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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 whose commitment is “to improve the health of our community.”

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.

Currently there are four subcommittees in the Healthy Communities Collaborative:

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

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 “It’s 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, Play Hard”
- 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
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.

The Data Analysis

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.

Overview of Data Analysis Results

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, 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.

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 out of a total of 6 tables available based on their preference for a brainstorming session.

The final list of topics were:

- Access to Care
- Obesity
- Choice/Behavior/Culture
- Mental Health
- Senior Health
- Binge Drinking

On June 2nd, 2016, a Community Health Assessment meeting was held with CLT members and community members.
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.
Community Health Assessment Process

**Community Behavior Survey Data**
- Collected Winter 2014

**Community Opinion Survey Data**
- Collected ongoing
- Annual focus groups

**Additional Data Sources**
- Hospitals
- MDH
- Other secondary sources
- HEDA

Community Input Session(s)

Community Health Assessment

Community Health Improvement Plan
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 multi-factorial 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

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
- In 2013, 25.5% of MN adults were obese, and 35.6% were overweight.

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

Gender and Age

<table>
<thead>
<tr>
<th>Education and Income</th>
<th>Residents Considered Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than high school education</td>
<td>Bachelor’s degree or higher</td>
</tr>
<tr>
<td>42.9%</td>
<td>24.4%</td>
</tr>
</tbody>
</table>

Highest Household Income with Obesity: Median at 37.7%

Residents Considered Obese

- 33.6% (McLeod)
- 35.4% (Sibley)
- 37.2% (Meeker)
Meeker-McLeod-Sibley Community Health Behavior Survey, 2014

**QUESTION 26E**: During an average week, how many times do you do the following? **Eat a home-cooked meal**

<table>
<thead>
<tr>
<th></th>
<th>0 times</th>
<th>1-2 times</th>
<th>3-4 times</th>
<th>5-6 times</th>
<th>7 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>All 3 counties combined</td>
<td>0.5%</td>
<td>8.2%</td>
<td>14.7%</td>
<td>29.3%</td>
<td>47.2%</td>
</tr>
</tbody>
</table>

**QUESTION 33J**: Please indicate whether you use the following resources and facilities in your community. **Physical activity classes or activities through Community Education**

<table>
<thead>
<tr>
<th></th>
<th>I use this</th>
<th>I do not use this</th>
<th>My community does not have this</th>
</tr>
</thead>
<tbody>
<tr>
<td>All 3 counties combined</td>
<td>54.8%</td>
<td>36.6%</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

**QUESTION 33B**: Please indicate whether you use the following resources and facilities in your community. **Bicycle paths, shared use paths, or bike lanes**

<table>
<thead>
<tr>
<th></th>
<th>I use this</th>
<th>I do not use this</th>
<th>My community does not have this</th>
</tr>
</thead>
<tbody>
<tr>
<td>All 3 counties combined</td>
<td>31.6%</td>
<td>49.0%</td>
<td>19.4%</td>
</tr>
</tbody>
</table>

**QUESTION 33C**: Please indicate whether you use the following resources and facilities in your community. **Public swimming pools or water parks**

<table>
<thead>
<tr>
<th></th>
<th>I use this</th>
<th>I do not use this</th>
<th>My community does not have this</th>
</tr>
</thead>
<tbody>
<tr>
<td>All 3 counties combined</td>
<td>17.8%</td>
<td>62.3%</td>
<td>19.9%</td>
</tr>
</tbody>
</table>

**QUESTION 33D**: Please indicate whether you use the following resources and facilities in your community. **Public recreation centers**

<table>
<thead>
<tr>
<th></th>
<th>I use this</th>
<th>I do not use this</th>
<th>My community does not have this</th>
</tr>
</thead>
<tbody>
<tr>
<td>All 3 counties combined</td>
<td>20.5%</td>
<td>56.2%</td>
<td>23.3%</td>
</tr>
</tbody>
</table>

**QUESTION 33H**: Please indicate whether you use the following resources and facilities in your community. **Health club, fitness center, or gym**

<table>
<thead>
<tr>
<th></th>
<th>I use this</th>
<th>I do not use this</th>
<th>My community does not have this</th>
</tr>
</thead>
<tbody>
<tr>
<td>All 3 counties combined</td>
<td>15.8%</td>
<td>73.1%</td>
<td>11.1%</td>
</tr>
</tbody>
</table>
# Meeker McLeod Sibley and Minnesota Health Indicator Prevalence Comparison

<table>
<thead>
<tr>
<th>Indicator</th>
<th>MMS - 2014</th>
<th>MN - 2014</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participated in any physical activities in the last month (Yes)</td>
<td>78.4%</td>
<td>79.8%</td>
<td></td>
</tr>
<tr>
<td>Total serving of fruit and vegetables ate yesterday</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 servings</td>
<td>6.7%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>1-2 servings</td>
<td>28.2%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>3-4 servings</td>
<td>29.2%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>5-9 servings</td>
<td>32.2%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>10 or more servings</td>
<td>3.7%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Eat out or order out a meal from a fast food place during an average week</td>
<td>36.6%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Purchase or get food from a Farmers Market/fruit or vegetable stand</td>
<td>42.9%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Use walking trails in your community (Yes)</td>
<td>41.3%</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

* Statewide comparison data not available
Senior Health

Promoting healthy aging throughout the life span and preventing chronic diseases is key to long-term care cost containment and quality of life improvement.

Costs for persons in long-term care facilities under age 65 are shared between federal, state, and local government. Since 2003, local governments have been responsible for paying 20% of the state’s share. The counties have reduced the number of people under age 65 who have been in nursing homes more than 90 days; however, some individuals require nursing facility level of care and there are no local community options for them to safely relocate.

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. We want adults to have choices as they age. Older adults who are prepared for long-term care costs, who are safe from exploitation, and who have caregivers in their lives have more choices for how they wish to live.

In order to provide promote healthy aging while containing chronic disease costs, we need to convene providers, community leaders, and consumers to facilitate improvements in service delivery and systems integration, and develop services that address priority needs of elders and their families.

