Tri-County Health Care

is becoming **Astera Health**

Community Health Needs Assessment 2022

Table of Contents

Table of Contents

Executive Summary

WHO WE ARE

Tri-County Health Care 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 in Bertha, Henning, Ottertail, Sebeka, Verndale, and Wadena. Tri-County is one of the few independent health care systems in Minnesota and is known for its innovation and expertise. Our mission is to improve the health of the communities we serve.

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 was 99,408 at the 2020 census. The primary service area population of Tri-County is estimated at 39,327 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 service area consists of primarily white/Caucasians at 96 percent with 4 percent minority. The state of Minnesota is also primarily white/Caucasian at 83.8 percent but has a greater minority population of 16.2 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. These prioritized issues were used to develop strategies for the 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:

- Healthy Behaviors and chronic disease management
- Mental Health / Opioid-use disorder and prescription management
- Social Determinants of Health

These priorities were determined through community survey responses, the top problem list, and input from internal and local health experts. After receiving this input, it was determined that focusing on certain issues like healthy behaviors gave the highest chance of affecting many other scores and health issues. Given the correlation between mental health and drug addiction, the two items in the second bulletpoint are included as a subset of one another as the work needs to happen in tandem. Tri-County Health Care's provider group agreed with the challenges listed as problem areas in the community.

Community Health Needs Assessment

Minnesota nonprofit hospitals have moral obligations to 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 September 2021 to a random sample via mail and online. 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.

Tri-County Health Care also worked with medical professionals with Todd and Wadena public health departments, Lakewood Health System, CHI St. Gabriel's, Centracare, and internal staff, including an operations council with medical providers. These groups all provided recommendations on areas to work on.

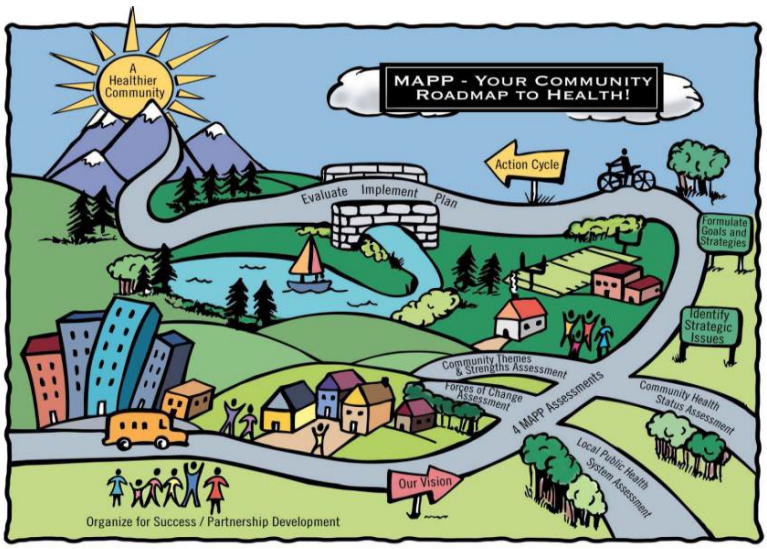
Tri-County Health Care also participates in the State of Minnesota's Integrated Health Partnerships (IHP). The IHP strives to deliver higher quality and lower cost healthcare through innovative approaches to care and payment. Participants receive a population-based payment for care coordination and are required to design an intervention to address specific healthcare disparities observed. This equity intervention is an opportunity for IHPs to innovate and advance efforts such as community partnerships, screening, referral, and care coordination for social needs, plus other strategies to meet their population's needs.

Contract requirements for the IHP included a population health component. TCHC was able to work with IHP staff to determine a population health issue and demonstrate ways to improve this issue. IHP staff indicated to TCHC opioid prescriptions in the attributed population were high compared to other IHPs. Because of this information, TCHC and IHP staff agreed to have TCHC focus on process and outcome measure improvement related to opioid prescriptions and use for the target population.

Source: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/integrated-health-partnerships/

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

Survey Instrument

The survey instrument content was largely taken from a similar survey conducted by these same counties in 2019. Local public health staff modified the survey questions with technical assistance from the Minnesota Department of Health Center for Health Statistics. The survey was formatted by the survey vendor, Survey Systems, Inc. of Shoreview, MN, as a self-administered English-language questionnaire.

Sample

A two-stage sampling strategy was used to obtain 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 the 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 sampling stage, the "most recent birthday" method of within-household respondent selection was used to specify one adult from each selected household to complete the survey.

Survey Administration

An initial survey packet was mailed to 6,400 sampled households, including a cover letter, the survey instrument, and a postage-paid return envelope on October 11, 2021. On October 18, 2021, one week after the first survey packets were mailed, 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. On November 8, 2021, three weeks after the reminder postcards were mailed, 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 six weeks, with the final date for the receipt of surveys being December 17, 2021.

Completed Surveys and Response Rate

Completed surveys were received from 1,270 adult residents of the three counties; thus, the overall response rate was 19.8%. County-level response rates were 19.3% (Morrison), 19.7% (Todd) and 20.5% (Wadena).

Data Entry and Weighting

The responses 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, the disproportionate stratification, and the city-level oversampling. 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 U.S. Census Bureau American Community Survey 2013-2017 population estimates.

SURVEY RESULTS: Frequency results from the Todd, Wadena, Morrison County respondents

	2022
General Health (rated good or higher)	86%
Obesity or Overweight Among Adults	40%
Overall Level of Stress (medium or higher)	70%
Current Smoker (Tobacco)	12%
High Blood Pressure/Hypertension	40%
High Cholesterol	31%
Mental Health Issues	32%
Chronic Lung Disease	7%
Cancer	16%
Heart Trouble or Angina	12%
Stroke or Stroke-related Health Issues	6%
Insurance Status	97%
Medical Care Costs Too Much (with insurance)	34%
Alcohol in past 30 Days	63%
Sexually Transmitted Diseases	4%
Marijuana Use	4%
Diabetes	14%
Access to Medical Health Care Services Since 2019 (Same or better)	79%
Dental Care Delay	27%
Mental Health Care Delay	12%
Lack of Childcare	1%
COVID Vaccination Status	70%
Employed	41%
In Relationship where have been physically hurt, threatened, or felt afraid	3%
Lack of Access to Mental Health Services (Could not get appt)	19%
Never Worry About Food Running Out	83%
Lack of Safe Places to Walk	10%

Online survey

New this year, an online survey was created asking some of the same questions as the mailed survey. The link for the survey was sent via email and shared on social media sites for all three counties. The online survey included questions on demographics and household information, quality of life, finances, concerns in the community, discrimination, COVID pandemic concerns and challenges, and healthcare concerns. Around 200 people filled out the survey and the results are summarized below.

Written comments to this document are welcome. To date, we have not received any feedback on the published report. Please send any comments in writing to:

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

Tri-County Health Care

Tri-County Health Care's medical staff comprises board-certified family practice physicians, a certified nurse midwife, three general surgeons, physician assistants, and family nurse practitioners. Specialty services offered have been enhanced be consulting physicians in pathology, oncology, cardiology, orthopedics, ophthalmology, urology, psychology, dermatology, podiatry, spine, wound management, rheumatology, midwifery, chiropractic, and pulmonology. Professional and support staff dedicated to excellence provide surgical, obstetrics, nursery, intensive and coronary care services, 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, occupational therapy, and speech therapy are all part of the outpatient services available at Tri-County. 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.

Tri-County takes pride in continually upgrading technology. The purchase of equipment and advanced technology enhances superior services. Tri-County is keeping its rural health care system on the leading edge of technology as a pioneer in 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. Tri-County expanded telehealth services to include e-ICU in the fall of 2016 and further developed in 2020 at the start of the COVID pandemic. This expansion included video visits, eClinic, and the phone health service.

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.

Tri-County added chiropractic care services in the summer of 2021. Two doctors of chiropractic offer joint realignment, pain relief, and several other health-related benefits to patients in Wadena and Sebeka. This service was identified as a need in the area and offers an alternative treatment option for communities. Additionally, the chiropractic care team can work in conjunction with the orthopedics and rehabilitation teams to promote bone and joint health.

TRI-COUNTY HEALTH CARE COMMUNITY BENEFIT IMPACTS

In addition to the priorities listed previously in this report, Tri-County 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.

The table below outlines historical numbers for many of Tri-County's services, including days of care for inpatient services, surgical procedures, clinic visits, physical and occupational therapy visits, diagnostic services provided, radiology exams performed, emergency room coverage, and ambulance runs from 2016 through 2021.

These services, combined with Tri-County's ongoing care coordination services and Community Paramedic program, are consistent with our mission to improve the health of the communities we serve.

	2016	2017	2018	2019	2020*	2021
Ambulance Service Runs	1,523	1,638	1,717	1,538	1,567	1,647
Aquatic Therapy Visits	729	797	970	1,068	424	1,062
Community Paramedic	191	441	538	185	536	369
Emergency Room Visits	5,898	6,026	6,219	5,427	4,398	5,342
Medical Outreach Visits	6,520	6,366	5,155	2,536	1,636	1,684
Physical Therapy Visits	12,458	11,653	12,500	13,776	9,956	14,836
Psychiatry Visits	3,176	3,324	3,752	2,292	2,468	3,181
Total Clinic Visits	52,568	52,993	53,176	55,918	45,533	56,035
Total Deliveries	153	162	131	129	131	133
Total Discharges	898	905	902	933	787	923
Total Laboratory	139,811	142,146	142,425	153,401	147,449	171,144
Total Patient Days	2,510	2,507	2,400	2,324	1,798	2,359
Total Radiology	23,335	23,680	24,236	25,006	21,883	25,651
Total ReadyCare Clinic Visits	6,260	7,195	7,136	5,623	4,972	6,501
Total Surgical Procedures	2,814	2,872	2,871	2,929	2,132	2,728

*-COVID shutdowns occurred beginning in March

TRI-COUNTY TOP 10 PROBLEM LIST – 2021

Diagnosis
Hypertension
Hyperlipidemia/hypercholesteremia
Anxiety
Diabetes
Low back pain
Depression
Gastroesophageal reflux disease
Hypothyroidism
Vitamin D deficiency
Atrial Fibrillation

Tri-County Health Care tracks and monitors the top problems in its service area to determine significant health challenges. This process helps identify significant issues and how best to assess priorities and strategies. For example, with hypertension at the top of the list, it justifies making healthy behaviors and chronic disease management a focus moving forward. The strategy for this priority includes community education and partnerships, increase preventative medical visits, employee wellness initiatives, expand occupational health, and continue chronic disease management efforts to improve optimal outcomes.

RN Health Coach

Tri-County Health Care incorporates health coaches to help deliver team-based care between the patient, the patient's family, and the primary health care team. There are two registered nurses in the health coach department at Tri-County Health Care. The health coaches work with care teams in the Wadena Clinic and satellite clinics to improve efficiency and communication between providers, staff, and patients. 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 with hypertension.

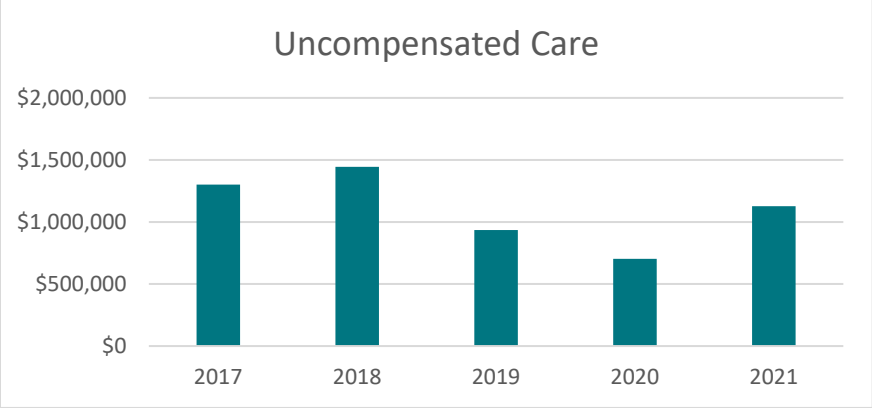
FRIENDLY RIDER

Friendly Rider is a demand-response service offering curb-to-curb transportation to and from many locations within the cities of Wadena and Staples and 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 recognized the benefit Friendly Rider would have for our patients. Tri-County offers complimentary tickets to patients who are coming and going from appointments. With this support from Tri-County, Friendly Rider has helped ensure patients have a safe way to travel for their medical care. This service allows individuals to stay in their communities longer and remain self-sufficient. In 2021, Friendly Rider dropped 1,412 passengers at Tri-County Health Care. It dropped off 1,442 in 2020 and 2,001 in 2019.

UNCOMPENSATED CARE PROGRAM

Tri-County Health Care provides free or reduced rates for services for individuals with a financial need. The amount of uncompensated care Tri-County has provided in our service area increased by 69 percent between 2014 and 2018, but decreased in 2019 and 2020 before rising again in 2021.



