



Community Health Needs Assessment 2016-2019



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EXECUTIVE SUMMARY

WHO WE ARE:

Tri-County Health Care (TCHC) began operating in 1925 in the Wadena community as Wesley Hospital and has grown into a health care organization with approximately 440 employees. It is now a private, not-for-profit health care corporation providing service through Tri-County Hospital (Wadena) and clinics located in Bertha, Henning, Ottertail, Sebeka, Verndale, Baxter and Wadena. TCHC is one of the few independent health care systems in Minnesota and is known for its innovation and expertise. TCHC's mission is to improve the health of the communities served and deliver services with the highest standard of care on a continuous basis.

OUR COMMUNITY:

The Tri-County Health Care community is located in West Central Minnesota and includes eastern/central Otter Tail, Todd and Wadena counties. The total population of all three counties is estimated at 96,225; the primary service area population of TCHC is estimated at 38,342 because it more specifically focuses on the cities of Wadena, Sebeka, New York Mills, Bertha, Deer Creek, Hewitt, Aldrich, Verndale, Bluffton, Henning, Menahga and Ottertail. The community is primarily of Caucasian descent (95.4 percent) followed by other race (1.7 percent), two or more races (1.3 percent), American Indian (0.6 percent), black (0.6 percent) and Asian (0.3 percent).

COMMUNITY HEALTH NEEDS ASSESSMENT:

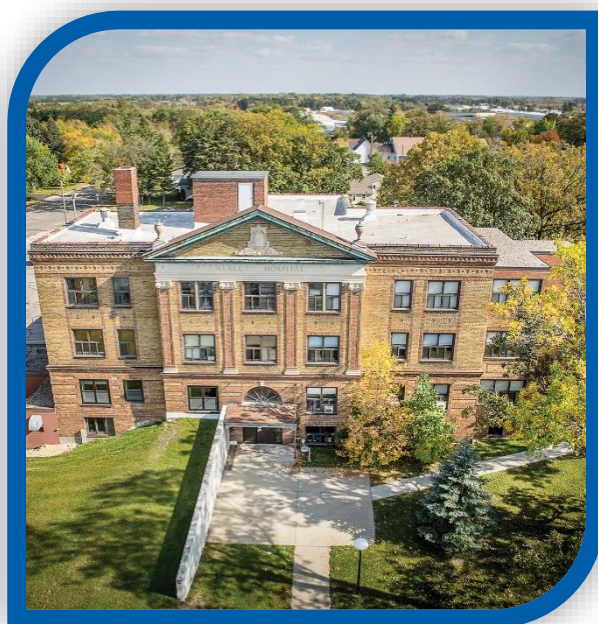
Tri-County Health Care conducted the following Community Health Needs Assessment (CHNA) with the collaboration of Todd, Wadena and Morrison County Public Health agencies; CentraCare Health System; CHI St. Gabriel's Hospital; and Lakewood Health System to ensure the most comprehensive assessment of the service area community. The MAPP Process (Mobilizing for Action through Planning and Partnerships, Page 14) was used as a "community-driven strategic planning process for improving community health" and provided the framework for data collection and prioritizing public health needs. Data was collected from a variety of sources including information from questionnaires for key stakeholders, a community health survey, and quantitative statistics from local, county and state public health sources. The data gathered was then used to identify specific issues and prioritize them according to need. This prioritized issues list was used to develop strategies for implementation of interventions. This report summarizes and highlights key findings and opportunities for implementation.

PURPOSE:

Validate progress toward organizational strategies and provide further evidence for retaining not-for-profit status.

PRIORITIES:

Based on the results of external and internal data, the community health survey, and key stakeholder input, our analysis states that our priorities are consistent with the 2013-2015 Community Health Needs Assessment. The priorities and implementation plan are discussed in greater detail on Page 15.



ABOUT TRI-COUNTY HEALTH CARE

Tri-County Health Care (TCHC) is a 25-bed critical access health care organization. TCHC owns and operates seven clinics, located in the communities of Baxter, Bertha, Henning, Ottertail, Sebeka, Verndale and Wadena, which exemplify the rich history of caring for patients in the area. As a private, nonprofit, primary health care organization, TCHC serves a population base of approximately 38,342 from Wadena, Todd and Otter Tail Counties in west central Minnesota. TCHC is proud of its commitment to quality patient care.

Our medical staff is comprised of 11 board-certified family practice physicians, two obstetrician/ gynecologists, one psychiatrist, two general surgeons, one radiologist, 11 physician assistants and seven family nurse practitioners. Specialty services offered have been enhanced by the addition of consulting physicians in the areas of pathology, oncology, cardiology, orthopedics, ophthalmology, urology, psychology, dermatology, spine, wound management and pulmonology. Professional and support staff dedicated to excellence provide services in areas of surgery, obstetrics, nursery, pediatrics, intensive and coronary care; 24-hour emergency room coverage; 24-hour ambulance services; Medicare skilled nursing; respite and transitional care. Outpatient surgeries include laparoscopy, arthroscopy, colonoscopy, endoscopy and cataract eye surgery. Cardiac and pulmonary rehab, ambulatory care, physical therapy and occupational therapy are all part of outpatient services available at TCHC. Ancillary services include the diagnostic imaging department, with in-house general X-ray, fluoroscopy, mammography, ultrasound, bone densitometry, nuclear medicine, CT and MRI scanning. A 24-hour laboratory is offered as well. Pharmacy, respiratory therapy, social service, dietary and nutritional counseling, speech, and nursing home consultations, diabetes education and various support groups complete the listings of services.

TCHC takes pride in continually upgrading technology. The purchase of equipment and advanced technology enhances superior services. TCHC is keeping its rural health care system on the leading edge of technology as a pioneer in the use of telemedicine and an interactive video telecommunication system that allows physician specialists to examine patients and consult with local practitioners using special medical equipment adapted for television usage. The advanced technology makes experts available onsite for patient diagnosis, saving time and travel and improving access to health care in our rural setting. TCHC expanded telehealth services to include e-ICU in the fall of 2016.

Tri-County Hospital Emergency Medical Service (TCH EMS) is the largest advanced life support (ALS) provider of 9-1-1 service in Wadena and Todd County, Minnesota. Located 85 miles northwest of St. Cloud, the service area encompasses 850 square miles in three counties. TCH EMS is the primary ALS intercept service for two smaller basic life support (BLS) services located within the communities we serve.

In January 2014, the Emergency Medical Services (EMS) Department began formally offering Community Paramedic services to our patients. The formation of this program was in relation to the work on RARE efforts (Reducing Avoidable Readmissions Effectively). TCHC has partnered with the statewide RARE program since its inception. The Community Paramedic model is an innovative, proven solution to provide high-quality primary care and preventative services by employing a currently available and often underutilized health care resource: a paramedic.

In 2014, Tri-County Hospital opened a rehabilitation clinic in Henning, MN, which is staffed by two physical therapists five days per week, and a Wellness Center in the community of Bertha. The Bertha Area Wellness Center offers a state-of-the-art fitness gym, educational classes on all aspects of wellness, personal



training and “Fitness on Demand,” a web-based software that allows members to pick from a library of hundreds of instructional workout videos 24/7. The Bertha Area Wellness Center has expanded to meet the needs of local patients in offering physical therapy three days a week as of April 2016.

INTRODUCTION

COMMUNITY HEALTH NEEDS ASSESSMENT

Minnesota nonprofit hospitals have moral obligations for the communities they serve. Under the Patient Protection and Affordable Care Act (ACA), the Community Health Needs Assessment is required for hospitals to maintain their tax-exempt, 501(c)(3) status. This requirement applies to tax years beginning after March 23, 2012. Tri-County Health Care has joined with Wadena County Public Health, Todd County Health and Human Services, Lakewood Health System, CHI St. Gabriel’s Health, Morrison County Public Health and CentraCare in order to make the most comprehensive assessment possible of our service areas and further enhance care in our rural health care community.



COMMUNITY DESCRIPTION

The community included in this assessment was the service area of Tri-County Health Care. This includes the counties of eastern Otter Tail, Todd and Wadena in Central Minnesota. The total population for these counties is estimated at 96,225. The population of the primary service area of Tri-County Health Care is estimated at 38,342 as it specifically includes the cities of Wadena, Sebeka, New York Mills, Bertha, Deer Creek, Hewitt, Aldrich, Verndale, Bluffton, Henning, Menahga and Ottertail, which are identified as primary service areas due to TCHC clinics located in or near these cities. The clinics that make up Tri-County Health Care are shown with red pins in the map above.

Ethnicity is primarily Caucasian (95.4 percent), other (1.7 percent), black (0.6 percent), American Indian (0.6 percent), Asian (0.3 percent) and two or more races (1.3 percent). The poverty rate for the Tri-County Health Care service area is at 14.2 percent (American Fact Finder: U.S. Census Bureau, 2013).

POPULATION STATISTICS

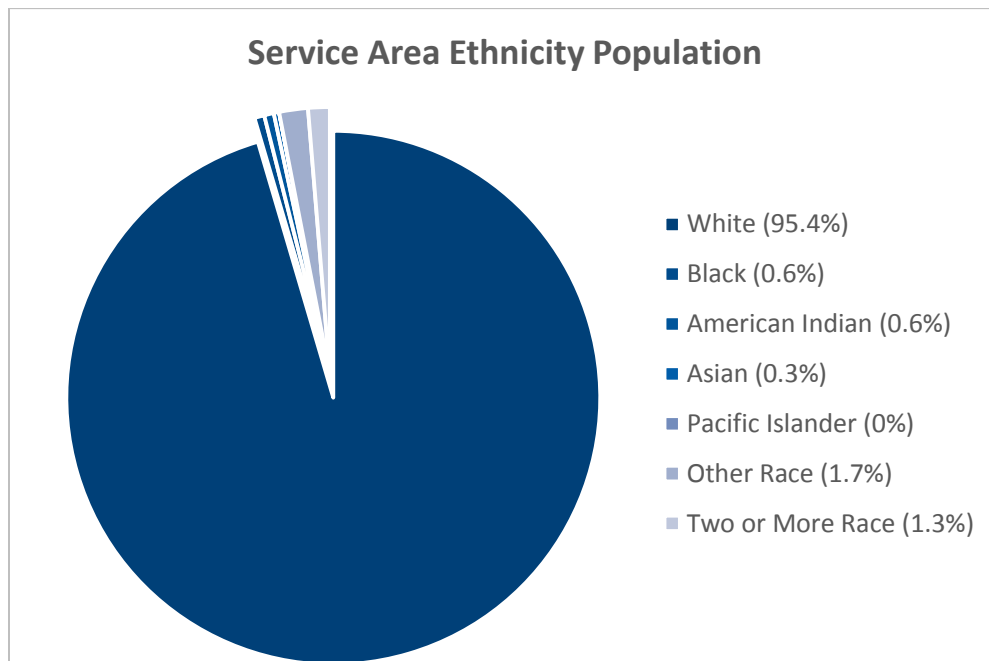
Children and youth make up 24.2 percent of the population; 55.5 percent are 18-64 years of age, and 20.3 percent are older than 65. The area has lower percentages of individuals between 18 and 64 than the state but has a higher percentage of individuals older than 65.

Data source: American Fact Finder, 2015. U.S. Census Bureau.

<https://www.census.gov/quickfacts/table/PST045215/27,27153,27159>

	Service Area	Minnesota
Under 5 Years	6.7%	6.4%
5-17 Years	17.5%	17.0%
18-64 Years	55.5%	61.9%
65 and Over	20.3%	14.7%

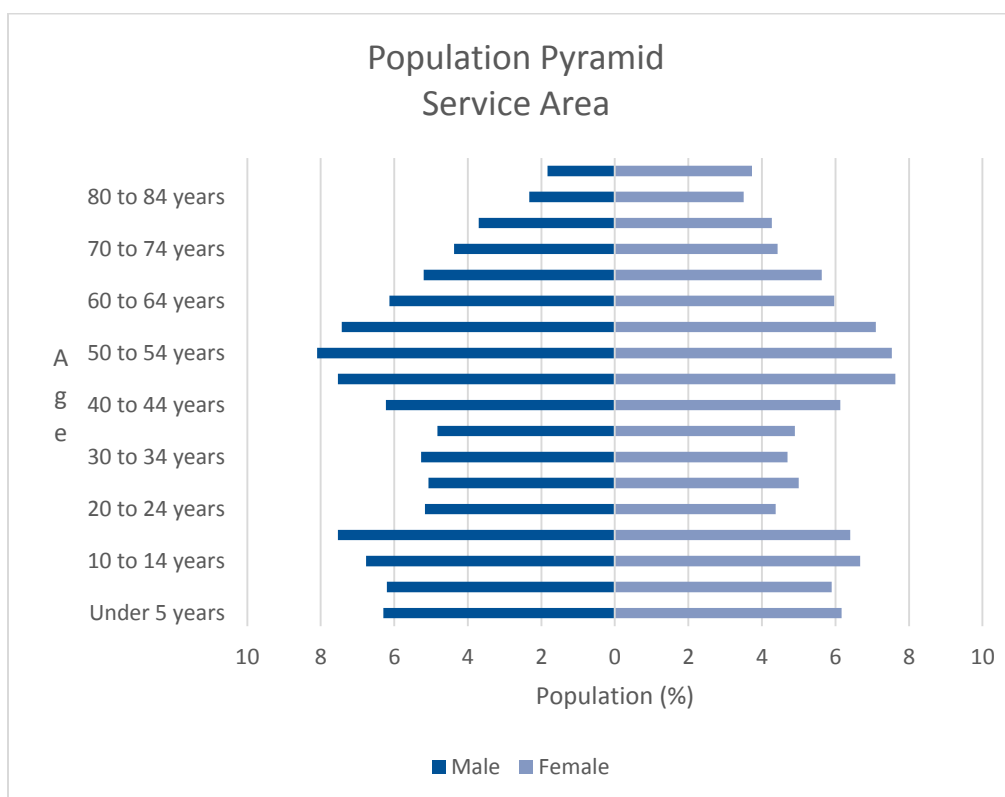
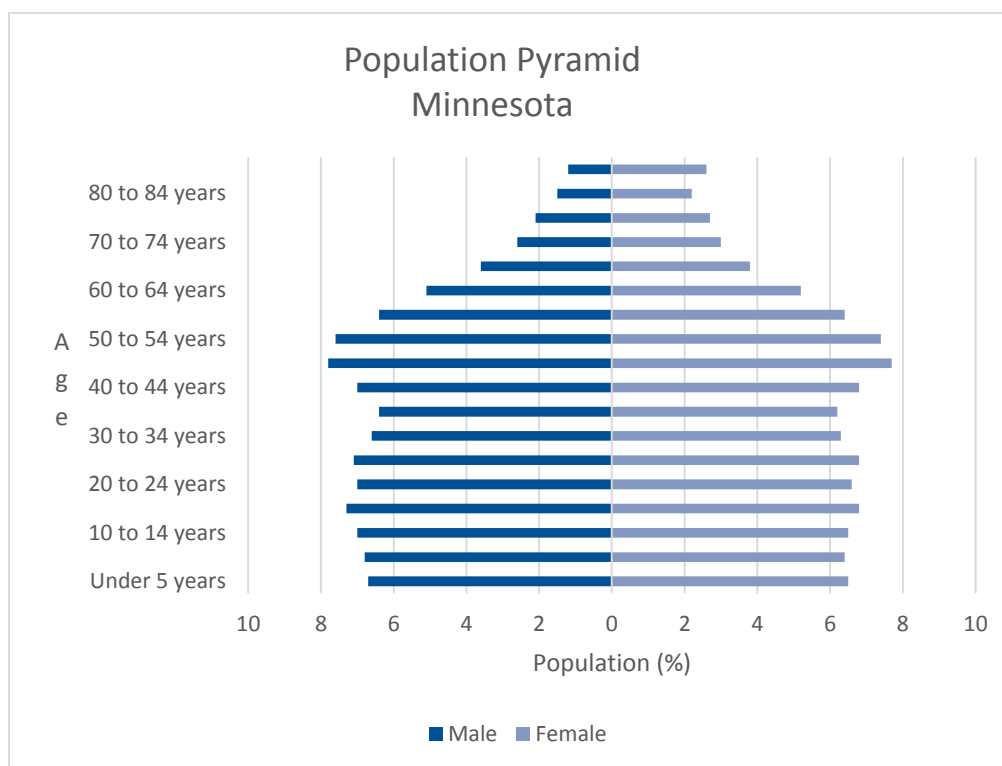
	Service Area	Minnesota
Total Households (2010-2014)	15,688	2,115,337
Persons Per Household (2010-2014)	2.38	2.48



The Tri-County Health Care service area consists of primarily white/Caucasians at 95.4 percent with 3.15 percent minority. The state of Minnesota is also primarily white/Caucasians at 85.2 percent but has a greater minority population of 14.8 percent.

Data source: American Fact Finder, 2014 U.S. Census:

https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_B02001&prodType=table



According to census data statistics, the service area has a higher median age of 43.6 compared to 37.3 years for Minnesota. Approximately one-third of the area population (32.8 percent) is older than 55 in comparison to the state average of 24.2 percent. The population pyramid within the assessment also shows the service area has a larger aging population compared to Minnesota. This is true for most rural areas in Minnesota compared to the Metro area. Additional health care services and providers will be needed to meet the needs of this subset of our population.

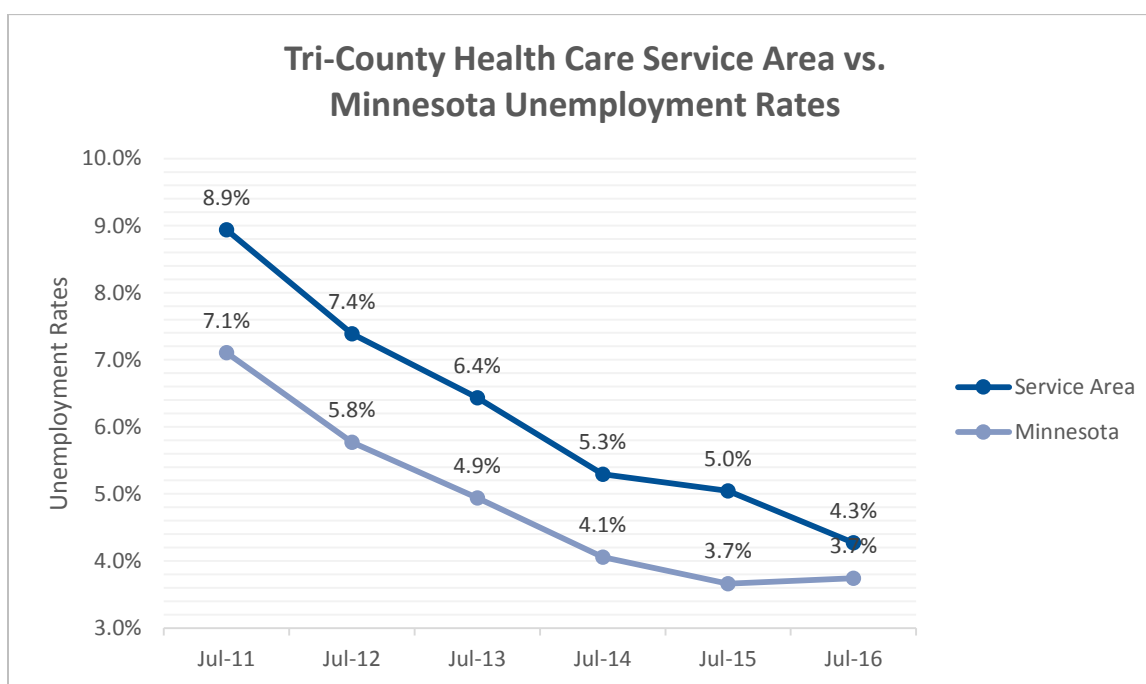
Data source: American Fact Finder, 2010. U.S. Census Bureau.

<https://www.census.gov/quickfacts/table/PST045215/27,27153,27159>

SOCIOECONOMIC FACTORS

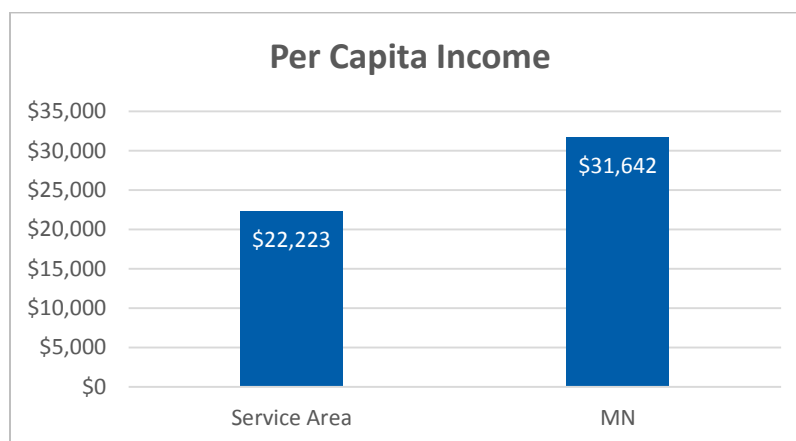
Unemployment Data

	Jul-11	Jul-12	Jul-13	Jul-14	Jul-15	Jul-16
Minnesota	7.1%	5.8%	4.9%	4.1%	3.7%	3.7%
Service Area	8.9%	7.4%	6.4%	5.3%	5.0%	4.3%



The Tri-County Health Care service area unemployment rate has been consistently higher than the state average.

Data source: Local Area Unemployment Statistics (LAUS) *Minnesota Department of Employment and Economic Development*. Retrieved August 25, 2016. <https://apps.deed.state.mn.us/lmi/laus/Default.aspx>



The per capita income is greater in the state of Minnesota with an average weekly wage of \$993, whereas the Tri-County Health Care service area average weekly wage is \$684.

Data Source: United State Census Bureau Quick Facts, 2010-2014. <http://www.census.gov/quickfacts/table/INC910214/27,27159>
Annual 2015 Average Weekly Income. Regional Labor Market Information. (n.d.). Minnesota Department of Employment and Economic Development. Retrieved June 20, 2016. <https://apps.deed.state.mn.us/lmi/rws/>

POVERTY

Percentages of All Ages Living in Poverty

	2009	2010	2011	2012	2013
Minnesota	10.9%	11.5%	11.8%	11.4%	11.2%
Service Area	15.2%	16.9%	17.2%	15.8%	14.2%

Percentages of People Younger than 18 Living in Poverty

	2009	2010	2011	2012	2013
Minnesota	13.9%	15.0%	15.3%	14.6%	14.0%
Service Area	21.8%	24.9%	24.9%	22.7%	20.6%

Poverty is defined by comparing annual household income to federally set poverty threshold determined by the U.S. Census Bureau and calculated based on household size and composition. This data is important because it shows the geographic distribution of poverty, which can inform the public and decision makers for program planning and evaluation.

The statistics indicate that children, as well as adults in the Tri-County Health Care service area, tend to have higher rates of poverty than the general population within Minnesota.

Data source: Minnesota Center for Health Statistics, Minnesota Department of Health, Vital Trend Report.
<http://www.health.state.mn.us/divs/chs/trends/index.html>

Number of Students Receiving Free and Reduced Priced Lunches

	2009	2010	2011	2012	2013
Minnesota	35.6%	36.7%	37.3%	38.3%	38.3%
Service Area	58.9%	57.4%	56.9%	55.9%	56.2%

Free and reduced lunch prevalence is an indicator of the socioeconomic status of the student population within a school district. The Tri-County Health Care service area has had a significantly higher rate of students receiving free and reduced lunches compared to the state of Minnesota.

Data source: Minnesota KIDS COUNT Data Center. <http://datacenter.kidscount.org/data/tables>

Food Stamp Utilization (AV Monthly Households)

	2009	2010	2011	2012	2013
Minnesota	3.2%	2.5%	4.4%	4.7%	4.8%
Service Area	5.2%	3.2%	5.0%	5.2%	5.2%

NATALITY DATA

Premature and Low Birth Weight of Singleton Births

Low birth weight is a negative birth indicator because babies born at a lower birth rate are at higher risk for disease, disability and possibly death. The Tri-County Health Care service area has a lower percentage of very low birth weight babies in Todd and Wadena Counties compared to Minnesota.

	% Preterm Births	% Low Birth Weight	% Very Low Birth Weight	% Small for Gest. Age
Minnesota	8.2%	4.9%	1.2%	4.0%
Todd County	7.3%	3.4%	1.0%	2.1%
Wadena County	10.4%	4.7%	0.4%	4.4%

Birth Outcomes/Socio-Demographics Factors

	% Births to Unmarried Mothers	% No Father on Birth Certificate	% Mother Smoked During Pregnancy
Minnesota	23.3%	11.9%	9.7%
Todd County	32.1%	7.4%	14.5%
Wadena County	34.8%	10.6%	19.7%

Teen Pregnancy Rates 15-19 Years Old

	Birth Rate	Pregnancy Rate
Minnesota	17.0	22.4
Todd County	26.1	28.5
Wadena County	27.8	30.1

Teen Birth Rate: Number of live births per 1,000 females in the population of the specified age.

Teen Pregnancy Rate: The number of live births, fetal deaths and induced abortions per 1,000 females in the population of the specified age.

Number of Infant Deaths

	1994-1998	1999-2003	2004-2008	2009-2013
Minnesota	2,010	1,805	1,903	1,641
Service Area	12	11	19	9

There were 9,180 abortions in Minnesota and 16 in the Tri-County Health Care service area in 2014. The Tri-County Health Care service area had a higher rate of mothers who smoke during pregnancy in 2014, with 14.5 percent in Todd County and 19.7 percent in Wadena County compared to Minnesota at 9.7 percent. The teen pregnancy average rates are also higher for Todd County (29.6) and Wadena County (33.2) compared to the state of Minnesota (24.2).

Data Source: Minnesota County Health Tables 2015: Minnesota Department of Health.

<http://www.health.state.mn.us/divs/chs/countytables/profiles2015/index.html>

METHODS

PRIMARY DATA COLLECTION

A community health survey was disseminated and analyzed during the community health needs assessment process in the Tri-County Health Care service area. Surveys were sent out in February 2016 to a random sample via mail. This qualitative and quantitative data is being used to guide the work of Tri-County Health Care and local public health departments. It is discussed in greater detail on Page 11.

