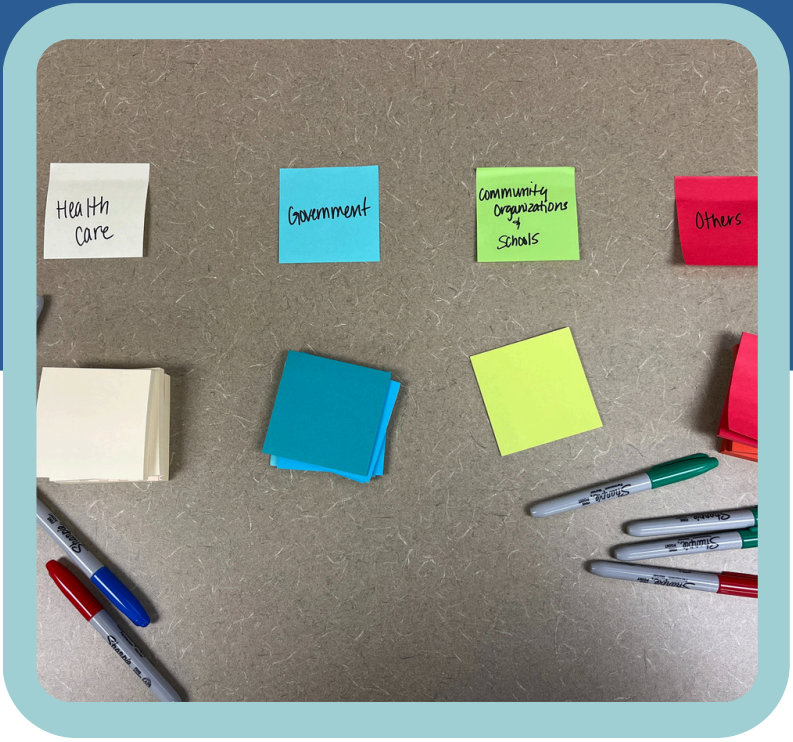
2025 COMMUNITY HEALTH IMPROVEMENT PLAN

Updated August 2025



Washington County
PUBLIC HEALTH & ENVIRONMENT

Executive Summary

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

When conducted, our Community Health Assessment (CHA) tells the story, at a point in time, of the different factors impacting the health of residents in Washington County. The resulting Community Health Improvement Plan (CHIP) is a long-term, systematic effort for the county and its partners to address priorities that arise out of that process.

The COVID-19 pandemic has had a fundamental impact on residents and the way we deliver services. It also shone a light on health disparities. While Washington County consistently ranks as one of the healthiest counties in Minnesota, and even the nation, we know that is not true for all residents.

A variety of tools and processes were utilized to develop the CHA and CHIP, including review of many types of data. A health equity lens was used to consider how different populations are impacted by the factors considered and how the priorities impact people with different needs. Themes from this data analysis were presented and reviewed in a facilitated discussion of more than 30 community leaders and members in January 2025. With further input from county leadership and staff, the resulting priorities that are addressed in this CHIP include (in alphabetical order):

Over the next five years, Washington County Public Health and Environment (PHE) and our partners will monitor progress in these priority areas. We will also align with other efforts including, but not limited to, Foundational Public Health Responsibilities, Washington County Strategic Plan, and Community Health Needs Assessments conducted by our health system partners. Efforts will be evaluated annually and updated as community needs change, and as new data becomes available. We will also continue our localized, place-based work in areas of greatest need.

Our department does not do this work alone. We depend on partnerships from all sectors of the community; other governmental agencies and county departments; business and industry; medical and health care; public and private education; nonprofit and faith communities; and most importantly, residents themselves.

David Brummel
Director, Washington County Public Health and Environment

Credits and Acknowledgements

Washington County Board of Commissioners

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

District 1 – Fran Miron
District 2 – Stan Karwoski
District 3 – Bethany Cox
District 4 – Karla Bigham
District 5 – Michelle Clasen

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

Ann Bensen
David Brummel
Emma Wallo
Jill Timm
Lia Burg
Rebecca Leighton
Smita Rakshit
Stephanie Souter
Tiffany Hoffman

Community Partners

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

About this report

PHE prepares a comprehensive assessment of the health of its residents at least every five years, and an accompanying Community Health Improvement Plan (CHIP). Health data is updated periodically within the health assessment cycle, through the Community Health Profiles. The Community Health Assessment, related data profiles, and additional reports can be found on the Washington County website. The CHIP report, along with annual progress reports, will be available via the same link.

For additional information, please contact us by e-mailing PHE@washingtoncountymn.gov or calling 651-430-6655.

Table of Contents

Washington County
Snapshot of People and Places

The total population in Washington County as of 2020 was 267,568, an increase of 29,431 or 12% since the 2010 Census.

The population is projected to increase to 339,650 by 2050, a 27% increase over the next 25 years. (Source: Metropolitan Council: Imagine 2050)

- 24% of the population is under 18 years of age.
- 16% are 65 years and older.

8% of the Washington County population is foreign-born.

According to the American Community Survey, 2019-2023, five-year estimates include:

- 78.4% of the population is non-Hispanic white.
- 7.3% is Asian.
- 4.8% is Black or African American.
- 0.2% is American Indian and Alaskan Native.
- 5.1% is Hispanic or Latino (of any race).

Washington County has 27 cities and 6 townships.

The county stretches more than 40 miles in length and totals 423.2 square miles. The county is located on the eastern edge of the Twin Cities metropolitan area, bordered by Wisconsin to the east across the St. Croix River. It is the fifth largest county by population in Minnesota.

Approximately 13% of the population in Washington County live below 200% of the federal poverty level. An estimated 11% of householders living alone are ages 65 and older.

50% of Washington County renter households and 18% of owner households spend one-third or more of their income on housing. The median household income in the county is $114,457, higher than the state at $87,556.