READYCARE

Our ReadyCare service gives patients a choice of timely, affordable, and quality same-day, walk-in, and same-day appointments for non-emergency but urgent illnesses and injuries. ReadyCare is available six days per week (Monday through Saturday). ReadyCare visits peaked at 7,195 in 2017 before falling to 4,972 in 2020 due to the pandemic. It increased to 6,501 in 2021.

TECHNOLOGY IN HEALTHCARE

Tri-County Health Care added eClinic services in 2018 so patients can receive the care they need without a trip to the Emergency Department or when ReadyCare is closed. This service is a simple way for patients to receive care for minor illnesses online, 24 hours a day, seven days a week. It also frees our emergency department to be readily available for advanced care needs.

Our eClinic offers online diagnosis and treatment services by connecting them virtually with trusted providers. For $45, patients can be treated for common health conditions, including cold and flu, pink eye, allergies, heartburn, bladder infections, and more. 122 patients completed visits in 2019, 367 in 2020, and 212 in 2021.
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, but it also allows our emergency department to be more readily available for the advanced care needs of our most urgent patients. Additionally, Tri-County Health Care began offering video and phone visits at the start of the pandemic in March 2020.

To further accommodate the expansion of technology services, Tri-County Health Care added direct scheduling through MyChart in the fall of 2020. This service expanded in the summer of 2022 with open scheduling widgets added to the orthopedics and chiropractic care web pages. From 2019 to 2022, there were 28,474 active MyChart patients and 43,646 unique patients, for an active MyChart rate of 65.3 percent. With the expansion of open scheduling, we anticipate an additional increase in active MyChart patients.

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. Tri-County employs a full-time certified nurse practitioner specializing in the field of psychiatry to meet the increasing demand for mental health services and a licensed independent clinical social worker. Together, we pledge to work with patients and families to provide individualized treatment and improved quality of life. Working collaboratively with your primary care provider, we offer a full spectrum of care to meet your ongoing health and wellness goals. Visits have increased over the past three years, showing the increased need in our area for mental health services. A full-time staff psychiatrist is currently an unmet need for the area. Tri-County is adding telehealth options until we find a new psychiatrist to fill the vacant position.

Adding a licensed independent clinical social worker (LICSW) offers patients increased access to cognitive-based therapy.

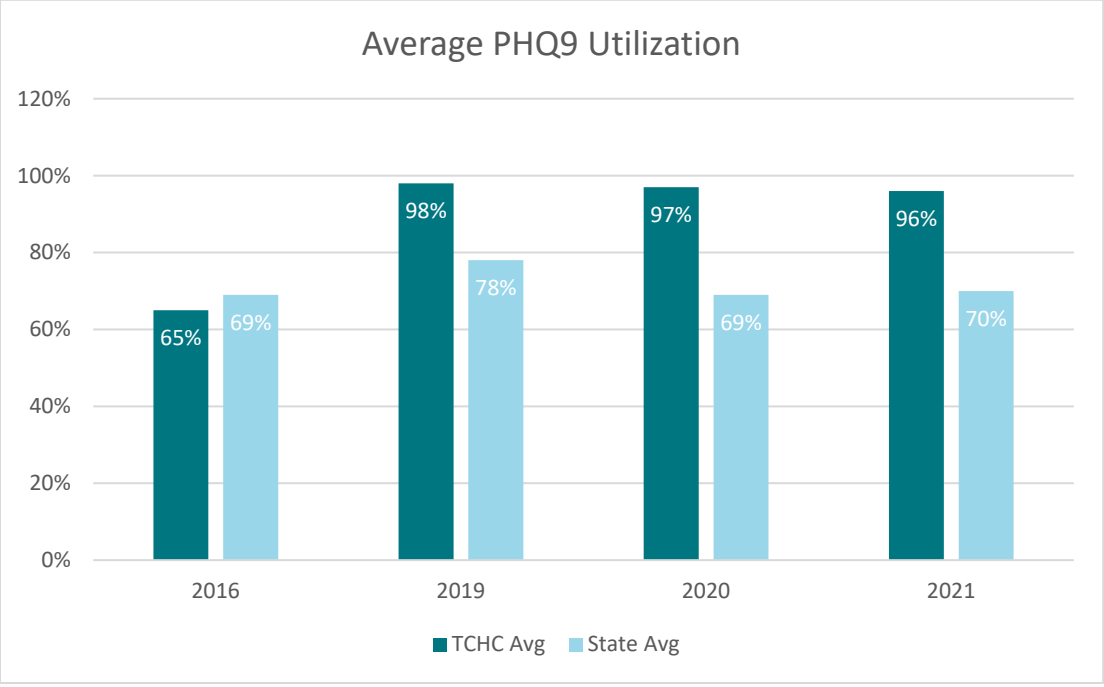
This LICSW provides individualized therapy and referrals and coordinates with primary care providers. This position was seen as a high need in our service area, with a long waitlist at counseling places in our region.

The program also added a behavioral health program coordinator in 2021. The goal of this position is to assist in long-range planning and determine what services are in high need in the community. The program coordinator also works between several departments, including primary care, emergency department, and behavioral health, linking the services to offer seamless patient care. The intent is to connect patients with primary care or another provider before experiencing a behavioral health crisis that requires emergency care. Another goal of the position is to find resources to offer virtual psychiatry.

	2018	2019	2020	2021
Psychiatry Visits	3,752	2,292	2,468	3,181

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 over 96 percent from 2019 through 2021. That rate has not dropped below 96 percent in the last three years. Our rate is considerably higher than the state average (70 percent). Maintaining a high rate of PHQ9 utilization will remain a focal point for Tri-County Health Care in the future.



Bipolar disorder and depression screening: bipolar disorder is highly associated 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 remained at 100 percent for an extended period. With an effective process in place, ongoing measurement ended.

Success Through Collaboration

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 visit the Emergency Department directly for patients needing assessment and determine the safest care plan.

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.

A study was completed to create a broad vision for Behavioral Health Services in the future for Tri-County. The review was completed in September 2019. Six months later, the world entered the COVID-19 pandemic, so while the services continued and the assessment plans were being implemented, the strategic plan for Behavioral Health Services paused. Once COVID became part of everyday life in 2020, TCHC began a complete overhaul of the organization's strategic plan. With the work of the senior leadership team, the strategic plan was created and approved by the TCHC Governing Board in 2021.

To support the community's need for mental health services, Tri-County Health Care partnered with Rural Psychiatry Associates in the summer of 2022. The partnership includes utilizing psychiatrist time with up to four providers to cover 16 hours of scheduled patient time. This service will be re-evaluated and potentially increased depending on need. Tri-County Health Care will continue to recruit psychiatry providers.

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 Tri-County, addresses opioid use for chronic non-cancer pain management and develops 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 were launched in 2019 to offer alternative approaches to ongoing uses of benzodiazepine medications to live with pain. Two chronic pain classes were offered in 2019, and into 2020. However, due to COVID-19, the 2020 class was postponed and then eventually canceled. We hope to bring this class back in 2023 after training new facilitators.

In June 2020, Tri-County was awarded a two-year grant for $210,000 from the Minnesota Department of Health with goals to reduce rates of opioid addiction, determine unmet social needs of this patient population, and engage partners outside of the health care system who can help to meet the grant goals collaboratively. Quarterly patient data is submitted to MDH, tracked over the past three years, and will be compiled in Fall 2022, showing the overall outcomes achieved.

In 2021, it was determined more staffing was needed to help support the care teams and patients who use opioids. Now, two RN health coaches work with patients using medication to treat opioid use disorder. Medication-assisted

treatment (MAT) is a way to help patients who may be addicted to or misusing opioid medications or heroin. The two RN health coaches work with these patients and their care team at Tri-County to manage their opioid addiction through close follow-up via phone calls and visits with their MAT provider. These two RNs help patients with opioid use disorder and assist providers and the care team in making sure any patients using opioids chronically have up-to-date care plans outlining the reason for the use of the opioid. The grant originally awarded in 2020 is being renewed for one more year as there is more funding available to continue this important work.

PATIENT AND FAMILY ADVISORY COUNCIL

Tri-County's Patient and Family Advisory Council remains highly engaged and continues to meet every other month. Tri-County believes partnering with patients and their families is essential to improving hospital quality and safety. Our partners provide a voice representing all patients and families receiving care at Tri-County. They partner with providers, nurses, and administrators to give us feedback and ideas to help improve the quality of our care. Our PFAC partners serve on safety and security committees and the Board Culture and Community Committee. They are frequently invited into performance improvement work as well. This team has played a major role in building our new facility, allowing us to have a patient perspective early in the planning phases. Their continued participation helps us make decisions that impact our patients in a very direct way. Tri-County is very thankful for our partnership with our patients and appreciates the dedication and hard work this group provides.

FREEDOM FROM SMOKING PROGRAM

Tri-County Health Care continues to offer the Freedom From Smoking program to patients and community members. The American Lung Association researched and developed the Freedom From Smoking self-help manuals in 1980. It was redesigned and relaunched in 2016, ensuring 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 on emphasizing the benefits of better health, improved lifestyle habits, and mastery of one's own life. The activities and assignments provide individuals who smoke with proven strategies for changing their behavior and lifestyle.

The Freedom from Smoking program has been offered at Tri-County twice a year since its inception. One-on-one sessions are offered at the clinics with an advanced practice provider and health coach for patients who are uncomfortable participating in a group environment. The ability to host in-person FFS classes was limited due to COVID and the need for social distancing. We have also seen fewer referrals and patients wanting to quit smoking during the COVID-19 pandemic.

CURRENT TRI-COUNTY 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, National Diabetes Prevention Program
Healthy Times Newsletter	• Three times a year publication of success stories and educational information for all
Internships	• Medical and nursing students – Rural Observation Education, Rural Medical Scholar Program, Students in Medicine • 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 Long Prairie, and Tri-County Health Care • Workgroups: Maternal Child Health, Health Education, and Community Health Assessment • Activities: Car seat clinics, health fairs, Rock-n-Rest at local county fairs, a state-wide annual breastfeeding educational seminar, 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
Community Donations	• Over $30,000 in donations to health and wellness-related community initiatives to support the efforts of other organizations in 2021 • Employee donations through fundraisers such as jeans days that are contributed to a variety of charitable organizations
EMS Education programs	• Classes offered to individuals who want to become EMTs • Heartsaver classes offered for the general public to increase CPR-trained individuals in communities • Classes offered to medical health professionals to ensure certifications ar up to date
Community Relations	• Host “Bite-Size Conversations,” a lunch and learn style event to bring community-related topics to our service area. 6-12 events per year. Topic included: chiropractic care, heart health, living will/advanced care directives, and more
Auxiliary	• Hosts fundraising through bake sales, shirt and sheet sales, and annual holiday auction to raise money for equipment and programming

NATIONAL DIABETES PREVENTION PROGRAM (NDPP)

Tri-County Health Care began offering the National Diabetes Prevention Program in early 2015. Since implementation, the organization has provided a total of 21 sessions, with the most recent session starting in June 2022. Tri-County currently has three employees trained to serve the role of facilitator. We have lost four employees who were trained lifestyle coaches to facilitate the program. Tri-County has made it a goal to offer these classes quarterly, alternating class times to accommodate the working class and those who prefer daytime classes. Due to COVID and staffing concerns, we have not been able to offer as many classes as in previous years. We are keeping our class sizes to 10 or less to be able to social distance.

Community education efforts around assessing a person's risk and readiness for change have been practiced by recruiting individuals ready to make a lifestyle change. Tri-County providers also recognize this program's importance and often refer patients to the classes. Nearly 258 individuals have participated in these sessions. We accept self-referrals for the classes, for those who have heard about the class from a friend, family member or in the community.

Tri-County utilized a post-survey to collect and evaluate data. The data revealed a strong correlation in the overall lifestyle change success for those who committed to regular attendance and daily tracking. Participants who journaled regularly and attended weekly sessions often shared they had more overall improvement in their health and lifestyle. The average weight loss for all sessions offered at Tri-County was about 8 percent, but this average has dropped to 5 percent in the past two years. The National Diabetes Prevention Program goal is 7 percent weight loss.

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

- "Getting group support and learning some new tricks"
- "My lifestyle coach was great and I enjoyed the class"
- "Meeting new people"
- "I had my A1C checked and it came down"
- "I have more stamina, stairs are much easier"
- "I am learning how to eat healthier"
- "If you follow the program, it works"
- "I can exercise longer"

Participating in the National Diabetes Prevention 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.