SECONDARY DATA COLLECTION

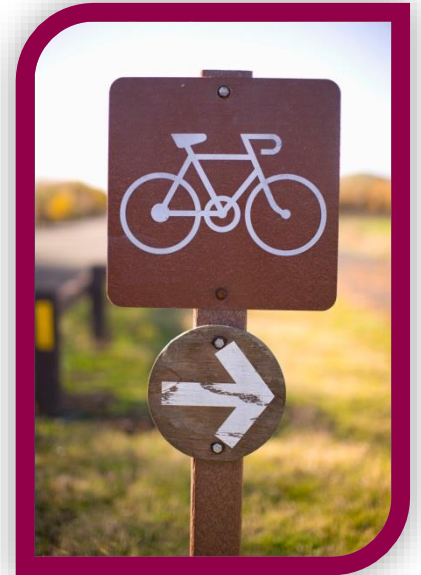
Secondary data was collected from a variety of local, county and state sources to compile a community profile, birth and death characteristics, access to health care, chronic disease, mental health and social issues, as well as school and social characteristics. When pertinent, this data was presented in the context of the Tri-County Health Care service area and the state of Minnesota, framing the scope of an issue as it relates to a broader community.

This report presents a summary that highlights the data findings and presents key needs and opportunities for action. What follows is a narrative that examines each of the data sets as well as state benchmark comparison data.

MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) PROCESS OVERVIEW

The MAPP process is a community-driven strategic planning tool that includes community visioning, conducting four assessments (community themes and strengths, organization capacity and performance, community health, and forces of change), prioritizing issues, selecting goals and strategies, and developing an action plan. Tri-County Health Care partnered with local public health agencies and other area health care facilities meeting routinely to share and analyze data, initiate the community survey and complete the MAPP assessments. Refer to Exhibit 6, 7A, 7B and 7C for details of the MAPP assessments.

Data source: National Association of County & City Health Officials, Mobilizing for Action through Planning and Partnerships, 2014, <https://www.naccho.org/topics/infrastructure/mapp/>



Phase 1:

Organize for Success and Partnership Development are part of the planning phase. This phase identifies who should be involved in the process and how the partnership will approach and organize the process.

Phase 2:

The Visioning phase is a collaborative and creative approach that leads to a shared community vision and common values.

Phase 3:

The Four Assessments inform the entire MAPP process. The assessment phase provides a comprehensive picture of a community in its current state using both qualitative and quantitative methods. The use of four different assessments is a unique feature of MAPP. Most planning processes look only at quantitative statistics and anecdotal data. MAPP provides tools to help communities analyze health issues through multiple lenses.

Phase 4:

Identify Strategic Issues uses the information gathered from the four assessments to determine the strategic issues a community must address in order to reach its vision.

Phase 5:

The Formulate Goals and Strategies phase involves specifying goals for each of the strategic issues identified in the previous phase. Many communities create a community health improvement plan at the end of this phase.

Phase 6:

The Action Cycle includes planning, implementation and evaluation of a community's strategic plan.

Your Community Roadmap to Health



COMMUNITY HEALTH SURVEY

The survey instrument content was largely taken from a similar survey conducted by these same counties in 2016. Modifications to the survey questions were developed by local public health staff and staff from CHI St. Gabriel's Health, CentraCare Health Long Prairie, Lakewood Health System and Tri-County Health Care, with technical assistance from the Minnesota Department of Health Center for Health Statistics. The survey was formatted as a self-administered English-language questionnaire.

Sample

Three distinct county-level samples were needed for this project. For each county, a two-stage sampling strategy was used to obtain a probability of adults living in the county. For the first stage of sampling; vendor (Marketing Systems Group of Horsham, PA) address-based sampling was used so all households would have an equal chance of being sampled for the survey. Marketing Systems Group obtained the list of addresses from the U.S. Postal Service. For the second stage of sampling, the "most recent birthday" method of within-household respondent selection was used to specify one adult from each selected household to complete the survey.

Survey Administration

An initial survey packet was mailed to 4,800 sampled households (1,600 in each county) that included a cover letter, the survey instrument, and a postage-paid return envelope on February 17, 2016. Approximately 10 days after the first survey packets were mailed (February 26), a reminder postcard was sent to all sampled households reminding those who had not yet returned a survey to do so and thanking those who had already responded. Approximately two weeks after the reminder postcards were mailed (March 9), another full survey packet was sent to all households that had still

not returned the survey. The remaining completed the surveys were received over the next four weeks, with the final date for the receipt of surveys being April 11, 2016.

Completed Surveys and Response Rate

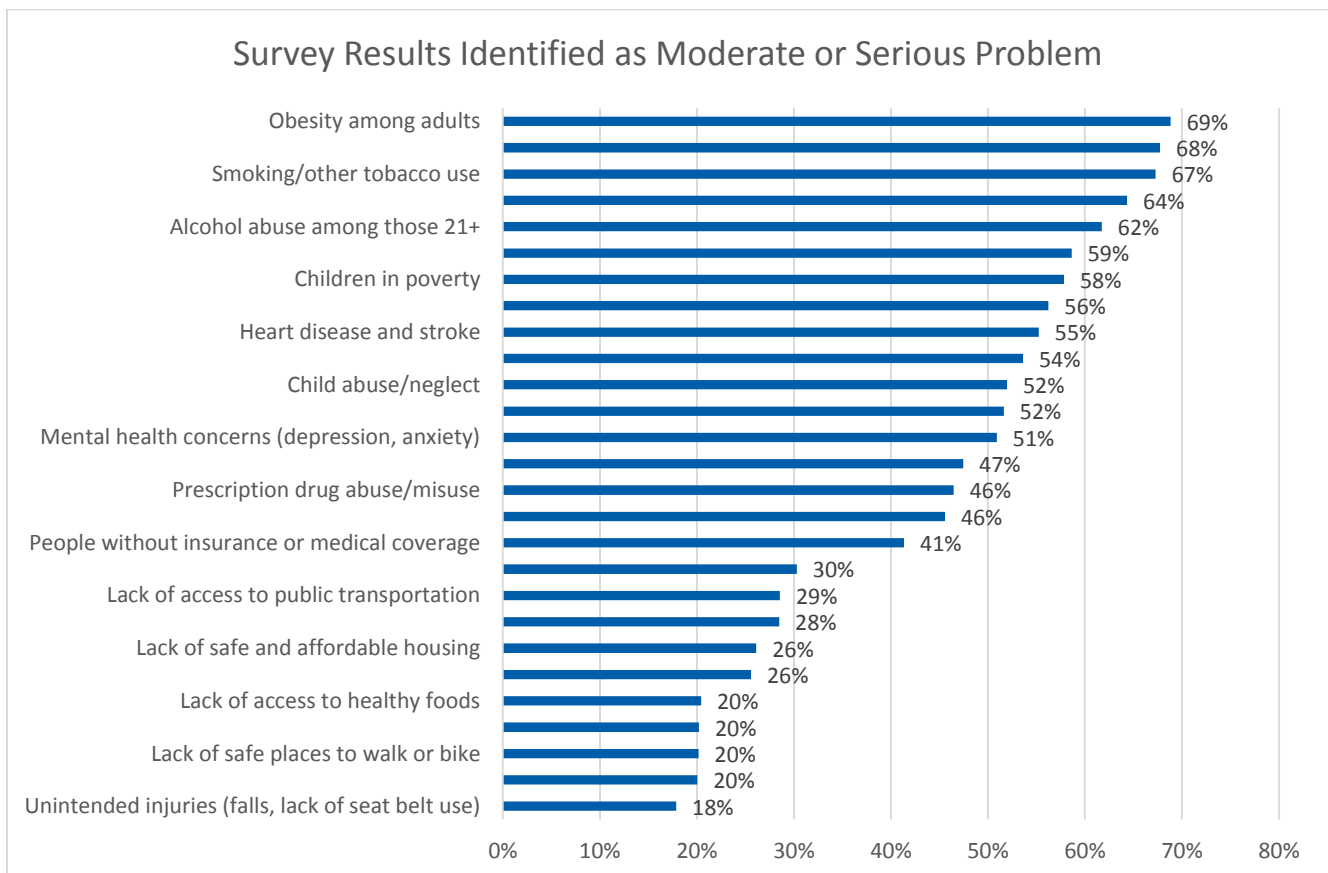
Completed surveys were received from 1,338 adult residents of the three counties; thus, the overall response rate was 27.9 percent (1,338/4,800). County-level response rates were 25.6 percent (Todd) and 28.8 percent (Wadena). Of the Tri-County Health Care service area respondents, 34 percent of the surveys completed were from households with income less than \$35,000, and 51.6 percent had a household income of less than \$50,000. More than 74.6 percent of households were married or living with a partner. Education levels for respondents included: 34.1 percent with a high school diploma or GED, 41.6 percent with trade/vocational or associates degree and 24.4 percent with a bachelor's degree or higher. Two point seven percent of respondents within the service area were of a minority race. Seventeen percent of respondents in the service area indicated they delayed or did not seek care due to lack of coverage, high costs, unable to get an appointment or other reasons. Twenty-six point four percent were older than age 65.

Data Entry and Weighting

The response from the completed surveys were scanned into an electronic file by Survey Systems, Inc.

To ensure that the survey results are representative of the adult population of each county and of the three counties combined, the data were weighted when analyzed. The weighting accounts for the sample design by adjusting for the number of adults living in each sampled household and for the disproportionate stratification. The weighting also includes a post-stratification adjustment so that the gender and age distribution of the survey respondents mirrors the gender and age distribution of the adult population in the three counties according to the U.S. Census Bureau American Community Survey 2010-2014 population estimates.

SURVEY RESULTS: ISSUES MARKED AS MODERATE OR SERIOUS PROBLEMS WITHIN THE TRI-COUNTY HEALTH CARE SERVICE AREA



HEALTH NEEDS

Based on the results of external and internal data, the community health survey and key stakeholder input, our analysis indicates our priorities are consistent with the 2013-2015 Community Health Needs Assessment.

The following bulleted areas of need were identified as issues needing additional focus after completing the data analysis and receiving community input. We have chosen to organize these issues in three broad areas:

1. Socioeconomic and Environmental Factors

- a. Access: affordable and preventable care
- b. Access: healthy food and physical activity opportunities
- c. Access: health care professional shortage area
- d. Social determinants of health and health equity: housing, employment, poverty, environment, transportation
- e. Access: decreased reimbursement
- f. Population health infrastructure

2. Disease and Injury

- a. Mental health: depression, anxiety, suicide, etc.
- b. Chronic disease: diabetes, heart disease, stroke, high cholesterol, hypertension, etc.
- c. Cancer
- d. Obesity: children and adults
- e. Unhealthy behaviors: alcohol, smoking, compliance with care, diet, exercise
- f. Preventative Health Care: breast and colon cancer screenings, prostate exams

3. At Risk and Vulnerable Populations

- a. Aging demographic
- b. Low income
- c. Minorities and Amish within the population

These key issues are based off of the following findings as referenced at the beginning of the assessment.

SOCIAL AND ENVIRONMENTAL FACTORS

- Minnesota unemployment statistics reveal Tri-County Health Care's service area has unemployment levels consistently higher than the state average for the last five years.
- The poverty level is high in the Tri-County Health Care service area in comparison to state averages. Most recent estimates cite 14.2 percent service area vs. Minnesota 11.2 percent. This is even more significant in people younger than 18 (20.6 percent vs. Minnesota 14 percent).
- There are a significant number of individuals in the service area paying 30 percent or more of their income just for housing. This high housing cost burden reduces the money families and individuals can spend on basic needs such as food and medicine.
- Tri-County Health Care is located in a geographic area designated as a Health Professional Shortage Area (HPSA) experiencing a shortage of primary care providers, psychiatry and dental services serving low income populations.
- The inadequacy of prenatal care is higher than the state average within the service area; this is especially true within Todd County at a rate of 7.6 percent (Wadena County: 5.6 percent, state of Minnesota: 4.3 percent).
- The teen pregnancy rate is at 28.5 (per 1,000) in Todd County and 30.1 in Wadena County, which is higher than the state average of 22.4.
- A high percentage of students receive free or reduced lunches in comparison to state averages. The average percentage for Minnesota was 38.3 percent in 2013 with the Tri-County Health Care service area at 56.2 percent of the student population receiving free or reduced price lunches.

- The community health survey respondents cited 17 percent had delayed or not obtained medical care when they felt it was needed. Top cited reasons for this were 1) cost too much, 2) not serious enough, 3) deductible too expensive, and 4) no insurance. These same top four responses were cited as the reasons people did not seek mental health care when felt they needed it.

DISEASE AND INJURY

- Lower than average numbers of students in 8th, 9th and 11th grade reported suicidal thoughts within the past year compared to the state averages.
- Students in 8th, 9th and 12th grades have higher than average percentages of alcohol utilization in the past year compared to the state averages.
- Student smoking is a concern in the Tri-County Health Care services area with higher than average percentages of students who have smoked in the last 30 days.
- A higher number of mothers smoked during pregnancy within the Tri-County Health Care service area at 14.5 percent in Todd County and 19.7 percent in Wadena County, which is higher than the state average of 9.7 percent.
- The Tri-County Health Care service area has lower rates of sexually transmitted infections compared to Minnesota (rate per 100,000: Todd County, 146.9; Wadena County, 138; Minnesota, 348.4).
- Eighty-six percent service area vs. 89 percent Minnesota received diabetic screenings. Similar rates of diabetes diagnoses in the areas, County Health Rankings 2016.
- More women age 67-69 received a mammography screening in Wadena County (67 percent) compared to the state of Minnesota (65 percent); however, fewer women (50 percent) received a mammography screening in Todd County.
- According to our community health survey responses, 10.3 percent of respondents had been diagnosed with diabetes compared to the state average of 8 percent.
- Thirty-one point four percent of respondents also said they had been diagnosed with high blood pressure compared to the 27 percent of Minnesota adults.
- The Tri-County Health Care service area has higher than average obesity rates among adults (29 percent vs. Minnesota 26 percent). County Health Rankings, 2016. The calculated BMIs for our service area referenced from the community health survey: 15 percent obese and 36 percent overweight but not obese. When asked to rate the severity of health topics in the community, 62 percent of people saw obesity as the most concerning issue of all.
- Most common injuries requiring hospitalization within the service area were falls, bites and stings, motor vehicle accidents to occupants, and poisonings.



VULNERABLE POPULATION

- The residents of the Tri-County Health Care service area are 95.4 percent Caucasian, followed by Other Race at 1.7 percent.
- A population of Amish people resides within the Tri-County Health Care service area. Todd County has five separate settlements, and Wadena County has two districts and includes the oldest Minnesota Amish community. As previously mentioned, eastern Otter Tail County is also home to Amish. It is unclear the specific population numbers, but the Amish seem to be growing in numbers in America. The Amish are known for seeking more alternative forms of medical treatment than doctors and hospitals, but their health does impact the community as seen in 2005, when a polio outbreak occurred in Todd County.
- The population pyramid within the assessment shows the service area has a larger aging population compared to Minnesota. Additional health care services and providers are needed to meet the needs of this subset population now and into the future.

TCHC COMMUNITY HEALTH PRIORITIES

As a result of work completed through the MAPP process in partnerships with local public health agencies and other area health care facilities, the following items were identified as the top 10 significant issues for the purpose of this assessment:

- Obesity
- Mental health
- Chronic disease
- Access to health care services/system navigation
- Healthy behaviors
- Population health infrastructure
- Data exchange
- Cancer
- Social determinants of health (poverty, employment, housing, environment, etc.)
- Decreased funding

Refer to Exhibit 9 for a summary of the top 10 health priorities identified on the previous community health needs assessment. The previous survey identified the majority of issues in 2013 are consistent with those issues identified in this assessment. TCHC prioritized the promotion of healthy behaviors as it has the potential to affect many significant items identified on the list, such as obesity, mental health and chronic disease, etc. Chronic disease management is also identified as a priority as the community measurement scores for optimal care of diabetes and vascular disease have been less than state averages, which needs to improve. In addition, the need to concentrate on preventative care to identify and manage chronic conditions in their early stages was determined as a priority. Exhibit 10 provides these top 10 identified issues with a summary of plans to address them. Refer to Exhibit 7B for identifying key stakeholders and their input as part of the MAPP process. Refer to Exhibit 5 for the health care resources in the Tri-County Health Care service area.

Priority 1: Healthy Behaviors

Goal: Improve healthy behavior with diet and exercise. Improving healthy behaviors will likely have positive impacts on other issues including: obesity, diabetes, heart disease, etc.

Strategy 1: Continue wellness initiatives with the Maslowski Research Study and expand to more employer groups.

Strategy 2: Provide educational opportunities.

Summary: In 2012, TCHC began work on the Maslowski Wellness and Research Study. The pilot group began with TCHC employees, and the study has shown TCHC made some nice shifts in overall culture as well as maintained health status of its employees. Employees who feel supported and receive support in making healthy lifestyle choices are more likely to participate and encourage such behaviors in other aspects of their lives including family and friends.

The next phase of the study began in 2015 and expanded to other area employer groups in an effort to promote and build a healthier culture. The study indicates changes are occurring in the cultures of those participating businesses, and this initiative is beginning to make a difference in the lives of those employees. Refer to Exhibit 1A to view the survey results as it relates to healthy behaviors. Refer to Exhibit 1B for results of the Maslowski Wellness and Research Study.

This study will continue for the next three to five years and will focus on the following:

- Continued development of Tri-County Health Care's wellness initiative
- Continued expansion of area businesses
- Community-wide events
- Continued promotion and coordination

TCHC also provides several educational opportunities for the community such as Women's Day Out, which provides educational sessions on women's health; Men's Night Out, which is an educational event regarding health issues for men; and I Can Prevent Diabetes. Refer to Exhibits 1C and 1D for information on this topic.

Priority 2: Chronic Disease Management

Goal: Improve quality outcomes for patients with chronic conditions.

Strategy 1: Expand Medical Home program and Care Coordination services with full utilization of high-risk patient care plans and protocols based on best practices to provide optimal management of specific chronic conditions. Expand registries to identify patients with chronic conditions and utilize data to identify trends and gaps. Utilize ancillary services for closer monitoring of non-optimal patients. Implement a new blood pressure compliance process to assist hypertensive patients in maintaining optimal results.

Strategy 2: Provide educational opportunities.

Summary: TCHC's goals for chronic disease management begin with providing optimal care for diabetes and vascular disease and helping patients with hypertension management. TCHC's Minnesota Community Measurement results for optimal diabetic care in 2013 were 20 percent and improved to 39 percent in 2015, and 66 percent of patients with hypertension were keeping it under control in 2015. TCHC's Minnesota Community Measurement results for optimal vascular care in 2013 were 27 percent and have improved to 52 percent in 2015. Refer to Exhibit 2A for more information on chronic disease management results. Refer to Exhibit 2B for the chart of overall Minnesota Community Measurement results and the breakdown for each clinic in the service area.

TCHC added the Community Paramedic Program working collaboratively with Care Coordination staff in an effort reduce readmissions by aiding high risk patients in managing their conditions. Refer to Exhibit 2C, which outlines this program and the effect on avoidable readmissions.

Priority 3: Preventive Medical Visits

Goal: Improve participation in preventive health care including annual physicals, screening mammograms and colonoscopies.

Strategy 1: Pre-visit planning initiatives to identify patients requiring preventive exam, well child visit, screening mammogram and screening colonoscopy. This will involve enhancing the recall system to identify patients due or overdue for annual visits and diagnostic screening exams.

Strategy 2: Provide dedicated events to promote annual diagnostic screening exams. Example: TCHC provides mammogram parties to promote mammogram screenings, Men's Night Out and Women's Day Out to provide health and wellness education.

Strategy 3: Effective 2016, TCHC provides 3D mammography technology for early detection of cancer.

Summary: TCHC provided 6,968 preventive visits in 2015 and 6,425 in 2014. As part of early cancer detection efforts, TCHC performed 2,073 mammograms in 2015 and 2,088 in 2014, as well as 537 colonoscopies in 2015 and 667 in 2014. Refer to Exhibit 3 for a summary of preventive health care in our service area. The goal is to improve the number of preventive and diagnostic screening exams in future years.



TRI-COUNTY HEALTH CARE COMMUNITY BENEFIT IMPACTS

In addition to the priorities listed previously in this report, TCHC serves the community in many other capacities. Where the organization may lack resources to manage socioeconomic and environmental factors, we have many initiatives in place to assist vulnerable populations in obtaining necessary services. In addition to programs/services offered, this section of the report addresses many of those initiatives.

TCHC has served the community by providing 3,017 days of care for inpatient services in 2015 and 3,142 days of care in 2014. TCHC's surgical program performed 2,825 procedures in 2015 and 3,121 in 2014. In 2015, clinics provided 54,238 professional visits and 53,861 in 2014. Physical and Occupational Therapy visits for 2015 totaled 14,760 and 13,690 in 2014.

Diagnostic services provided 110,819 and 112,023 lab tests in 2015 and 2014, respectively. Radiology exams performed in 2015 totaled 22,580 and 22,485 in 2014.

TCHC provides 24/7 emergency room coverage and served 6,153 patients in 2015 and 6,046 in 2014. TCHC's hospital-based ambulance service provided 1,835 ambulance runs in 2015 and 1,793 in 2014.

These services in conjunction with TCHC's initiatives of adding a patient-centered medical home, care coordination services and community paramedic program are consistent with our mission to improve the health of the community served.

	2013	2014	2015
Ambulance Service Runs	1,811	1,547	1,668
Aquatic Therapy Visits	-	-	708
Community Paramedic	0	458	1,162
Emergency Room Visits	6,177	6,046	6,153
Medical Outreach Visits	6,322	6,314	6,770
Physical Therapy	10,898	11,707	12,775
Psychiatry Visits	2,873	3,701	3,308
Total Clinic Visits	48,732	53,861	54,238
Total Deliveries	170	184	163
Total Discharges	1,149	1,093	1,066
Total Laboratory	111,092	112,023	110,819
Total Patient Days	3,526	3,142	3,017
Total Radiology	21,476	22,485	22,580
Total ReadyCare Clinic Visits	-	5,024	6,531
Total Surgical Procedures	3,300	3,121	2,825

HEALTH CARE HOME/CARE COORDINATION

Health Care Home allows patients to work in partnership with their primary care provider and family members to improve their health outcomes and quality of life. Tri-County Health Care first became Health Care Home certified at the Wadena Clinic in May of 2015 and was recertified in June of 2016. The Health Care Home certification is a voluntary program available through the Minnesota Department of Health. This certification guarantees that this team-based care

approach is being delivered by the organization to participating patients. Tri-County Health Care incorporates Care Coordinators to help deliver team-based care between the patient, their family and the primary care provider. There are two Registered Nurses and one Licensed Practical Nurse in the Care Coordination department at Tri-County Health Care. The Care Coordinators are designated to specific Care Team Pods within the Wadena Clinic to improve efficiency and communication between the provider, staff and patient.

Tri-County Health Care started its Health Care Home program focusing on patients repeatedly using Emergency Department services and requiring frequent use of clinical staff via phone calls and clinic visits. Diabetic patients were added to the focus group as of October of 2016. Patients with various physical and mental health conditions participate in the Health Care Home program. The patient growth of this program has expanded from 16 patients in May of 2015 to 110 in October of 2016.

The Care Coordinators also participate in the Chronic Condition Program through the Institute for Clinical Systems Improvement and the Centrally Integrated Network, as well as the Asthma Control Test Registry.

FRIENDLY RIDER

Friendly Rider is demand-response service offering curb-to-curb transportation to and from many locations within the cities of Wadena and Staples as well as locations within Wadena and northern Todd County. The service is provided based on space availability and is open to the general public. All buses are wheelchair and handicap accessible.

Tri-County Health Care realized the benefit Friendly Rider would have for our patients. TCHC offers complimentary tickets to patients who are coming and going from appointments. This has ensured patients have a safe way to travel for their medical care. In 2015, Tri-County Health Care provided 5,339 transportation tickets and 8,706 in 2014.

In 2013, Friendly Rider created a route incorporating Tri-County Health Care main campus as well as our Rehabilitation clinic. Stops are made at each of these locations once an hour during 9-5 weekdays. That is a total a 1,275 trips to TCHC each year as scheduled. They also accommodate additional trips when needed or requested by patients.

Since early 2015, Friendly Rider has expanded the service area. They provide daily service trips along the Highway 10 corridor heading east as well as along the Highway 71 corridor heading south. A great deal of work has gone into assessing the needs of our region, and some service changes took place in 2016. They expended the hours of operation from 6 a.m. to 6 p.m. for those residents within 0-5 miles of Wadena. They continued to offer services Saturday mid-day and Sunday mornings to accommodate church services. The same weekday schedule is also being offered in the community of Staples. This expanded schedule has aligned well with clinic-based services, including ReadyCare walk-in clinic, allowing patients more options when they have a more urgent medical need to address.

There are plans to add services to Deer Creek, Bluffton and New York Mills in 2017. Friendly Rider covers a very large portion of the TCHC service area.

UNCOMPENSATED CARE PROGRAM

Tri-County Health Care provides free or reduced rates for services for individuals with a financial need. In 2014 and 2015, Tri-County Health Care reduced patient charges by a collective total of \$853,415 and \$1,110,802, respectively.

READYCARE

ReadyCare, when you need to feel *better, faster*. ReadyCare gives patients a choice for timely, affordable and quality same-day and walk-in care and same-day appointments for non-emergency but urgent illnesses and injuries. ReadyCare is available six days per week (Monday through Saturday).

MENTAL HEALTH PROGRAM

Tri-County Health Care’s psychiatry and therapy professionals provide services to those needing medication management, ongoing individual therapy and other psychiatric services. Refer to Exhibit 4 for more details. Together, we pledge to work with patients and families to provide individualized treatment and an improved quality of life. By working collaboratively with your primary care provider, we are able to provide a full spectrum of care in meeting your ongoing health and wellness goals.

	2013	2014	2015
Psychiatry Visits	2,873	3,701	3,308

Mental Health Taskforce:

Since early 2015, representatives of 14 local organizations have been meeting in Wadena County to find creative, local solutions to the current crisis in managing acute mental health situations in Minnesota.

- Legislative change: The taskforce appointed some of the senior members to prepare a unified response to some of the legislative changes occurring. This provides a single voice for the region to help ensure our message is heard.
- Prevention and promotion: Local public health and other service providers continue to look for ways to educate and provide resources focusing directly on promotion and awareness regarding mental health services and resources. Another area of focus is to reach individuals and educate those individuals regarding signs/symptoms in an effort to ensure patients receive necessary help to address mental health issues.
- Service delivery: Assessing the way current services are delivered and identifying gaps or process improvement opportunities to create more streamlined services.

Success through collaboration:

Tri-County Health Care has a strong history of collaboration when it comes to mental health and associated services. Currently, TCHC’s Psychiatry Department provides office space to Northern Pines for psychology services. This ensures patient needs are met under one roof. With transportation or other factors often affecting “no-show” rates, this is an important piece essential to comprehensive care.

Since 2007, Region 5+ has provided funding for Mobile Crisis Outreach (MCO) services. This service covers a portion of Central Minnesota where mental health practitioners are available to provide community response to individuals, families and children experiencing a mental health crisis. The MCO is a supportive service and will make visits directly to the Emergency Department for patients in need of assessment and determination of the safest plan of care.