The current estimated unemployment rate is 3% in Washington County. Of the population ages 25 and older, 96% have a high school diploma or higher, and 49% have a bachelor's degree or higher.

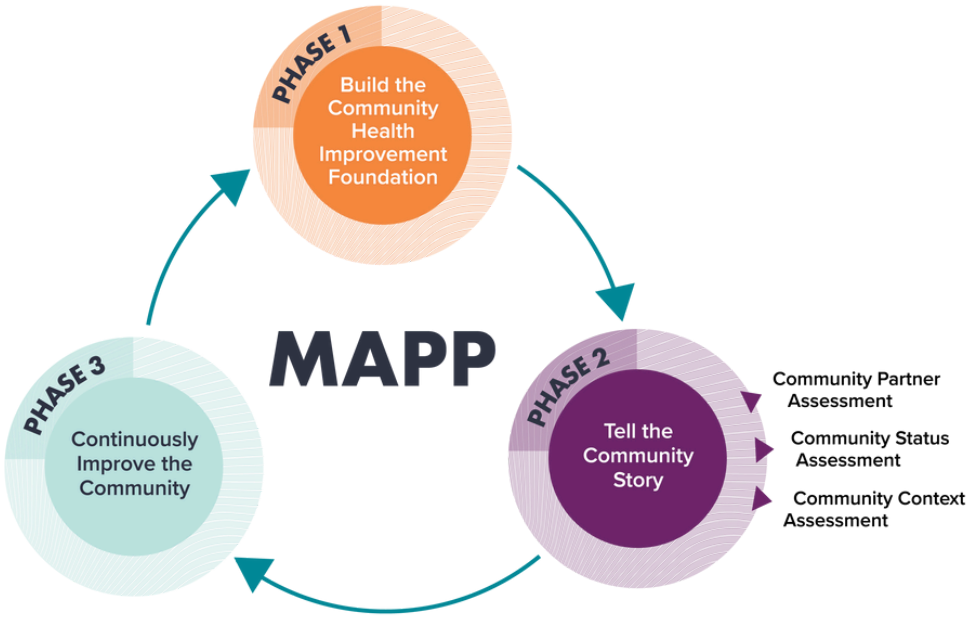
Planning Process

Framework

PHE used elements of the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework to steer CHA and CHIP efforts.

MAPP 2.0 framework incorporates traditional strategic planning with modern approaches such as systems thinking, collaborative partnerships, and data-informed decision making. These elements help communities identify key health challenges, set clear priorities, and take coordinated action. This framework places a strong emphasis on equity, encouraging meaningful community involvement, and inclusive engagement throughout the process. The overall goal is to strengthen local health systems and create lasting solutions that reflect each community's unique needs and priorities.

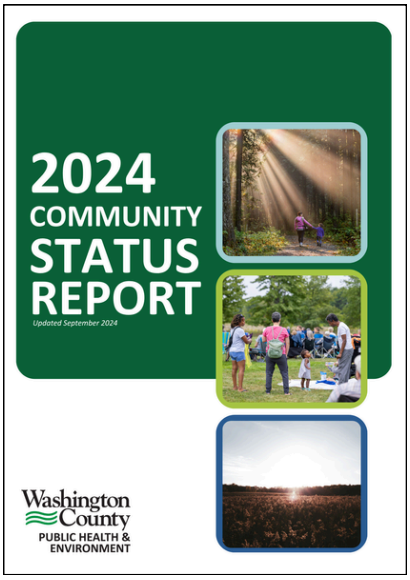
MAPP 2.0 provides a structure for communities to assess their most pressing population health issues and align resources across sectors for strategic action. It emphasizes the vital role of broad stakeholders and community engagement, the need for policy, systems, and environmental change, and alignment of community resources toward shared goals.



Phase 1 of MAPP 2.0, *Build the Community Health Improvement Foundation*, is something Washington County, through PHE, has been doing for many years through the partnerships and networks that help us accomplish our work. **Phase 2** of MAPP 2.0, *Tell the Community Story*, was captured through a series of reports conducted in 2024 and 2025. These full reports can be found here, with a short summary provided on the following page.

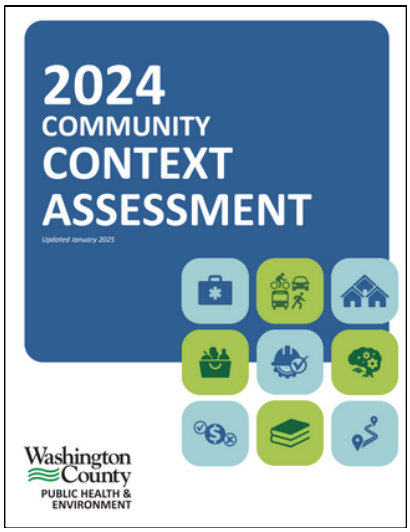
Community Status Assessment (CSA)

The Community Status Assessment utilizes both primary and secondary data from a variety of sources to describe the status of the community. Health data profiles, organized as ArcGIS StoryMaps, make up the backbone of the CSA. These health data profiles represent a dynamic health assessment and are updated and available on the county's website as new data is available. A static "point in time" CSA report was also prepared in the fall of 2024.



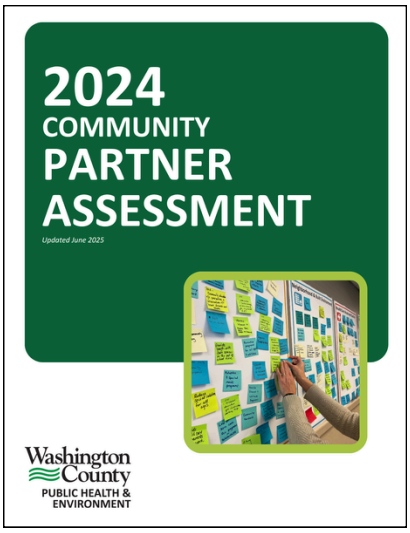
Community Context Assessment (CCA)

The Community Context Assessment centers on people and communities with lived experiences and lived expertise. It focuses on the views, insights, values, cultures, and priorities of those experiencing inequities firsthand. The CCA seeks to understand the strengths and assets of a community, current and historical forces of change, physical and cultural assets, and what is happening in the community to improve health. The primary data source for the CCA in this cycle was a series of community conversations held in the fall 2024.



