2024 – 2026 OLMSTED COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

A Collaborative Community Effort Led by: Olmsted County Public Health Services, Olmsted Medical Center, and Mayo Clinic

Effective Date: January 1, 2024

Prepared By:
Olmsted County Public Health Services (OCPHS)
Performance Management, Quality Improvement, and Accreditation (PMQIA) Team
2100 Campus Drive SE, Suite 100
Rochester, MN 55904-4722
(507) 328-7500
www.olmstedcounty.gov

This report has been approved by the following individuals:

_____ Name and Title	_____ Date

Contents

Executive Summary

The Community Health Assessment and Planning (CHAP) Process is about improving the health and well-being of residents in Olmsted County. Every three years the community conducts a health needs assessment to determine Olmsted County's health priorities; formulate a plan to address the needs; and publish an annual progress report. Olmsted County Public Health Services, Mayo Clinic, and Olmsted Medical Center engage with diverse partners across our community to lead this process.

This report serves as a formal plan to address Olmsted County's health priorities.

The core values of the CHAP process are:

- Actionable and Sustainable.
- Collaboration.
- Community Focus.
- Data Driven.
- Health Equity.

The purpose of the 2024 – 2026 CHIP is to provide guidance to the community on improving the community health priorities. The priorities were identified by community members as part of the 2022 Community Health Needs Assessment (CHNA) process. The three community health priorities are:

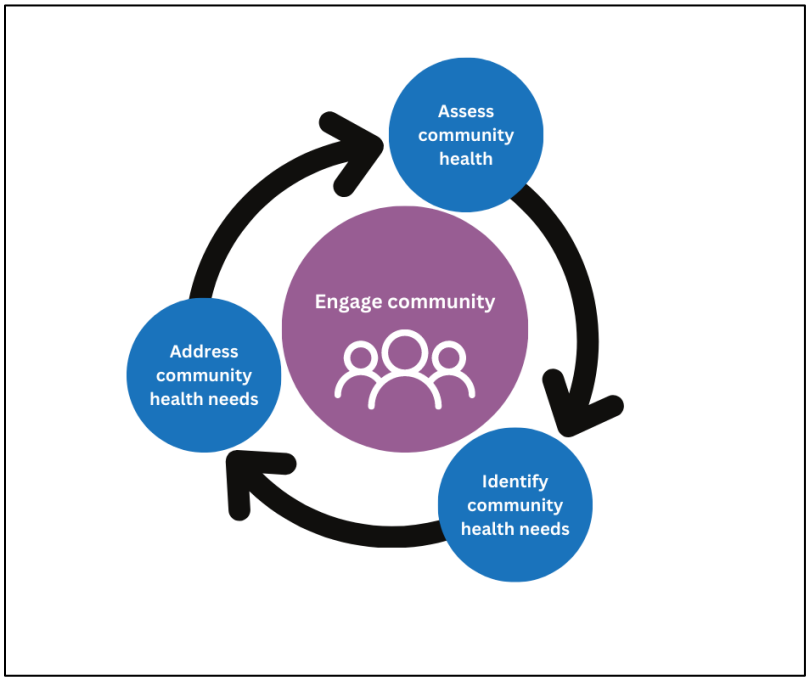
1. Mental Health.
2. Drug Use.
3. Access to (Health) Care.

This report describes strategies identified by the community to address each of the priorities. This cycle will pilot a “collective impact” approach to address these complex issues. This new approach has a main goal of expanding the individual and collaborate efforts of more Olmsted County partners over the course of the three-year cycle. The commitment by many organizations throughout Olmsted County demonstrates the excitement for implementing this pilot approach and dedication by partners to impact these health priorities.

CHAP Process Overview

CHAP Process Statement and Visual:

The Community Health Assessment and Planning (CHAP) Process is about improving the health and well-being of residents in Olmsted County. Every three years the community conducts a health needs assessment to determine Olmsted County's health priorities; formulate a plan to address the needs; and publish an annual progress report. Olmsted County Public Health Services, Mayo Clinic, and Olmsted Medical Center engage with diverse partners across our community to lead this process. It is a continuous improvement process with many partners and modes of gaining community input and action.