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 AND LOCAL DATA
- 65.4% of MMS residents 65+ have been told they have high blood pressure compared to 58.3% of all Minnesota residents 65+.
- 27.1% of MMS residents 65+ have been told they have diabetes or pre-diabetes compared to 22.1% of all MN residents 65+.
- 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

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

<table>
<thead>
<tr>
<th>Question</th>
<th>2014 MMS 65+</th>
<th>2014 MMS All</th>
<th>2014 MN All</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. What kind of place do you usually go to when you are sick and need advice about your health?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor’s office</td>
<td>51.4%</td>
<td>36.8%</td>
<td>*</td>
</tr>
<tr>
<td>Clinic</td>
<td>54.6%</td>
<td>59.2%</td>
<td>*</td>
</tr>
<tr>
<td>Some other health center</td>
<td>0.4%</td>
<td>0.3%</td>
<td>*</td>
</tr>
<tr>
<td>Emergency room</td>
<td>5.8%</td>
<td>2.4%</td>
<td>*</td>
</tr>
<tr>
<td>Urgent Care clinic</td>
<td>5.6%</td>
<td>4.3%</td>
<td>*</td>
</tr>
<tr>
<td>No usual place</td>
<td>1.2%</td>
<td>5.9%</td>
<td>*</td>
</tr>
<tr>
<td>Other place</td>
<td>3.5%</td>
<td>3.9%</td>
<td>*</td>
</tr>
<tr>
<td>8. During the past 12 months, have you seen a doctor, nurse, or other health professional about your own health?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>92.9%</td>
<td>77.9%</td>
<td>69.8%</td>
</tr>
<tr>
<td>No</td>
<td>7.1%</td>
<td>22.1%</td>
<td>30.2%</td>
</tr>
<tr>
<td>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?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>11.6%</td>
<td>23.7%</td>
<td>*</td>
</tr>
<tr>
<td>No</td>
<td>88.4%</td>
<td>76.3%</td>
<td>*</td>
</tr>
<tr>
<td>11. Why did you not get or delay getting the medical care you thought you needed? (Mark all that apply)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I could not get an appointment</td>
<td>7.6%</td>
<td>5.6%</td>
<td>*</td>
</tr>
<tr>
<td>I did not think it was serious enough</td>
<td>64.1%</td>
<td>46.6%</td>
<td>*</td>
</tr>
<tr>
<td>I had transportation problems</td>
<td>2.7%</td>
<td>1.4%</td>
<td>*</td>
</tr>
<tr>
<td>It costs too much</td>
<td>19.2%</td>
<td>40.9%</td>
<td>*</td>
</tr>
<tr>
<td>I did not have insurance</td>
<td>0.8%</td>
<td>11.9%</td>
<td>*</td>
</tr>
<tr>
<td>My insurance did not cover it</td>
<td>7.0%</td>
<td>13.4%</td>
<td>*</td>
</tr>
<tr>
<td>Other</td>
<td>10.7%</td>
<td>14.6%</td>
<td>*</td>
</tr>
</tbody>
</table>

*Statewide comparison data not available

Continue on next page
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?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>13.4%</td>
<td>20.6%</td>
</tr>
<tr>
<td>No</td>
<td>86.6%</td>
<td>79.4%</td>
</tr>
</tbody>
</table>

13. Why did you not get or delay getting the dental care you thought you needed? (Mark all that apply)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I could not get an appointment</td>
<td>1.8%</td>
</tr>
<tr>
<td>I was too nervous or afraid</td>
<td>5.0%</td>
</tr>
<tr>
<td>I had transportation problems</td>
<td>0.7%</td>
</tr>
<tr>
<td>It costs too much</td>
<td>58.3%</td>
</tr>
<tr>
<td>I did not have insurance</td>
<td>45.8%</td>
</tr>
<tr>
<td>My insurance did not cover it</td>
<td>5.9%</td>
</tr>
<tr>
<td>I did not know where to go</td>
<td>4.1%</td>
</tr>
<tr>
<td>Other</td>
<td>11.4%</td>
</tr>
</tbody>
</table>

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?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>5.7%</td>
<td>10.6%</td>
</tr>
<tr>
<td>No</td>
<td>94.3%</td>
<td>89.4%</td>
</tr>
</tbody>
</table>

16. About how many days did you wait for an appointment with a mental health professional?

<table>
<thead>
<tr>
<th>Days</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3 day</td>
<td>74.3%</td>
</tr>
<tr>
<td>4-6 days</td>
<td>5.7%</td>
</tr>
<tr>
<td>7-14 days</td>
<td>2.9%</td>
</tr>
<tr>
<td>15-28 days</td>
<td>2.9%</td>
</tr>
<tr>
<td>29-45 days</td>
<td>8.6%</td>
</tr>
<tr>
<td>More than 45 days</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

* Statewide comparison data not available
Collective Action Plan: Table 2 (cont.)

17. How far did you have to travel to get the appointments?

<table>
<thead>
<tr>
<th>Distance</th>
<th>Local</th>
<th>Statewide</th>
<th>*</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9 miles</td>
<td>63.9%</td>
<td>50.2%</td>
<td></td>
</tr>
<tr>
<td>10-29 miles</td>
<td>22.2%</td>
<td>27.6%</td>
<td></td>
</tr>
<tr>
<td>30-49 miles</td>
<td>11.1%</td>
<td>15.8%</td>
<td></td>
</tr>
<tr>
<td>50 miles or more</td>
<td>2.8%</td>
<td>6.5%</td>
<td></td>
</tr>
</tbody>
</table>

13. In the past 6 months, which statement best describes medications prescribed for you?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Local</th>
<th>Statewide</th>
<th>*</th>
</tr>
</thead>
<tbody>
<tr>
<td>I had no medications prescribed for me</td>
<td>13.2%</td>
<td>41.0%</td>
<td></td>
</tr>
<tr>
<td>I had medications prescribed for me and I filled ALL of the prescriptions</td>
<td>85.1%</td>
<td>55.3%</td>
<td></td>
</tr>
<tr>
<td>I had medications prescribed for me and I did not fill at least one of them</td>
<td>1.7%</td>
<td>3.8%</td>
<td></td>
</tr>
</tbody>
</table>

