Tri-County Health Care

Community Health Needs Assessment 2019-2022

Table of Contents

Table of Contents

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 460 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, and Wadena. Tri-County Health Care 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 we serve. Tri-County Health Care (TCHC) is a 25-bed critical access health care organization. As a private, nonprofit, primary health care organization, TCHC serves a population base of approximately 38,184 from Wadena, Todd and Otter Tail counties in West Central Minnesota.

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 95,839; the primary service area population of TCHC is estimated at 38,184 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 Tri-County Health Care service area consists of primarily white/Caucasians at 95.7 percent with 4.3 percent minority. The state of Minnesota is also primarily white/Caucasians at 83.7 percent but has a greater minority population of 16.3 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) 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

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 three most significant issues for the purpose of this assessment:

- Barriers of Social determinants of health (poverty, employment, housing, environment, etc.)
- Community Infrastructure to Address Population Health
- Mental health / Access to Mental Health Care
    - Drug Addiction - Pain/Prescription Management (opioid epidemic)

Given the correlation between mental health and drug addiction, these two items are included as a subset of one another as the work needs to happen in tandem.

Tri-County Health Care

Tri-County Health Care (TCHC) is a 25-bed critical access health care organization. TCHC owns and operates six clinics, located in the communities of 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 38,184 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, a certified nurse midwife, one psychiatrist, two general surgeons, one radiologist, nine 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, podiatry, spine, wound management and pulmonology. Professional and support staff dedicated to excellence provide services in areas of surgery, obstetrics, nursery, 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, 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 counties, 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 four 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.

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 2,400 days of care for inpatient services in 2018 and 2,507 days of care in 2017. TCHC's surgical program performed 2,871 procedures in 2018 and 2,872 in 2017. In 2018, clinics provided 37,332 professional visits and 38,704 in 2017. Physical and Occupational Therapy visits for 2018 totaled 15,280 and 14,154, respectively, in 2017.

Diagnostic services provided 142,425 and 142,146 lab tests in 2018 and 2017, respectively. Radiology exams performed totaled 24,236 in 2018 and 23,680 in 2017.

TCHC provides 24/7 emergency room coverage and served 6,219 patients in 2018 and 6,026 in 2017. TCHC's hospital-based ambulance service provided 1,717 ambulance runs in 2018 and 1,638 in 2017.

These services in conjunction with TCHC's initiatives of adding care coordination services and Community Paramedic program are consistent with our mission to improve the health of the communities we serve.

	2013	2014	2015	2016	2017	2018
Ambulance Service Runs	1,811	1,547	1,668	1,523	1,638	1,717
Aquatic Therapy Visits	-	-	708	729	797	970
Community Paramedic	0	458	1,162	191	441	538
Emergency Room Visits	6,177	6,046	6,153	5,898	6,026	6,219
Medical Outreach Visits	6,322	6,314	6,770	6,520	6,366	5,155
Physical Therapy Visits	10,898	11,707	12,775	12,458	11,653	12,500
Psychiatry Visits	2,873	3,701	3,308	3,176	3,324	3,752
Total Clinic Visits	45,859	45,146	44,399	39,499	38,704	37,332
Total Deliveries	170	184	163	153	162	131
Total Discharges	1,149	1,093	1,066	898	905	902
Total Laboratory	111,092	112,023	110,819	139,811	142,146	142,425
Total Patient Days	3,526	3,142	3,017	2,510	2,507	2,400
Total Radiology	21,476	22,485	22,580	23,335	23,680	24,236
Total ReadyCare Clinic Visits	-	5,024	6,531	6,260	7,195	7,136
Total Surgical Procedures	3,300	3,121	2,825	2,814	2,872	2,871

TCHC TOP 10 PROBLEM LIST – 2018

Diagnosis	# Patients
Hypertension	1003
Anxiety/Depression	935
Overweight/obesity/morbidly obese	891
Diabetes	795
Hypercholesterolemia/Hyperlipidemia	654
Pain	590
Tobacco abuse	379
Gastroesophageal reflux disease without esophagitis	324
Hypothyroidism	305
Asthma	228

HEALTH CARE HOME/CARE COORDINATION

Tri-County Health Care incorporates health coaches to help deliver team-based care between the patient, the patient's family and the primary care provider. There are three Registered Nurses in the health coach department at Tri-County Health Care. The health coaches work with all of the care teams in the Wadena clinic to improve efficiency and communication between the provider, staff and patient. Patients with various physical and mental health conditions participate in the Health Care Home program. The focus of the health coaches has been working with patients to self-manage their congestive heart failure diagnosis, individual or group classes to aid in nicotine cessation, and those patients who frequently use the emergency department for non-emergent visits.

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 counties. The service is provided based on space availability and is open to the general public. All buses are wheelchair and handicap accessible.

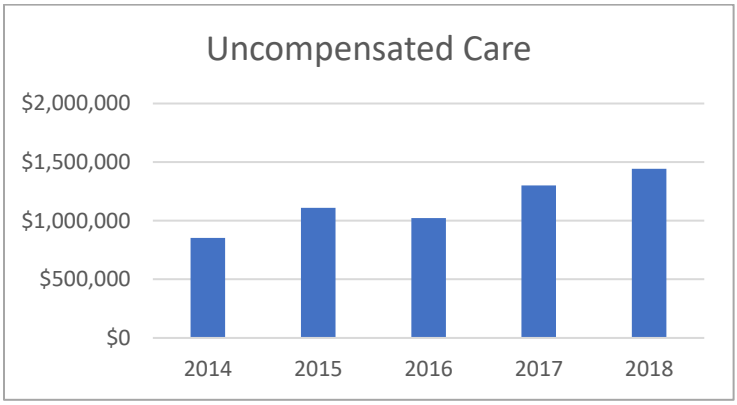
Tri-County Health Care realized the benefit Friendly Rider would have for our patients. TCHC offers complimentary tickets to patients who are coming and going from appointments. This has ensured patients have a safe way to travel for their medical care. In 2018, Tri-County Health Care provided 5,000 transportation tickets and 7,100 in 2017.

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 of 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. In addition, services were added to additional parts of our service area including Deer Creek, Bluffton and New York Mills in 2017.

UNCOMPENSATED CARE PROGRAM

Tri-County Health Care provides free or reduced rates for services for individuals with a financial need. Since 2014, the amount of uncompensated care that TCHC has provided in our service area has increased by 69 percent with consistent increases each year.



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). Our visits have increased steadily since launching this service in 2014, maxing out at more than 7,000 visits per year.

eCLINIC

In 2018. Tri-County Health Care added eClinic services to our patient offerings so patients can receive the care they need without always going to the Emergency Department when our clinics and ReadyCare are closed for services. This not only provides our patients with an easy way to receive care for minor illnesses 24/7, it allows our emergency department to be more readily available for the advanced care needs of our most urgent patients.

Our eClinic offers online diagnosis and treatment service for residents aged 2-75 by connecting them virtually with trusted providers. For a fee of $25, patients can be treated virtually for common health conditions including cold and flu, pink eye, allergies, heartburn, bladder infections and more. In the first year of launch, 122 patients have logged 163 visits into the system.

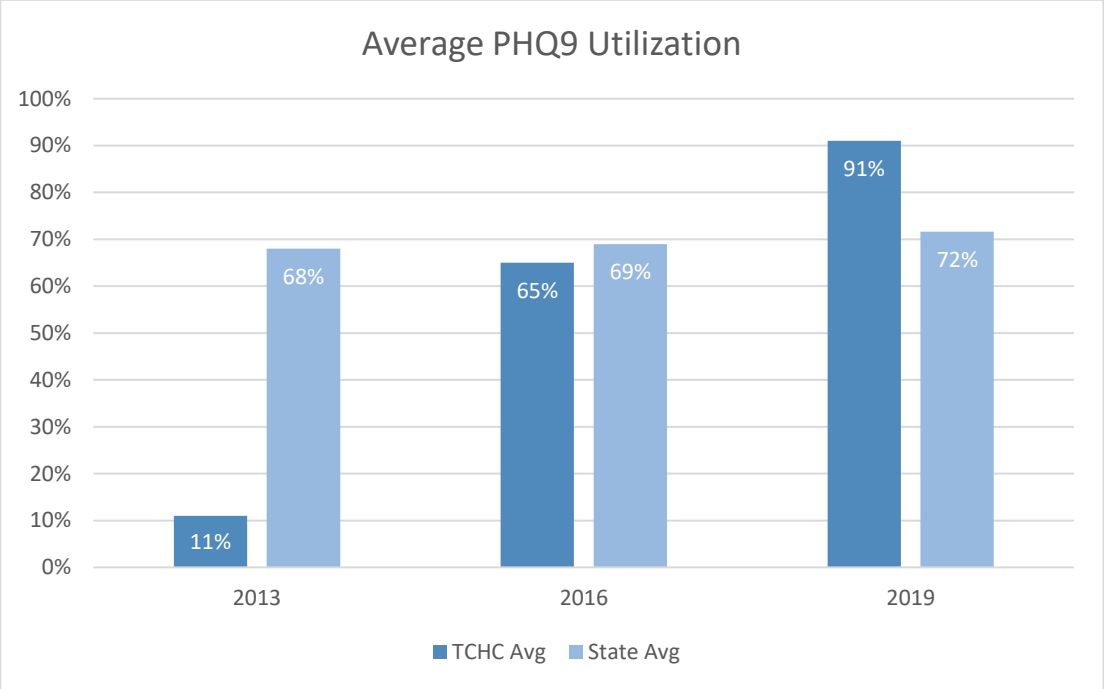
MENTAL HEALTH PROGRAM

Tri-County Health Care's psychiatry and therapy professionals provide services to those needing medication management, ongoing individual therapy and other psychiatric services. 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. 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 provide a full spectrum of care in meeting your ongoing health and wellness goals. Visits have increased over the past there years, showing the increased need in our area for mental health services.

	2016	2017	2018
Psychiatry Visits	3,176	3,324	3,752

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). Administration of the PHQ9 has been a focus for Tri-County Health Care as catching mental health issues earlier in the process can lead to prompt treatment. Utilization rates of the PHQ9 increased from 11 percent in 2013 to 65 percent in 2016 to an amazing 91 percent in 2018 and are exceeding state averages. This will continue to be a focal point for Tri-County Health Care in the future as we work to maintain and even continue to improve upon the great success we have found in the utilization of this tool.



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. Tri-County Health Care's screening for suicide is at 100 percent levels in 2016 and continued at 100 percent every year since then.

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, Tri-County Health Care'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 in conjunction with Wellness in the Woods 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. This collaboration includes using the Minnesota Hospital Association Roadmap for health care and law enforcement. A contractor has been hired by Tri-County Health Care in the summer of 2019 to evaluate our mental health offerings in comparison to demand in the region to offer recommendations on improving our current offerings.

OPIOID ADDICTION

In January 2018, Tri-County Health Care was awarded $39,213 through the Minnesota Rural Hospital Planning and Transition Grant Program to implement a case management program for opioid patients. Known as the Opioid Management Program, this project now launched with matching funds from TCHC, addresses opioid use for chronic non-cancer pain management and develop consistent standards of practice for opioid management for Tri-County's patients.

During the 12-month grant cycle, Tri-County created a system-wide, standardized opioid management process and implemented tools to assist patients in reducing opioid use. Tri-County established a dedicated registered nurse case manager for patients. The case manager meets with patients to develop an individualized plan of care that meets evidence-based practices, using the support of an interdisciplinary team to help patients achieve their goals.
The case manager works with providers to execute pain management care plans for patients, which will be critically important for patients with chronic pain.

Chronic Pain classes are being launched in 2019 to offer alternative approaches to ongoing uses of benzodiazepine medications to live with pain.

TRI-AQUATIC THERAPY

In December 2015, TCHC opened a warm-water aquatic therapy pool in the Maslowski Wellness and Research Center in Wadena. The next closest facility with a warm-water pool 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 and occupational 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 and occupational 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 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. In 2018, one of our Patient and Family Advisors asked for bars to be installed at the pool to aid in therapy sessions. This was completed in early 2019 and has been met with resounding support by our patients.

PATIENT AND FAMILY ADVISORY COUNCIL

In 2019, Tri-County's Patient and Family Advisory Council began meeting every other month. Tri-County Health Care believes that partnering with patients and their families is essential to improving hospital quality and safety. Our partners provide a voice that represents all patients and families who receive care at Tri-County Health Care. They partner with providers, nurses and administrators to give us feedback and ideas to help improve the quality of our care.

This 12-member panel is an engaged group that also serves on additional committees in the organization with plans to expand their roles to the Governing Board in 2020.

MY CHART

Improving communication between provider and patient has been a focus for Tri-County Health Care over the past two years. One major element to that has been the adoption of MyChart by our patients. Through marketing, education, and provider reinforcement, TCHC's usage of this valuable tool that provides access and tracking of medical records for our patients has improved. Our clinics range anywhere from 29 percent to 48 percent in activation of the MyChart tool.

FREEDOM FROM SMOKING PROGRAM

Tri-County Health Care began offering the Freedom From Smoking Program in the second quarter of 2019. The American Lung Association has researched and developed the Freedom From Smoking self-help manuals in 1980. It was redesigned and relaunched in 2016, making sure the program remained "America's gold standard in smoking cessation programs."

This program offers a systematic approach to quitting. There is a logical progression from awareness of smoking dependence to actual behavior change. This program has a positive focus, by emphasizing the benefits of better health and improved lifestyle habits as well as mastery of one's own life. The activities and assignments provide individuals who smoke with proven strategies for changing their behavior and lifestyle.

This class is offered every week at no charge to our participants. One-on-one sessions are offered at the clinics with an advanced practice provider and health coach for patients who are not comfortable to participate in a group environment. In the few months that this program has been offered, five individuals have been deemed as quitting smoking out of the 20 participants.

CURRENT TCHC COMMUNITY INITIATIVES

Classes	• Breastfeeding techniques and benefits, prenatal classes, Change Your Weighs, American Heart Association CPR and first aid, (CPR, first aid, etc.), Smoking Cessation, I can Prevent Diabetes
Digital Education	• YoMingo pregnancy app
February Festival of Health	• 75 exhibits from local agencies promoting health and wellness.
Healthy Times Newsletter	• Three times a year publication of success stories and educational information for all
Internships	• Medical and nursing students. • High school internship program • Rural Physician Associate Program (RPAP) rotation
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, Memory Loss , Adult Survivors of Suicide Support Groups, Change Your Weights and Parents Who Have Lost a Child support groups • Lactation consultation
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, Community Health Committee 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 Scholarships	• Provides 13 scholarships through our Foundation for students pursuing health care careers • Children of employee scholarships also available
Patient & Family Engagement	• Patient Family Advisory Council • Patients on marketing committee, Quality & Safety committee
Wellebrate	• Free health education programs, educational sessions on wellness, nutrition, sex and relationships
Community Donations	• $40,000 in donations to health and wellness related community initiatives to support the efforts of other organizations • Employee donations through fundraisers such as jeans days and pickle jars that are contributed to a variety of charitable organizations
Community Paramedics	• Blood pressure checks by community paramedics at Henning Assisted Living and the Meadows, Wadena Senior Citizen Center • EMS classes offered to individuals who want to become EMT's

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 13 sessions, with most recent session beginning in September 2019. Tri-County Health Care has trained six employees to serve the role of facilitator. Tri-County Health Care has made it a goal to offer these classes quarterly, alternating times of the classes to accommodate the working class as well as those who prefer daytime classes.