CHAP Requirements:

Nonprofit Hospitals

Since its passage into law in 2013, the Patient Protection and Affordable Care Act (PPACA), requires hospitals to conduct a community health needs assessment and adopt an implementation strategy every three years in order to maintain their tax-exempt status.

Additional Information can be found on the Internal Revenue Service (IRS) website: *CHNA for Charitable Hospital Organizations – Section 501(r)(3)*

Local Public Health Departments

A thorough and valid community health assessment and health improvement plan are customary practices and are core functions of public health. Additionally, health assessments and health improvement plans are a national standard for all public health departments. Since the passage of the Local Public Health Act in 1976, Minnesota community health boards (CHBs) have been required to engage in a community health improvement process, beginning with a community health assessment.

Additional information can be found on the Minnesota Department of Health's website: Assessment and Planning for Local Public Health

Public Health Accreditation

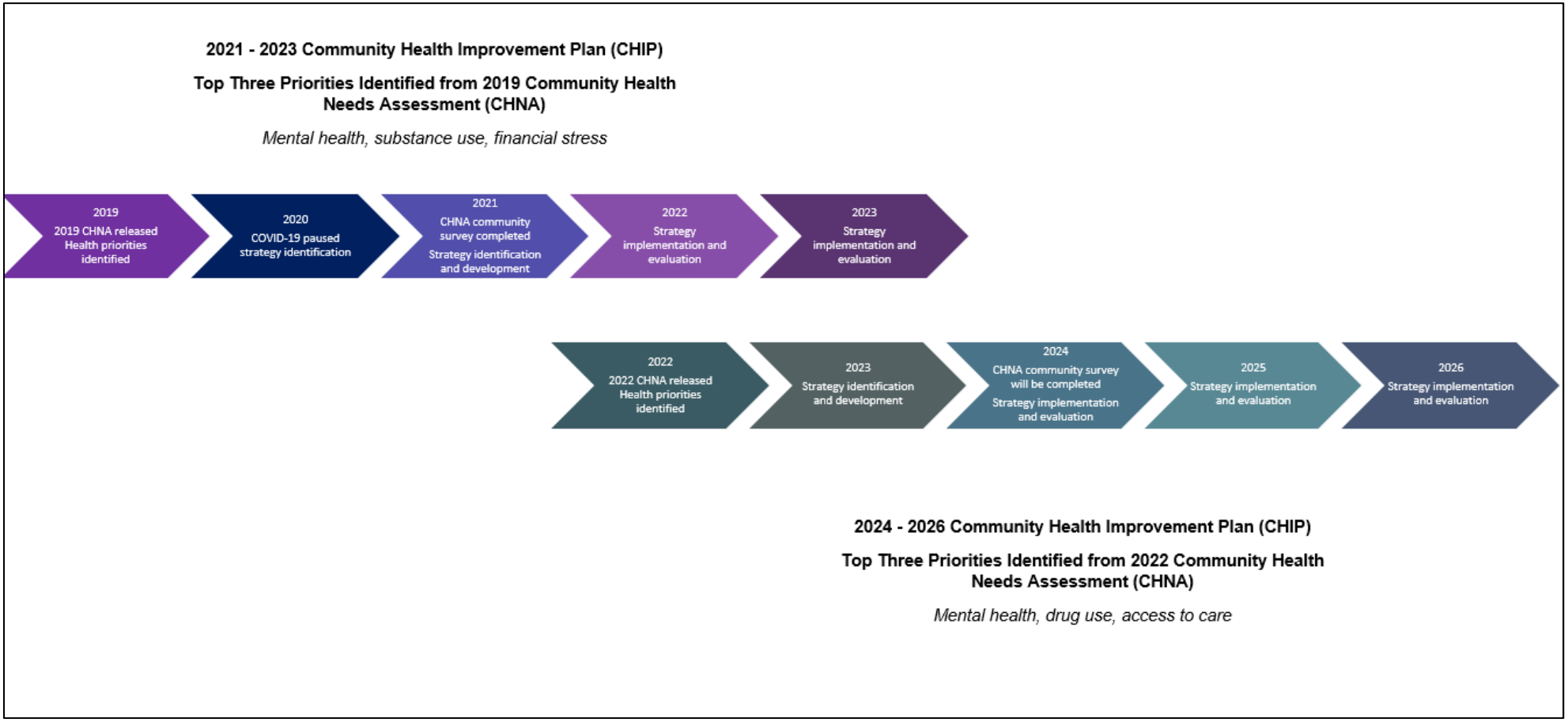
Olmsted County Public Health Services is a nationally accredited local health department through the Public Health Accreditation Board (PHAB)—a national voluntary accreditation program for public health agencies. The goal of the voluntary national accreditation program is to improve and protect the health of the public by advancing the quality and performance of public health departments. Accreditation standards define the expectations for all public health departments—for a public health department to be accredited, it must meet stringent requirements for the 10 essential services of the core public health functions and demonstrate a commitment to constant improvement. Specifically, to meet national reaccreditation related to CHIP activities, local public health agencies are required to conduct a comprehensive planning process resulting in a community health improvement plan that includes broad participation of community partners; uses assessment data to identify priority issues; develops and implements strategies for action; and establishes accountability to ensure measurable health improvement.