Community Partner Assessment (CPA)

The Community Partner Assessment allows community partners to look critically at (1) their individual systems, processes, and capacities; and (2) collective capacity as a network of community partners to address health inequities. Through a partner assessment, we engaged with organizations in the county to document the landscape of community partners, disseminate health data, and weigh in on health priorities. The partner engagement process is described further in a later section.



Phase 3 of the MAPP 2.0 process is to *Continuously Improve the Community*. This phase, represented in this document, offers a structured approach to prioritize health issues, establish shared goals, implement data-informed actions, and set up a system to track progress and evaluate the impact on the priority areas.

Partner Engagement

In early 2025, as part of our Community Partner Assessment, PHE convened over 30 community partners to engage in data sharing, discussion, and prioritization of health issues. These partners, ranging from other county departments (e.g., libraries, parks), local government, health systems, nonprofit and community organizations, and school districts, were selected for their roles in improving community health through their connection to key populations. A list of these participants can be found in Appendix A.

First Partner Convening

The purpose of the first partner convening was to help them understand their relationship to the local public health system and their role in advancing health equity. The following activities were conducted to help achieve this goal:

- Collectively defined health equity.
- Introduced *Healthy People 2030 Social Determinants of Health* and described how they relate to our collective work to promote community health.
- Identified the main ways in which partners impact each social determinant of health domain.
- Introduced the concepts of root causes of inequities and the spectrum of prevention using the upstream versus downstream river metaphor.
- Mapped partner activities on a visual representation of the spectrum of prevention in the *On the River* exercise.

For more details on these activities, please refer to the Community Partner Assessment.

Second Partner Convening

The second partner convening focused on reviewing data from other components of the CHA process and providing input on top health priorities.

PHE staff and an external data consultant, *arcadia research and evaluation*, presented a variety of quantitative and qualitative data grouped into several different health topics/issues. The data presented can be found in the appendices of the Community Partner Assessment.

Topic areas included: mental health, healthcare access and quality, housing, substance use, environmental conditions, transportation, infectious disease, community safety, food access, economic stability, education, and built environment.

Participants were also reminded that there are many other assessments, plans, and initiatives taking place in Washington County with the goal of impacting community health.

Prior to data being shared, participants were given an assignment for the meeting: to weigh the data presented, along with their insights as someone who works, lives, and/or plays in Washington County, and ultimately select three topic areas that PHE should focus additional resources on for the next three years.

Partners were asked to consider the following selection criteria as they listened to the presentations:

Size of the problem (number of individuals impacted)

Effectiveness of public health interventions to impact problem

Seriousness of the problem

Momentum (related efforts in the community)

Availability of solutions

Cost to address the problem

Potential to positively impact health disparities

Partners were provided with materials (e.g., notetaking tools, guiding questions) to engage with the data presented. They were also reminded that PHE plans to use their input, along with other data, to help prioritize health issues for the coming planning cycle. The county will continue its work addressing all the topic areas discussed, with additional resources and staff time devoted to the areas selected as priorities.

After data was presented, partners engaged in a multi-stage voting process to select health priorities. First, partners voted on the top three health issues they felt the county should focus on based on available data, their experiences, and the selection criteria. Each participant was given three stickers to vote on their top priorities from the presented issues. Although partners had an option to vote for "something else" to add another topic to the list, no one chose to do so. After all partners had completed the first stage, they were asked to designate their overall top priority area using a different colored dot.

The internal community health assessment planning group and senior leaders within PHE reviewed the top health priorities identified by community members in the CCA, those selected by partners during the CPA convenings, and also considered priorities in other planning efforts such as the County Strategic Plan and Community Health Needs Assessments completed by health systems. Four priorities rose to the top and were selected as priorities for the CHIP (in alphabetical order). On the following pages, each of these priorities are described in more detail, along with **result statements** that describe a future state we are trying to achieve, population level **indicators**, and **strategies** to address the issues.

Implementation and Monitoring

PHE will lead implementation and monitoring of the CHIP. Initial action plans have been developed as a starting point for tracking progress and can be found in appendices C-F. More detailed action plans for various strategies will be developed over the course of the CHIP implementation.

Performance measures are developed around specific programs or efforts and will be further developed as work occurs. PHE will also align data collection with other plans such as the County Strategic Plan, department Strategic Plan, and health system Community Health Needs Assessments, where possible.

The development of objectives and targets for population health indicators utilizes state and national targets, including Healthy People 2030 and the Minnesota Statewide Health Improvement Framework, when available. These frameworks provide state and national context and targets for a variety of population health indicators.

In some cases, Washington County is meeting or exceeding national or state objectives for population health. State and national goals or targets are woven into the sections below for each priority area, and will be further utilized in action planning.

As national frameworks are updated, targets will be revised accordingly. PHE's role in implementation will vary depending on the strategy. Its roles can include:

Lead

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

Partner

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

Support

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

On a yearly basis, tracking and progress of priority areas will be compiled by PHE staff in partnership with respective community partners and revised in a CHIP annual report. PHE acknowledges a CHIP annual report will never fully capture all the efforts underway to address health priorities. Staff resources and access to data will limit reporting efforts to where it is reasonable. In addition, reporting is more feasible where PHE has either a lead or a strong partner role and therefore has access to data.

PHE will convene partners at least annually to share updates and progress on CHA and CHIP priorities, as part of our Community Health Partnership efforts. In addition, we recognize that one of the best ways to advance work is to recognize and participate in the many coalitions and networks that our partners already engage in.