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. Providers at Tri County Health Care also recognize the importance of this program and refer patients often to the classes. Nearly 200 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. Average weight loss for all session offered at Tri County Health Care is about 8 percent, which is above the I CAN Prevent Diabetes program goal of 7 percent weight loss.

Some personal testimonials when asked what they are most proud of from the sessions include:

- Weight loss of 33 pounds during the year-long session. This individual was also able to walk a 5K without joint pain.
- "I attended almost every meeting and learned some new life practices that will always be with me."
- "I increased my activity to 150 minutes every week."
- "The most useful part of the class was making us accountable by keeping our food tracker."
- "I lost weight, feel great and people notice that I have more energy."
- "I increased my activity level, my steps used to be at 5000 a day, now at 6000-7000, some days 13000."
- "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.

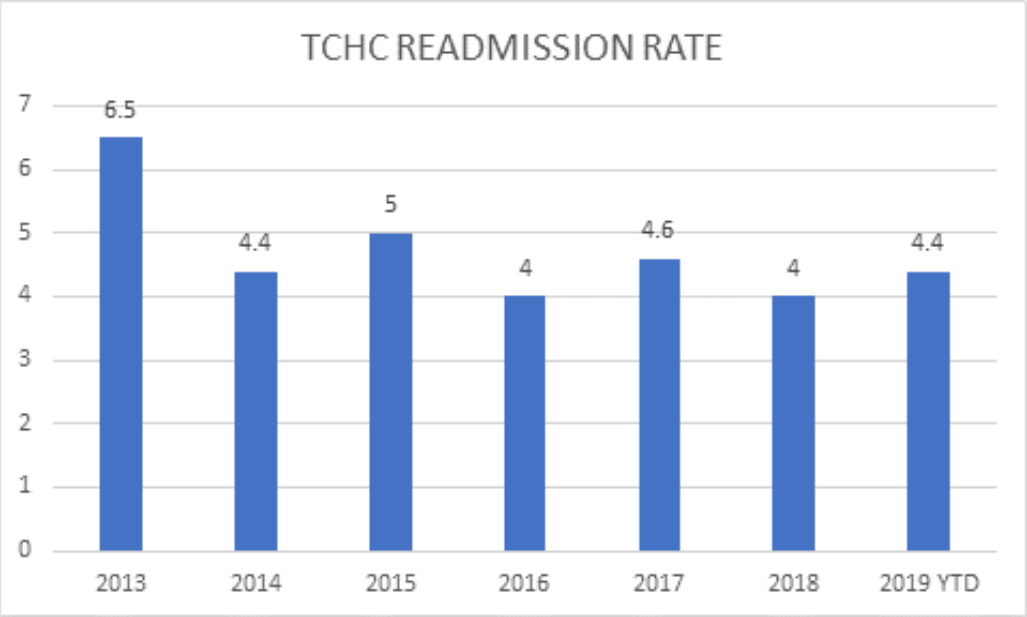
Nine out of 10 people with prediabetes do not know they have it. Prediabetes is when your blood sugar level is higher than normal but not high enough yet to be diagnosed as type 2 diabetes. Without weight loss and moderate physical activity, 15-30 percent of people with prediabetes will develop type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

EMS/COMMUNITY PARAMEDIC PROGRAM

Tri-County Hospital Emergency Medical Service is the largest advanced life support (ALS) provider of 9-1-1 service in Wadena and Todd counties, 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. 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. There are ten community paramedics providing 24/7 accessibility. These paramedics huddle every day to identify patients who may need a community

paramedic post-discharge visit. These visits vary from patient to patient but can include a medication reconciliation, home safety evaluation or wound check. The paramedics also participate on a committee who assesses charts of patients who frequently use the emergency department to identify healthcare concerns in an effort to reduce repeat visits to the emergency department. The paramedics also conduct monthly blood pressure checks at area senior centers and assisted living facilities.



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
- Patient interviews to identify potential risks
- Collaboration with the patient's primary care provider
- Referrals for Durable Medical Equipment
- Community referrals for additional support as needed

TCHC PREVENTATIVE HEALTH CARE

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, Tri-County Health Care 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 3-D 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, 3-D Mammography is the standard in breast cancer screening today, with Tri-County's Genius 3-D 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 is recommended that all women 40 years of age or older receive an annual mammogram.

With 3-D 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
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 3-D 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.

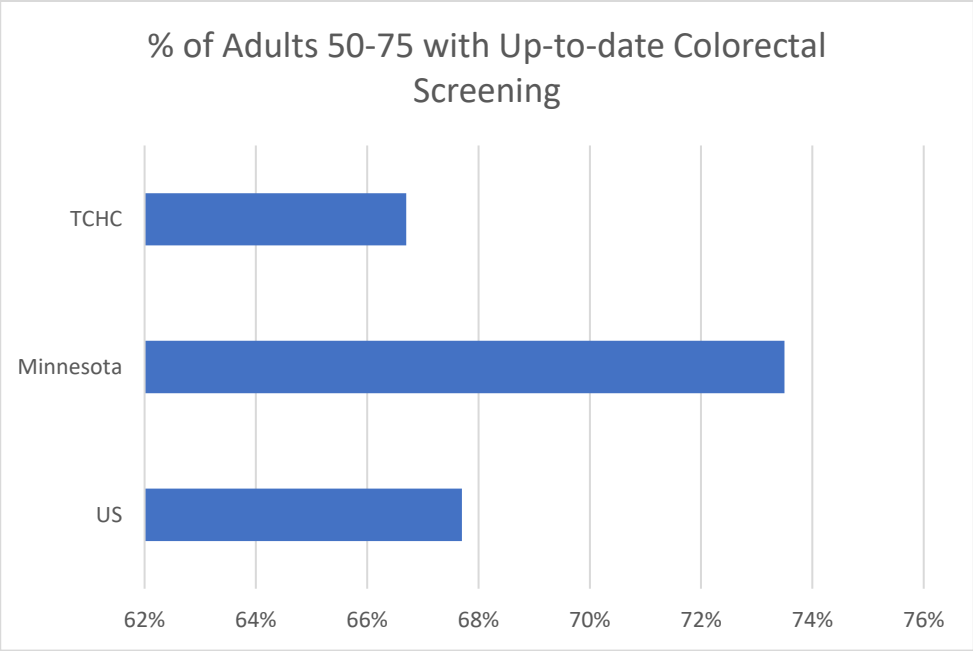
TCHC Metrics

In 2018, 4,500 women were diagnosed with invasive breast cancer in Minnesota (an increase of 400 women from 2012). Breast cancer is the most commonly diagnosed cancer for women, accounting for nearly one out of every three cancers. (Data source: Minnesota Cancer Facts and Figures 2018)

From July 1, 2018 through June 30, 2019, Tri-County Health Care screened 78 percent of our patients that are eligible for breast cancer screening. Efforts continue throughout the organization to continue to increase this metric which has shown a 5 percent improvement since 2016. The goal is to hit 81 percent by the end of 2019.

Colorectal Cancer Screening

While Tri-County Health Care still lags the state and national averages in percentage of adults that are current with their colorectal cancer screenings, the work that has been done over the past several years has moved our measurements in the right direction. Tri-County grew from 60% in 2016 to 67% at the end of June 2019. The greatest disparity in screening percentage comes from our non-Caucasian patients. While this represents only 2.5 percent of the total patients eligible for screening, there is a 27 percent point variance in those patients that are up-to-date.



In addition, in 2018, Tri-County Health Care expanded its colorectal cancer screening options to include Cologuard and in 2019 marketing efforts included emails, videos and social media posts to encourage our population to be screened.

Source: https://www.americashealthrankings.org/explore/annual/measure/colorectal_cancer_screening/state/MN

Prostate Cancer

Prostate cancer is the most common cancer diagnosed among men in Minnesota and in the U.S., regardless of race/ethnicity. In 2018, 2,920 men were diagnosed with prostate cancer in Minnesota. This is a decline from the 3,355 men that were diagnosed in 2012, showing an improving trend across the state.

Source: American Cancer Society Fats and Figures 2018

Wellness Initiatives

Tri-County launched a wellness initiative with Wellworks for its employees and their spouses in an effort to prove that preventive initiatives and wellness efforts can improve key metrics and benefit financial outcomes for an organization. This, coupled with our employee wellness programs coordinated throughout the year by our Wellness Committee, has had great impacts on the health of the organization.

The Wellworks program looks at annual biometrics tied to an annual physical with a provider in conjunction with an online health assessment course. If these are both completed by deadline, then a stipend is paid for both the employee and their spouse into the employee's HSA. In addition, a surcharge is being instituted for individuals that smoke and do not attempt a smoking cessation program. 325 out of the 862 eligible for the program (38 percent) participated in the wellness initiative.

From 2016 to 2018, the organization experienced a 27 percent increase in preventive office visits and a 28 percent reduction in ER utilization and a 39 percent reduction in inpatient days. Financially, there was a savings of $237 per employee per year when comparing 2018 to 2017 on total medical and prescriptions costs. With an average enrollment of 862 members, this equates to approximately $204,294 in savings from the prior year. This exceeds the increase in expense paid out for the increase in preventive visits. Being one of the largest employers in the county, initiatives that Tri-County Health Care undertakes for its employees have ramifications on county performance indicators.

Routine Checkups

In the last two years Tri-County Health Care has seen an increase in the percentage of patients that have completed a Medicare well-exam, a child well-exam or a physical. Changes were made in our electronic health record (EHR) to the classification of Medicare wellness-exams from physicals going into 2018, but even with that, increases were seen in total for patients in our care being proactive in the management of their health and well-being.

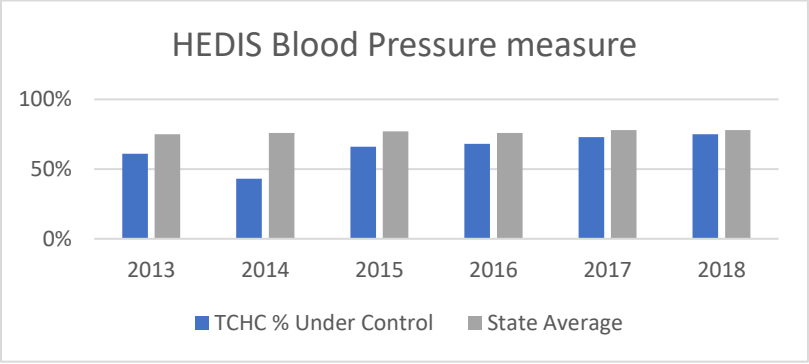
	2017	**2018**
Medicare Wellness	1.9%	18.27%
Well Child	10.9%	12.75%
Physicals	32.9%	20.5%
Combined Total	**45.7%**	**51.5%**

Changes were put in place in 2018 for the notification for preventive care. Letters to our patients have been combined to include colonoscopy and mammogram appointments into the same notification regarding a physical/wellness exam. This streamlines the communication and allows the patient to place all of those appointments in one call and to in some instances, have the colon cancer screening and mammogram done prior to meeting with their provider for their physical so the results can be discussed at once. In addition, the colon cancer screening appointments are now available in MyChart making it much more top of mind for our patients that they are due for this diagnostic service.

CHRONIC DISEASE MANAGEMENT

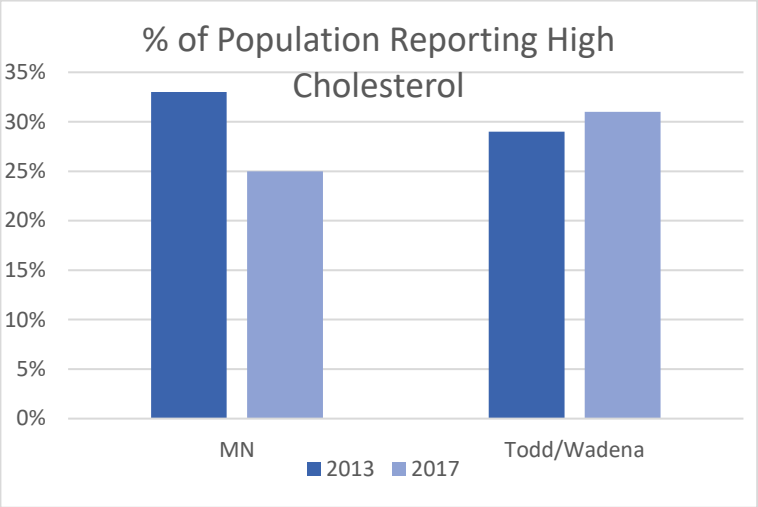
Hypertension

This graph represents the percentage of TCHC patients maintaining blood pressure compliance from 2013-18 compared to state averages. TCHC has made significant improvements in HEDIS blood pressure measurements from 2014 in comparison to the state, almost matching state averages by the end of 2018.



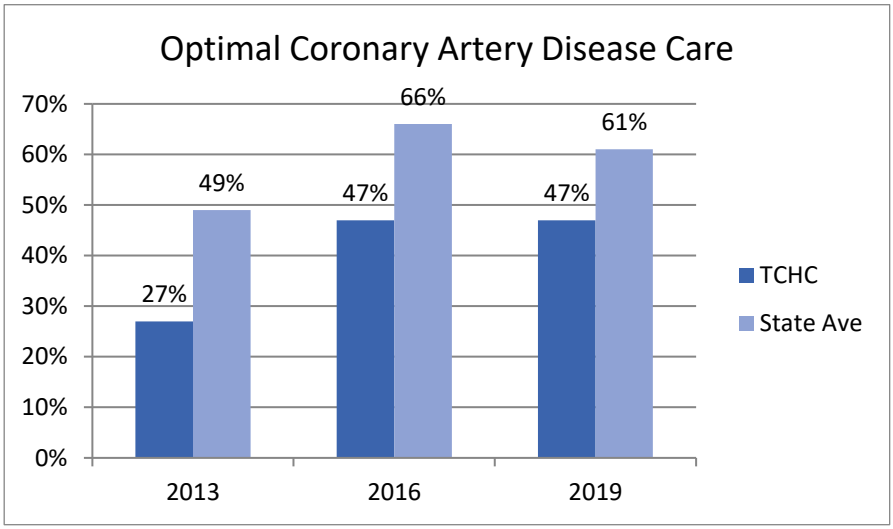
Cholesterol

The Minnesota Department of Health reports that the number of Minnesotans that have reported high cholesterol has dropped from 33 percent to 25 percent from 2013 to 2017. Survey respondents in Todd and Wadena Counties reported increases in high cholesterol from 2016 to 2019, increasing from 29 percent to 31 percent.