Additional information can be found within the Public Health Accreditation Board's (PHAB) Guide to Reaccreditation: *2022 Standards*

2021 – 2023 CHIP Timeline

CHIP Timeline Visual:

The following visual depicts the Community Health Improvement Plan (CHIP) cycle timeline at a high-level from 2019 to 2026:



The biggest takeaway from this visual is that, in 2022 and 2023, activities for both the 2021 – 2023 CHIP and the 2024 – 2026 CHIP overlapped.

In 2023, strategies for the 2021 – 2023 priorities continued to be implemented, while, at the same time, population indicators and strategies for the 2024 - 2026 priorities (access to care, mental health, and drug use) were identified. This allows the strategies for the new priorities to begin immediately starting in 2024.

2024 – 2026 CHIP Priorities

After a community-based prioritization process, the following three health issues were identified as community health priorities for 2024 to 2026:

- Mental Health.
- Drug Use.
- Access to Care.

2024 – 2026 CHIP Overview

Purpose:

The purpose of the CHIP is to provide guidance to the community on improving the community health priorities ("community health priorities will be hereby referred to as "priorities"). The priorities were identified by community members as part of the 2022 Community Health Needs Assessment (CHNA) process.

Specifically, the 2024 – 2026 CHIP:

- Describes the CHAP process and a multi-year timeline.
- Provides an overview of the CHIP process, including work completed in 2023.
- Outlines the three health priorities identified by community members.
- Identifies population data indicators, along with strategies, that organizations throughout Olmsted County will collectively work on to improve the priorities.
- Shares a list of community assets Olmsted County has around the priorities.
- Describes the process for sharing implementation and evaluation results moving forward.

Framework:

In previous CHIP cycles, CHAP partners have come together to identify strategies our community would work on for each priority. Then, once the strategies were identified, additional partners would be pulled in to identify strategy goals and action plans.

The 2024 – 2026 CHIP process will be enhanced to include the individual efforts of organizations in addition to collaborative community work. For this CHIP cycle, a "collective impact" approach will be piloted. Core Group, the CHAP process's leadership team, approved this pilot approach in January 2023. The collective impact approach brings in principles of Results Based Accountability (RBA). In short, RBA allows communities to track data-driven population indicators over time. The goal is to "turn-the-curve" and advance health outcomes that need improvement; in this case, the three priorities.

For this CHIP cycle, Olmsted County as a whole will be attempting to improve population indicators for each of the three community health priorities. To do this, organizations throughout the community have offered strategies that they will implement between January 2024 and December 2026 as an effort to improve outcomes. These strategies are either brand new, or enhancements to current efforts. The goal is, with multiple agencies offering different solutions, our community will see **measurable impact on these issues in the next few years**.

