

# WORKING TOGETHER FOR A HEALTHY DULUTH: 2017–2019 Implementation Plan



## 2017-2019 Community Health Needs Assessment Implementation Plan

The full Community Health Needs Assessment (CHNA) conducted collaboratively by Essentia Health, St. Luke's and St. Louis County Public Health alongside the Carlton-Cook-Lake-St. Louis Community Health Board, Healthy Northland, Generations Healthcare Initiatives and the Zeitgeist Center for Arts & Community can be found online at <a href="http://www.essentiahealth.org/main/community-benefit-chna.aspx">http://www.essentiahealth.org/main/community-benefit-chna.aspx</a> or <a href="http://www.slhduluth.com/CHNA">www.slhduluth.com/CHNA</a>.

This collective group is henceforth known as Bridging Health Duluth.

The mission of Bridging Health Duluth is to support a healthier community for all. Bridging Heath Duluth will seek out and bring together other individuals and organizations who are interested in positively impacting the priority areas identified in the CHNA. We believe through collaboration and complementary initiatives, we will have the greatest positive impact on the health of Duluthians.

As this collaboration moved from the assessment phases to the planning involved in creating the implementation strategy, it is imperative to review the overarching goals of working together to better the health of Duluth, Minnesota. The Implementation Plan is considered Phase 3 of the Community Health Needs Assessment process.

Bridging Health Duluth has continued to work together to design an implementation strategy with internal stakeholders as well as additional external partners and stakeholders who represent the existing healthcare facilities and resources within the community that are available to respond to the health needs of the community as identified in this assessment.

This implementation strategy will be reviewed and approved by organization's board of directors in November 2016.

#### 2016 COMMUNITY HEALTH NEEDS ASSESSMENT OBJECTIVES

In conducting the 2016 Community Health Needs Assessment, Essentia Health and St. Luke's have collaborated with community partners to work towards a healthy Duluth and embrace these guiding principles:

- Seek to create and sustain a united approach to improving health and wellness in our community and surrounding area;
- Seek collaboration towards solutions with multiple stakeholders (e.g. schools, work sites, medical centers, public health) to improve engagement and commitment on improving community health; and
- Seek to prioritize evidence-based efforts around the greatest community good that can be achieved through our available resources.

The goals of this collaborative 2016 Community Health Needs Assessment were to:

- 1. Assess the health needs, disparities, assets and forces of change in the hospitals' shared service area.
- 2. Prioritize health needs based on community input and feedback.
- 3. Design a collective impact-based implementation strategy focusing on a multi-sector collaborative approach.
- 4. Engage community partners and stakeholders in all aspects of the Community Health Needs Assessment process.

#### COMMUNITY HEALTH NEEDS ASSESSMENT PRIORITIES

The in-depth assessment and community focus groups resulted in the identification of four (4) community health priorities. The needs were prioritized as follows:

- 1. Mental health
- 2. Alcohol, tobacco and other drugs
- 3. Socioeconomic disparities based on race and neighborhood
- 4. Obesity, including lack of access to healthy foods and physical inactivity

As noted in the original report, each priority area has multiple aspects in which the hospitals will work with community partners and stakeholders to address. By adopting a collective impact model to improve overall health and wellness in our community, not all issues will be directly addressed by the hospitals, but through a multi-sector coalition-based approach.

#### IMPLEMENTATION PLAN METHODOLOGY

In order to formulate an implementation plan that will work to address the above priorities, Bridging Health Duluth members assembled for a strategic planning session and to determine the current opportunities and gaps surrounding each priority area. This allowed for the general formation of the structure of the forthcoming implementation strategy and a chance for the group to also address opportunities for coalition building amongst members. It was determined the plan would include the following for each priority area:

- 1. Overarching goal(s)
  - a. Objectives, and example tactics as able
- 2. Priority population(s)
- 3. Potential partners
- 4. Sources of measuring outcomes (to be consistent with graphs)

Therefore, the following implementation plan will outline these areas. Additional tactics and resources needed will be included in more-detailed work plans developed over the course of 2016 and completed by February 15, 2017. These specific work plans will be crafted collaboratively by teams of subject matter experts. In order to best meet the needs of our community, building working groups for each priority area or partnering with existing working groups will allow for a cohesive, collective impact model with shared data, continual best practice sharing and the opportunity to avoid duplication while filling gaps. The work plans will expand on the implementation plan and will include specific partners, priority populations, metrics, expected outcomes and resources needed.