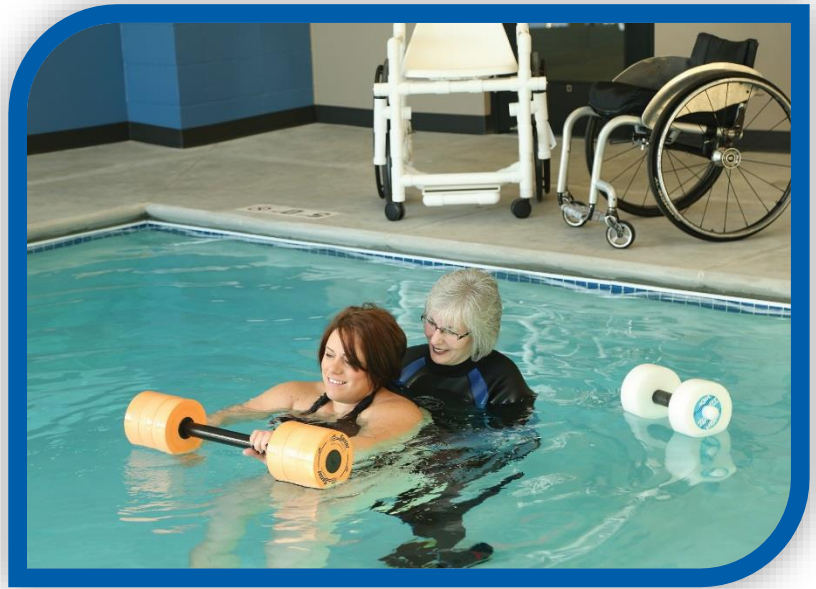
As a result of collaboration and consumer feedback, a local “warmline” was opened in October 2016 for individuals to call when needing someone with whom they can “talk.” The goal is to provide support and resources for individuals before their situation rises to crisis level.

Safe Harbor was added to the region in 2015 and provides supervised residential rehabilitative service on a time-limited basis with referrals for other services. This service allows the individual a chance to return to baseline after a crisis.

Ongoing collaboration regarding new services and process improvement of existing services results in positive impacts in service delivery and availability of those critical services.

TRI-AQUATIC THERAPY

In December 2015, TCHC opened a warm-water aquatic therapy pool in the Maslowski Wellness and Research facility. The closest facility is 60 miles away. This addition allows TCHC to provide a necessary service locally for patients with limited means of travel. Warm water therapy allows physical therapists to help patients do exercises they couldn't do on land. The warm water relaxes muscles, reduces swelling and gives those who can't exercise on land a safe place for therapy. Tri-Aquatic Therapy is a specialized form of physical therapy. Water has been, and remains, the best environment to achieve full function regardless of the injury. It not only improves motion and flexibility, but the warmth of 92 degree Fahrenheit water and its massaging effects allow a patient's muscles to relax while helping reduce pain. Through an arrangement with the Maslowski Wellness and Research Center, Tri-County Health Care offers access to one of the area's premiere therapy pools. Paired with our highly skilled and trained staff, patients can expect one of the most comprehensive aquatic therapy programs in Central Minnesota.



COMMUNITY NEEDS ASSESSMENT OVERVIEW OF KEY FINDINGS

The priorities and issues identified by this assessment are very similar to the 2013-2015 Community Health Needs Assessment. TCHC will continue to concentrate on promoting wellness, chronic disease management and encouraging preventive care. These initiatives are important for long-term health effects and improving the health and well-being of the community. Mental health issues are a continued area of focus as the demand for these services continues to increase.

TCHC has seen improvements in health status and increased awareness with our employees as well as other community employer groups with the work on the Maslowski research study. This work is ongoing as we will continue to expand this to other groups within the service area in an effort to promote healthy behaviors and improve health outcomes.

It is TCHC's objective to provide optimal care for patients with chronic conditions by implementing a medical home and care coordination program in collaboration with community paramedics to help high-risk patients maintain compliance with their care, reduce avoidable readmissions, reduce unnecessary emergency room visits and improve quality of life. Success in these areas is evidenced by improved scores with Minnesota Community Measurements and improvement in reducing avoidable readmissions.

In an effort to promote early detection of cancer and chronic conditions, TCHC continues to promote preventive physical exams, well child visits, screening mammograms and screening colonoscopies.

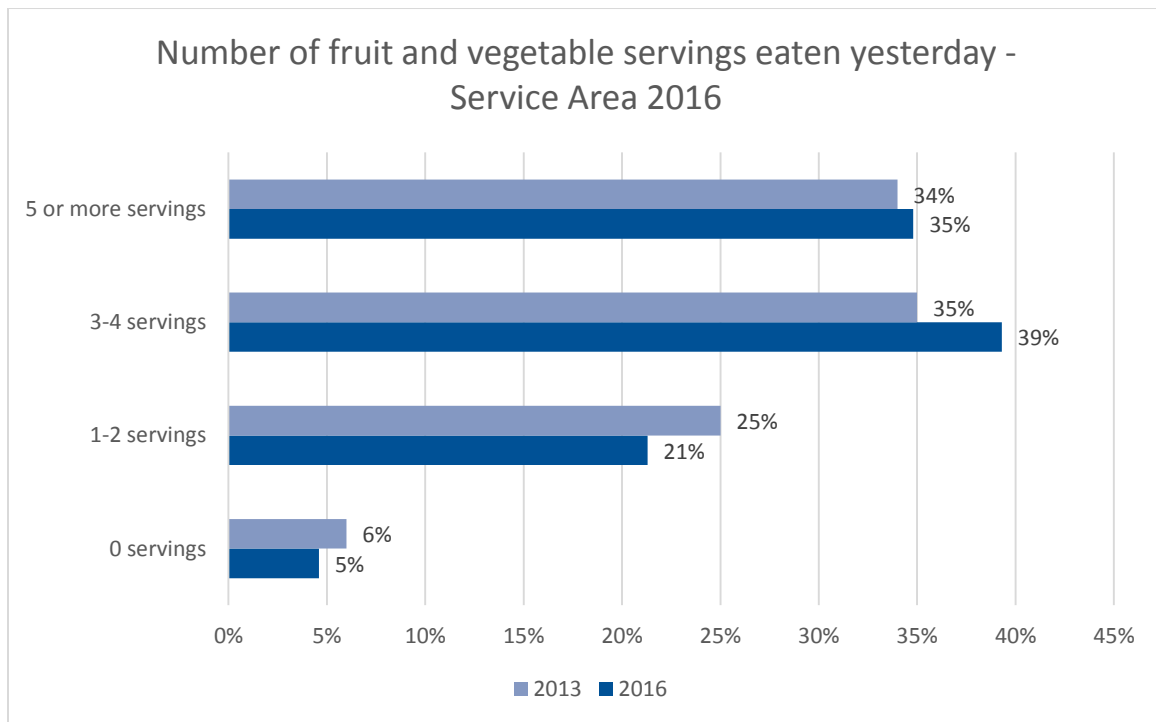
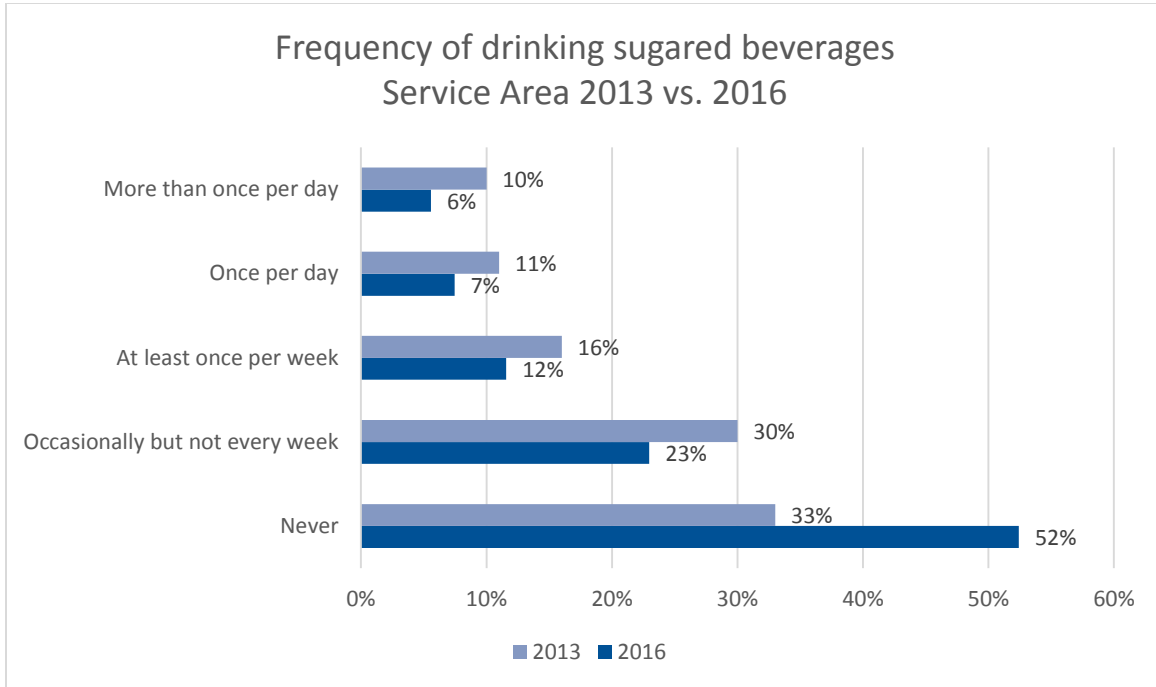
TCHC lacks resources to mend socioeconomic issues such as poverty, unemployment, etc. However, TCHC has initiatives to provide services at free or reduced rates for those who lack the ability to pay. TCHC also provides free transportation to medical visits in those areas served by Friendly Rider.

A continued challenge for the TCHC community is our location in a health professional shortage area. This directly impacts access as we are experiencing a shortage of health care providers, and we continue to focus on physician recruitment to meet the needs of the community.

EXHIBIT 1A

HEALTH CARE IN THE TCHC SERVICE AREA: HEALTHY BEHAVIORS

Diet and Exercise



There has been slight increase in fruit and vegetable serving consumption as displayed in the graph above. The Tri-County Health Care service area has a higher than average number of students receiving free/reduced priced school lunches.

Mothers and Children Receiving WIC
(Special Supplemental Nutrition Program)

	2007	2008	2009	2010	2012
Minnesota	234,855	228,715	240,041	230,110	206,900
Service Area	4,986	5,009	5,685	4,519	3,935

Households with Children Receiving
Supplemental Nutrition Assistance Program (SNAP)

	2009	2009	2010	2011	2012
Minnesota	66,363	80,276	93,688	106,117	111,682
Service Area	1,069	1,341	1,578	1,711	1,770

Percentage of Students Receiving
Free and Reduced Priced Lunches

	2009	2010	2011	2012	2013
Minnesota	35.6%	36.7%	37.3%	38.3%	38.3%
Service Area	58.9%	57.4%	56.2%	55.9%	56.2%

Minnesota Student Survey
Physically Active for at Least
60 Minutes per Day in the Last Seven Days

	Grade 5	Grade 8	Grade 9	Grade 11
Minnesota	89.9%	92.7%	91.0%	87.6%
Service Area	87.5%	96.6%	93.7%	92.0%

Data source: Minnesota Department of Health: County Health Tables.

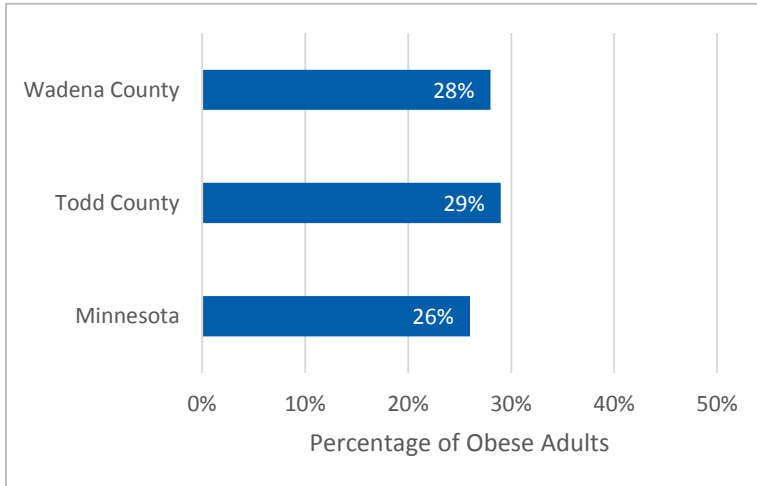
<http://www.health.state.mn.us/divs/chs/countyttables/profiles2015/index.html>

2013 Student Survey completed by the Minnesota Departments of Education, Health, Human Services and Public Safety.

http://w20.education.state.mn.us/approot/mss_reports/mss_student_survey_reportlaunch.htm



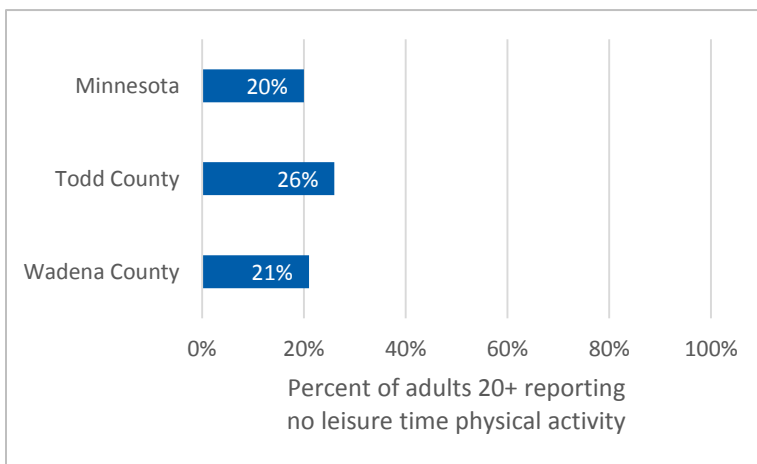
Adult Obesity Prevalence



Compared to the state of Minnesota, the prevalence of adult obesity is higher in the Tri-County Health Care service area.

Adult obesity prevalence represents the adult population older than 20 years of age that has a body mass index greater than or equal to 30kg/m². This data is based off of the Behavior Risk Factor Surveillance System. Obesity prevalence is important because it increases the risk of heart disease, stroke, cancer, type 2 diabetes, sleep apnea and many other conditions.

Adult Physical Inactivity



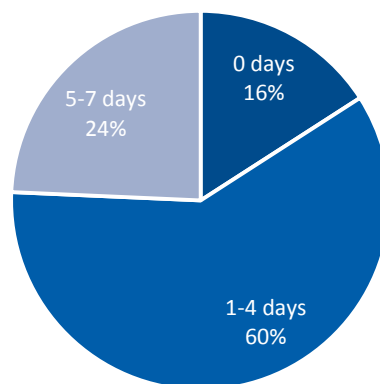
More adults report physical inactivity in the Tri-County Health Care service area than in the overall state of Minnesota.

The percentage of adult physical inactivity is a self-reported measure. The degree of intensity, duration or frequency for those who report physical activity was not listed. Physical inactivity is related to premature mortality, obesity, cardiovascular disease, stroke, type 2 diabetes, etc.

Data source: County Health Rankings and Roadmaps: A Healthier Nation County by County, 2016.

http://www.countyhealthrankings.org/app/minnesota/2016/compare/snapshot?counties=27_159%2B27_153%2B27_111

Days per week where at least 30 minutes of moderate physical activity has been achieved Service Area 2016



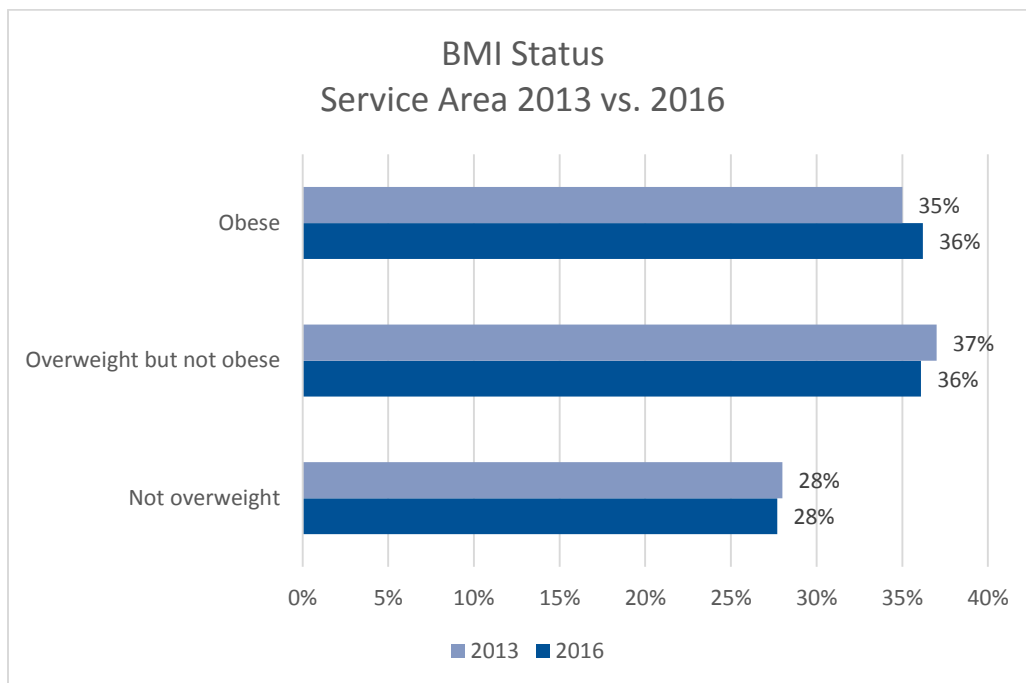
Body Mass Index (BMI)

A Body Mass Index (BMI) of 25.0-29.9 is considered overweight and more than 30.0 is obese. Both terms are considered unhealthy weight.

People who have obesity, compared to those with normal or healthy weight, are at increased risk for:

- High blood pressure
- Type 2 diabetes
- Coronary heart disease
- Stroke
- Osteoarthritis (a breakdown of cartilage and bone within a joint)
- Sleep apnea and breathing problems
- Cancers such as endometrial, breast, colon, kidney, gallbladder and liver
- Low quality of life
- Mental illness such as clinical depression, anxiety and other mental disorders
- Body pain and difficulty with physical functioning

According to the County Health Rankings and Roadmaps, 26 percent of Minnesotans are obese and 28-29 percent of adults in the Tri-County Health Care service area are considered obese. The local survey revealed those who self-reported are at a slightly higher rate than of the county health rankings.



Data source: County Health Rankings and Roadmaps: A Healthier Nation County by County, 2016

Adult Obesity Causes & Consequences. Centers for Disease Control and Prevention. <http://www.cdc.gov/obesity/adult/causes.html>

Smoking

Utilizing the community health survey data, those self-reporting as a current smoker are above state average.

Due to a vast amount of research around the negative effects of cigarette smoking, this continues to be an important indicator.

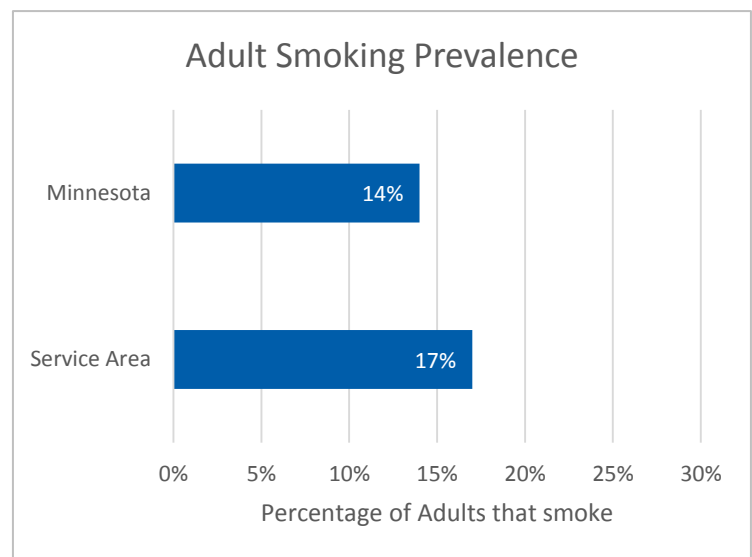
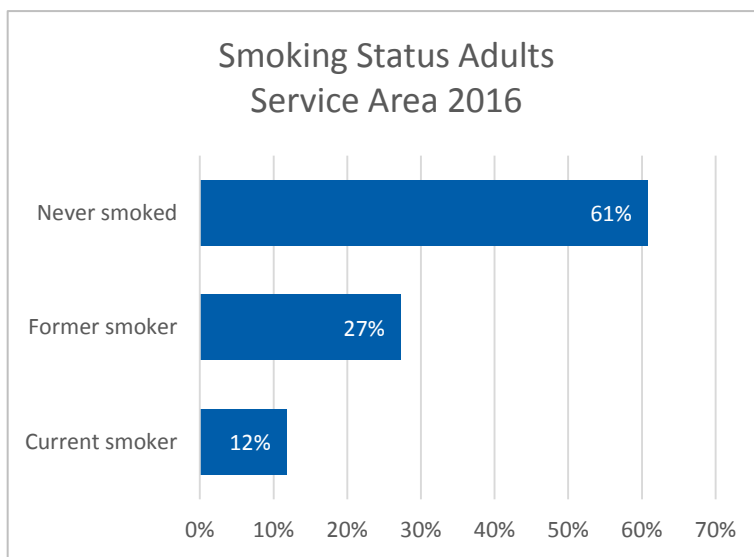
Based on the Minnesota student survey regarding cigarette smoking in the last 30 days, there is a higher than average number of high school aged students partaking in this behavior.

Tobacco in Minnesota:

- 5,900 Minnesotans die every year due to smoking
- Smoking causes more than \$2.5 billion in medical costs annually in Minnesota
- 580,000 Minnesotans, 14.4 percent of the state's population, still smoke
- 102,100 Minnesota youth are projected to die from smoking
- Tobacco kills more Minnesotans than alcohol, homicides, car accidents, AIDS, illegal drugs and suicide combined

Minnesota Student Survey Smoked Cigarettes During the Previous 30 Days

	Grade 5	Grade 8	Grade 9	Grade 11
Minnesota	6.0%	4.2%	7.5%	12.2%
Service Area	2.6%	5.5%	11.9%	17.6%



Adult smoking rates are slightly higher in the Tri-County Health Care service area compared to the state. The community health survey measured 14 percent for the state of Minnesota and 17 percent for the service area.

Adult (ages 18 or older) cigarette smoking prevalence is an estimated percentage of adults that smoke every day/most days based off the Minnesota Department of Health, Tobacco Data. Cigarette smoking is attributed to premature death, various cancers, low birth weight, cardiovascular disease, etc., and high prevalence points communities to a need for cessation programs.

Data source: Minnesota Department of Health, Tobacco Data, 2014

http://www.health.state.mn.us/divs/hpcd/tpc/docs/tobacco_data.pdf

2013 Student Survey completed by the Minnesota Departments of Education, Health, Human Services and Public Safety.

http://w20.education.state.mn.us/approot/mss_reports/mss_student_survey_reportlaunch.htm

Minnesota Department of Health - Tobacco Data. http://www.health.state.mn.us/divs/hpcd/tpc/docs/tobacco_data.pdf

Sexually Transmitted Infection (STI)

	Chlamydia	Gonorrhea	Primary/ Secondary Syphilis	Syphilis - All Stages	HIV
Minnesota	18,048	3,082	118	335	315
Service Area	28	0	0	0	0

Sexually Transmitted Infection Rate, 2016

	2016 Rate per 100,000	2010 Rate per 100,000
Minnesota	348.4	276
Todd County	146.9	76
Wadena County	138	36

Sexually transmitted infections are measured as chlamydia incidence (number of new reported cases) per 100,000. Chlamydia is the most common bacterial sexually transmitted infection in North America and is associated with unsafe sexual activity. It is important to note that communities with poor screening may have artificially low rates of chlamydia incidence.

Minnesota Student Survey Have Ever Had Sexual Intercourse

	Grade 9	Grade 11
Minnesota	15.0%	37.5%
Service Area	17.0%	36.3%

Data source: Minnesota County Health Tables by State and County, 2013.

<http://www.health.state.mn.us/divs/chs/countytables/profiles2013/>

County Health Rankings & Roadmaps: A Healthier Nation County by County, 2016.

http://www.countyhealthrankings.org/app/minnesota/2016/compare/snapshot?counties=27_159%2B27_153%2B27_111

2013 Student Survey completed by the Minnesota Departments of Education, Health, Human Services and Public Safety.

http://w20.education.state.mn.us/approot/mss_reports/mss_student_survey_reportlaunch.htm

EXHIBIT 1B

FRANK AND ELEANOR MASLOWSKI CHARITABLE TRUST RESEARCH STUDY PROPOSAL TRI-COUNTY HEALTH CARE AND WADENA REGIONAL WELLNESS CENTER

Subject:

To identify factors that may be predictive or explanatory of health risk status of various resident cohorts in the Tri-County Health Care service area population.

Scope of Project:

Using three population sample cohorts in the Tri-County Health Care service area, we will analyze the current and future health risk status of the sample groups. The goal is to improve health risk status by various interventions including:

- Awareness of health risk status through testing and education of subjects.
- Medical interventions for subjects as indicated.
- Education and tools to improve nutritional intelligence and practiced habits.
- Education and implementation of physical activity programs.
- Development of support groups and other subject networking opportunities.
- Other areas of intervention yet to be determined to impact spiritual, mental and social health.

Project Background:

Tri-County Health Care and the Wadena Regional Wellness Center, along with several other key community organizations including but not limited to the city of Wadena and Wadena-Deer Creek School District, have been working to redevelop a replacement facility for the Wadena Community Center, which was destroyed when an EF4 tornado hit the Wadena area on June 17, 2010. There are multiple funding sources for this facility including insurance proceeds (although the facility was significantly under-insured), Minnesota State Department of Employment and Economic Development grants, and private fundraising. Additional funds are being requested from the Maslowski Trust to help complete the project.

As part of this project, we have been working hard to not replace an activity-centered facility but rather create a results-oriented wellness initiative for the Wadena community and the surrounding area. The Wadena trade area is consistent with the service area for Tri-County Health Care, which consists of approximately 23,000 residents in Wadena, Todd and Otter Tail counties. Primary communities included are Wadena, Bertha, Hewitt, Henning, New York Mills, Ottertail, Deer Creek, Bluffton, Sebeka, Menahga, Verndale and Aldrich. These areas present a population base that consistently ranks in the bottom 10 percent of per capita income in the state of Minnesota and are amongst the highest in poverty and the use of free and reduced meals in the school lunch programs. Additionally, a grant has been awarded for a similar project in the Bertha community. We will include in this study a Bertha population sample cohort.