22. Currently insured

<table>
<thead>
<tr>
<th>Insured Status</th>
<th>Local</th>
<th>Statewide</th>
<th>*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>13.2%</td>
<td>41.0%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>85.1%</td>
<td>55.3%</td>
<td></td>
</tr>
</tbody>
</table>

28. During the past 12 months, how often did you worry that your food would run out before you had money to buy more?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Local</th>
<th>Statewide</th>
<th>*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Often</td>
<td>1.1%</td>
<td>3.7%</td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>6.0%</td>
<td>8.0%</td>
<td></td>
</tr>
<tr>
<td>Rarely</td>
<td>3.7%</td>
<td>11.7%</td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>89.2%</td>
<td>76.7%</td>
<td></td>
</tr>
</tbody>
</table>

29. During the past 12 months, have you used a community food shelf program?

<table>
<thead>
<tr>
<th>Status</th>
<th>Local</th>
<th>Statewide</th>
<th>*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3.5%</td>
<td>5.7%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>96.5%</td>
<td>94.3%</td>
<td></td>
</tr>
</tbody>
</table>

56. Do you have access to at least one working car or other vehicle to use when you need to?

<table>
<thead>
<tr>
<th>Access</th>
<th>Local</th>
<th>Statewide</th>
<th>*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>93.7%</td>
<td>97.2%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>6.3%</td>
<td>2.8%</td>
<td></td>
</tr>
</tbody>
</table>

57. Do you ever use public transportation such as Trailblazer Transit or Meeker County Transit?

<table>
<thead>
<tr>
<th>Use of Public Transportation</th>
<th>Local</th>
<th>Statewide</th>
<th>*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>7.8%</td>
<td>7.5%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>92.2%</td>
<td>92.5%</td>
<td></td>
</tr>
</tbody>
</table>

* Statewide comparison data not available
### Collective Action Plan: Table 3

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2014 MMS 65+</th>
<th>2014 MMS All</th>
<th>2014 MN All</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall health status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>4.5%</td>
<td>10.7%</td>
<td>20.2%</td>
<td></td>
</tr>
<tr>
<td>Very good</td>
<td>30.9%</td>
<td>45.9%</td>
<td>37.5%</td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>45.7%</td>
<td>33.8%</td>
<td>30.3%</td>
<td></td>
</tr>
<tr>
<td>Fair</td>
<td>17.1%</td>
<td>8.6%</td>
<td>9.3%</td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>1.8%</td>
<td>1.0%</td>
<td>2.7%</td>
<td></td>
</tr>
<tr>
<td>Adults who have been told they have high blood pressure</td>
<td>65.4%</td>
<td>33.1%</td>
<td>27.0%</td>
<td>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)</td>
</tr>
<tr>
<td>Diabetes or prediabetes (non-pregnancy related)</td>
<td>27.1%</td>
<td>15.3%</td>
<td>9.5%</td>
<td></td>
</tr>
<tr>
<td>Overweight</td>
<td>36.2%</td>
<td>34.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin cancer or other cancer (calculated)</td>
<td>22.4%</td>
<td>8.1%</td>
<td>10.4%</td>
<td>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)</td>
</tr>
<tr>
<td>Chronic lung disease</td>
<td>12.0%</td>
<td>5.1%</td>
<td>4.3%</td>
<td>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?</td>
</tr>
<tr>
<td>Heart trouble or angina</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angina or coronary heart disease or heart attack (calculated)</td>
<td>21.5%</td>
<td>7.3%</td>
<td>5.5%</td>
<td>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.</td>
</tr>
<tr>
<td>Stroke or stroke related health problems</td>
<td>6.9%</td>
<td>2.3%</td>
<td>2.2%</td>
<td></td>
</tr>
<tr>
<td>High cholesterol</td>
<td>51.1%</td>
<td>29.5%</td>
<td>33.6%</td>
<td>MN rate is from 2013</td>
</tr>
<tr>
<td>Arthritis</td>
<td>49.3%</td>
<td>23.3%</td>
<td>21.8%</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>14.5%</td>
<td>18.6%</td>
<td>18.2%</td>
<td></td>
</tr>
<tr>
<td>Anxiety or panic attacks</td>
<td>11.0%</td>
<td>14.8%</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Other mental health problems</td>
<td>2.7%</td>
<td>3.2%</td>
<td>*</td>
<td></td>
</tr>
</tbody>
</table>

*Statewide comparison data not available*
## Collective Action Plan: Table 3 (cont.)

<table>
<thead>
<tr>
<th></th>
<th>State</th>
<th>Local</th>
<th>Statewide Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity</strong></td>
<td>13.1%</td>
<td>12.4%</td>
<td>*</td>
</tr>
<tr>
<td><strong>Asthma</strong></td>
<td>9.3%</td>
<td>11.8%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Adults 65+ who have had a flu shot within the past year</td>
<td>77.4%</td>
<td>77.4%</td>
<td>64.3%</td>
</tr>
<tr>
<td>Visited the dentist or dental clinic within the past year for any reason</td>
<td>71.8%</td>
<td>74.2%</td>
<td>72.6%</td>
</tr>
<tr>
<td><strong>Hearing test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within the past year</td>
<td>28.7%</td>
<td>25.2%</td>
<td>*</td>
</tr>
<tr>
<td>Within the past 2 years</td>
<td>12.5%</td>
<td>12.2%</td>
<td>*</td>
</tr>
<tr>
<td>2 years or more</td>
<td>32.1%</td>
<td>48.3%</td>
<td>*</td>
</tr>
<tr>
<td>Never</td>
<td>26.9%</td>
<td>14.3%</td>
<td>*</td>
</tr>
<tr>
<td><strong>Eye exam</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within the past year</td>
<td>75.1%</td>
<td>61.2%</td>
<td>76.8%</td>
</tr>
<tr>
<td>Within the past 2 years</td>
<td>16.2%</td>
<td>19.7%</td>
<td>13.7%</td>
</tr>
<tr>
<td>2 years or more</td>
<td>8.2%</td>
<td>17.9%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Never</td>
<td>0.5%</td>
<td>1.2%</td>
<td>3.5%</td>
</tr>
<tr>
<td><strong>Blood pressure checked</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within the past year</td>
<td>96.8%</td>
<td>87.1%</td>
<td>*</td>
</tr>
<tr>
<td>Within the past 2 years</td>
<td>2.8%</td>
<td>9.3%</td>
<td>*</td>
</tr>
<tr>
<td>2 years or more</td>
<td>0.5%</td>
<td>3.3%</td>
<td>*</td>
</tr>
<tr>
<td>Never</td>
<td>0.0%</td>
<td>0.3%</td>
<td>*</td>
</tr>
<tr>
<td><strong>Blood Cholesterol</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within the past year</td>
<td>85.1%</td>
<td>87.1%</td>
<td>57.2%</td>
</tr>
<tr>
<td>Within the past 2 years</td>
<td>8.7%</td>
<td>15.1%</td>
<td>12.5%</td>
</tr>
<tr>
<td>2 years or more</td>
<td>4.7%</td>
<td>11.7%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Never</td>
<td>1.4%</td>
<td>11.5%</td>
<td>19.4%</td>
</tr>
</tbody>
</table>

