (Healthy People 2020)
2014 SHAPE: 87.9%
2014 SHAPE low income: 57.3%

P Support ongoing and new partnerships and implementation efforts to increase access to healthy food.

P Support ongoing and new partnerships and implementation efforts to increase access to physical activity.

P Develop a countywide bike and pedestrian plan.

P Support and expand partnerships in the community.

R Promote and support breastfeeding as the healthiest option for the first 12 months and beyond.

I Maintain or increase the proportion of infants who are ever breastfed and are enrolled in WIC services.
2017: 85% Healthy people 2020 Target: 81.9%

I Increase the proportion of infants who breastfeed at 6 months, and are enrolled in WIC services, from 38% to 60.6%. (Healthy People 2020)

P Support and expand partnerships that support breastfeeding in the community.

P Support breastfeeding through family home visiting and WIC services.

P Lead and support breastfeeding coalition work in the county.

What needs to happen?

Potential policy and system level changes may include:

- Long term planning processes at the city or county level (such as comprehensive or master plans) that promote and expand active living and/or healthy eating opportunities for residents. One example of a guiding document that is being developed is the Countywide Bike and Pedestrian Plan.
- School nutrition policies to increase fruits and vegetables, decease sodium, saturated fat, and added sugar.
- Worksite wellness policies addressing nutrition, tobacco, physical activity, and breastfeeding support.
- Promote small scale food production of healthy foods and countywide availability.

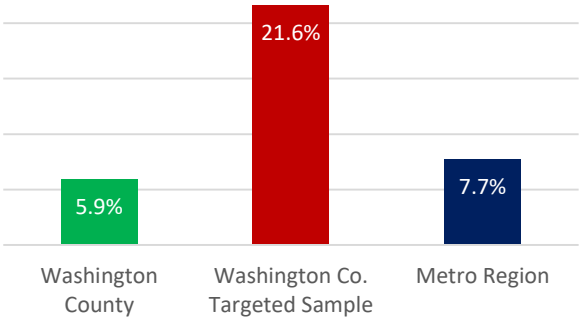
Substance Abuse

Definition: Substance abuse refers to the excessive use of substances including alcohol, tobacco, prescription drugs, opioids, and other drugs in a manner that is harmful to health and well-being.

Why do we care?

Substance abuse and tobacco use continues to be a top concern in the county. Tobacco use is associated with many chronic diseases and health conditions, including respiratory disease, heart disease, and cancer. About 6% of Washington County residents are current smokers which is slightly lower than the metro region average. However when we look specifically at Washington County's low income population, we see that number increase dramatically to a little under 22%.

Percentage of adults who are current smokers
Source: Metro SHAPE, 2014; Washington County Targeted Survey, 2014



There is increasing concern about opioid use in our community. The CDC has stated that the country is experiencing an opioid crisis. From 1997 to 2017 almost 400,000 people have died from opioid overdoses which include both prescription and illicit opioids. From 2012-2016, Washington County has lost 48 residents to opioid drug overdoses.

R All residents are empowered to lead lives free of substance abuse.

I Reduce the percentage of 9th and 11th graders who report using alcohol- last 30 days to be 15.5% or lower (Healthy Minnesota 2020)
2016 MSS: 9th grade- 10.3%; 11th grade- 25.8%

I Reduce the proportion of adolescents reporting use of marijuana during the past 30 days to 8.6% or less (Healthy Minnesota 2020)
2016 MSS: 9th grade- 8.2%, 11th grade- 19%

I Number of opioid-involved drug-overdose deaths should be less than 11.3 per 100,000 deaths (Healthy People 2020)
2017 data: 11 per 100,000

I Reduce the number of babies born addicted to opiods from current level (41.6 per 10,000 births)

P Reduce Stigma around addiction and substance abuse.

P Increase awareness and access to treatment for substance abuse.

P Reduce access to and dependence on opioids and other drugs.

P Align efforts and collaborate with internal and external partners.

R Tobacco use and exposure is reduced for all ages.

I Proportion of adults who currently smoke cigarettes should be 12% or lower (Healthy People 2020)
2014 SHAPE: 5.9%
2014 SHAPE low income: 21.6%

I Percentage of high school students smoked 1 or more cigarettes in the past 30 days should be 18.6% or less (Healthy Minnesota 2020)
2016 MSS: 4.4%

I % of high school students smoked 1 or more e-cigarettes in the past 30 days should be 16% or less
2016 MSS: 12.3%

P Support and engage with partners in reducing tobacco rates for all ages

P Ensure tobacco compliance for retailers.