This implementation plan and the forthcoming work plans will be reviewed on an annual basis by the members of Bridging Health Duluth, with progress reported to each agency's or organization's governing body or leadership team.

## BRIDGING DULUTH COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION PLAN

Priority Area: Mental Health

## Goal #1: Improve overall mental health and well-being in Duluth with a focus on prevention/early intervention.

Objective #1: Implement evidenced-based strategies for improving mental well-being for children and families living in low-income neighborhoods

#### **Example Tactics:**

- o Research evidenced-based practices effective in community mental health prevention/early intervention.
- o Select target neighborhoods and sites (i.e. schools, youth centers, community organizations, etc.) in which to offer programing.

Objective #2: Increase awareness of current mental health resources within the community. Example Tactics:

o Conduct a community-wide campaign on mental health and current resources available within Duluth.

Potential Partners	Priority Population(s)	Sources of Measuring Outcomes
<ul> <li>K-12 Schools</li> <li>Community School Collaboratives</li> <li>Non-Profit Organizations</li> <li>Local mental health organizations</li> <li>Other healthcare providers &amp; clinics</li> </ul>	<ul> <li>Parents of elementary and middle school students living in the Hillside and Lincoln-Park neighborhoods</li> <li>Children age birth to 12 years</li> <li>Low income residents</li> </ul>	<ul> <li>Evaluation results for specific programs/services that will be implemented</li> <li>Bridge to Health Survey</li> <li>MN Student Health Survey</li> </ul>

#### Goal #2: Reduce gaps in Duluth's continuum of mental health care.

Objective #1: Support the development and implementation of innovative strategies to address issues related to mental health crisis care in Duluth.

#### Example Tactics:

o Strategically partner with additional community partners and stakeholders to further map current mental health assets

Potential Partners	Priority Population(s)	Sources of Measuring Outcomes
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readmissions data  Records of where those experiencing a mental health crisis are transferred  Number of contacts with policy makers  Policies changed/legislation passed  New funding allocated

Priority Area: Alcohol, tobacco and other drugs

#### Goal #1: Decrease the negative impact of alcohol on Duluth residents.

Objective #1: Increase responsible behaviors in alcohol use for Duluth residents aged 21 and over. Example Tactics:

• Increase access to responsible server training for local bars and establishments.

Objective #2: Reduce high risk and underage alcohol abuse and the problems associated with it in Duluth.

#### **Example Tactics:**

• Implement a community education program for all high school students.

Potential Partners	Priority Population(s)	Sources of Measuring Outcomes
<ul> <li>Local coalitions focused on alcohol use and abuse</li> <li>State health initiatives</li> <li>State government</li> <li>K-12 schools</li> <li>Local non-profits</li> <li>Local government</li> <li>Local businesses</li> </ul>	<ul> <li>Duluth residents under the age of 21</li> <li>High school students</li> <li>Low income residents</li> </ul>	<ul> <li>Bridge to Health Survey</li> <li>Minnesota Student Survey</li> </ul>

Goal #2: Decrease the impact of tobacco on priority populations, specifically 1) e-cigarettes and flavored tobacco in youth, 2) commercial tobacco in Native Americans and 3) menthol in African Americans.

#### **Example Tactics:**

• Influence public policy on tobacco sales practices in our community (e.g. availability of e-cigarettes).