Data Source: Minnesota Department of Health, Quick Facts http: //www.health.state.mn.us/diseases/cardiovascular/cardio-dashboard/index.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.

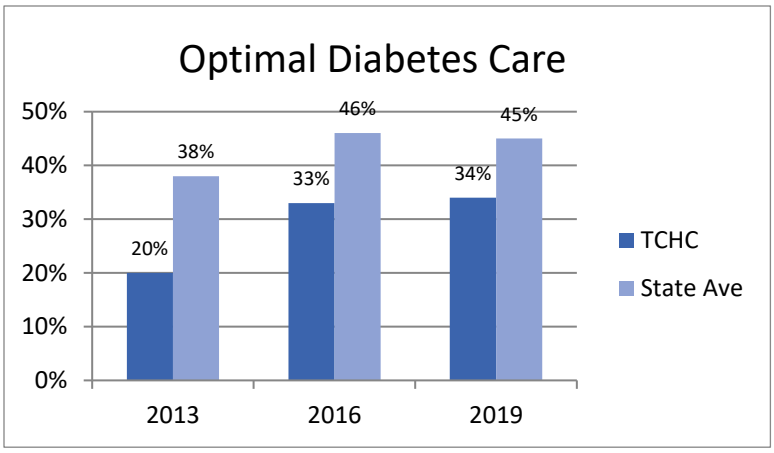


Diabetes

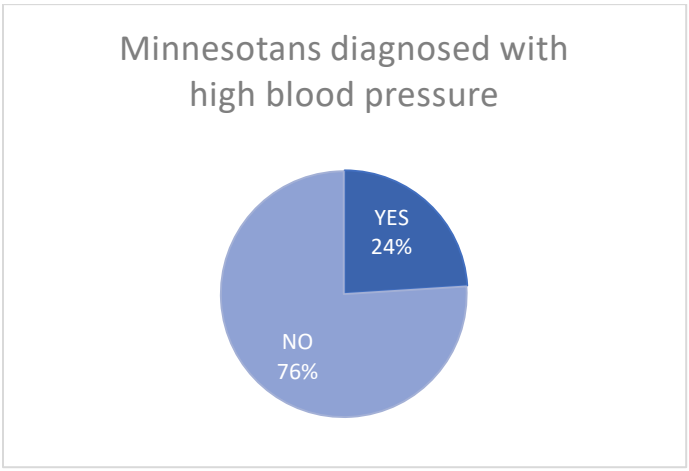
Optimal Care is achieved when a patient meets all five measures in the Minnesota Community Measurement Diabetic Measure set. These measures are; blood pressure, Hemoglobin A1C in good control, Tobacco free, Daily Aspirin if indicated and use of a Statin medication for high cholesterol.

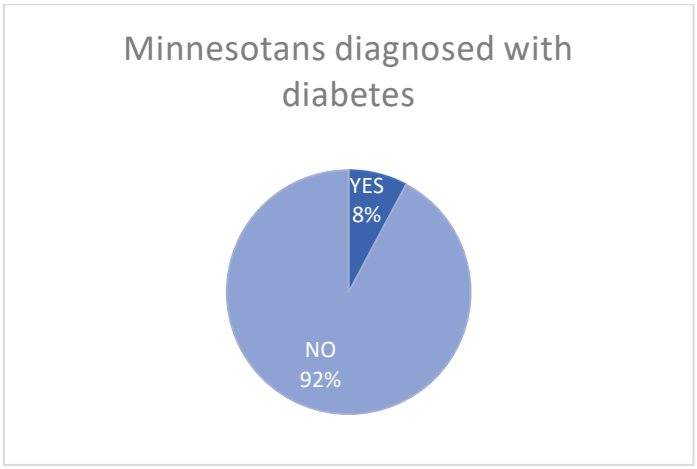
Tri-County Health Care made a 65 percent improvement from 2013 to 2016, whereas the state only made a 21 percent improvement. In addition, TCHC continued to increase into 2019 while the state has started to decline.

According to the Minnesota Department of Health, in 2017, 7.8 percent of Minnesota adults were diagnosed with diabetes (Type 1 or 2), and in 2017, 24.3 percent of Minnesota adults reported having high blood pressure.

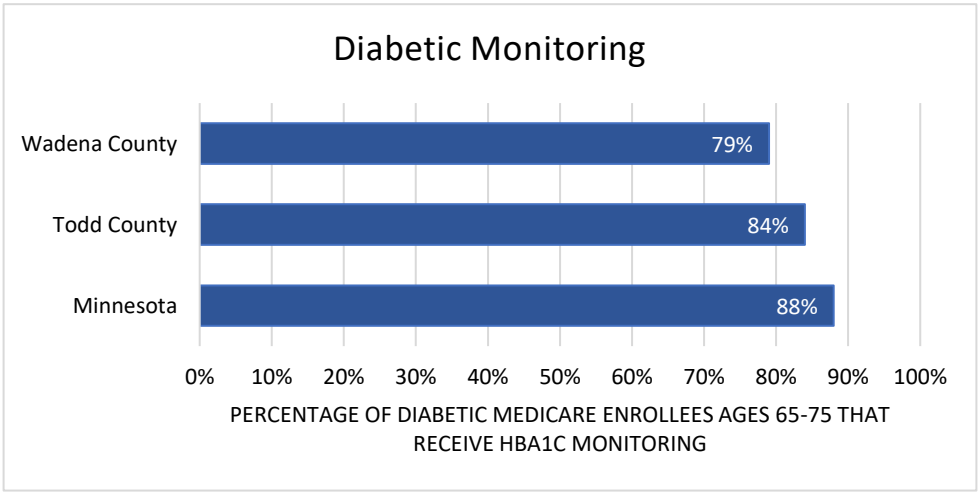


People who have diabetes are at a higher risk of serious health complications such as blindness, kidney failure, heart disease, stroke and loss of toes, feet or legs.





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
https://www.health.state.mn.us/diseases/diabetes/data/diabetesfacts.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, 2018.
http://www.countyhealthrankings.org/app/minnesota/2016/compare/snapshot?counties=27_159%2B27_153%2B27_111

CLINIC SCORECARD

All Clinics Combined

PILLAR	DOMAIN	90th %tile GOAL	2019 GOAL	2016 Roll up	2017 Roll up	2018 Roll Up	Q1 2019	Q2 2019
	OPTIMAL CARE	72.0	67.0	55	57.2	55.3	60	60.3
QUALITY	OPTIMAL DIABETES CARE	50.9	45.9	37	36.9	34	33.7	37.3
	OPTIMAL VASCULAR CARE	67.4	60.8	45	50.8	47.8	53.2	53.6
	OPTIMAL ASTHMA CARE Adults	78.1	67.5	55.5	42.1	43.8	42.5	49.2
	OPTIMAL ASTHMA CARE Children	61.2	52.3	60.4	43.4	37.9	39.5	49.7
	USE OF PHQ9	90	85	65	74	91	95	97
	DEPRESSION REMISSION 6 MO	8.9	6.8	3	2	4	6.9	9.2
	HYPERTENSION MEASURE	86.5	82.5	68	73	74	77.2	78.4
	PREVENTIVE CARE	82	77	64	65.8	67.9	69	70.1
	COLORECTAL CANCER SCREENING RATE	74	69	60	61.3	64.4	65.2	66.7
	BREAST CANCER SCREENING RATE	86	81	73	73.6	75	75.4	77.7
SERVICE	RECOMMEND the OFFICE	95	90	88.3	88.3	87.1	88.3	89.2
	RATE DOCTOR 9-10	90.4	84.6	80.2	81.1	79.6	80.5	82.1
	PHYSICIAN COMMUNICATION QUALITY	95.2	93	90.4	91.2	90.8	90.9	91.3
	OFFICE STAFF QUALITY	96.1	93.6	95.7	94.2	95.8	96.3	96.2
	ACCESS TO CARE/ TIMELY APPT	86.4	81.3	81	82.7	82.5	83.8	84
	BETWEEN VISIT COMMUNICATION	66.7	50.8	74.4	71.2	68.4	68.4	68.9
	CARE COORDINATION	82.4	74.6	78.7	78.5	77	76.8	76.8
	SHARED DECISION MAKING	83.9	77.2	77	77	77.5	78.6	79
	EDUCATION ABOUT MEDICATION	90.9	83.9	82	83.5	81	82.4	82.4
	ACCESS TO SPECIALISTS	68.2	55.6	58.7	57	57.2	54.7	53.1
	HEALTH PROMOTION EDUCATION	67.9	55.4	53	53	57.1	58.6	60
	STEWARDSHIP OF RESOURCES	31.8	20.6	16.6	19.4	18.7	20.3	20.3

	Positive varience =goal or >goal
	Neutral=<% below goal
	Negative varience=>-5%

Our Communities

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 95,839. The population of the primary service area of Tri-County Health Care is estimated at 38,184 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 below.

Ethnicity is primarily Caucasian (95.7 percent), other (0.8 percent), black (0.7 percent), American Indian (0.6 percent), Asian (0.4 percent) and two or more races (1.7 percent). The poverty rate for the Tri-County Health Care service area is at 13.7 percent (American Fact Finder: U.S. Census Bureau, 2018).

POPULATION STATISTICS

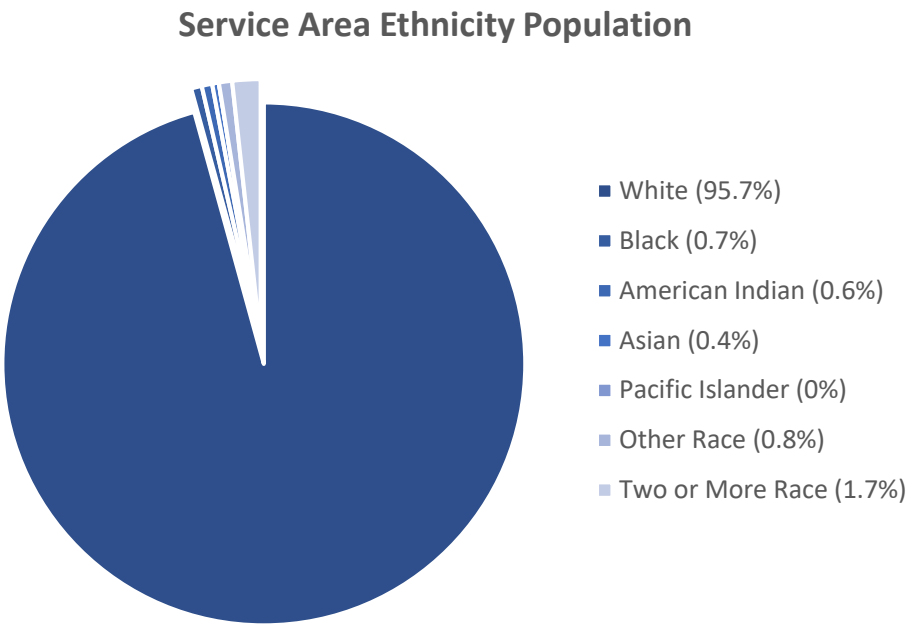
Children and youth make up 31.0 percent of the population; 47.9 percent are 18-64 years of age, and 21.0 percent are older than 65. The area has lower percentages of individuals between 18 and 64 than the state but has a higher percentage of individuals older than 65.

	Service Area	Minnesota
Under 5 Years	6.7%	6.4%
5-17 Years	24.3%	23.3%
18-64 Years	47.9%	54.9%
65 and Over	21.0%	15.4%

	Service Area	Minnesota
Total Households (2013-2017)	15,487	2,153,202
Persons Per Household (2013-2017)	2.39	2.49

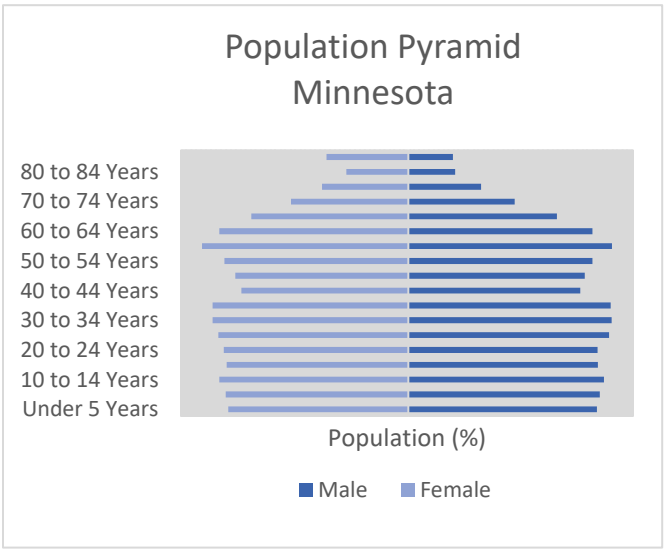
Data source: American Fact Finder, 2018. U.S. Census Bureau.

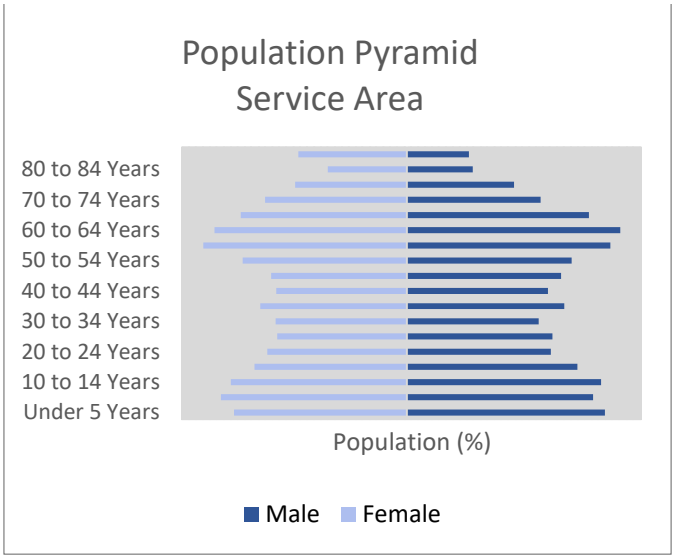
https://www.census.gov/quickfacts/table/PST045215/27,27153,27159



The Tri-County Health Care service area consists of primarily white/Caucasians at 95.7 percent with 4.3 percent minority. The state of Minnesota is also primarily white/Caucasians at 83.7 percent but has a greater minority population of 16.3 percent.