*Statewide comparison data not available*
### Collective Action Plan: Table 3 (cont.)

<table>
<thead>
<tr>
<th>Blood sugar checked</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Within the past year</strong></td>
<td>83.0%</td>
<td>58.2%</td>
<td>*</td>
</tr>
<tr>
<td><strong>Within the past 2 years</strong></td>
<td>6.9%</td>
<td>13.4%</td>
<td>*</td>
</tr>
<tr>
<td><strong>2 years or more</strong></td>
<td>4.5%</td>
<td>14.4%</td>
<td>*</td>
</tr>
<tr>
<td><strong>Within the past 3 years</strong></td>
<td>*</td>
<td>*</td>
<td>47.4%</td>
</tr>
<tr>
<td><strong>Never</strong></td>
<td>5.6%</td>
<td>14.1%</td>
<td>*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Any screening for skin cancer</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Within the past year</strong></td>
<td>33.1%</td>
<td>17.4%</td>
<td>*</td>
</tr>
<tr>
<td><strong>Within the past 2 years</strong></td>
<td>7.9%</td>
<td>8.8%</td>
<td>*</td>
</tr>
<tr>
<td><strong>2 years or more</strong></td>
<td>14.5%</td>
<td>14.6%</td>
<td>*</td>
</tr>
<tr>
<td><strong>Never</strong></td>
<td>44.5%</td>
<td>59.2%</td>
<td>*</td>
</tr>
</tbody>
</table>

| Any screening for colon cancer    | 45+  | 50+  |
|-----------------------------------|--|--|--|
| **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% |
| **5 years or more**               | 18.6% | 14.0% | 18.5% |
| **Never**                         | 10.1% | 25.7% | 26.2% |

<table>
<thead>
<tr>
<th>Men who have had a prostate exam within the past two years</th>
<th>68.9%</th>
<th>61.5%</th>
<th>45+</th>
<th>36.7%</th>
<th>50+</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Women aged 45+ who have had a mammogram in the past two years</th>
<th>79.6%</th>
<th>79.2%</th>
<th>78.7%</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Visited a doctor for a routine checkup within the past year</th>
<th>82.0%</th>
<th>66.5%</th>
<th>69.8%</th>
</tr>
</thead>
</table>

* Statewide comparison data not available

In BRFSS asked as: *Have you had a test for high blood sugar or diabetes within the past three years?*

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 1-2 years, why not? | 0.0% | 1.3% | * |
| Could not get an appointment | | | |
| Transportation problems | 1.2% | 0.5% | * |
| Cost too much | 10.3% | 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) | 77.4% | 78.4% | 79.8% |
| Number of days at least 30 minutes of moderate physical activity | | | |
| 0-4 days | 69.8% | 76.0% | * |
| 5-7 days | 30.2% | 24.1% | * |

* Statewide comparison data not available
Collective Action Plan: Table 3 (cont.)

<table>
<thead>
<tr>
<th>Number of days at least 20 minutes of vigorous physical activity</th>
<th>0-2 days</th>
<th>3-7 days</th>
<th>Overweight</th>
<th>Obesity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80.1%</td>
<td>74.6%</td>
<td>44.3%</td>
<td>33.1%</td>
</tr>
<tr>
<td></td>
<td>19.9%</td>
<td>25.4%</td>
<td>36.5%</td>
<td>27.6%</td>
</tr>
</tbody>
</table>

* Statewide comparison data not available

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).

LOCAL DATA

- 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 they wanted to talk with or seek help from a health professional about mental health issues but did not, or delayed talking to someone (MMS Community Health Behavior Survey).
Minnesota Mental Unhealthy Days

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
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.
Access to Health Care

Access to Dental Care

Physicians, 2011

Physicians per 10,000 residents

- Fewer than 6
- 6-8
- 9-11
- 12-15
- 16 and above

Dentists, 2011

Dentists per 10,000 residents

- 2
- 3
- 4
- 5
- 6 and above
Access to Mental Health Care

MN Rational Service Areas - Mental Health
Geographic HPSA Designations

- Central Region (Designated 4/2008)
- Crest Region (Not Designated)
- Metro Region (Not Designated)
- Region 1 (Designated 9/2011)
- Region 2 (Designated 10/2011)
- Region 3 (Designated 3/2012)
- Region 4 (Designated 4/2012)
- Region 5 (Designated 10/2009)
- Region 7E (Designated 8/2010)
- S. Central Region (Designated 2/2012)
- SW Central Region (Designated 2/2011)
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. 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
✓ 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 drank 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).

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).
**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. 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. 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.” 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).
Health Inequity in Meeker McLeod and Sibley Counties

Everyone deserves equal opportunities for health to achieve health equity.