For example, our health system partners convene localized community partners focused on hospitals serving our jurisdiction to advance Community Health Needs Assessment (CHNA) work they are responsible for. This includes Lakeview Hospital (Health Partners) in Stillwater; M Health Fairview Woodwinds Hospital in Woodbury, and M Health Fairview Lakes Medical Center in Wyoming (serving northern Washington County).

A list of these coalitions and partner groups and others can be found in Appendix B and are also referenced in the priority descriptions as community assets and resources, where relevant.

Place-Based Efforts

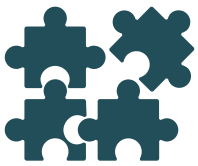
In addition to the broader CHA and CHIP work that occurs at the county level and is the focus of this plan, PHE will continue to implement place-based, equity-focused work referred to as Healthy Opportunities for People through Equity (HOPE). The county launched the HOPE process in 2022.

The work centers on 1) utilizing available data to identify areas in the county, down to the census tract level, that experience the greatest health and income disparities and 2) co-creating solutions alongside community. HOPE efforts were first piloted in the community of Landfall, where work continues into 2025.

Additional HOPE work is underway in other areas of th county including Oakdale, Cottage Grove, and Forest Lake. This work is led by PHE but includes other county departments, external partners, and community members themselves.

HOPE Health Equity Values

Place-Based
Focusing resources on specific census tracts with higher inequities.



Integrated
Fostering cross-departmental collaborations to provide holistic care to communities.

Community-Centered
Engaging and uplifting residents with lived experience.

Sustainable
Ensuring the HOPE model is sustainable by embedding community engagement efforts into existing departmental roles and responsibilities.

Priority

Access to Healthcare

Why is this important?

Access to high-quality health care significantly influences individual and community well-being. This access helps ensure individuals receive timely preventive services, prompt diagnoses, and effective treatments, ultimately reducing morbidity and mortality rates.

Quality health care services also promote better management of chronic diseases, enhance patient safety, and improve overall health outcomes. Barriers to health care access, like financial constraints, lack of insurance, and geographic limitations, disproportionately affect marginalized populations, exacerbating existing health disparities.

Another key factor in health care delivery is ensuring that services are respectful of and responsive to the cultural and linguistic needs of patients. This approach builds trust, improves patient engagement, and leads to better health outcomes, especially in diverse communities. Addressing these access, quality, and cultural issues is essential for achieving health equity and fostering healthier communities.

Access to health care was identified as a top issue in community conversations, at the partner convening meeting, and in the CHNAs for the health systems with the largest presence in Washington County. Equitable access and care are also identified in the Minnesota Statewide Health Improvement Framework adopted by Minnesota Department of Health in 2025. Proposed solutions include increasing culturally competent care and resources, reducing healthcare costs, and increasing medical personnel availability and transportation options.

Measure	Population to Provider Ratio
Primary Care Physicians Ratio	959:1
Mental Health Provider Ratio	296:1
Dentist Ratio	1,295:1

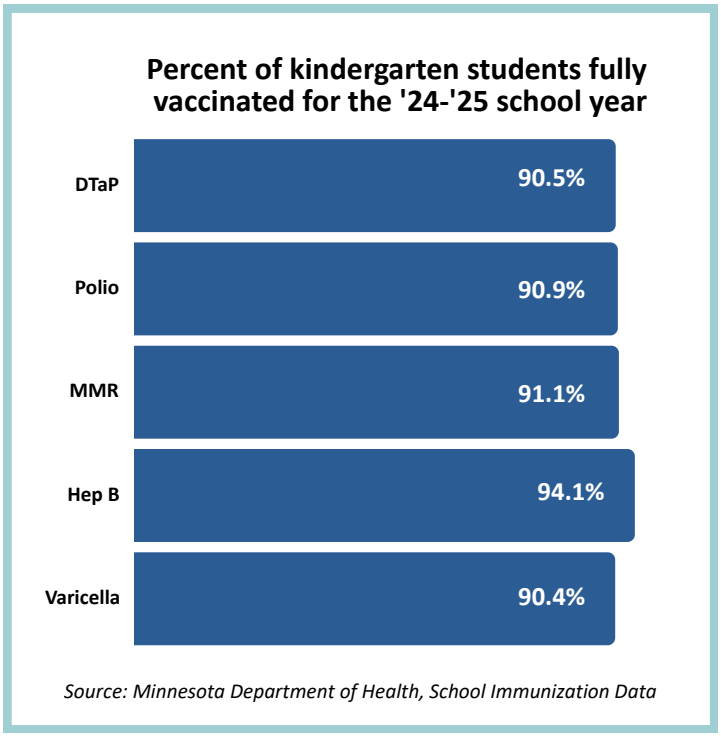
Sources: County Health Rankings, 2025; Area Health Resource File/American Medical Association, 2021; CMS, National Provider Identification, 2024; Area Health Resource File/National Provider Identifier Downloadable File, 2022

4.0% of the population ages 64 and under are without health insurance coverage

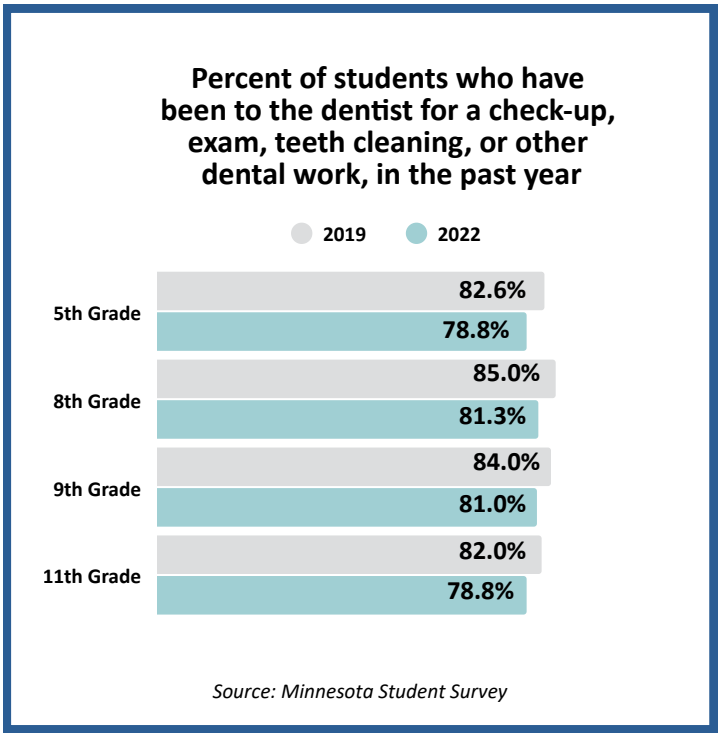
Source: American Community Survey, 2019-2023