This high level of poverty, along with other factors, has contributed to a very low health status of the population of area residents. For the 2010 and 2011, the Robert Wood Johnson Foundation, in conjunction with the University of Wisconsin Population Health Institute, published a County Health Rankings Report. The following is relevant for the counties of Wadena and Todd. Note that Otter Tail County ranks better on these reports; however, the demographics of the county in which the larger communities of Fergus Falls and Perham, along with a greater of lake community residents live in the Western portion of Otter Tail County. Eastern Otter Tail County is more similar to their brethren to their east in Wadena and Todd Counties than to the western portion.

Ranking of 85 Counties:

	Wadena County		Todd County	
	2010	2011	2010	2011
Health Outcomes:	82	84	66	76
Mortality	82	82	69	74
Morbidity	71	76	57	69

As evidenced by these health outcomes that measure premature death, poor or fair health, poor or fair physical and mental health days, and low birth weight, there is work to do in the area.

Research Question:

The primary research question to be considered is: What interventions can impact population health risk status over the course of a 7-10-year period in a highly impoverished area?

Research Design and Requirements:

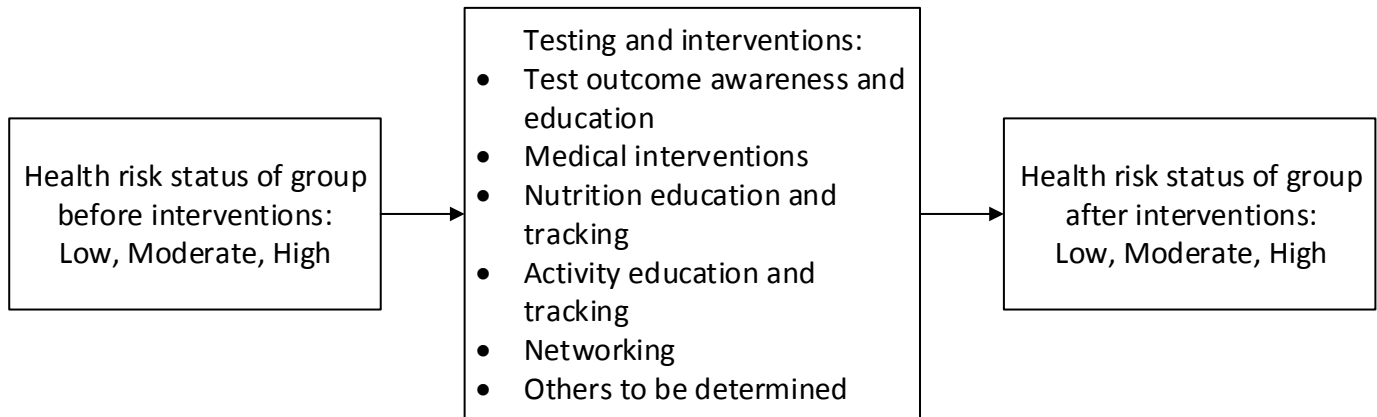
We envision a research study of 7-10 years using three cohort groups.

- Year one will entail the captive sample group that is made of the Tri-County Health Care employee group. This is a group of approximately 400 individuals.
- Year two will add the dependents (spouses and children), an additional group of 600, along with one other area employer group and a Bertha area group with an expectation of another 100-125 participants.
- Year three will add three additional employee groups (another 125), plus a voluntary group of participants in the Tri-County Health Care Men's and Women's Night Out health fairs (approximately 1,000 potential participants available, although less than 50 percent will likely volunteer).
- Years beyond will follow the groups to track long-term health risk status.
- In partnership with the Wellness Council of America (WELCOA), we will utilize health biometric screenings along with a health risk assessment tool to determine health risk status of the study groups into low, moderate and high risk categories. The intention is that through various interventions, we will indicate that it is possible to maintain low status and prevent the more natural maturation to higher risk categories, maintain or reduce moderate status based on quick and definitive interventions, and maintain high risk individuals as high risk vs. catastrophic and potentially prolong life and/or improve quality of life.
- We have already initiated discussions with the University of Minnesota School of Public Health to potentially provide assistance in the design and implementation of this study and the data analysis.

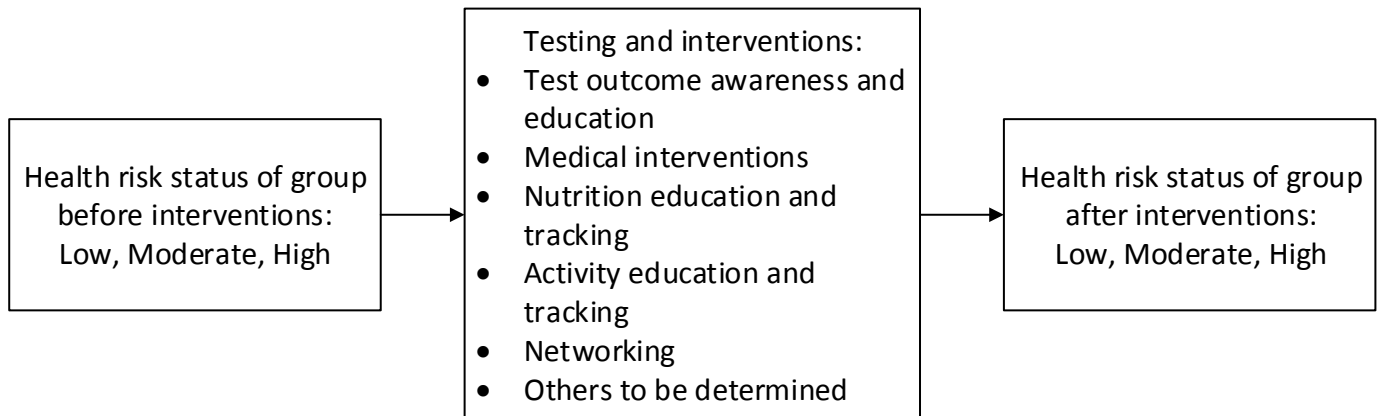


Conceptual Model

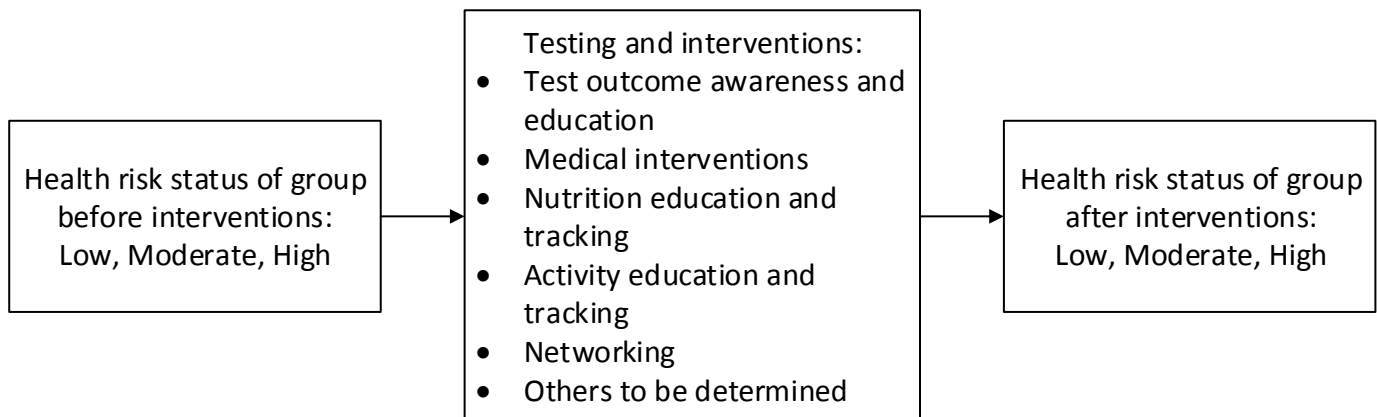
Cohort #1: Tri-County Health Care Employees (Year 1)



Cohort #2: Cohort #1 Plus Tri-County Health Care Dependents, 1 Wadena Area Employer, and Bertha area group (Year 2)



Cohort #3: Cohort #2 Plus 3 Additional Wadena Area Employers and Men's and Women's Night-Out Participants (Year 3)



Dependent Variable: Health Risk Status as measured over time.

Operational Definition: Using analysis tools including health biometric screenings in conjunction with a health risk assessment query tool, to determine the health risk status of the population cohorts.

Maslowski Community Health Improvement Project

In 2016, Tri-County Health Care presented the research year three results of the Maslowski Wellness and Research Study to the Frank and Eleanor Maslowski Charitable Trust. The study has shown TCHC has made some nice shifts in overall culture as well as maintained health status of its employees. Employees who feel supported and receive support in making healthy lifestyle choices are more likely to participate and encourage such behaviors in other aspects of their lives including family and friends.

Since Tri-County Health Care was the primary pilot group, it is used as a comparison to other businesses and community-based participants including Jolene Johannes State Farm Agency, Todd-Wadena Electric, Wadena Deer Creek Schools, Wadena State Bank and West Central Telephone Association. The chart below shows a comparison of the organizational changes within Tri-County Health Care from the inception of this research study. Tri-County Health Care leaders have made significant improvement over the past four years in adopting and supporting the essential components of a well workplace.

Organizational Health Improvements

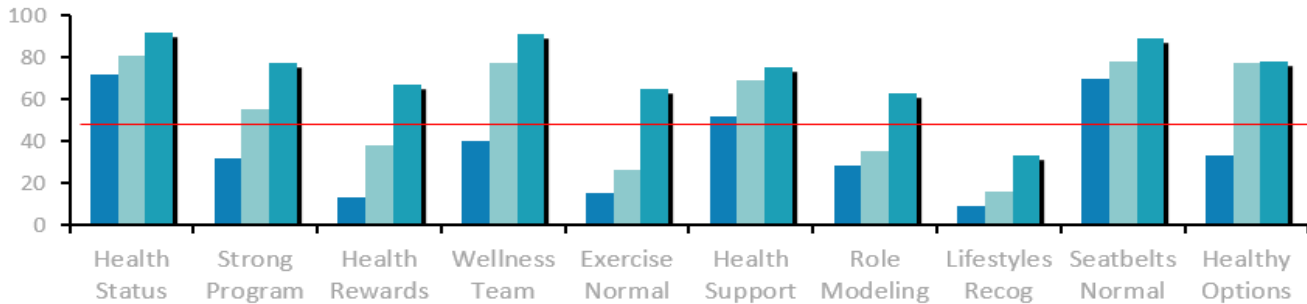
TCHC Is Making Significant Inroads In Creating A Culture Of Organizational Health

From 2012 to 2016, TCHC has made remarkable improvements in creating a culture of health for all employees. Using WELCOA's nationally-validated Well Workplace Checklist as the assessment tool, TCHC leaders have made significant progress over the last 60 months.



Culture Scores: TCHC Improvements 2013-2016

TCHC's Culture Continues To Demonstrate Year-Over Year Improvements



1

Culture Audit TCHC: 2013

TCHC's employee results of the administration of it's organization-wide health culture audit.

2

Culture Audit TCHC: 2015

TCHC's employee results of the administration of it's organization-wide health culture audit.

3

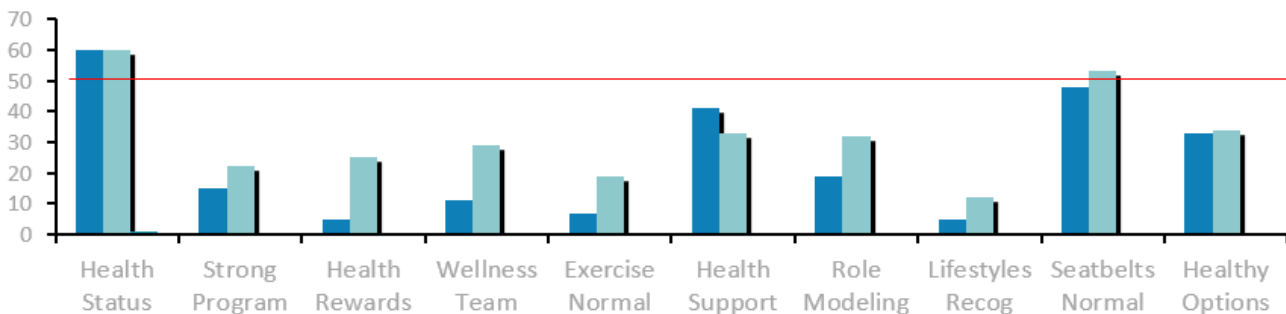
Culture Audit TCHC: 2016

TCHC's employee results of the administration of it's organization-wide health culture audit.

The graph above displays the overall culture as rated by the employees of Tri-County Health Care. The red line through the middle of the graph represents the 50 percent mark, referred to as the tipping point. Once this mark is met, the organization is at the point of more than half of its employees feeling a positive culture is present. This serves as a useful tool for those employees who may not be fully engaged, as more than half of their peers are at a higher level of engagement, which continues to promote a shift in overall culture.

Community Culture Scores: 2015-2016

Participating Businesses Are Beginning To See Improvements In The Health Of Their Cultures



1

Culture Audit: Area Org's 2015

Results of the organization-wide health culture audit conducted for area businesses.

2

Culture Audit: Area Org's 2016

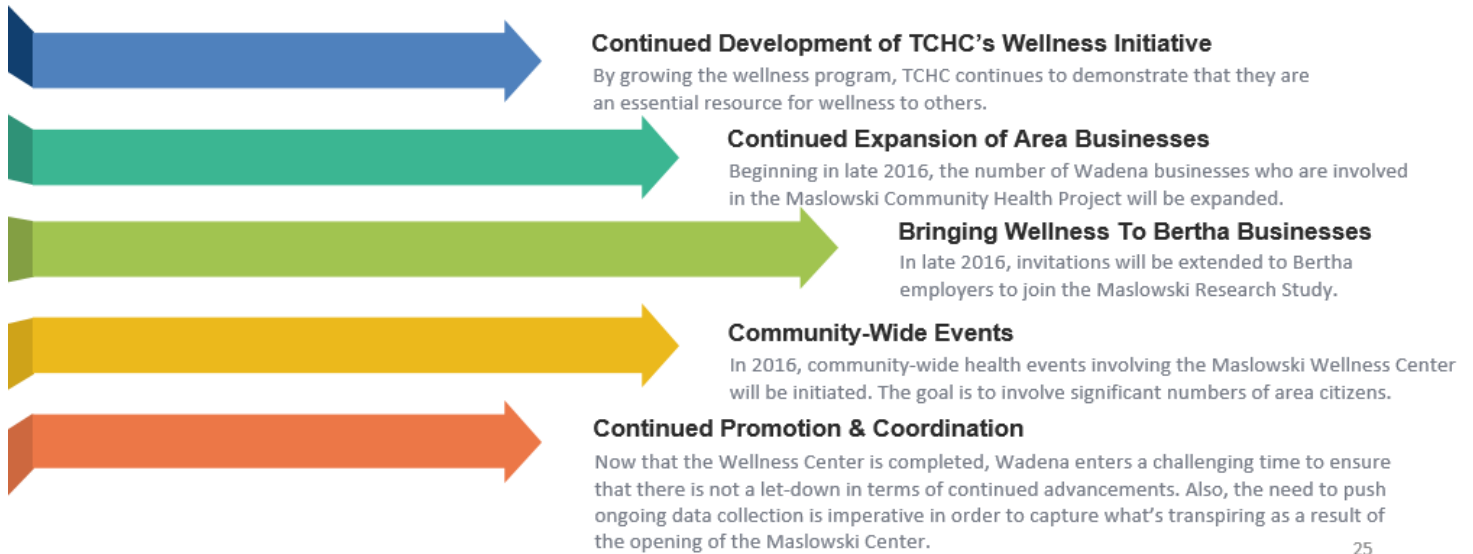
Results of the organization-wide health culture audit conducted for area businesses.

As a comparison to the Tri-County Health Care culture scores, the graph above displays the culture scores of some area employers. Creating healthier cultures makes healthy decision making easier. With commitment from area employers in building a healthier culture, they will make a difference in the lives of their employees.

2016 & Beyond: The Road Ahead

Creating A Culture Of Health Is The Goal For Wadena And The Surrounding Communities

Since 2013, much progress has been made in advancing the idea of better health in Wadena and the surrounding communities. As the initiation of Phase 3 begins, there is still much work to be done. Below is an overview of the major milestones yet to be completed.



The study will continue for another three to five years and will focus on the following areas:

- Continued development of Tri-County Health Care's wellness initiative
- Continued expansion of area businesses
- Community-wide events
- Continued promotion and coordination

EXHIBIT 1C

CURRENT TCHC COMMUNITY INITIATIVES

Classes:	• Infant massage, breastfeeding techniques and benefits, prenatal classes, American Heart Association CPR and first aid, babysitting (CPR, first aid, etc.).
E-Newsletters:	• Monthly <i>My Health</i>, <i>New Parent</i>, or <i>Pregnancy</i> E-newsletters filled with up-to-date health information and latest news.
February Festival of Health:	• 75 exhibits from local agencies promoting health and wellness. Free health screenings: blood pressure, blood glucose, pulmonary function, body fat analysis and more.
Healthy Times Newsletter:	• Quarterly publication of success stories and educational information for all.
I-CAN Prevent Diabetes:	• Evidence based diabetes preventive program.
Internships:	• Medical and nursing students.
Summer Block Party:	• Bike rodeo, backpack fittings, emergency vehicle tours, music, food, etc.
Sunnybrook Stomp:	• Annual run/walk event to encourage physical activity.
Support Groups and Support:	• Grief, Diabetes, and Memory Loss Support Groups. • Lactation Consultant.
Todd-Wadena Healthy Connections:	• Goals: Collaboration on building healthy communities. • Partners: Lakewood Health System, Todd County Health and Human Services, Wadena County Public Health, CentraCare and Tri-County Health Care. • Workgroups: Maternal Child Health, Health Education, and Community Health Assessment. • Activities: Car seat clinics, 5-2-1-0 educational handouts for community and schools, health fairs, and Pregnancy to Parenthood guide.
Tri-County Health Care Foundation Scholarships:	• Provides 13 scholarships for students pursuing health care careers.
Venture Crew 54:	• Twice monthly opportunity for high school student's thinking about medical careers to get hands-on experience and skills from Minnesota First Responder Course.
Women's and Men's Days Out:	• Free health education programs, lab work certificates, cooking demonstration, educational sessions on wellness, nutrition, sex and relationships.

EXHIBIT 1D

I-CAN PREVENT DIABETES PROGRAM: NATIONAL DIABETES PREVENTION PROGRAM (NDPP)

Tri-County Health Care began offering the I-Can Prevent Diabetes program in early 2015. Since implementation, the organization has offered a total of four sessions, with two additional sessions planned in 2016. Tri-County Health Care has trained three employees to serve the role of facilitator. In addition, Tri-County Health Care has partnered with the University of Minnesota Extension to offer additional sessions throughout the region.

Community education efforts around assessing a person's risk and readiness for change have been practices to recruit individuals who are ready to make a lifestyle change. Nearly 60 individuals have participated in these sessions.

Tri-County Health Care utilized a post-survey to collect and evaluate data. The data revealed there is a strong correlation in the overall lifestyle change success for those who made the commitment to regular attendance and daily tracking. Participants that journaled regularly and attended weekly sessions often shared they had more overall improvement in their health and lifestyle.

Some personal testimonials from the sessions include:

- Weight loss of 40 pounds during the year-long session. This individual was also able to increase the distance of walking from one mile to two miles daily as well as reduce and eliminate some medications.
- "I found this session to be a fun way to learn, share and lose weight for better health."
- "I can now exercise more and my legs don't get so tired."
- "The most useful part of the class was making us accountable by keeping our food tracker."
- "I am making an active attempt to increase the amounts of physical activity that I participate in."
- "I feel better able to read food labels and learned a lot about measuring out food portions."
- "I am eating more fruits and vegetables."

Participating in the I-Can Prevent program is a safe option providing patients the skills and knowledge to make healthy decisions. Health improvement does not come overnight; therefore, it is important for patients to be committed to the program as they enter to ensure a successful experience.

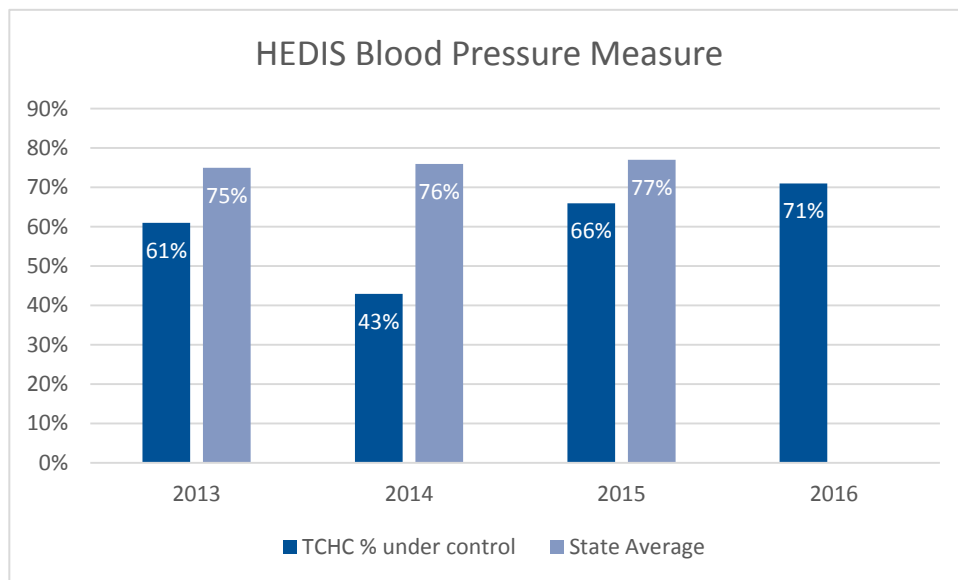
Nine out of 10 people with prediabetes do not know they have it. Prediabetes is when your blood sugar level is higher than normal but not high enough yet to be diagnosed as type 2 diabetes. Without weight loss and moderate physical activity, 15-30 percent of people with prediabetes will develop type 2 diabetes within five years.

EXHIBIT 2A

CHRONIC DISEASE MANAGEMENT

Hypertension

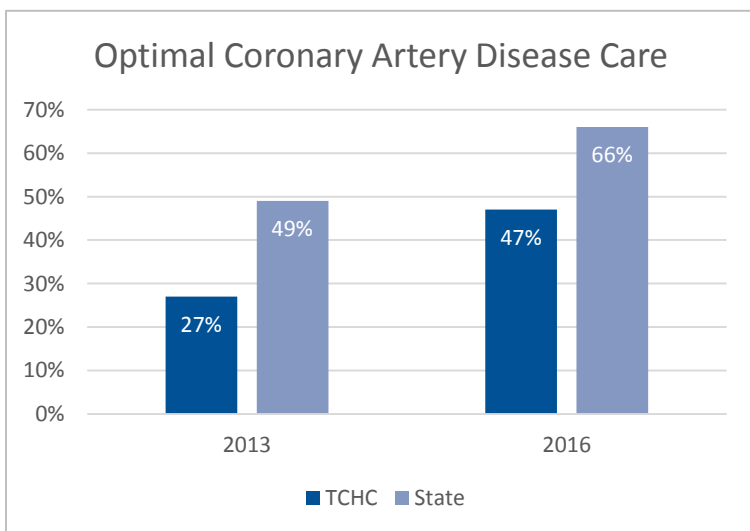
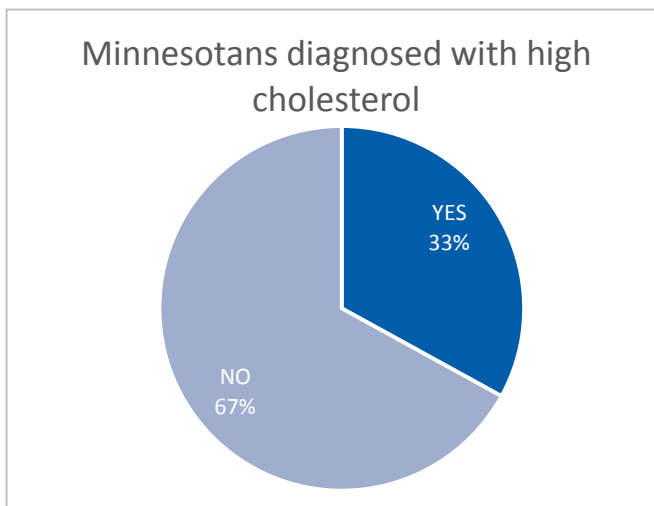
This graph represents the percentage of TCHC patients maintaining blood pressure compliance from 2013-2016 compared to state averages. Note: The 2016 results reflect a partial year for TCHC and no state average due to unavailability.



Cholesterol

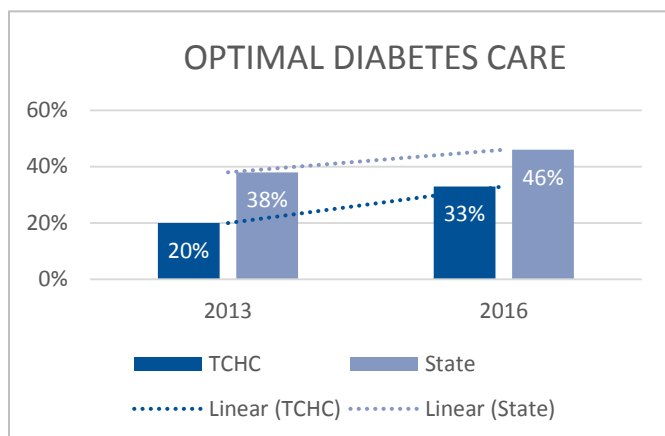
The Minnesota Department of Health reports that approximately 33 percent of adults have been diagnosed with high cholesterol in 2013.

