BUFFALO HOSPITAL
NORTHWEST REGIONAL

Community Health Needs Assessment and Implementation Plan 2014–2016

Allina Health
BUFFALO HOSPITAL

NORTHWEST REGIONAL

Identifying and Responding to Community Needs

BUFFALO HOSPITAL
303 Catlin Street
Buffalo, MN 55313

Buffalo Hospital is a not-for-profit regional medical center located on the western edge of the Twin Cities metropolitan area. Each year the hospital provides advanced care to nearly 70,000 patients and their families.

Buffalo Hospital offers state-of-the-art facilities, personalized care in private rooms and services that are continuously being expanded. Buffalo Hospital has been repeatedly recognized for quality, safe care and outstanding patient outcomes. Employees overwhelmingly say they are proud to work at Buffalo Hospital and would refer their loved ones to the hospital for care. Buffalo Hospital has won many awards over the past several years which include being the first hospital in the state of Minnesota to be awarded the Pathway to Excellence American Nurse Credentialing, award from the MN Business Magazine for developing wellness programs and MN Hospital Association awards for Patient Safety, Best Workplace, and Community Benefit.

Buffalo Hospital is a part of Allina Health, a not-for-profit health system dedicated to the prevention and treatment of illness through its family of clinics, hospitals, care services and community health improvement efforts in Minnesota and Western Wisconsin. The Buffalo Hospital campus includes Allina Medical Clinic – Buffalo and Buffalo Clinic.

Buffalo Hospital also has a long history of working to improve health in the community it serves through both charitable giving by the Buffalo Hospital Foundation and direct programming efforts which address health needs in the community. *continued on page 4*

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2012 Buffalo Hospital Statistics

Licensed beds
65

Staffed beds
34

Total Operating Revenue
$71,505,133

Total Operating Expense
$60,035,948

Total Admits
2,648

Adjusted Admits
7,925

Total Patient Days
6,350

Total Number of ER Visits
18,726

Total Number of Outpatient Visits
70,727

Total Births
882

Number of Full Time Equivalents
313.5

Over the past several years, Buffalo Hospital has rolled out and provided several evidence based classes to the community that include Healthy Eating for Successful Living, Stepping on Falls, Chronic Pain Management and Living Well with Chronic Conditions. Buffalo Hospital also developed and provided 'Let's Talk Wellness'; a program developed in response to the community health needs assessment done in 2010. This program provides nuggets of information to community members in coordination with Buffalo Hospital and the group to help individuals with behavior change in the areas of nutrition, physical activity and stress management.

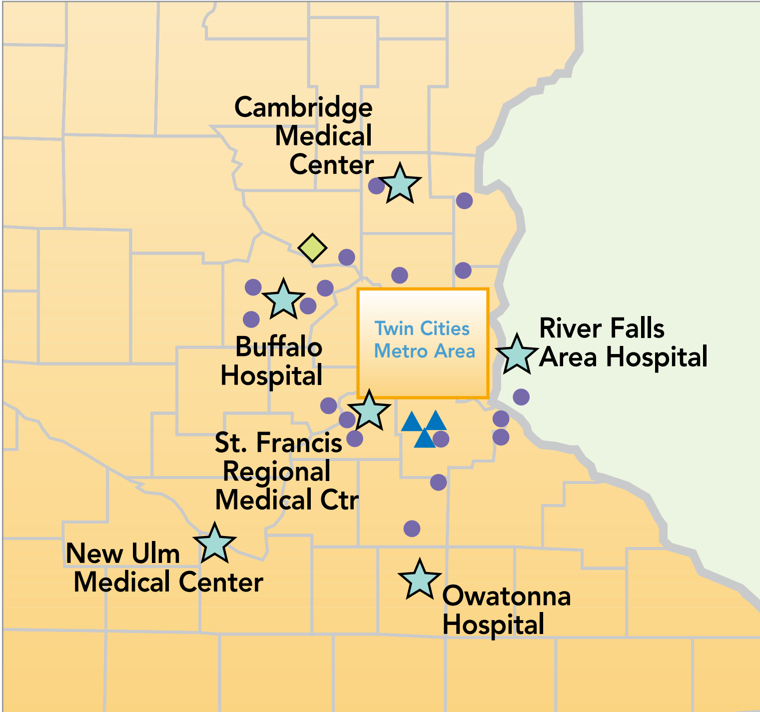
Other areas of partnership and health promotion include our Heart Safe Community program (nationally nominated for the Jackson Charitable Hospital award), Healthy Communities Partnership health screening and coaching, grocery store tours, coffee chats at area senior centers and cancer support with our 'Tough Enough to Wear Pink' rodeo event and the Connect Retreat for women surviving and experiencing cancer.

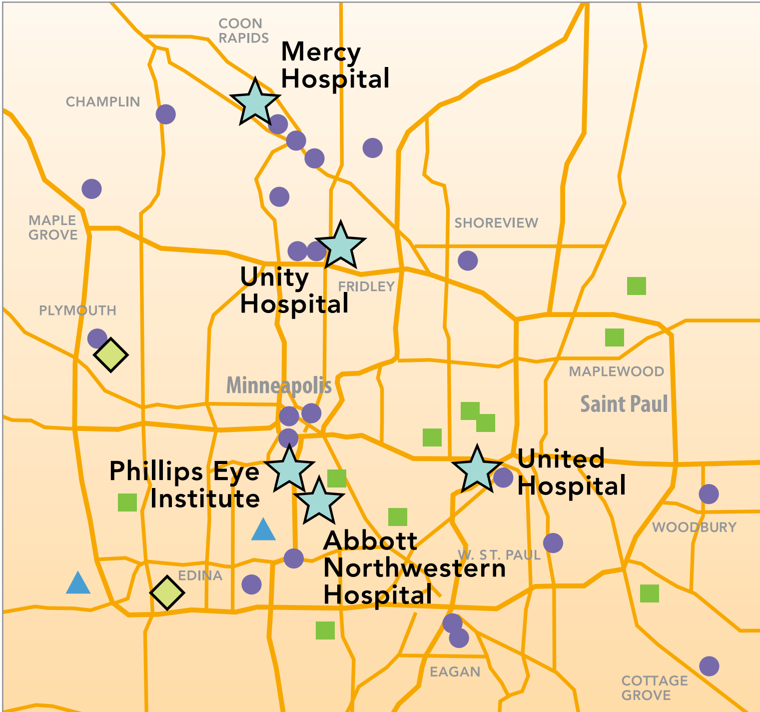
Allina Health and Buffalo Hospital Service Area

Buffalo Hospital is part of Allina Health, a not-for-profit health system of clinics, hospitals and other health and wellness services, providing care throughout Minnesota and western Wisconsin.

Allina Health cares for patients and members of its communities from beginning to end-of-life through:

- 90+ clinics
- 11 hospitals
- 14 pharmacies
- specialty medical services, including hospice care, oxygen and home medical equipment and emergency medical transportation
- community health improvement efforts



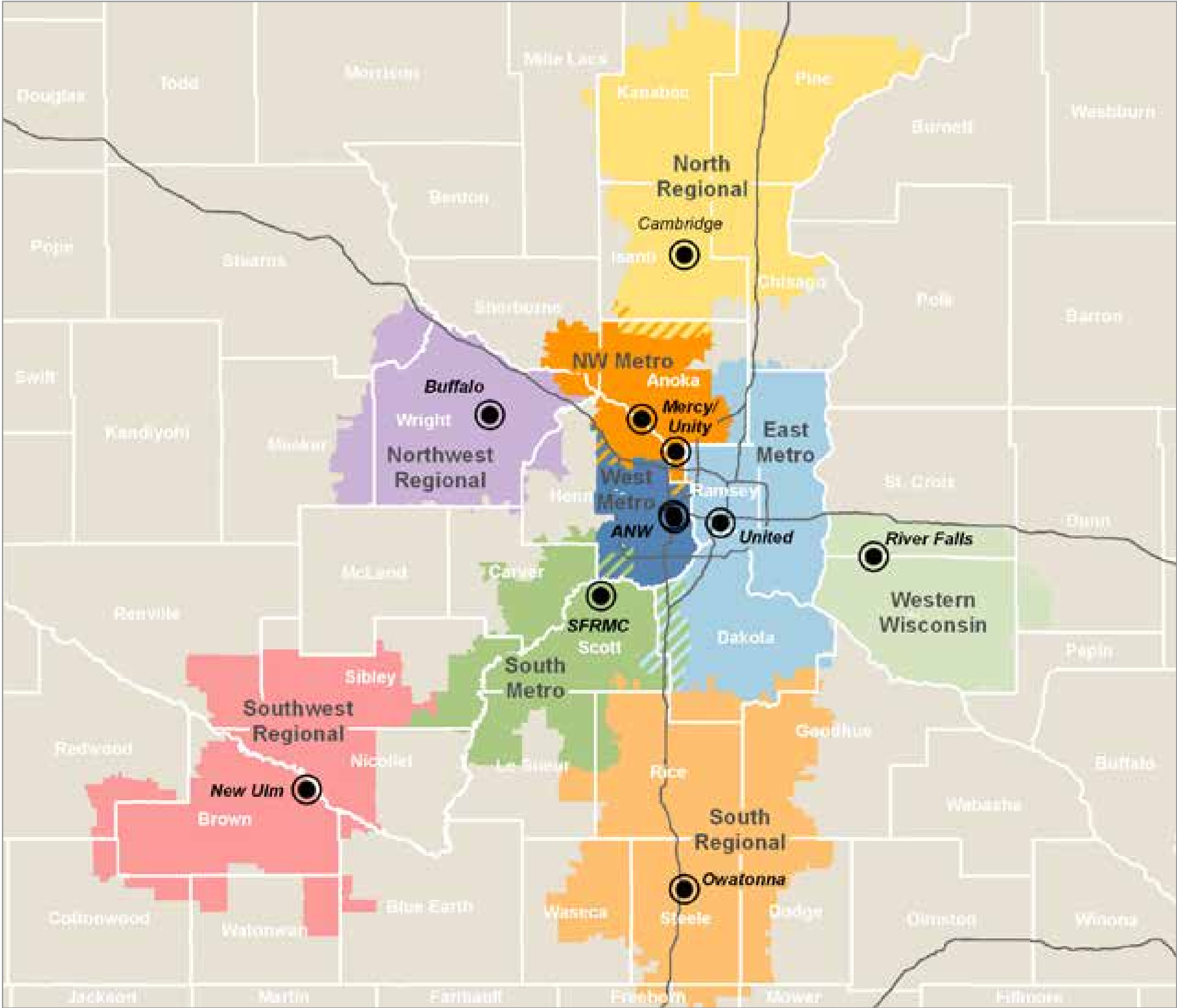


Allina Health Hospital
Allina Health Ambulatory Care Center
Allina Medical Clinic
Aspen Medical Group
Quello Clinic

Description of Community Served by Buffalo Hospital

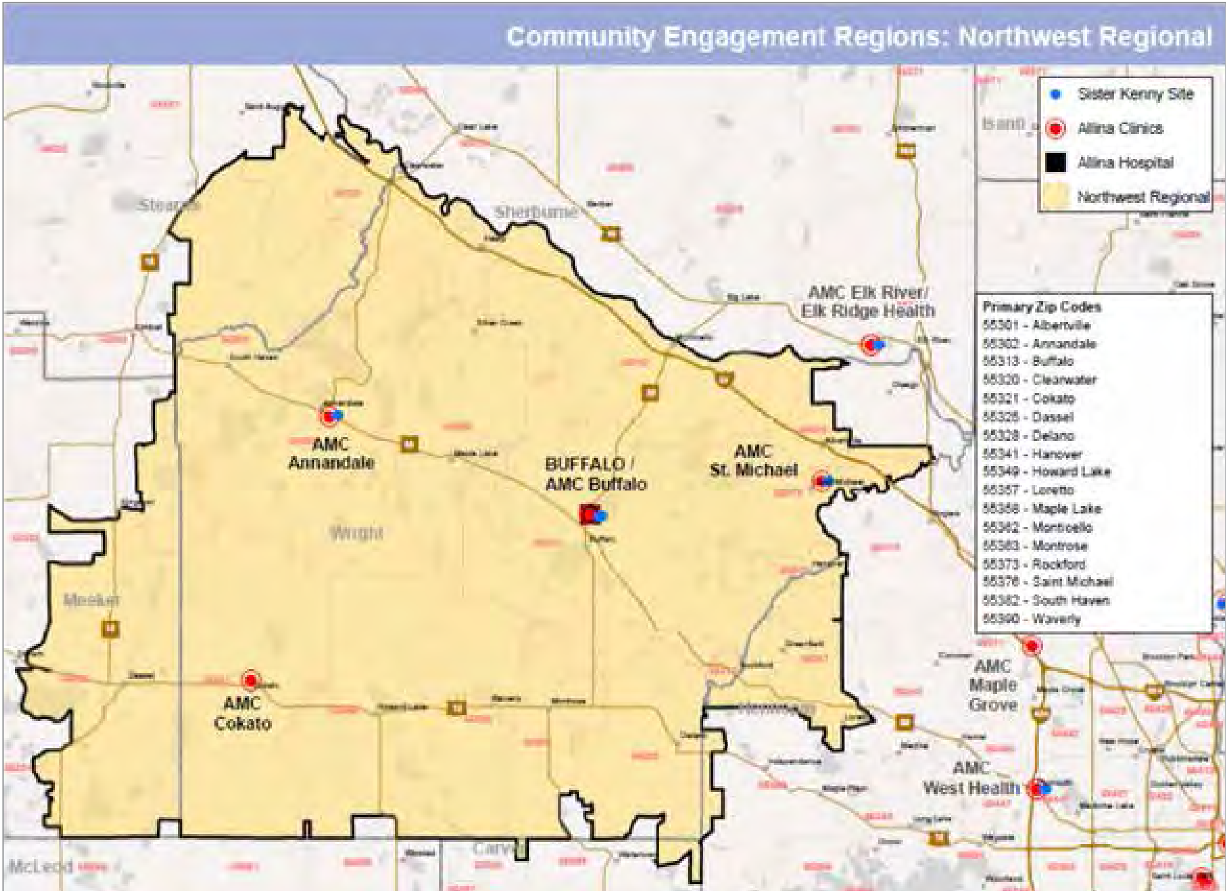
For the purposes of community benefit and engagement, Allina Health divides its service area into nine regions.

FIGURE 1: COMMUNITY BENEFIT & ENGAGEMENT REGIONAL MAP



The region associated with Buffalo Hospital is known as the Northwest Region and primarily serves Wright County in Minnesota. For the Northwest Region community health needs assessment (CHNA), the focus of inquiry was Wright County. See Appendix A for a detailed report on Wright County, prepared by Stratis Health. All appendices can be found on the Allina Health website (**allinahealth.org**).

FIGURE 2: NORTHWEST REGIONAL MAP



Assessment Partners

Buffalo Hospital's CHNA was conducted in collaboration and partnership with community members, community organizations, stakeholders from local public health and internal stakeholders at Buffalo Hospital. These partners assisted in the development of the hospital's priorities as well as in building the implementation plan. In addition, Buffalo Hospital partnered with Wilder Research, a branch of the Amherst H. Wilder Foundation, to conduct the community health dialogues in the Northwest region. Wilder Research developed the dialogue plan and materials, provided technical assistance related to recruitment strategies, facilitated the dialogues and synthesized the information into a report. See Appendix B for details on the CHNA partners.

Assessment Process

The Allina Health System Office CHNA Team developed a template plan for the eleven hospitals within the system. This plan was based on a set of best practices for community health assessment developed by the Catholic Health Association with the purpose of identifying two to three regional priority areas to focus on for FY 2014–2016. The process was designed to rely on existing public data, directly engage community stakeholders, and collaborate with local public health and other health providers. From there, each hospital was responsible for adapting and carrying out the plan within their regions. The Northwest Region Community Engagement lead and the Community Health Programs Coordinator guided the effort for Buffalo Hospital.

The Buffalo Hospital assessment was conducted in three stages: data review and setting priorities, community health dialogues and action planning. The process began in April 2012 when the CHNA plan was developed and was completed in August 2013 with the final presentation of the assessment and action plan to the Buffalo Hospital Community Benefit Advisory Council and the Buffalo Hospital Board of Directors. The following is a description of the assessment steps and timeline.

PHASE 1 — DATA REVIEW AND PRIORITY-SETTING

MAY – JULY 2012

DATA COLLECTION

Compiled existing county-level public health data, developed regional data packets, invited internal and external stakeholders to data review and issue prioritization meetings

SEPTEMBER 2012

DATA REVIEW

Reviewed data packets with stakeholders, selected initial list of regional health-related needs and priorities, identified additional data needs

OCTOBER 2012

ISSUE PRIORITIZATION

Reviewed revised data packet and completed formal prioritization process with stakeholders

PHASE 2 — COMMUNITY HEALTH DIALOGUES

FEBRUARY – MARCH 2013

DATA COLLECTION

Conducted community health dialogues related to priority areas identified in the data review and prioritization process

APRIL 2013

REPORT PRODUCTION

Developed report of findings from needs assessment and community dialogues

PHASE 3 — ACTION PLANNING

APRIL – JUNE 2013

IMPLEMENTATION/PLAN

Internal and external stakeholders reviewed report and developed strategies to address health needs

AUGUST – DECEMBER 2013

APPROVAL

Presented implementation plans to local boards, committees and leaders for approval (August 2013) and sent to Allina Health Board for final approval (December 2013)

Data Review and Priority-Setting

The first phase in the process was to review data in order to determine two to three regional priority areas. Best practices for community health needs assessments state that this process begins with a systematic look at data related to the health of community members. This allows stakeholders to both understand the demographic profile of the community and compare and contrast the effect of health-related issues on the overall well-being of the community. The data review process then allows the stakeholders to make data-driven decisions about the priority areas.

Data Collection and Review

For this phase in the process, Buffalo Hospital did not collect primary data, but instead compiled existing public health data to create a set of indicators specific to health in Wright County. Stakeholders were given this set of indicators, which they reviewed prior to and during meetings, to gain a sense of current health needs. These data sets included:

MINNESOTA COUNTY PROFILES: STRATIS HEALTH

This set of data provided stakeholders with the demographic characteristics of the community. The Minnesota County Profiles describe the characteristics of individual counties. Each report contained data on:

- Demographics: age, gender, race and foreign born
- Socio-economic status: income, education and occupation
- Health status: birth rate and morbidity

MINNESOTA COUNTY-LEVEL INDICATORS FOR COMMUNITY HEALTH ASSESSMENT

The Minnesota County-level Indicators for Community Health Assessment is a list of indicators across multiple public health categories and from various data sources. This list of indicators was developed by the Minnesota Department of Health to assist local health departments (LHD) and community health boards (CHB) with their community health assessments and community health improvement planning processes.

The indicators were placed in six categories: People and Place, Opportunity for Health, Healthy Living, Chronic Diseases and Conditions, Infectious Disease, and Injury and Violence. (http://www.health.state.mn.us/divs/chs/ind/) The main data sources for County-level Indicators were:

- 2011 Minnesota County Health Tables
- Minnesota Student Survey Selected Single Year Results
- 1991–2010 Minnesota Vital Statistics State, County and CHB Trends
- Minnesota Public Health Data Access

These data provided Allina Health and its individual hospitals a standard set of indicators to review across our service area. For a full list of the indicators used, see Appendix C.

COUNTY HEALTH RANKINGS

The County Health Rankings (http://www.countyhealthrankings.org) rank the health of nearly every county in the nation and show that much of what affects health occurs outside of the doctor's office. The County Health Rankings confirm the critical role that factors such as education, jobs, income and environment play in how healthy people are and how long they live.

Published by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation, the Rankings help counties understand what influences how healthy residents are and how long they will live. The Rankings look at a variety of measures that affect health such as the rate of people dying before age 75, high school graduation rates, access to healthier foods, air pollution levels, income, and rates of smoking, obesity and teen births. The Rankings, based on the latest data publically available, provided assessment stakeholders information on the overall health of Wright County and comparison data for other counties in the state.

WRIGHT COUNTY COMMUNITY HEALTH ASSESSMENT

The stakeholder group also reviewed the 2010-2014 Wright County Community Health Assessment (See Appendix D). This required assessment was done

by the Wright County Public Health Department to study the health status of the county as they work towards their accreditation.

Based on the review of data over the course of these meetings, Buffalo Hospital's community health assessment group identified ten issues to be considered in the next step of the prioritization process.

1. Adolescent alcohol use
2. Alcohol related deaths
3. Bullying in schools
4. Low rates of cancer self examinations
5. Chronic disease and chronic disease management
6. Heart disease and cardiac hospitalizations
7. Mental health/mental illness
8. Obesity
9. Physical activity
10. Traffic safety

Prioritization Process

In order to systematically select priorities, Buffalo Hospital used two approaches: the Hanlon Method and group discussion questions. These approaches were chosen to allow participants to assign a numeric value to each priority issue and to also ensure that participants engaged in a deeper discussion about how each issue fit within Buffalo Hospital's mission and its role in the community as a health care provider.

THE HANLON METHOD

The Hanlon Method is a prioritization process which objectively takes into consideration explicitly defined criteria and feasibility factors. The Hanlon Method is used when the desired outcome is an objective list of health priorities based on baseline data and numerical values. For a more detailed description of this process see Appendix E. The method has three major objectives:

- to allow decision-makers to identify explicit factors to be considered in setting priorities
- to organize the factors into groups that are weighted relative to each other
- to allow the factors to be modified as needed and scored individually.

The Hanlon Method ranks health-related issues based on three criteria:

Component A = Size of the problem
Component B = Seriousness of the problem
Component C = Estimated effectiveness of the solution

Each possible priority is given a numerical score for each component and combined to provide a composite numerical score for each priority. (See Appendix F for full list of health issues and ranked scores.)

DISCUSSION QUESTIONS

Participants were asked to consider the numerical rankings for each issue along with the following questions in choosing their final two to three priority issues. This allowed stakeholders the chance to consider health issues that may have a great impact on their community, but fell short of the top three identified in the ranking method. These questions were based on a set of questions which are commonly used in conjunction to Hanlon-based prioritization work (http://www.naccho.org/topics/infrastructure/CHAIP/upload/Final-Issue-Prioritization-Resource-Sheet.pdf):

- Does work on this issue fit within the Allina Health mission? Does this fit within work we're already doing?
- What is the role of Allina Health? Leader, partner or supporter? What are the opportunities for collaboration?
- What's the economic impact of the issue? What's the cost to address the problem? What are the costs associated with not doing anything?
- Will the community accept and support Allina Health efforts on this issue?
- Does work on this issue provide an opportunity to address the health needs of vulnerable populations? Can Allina Health impact barriers to health for groups around this issue?
- Are there legal implications involved in addressing the health issue? (e.g., HIPAA privacy concerns, the need for consent for minors, undocumented citizens, etc.)

Notes from this discussion are found in Appendix G.

Stakeholders were also given a report prepared by the Health Disparities Work Group of Allina Health (see Appendix H). This report was to be used as a resource when considering the needs of vulnerable populations in the region.

Priority Health Needs for 2014–2016

Upon completion of the prioritization process, Buffalo Hospital determined the following three community health priority needs:

1. Obesity and physical activity

Both priorities scored very high (top two scores) and the group felt it would be appropriate to combine them into one, since they are connected and underlying issues relevant to these topics are very similar. Interventions to address obesity and physical activity have a strong prevention component and represent modifiable behaviors that can be influenced. These issues relate to most (if not all) other priorities on the list or at least somehow connected, which means these two topics are important and touch most other areas our community is concerned about. Both issues impact vulnerable populations in the community greatly (low income class, minors and older adults in the community) and address the topic of disparities and working with minimizing the gap between our region's socio-economic classes.

2. Chronic disease and chronic disease management

This issue was chosen because interventions for obesity and physical activity priorities will assist with finding solutions and developing action plans for chronic disease and chronic disease management. The stakeholders also felt assisting with chronic disease issues has been and still is one of the Allina Health strengths, and Buffalo Hospital should use the opportunity to build on that strength. The stakeholder group felt very strongly it is a social responsibility of the local hospital to intervene in this issue, and Buffalo Hospital is the most suited to lead that intervention in the community due to its strong clinical background and knowledge.

3. Mental health

The stakeholders felt that mental health and mental illness is a national challenge, and it should be addressed on a variety of levels, including intervention from local hospitals and community. The stakeholders identified a lack of local resources, and stated that the community is absorbing the impact of the issues. The hospital has an opportunity to intervene by providing resources or expanding services, as well as partnering with the community to address the concern. Most important, the group felt this issue is currently discussed, and is concerning – everyone feels it has to be addressed – yet it isn't anyone's priority, so nothing happens. The community feels it is time to take the lead and address this concern. Additionally, the issue has great effect on our vulnerable populations in the community that Buffalo Hospital serves.

Finally, all the priority health needs were chosen based on the ability of Buffalo Hospital to collaborate, maximize assets and implement interventions beyond clinical services in addressing these needs in the community.

IDENTIFIED HEALTH NEEDS NOT SELECTED AS PRIORITIES

Low rates of cancer self-examinations: Stakeholders felt the priority scored high because clearly this issue is important and possible interventions are easily implemented; however, the stakeholders thought sufficient efforts are already being put in by the hospital and the community to address this concern. The group felt that although this priority scored very high, additional interventions are not necessary as this time. The stakeholders felt that the primary intervention in this case is education, which is already in place, being used to raise awareness, and being promoted through hospitals and clinics and in the community.

Heart disease and heart attack hospitalizations: This priority also scored high, but the group felt that lifestyle modifications that will help address this issue could be achieved by concentrating on the top priority – obesity and physical activity.

Traffic safety: The group felt the community is already doing a lot to address this issue through the work and efforts provided by the Safe Communities project. The group also felt that it isn't the hospital's role to address this issue.

Adolescent alcohol use: The stakeholders felt this issue is something that Buffalo Hospital has limited ability to influence in its community, as this is often regulated and addressed on an individual family level. The group felt this issue is a low priority in comparison to other concerns listed. The schools and community should focus on education about the topic, in hopes to change the regional dynamic and acceptance of this norm.

Alcohol-related deaths: The data showed that the deaths per capita are fairly low and are declining based on the data for the region. Also, this issue was scored at a low priority level in comparison to other issues and concerns. The group felt there is no appropriate intervention available, aside from educating the population about the risky behaviors, which will hopefully result in fewer deaths related to alcohol.

Bullying in school: The group felt that schools in the region are already working on this issue. The community is aware and addressing this important issue actively (forums, educational efforts, community partnerships, etc.), and there is no need to duplicate the efforts. Further, this issue received a low score in the prioritization process.

Community Health Dialogues

In spring of 2013, Buffalo Hospital held a series of meetings which were designed to solicit feedback from the community on how Buffalo Hospital could most effectively address the selected priority issues. These dialogues were facilitated by a community partner and contractor, Wilder Research. The community dialogues were an opportunity for Buffalo Hospital to hear from a broader group of community members, identify ideas and strategies to respond to the priority issues, and inform the action-planning phase of the needs assessment.

Invitations were sent via email or in-person by Buffalo Hospital's Community Engagement lead to community members including representatives from education, local government, religious, social service and other non-profit organizations in the community. There was intentional outreach to representatives from the medically underserved, low income and minority populations, and populations with chronic disease conditions to ensure vulnerable populations were included. All potential participants were told that their feedback was important in representing the many roles they might play in the community: as a worker, neighbor and citizen. A total of 36 people participated in the two community health dialogues in the Northwest Region.

KEY QUESTIONS

Participants were asked to answer the following questions:

1. What is the impact of each issue in your community?
2. What should be done to address each issue in your community?
3. What is the role for Buffalo Hospital, as part of Allina Health, in addressing this issue in your community?

KEY FINDINGS

Obesity and physical activity: Dialogue participants felt that Buffalo Hospital's role is to create classes to educate the community about the nutrition and provide opportunities for physical activity. Ideas included:

- Offering free health screenings and free or low-cost nutrition classes and exercise opportunities, particularly for families
- Creating a wellness center focused on fitness and holistic health
- Assisting local restaurants in developing healthier menus
- Partnering with local public health entities to provide a program like the Heart of New Ulm that brings the community together to make preventative change
- Pairing pediatricians and nutritionist with schools to teach parents, teachers, and students about healthy eating.

Chronic disease and chronic disease management: Dialogue participants felt that Buffalo Hospital's role, as part of Allina Health, would be to foster more education about chronic disease and disease management in the community and to offer increased services and programs addressing this issue. Ideas included:

- Having "medical bill advocates" for people with low income
- Facilitating support groups for people with chronic medical conditions
- Offering free disease management classes and health screenings
- Increasing the focus on the "wellness model" for those with chronic diseases
- Developing more education for physicians focused on nutrition.

Mental health: Dialogue participants felt that Buffalo Hospital's role, as part of Allina Health, would be to increase mental health services and provide education to the community on mental health and mental illness. Ideas included:

- Administering support groups for parents of children with ADHD or anxiety, or for people with ADHD or anxiety
- Hosting local depression screening at churches, schools, and workplaces
- Developing classes focused on educating people about how to recognize mental illness and reduce the stigma that accompanies mental illness
- Investigating the connection between mental health and nutrition; supporting efforts to provide more fresh food
- Increasing resources and support for parents with post-partum depression.

For a full copy of the report see Appendix I.

Community Assets Inventory

Between the community health dialogues and the action-planning phase, the Community Engagement lead for Buffalo Hospital developed an inventory of existing programs and services within the region related to the priority areas identified in the needs assessment. The inventory included the location of the program (hospital, clinic or community) as well as the target population and community partners. The purpose of the inventory was to identify:

- Gaps in services and opportunities for new work
- Where and with whom there is a lot of work already being done
- Opportunities for partnership and/or collaboration.

See Appendices J and K for full inventory of hospital and community-based programs.

Action Planning

The final phase of the CHNA process was to develop the implementation plan for Buffalo Hospital. The implementation plan is a set of actions that the hospital will take to respond to the needs identified through the community health needs assessment process. Buffalo Hospital used its Community Benefit Advisory Council to engage with internal and external stakeholders including representatives from Wright County Public Health, Buffalo City Council, the Buffalo Hospital Foundation executive director and board members, and mental health providers over three meetings to develop the implementation plan for FY 2014–2016.

THE PROCESS INCLUDED FOUR STEPS:

1. Identifying key goals, objectives and indicators related to the priority issues
2. Reviewing Community Health Dialogues report and Community Assets Inventory
3. Selecting evidence-based strategies and programs to address the issues
4. Assigning roles and partners for implementing each strategy.

STEP 1: Identifying key goals, objectives and indicators

Following best practices for community health improvement planning, Buffalo Hospital identified key goals and objectives for the implementation plan. These goals and objectives provided structure for the plan elements and helped identify areas for program evaluation and measurement.

Stakeholders also looked at Healthy People 2020 (http://www.healthypeople.gov/2020/default.aspx) for a set of indicators that reflected overall trends related to the priority issues. These indicators will not be used to evaluate the programs, but rather to outline and monitor the issues within a national framework.

STEP 2: Review Community Health Dialogues report and Community Assets Inventory

Stakeholders reviewed the Community Health Dialogues report for ideas and strategies to incorporate into the implementation plan. In addition, they reviewed the Community Assets Inventory to identify gaps and opportunities for action. The information from these sources served as context as stakeholders moved into the next step of looking at evidence-based strategies.

STEP 3: Selecting evidence-based strategies

Buffalo Hospital used Community Anti-Drug Coalitions of America's (CADCA) "Defining the Seven Strategies for Community Change." Evidence shows that a diverse range of strategies and interventions will have a greater impact on community health. Therefore, the CADCA strategies provided the framework to address the priority issues in multiple ways and on multiple levels and the implementation plan includes actions in each strategy area. These strategies are:

1. Providing information
2. Enhancing skills
3. Providing support
4. Enhancing access/reducing barriers
5. Changing consequences
6. Physical design
7. Modifying/changing policies.

For more information on CADCA's strategies see Appendix L.

In choosing evidence-based strategies, Buffalo Hospital looked to the What Works for Health through the County Health Rankings and Roadmaps website (http://www.countyhealthrankings.org/roadmaps/what-works-for-health). What Works for Health provides information to help select and implement evidence-informed policies, programs, and system changes and rates the effectiveness of these strategies that affect health through changes to:

- health behaviors
- clinical care
- social and economic factors
- the physical environment.

STEP 4: Assign roles and partners for implementing each strategy

When selecting the strategies, Buffalo Hospital identified when the hospital was going to lead the work, support the work or partner on the work. This was important to not only budget accordingly, but to identify and leverage the expertise of the various assets in the community.

Implementation Plan

The implementation plan is a 3-year plan depicting the overall work that Buffalo Hospital plans to do to address its priority issues in the community. Yearly work plans will be developed to provide detailed actions, accountabilities, evaluation measures and timelines.

In formulating its implementation strategy for each of the priority areas, Buffalo Hospital chose to focus on strategies and programs that would not just educate people about the issues, but also empower people in the community to take action to address these issues. For example, Buffalo Hospital has a history of creating wellness initiatives which are designed to create educational programming that goes beyond providing information to the participants. These programs are based on the belief that self-motivation is essential to making and sustaining positive behavioral modifications. These programs teach participants to discover their true motivation for making lifestyle changes and provide them with strategies and resources on how to sustain their positive behaviors once the changes take place.