Data source: American Fact Finder, 2018 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 an older population than the rest of the state, which is typical of more rural population.

Median Age

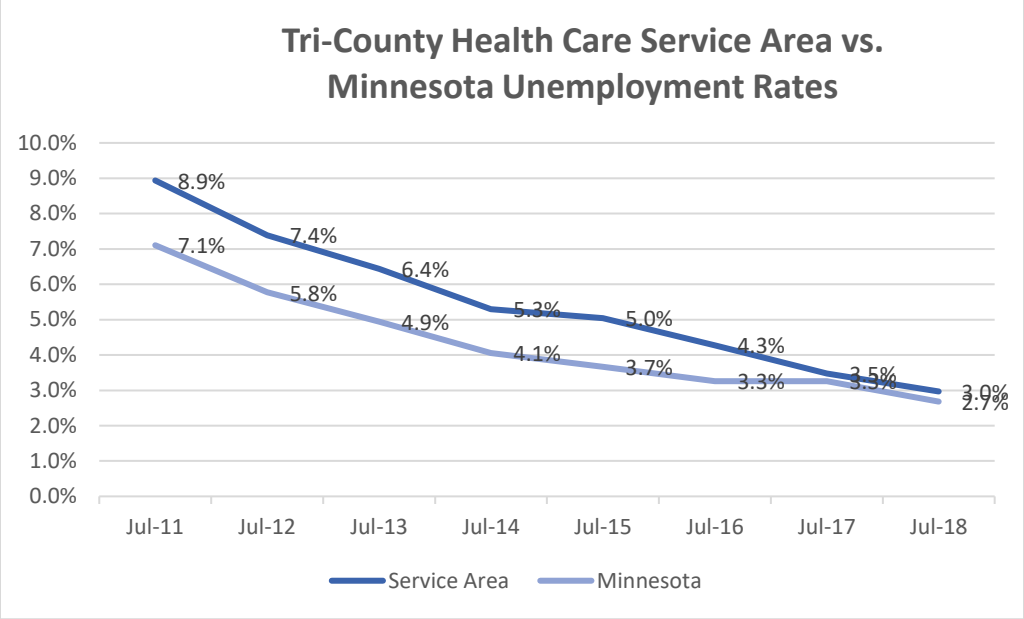
Todd County	43.7
Wadena County	41.7
State of Minnesota	37.9

Data source: American Fact Finder, 2018. U.S. Census Bureau. https://www.census.gov/quickfacts/table/PST045215/27,27153,27159

SOCIOECONOMIC FACTORS

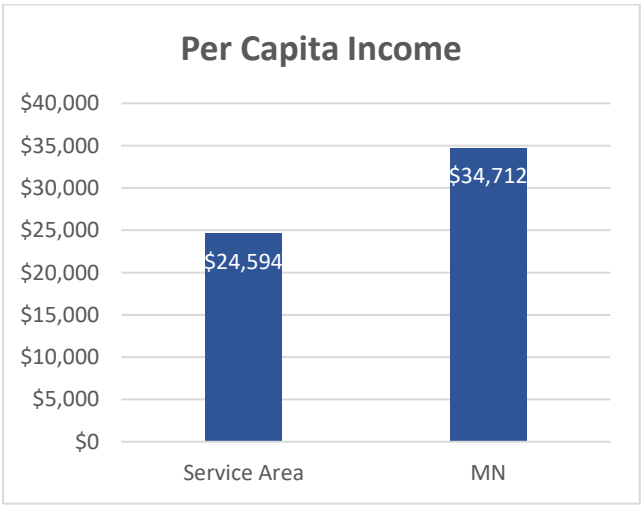
Unemployment Data

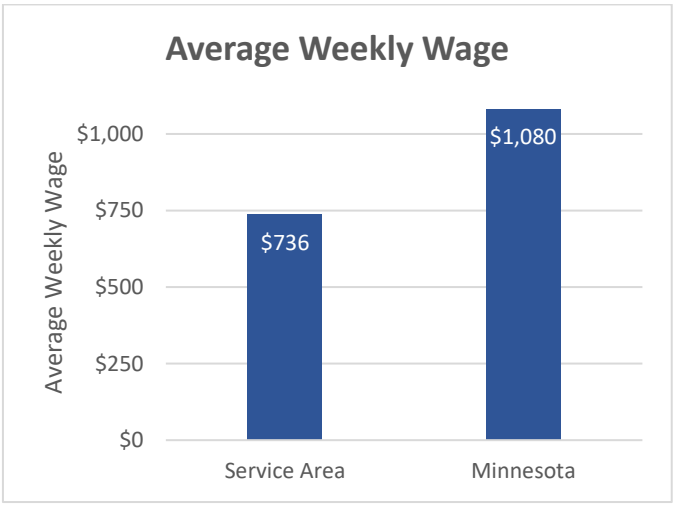
	Jul-11	Jul-12	Jul-13	Jul-14	Jul-15	Jul-16	Jul-17	Jul-18
Minnesota	7.1%	5.8%	4.9%	4.1%	3.7%	3.3%	3.3%	2.7%
Service Area	8.9%	7.4%	6.4%	5.3%	5.0%	4.3%	3.5%	3.0%



The Tri-County Health Care service area unemployment rate has been consistently higher than the state average though the last two years has been much more in line with state numbers.

Data source: Local Area Unemployment Statistics (LAUS) *Minnesota Department of Employment and Economic.* Retrieved May 13, 2019. 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 $1,080, whereas the Tri-County Health Care service area average weekly wage is $736.

Data Source: United State Census Bureau Quick Facts, 2013-2017. http://www.census.gov/quickfacts/table/INC910214/27,27159
Annual 2017 Average Weekly Income. Regional Labor Market Information. (n.d.). Minnesota Department of Employment and Economic Development. Retrieved April 9, 2019. https://apps.deed.state.mn.us/lmi/rws/

POVERTY

Percentages of All Ages Living in Poverty

	2009	2010	2011	2012	2013	2014	2015	2016	2017
Minnesota	10.9%	11.5%	11.8%	11.4%	11.5%	11.5%	11.3%	10.8%	10.5%
Service Area	15.2%	16.9%	17.2%	15.8%	16.1%	16.5%	15.3%	14.2%	13.7%

Percentages of People Younger than 18 Living in Poverty

	2009	2010	2011	2012	2013	2014	2015	2016	2017
Minnesota	13.9%	15.0%	15.3%	14.6%	14.7%	14.8%	14.5%	13.9%	13.4%
Service Area	21.8%	24.9%	24.9%	22.7%	24.4%	24.4%	24.3%	24.3%	24.1%

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 though the last two years have shown a narrower gap between the state and service area numbers, with a two percentage point drop in poverty in our service area over the past nine years.

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	2015	2016	2017	2018	2019
Minnesota	35.6%	36.7%	37.3%	38.3%	38.3%	38.4%	38.1%	37.6%	37.1%	36.4%
Service Area	58.9%	57.4%	56.9%	55.9%	56.2%	54.9%	53.7%	52.9%	52.9%	52.0%

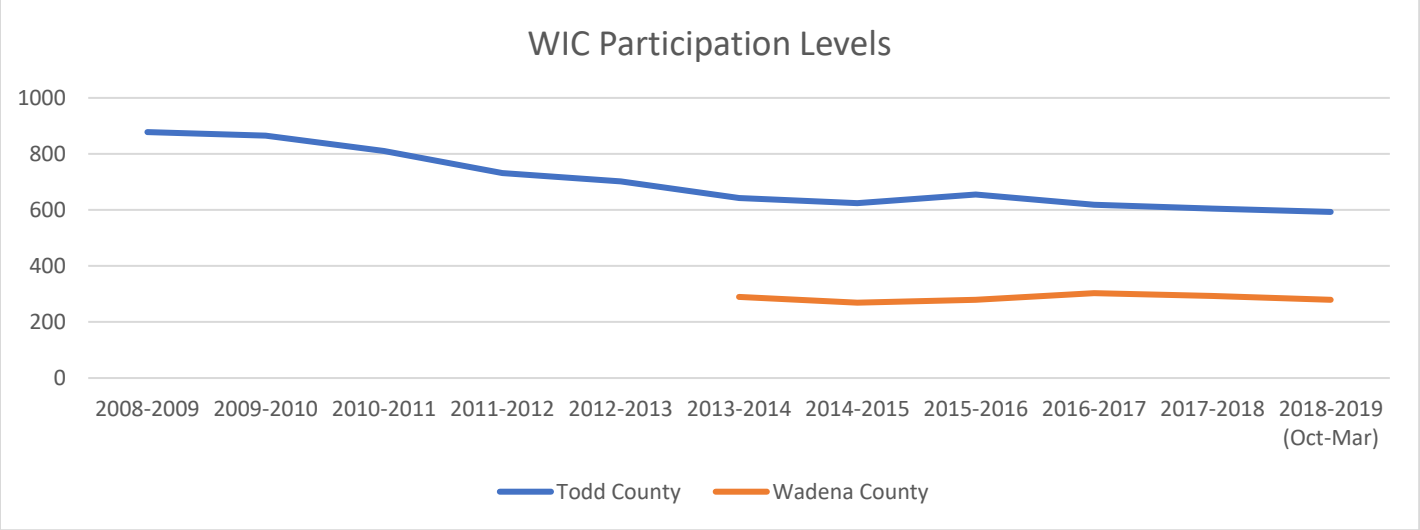
Free and reduced lunch prevalence is an indicator of the socioeconomic status of the student population within a school district. The Tri-County Health Care service area has had a significantly higher rate of students receiving free and reduced lunches compared to the state of Minnesota, though it has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

Mothers and Children Receiving WIC (Special Supplemental Nutrition Program)

	2015	2016	2017	2018	2019
Minnesota	121,755	119,403	116,031	111,121	105,961
Service Area	933	893	934	922	898

These numbers are defined by the total number of pregnant, post-partum and nursing women, infants and children less than 5 years of age who received WIC vouchers. DOES NOT INCLUDE OTTER TAIL COUNTY.

https://www.fns.usda.gov/pd/wic-program

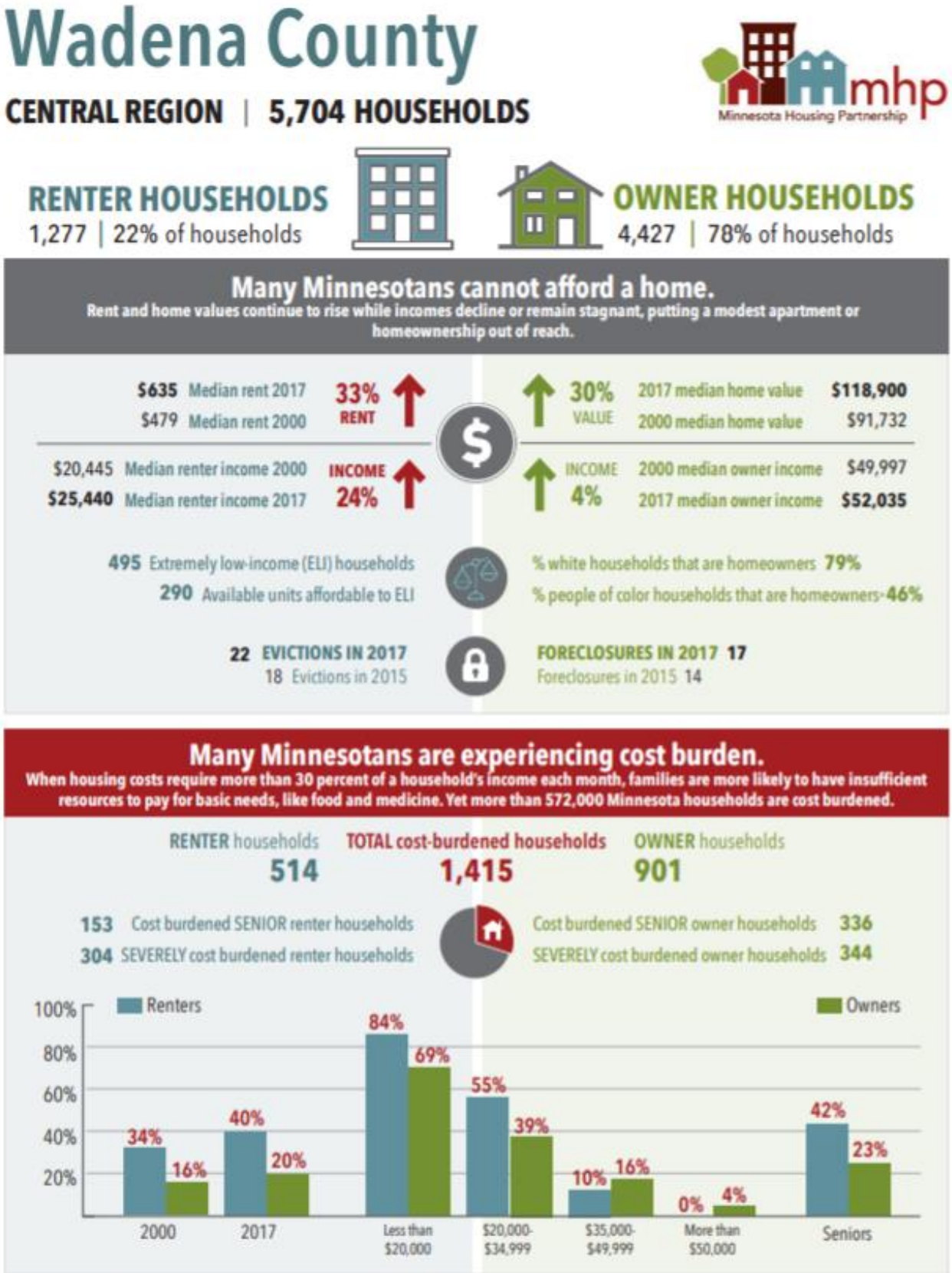


Food stamps are utilized by some of the most vulnerable within a population (children, elderly, single parent families, etc.) and helps ensure better nutrition for those who can't afford healthy food. The food stamp utilization in our service area is higher than the state average but has declined more rapidly than across the state over the past several years.

	2015	2016	2017
Minnesota	8.9%	8.9%	8.6%
Service Area	11.3%	10.8%	9.9%

HOUSING

Housing Costs



In-demand jobs don't cover housing costs.

The median earnings for most of the top in-demand and high-growth jobs throughout Minnesota do not cover housing costs for a two-bedroom apartment or the mortgage for a median-value home.

WAGES & HOUSING AFFORDABILITY IN WADENA COUNTY

Hours per week minimum wage employee must work to afford 1-bedroom apartment **44**

% of employees who live in county of workplace **66%**

New job growth in the Central Planning Area by 2026 **26,629**

Our housing stock won't meet the needs of a growing Minnesota.