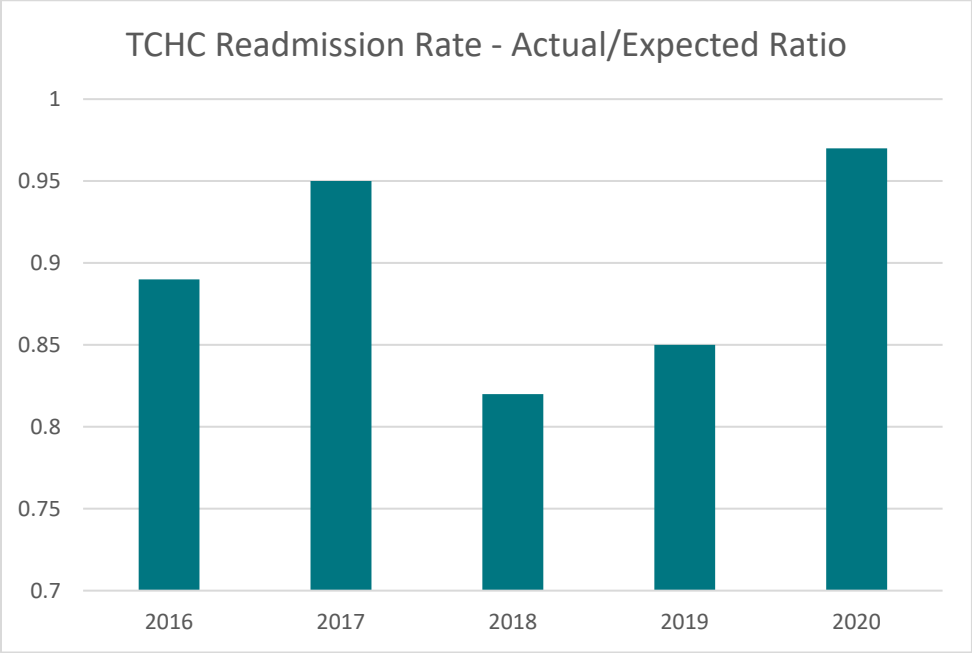
Approximately 96 million American adults—more than 1 in 3—have prediabetes. Of those with prediabetes, more than 80% don't know they have it. Prediabetes increases your risk of developing type 2 diabetes, heart disease, and stroke. Without weight loss and moderate physical activity, 15-30 percent of 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 Tri-County EMS department aims to ensure 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 backup crew in daily operations. The third backup rig is not staffed 24/7; however, staff on-call respond when needed. The EMS department includes 22 trained EMTs 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 to keep them healthy and out of the hospital. Statistics show the continued use of the community paramedic program. In 2020, 527 visits were made, while in 2021, 369 visits were made (we saw variations in the visit numbers due to the COVID-19 pandemic). Most of these visits with patients consisted of medication reconciliation and lab draws. More recently, the community paramedic has been used to give COVID vaccines to patients in their homes and transport them upon discharge from the hospital. A newer 4-wheel-drive vehicle was purchased in 2021 for the community paramedic to use to aid in ease of driving during the winter months. Lastly, the community paramedic was asked to collaborate with the physical and occupational therapy departments to go on home visits. The CP, PT, and OT will attend a home visit for a patient together to determine if the patient can live in their home safely. This collaboration was implemented for better patient outcomes from a safety and clinical perspective.



Community Paramedics see patients through referrals from physicians or in 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 EKGs
- 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
- Community referrals for additional support as needed

TRI-COUNTY PREVENTATIVE HEALTH CARE

Women's Breast Health

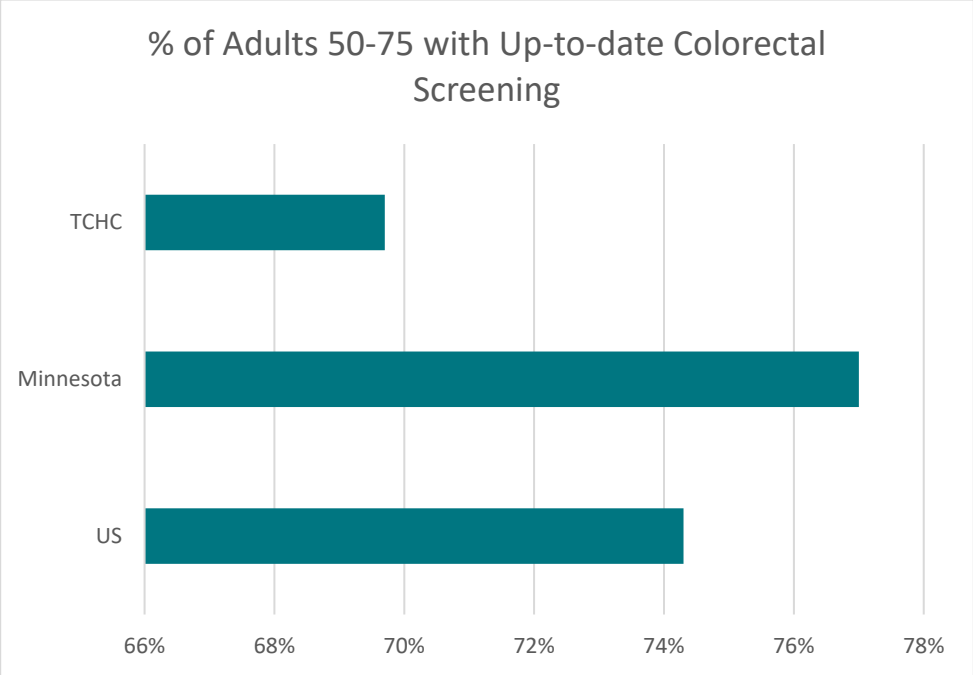
In 2018, 4,500 women were diagnosed with invasive breast cancer in Minnesota (an increase of 400 women from 2012). Breast cancer is the most commonly diagnosed cancer in women, accounting for nearly one out of every three cancers.

Tri-County Health Care screened 72.7 percent of eligible patients for breast cancer in 2020. That increased to 75.2 percent in 2021. The goal is to continue to increase that percentage and reach 81 percent. This is measured by the Healthcare Effectiveness Data and Information Set (HEDIS), a comprehensive set of standardized performance measures designed to provide purchasers and consumers with the information they need for a reliable comparison of health plan performance.

Source: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-HEDIS

Colorectal Cancer Screening

While Tri-County Health Care still lags the state and national averages in the percentage of adults that are current with their colorectal cancer screenings, the work done over the past several years has moved our measurements in the right direction. Tri-County grew from 60 percent in 2016 to 67 percent at the end of June 2019. That increased to 69.7 percent in 2021.



*State and national data from 2020

In addition, in 2018, Tri-County Health Care expanded its colorectal cancer screening options to include Cologuard. Annual marketing efforts include 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 the U.S., regardless of race/ethnicity. In 2022, an estimated 4,290 people will be diagnosed with prostate cancer. In 2018, 2,920 men were diagnosed with prostate cancer in Minnesota. This is a decline from the 3,355 men diagnosed in 2012, showing an improving trend across the state.

Source: American Cancer Society Facts and Figures 2022

Wellness Initiatives

Tri-County Health Care continued its wellness initiatives with Wellworks For You 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 For You program looks at annual biometrics tied to an annual physical with a provider in conjunction with an online health assessment course. If the annual physical with biometrics is completed by the deadline, then a stipend is paid for both the employee and their spouse into the employee's HSA plan. In addition, a premium surcharge was instituted for individuals that smoke and do not attempt a smoking cessation program.

Routine Checkups

Tri-County Health Care began tracking the number of patients who 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. Still, even with that, increases were seen in total for patients in our care being proactive in managing their health and well-being into 2019. The COVID pandemic led to a dip in patients coming in for preventative care in 2020, but marketing efforts are in place to message these patients not to put off routine care.

	2017	**2018**	**2019**	**2020**	**2021**
Medicare Wellness	247	2,370	2,774	2,571	2,781
Well Child	2,237	2,452	2,407	2,177	2,388
Physicals	5,835	3,976	4,137	3,601	3,364
Combined Total	**8,319**	**8,798**	**9,318**	**8,349**	**8,533**

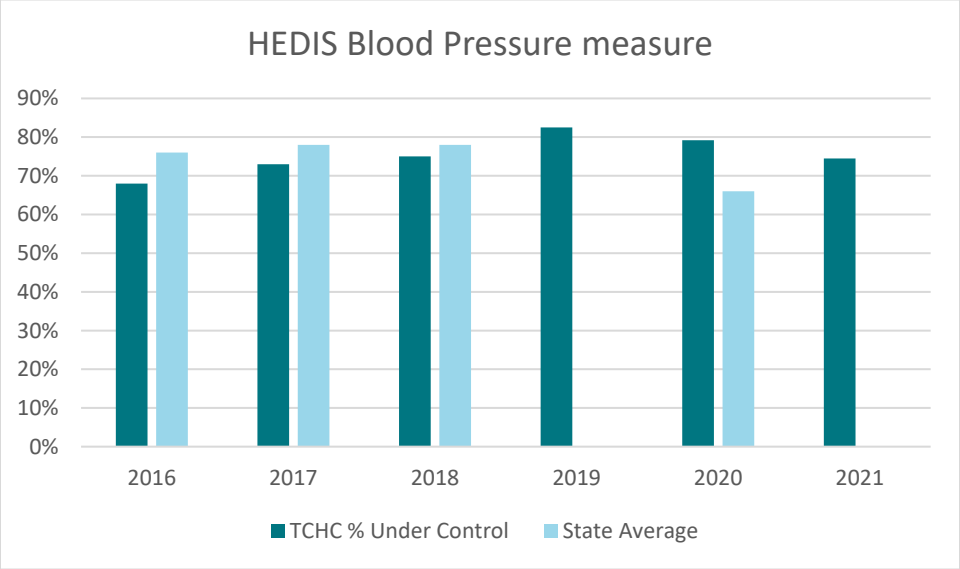
Changes were put in place in 2018 for the notification of preventive care. Letters to our patients have been combined to include colonoscopy and mammogram appointments into the same notification regarding a physical/wellness exam. This streamlines the communication and allows the patient to place all of those appointments in one call and, in some instances, have the colon cancer screening and mammogram done before 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.

Additionally, with the construction of a new medical campus set to open in 2023, the registration team plans to focus more on outbound calls to further streamline communication efforts to patients. The goal would be to assist patients in getting their routine checkups scheduled by proactively calling them in addition to sending them reminder letters.

CHRONIC DISEASE MANAGEMENT

Hypertension

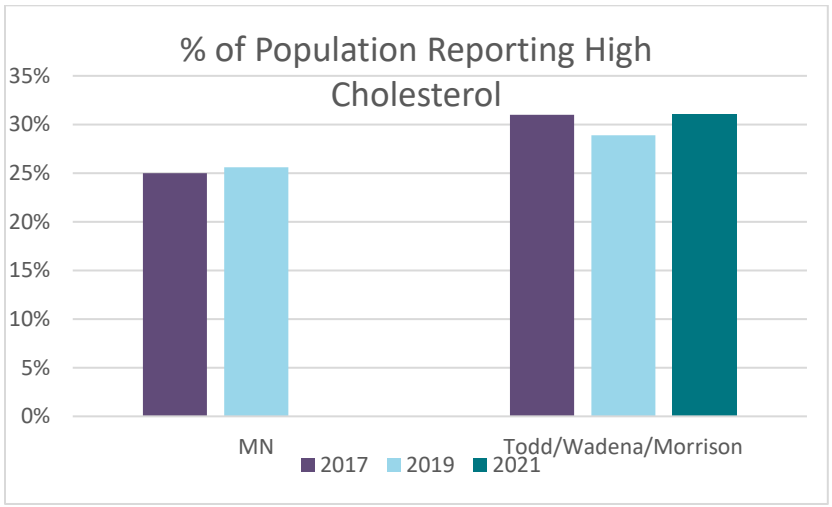
This graph represents the percentage of Tri-County patients maintaining blood pressure compliance from 2016-21 compared to state averages. Tri-County has made significant improvements in HEDIS blood pressure measurements and surpassed 80 percent in 2019 and was above the state average in 2020.