Obesity and physical activity

GOAL: Reduce obesity and increase physical activity

INDICATORS

- Reduce proportion of adolescents and adults who are overweight or obese.
- Increase the proportion of adults and teens who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity

Buffalo Hospital's strategy to address obesity and encourage physical activity in its community will focus on two key areas: education around the risks of obesity, and providing programs designed to reduce obesity and increase physical activity in the community by encouraging and motivating people to take actions that will improve their overall health. Planned programs include:

- Partnering with local food vendors to raise awareness in the community about healthy eating and venues to access healthy food: raising awareness of local farms, identifying healthy options at restaurants, supporting and promoting community gardens. *Partners: public health, local restaurants, farmers markets, community co-ops*
- Continuing the "Let's Talk Wellness" programming in community worksite settings. *Partners: local employers*
- Continuing and expanding the Healthy Community Partnership initiative. *Partner: public health*
- Creating and supporting programming that combines educational, environmental and behavioral activities at worksites and community centers. *Partners: senior centers, community fitness centers, clinics, employers*
- Enhancing and expanding options for physical activity and nutrition education using the Health Powered Kids developed by Allina Health. *Partners: clinics, local school districts, community programs targeting children*
- Facilitating and promoting nutritional coaching and groups targeting families and children. *Partners: schools, community centers, community programs*
- Continuing to expand the Healthy Eating for Successful Living for people older than the age of 55. *Partners: Senior centers, fitness centers*
- Supporting the Silver Sneakers program in the community. *Partners: Senior centers, fitness centers*
- Organizing and implementing a promotional campaign to encourage healthy choices. *Partners: public health, local health and wellness groups and organizations*
- Providing motivational talks in the community encouraging healthy changes in behavior. *Partners: providers, clinics, public health, local health and wellness groups and organizations*
- Piloting an "Adopt a School Program," which pairs physicians with schools to provide monthly educational talks combined with events and other activities that promote healthy eating and physical activity. *Partners: clinics, schools, public health*

Chronic disease and disease management

GOAL: Increase early detection and improve self-management of chronic diseases

INDICATORS

- Increase the number of adults who are screened for chronic diseases
- Increase the number of adults who are able to monitor and manage their chronic conditions

Buffalo Hospital's strategy to address chronic diseases and chronic disease management in its community will focus on two key areas: increasing early detection of chronic disease, and encouraging and promoting self-management of chronic diseases. Planned programs include:

- Continuing work with health care providers to implement patient care strategies to detect chronic disease. *Partners: Clinics, hospital doctors, public health*
- Providing education to providers and community members around detection and prevention of chronic disease. *Partners: Clinics, hospital doctors, public health*
- Partnering with local employers to provide workplace screenings for risk factors for chronic disease. *Partners: Clinics, hospital doctors, public health, employers, wellness groups and organizations*
- Continuing to offer Living Well with Chronic Disease workshops for people managing chronic conditions. *Partners: Clinics, hospital doctors, public health*
- Continuing the work of clinical service lines around chronic disease. *Partners: Clinics, hospital doctors, public health*
- Developing referral processes for providers to connect people with chronic diseases to community assets. *Partners: Clinics, hospital doctors, public health*

Mental health

GOAL: Reduce stigma related to mental health conditions and increase awareness of mental illness resources

INDICATORS

- Increase the proportion of adults and children with mental health disorders who receive treatment
- Reduce stigma around mental health issues

Buffalo Hospital's strategy to address mental health in its community will focus on two key areas: reducing the stigma around mental health conditions and treatment, and providing and facilitating education around mental health to members of the community and health care providers. Planned programs include:

- Leading a taskforce to help identify resources in the community related to mental health. *Partners: Clinics, mental health providers, public health, police, local mental health centers*
- Developing collaborations that link the community to those resources; developing networks related to addressing mental health in the community. *Partners: Clinics, hospital doctors, public health*
- Partnering with community partners to host depression screenings at community events, workplaces and schools. *Partners: Clinics, hospital doctors, public health, employers, schools*
- Developing and offering classes to the community focusing on recognizing the symptoms related to mental illness, and providing people with the resources and knowledge to help individuals in crisis connect with appropriate professional, peer, social and self-help care. *Partners: Clinics, hospital doctors, public health, mental health advocacy organizations*
- Actively engaging providers in public discussions around mental health and mental illness with the goal of decreasing stigma. *Partners: Clinics, hospital doctors, public health, employers, schools*

Conclusion

As a not-for profit hospital, Buffalo Hospital is dedicted to improving the health of the communities it serves. This implementation plan is intended to show that the hospital will partner with and support community and clinical programs that positively impact the identified health needs in 2014–2016. In addition, the hospital will participate in system-wide efforts, as part of Allina Health, that support and impact community health. There are other ways in which Buffalo Hospital will indirectly address these priority issues along with other needs, such as through the provision of charity care, support of Medicare and Medicaid programs, discounts to the uninsured and others. Buffalo hospital will continue with its commitment to engage with the community to ensure that the work in the plan is relevant and effective and to modify its efforts accordingly.

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BUFFALO HOSPITAL
NORTHWEST REGIONAL

Appendix A

Wright County Profile

Community Health Needs Assessment
and Implementation Plan 2014–2016

Wright County

(Central Region)

CULTURE CARE CONNECTION

CULTURE CARE CONNECTION is an online learning and resource center designed to increase cultural competence of health care providers, administrators, and health care organization staff in serving diverse populations. Simply put, "culture" can refer to a variety of factors, including age, education level, income level, place of birth, length of residency in a country, individual experiences, and identification with community groups; "competence" refers to knowledge that enables a person to effectively communicate; and "care" refers to the ability to provide effective clinical care.

Through Stratis Health's Culture Care Connection Minnesota County Profiles, health care organizations can better understand their geographic service areas by observing the characteristics of the counties, surrounding region, greater Minnesota, and the nation with respect to demographic, socioeconomic, and health status data. The quantitative and qualitative data in this profile can broaden understanding and help users consider actions for responding to the area's most pressing needs.

Apply this information to advance your organization's implementation of the Office of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) Standards. The 14 CLAS standards serve as guiding principles for ensuring accessibility and appropriateness of health care services delivered to diverse populations. This information is also valuable if your organization is using less formal approaches in providing culturally sensitive services, as well as if you are just interested in learning more about health disparities in your county.

Funding provided by

Region is defined as Economic Development Region (EDR), the multi-county groupings established by the Minnesota Department of Employment and Economic Development. The Central EDR is composed of Benton, Sherburne, Stearns, and Wright counties.

Careful attention should be paid to identifiers in graphs and narrative, which delineate between county, region, and state level data to prevent inaccurate extrapolation.

Demographics

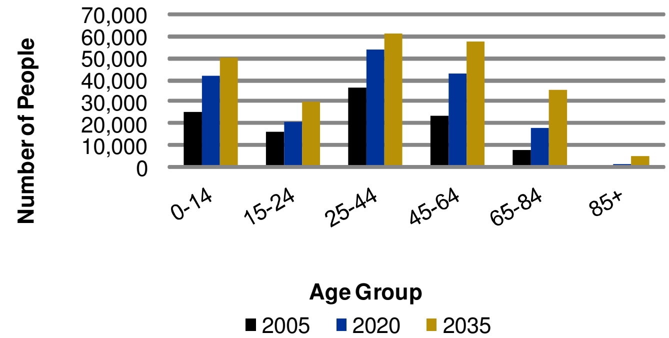
Age • Gender • Race • Foreign Born

Demographic data reveal the following state-level trends:

- Minnesota's population is projected to grow substantially by 2035, with slight growth in the younger age groups and substantial growth in the older age groups. These changes will influence the overall age composition of the state.
- Gender is evenly distributed across age groups, with notable exception in the older age groups which have larger proportions of females.
- Minnesota's population continues to become more diverse. Between 2000 and 2007, the Asian, black, and Hispanic/Latino populations increased at a faster pace than the white population.

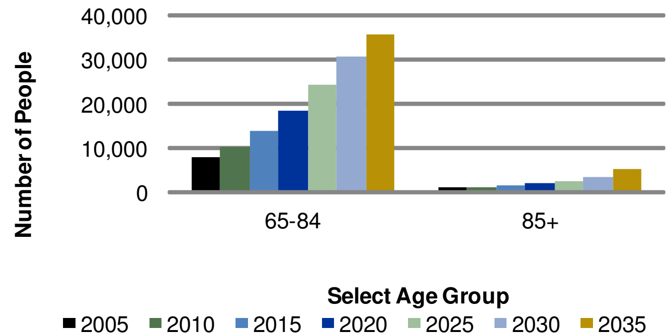
Age

Between 2005 and 2035, the population of Minnesotans over age 65 will more than double due to greater longevity. By contrast, the population under age 65 will grow only 10 percent. As a result, the age composition of all parts of the state, including Wright County, will be much older in 2035.



Population projections:

- 14 and under to rise 96%
- 15 to 24 to rise 82%
- 25 to 44 to rise 70%
- 45 to 64 to rise 141%
- 65 to 84 to rise 341%
- 85 and above to rise 342%



What providers need to know:

The proportion of Minnesota's older population, as well as ethnic and immigrant communities, will grow faster than the rest of the state's population in the next 25 years. Consider whether your organization is prepared to meet the special needs of these populations.

Suggestions:

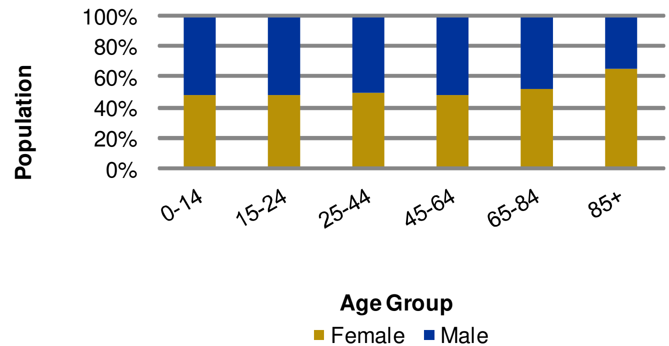
Become familiar with the needs of older populations, as well as individuals from diverse backgrounds, and develop strategies to accommodate them including: referrals to transportation services, allowing more time for patient encounters, and providing patient education materials in alternative formats.

Gender

In 2015, projections indicate the overall gender distribution for Wright County to be 50% female, 50% male

Variations appear when the data are viewed by age range:

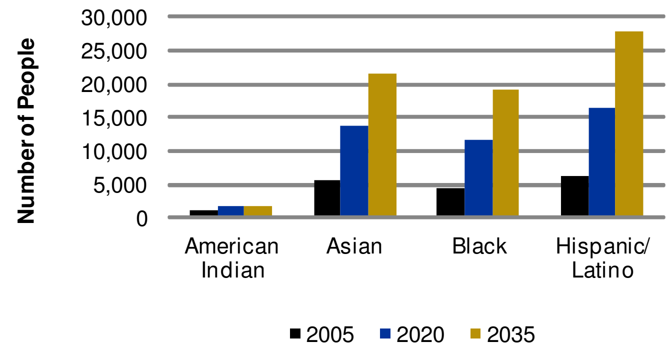
- 15 to 24: 49% female, 51% male
- 65 to 84: 53% female, 47% male
- 85 and above: 65% female, 35% male

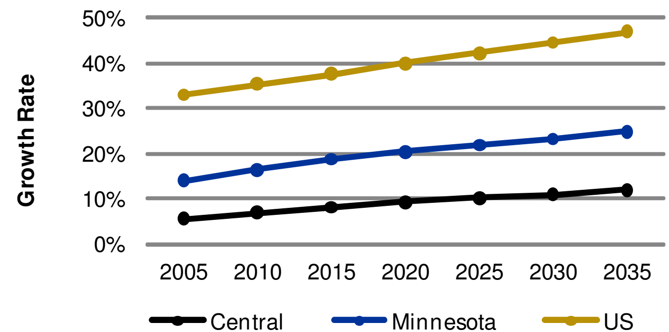


Race

Minnesota's population is considerably less diverse than the US population. Minnesota's populations of color accounted for 14 percent of the population in 2007 compared to 34 percent of the national population. However, populations of color are growing faster in Minnesota, 28 percent compared to 19 percent nationally.

In the Central EDR between 2005 and 2015, the population is expected to grow 29.8 percent. The white population is expected to grow 26.2 percent while populations of color are expected to grow 92.3 percent. Growth will be most notable in the Black population (109.2%). Growth in populations of color in the Central EDR will exceed the national growth rate of 47.1 percent.





What providers need to know:

The health issues, health-seeking behaviors, cultural norms, and communication preferences of populations of color vary considerably. As Minnesota's population becomes more diverse, patient populations within the state's health care organizations will become more diverse as well.

Suggestions:

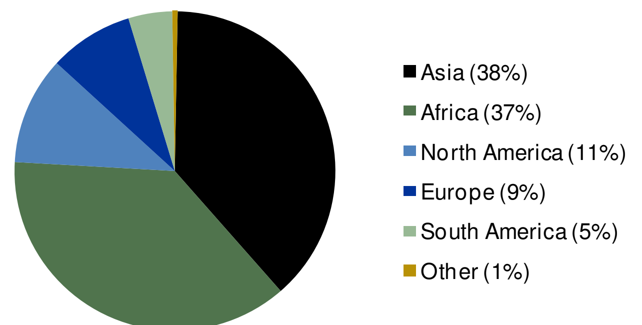
Get to know patients and staff on an individual level. Not all patients and staff from diverse populations conform to commonly known culture-specific behaviors, beliefs, and actions. Understanding an individual's practice of cultural norms can allow providers to quickly build rapport and ensure effective health care communication.

Foreign Born

Thirty-six percent of the minority population in Minnesota is foreign born, compared to 2 percent of the white population. In 2007, one-third of Minnesota's foreign born population came from one of four countries: Somalia (13.0%), Thailand (8.7%), Ethiopia (7.0%), and Mexico (4.0%).

What providers need to know:

Important factors to consider in providing care to foreign born populations include: nutritional status, mental health (especially in refugee populations), infectious disease, dental screening, and preventive health measures, including cancer screenings, which are not often available in third world countries. Specific health care screening recommendations depend on an individual's country of origin and immigration status.



Suggestions:

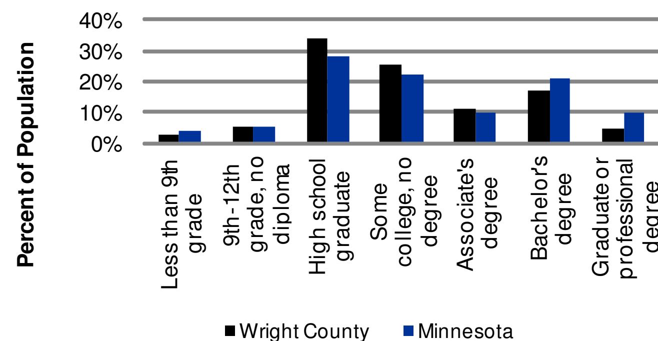
Provide information to patients not familiar with the western medical system, including guidance on obtaining health insurance, setting up initial and follow-up appointments, and practicing preventive health measures.

Socioecomonic Status

Education • Income • Occupation

Socioeconomic status, a measure of an individual's economic and social position relative to others based on income, education, and occupation can provide valuable insights about diverse populations.

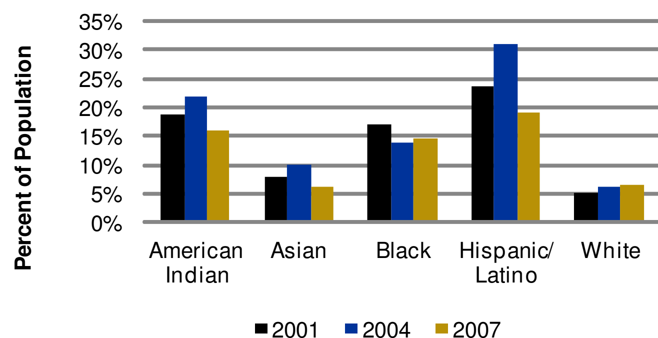
- Education influences occupational opportunities and earning potential in addition to providing knowledge and life skills that may promote health.
- Income provides a means for purchasing health care coverage but also may determine eligibility for assistance programs for those who cannot afford coverage.
- Occupation, and whether or not one is employed, may expose an individual to a variety of health risks.



Education

Across Minnesota, high school graduation rates increased between 2005 and 2009. While projections indicate a steady decline for the general population, high school graduation rates in populations of color will increase as much as 40 percent between 2005 and 2015.

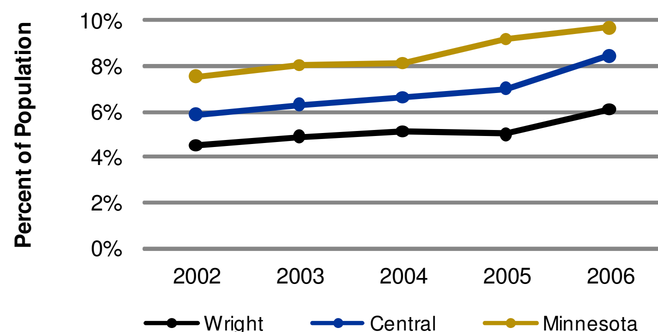
In Wright County, for all races, historic data indicate a higher percentage of individuals receiving at least a high school diploma compared to state level data. Attainment rates of a Bachelor's degree or greater in Wright County were lower than state level rates.



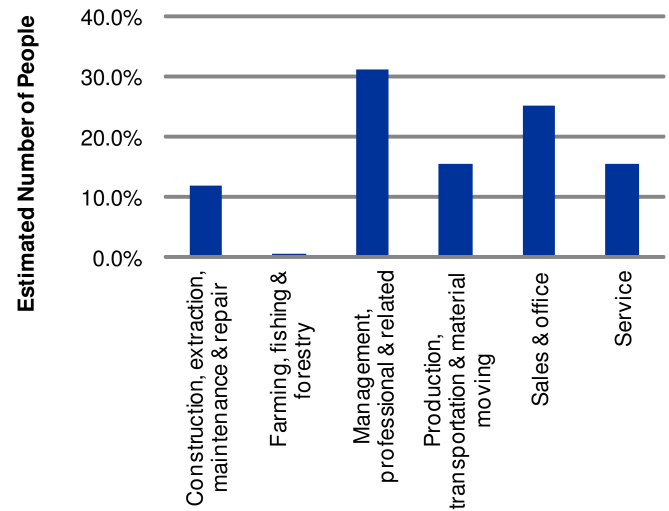
Income

In Wright County, the median household income based on 2005-2007 estimates was $65,419. Income level influences an individual's access to health care (as measured by rates of uninsurance) and is used to determine poverty status, which may determine eligibility for various assistance programs.

Rates of uninsured can be difficult to measure. One certainty is that wide variability across racial and ethnic groups exists. Historically, white populations are the least likely to be uninsured in contrast to Hispanic/Latino populations which are the most likely to be uninsured.



Poverty status, which is based on a minimum level of income necessary to achieve an adequate standard of living, is on the rise in Minnesota. According to federal poverty guidelines this level of income in 2008 equaled $21,200 for a family of four. Families whose income falls near or below this amount may be eligible for medical assistance and other social service programs.



Occupation

According to 2005-2007 estimates, 76.8 percent of the population in Wright County over 16 years of age were employed. Individuals in office-based occupations are at risk for repetitive stress injuries and musculoskeletal disorders due to the sedentary nature of this work.

For current, quarterly unemployment data, visit the Minnesota Department of Employment and Economic Development. Individuals who are unemployed or experience job insecurity may face health risks such as increased blood pressure and stress.

What providers need to know:

Chronic stress associated with lower socioeconomic status can contribute to morbidity and mortality and is linked to a wide range of health problems including arthritis, cancer, cardiovascular disease, hypertension, and low birthweight.

Suggestions:

Consider how patient's socioeconomic status may affect health risks and ability to follow treatment plans. Become familiar with eligibility requirements and service offerings from local health, housing, and social service programs including medical assistance, food support, and cash assistance. Establish a culturally sensitive plan for identifying and referring patients who may benefit.

Health Status Data

Birth Rate • Morbidity

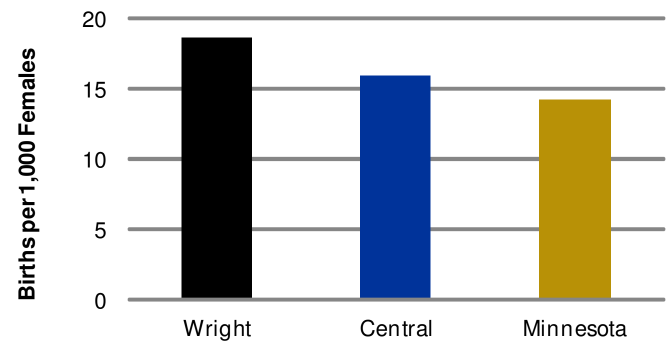
The health status data concerning birth rates and factors contributing to the incidence of disease revealed the following:

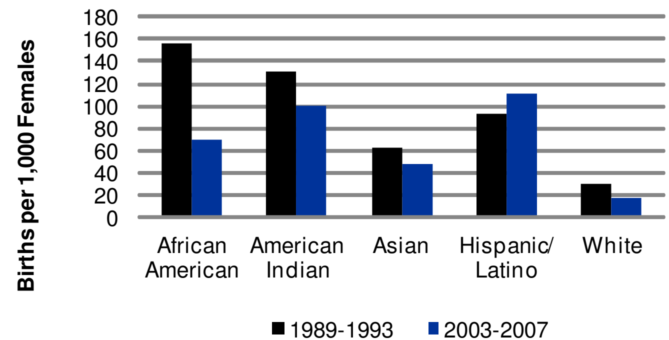
- A need for increased efforts to provide prenatal care in the general population as well as an awareness of birth trends in populations of color.
- Greater potential for engagement in behaviors which increase the burden of poor health in populations of color.

Birth Rate

Wright County's birth rate of 18.6 per 1,000 population is higher than the regional and state-level rates of 15.9 and 14.2 respectively. In 2007, prenatal care was received in the first trimester for 89.4 percent of cases compared to 92.3 percent in 2003.

Minnesota's teen birth rates reveal marked disparities. Although teen birth rates decreased for African Americans and American Indians over time, the rates remain 3.8 to 5.5 times higher than that for whites. The Asian rate was over 2.5 times the white rate, and the Hispanic/Latino rate is nearly six times the white rate.





Morbidity

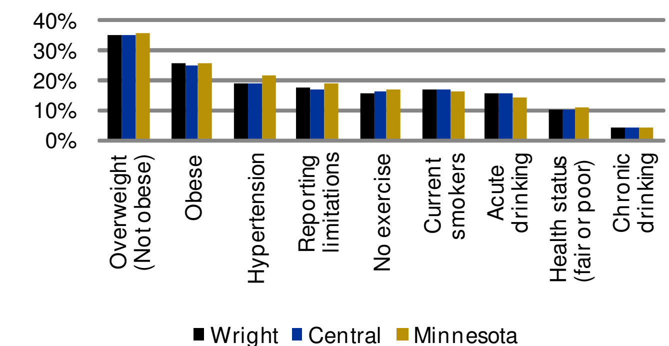
Behaviorial risk factors such as use of alcohol and tobacco, diet, exercise, and preventive health practices play an important role in determining a person's overall health status. Control over such factors can decrease a person's risk for adverse health outcomes including illness and premature death.

What providers need to know:

Patients from diverse cultures have varying perceptions of the concepts of disease and preventive care. Help patients understand the reason for their illness and the importance of keeping follow-up appointments and adhering to treatment plans even though they may no longer be feeling symptoms.

Suggestions:

Provide alternative treatment options and acknowledge that patients may use traditional approaches. Use interpreters with patients who do not speak English or who have Limited English Proficiency as a way to encourage them to freely communicate expectations and preferences.



Next Steps

CLAS Assessment • Visit www.culturecareconnection.org

1) Conduct a CLAS (Culturally and Linguistically Appropriate Services) Standards Assessment to identify areas of strength and opportunities for improvement in the services your organization offers to diverse populations. An online assessment which offers customized evaluation and recommendations can be found at: CLAS Standards Assessment.
2) Visit the Culture Care Connection Web site, an online learning and resource center aimed at providing Minnesota health care organizations with actionable tools in support of providing culturally and linguistically appropriate services.
3) Contact Stratis Health to learn more about how we can assist in your organization's efforts to build culturally and linguistically appropriate service offerings.

Sources

2008 Minnesota County Health Tables, Minnesota Department of Health, Center for Health Statistics, 2008.

American Fact Finder, US Census Bureau, (http://factfinder.census.gov) viewed on 6/17/09.

"Medical Care for Immigrants and Refugees," Gavagan, T. and Brodyaga, L. *American Family Physician*, 1998.

"Minnesota High School Graduation Rates Will Peak in 2009," Minnesota Office of Higher Education, *Insight,* 2006.

Minnesota's Nonwhite and Latino Populations 2007, Minnesota State Demographic Center, 2008.

Minnesota Populations by Race and Hispanic Origin 2005 – 2035, Minnesota State Demographic Center, 2009.

Minnesota Population Projections 2005 – 2035, Minnesota State Demographic Center, 2007.

Populations of Color in Minnesota Health Status Report Update Summary, Minnesota Department of Health, Center for Health Statistics, 2009.

"Socioeconomic Disparities in Health: Pathways and Policies," Adler, N. and Newman, K. *Health Affairs,* 2002.

Supplemental Table 1. Immigrants Admitted by Country of Birth and Intended State of Residence, Department of Homeland Security and Immigration and Naturalization Services, 2007.

The 2008 HHS Poverty Guidelines, Department of Health and Human Services, (http://aspe.hhs.gov/poverty/08poverty.shtml) viewed on 6/17/09.

Contact us for assistance with your quality improvement and patient safety needs related to reducing health care disparities.

Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

Stratis Health works with the health care community as a quality improvement expert, educational consultant, convenor, facilitator, and data resource.

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info@stratishealth.org

BUFFALO HOSPITAL
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Appendix B

Community Partners

Community Health Needs Assessment and Implementation Plan 2014–2016

For planning purposes, Buffalo Hospital used its Community Engagement Council, a group of external and internal stakeholders with an interest in promoting health in the community that Buffalo Hospital serves. The full roster is listed below along with which members attended the planning meetings related to the community health needs assessment process.

Meeting 1: August 13, 2012, Data Review and Data Prioritization

Janna Anderson, Steve Berg. Linda Dircks, Jill Gatzke, Joann Hedin, Karla Heeter, Maria Johnson, Laura Jones, Devonna Tierney, Joel Torkelson, Mona Volden

Meeting 2: November 12, 2012, Selection of final priorities

Who Attended: Jody Mattson, Karla Heeter, Pat Hackman, Devonna Tierney, Sue Thompson, Jen Myster, Nicole Wilke, Mona Volden, Janna Anderson, Maria Johnson, Jill Gatzke, Joel Torkleson, Laura Jones, Laureen Bodin, Patty Erickson, Brenda Christensen

2013 Northwest Regional Community Engagement Advisory Council Roster

Anderson, Janna	Community Health Programs Coordinator Buffalo Hospital
Berg, Steve	Director/Wright County Emergency Management Services Wright County Sheriff's Office
Bodin, Laureen	Assistant Administrator, City of Buffalo
Boman, Cindy	Head Start Manager Wright County Community Action, Inc.
Christensen, Brenda	Admin Support/ Event Coordinator Buffalo Hospital
Dircks, Linda	Administrator, Buffalo Clinic
Dunnigan, Vicki	Owner Synergy Home Care of Monticello
Edwards, Hatti	Heart Safe Community Coordinator Buffalo Hospital
Erickson, Patty	Community Outreach Coordinator CRCS-WISDM
Gatzke, Jill	Development Coordinator Crisis Nursery Serving Wright County
Hackman, Pat	Safe Communities, Executive Director
Hedin, Joann	Allina Home & Community Services
Heeter, Karla	Executive Director Buffalo Hospital Foundation
Johnson, Maria	Community Volunteer St John's Lutheran Church/Annandale

Jones, Laura	Director Community Health Foundation
Kaminski, Katie	Licensed Therapist Annandale Allina Medical Clinic
Kunz, Tom	Director Love INC – Big Woods
Mattson, Jody	Cancer Care Coordinator Buffalo Hospital
Myster, Jennifer	President Buffalo Hospital
Steffel, Joe	Buffalo Food Shelf Former Executive Director
Swenson, Jeff	Buffalo Wellness Club
Thomson, Sue	Buffalo Elementary Schools Licensed School Nurse
Tierney, Devonna	ECFE Buffalo, Hanover, Montrose Coordinator
Torkelson, Joel	Wright County Public Health
Tregaskis, William	Site Manager, Central MN Mental Health Center
Volden, Mona	Northwest Regional Lead Community Engagement and Wellness Manager Buffalo Hospital
Wilke, Nicole	Director, Annandale/Maple Lake Community Education
Ylitalo, Carmen	Manager, Allina Medical Clinic – Buffalo

BUFFALO HOSPITAL

NORTHWEST REGIONAL

Appendix C

Full Indicator List

Community Health Needs Assessment
and Implementation Plan 2014–2016

County- Leading Health Indicators

People and Place

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Wright
People and Place	1. Total population	Census	5,303,925	124,700
People and Place	2. Population by age and sex	Census	Table I	Table I
People and Place	3. Number of females aged 15-44	Census	1,045,681	25,085
People and Place	4. Number of births	MDH MCHS	70,617	1,900
People and Place	5. Birth rate	MDH MCHS	13.7	17.2
People and Place	6. School enrollment for prekindergarten – 12th grade	Census	837,640	25,626
People and Place	7. Number and percent of children under age 5	Census	355,504/6.7	10.699/8.6%
People and Place	8. Number and percent of children aged 0-19	Census	1,431,211/26.9	39,983/32.1%
People and Place	9. Child (under 15 years) dependency ratio (per 100 population 15-64)	Census	29.5	38
People and Place	10. Number of households	Census	2,108,843	44,627
People and Place	11. Number of deaths	MDH MCHS	37,801	642

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Wright
People and Place	12. Total population by race and ethnicity	Census	Table II	Table II
People and Place	13. Number of prekindergarten – 12th grade students by race/ethnicity	MDE	Table III	Table III
People and Place	14. Percent of prekindergarten – 12th grade students with limited English proficiency	MDE	7.3%	1.8%
People and Place	15. Number and percent of people aged 65 years and older	Census	683,121/12.9%	11,934 /19.6%
People and Place	16. Elderly (65+ years) dependency ratio (per 100 population 15-64)	Census	19.2	14.7
People and Place/Opportunity for Health	17. Percent of households in which the resident is 65 and over and living alone	Census	9.7%	6.7%
People and Place	18. Arsenic levels in MN	Arsenic MDH	n/a	
People and Place	19. Radon levels by zone (low, moderate, high)	US EPA	High/moderate	High

Opportunity for Health

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Wright
Opportunity for Health	20. Four year high school graduation rate	MDE	76.9%	87.7%
Opportunity for Health	21. High school dropout rate	MDE	4.8%	2.8%
Opportunity for Health	22. Percent of population aged 25 years and older with less than or equal to high school education or equivalent (e.g. GED)	Census	37.1%	41.3%
Opportunity for Health	23. Percent of prekindergarten – 12th grade students receiving special education	MDE	14.6%	13.4%
Opportunity for Health	24. Unemployed rate - annual average	MN DEED	7.3%	7.9%
Opportunity for Health	25. Total per capita income	Census	$42,953	$34,466
Opportunity for Health	26. Percent of prekindergarten – 12th grade students eligible for free and reduced meals	MDE	35.5%	23.5%
Opportunity for Health	27. Percent of people under 18 years living in poverty	Census	11.4%	6.4%
Opportunity for Health	28. Percent of all ages living in poverty	Census	10.9%	6.2%
Opportunity for Health	29. Percent of people of all ages living at or below 200% of poverty	Census 5 yr ACS	25.5%	18.1%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Wright
Opportunity for Health	30. Percent of housing occupied by owner	Census 5 yr ACS	78.1%	88.6%
Opportunity for Health	31.Percent of births to unmarried mothers	MDH MCHS	33.5%	19.4%
Opportunity for Health	32. Carbon monoxide poisoning (hospitalizations and ED visits age adjusted rates per 100,000)	MNHDD	6.54/.63	10/.8
Opportunity for Health	33. Percent of dwellings built before 1940	Census 2000	3.2%	13.9
Opportunity for Health	34. Percent of birth cohort tested with elevated blood lead levels	MDH Lead	.5%	0
Opportunity for Health	35. COPD hospitalizations (age adjusted rate per 10,000)	MNHDD	31.5	34.6
Opportunity for Health	36. Percent of children under 18 living in single parent-headed households	Census 5 yr ACS	26.1%	18.9%
Opportunity for Health/People and Place	37. Percent of households in which the resident is 65 and over and living alone	Census	9.7%	6.7%
Opportunity for Health	38. Percent of 9th graders who have changed schools at least once since the beginning of the school year	MSS	5%	4%
Opportunity for Health	39. Number of children under 18 years arrested for violent crimes (Part 1) per 1,000 population 10 - 17 years old	MN DPS	20.5	14.3
Opportunity for Health	40. Percent of 9th graders who skipped school one or more days in the last 30 days due to feeling unsafe at or on the way to school	MSS	5%	3%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Wright
Opportunity for Health	41. Percent of 9th graders who report that a student kicked, bit, or hit them on school property in the last 12 months	MSS	21%	21%
Opportunity for Health	42. Percent of 9th graders who report that they have hit or beat up another person one or more times in the last 12 months	MSS	22%`	20%
Opportunity for Health/Healthy Living	43. Rate of children in out of home care per 1,000 (aged 0-17)	MN DHS	8.8	5
Opportunity for Health	44. Number of physicians per 10,000 population	MDH ORHPC	27	7
Opportunity for Health	45. Number of dentists per 100,000	MDH ORHPC	61.4	25.3
Opportunity for Health	46. Percent currently uninsured	MDH MNHAS	9	9%
Opportunity for Health/Healthy Living	47. Percent of mothers who initiated prenatal care in the 1st trimester	MDH MCHS	85.9%	90.1%

Healthy Living

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Wright
Healthy Living	48. Birth rate per 1,000 population	MDH MCHS	13.4	17.2
Healthy Living	49. Number of births	MDH MCHS	70,617	
Healthy Living	50. Percent of births by race/ethnicity of mother	MDH MCHS	Table IV	Table IV
Healthy Living	60. Percent of mothers who smoked during pregnancy	MDH MCHS	9.8%	8.2%
Healthy Living	61. Percent of births to unmarried mothers	MDH MCHS	33.5%	19.4%
Healthy Living/Opportunity for Health	62. Percent of mothers who initiated prenatal care in the 1st trimester	MDH MCHS	85.9 %	90.1%
Healthy Living	63. Percent of births that were born premature, less than 37 weeks gestation (singleton births)	MDH MCHS	7.8%	7.5%
Healthy Living	64. Percent of birth born low birth weight, less than 2,500 grams (singleton births)	MDH MCHS	4.8%	4%
Healthy Living	65. Number of infant deaths	MDH MCHS	429	
Healthy Living	66. Percent of 9th graders who participate in religious activities one or more times per week	MSS	43%	44%
Healthy Living	67. Teen birth rate per 1,000 females aged 15-19 years	MDH MCHS	26.6	22.3

Healthy Living/Opportunity for Health	68. Rate of children in out of home care per 1,000 (aged 0-17)	MN DHS	8.8	5
Healthy Living	69. Percent of 9th graders who ate five or more servings of fruit, fruit juice, or and vegetables yesterday	MSS	18%	17%
Healthy Living	70. Percent of 9th graders who drank three or more glasses of pop or soda yesterday	MSS	14%	12%
Healthy Living	71. Percent of adults who consumed five or more servings of fruits and vegetables per yesterday	Local Surveys		31.5%
Healthy Living	72. Percent of adults who reported 30+ minutes of moderate physical activity on five or more days per week	Local Surveys		46.7%
Healthy Living	73. Percent of 9th graders who were physically active for 30 minutes or more on at least five of the last seven days	MSS	56%	53%
Healthy Living	74. Percent of 9th graders who engaged in strenuous exercise for at least 20 minutes on at least three of the last seven days	MSS	71%	78%
Healthy Living	75. Percent of 9th graders who spend six or more hours per week watching TV, DVDs or videos	MSS	44%	43%
Healthy Living	76. Percent of adults who are excessive drinkers (binge+ heavy)	Local Surveys	20.2%	
Healthy Living	77. Percent of 9th graders who engaged in binge drinking in the last two weeks	MSS	10%	7%
Healthy Living	78. Percent of 9th graders who used alcohol one or more times in the last 12 months	MSS	32%	27%