What needs to happen?

Potential policy and system level changes may include:

- Implement medication-assisted therapy in county correctional facility and promotion in the community.
- Continued promotion of drug disposal boxes in the county (currently 5 locations).
- Smoke-free housing policies in multi-unit housing complexes.
- Worksite wellness policies that promote some free campuses and tobacco cessation.
- Implementing and promoting state-level changes (e.g. indoor clean air act expansion to e-cigarettes).
- Support, maintain, and enhance county policies related to the reduction in tobacco use and exposure to secondhand smoke.

Implementation, Monitoring and Evaluation

To track and monitor implementation of the CHIP, PHE will utilize the department's performance management system (PMS), through the use of Clear Impact scorecards. This system is built to utilize Results Based Accountability, in asking the questions of:

How much did we do?

How well did we do it?

Is anyone better off?

Action plans have been compiled and are included in Appendix C. These action plans represent point-in-time status of the various CHIP priority areas, as of 2019, and identify 1) indicators and targets for population level data, 2) shorter term action steps, where appropriate, 3) timeframes for implementation, 4) lead agency and other relevant community partners, and 5) performance measures, as available. Indicators and targets will be revised if, and when, new data becomes available, and if state or national targets for population health are adjusted.

A **performance measure** is a measure of how well a program, agency, or service area is working. This are denoted in the Clear Impact scorecard and the action plans as PM

Performance measures are developed around specific programs or efforts, and will be further developed as work occurs. On a yearly basis, tracking and progress of priority areas will be compiled by PHE staff in partnership with respective community agencies and revised in a CHIP annual report, displayed primarily in Clear Impact scorecards. Below are links for the five priority areas.

Access to Care: https://app.resultsscorecard.com/Scorecard/Embed/50118

Access to Health: https://app.resultsscorecard.com/Scorecard/Embed/50119

Nutrition: https://app.resultsscorecard.com/Scorecard/Embed/48652

Mental Health & Well-being: https://app.resultsscorecard.com/Scorecard/Embed/52206

Substance Abuse: https://app.resultsscorecard.com/Scorecard/Embed/52207

Progress and activities related to environmental health are tracked and reported through other planning efforts.

The CHIP, along with its associated report and scorecards, is a **living document** that will change as the community priorities, progress, and landscape changes. The Clear Impact scorecards make it easy to see and get up-to-date information about:

- **Results** we hope to see as our health improves
- **Data** trends and the stories behind the data that help us understand why things are getting better or worse
- **Partners and programs working together** to make things better
- **Ways we are measuring success** and describing how we are making a difference

Washington County PHE's role in implementation will vary depending on the strategy and is identified in action plans, as well as in the Clear Impact scorecards. The role can include:

Lead: The health department is in a central role for implementation, including dedicated staff time and funding resources, and full control of data. As such, PHE will update the plan to reflect lead implementation.

Partner: The health department is a partner, while another agency, such as another county department or a community partner (e.g. health system, non-profit, school, city, etc.), leads in implementation. The health department may be providing funding, and/or is actively participating in the effort. In this case, PHE will coordinate with implementation partners to retrieve necessary data.

Support: The health department supports implementation but is not directly involved in the work. As in the 'partner' role, PHE will coordinate with the lead to retrieve necessary data and designated staff leads will hold partners accountable.

The CHIP scorecards will be updated at least annually, by March of each year. PHE acknowledges a CHIP annual report will never fully capture all the efforts underway to address these health priorities. Limited staff resources and access to data will limit reporting efforts to where it is reasonable. In addition, reporting is more feasible where PHE has either a lead or a strong partner role, and therefore has access to data.

The review and modification of strategies will occur on a rolling or continuous basis. For example, in the area of nutrition and physical activity, the Statewide Health Improvement Partnership (SHIP) funding drives a large body of work related to promoting healthy behaviors. Work planning for SHIP occurs during the summer months, but the annual CHIP report is not completed until the following winter.

Appendices

Appendix A - Community Assets and Resources

Partnerships and Coalitions

The county has many coalitions and partnerships that work towards furthering community health. Some key coalitions are identified.