Housing production is not keeping up with demand, undermining the economic development and prosperity of many communities, and worsening housing disparities for seniors and households of color.

-187	Total population growth by 2035	Total senior population by 2035	3,519
85%	Growth in # of people of color (POCI)*	Growth in # of seniors by 2035	17%
11%	POCI % of overall population in 2035	Senior % of overall population in 2035	26%
33%	% rental units built before 1960	% single family homes built before 1960	34%
0	Multi-family units permitted in 2017	Single-family units permitted in 2017	18
0	Multi-family units permitted in 2015	Single-family units permitted in 2015	28

SOURCES – Renter households: *Rent and income adjusted for inflation.* U.S. Census Bureau, American Community Survey 2017, 5 year estimates | **Owner households:** Home value and income adjusted for inflation. U.S. Census Bureau, American Community Survey 2017, 5 year estimates | **Cost burden:** U.S. Census Bureau, American Community Survey 2017, 5 year estimates | **Evictions:** Minnesota State Court Administrator, Monthly Unlawful Detainers by County | **Foreclosures:** Minnesota Homeownership Center, County Sheriff's Data 2017 | **ELI Units and Renters:** MHP Analysis of HUD's CHAS Portal Data using the NLIHC methodology | **Wages:** Minnesota Department of Employment and Economic Development (MN DEED), Occupations in Demand, July 2017; Employment Outlook, MN DEED | **Housing Stock:** U.S. Census Bureau, American Community Survey 2017, 5 year estimates, U.S. Census Bureau, Building Permits Survey, 2018 | **Seniors / Population growth:** Minnesota County Population Projections by Age and Gender, Minnesota State Demographic Center, March 2017 |
*Homeownership rates and growth estimates for POCI are regional

Homelessness

Central Minnesota saw a bigger jump in homelessness than the rest of the state between 2015 and 2018, according to a new report.

Wilder Research's 2018 report found 944 people experiencing homelessness in Central Minnesota, nearly a 20 percent increase from the 787 homeless people counted in 2015.

Statewide, outreach workers found 10,233 homeless people — almost a 10 percent jump from the 2015 count of 9,312. Older adults, age 55 and up, experienced the largest increase — a 25 percent jump from 2015.

Wilder Research does a single-day count of homeless people throughout the state once every three years.

Homelessness
Central Minnesota

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

	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	53	69	207	292	1517	1734	597	193	2852	7461
Not in Shelters	35	35	123	137	952	712	193	94	413	2694
Total	88	104	330	429	2469	2446	790	287	3265	10155

Data Source: Wilder Research, 2018 Minnesota Homeless Survey
http://mnhomeless.org/minnesota-homeless-study/detailed-data-counts/2018/Statewide-2018-Homeless-Counts_3-19.pdf?v=2

Rent Affordability

In Minnesota, working full-time (or more) doesn't mean you'll have enough to pay rent. According to a new report from Minnesota Housing Partnership, the gap between wages and rent is growing.

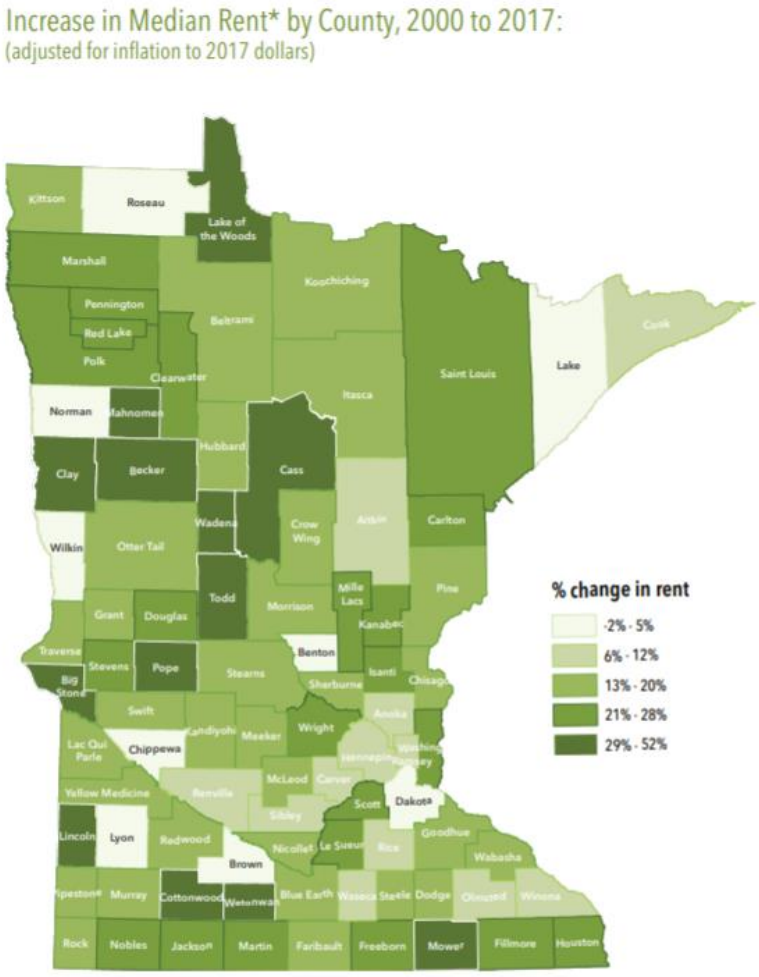
Building on an annual report from the National Low Income Housing Coalition, MHP's Out of Reach Minnesota 2019 reveals that Minnesota's housing wage — the wage necessary to afford a two-bedroom apartment — has jumped by 9 percent over the past decade alone. Meanwhile, as housing costs have climbed, median renter income declined by 5 percent from 2000 to 2017, with disproportionately severe impacts on communities of color.

From personal care aides and cashiers to restaurant cooks and nursing assistants, top in-demand jobs don't pay enough to afford a modest two-bedroom apartment. Minimum wage earners can't afford to rent a modest one-bedroom apartment in any Minnesota county. And people earning median wages can't afford to rent a modest two-bedroom apartment in almost half of Minnesota counties.

Todd and Wadena Counties are two of the counties in Minnesota that have experienced the most significant increases in median rent levels from 2000 to 2017. Escalating an issue where shortage of available affordable rental space is an issue.

County	Rank in State for Increase in Gross Median Rent	% Change in Rent	Median Gross Rent
Wadena County	4	33%	$635
Todd County	12	28%	$630

In Wadena County, 24 percent of renters pay more than half of their income in rent each month, ranking the county 11th in the state for this metric.



Home Values

The median home value in Wadena County is $105,100. Wadena County home values have gone up 4.8 percent over the past year. The median list price per square foot in Wadena County is $111, which is lower than the Minnesota average of $189. The median home value in Todd County is $126,900. Todd County home values have gone up 11.5 percent over the past year, and Zillow predicts they will rise 3.8 percent within the next year. The median list price per square foot in Todd County is $125, which is lower than the Minnesota average of $189. It is estimated that 21.9 percent of houses in Wadena County and 15.6 percent of houses in Todd County have a negative equity versus the nationwide average of 8.2 percent. (source: Zillow)

EDUCATION

K-12 Public School Enrollment

Education enrollment numbers have declined in our service area by almost 13 percent while the numbers across the state have seen an increase of more than 15 percent. Stagnant and declining population in the region are resulting in lower attendance rates at our local schools.

	2013	2014	2015	2016	2017
Minnesota	829,896	831,560	836,112	836,988	842,909
Service Area	6,642	5,884	6,008	6,020	5,804

In addition, as one would expect in a lower income region, the graduation rates in the region are lower than state averages as are the percentages of adults with a bachelor's degree or higher. According to the County Health Rankings however, Wadena County outperforms the state and Todd County for high school graduation rates that are reported by the schools.

High school graduation or higher, percent of adults 25 years +
State of MN – 92.8%
Todd County – 87.0%
Wadena County – 89.4%

Bachelor's Degree or higher, percent of adults 25 years +
State of MN – 34.8%
Todd County – 14.5%
Wadena County – 12.9%

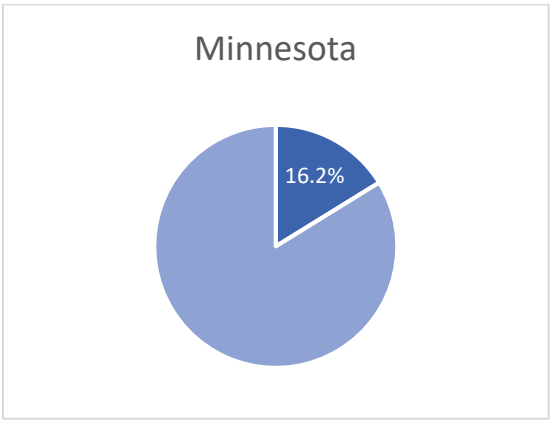
Source: Census.gov/quickfacts/MN

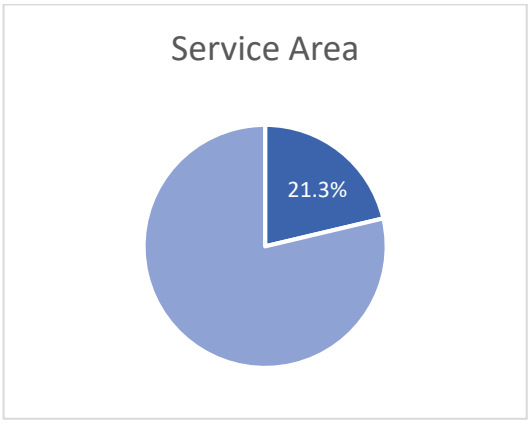
High School graduation rates
MN – 83%
Todd County – 80%
Wadena County – 87%

Source: countyhealthrankings.org/ app/minnesota/2018/measure/factors/21/map

K-12 Special Ed Enrollment

Our service area has 30 percent more students enrolled in special education programs than the state average.





DAYCARE

Communities across Minnesota report a shortage of available childcare options. This shortage is due, in part, to the decrease in licensed childcare capacity in Greater Minnesota and a state-wide decline in family childcare providers. The number of licensed family childcare providers has decreased approximately 3 percent per year on average, or almost 30 percent since 2005. According to Minneapolis-based First Children's Finance, a nonprofit that provides funding, business financing, training and other support for providers, Central Minnesota has a deficit of 14,332 childcare slots. Issues such as tightened political regulations and low pay wages have made it difficult for family childcare providers to open and expand.

First Children's Finance constructed a gap analysis summary of Wadena Area Child Care Supply in August 2017. This analysis shows severe shortages of day care across the region often making it difficult for a single parent or a second parent in a married home to obtain employment. Couple this with the high poverty rates in the region and this is a barrier to helping families get out of poverty in our region.

Zip Code	City	Supply/Demand Variance
56453	Hewitt	-20
56464	Menahga	-131
56477	Sebeka	-71
56481	Verndale	-64
56482	Wadena	-61
56567	New York Mills	-156
		-503

HEALTH BEHAVIORS

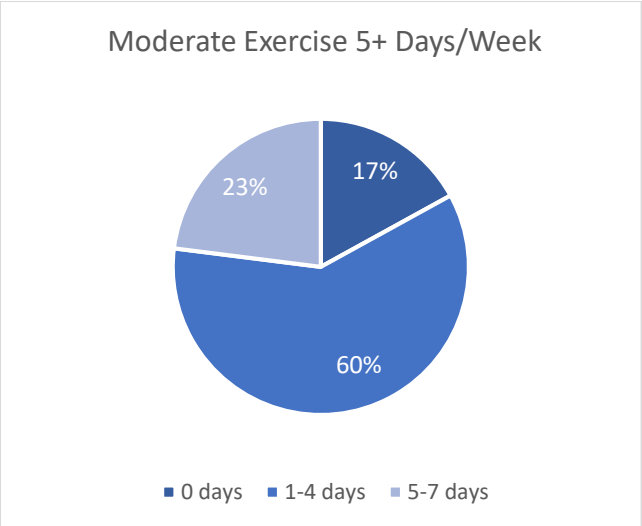
Health Outcomes

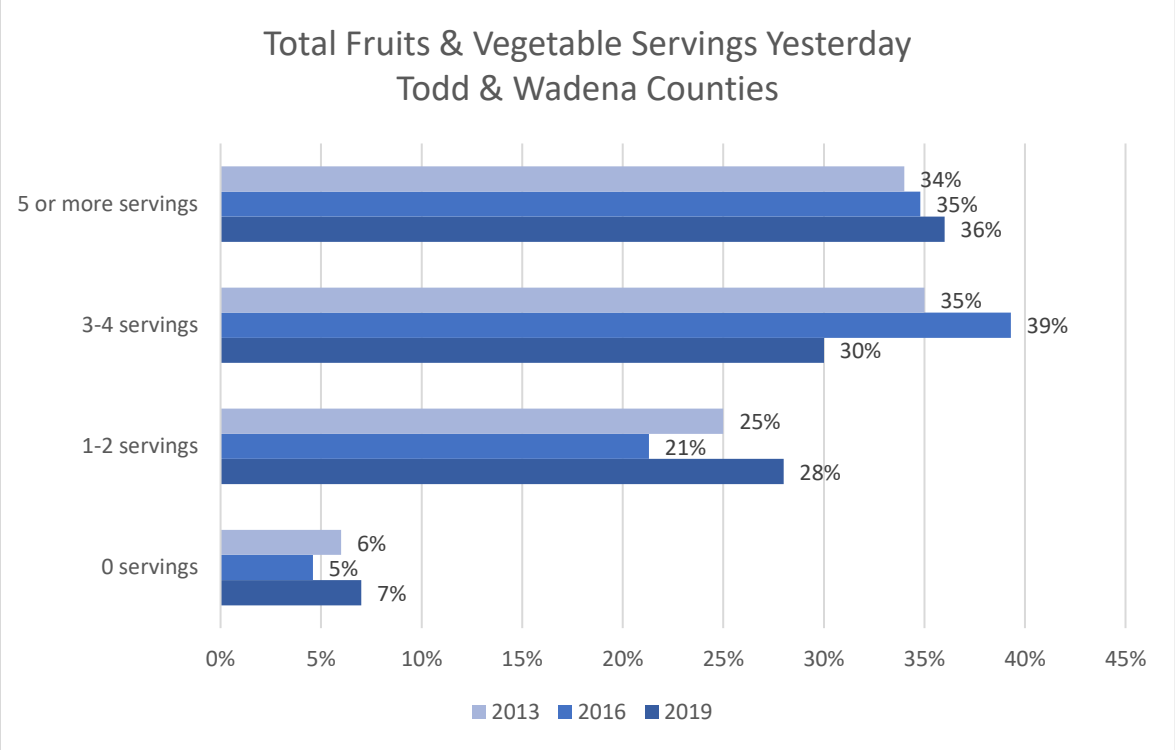
Wadena County ranks 83 out of 87 counties in Minnesota for overall health. Todd outranks Wadena County, but this is attributed more to their high quality of life rankings as Todd County drags behind Wadena County in Health Behavior ranks and key metrics. Overall, both counties have higher-than-state averages in smoking, obesity, teen births and alcohol impaired driving. Interestingly, both counties are lower than the state for excessive drinking. Both counties also have lower than state averages for access to exercise opportunities. Wadena performs stronger given the Maslowski Wellness and Research Center that exists in the county and provides ample opportunity for exercise for its residents.