Healthy Living	79. Percent of 9th graders who used alcohol one or more times in the 30 days	MSS	19%	14%
Healthy Living	80. Percent of 9th and 12th graders who drove a motor vehicle after using alcohol or drugs one or more times in the last 12 months	MSS	4%/19%	2%/19%
Healthy Living	81. Percent of 9th graders who rarely or often ride with friends after those friends have been using alcohol or drugs	MSS	17%	12%
Healthy Living	82. Percent of 9th graders who smoked cigarettes during the last 30 days	MSS	9%	8%
Healthy Living	83. Percent of adults who are current smokers	Local Surveys	16.8%	
Healthy Living	84. Percent of 9th graders who used chewing tobacco, snuff, or dip during the last 30 days	MSS	5%	4%
Healthy Living	85. Exposure to second hand smoke	Local Surveys	45.6%	
Healthy Living	86. Percent of 9th graders who used marijuana one or more times in the last 12 months	MSS	15%	8%
Healthy Living	87. Percent of 9th graders who used marijuana one or more times in the last 30 days	MSS	10%	5%
Healthy Living	88. Colorectal cancer screening	Local Surveys		
Healthy Living	89. Breast cancer screening	Local Surveys		
Healthy Living	90. Percent of children age 24-35 months up to date with immunizations (vaccine series)	MDH MIIC	58.1%	59.6%

Healthy Living	91. Percent of 9th and 12th graders who have ever had sexual intercourse	MSS	20%/51%	14%/53%
Healthy Living	92. Among sexually active 9TH and 12th grade students: percent reporting always using a condom	MSS	56%/45%	58%/46%
Healthy Living	93. Percent of 9th graders who report always wearing a seatbelt when riding in a car	MSS	66%	69%
Healthy Living	94. Percent of 9th graders who have felt nervous, worried, or upset all or most of the time during the last 30 days	MSS	13%	10%
Healthy Living	95. Percent of 9th graders who feel that people care about them very much or quite a bit (parents, other adult relatives, teacher/other adults, religious or spiritual leaders, other adults in the community, friends)	MSS	Table V	Table V
Healthy Living	96. Percent of 9th graders who felt sad all or most of the time in the last month	MSS	14%	17%
Healthy Living	97. Percent of 9th graders who report that a student/students have made fun of or teased them in the last 30 days	MSS	38%	40%
Healthy Living	98. Percent of 9th graders who report that a student pushed, shoved, or grabbed them on school property in the last 12 months	MSS	37%	36%
Healthy Living	99. Percent of 9th graders who report that they have made fun of or teased another student in the last 30 days	MSS	45%	44%
Healthy Living	100. Percent of 9th graders who had suicidal thoughts in last year	MSS	17%	15%
Healthy Living	101. Percent of 9th graders who tried to kill themselves in the last year	MSS	3%	3%

Chronic Diseases and Conditions

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Wright
Chronic Dis. and Cond.	102. Percent of 9th graders who are overweight but not obese according to BMI	MSS	13%	13%
Chronic Dis. and Cond.	103. Percent of 9th graders who are obese according to BMI	MSS	9%	6%
Chronic Dis. and Cond.	104. Percent of adults who are overweight according to BMI	Local Surveys	38.1%	
Chronic Dis. and Cond.	105. Percent of adults who are obese according to BMI	Local Surveys	24.7%	24.4%**
Chronic Dis. and Cond.	106.Percent of WIC children under aged 2-5 years who are obese according to BMI	MDH WIC	13.1%	10.7%
Chronic Dis. and Cond.	107. Leading causes of death - age adjusted rates per 100,000 (e.g. cancer, heart disease, stroke)	MDH MCHS	Table VI	Table VI
Chronic Dis. and Cond.	108. Asthma hospitalizations (age adjusted rate per 10,000)	MNHDD	7.5	6.4
Chronic Dis. and Cond.	109. Cancer incidence per 100,000 (all cancer types combined, age adjusted rate per 100,000)	MDH MCSS	474.9	476.9
Chronic Dis. and Cond.	110. Breast cancer incidence (age adjusted rate per 100,000)	MDH MCSS	127.3	105.6
Chronic Dis. and Cond.	111. Heart attack hospitalizations (age adjusted rate per 10,000)	MNHDD	27.3	35.5
Chronic Dis. and Cond.	112. Heart disease prevalence	Local Surveys	4.9%	
Chronic Dis. and Cond.	113. Stroke prevalence	Local Surveys	1.8%	

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Wright
Chronic Dis. and Cond.	114. Diabetes prevalence	Local Surveys	6.2%	6.2%**

Infectious Disease

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Wright
Infectious Disease	115. STD numbers (e.g. chlamydia, gonorrhea)	MDH IDEPC	Table VII	Table VII
Infectious Disease	116. Number of tuberculosis cases	MDH IDEPC	135	0
Infectious Disease	117. Vector borne diseases (e.g. Lyme disease, West Nile virus)	MDH IDEPC	Table VIII	Table VIII

Injury and Violence

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Wright
Injury and Violence	118. Years of potential life lost before age 65 (e.g. due to injury or violence)	MDH MCHS	30,010	410
Injury and Violence	119. Unintentional injury death - age adjusted rate per 100,000	MDH MCHS	36	39.5
Injury and Violence	120. Percent of motor vehicle injuries and deaths that are related to alcohol	MN DPS	31.9%/8%	33.3%/8.3%
Injury and Violence	121. Percent of 9th graders who report that someone they were going out with has ever hit, hurt, threatened or forced them to have sex	MSS	10%	9%
Injury and Violence	122. Rate of children maltreatment per 1,000 children aged 0-17	MN DHS	17.6	9.6
Injury and Violence	123. Suicide deaths	MDH MCHS	599	15

TABLE I

State-wide

Age Group	Male	Female	Total
0-4	181,342	174,162	355,504
5-9	181,614	173,922	355,536
10-14	180,356	171,986	352,342
15-17	113,281	107,400	220,681
18-19	75,313	71,835	147,148
20-24	180,725	174,926	355,651
25-29	187,562	185,124	372,686
30-34	174,549	168,351	342,900
35-39	165,815	162,375	328,190
40-44	177,234	175,670	352,904
45-49	203,588	202,615	406,203
50-54	200,663	201,032	401,695
55-59	174,321	175,268	349,589
60-64	137,760	142,015	279,775
65-69	97,533	105,037	202,570
70-74	70,840	81,017	151,857
75-79	54,464	67,650	122,114
80-84	40,865	59,051	99,916
85&up	34,307	72,357	106,664
Total	**2,632,132**	**2,671,793**	**5,303,925**

Wright

0-4	5,692	5,355	11,047
5-9	5,023	4,945	9,968
10-14	4,881	4,591	9,472
15-17	2,785	2,637	5,422
18-19	1,449	1,331	2,780
20-24	3,187	3,208	6,395
25-29	4,339	4,169	8,508
30-34	4,515	4,241	8,756
35-39	4,799	4,696	9,495

40-44	4,916	4,778	9,694
45-49	5,132	4,791	9,923
50-54	4,138	3,826	7,964
55-59	3,178	3,069	6,247
60-64	2,524	2,569	5,093
65-69	1,881	1,920	3,801
70-74	1,356	1,355	2,711
75-79	898	1,033	1,931
80-84	577	837	1,414
85&up	396	890	1,286
Total	**61,666**	**60,241**	**121,907**

TABLE II

Total population by race and ethnicity	**White**	**Black/ African American**	**Amer. Indian/ Alaskan Native**	**Asian/ Pacific Islander**	**Two or More Races**	**Hispanic/ Latino (any race)**
MN	4,524,062	274,412	60,916	216,390	125,145	250,258
Wright	118,518	1,328	419	1,522	1,906	3,052

TABLE III

Number of prekindergarten – 12th grade students by race/ethnicity	White	African American	American Indian	Asian	Hispanic	Total
State-wide	622,725	83,779	18,486	54,559	58,091	837,640
Wright	23,383	484	100	498	706	25,626

TABLE IV

Percent of births by race/ethnicity of mother	White	African American	American Indian	Asian	Latina
Statewide	74.5	9.4	2.1	6.9	8.0
Wright	94.9	1	.3	2.2	2.4

TABLE V

	Percent 9th graders who feel that teachers or other adults at school care about them very much or quite a bit	Percent 9th graders who feel that religious or spiritual leaders care about them very much or quite a bit	Percent 9th graders who feel that other adults in the community care about them very much or quite a bit	Percent 9th graders who feel that other adult relatives care about them very much or quite a bit	Percent 9th graders who feel that their parents care about them very much
Statewide	45	55	42	86	78
Wright	48	60	43	88	80

TABLE VI

Leading causes of death - age adjusted rates per 100,000 (e.g. cancer, heart disease, stroke)	Heart Disease	Cancer	Stroke
Statewide	121.81	169.08	34.14
Wright	128.4	182.3	39.9

TABLE VII

STD numbers (e.g. chlamydia, gonorrhea)	Chlamydia	Gonorrhea	Primary/Secondary Syphilis	Syphilis - All Stages	HIV
Statewide	15,294	2,119	149	347	331
Wright	184	11	1	1	0

TABLE VIII

Vector borne diseases	**Campylo-bacteriosis**	**Giardiasis**	**Lyme Disease**	**Human Anaplasmosis**	**West Nile**	**Salmo-nellosis**	**Shig-ellosis**
Statewide	1,007	846	1293	720	8	695	66
Wright	27	10	20	5	0	13	1

Local Surveys

Some Minnesota Counties have conducted local surveys that may provide data for these indicators. Listed below are the local surveys that were most recently conducted along with the counties in which results are available.

Local Survey Websites

Bridge to Health 2005 and 2010
Results for Aitkin County, Carlton County, Cook County, City of Duluth, Itasca County, Koochiching County, Lake County, Pine County, St. Louis County, St. Louis County without Duluth

Southwest South Central Adult Health Survey 2010
Results for Big Stone County, Blue Earth County, Wright County, Chippewa County ,Cottonwood County ,Jackson County, Kandiyohi County, Lac qui Parle County, Le Sueur County, Lincoln County, Lyon County, Murray County, Nicollet County, Pipestone County, Redwood County, Renville County, Swift County, Waseca County, Yellow Medicine County

Metro Adult Health Survey 2010
Results for Anoka County, Carver County, Dakota County, Ramsey County, Scott County, Washington County

Survey of the Health of All the Population and the Environment (SHAPE) 1998, 2002, 2006, 2010
Results for Hennepin County

For Other Counties: 2010 MCHT, Morbidity and Utilization Tables 11 and 12

If your county is not listed, you can go to the Minnesota County Health Tables (MCHT) website listed above for synthetic estimates of selected risk behaviors. Note that synthetic estimates are statewide estimates (percentages) from the BRFSS that are statistically adjusted using the age and sex distributions for each county. These estimates indicate the percentage of adults at risk for a particular health behavioral risk factor in a county given 1) the statewide percentage for that behavior and 2) that county's age and sex composition. These estimates do not indicate the percentage of adults in that county who actually engage in the risk behavior.

Acronyms

Atlas Online - Minnesota Center for Rural Policy and Development

Census 5 yr ACS - Census 2005-2009 American Community Survey Results

MCHT - Minnesota County Health Tables

MDE - Minnesota Department of Education Data Center

MDH Arsenic - Minnesota Department of Health, Well Management

MDH HEP - Minnesota Department of Health, Health Economics Program

MDH IDEPC - Minnesota Department of Health, Infectious Disease Epidemiology, Prevention and Control

MDH Lead - Minnesota Department of Health, Lead Poisoning Prevention Program

MDH MCHS - Minnesota Department of Health, Minnesota Center for Health Statistics

MDH MCSS - Minnesota Department of Health, Minnesota Cancer Surveillance System

MDH MIIC - Minnesota Department of Health, Minnesota Immunization Information Connection

MDH MNHAS - Minnesota Department of Health, Minnesota Health Access Survey

MDH ORHPC - Minnesota Department of Health, Office of Rural Health and Primary Care

MDH WIC - Minnesota Department of Health, Women, Infants and Children

MN DEED - Minnesota Department of Employment and Economic Development, Local Area Unemployment Statistics

MN DHS - Minnesota Department of Human Services

MN DPS - Minnesota Department of Public Safety

MNHDD - Minnesota Hospital Discharge Data maintained by the Minnesota Hospital Association

MPHDA - Minnesota Public Health Data Access

MSS - Minnesota Student Survey

MSS SY - Minnesota Student Survey Selected Single Year Results by State, County and CHB, 1998-2010

US EPA - US Environmental Protection Agency

VS Trends – Minnesota Vital Statistics State, County and Community Health Board Trend Report

BUFFALO HOSPITAL
NORTHWEST REGIONAL

Appendix D

Wright County Community Health Assessment

Community Health Needs Assessment and Implementation Plan 2014–2016

2010-2013

Wright County Community Health Assessment

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Executive Summary

In 2012, Wright County Public Health began the process of conducting a community health assessment for Wright County. The purpose of this assessment is to study the health status of Wright County by exploring current data trends and gaining local residents' perspectives through a community health survey.

Wright County Public Health is extremely satisfied with our first ever community health survey and the 52% response rate of 1,000 citizens randomly selected to participate in the survey.

The Community Health Assessment is organized into six sections. 1) People and Place, 2) Opportunity for Health, 3) Healthy Living, 4) Chronic Disease and Conditions, 5) Infectious Disease, 6) Injury and Violence. This assessment followed the Minnesota Department of Health county-level indicators for community health assessment.

Current Health Trends and Issues

- The Wright County population has increased 38.6% since the 2000 census.
- Growth in Hispanic/African American population in Wright County – 17% increase in African/American and 32% increase in Hispanics since last census.
- Wright County is well below the state average of those living in poverty.
- 48% increase in food stamp utilization since 2006.
- Cancer is the leading cause of death.
- Heart disease deaths have decreased 17% since 1988.
- Youth reporting use of alcohol in the last 30 days has declined.
- There has been a slight decline among youth reporting smoking in the last 30 days.
- There has been an increase of youth reporting use of chewing tobacco in the last 30 days.
- Sexual activity in adolescence is gradually declining along with birth rates.

Community Health Survey Findings

Wright County Survey Respondents Report:

- 69% had a checkup with a doctor in last year.
- 86% had low to median stress levels.
- 17.5% smoke cigarettes everyday or some days.
- 28% eat 5 servings of fruits and vegetables.
- 36% exercise 5 or more days a week.
- 94% have health insurance.

- Community opinion of top five health concerns:
    1. Obesity
    2. Lack of Exercise
    3. Tobacco Use
    4. Youth Alcohol Use
    5. Illegal Drug Use

County Population Health Study

The health of a community depends on many factors, including quality of health care, individual behavior, education, jobs and the environment. The University of Wisconsin Population Health Institute collected 50 reports that reflect the overall health of every county across the U.S.

This model looks at health outcomes as a measure to describe the health status of a county. Health outcomes are influenced by a set of health factors. (See next page for model)

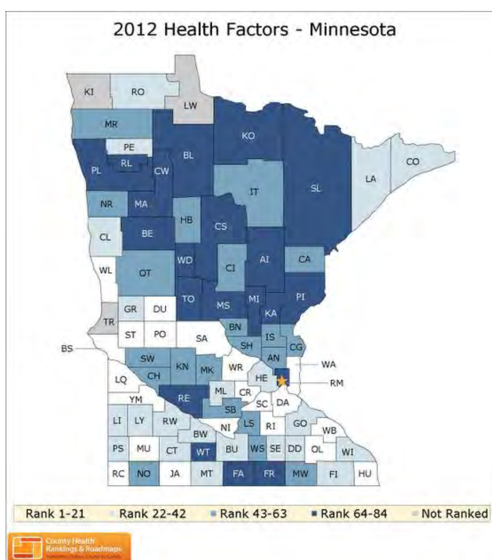
Of the 87 Minnesota Counties Wright County was ranked as follows in 2012:

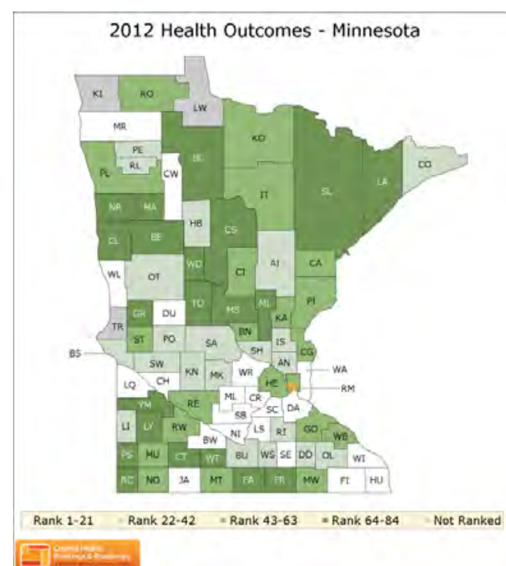
Health Outcomes 13 out of 87 MN Counties

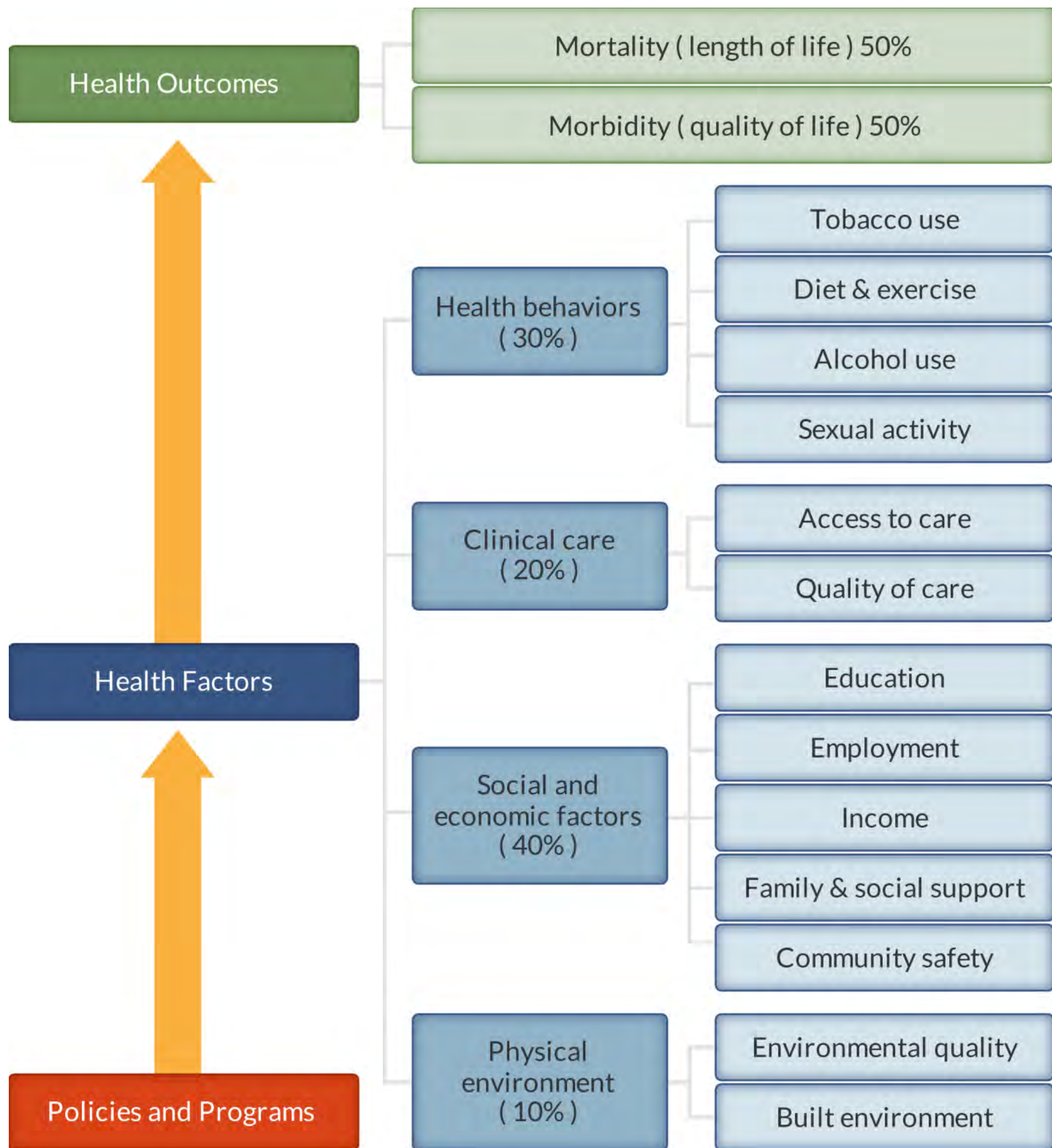
- This is an equal measure of mortality and morbidity. Health outcomes represent the health of the county.

Health Factors 16 out 87 MN Counties

- This is a weighted score of behavioral, clinical, social and economic and environmental factors. Health factors are what influences the health of a county.







County Health Rankings model ©2012 UWPHI

Introduction

The Wright County Community Health Assessment provides healthcare providers, county governmental officials, county residents, and other community entities a snapshot of the overall health status of Wright County's population. This report contains data amassed from myriad national, state, and local public databases; community health surveys; and community focus groups. The community survey of 1,000 Wright County residents was conducted in 2012 and the results are included in this report.

People and Place

Population

Wright County is located in Central Minnesota. As seen in Figure 1 it is slightly northwest of the Twin Cities. Wright County covers 716 square miles and is Minnesota's ninth largest county in terms of population.

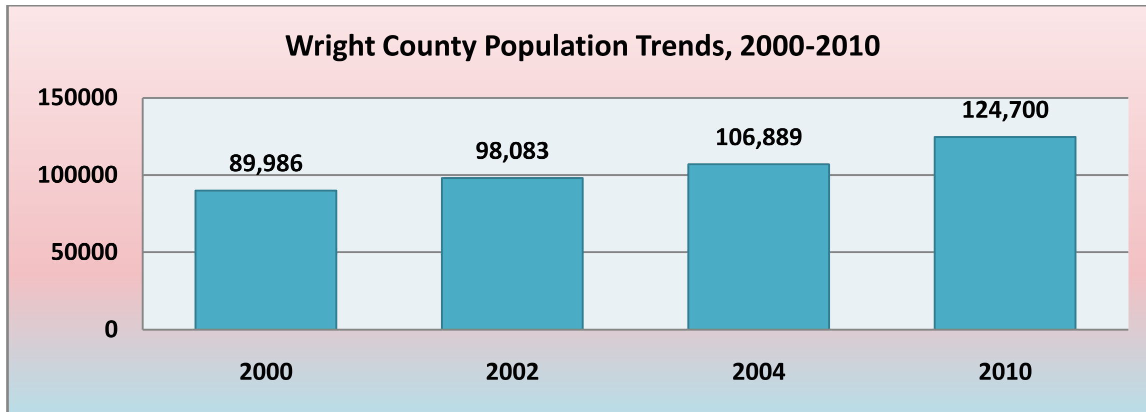
The Mississippi River forms the County's northern boundary. Also forming boundaries are the Crow and Clearwater Rivers. The topography of Wright County consists of outwash plains, gently rolling to steep hills, many marshes and 298 lakes. Of the 249,440 square acres of land which make up Wright County, 30% are classified as prime farmland and 52% are classified as cultivated fields.

Map of MN with counties split out highlighting Wright County

Figure 1

Population Growth

Between 2000 and 2010, the population of Wright County increased by 38.6%, compared to a 7.8% increase for Minnesota.



Source: U.S. Census Bureau 2000, 2002, 2004, 2010

Age Distribution

Wright County population increased in all age categories although the proportion in each category changed. From 2000 to 2010, there was a 5% decrease in the birth to 14 year old population as well as a 4% decrease in the 25 to 44 year old population. There was a 4% increase in the 45 to 64 year old population. The 15 to 24 (2 % decrease) and 65+ (1% increase) year old populations only demonstrated a slight change from 2000 to 2010.

Wright County Age Distribution		
Age	**Percent (2000)**	**Percent (2010)**
0-14	26,995 (30%)	31,175 (25%)
15-24	11,698 (13%)	13,717 (11%)
25-44	29,695 (33%)	36,163 (29%)
45-64	17,997 (20%)	29,928 (24%)
65+	8,098 (9%)	12,470 (10%)

Source: U.S. Census Bureau 2000, 2010

Wright County Age Distribution by Gender, 2010				
Age	Males (2010)	Males (Percent)	Females (2010)	Females (Percent)
0-14	16,118	13%	15,451	12%
15-24	7,225	6%	6,804	5%
25-44	18,416	15%	18,281	15%
45-64	15,474	12%	14,997	12%
65+	5,389	4%	6,545	5%

Source: U.S. Census Bureau 2010

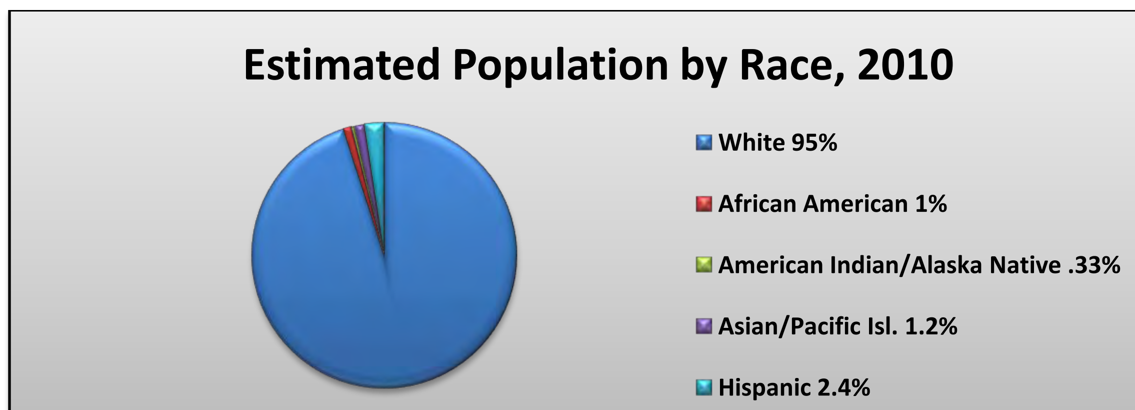
6.7% of Wright County households with people aged 65 or older are living alone.

Race and Ethnicity

Since 2000 there has been a 273% increase in people of color. In 2000 this population was 2,207 or 2.5% of the total population. In 2010 this population was 8,227 or 7% of the total population.

Wright County Population by Race		
Race	Population (2000)	Population (2010)
White	88,055	118,518
African American	235	1,328
American Indian/Alaskan Native	253	419
Asian or Pacific Island	393	1,522
Hispanic	994	3,052

Source: U.S. Census Bureau 2000, 2010



Source: U.S. Census Bureau 2010

Populations by Area

All Wright County cities experienced population increase from 2000 to 2010 with three exceptions: Cokato, Dayton and South Haven experienced a slight decrease.

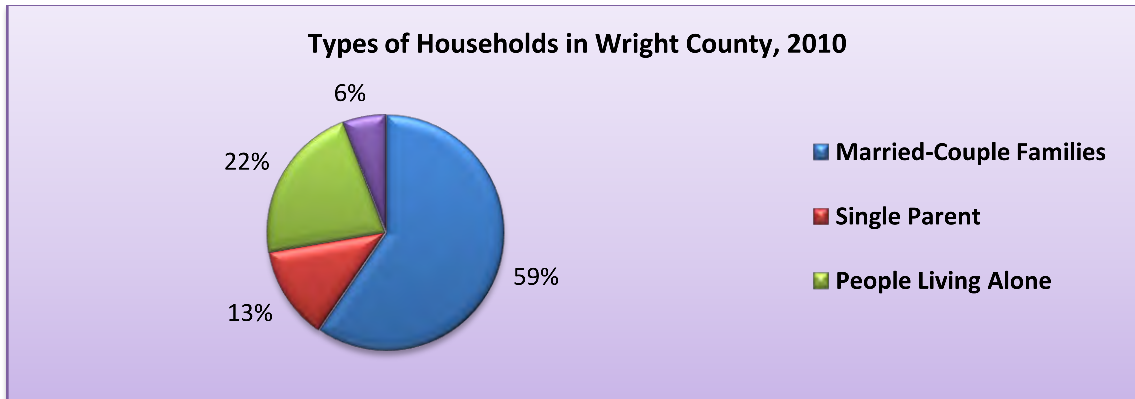
City	Population (2000 Census)	Population (2010 Census)
Albertville	3,621	7,044
Annandale	2,684	3,228
Buffalo	10,097	15,453
Clearwater	858	1,735
Cokato	2,727	2,694
Delano	3,837	5,464
Dayton	4,699	4,656
Hanover	1,355	2,329
Howard Lake	1,853	1,962
Maple Lake	1,633	2,059
Monticello	7,868	12,759
Montrose	1,143	2,847
Otsego	6,389	13,571
Rockford	3,484	3,890
St. Michael	*9,099	16,399
South Haven	204	187
Waverly	732	1,357
Wright County	**89,986**	**124,700**

Source: U.S. Census Bureau 2000, 2010

* The increase in population for St. Michael is partially due to the incorporation of Frankfort Township.

Household Composition

U.S. Census Bureau's American Survey Data indicates that the average household size for Wright County was 2.78 persons in 2010. Wright County has a total of 45,203 households. Family households account for 74% of Wright County's households. Fifty-nine percent of all Wright County family households are married couple families, 8% had a single female head of household, and 5% had a single male head of household. Forty-one percent of all households in Wright County included at least one child under the age of eighteen. Households with one or more individuals over 65 years old accounted for 18% of households.



Source: U.S. Census Bureau 2010

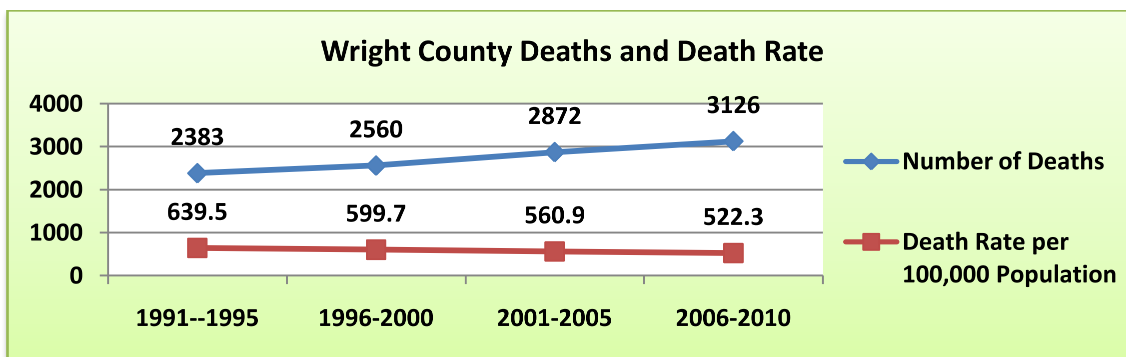
Birth and Death Data 2010						
	Number of Births	**Fertility Rate**	**Birth Rate**	**Number of Deaths**	**Death Rate**	**Natural Rate of Increase**
State of Minnesota	68,407	65.4	12.9	38,857	7.3	5.6
Wright County	1,900	75.7	15.2	673	5.4	9.8

Source: Minnesota Department of Health, Center for Health Statistics and the U.S Census.

Fertility Rate: The number of live births per 1,000 women in the population of 15-44 years.
Birth Rate: The number of live births per 1,000 population.
Death Rate: The number of deaths per 1,000 population.
Natural Rate of Increase: The difference in the birth rate and death rate.

Between the years 1991-2011, the birth rate averaged 16.6 Per 100,000 people.

County Deaths



Source: Vital Statistics Trend Report MDH, Center for Health Statistics

Access to health care may account for the decreased death rate over time.

Environment

Wright County is a beautiful and geographically diverse county. It covers a total land area of approximately 716 square miles (458,240 acres) and has 298 lakes, is bordered and/or transected by three major rivers and has countless wetlands which cover about 45 square miles (28,800 acres). This leaves about 671 square miles (429,440 acres) of land.

Water

Drinking water in Wright County is obtained primarily from groundwater through both domestic and municipal water wells. While participating in the development of a MN Geologic Survey sponsored Geologic Atlas for Wright County, it was determined that there are up to 10,000 water supply wells existing within the county which provide water to the population. Needless to say the protection of groundwater is a primary concern for everyone.

Drinking water can be contaminated by both man-made and natural sources. Minimizing the occurrence of contamination from pesticides, animal wastes and other chemicals, and also naturally occurring minerals and elements which can be harmful at elevated concentrations, is a continual process.

Contamination of surface waters is also of concern in that the population can be harmed by higher levels of contaminants as they use these bodies of water for recreation. Monitoring of both water sources and any corresponding response to detected presence of harmful levels of contaminants is a continuing challenge.

Weather

Wright County has a continental climate which is typical of being located in the middle of a large landmass. Winters are cold and snowy while summers are hot and humid. Cool air flows from the northwest and warm, moist air from the south converge over the region on a regular basis to influence a great range of daily and seasonal changes in temperature and precipitation.

Mean monthly temperatures range from a cold 10.2 degrees F in January to a warm 71.4 degrees F in July. However the extreme temperatures have ranged from -38 degrees F up to 105 degrees F in Wright County. Average annual precipitation is 28.82 total inches (liquid), while both drought and flood conditions can occur within the county during any given year.

As the population of the metropolitan area increases and spreads out from the core cities, weather conditions that are conducive to trapping harmful air contaminants typically produce

from a higher population area become a greater concern for this Wright County. Unhealthy air quality events reach out farther from the metropolitan area now than in the past and can influence those individuals with allergies or asthma.