Data Source: Minnesota Department of Health, Quick Facts
<http://www.health.state.mn.us/divs/healthimprovement/health-information/disease/heartdisease.html>

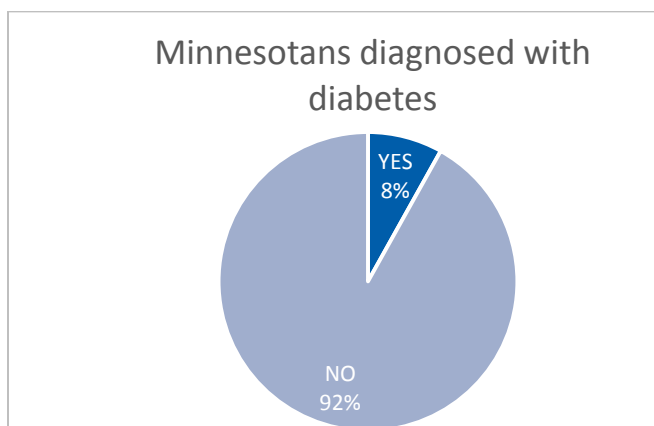
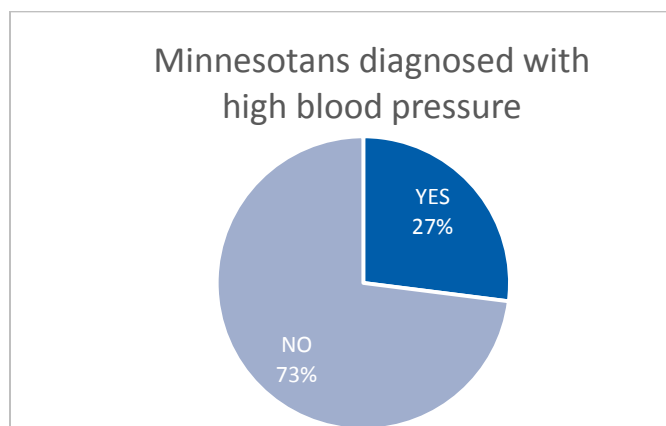


Optimal Care is achieved when a patient meets all four measures in the Minnesota Community Measurement Coronary Artery Disease Measure set. These measures are: blood pressure, Tobacco free, Daily Aspirin if indicated and use of a Statin medication for high cholesterol. Tri-County Health Care has made a 74-percent improvement from 2013 to 2016, which is a higher improvement from the state of Minnesota's 35 percent.

Diabetes

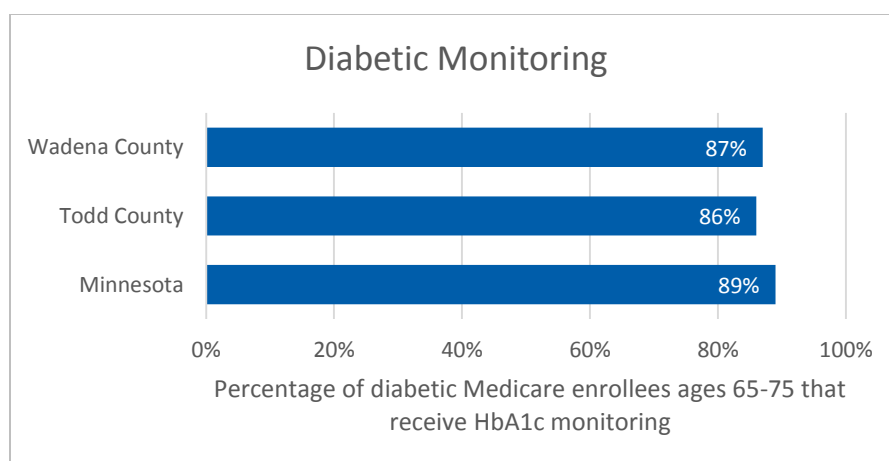


Optimal Diabetes Care is achieved when a patient meets all four measures in the Minnesota Community Measurement Coronary Artery Disease Measure set. These measures are: blood pressure, Tobacco free, Daily Aspirin if indicated and use of a Statin medication for high cholesterol. Tri-County Health Care rates are improving at a faster rate than the state. Tri-County Health Care has made a 65 percent improvement from 2013 to 2016, whereas the state only made a 21 percent improvement.



According to the Minnesota Department of Health, in 2014, 8.1 percent of Minnesota adults were diagnosed with diabetes (type 1 or 2), and in 2013, nearly 27 percent of Minnesota adults reported having high blood pressure.

People who have diabetes are at a higher risk of serious health complications such as blindness, kidney failure, heart disease, stroke and loss of toes, feet or legs.



Diabetic Monitoring is measured as a percentage of diabetic Medicare enrollees whose blood was screened in the past year using a test of their glycated hemoglobin (HbA1c).

Data Source: Minnesota Department of Health, Quick Facts

<http://www.health.state.mn.us/divs/healthimprovement/data/quick-facts/diabetes.html>

<http://www.health.state.mn.us/divs/healthimprovement/data/quick-facts/hypertension.html>

County Health Rankings and Roadmaps: A Healthier Nation County by County, 2016.

http://www.countyhealthrankings.org/app/minnesota/2016/compare/snapshot?counties=27_159%2B27_153%2B27_111

Incident Rates of Asthma Hospitalizations, Cancer and COPD Hospitalizations

	Asthma Hospitalizations	Cancer	COPD Hospitalizations	MI Hospitalizations
Minnesota	5.6	466.2	28.0	26.5
Todd County	1.9	429.9	21.4	17.2
Wadena County	10.9	487.3	47.2	30.5

Rates are measured per 100,000. Asthma hospitalizations and Chronic Pulmonary Disorder (COPD) data was collected from the Minnesota Hospital Discharge Data, maintained by the Minnesota Hospital Association. Cases are calculated using U.S. Census Data as the denominator and patients having a primary discharge diagnosis of asthma or COPD as the numerator for the years 2011-2013.

Cancer data was collected by the Minnesota Cancer Surveillance System, MDH. Incidence rates for cancer count all newly diagnosed cancer cases in a region for the years 2008-2012 specified.

Data Source: Minnesota Public Health Data Access, 2013. <https://apps.health.state.mn.us/mndata/>

Top Causes of Death (Excluding “Other” Category) in the Tri-County Health Care Service Area

1. Cancer
2. Heart Disease
3. Chronic Lower Respiratory Disease
4. Unintentional Injury
5. Stroke

Data Source: Minnesota County Health Tables: Mortality Table 1: Minnesota Leading Causes of Death by Age Group by State and County, 2013.



EXHIBIT 2B

MINNESOTA COMMUNITY MEASUREMENTS

TRI- COUNTY HEALTH CARE

MNCM Results for Diabetes and Vascular Care

OPTIMAL DIABETIC CARE 2013 (2012 DOS)-2016 (2015 DOS)

Clinic	Clinic ID	Optimal Care				Blood Pressure				Statin Use				HbA1c Control				Tobacco-free				Daily Aspirin			
		2013	2014	2015	2016	2013	2014	2015	2016	2013	2014	2015	2016	2013	2014	2015	2016	2013	2014	2015	2016	2013	2014	2015	2016
MNCM AVERAGE		38%	39%	54%	46%	84%	84%	84%	84%	62%	64%		87%	74%	74%	73%	72%	84%	84%	84%	84%	99%	100%	99%	99%
		20%	17%	39%(n=801)	33%(n=791)	68%	65%	68%	69%	43%	43%		79%	71%	66%	69%	71%	77%	77%	77%	79%	99%	99%	99%	99%
Wadena Clinic	769	21%(n=542)	18%(n=532)	37%(n=554)	33%(n=560)	66%	66%	67%	70%	47%	45%		79%	73%	67%	68%	68%	78%	77%	75%	78%	99%	98%	99%	99%
Henning Clinic	1199	20%(n=92)	12%(n=94)	37%(n=105)	34%(n=105)	84%	70%	69%	71%	34%	38%		73%	62%	56%	68%	74%	79%	82%	87%	86%	98%	100%	100%	99%
Sebekla Clinic	1198	17%(n=29)	5%(n=37)	45%(n=40)	30%(n=50)	66%	68%	63%	64%	41%	24%		78%	79%	78%	90%	86%	72%	73%	73%	66%	95%	98%	96%	96%
Ottertail Clinic	1178	16%(n=61)	20%(n=61)	52%(n=60)	35%(n=26)	57%	57%	77%	62%	36%	43%		81%	69%	69%	78%	81%	72%	70%	78%	88%	98%	100%	100%	100%
Bertha Clinic	1197	13%(n=30)	27%(n=41)	48%(n=42)	35%(n=43)	73%	56%	74%	67%	20%	37%		88%	63%	56%	62%	77%	77%	80%	83%	79%	100%	100%	100%	100%
Verndale Clinic	2705				29%				57%				57%				71%				100%				57%

OPTIMAL VASCULAR CARE 2013 (2012 DOS)-2016(2015 DOS)

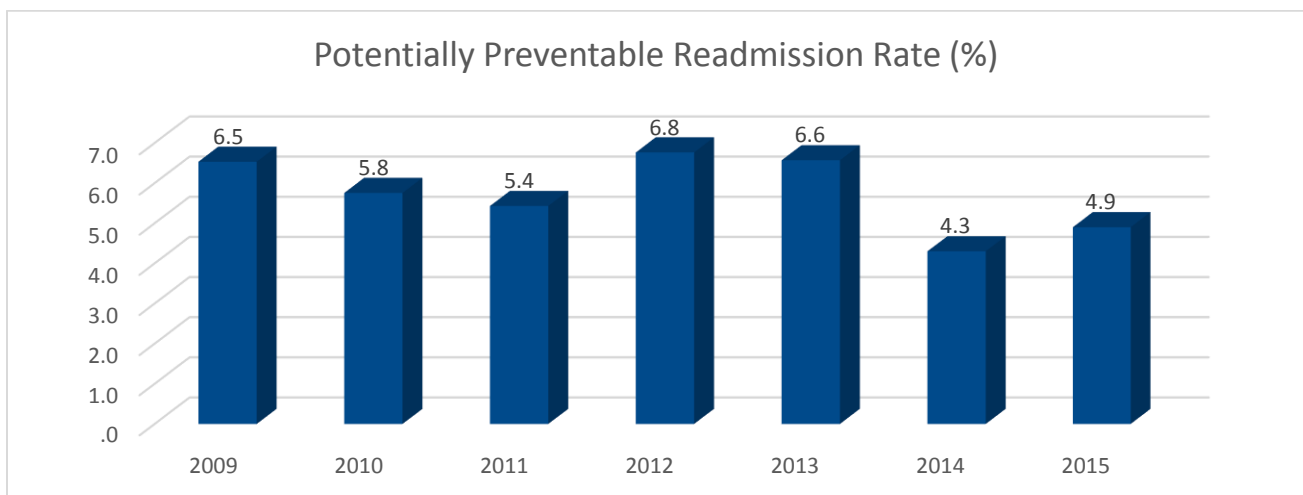
Clinic	Clinic ID	Optimal Care				Blood Pressure				Statin Use				Tobacco-free				Daily Aspirin			
		2013	2014	2015	2016	2013	2014	2015	2016	2013	2014	2015	2016	2013	2014	2015	2016	2013	2014	2015	2016
MNCM AVE		49%	50%	69%	66%	84%	85%	85%	85%	67%	68%		95%	84%	84%	83%	83%	96%	97%	97%	97%
		27%	32%	52%	47%(n=246)	64%	69%	69%	70%	59%	57%					81%	77%	93%	93%	95%	92%
Wadena Clinic	769	28%(n=238)	35%(n=223)	48%(n=206)	45%(n=187)	58%	67%	64%	67%	64%	61%					83%	78%	93%	94%	96%	91%
Henning Clinic	1199	16%(n=38)	24%(n=38)	71%(n=31)	69%(n=35)	87%	79%	87%	86%	29%	45%					79%	77%	92%	97%	97%	97%
Sebekla Clinic	1198	33%(n=6)	14%(n=7)	58%(n=12)	38%(n=13)	83%	71%	83%	62%	67%	57%					57%	67%	100%	86%	92%	85%
Ottertail Clinic	1178	33%(n=15)	19%(n=16)	60%(n=20)	no pts	87%	75%	80%	no pts	47%	44%					81%	80%	93%	81%	90%	no pts
Bertha Clinic	1197	25%(n=4)	14%(n=7)	50%(n=10)	33%(n=9)	100%	57%	90%	67%	75%	43%					57%	50%	100%	100%	100%	100%
Verndale Clinic	2705				0% (n=2)				100%												100%

EXHIBIT 2C

EMS/COMMUNITY PARAMEDIC PROGRAM

Tri-County Health Care is located in Wadena County and serves a three-county area including Todd, Otter Tail and Wadena counties. Tri-County Hospital Emergency Medical Service is the largest advanced life support (ALS) provider of 9-1-1 service in Wadena and Todd County, Minnesota. Located 85 miles northwest of St. Cloud, the service area encompasses 850 square miles in three counties. TCH EMS is the primary ALS intercept service for two smaller basic life support services located within the communities we serve. The goal of the TCHC EMS department is to assure the highest level emergency medical service in an effective, caring and professional manner. Currently, the department operates two fully staffed ambulances 24/7 and one ALS back-up crew in daily operations. The third back-up rig is not staffed 24/7; however, staff on-call respond when needed. The EMS department includes 22 trained EMT and Paramedic staff members.

Tri-County Health Care began its Community Paramedic Program in January 2014. There are six community paramedics providing 24/7 accessibility. The formation of this program was in relation to the work on the RARE initiative (Reducing Avoidable Readmissions Effectively). TCHC has partnered with the statewide RARE program since its inception. In 2014, TCHC provided 458 Community Paramedic visits and 1,162 in 2015. Initial results indicated success as the possible avoidable readmission rate decrease from 6.6 percent to 4.3 percent the first year of implementation (see chart below). In 2015, we experienced an increase in readmission rates; however, this rate increase remained lower than prior to program implementation. As program awareness increased, more requests were received to assist with more vulnerable patients. This includes patients with mental health issues in an effort to assist with medication compliance and other patients who are struggling to adhere to their plan of care.



The goal of the Community Paramedic Program is to help patients become more independent and confident in their health care. This may mean medication reconciliation, lifestyle changes, ideas to promote home safety or equipment modifications/recommendations shared with the patient in an effort to keep them healthy and out of the hospital.

Success Stories:

A 62-year-old male patient with multiple comorbidities, a history of five Emergency Department visits and two hospitalizations from April 10, 2014, to April 20, 2015. This patient's care was managed by Care Coordination staff in partnership with the Community Paramedic Program, resulting in one Emergency Department visit and one hospitalization from April 20, 2015, through November 2016. This patient has gone as long as 272 days without a hospital admission.

A patient visited the Emergency Department 11 times and had one hospitalization between June 1, 2014, and Aug 17, 2015. This patient received Care Coordination services in partnership with the Community Paramedic Program and has only had one Emergency Department visit since Aug 25, 2015, through November 2016.

A 47-year-old patient outside of the Tri-County Health Care service area needed to move into the service area for the ability to maintain medication compliance. This patient is diagnosed with a mental illness of depression and Schizophrenia and was well known to correctional system. All avenues were explored to keep this patient from being civilly committed. Through collaboration with Wadena County Social Services and the Community Paramedic Program, this patient is now living at home and working in the community.

Community Paramedics continue to visit four patients in their homes to provide medical maintenance services such as feeding tube changes and suprapubic catheter changes on a monthly basis. These patients are non-ambulatory and were previously utilizing the ambulance to provide transportation to the hospital for these services. This has also been a useful service for the area nursing home residents for whom coming to the clinic for care can be extremely taxing.

Community Paramedics were requested to monitor a high-risk pregnancy patient that was ordered to be on bed rest for her third trimester. The Paramedics were able to give her weekly injections without the patient needing to leave her home.

Community Paramedics see patients through referrals from physicians or collaboration with Care Coordination, medical social services, and Wadena County Health and Human Services. Visits are documented in our electronic medical record system (EPIC) and viewable by the primary care physician and the multi-disciplinary team. Community Paramedics provide the following services:

- Lab draws on long-term care patients or home-bound patients
- Post discharge follow-up
- Medication administration
- Medication reconciliation
- Medication education
- Twelve lead EKG's
- Tracheostomy, feeding tube, suprapubic catheter changes
- Wound care
- Home safety assessment
- Post-surgery follow up assessing sepsis potential
- Conducts patient interviews to identify potential risks
- Communicates/collaborates with the patient's primary care provider
- Referrals for Durable Medical Equipment
- Community referrals for additional support as needed

EXHIBIT 3

HEALTH CARE IN THE TCHC SERVICE AREA: PREVENTION

Women's Breast Health

What is a Breast Navigator?

A breast navigator is your point-of-contact for any questions or concerns related to breast health.

What does a Breast Navigator do?

The Breast Navigator assists patients in scheduling screening/diagnostic mammograms, breast ultrasounds and MRIs, if needed. She is able to place additional imaging orders per your radiologist's or primary care provider's recommendations. Calls are made to the patient instructing him or her when additional imaging procedures need to be performed to clarify interpretation and also gives results of those imaging tests.

With a designated person readily available throughout the treatment process to answer questions or concerns, TCHC hopes to improve the experience of any of our breast health patients.

When it comes to breast health, every woman deserves the very best care possible. With the addition of 3D Mammography and Minimally Invasive Breast Biopsies at Tri-County Health Care, that is exactly what they will get.

A revolutionary tool in the early detection of breast cancer, 3D Mammography is the new standard in breast cancer screening today, with Tri-County's new Genius 3D technology providing a 41 percent increase in the detection of invasive breast cancers compared to 2D alone, as well as up to a 40 percent reduction in anxiety-producing false-positive recalls. The results are greater accuracy in diagnosis and, ideally, reduced stress on the patient.

Who should have a Mammogram?

It's recommended that all women 40 years of age or older receive an annual mammogram.

With 3D mammography, do I still need an annual screening?

Yes. All women are at risk for breast cancer, regardless of symptoms or family history. Mammograms often can detect potential problems before they can be felt. Early detection greatly increases treatment options and the likelihood of successful recovery.

Minimally Invasive Breast Biopsies

One of the only systems in the immediate region to offer minimally invasive breast biopsies, Tri-County Health Care is committed to providing female patients with care and technology required for the early detection and treatment of breast cancer.

A minimally invasive breast biopsy (or Stereotactic Breast Biopsy) is a procedure that uses mammography to precisely identify and biopsy an abnormality within the breast. It is normally done when the radiologist sees a suspicious abnormality on a mammogram that can't be felt in a physical exam. This procedure will help determine whether or not you have breast cancer or any other concerning abnormalities in your breast.

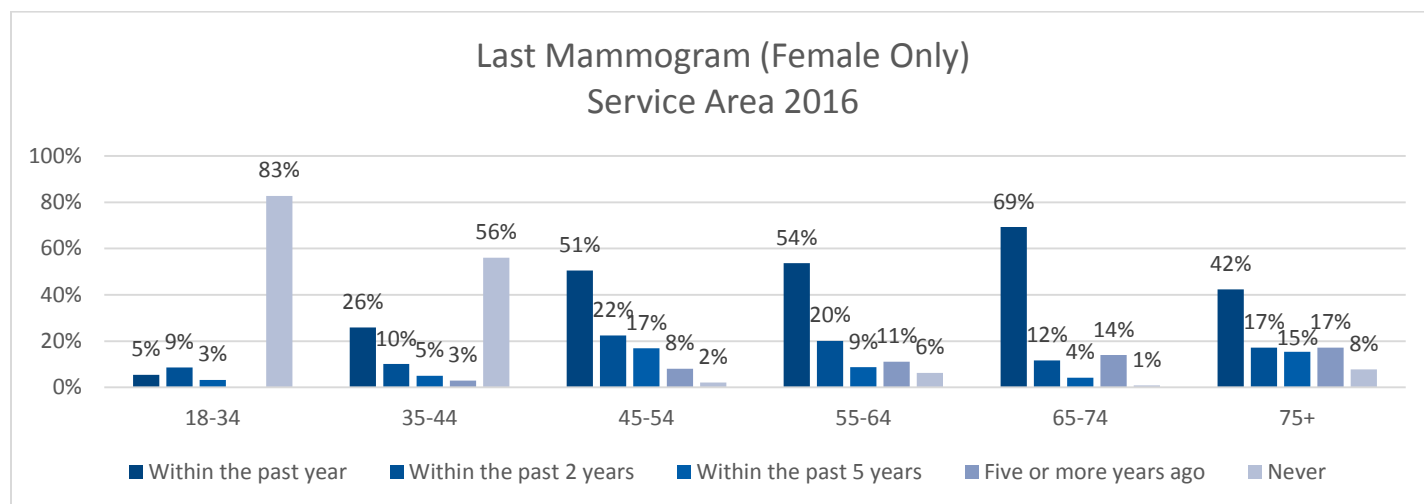
Utilizing 3D Mammography as a guide, stereotactic breast biopsies use mammographic images to locate and target the area of concern and to help guide the biopsy needle to a precise location. This technique helps ensure the area that is biopsied is the exact area where the abnormality was seen on the mammogram.



Mammogram Parties

In an effort to reach more women and provide them a more relaxed atmosphere, TCHC offers mammogram parties throughout the year. This party accommodates up to 12 women at a time, providing them with some refreshments, massages and other fun trinkets. Women who choose to partake may wish to be around friends and family as they participate in this important health screening.

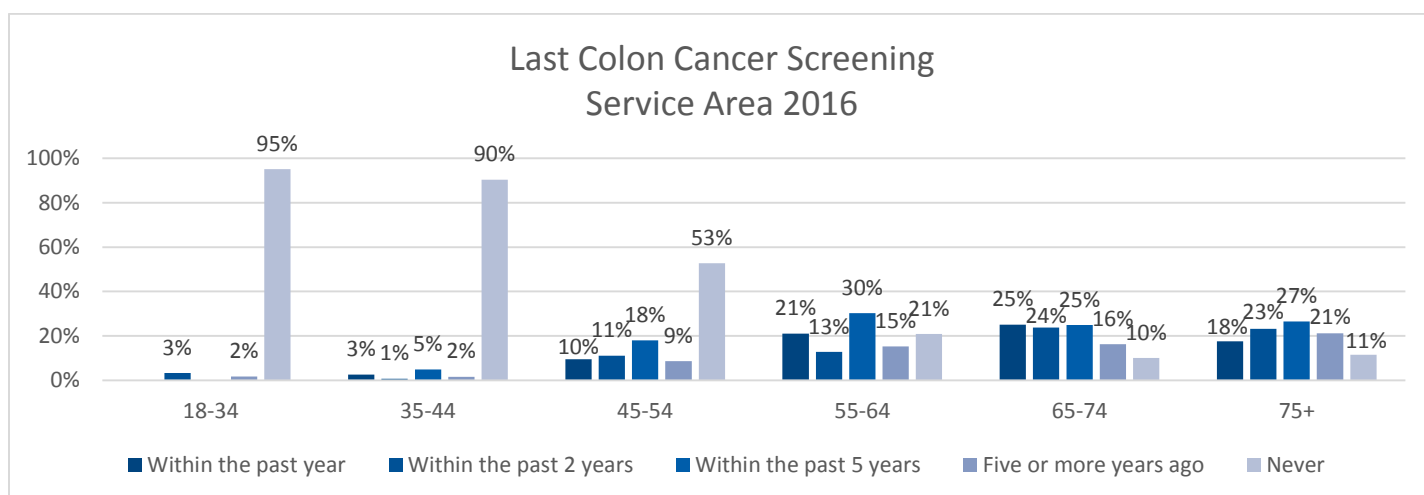
Mammography



In 2012, 4,013 women and 24 men were diagnosed with invasive breast cancer in Minnesota. Breast cancer is the most commonly diagnosed cancer for women, accounting for nearly one out of every three cancers. About 44 percent of Minnesota women diagnosed with breast cancer were 65 years of age or older, and 37 percent were between the ages of 50 and 64.

Data source: Minnesota Cancer Facts and Figures 2015

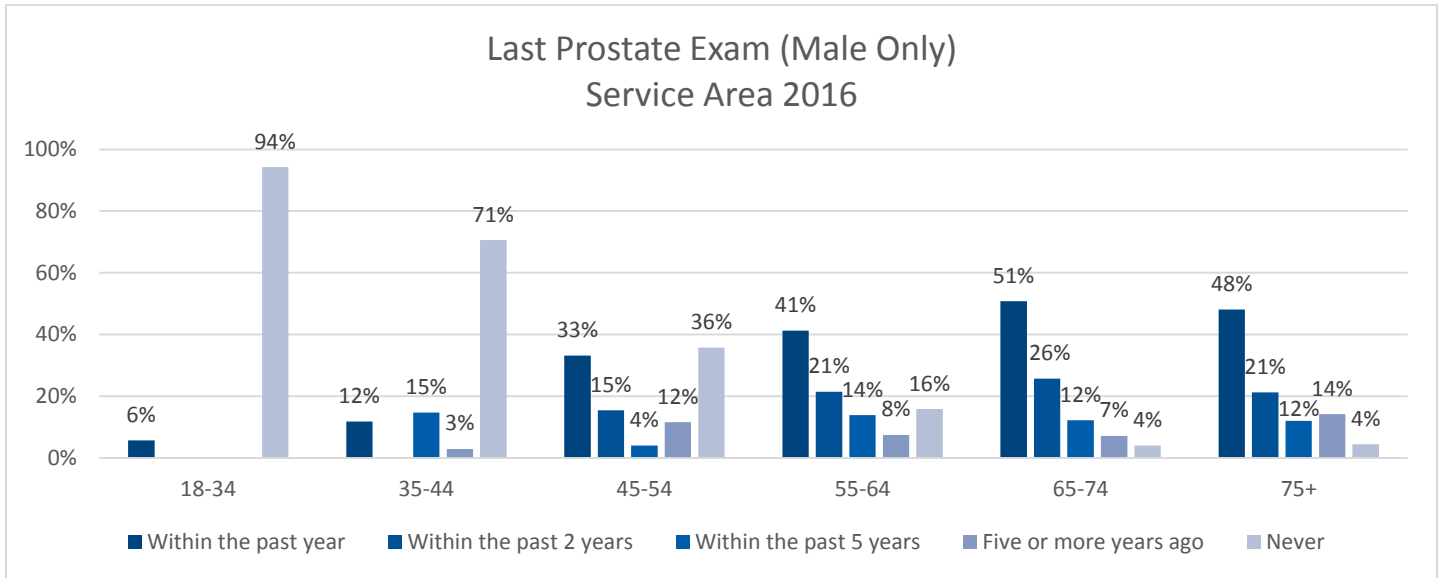
Colon Cancer



During 2008-2012, the colon and rectum cancer mortality rate was somewhat lower in Minnesota than among non-Hispanic whites in the U.S. as a whole. Adults age 50 or older should be screened for colorectal cancer, even if they have no symptoms. A number of effective tests have been developed to screen for this cancer, which differ in how frequently they are recommended to be performed. Based on the data from the 2012 BRFSS, 71 percent of Minnesotans of screening age were up-to-date on screening.