What do people need??
- Healthy living conditions and community space
- Equitable opportunities in education, jobs and economic development
- Reliable public services and safety
- Non-discriminatory practices in organizations

Inequities and Health Outcomes

Results show inequities between income groups in most of the chronic diseases and associated risk factors included in the 2014 community health survey.

- According to the 2010-2014 American Community Survey 5 year estimates, close to 1/3 of households in Meeker (31%), McLeod (29%) and Sibley (30%) counties have an income less than $35,000.

- People of color in our region are more likely to be lower income - 40% of non-white and/or Hispanic residents residents have income of less than $35,000 while only 29% of white, non-Hispanic residents have an income of less than $35,000.

Social Determinants of Health

Health is generated through the interaction of individual, social, economic, and environmental factors and in systems, policies, and processes encountered in everyday life.

These include job opportunities, wages, transportation options, the quality of housing and neighborhoods, the food supply, access to health care, the quality of public schools and opportunities for higher education, racism and discrimination, civic engagement, and the availability of networks of social support.
Those interviewed were asked about the living and working conditions that contribute to worse health outcomes such as heart disease and diabetes for residents with lower incomes and challenges this population faces that prevent them from being as healthy as they want to be. The following themes emerged from these conversations:

- **social and community networks**
  - Competing priorities: Health is often a lower priority than more immediate concerns such as housing, paying bills, providing any food vs healthy food.

- **material circumstance**
  - Lack of education
  - Lack of healthcare
  - Lack of quality affordable housing
  - Proximity issues to affordable physical activity options & healthy food options

- **policies, governance, and environmental conditions**
  - Less flexible, less paid time from job
  - The lack of policy for healthy living in rental units

Essentially, these conversations indicate that barriers to health for low-income populations comprise of lack of access to healthy food, health care and routine medical care, but go beyond factors we typically think of as impacting health, such as limited access to transportation and quality affordable housing. These barriers make it challenging for people with low income to focus on health.

**Next steps ....**

Meeker-McLeod-Sibley Community Health Service’s role is to:

- Increase community awareness and understanding of the social determinants of health that impact the health of residents living in Meeker McLeod and Sibley Counties.
- Continue to identify sub-populations negatively impacted by social determinants of health.
- Work with local partners
- Build workforce knowledge and skills on health inequities in order to incorporate a health equity lens into all public health programs
- Strengthen workforce capacity by exploring emerging health profession that address health inequities like a community health worker (CHW)
Appendix 1

June 2nd, 2016 - CHA Workshop Attendance

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

June 2, 2016 – Table Notes from Community Health Assessment Workshop

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 “band-aid”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 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, 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
Group 2 (cont.)

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. 

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 

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, how to be healthy, and how to prepare foods for those children? If you cut up an apple they will eat it. 
vii. Education to parents? Support?
Group 3 (cont.)

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 20's)
   - 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 lifestyle 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 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
   - Chick-fil-A 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

4. Challenges
   - Coalitions for underage drinking
   - Joyride – rides for those that have been drinking and need a ride (Meeker)

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
Group 2 (cont.)

- 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.

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**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
Group 3 (cont.)

- 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

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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
Group 1 (cont.)

- 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 overcome 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)
   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. PACT4Families Collaboratives
      i. Funding
      ii. Services
         1. School Based Services reduced socioeconomic burdens for families (less time off work, less missed school)

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
   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. PACT4Families Collaboratives
      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
   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
   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. PACT4Families Collaboratives
      i. Funding
      ii. Services
         1. School Based Services reduced socioeconomic burdens for families (less time off work, less missed school)
Group 2 (cont.)

2. (DO SEE STRENGTHS FOR THIS AREA)

4. Current Players (refer to Jelly Bean Chart)
   a. Jail, Clinic, MHPPractitioners, 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 (cont.)

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. Huge lack of crisis intervention services
      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
Senior Health (cont.)

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 combined

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.
Binge Drinking (cont.)

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
Binge Drinking (cont.)

- 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

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

Sources


## Appendix 3

*Meeker-McLeod-Sibley Community Health Behavior Survey, 2014*

<table>
<thead>
<tr>
<th>Question</th>
<th>Very Pleasant</th>
<th>Somewhat Pleasant</th>
<th>Not very pleasant</th>
<th>Not at all pleasant</th>
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<td><strong>QUESTION 34:</strong> Overall, how would you rate your neighborhood as a place to walk?</td>
<td>4.554.8</td>
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<td>6.3%</td>
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<td><strong>QUESTION 76A:</strong> In your opinion, how much of a problem is each of these issues in your county? Lead contamination</td>
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<tr>
<td></td>
<td>47.3%</td>
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<td>8.5%</td>
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<td><strong>QUESTION 76B1:</strong> In your opinion, how much of a problem is each of these issues in your county? Radon</td>
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<td></td>
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<td>38.9%</td>
<td>17.7%</td>
<td>1.8%</td>
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<td><strong>QUESTION 76B2:</strong> In your opinion, how much of a problem is each of these issues in your county? Secondhand smoke</td>
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<tr>
<td></td>
<td>32.8%</td>
<td>29.4%</td>
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<td><strong>QUESTION 76B3:</strong> In your opinion, how much of a problem is each of these issues in your county? Carbon Monoxide</td>
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<td>12.4%</td>
<td>1.1%</td>
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<td><strong>QUESTION 76D1:</strong> In your opinion, how much of a problem is each of these issues in your county. Garbage/litter</td>
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<td><strong>QUESTION 76E:</strong> In your opinion, how much of a problem is each of these issues in your county? Stray animals</td>
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<td>45.0%</td>
<td>9.9%</td>
<td>1.6%</td>
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<td>Question</td>
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<td>Mold in businesses</td>
<td>Mold in schools</td>
<td>Sexually transmitted diseases</td>
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<td>15.3%</td>
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<td>QUESTION 76H3: In your opinion, how much of a problem is each of these issues in your county?</td>
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<td>34.9%</td>
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<td>43.1%</td>
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<td>QUESTION 76I: In your opinion, how much of a problem is each of these issues in your county?</td>
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<td>QUESTION 76J: In your opinion, how much of a problem is each of these issues in your county?</td>
<td>41.5%</td>
<td>36.6%</td>
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Abstract

Public health activities in the United States are delivered through multiple public and private organizations that vary widely in their resources, missions, and operations. Without strong coordination mechanisms, these delivery arrangements may perpetuate large gaps, inequities, and inefficiencies in public health activities. We examined evidence and uncertainties concerning the use of partnerships to improve the performance of the public health system, with a special focus on partnerships between public health agencies and health care organizations. We found that the types of partnerships likely to have the largest and most direct effects on population health are among the most difficult, and therefore least prevalent, forms of collaboration. High opportunity costs and weak and diffuse participation incentives hinder partnerships that focus on expanding effective prevention programs and policies. Targeted policy actions and leadership strategies are required to illuminate and enhance partnership incentives.