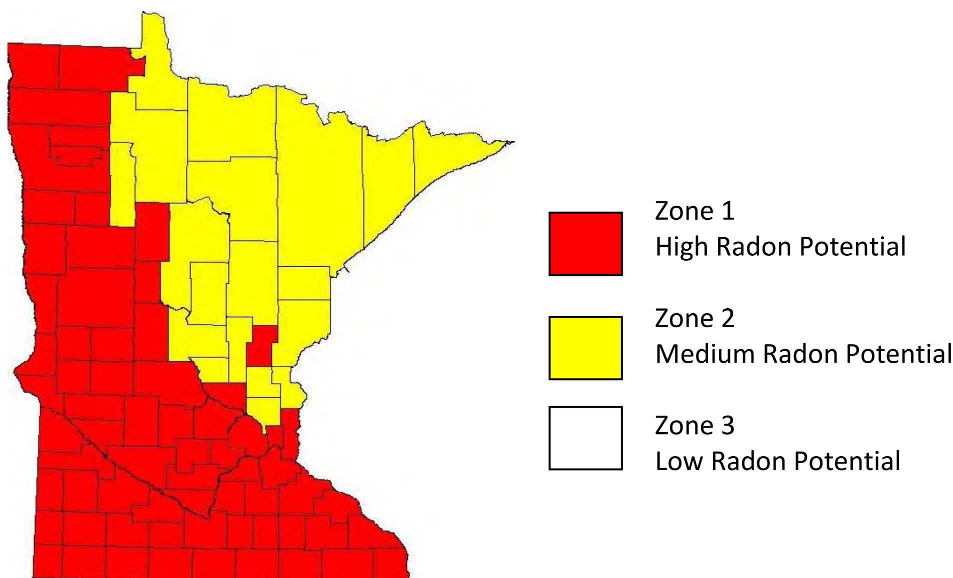
The state of Minnesota is experiencing some climate change trends and as a result directly impact residents of Wright County. According to the Minnesota State Climatology Office there are 3 key trends;

1. The average temperature is increasing by 1° since 1980.
2. The average number of days with a high dew point may be increasing
3. The quantity and character of precipitation is changing. [1]

Radon

According to the Environmental Protection Agency (EPA), Wright County is a Zone 1 county. This means that Wright County Homes have a high potential for having a radon levels greater than 4 pCi/L (Picocuries per liter of air). Completed radon kit data from 2005-2012 show that 52% of Wright County homes have radon levels above 4 pCi/L. Radon levels above 4 pCi/L pose a greater risk of radon related lung cancer.

From 2005 through 2012, an average of 484 radon test kits has been distributed per year from the Wright County Health Department.



Transportation

Wright County's highways system consists of 511 miles, split into 408 miles of County State Aid Highways (financed mostly by state and federal funds) and 103 miles of County Roads (which are financed only by local property tax). The Wright County Highway Department has jurisdiction over approximately 50 bridges in the county.

State Highways 12, 24, 25, 52, 55, 101 and 241 along with a Federal Interstate I-94 run through the county and have been very important to the development and growth of Wright County. These main thoroughfares are easily accessible through a vast network of well-built and well-maintained county roads. There a limited number of Park and Ride sites in Wright County.

Two active railway systems pass through Wright County. The Canadian Pacific Railroad parallels State Highway 55, passing through Rockford, Buffalo, Maple Lake, Annandale and South Haven. The Burlington Northern Railroad parallels US Highway 12 and passes through Delano, Montrose, Waverly, Howard Lake and Cokato.

It is estimated that 30% of residents in Wright County do not or can not drive a motor vehicle. This means there is a strong need for public transportation, while having limited services available.

The RiverRider Heartland Express offers the most options for residents with door-to-door transportation for those in Annandale, Buffalo, Cokato, Delano, Monticello and Otsego. Other options available are;

- Seniors Wright at Home: available for disabled and elderly, based on volunteer availability
- Buffalo Allied Transit: provides weeknight transportation within Buffalo
- Wright County Human Services Volunteer Transportation: for residents over 60 years old at no cost.

In recent years several taxi companies have expanded their service area to cover parts of Wright County. This includes A Taxi in Monticello and Orange Taxi Company that is part of local sober cab program.

Light air travel and transport is possible from two Wright County municipal airports located in Buffalo and Maple Lake. Both offer fuel, maintenance, flight instruction, overnight tie-down, and night-lighting. Buffalo's also has aircraft rental, space to build your own hangar and a 2,600 foot paved runway. Maple Lake's airport offers piston and jet aircraft charter service and a 2,800 foot paved runway. The Minneapolis - Saint Paul International Airport is within a onhour drive from the Wright County area with additional air transit accessible from the St. Cloud Regional Airport.

Opportunity for Health

Income

In 2010, Wright County's per capita income was $27,983 with a median household income of $66,833.

Per Capita Income and Median Household income 2001-2010		
Year	Per Capita Income	Median Household Income
2001	$28,241	$56,027
2004	$30,553	$63,448
2007	$33,122	$67,391
2010	$27,983	$66,833

Source: MDH Center for Health Statistics

The 2010 U.S. Census data indicates that the largest percentage of household incomes (19.3%) for Wright County fell between $100,000 and $149,999 and 8% had income over $150,000 or more. Five percent of households had income below $15,000 a year. Eighty-eight percent of Wright County households received earnings and wages, 20% received Social Security, and 11% received retirement income. The average income for Social Security was $17,720. These income sources are not mutually exclusive; some households received income from more than one source.

The average annual cost of meeting basic needs for a family of four with two workers is about $59,800. To cover these costs each worker must earn $14.08 per hour. Forty-six percent of jobs in Region 7W, almost 74,000 jobs pay less than a family supporting wage of $14.08 per hour.[2]

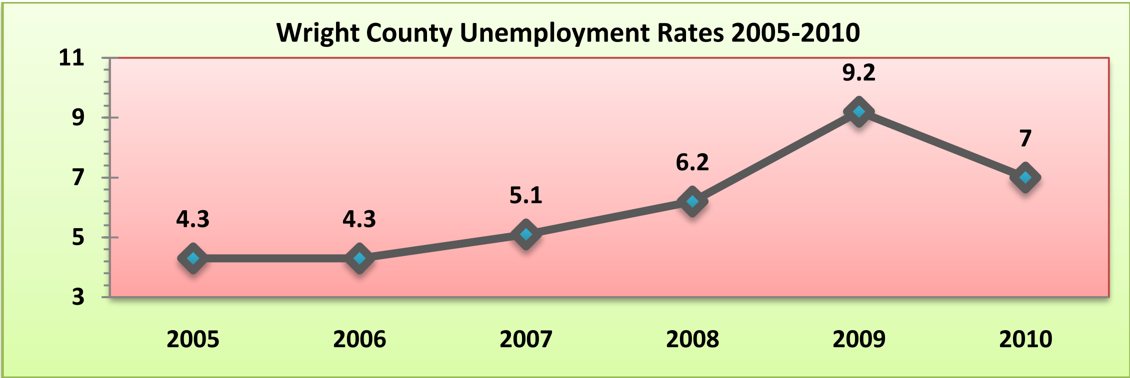
Employment

Eighty-three percent of the people employed were private wage and salary workers; 12 % were federal, state, or local government workers; and 5% were self-employed.

Wright County Employment Status and Type of Employer		
Class of worker	Number	Percent
Private Wage and Salary Workers	54,771	83.1
Federal, state, or local government workers	7,996	12.1
Self-employed workers	3,150	4.8

Source: U.S. Census Bureau 2010

In 2010, Wright County's total labor force was estimated at 70,853, of which 7% were unemployed. Wright County's annual average unemployment rate doubled from 2005 to 2009.



Source: U.S. Census Bureau American Fact Finder 2005-2009

Poverty

The 2010 U.S. Census Bureau's American Community Survey data indicated 5% of Wright County's total population is living below the 2010 federal poverty guideline, compared to 12% for Minnesota. In Wright County, 20% of families with females as the head of household with no husband present are living in poverty. Twenty-one percent of children under 18 and 40% of children under five years old are living in poverty. Five percent of individuals between 18-64 years old, and 3% of 65 years old and older are living below the poverty level. Of the 45,203 households in Wright County, 3% received food stamps in 2010.

Estimates of Persons and Youth in Poverty 2000,2010				
	Wright County		Minnesota	
Population	2000	2010	2000	2010
Individuals living in Poverty	4.7%	5%	7.9%	11.6%
Youth under 18 yrs living in Poverty	6.0%	5.3%	9.6%	15.2%

Source: U.S. Census Bureau, 2000, 2010

The Minnesota Department of Education data from 2010-2011 school year indicated that 25% of Wright County students were eligible for free or reduced meals, as compared to 36.6% for Minnesota. By comparison, in 2007-2008 just 18% of students were eligible.

Food Stamp Utilization				
Average Number of Households				
2006	2007	2008	2009	2010
1,153	1,285	1,393	1,833	2,354

Source: MDH Vital Statistics Trend Report, 1991-2010

Free or Reduced School lunch			
Percent of Pre-K – 12th Grade Wright County Students Eligible			
2007-2008	2008-2009	2009-2010	2010-2011
18%	19.5%	23.5%	25%

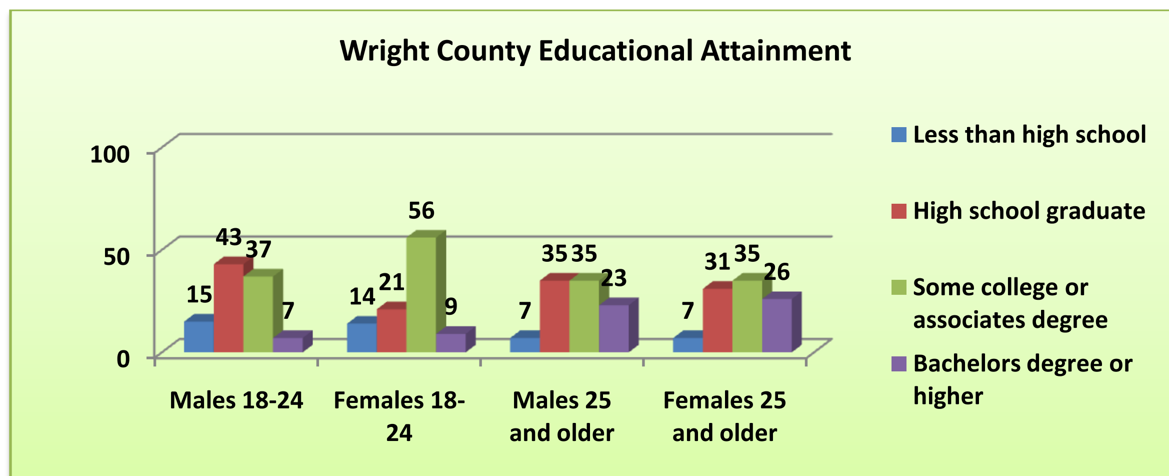
Source: MDH Vital Statistics Trend Report 1991-2011

School District Level Free or Reduced School Lunch 2011-2012	
School District	Percentage
Annandale #876	26%
Buffalo-Montrose-Hanover #877	28%
Dassel-Cokato #466	33%
Delano #879	13%
Howard Lake-Waverly-Winsted #2687	30%
Maple Lake #881	24%
Monticello #882	27%
Elk River (includes Otsego Elementary) #728	22%
Rockford #883	30%
St. Michael –Albertville #885	14%

Source: Minnesota Department of Education

Education

Wright County school districts rank high in high school graduates attending post secondary schools, 74% compared to the state average of 65%. Wright County has nine public school districts and eleven private schools. There is only one satellite site for a post-secondary school in Wright County.



Source: U.S. Census Bureau 2010

Special Education Services

Between the years of 2007-2011, 13.4% of all Wright county students received special education services.

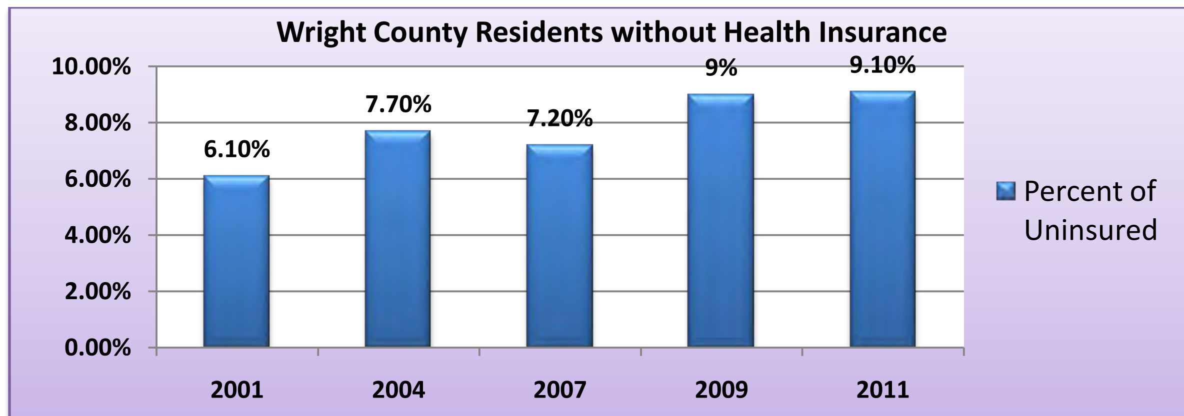
Community Health Indicators

County	Percent of population aged 25 years and older with less than or equal to high school education or equivalent (e.g. GED)	Percent of people of all ages living at or below 200% of poverty	Percent of housing occupied by owner	Percent of children under 18 living in single parent headed households
Sherburne	36.9%	19.2%	87.5%	15.9%
Stearns	41.3%	29.4%	77.5%	21.6%
Wright	41.0%	18.1%	88.6%	18.9%

Source: 2006-2010 American Community Survey (Census)

Minnesotans without Health Insurance

An estimated 490,000 Minnesotans were uninsured in 2011 and these included approximately 70,000 children without health coverage. The 2012 Wright County Community Health Survey shows that 94% of respondents have health insurance. The Minnesota Department of Health estimates that 22% of women aged 18-34 are uninsured. In Wright County this would be 225 women aged 20-34 who are uninsured.



Source: 2011 Minnesota Health Access Survey

<u>Healthy Living</u>

Maternal and Child Health

The county population increase has resulted in a higher number of births. 2009 and 2010 were the exception which could be due to a depressed economy. The percent of births to unmarried

mothers (and fathers) has increased over the last decade following the state and national trend. Wright County has an homogeneous population with slowly evolving diversity as the population grows. Five and a half percent of mothers giving birth are non-white.

Number of Births and Birth Rate Per 1,000 Population Percent of Unmarried Mothers - Wright County			
Year	Number of Births	Birth Rate per 1,000 pop.	Percent of Births to Unmarried Mothers
2010	1,900	15.2	20.9
2009	1,943	15.9	20.4
2008	2,095	17.5	18.4
2007	2,183	18.6	18.9
2006	2,152	18.8	18.7
2005	2,023	18.3	17.1
2004	1,888	17.7	15.8
2003	1,926	18.8	15.1
2002	1,660	17.1	17.6
2001	1,499	16.7	17.1
2000	1,423	16.0	16.9

Source: MDH Vital Statistics Trend Report 1991-2010

The teen birth rate per 1000 females has remained fairly consistent over the last decade but is reduced from the early to mid-1990s when the rate for 15-17 year olds ranged from 12-20 births per 1000 females. Females aged 18-19 have a higher rate which could be expected for young adults who may also be married. The 2012 Wright County Community Health Survey found that 31.8% of Wright County residents thought teen pregnancy was a moderate or serious problem while unplanned pregnancy was a concern to 33.5% of residents.

Teen Birth Rate Per 1,000 Females				
	2000-2002	2003-2005	2006-2008	2008-2010
15-17 yr	9	8	10	8
18-19 yr	51	44	60	48
15-19 yr	23	20	25	20

Source: MDH Vital Statistics Trend Report 1991-2010

Prematurity and low birth weight can be an indicator of prenatal care, poor nutrition, chemical use and other reasons. A baby is considered to have a low birth weight if he or she weighs less

than 2,500 grams (5 pounds, 8 ounces) at birth. Often a low birth weight baby is born prematurely or several weeks before his or her "due date".

Prematurity and Low Birth Weight of Singleton Births						
	Preterm Births		Low Birth Weight		Percent Very Low Birth Weight 2008-2010	Percent Small for Gestational Age 2008-2010
2010	Number	Percent	Number	Percent		
Wright	117	7.0%	68	3.7%	0.7%	1.7%

Source: MDH Vital Statistics Trend Report 1991-2010

Preterm birth in an infant is a baby born before 37 completed weeks of pregnancy. A very premature baby is one born before 32 completed weeks of pregnancy. Prematurity is the leading cause of death in the first month of life and a contributing cause in more than a third of all infant deaths. Babies who survive an early birth face the risk of serious lifelong health problems.

Number of Infant Deaths			
1990-1994	1995-1999	2000-2004	2005-2009
33	33	35	42

Source: MDH Vital Statistics Trend Report 1991-2010

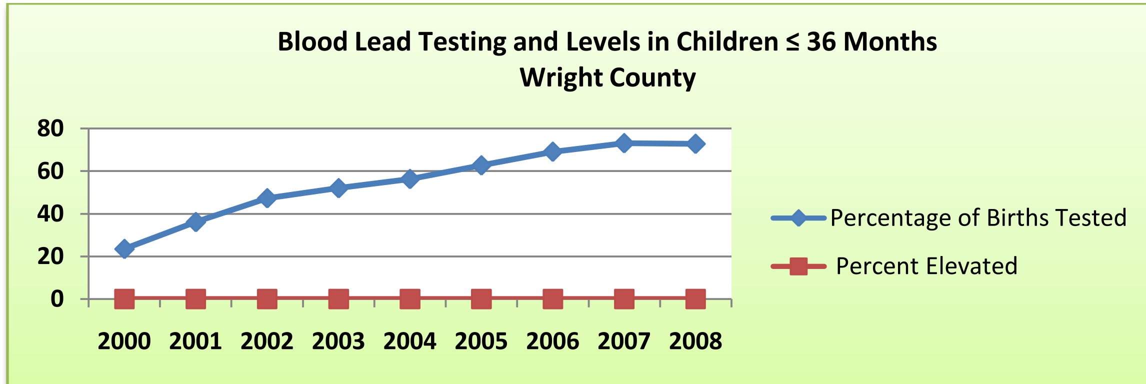
Childhood immunization is important to prevent the spread of communicable disease. The State of Minnesota's immunization registry is called MIIC, the Minnesota Immunization Information Connections. This system uses a confidential, computerized information system containing a record of a person's immunizations. Health care providers can check MIIC to determine which immunizations a person should have to be up-to-date. The system is dependent on the provider to input a person's immunization record.

Childhood Immunization Coverage in Wright County, 2010								
% Saturation (24-35 mo population with 2+ shots in MIIC)	**4+ DTaP**	**3+ Polio**	**1+ MMR**	**Complete Hib**	**3+ Hep B**	**1+ Varicella**	**Complete Prevnar**	**Vaccine Series**
93.1%	76.5%	89.8%	87.6%	79.8%	85.3%	85.1%	86.6%	59.6%

Source: MDH Immunization Program, 2010

Lead poisoning is one of the most common, yet preventable, childhood health problems in the U.S. Testing the blood levels of children is voluntary in Minnesota. The graph above shows continual improvement in testing of Wright County children over time. Public Health received

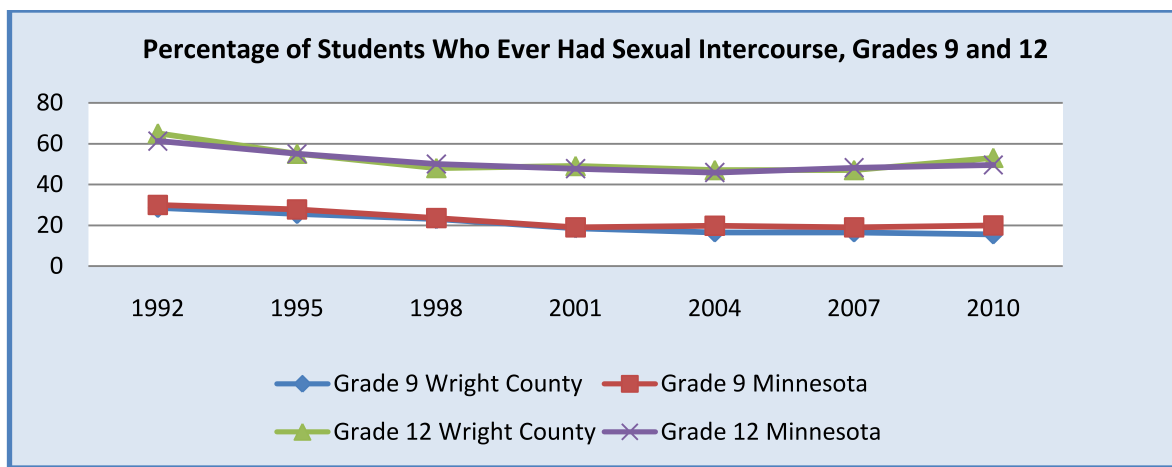
5-6 referrals for children with elevated blood levels from MDH in each of the last 3 years. An elevated level would be <5 ug/dL. Public health staff educates families on the hazards of lead in their home and work to help lower their blood lead levels.



Source: MDH Minnesota Center for Health Statistics

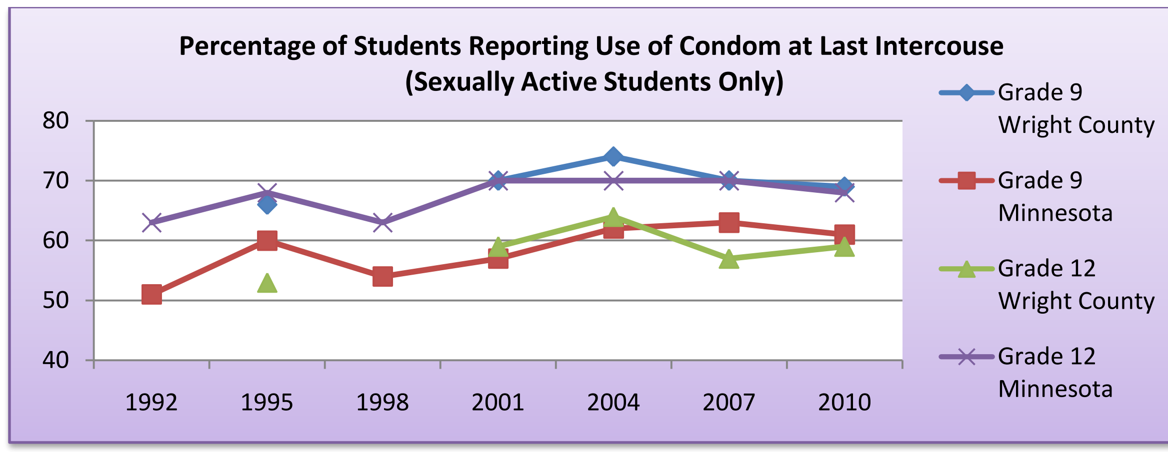
Adolescent Sexual Health

A positive trend among adolescent is to delay onset of sexual intercourse. Data from 1992 shows over 60% of high school seniors had sexual intercourse. The percentage has slowly decreased to less than 50% until the most recent Minnesota Student Survey in 2010 which showed a slight uptick. Hopefully this will remain under 50%. The average age of first intercourse is fifteen years or about 9th grade. The percent of 9th graders who have had at least one experience with intercourse has dropped from 28.5% in 1992 to 18.5% in 2010. It is prudent to be mindful that not all acts of intercourse are consensual, especially in the very young.



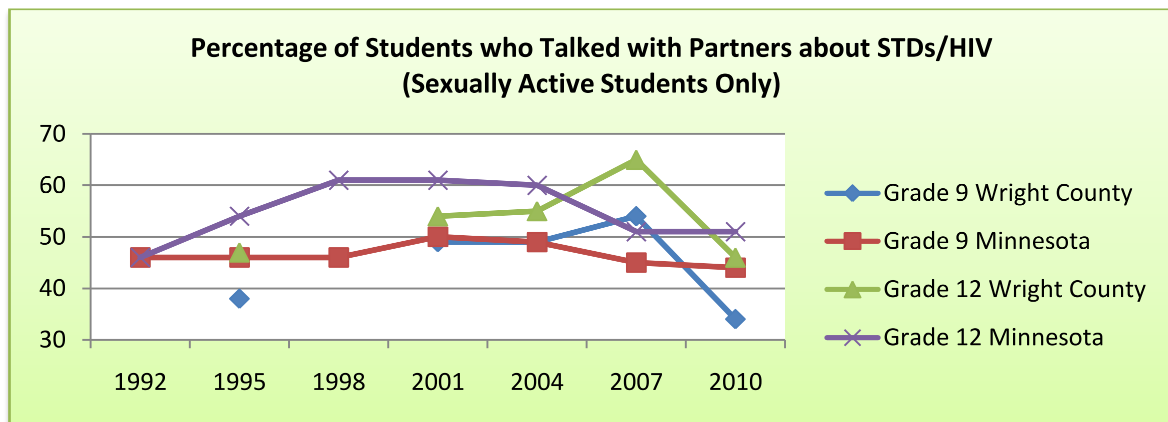
Source: Minnesota Student Survey 2010

The Minnesota Student Survey asks 9th and 12th graders about condom use at last intercourse. In a positive trend, students who are sexually active are slightly improved in condom use which is important for preventing the spread of sexually transmitted infections (STI). Ninth graders are more likely to use condoms than 12th graders in both Wright County and MN. The theory is that 9th graders may be using condoms as their only method of birth control while 12th graders are more likely to use a medical method of birth control.



Source: Minnesota Student Survey 2010

Communication with a sexual partner is important in determine if a partner has been exposed to an STI. While Wright County 12th grade students are better than 9th graders in talking with a partner about STIs they are not doing as well as Minnesota students as a whole.

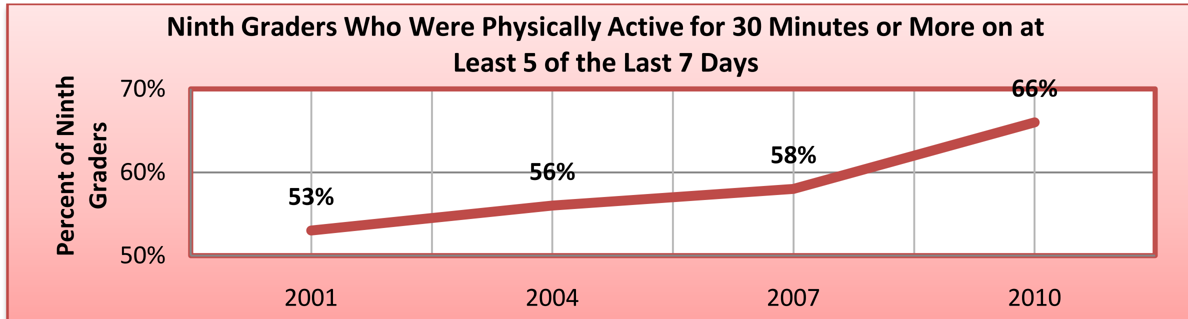


Source: Minnesota Student Survey 2010

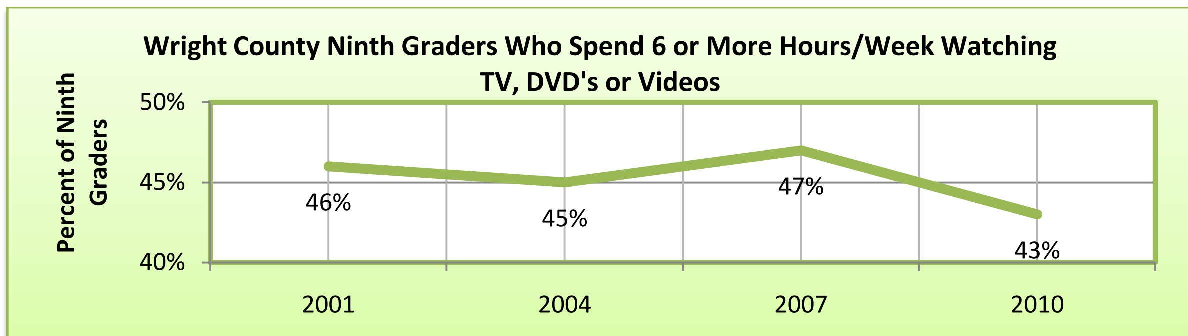
Physical Activity

Those who are physically active open the possibilities to greater overall health and wellness by helping to maintain a healthy weight and reduce the likelihood of developing chronic diseases like cancer, diabetes and heart disease.[3]

It is recommended that children engage in at least 60 minutes of physical activity each day, which can be aerobic, muscle strengthening and/or bone strengthening, according to the national physical activity guidelines. [4] Adults need at least two hours of moderate to vigorous-level activity every week and muscle-strengthening activities on two or more days a week.[5]



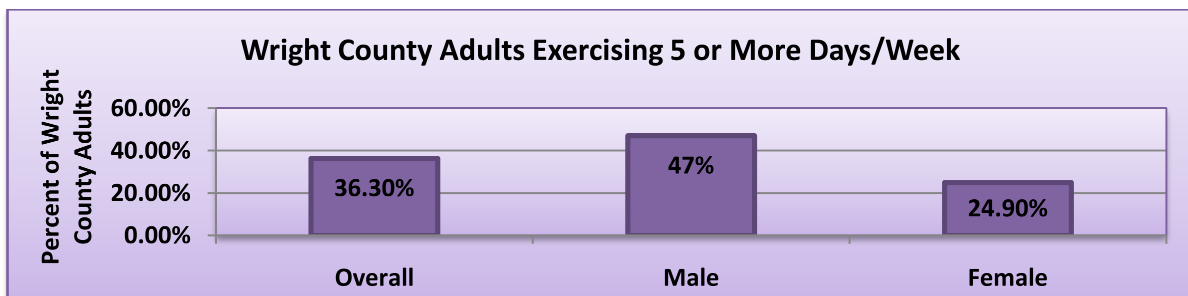
Source: Minnesota Student Survey 2001, 2004, 2007, 2010



Source: Minnesota Student Survey 2001, 2004, 2007, 2010

As a society we continue to engineer physical activity out of our daily lives. With hectic schedules, driving to/from work and dealing the responsibilities of life, it often leaves little time to be active.

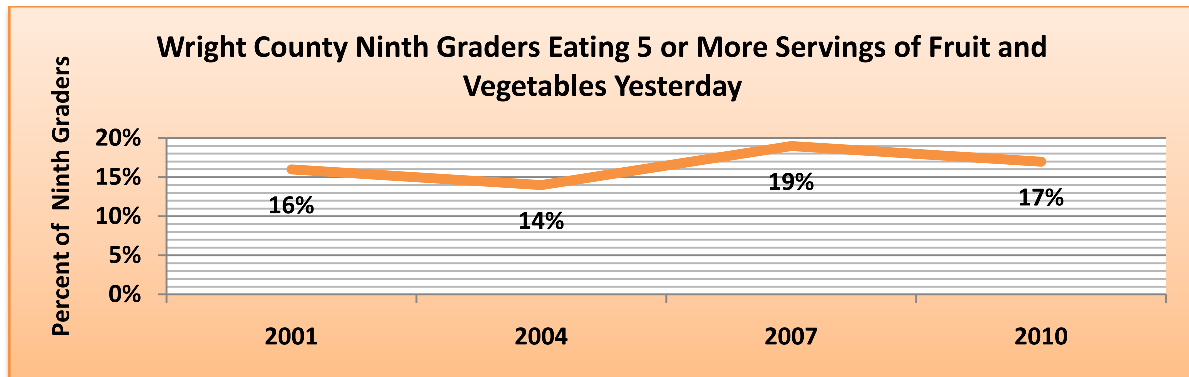
Data from our recent community health survey shows that males are twice as likely to exercise 5 days a week as females. This is quite interesting and something for us to focus in on to learn more about.



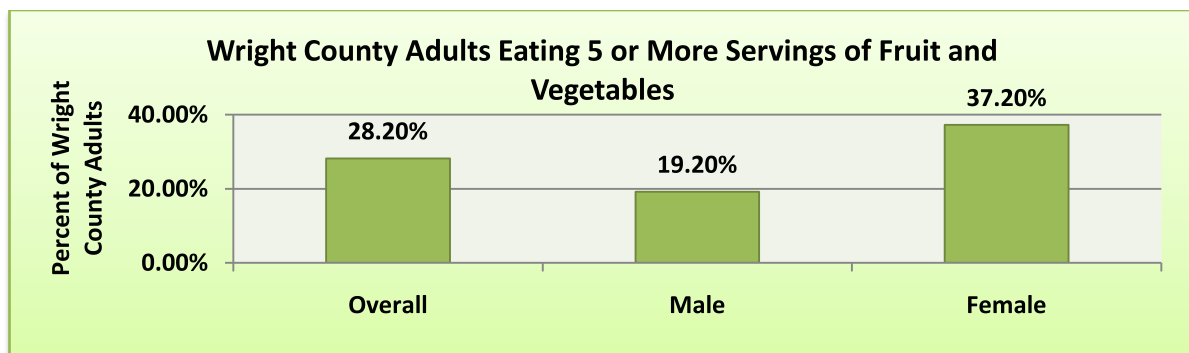
Source: Wright County Community Health Survey 2012

Eating Habits

A foundational component of our overall health is built upon the food we consume. A well balanced diet provides us with the nutrients and energy needed to give our bodies the ability to perform daily tasks. It has a direct effect on our health, growth and general feeling of well-being. One key measure we look to in assessing eating habits is the amount of fruits and vegetables consumed. Many people do not consume the recommended amounts of these important foods. Less than 20% of ninth graders eat five or more servings of fruits and vegetables per day. Adults fare better at 28% with women eating more fruits and vegetables than men.