Data source: Minnesota Cancer Facts and Figures 2015

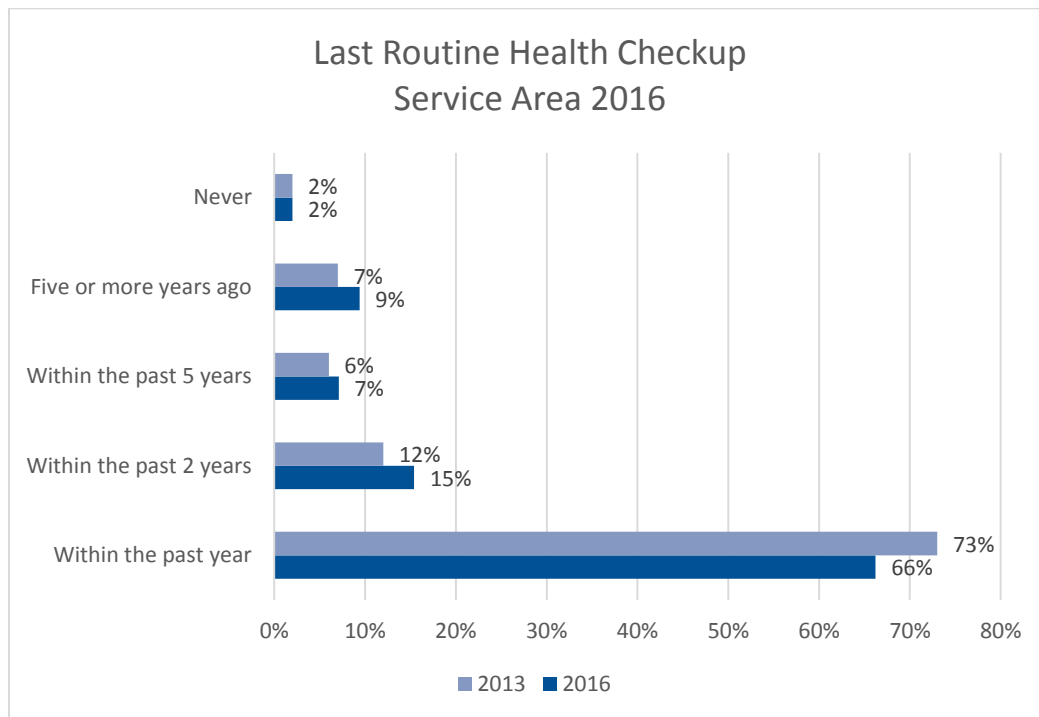
Prostate Cancer



Prostate cancer is the most common cancer diagnosed among men in Minnesota and in the U.S., regardless of race/ethnicity. In 2012, more than 3,355 men were diagnosed with prostate cancer in Minnesota. About 55 percent of Minnesotans diagnosed with prostate cancer were 65 years of age or older.

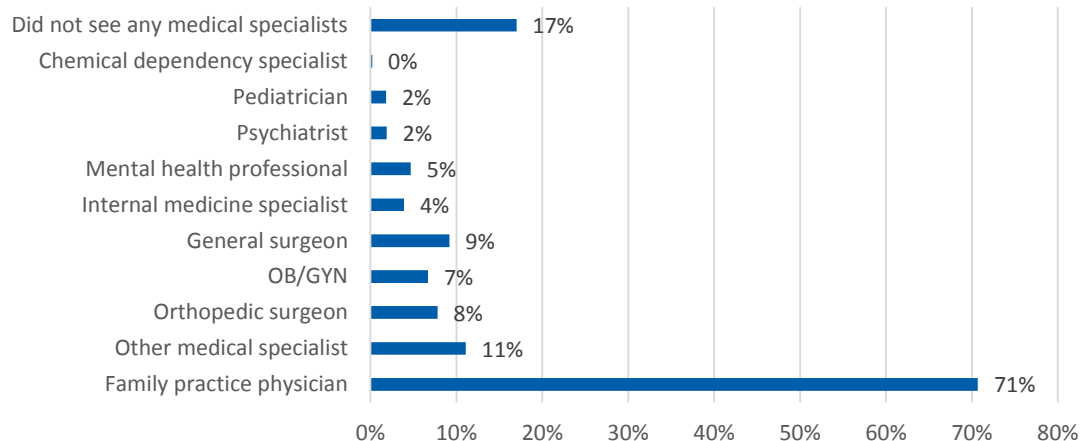
Data source: Minnesota Cancer Facts and Figures 2015

Routine Checkups

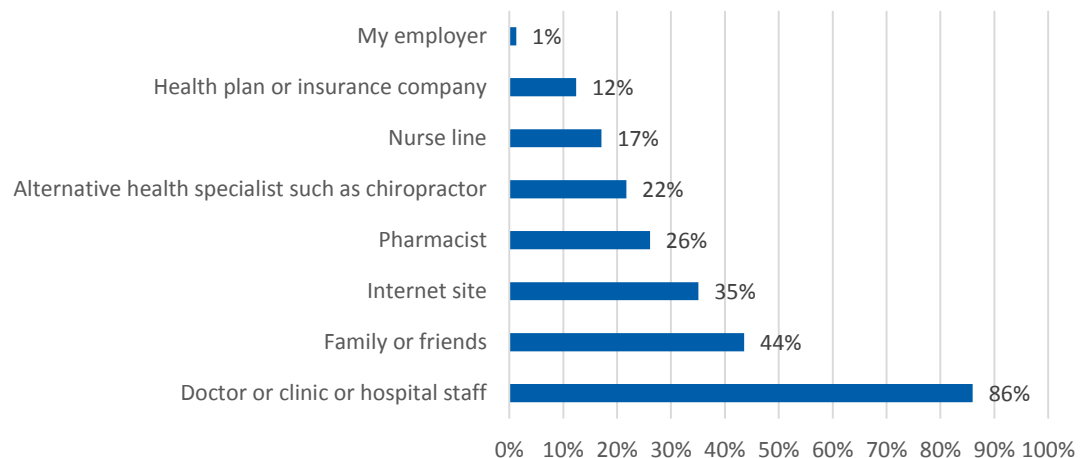


This graph shows a decline in the annual routine health checkup. This trend will continue to be monitored to determine what factors may influence this. With an increase in high deductible plans, more education may be needed regarding the annual preventative visit. Tri-County Health Care has observed an increase in the number of patient responsibility balances that are collected after the insurance portion is paid.

Medical Specialists Seen in the Last 12 Months Service Area 2016



Source of General Health Care Advice 2016



Childhood Immunization Coverage of Vaccine Series (2014 data, as reported August 2015)

	Series	DTaP	Polio	MMR	HIB	Hep B
Minnesota	70.5%	87.7%	95.5%	94.3%	79.9%	92.8%
Todd County	40.6%	60.0%	73.9%	67.0%	64.5%	70.3%
Wadena County	36.6%	64.9%	77.2%	72.3%	67.3%	75.2%

	Varicella	PCV	Rotavirus	Hep A	MIIC Population
Minnesota	91.2%	86.3%	74.6%	56.4%	n/a
Todd County	65.8%	50.6%	56.7%	17.9%	330
Wadena County	67.8%	51.0%	45.0%	18.8%	202

EXHIBIT 4

MENTAL HEALTH

Mental health issues are a continuous area of focus for our organization. TCHC employs one full-time psychiatrist and a full-time certified nurse practitioner specializing in the field of psychiatry to meet the increasing demand for mental health services.

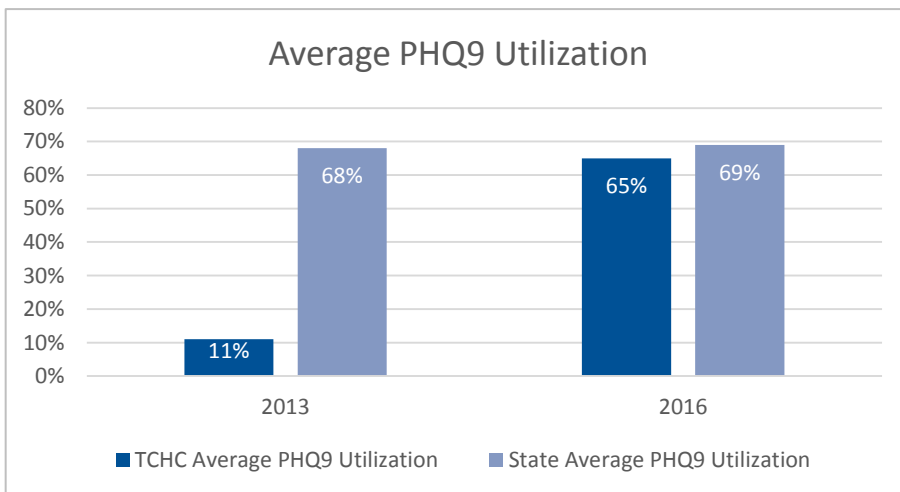
Diagnosis

Importance of screening: In any given year, 13-20 percent of children in the United States experience a mental health condition (CDC, 2013). Half of all lifetime cases of mental illness begin by early adolescence (Weitzman & Wegner, 2015).

	2013	2016
TCHC PHQ9 Utilization	11%	65%
State Average PHQ9 Utilization	68%	69%
Screening for Suicide for Bipolar disorder	83%	100%
Monitoring BMI for Schizophrenia	97%	100%

Bipolar disorder and depression screening: Bipolar disorder has a high association with suicide and suicide risk. This measure identifies if appropriate suicide screening is done for bipolar patients.

BMI (Body Mass Index): People with serious mental illness have a two to three times higher risk of obesity largely due to poor diet, lack of exercise and factors related to mental illness and its treatment (e.g., use of antipsychotics, certain antidepressants and mood stabilizers) This measure identifies if patients are screened for BMI and, if appropriate, received follow-up care for obesity.

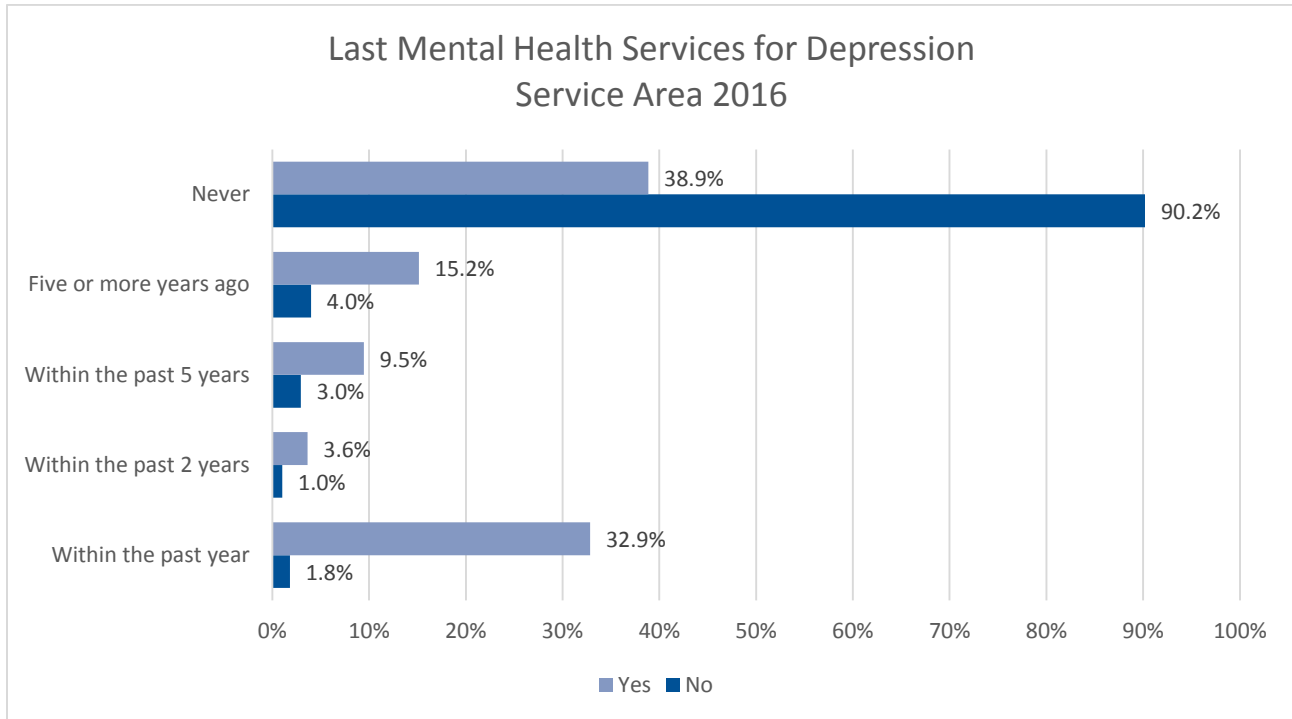


Depression is a medical condition that is not always diagnosed easily but is very treatable. The PHQ9 is a depression screening tool that is used in clinics to assess if a person has depression. Utilization of PHQ9 is the Minnesota Community measurement of clinics use of this tool.

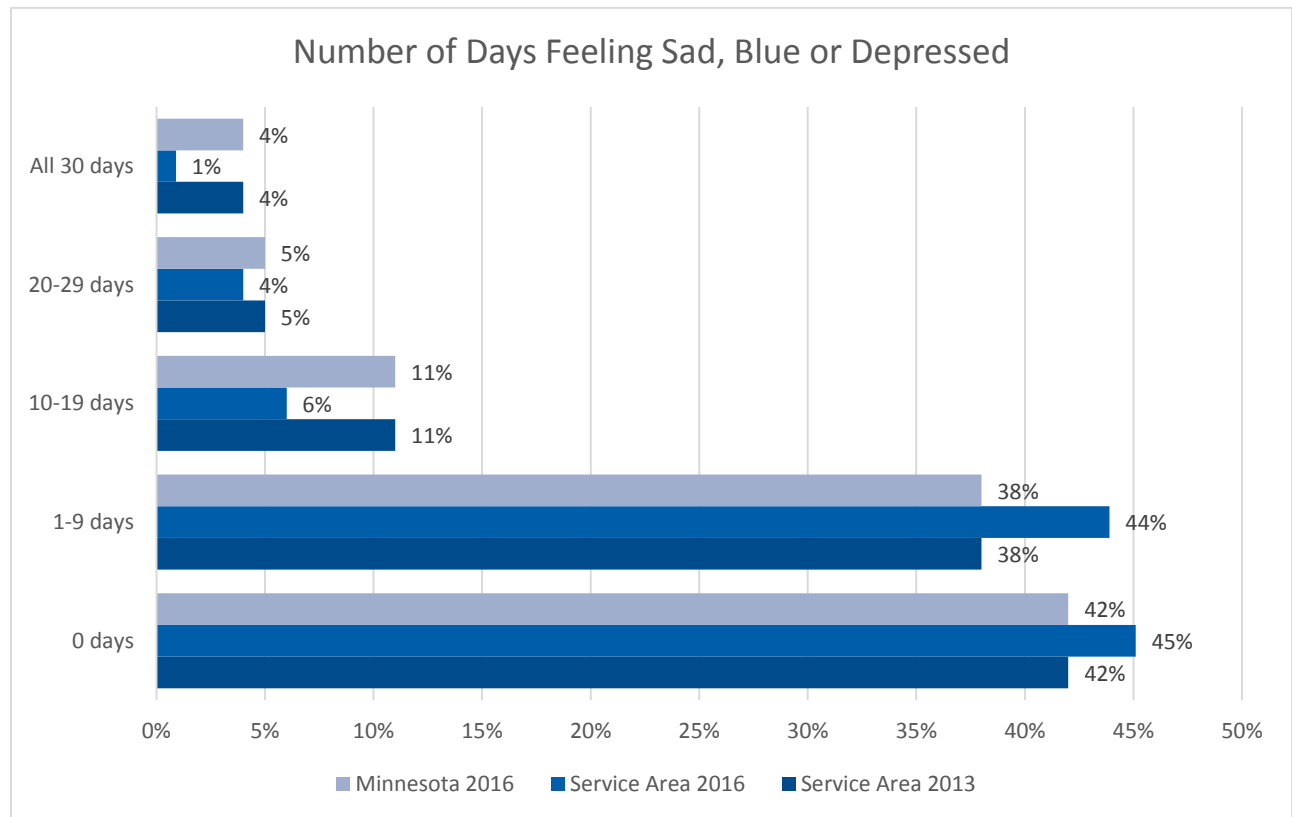
Minnesota Student Survey Had Suicidal Thoughts in the Past 12 Months

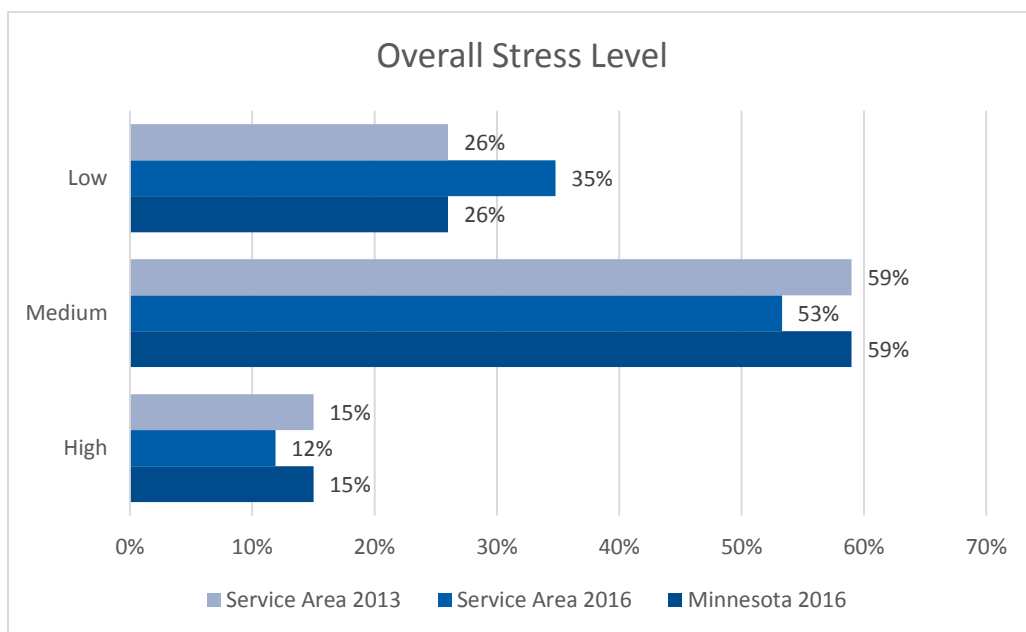
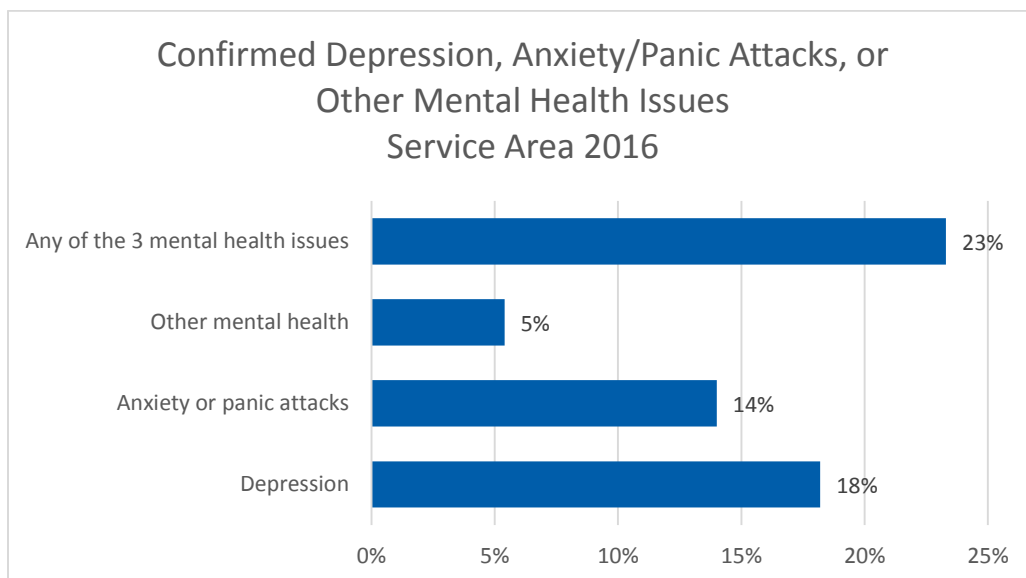
	Grade 8	Grade 9	Grade 11
Minnesota	14%	15%	13%
Service Area	10%	13%	10%

Delayed Care



The Tri-County Health Care service area has a 10 percent delay of respondents getting medical care related to depression. Two percent of respondents reported missing school or work due to mental health issues.





Accurate prevalence data pertaining to stress is hard to find, but stress is an important health topic because chronic stress can lower your immunity and lead to heart disease, high blood pressure, diabetes, depression and other illnesses.

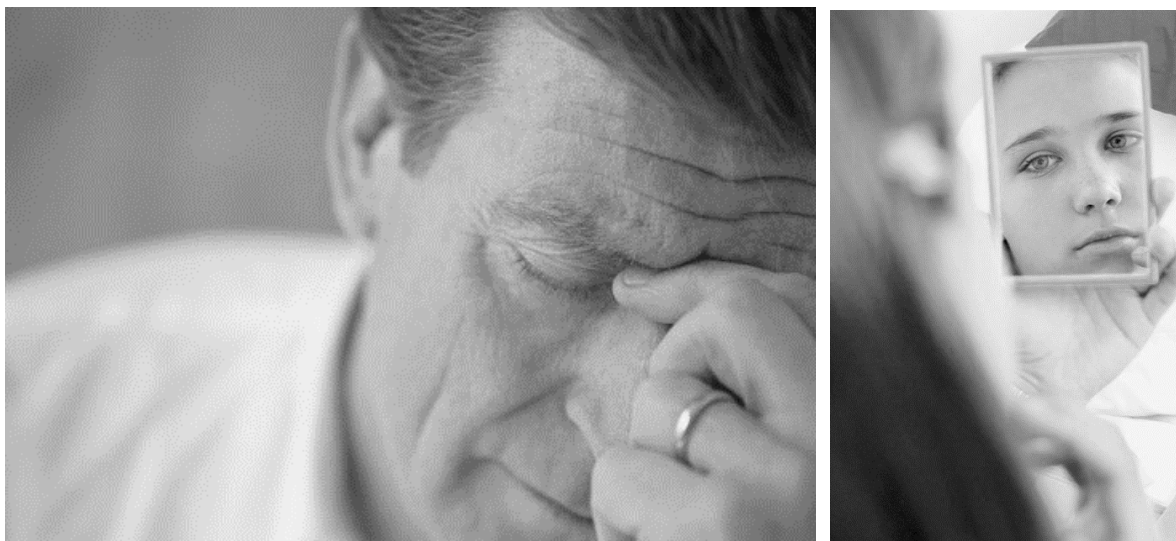


EXHIBIT 5

HEALTH CARE RESOURCES IN THE SERVICE AREA

Clinics

- Essentia Health – Menahga
- Tri-County Health Care – Bertha, Henning, Ottertail, Sebeka, Verndale and Wadena
- Sanford Health – New York Mills and Ottertail

County Public Health Departments

- Otter Tail County Public Health
- Todd County Health and Human Services
- Wadena County Public Health

Home Health Agencies

- CK Home Health Care – Ottertail
- Caring Hands Home Care – Sebeka
- Knute Nelson Home Care and Hospice – Wadena
- Lake Country Home Care – New York Mills
- Tender Hearts Home Care – New York Mills

Hospitals

- Minnesota Specialty Health System – Wadena (focusing on adult mental illness)
- Tri-County Health Care – Wadena

Nursing Homes

- Elders Homes Inc. – New York Mills
- Fair Oaks Lodge, Inc. – Wadena
- Green Pine Acres Nursing Home – Menahga
- Golden Living Center – Henning

Nutrition Support

- Hilltop Regional Kitchen – Eagle Bend
- Regional Food Shelves – Henning, New York Mills, Sebeka and Wadena

Pharmacies/Drug Stores

- Seip Drug – Bertha, Henning, Menahga, New York Mills, Ottertail and Wadena
- Thrifty White Pharmacy – Wadena
- Walmart Pharmacy – Wadena

Supported Living Facilities

- Comfort Care Cottages – Wadena
- Fair Oaks Apartments – Wadena
- Greenwood Connections – Menahga
- Heritage House – Sebeka
- Heritage Manor Inc. – New York Mills
- Home Sweet Home – New York Mills
- Little Bit of Country – Wadena
- Our Home Your Home – Henning
- Willow Creek Senior Living – Henning
- Wood Side Manor – Menahga

Transportation Services

- Care Van – Staples
- Friendly Rider Transit – Todd and Wadena counties and the cities of Bertha, Hewitt and Staples
- Otter Tail County Volunteer Transportation Program – Ottertail
- Peoples Express – Wadena
- Medi Van – Detroit Lakes, serving all of Otter Tail County
- Rainbow Rider Bus – Todd County

Other

- Aneway Treatment Center – Wadena
- Bell Hill Recovery Center – Wadena
- Bertha Area Wellness Center – Bertha
- Endeavor Place LLC – Verndale
- Maslowski Wellness and Research Center – Wadena
- Northern Pines Mental Health – Wadena
- Rewind Inc. Drug and Alcohol Treatment – Perham
- ShareHouse Stepping Stones – New York Mills

EXHIBIT 6

MORRISON-TODD-WADENA COMMUNITY HEALTH BOARD COMMUNITY HEALTH IMPROVEMENT PLAN

Community Health Priorities

The Morrison-Todd-Wadena Community Health Board and community partners identified the following community health priorities:

Community Health Priorities	
1.	Obesity in Children and Adults
2.	Mental Health
3.	Social Determinants of Health

Priority Areas: Goals and Strategies Overview

Action Plan 1: Obesity

Goal: Prevent and reduce obesity in adults and children by increasing physical activity and healthy eating opportunities

Strategy 1: Increase healthy food access, availability, and consumption

Strategy 2: Increase access to physical activity opportunities (various settings)

Action Plan 2: Mental Health

Goal: Increase access to high quality mental health prevention and intervention services

Strategy 1: Increase awareness of mental health issues; develop a campaign to increase utilization of mental health system and resources on how to seek help to mental health services

Action Plan 3: Social Determinants of Health

Goal: Assure that the opportunity to be healthy is available everywhere for everyone

Strategy 1: Increase community knowledge, skills, and partnerships in the understanding and utilization of social determinants of health (SDOH)

EXHIBIT 7A

MAPP EXHIBIT – PATIENT PROBLEM LIST

Summary of Top 10 Problems from Patient Problem List by Facility - 2015

Lakewood Health System

Unspecified Essential Hypertension	4030
Type 2 (Non-Insulin Dependent) or unspecified diabetes mellitus without complication not stated as controlled	3232
Encounter for therapeutic drug monitoring	3009
Depressive disorder not elsewhere classified	2975
Routine infant or child health check	2713
Encounter for long-term use of other medications	2668
Anxiety state, unspecified	2410
Other dermatitis due to solar radiation	2302
Routine general medical exam at health care facility	2099
Generalized anxiety disorder	1819

CCH - Long Prairie

Essential Hypertension	986
Health check for child older than 28 days	910
Sore throat	651
Annual physical exam	621
Cough	609
Hyperlipidemia	605
Need for immunization against influenza	594
Hypertension	521
Type 2 diabetes mellitus without complication	402
Screening	377

Tri-County Health Care

Essential hypertension	1152
Depressed mood	497
Type 2 diabetes mellitus with hyperglycemia	470
Current smoker	376
Anxiety state	362
Acid reflux	319
Acquired hypothyroidism	299
Elevated LDL cholesterol level	271
Cataract	262
Asthma, intermittent	242

St Gabriel's Hospital

Hypertension	12517
Atrial fibrillation	7731
Physical exam	5902
Diabetes	5414
Hyperlipidemia	4833
Flu vaccine	4443
Back pain	4200
Osteoarthritis	3908
Newborn weight check	3406
Difficulty walking	2666

Note: All four facilities have the same condition as the most common condition on patient problem lists.