*State data not available for 2019 & 2021

Cholesterol

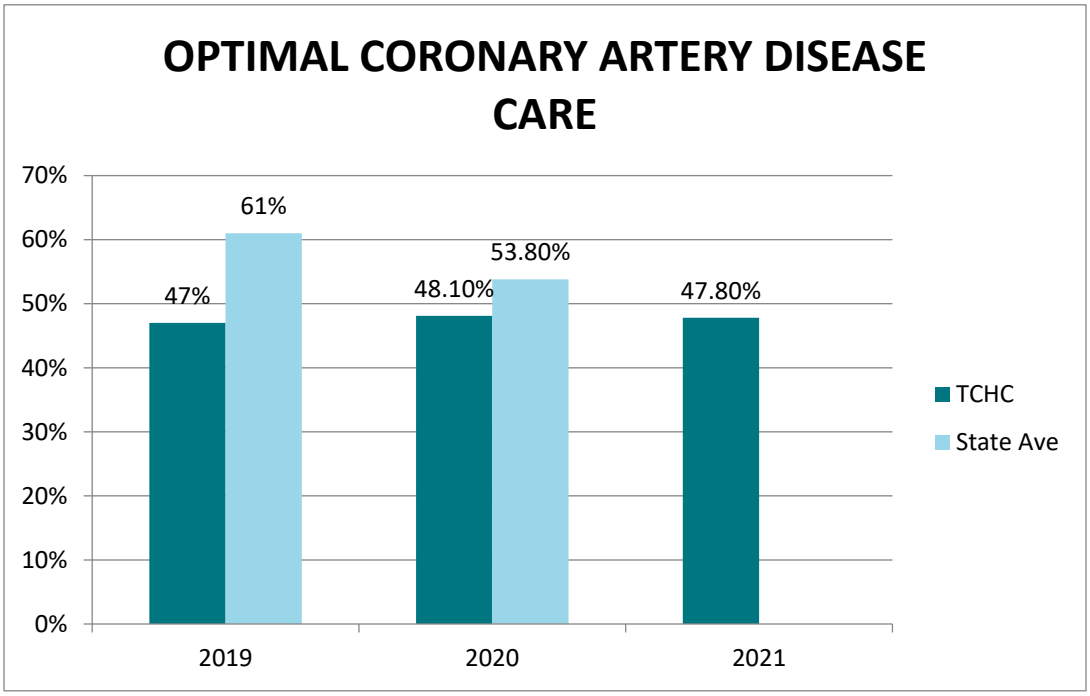
The Minnesota Department of Health reports that the number of Minnesotans who reported high cholesterol in 2013 was 33 percent, and it decreased and remained consistent at 25 percent from 2017-19. MDH has noted it's an improving trend. Survey respondents in Todd, Wadena, and Morrison counties reported high cholesterol increases from 29 percent to 31 percent in 2021.



*State data not available for 2021

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

Optimal Coronary Artery Disease 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.

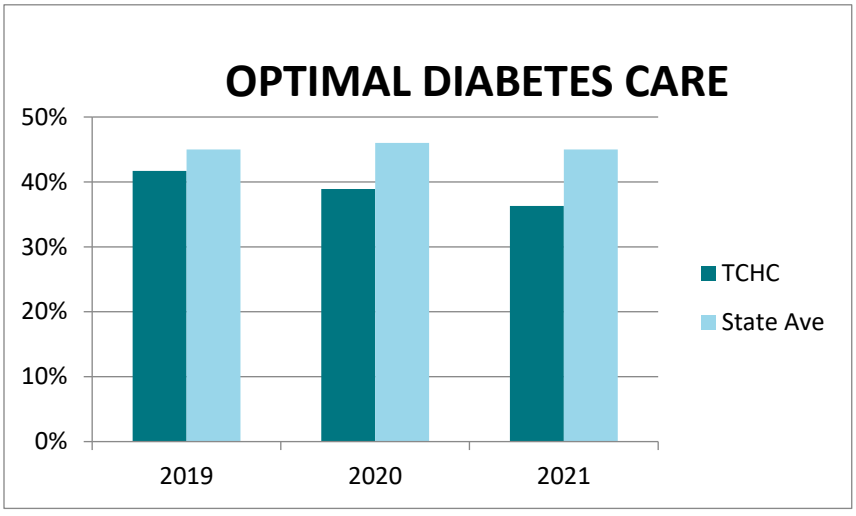


Diabetes

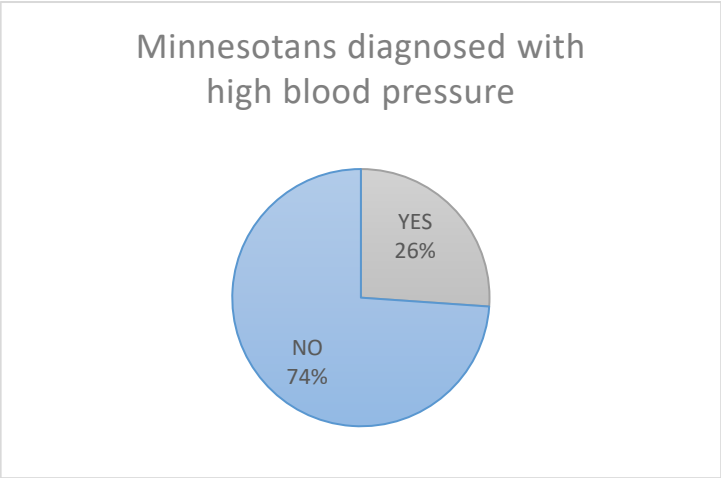
Optimal Diabetes Care is achieved when a patient meets all five measures in the Minnesota Community Measurement Diabetic Measure set. These measures are blood pressure, Hemoglobin A1C in good control, Tobacco free, Daily Aspirin if indicated, and use of a Statin medication for high cholesterol.

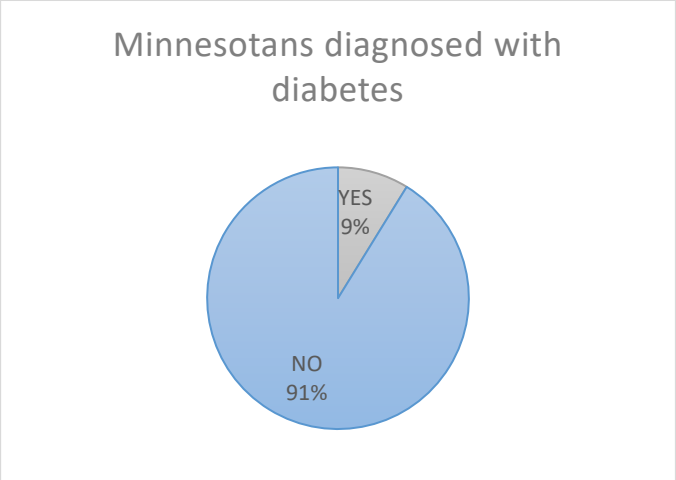
Tri-County Health Care has seen a decline in optimal diabetes care since 2019. It has gone from 41.7 percent in 2019 to 36.3 percent in 2021.

According to the Minnesota Department of Health, in 2020, 8.8 percent of Minnesota adults were diagnosed with diabetes (Type 1 or 2), and in 2019, 26.1 percent of Minnesota adults reported having high blood pressure.

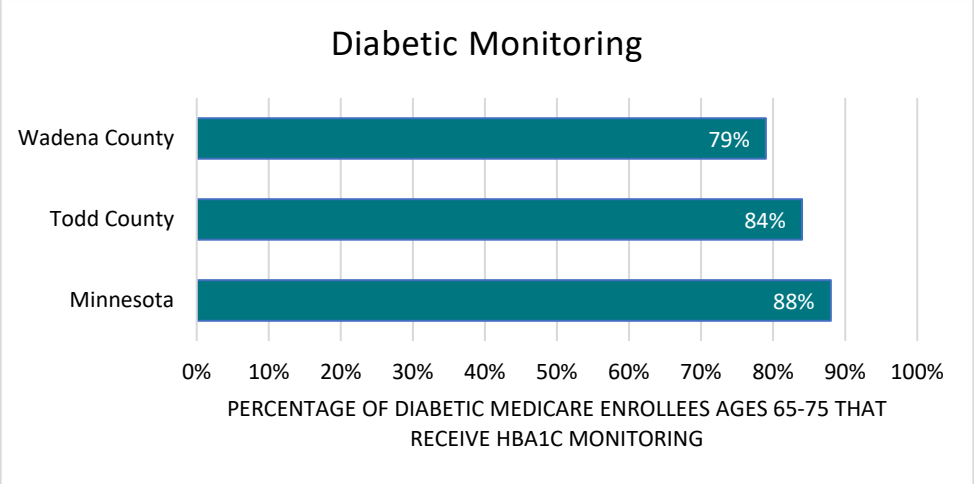


People with diabetes are at a higher risk of serious health complications such as blindness, kidney failure, heart disease, stroke, and loss of toes, feet, or legs.





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

PILLAR	DOMAIN	90th %tile GOAL	2022 GOAL	2019 Roll Up	2020 Roll Up	2021 Roll Up	Q1 2022	Q2 2022	Q3 2022
	OPTIMAL CARE	72.0	67.0	63.8	59.75	54.4	54	57.8	59.8
QUALITY	OPTIMAL DIABETES CARE	50.0	42.0	41.7	38.9	36.3	36.3	36.9	39.1
	Hgb A1C <8	75.0	70.0	68.2	65.1	64.8	64.9	62.6	65.6
	OPTIMAL VASCULAR CARE	63.0	60.0	56.1	48.1	47.8	48.9	50	53
	OPTIMAL ASTHMA CARE Adults	71	55	51.2	42.94	40.74	43.7	53.6	58.77
	OPTIMAL ASTHMA CARE Children	80	59	55	49.62	53.7	44.4	51.5	55.5
	USE OF PHQ9	100	95	98	97.0	96.0	96.0	96.0	96.0
	DEPRESSION REMISSION 6 MO	12	10	11	9	7	8.8	9	11.0
	HYPERTENSION MEASURE	90	79	82.5	79.2	74.5	72.4	77	77
	PREVENTIVE CARE	90	76	70.3	69.7	71.6	72	73.8	73.2
	COLORECTAL CANCER SCREENING RATE	90	76	68.8	67.9	69.7	69.8	71.6	70.9
	BREAST CANCER SCREENING RATE	90	76	73	72.7	75.2	76.1	77.3	76.9
ALL CLINICS SERVICE	RECOMMEND the OFFICE	94.8	92.8	89.9	92.2	91.3	90.3	89.6	89.4
	RATE DOCTOR 9-10	92.3	88.5	85.2	87	86.1	84.4	83.6	84.5
	PROVIDER COMMUNICATION QUALITY	95.7	93.3	92.4	93.1	92.5	91.9	92.2	92.4
	OFFICE STAFF QUALITY	96.6	96.1	96.3	95.1	94.7	94.5	94.6	94.1
	ACCESS TO CARE/ TIMELY APPT	87.1	86.4	85.2	83.9	84.9	83.3	82.5	82.7
	CARE COORDINATION	79.1	78.1	79.1	79.6	78.1	77.2	77.5	77.6
	Positive varience =goal or >goal								
	Neutral=<% below goal								
	Negative varience=>-5%								

ALL DATA IS ROLLING 12 MONTHS

Our Communities

The community included in this assessment was the service area of Tri-County Health Care. This consists of the counties of eastern Otter Tail, Todd, and Wadena in Central Minnesota. This service area was determined through a geographical area surrounding the main hospital and our clinic locations. The total population for these counties is estimated at 99,408. The population of the primary service area of Tri-County Health Care is estimated at 39,327 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 Tri-County clinics located in or near these cities. The clinics that make up Tri-County Health Care are shown with red pins and competitors are shown in blue on the map below.

Ethnicity is primarily Caucasian (90.4 percent), other (3.5 percent), black (0.6 percent), American Indian (0.4 percent), Asian (0.4 percent), and two or more races (4.4 percent). The poverty rate for the Tri-County Health Care service area is 11.8 percent (American Fact Finder: U.S. Census Bureau, 2018).