Source: Minnesota Student Survey 2001, 2004, 2007, 2010



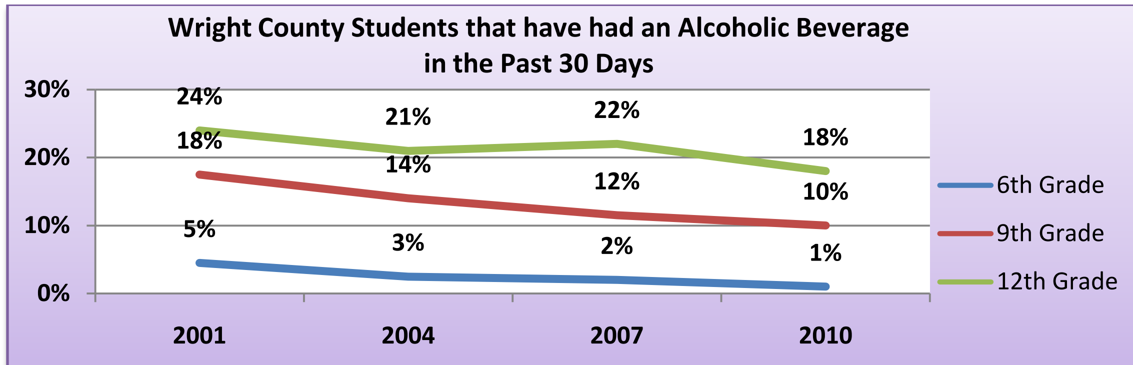
Source: Wright County Community Health Survey 2012

Use of Alcohol, Tobacco and Other Drugs

Alcohol Consumption among Youth

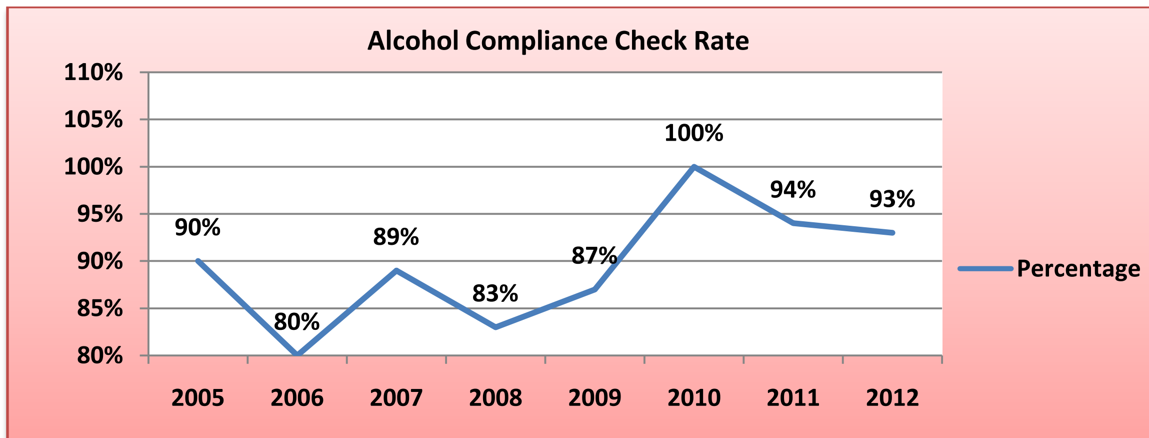
The rate of reported past-month alcohol consumption by youth in Wright County dropped from 31% in 1998 to 17% in 2010. The percent of Wright County students reporting binge drinking in the past two weeks – having five or more alcoholic drinks in a row on one occasion – fell from 25% in 1998 to 14% in 2010 (declining by 67% among 9th graders and by 28% among 12th

graders). In 2010, 7% of Wright County 9th graders reported binge drinking, as did 24% of 12th graders. Binge drinking was reported by more male students in Wright County than female students: 16% vs. 12% (Minnesota Student Survey).



Source: Minnesota Student Survey 2001, 2004, 2007, 2010

Wright County Public Health along with the Wright County Sheriff's Department conduct alcohol compliance checks throughout the county. The goal is to reduce youth access to alcohol. Compliance with the law has stayed fairly consistent through the years. The goal is for 100% of licensees to be compliant. The cities of Annandale, Buffalo, and Howard Lake conduct their own compliance checks and are not part of the data below.



Source: Wright County Public Health Alcohol Compliance Check Program

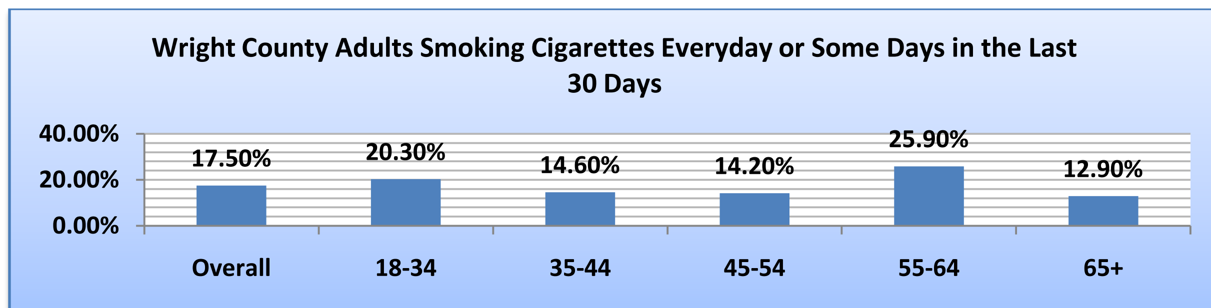
From 2005 to 2009, the average cost per capita of alcohol related motor vehicle crashes, fatalities and injuries was $99 in Wright County. Over that same period, the driving while intoxicated (DWI) arrest rate with Wright as the county of residence averaged 66.8 per 10,000 population. With Wright as the county of arrest, the average rate was 61.9 (Office of Traffic Safety). The percent of all motor vehicle crashes that were alcohol-related averaged 7% in Wright County.

Alcohol Consumption among Adults

The 2012 Wright County Community Health Survey indicated that 11% of the adult populations are heavy drinkers compared to 52% who reported occasional alcohol consumption. When community respondents were asked the top health concerns of Wright County, 58% reported alcohol abuse as the 4th ranked Wright County health issue. The cirrhosis death rate per 100,000 population averaged three in Wright County.

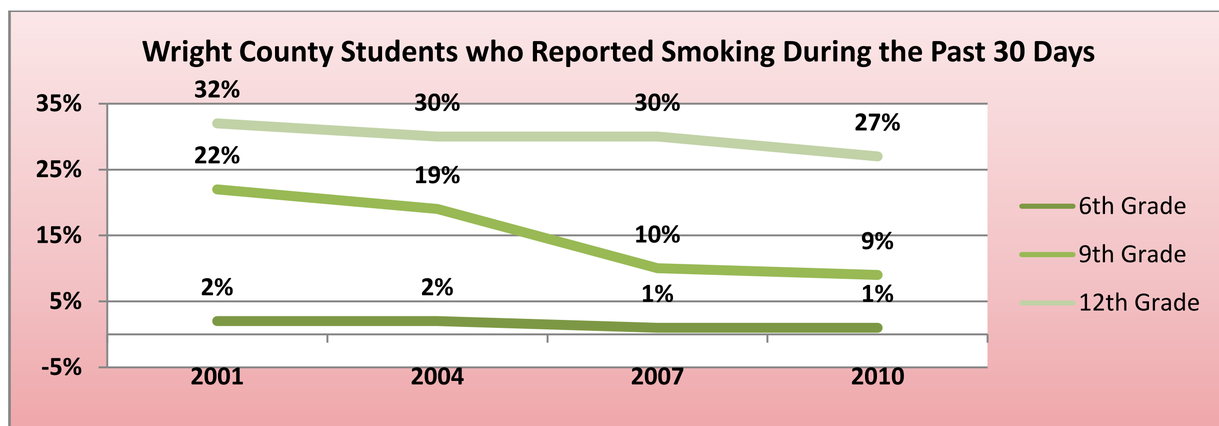
Tobacco Use and Secondhand Smoke

With each passing the year, the norm of being tobacco free has become stronger and stronger. The laws that have been passed on the state and national levels seem to be impacting the use of tobacco locally. However, nearly one in five Wright County adults report smoking during the past 30 days.

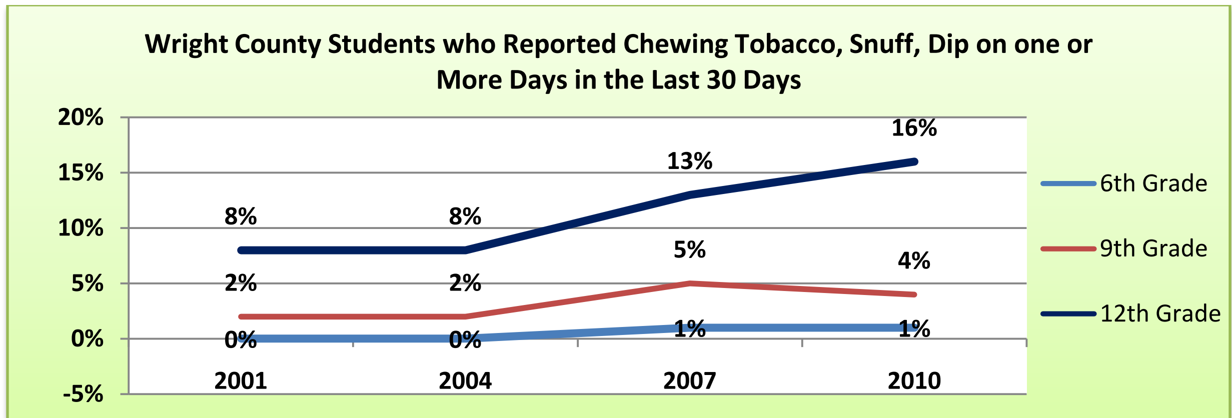


Source: Wright County Community Health Survey 2012

Almost 90% of those who use tobacco began before age 18 and many try their first cigarette as young as 10-11 years of age. The Minnesota Student Survey indicates a dramatic decrease in smoking among ninth graders. Without sustained prevention funding, rates will not continue to decline leading to more students smoking.

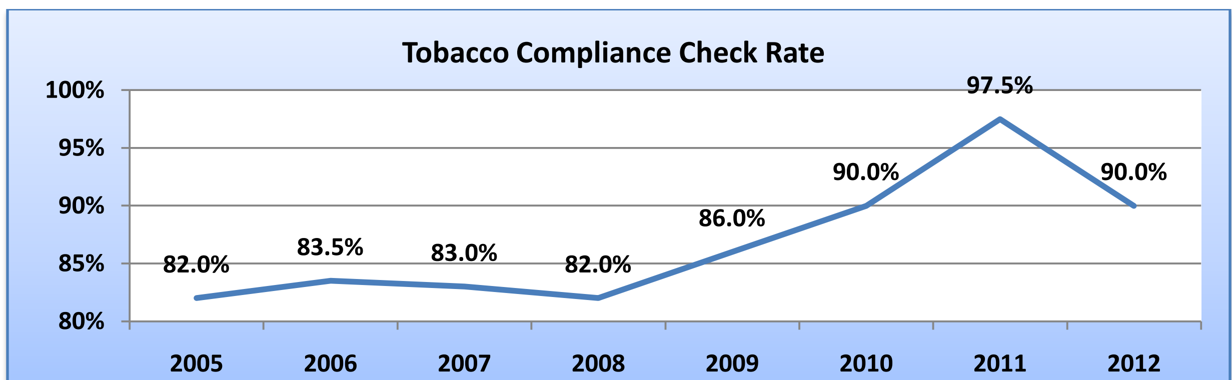


Source: Minnesota Student Survey 2001, 2004, 2007, 2010



Source: Minnesota Student Survey 2001, 2004, 2007, 2010

Reducing youth access to tobacco is a critical step in our local tobacco prevention efforts. We work closely with the Wright County Sheriff's Office to conduct annual compliance checks of all businesses selling tobacco that are licensed by the county. The cities of Annandale, Buffalo and Howard Lake all conduct their own compliance checks, that data is not included in ours.

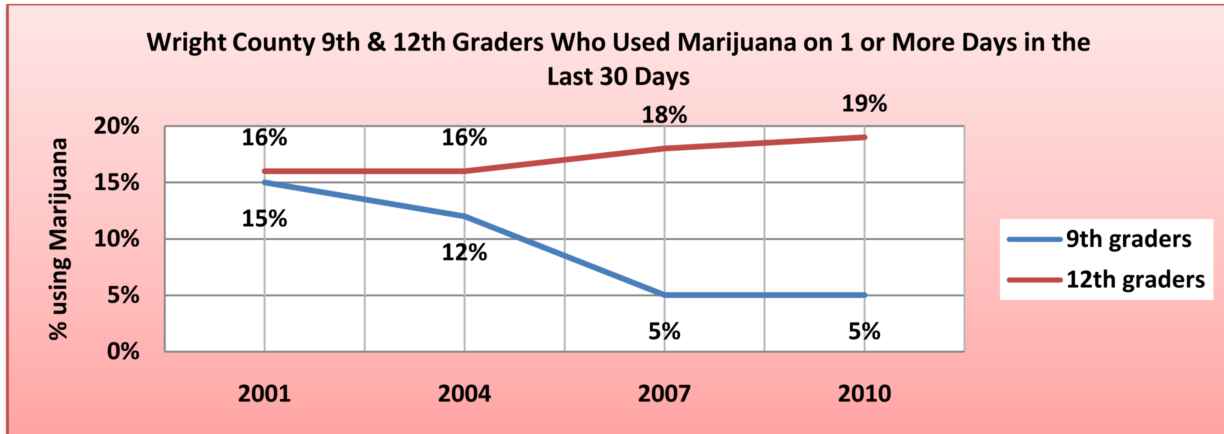


Source: Wright County Public Health Tobacco Compliance Program

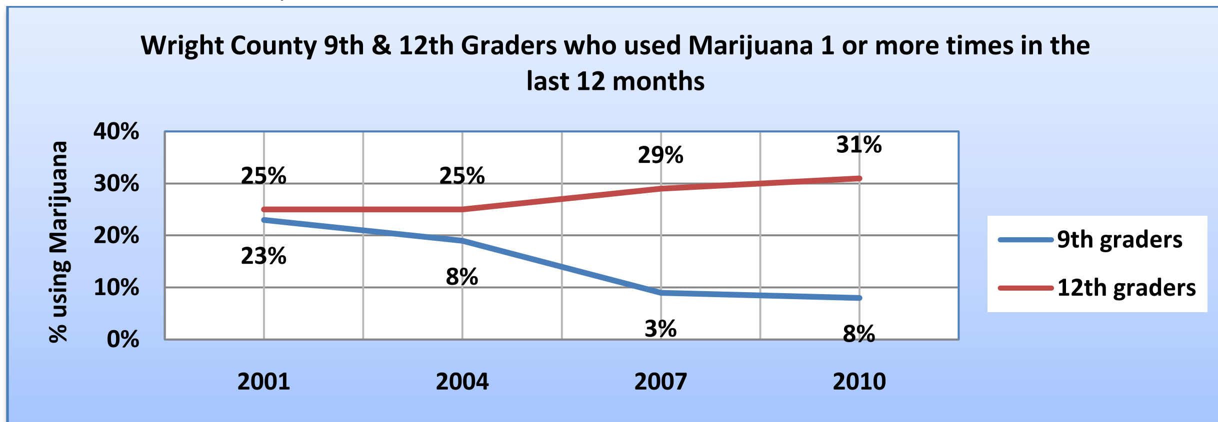
Secondhand smoke is a mixture of gases and fine particles given off by a burning cigarette. It is also present from smoke that is exhaled or breathed out by the person smoking. Thousands of chemicals exist in secondhand smoke and about 70 are known to cause cancer. Most exposure to secondhand smoke now occurs in the home, private vehicles and casinos. With the enactment of the Freedom to Breathe Law in 2007, Minnesotans and residents in Wright County are now protected in the workplace, including; bars and restaurants. [6] Forty-six point one percent of Wright County adults report being exposed to secondhand smoke in the last 30 days. [7]

Marijuana Use

The most recent data of local adolescent use of marijuana shows an interesting trend. Marijuana use among 9th graders has decreased or stayed the same while use among 12th graders risen since 2004.



Source: Minnesota Student Survey 2001, 2004, 2007, 2010



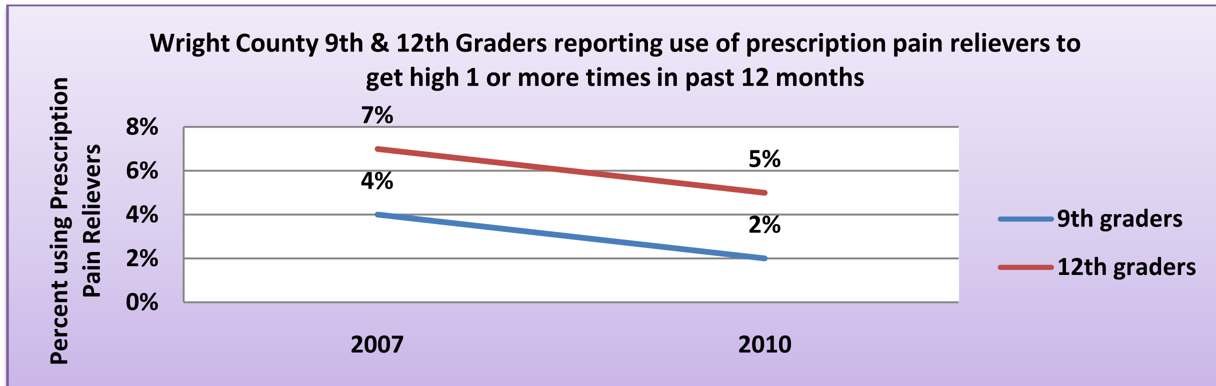
Source: Minnesota Student Survey 2001, 2004, 2007, 2010

Marijuana continues to be an available illegal drug in our communities, along with it being a very potent form due to the high tech growing methods. The use of marijuana, especially among youth, can be associated with the potential for a variety of problems: criminal activity, gateway drug, need for treatment services, and self medication due to mental health issues.

Prescription Drugs

According to survey data, the use of prescription drugs to get high among local youth is much less than the use of tobacco, alcohol and marijuana. Due to the availability of prescription drugs and common misperceptions that they are safe to use even if not prescribed to an individual, we will need to monitor reported use locally. With an estimated 85% percent of Americans

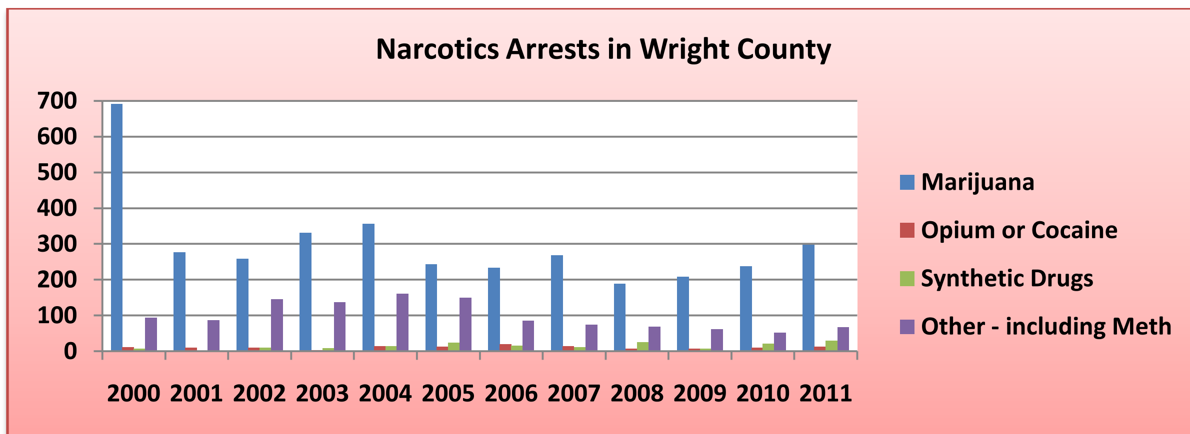
having a prescription for some pill, the misuse and abuse of these drugs occur among nearly all age groups.



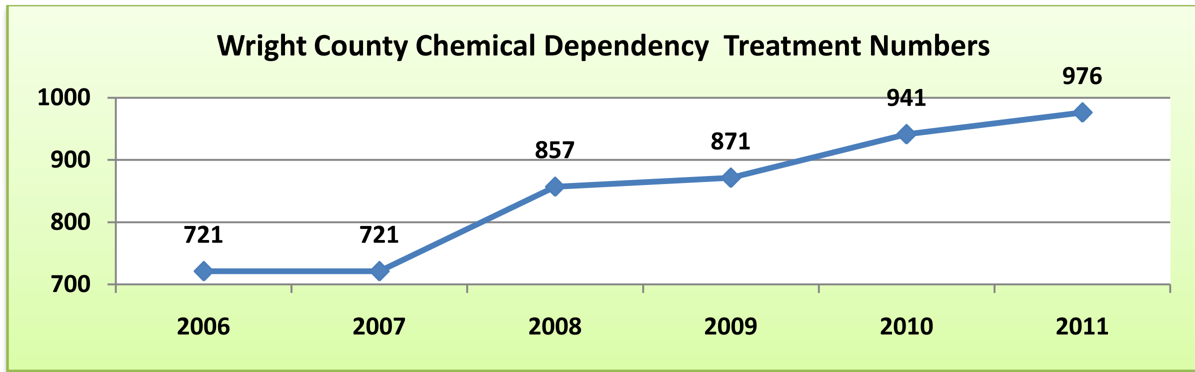
Source: Minnesota Student Survey 2007, 2010

Heroin

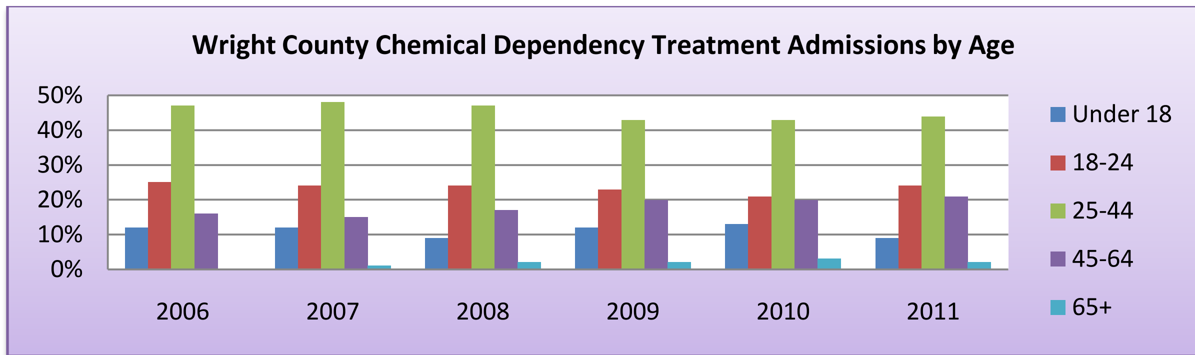
Among a variety of local settings we are hearing of an uptick of use of Heroin, especially among young adult males. Over the last year we have heard of several overdoses and that intravenous is the preferred method of use. We lack sufficient local data about the impact of Heroin, but do have updated Narcotics arrests and treatment admissions that help to explain the ever changing landscape of illegal drug use.



Source: Wright County Sheriff's Office



Source: Drug and Alcohol Normative Evaluation System DAANES

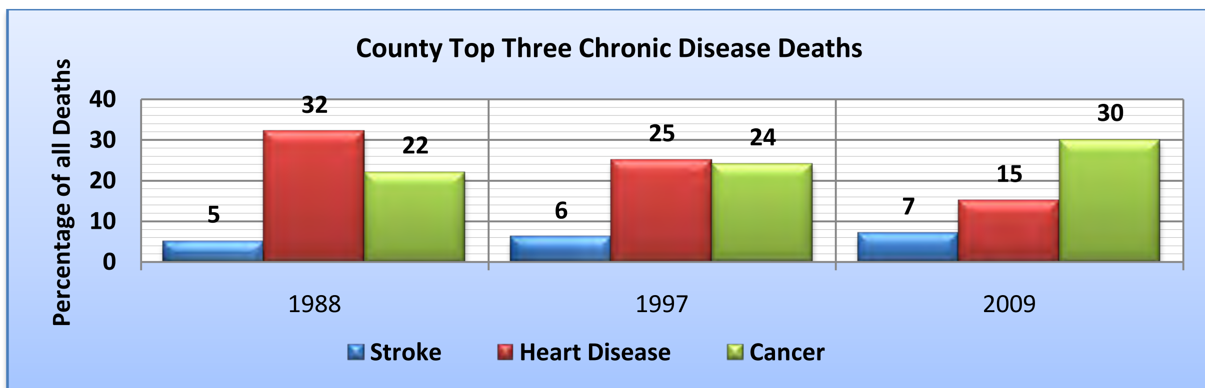


Source: Drug and Alcohol Normative Evaluation System DAANES

Chronic Disease and Conditions

Unhealthy lifestyle behaviors and other environmental factors contribute to premature morbidity and mortality from diseases, such as, heart disease, cancer, stroke, diabetes and obesity.

Heart disease, cancer and stroke account for 53% of all deaths in 2010.[8] Cancer is now the leading cause of death among county residents. The percentage of heart disease deaths have decreased 17% from 1988-2009.



Source: Minnesota County Health Tables, MDH 2010

Cancer

Cancer is the leading cause of death in Wright County. About half of all Minnesotans will be diagnosed with a potentially serious cancer during their lifetime, and about 25% of all those will die of cancer.[9] The overall incidence rate for all cancer in Wright County is 467 Per 100,000 people which are slightly lower than the Minnesota incidence rate.[10]

Wright County Top Four Cancer Types and Deaths		
Site	**MN Cases 2010**	**Wright County Deaths 2006-2008**
Breast	3,330	27
Colon	2410	49
Lung	3150	131
Prostate	3,830	23

Source: Minnesota County Health Tables, MDH 2010

County Heart Disease Deaths

YEAR	1991-1995	1996-2000	2001-2005	2006-2010
NUMBER	693	603	598	562

Source: Minnesota County Health Tables, MDH 2010

County Stroke Deaths

YEAR	1991-1995	1996-2000	2001-2005	2006-2010
NUMBER	223	221	199	171

Source: Minnesota County Health Tables, MDH 2010

Life style factors contribute significantly to a person's risk of getting chronic disease. Tobacco use, diet and obesity greatly increase the risk. According to the 2010 Behavior Risk Factor Surveillance Survey (BRFSS),[11] 20% of Minnesota adults are overweight or obese.

The Wright County Community Health Survey indicates that 17% of county adults report using tobacco everyday.[12]

Alzheimer's Disease

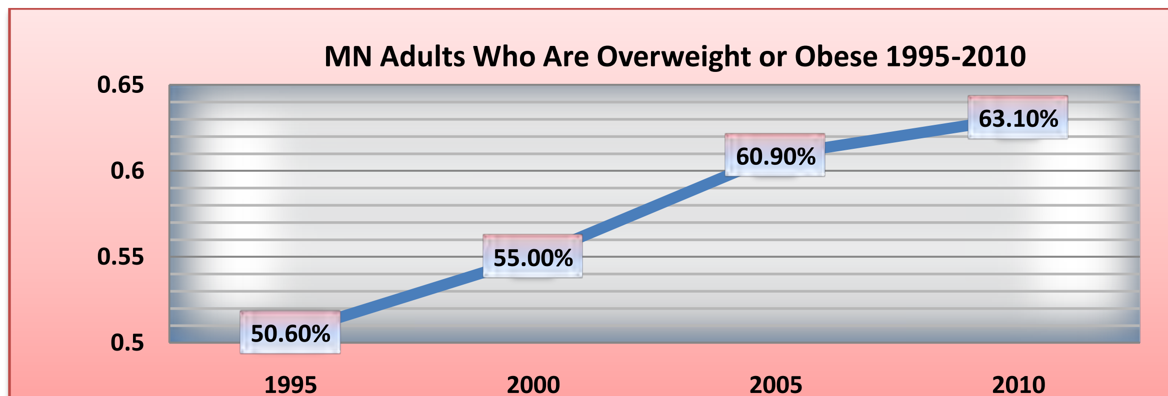
Alzheimer's disease is the most common form of dementia among older adults. It affects a person's ability to think, remember and make decisions. Adults younger than 65 may get

Alzheimer's disease, but it is much less common than among adults over 65; the risk for developing Alzheimer's in any population goes up with age, doubling every five years beyond age 65. About 5 percent of men and women ages 65 to 74 have Alzheimer's disease and it is estimated that nearly half of those age 85 and older may have the disease. About 94,000 Minnesotans are estimated to have Alzheimer's disease.

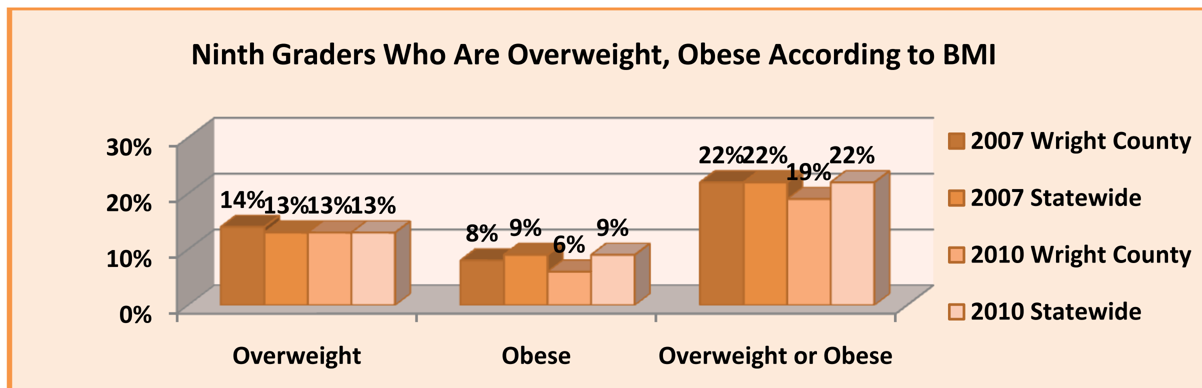
Diabetes

Diabetes is a leading cause of death in Minnesota, and is on the rise. 43% of MN population is living with diabetes. It is the leading cause of blindness in adult Minnesotans, the leading cause of chronic kidney disease among the same group, and the leading complication among mothers giving birth in the state.

Obesity and being overweight are the primary risk factors for diabetes. The growing burden of diabetes affects everyone in Minnesota.



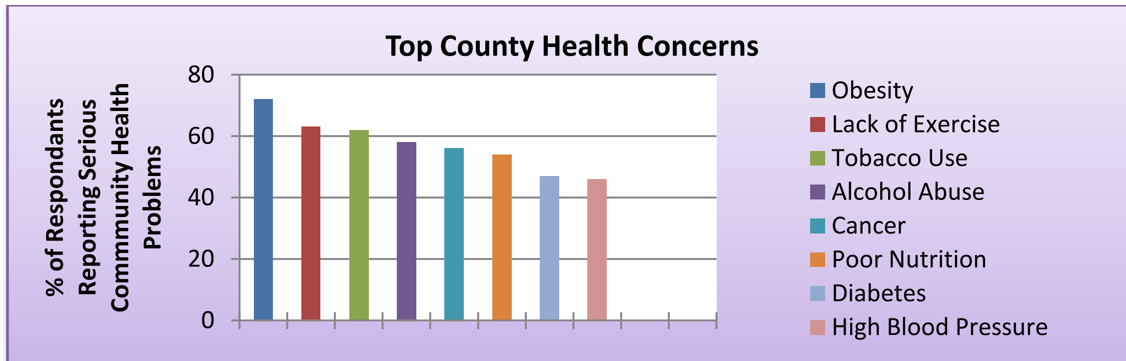
Source: Minnesota Behavioral Risk Factor Surveillance Survey 1995, 2000, 2005, 2010



Source: Minnesota Student Survey 2007, 2010

The rate of obesity continues to rise in Minnesota, as well as among children, adolescents, and adults. Obesity puts people at much greater risk for the development and early onset of a wide

variety of chronic diseases and health conditions including: hypertension, diabetes, coronary heart disease, stroke, gallbladder disease, depression, osteoarthritis, sleep apnea, and some cancers.[13] Because of its link to so many serious health conditions, obesity significantly raises health care costs. According to a recently published study, in 2009 Minnesota paid an estimated $2.8 billion in state funds for obesity-related Medical Assistance (Medicaid) and Medicare costs.[14]



Source: Wright County Community Health Survey, 2012

Percent of Adults Who Exercise 5 or more days per week.				
	Wright County	**Hennepin County**	**Anoka County**	**Carver County**
0 Days	10.8	6.7	8.4	7.7
1-4 Days	52.9	58.5	51.9	48.9
5-7 Days	36.3	34.8	39.7	43.4

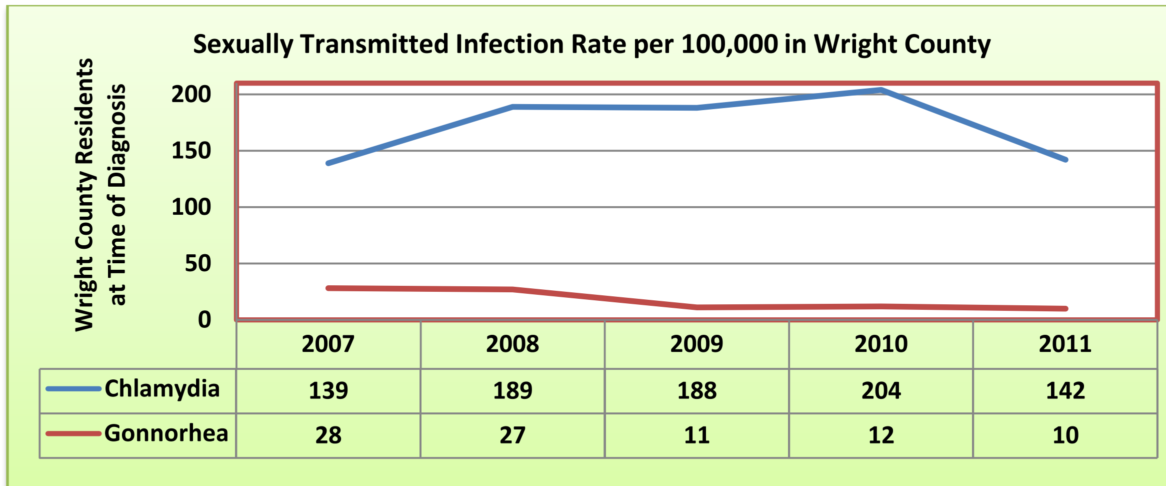
Source: Wright County Community Health Survey, 2012 Data from Hennepin, Anoka and Carver Counties is from the individual county surveys in 2010.

Percentage of County Adults getting Routine Check-ups:[15]

- 68% visited the doctor in the last year.
- 44% performed cancer self-exams.
- 64.7% had their cholesterol checked.
- 87% had their blood pressure checked.

Infectious Disease

Among communicable diseases that are reportable in Minnesota, chlamydia ranks as one of the most common for Minnesota and Wright County. While people in their teens and twenties account for most cases people of all ages are affected. The rate of infection showed a dramatic increase between 2007 and 2008 and remained high until reducing again in 2011. Gonorrhea rates are low in comparison and have decrease over the past five years.