71.3% of adults said they had visited a doctor for an annual check-up, in the past year

Source: PLACES, CDC, BRFSS, 2022



Source: Minnesota Department of Health, School Immunization Data



Source: Minnesota Student Survey

What we're going to do about it

Result: All residents are able to access health care.

Indicators:

- Percent of uninsured residents.
- Availability of care ratios.

Strategies:

- Support and explore safety net health care services for residents who are under- or uninsured.
- Continue to assist under- or uninsured residents in obtaining health insurance.

Result: All residents know how to use preventative health care services and navigate the healthcare system.

Indicators:

- Percent of kindergarten students fully vaccinated.
- Percent of adults who have visited the doctor or had an annual check-up in the past year.
- Percent of students who have been to the dentist for a check-up, exam, teeth cleaning, or other dental work, in the past year.

Strategies:

- Continue outreach on and opportunities for immunizations for both children and adults.
- Continue and explore preventative care opportunities and promotion with health care and other partners.
- Explore, with health care partners, opportunities for improving health care literacy.

Priority

Housing

Why is this important?

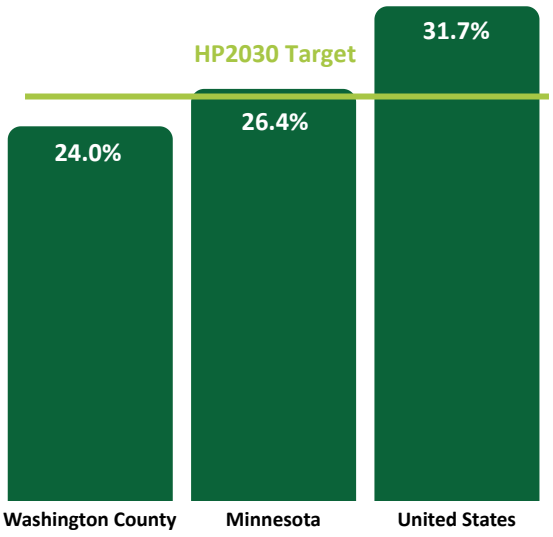
Housing directly impacts physical and mental well-being. Stable, affordable, and safe housing conditions are essential for maintaining good health, while inadequate housing can lead to chronic stress, exposure to environmental hazards, and limited access to necessary community resources.

Issues such as high rental costs, housing discrimination, and insufficient affordable housing options disproportionately affect marginalized populations, exacerbating health disparities.

Addressing these housing challenges is crucial for fostering healthier communities and achieving health equity. Housing concerns highlighted by participants reflect widespread challenges with affordability, accessibility, and discrimination, leaving many residents unable to secure safe and stable housing.

Proposed solutions to housing challenges from participants focus on increasing affordability, accessibility, and education to address systemic barriers and create more equitable housing opportunities. Health and housing were also identified in the Statewide Health Improvement Framework adopted by Minnesota Department of Health in 2025.

Percent of households who spend 30% or more of their income on housing

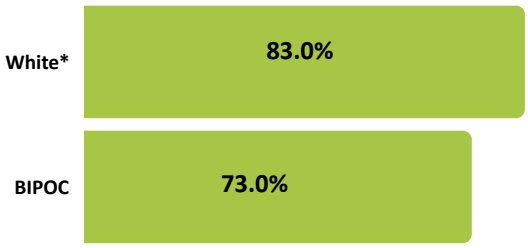


Source: American Community Survey, 2019-2023

50% of renter households spend one-third or more of their income on housing

Source: American Community Survey, 2019-2023

County Homeownership Rate



**non-Hispanic white*

Source: Minnesota Housing Partnership, American Community Survey, 2021

In 2024, Washington County **prevented 242 families from** becoming homeless.

Source: Washington County Community Resources Partnership

83 people were experiencing **homelessness** in Washington County in 2024.

Source: Point in Time Count; Washington County Community Services and Minnesota's Homeless Management Information System, 2024

What we're going to do about it

Result: A diverse range of accessible and affordable housing options are available in all areas of the county.

Indicators:

- Percent of residents who are cost-burdened.
- Percent of homeowners who are BIPOC.

Strategies:

- Collaborate with the Washington County Community Development Agency (CDA) and other partners to promote an increase in affordable housing supply and provide a range of housing options.
- Support Washington County Community Development Agency (CDA) and Washington County policies and funding for affordable housing.

Result: All residents have access to supportive and healthy housing.

Indicators:

- Number of people experiencing homelessness.
- Number of families prevented from becoming homeless.

Strategies:

- Establish reliable and supportive housing options, including emergency housing, to provide shelter for "at-risk" individuals.
- Healthy housing: Work with partners to improve existing housing and explore additional healthy housing program opportunities.

Priority

Mental Health and Community Safety

Why is this important?

Mental health is as important as physical health. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery. Mental health disproportionately affects communities of color, exacerbated by systemic inequities and socioeconomic challenges. These communities often face higher levels of stress, trauma, and mental health disorders, such as anxiety and depression, due to factors like discrimination, poverty, and limited access to mental health services.