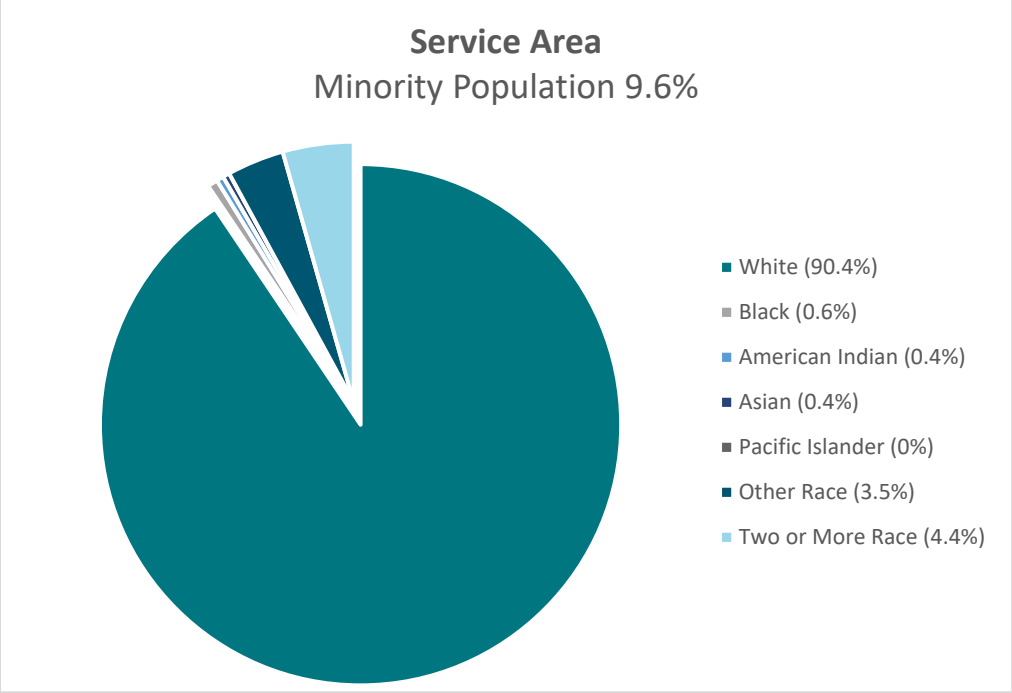
POPULATION STATISTICS

Children and youth comprise 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	6.6%	5.9%
5-17 Years	25.3%	23.1%
18-64 Years	46.2%	54.3%
65 and Over	21.9%	16.7%

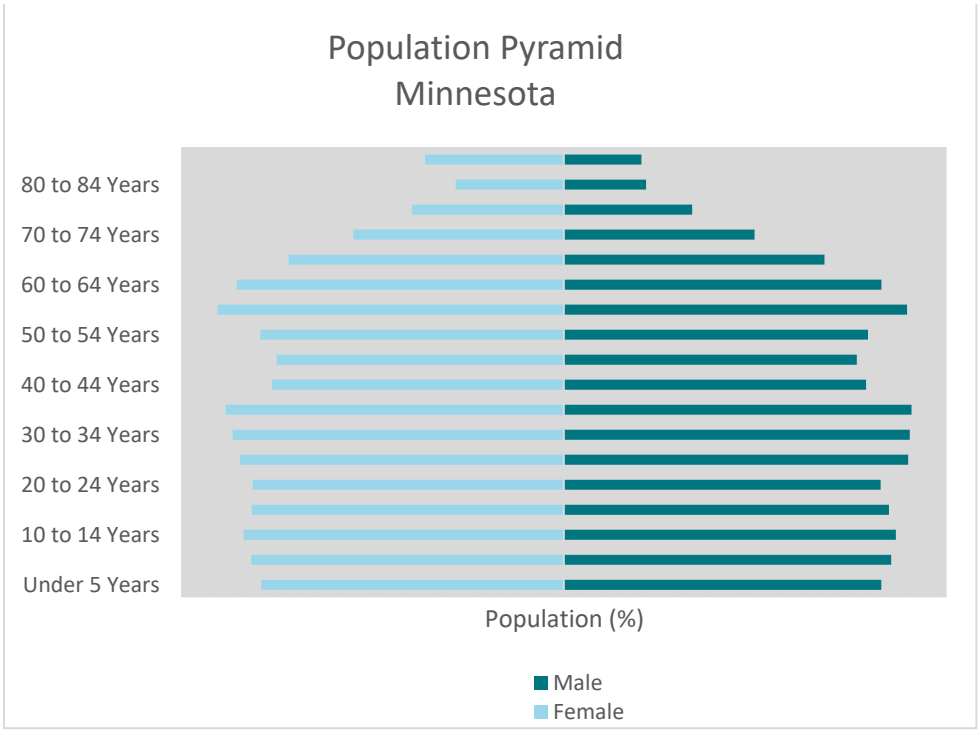
	Service Area	Minnesota
Total Households (2016-2020)	15,636	2,207,988
Persons Per Household (2021)	2.38	2.48

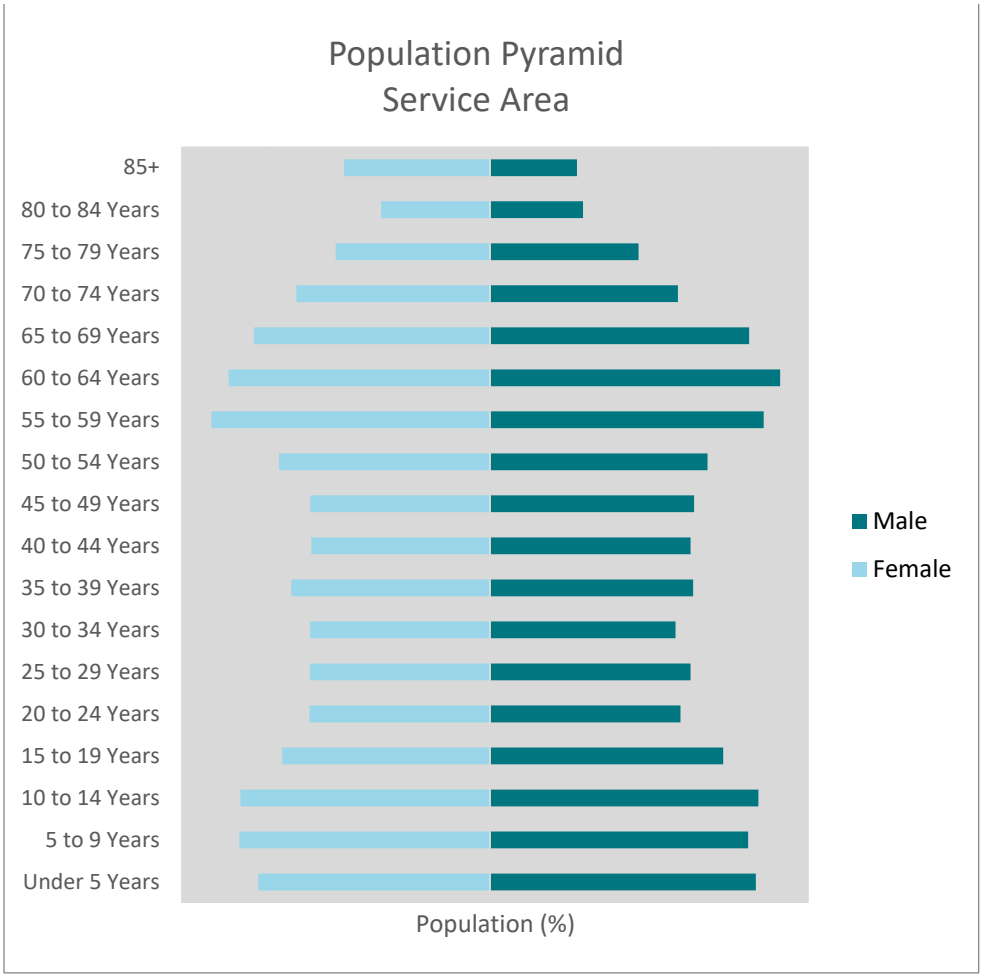
Data source: Population estimates, 2021. U.S. Census Bureau.
https://www.census.gov/quickfacts/table/PST045215/27,27153,27159



The Tri-County Health Care service area consists primarily of White/Caucasians (90.4%) compared to the state of Minnesota (77.5%). The Tri-County service area has a low minority population compared to Minnesota, with a difference of 12.9%.

Data source: 2020 U.S. Census:
https://data.census.gov/cedsci/table?q=United%20States





According to census data statistics, the service area has an older population than the rest of the state, which is typical of a more rural population.

Median Age

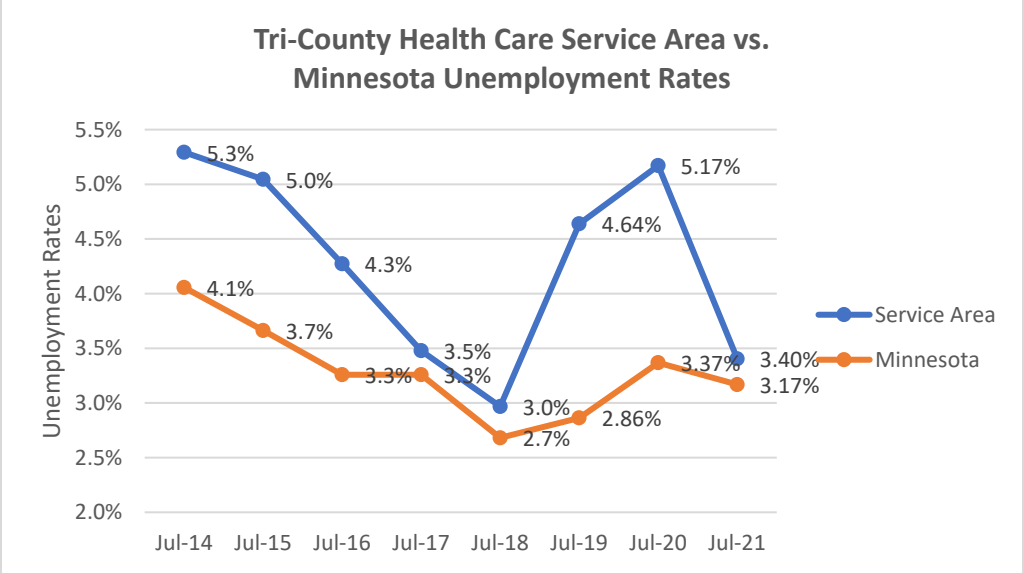
Todd County	43.7
Wadena County	41.2
State of Minnesota	38.3

Data source: County Population by Characteristics, 2010-2019. U.S. Census Bureau. https://www.census.gov/data/tables/time-series/demo/popest/2010s-counties-detail.html

SOCIOECONOMIC FACTORS

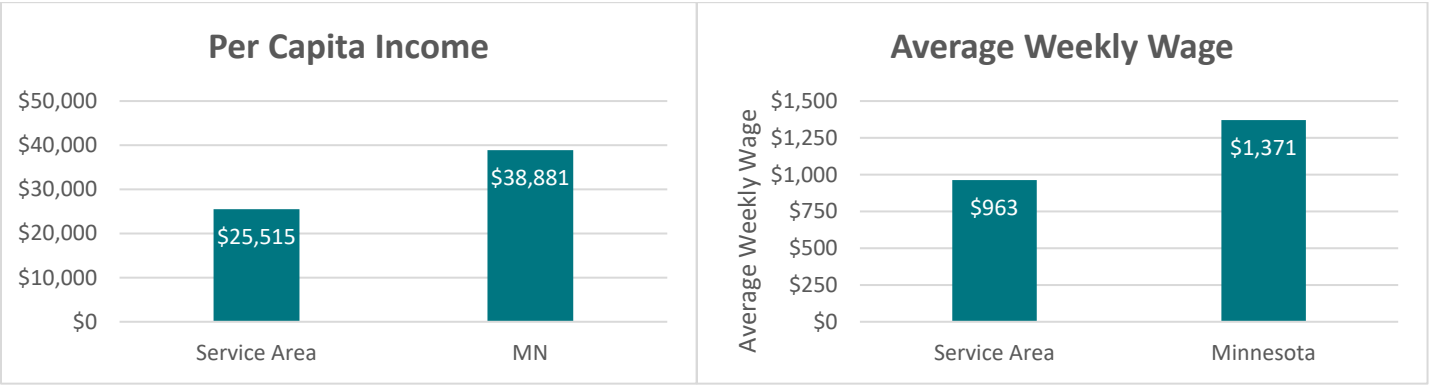
Unemployment Data

	Jul-14	Jul-15	Jul-16	Jul-17	Jul-18	Jul-19	Jul-20	Jul-21
Minnesota	4.1%	3.7%	3.3%	3.3%	2.7%	3.4%	8.1%	3.2%
Service Area	5.3%	5.0%	4.3%	3.5%	3.0%	5.25%	5.5%	3.45%



Historically, the Tri-County Health Care service area's unemployment rate has been consistently higher than the state average. That increased in 2019 and 2020 before returning to near the state average in 2021.

Data source: Local Area Unemployment Statistics (LAUS) *Minnesota Department of Employment and Economic.* Retrieved April 18, 2022. 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 $1,371, whereas the Tri-County Health Care service area's average weekly wage is $963.

Data Source: United State Census Bereau QuickFacts, 2021.
https://www.census.gov/quickfacts/fact/table/mn,wadenacountyminnesota/INC910217

Data Source: Annual 2021 Average Weekly Income. Regional Labor Market Information. (n.d.). Minnesota Department of Employment and Economic Development. Retrieved April 18, 2022 from https://apps.deed.state.mn.us/lmi/rws/

POVERTY

Percentages of All Ages Living in Poverty

	2015	2017	2021
Minnesota	11.3%	10.5%	8.3%
Service Area	15.3%	13.7%	11.7%

Poverty is defined by comparing annual household income to the 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, informing the public and decision-makers for program planning and evaluation.

The statistics indicate that people in the Tri-County Health Care service area tend to have higher rates of poverty than the general population within Minnesota. Both the Tri-County Health Care service area and the state of Minnesota have seen declines in the rate of poverty since 2017. However, the Tri-County Health Care service area remains just over three points higher.

Source: Census 2020:
https://www.census.gov/quickfacts/fact/table/wadenacountyminnesota,toddcountyminnesota,MN/PST045221

Number of Students Receiving Free and Reduced Priced Lunches

	2013	2016	2019	2022
Minnesota	38.3%	38.1%	36.4%	37.1%
Service Area	56.2%	53.7%	52.0%	52.8%

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.

Mothers and Children Receiving WIC (Special Supplemental Nutrition Program)

	2018	2019	2020	2021
Minnesota	111,121	105,961	100,123	100,829
Service Area	922	898	874	922

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.