Introduction

Public health activities in the United States are implemented through the combined actions of multiple government and private organizations that vary widely in missions, resources, and operations. Public health agencies serve as focal points, but these agencies rely heavily on their ability to inform and influence the work of others. Public health delivery systems thus are complex and adaptive systems that operate through the interactions of multiple heterogeneous actors. Without strong coordination mechanisms, these systems may perpetuate large gaps and inequities in the availability and effectiveness of public health activities and substantial inefficiencies in performance (1). In other sectors, interorganizational partnerships and alliances have been used to coordinate action in ways that improve information flow, reduce duplication of effort, achieve economies of scale and scope, and accelerate adoption of effective practices (2).

Recognizing these issues, the Institute of Medicine's 2003 review of the nation's public health system called for "a new generation of intersectoral partnerships" that span the many different sectors of organizational activity that affect population health and that coordinate activities across these sectors (3). Partnerships that integrate medical care and public health approaches to achieve comprehensive health improvement are particularly important. In this article, we examine evidence, uncertainties, and emerging opportunities regarding the use of partnerships to improve the public health system.

Conceptual Framework: Partnerships as Collective Action

Public health partnerships are forms of collective action undertaken to promote health and prevent disease and injury in populations at risk. Collective action occurs when
organizations agree to coordinate activities in pursuit of shared objectives (4). Partnerships may benefit member organizations by allowing them to share information and expertise, human and material resources, or intangibles such as reputation, trust, and visibility. Partnerships may allow organizations to combine operations and realize economies of scope and scale in the production of public health services. Similarly, partnerships may allow coordinated delivery of related programs and services, potentially resulting in a larger combined impact on population health. In these ways, partnerships allow organizations to pursue objectives that may not be possible through independent actions.

Partnership formation in public health depends on the range of organizations available in a given community and the ability and willingness of each organization to contribute to public health activities (5,6). For some activities, economic incentives may encourage organizations to contribute voluntarily—such as the opportunity to gain revenue, reduce costs, or achieve visibility and recognition that confers a political or marketing advantage (7,8). Many organizations also may have noneconomic motives to contribute, such as an altruistic mission to improve health and social welfare (9). Policy and regulatory actions, such as the requirement that tax-exempt hospitals meet community benefit standards, may motivate contributions. Like other public goods, however, public health activities may not generate sufficiently powerful incentives to ensure that they will be fully provided by voluntary action (10,11). In some cases, noncontributing organizations benefit from the public health activities performed by others, such as when health insurers realize cost savings from tobacco use cessation programs or vaccination programs (12). A traditional role for public health agencies is to directly provide beneficial activities that are underperformed by others, while also stimulating contributions by other organizations to minimize unfair benefits (5). An agency’s success in these endeavors will influence partnership formation.

Concepts from behavioral economics suggest that collective actions may falter even when participation incentives are strong. Organizations often fail to value accurately the expected gains from collective action because of common decision errors, including inconsistent information, risk aversion, mistrust, and tendencies to favor the status quo (11). A fundamental challenge for public health professionals is to improve understanding of the expected value of partnerships among key stakeholders and to use policy and leadership strategies to enhance the incentives and blunt the disincentives for participation.

Current Evidence and Uncertainties About Partnerships

Partnership incentives

Partnerships provide a structure in which organizations can cooperate in producing activities designed to promote health and prevent disease and injury, but organizations will participate only if they have sufficient incentives. The perception of health care providers or payers that participation in a partnership will enhance revenues or reduce costs by increasing the reach and uptake of cost-effective prevention programs and services is an economic incentive. However, the magnitude, distribution, and timing of such financial gains or cost savings are areas of considerable uncertainty and depend heavily on the nature and success of the partnership (13,14). Partnerships designed to increase the reach of underused but highly cost-effective clinical preventive services—such as smoking cessation, influenza vaccination, aspirin use, colorectal cancer screening, or family planning services—may reduce future medical care costs, especially if the partnerships target services to the populations at risk and allow implementation costs to be shared among multiple organizations (15,16). Similarly, partnerships designed to increase implementation of and compliance with nonclinical public health programs and policies—such as smoking bans, seat belt laws, and environmental changes that promote nutrition and physical activity—may produce cost savings by reducing disease burden and the future need for medical care (17,18). Such partnerships for nonclinical interventions may have the added economic advantage of low implementation costs.

The strength of economic incentives for partnership formation depends not only on the magnitude of expected cost savings but also on the timing and distribution of these savings. Partnerships to promote colorectal screening, for example, involve time lags of a decade or more before cost savings from disease prevention can be expected, while partnerships that enhance tobacco control or vaccination coverage may generate a mix of short-term and longer-term savings. Time lags weaken the economic incentives for public health partnerships, especially for
investor-owned organizations that operate under short-
term financial expectations and for employers and health
insurers that experience turnover in their covered popu-
lations over time (19). Health care payers such as health
insurers, employers, Medicare, and Medicaid stand to
gain most directly from partnerships that enhance the
delivery of cost-effective preventive services under cur-
rent payment policies. Some physicians and hospitals
may lose revenue as a result of public health partnerships
that reduce medical care use (20). On the other hand,
some providers may realize savings from partnerships
that target segments of the population that are uninsured
and would otherwise require uncompensated medical
care. The expected distribution of these economic gains
and losses in a community shape economic motivations
for participating in partnerships.