Committee Name or Community Meeting Name	Purpose
Center for Community Health (CCH) Committee	The Center for Community Health (CCH) is a collaborative between public health agencies, non-profit health plans, and not-for-profit hospital/health systems in the seven-county metropolitan area in Minnesota. The mission is to advance community health, well-being, and equity through collective understanding of needs and innovative approaches to foster community strengths.
Community Health Action Team (CHAT)	CHAT meets monthly to discuss and address unmet community health needs in the area through action, networking and educational opportunities. Attendees are from Stillwater Area School District and Washington County partners.
SHIP Community Leadership Team	The SHIP Community Leadership Team oversees the work being done in Washington County under the state SHIP grant.
Health and Wellbeing Advisory Committee (HWA)	The Health and Wellbeing Advisory Committee serves as the eyes and ears for Lakeview Hospital and provides resources and services to meet the health and wellbeing needs of the community.
Fairview Lakes Community Health Steering Committee	The Fairview Lakes Community Health Steering Committee comprised of local public health, community partners, and local officials work to understand the health needs of the local community through a CHNA process
CONNECT	CONNECT is a Washington County coalition that strives to promote behavioral health through prevention, early recognition and intervention for children youth and their families. Member agencies include: Tubman, Family Means, Youth Service Bureau, Canvas Health, Hazelden Foundation, Washington County Community Services, Washington County Community Corrections, and Canvas Health.
Transportation Consortium	Lead by Washington County Community Services, the transportation consortium is a newly formed group intended to address transit and transportation gaps in Washington County. Members include various county departments (community services, public health and environment, public works, administration), Washington County Community Develop Agency, Metropolitan Council, local business owners and others.

Government agencies

Resource/Asset	How does this support community health
County departments and agencies	In addition to PHE, many county departments have a role in supporting community health efforts. This includes Community Services, Public Works, Administration, Community Corrections, Sherriff's Office and Attorney's Office.
Community Development Agency (CDA)	The CDA provides programming to assist and promote the development of affordable owner-occupied and rental housing options including its ownership of affordable rental units. In addition, the CDA assists cities and townships with a variety of community development efforts, including public facility financing and redevelopment initiatives.
Cities and townships	Cities and townships have a unique role in keeping people healthy. These local units of government have primary responsibility for long term planning and decisions about housing, land use, land protection, and many other local zoning issues.
School districts/charter schools	School districts and charter schools are a central partner in improving community health, for both youth (in school programming and services) and adults (community education). There are 5 independent school districts serving county residents, along with several charter schools.
Watershed districts/WCD	Watershed Management Organizations are special purpose units of government that provide long-term protection for surface and groundwater resources. The Washington Conservation District The Washington Conservation District (WCD) is a special purpose local unit of government dedicated to managing soil and water resources in Washington County under the direction of a five-member elected board.
Metropolitan Council	The Metropolitan Council is the regional policy-making body, planning agency, and provider of essential services (including transportation/transit, wastewater, and housing) for the Twin Cities metropolitan region. The most recent vision and framework developed for the Twin Cities Region, Thrive MSP2040, calls regional investments that support a prosperous, equitable, and livable region now and in the future.
State agencies	Various state agencies are involved in statewide efforts to improve the health of residents. Minnesota Department of Health (MDH) is the primary state health agency, and is charged with overseeing local health departments and implementation of the Local Public Health Act. Many other agencies also provide critical policy direction, infrastructure, and funding support for community and environmental health efforts, including Departments of Human Services, Natural Resources, Transportation, Pollution Control Agency.

Funding resources

Resource/Asset	How does this support community health
SHIP	Statewide Health Improvement Partnership (SHIP) dollars are appropriated by the state Legislature, and support community-driven solutions to expand opportunities for active living, healthy eating and commercial tobacco-free living.
Local Public Health Grant	Local Public Health Grant, authorized by the MN Legislature every two years, provides funding to community health boards and tribal governments in Minnesota.
County funding	The county collects funds through property tax levy and the County Environmental Charge, a fee on solid waste collection.
Child and Teen Checkups	Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program
Other funding	Potential funding sources include state and federal agencies, foundations, or private funding.
Temporary Assistance for Needy Families block Grant	Used for eligible program services including non-medical home visiting for families, Women's Infants and Children (WIC) clinic services, and youth development
Maternal, Infant and Early Childhood Home visiting Grant	Support the delivery of coordinated and comprehensive high-quality voluntary early childhood home visiting services to eligible families.
Title V Maternal and Child Health Block Grant	Key source of support for promoting and improving the health and well-being of the nation's mothers, children, including children with special needs, and their families.