Health Behavior	Wadena County	Todd County	Minnesota
Health Outcome Rank	83 / 87	38 /87	
Quality of Life	81 / 87	45 / 87	
Health Behavior Rank	52 / 87	79 / 87	
Adult Smoking	16%	16%	15%
Adult Obesity	29%	33%	27%
Food environment Index	7.4	7.9	8.9
Access to exercise opportunities	79%	43%	88%
Excessive Drinking	19%	22%	23%
Alcohol impaired driving deaths	40%	53%	30%
Sexually Transmitted Diseases	94.4	164.9	389.3
Teen births	34	27	17

Source: https://www.countyhealthrankings.org/app/minnesota/2019/rankings/outcomes/overall

Diet and Exercise

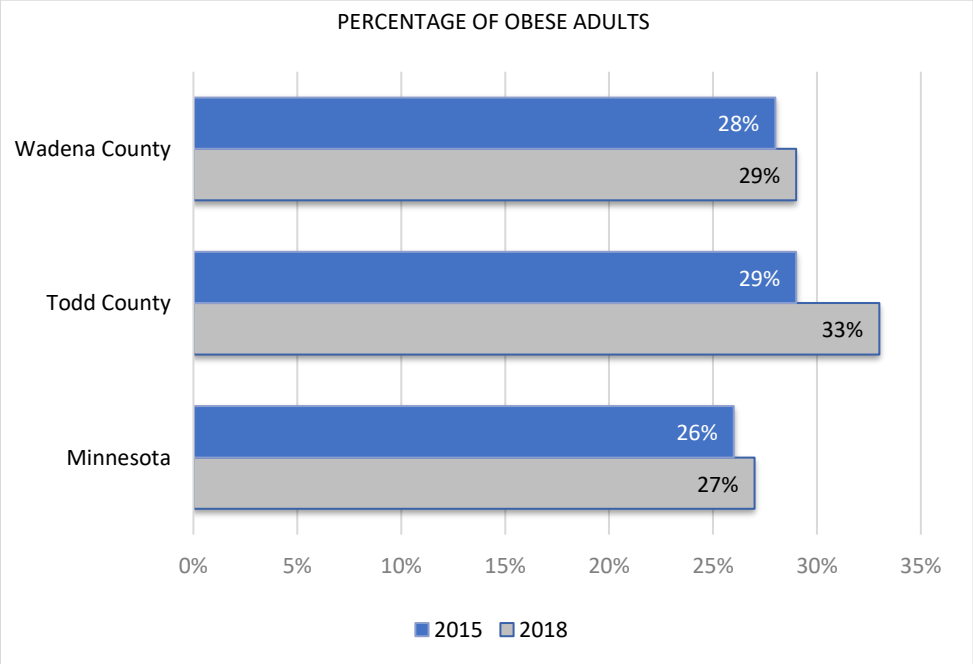




There has been slight increase in fruit and vegetable serving consumption as displayed in the graph above. Almost half of the adults in our service area are not getting any vigorous exercise in a given week.

Data source: Minnesota Department of Health: County Health Tables.
http://www.health.state.mn.us/divs/chs/countytables/profiles2015/index.html

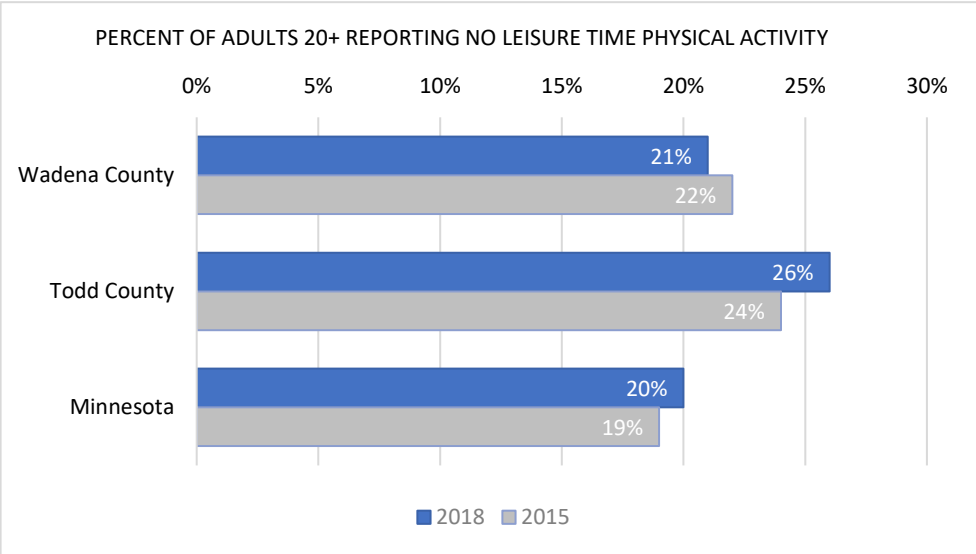
Adult Obesity Prevalence



The prevalence of adult obesity is higher in the Tri-County Health Care service area compared to the state of Minnesota and has increased in the past three years.

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, 2018
http://www.countyhealthrankings.org/app/minnesota/2018/compare/snapshot?counties=27_159%2B27_153%2B27_111

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.

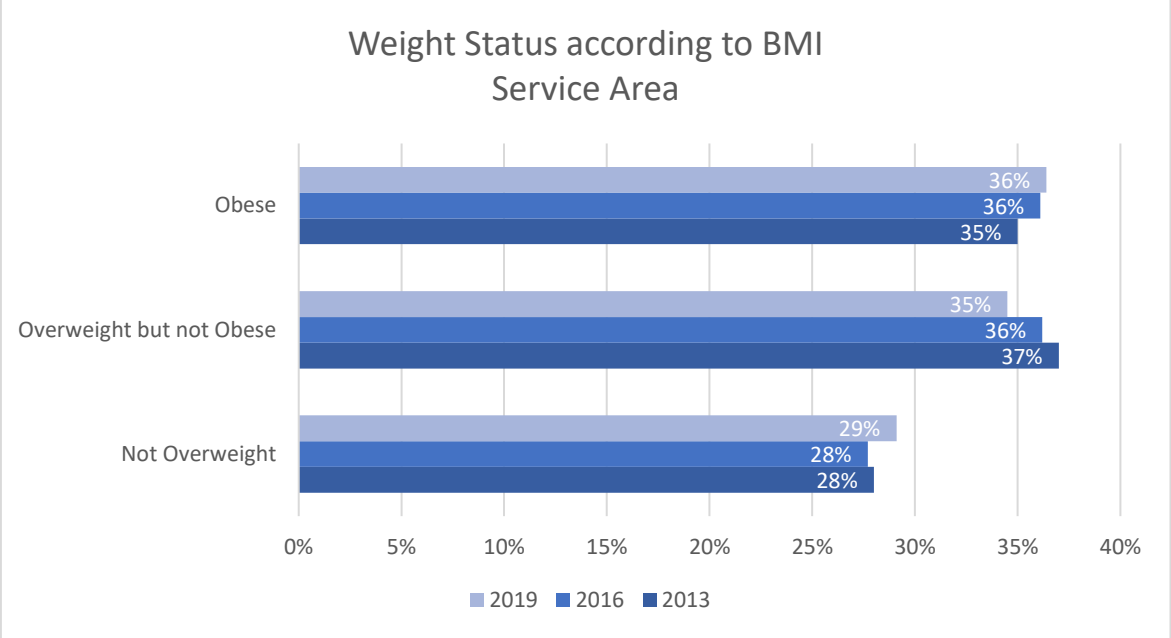
People who have obesity, compared to those with normal or healthy weight, are at increased risk for:

- 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, 27 percent of Minnesotans are obese and 29-33 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 and the numbers haven't changed much in the past six years.

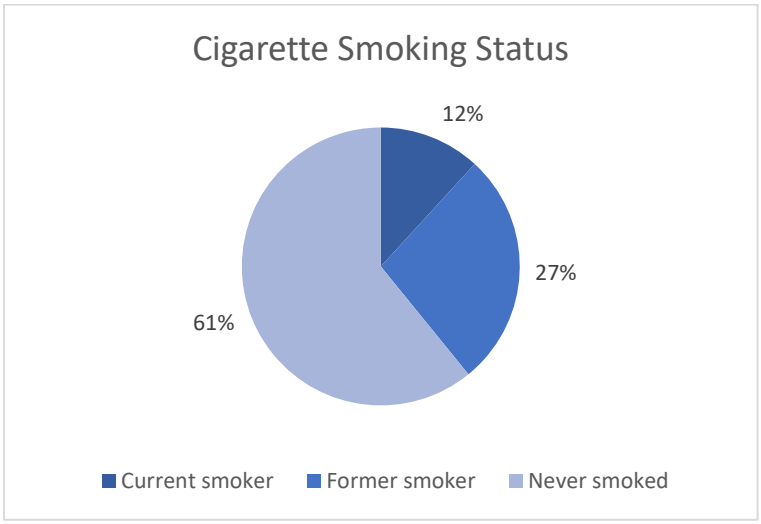
Data source: County Health Rankings and Roadmaps: A Healthier Nation County by County, 2019

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



Smoking

Based on the results from our Community Health Needs Assessment, the percentage of adults that currently smoke is below state averages. This is the opposite of what was shown in our 2016 report. In 2019, 10 percent of those who reported to be current or former cigarette smokers responded that they currently utilize e-cigarettes or vape products, which could be driving down the level of those who consider themselves smokers when they self-report.



Efforts to increase the age able to purchase tobacco has increased in recent years across the state of Minnesota. Our neighboring county, Ottertail County, was the first county in Minnesota to pass the T21 initiatives effectively raising the age of tobacco purchase. Tri-County Health Care has started a tobacco surcharge for our employees and their spouses that engage in this unhealthy behavior and are encouraging tobacco cessation initiatives for these individuals.

Incident Rates of Asthma Hospitalizations, Cancer and COPD Hospitalizations per 100,000

	Asthma Hospitalizations	Cancer	COPD Hospitalizations
Minnesota	5.6	457.3	16.3
Todd County	2.2	412.8	16.7
Wadena County	8.0	481.9	38.1

Asthma hospitalizations and chronic obstructive 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 2013-2015.

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 2013-2015 specified.

Data Source: Minnesota Public Health Data Access, 2015. https://apps.health.state.mn.us/mndata/

Mental Health

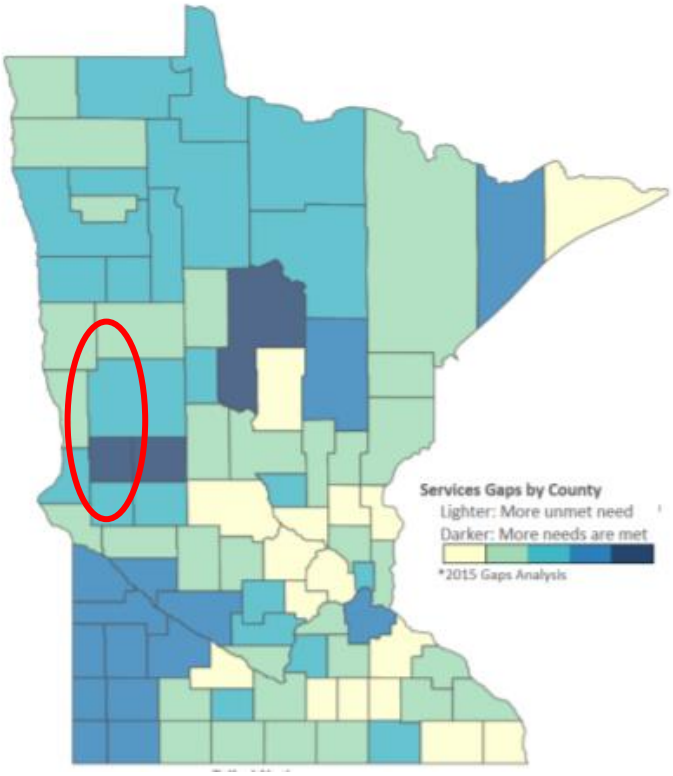
According to the MN Dept of Health, one in five Minnesotans face mental illness each year. In addition:

- One in 25 people live with serious illness, such as schizophrenia, bipolar disorder or major depression
- One in 10 young people experienced a period of major depression
- 10-25 years shorter lifespan for people with serious mental illness

Nearly two-thirds of Minnesota's homeless population has a mental illness, according to a new study from the Wilder Foundation. The results are based on a survey of nearly 4,300 people experiencing homelessness. With the growing number of homeless in Central Minnesota that was previously outlined in this report, this correlation emphasizes the need to focus on mental health in our region.

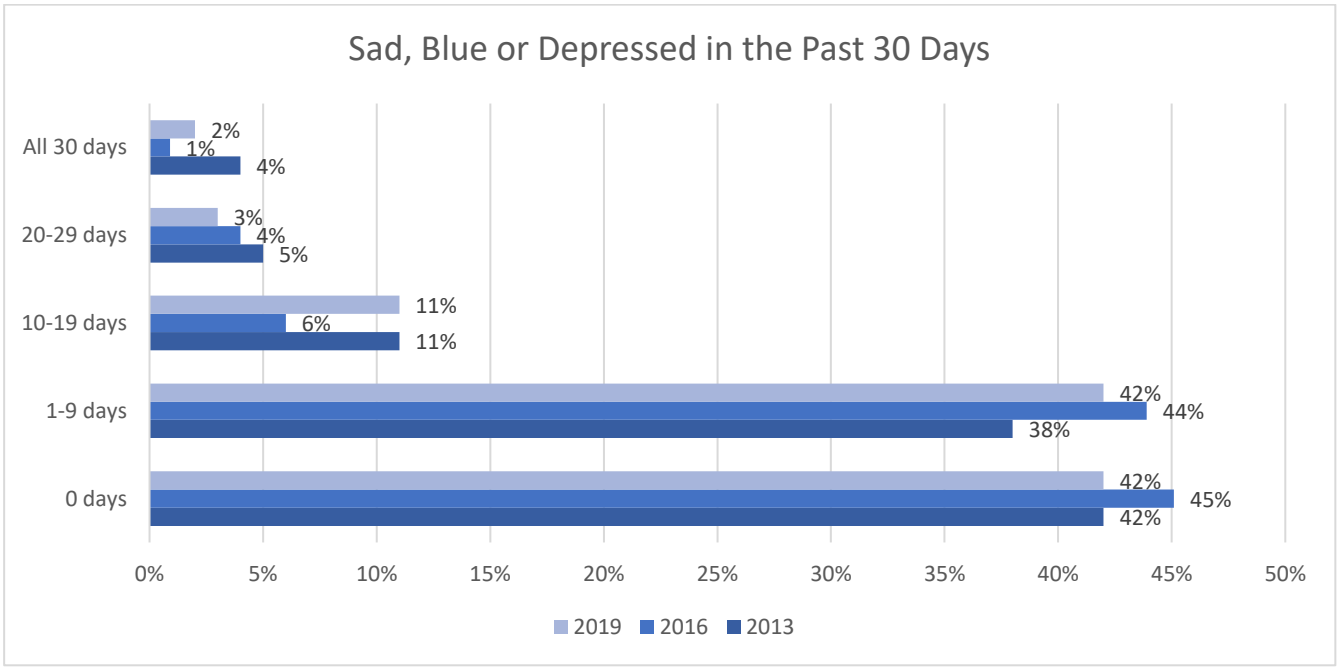
These numbers hold true with our service area, as 20 percent of the CHNA survey respondents report having anxiety or panic attacks. In addition, 20 percent report diagnosis of depression and another 6% report other mental health problems. A total of 27 percent report any mental health problems.