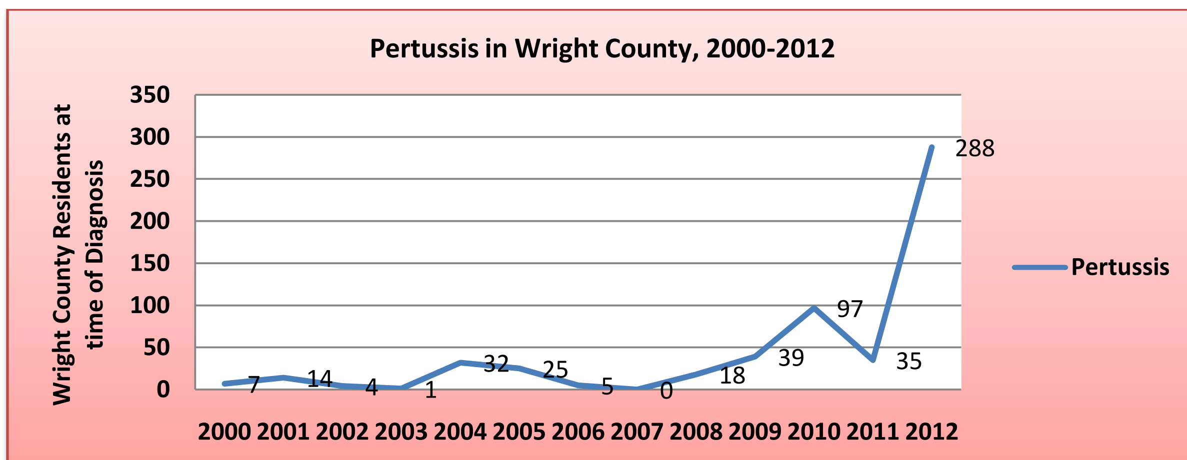


	2007	2008	2009	2010	2011
Chlamydia	139	189	188	204	142
Gonnorhea	28	27	11	12	10

Source: MDH Center for Health Statistics

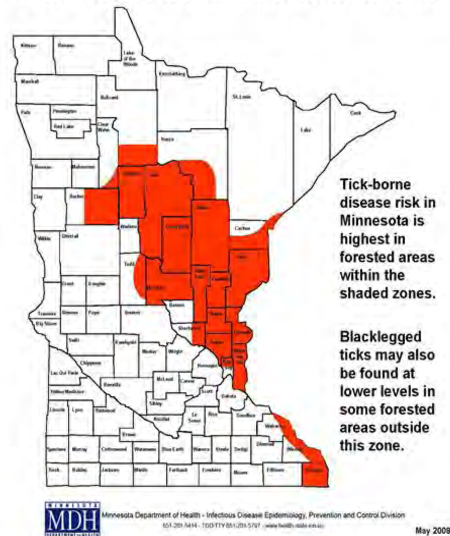
Cases of syphilis occur infrequently in Wright County with 0-2 cases per year. HIV and AIDS also occur at a low level in the county with 0-3 new cases per years. Since this illness is not curable Wright County residents continue to live with HIV/AIDS at a rate of 25.7 per 100,000 population in 2011.

Pertussis (whooping cough) has been on the upswing in recent years. The first half of the 2000 decade had very few cases in Wright County from zero to a high of 32 in 2004. There again were a few years with fewer cases but then a large increase occurred in 2010 with a record high of 97cases. While this pertussis is cyclical in nature, increasing every 3-5 years, this was the highest level since the vaccine was developed. Fewer cases were reported in 2011, but 2012 once again had record levels with 282 cases reported. It is suspected that immunity from the newer Tdap vaccine wanes sooner than the previous vaccine which tended to have more minor side effects.



Source: MDH Center for Health Statistics

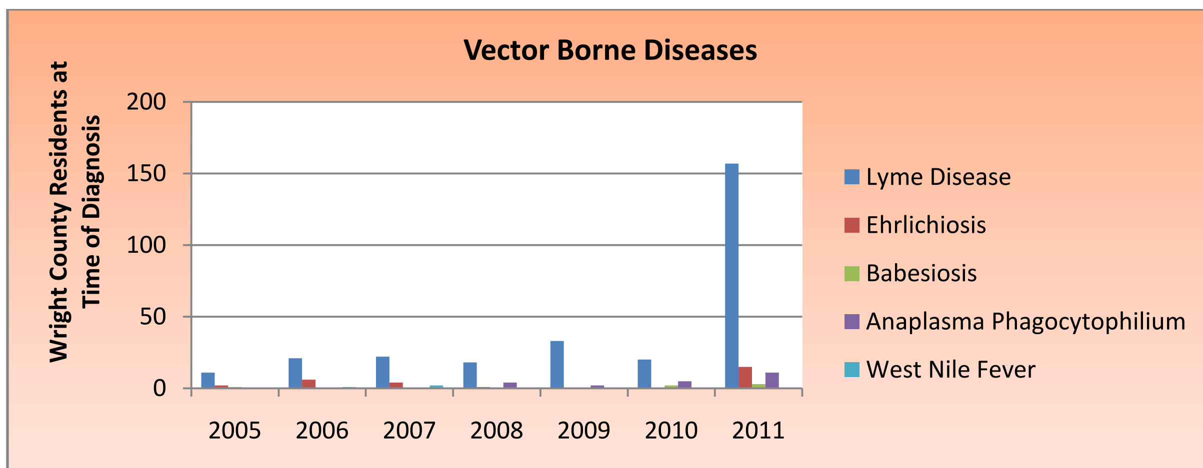
Tuberculosis occurs at a low level in Wright County, most often occurring in new immigrants. There are very few active cases with 0-1 cases per year over the last twenty years. Tuberculosis is not highly contagious. Public health works with individuals with a suspect or active case to ensure medication is taken to prevent the spread of the disease to others.



Vector borne diseases are those spread by insects, most commonly ticks or mosquitoes. Wright County had its first case of West Nile Virus in 2002 with seven cases in 2003. Since then there have been even fewer cases with none from 2008 to present.

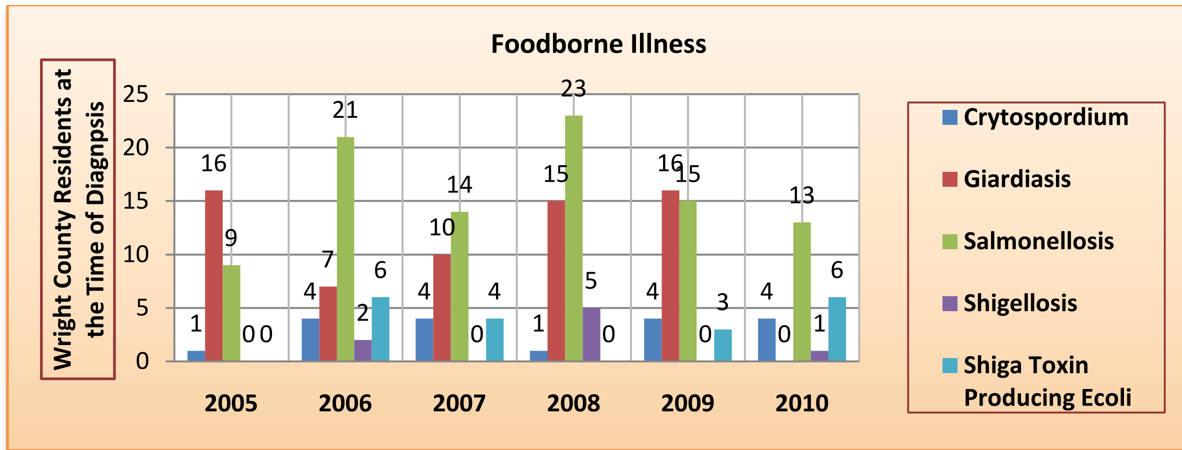
Tick borne diseases are increasing in Minnesota and Wright County. In 2011, there was a record high 157 cases of Lyme disease. Wright County is on the edge of the Minnesota high risk area with infected tick bites occurring in the county along with residents traveling to other highly infected areas of the state.

In the last 5-10 years additional tick borne diseases have occurred in MN and Wright County. These include ehrlichiosis, babesiosis, and anaplasma phagocytophilium.



Source: MDH Center for Health Statistics

Food borne illness is a common occurrence caused either by improperly cooked foods or poor handwashing. Norovirus is commonly known as stomach flu. This is not a reportable disease so accurate data is not available. The chart below shows the most frequent food borne illnesses are caused by salmonella and giardia.



Source: MDH Center for Health Statistics

Injury and Violence

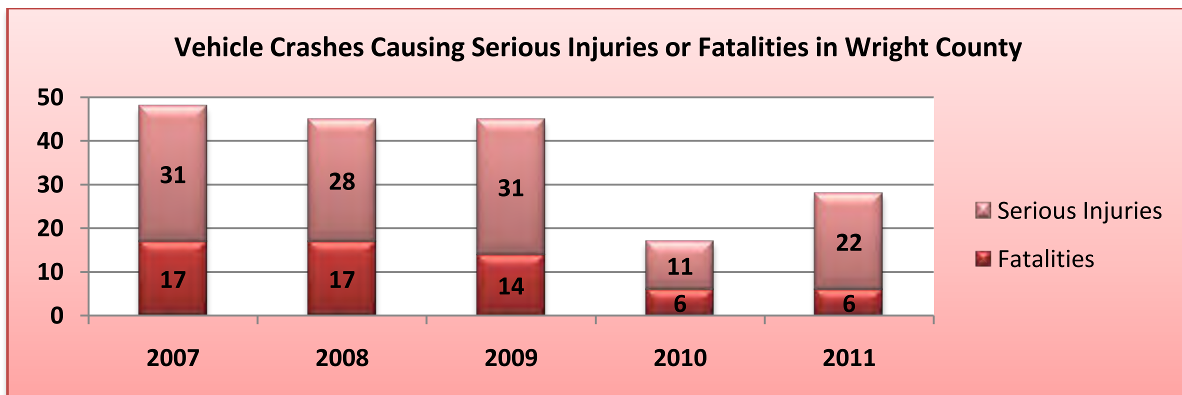
Injury is the fifth leading cause of death for citizens of Wright County in 2010. Injuries may be intentional or unintentional. The leading causes of unintentional injury-related deaths in Wright County are motor vehicle crashes, falls, and poisoning.

Wright County Hospital Emergency Room Injury Cases, 2011					
Age Group	<1-14	15-34	35-54	55-74	75-85+
Injuries	1,487	1,554	993	509	283

Minnesota Injury Data Access System

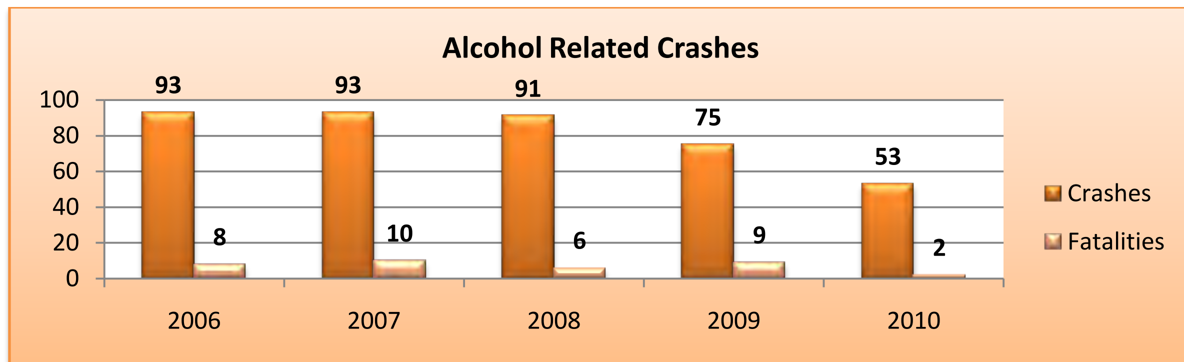
Motor Vehicle Crashes

Traffic crashes cause death and injury; they are the leading cause of death for people age 1-34.[16] In Minnesota, traffic crashes are decreasing, but still remain at epidemic levels in which seatbelt use, distracted and impaired driving and unsafe speed continue to contribute to fatalities and injuries.



Source: Minnesota Vital Statistic Trend Report, MDH 2010

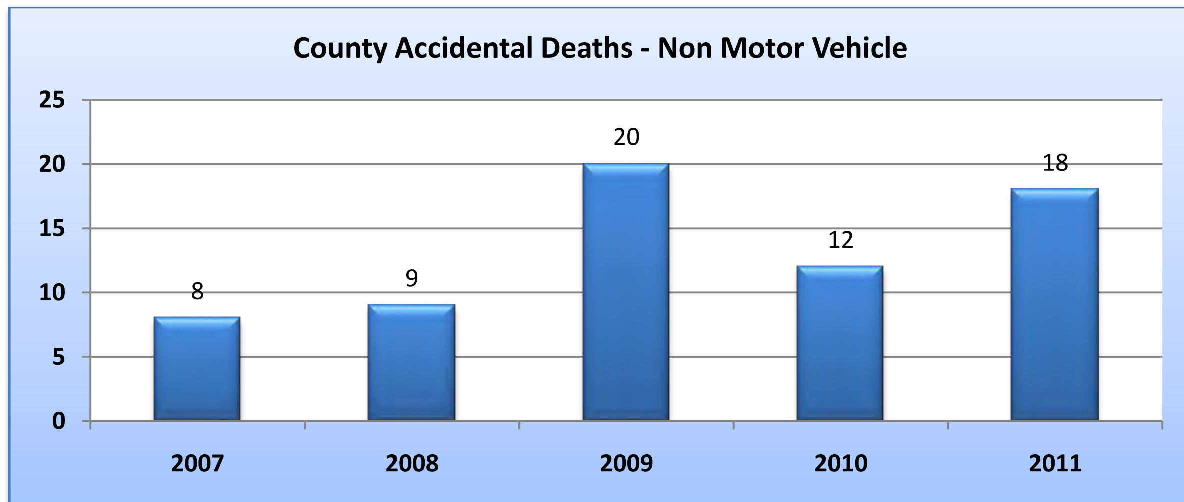
From 2006 to 2010 there were 405 alcohol related crashes, with 34 fatalities.



Source: Minnesota Vital Statistic Trend Report, MDH 2010

Falls

Falls are the leading cause of injuries for children under 19 and the leading cause of hospitalization among persons over age 65. Falls can cause moderate to severe injuries including; hip fractures, head trauma, and the increased risk of early death. Eleven elderly citizens died from injuries sustained by falls in 2011.[17]



Source: Minnesota Vital Statistic Trend Report, MDH 2010

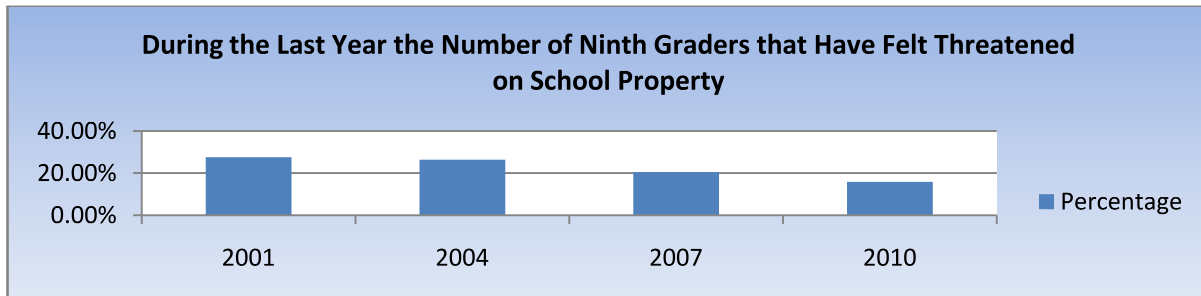
Drug Poisoning

Poisonings, both self-inflicted and unintentional, is a cause of injury and death in Wright County. In 2011, four fatalities occurred from drug overdose or misuse of prescription medication.

Violent Crime

Wright County Assaults/Sexual Assaults/Rape/Violent Crime				
Year	1993	1996	2007	2011
Criminal Sexual Conduct	18	16	15	11
Other Sex Offenses	7	1	29	38
Aggravated Assault	20	15	80	61
Other Assaults	249	221	253	233
Murder	0	0	1	0

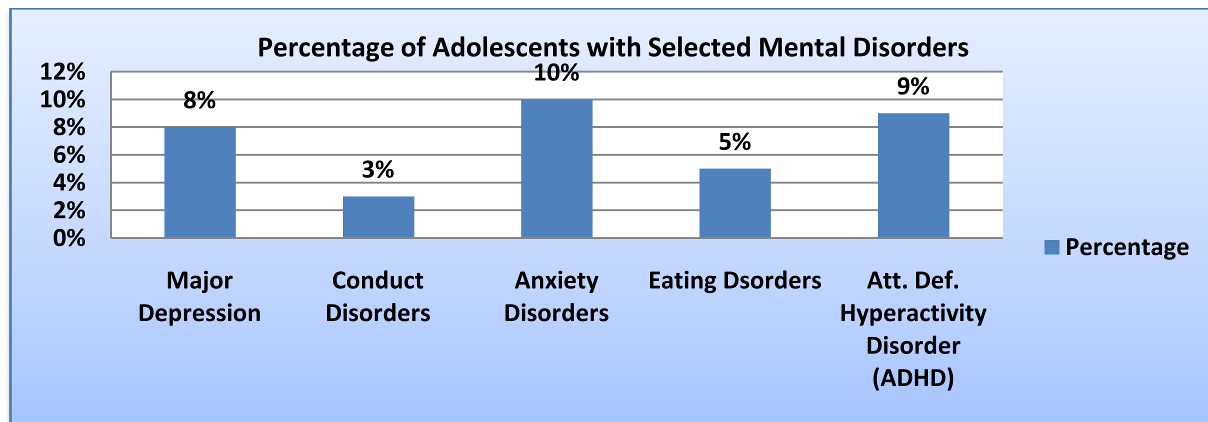
Source: Wright County Sheriff's Department Crime Statistics



Source: Wright County Minnesota Student Survey 2001, 2004, 2007, 2010

Mental Health

According to the National Institute of Mental Health, mental disorders are the leading cause of disability in the United States and Canada for people 15-44 years of age. Published studies report that about 25% of all U.S. adults have a mental illness and that nearly 50% of U.S. adults will develop at least one mental illness during their lifetime. In 2008, 13.4 percent of adults in the United States received treatment for a mental health problem. This includes all adults who received care in inpatient or outpatient settings and/or used prescription medication for mental or emotional problems.



Source: The Mental Health of Adolescents: A National Profile, 2008. National Adolescent Health Information Center

Wright County Ninth Graders Who Felt Sad all or Most of the Time in the Last Month			
2001	2004	2007	2010
13.5%	14%	11%	10%

Source: Minnesota Student Survey 2001, 2004, 2007, 2010

Suicide

Anecdotal data from law enforcement and ambulance services has shown a significant increase in service demand related to mental health issues. From 1997 through 2011, 92% of completed suicides were in individuals over the age of 21.

Deaths by Suicide				
2007	**2008**	**2009**	**2010**	**2011**
14	11	15	15	18

Source: MDH Minnesota County Health Tables and County Coroner's Report

Wright County Ninth Graders Who Reported Trying to Kill Themselves in the Last Year			
2001	**2004**	**2007**	**2010**
5.5%	**8%**	**3.5%**	**2.5%**

Source: Minnesota Student Survey 2001, 2004, 2007, 2010

Child Abuse and Neglect

The Wright County Human Services Child Protection Unit receives reports of suspected child maltreatment that includes physical, sexual and emotional abuse. This type of violence has been recognized as a serious health problem for decades. The vast majority of child protection investigations are reports of sexual abuse among children.

Wright County Child Protection Cases Investigated				
1994	**1996**	**1998**	**2010**	**2011**
179	165	152	106	145

Source: Wright County Human Services Annual Report

Wright County Ninth Graders Who Reported that a Student Pushed, Shoved or Grabbed them on School Property in the Last Month			
2001	**2004**	**2007**	**2010**
51.5%	53.5%	46.5%	35.5%

Source: Minnesota Student Survey 2001, 2004, 2007, 2010

Wright County Community Health Survey 2012

Wright County Public Health conducted a community health survey with help from the Minnesota Department of Health, Center for Health Statistics. We purchased a random sample of 2,000 households in Wright County. Our sample design was a two stage sample that included one adult per household. We used a stratified-weighted method to analyze data collected from the surveys returned as a represented sample of our county.

519 surveys were returned out of 1,000 random samples sent to the community. The following are the results from our 2012 survey.

1. Would you say in general your health is?

   Excellent 18.2%
   Very Good 44.8%
   Good 29.9%
   Fair 4.9%
   Poor 2.2%

2. About how long has it been since you last visited a doctor for a routine check-up?
   Please check ☑ one.

   Within the last year (1-12 months ago) 68.3%
   Within the past 2 years (1-2 years ago) 17.2%
   Within the past 5 years (2-5 years ago) 9.9%
   5 or more years ago 4.2%
   Never .5%

3. How would you rate your overall level of stress?
   Low 26.2%
   Medium 60%
   High 13.8%

4. For each question, please check ☑ one.

How often do you…	Always	Sometimes	Seldom	Never
…wear a seat belt when you drive or ride in a car?	94.8%	3.8%	1.1%	.3%
…feel safe in your community?	84.8%	14.7%	.5%	.1%

How often do you …	Every day	Some days	Never
… smoke cigarettes?	10.1%	7.4%	82.5%
… chew tobacco?	4.8%	2.2%	93.1%
… use illegal drugs (marijuana, cocaine, etc.)?	.1%	1.7%	98.1%
How often are you exposed to second hand smoke?	9.6%	36.5%	53.9%

Do you…	Yes	No
…perform self-exams for cancer?	44.4%	55.6%
…get a yearly flu shot?	50.3%	49.7%
…need medication to control a chronic illness?	26.9%	73.1%
…have a family emergency plan?	39.5%	60.5%
Have you had your cholesterol checked in the last year?	64.7%	35.3%
Have you had your blood pressure checked in the last year?	87.2%	12.8%

5. A serving of vegetables is a half cup of any vegetables or one cup of salad greens. **Yesterday,** how many servings of vegetables did you eat? _______servings

6. A serving of fruit is one medium sized fruit, a half cup chopped, cut, or canned fruit or 6 ounces of 100% fruit juice**.** **Yesterday,** how many servings of fruit did you eat? _______servings
   Combined responses from question 5 and 6
   0 servings: 4.9%
   1-4 servings: 66.9%
   5 or more servings: 28.2%

7. During an average week, whether at work, at home or anywhere else, **how many days** did you get at least 30 minutes of moderate physical activity? *(Moderate activities cause light sweating and a small increase in breathing or heart rate.)* _______days per week

   0 days 10.8% 1-4 days 52.9% 5-7 days 36.3%

8. A drink is equivalent to a 12 ounce beer, a 5 ounce glass of wine, or a drink with one shot of liquor. On the days when you drank during the past 30 days, about **how many drinks** did you have, on average? ______drinks

   No drinking 36.3% Drinking not heavy 52.5% Heavy drinking 11.2%

9. During the past 30 days, how many days did you have at least one drink of any alcoholic beverage? _______days

   Drinking not heavy 82.4% Heavy drinking 17.6%

10. Your age group:

    18-34 year olds 12.3%

    35-44 year olds 19.3%

    45-54 year olds 27.3%

    55-64 year olds 19.5%

    65+ 21.6%

11. Are you:

    Male 47.8% Female 52.2%

12. Your education level:

    Did not complete high school 4.4% Associate degree 9.7%

    High school diploma/GED 20.7% Bachelor's degree 19.8%

    Trade/Vocational school 17% Graduate/Professional degree 8.1%

    Some college 20.2%

13. Which of the following describes your current health insurance status? Please check one.

    Have health insurance – 94.3%

    No health insurance – 5.7%

14. How many adults (aged 18 years or over) currently live in your household? ______ adults

15. Household income per year:

    Less than $20,000 7.4% $50,000 - $74,999 26.6%

    $20,000 - $34,999 11% $75,000 or more 38.2%

    $35,000- $49,999 16.8%

16. In Your Opinion how much of a problem is each of these issues in Wright County?

Top 12 "Moderate or Serious Problems"	No problem	Minor problem	Moderate problem	Serious problem	Moderate OR serious problem
Q16z. Obesity	8.8%	19.0%	46.5%	25.7%	72.2%
Q16w. Lack of physical exercise	8.5%	28.1%	43.6%	19.9%	63.5%
Q16ad. Smoking/other tobacco use	10.6%	27.5%	46.4%	15.4%	61.8%
Q16c. Alcohol use among those < 21	8.9%	32.6%	44.7%	13.8%	58.6%
Q16r. Illegal drug use among teens	8.1%	33.7%	41.5%	16.7%	58.2%
Q16b. Alcohol abuse among those 21+	10.2%	31.7%	46.1%	12.0%	58.1%
Q16f. Cancer	9.6%	34.1%	42.9%	13.3%	56.2%
Q16aa. Poor nutrition	12.0%	33.8%	38.5%	15.7%	54.2%
Q16s. Illegal drug use among adults	13.9%	36.9%	35.3%	13.9%	49.2%
Q16j. Diabetes	17.0%	35.8%	38.1%	9.1%	47.2%
Q16p. High blood pressure	13.0%	40.2%	38.1%	8.7%	46.8%
Q16e. Bullying	12.4%	40.9%	34.0%	12.7%	46.7%

16.2. In your opinion how much of a problem is each of these issues in Wright County?

Top 12 "No problems"	No problem	Minor problem	Moderate problem	Serious problem	Moderate OR serious problem
Q16l.Environmental health issues	40.3%	42.8%	12.8%	4.1%	16.9%
Q16t.Infant death/premature birth	36.8%	54.5%	7.4%	1.3%	8.8%
Q16m.End of life care	36.5%	42.2%	17.4%	3.9%	21.3%
Q16n.Healthy child growth and dev	36.3%	44.5%	17.1%	2.1%	19.2%
Q16ab.Rape/sexual assault	30.6%	51.6%	14.1%	3.7%	17.8%
Q16v.Insect-borne disease	29.5%	53.2%	15.7%	1.6%	17.3%
Q16d.Asthma	28.3%	46.6%	23.4%	1.7%	25.2%
Q16ac.Respiratory/lung disease	27.6%	47.4%	21.4%	3.6%	25.0%
Q16u.Injuries	24.8%	52.7%	21.6%	1.0%	22.6%
Q16q.STDs	23.7%	50.5%	23.1%	2.6%	25.8%
Q16ae.Suicide	23.1%	47.9%	22.7%	6.2%	29.0%
Q16g.Contagious disease	21.1%	49.0%	24.6%	5.3%	29.8%

[1] Minnesota State Climatology Office, 2012
[2] Labor Market Information Office of the Minnesota Department of Employment and Economic Development , 2nd quarter 2009
[3] CDC – Healthy Weight: Physical Activity for a Healthy Weight
[4] US Dept. HHS - 2008 Physical Activity guidelines for Americans
[5] US Dept. HHS - 2008 Physical Activity guidelines for Americans
[6] CDC, Smoking & Tobacco Use – Secondhand Smoke (SHS) Facts
[7] Wright County Community Health Survey, 2012
[8] MN Vital Statistics and County Trends, MDH 2009
[9] MN American Cancer Society Facts and Figures, 2011
[10] MN Cancer Surveillance System, MDH 2011
[11] Behavioral Risk Factor Surveillance Survey, 2010
[12] Wright County Community Health Survey, 2012
[13] Trust for America's Health (2010) F as in Fat
[14] Trogdon, Finkelstein, Feagan and Cohen, (2010) State Medical Expenditures to Obesity. Obesity 20, 214-220
[15] Wright County Community Health Survey, 2012
[16] Minnesota Department of Public Safety-Office of Traffic Safety, 2011
[17] Wright County Medical Examiners Report, 2011

BUFFALO HOSPITAL
NORTHWEST REGIONAL

Appendix E

Hanlon Process

Community Health Needs Assessment
and Implementation Plan 2014–2016

NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

First Things First: Prioritizing Health Problems

Introduction

Despite the many accomplishments of local public health, we continue to see emerging population-wide health threats as we forge ahead into to the 21st Century. We are in an economic climate where LHD personnel are facing dire budget cutbacks while simultaneously dealing with issues like H1N1, chronic diseases, and natural disasters. Because LHDs are the backbone of the public health system, the recent movement to establish a national system of accountability for governmental health agencies is particularly timely. The Public Health Accreditation Board (PHAB) is developing a voluntary national accreditation program which is grounded in continuous quality improvement. As LHDs work toward meeting accreditation standards and implementing quality improvement efforts, they are faced with an infinite number of competing health issues to address, while keeping in mind several external considerations such as urgency, cost, impact and feasibility, to name just a few. Fortunately, a number of prioritization methods specifically designed to assist agencies with this very challenge have been developed and widely used in a range of industries including public health. When faced with these tough decisions, employing a defined prioritization technique can provide a structured mechanism for objectively ranking issues and making decisions, while at the same time gathering input from agency-wide staff and taking into consideration all facets of the competing health issues.

This document serves as a guide and provides five widely used options for prioritization including guidance on which technique best fits the needs of your agency, step-by-step instructions for implementation, and practical examples.

Getting Started

Prior to the implementation of any prioritization process, preliminary preparations are necessary to ensure the most appropriate and democratic selection of priority health issues:[i]

1. **Community assessment** – Conducting assessments will determine the current status and detect gaps to focus on as potential priority areas. LHDs engaging in the Public Health Accreditation Board (PHAB) accreditation process must conduct a *community* health assessment (CHA) as a prerequisite for eligibility. A CHA provides data on the overall health of a community and uncovers target priority areas where a population may have increased risk for poor health outcomes.
2. **Agency self-assessment -** As part of the national accreditation process, LHDs must use the PHAB *agency* self-assessment tool to evaluate agency performance against nationally recognized standards. Post-assessment, LHDs can analyze their results and determine strengths and areas for improvement to address through continuous quality improvement efforts. Prioritization methods can be used to help select areas for improvement from a CHA or PHAB self-assessment.
3. **Clarify objectives and processes –** Before beginning the process, LHD leadership must ensure that all team members have a clear understanding of the goals and objectives along with the chosen prioritization process.
4. **Establish criteria -** Selection of appropriate prioritization criteria on which to judge the merit of potential focus areas is important to avoid selection based on bias or hidden agendas and ensure that everyone is 'on the same page.' **Table 1.1** below identifies criteria commonly used in prioritization processes:

Table 1.1: Commonly Used Prioritization Criteria[ii]

Criteria to Identify Priority Problem	Criteria to Identify Intervention for Problem
• Cost and/or return on investment • Availability of solutions • Impact of problem • Availability of resources (staff, time, money, equipment) to solve problem • Urgency of solving problem (H1N1 or air pollution) • Size of problem (e.g. # of individuals affected)	• Expertise to implement solution • Return on investment • Effectiveness of solution • Ease of implementation/maintenance • Potential negative consequences • Legal considerations • Impact on systems or health • Feasibility of intervention

Prioritization in Practice

The following section highlights five prioritization methods:

1. Multi-voting Technique
2. Strategy Grids
3. Nominal Group Technique
4. The Hanlon Method
5. Prioritization Matrix

Each sub-section includes step-by-step instructions on implementation followed by examples illustrating practical application. It is important to remember that no right or wrong method of prioritization exists. Although the provided examples in this document are useful in gaining an understanding of how to use prioritization techniques, they are not meant to be prescriptive but rather, should be tailored to the needs of individual agencies. Additional information on prioritization processes can be found in the Assessment Protocol for Excellence in Public Health (APEX*PH*).

Multi-voting Technique [iii]

Multi-voting is typically used when a long list of health problems or issues must be narrowed down to a top few. Outcomes of Multi-voting are appealing as this process allows a health problem which may not be a top priority of any individual but is favored by all, to rise to the top. In contrast, a straight voting technique would mask the popularity of this type of health problem making it more difficult to reach a consensus.

Step-by-Step Instructions:

1. **Round 1 vote –** Once a list of health problems has been established, each participant votes for their highest priority items. In this round, participants can vote for as many health problems as desired or, depending on the number of items on the list, a maximum number of votes per participant can be established.
2. **Update list** - Health problems with a vote count equivalent to half the number of participants voting remain on the list and all other health problems are eliminated (e.g. if 20 participants are voting, only health problems receiving 10 or more votes remain).
3. **Round 2 vote** – Each participant votes for their highest priority items of this condensed list. In this round, participants can vote a number of times equivalent to half the number of health problems on the list (e.g. if ten items remain on the list, each participant can cast five votes).

4. **Repeat** – Step 3 should be repeated until the list is narrowed down to the desired number of health priorities.

Multi-voting Example: The following example illustrates how an LHD used the Multi-voting technique to narrow down a list of ten health problems, identified by an agency self-assessment, to one priority focus area for a quality improvement (QI) project. **Table 2.1** illustrates the results of a three-round multi-voting process implemented by a group of 6 project directors using the following steps:

1. **Round-one vote** – On a note card, all participants anonymously voted for as many priority focus areas as desired.
2. **Update list** – All votes were tallied and the six health indicators receiving three or more votes were posted for the group to view.
3. **Round-two vote** – All participants voted up to three times for the remaining health indicators.
4. **Update list** – All votes were re-tallied and the three health indicators receiving less three or more votes were posted for the group to view.
5. **Round-three vote** - All participants voted up to two times and the only item with three or more votes, “Effective Media Strategy,” was the chosen focus area for a QI project.

Table 2.1: Three-Round Multi-voting Example
Jane Doe County Health Department wanted to prioritize one health problem to address with funds from a small grant. They began with a list of 12 health problems, which they identified through standards and measures where they scored poorly on PHAB’s self-assessment tool. The director convened the management team and implemented the multi-voting method to select the priority area.

Health Indicator	Round 1 Vote	Round 2 Vote	Round 3 Vote
~~Collect and maintain reliable, comparable, and valid data~~	√√√√	√√	
Evaluate public health processes, programs, and interventions.	√√√√√	√√√√	√√√√√
~~Maintain competent public health workforce~~	√√		
~~Implement quality improvement of public health processes, programs, and interventions~~	√√√√	√√	
~~Analyze public health data to identify health problems~~	√√		
~~Conduct timely investigations of health problems in coordination with other governmental agencies and key stakeholders~~	√√		
~~Develop and implement a strategic plan~~	√√√√√	√√√√	√√
~~Provide information on public health issues and functions through multiple methods to a variety of audiences~~	√√		
~~Identify and use evidence-based and promising practices~~	√√		
~~Conduct and monitor enforcement activities for which the agency has the authority~~	√		
~~Conduct a comprehensive planning process resulting in a community health improvement plan~~	√√√√√	√√√√	√√
~~Identify and implement strategies to improve access~~	√√√	√√	

~~to healthcare services~~			

Red = Round 1 Elimination Green = Round 2 Elimination Blue = Round 3 Elimination

Strategy Grids [iv]

Strategy grids facilitate agencies in refocusing efforts by shifting emphasis towards addressing problems that will yield the greatest results. This tool is particularly useful when agencies are limited in capacity and want to focus on areas that provide 'the biggest bang for the buck.' Rather than viewing this challenge through a lens of diminished quality in services, strategy grids can provide a mechanism to take a thoughtful approach to achieving maximum results with limited resources. This tool may assist in transitioning from brainstorming with a large number of options to a more focused plan of action.