Sources: https://www.health.state.mn.us/people/wic/localagency/reports/ &
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 help 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	2018	2019	2020
Minnesota	8.9%	8.9%	8.6%	7.3%	7.4%	7.5%
Service Area	11.3%	10.8%	9.9%	9.7%	10.3%	11.1%

2021 County Profile

Wadena

5,666 Households | CENTRAL REGION

Access to safe, affordable homes builds a strong foundation for families and communities. But too many Minnesotans lack good housing optons.

In Wadena County, incomes are increasing faster than rent bucking a trend across the state where rent increases far surpass income increases.

The income for families is not rising at the same pace as home values, making it more difficult for families to purchase and own a home.

RENTER HOUSEHOLDS

1,331 | 23% of all households

Median rent, 2000: $499
Median rent, 2019: $668
rent up 34%

Renter income, 2000: $21,309
Renter income, 2019: $30,422
income up 43%

OWNER HOUSEHOLDS

4,335 | 77% of all households

Home value, 2000: $95,608
Home value, 2019: $132,000
value up 38%

Owner income, 2000: $52,109
Owner income, 2019: $55,047
income up 6%

HOUSING STOCK: While a significant portion of the rental and owner-occupied housing is aging (built before 1970), new construction is not keeping up with demand. Of particular concern is the gap between the number of available units for extremely low income households – and the number of people who need them.

Disparities: Disparaties are stark for BIPOC residents of all 87 counties. Homeownership disparities are above 65% in every county in Minnesota with most over 90%. Cost-burden is higher for BIPOC renters (52%) than white renters (44%) in Greater MN.

% of homes built before 1970: 43%
Single-family units permitted in 2019: 24

% of rental units built before 1970: 47%
Multi-family units permitted in 2019: 0

Number of extremely low income households: 410
Units affordable to extremely low income households: 250
Gap between ELI households and units in Wadena county: 160

Greater MN	Renter Cost Burden	Severe Renter Cost Burden
White	44%	22%
Black	59%	36%
Indigenous	48%	24%
Hispanic	51%	29%

Homeownership in Wadena County

BIPOC Homeowners 84

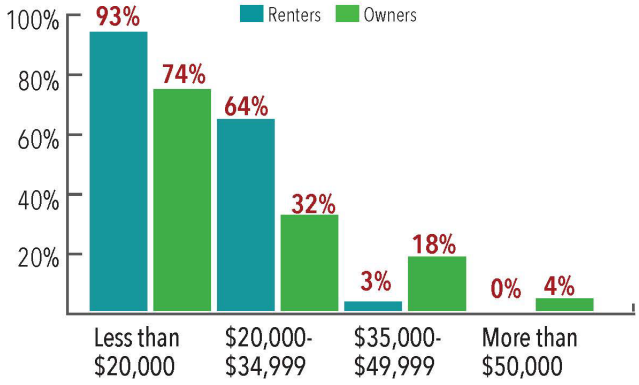
White Homeowners 4,251

Housing Costs

1,418 households in Wadena County pay more than 30 percent of their income toward housing costs, putting them at risk of being unable to afford basic needs like food and medicine. 544 are severely cost-burdened and pay more than 50 percent of their income on housing.

COST BURDEN

Percentage of households paying more than 30% of their income toward housing.



Number of households paying more than 30% of their income toward housing

	RENTERS	OWNERS
Under $20,000	411	405
$20,000-34,999	137	229
$35,000-49,999	8	124
Over $50,000	0	104
Seniors	168	364
All cost-burdened households	556	862

SEVERE COST BURDEN

Number and percent of households paying **more than 50%** of their income toward housing.

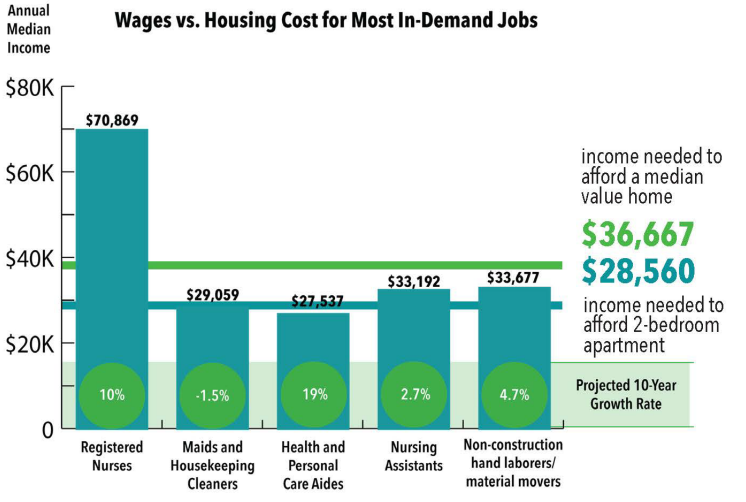
Severe Renter Cost Burden — **202** households or **18%** of all renter households

Severe Owner Cost Burden — **342** households or **8%** of all owner households

WAGES: Housing remains a challenge even for Minnesotans who are fully employed. The median earnings for most of the top in-demand and high-growth jobs in the Northwest region do not cover housing costs at an affordable level. Those working at the median wage – and especially those earning the minimum wage – cannot afford a two-bedroom apartment or the mortgage for a median price home.

HOMELESSNESS: In the Central region, too many families, seniors and children are still suffering the devastating consquences of having no place to call home.

Northwest Region Data



Median household income for county **$46,605**

Hours / week minimum wage employee must work to afford 1- bd apartment **43**

# of homeless on a given night in 2018	**944**
Change in homeless since 2000	**20%**
Number of homeless children	**347**
Number of homeless seniors	**78**

mhp improving home & community

SOURCES – Renter households: Rent and income adjusted for inflation. U.S. Census Bureau, American Community Survey 2019, 5 year estimates | Owner households: Home value and income adjusted for inflation. U.S. Census Bureau, American Community Survey 2019, 5 year estimates | Cost burden: U.S. Census Bureau, American Community Survey 2019, 5 year estimates | 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, November 2020; Employment Outlook, MN DEED | Housing Stock: U.S. Census Bureau, American Community Survey 2019, 5 year estimates, U.S. Census Bureau, Building Permits Survey, 2019 | Homelessness: Wilder Research Center, 2018 Minnesota Homeless Study

Homelessness

Central Minnesota saw a bigger increase in homelessness than the rest of the state between 2015 and 2018. 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 Minnesota Housing Partnership report, the wage and rent gap is growing.

Building on an annual report from the National Low Income Housing Coalition, MHP's Out of Reach Minnesota 2022 reveals that Minnesota's housing wage — the wage necessary to afford a two-bedroom apartment — is $22.41 per hour statewide, and $15.76 in non-metro areas.

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.

The housing wage for Wadena County and Todd County was $14.12. There were 23 percent of renter households in Wadena County and 17 percent in Todd County. According to RentData, the fair market rent (FMR) in Wadena County for a two-bedroom apartment was $757, which is less expensive than 72 percent of other areas and an increase of 3.13 percent from 2021. Todd County's FMR was also $757.

In Wadena County, 36 percent of renters reported paying more than 30 percent of their income in rent each month.

Home Values

The median home value in Wadena County is $135,000, and in Todd County is $151,800. Estimated monthly owner costs for mortgages were $1,091 in Wadena County and $1,151 in Todd County.

Source: 2021 Census estimates

EDUCATION

K-12 Public School Enrollment

Education enrollment numbers have fluctuated in our service area over the last five years, peaking in 2020. The trends for the state of Minnesota were similar.

	2017	2018	2019	2020	2021
Minnesota	862,160	884,944	889,304	893,203	872,083
Service Area	5,804	6,003	6,116	6,058	5,990

In addition, as one would expect in a lower-income region, the graduation rates in the area are lower than state averages, as are the percentages of adults with a bachelor's degree or higher. However, according to the County Health Rankings, both Todd and Wadena counties are slightly behind state averages for high school graduation rates.

High school graduation or higher, percent of adults 25 years +
State of MN – 93.4%
Todd County – 87.4%
Wadena County – 91.4%

Bachelor's Degree or higher, percent of adults 25 years +
State of MN – 36.8%
Todd County – 13.9%
Wadena County – 16.9%

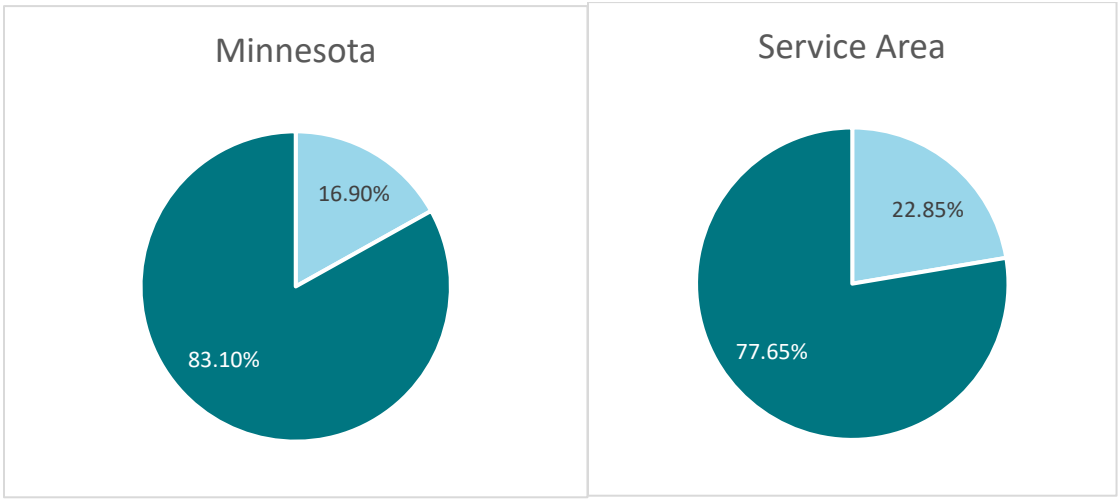
Source: Census.gov/quickfacts/MN

High School graduation rates – 2022
MN – 93%
Todd County – 87%
Wadena County – 91%

Source: https://www.countyhealthrankings.org/reports/state-reports/2022-minnesota-state-report

K-12 Special Ed Enrollment

Our service area has over 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 by approximately 3 percent per year, 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 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 daycare shortages across the region, often making it difficult for a single parent or a second parent in a married home to obtain employment. This, along with the region's high poverty rates in the region, is a barrier to helping families get out of poverty in our region.

The COVID-19 pandemic slowed the implementation of a childcare expansion project. With the shortage still greatly affecting Wadena County, the project will continue to move forward to potentially provide more care options for parents.

HEALTH BEHAVIORS

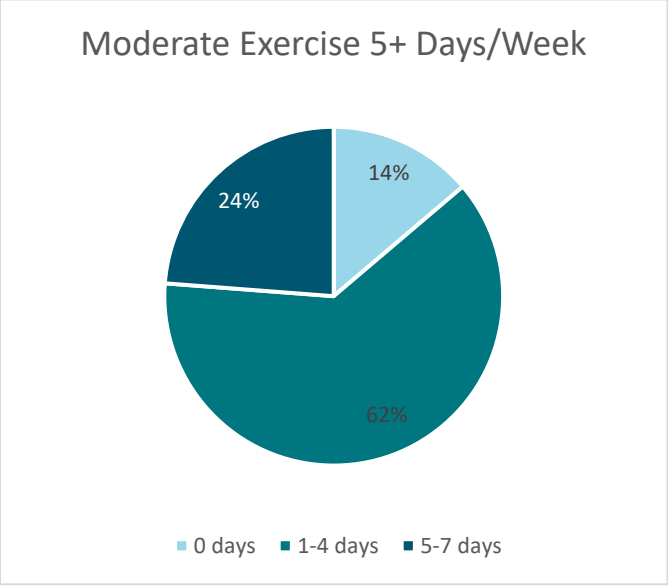
Health Outcomes

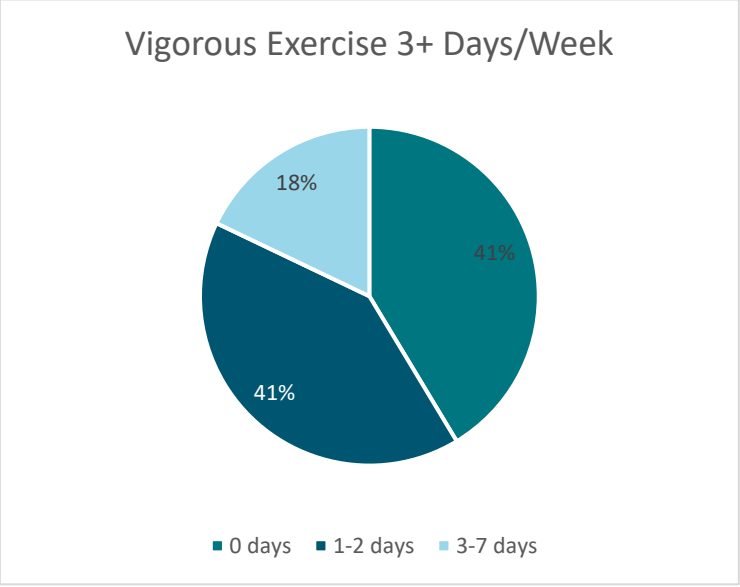
Wadena County ranks 81 out of 87 counties in Minnesota for overall health. Overall, both Wadena and Todd counties have higher-than-state averages in smoking, obesity, and teen births. Both counties also have lower than state averages for access to exercise opportunities. Wadena performs stronger given the Maslowski Wellness and Research Center that exists in the county and provides ample opportunity for exercise for its residents.