The stigma surrounding mental health, coupled with inadequate culturally competent care, further hinders the ability to seek and receive appropriate treatment, leading to a cycle of poor mental health outcomes. Addressing these disparities is essential for promoting overall health and well-being within these vulnerable populations.

Mental health challenges described by participants reveal a complex intersection of stigma, resource shortages, and cultural barriers. Participants suggest addressing mental health challenges by expanding access, reducing stigma, and fostering culturally tailored care.

Community safety significantly impacts physical, mental, and emotional well-being. A safe community environment fosters trust and social cohesion among residents, reducing stress and anxiety while promoting healthier lifestyles. Conversely, communities with violence, crime, and lack of security face numerous health challenges. Increased exposure to crime and violence can lead to chronic stress, trauma, and mental health disorders like anxiety and depression. These adverse conditions often result in reduced physical activity, poorer diet, and limited outdoor activities, all of which contribute to negative health outcomes.

Community safety was rated high in community conversations, while mental health was a top priority in partner convenings. Due to their interrelated nature, they are combined under the CHIP into one priority.

34%

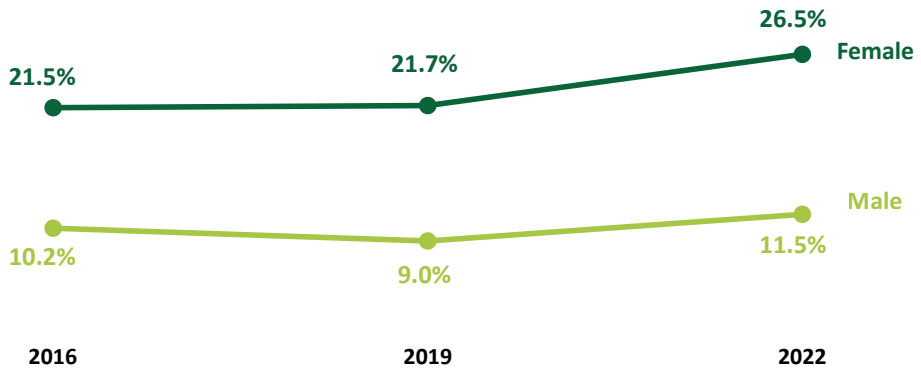
of residents **delayed mental health care** due to cost or no insurance

Source: Washington County Adult Health Survey, 2019

Percentage of adults reporting 14 or more days of poor mental health per month		
Washington County	**Minnesota**	**United States**
14%	16%	16%

Source: County Health Rankings, 2025; Behavioral Risk Factor Surveillance System, 2022

Over the past two weeks, 9th graders who have been feeling down, depressed, or hopeless, more than half the days or nearly every day



Source: Minnesota Student Survey

What we're going to do about it

Result: All community members are empowered to navigate mental health services and support.

Indicator:

- Percent of residents delaying mental health care due to cost or lack of insurance.

Strategies:

- Improve availability and quality of community-specific mental health services, resources, and support systems.
- Partner internally and externally to share mental health resources.
- Improve access to quality mental health services.

Result: All community members experience a stigma-free environment that fosters resilience, recovery, safety and overall well-being.

Indicators:

- Percent of students who were bothered by feeling down, depressed, or hopeless.
- Percent of adults reporting 14 or more days of poor mental health per month.

Strategies:

- Promote and embed a trauma-informed lens internally and externally.
- Foster opportunities for people across the life span to build and leverage protective factors that benefit mental health.
- Increase mental health literacy.

Priority

Transportation

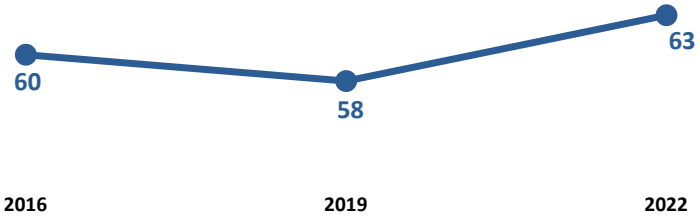
Why is this important?

Transportation plays a critical role in shaping health outcomes by influencing access to employment opportunities, nutritious food, social activities, and healthcare services. Reliable and efficient transportation systems enable individuals to reach medical appointments, which can help ensure the timely diagnosis and treatment of health conditions.

Additionally, access to public transportation can reduce financial burdens associated with car ownership and parking fees, which can support overall financial security and reduce stress-related health issues. Transportation infrastructure also impacts physical activity levels through the availability of safe walking and cycling paths, promoting active lifestyles and reducing the risk of chronic diseases like heart disease and diabetes.

Conversely, inadequate transportation can lead to social isolation and limited access to essential services, both of which negatively affect physical and mental health.

Availability of bicycle and pedestrian transportation options
(0 = Poor, 100 = Excellent)



Source: County Resident Survey

107.6

miles of trails built in Washington County, as of June 2025.

Source: Washington County GIS

What we're going to do about it

Result: All residents have accessible transportation options that support well-being and improve access to essential services.

Indicators:

- Increase use of multimodal transportation as reported in biennial Resident Survey.
- Miles of dedicated trails built as envisioned in pedestrian and bike plan.

Strategies:

- Maintain, develop, and expand multimodal transportation options.
- Update the Transit Needs Study and implement recommendations.
- Advocate for health considerations in transportation planning and policies.
- Enhance GoWashington efforts to increase awareness and improve access to information about transit options.