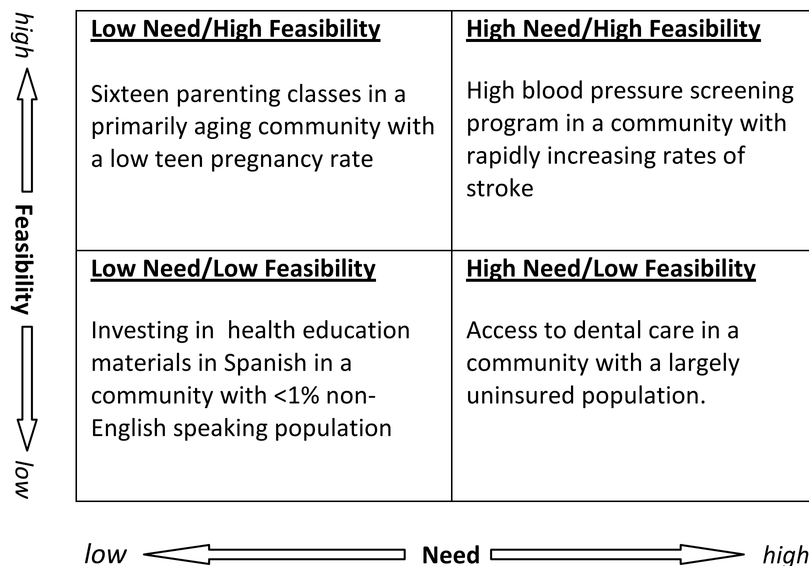
The strategy grid below provides an example of an LHD's effort to refocus efforts towards programs that will feasibly result in the greatest impact. Refer to the example strategy grid below while working through the step-by-step instructions.

<u>Step-by-Step Instructions:</u>

1. **Select criteria** – Choose *two* broad criteria that are currently most relevant to the agency (e.g. 'importance/urgency,' 'cost/impact,' 'need/feasibility,' etc.). Competing activities, projects or programs will be evaluated against how well this set of criteria is met. The example strategy grid below uses 'Need' and 'Feasibility' as the criteria.
2. **Create a grid** – Set up a grid with four quadrants and assign one broad criteria to each axis. Create arrows on the axes to indicate 'high' or 'low,' as shown below.
3. **Label quadrants** – Based on the axes, label each quadrant as either 'High Need/High Feasibility,' 'High Need/Low Impact,' 'Low Need/High Feasibility,' 'Low Need/Low Feasibility.'
4. **Categorize & Prioritize -** Place competing activities, projects, or programs in the appropriate quadrant based on the quadrant labels. The example below depicts 'Need' and 'Feasibility' as the criteria and items have been prioritized as follows:

    - *High Need/High Feasibility* – With high demand and high return on investment, these are the highest priority items and should be given sufficient resources to maintain and continuously improve.
    - *Low Need/High Feasibility* – Often politically important and difficult to eliminate, these items may need to be re-designed to reduce investment while maintaining impact.
    - *High Need/Low Feasibility* – These are long term projects which have a great deal of potential but will require significant investment. Focusing on too many of these items can overwhelm an agency.
    - *Low Need/Low Feasibility* – With minimal return on investment, these are the lowest priority items and should be phased out allowing for resources to be reallocated to higher priority items.

Strategy Grid



Nominal Group Technique [v]

The Nominal Group Technique (NGT) has been widely used in public health as a mechanism for prioritizing health problems through group input and information exchange. **This method is useful in the early phases of prioritization when there exists a need to generate a lot of ideas in a short amount of time and when input from multiple individuals must be taken into consideration.** Often, the Multi-voting Technique is used in conjunction with NGT whereby NGT can be used to brainstorm ideas and create a broad list of possibilities and Multi-voting can be used to narrow down the list to pinpoint the top priorities. One of the greatest advantages of using this technique is that it is a democratic process allowing for equal say among all participants, regardless of position in the agency or community.

Step-by-Step Instructions:

1. **Establish group structure –** Establish a group of, ideally, 6-20 people to participate in the NGT process and designate a moderator to take the lead in implementing the process. The moderator should clarify the objective and the process.
2. **Silent brainstorming –** The moderator should state the subject of the brainstorming and instruct the group to silently generate ideas and list them on a sheet of paper.
3. **Generate list in round-robin fashion –** The moderator should solicit one idea from each participant and list them on a flip chart for the group to view. This process should be repeated until all ideas and recommendations are listed.

4. **Simplify & clarify –**The moderator then reads aloud each item in sequence and the group responds with feedback on how to condense or group items. Participants also provide clarification for any items that others find unclear.
5. **Group discussion –** The moderator facilitates a group discussion on how well each listed item measures up to the criteria that was determined by the team prior to the NGT process.
6. **Anonymous ranking –** On a note card**,** all participants silently rank each listed health problems on a scale from 1 to 10 (can be altered based on needs of agency) and the moderator collects, tallies, and calculates total scores.
7. **Repeat if desired –** Once the results are displayed, the group can vote to repeat the process if items on the list receive tied scores or if the results need to be narrowed down further.

John Doe County Health Department: Nominal Group Technique Example

The John Doe County Health Department (JDCHD) implemented NGT to choose one priority focus area for a QI project. In an effort to remain objective, the process was facilitated by an external consultant and the decision making team was a large group of 27 program and division managers and staff from throughout the agency. The goal of the exercise was to identify a focus area for a QI project based on the following criteria: 1) areas of weakness determined by agency self-assessment results; 2) the degree to which the health department is used for a particular service; and 3) the level of impact the health department can make to bring forth an improvement. In preparation for the exercise, the group was also provided with a detailed report of findings from the agency self-assessment to read prior to the decision-making process. From this point, the following steps were followed to identify a primary focus area for improvement:

1. **Silent brainstorming –** Two weeks in advance of the meeting**,** team members were provided with results of the self-assessment for review and to individually brainstorm ideas on which health issues should be the focus of a QI project.
2. **Generate list –** At the start of the meeting, the facilitator collected potential health issues from all group members, one by one, and recorded them on a flip chart. The list was simplified by combining and grouping similar items, resulting in the 6 potential health indicators shown in **Table 3.1**.
3. **Group discussion –** The facilitator led a discussion where everyone was given the opportunity to provide input on how each of the 6 priorities measured up against the criteria previously established.
4. **Anonymous voting –** Following the meeting**,** all group members individually completed an on-line ranking for their top three choices by assigning a number of 1-3 next to each option, with 1 being the last choice and 3 being the first choice.
5. **Calculate priority score –** The total priority scores were calculated by adding scores given by every group member for each item on the list **Table 3.1** shows a compilation of the rankings from the 27 group members with improved communication and coordination between divisions and programs within the health department as the top priority:

Table 3.1: Count of Staff Responses to QI Focus Areas

Priority Health Indicator	1st Choice Score = 3	2nd Choice Score = 2	3rd Choice Score = 1	Total Score
Improve communication and coordination between divisions and programs within health	4	6	6	30

department				
Engage policymakers and community to support health department initiatives	1	6	3	18
Promote understanding of public health in general and health department as an organization among stakeholders (may include internal and external stakeholders)	3	1	6	17
Better utilize data and best practices to inform health department program decisions and to generate community support and understanding of the health department's role and contribution to public health	2	4	6	20
Establish a health department presence and recognition at a level comparable to other major City departments	4	5	5	27

The Hanlon Method [vi]

Developed by J.J. Hanlon, the *Hanlon Method for Prioritizing Health Problems* is a well respected technique which objectively takes into consideration explicitly defined criteria and feasibility factors. **Though a complex method, the Hanlon Method is advantageous when the desired outcome is an objective list of health priorities based on baseline data and numerical values**.

Step-by-Step Instructions:

1. **Rate against specified criteria** – Once a list of health problems has been identified, on a scale from zero through ten, rate each health problem on the following criteria: *size of health problem, magnitude of health problem, and effectiveness of potential interventions*. It is important to remember that this step requires the collection of baseline data from the community such as from a community health assessment. **Table 4.1** illustrates an example numerical rating system for rating health problems against the criteria.

Table 4.1

The Hanlon Method: Sample Criteria Rating			
Rating	**Size of Health Problem** *(% of population w/health problem)*	**Seriousness of Health Problem**	**Effectiveness of Interventions**
9 or 10	>25% (STDs)	Very serious (e.g. HIV/AIDS)	80% - 100% effective (e.g. vaccination program)
7 or 8	10% - 24.9%	Relatively Serious	60% - 80% effective
5 or 6	1% - 9.9%	Serious	40% - 60% effective
3 or 4	.1% - .9%	Moderately Serious	20% - 40% effective
1 or 2	.01% - .09%	Relatively Not Serious	5% - 20% effective
0	< .01% (Meningococcal Meningitis)	Not Serious (teen acne)	<5% effective (access to care)
Guiding considerations when ranking health problems against the 3 criteria	• Size of health problem should be based on baseline data collected from the individual community.	• Does it require immediate attention? • Is there public demand? • What is the economic impact? • What is the impact on	• Determine upper and low measures for effectiveness and rate health problems relative to those limits. • For more information on assessing effectiveness of

		quality of life? • Is there a high hospitalization rate?	interventions, visit http://www.communityguide.org to view CDC's Guide to *Community Preventive Services.*

**Note: The scales in Table 1 are arbitrary models of how numerical scales are established and are not based on real epidemiological data; LHDs should establish scales that are appropriate for the community being served.*

2. **Apply the 'PEARL' test** - Once health problems have been rated by criteria, use the 'PEARL' Test, to screen out health problems based on the following feasibility factors:

    - **P**ropriety – Is a program for the health problem suitable?
    - **E**conomics – Does it make economic sense to address the problem? Are there economic consequences if a problem is not carried out?
    - **A**cceptability – Will a community accept the program? Is it wanted?
    - **R**esources – Is funding available or potentially available for a program?
    - **L**egality – Do current laws allow program activities to be implemented?

    Eliminate any health problems which receive an answer of "No" to any of the above factors or proceed with corrective action to ensure that potential health priorities meet all five of the feasibility factors.

3. **Calculate priority scores** – Based on the three criteria rankings assigned to each health problem in Step 1 of the Hanlon Method, calculate the priority scores using the following formula:

    D = [A + (2 x B)] x C

    Where: D = Priority Score
    A = Size of health problem ranking
    B = Seriousness of health problem ranking
    C = Effectiveness of intervention ranking

    **Note: Seriousness of health problem is multiplied by two because according to the Hanlon technique, it is weighted as being twice as important as size of health problem.*

4. **Rank the health problems** – Based on the priority scores calculated in Step 3 of the Hanlon Method, assign ranks to the health problems with the highest priority score receiving a rank of '1,' the next high priority score receiving a rank of '2,' and so on.

McLean County Health Department - The Hanlon Method Example:
As a part of the Illinois Project for Local Assessment of Needs (IPLAN), a community health assessment and planning process, the McLean County Health Department (MCHD) used the Hanlon Method to prioritize health problems in the community. After determining the top eight health problems from the community health assessment data, MCHD used the Hanlon Method to establish the top three focus areas the agency should address. The following steps were taken to implement the prioritization process:

1. **Rate against specified criteria** – To rate each health problem, MCHD used the following considerations for each Hanlon criterion. **Table 3.2** illustrates the top three of the eight health problems and corresponding ratings for each criterion.
    - *Size of the problem* – the percentage of the population with the problem, with an emphasis on the percentage of the population at risk for the problem
    - *Seriousness of the problem* – morbidity rates, mortality rates, economic loss, and the degree to which there is an urgency for intervention
    - *Effectiveness of the intervention* – the degree to which an intervention is available to address the health problem

2. **Apply the 'PEARL' test –** After long discussion, all eight health problems passed the 'PEARL' test as the interventions for each problem were judged to be proper, economical, acceptable, feasible based on available resources, and legal.

3. **Calculate the priority scores –** Priority scores were calculated by plugging in the ratings from Columns A through B into the formula in Column D. The calculations of the top three priority scores are illustrated in **Table 3.2**

Table 4.2: MCHD Hanlon Priority Scoring

Health Problem	A Size	B Seriousness	C Effectiveness of Intervention	D Priority Score (A + 2B)C	Rank
Cancer	8	10	6	168	3
Cerebrovascular Disease	7	9	7	175	2
Heart Disease	10	10	7	210	1

<u>Livingston County Department of Health - The 'PEARL' Test Example:</u>

Often, the 'PEARL' component is pulled out of the Hanlon Method and applied on its own or used in conjunction with other prioritization techniques. The following example illustrates how the Livingston County Department of Health (LCDOH) in New York applied the "PEARL" test to assist in the selection of a QI project in preparation for accreditation.

The LCDOH accreditation team was comprised of the agency's center directors and supervising staff and the process was facilitated by an external consultant to ensure objectivity and minimization of bias. Initially, the team completed a scoring matrix to identify areas of weakness and came up with the following focus areas: *engaging in research, connectedness to universities, strategic planning,* and *development and maintenance of an effective performance appraisal system*. Once the team reached a consensus on these potential focus areas, a 'process of elimination' tactic was employed by utilizing the 'PEARL' Test. The facilitator led the group through a discussion allowing all team members to provide input on how well each focus area measured up to the 'PEARL' feasibility criteria. Upon consideration of the criteria, LCDOH initially eliminated engagement in research and connectedness to universities because the group felt that, at that time, any time or resources put into these issues would yield minimal results. Additional focus areas were also eliminated until, ultimately, the group agreed that improving and maintaining an effective performance appraisal system passed all 'PEARL' criteria. Since the previous system lacked basic core competencies, as a part of a QI project, LCDOH went on to

develop a new performance appraisal system which incorporated eight fundamental core competencies which all staff are expected to meet. The new system was tested and changes were made based on feedback provided from the staff. In an effort to continually improve the system, each center is developing more specific competencies for particular job titles.

Prioritization Matrix [iv]

A prioritization matrix is one of the more commonly used tools for prioritization and is ideal when health problems are considered against a large number of criteria or when an agency is restricted to focusing on only one priority health issue. Although decision matrices are more complex than alternative methods, they provide a visual method for prioritizing and account for criteria with varying degrees of importance.

Step-by-Step Instructions:
The following steps outline the procedure for applying a prioritization matrix to prioritize health issues. While working through each step, refer to **Table 4.1** below for a visual representation:

Table 5.1: Example Prioritization Matrix

	Criterion 1 (Rating X Weight)	**Criterion 2 (Rating X Weight)**	**Criterion 3 (Rating X Weight)**	**Priority Score**
Health Problem A	2 X 0.5 = 1	1 X .25 = .25	3 X .25 = .75	2
Health Problem B	3 X 0.5 = 1.5	2 X .25 = 0.5	2 X .25 = 0.5	2.5
Health Problem C	1 X 0.5 = 0.5	1 X .25 = .25	1 X .25 = .25	1

1. **Create a matrix –** List all health issues vertically down the y-axis (vertical axis) of the matrix and all the criteria horizontally across the x-axis of the matrix so that each row is represented by a health issue and each column is represented by a criterion. Include an additional column for the priority score.
2. **Rate against specified criteria –** Fill in cells of the matrix by rating each health issue against each criterion which should have been established by the team prior to beginning this process. An example of a rating scale can include the following:

   3 = criterion met well
   2 = criterion met
   1 = criterion not met

3. **Weight the criteria –** If each criterion has a differing level of importance, account for the variations by assigning weights to each criterion. For example, if 'Criterion 1' is twice as important as 'Criterion 2' and 'Criterion 3,' the weight of 'Criterion 1' could be .5 and the weight of 'Criterion 2' and 'Criterion 3' could be .25. Multiply the rating established in Step 2 with the weight of the criteria in each cell of the matrix. If the chosen criteria all have an equal level of importance, this step can be skipped.
4. **Calculate priority scores –** Once the cells of the matrix have been filled, calculate the final priority score for each health problem by adding the scores across the row. Assign ranks to the health problems with the highest priority score receiving a rank of '1.'

Lawrence-Douglas County Health Department: Example Prioritization Matrix

Prior to beginning the prioritization process, Lawrence-Douglas County Health Department (LDCHD) developed a decision-making team which was comprised of ten people including directors and coordinators from throughout the department. Next, upon completion of an agency self-assessment, LDCHD identified areas of weakness and created a list of three potential health indicators to improve upon, along with five criteria found to be most relevant in pinpointing which health indicator will prove to have the greatest impact on the needs of Lawrence-Douglas County. Once these variables were determined, the groundwork was in place and LDCHD was ready to use a prioritization matrix to weigh the identified health indicators against each criterion to make a final decision on a focus area for a QI project. The following steps were used to implement the process:

1. **Create a matrix** – LDCHD used the prioritization matrix shown in **Table 4.2**, with the chosen health indicators listed on the Y-axis and each criterion listed across the X-axis:

Table 5.2: LDCHD Prioritization Matrix

	Evaluative Criteria					
Proposed Area for Improvement Based on LHD Self-Assessment	Linkage to Strategic Vision (.25)	Do we need to improve this area? (.25)	What chance is there that changes we put into place will make a difference? (.5)	Likelihood of completion within the timeframe we have (.5)	Importance to Customer (customer is the one who would benefit; could be patient or community) (.75)	**Total Score**
Media strategy & Communications to raise public health awareness	3 X (.25)	4 X (.25)	4 X (.5)	3 X (.5)	3 X (.75)	**7.5**
Work within network of stakeholders to gather and share data and information	2 X (.25)	3 X (.25)	2 X (.5)	1 X (.5)	1 X (.75)	**3.5**
Continuously develop current information on health issues that affect the community	4 X (.25)	2 X (.25)	3 X (.5)	1 X (.5)	2 X (.75)	**5**

**Note: The numerical rankings in Table 3.1 are meant to serve as an example and do not reflect the actual rankings from LDCHD's prioritization process.*

2. **Rank each health indicator against criteria** – Each member of the decision-making team was given this prioritization matrix and asked to fill it out individually based on the following rating scale:

   4 = High priority
   3 = Moderate priority
   2 = Low priority
   1 = Not priority

   After completing the matrix, each team member individually discussed with the facilitators of the process the reasoning behind how the health indicators were rated.

3. **Weight the criteria –** Although LDCHD weighted each criterion equally, (i.e. each criterion was assigned a multiplier of 1) the numbers in red provide an arbitrary example of how an agency

could assign weights to the criteria based on perceived importance. In this example, with multipliers of .5, 'Likelihood of making a difference' and 'Completion within timeframe' are weighted as twice as important as 'Linkage to strategic vision' and 'Need for improvement,' with multipliers of .25. With a multiplier of .75, 'Importance to customer' is weighted as three times as important.

4. **Calculate priority scores –** Final priority scores are calculated by adding the weighted scores across the row and recording it in the 'Total Score' column. Since LDCHD had the team complete multiple matrices, the total scores for each health indicator were added together to determine the final priority scores. With 'Media Strategies' receiving the highest priority score of 7.5, it was assigned a rank of '1' and identified as the highest priority health indicator.

Conclusion

In a world with a growing number of health concerns, scarce resources, budget cuts, and conflicting opinions, it is very easy to lose sight of the ultimate goal - improving health outcomes. Often times these external forces drive the decision making process within a health department and make determining where to focus resources and time challenging. Prioritization techniques provide a structured approach to analyze health problems and solutions, relative to all criteria and considerations, and focus on those that will prove to have the greatest impact on the overall health of a community.

Appendices

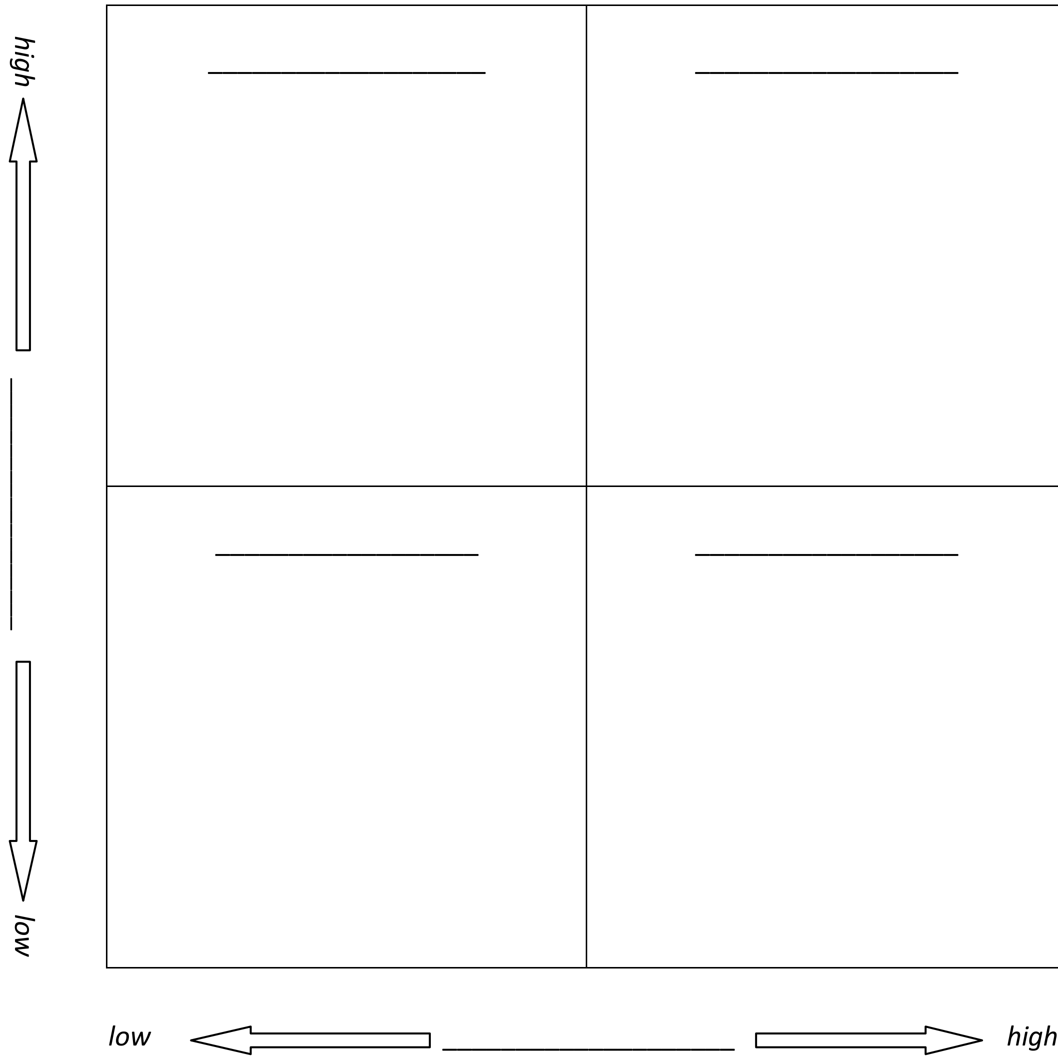
3 Round Multi-voting Template

Health Indicator	Round 1 Vote	Round 2 Vote	Round 3 Vote

Instructions:

1. Fill in items to be prioritized under the 'Health Indicator' column
2. Tally votes for each round of voting in the respective column

Strategy Grid



Instructions:

1. Fill in the blank spaces on each axis with the desired criteria
2. Label each quadrant according to the axes
3. Place competing programs/activities into the appropriate quadrant

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Hanlon Method Worksheet

Health Indicator	A Size	B Seriousness	C Effectiveness of Intervention	D Priority Score (A + 2B)C	Rank

Instructions:

1. Fill in items to be prioritized under the 'Health Indicator' column.
2. Fill in the 'A,' 'B,' and 'C' columns with the assigned ratings for each health indicator with respect to the three criteria.
3. Calculate the priority score using the formula in column 'D.'
4. Rank the health indicators with the highest priority score receiving a rank of '1.'

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Prioritization Matrix

Health Indicator	______________	_______________	________________	**Priority Score**

Instructions:

1. Fill in items to be prioritized under the 'Health Indicator' column.
2. Fill in the blank spaces in columns 2, 3 and 4 with the chosen criteria.
3. Fill in the ranks for each health indicator under the appropriate criteria.
4. Calculate the priority score by adding the rankings in each row.

[i] Health People 2010 Toolkit. Setting Health Priorities and Establishing Objectives. Available at http://www.healthypeople.gov/State/toolkit/priorities.htm. Accessed February 9, 2009.

[ii] Public Health Foundation. Priority Setting Matrix. Available at http://www.phf.org/infrastructure/priority-matrix.pdf. Accessed February 9, 2010

[iii] American Society for Quality. Evaluation and Decision Making Tools: Multi-voting. Available at http://www.asq.org/learn-about-quality/decision-making-tools/overview/mutivoting.html. Accessed December 2, 2009.

[iv] Duttweiler, M. 2007. *Priority Setting Tools: Selected Background and Information and Techniques*. Cornell Cooperative Extension.

[v] American Society of Quality. Idea Creation Tools: Nominal Group Technique. Available at http://www.asq.org/learn-about-quality/idea-creation-tools/overview/nominal-group.html. Accessed December 2, 2009.

[vi] National Association of County and City Health Officials. 1996. Assessment Protocol for Excellence in Public Health: Appendix E.

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Appendix F

Prioritization Sheet

Community Health Needs Assessment
and Implementation Plan 2014–2016

NW Regional

Priority 1 (Adolescent alcohol use)	Size	Seriousness	Effectiveness	Priority Score
Group 1	5	5	5	
Group 2	7	7	2	
Group 3	9	1	7	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	7	4.33333333	4.66666667	**73.1111111**

Priority 2 (Alcohol related deaths in children and adults)	Size	Seriousness	Effectiveness	Priority Score
Group 1	2	9	5	
Group 2	7	7	2	
Group 3	1	6	2	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	3.33333333	7.33333333	3	**54**

Priority 3 (Lack of cancer self-examinations)	Size	Seriousness	Effectiveness	Priority Score
Group 1	9	9	9	
Group 2	3	3	2	
Group 3	9	10	8	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	7	7.33333333	6.33333333	**137.222222**

Priority 4 (Heart disease and heart attack hospitalizations)	Size	Seriousness	Effectiveness	Priority Score
Group 1	9	9	3	
Group 2	4	4	5	
Group 3	10	10	9	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	7.66666667	7.66666667	5.66666667	**130.333333**

Priority 5 (Obesity)	Size	Seriousness	Effectiveness	Priority Score
Group 1	10	9	4	
Group 2	10	10	9	
Group 3	10	10	10	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	10	9.66666667	7.66666667	**224.888889**

Priority 6 (Lack of physical activity)	Size	Seriousness	Effectiveness	Priority Score
Group 1	9	9	4	
Group 2	10	10	9	
Group 3	10	9	6	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	9.66666667	9.33333333	6.33333333	**179.444444**

Priority 7 (Bullying in schools)	Size	Seriousness	Effectiveness	Priority Score
Group 1	8	7	3	
Group 2	5	5	2	
Group 3	5	5	6	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	6	5.66666667	3.66666667	**63.5555556**

Priority 8 (Traffic safety)	Size	Seriousness	Effectiveness	Priority Score
Group 1	3	6	8	
Group 2	5	5	2	
Group 3	7	6	7	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	5	5.66666667	5.66666667	**92.5555556**

Priority 9 (Mental health/illness)	Size	Seriousness	Effectiveness	Priority Score
Group 1	9	9	4	
Group 2	10	10	8	
Group 3	10	10	2	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	9.66666667	9.66666667	4.66666667	**135.333333**

Priority 10 (Chronic disease and chronic disease management)	Size	Seriousness	Effectiveness	Priority Score
Group 1	10	9	4	
Group 2	8	8	8	
Group 3	8	10	6	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	8.66666667	9	6	**160**

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Appendix G

Justification Worksheet

Community Health Needs Assessment
and Implementation Plan 2014–2016

Please use the Facilitation Questions, Part 2 – Choosing Final Priorities, as a guide to complete this worksheet.

Health Priority	Justification for Why a Priority was Chosen
1. Obesity and Physical Activity	• Both priorities scored very high (top two scores) and the group felt it would be appropriate to combine those into one, since they are connected and underlying issues relevant to those topics are very similar. • Both issues are preventable • Both behaviors are modifiable and can be influenced with appropriate intervention • Both issues relate to most (if not all) other priorities on the list or at least somehow connected. That means these two topics are important and touch most other areas our community is concerned about. • Both issues impact our vulnerable population greatly (low income class, minors and older adults in the community). • Both issues address the topic of disparities and working with minimizing the gap between our region's socio-economical classes.
2. Chronic Disease and Chronic Disease Management	• Interventions for obesity and physical activity priorities will assist with finding solutions and developing action plan for chronic disease and chronic disease management. • The group felt assisting with chronic disease issues has been and still is one of Allina Health strengths and Buffalo Hospital should use the opportunity to build on that strength. • The group felt very strongly it is a social responsibility of the local hospital to intervene, and Buffalo Hospital is the most suited to lead that intervention in the community due to strong clinical background and knowledge.
3. Mental Health/Illness	• The group stated we are lacking any resources and services in our region related to this issue. • This concern is a national challenge, and

	should be addressed on the variety of levels, including intervention from local hospitals and community. • There is a lack of local resources, yet the community is assuming the impact of the issues. The hospital has an opportunity to intervene by providing resources or expanding services, as well as partnering with the community to address the concern. • Most important, the group felt this issue is currently discussed, and is concerning – everyone feels it has to be addressed – yet it isn't anyone's priority, so nothing happens. The community feels it is time to take the lead and address this concern. • The issue has great effect on our vulnerable population.

Health Priority	Justification for Why a Priority was **NOT** Chosen
1. Lack of cancer self-examinations	• Lack of data, other than self-reported through survey. • The group felt the priority scored high because clearly this issue is important and possible interventions are easily implemented; however, the council thought sufficient efforts are already being put in by the hospital and the community to address this concern. • Lack of knowledge and education on the topic is the biggest concern. The group felt as though this priority scored very high, that doesn't mean additional interventions are necessary as this time. The group stated primary intervention in this case id education on the topic, and this is already in place and being utilized to raise awareness. • Already being promoted through hospital, clinics and in the community – many resources already exist and available.
2. Heart Disease and Heart attack hospitalizations	• This priority also scored high, but the group felt that lifestyle modifications will help address this issue on a larger scale by concentrating on top priority – obesity and physical activity.

3. Traffic Safety	• The group felt the community is already doing a lot to address this issue through the work and efforts provided by Safe Communities project. • The group stated this isn't hospital's role to address an issue such as this one.
4. Adolescent alcohol use	• The council felt this issue is something we cannot influence in our specific community, as this is often regulated and addressed on an individual family level. • The group felt this issue is a low priority in comparison to other concerns listed. • The schools and community should focus on education about the topic, in hopes to change the regional dynamic and acceptance of this norm.
5. Alcohol related deaths in children and adults	• The deaths per capita are fairly low and are declining based on the data for our region. • Low priority in comparison to other issues and concerns. • The group felt there is no appropriate active intervention available, as we can try and educate the population about the behaviors, which hopefully will result in further deaths (see above).
6. Bullying in schools	• The group felt that schools in our region are already working on this issue, providing education and active interventions. • The community is aware and addressing these issue actively (forums, educational efforts, community partnerships, etc.). No need to duplicate the efforts – the hospital should concentrate on higher priority items.

BUFFALO HOSPITAL
NORTHWEST REGIONAL

Appendix H

Framing CHNA Health Disparities

Community Health Needs Assessment
and Implementation Plan 2014–2016

Framing CHNA's in the Context of Healthcare Equity

"A prerequisite to improving health and reducing inequities is to consider and address social determinants of health, namely the social and physical environments in which people are born, live, learn, work, play, worship and age." (American Public Health Association et al, 2012)

What are health disparities?
Health disparities, or the unequal distribution and prevalence of illness, chronic disease, and death, are ubiquitous at a national, state and local level. Health disparities are connected to a myriad of historical, social, behavioral, environmental and biological factors. An individual's health (physical, mental, emotional, social, cultural and spiritual) is uniquely shaped by a number of factors, including (but not limited to):

- Lifestyle
- Behaviors
- Family History
- Cultural History/Heritage
- Values and Beliefs
- Hopes and Fears
- Life Experience
- Level of Education
- Neighborhood
- Spiritual Beliefs/Practices
- Cultural Group
- Gender
- Language
- Employment Status/Occupation
- Sexual Orientation
- Relationship Status
- Disability Status
- Social, Economic and Environmental Circumstance

An individual's health can be promoted or constrained by these factors, placing specific patients and populations at greater risk for chronic disease and suboptimal health.

What are health*care* disparities?
The care that patients access and receive in the hospital, clinic, community and household setting is also a factor in health disparities. Evidence of disparities within the health care setting has been documented. For example,

- the 2003 Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* highlighted racial and ethnic disparities in access to care and also disparities in quality of care for those who had access (IOM, 2012), and
- the most recent *National Healthcare Disparities Report* documents socioeconomic, racial/ethnic and age disparities for a large percentage of quality of care measures they assessed (AHRQ, 2011).

What are a few examples of disparities?
National Level
Health disparities have persisted over time, where minority racial groups such as African Americans and American Indians have higher mortality rates compared to whites (IOM, 2012). Examples include:

- gaps in heart disease and cancer mortality rates between African Americans and whites (even though these mortality rates have declined in both groups, the gap between both racial groups still exists),
- a considerable gap in diabetes-related mortality rates has been present between American Indians and whites since the 1950s, and

- disparities in mortality rates for both African Americans and American Indians compared to whites exist at all age levels (across the life span).

Health disparities have also been documented where racial and ethnic minorities "experience an earlier onset and a greater severity of negative health outcomes" (IOM, 2012). Examples include:

- breast cancer outcomes,
- major depression outcomes, and
- and first birth neonatal mortality.

State Level

Statewide, there are racial/ethnic disparities in the number and magnitude of select health indicators, especially for African Americans and American Indians (MDH, 2009a; MDH, 2009b). Examples include:

- increased incidence of select STDs (HIV, gonorrhea, chlamydia),
- pregnancy and birth disparities (prenatal care, low birth weight, teen births, infant mortality),
- select chronic disease mortality (diabetes, heart disease, cancer, chronic lower respiratory disease), and
- stroke, mortality rates, and homicide.

Disparities are also present among Hispanics, especially with select STDs incidence, pregnancy and birth disparities, and diabetes mortality rates (MDH, 2009a; MDH, 2009b). All of the mentioned racial/ethnic minorities also have higher rates of uninsurance compared to Whites (MDH, 2009b). Evidence also suggests significant disparities for specific health indicators when comparing urban versus rural populations (MDH, 2011). Examples include:

- higher diabetes, stroke, heart disease, pneumonia and influenza mortality rates are some examples of disparities in rural populations compared to urban populations, and
- higher uninsurance, smoking, obesity, and suicide rates and reporting of "fair" or "poor" health are also examples of disparities in rural communities.