In addition to specific organizations' individual work to collectively impact these issues, there is space for collaborative strategies (two or more agencies working on the same strategy), particularly for existing partnerships and groups. For example, the Coalition for Community Health Integration (CCHI) is implementing a collaborative strategy around access to care, the Mental Health Workgroup is implementing a collaborative strategy for mental health, and the Substance Use Workgroup is implementing a collaborative strategy for drug use.

Timeline and Process for Strategy Identification:

A visual with a timeline for the development of the 2024 – 2026 CHIP is below:

Once the CHIP priorities were identified in November 2022, the CHAP Coordinator, along with their supervisor, started working on drafting a proposal for the "collective impact" approach. During their January meeting, the CHAP Core Group unanimously agreed to pilot this approach for the upcoming CHIP.

In the meantime, data experts within Olmsted County Public Health Services (OCPHS) worked on compiling three data profiles, one for each health priority. The purpose of the data profiles was to provide a deeper dive into the CHIP priorities. By providing quantitative data from a variety of data sources on each issue in our community, as well as on factors that contribute to the health priority, these documents assisted Olmsted County partners with strategy selection for the 2024 – 2026 CHIP. Specifically, the reports helped identify population indicators for each priority, along with showcasing specific data-driven needs that community partners can impact. The data profiles were started in January and finalized in June. They are posted on the CHAP section of the Olmsted County website, within the "CHIP" button.

In addition to the data profiles for each of the three priorities, another data profile was created focusing on a specific population: non-heterosexual adults, as this community was identified as one with the most significant disparities across all three priorities.

In June 2023, the CHAP process's Data Subgroup met with the writers of each of the data profiles to identify recommended population indicators for the three community health priorities. The purpose of the population indicators is to provide community-level data that partners throughout Olmsted County will try to make a long-term measurable impact on, through the collective impact approach. On June 28, 2023, CCHI met, reviewed each of the recommendations, and offered their feedback. Additionally, given there are several youth indicators, a few Core Group partners met with Rochester Public Schools to gain their insights. The population indicators were finalized on July 26, 2023. Each population indicator is shared below, within their respective CHIP priority.

Beginning August 2023, the CHAP process began inviting organizations to participate in the collective impact approach. Given that the collective impact approach is new and a pilot approach for the 2024-26 CHIP, the Core Group suggested inviting CCHI organizations first, and then expanding out to other organizations in the future. In addition to individual organizations, CCHI decided to implement a collective strategy around access to care, and the current CHIP workgroups, focused on mental health and substance use, were asked to implement a project in their focus area, as well.

From August 2023 to November 2023, the CHAP process, including OCPHS staff, met with several organizations regarding a potential strategy to contribute to the collective impact approach. During these

conversations, strategies were brainstormed, programmatic data was identified, and a timeline and action steps were developed.

The strategies were included into the CHIP as they were identified. Each of the strategies decided upon are shared below, within their respective CHIP priority.

Organizations Contributing to One or More Priorities:

- Individual Organizations:
  - Mayo Clinic.
  - Medica.
  - OCPHS.
  - Olmsted Medical Center (OMC).
  - Rochester Public Schools (RPS).
  - UCare.
  - United Way of Olmsted County.
  - Zumbro Valley Health Center (ZVHC).
- Groups:
  - CCHI.
    - Includes all of the individual organizations listed, along with Blue Cross Blue Shield and Rochester Area Foundation.
  - CHIP Mental Health Workgroup.
    - OCPHS, Pine Island Schools, and RPS.
  - CHIP Substance Use Workgroup.
    - Organizations include a mixture of Olmsted County government, substance use treatment providers, and non-profit partners.

Access to Care

Goal and Population Indicator:

Overall Goal: Reduce Olmsted County residents who delay health care.