Research suggests that partnership incentives may
depend partly on the size and market position of contribut-
ing organizations. Organizations that serve large segments
of the community have strong incentives for partnership
because they stand to gain large shares of any public goods
produced through collective action (8,21). Small organiza-
tions may achieve economies of scale through partnerships
by producing public health activities collaboratively that
would be inefficient or unfeasible to produce independ-
ently (22). Organizations that fall between these 2 extremes
may face diminished incentives.

Many organizations pursue public health partnerships
primarily for noneconomic reasons, such as the desire
to reach new target populations, expand the quantity
or quality of services, and influence high-priority health
issues. Noneconomic incentives often attract organizations
with closely compatible missions, resulting in a preponder-
ance of government and nonprofit participants in many
public health partnerships (5,8). Partnerships that include
both economic and noneconomic incentives may appeal to
other participants.

**Partnership functions**

Partnerships provide a structure for accomplishing
several public health functions, including information
exchange, planning and policy development, and imple-
mentation of programs and policies. Partnerships focus
on information exchange by supporting surveillance, epi-
demiologic investigation, needs assessment, and research
translation activities. Contemporary examples include
sentinel provider networks for influenza, syndromic sur-
veillance systems, and health registries such as those
for monitoring cancer, vaccination, and communicable
diseases. More recently, some communities have formed
partnerships to support the exchange of electronic health
information for clinical decision making as well as public
health surveillance and research. Research suggests that
the quality of information generated through such part-
nerships depends partly on the nature of the relationships
among participants (23).

Planning and policy development partnerships promote
coordination and reduce duplication among organizations
that otherwise work independently. Often these partner-
ships form as a result of communitywide assessment
and performance measurement processes that identify
unmet needs and opportunities for coordination, such as
the National Association of County and City Health
Officials’ Mobilizing for Action Through Planning and
Partnerships program, or the Centers for Disease Control
and Prevention’s National Public Health Performance
Standards program. In some cases, these partnerships
also function as advocacy coalitions that develop and pro-
mote policy proposals of common interest (24). Tobacco
control coalitions are successful contemporary examples
that work to secure smoking restrictions and tobacco tax
increases in many states and communities.

Implementation partnerships bring organizations togeth-
er to collaborate in delivering public health interventions.
The focus on implementation can allow these partner-
ships to have more direct and immediate health effects
than those focused exclusively on information exchange
and planning. However, the success of these endeavors
hinges on their ability to focus on evidence-based interven-
tions, target interventions tightly to populations at risk,
and pursue implementation on a sufficiently large scale
(17,18,25,26). Success is likely to depend heavily on infor-
mation exchange and planning and policy development
activities. For this reason, large-scale implementation
partnerships often develop only after other, prerequisite
forms of collaboration have succeeded (5). Additionally,
these partnerships may demand more human and finan-
cial resources and require more sacrifice of organizational
autonomy and control than other forms of collaboration.
Consequently, participating organizations may face sub-
stantial opportunity costs — alternative pursuits and indi-
vidual interests that must be sacrificed — to make these
partnerships successful.
Some of the most successful implementation partnerships use external funding to diminish opportunity costs. Prominent examples include federally funded initiatives such as Steps to a HealthierUS, Racial and Ethnic Approaches to Community Health Across the U.S., and most recently Communities Putting Prevention to Work—all of which focus on preventing chronic diseases and reducing health disparities through community-level, multiorganizational actions. The realities of high operating costs but limited external funding mean that these types of partnerships reach a small number of communities nationwide. Moreover, the time-limited nature of external funding creates uncertainties about long-term sustainability of the partnership. Success in securing ongoing financial support and in expanding geographic reach depends heavily on the partnership’s entrepreneurship and ability to document health and economic gains (13).

**Partnership composition and structure**

Partnerships are social networks formed among organizations; consequently, the substantial body of knowledge about social network structure helps to elucidate these collaborations (27,28). Network breadth reflects the array of different actors, which determines the amount and type of organizational resources that may be contributed. Network density measures the amount of interconnectedness between organizations, which facilitates their ability to work together. Network centrality reflects the relative influence of a single organization within a partnership, which can be important for coordinating and focusing collaborative actions. Both theory and research suggest that these constructs may influence partnership functioning, but their magnitudes and mechanisms of effect in public health are largely unknown.

Evidence suggests that both the breadth of organizations contributing to public health activities and the scope of their participation has been increasing in recent years. A study of partnerships in US communities with at least 100,000 residents found significant increases in the types of organizations that participate in public health activities from 1998 to 2006 (29,30). Not surprisingly, local and state government agencies were among the most frequent contributors to public health partnerships (Table), but hospitals, physicians, community health centers, and universities significantly increased their participation over time.

Research also shows that public health partnerships generally adhere to 1 of 7 distinct structural configurations based on network breadth, density, and centrality (Figure) (29,30). Three of these configurations support a broad and comprehensive scope of public health activities, of which 1 configuration relies heavily on the work of government public health agencies and 2 others delegate considerable responsibility to other partner organizations. Two partnership configurations deliver an intermediate (conventional) scope of public health activities and differ primarily in the centrality of the local public health agency in these activities. The final 2 configurations deliver a limited scope of public health activities and differ in both the centrality and density. Partnerships frequently migrate from 1 configuration to another over time, with a trend toward supporting a broader scope of activities and engaging a wider range of organizations.

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specialized collaborations, and the public health agency plays more peripheral roles. In the smallest communities, partnerships achieve more density when the local public health agency operates under centralized state governance, but in larger communities decentralized governance appears to foster denser partnerships, perhaps through enhanced autonomy and opportunities for entrepreneurship. These findings imply that partnership strategies should be tailored to the size of the community, the governance and legal environment for public health, and the types of activities to be undertaken through collective action. Considerable uncertainties remain about which partnership network structures work best in which public health settings.