Diabetes is identified in the top 10 for all four facilities.

Hyperlipidemia / elevated LDL is identified in the top 10 problems for three of the four facilities.

Depression / Anxiety have been identified in the top 10 problems for two of the four facilities.

EXHIBIT 7B

MAPP EXHIBIT: KEY STAKEHOLDER INPUT

The key stakeholders who collaborated on this community health needs assessment represented a cross-section of agencies serving the Tri-County Health Care service area. Key stakeholders collected and analyzed the data gleaned from the primary and secondary data described above to come up with the following concerns/strategic issues, trends, barriers and plan.

Vision Statement

The following visioning statement was developed November 2012 by the stakeholders as one of the first steps in the visioning process.

We will be a community whereby all are involved in healthy living through:

- Safe and sustainable communities
- Healthy environments (food, water, housing, recreation, transportation)
- Vibrant economic opportunities
- Dynamic, engaged community leadership (business, education, government, civic)
- Nurturing social, cultural, and spiritual opportunities

Concerns and Strategic Issues of Tri-County Health Care Service Area

1. Mental health (depression, anxiety and suicide)
2. Obesity
3. Diabetes, heart disease, stroke, high cholesterol, hypertension
4. Cancer
5. Unhealthy behaviors – exercise, diet, smoking, alcohol, compliance with care
6. Parenting (includes injury prevention, immunizations, etc.)
7. Access – affordable care, perception of importance, preventive care
8. Poverty
9. Aging demographic
10. Unintended injury
11. Social determinants of health, health equity (housing, employment, environment, transportation, etc.)

Stakeholder Interviews: Morrison, Todd and Wadena Counties

Methodology

The Initiative Foundation is proud to serve the 14 counties of Central Minnesota that include 160 hometowns and two tribal nations, each with its own unique character and local assets. The Initiative Foundation believes that local people have the enthusiasm and insights to power what's possible for their communities. Our community, organizational and economic development work is supported by a spectrum of public and individual donors who partner with the Foundation to build thriving communities. All of our grant-making, lending and leadership development activities are designed to create a skilled workforce; to make Central Minnesota a destination of choice to live, work and play; and to inspire people to share their time, talent and resources. Katie Spoden, the AmeriCorps VISTA Leader (Volunteers in Service to America) at the Initiative Foundation conducted and summarized the one-to-one stakeholder interviews. This approach was utilized in order to avoid having one of the sponsoring organizations conduct the interviews and risk impartiality being compromised or answers being less than frank or complete due to the interviewee's feelings/relationship with one of the sponsors. A total of 53 interviews were scheduled and conducted with individuals throughout Morrison, Todd and Wadena counties (see Page 57). The questions asked of participants are listed on Page 58.

Stakeholders were individuals that came from two *groups-systems people*, individuals whose jobs or volunteer activities had significant relevance to the broad spectrum of health care throughout the county, and *community-minded individuals* who were not necessarily involved in any aspect of health care but possessed a genuine concern for improving the health of the people of Morrison, Todd and Wadena counties. The selection process was driven by the CHNA sponsors and their recommendations of people with knowledge of health or thoughtful, verbal individuals willing to state their opinions about improving health in the county. Despite the “hand-picked” nature of the selection process, every effort was made to separate any potential feelings the interviewees may have about the sponsors from their value in providing input to the CHNA process.

The interviews were conducted over the phone and notes were taken on each conversation. For a complete list of the interviewees as well as their roles in the community, please refer to Page 57. The interviewer has written four separate sections summarizing the Stakeholder Interviews, one for each county and one presenting themes prevalent across counties. The sections specifically identify any common themes that surfaced during the discussion and then noting any additional relevant information related to community health needs discussed. The summaries, and the physical notes taken by the interviewer, provided the “data” for this section of the CHNA. Fifty-three individuals responded to the invitation for a phone interview.

Todd County

The following themes represent a summary of the opinions, experiences and strategies provided by 16 stakeholders in Todd County on community health needs, concerns and solutions.

Health is Improved with Accessible, Affordable and Accurate Health Care and Health Information

There was an elevated discussion in Todd County, more so than the other two counties, on access to providers, access to affordable health care, and access to accurate health information. There were suggestions to provide more education on health care use and options through various communication channels and to be sure the information provided was accurate. A few individuals stated that there should be outreach and education to individuals living in poverty because there is a health disparity associated with socioeconomic status and often in connection, a lack of health care knowledge. A few stakeholders stated that inaccurate health care information is commonly spread through television and social media and that there should be a way to address false health information on pharmaceuticals, diets, etc. from a health care perspective. The themes of access and availability were commonly mentioned, access referencing how individuals get to appointments and resources, and availability being how many providers serve the community. Multiple people stated that Lakewood Hospital is excellent, one stating that “Lakewood is a beacon of light.” However, there was a suggestion for more urgent care clinics that provided quick care versus requiring scheduled appointments. One stakeholder credited a lack of providers to a lack of individuals with necessary education (MDs and Physician Assistants). To address a need for more providers, it was suggested to continue the community paramedic program that utilizes volunteers with training to do home visits, administer medications and understand medication schedules.

An inability to afford health care was mentioned frequently. It was suggested that there be more dentists that accept medical assistance within the region. Currently, individuals have to drive more than 60 miles to use their medical assistance for dental care. Pediatric dental care was mentioned as a specific health need. Additionally, it was mentioned that there be more access to free or reduced care, especially for pregnant women who do not normally go to doctor because they do not have the resources or insurance.

A few stakeholders mentioned an additional barrier to accessing health care is the language barrier, primarily with Spanish-speaking individuals living in Todd County. It was suggested that there be a liaison who knows about the health care system, medical assistance and other health resources that can share information with families and communities who do not speak English as a native language. Additionally, it was suggested that there be translators available for health clinics and dentists’ offices.

There were two policy level suggestions: decreasing the rules and regulations on providers so that providers can spend more time with patients to accurately assess health issues and that there be more competition between area health clinics so that the patient can be educated on the costs of their care, procedures and other services.

In Addition to Increasing Access, There is an Overall Lack of Mental Health Professionals

Elevated in the discussion on a lack of health care professionals was a specific mention of a need for more mental health professionals. One individual specifically mentioned a need to focus on social compatibility within the spectrum of mental illness, not ignoring the needs of individuals with depression and anxiety who need strategies for managing and controlling mental health. Much of the focus is currently spent on focusing on individuals who are severely hampered by mental illness and are a danger to themselves or others.

Addressing Substance Abuse Through Interdisciplinary Recovery Programs.

Drug, alcohol, and tobacco use were mentioned as key health concerns, though not as frequently as mental health concerns. However, a few mentioned the strong connection between drug and alcohol use and mental health. There was mention of a lack of adequate drug dependency groups and chemical abuse recovery programs.

Need for Safe Spaces to Live, Gather and Exercise for Individuals of All Ages.

“Safe spaces” was a commonly reoccurring theme -providing a strategy for many identified community health concerns. Two individuals stated a lack of safe housing has resulted in homelessness and a lack of housing for students, especially young women, who are more at risk for being sex trafficked if they do not have reliable housing. There was also a call for making homes “more safe” for older adults. One way to address this is to provide home visits for elderly to allow them to age in place by helping to prepare food, administer medicine and clean.

Safe spaces to gather were mentioned for both kids and adults. Suggestions included more offerings at the community center, such as family activities, meeting spaces and education. However, it was noted the community center would need more funding to build administrative capacity to offer more activities and services. Another stakeholder mentioned the creation of a “Cultural Center” that fosters integration for new members of the community. The Center would include resources on where to access services, shop, worship, learn and more. The Center would also serve as a gathering space to foster civic engagement. Additionally, it was suggested that a Boys and Girls Club be supported as a place for kids to gather after school, especially kids who are not involved in sports, so they have a safe and sober place to hangout. It was mentioned that it should not be assumed all kids will participate in sports, so there should be other offerings for extracurricular activities that are engaging, such as tech-based activities (e.g. robotics, computer science) that build interest in career fields.

A need for more safe places to exercise was mentioned as a way to address physical inactivity. One individual stated that summer recreation programs are great, but not everyone can afford or get their kids there. “How could barriers be taken away (e.g. transportation, cost, time) to ensure kids can exercise safely?” It was suggested that there be more opportunities for physical entertainment like biking, fitness centers, walking, but specifically for opportunities all, “not just the physically fit,” as to make exercising more accessible for all skill levels. It was suggested that there be free spaces for exercise and personal coaches that regularly work through exercise plans in coordination with dietitians. Access to these coaches and dietitians would be available at the place of exercise, without a need for a doctor’s visit, and at a reduced cost.

Healthy Eating Requires Making Choices Easier, Changing Systems

A stakeholder stated, “We can’t say, ‘We can’t.’ Making systems changes like getting doughnuts out of health clinic break rooms is just one example of where to begin.” Stakeholders also mentioned providing healthy options in the schools for snacks and meals, making local healthy food more available to all families and utilizing the farmers market as a way to purchase healthier food. The Choose Health program was frequently mentioned as a way to increase access to healthy, affordable food to positively impact hunger, obesity and diet-related illness.

Summary: Todd County

Although these five themes were the most common expressed by stakeholders interviewed as part of the CHNA, other topics were discussed as well.

- More resources and support for: diabetes, cancer and chronic disease

Wadena County

The following themes represent a summary of the opinions, experiences and strategies provided by 17 stakeholders in Wadena County on community health needs, concerns and solutions.

Mental Health Needs to be Addressed Through More Providers, Beds, Awareness and Support

Meeting the needs of those living with mental health problems was the most identified health concern in Wadena County. A need for more psychologists and psychiatrists was frequently mentioned, especially providers in more rural areas. Many stated a need for more access to school-based mental health care, one stakeholder stating that mental health professionals can be “more effective with consistent access to students. They spend 180 days with 100 kids. A lot can be done in that time.” A need for more crisis beds and long-term care facilities was mentioned frequently. Additionally, there was a call for more beds specifically for youth coping with mental illness. Many mentioned the stigma associated with mental illness and hesitancy to schedule appointments. However, many individuals mentioned that those with appointments have long wait times, one stating that it can be more than a six-week wait. As a means for bringing awareness to mental health, it was suggested to have specific health fairs around mental health and to offer a mental health screening at every doctor visit. For supporting those living with mental illness, it was suggested to have a “mental health version of AA, hosted at churches or social services.” It was also suggested to seek a variety of treatments for mental illness including healthy eating for whole body health, treatment through art and culture (shown to minimize unpredicted, dangerous behavior) and hands-on technical skill training.

Preventative Services Help Change Unhealthy Habits and Prevent the Costs of Crisis

More frequently mentioned than in the other two counties, a need for more preventative services was brought up as a key community health strategy. One stakeholder explained the three prongs of preventative services: Primary prevention services prevent problems; secondary prevention services acknowledge someone is on a path for problems and it’s getting worse; tertiary prevention services is focused solely on crisis prevention. Related, one individual stated that many individuals don’t understand the intersection of their decisions and how it relates to their short-term and long-term health. Across all stages of prevention services, it was stated that there should be more education, affordable physicals, access to care, and greater recruitment and retention of physicians. Prevention education includes spreading awareness to individuals on how to recognize when a health issue is serious and when they should receive care.

Two suggestions were made on providing low-cost physicals. One stakeholder stated low-cost physicals are a way to bring awareness to healthier habits, making it more likely for change in both kids and parents. A second stakeholder provided a suggestion for a “mini-physical” based on what is done elsewhere in the state. The option would be offered once a year, for one week and run by volunteers from the community and health care professionals. The mini-physical would cost \$20 or less, and individuals would receive blood glucose testing, cholesterol testing, blood pressure, etc. Upon completing tests, there would be an exit interview screening for mental health issues. If anything identified at the mini-physical was of concern, the individual would be referred to a clinic or other health care professional. Creating a low-cost, designated time for basic care could prevent a larger health care crisis in the future.

In addition, many individuals stated there needs to be better access to emergency care, access to dental care (especially for children) and access to high-quality health care. As part of creating greater access, a few individuals stated there needs to be a stronger commitment to maintaining and retaining physicians in the community.

Chemical Use and Abuse Education Needs to Begin at Young Age

Stakeholders identified drug use (especially teen drug use), smoking and alcohol use as a problem within the community. It was stated that there is no specific K-12 substance abuse education program being used. Many stated it is important to have a strong stance and clear punishments on substance abuse, especially underage alcohol consumption. Like mental health, it was mentioned that there are long wait times for drug treatment programs. One individual mentioned that they called 26 treatment centers and they were all full. This indicates a clear need for more providers or outlets for alternative care. To supplement treatment, it was also mentioned that there should be more support groups, like AA, but for specific drugs.

Build on Infrastructure for Physical Activity and Community-Based Activities

The Maslowski Wellness and Research Center in Wadena was frequently mentioned as a positive asset in the community and a needed resource for increasing physical activity. However, some individuals mentioned a need for physical activity infrastructure in more rural towns throughout the county and a need to provide more activities for seniors and be mindful of their mobility access. Individuals stated they would like to see reduced prices for membership at the Center for low-income individuals, more summer time activities for everyone and more opportunities to gather socially and host support networks for a variety of audiences (e.g. parents, disease-specific, drug abuse, teens, etc.) at the Center.

Mobile Food Resources Create Access and Address Food Insecurity and Obesity

Stakeholders in Wadena County, like in the other two counties, frequently tied obesity to lack of access to healthy food and lack of nutrition and cooking education. One stakeholder suggested that every person receiving food assistance should also be offered a cooking course. In tandem with a frequent mention of transportation as a barrier to health services, lack of transportation was also mentioned as a barrier to healthy eating. It was suggested to utilize a mobile food market to address food needs in rural areas. It was suggested to base it off of models used in the Twin Cities metro with mobile food shelves and mobile food markets. Creating mobile access, as one stakeholder states, takes it one step beyond what a food shelf can provide. A food shelf is only helpful if an individual is physically able to get to the food shelf and receive emergency food within their hours of operation, often during the work day. Removing barriers to healthy food for all people, regardless of income, is necessary to increase health, decrease obesity and increase food security. One stakeholder stated that addressing obesity-related chronic illness requires “outside of the box” thinking. Solutions need to go beyond policies but engage the built environment, financial structures and need to have more “slashes” in the title; for example, an economic development/hunger prevention/community health program to address the complexity of obesity, health disparities and hunger in a multi-faceted approach with many different funders and policy strategies.

Summary: Wadena County

Although these five themes were the most common expressed by stakeholders interviewed as part of the CHNA, other topics were discussed as well:

- More resources and support for chronic diseases such as cancer and respiratory issues
- Lice epidemics in school lead to students being teased and isolated
- There is a need for a supervised visitation center for parents to interact with one another and their children in a safe setting. Supervised visitation is sometimes legally required in cases of domestic abuse, separation, divorce, etc.)

Common Themes Across County Borders

The following are themes that were identified frequently by individuals across all three counties. These themes represent key barriers for improving health, possible strategies for how to address barriers, and strategies for addressing health concerns mentioned on previous community health needs assessments.

Poverty and Lack of Opportunity Contribute to Health Inequity

Across every county and mentioned in answers to every question, stakeholders made explicit and implicit references to poverty as the key determinant of health. Poor health was often linked to a lack of funds as a result of unemployment, underemployment or lack of living wage jobs across all three counties. One stakeholder stated that “poverty is the biggest factor in the lack of preventative care in children because there is no push from their parents to receive care because they are struggling to put food on the table. Immediate needs are met first.” Lack of preventative care is exacerbated by lack of dentists that accept medical assistance within the three-county region (this was mentioned by at least one person from every county) and the overall cost of health insurance. Every stakeholder was asked, “What non-health care factors contribute to poor health,” and were given a list of examples. “Poverty” was not mentioned in the list of examples yet was one of the only answers given that did not specifically come from the list of examples offered. Poverty was often named as “generational poverty” and referenced many generations lacking resources, opportunity and ability to improve the physical, mental and financial health of their children and grandchildren’s welfare.

Transportation Identified as a Primary Barrier to Achieving a Healthier Community

Lack of transportation is often connected to poverty; low-income families often do not have access to reliable, consistent transportation. However, transportation for older adults and young families needing transportation to child care, work and school was often frequently mentioned. Because a need for transportation was so frequently mentioned, it deserved to be highlighted as a key strategy for improving health. Many mentioned a need for transportation to medical appointments, with one stakeholder stating there “should be a system where lack of transportation is never an excuse for missing an appointment.” There were mentions of bus systems, taxi services and other transportation options, but it was always followed up with “hours are limited,” “it’s not convenient,” “it’s not well publicized” and other comments stating that the existing transportation system was not strong enough to be effective for all. A few stakeholders stated that there is often a lack of transportation for patients leaving the emergency room, sometimes having to take an ambulance back to their home because there is no other option of family or friends able to drive them back home. Transportation was primarily talked about in terms of getting to medical appointments, but it was also mentioned as a barrier for individuals to get to programming around healthy eating, options for physical activity, attending parenting courses and receiving other services. One individual put this into perspective by stating that low-income families are limited in transportation because, often, it is a financial decision of “spending gas money or buying food.”

Behaviors are Learned; Healthy Choices Start in the Home, are Reinforced through Education and Supported by Peers

Although this topic has been indirectly stated in many of the previously stated themes, it deserves to be addressed as a separate item due to the frequency with which it was highlighted. Stakeholders believe that many suggestions and solutions to health care concerns have an educational component. For example, that nutrition education is critical to effectively addressing obesity; and that chemical abuse and mental health require an education component to spread awareness and inform of resources. However, many stated that education can only go so far if healthy habits do not take place within the home. One stakeholder stated that “unhealthy kids are a result of unhealthy kids.” For drug and chemical use, a primary strategy mentioned was to model responsible behavior in the home. Additionally, with parenting it was frequently mentioned that there is a need for more home visits and an expansion of the Nurse Family Partnership, which focuses on home visits to create healthy environments for new parents. To sustain behaviors, it was frequently cited that there needs to be opportunities for mentoring. Mentoring was mentioned as a strategy for everything from weight-loss to heroin abuse to parenting teenagers. Stakeholders frequently cited mentoring as a strategy because it is built on relationships with peers with shared experiences as opposed to social workers, health care professionals or law enforcement who may be removed from their day-to-day challenges.

Community Health is Improved when Individuals and Families are Engaged

When asked the question on how to get individuals engaged in improving health, a common response from stakeholders was, “Now, that’s a hard question. Let me know when you find the answer.” Additionally, a common sentiment was, “There are a lot of good programs in the area. It’s just that people don’t know they’re there.” The question then becomes, “How effective can a program be if few are utilizing the resource?” There were a multitude of suggestions, but very few stakeholders were confident in the effectiveness of the strategies suggested to get individuals engaged in their health (e.g. participate in activities, attend health-related classes, exercise regularly, schedule regular health appointments, etc.). The strategies presented can be split into three different buckets: incentives, personal invitations and community-driven programming.

Suggestions for incentives included: free meals, free child care, insurance incentive to reduce fitness center membership, credits for professional development (when applicable), ongoing recognition and awards (especially for volunteers), punch cards that can be redeemed for gift cards and other prizes, and providing cash stipends.

Suggestions for personal invitations includes asking people how they would like to receive notifications and consistently using that mode of communication (text, phone call, in-person visit), inviting individuals to be a part of the design of the program, asking individuals on a personal level what motivates them and responding to that information, providing information directly to every new person who moves into the community with resources for every stage of life (a suggested title for this resource was “One to Ninety-Two – Services for Babies to Seniors”) and engaging in every

possible circle of people's lives to educate and provide access to health services. One stakeholder summarized the power of personal invitations by stating, "People bring people."

Community-driven programming is important because individuals will only attend if they believe it is in their best interest to do so; one stakeholder stated a key strategy for engagement is "not assuming to know what a 'community needs' without asking them to be a part of the solution." Community-driven programming also fosters a welcoming environment. One stakeholder said a sure-fire way to ensure individuals won't participate is if they feel they are being scolded or being "preached" to while accessing resources or assistance. Another stakeholder stated that if individuals feel it is their "choice" to attend an event, it will be more effective.

It's important to note that engagement was seen as the foundation for providing high-quality events, resources and opportunities for improving overall health. If individuals aren't engaged (especially the targeted populations), strategies will not be successful.

Parenting is Difficult; Strong Healthy Parents Need Support and Tools

All stakeholders were asked, "If given funding to create an initiative targeted at parenting, what would that initiative look like?" Much of the response was focused on education, resources and learning in community with peers. One individual stated that parenting courses need to begin pre-natal and be offered until the child turns 18. Many focused on supporting parents of newborns, suggesting policies around paid maternal and paternal leave and providing long-term support over the first two years with "multiple touches" to parents and children. One individual suggested gathering contact information from hospitals and calling all parents with a newborn to talk about available community resources. Additionally, it was suggested to have co-parenting courses for parents who are separated, access to high-quality and meaningful mentoring from older parents, and continuing programs like Love and Logic, Nurse Family Partnership and a church-based program called "Better Kid by Friday."

Many individuals highlighted that although parenting classes should be offered and accessible to parents of all income levels, classes should not be "required." It was mentioned that there is a stigma around parenting classes and attending means you are a "bad parent." One individual suggested marketing parenting classes as opportunities for parents to build and gain tools to keep in their "parenting toolbox." Another individual mentioned that classes should be a welcoming environment where parents can access resources freely and without judgment.

A common statement around parenting and strengthening families was having a designated time to gather for dinner often, if not every night. This was cited as a time to create deeper connection with children, foster trust, listen to children and designate time away from screens.

Domestic Violence Occurs in Many Forms and Necessitates a Many-Pronged Approach

In the previous stakeholder interviews, domestic violence was mentioned on several occasions as an issue with negative impacts on families, children and the community. Only one stakeholder, across all three counties, mentioned domestic violence in their top three community health needs, but every stakeholder was asked to define domestic violence in their own words and to provide their ideas for ways to address domestic violence in the community. Almost every individual provided their own definition and stated domestic violence was a complex health concern that needs to be better addressed within their community. A cumulative definition for domestic violence is as follows: Domestic violence is any aggressive act, threat or perception of threat that incites fear or inflicts pain and occurs between two individuals living in the same home or in relationship with one another. These individuals could be married couples, intimate partners, family members or friends. Domestic violence can be physical abuse, mental abuse, emotional abuse, verbal abuse, financial acts of dominance or spiritual abuse (forcing to follow one's religious beliefs).

Hands of Hope was identified as a strong organization, advocating for women throughout the region, but it was stated there needs to be more knowledgeable people across all possible places of crisis: law enforcement, chemical use centers and unemployment centers. It was mentioned that law enforcement needs more resources to be able to refer victims to counseling and advocacy services, especially in discreet ways if called to the home for a domestic dispute. It was mentioned there was a lack of shelters and long-term housing for victims, with the closest shelter many miles away. There is a domestic violence crisis line and crisis response team. A stakeholder shared that there were more than 7,000

calls on the crisis line last year that covers Morrison, Todd, and Wadena in addition to Aitkin, Cass and Crow Wing counties. This stakeholder also shared that the crisis response unit is called up to four times a day. Based on these numbers and other anecdotes from stakeholders, domestic violence is a prevalent health concern and as one stakeholder put it, “When someone cries for help, give it to them.”

Although many mentioned strategies to support women, many specifically noted that men can also be victims of domestic violence and are in need of support as well. One stakeholder mentioned a need to foster a father’s role and not disempower dads by only focusing on programming for moms. Another strategy mentioned was education starting in school at an early age on acceptable behaviors in relationships including honest discussion on date rape, consent and sexual assault.

School-Based Policies Address Bullying, Room for Growth

Although no stakeholder across all three counties identified bullying in their top three community health concerns, every individual was asked about bullying because it was mentioned before in previous community health needs assessments. Many thought that schools were handling bullying well through a variety of strategies: peer mediators, signage in schools, strict teacher policies on reporting, speakers and student-led coalitions. Many thought it was an issue but were fairly satisfied with the many strategies being utilized. Successful programs mentioned were Flyer Pride and OLWEUS. Some stakeholders stated that programs could be stronger if all teachers were on board and there was more teacher buy-in. A common concern was cyberbullying and the inability to monitor cyberbullying in an efficient way. One stakeholder sadly shared that there has been at least one recent suicide related to cyberbullying.

Outside of school, it was mentioned that church youth groups can provide a safe place to discuss bullying. It was shared that some students fear telling adults about bullying at school, and church can provide a protected place. Additionally, support groups for bullied kids and their parents, outside of the school system, were also mentioned as a strategy for improving bullying.

Although not a frequently mentioned position, it was brought up across counties that bullying has been used as a buzzword for every behavior, some of these opinions coming from stakeholders within the school system. There was a call for distinguishing bullying from having conflict with another student. It was expressed by a few stakeholders that schools should focus on teaching conflict management skills and teaching strategies for having difficult conversations in addition to enacting bullying policies. The rationale was that bullying certainly is a reality and needs to be addressed, but students also need to build skills to work with others in a respectful manner.

Recommendations for CHNA Stakeholder Interviews

The following are successes, challenges and opportunities for growth to inform how the stakeholder interviews are conducted in the future.

Positive Reaction to Insightful Questions

Success: The majority of stakeholders commented throughout the interview on the questions, saying, “That’s a good question” or “I had never thought about that before.” The questions, in general, were received positively, although many stakeholders commented, “That’s a tricky question.” The questions were written in a way that invited answers that included specific strategies but for large and complex health concerns.

Opportunity for Growth: Questions that ask for opinions and strategies are a great way to receive specific feedback and references to community-based programming that stakeholders find effective. However, some of the questions were re-worded throughout the interviews because not every stakeholder understood what the question was asking. For example, explaining what was meant by “how to get individuals engaged” and examples had to provide for the question on “non-health care-related issues impacting overall health (e.g. public safety, access to housing, transportation, etc.).”