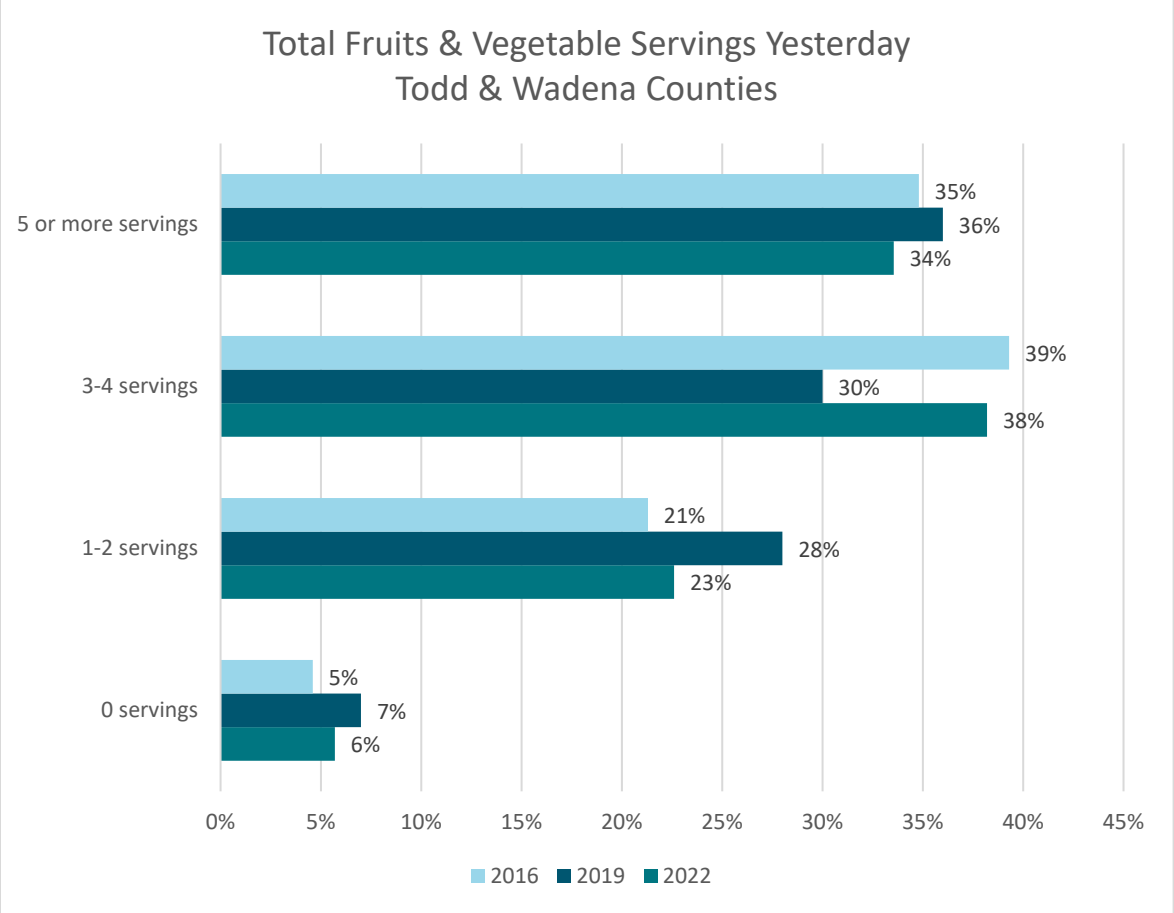
Health Behavior	Wadena County	Todd County	Minnesota
Health Outcome Rank	81 / 87	44 /87	
Quality of Life	76 / 87	45 / 87	
Health Behavior Rank	84 / 87	78 / 87	
Adult Smoking	23%	21%	16%
Adult Obesity	39%	38%	29%
Food environment Index	7.4	7.8	8.9
Access to exercise opportunities	67%	40%	87%
Excessive Drinking	23%	24%	23%
Alcohol impaired driving deaths	17%	20%	30%
Sexually Transmitted Diseases	182.9	240.7	422.6
Teen births	27	24	13

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

Diet and Exercise



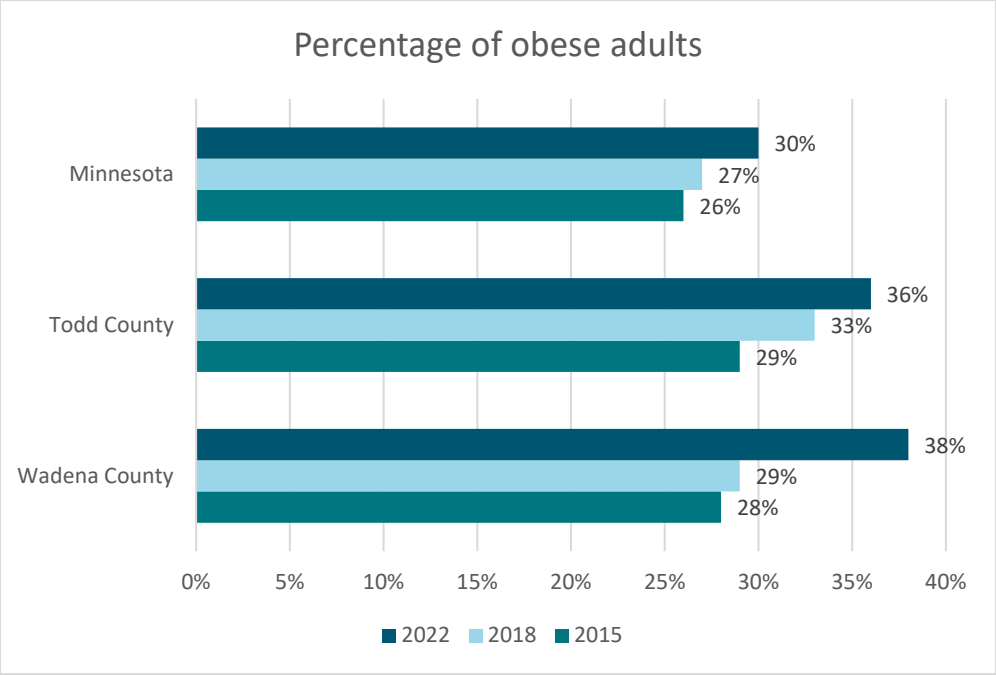




There has been a slight increase in fruit and vegetable serving consumption, as displayed in the graph above. Almost half of the adults in our service area are not getting vigorous exercise in a given week.

Data source: Minnesota Department of Health: County Health Tables.
https://www.health.state.mn.us/data/mchs/genstats/countytables/index.html

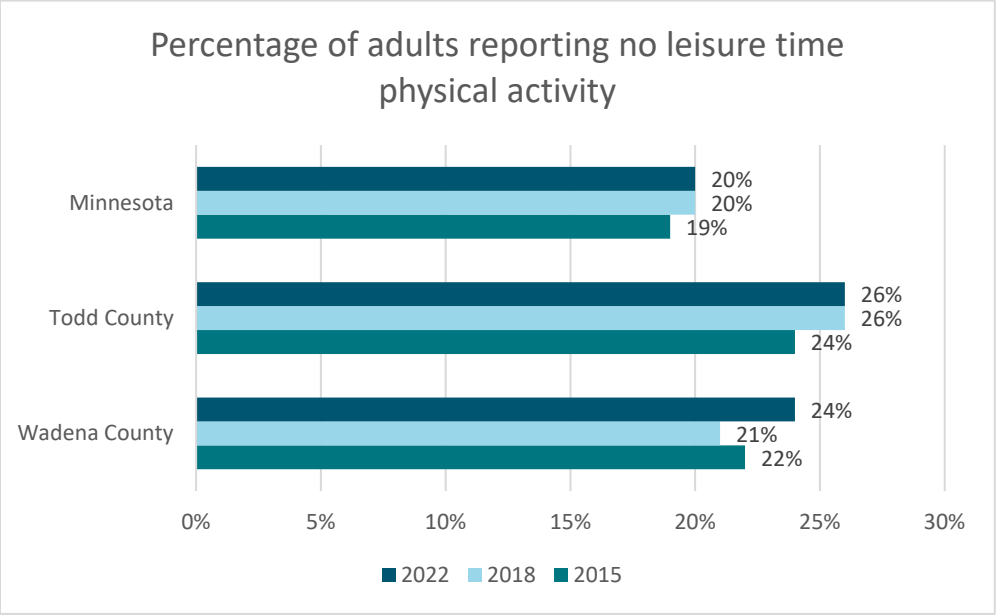
Adult Obesity Prevalence



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. Both the Tri-County Health Care service area and the state of Minnesota continue to indicate a growing number of adult obesity.

Adult obesity prevalence represents the adult population older than 20 years old with a body mass index greater than or equal to 30kg/m². This data is based on the Behavior Risk Factor Surveillance System. Obesity prevalence is essential 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, 2022
https://www.countyhealthrankings.org/app/minnesota/2022/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.

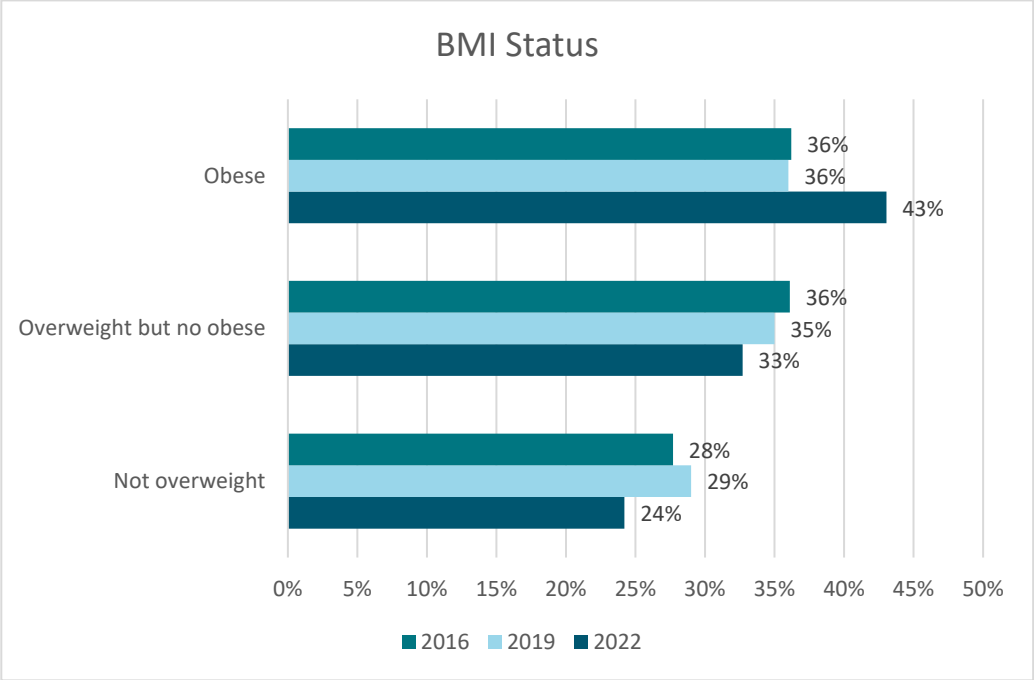
People who have obesity, compared to those with normal or healthy weight, are at increased risk for:

- 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 illnesses such as clinical depression, anxiety, and other mental disorders
- Body pain and difficulty with physical functioning

According to the County Health Rankings and Roadmaps, 29 percent of Minnesotans are obese, and 36-38 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 higher rate than the county health rankings, and the numbers have increased in recent years.