Community organizations

Resource/Asset	How does this support community health
United Way East	The mission of United Way East is to unite our community and local resources to give each person the opportunity to build a better life. They include focus areas on: YOUTH: Promote Thriving Children and Youth, BASIC NEEDS: Provide Basic Needs and Financial Stability, HEALTH: Improve Health and Independence, SELF-SUFFICIENCY: Support Self-Sufficiency and Connection to Services
Community Thread	Community Thread provides services aimed at older adults as well as advocates and supports volunteers throughout the St. Croix Valley region.
FamilyMeans	FamilyMeans is a multi-service, nonprofit organization with the mission to strengthen communities by helping individuals and families through challenges in all life stages.
YMCA	The county has two YMCA centers located in Washington County – Woodbury and Forest Lake. Both centers provide youth and adult programming and actively participate in wellness initiatives in their respective communities.

Natural and built environment

Resource/Asset	How does this support community health
Surface Water	The county is bordered by two major river systems, the Mississippi, and the St Croix, the latter of which is a National and Scenic River. Surface waters cover about ten percent of Washington County's 424 square miles. The majority of the county's surface waters consist of lakes and wetlands, and most are located in the northern half of the county. See Water Resources chapter of the County Comprehensive Plan for more information.
Groundwater	Groundwater provides 100% of drinking water for county residents. See Washington County Groundwater Plan for additional information on groundwater quantity and quality issues. See County Groundwater Plan for more information.
Natural Areas	There are Scientific and Natural Areas (5) and Wildlife Management Areas and Wildlife Management Areas (5) found within the county. Both of these amenities are owned by the DNR.
County/Regional Parks	County parks, which are part of the regional system, provide gathering places, physical activity opportunities, and access to natural areas for both county residents and those of neighboring jurisdictions. The county park system, which includes over 4,400 acres, logged approximately 1.35 million visits to 7 regional parks in 2016.
Other parks	There are a many additional parks within the county that are operated by cities or townships, in addition to two state parks.
County/regional trail system	The county is involved in development and/or maintenance of several types of trails. There are currently 17.5 miles of existing county-owned regional trails, with an additional 27.1 miles to be completed. Additional County Comprehensive Plan identifies several "search corridors" within the county that are envisioned as part of the regional trail system.
Other trails	Two major state trails exist in the county, Gateway and Brown's Creek, totaling 24 miles. A state trail is described as a route that connects state or national park destinations, and provides access to significant scenic, historic, scientific, or recreational areas.
Road system	The County contains approximately 2,195 centerline miles of highways, which includes all state, county, and local roads. Washington County Public Works is responsible for 282 centerline miles of highway.
Transitways	There are three major transit ways planned within the county. Washington County leads two joint powers boards overseeing the development of the METRO Gold Line (previously known as the Gateway Corridor) and the Red Rock Corridor. Additionally, the county is a member of the Rush Line Corridor Task Force. More information available in the County Comprehensive Plan.

Businesses and industries

Overall, Washington County is home to over 5,500 businesses. Many of these businesses (86 percent) are comprised of less than 20 employees. Furthermore, Washington County is home to 17,847 self-employed businesses or "non-employers" in 2014 (defined as businesses without employees that are subject to federal income tax).See County Comprehensive Plan Economic Development Chapter for more information.

Appendix B – Community Conversation Participants

Participants in August 2018 Community Conversation and Prioritization Exercise

- Lakeview Hospital
- Lakeview Health Foundation
- Washington County Public Health
- Lakeview Hospital – Birth & Women's Center
- Stillwater Medical Group
- Bicycle Alliance of Minnesota
- Canvas Health, Inc
- Stillwater Area Public Schools
- Courage Kenny Rehab Institute – St. Croix
- YMCA Forest Lake
- Community Thread
- Allina Health
- HealthPartners
- Hudson Hospital, Westfield's Hospital & Clinic
- FamilyMeans
- PowerUp Ambassador (Community Member)
- Valley Outreach
- Washington County Community Services
- Lakeview Hospital – Make it OK
- Community Center Friends
- HealthPartners
- United Way of Washington County East

Appendix C – Action Plans

Priority: Access to Care

R **Result:** Increase utilization of preventive services, including immunization services				
I Increase immunization rates for children aged 19 to 35 months who receive recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (PCV) from **75%** to **80%** (Healthy People 2020)				
P **Program**	**Action Steps**	**Time Frame**	**Responsible parties**	**Performance Measure(s)** PM
P Support and explore expanded options for dental services	• Continue to offer and promote low cost dental care through Children's Dental services • Mobile dental clinics	Annually	Lead: PHE Lead: Lakeview	• # of clients served through children's dental services • Mobile dental clinics (Health Partners)
P Increase utilization of Child and Teen Checkup (C&TC) services for those that are eligible	• Continue outreach of program	Annually	Lead: PHE	• % of CTC enrollment of eligible families
P Continue and expand outreach on the importance of immunizations in children, adolescents and adults	TBD	TBD	Lead: PHE	TBD