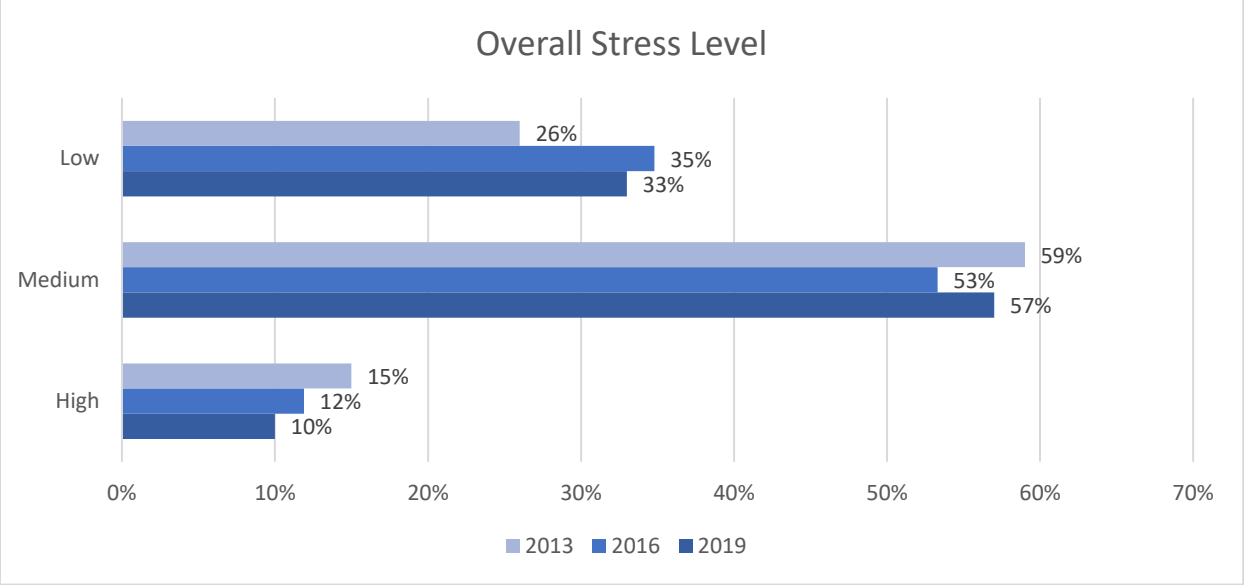
While much progress has been made in the past few years, most areas of the state still do not have the range of services needed. As a result, people often travel long distances or receive an inappropriate level of care. Wadena County portrays a service gap for mental health with more needs going unmet than Todd County and others across the state.



Thirty-one percent of our survey respondents reported the lack of access to mental health services as a moderate or serious problem and 54 percent reported mental health concerns as a moderate or serious problem in our service area.

Twelve percent of our respondents who reported mental health concerns delayed achieving care. The top-ranking reasons for the delay were costs too much, they didn't think it was serious enough and they didn't know where to go.





Drug Addiction (Prescription and Street Drugs)

According to the Minnesota Department of Health, drug overdose deaths among Minnesota residents continued an alarming trend, increasing 9 percent from 2016 to 2017. Final data collected from Minnesota death certificates show 733 people died from a drug overdose in 2017 compared to 675 deaths in 2016.

In 2017, there were 422 overdose deaths involving opioids in Minnesota—a rate of 7.8 deaths per 100,000 persons compared to the average national rate of 14.6 deaths per 100,000 persons. The greatest rise occurred among deaths involving synthetic opioids other than methadone (predominantly fentanyl), with a nearly six times increase from 31 cases in 2011 to 184 cases in 2017 (Figure 1). Heroin-involved overdose deaths increased from 16 deaths in 2010 to 149 deaths in 2016 before decreasing in 2017 to 111 deaths. Prescription opioid-involved deaths have remained steady since 2008 with 195 cases of overdose deaths reported in 2017.

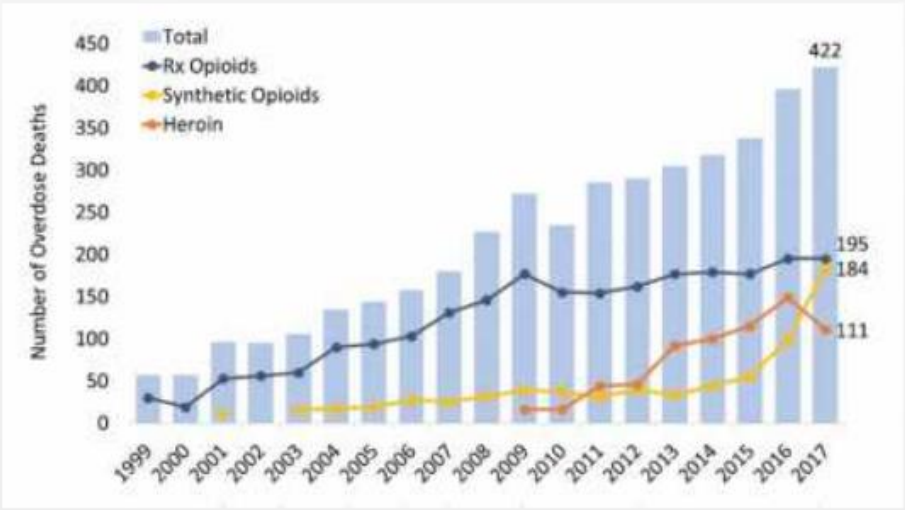


Figure 1. Number of overdose deaths involving opioids in Minnesota, by opioid category. Drug categories presented are not mutually exclusive, and deaths might have involved more than one substance. Source: CDC WONDER.

Sixty-six percent of survey respondents feel that illegal drug use (heroine, meth and cocaine) is a moderate to serious problem in our service area (a three-percentage point decrease from the 2016 survey). Fifty percent of respondents reported that prescription drug use is a moderate to serious problem in our service area. (a four-percentage point increase from the 2016 survey).

Vaccinations

Children who receive full series (age 24-35 months) – 2018

Wadena County	53.36%
Todd County	55.12%
Minnesota	67.77%

Adolescents who receive full series (Age 13 years) – 2018

Wadena County	11.7%
Todd County	14.4%
Minnesota	20.3%

Source: https://data.web.health.state.mn.us/web/mndata/info-by-location

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

1. Cancer
2. Heart Disease
3. Alzheimer's Disease
4. Accidents
5. Chronic Lower Respiratory Disease

Data Source: Minnesota County Health Tables: Mortality Table 1: Minnesota Leading Causes of Death by Age Group by State and County, 2017.

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 – Fergus Falls
- 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
- Fair Oaks Lodge, Inc. – Wadena
- Greenwood Connections – Menahga

Nutrition Support
- Hilltop Regional Kitchen – Eagle Bend
- Regional Food Shelves – Henning, New York Mills, Sebeka and Wadena
- Senior Nutrition Program – Wadena
- Ruby's Pantry in Menahga and Perham (happens once a month and is not dependent on financial status)
- Living Bread Pantry in Eagle Bend (happens once a month and is not dependent on financial status)

Pharmacies/Drug Stores
- Seip Drug – Battle Lake, Bertha, Clarissa, Frazee, Henning, Menahga, New York Mills, Ottertail and Wadena
- Thrifty White Pharmacy – Wadena
- Walmart Pharmacy – Wadena

Assisted Living Facilities
- Comfort Care Cottages – Wadena
- Fair Oaks Lodge – Wadena
- Greenwood Connections – Menahga
- Heritage Home – Sebeka
- Home Sweet Home – New York Mills
- Little Bit of Country – Wadena
- The Meadows – Wadena
- Our Home Your Home – Henning
- Tender Heart Assisted Living – Sebeka
- Willow Creek Assisted Living – Henning

Transportation Services
- Care Van – Staples
- Friendly Rider Transit – Todd and Wadena counties
- The Express – Ottertail
- Peoples Express – Wadena
- Medi Van – Detroit Lakes, serving all of Otter Tail County
- Rainbow Rider Bus – Todd County

Other
- Alano Society of Wadena
- Aneway Treatment Center – Long Prairie
- 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 Center – Perham
- ShareHouse Stepping Stones – New York Mills
- Tri-Counth Health Care Rehabilitation – Wadena & Henning
- Wadena Area Family Counseling

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.

METHODOLOGY

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 2019 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.

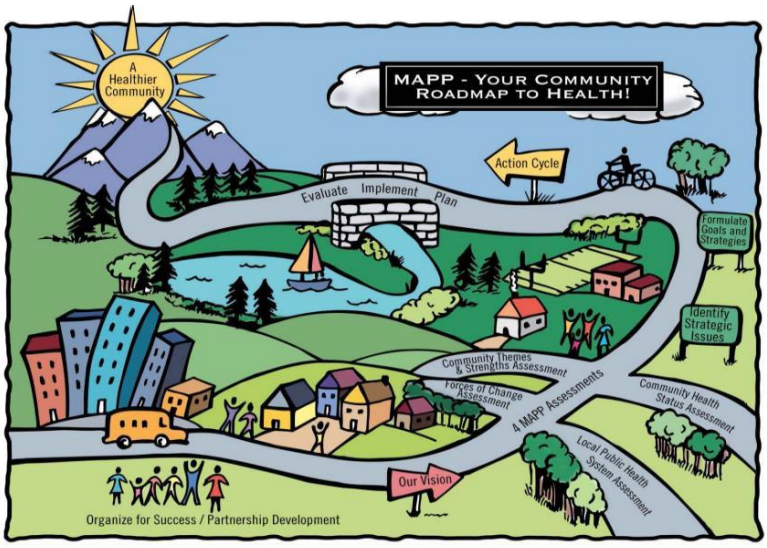
Secondary Data Collection

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.



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.

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
A two-stage sampling strategy was used for obtaining probability samples of adults living in each of the three counties. A separate sample was drawn for each county. Additional samples were drawn in each of four cities in the region (Little Falls, Long Prairie, Staples and Wadena). For the first stage of sampling, a random sample of residential addresses was purchased from a national sampling vendor (Marketing Systems Group of Horsham, PA). Address-based sampling was used so that 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. Given this was a weighted sample of the population, it ensured representation from minority and medically underserved populations.

Survey Administration
An initial survey packet was mailed to 6,400 sampled households (1,600 in each county and 400 in each of the oversampled cities) that included a cover letter, the survey instrument, and a postage-paid return envelope on January 25, 2019. One week after the first survey packets were mailed (February 1), 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. About two weeks after the reminder postcards were mailed (February 15), another full survey packet was

sent to all households that had still not returned the survey. The remaining completed surveys were received over the next four weeks, with the final date for the receipt of surveys being March 13, 2019.

Completed Surveys and Response Rate

Completed surveys were received from 1553 adult residents of the three counties; thus, the overall response rate was 24.3 percent. County level response rates were 25.7 percent (Morrison), 22.9 percent (Todd) and 24.3 percent (Wadena).

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 2013-2017 population estimates.

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

	2016	2019	Var
Obesity Among Adults	69%	69%	0%
Illegal Drug Use (heroine, meth, cocaine)	68%	65%	-3%
Smoking/e-cigarettes/other tobacco use	67%	64%	-3%
Parents with Inadequate or Poor Parenting Skills	64%	62%	-2%
Obesity Among Children	56%	54%	-3%
Mental Health Concerns (depression, anxiety)	51%	52%	1%
Children in Poverty	58%	51%	-7%
Prescription Drug Abuse/Misuse (codeine, oxycodone, morphine)	46%	50%	4%
Heart Disease & Stroke	55%	49%	-6%
People without Health Insurance or Medical Coverage	41%	48%	7%
Alcohol Abuse Among Those 21+	62%	47%	-15%
Bullying in Schools	54%	46%	-8%
Alcohol Abuse Among Those < 21	59%	46%	-13%
Marijuana Use	N/A	45%	
Diabetes	52%	44%	-8%
Child Abuse & Neglect	52%	43%	-9%
Unemployment	47%	39%	-8%
Domestic Violence	46%	35%	-11%
Lack of Access to Indoor Recreational Space	30%	34%	4%
Lack of Access to Transportation	29%	31%	2%
Lack of Access to Mental Health Svc.	26%	31%	5%
Lack of Safe and Affordable Housing	26%	31%	5%
Lack of Access to Healthy Food	20%	23%	3%
Infectious disease (flu, pneumonia, whooping cough)	28%	21%	-7%
Lack of Access to Health Care	20%	21%	1%
Sex Trafficking	N/A	20%	
Lack of Safe Places to Walk or Bike	20%	20%	-1%
Unintended Injuries	18%	16%	-2%
Homelessness	N/A	13%	
Eating Disorders	20%	13%	-7%