Appendix A

Convening Meeting Participants

Attendee and Organization

- Andrea Anderson, HealthPartners Lakeview
- Andrea Martinez, Fairview Health Services
- Ann Bensen, Washington County Public Health and Environment
- Annette Sallman, Stillwater Area Schools
- Barbara Bursack, Washington County Community Services
- Brandi Poellinger, Allina Health
- Dan Parnell, National Alliance on Mental Illness (NAMI)
- David Brummel, Washington County Public Health and Environment
- Emma Wallo, Washington County Public Health and Environment
- Emily Carpenter, Fairview Health Services
- Heather Peterson, American Heart Association
- Jill Timm, Washington County Public Health and Environment
- Kristin Kroll, United Way of East Washington County
- Laure Lofgren, ISD 622
- Lia Burg, Washington County Public Health and Environment
- Liz Radel Freedman, arcadia research and evaluation
- Mark Skeie, Vital Aging Network
- Melissa Taphorn, Washington County Community Development Agency
- Commissioner Michelle Clasen, Washington County
- Mike Adams, Lakeview Hospital
- Rachel Presslein, Community Thread
- Rebecca Leighton, Washington County Public Health and Environment
- Reed Smidt, City of Woodbury
- Roger Green, Woodbury THRIVES (Woodbury Foundation)
- Shelly Schafer, City of Woodbury
- Smita Rakshit, Washington County Public Health and Environment
- Stephanie Kovarik, HealthPartners Lakeview Hospital
- Stephanie Souter, Washington County Public Health and Environment
- Tiffany Hoffman, Washington County Public Health and Environment
- Tina De Ruyter, Washington County Library
- Jacob Wasmund, Washington County Community Services
- Gerald Klebsch, Washington County Community Services
- Murugi Mutiga, Washington County Community Services/Public Health and Environment

Appendix B

Coalitions and Community Partner Networks

Resource/Asset	Lead Agency	Focus	Geography
Community Health Action Team (CHAT)	HealthPartners	General health and well-being; CHNA implementation	Stillwater (Central)
CONNECT Washington County	Washington County	Youth substance use and mental health	Countywide
Forest Lake Health UP	Forest Lake YMCA	General health and well-being	Forest Lake (Northern)
Heading Home	Washington County / Community Development Agency	Housing and homelessness	Countywide
Lakeview Health and Wellness Advisory Committee	HealthPartners	General health and well-being; CHNA implementation	Stillwater (Central)
Mental Health Local Advisory Council (LAC)	Washington County	Mental health	Countywide
M Health Fairview Lakes Community Advisory Committee (CAC)	Fairview Health Services	General health and well-being; CHNA implementation	Woodbury (Southern)
M Health Fairview Woodwinds Community Advisory Committee (CAC)	Fairview Health Services	General health and well-being; CHNA implementation	Forest Lake (Northern)
Substance Use Prevention Education & Action Coalition (SPEAC)	Forest Lake Schools	Substance use	Forest Lake (Northern)
Transportation Consortium	Washington County Community Services	Transportation	Countywide

Appendix C

Action Plan: Access to Health Care

Assets/Resources:

County departments including PHE and Community Services; health systems and clinics (e.g., Fairview Health Services, Health Partners, Allina, Entira); health plans (e.g., UCare); navigation services (e.g., Portico); community organizations; state agencies (Minnesota Department of Health and Department of Human Services).

Challenges/Barriers:

Federal or state changes related to eligibility for coverage; health care costs and premiums; access to transportation; financial constraints; lack of insurance; geographic limitations.

Collaborative Partnerships:

Advisory committees with focused hospital jurisdictions – Lakeview Hospital (HealthPartners), M Health Fairview Woodwinds, M Health Fairview Lakes; state and regional partnerships; coordinated efforts with neighboring counties.

Result: All residents are able to access health care.

Indicators:

- Percentage of uninsured residents.
- Availability of care ratios.

Strategies	Timeframe	Strategy Lead	Performance Measure Examples
Support and explore safety net health care services for residents who are under- or uninsured.	2025-2027	Public Health and Environment	# of dental clinics # of vaccine clinics # of vaccines given
Continue to assist under- or uninsured residents in obtaining health insurance.	2025-2027	Community Services	# of new residents on insurance programs # of new residents on Medical Assistance and MinnesotaCare # of cases who maintain Medical Assistance eligibility at renewal # of people that complete Medical Assistance renewal process # of referrals to insurance navigation services (e.g., CHWs, Portico)

Appendix C

Action Plan: Access to Health Care

Result: All residents know how to use preventative health care services and navigate the healthcare system.

Indicators:

- Percent of kindergarten students fully vaccinated.
- Percent of adults who have visited the doctor or had an annual check-up, in the past year.
- Percent of students who have been to the dentist for a check-up, exam, teeth cleaning, or other dental work, in the past year.

Strategies	Timeframe	Strategy Lead	Performance Measure Examples
Continue outreach on and opportunities for immunizations for both children and adults.	2025-2027	Public Health and Environment	# of messages/posts
Continue and explore preventative care opportunities and promotion with health care and other partners.	2025-2027	Public Health and Environment	# of trainings # of screening events # of campaigns # of partners engaged or projects
Explore, with health care partners, opportunities for improving health care literacy.	2025-2027	Public Health and Environment	# of campaigns # of partners engaged or projects

Appendix D

Action Plan: Housing

Assets/Resources:

Various county departments and agencies; Community Development Agency; cities and townships; faith-based organizations.

Challenges/Barriers:

Challenges and obstacles include funding (building units, assistance, staffing); administrative burdens; high rent (highest in State); seniors (60+) in shelters; "not in my backyard" community opposition that prevents local housing developments from moving forward on a local level; income gap due to high rental costs; domestic violence; certain groups such as individuals with physical, mental, or chemical health disabilities, seniors, single parents, and BIPOC households experience housing instability at disproportionately high rates; transportation; families seeking shelter outside of community due to lack of beds; having enough ongoing supportive services.

Collaborative Partnerships:

These partnerships will be crucial in advancing the strategies outlined in this plan: Heading Home Washington, Suburban Metro Area Continuum of Care (SMAC), Regional Metro Committee (RMC), faith communities, cities and townships. Heading Home Washington includes the following members: Solid Ground, Southern Minnesota Legal Services (SMRLS), Connect Center, McKinney-Vento Homeless School Liaisons – (specifically school districts 833 and 622), Tubman, Community Action Partnership of Ramsey and Washington, UCare, Stepping Stone Emergency Housing, Valley Outreach, MN One Stop, Greater Twin Cities United Way, Basic Needs, St. Andrews Community Resource Center, MN Housing and MN DHS, YMCA MN, St. Michaels and Trinity Lutheran, Washington County residents, people with lived experience, various Washington County departments/divisions.