Priority: Access to Care

R **Result:** Support and explore options for health care services for residents who are under or uninsured				
I Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care from 16.2% to 4.2% (Healthy People 2020)				
I Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary prescription medicines from 5.1% to 2.8% (Healthy People 2020). 2016 SHAPE low income respondents: 14.4%				
P **Program**	**Action Steps**	**Time Frame**	**Responsible parties**	**Performance Measure(s)** PM
P Increase transportation options that connect residents with health care services	See Access to Health.			See Access to Health
P Develop alternative options for sexually transmitted infection testing and treatment	• Hold 2 STI education/screening events per year. • Develop a free testing drop off protocol and process • Promote testing option	Events are held annually Protocol to be developed in Fall 2019	Lead: PHE	# of event participants # of screenings 1 protocol developed # of free tests conducted
P Continue to offer immunization clinics for under and uninsured residents	• Continue to host monthly immunization clinics • Promote to school districts, parish nurses, and others	Annually	Lead: PHE	# of clinics # of immunizations given
P Continue to explore options for development of community clinic that serves under and uninsured residents	County strategic facility plan is under development	2018-2019	Determining community interest and roles	N/A

R **Result:** Residents have improved transportation options that link them with a variety of health services and opportunities to be healthy				
I % of trip denials for Transit Link and Metro Mobility				
P **Program**	**Action Steps**	**Time Frame**	**Responsible parties**	**Performance Measure(s)** PM
P Implement One-Stop for transportation information and referral	Apply for MNDOT 5310 Funds to support transportation efforts and development of One-Stop	MnDOT funding: Summer 2019 Implementation of One-Stop: January 2020-December 2021	Lead: Washington County Community Services	• # of visitors to the webpage • # of contacts/calls • # of referrals to existing service • % of referrals that yield a successful trip
P Increase awareness of the One-Stop and of existing transportation options through high-quality training and outreach events	Awaiting MNDOT funding decision	January 2020- December 2021	Lead: Washington County Community Services	• # of partners trained • # county staff trained • # of community outreach events
P Provide twenty high-quality travel orientation events that supports greater mobility for persons with disabilities and older adults	Awaiting MNDOT funding decision	January 2020- December 2021	Lead: Washington County Community Services	• # of orientation events • #of residents who participated
P Sustain the involvement of both external and internal partners in increasing awareness and improving opportunities for mobility for those who cannot, do not, or opt not to drive	Continue convening transportation consortium and workgroups	Fall 2019 (ongoing)	Lead: Washington County Community Services	• Quarterly meetings • # of pilot programs initiated • External funding sources generated
P Advocate and promote long-term investments in transit to provide reliable and efficient transit services.	Gold Line development underway	Gold Line opening: 2024	Lead for Gold Line: Metropolitan Council Lead for other transit planning: Washington County Regional Rail Authority (Public Works)	• % change in park and ride usage

R **Result:** Residents have affordable and accessible housing options				
Reduce/maintain the percentage of households that are considered housing cost burdened (% of households spending 30% or more of their income on housing costs) Renter: 45% Owner: 18%				
Reduce the number of people experiencing homelessness: 2018 HOST Face to face contacts: 466				
P **Program**	**Action Steps**	**Time Frame**	**Responsible parties**	**Performance Measure(s)** PM
P Promote a diverse housing supply to provide residents with a range of housing options, including affordable housing	PHE to engage with CDA and Community Services	Fall 2019	Lead: CDA/ Comm Services Partner: PHE	TBD
P Strengthen existing and explore new community partnerships to address housing and homelessness in Washington County	• PHE joins Heading Home • Shelter workgroup to investigate models, cost, locations)	• July 2019 • Develop recommendations by Fall 2019	• Lead: Community Services • Lead: Community Services Partner: PHE	TBD