HEALTH NEEDS

STAKEHOLDER INTERVIEW FINDINGS

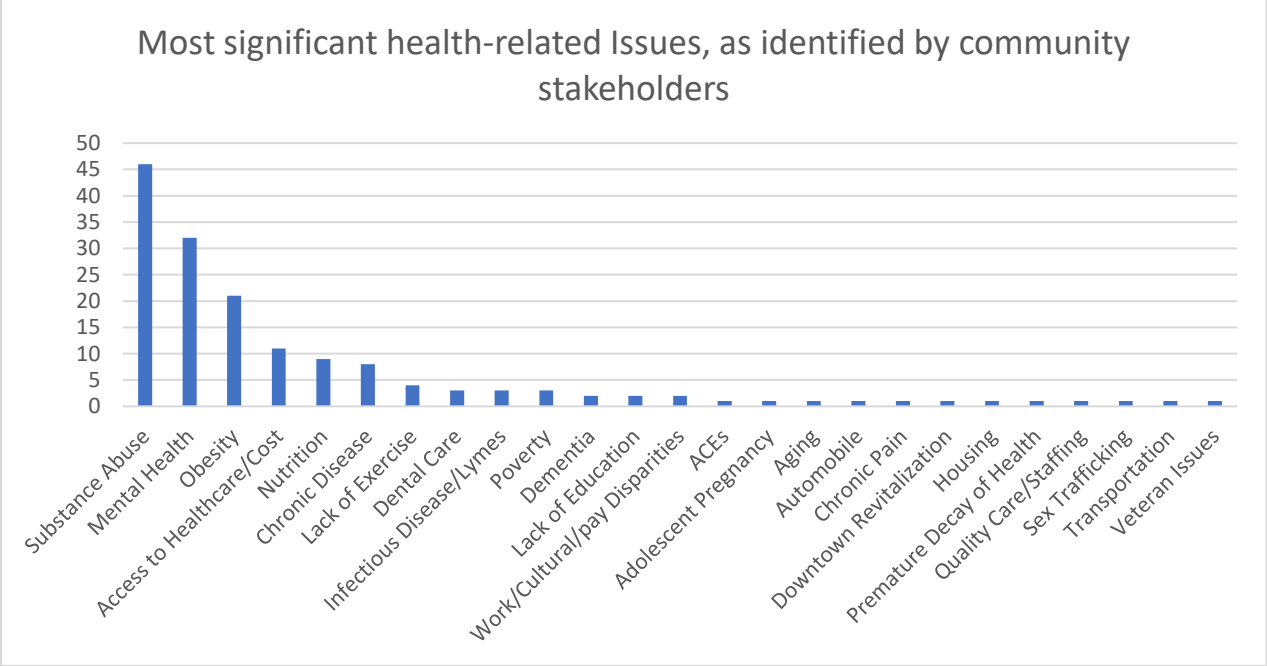
Community stakeholder interviews were conducted with 54 individuals across Morrison, Todd, and Wadena Counties. Interviews were conducted by public health and health care staff utilizing the Community Stakeholder Questionnaire. Interviews were conducted in person and via phone and typically lasted 45 minutes to 1 hour. Twenty-two interviews were conduct in Morrison County, 15 interviews were conducted in Todd County, and 17 interviews were conducted in Wadena County. Community stakeholders were selected from a variety of sectors. Table 1 below shows each sector represented.

Table 1. Community Stakeholder Interviewees by Sector

Interviewees included the following: providers, business leaders, two community members, two from the Wadena Deer Creek School District, Independent News Herald, Niles Law Office, Wadena County Transit, Wadena County Human Services, Wadena County Sheriff's Department, Immanuel Lutheran Church, Wadena Food Shelf/Backpacks for Hungry Children in School, two school board members and the City of Wadena Police Department. The goal was to obtain information from people that work with individuals from a variety of sectors across our community, including minorities and the medically underserved population.

Sector	Percent	Number
Healthcare professionals	20%	11
State, local or tribal govt. agencies with expertise in substance misuse	19%	10
Businesses	13%	7
Schools	13%	7
Civic or volunteer groups	9%	5
Law enforcement	7%	4
Youth	7%	4
Media	6%	3
Religious or fraternal orgs.	4%	2
Youth-serving org.	2%	1

Interviewees were asked to identify the three most significant health-related issues in their community. The aggregate list is shown below.



Substance abuse was the most frequently cited health-related issue. Within the area of substance abuse specific substances including e-cigarettes, tobacco products, opioids, alcohol, and marijuana were cited as concerns.

Interviewees were asked to identify specific community projects or initiatives that address these health-related issues and their effectiveness. The following projects and initiatives were identified:

- Jail Suboxone project in Morrison County
- Food insecurity work at the hospitals and schools (e.g., Choose Health, backpack programs, care closets)
- Live Better Live Longer initiative
- Comprehensive re-entry project including a social worker in the jails

Social determinants of health are conditions in the environments that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of social determinants of health include: access to health care services, quality of education/job training, transportation options, public safety, social support, and availability of community-based resources. We asked community stakeholders to specifically identify non-healthcare related issues that impact the overall health of their community. The responses that were commented on most frequently are listed below in Table 2.

Table 2. Community stakeholder identified non-healthcare related issues impacting overall health

Responses	Percentage	Number
Housing	33%	21
Transportation	25%	16
Access to Healthy Food	17%	11
Education/Life Skills	9%	6
Childcare	8%	5
Poverty	5%	3
Mental Health	3%	2

Community stakeholders were asked if they were aware of or could identify any ideas, project, or initiatives that would effectively address the identified social determinants of health.

- Housing- renter advocacy program,
- Transportation- state legislation, better coordination across county lines, Uber/Lyft options
- Access to healthy food- Meals on Wheels, Care Closets at Schools, Lakewood's Food Farmacy, Wadena greenhouse project, farmers' market
- Education- promoting life skills programming, addressing ACEs (Adverse Childhood Experiences)
- Childcare- more daycare centers with longer hours, regional licensing model with Sourcewell, expanded before/after school programming

Health equity means achieving the conditions in which all people have the opportunity to attain their highest possible level of health. Structural inequities within our population— such as finance, housing, transportation, education, social opportunities, etc. — may unfairly benefit one population over another population. Community stakeholders were asked to think about those who experience relatively good health and those who experience poor health; and to identify why there might be differences in these two groups.

- Financial status/poverty
- Education
- Routine preventative care / access to care / access to health insurance
- Social support / community connections
- Lifestyle choices / learned behaviors

Interviewees were asked to identify any services that could improve overall health in their community that are currently unavailable or have limited availability, if money was no object.

- Health and fitness centers
- Mental health services
- More transportation services

- Early intervention programs for families/youth at-risk
- Comprehensive services for low income families

Strengthening families is a community health strategy for Morrison, Todd, and Wadena County public health agencies. Community stakeholders were asked what could be done to strengthen families and promote more positive parenting in the community.

- Affordable and accessible childcare
- Education in high schools on parenting
- Promotion of positive parenting and increased social support for parents (e.g., Circle of Parents, Love & Logic, ECFC)
- Free events and classes for families
- Increased involvement with churches and religious organizations

Finally, community stakeholders were asked to identify the best strategies for getting people engaged in improving the health of their community.

- Incentives- free meals, events, etc.
- Identify areas of interest and activities for diverse populations
- Remove barriers to participation (e.g., transportation, childcare)
- Community gatherings for all (e.g., block parties)
- Engaging community members in conversations and projects

Written comments to this document are welcome. Please send any comments in writing to:

Tri-County Health Care
CHNA Feedback
415 Jefferson St. N.
Wadena, MN 56482

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	Improve Ability to Share Health Information	Cost to Implement
Factor	Economic Issues	Community Support Volunteerism Priority Setting	Poverty Jobs Income Lack of Day Care
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 Expensive to Treat/Lack of Facilities
Factor	Alcohol and Tobacco Use	Improve Access for Preventive Services Funding available	Ability to Meet Demands Health Equity Student Vaping Age Increase in Tobacco Purchase
Trend	Regionalization / Consolidation of Healthcare 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	Low Vaccination Rates	Prevention Collaboration	Funding Less Ability to Manage
Trend	Limited Work Force	Recruitment Potential Volunteerism	Ability to Meet Demands of Aging Population Access Demands
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 Limited Resources/Lack of Broadband
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 Adequate Tracking/Identification

Priorities & Strategies

TCHC COMMUNITY HEALTH PRIORITIES – 2019 ASSESSMENT

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:

- Barriers of social determinants of health (poverty, employment, housing, environment, etc.)
- Community Infrastructure to address population health
- Mental health / access to mental health care
- Drug addiction - pain/prescription management (opioid epidemic)
- Healthy behaviors (smoking, alcohol, eating habits)
- Obesity
- Chronic disease / cancer
- Access to health care services/system navigation
- PHI data exchange/extrapolation/analysis across healthcare systems/organizations
- Decreased funding

Given the correlation between mental health and drug addiction, these two items are included as a subset of one another as the work needs to happen in tandem.

Barriers of Social Determinants of Health was put at the forefront of our priority list given that work done will impact the other priorities on the list. With the disparaging socio-economic issues that were spelled out earlier in this report in our region, identifying the proper issues our patient population is dealing with and putting initiatives in place to improve those issues will have great impact on other health priorities.

Changes to the priority list from 2016 include movement of barriers of social determinants of health from the bottom of the list to the forefront. Chronic disease and cancer were combined into one priority as cancer is a chronic disease. Drug addiction was added to the priority list in 2019 and did not appear in 2016. While this is listed as subset of mental health given the fact that they are so closely related, it is worth noting the addition. Data exchange and decreased funding still both reside on the list but have been moved down in terms of priority given the infrastructure elements that are out of our control that need to be addressed.

Priority 1: Social Determinants of Health

Strategy 1: Tracking/system/identification
Strategy 2: Infrastructure – identify community partners/resources
Strategy 3: Increase medical visits – capture the data on our patients

1. Explanation of the actions you plan to take: Develop and implement system for identification of social determinants of health of patients, determine and establish relationships with community stakeholders and identify resources for social needs determined through screening process, utilize data to determine patterns and trends of social challenges patients are facing
2. Resources plan to commit: wages of staff members planning, developing, and analyzing social determinants of health of patients in service area, cost of design and implementation to capture social determinants of health in electronic health record
3. Anticipated impact of the action: improvement in health outcomes, increased patient satisfaction, increased patient engagement
4. Any planned collaborations: Will determine necessary collaboration with external stakeholders as part of strategies for this priority.

Priority 2: Healthy Behaviors

Strategy 1: Community education and partnerships
- Tactic: IHP and ACO/CIN work

Strategy 2: Increase preventative medical visits
- Tactic: Identifying frequent ED visitors without PCP to establish care

Strategy 3: Employee wellness initiatives

Strategy 4: Expand occupational health through health fairs/ biometric screenings for local employers

Strategy 5: Continue chronic disease management efforts to improve optimal care outcomes
- Tactic: I CAN Prevent Diabetes classes
- Tactic: Ensure healthy behaviors to better live with diagnosed chronic diseases

1. Explanation of the actions you plan to take: Focused attention on quality improvements associated with ACO, CIN and IHP partnerships, review of patients frequently using the emergency department for care and determine alternative care options for these patients, provide evidence based health education classes to patients (I CAN prevent diabetes, Living well with chronic pain, living well with chronic conditions), provide education opportunities to service area
2. Resources plan to commit: wages of staff developing, planning and implementing education classes and events, education classes and events are provided to patients and service area at no cost, wages of staff focusing efforts on improvement of quality metrics of ACO, CIN and IHP contracts
3. Anticipated impact of the action: improvement in patient health outcomes, increased patient engagement, increased quality metrics
4. Any planned collaborations: Juniper, Central Minnesota Council on Aging, Wadena County Public Health, local businesses

Priority 3: Mental Health / Drug Addiction – Pain/Prescription Management

Strategy 1: Identification of patient population

Strategy 2: Mental health service line assessment and strategic plan developed

Strategy 3: Opioid plan execution (care plan, more visits, rehab, medication assisted treatment)

Strategy 4: Pain Management
- Tactic: Living Well with Chronic Pain classes
- Tactic: Rehab

1. Explanation of the actions you plan to take: Identify patients using opioids and controlled substances on a consistent basis, increase controlled substance care plans for patients, decrease number of patients chronically using opioids and controlled substances, identify gaps in mental health care provided to patients, provide medication assisted treatment for patients addicted to opioids, provide and refer patients to Living Well with Chronic Pain education classes
2. Resources plan to commit: wages of staff who provide education and assistance to patients using opioids/controlled substances, educations classes offered to patient at no cost
3. Anticipated impact of the action: decreased risks to patients chronically using opioids and controlled substances and providers who prescribe to these patients
4. Any planned collaborations: Wadena County CHAMP (Chemical Health Awareness and Multi-drug Prevention), Ottertail County Opioid Taskforce, local businesses, area health care agencies Opioid ECHOs

TCHC COMMUNITY HEALTH PRIORITIES 2016 ASSESSMENT

Top ten priority list from 2016 (this list did not change from our 2013 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

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.

This study ran for three consecutive years and focused 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

Tri-County Health Care 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.

2019 Status Update: Strategies previously identified haven't moved the needles as quickly as we would have liked. The overall rankings of Wadena County have dropped since the previous assessment. While Tri-County has worked internally to take measure to improve the healthy behaviors of our patients, we need an emphasis on the infrastructure and social determinants of health if we are truly going to impact the quality of health in our community. Focusing on these factors, (infrastructure and social determinants of health) will lead to faster improvements in quality of life for our community. Healthy behaviors still remains a top priority for Tri-County Health Care, but we must work with our community partners before our work on healthy behaviors will have community-wide ramifications. The Maslowski Research partnership was finalized in 2018. Plans to rekindle that partnership are in discussions but have not been included in our 2019 assessment until more details are finalized.

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: TCHCs 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.

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.

> **2019 Status Update:** Strategies implemented over the past several years lay the foundation for the direction Tri-County will take in in the coming years. Our care coordination program has been executed and is in full-swing allowing us to expand our efforts in the chronic care arena. Success with our educational events surrounding hypertension, diabetes and weight-loss continue as we work to refine and expand those programs in the coming years. Explanation of the actions you plan to take: prioritize chronic diseases needing development of education programs, develop education and plans to encourage patient self-management of chronic disease, re-evaluate education programs already in place, identify patients needing increased education and support of known chronic disease.

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: Tri-County Health Care 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: Tri-County Health Care provided 6,968 preventive visits in 2015 and 6,425 in 2014. As part of early cancer detection efforts, Tri-County Health Care performed 2,073 mammograms in 2015 and 2,088 in 2014, as well as 537 colonoscopies in 2015 and 667 in 2014. The goal is to improve the number of preventive and diagnostic screening exams in future years.

> **2019 Status Update:** Events that provide annual diagnostic screening exams have been disbanded as research has found that our patients were using those in lieu of scheduling an annual wellness exam or physical with their primary care provider, which was counter-productive to our overarching strategy. Given the importance to have that face to face interaction and discuss overarching health concerns

other than the lipid panels, Tri-County Health Care made a decision to discontinue offering free labs at our events and are focusing on getting more patients in the door for annual physicals/well-checks. Numbers for colon cancer screening and mammograms have shown steady improvement as previously outlined in this report and continue to be a large focus for our patients as early detection is key.

Addendum

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.