Time Commitment of Scheduling Correspondence

Challenge: Often, scheduling phone interviews with stakeholders across a three-county region was as time consuming as conducting the interviews themselves. Scheduling requires persistent communication via email and phone to establish a

time period when a stakeholder can commit 20-30 minutes to be interviewed. Because the interviewer did not have the flexibility to conduct phone interviews during her daily office responsibilities, it was very difficult to schedule a time to interview individuals outside of normal work hours. Additionally, many individuals did not respond to consistent emails or voicemails, meaning more time spent finding other potential stakeholders.

Opportunity for Growth: The interviewer should be an individual who has the flexibility to conduct phone interviews during his or her daily office responsibilities. If it is difficult to find an individual who can take on this responsibility in addition to daily work, there should be a dedicated time when phone or in-person interviews are conducted. The scheduling should be done in advance of these interviews to alleviate the time burden of scheduling correspondence.

Lack of Information about Stakeholders

Challenge: The interviewer was provided with names and contact information for stakeholders in each county. However, there was little context provided on the profession or community role of each stakeholder. Often, there was either a phone number or an email, not both modes of communication provided to the interviewer. Additionally, there were a handful of emails and phone numbers that were incorrect.

Opportunity for Growth: The individual who initially is charged with informing stakeholders that they will be receiving a call from an interviewer should confirm the job title, organization, phone number, email and preferred name of each stakeholder. This detailed contact information should be kept in a shareable format to be updated and used for future stakeholder interviews.

Lack of Diversity in Stakeholders

Challenge: There is no demographic data collected on stakeholders; however, based on phone interviews, 75 percent of the stakeholders were women and all but one stakeholder spoke English fluently. A large majority of the stakeholders were in professions where they frequently interacted with individuals living in poverty, and many expressed the intersection of poverty and health; however, only a few indicated that they themselves had ever lived in poverty. The large majority of the stakeholders interviewed were able to speak about experiences within their county's larger cities (Little Falls, Long Prairie, Wadena, Staples), but fewer were able to provide information relevant to the towns outside of the larger cities.

Opportunity for Growth: A wider net should be cast on each county to more intentionally engage individuals across age, gender, nationality, religion, socioeconomic status, educational achievement and geography within the county. Many of the stakeholders interviewed were in professional roles such as doctors, police officers, social workers, mayors and teachers. A suggested strategy for increasing the diversity of stakeholders interviewed is to ask patients, clients, constituents, students and others served by these traditional stakeholders to participate in a stakeholder interview. A more diverse stakeholder interview pool will provide a richer and more reflective perspective on the health needs of the community members.

Stakeholders Interviewed

The following individuals were interviewed over the phone. The opinions, strategies and ideas reflected in the CHNA reports represent a summary of the qualitative data collected. The views expressed in the report do not reflect every individual's unique perspective on community health needs in their community.

Name	Agency
Morrison County	
Mayor Andrea Lauer	Mayor of Royalton
Beka Swisher	ECFE
Bridget Britz	Horizon Health
George Weber	Pierz Superintendent
Dr. Greg McNamara	Physician
Gregg Valentine	Pastoral Care

Julie Leikvoll	Northern Pines Mental Health Center
Kate Bjorge	Live Better Live Longer
Katy Kirchner	Public Health
Dr. Kurt Devine	Physician
Linda Lippert	ER Nurse/Violence Prevention Council
Lynette Gessell	Morrison County Social Services
Marilyn Keith	Pierz School, Juvenile Justice
Paul McIntyre	Gold Cross
Rachel Barta	Morrison County Social Services MH/CD
Shawn Larsen	County Sheriff
Sheila Funk	Little Falls School District
Susan Doran	Swanville School Nurse
Tammy Fillipi	Initiative Foundation Early Childhood Specialist
Terri Weyer	Senior Center
Todd County	
Bernice Desotell	Public Health Advisory Committee
Elizabeth Quillo	Todd County SNAP-ED
Jackie Och	Health and Human Services Supervisor
Dr. John Halfen	Medical Consultant Lakewood Health
Jennifer Hove	Tri-County Community Action
Katie Polman	Lakewood Health
Kevin Grondahl	Staples Park and Recreation Director
Kevin Jenkins	LEAP Member
Lani Roberts	Longbella Drug
Dr. Loren Morey	Lakewood Health Board Chair
LuAn Thomas-Brunkhorst	Chamber of Commerce
Mary Theurer	District Board
Olga Morazan	Pastor
Rona Bleess	CentraCare – Long Prairie
Sara Gorton	LEAP Member
Sue Nanik	LEAP Member
Wadena County	
Cathy Hansen	Northern Pines Mental Health Center
Cheryl Hills	Region Five Development Commission
Cindy Pederson	Wadena County Public Health Director
Dave Fjeldheim	Sebeka School Superintendent
Deb Zacharias	ER Supervisor, Tri-County Health Care
Faye Kumara	Wadena Senior Center
Mayor George Deiss	Wadena Mayor
Jenny Doll	Tri-County Health Care
Laura Kiser	Wadena – Deer Creek School Social Worker
Leah Pigatti	Mahube Otwa
Mary Ann Haugen	Food Shelf
Nate Loer	Immanuel Lutheran Church
Rachel Kern	Sebeka School Social Worker
Sandie Rentz	Wadena – Deer Creek Food Services Director and Community Education
Stephanie Hakes	University of MN Extension
Tanja Richter	Someplace Safe
Tanya Leskey	Wadena Social Services

Stakeholder Interview Questions

The following questions were asked of each stakeholder. If the stakeholder identified a health concern in Questions 1-3 that reflected a health concern asked about in Questions 5-9, the question was not repeated, so long as the stakeholder identified strategies for addressing the health concern (e.g. Stakeholder prioritizes mental health as their top concern in Question 2 and shares strategies for improving mental health in the community in Question 3. Therefore, Question 5 is not asked, as it is duplicative).

1. What do you think are the three most significant health-related issues in the community and why? (Please think of health in the broadest sense of the word.)
2. Please prioritize those top three issues and explain why you put them in that order.
3. For your top two issues, please list any ideas/strategies you believe may be effective in addressing those two issues.
4. What non-health care-related issues do you see impacting the overall health in the community? (For example, safe housing, transportation, access to healthy food, etc.)
5. Mental health concerns were frequently expressed on previous community health surveys (e.g. depression, suicide, anxiety, eating disorders, etc.). What can be done to improve mental health in the community?
6. Adult and child obesity was another issue identified as a significant local health concern. What ideas do you have for addressing obesity?
7. Domestic violence is a health concern. How do you define domestic violence? And what do you think can be done to address it?
8. Substance abuse is a health concern. How do you define substance abuse? And what do you think can be done to address it?
9. Bullying is a health concern. Are you aware of what services and/or programs are being offered around this topic in your community? And what do you think can be done to address it?
10. If I said you had to spend public health dollars on some initiative targeted at parenting, what would you do with the money?
11. Strengthening families is a community health strategy. What can be done to strengthen families in the community?
12. If you could add services to improve overall health in the community that are currently unavailable or have limited availability, what would your top choices of services be?
13. In your opinion, what are some of the best strategies for getting people engaged in improving the overall health in the community?
14. Are there any other comments or suggestions you would like to make that you believe are important to improving the health of the community?

For questions, contact:

Katie Spoden, AmeriCorps, VISTA Leader

Initiative Foundation

ksoiden@ifound.org

EXHIBIT 7C

MAPP EXHIBIT: FORCES OF CHANGE

		Opportunity	Threat
Event	Health Care Reform	Improve Prevention Covered Population Increases (Ins) Clinical Integrating Network	Provider Choice/ Consolidation Increase Strain Effect on Small Business Narrow Network
Event	Natural Disaster	Collaboration	Housing Shortage Mental Health Issues
Event	Data Exchange 2015	Improve Ability to Share Health Information	Cost to Implement
Factor	Economic Issues	Community Support Volunteerism Priority Setting	Poverty Jobs Income
Factor	Mental Health	Awareness Education Workforce Coordination Simplifying credentialing	Access Limited Interventions Mental Health Providers
Factor	Insurance Coverage	Covered Population Increases	Lower Standards Lower Reimbursement Insurance companies exiting Increase costs
Factor	Increase in Minority Populations	Cultural Sensitive Care Models	Discrimination - Less Services Language Barrier Immunization Cultural Practices/ Values
Factor	Chemical Dependency Issues	Cultural Sensitive Care Models High Health Needs	Discrimination
Factor	Alcohol and Tobacco Use	Improve Access for Preventive Services Funding available PSE work	Ability to Meet Demands Health Equity
Trend	Regionalization / Consolidation of Health Care Services	Efficiency Collaboration	Less Choice Less Access Economic Impact Less Local Control
Trend	Aging Population	Volunteerism Wealth	Increase Need - Health Services Increase Costs for Health care Work Force
Trend	Decreased Funding	Collaboration Efficiency	Less Ability
Trend	Rise in Infectious Disease	Prevention Collaboration	Funding Less Ability to Manage
Trend	Limited Work Force	Recruitment Potential Volunteerism	Ability to Meet Demands of Aging Population
Trend	Rise in Obesity	Prevention	Increase Cost Decrease in Life Satisfaction Increase in Chronic Disease
Trend	Changes in Technology	Easy Access to Information Improve Consumer Knowledge/Better Informed Increase in Health Literacy Patient More Accountable	Self-Diagnosis
Trend	Birth Rates & School Enrollment	Increased Need for Services	Increased Need for Support
Trend	Infrastructure	Funding	Capacity for resources Water Supply
Trend	Transportation		Barriers to access Infrastructure Safety
Trend	Sex Exploited Youth / Homelessness	Funding	Lack of Resources Workforce Poverty

EXHIBIT 8

HOUSING

Housing Costs

Housing costs are rising in the state of Minnesota. In 2010, the cost of housing consumed more than half of income for almost 1 in 7 Minnesota households. In 2000, only 1 in 12 households experienced this level of cost burden. Housing is considered affordable if it consumes less than 30 percent of a household's gross income. At greater than 30 percent, families need to choose between housing costs and other basic needs, such as food and medicine. (U.S. Census Bureau)

Data source: Homes for All in Minnesota, 2012. www.mhponline.org,

Households Impacted in the Tri-County Health Care Service Area

Household Income:

Less than \$20,000

2,940 Renters

3,375 Owners

\$20,000-\$34,999

680 Renters

2,366 Owners

\$35,000-\$49,000

75 Renters

1,803 Owners

More than \$50,000

4 Renters

1,675 Owners

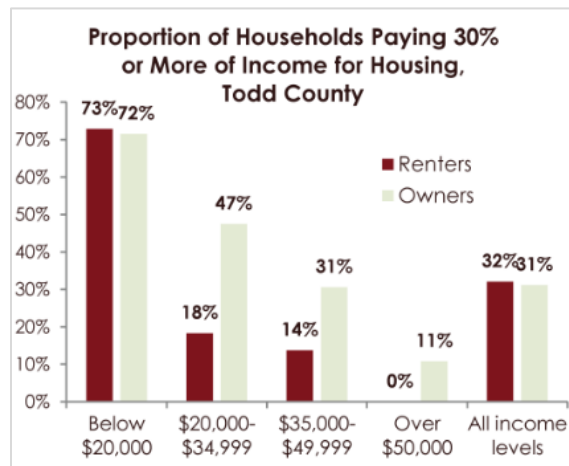
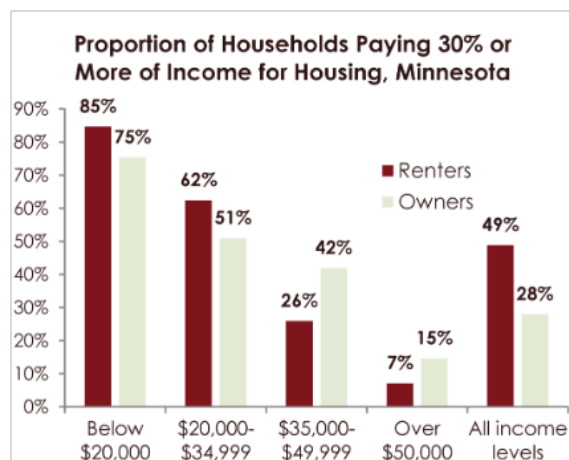
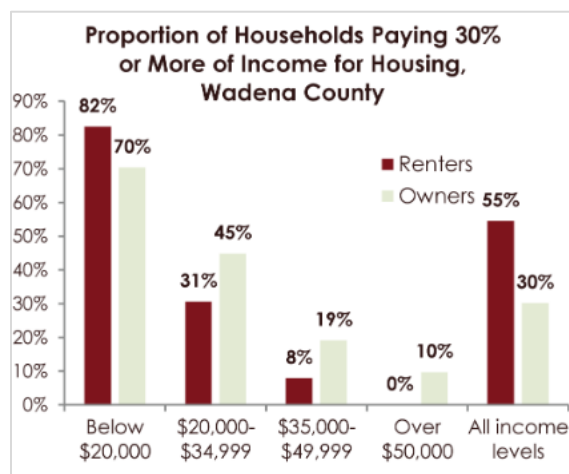
The U.S. Census Bureau estimates that there are 7,388 occupied units paying rent in the service area. The average cost of rental was \$557.

A worker within the service area must earn \$11.21 per hour, 40 hours a week, all year long to afford rent and utilities for a safe, two-bedroom, fair market value monthly rent of \$583. A typical renter earns on average \$7.39 in this area.

Data source: Homes for All in Minnesota 2012,

www.mhponline.org

U.S. Census Bureau. 2007-2011 American Community Survey 5-Year Estimates.



Homelessness

The chart below outlines homelessness in the Central Region of Minnesota, which includes Todd and Wadena counties. *Community demographic and Assessment Information for the Minnesota counties of Benton, Cass, Chisago, Crow Wing, Isanti, Kanabec, Mille Lacs, Morrison, Pine, Sherburne, Stearns, Todd, Wadena and Wright.*

Data source: Wilder Research, 2015 Minnesota Homeless Survey.

<http://mnhomeless.org/minnesota-homeless-study/detailed-data.php#interview-data>

	Minors <18 Male	Minors <18 Female	Age 18- 21 Male	Age 18- 21 Female	Age 22- 54 Male	Age 22- 54 Female	Age 55+ Male	Age 55+ Female	Children with Parents	Total
In Shelters	-	1	39	31	114	138	30	9	231	593
Not in Shelters	8	7	15	8	82	42	16	6	25	209
Total	8	8	54	39	196	180	46	15	256	802

Greater Minnesota has less than one-third (32.6 percent) of the homeless population in Minnesota. This is a decrease from 34 percent in 2012.

The number of homeless people in Minnesota has decreased by 8.8 percent since 2012, with the total amount of homeless in Minnesota at 9,312 as of October 22, 2015. Only 10.7 percent of the 9,312 homeless were younger than 21 years of age. The largest percent decrease in homelessness was among young adults (age 18-21), with a 22.5 percent decrease from 2012 to 2015. Despite the overall decrease in homelessness, the amount of homeless unaccompanied minors (younger than age 18) has increased by 31.5 percent.

Data source: Wilder Research, 2015 Minnesota Homeless Survey.

<http://mnhomeless.org/minnesota-homeless-study/detailed-data.php#interview-data>

EXHIBIT 9

2013-2015 Community Health Needs Assessment

Concerns & Strategic Issues of Tri-County Health Care Service Area in Order of Priority:

1. **Unhealthy Behaviors:** This item was identified as the first priority as successful results in this area may also have positive impacts on obesity, heart disease, stroke, diabetes, high cholesterol, high blood pressure, cancer, etc. It includes exercise, diet, smoking, alcohol use, drug use and health care compliance. TCHC is partnering with Wadena Regional Wellness Center, city of Wadena, Wadena Deer Creek Schools, Wadena 2.0 Tornado Recovery Committee and several other key community organizations to build a community wellness center and create a results-oriented wellness initiative for the Wadena Community and surrounding area. Groundbreaking for the physical structure began fall of 2013. The building was completed in 2014. With the aid of the Frank and Eleanor Maslowski Charitable Trust and the Wadena Regional Wellness Center, TCHC is conducting a research study to identify factors that may be predictive or explanatory of health risk status in the TCHC service area population. The first phase of the research study began in 2013 as with TCHC compiling baseline health care data from the TCHC employee group. TCHC will be implementing health care initiatives and education within the employee group and analyzing the effect of those initiatives for the employees. The next phase of this project is to conduct this same activity with groups from Wadena and Bertha communities.

Health care compliance will be addressed through TCHC's strategic plan found on Pages 67 and 69 of the 2013-2015 Community Health Needs Assessment, specifically item #3 "Care Coordination Program." Other items will be addressed in the Strategic Plan items #1 "Community Building, Education, and Employer Partnerships," #5 "Relationship Development," #6 "Develop Culture of Excellence," #7 "Targeted Program Development" and #8 "Facility Development."

2. **Obesity:** This can be addressed with the initiatives being undertaken for unhealthy behaviors. See items #1 "Community Building, Education, and Employer Partnerships" and #6 "Develop Culture of Excellence" in the Strategic Plan.
3. **Chronic Disease:** Includes diabetes, heart disease, stroke, high cholesterol, high blood pressure, cancer, etc. In addition to the wellness initiatives being undertaken for unhealthy behaviors, TCHC will be implementing a Medical Home program to aid persons with chronic illnesses and help them manage these conditions to remain compliant with their care and achieve positive outcomes. TCHC will also be implementing Care Coordination Programs to identify and monitor patients due for preventive care and contacting those patients in an effort to identify patients at risk earlier in the disease process. TCHC will continue to offer the diabetic education and diabetic support group. Items #1 "Community Building, Education, and Employer Partnerships," #3 "Care Coordination Program," and #6 "Develop Culture of Excellence" in the Strategic Plan discuss this in more detail.
4. **Mental Health:** In November of 2012, TCHC hired Dr. Aaron Larson and Andrea Craig, FNP, to provide full-time psychiatric services in the Wadena clinic. In the fall of 2013, TCHC also entered into an arrangement with Lake Country Associates in Park Rapids, MN, in an effort to collaborate to see to the psychiatric needs of patients in a health professional shortage area. Dr. Larson also conducts visits at area group homes in an effort to see to the needs of persons unable to live independently. TCHC offers grief and memory loss support groups. This is further discussed in the Strategic Plan item #7 "Targeted Program Development" and #5 "Relationship Development."
5. **Parenting:** TCHC provides educational classes to the community for parents on injury prevention by offering car seat clinics, bike rodeo and helmet fittings for children, first aid/CPR, prenatal and breastfeeding classes, lactation consultations and babysitting classes. TCHC also partners with the Child Protective Program for Wadena County, including law enforcement agencies, social services, public health

and school representatives to identify and assist at-risk children. This item is covered under the Strategic Plan item #1 “Community Building, Education and Employer Partnerships.”

6. **Access to Health Care:** TCHC offers an Uncompensated Care plan for patients who do not have the ability to pay. This plan is offered to persons with annual income at 150 percent of federal poverty guidelines. TCHC is located in a health care professional shortage area where access to a provider may be limited at times. TCHC has developed a provider recruitment plan to recruit more physicians to the TCHC area. In addition, TCHC is working on developing a model that utilizes Nurse Practitioners and Physician Assistants to practice alongside the physician to provide necessary services in a more cost-effective manner.

In an effort to improve access to health care, TCHC is working to implement a walk-in clinic that will have extended hours Monday through Thursday and Saturday mornings. We implemented this in 2014. As part of our care coordination plan, TCHC is collaborating with payor plans to implement necessary health screenings for specific diseases in an effort to prevent/detect specific issues such as lead testing, chlamydia screenings for specified age groups, etc. These issues are covered in the Strategic Plan under items #3 “Care Coordination Program” and #4 “Maximize Resources.”

7. **Poverty:** TCHC lacks the resources to fully address this issue. In partnership with Wadena County Social Services, TCHC has a county financial worker on site to assist patients with financial difficulty to determine eligibility for public assistance. In addition, TCHC offers an uncompensated care program for persons with an annual income less than 150 percent of federal poverty guidelines. TCHC’s Social Services Department assesses both inpatient and clinic patients and makes referrals as necessary. TCHC provides for transportation services to appointments via our local public transportation “Friendly Rider” (handicap accessible) at no cost to the patient. It is TCHC’s plan to partner with local government and business leaders to collaborate on community building in an effort to increase population, improve socio-economic status, and build/enhance community reputation. This is discussed further in the Strategic Plan item #1 “Community Building, Education and Employer Partnerships.”
8. **Aging Demographic:** An increased demand for services goes along with an aging demographic. TCHC will be addressing this issue by implementing care coordination plans as identified above, utilizing more physician assistants and nurse practitioners to meet the increasing demand, and implementing the wellness initiatives identified above. Our elderly population is an area of vulnerability in the sense that many of these people are living on a fixed income with high health care needs. TCHC will continue to assess the system for ease of scheduling, care coordination, and use of technology to improve access. This population also takes advantage of the free public transportation services subsidized by TCHC. This priority will also be addressed in the Strategic Plan item numbers #3 “Care Coordination,” #6 “Develop Culture of Excellence” and #7 “Targeted Program Development.”
9. **Unintended Injury:** The top injuries requiring hospitalization from our analysis included bites and stings, car/ATV accidents, poisonings and fires. TCHC provides a level IV trauma facility for patients in need. Injury education is provided through various means such as CPR classes, bike rodeo for children, car seat safety classes, etc. TCHC has chosen not to focus on this item at this time to more fully address the health issues listed above. As discussed above in the “Parenting” section, educational classes are offered such as prenatal and babysitting.
10. **Social Determinants of Health:** Includes health equity, housing, employment, environment and transportation. As with the issue of poverty above, TCHC lacks the resources to fully address this issue but plans to partner with local government and business leaders to collaborate on community building in an effort to increase population, improve socioeconomic status and build/enhance the community reputation. Please see Strategic Plan items #1 “Community Building, Education and Employer Partnerships” and #5 “Relationship Development.” TCHC will continue to help pay for car seats and bike helmets for safe transportation of infants and children. TCHC will continue subsidize fare for individuals utilizing Friendly Rider public transportation services to get to their appointments at TCHC.

EXHIBIT 10

2016-2018 Community Health Needs Assessment

Significant Issues for the Tri-County Health Care Service Area:

1. **Unhealthy Behaviors:** This item was identified as a first priority as successful results in this area may also have positive impacts on other significant health issues including obesity, heart disease, stroke, diabetes, high cholesterol, high blood pressure, cancer, etc. Healthy behavior promotion addresses exercise, diet, smoking, alcohol use, drug use and health care compliance. As part of the Maslowski research study, TCHC is partnering with Wadena Regional Wellness Center, city of Wadena, Jolene Johannes State Farm Agency, Todd Wadena Electric Association, Wadena Deer Creek Schools, Wadena State Bank and West Central Telephone with plans to expand several other key community employer groups to create a results-oriented wellness initiative for the Wadena Community and surrounding area.

With the aid of the Frank and Eleanor Maslowski Charitable Trust and the Wadena Regional Wellness Center, TCHC is conducting a research study to identify factors that may be predictive or explanatory of health risk status in the TCHC service area population. The first phase of the research study began in 2013 with TCHC compiling baseline health care data from the TCHC employee group and has expanded this to the employer groups identified in the previous paragraph. Please refer to Exhibit 1 for a more detailed explanation and results of this study. The next phase of this project is to conduct this same activity with groups from Wadena and Bertha communities.

Health care compliance and prevention will be addressed through our Care Coordination Program.

2. **Obesity:** This can be addressed with the initiatives being undertaken for unhealthy behaviors.
3. **Chronic Disease:** Includes diabetes, heart disease, stroke, high cholesterol, high blood pressure, cancer, etc. In addition to the wellness initiatives being undertaken for unhealthy behaviors, TCHC has implemented a Medical Home program in partnership with community paramedics to aid persons with chronic illnesses and help them manage these conditions to remain compliant with their care and achieve positive outcomes. TCHC has also implemented Care Coordination Program to identify and monitor patients due for preventive care and contacting those patients in an effort to identify patients at risk earlier in the disease process. TCHC will continue to offer the diabetic education and diabetic support group.
4. **Mental Health:** In November of 2012, TCHC hired Dr. Aaron Larson, Psychiatrist, and Andrea Craig, FNP, to provide full-time psychiatric services in the Wadena clinic. Dr. Larson also conducts visits at area group homes in an effort to see to the needs of persons unable to live independently. TCHC is continuing to recruit providers to meet increasing demands for psychiatric services. TCHC offers grief and memory loss support groups.
5. **Access to Health Care:** TCHC offers an Uncompensated Care plan for patients who do not have the ability to pay. This plan is offered to persons with annual income at 150 percent of federal poverty guidelines. TCHC is located in a health care professional shortage area where access to a provider may be limited at times and recruiting providers to rural areas continues to be a challenge. In addition, TCHC has developed a model that utilizes Nurse Practitioners and Physician Assistants to practice alongside the physician to provide necessary services in a more cost effective manner.

In an effort to improve access to health care, TCHC has implemented a walk-in clinic extending hours Monday through Thursday and Saturday mornings.

As part of our care coordination plan, TCHC is collaborating with payor plans to implement necessary health screenings for specific diseases in an effort to prevent/detect specific issues such as diabetes, cancer screenings, etc.

6. **Population Health Infrastructure:** TCHC has been establishing relationships and partnering with other facilities and providers to establish a model for managing population health. Currently, TCHC is partnering with CentraCare hospitals and several other affiliates including Douglas County Hospital and Rice Memorial Hospital on a clinically integrated network. TCHC, along with these facilities, utilizes the EPIC electronic medical records system with a goal to implement the “Healthy Planet” module as a tool to aid with population health management.
7. **Data Exchange:** TCHC’s partnership with CentraCare hospitals and other CentraCare affiliates as part of the EPIC electronic medical records system allows us to meet federal meaningful use requirements. This system allows communication between hospitals by utilizing the “Care Everywhere” feature of this system.
8. **Cancer:** TCHC’s initiatives to increase preventive visits and diagnostic screening exams will aid with early detection of cancer. In addition, TCHC’s partnership with Lake Region Health care in Fergus Falls, MN, allows us to provide oncology services for cancer patients in addition offering outpatient chemotherapy services.
9. **Social Determinants of Health:** Includes health equity, housing, employment, environment and transportation. TCHC lacks resources to fully address this issue but plans to partner with local government and business leaders to collaborate on community building in an effort to increase population, improve socio-economic status and build/enhance the community reputation. TCHC will continue to provide uncompensated care for those who lack the ability to pay for health care services. TCHC also participates in helping pay for car seats and bike helmets for safe transportation of infants and children. TCHC will continue subsidize fare for individuals utilizing Friendly Rider public transportation services to get to their appointments at TCHC.
10. **Decreased Funding:** This is a continued challenge for our organization as the funds for health care decrease while the demand continues to rise. TCHC collaborates with the Minnesota Hospital Association and American Hospital Association for advocacy efforts for rural health care.