Population Indicator(s):

1. Decrease the % of adults who delay any care (including medical, mental health, and/or dental care) from 31.8% in 2022 to 25% in 2028 *(Community Health Needs Assessment).*

Strategies, Work Plans, and Organizations Implementing the Work:

Organization	Goal and Strategies	Baseline	Target

BlueCross BlueShield	[New effort for 2025]
	
	Implement "Omada" program.
	• One in nine adults have diabetes and 60% of adults have hypertension by age 60. Diabetes is the top trend driver for all lines of business and hypertension is a significant risk factor for the leading cardiovascular cost drivers (i.e. ischemic heart disease).
	• Omada provides personalized, human-led digital care to guide, support, and offer feedback to help members develop sustainable healthy lifestyle habits.
	• Omada eliminates the barriers to diabetes prevention/ management and hypertension management programs through the following Omada virtual programs to all Medicaid members:
	  ○ Diabetes Prevention.
	  ○ Diabetes Management.
	  ○ Hypertension.
		Baselines for both efforts are member-specific, and outcomes are evaluated by member.	*Diabetes Prevention:*
			• % of actively engaged who achieve 5% weight loss.
			• Average weight loss.
			Diabetes Management:
			• % of actively engaged who achieve their target A1c.
			• Average A1c reduction for those who baseline was 7+.
			• Average A1c reduction.
			Hypertension:
			• % of actively engaged who achieve their target blood pressure.
			• Average blood pressure reduction for those who baseline was a certain amount.
			• Average blood pressure reduction.
			Maven Program:
			• Increase in birthing support received (doula, cultural support, etc.).
			• Receive prenatal care in the first trimester before Medicaid enrollment start or within 42 days of Medicaid enrollment.
			• Increase childhood immunizations.
			• Increase childhood wellness visits (W15 & W30).

Organization	Goal and Strategies	Baseline	Target
	Implement “Maven End to End Maternity” program. • Up to 21-month end-to-end program supporting expecting parents during pregnancy and for 12 months after birth through the postpartum and return-to-work periods. • Program includes pregnancy, partner, and loss and pregnancy options tracks, and a participant may move from one track to another within the same Maternity Product Line enrollment up to 12 months postpartum.		
OCPHS	Increase access to care for LBGTQIA+ residents by reducing the portion of non-heterosexual adult residents who have delayed medical care in the past 12 months. • Improve navigation of the health care system for LGBTQIA+ residents **(Coalition for Community Health Integration led strategy).** • Improve local health-related resource wayfinding for LGBTQIA+ residents. • Improve health care staff training to increase safety and comfortability for LGBTQIA+ residents.	31% (2022).	29% (2025) and 25% (2028).
Mayo Clinic	Increase the number of primary care patients in Rochester/Kasson who are screened for social	# of patients screened for social determinants of health.	Increase baseline by 10%.

Organization	Goal and Strategies	Baseline	Target
	determinants of health for community patients and referred for food insecurity concerns. • Refer community patients presenting with food insecurity social determinant of health challenges to local resources using community health workers and findhelp.org.	# of patients referred to resources for food insecurity.	
Medica	Increase usage of Intensive Community Based Services (ICBS) by Olmsted County residents who are Medica members each year from 2024 to 2026. • Contract with a local provider to offer ICBS program in Olmsted County. • Refer Medica members to the program.	0	5
OMC	Improve access to and awareness of non-traditional care (virtual, after-hours, asynchronous) by enhancing patient communication and promoting alternative methods of appointment scheduling as appropriate.	# of telehealth visits.	Increase by 5-10% each year (2024, 2025, and 2026).
UWOC	Improve access to information about community care resources by increasing use of 211. • Work with community partners to disseminate information and materials into the community. • Use 211 data to inform community partners about needs and gaps in the	5,276 users (2023).	Increase of 300 users per year in 2024, 2025, and 2026.

Organization	Goal and Strategies	Baseline	Target
	community and spread awareness about issues and available resources (including 211). • Issue an all agency message to the organizations currently listed in the 211 database to encourage them to update their information regularly and remind them of the importance of 211. • Use social media to spread awareness. • Continue participating in events and tabling opportunities.		
ZVHC	Increase access to dental care by clients. • Establish baseline of percentage of ZVHC clients seen for dental care per year in 2024. • Supporting Apple Tree Dental to increase dentist and hygienist capacity (space). • Standardizing dental screening and referrals.	Identify in 2024.	Identify in 2024.

Drug Use

Goal and Population Indicators:

Overall Goal: Reduce drug use among Olmsted County residents.