Potential Partners	Priority Population(s)	Sources of Measuring Outcomes
<ul> <li>Local non-profits</li> <li>State Health Initiatives</li> <li>Statewide organizations</li> <li>K-12 Schools</li> <li>Other healthcare providers &amp; clinics</li> <li>Youth serving organizations</li> <li>Residential treatment sites</li> <li>Local Government</li> <li>Tribal organizations</li> <li>Local coalitions on tobacco use</li> </ul>	Named in goal.	<ul> <li>Minnesota Student Survey (MDH)</li> <li>Teens and Tobacco (MDH)</li> <li>Tribal Tobacco Use Survey</li> <li>Minnesota Adult Tobacco Survey (MDH)</li> <li>Bridge to Health Survey</li> </ul>

#### Goal #3: Reduce drug (opiates and heroin) abuse and the problems associated with these behaviors.

Example Tactics:

• Modify prescribing practices within health care organizations and dental practices.

Potential Partners	Priority Population(s)	Sources of Measuring Outcomes
Local coalitions focused on drug abuse	All residents of Duluth	TBD - will work to identify shared metrics with community opiates groups as to support not duplicate any of their work.

Priority Area: Socioeconomic Disparities Based on Race and Neighborhood

#### Goal #1: Improve the quality of life in low-income neighborhoods.

Objective #1: Increase engagement with local residents and community development leaders from a variety of sectors to address the social determinants of health such as housing, food access, safety, transportation, employment, and asset and income building.

#### **Example Tactics:**

• Work with existing collaborative efforts and organizations (e.g. Building Sustainable Communities Initiative) to improve the quality of life for priority populations.

Potential Partners	Priority Population(s)	Sources of Measuring Outcomes
<ul> <li>K-12 schools</li> <li>Local non-profit organizations</li> <li>Youth serving organizations</li> <li>State health initiatives</li> </ul>	Central Hillside, Lincoln Park, Gary residents	<ul> <li>Neighborhood census data on poverty</li> <li>Median household income, housing</li> <li>Quality, home ownership</li> <li>Cost burden of housing</li> <li>Unemployment</li> <li>Educational status</li> <li>High school graduation rates</li> </ul>

#### Goal #2: Increase health care career development and training opportunities throughout Duluth.

#### **Example Tactics:**

 Partnering with Health Occupation Students of America (HOSA) for hands-on learning opportunities and exposure to healthcare careers.

Potential Partners	Priority Population(s)	Sources of Measuring Outcomes
<ul> <li>K-12 Schools</li> <li>Non-profit organizations</li> <li>Youth Serving Organizations</li> </ul>	<ul><li>High School Students</li><li>Low income residents</li></ul>	• TBD

## Goal #3: Support the adoption of Health in all Policies by local government, schools and employers.

#### **Example Tactics:**

• Engaging with the City of Duluth Comprehensive Plan process to identify health equity principles and policies within the plan.

Potential Partners	Priority Population(s)	Sources of Measuring Outcomes

<ul> <li>Local government</li> <li>K-12 Schools</li> <li>Non-profit organizations</li> <li>Local businesses</li> <li>Other healthcare providers &amp; clinics</li> </ul>	Low income residents	<ul> <li>Number of policies developed and implemented.</li> </ul>
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Priority Area: Obesity, including lack of access to healthy foods and physical inactivity

#### Goal #1: Reduce the rate of obesity and the chronic diseases associated with obesity in Duluth.

Objective #1: Increase physical activity among people in Duluth

#### **Example Tactics:**

• Implementing active recess in schools.

Objective # 2: Increase healthy eating among people in Duluth.

#### **Example Tactics:**

• Expand acceptance of EBT/SNAP at local farmers' markets.

*Objective #3:* Increasing awareness of healthy weight by intentionally changing the current narrative around obesity.

### **Example Tactics:**

• Implement a community-wide campaign on healthy weight behaviors.

Potential Partners	Priority Population(s)	Sources of Measuring Outcomes
<ul> <li>State health initiatives</li> <li>K-12 schools</li> <li>Youth-serving agencies</li> <li>Local government</li> <li>Local athletic leagues</li> <li>Local non-profits</li> <li>Area colleges and academic institutions</li> <li>Local growers/producers</li> <li>Local initiatives related to physical activity, multi-modal transportation and food access</li> </ul>	Low-income communities	<ul> <li>Bridge to Health Data</li> <li>MN Student Survey</li> <li>BRFSS</li> </ul>