R **Result:** Washington County promotes health equity concepts both within county departments, and with external stakeholders				
I Percentage of adults who report food insecurity does not exceed current value of 5.4%. (Healthy People 2020 target: 5.8%) Low income reported 53%				
P **Program**	**Action Steps**	**Time Frame**	**Responsible parties**	**Performance Measure(s)** PM
P Continue and expand Health Equity efforts within PHE	• Continue regular meetings of Health Equity Action Team • Select 3 HEAT projects to advance Healthy Equity work	Annually	Lead: PHE	• 3 projects selected
P Strengthen existing and explore new community partnerships to address healthy equity	TBD		Lead: PHE	(potential) • # of coalitions who were provided training on health equity • # of projects outside of PHE that receive technical assistance from HEAT on health equity
P Continue and expand efforts to address food insecurity	• Seek funding assistance to explore gaps in Supplemental Nutrition Assistance Program (SNAP) • Support SuperShelf efforts • SNAP Rx • Encourage and support health system screening for food insecurity	July-September 2019 Ongoing November 2019 Ongoing	• Lead: PHE • Lead: Health Partners, Valley Outreach, The Food Group, University of Minnesota Extension • Lead: Hunger Solutions, Health Partners (SHIP support) Lead: Health systems	# of coalitions with active PHE participation around the topic of food insecurity

R **Result:** Promote early child brain development				
3rd grade reading level				
P **Program**	**Action Steps**	**Time Frame**	**Responsible parties**	**Performance Measure(s)** PM
P Nurture child development through intensive-targeted (Healthy Families America) home visiting and work to increase the engagement and retention of more families in services.	Continue to offer family home visiting services and promote services to eligible families	Annually	Lead: PHE	• # of families enrolled • Retention rate
P Incorporate early childhood resources into clinics and community.	TBD	TBD	Lead: Health Partners/Lakeview Health	TBD

R **Result:** All Residents achieve optimal mental health and well-being.				
I The percentage of adults reporting having poor mental health on 14 or more days in the past 30 days should be at or below 5.8% (Healthy People 2020) 2014 SHAPE response: 5.4%; 2014 SHAPE low income respondents: 27.7%				
I Reduce the percentage of adults that have been told by professional having anxiety and depression 2014 SHAPE response: Depression-20.8%, anxiety-19.4% 2014 low income SHAPE respondents: Depression-31.9%, Anxiety-30.4%				
I Reduce the percentage of youth bothered by feeling down, depressed or hopeless, past 30 days 2016 MSS: Male- 28.5%, Female-49.6%				
I Reduce suicide rate from 13.7/100,000 deaths to 10.2/100,000 (Healthy People 2020)				
P **Program**	**Action Steps**	**Time Frame**	**Responsible parties**	**Performance Measure(s)** PM
P Reduce stigma surrounding mental illness	Trainings for: Make It Ok, QPR, Change to Chill, and Mental Health First Aid.	Annually	Lead: PHE, Health Partners	• # of individuals trained in Make it OK • # of Make it OK ambassadors • Health Partners Impact survey
P Increase access to education and resources around mental health and mental well-being	Washington County PHE increases access to education and resources around mental health and mental well-being through: resource sharing, training opportunities, networking, and coalition building.	Annually	Lead: PHE	• # of trainings offered • # of partners engaged • % of external partners that agree PHE partnership increased their capacity to address mental health and well being
P Improve timely access to mental health services	Promoting Fast Tracker Supporting other departments' efforts (Stepping Up, Mobile Crisis Unit)	Annually	Lead: other county departments. PHE provides support.	TBD
P Build community resilience across the lifespan	2020 funding in a 3 pronged approach for: Collaborative leadership Special project funding Beyond Resilience Partner Projects (6 total)	November 2019-December 2020	Lead: PHE Partners: Sheriff's Office/Sheriff CORE, Lakeview Hospital/HealthPartners, Community Services, Washington County CDA, Fairview,YMCA, Alina Health, Washington County Parks, Newport Farmer's Market.	• # of partner projects