Population Indicator(s):

1. Decrease the number of overdose fatalities among Olmsted County residents from 42 in 2022 to 0 in 2028 *(Minnesota Department of Health).*
2. Increase the % of students who reported that they feel using marijuana and/or prescription drugs is a risk from 72.4% (marijuana) and 82.6% (prescription drugs) in 2022 to 80% (marijuana) and 88% (prescription drugs) in 2028 *(Minnesota Student Survey).*
3. Decrease the % of 8th, 9th, and 11th graders who have used any drugs in past 12 months from 16.8% in 2022 to 12% in 2028 *(Minnesota Student Survey).*

Strategies, Work Plans, and Organizations Implementing the Work:

Organization	Goal (Strategies)	Baseline	Target
CHIP Substance Use Workgroup	Implement at least three strategies to increase drug use education for school staff, families, and students by the end of 2024.	0	3 activities in 2024.
Mayo Clinic	Identify more adolescents at risk for substance use disorder. • Improve screening for substance use disorders. Improve providers awareness and skills in identifying and treating substance use disorders. • Increase substance use disorder educational efforts for health care professionals inside and outside of Mayo Clinic. Improve access to Naloxone to treat opioid overdose. • Advocate to influence policy to keep Naloxone as affordable as possible.	% of unique patients ages 12-18 screened and who screened positive for substance use disorder in primary care in the two pilot sites during the 3-month pilot period. # of people completing training courses. # of policies advocated for.	Identify in 2024.

Organization	Goal and Strategies	Baseline	Target
Medica	Increase usage of Intensive Community Based Services (ICBS) by Olmsted County residents who are Medica members each year from 2024 to 2026. • Contract with a local provider to offer ICBS program in Olmsted County. • Refer Medica members to the program.	0	5
OCPHS	Support the passing of a local cannabis ordinance(s) and establish a system to license, regulate, and educate the public. • 2024—Support the development of a potential cannabis ordinance(s) in Olmsted County. Investigate best practices and draft a potential plan for local licensing, regulation and education. • 2025—Finalize and roll out plan for local licensing policy, regulation and education. • 2026—Cannabis education will be mandatory in schools. Therefore, OCPHS' SAS team will engage with schools to offer this and set a specific goal at that time.	Cannabis ordinance passage (2024). Student contacts with Cannabis education (2026).	Identify in 2025 or 2026.
OMC	Improve Medication Assisted Treatment (MAT) clinic access and program adherence through expanded services. • Introduce an integrated alcohol and drug counseling program within the MAT clinic. • Conduct outreach services in collaboration with community partners.	Adherence to treatment for 12+ months and # of referrals to MAT Clinic.	Show improvement each year (2024, 2025, and 2026) in the # of patients who adhere to treatment and increase # of referrals to the MAT clinic by 5 -

Organization	Goal and Strategies	Baseline	Target
			10% each year (2024, 2025, and 2026).
UCare	Reduce substance use for Olmsted County residents who are UCare members by increasing utilization of Intensive Community Based Treatment services. • Increase Olmsted County stakeholder awareness of program and referral pathways.	12 members (2023).	30 members (2026).

Mental Health

Goal and Population Indicators:

Overall Goal: Increase overall mental wellbeing among Olmsted County residents.

Population Indicator(s):

1. Decrease the number of deaths by suicide in Olmsted County from 25 in 2022 to 0 in 2028 (Syndromic Surveillance - ESSENCE).
2. Decrease the % of Olmsted County adults with a WHO Well-Being Index Below 51 from 20.8% in 2022 to 13% in 2028 *(Community Health Needs Assessment)*.
3. Decrease the % of adolescents reporting emotional distress from 76.2% in 2022 to 72% in 2028 *(Minnesota Student Survey)*.