Result: A diverse range of accessible and affordable housing options are available in all areas of the county.

Indicators:

- Percent of renters who are cost-burdened.
- Percent of homeowners who are BIPOC.

Strategies	Timeframe	Strategy Lead	Performance Measure Examples
Collaborate with the Washington County Community Development Agency (CDA) and other partners to promote an increase in affordable housing supply and provide a range of housing options.	2025-2027	Washington County CDA Community Services	# of housing units that are at or below 30% Area Median Income (AMI) # of potential BIPOC homeowners receiving homeownership advising
Support Washington County Community Development Agency (CDA) and Washington County policies and funding for affordable housing.	2025-2027	Community Services Public Health and Environment	# of city comprehensive plans (housing) PHE provides comments on

Appendix D

Action Plan: Housing

Result: All residents have access to supportive and healthy housing.			
Indicators: • Number of people experiencing homelessness. • Number of families prevented from becoming homeless.			
Strategies	**Timeframe**	**Strategy Lead**	**Performance Measure Examples**
Establish reliable and supportive housing options, including emergency housing, to provide shelter for "at-risk" individuals.	2025-2027	Community Services	# of adults served in the emergency housing # of families served by hotel and shelter program # of new county-sponsored supportive housing beds
Healthy housing: Work with partners to improve existing housing and explore additional healthy housing program opportunities.	2025-2027	Public Health and Environment	To be determined

Appendix E

Action Plan: Mental Health and Community Safety

Assets/Resources:

Multiple organizations in Washington County are actively providing or exploring ways to expand mental health services and opportunities for connection including AMHI, NAMI, HealthPartners, MakeItOk, Family Means, county/regional parks, Washington County libraries, and gathering spaces.

Challenges/Barriers:

Challenges and obstacles include stigma and societal attitudes; transportation difficulties; language and cultural barriers; limited mental health education and recognition of symptoms; lack of awareness about available resources; insurance; substance misuse; and intake procedures, as well as workforce recruitment barriers.

Collaborative Partnerships:

These partnerships will be crucial in advancing the strategies outlined in this plan: CONNECT, Local Advisory Council (LAC), AMHI Board, Opioid Settlement Council, sheriffs and police departments, schools, Washington County chemical health providers, Trusted Messengers, Metro Substance Misuse Prevention and Mental Health - Public Health Collaborative.

Result: All community members are empowered to navigate mental health services and support.

Indicator:

- Percent of residents delaying mental health care due to cost or lack of insurance.

Strategies	Timeframe	Strategy Lead	Performance Measure Examples
Improve availability and quality of community-specific mental health services, resources, and support systems.	2025-2027	Community Services Public Health and Environment	# of trainings held # of partners engaged # of events
Partner internally and externally to share mental health resources.	2025-2027	Community Services Public Health and Environmental	# of partners # of events # of individuals reached
Improve access to quality mental health services.	2025-2027	Community Services	# of providers (per population) # of referrals

Appendix E

Action Plan: Mental Health and Community Safety

Result: All community members experience a stigma-free environment that fosters resilience, recovery, safety, and overall well-being.

Indicators:

- Percent of students who were bothered by feeling down, depressed, or hopeless.
- Percent of adults reporting 14 or more days of poor mental health per month.

Strategies	Timeframe	Strategy Lead	Performance Measure Examples
Promote and embed a trauma-informed lens internally and externally.	2025-2027	Public Health and Environment Healthy Communities	# of internal trainings # of external trainings/participants # of policy or systems changes
Foster opportunities for people across the life span to build and leverage protective factors that benefit mental health.	2025-2027	Public Health and Environment Healthy Communities	# of participants in events # of events # of protective factors leveraged
Increase mental health literacy.	2025-2027	Public Health and Environment HealthPartners	# of trainings/events # of participants

Appendix F

Action Plan: Transportation

Assets/Resources:

Funding sources include the county levy; section 5310 grant; home and community-based waivers; state aid; Transportation Advancement Account (TAA); wheelage tax; county sales tax; new regional sales tax; non-emergency medical transportation; Disabled American Veterans (DAV); county transportation infrastructure (roads and trails).

Challenges/Barriers:

Challenges and barriers include funding; political will; nimbyism; land use and density; public perception (that everyone can drive); bias towards personal vehicle (everyone should drive); resistance to change.

Collaborative Partnerships:

These partnerships will be crucial in advancing the strategies outline in this plan: Transportation Consortium, Metro Transit, Met Council, East Metro Strong, cities/townships, DNR (for trails), Community Thread, Providers, Newtrax, DARTS, Trellis, CDA, healthcare partners (Allina, HealthPartners, Fairview Health Services), school districts, MnDOT/OTAT, neighboring county mobility managers, YMCA, Foreverwell, Oakdale Wellness 50+, FamilyMeans.

Result: All residents have accessible transportation options that support well-being and improve access to essential services.

Indicators:

- Increase use of multimodal transportation as reported in biennial Resident Survey.
- Miles of dedicated trails built as envisioned in pedestrian and bike plan.

Strategies	Timeframe	Strategy Lead	Performance Measure Examples
Maintain, develop, and expand multimodal transportation options.	Ongoing	Public Works	Completed plans # of new trails or trail connections
Update the Transit Needs Study and implement recommendations.	2026	Public Works/Community Services	Complete the update of the Transit Needs Study
Advocate for health considerations in transportation planning.	Ongoing	Public Health and Environment	# of comp plan comments
Enhance GoWashington efforts to increase awareness and improve access to information about transit options.	Annual	Community Services	# of consortium meetings # of contacts/calls