R	All youth have the opportunity to be active, eat healthy food, and strive for a healthy lifestyle.			
I	9th graders who are physically active for 60+ minutes or more at least 5 days a week 2016 MSS: 92% for boys and 89% for girls			
I	% of youth who report eating at least 1 serving of fruits and veg per day should be 30% or greater (Healthy Minnesota 2020) 2016 MSS: Fruit-53.2%, Veg-45.5%			
I	Reduce the percentage of 9th graders who report being overweight or obese from 19% to 16.1% (Healthy Minnesota 2020)			
P	**Program**	**Action Steps**	**Time Frame**	**Responsible parties**	**Performance Measures** PM
P	Support ongoing and new school partnerships and implementation efforts to increase access to **physical activity** and **healthy food** in school settings.	Initiate, support and complete SHIP partner projects. Projects may include: • Annual assessment of school policies and practices (e.g., CDC's School Health Index) • School-based agriculture projects (e.g., implementing community gardens, Tower Gardens) • Training staff on specific techniques (e.g. food preparation training for food service staff, classroom movement training for teachers) Purchasing active classroom and active recess equipment	November 1, 2019 – October 31, 2020	Lead: PHE	# of school buildings engaged # of students reached % of partners that feel PHE support increased their capacity to support healthy choices for youth • % of partners that adopt at least 1 policy change • % of partners that implement at least 1 systems-level change • % of partners that implement at least 1 environmental change
P	Support ongoing and new childcare partnerships and implementation to increase **physical activity** and **healthy food** in childcare settings.	Train and support implementation of evidence based curriculum and supporting policies. Projects include: Training child care providers on evidence-based curricula for increasing physical activity and healthy eating (e.g., LANA, CATCH, Breastfeeding, Chef Marshall)	November 1, 2019 – October 31, 2020	Lead: PHE	# of childcare centers/providers participating in trainings # of staff trained on evidence-based curricula % of trained individuals that report knowledge gained from training % of partners that feel PHE support increased their capacity to support healthy choices for youth % of partners that adopt at least 1 policy change % of partners that implement at least 1 systems-level change % of partners that implement at least 1 environmental change
P	Support and expand other partnerships that support healthy food and physical activity in youth	Engage external partners engaged in obesity prevention efforts. Projects may include: • Joining or leading coalitions, collaborations or community-based obesity prevention efforts	November 1, 2019 – October 31, 2020	Lead: Health Partners (Power Up)	# of partnerships engaged in obesity prevention efforts % of partners that feel PHE support increased their capacity to support healthy choices for youth

R	**Result:** Increase access to and availability to healthy food and physical activity in the community (all ages).
I	Proportion of adults who are obese is less than 27.8%. (Healthy Minnesota 2020) 2014 SHAPE: 23.5% 2014 SHAPE low income: 41.1%
I	% of adults eating 2+ servings of fruits and 3+ servings of veg each day 2014 SHAPE: Fruit- 57.9%; Veg-31.0% 2014 SHAPE low income: Fruit- 46.2%; Veg- 20.9%
I	75% or more of adults report 150 or more minutes of physical activity per week. (Healthy People 2020) 2014 SHAPE: 87.9% 2014 SHAPE low income: 57.3%

P **Program**	**Action Steps**	**Time Frame**	**Responsible parties**	**Performance Measures** PM
P Support ongoing and new worksites wellness implementation efforts to increase access to **physical activity** and **healthy food** in **work settings**.	Initiate, support and complete SHIP partner projects. Projects may include: • Worksite wellness assessment; development and implementation of healthy eating or physical activity initiatives • Training staff on specific techniques (e.g. food preparation training for employees) • Providing small exercise equipment to support comprehensive physical activity initiatives	November 1, 2019 – October 31, 2020	Lead: PHE Partners: employers in the county	# of worksites engaged # of employees impacted by wellness projects % of partners that feel PHE support increased their capacity to support healthy choices for adults % of trained individuals that report knowledge gained from training % of partners that adopt at least 1 policy change % of partners that implement at least 1 systems-level change % of partners that implement at least 1 environmental change
P Support ongoing and new community-based partnerships to increase access to **healthy foods** in **community settings.**	Engage external partners engaged in obesity prevention efforts. Projects may include: • Supporting or expanding accessibility of healthy foods at Farmer Markets (e.g., installing EBT) • Supporting community partners in constructing and maintaining community gardens • Increasing access to fresh produce in food emergency settings (e.g., food shelves, churches, nonprofits)	November 1, 2019 – October 31, 2020	Lead: PHE Partners: nonprofit organizations, Farmers Markets, religious organizations	# of residents impacted by wellness projects % of partners that feel PHE support increased their capacity to support healthy choices for adults % of partners that adopt at least 1 policy change % of partners that implement at least 1 systems-level change % of partners that implement at least 1 environmental change
P Support ongoing and new community-based partnerships to increase access to **physical activity** in **community settings.**	• Support county and municipality partners implementing projects that will increase access to physical activity options (e.g., trails, bike lanes, etc.) in comprehensive planning efforts. • Recruit and support community partners implementing strategies for increasing access to physical activity including providing equipment (e.g., bike racks, bike maintenance stations, and benches) in parks and along trails	November 1, 2019 – October 31, 2020	Lead: PHE Partners: nonprofit organizations, businesses, and government units	# of residents impacted by wellness projects % of partners that feel PHE support increased their capacity to support healthy choices for adults % of partners that adopt at least 1 policy change % of partners that implement at least 1 systems-level change % of partners that implement at least 1 environmental change
P Develop a countywide bike/pedestrian plan	Convene Technical Advisory Committee. Conduct public engagement. Analyze existing networks and determine gaps.	May 2019 to June 2020	Lead: County Public Works	Bike Plan Completed by June 30, 2020

R	**Result:** Promote breastfeeding as the preferred option for the first 12 months of life.
I	Maintain or increase the proportion of infants who are ever breastfed and are enrolled in WIC services. 2017: 85% Healthy people 2020 Target: 81.9%)
I	Increase the proportion of infants who breastfeed at 6 months, and are enrolled in WIC services, from 38% to 60.6% (Health People 2020).