Strategies, Work Plans, and Organizations Implementing the Work:

Organization	Goal and Strategies	Baseline	Target
Olmsted County Mental Health education Workgroup (OCMHE)	Educate all school districts in Olmsted County about the School Health Assessment and Performance Evaluation (SHAPE) system and related educational materials. • Promote "Stay Connected Minnesota" campaign with Olmsted County Schools (Q1 2024). • Educate all public and private schools in Olmsted County about the SHAPE system, along with the latest statewide SHAPE cohort (Q2 2024). • Determine next steps with Olmsted County school teams as state cohort program finishes (Q4 2024). • Educate schools in Olmsted County on CredibleMind resource (Q4 2024).	2 school districts (2023).	6 school districts in 2024.

Organization	Goal and Strategies	Baseline	Target
Mayo Clinic	Prevent escalation of undiagnosed mental health conditions among young children. • Increase the number of autism (M-CHAT) and social emotional screens (PPSC) done each month at Mayo Clinic in children under age 6 years old.	# of socio-emotional screens completed. # of autism screens completed. # and % of failed autism screens that there is documentation of an intervention plan.	Identify in 2024.
Medica	Increase usage of Intensive Community Based Services (ICBS) by Olmsted County residents who are Medica members each year from 2024 to 2026. • Contract with a local provider to offer ICBS program in Olmsted County. • Refer Medica members to the program.	0	5
OCPHS	Increase usage of the CredibleMind platform. • Strategies to be identified in 2024.	0	20,000 (10,000 per year in 2024 and 2025).

Organization	Goal and Strategies	Baseline	Target
OMC	Improve mental health service accessibility by diversifying support beyond Psychiatry/Psychology Departments. • Introduce Nurse visits for ongoing assistance between provider appointments, encompassing medication review, monitoring, and addressing patient concerns. • Expand outreach services to branch offices, additional departments, and community partners, ensuring comprehensive coverage and support.	# of outreach visits and # of nurse visits.	Increase both by 5 - 10% each year (2024, 2025, and 2026).

Organization	Goal and Strategies	Baseline	Target
RPS	Implement universal mental health screening in all school buildings within the Rochester Public School district. • In SY 23-24, pilot two validated and normed mental health screeners in 8 buildings who have self-selected screening as a goal. ○ Using data and feedback from the two screeners, select one for universal adoption in Rochester Public Schools. • Screening will be implemented three times a year and be used to identify students for referral to intervention resources as appropriate. • Screening data will also be used to inform building-wide and district-wide initiatives.		• In SY 23-24, screen 400-600 students using the two screeners selected. • In SY 24-25, increase adoption of mental health screener to additional schools, based on what is appropriate for the RPS strategic plan roll-out.

# denotes recommendations related to policy—either new policies or changes to existing policies.

Sharing Results over Time

The 2024 - 2026 CHIP will be released, and the strategies will begin implementation in January 2024. Each organization involved will be responsible for their efforts, including sharing the results of their work with the community over time.

Every quarter, the CHAP process hosts a community-wide meeting called the Health Assessment Planning Partnership (HAPP). Beginning in 2024, time will be devoted for organizations contributing to the CHIP to share progress on their efforts at least annually. This includes a general update, along with an opportunity to discuss challenges and hurdles with HAPP membership. Not only will this be a transparent update by each organization, but it will also be an opportunity for residents throughout Olmsted County to brainstorm potential solutions for hurdles in strategy implementation.

In addition to these quarterly community updates, organizations will meet with the CHAP Coordinator at least annually. These more detailed meetings will give organizations time to discuss progress on their strategy's work plan, share programmatic data they have, and answer questions.

Lastly, every January, the CHAP process will release a CHIP annual progress report to the community. This report will be posted on the Olmsted County website. This progress report will share updates to each strategy's workplan, highlights from the year, and next steps.