Partnership outcomes and impact

Evidence for the influence of public health partnerships on population health is limited but has grown in recent years alongside the larger evidence base supporting population-based disease prevention interventions (25). Measuring the effects of partnerships is complicated by the long time periods often required to change health behaviors and outcomes at a population level, the many confounding factors that simultaneously influence health endpoints of interest, and the fact that partnerships may have diffuse effects on multiple public health programs and outcomes. Nevertheless, a comprehensive evidence review found that among 34 reviewed studies of public health partnerships, 10 produced evidence of improved population health outcomes potentially attributable to partnerships, including such outcomes as incidence of lead poisoning, adolescent pregnancy, infant mortality, and motor vehicle crashes (32). Another 14 studies found evidence of behavior change attributable to partnership activity in areas such as tobacco use, alcohol use, physical activity, and safe sexual practices. The strongest of these studies, however, suggested that the effects on health behaviors may not be as large as intended (33). Another set of 22 studies suggested that partnerships generated beneficial changes in policies, programs, or environmental conditions such as the adoption of smoking bans, changes in school lunch menus, or the creation of exercise trails and community exercise groups (32). These types of partnership effects could be expected to produce population health improvements over time if appropriately sustained. However, these studies relied on case study research designs that could not establish definitively that observed changes were attributable to the partnerships.

Nevertheless, this review and more recent studies collectively suggest that partnerships can produce beneficial outcomes under the right circumstances (34-36).

Evidence concerning the economic impact and cost-effectiveness of public health partnerships is an area largely unaddressed in the empirical literature, as is the more general question of the cost-effectiveness of community preventive services (13,14). Producing this evidence requires measuring the direct and indirect costs of participating in public health partnerships, including the opportunity costs that organizations incur. Obtaining valid measures of such costs is likely to require the active engagement of partnering organizations such as through practice-based research networks and participatory research methods. Such evidence is likely to be highly influential in shaping both government and private-sector decisions about contributing to partnerships.

Policy Implications and Future Prospects

A growing body of evidence and experience suggests that multiorganizational partnerships are promising mechanisms for improving public health practice. However, the types of partnerships likely to have the most direct effects on population health are among the most difficult, and therefore least prevalent, forms of collaboration. These implementation partnerships are those that focus on expanding the reach of proven but underused interventions and policies through collaboration among public health agencies, health care organizations, and other stakeholders. To succeed in improving population health, such partnerships must target programs and policies tightly to populations at risk, implement activities on a sufficiently large scale, and maintain fidelity to key program and policy components over time. If successful, these partnerships can serve as vehicles for transforming public health practice from a diverse collection of activities and organizations into an organized and accountable delivery system for public health interventions.

Because the opportunity costs associated with these types of partnerships are high, policy and administrative actions are needed to strengthen the incentives for partnership formation. Better systems for measuring and reporting on the delivery of effective prevention programs and policies at the community level are needed to raise awareness of gaps in implementation and opportunities...
for collaboration. Accreditation systems and performance standards that are being developed for government public health agencies can be tailored to create incentives for partnerships (37). Moreover, the 2010 federal health reform law creates opportunities for adapting both medical care and public health funding streams to reward partnerships that expand the implementation of effective but underused prevention strategies. Collectively, these changes could serve as incremental steps along a path toward the more comprehensive pay-for-population health approaches that realign incentives for health improvement (38).

Beyond incentives, successful partnerships are likely to require changes in organizational culture, values, and strategy that can be achieved only through strong organizational leadership. Partnerships require leaders who can elucidate the participation incentives and constraints faced by individual organizations and identify shared objectives and compatible interests. Collaborative leadership can reveal the potential gains from partnerships and help organizations commit to difficult but beneficial public health actions that cannot be accomplished through independent endeavors.

Acknowledgments

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Table

Table. Partnerships Between Local Public Health Agencies and Selected Organizations, 1998 and 2006*

<table>
<thead>
<tr>
<th>Type of Organization</th>
<th>Agencies Reporting Partnerships With Selected Organizations, N = 351</th>
<th>Scope of Activity in Partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1998, No. (%)</td>
<td>2006, No. (%)</td>
</tr>
<tr>
<td>State government agencies</td>
<td>343 (98)</td>
<td>348 (99)</td>
</tr>
<tr>
<td>Local government agencies</td>
<td>322 (92)</td>
<td>339 (97)</td>
</tr>
<tr>
<td>Federal government agencies</td>
<td>155 (44)</td>
<td>215 (61)</td>
</tr>
<tr>
<td>Physician organizations</td>
<td>299 (85)</td>
<td>325 (93)</td>
</tr>
<tr>
<td>Hospitals</td>
<td>339 (97)</td>
<td>351 (100)</td>
</tr>
<tr>
<td>Community health centers</td>
<td>179 (51)</td>
<td>297 (85)</td>
</tr>
<tr>
<td>Nonprofit organizations</td>
<td>334 (95)</td>
<td>335 (95)</td>
</tr>
<tr>
<td>Faith-based organizations</td>
<td>NA†</td>
<td>286 (82)</td>
</tr>
<tr>
<td>Community-based organizations</td>
<td>NA†</td>
<td>325 (93)</td>
</tr>
<tr>
<td>Health insurers</td>
<td>159 (45)</td>
<td>186 (53)</td>
</tr>
<tr>
<td>Universities</td>
<td>230 (66)</td>
<td>275 (78)</td>
</tr>
<tr>
<td>Schools</td>
<td>NA†</td>
<td>315 (90)</td>
</tr>
<tr>
<td>Employers and business groups</td>
<td>NA†</td>
<td>269 (77)</td>
</tr>
</tbody>
</table>

Abbreviations: NA, not assessed; NC, not calculated.

* Data were obtained from a survey of all US local public health agencies that serve communities with at least 100,000 residents (29,30). These 497 agencies represent approximately 17% of all local public health agencies nationally but serve approximately 70% of the US population. Each agency was surveyed in the fall of 1998 (78% response rate) and again in the fall of 2006 (70% response rate). Data pertain to the 351 agencies that responded in both years.

† Defined as participating in 1 or more of 20 core public health activities.

‡ Defined as the mean proportion of activities undertaken through partnerships, based on a list of 20 core public health activities.

§ Calculated by using χ² test.

∥ Calculated by using equality of proportions test.

¶ Data element was collected in 2006 only.