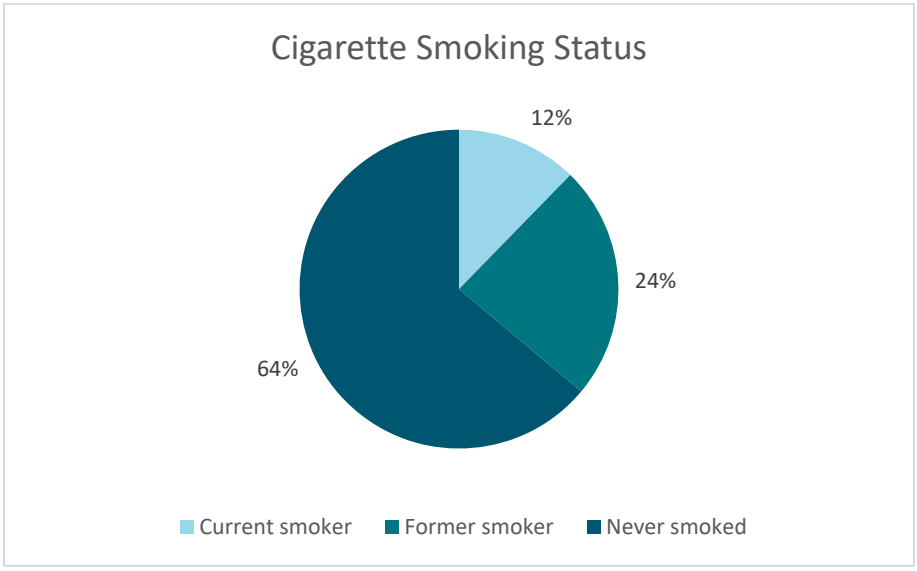
Data source: County Health Rankings and Roadmaps: A Healthier Nation County by County, 2022

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. 12.3 percent of respondents currently smoke, compared to the state average of 13.8 percent in 2020. Just 5.8 percent of respondents use e-cigarettes or vape products, a drop from the 10 percent who stated using these products in 2019.



In 2020, Minnesota increased the age to purchase tobacco to 21. Our neighboring county, Otter Tail County, was the first county in Minnesota to pass the T21 initiatives, effectively raising the age of tobacco purchase.

Incident Rates of Asthma Hospitalizations, Cancer and COPD Hospitalizations

	Asthma Hospitalizations (per 10,000)	Cancer (per 100,000)	COPD Hospitalizations (per 10,000)
Minnesota	3.1	458.2	14.6
Todd County	1.8	433.7	15.2
Wadena County	3.2	478.2	19.1

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 year 2019.

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 2021.

Data Source: Minnesota Public Health Data Access, 2022. https://apps.health.state.mn.us/mndata/

Mental Health

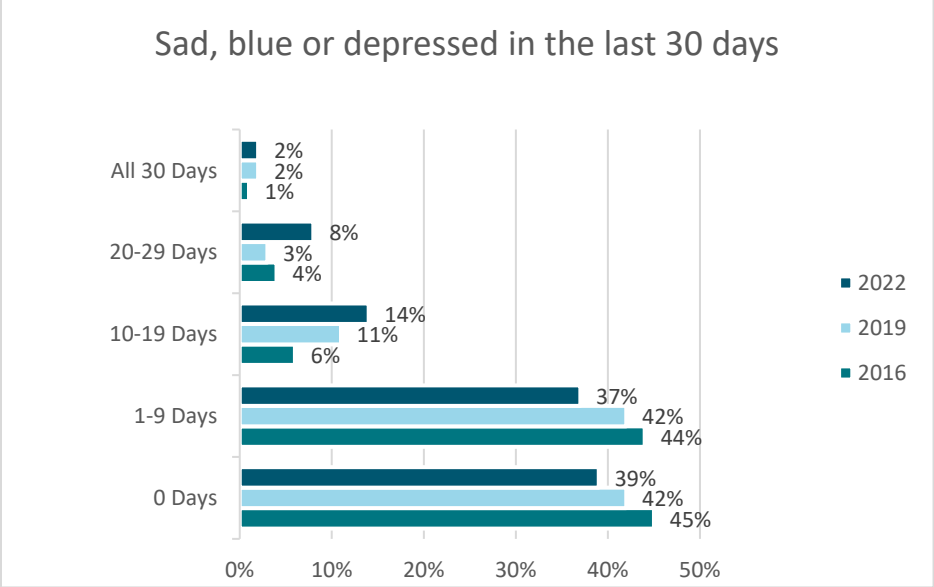
According to the MN Dept of Health, one in five Minnesotans face mental illness each year. In addition:

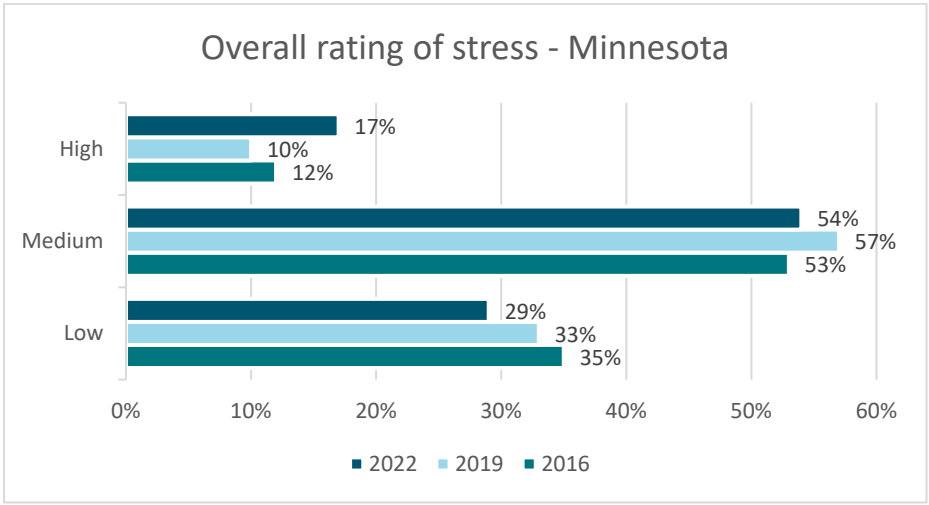
- One in 25 people live with serious illness, such as schizophrenia, bipolar disorder, or major depression
- One in 10 young people experienced a period of major depression
- 10-25 years shorter lifespan for people with serious mental illness

Nearly two-thirds of Minnesota's homeless population has a mental illness, according to a 2018 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 in our service area. Nearly 29 percent of the CHNA survey respondents report having mental health issues. Additionally, 13.5 percent of respondents reported delaying mental health care. 26.4 percent of survey responses stated they felt the need to hide 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.





Drug Addiction (Prescription and Street Drugs)

According to the Minnesota Department of Health, drug overdose deaths among Minnesota residents continued an alarming trend, increasing to a record in 2021. Final data collected from Minnesota death certificates show 733 people died from a drug overdose in 2017 compared to 675 deaths in 2016.

In 2021, there were 1,286 overdose deaths reported. In 2017, the total was 422, a 304 percent increase in four years. The greatest rise occurred among deaths involving synthetic opioids other than methadone (predominantly fentanyl), which increased from 184 cases in 2017 to 834 in 2021. The MDH notes that fentanyl is becoming more common in illicit drugs, even laced with drugs like cocaine and methamphetamine. Deaths involving commonly prescribed opioids decreased 11 percent from 2020 to 2021, and deaths involving heroin also decreased by 20 percent between the two years.

Source: MDH drug overdose deaths - 2021

Vaccinations

Children who receive full series (age 24-35 months) – 2019

Wadena County	55.8%
Todd County	57.4%
Minnesota	69.2%

Adolescents who receive full series (Age 13 years) – 2021

Wadena County	15.73%
Todd County	20.15%
Minnesota	27.32%

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. Chronic Lower Respiratory Disease
4. Stroke
5. Alzheimer's Disease
6. Accidents

Data Source: Minnesota County Health Tables: Mortality Table 1: Minnesota Leading Causes of Death by Age Group by State and County, 2019.

2019 Status Update

TRI-COUNTY COMMUNITY HEALTH PRIORITIES – 2019 ASSESSMENT STATUS UPDATE

During the majority of this CHNA cycle, the entire nation was working through challenges associated with the COVID pandemic. Tri-County Health Care had to reprioritize goals to get some of the most basic healthcare services and access to patients in our service area.

Specifically, technology and internet access were new needs for our organization and patients. Because patients were asked to stay home to slow the spread of COVID, schools, businesses, and especially healthcare organizations had to pivot and provide services virtually. Geographically, our service area saw challenges in the ability to use technology. Internet access and cell phone service were non-existent in certain areas, along with antiquated internet infrastructure. Some patients had access to updated computers, cell phones, and virtual devices, while others had limited or dated hardware that restricted their access to healthcare virtually. Because of these challenges, Tri-County Health Care focused on providing opportunities to patients via parking lot virtual visits and use of internet hot spots in rural communities.

Another shift in priorities was when COVID vaccines became available. Staff and patients wanted to be vaccinated for COVID, and because of the variety of options, communication and scheduling needs were at an all-time high. An internal task force was created, and they collaborated with county public health agencies to ensure vaccines were available to those wanting them, including nursing home residents and assisted living tenants. Once the first and second dose vaccines were given to those who desired them, the task force then worked with the marketing team on ways to provide more information to those who were hesitant to be vaccinated for COVID. While the messaging continued for vaccine hesitancies, the task force had to start promoting the booster dose available for patients. All these efforts were important, and some of them continue today.

With the priority shifts identified above, during the pandemic, we experienced major changes to the workforce in the community and our organization. During the intense portion of the pandemic, Tri-County Health Care staff frequently reinvented workflows and changed daily duties to meet the needs of our patients. With the constant changes, our organization lost staff to early retirements because of increased workplace stress. The work our staff was completing constantly changed, and many were also at risk for contracting COVID due to exposure with patients who had COVID.

The staff shortages became a reality when many were out sick or had high-risk exposures at work or with family. A large portion of staff time that did not normally occur was intense education for patients who were experiencing COVID-like symptoms but were unable to test and administer treatments for patients who did test positive for COVID.

While much of the work done during COVID was stressful and ever-changing, successes were abundant. Internally, our organization saw increased collaboration between medical staff, administration, and staff. Wherever work needed to be done or shifts needed to be covered, everyone was ready and willing to jump in to help. With the changes in technology for patients, the organization saw benefits surrounding communication using new technology platforms such as virtual meetings and quick chat.

Below are the 2019 priorities and detailed status updates.

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 a 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 a 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 the 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.

2022 status update: During the 2019-2021 reporting period, Tri-County Health Care was working through the COVID-19 pandemic. Many factors played a part in providing health care to our service area in both positive and negative ways. While state and government offices helped our community members during the pandemic, Tri-County Health Care's priority on social determinants of health was tabled during the pandemic.

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 educational 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

2022 status update: The healthy behaviors priority for the 2019 CHNA saw some traction, while some areas proved difficult to focus on during the COVID-19 pandemic. When the state and federal government enforced business shutdowns, patients in the community also refrained from seeking medical care and treatment. This had a dramatic impact on patient outcomes and our ability to support patients with their health needs. Strategies 1 and 3 were able to be worked on, and Tri-County Health Care continued to reinforce workflows that were established prior to the pandemic to encourage healthy behaviors to our patients. The community-based education classes (I Can Prevent Diabetes, Freedom from Smoking, Living Well with Chronic Pain) had to pause during the pandemic until we could provide hybrid virtual classes. Funding from Wadena County Public Health and SHIP provided Tri-County Health Care with two devices placed in meeting rooms to host virtual meetings. Health fairs and biometric screenings for local employers were also paused during the pandemic.

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 the 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 patients 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

2022 status update: During this CHNA cycle, our organization was able to work on some of the tactics in this priority. The RN opioid health coach was able to work with patients who use medication for opioid use disorder. The monthly visits were conducted in person or virtually, depending on the patient's preference. The organization determined these visits to be a priority and important in the patient's treatment. The Living Well with Chronic Pain classes were initially canceled and then postponed until in person sessions could be held again. We continued to work with area agencies, CHAMP, Otter tail County Opioid Taskforce and ECHOs, which was helpful to shared challenges and successes during the pandemic. A staffing change in late 2021 resulted in two RN opioid health coaches learning this work and supporting patient population. We have been working diligently on formalizing care for patients using opioids including policies on urine drug screens, frequency of visits, and medication contracts.

In summary, the challenges with the pandemic and patients refraining from seeking care, we continue to work on these issues but had to reprioritize the work of staff. But with the technological advancements we were forced to use, we now find this to be an advantage to help manage chronic disease. We will re-focus on the priorities for 2022.

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
- 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-County Health Care Rehabilitation – Wadena & Henning
- Wadena Area Family Counseling

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	Medical Pandemic	Increased collaboration Telehealth/virutal health care visits Virtual meetings Efficiencies	Fear of healthcare organizations Withholding of care Workforce shortages Increased patient demand Patient illnesses more severe
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 Workforce challenges
Trend	Decreased Funding	Collaboration Efficiency	Less Ability
Trend	Low Vaccination Rates	Prevention Collaboration	Funding Less Ability to Manage Vaccine hesitancy
Factor	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	Antiquated technology Self-Diagnosis Limited Resources/Lack of Broadband Lack of supply of devices
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