Community Assets

During the March 2023 HAPP meeting, community partners throughout Olmsted County identified assets for the three CHIP priorities. These organizations will be considered for future CHIP collective impact approach expansion. A list of identified community assets is shared below:

Access to Care

- Apple Tree Dental.
- Blue Cross.
- Children's Dental Health Services.
- Communities Coordinating for Healthy Development.
- Community Dental Care.
- Community Health Services, Inc.
- Community Paramedicine.
- Destination Medical Center (DMC) Beam Health Search.
- Dr. Richard Cohen Dental Care.
- EA Therapeutic Health.
- Elder Network.
- Family Service Rochester.
- Fernbrook Family Center.
- First Care Pregnancy Center.
- Global Home Health Care.
- Health Access MN.
- Intercultural Mutual Assistance Association (IMAA).
- The Landing Clinic.
- Mayo Clinic.
- Medica.
- Olmsted County Public Health Services.
- Olmsted County Veteran Services.
- Olmsted Medical Center.
- Planned Parenthood.
- Pamoja Women.
- Rochester Community and Technical College (RCTC) Dental Hygiene Clinic.
- Rochester Veteran (VA) Clinic.
- Salvation Army Good Samaritan Health Clinic.
- Seasons Hospice.
- Southeast Minnesota Center for Independent Living (SEMCIL).
- Southeast Regional Crisis Center (SERCC).
- UCare.
- University of Minnesota-Rochester.
- Zumbro Valley Health Center.
- Zumbro Valley Medical Society.

Drug Use

- Alateen (Al-Anon).
- Alcoholics Anonymous (AA).
- Apex Recovery School.

- Common Ground.
- Community Pathways to Family Health and Recovery.
- Cronin Home.
- Damascus Way.
- Doc's Recovery House.
- Dorothy Day.
- Empower Treatment Center.
- Fernbrook Family Center.
- Fountain Center.
- Highland Meadows Counseling Center.
- Mayo Clinic.
- Minnesota Adult and Teen Challenge.
- National Alliance on Mental Illness (NAMI).
- Narcotics Anonymous (NA).
- New Season- Rochester Metro.
- Nystrom and Associates.
- Olmsted County Adult and Family Services.
- Olmsted County Case Managers.
- Olmsted County Chemical Dependency Consortium.
- Olmsted County Community Corrections.
- Olmsted County Sheriff Department.
- Olmsted Medical Center MAT Clinic.
- Pathway House.
- Recovery is Happening.
- Southeast Minnesota Emergency Medical Services.
- The Gables and NuWay.
- Zumbro Valley Health Center.

Mental Health

- Adapta.
- American Foundation for Suicide Prevention - Southeast Minnesota Chapter.
- Blue Stem.
- Catholic Charities of Southern Minnesota.
- Christian Family Solutions.
- Crisis Response.
- Ellie Family Services.
- Families First.
- Family Service Rochester.
- Fernbrook Family Center.
- Flourish Counseling Center.
- Great Lakes Psychological Services.
- Highland Meadows Counseling Center.
- Interfaith Hospitality Network of Greater Rochester.
- Mayo Clinic.
- National Alliance on Mental Illness (NAMI).
- Nystrom and Associates.
- Olmsted County BRIDGE Collaborative.

- Olmsted County Public Health Services - School Aged Services.
- Olmsted Medical Center.
- Parks Rx.
- PraireCare.
- Rochester Public Schools.
- Salvation Army Good Samaritan Health Clinic.
- Southeast Regional Crisis Center (SERCC).
- Zumbro Valley Health Center.

Record of Changes

Date	Changes/Updates Summary	Responsible Person(s)
March 28, 2024	Updated Mayo Clinic's strategies and goals	Derrick Fritz, CHAP Coordinator and Sue Fargo, Mayo Clinic
January 30, 2025	Added BlueCross BlueShield's strategies and goals	Derrick Fritz, CHAP Coordinator and Lynn Price, BlueCross BlueShield

Acknowledgements

A special thank you to all the individuals, organizations, and partners that have been involved throughout the CHAP process!

The development of the CHIP would not have been feasible without the leadership, guidance, direction, and dedication from the:

- CHAP Community Engagement Workgroup.
- CHAP Core Group.
- CHAP Data Subgroup.
- CCHI.
- Health Assessment Planning Partnership.
- OCPHS Performance Management, Quality Improvement, and Accreditation, and Epidemiology, Surveillance, and Preparedness Teams.

Questions regarding the CHIP document or process can be directed to:

OCPHS

Performance Management, Quality Improvement, and Accreditation Team

507-328-7107

derrick.fritz@olmstedcounty.gov

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