P	**Program**	**Action Steps**	**Time Frame**	**Responsible parties**	**Performance Measures** PM
P	Support and expand partnerships that support breastfeeding in the community	• Continue to fund worksite projects that promote breastfeeding. • Work with hospital/clinic partners	November 1, 2019 – October 31, 2020	Lead: PHE	# worksite projects % of BF friendly hospitals?
P	Promote breastfeeding through family home visiting and WIC services	• Implement breastfeeding programming through evidence-based practice	Ongoing	Lead: PHE	# of families served % of families who BF
P	Lead and support breastfeeding coalition work in the county	• Hold 6 coalition meetings per year	Annually	Lead: PHE Partners: Hospitals, clinics, community organizations and related businesses	TBD

R **Result:** All residents are empowered to lead lives free of substance abuse				
I Reduce the percentage of 9th and 11th graders who report using alcohol- last 30 days to be 15.5% or lower (Healthy Minnesota 2020) 2016 MSS: 9th grade- 10.3%; 11th grade- 25.8%				
I Reduce the proportion of adolescents reporting use of marijuana during the past 30 days to 8.6% or less (Healthy Minnesota 2020) 2016 MSS: 9th grade- 8.2%, 11th grade- 19%				
I Number of opioid-involved drug-overdose deaths should be less than 11.3 per 100,000 deaths (Healthy People 2020) 2017 data: 11 per 100,000				
I Reduce the number of babies born addicted to opiods from current level (41.6 per 10,000 births)				
P **Program**	**Action Steps**	**Time Frame**	**Responsible parties**	**Performance Measure(s)** PM
P Reduce stigma around addiction and substance abuse	CONNECT meetings Resource sharing Training opportunities	Annually	CONNECT PHE in support role	# of trainings offered # of partners engaged
P Increase awareness and access to treatment for substance abuse.		Annually	CONNECT PHE in support role	
P Reduce access to and dependence on opioids and other drugs.	Continue drug drop boxes	Annually	CONNECT PHE in support role	lbs of drugs collected from drug drop boxes Prescriber rates (HP)
P Align efforts and collaborate with internal and external partners.	Explore partnerships with other county departments	Annually	PHE, County departments (Sheriff, Community Corrections, Community Services	% of external partners that agree PHE partnership increased their capacity to address substance abuse

R **Result:** Tobacco use and exposure is reduced for all ages				
I Proportion of adults who currently smoke cigarettes should be 12% or lower (Healthy People 2020) 2014 SHAPE: 5.9% 2014 SHAPE low income: 21.6%				
Percentage of high school students smoked 1 or more cigarettes in the past 30 days should be 18.6% or less (Healthy Minnesota 2020) 2016 MSS: 4.4%				
I Reduce smokeless tobacco (e-cigarettes) products by adolescents from 19.2% to 6.9% (Healthy People 2020).				
I Adult e-cigarette rate (new with 2019 SHAPE data)				
P **Program**	**Action Steps**	**Time Frame**	**Responsible parties**	**Performance Measure(s)** PM
P Support and engage with partners in reducing tobacco rates for all ages	• Contract with American Lung Association (ALA) to conduct tobacco cessation outreach and education to teachers, parents, health care and multi-unit housing	Annually	Lead: PHE ALA on contract through SHIP Partners: CDA, health care providers, schools	• # of trainings offered • # of partners engaged • % of partners that achieved at least 1 PSE change • % of external partners that agree PHE partnership increased their capacity to limit or reduce exposure to tobacco products
P Support worksites implementing cessation and tobacco free campus programs	• Initiate, support and complete SHIP partner projects. Projects may include: • Providing training and resources for cessation programs in partner worksites • Providing policy samples, education, promotion, signage and supports for tobacco free campus efforts in worksite setting	Annually	Lead: PHE ALA on contract through SHIP	• # of trainings offered • # of partners engaged • % of partners that achieved at least 1 PSE change
P Ensure compliance for retailers	• Annual trainings and compliance checks for businesses	Annually	Lead: PHE	# businesses that attend training % of business that pass compliance checks