Metro Area

In the Metro Area, a study by Wilder Research in 2010 commissioned by the Blue Cross and Blue Shield of Minnesota Foundation identified unequal distribution of health in the Twin Cities based on median area income, education, race and neighborhood conditions (Helmstetter et al, 2010). For example, the report highlights disparities in health outcomes for American Indians residing in the Twin Cities Metro Area, indicating American Indians in the metro area have: the lowest life expectancy (61 years) compared to Asians (83 years) and whites (81 years); the highest mortality rate (3.5 times higher than whites); and the highest diabetes rate (18%) compared with the overall average for Hennepin County (6%).

Hennepin County

In Hennepin County, according to a Survey of the Health of All the Population and the Environment (SHAPE), lesbian, gay, bisexual, and transgender (LGBT) persons have much higher prevalence of poor mental health, including frequent mental distress, depression, anxiety or panic attack, serious psychological distress, and any psychological distress. Smoking, binge drinking, and heavy alcohol use are also higher among LGBTs compared to non-LGBT adults. Rates of LGBTs who currently lack health insurance, or who were not insured at least part of the past year were almost twice as high as those who are not LGBT. Disparities within the healthcare setting are also apparent: "[c]ompared to their non-LGBT peers, LGBT residents are more likely to report experiencing discrimination while seeking health care, have unmet medical care needs and unmet mental health care needs" (SHAPE, 2012).

Allina Health

At Allina Health, preliminary research is beginning to suggest disparities in care and outcomes. For example:

- an internal study by Pamela Jo Johnson, MPH, PhD and her cohorts identified significant disparities in hospital admission rates for potentially-avoidable hospital care for Ambulatory Care Sensitive Conditions (ACSC), especially for chronic conditions. Overall, 10% of 2010 hospital admissions at Abbott Northwestern Hospital were due to diabetes complications and significant disparities by race/ethnicity were noted. Specifically, 36% of Hispanic admissions, 20% of American Indian admissions, and 15% of Black admissions were due to diabetes, compared with only 8% of White admissions (Johnson et al, 2012), and

- preliminary analysis of 2010 optimal diabetes control data from Allina clinics 2010 data by Jennifer Joseph, MPH, and her cohorts show substantial disparities in optimal status by race/ethnicity. Only 37% of Blacks and 37% of American Indians achieved optimal control status compared with 51% of non-Hispanic whites. Analysis indicates that Blacks and American Indians have significantly higher odds of sub-optimal diabetes control compared to non-Hispanic whites (Joseph et al, 2012).

These examples indicate that opportunities may exist for enhanced clinical care and self-management support for chronic disease for some populations to reduce potentially-avoidable hospital care and to improve optimal control of chronic disease, such as diabetes.

What are healthcare systems doing to eliminate healthcare disparities?

Many healthcare systems, including Allina, are working to identify and understand disparities in care and outcomes and to develop and implement evidence-based solutions to promote healthcare equity. Healthcare equity is a key component of our national and local healthcare agenda (U.S. Department of Health and Human Services, 2012; National Prevention Council, 2011). In addition, health equity is inherently related to care quality, and equitable care is one of the six aims for quality improvement identified by the IOM in their groundbreaking report *Crossing the Quality Chasm* (IOM, 2001). Healthcare equity initiatives are expected to:

Improve:

- Quality of Care
- Patient Outcomes
- Patient Safety
- Patient Experience/Satisfaction

Reduce:

- Potentially Preventable Events
- Potentially Preventable Hospital Care
- Readmissions
- Medical Errors
- Overall Healthcare Costs

Identifying Healthcare Disparities within the Hospital and Clinic Setting

Recent improvements in health information technology (HIT) and electronic medical records are helping healthcare systems identify disparities in care, utilization, and outcomes. For example, leading agencies and institutions (such as the National Quality Forum, the Department of Health and Human Services, the IOM, the Joint Commission, the Health Policy Institute, and Minnesota Community Measurement) recommend stratifying hospital quality data/measures by race, ethnicity, and language data to determine whether there are differences in quality of care for different populations. This information can be used to inform specific quality improvement initiatives to reduce disparities and improve outcomes.

Eliminating Healthcare Disparities within the Hospital and Clinic Setting

Central to the goal of eliminating disparities *within* healthcare setting are 1) knowing the unique physical, mental, emotional, social, cultural and spiritual needs of each patient we serve, 2) being aware of the unique resources and barriers to healing that are present in each patient's path to optimal healing and optimal health, and 3) engaging patients as active collaborators in the care of their health. Initiatives in data collection/analysis, patient-centered care, culturally-and linguistically appropriate services, patient engagement, patient-provider communication and shared-decision making are examples of ways that Allina is working toward this goal. In addition, there are a number of evidence-based strategies available to promote healthcare equity within healthcare settings, such as:

- Culturally-Responsive Care
- Cultural Competence Training for Providers
- Interpreter Services (for patients with a primary language other than English)
- Community Health Workers and Promotoras
- Innovative HIT Tools
- Patient-Centered Care
- Patient-Centered Communication
- Bilingual Staff
- Data Collection & Analysis
- Care Management
- Care Navigators
- Coordinated Care
- Prevention and Wellness Initiatives
- Advanced Care Teams
- Meaningful Use
- Patient Materials/Signage in Multiple Languages
- Workforce Diversity

How can Allina's Community Engagement Programs and Projects Such as the CHNA Reduce Disparities?

Allina's community engagement, community benefit, charitable contributions, community health improvement, and public policy initiatives are critical vehicles for reducing disparities and promoting healthcare equity. Since most barriers and resources to health are present within the contexts where patient's carry out their daily lives, the ability to eliminate health disparities from within the walls of hospitals and clinics is limited; conversely, the capacity to capture insights from patient voices and develop solutions within patients and their communities is almost limitless. The IOM, in their groundbreaking report *Unequal Treatment*, explain that racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life (IOM, 2003). So, as Allina works to meet the needs the physical, mental, emotional, social, cultural and spiritual needs of our patients, we have to understand and collaboratively care for our patients in the context of the homes, schools, neighborhoods, communities, and environments where our patients carry out their daily lives.

- For example, community-based efforts, multi-factorial approaches, and HIT are the 'new frontier' for reducing disparities in diabetes, according to leaders in disparities reduction who summarized the latest research in on this topic (Betancourt et al, 2012). What could this mean for Allina? Dialogue and research with patients, providers and community leaders about obstacles to optimal diabetes control at the personal, community, system and policy level may help Allina understand why standard care alone is not successful for some patients/populations. These insights and perspectives could be used to 1) inform quality improvement initiatives in diabetes clinical care delivery, 2) facilitate collaborative bridges between the medical care that is delivered in the clinic setting with additional self-care that is being fostered in the community setting, and 3) improve diabetes control in patients/populations for whom standard care alone is not successful.

Community Health Needs Assessments (CHNA's), as mandated under section 9007 of the Patient Protection and Affordable Care Act and outlined in IRS policy 2011-52, are especially promising for

understanding the specific needs of our patients and informing solutions through patient-centered dialogue in the broader context of the communities we serve. CHNA's will help Allina begin to understand 1) the barriers and resources to health and unmet medical needs of the community, 2) identify actionable opportunities, and 3) implement a community benefit implementation strategy to respond to such needs. To reduce disparities, it is important that Allina understand the needs of our communities overall, and understand the *specific needs of specific patients and populations* within the overall community. In this way, CHNA's present an opportunity for hospitals to maximize community health impact and reduce health disparities by considering social determinants of health and creating strategies to address health inequities (American Public Health Association et al., 2012; Crossley, 2012). CHNA's can be a critical tool to inform prevention, health promotion, quality improvement and healthcare equity initiatives because such assessments "can be considered alongside clinical, utilization, financial and other data to help craft health improvement solutions that take into account both the individual's health and the community context in which they live" (Bilton, 2011; Bilton, 2012).

References Cited

Agency for Healthcare Research and Quality (AHRQ)
2011 National Healthcare Quality and Disparities Report. U.S. Department of Health and Human Services, AHRQ Publication No. 12-0006.

American Public Health Association (APHA), Association of Schools of Public Health (ASPH), Association of State and Territorial Health Officials (ASTHO), National Association of County and City Health Officials (NACCHO), National Association of Local Boards of Health (NALBOH), National Network of Public Health Institutes (NNPHI), and Public Health Foundation (PHF)
2012 Maximizing the Community Health Impact of Community Health Needs Assessments Conducted by Tax-exempt Hospitals. A Consensus Statement.

Bilton, Michael
2011 Executive Briefing 3: Community Health Needs Assessment. Trustee, October 2011, pages 21 – 24.

Bilton, Michael
2012 Assessing Heath Needs: IIt's a Good Strategy. Health Progress, Sept-Oct 2012, pages 78 – 79.

Betancourt, J. Duong, J., Bondaryk, M.
2012 Strategies to Reduce Diabetes Disparities: An Update. Current Diabetes Report.

Crossley, Mary A.
2012 Tax-Exempt Hospitals, Community Health Needs and Addressing Disparities. Howard Law Journal. Vol 55, No. 3 p. 687 – 704.

Helmstetter, C, Brower, S and Egbert, A.
2010 The Unequal Distribution of Health in the Twin Cities: A Study Commissioned by the Blue Cross and Blue Shield of Minnesota Foundation. Blue Cross and Blue Shield of Minnesota Foundation and Amherst H. Wilder Foundation.

Institute of Medicine (IOM)
2012 How far have we come in reducing health disparities? Progress since 2000: Workshop summary. Washington, DC: The National Academies Press.

Institute of Medicine (IOM)
2003 Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Institute of Medicine. Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, Editors, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care.

Institute of Medicine (IOM)
2001 Crossing the Quality Chasm: A New Health System for the 21st Century. Institute of Medicine. Committee on Quality of Health Care in America.

Johnson PJ, Ghildayal N, Wheeler P.
2012 Disparities in Potentially Avoidable Hospital Admissions. Paper presented at: MN Health Services Research Conference; March 6, 2012; St. Paul, MN.

Joseph J, Johnson PJ, Wholey D, Frederick ML.
2012 Disparities in Optimal Diabetes Care. Paper presented at: Minnesota Health Services Research Conference; March 6, 2012; St. Paul, MN.

Minnesota Department of Health (MDH)
2009a Health Disparities by Racial/Ethnic Populations in Minnesota. Center for Health Statistics Minnesota Department of Health. St. Paul, MN

Minnesota Department of Health (MDH)
2009b Populations of Color in Minnesota. Health Status Report Update Summary. Center for Health Statistics Minnesota Department of Health. St. Paul, MN

Minnesota Department of Health (MDH)
2011 Health Status of Rural Minnesotans. Minnesota Health Information Clearinghouse. St. Paul, MN.

National Prevention Council
2011 National Prevention Strategy, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General.

U.S. Department of Health and Human Services
2012 Healthy People 2020. Office of Disease Prevention and Health Promotion. Washington, DC.

Survey of the Health of All the Population and the Environment (SHAPE)
2012 The Health and Well-being of LGBT Residents in Hennepin County. Hennepin County Human Service and Public Health Department and LGBT Data Forum Planning Committee. LGBT Data Forum Presented on October 12, 2012.

BUFFALO HOSPITAL
NORTHWEST REGIONAL

Appendix I

Community Dialogue Report

Community Health Needs Assessment
and Implementation Plan 2014–2016

ALLINA HEALTH COMMUNITY DIALOGUE

NORTHWEST REGIONAL

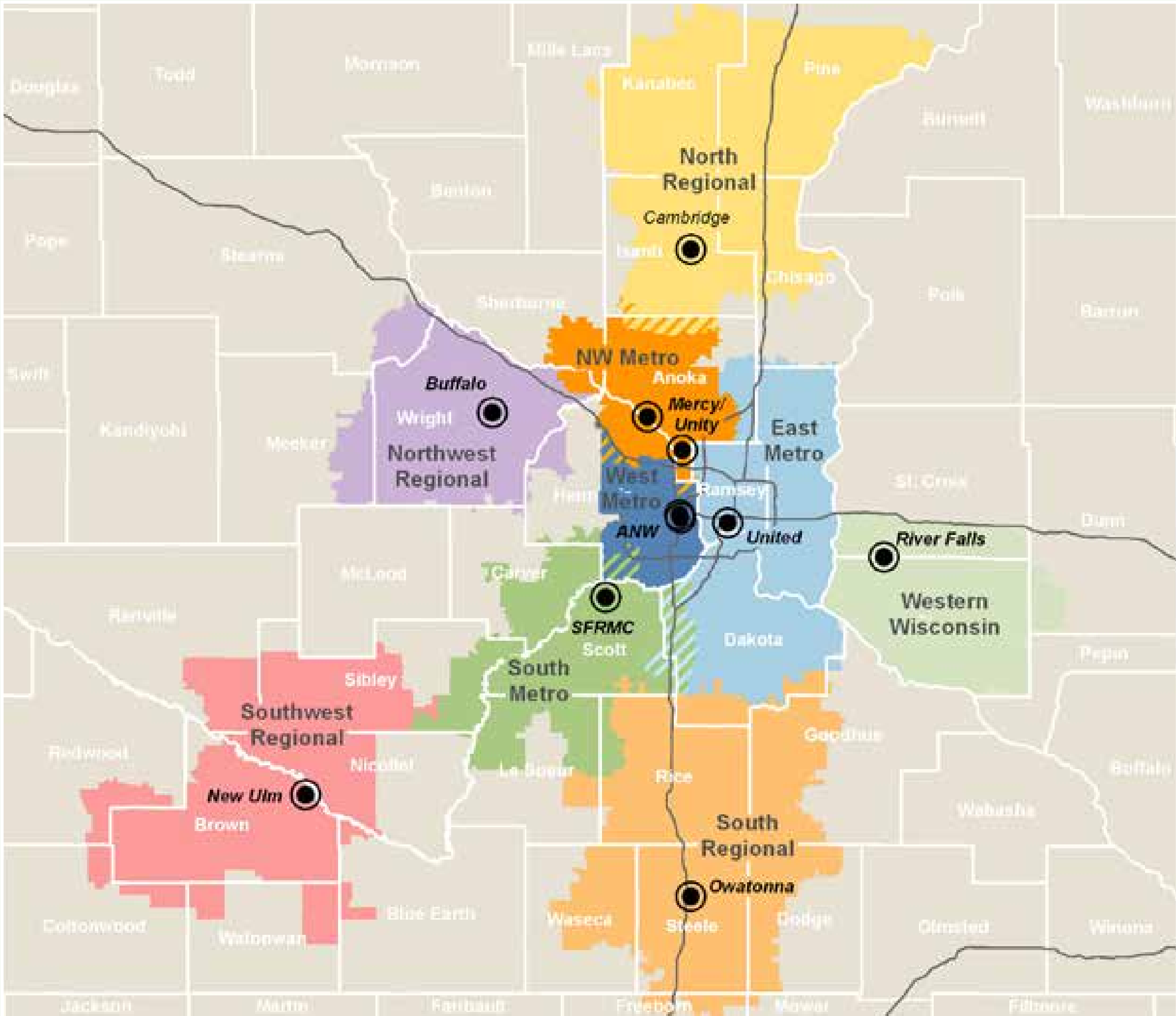
MARCH 2013

Allina Health

Improving health in our community

Allina Health is dedicated to the prevention and treatment of illness and enhancing the greater health of individuals, families and communities throughout Minnesota and western Wisconsin.

Allina Health Community Benefit & Engagement Regional Map



Introduction

Allina Health is a not-for-profit organization of clinics, hospitals and other health and wellness services that cares about improving the health of all communities in its service area of Minnesota and Western Wisconsin. Allina Health divides its service area into nine community engagement regions, each with a regional Community Engagement Lead dedicated to working with community partners to develop specific, local plans based on community needs.

To identify and respond to the community needs present in its service area, Allina Health recently conducted a community health needs assessment at an Allina Health hospital in each of the nine community engagement regions.

The needs assessment at Buffalo Hospital, part of the Northwest Region, identified three priority health issues to focus on from 2014–2016 (see **allinahealth.org** for the full community health needs assessment report). They included:

- OBESITY AND PHYSICAL ACTIVITY,
- CHRONIC DISEASE AND CHRONIC DISEASE MANAGEMENT,
- AND MENTAL HEALTH.

As a part of the process, the hospital hosted two community health dialogues with leaders and residents from the region to hear from a broader group of community members, identify ideas and strategies to respond to the priority issues and inform the action-planning phase of the needs assessment. A total of thirty-five people participated.

This summary highlights the findings from the 2013 dialogues in the Northwest Region, which includes Buffalo Hospital.

In February 2013, Buffalo Hospital and Allina Health convened two Community Dialogues in the Northwest Region.

Participants were asked to share their knowledge about the local health concerns that are most pressing among residents and their ideas about what works and what needs to be done to improve health in their community. Participants engaged in a World Café or participatory dialogue facilitated by members of Wilder Center for Communities. Participants moved through different rounds of conversation focused on obesity, physical activity, chronic disease and chronic disease management, and mental health.

The following summarizes key themes identified through analysis of individual discussion guides, completed by participants prior to engaging in the dialogues. In addition, where possible, themes from the dialogues are also included in the analysis. The information presented in this summary reflects the perspectives of a relatively small number of community members, and may not fully convey the diversity of experiences and opinions of residents who live in the Northwest region. Allina Health believes the community members included in the dialogues conveyed useful information and insight, and they continually seek to develop an understanding of the diverse experiences and opinions of community residents.

COMMUNITY DIALOGUE PARTICIPANTS

Buffalo (February 18)

Eleven community members participated in the February 18 community dialogue in Buffalo. The majority of the participants was between 45 and 64 years of age and reported living in a small town. Various participants indicated representing the healthcare sector. Participants also cited a diversity of expertise in health topics such as mental health, physical activity, and nutrition. Nearly all participants reported representing and/or working with adults (25-64). Additionally, several participants indicated working with and/or representing children/youth (6-17), young adults (18-24), and senior citizens (65+).

Buffalo (February 28)

Twenty-four community members participated in the February 28 community dialogue held in Buffalo. Over half of the participants were between 45 and 64 years of age. A smaller number of participants were between 24 and 44 years of age or 65 years or older. Over three quarters of the participants reporting living in a small town or rural community. Several participants identified representing the education and healthcare sectors. Participants noted expertise in a variety of health topics, such as: nutrition, physical activity, mental health, and chronic disease management/treatment/ prevention Many participants indicated working with and/or representing white community members, adults (25-64), senior citizens (65+), parents of children, and children/youth (6-17).

Community impact

OBESITY AND PHYSICAL ACTIVITY

Participants were asked to reflect on how obesity and physical activity impacts people in their community. They reported that obesity stems from easy access to fast food and an overall absence of exercise resulting from a lack of time, reduced focus on physical education in schools, and sedentary lifestyles. Some participants shared that it is difficult to be physically active during the winter season and they would like more opportunities to exercise. Several participants noted the chronic health conditions related to obesity such as heart disease and diabetes. They also cited the impact of obesity on rising healthcare costs and how children are being impacted by obesity at early ages.

CHRONIC DISEASE AND CHRONIC DISEASE MANAGEMENT

Participants were asked to reflect on how chronic disease and chronic disease management impacts people in their community. They shared that chronic disease leads to higher healthcare costs, disproportionately impacts the elderly population (and is increasingly affecting younger people), is often left untreated, and leads to a reduced quality of life stemming from, for example, family and financial stress. Participants referenced various factors that contribute to chronic disease, such as lack of exercise, obesity, high stress lifestyles, and an absence of education regarding negative behaviors such as smoking and unhealthy eating.

MENTAL HEALTH

Participants were asked to reflect on how mental health impacts people in their community. They indicated that there is a stigma that surrounds mental health and that people do not understand the impacts of mental illness or how it should be treated. Some participants noted that students and veterans especially struggle with mental health issues. A participant described how schools encounter difficulties in attempting to treat mental illness and help students. The high cost of mental health treatment and the lack of mental health facilities were also cited as a barrier.

Addressing health concerns in the community

OBESITY AND PHYSICAL ACTIVITY

Participants were asked to reflect on what should be done to address obesity and physical activity. Nearly all participants highlighted the need for increased opportunities for physical activity and more education regarding healthy eating and nutrition. Participants recommended:

- Creating school gardens to increase students' access to healthy foods
- Having free or low-cost classes devoted to the preparation of healthy foods
- Creating better access to gardening resources for the community
- Supporting CSAs and farmers markets
- Increasing access to bicycles
- Providing low- to no-cost opportunities for exercise
- Creating a community center that is affordable for families
- Focusing on family exercise (a participant referenced a program in Monticello called "Walk n' Roll")
- Creating more time for exercise or physical activity during the school day

CHRONIC DISEASE AND CHRONIC DISEASE MANAGEMENT

Participants were asked to reflect on what should be done to address chronic disease and chronic disease management. They suggested the following:

- Increasing education about chronic disease and specific programs or classes focused on developing awareness of chronic disease
- Creating a marketing campaign or more public information about the impact of chronic disease and how to properly manage it
- Launching prevention initiatives with schools and local communities
- Developing specific classes or programs to address chronic disease, such as disease management programs at clinics or free classes for families that are contending with chronic disease

MENTAL HEALTH

Participants were asked to reflect on what should be done to address mental health. They suggested increasing awareness and creating services and supports, such as:

- Offering more psychiatric care for children and adults
- Having mental health screening available for the elderly
- Hosting classes focused on mental health awareness
- Increasing the number of mental health providers in schools

How Allina Health can help address health concerns

OBESITY AND PHYSICAL ACTIVITY

Participants were asked to reflect on how Allina Health could help address obesity and physical activity. They reported that Allina Health could help address obesity through creating classes and more opportunities for nutrition education and physical activity, forging partnerships with schools and communities, and creating more education and awareness. Participants suggested:

- Offering free health screenings and free or low-cost nutrition classes and exercise opportunities, particularly for families
- Creating a wellness center focused on fitness and holistic health
- Assisting local restaurants in developing healthier menus
- Partnering with local public health entities to provide a program like the Heart of New Ulm that brings the community together to make preventative change
- Pairing pediatricians and nutritionist with schools to teach parents, teachers, and students about healthy eating

CHRONIC DISEASE AND CHRONIC DISEASE MANAGEMENT

Participants were asked to reflect on how Allina Health could help address chronic disease and chronic disease management. They shared that Allina Health could help address chronic disease and chronic disease management by fostering more education for the community and offering increased services and programs. Participants specifically noted:

- Having “medical bill advocates” for people with low income
- Facilitating support groups for people with chronic medical conditions
- Offering free disease management classes and health screenings
- Increasing the focus on the “wellness model” for those with chronic diseases
- Developing more education for physicians focused on nutrition

MENTAL HEALTH

Participants were asked to reflect on how Allina Health could help address mental health. They indicated that Allina Health could help address mental health by increasing mental health services and providing more education focused on mental health and mental illness. Participants proposed:

- Administering support groups for parents or people with ADHD or anxiety
- Hosting depression screening at churches, schools, and workplaces
- Developing classes focused on educating people about how to recognize mental illness and reduce the stigma
- Investigating the connection between mental health nutrition; supporting efforts to provide more fresh food
- Increasing resources and supports for parents with post-partum depression

Conclusion

The community dialogues were an opportunity for Buffalo Hospital to hear from a broader group of community members and identify ideas and strategies to respond to the priority issues to inform the action-planning phase of the needs assessment, and ultimately the action plan for Buffalo Hospital for FY 2014–2016.

Intersecting social, economic, and cultural barriers impact the health of the community, and by conducting community dialogues, Allina Health gained insight into how to support the community, building on the existing assets, and engage more people in defining the problems, and coming up with appropriate solutions.

allinahealth.org

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BUFFALO HOSPITAL
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Appendix J

Buffalo Hospital Inventory

Community Health Needs Assessment
and Implementation Plan 2014–2016

ALLINA HEALTH

Buffalo Hospital's Community Programs

Allina Health

BUFFALO HOSPITAL

The Community Engagement and Wellness Philosophy

is to improve the health of the communities Allina serves and develop a culture and reputation as a compassionate trusted community partner.

To learn more about these programs, please call us at 763-684-7025.

Wellness

An Apple a Day

Clinical staff from Buffalo Hospital speak on a variety of health-related topics including, but not limited to: Heart Health, Healthy Eating on a Budget, Sleep Deprivation, and Stress Management.

Coffee CHATS

Coffee CHATS (Community Health Awareness Talk) are designed to pull the community for lively discussions on various topics to keep you healthy. These chats take place with Buffalo Hospital clinical staff and are hosted at locations throughout our community. Topics include, but are not limited to: advanced care directives, pharmaceuticals, self-care, bone health, hearth health and nutrition.

Group Health Coaching

In this program participants meet as a group with a coach from Buffalo Hospital's Community Engagement and Wellness Team. Six sessions will be held for 30 minutes each. Participants will work together towards accomplishing their health-related goals. During each session, the health coach will help participants establish a specific goal and the steps to achieve it.

Individual Health Coaching

Wellness coaching includes fun and easy personalized health coaching programs for workplaces. Participants meet for 15 minutes in six sessions with a coach from Buffalo Hospital's Community Engagement and Wellness Team. During each session, the health coach will work with you towards health goals such as increased physical activity, life balance, stress management and nutrition. During each session, the health coach will help participants establish a specific goal and help create steps for achieving them. Health coaches will also go over workplace health assessments if available.

Healthy Eating for Successful Living

Healthy Eating for Successful Living in Older Adults is a program for seniors who want to learn more about nutrition and how lifestyle changes can promote better health. The focus of this program, which uses behavior change strategies and the MyPlate food guide as a framework, is to maintain or improve participants' wellness, specifically heart and bone health, and prevent chronic disease development or progression. The program includes recommendations and support for physical activity. Through participation individuals build a sense of empowerment as they accomplish incremental changes.

Living Well with Chronic Conditions Workshop

This is a 6 session interactive workshop for people who have chronic conditions or are caregivers to those who have chronic conditions. Participants gain knowledge on ways to self-manage their symptoms and conditions. Chronic Conditions include, but are not limited to, depression, high blood pressure, arthritis, pain, fatigue, diabetes, heart disease, bronchitis, emphysema, COPD, and others.

Chronic Conditions Pain Management

The Chronic Pain Self-Management Program provides knowledge and information, teaches skills that people can use to manage chronic pain, gives people greater confidence in their ability to manage chronic pain and helps improve the quality of life.

Falls Prevention Workshops

Falls prevention workshops empower older adults to carry out health behaviors that reduce the risks of falls. It is a community-based workshop offered once a week for seven weeks using adult education and self-efficacy principles. In a small-group setting, older adults learn balance exercises and develop specific knowledge and skills to prevent falls. Individual who should attend are those who: are at risk of falling, have a fear of falling, or who have fallen one or more times.

Let's Talk Wellness

Let's Talk Wellness is an interactive six-week educational series designed to introduce balanced living and general wellness concepts in the form of hands-on learning. The goal of the series is to increase knowledge about healthy behaviors, provide specific information on making lifestyle changes and sustaining motivation to continue after the changes are in place. Experts from Buffalo Hospital will feature "nuggets" of information to use at low cost with resources available right here in the community.

Wellness Campaigns

12 Days to Wellness (Holiday Theme)

This program is a 12 day campaign reminding participants about self care in 12 different areas: Exercise, Nutrition, Family, Safety, Career, Intellectual, Social, Emotional, Self-Care, Financial, Cultural, and Conservation. Good health involves daily choices and habits that contribute to a participant's well being, now and for the future. In a hurry-up lifestyle, especially during the holidays, people sometimes forget to do the things that ensure balance and lead to good health. The goal of this program is to perform a different activity, which is meaningful and contributes to your good health, for each area during the 12 days. Included in the campaign: a customized letter, an introduction sheet, a 'make your list log' form and completion slip, 12 days of e-mails including suggestions in specific areas, and a wellness website resource.

Merry Maintenance (Holiday Theme)

This is a 4-week program centered on festive parties and holiday treats. Merry Maintenance is designed to make individuals more active and help them eat healthfully so maintaining current weight is more manageable. Each week of this campaign participants receive a motivating e-mail message. There is an option of donating $5 - $10 at the beginning of the program to keep participants accountable. If they lose or maintain their current weight through the program they will get their money back. If the participant gains, the money will go to a holiday charity. Included in the campaign: a customized cover letter, instruction/log sheet, and 4 weekly motivational e-mails.

The Next Step

This is a 6 week pedometer program. Participants will track the number of steps taken daily and set goals to increase physical activity each week. By simply following the Next Step challenge and adding up steps, participants will change overall wellness day by day. The goal is that participants become more aware of the amount of steps taken each day, how easy it is to take even more steps, and hopefully change physical activity habits permanently. Included in program: an instruction sheet, 6 week step log and completion sheet, and walking tip sheet.

Weight No More

This 8 week healthy weight management program teaches participants that weight is no more than just a number. The first four weeks introduce participants to the fundamental weight management tools, one week at a time: physical activity, health food choices, portion sizes, and social and emotions challenges of achieving and maintaining a healthy weight. After the fourth week, participants sign a contract for themselves and practice the skills they use for the next four weeks. Included in program: a customized cover letter, program instruction sheet, 4 areas of "information and skills sheets," and 8 worksheets. The program also includes weekly presentations and weigh-ins for participants

Living Green Campaign

This is a 4 week earth-friendly program. Living green is a smart, healthy choice. This program has simple, practical, and healthy everyday habits anyone can do starting now. Each day you will select from a list of 100 reasonable, achievable green living activities. Each activity is assigned a value of 1 to 4 green points, depending on its potential impact. By the end, participants will have developed new green healthy habits for living healthfully. Included in the campaign: a customizable cover letter, program instruction, log and completion slip sheets, Living Green point list and a poster for the participant's workplace.

Step Across the State

This pedometer campaign is a 6 week program. Participants will track steps as they make their way across Minnesota. Included with campaign: a state of Minnesota scenic byway map, instruction sheet, tracking sheet with completion chart, and walking tips.

Wild on Wellness

This 6 week program is sure to be an adventure. Participants will pick one of 6 different animals (koala, toucan, elephant, monkey, warthog, or cheetah) to follow through the safari of offerings. Each week the safari guides will offer participants different types of wellness activities to try. Activities include: endurance, nutrition, flexibility, teamwork, bad habits, and lifetime health. The program is designed to see how may will survive the jungle, without becoming extinct! Including in campaign: a safari activity program sheet, a customized letter with instructions and tracking sheet and weekly wellness activity posters.

Fitness Services

VO2 Max Testing

VO2 max determines the optimal intensity and duration for an exercise program bases on individual testing. By evaluating the body's ability to carry oxygen to the muscles and to remove carbon dioxide, VO2 sub-max is the gold standard testing tool, used to define the participant's level of cardiovascular endurance.

VO2 max allows the participant to monitor changes in the level of aerobic fitness by measuring cardiovascular endurance and defining:

- Personal ideal heart rate training zones
- An ideal starting duration and level of intensity for exercising
- Anaerobic training threshold and maximal fitness level

The assessment takes about 20 minutes, including warm up and cool down, and is performed on a treadmill. Participants will leave with a printout of the session including: personal physiological metabolism and a personalized goal setting consultation.

RMR Testing

RMR stands for Resting Metabolic Rate and is an estimate of how many calories a person would burn if they were to do nothing but rest. This calculation is used to determine daily calorie needs for each individual. Knowing how many calories your body needs each day is the secret to losing, gaining or maintaining body weight successfully. Scientific

studies have shown that there are significant differences in metabolic rates of different people. The ability to measure your unique metabolic rate ensures participants are eating the right amount of calories to attain a weight goal in a healthy manner.

Our Mobile Lab technology allows our Wellness specialist to perform a metabolic rate assessment while the participant is seated in a chair. The assessment takes about 15 minutes and the results are available immediately. Participants will leave with a printout of the session including: a personal physiological metabolism, how many calories to take in daily and a personalized goal setting consultation.

Group Exercise Classes

Several classes are available in our group exercise offering. Resistance training, walking, stretching, aerobic and others.

Pedometers

A pedometer is a portable electronic device that counts each step a person takes by detecting the motion of the person's hips. Pedometers have been shown in clinical studies to increase physical activity, and reduce blood pressure levels and Body Mass Index.

Heart Rate Monitors

A heart rate monitor is a personal monitoring device which allows a subject to measure his or her heart rate in real time or record his or her heart rate for later study. They are designed to provide motivation and training guidance to improve fitness levels and track calories.

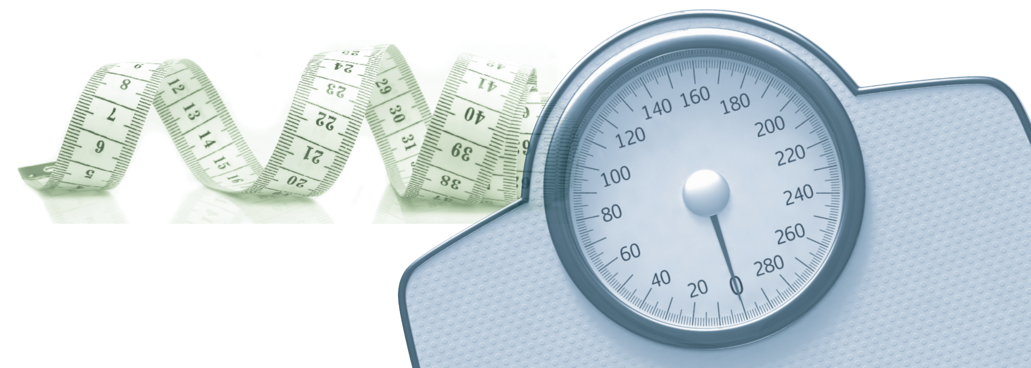
Fitness Rehabilitation Services

Ergonomic Assessments

Consultants from Sister Kenny Rehabilitation Institute are available to perform an onsite job analysis and ergonomic assessment designed to create healthy and safe work environment using quality and cost effective services. Work site educational presentations are also available for various work ergonomic issues.

ImPACT Testing

ImPACT (Immediate Postconcussion Assessment and Cognitive Testing) is offered though Sister Kenny Rehabilitation Institute at no cost to all Buffalo, Maple Lake, Rockford and St. Michael high school athletes. This 20-minute test is a standard tool used in clinical management of concussions. Memory, impulse control, and reaction time are measured.



Nutrition Services

Nutrition Consultations

Registered dietitians are available for consultations on a variety of topics including, but not limited to: weight loss, high blood pressure, heart disease, sports and basic nutrition, food allergies, and diabetes.

Also available is a 12 week weight loss class, open to anyone desiring to lose weight. For those who are a candidate for gastric bypass, additional monthly classes will fulfill requirements for surgery.

Education Classes

CPR & Babysitting Classes

This class teaches adult cardiopulmonary resuscitation (CPR) skills, rescue breathing, how to clear airway obstructions and how to use an automatic external defibrillator (AED). Participants also will learn to identify and control heart disease risk factors. Certified and non-certified classes are available.

Childbirth Preparation Classes

These classes focus on preparation for labor, birth and newborn safety. Topics include labor and birth and the options available, relaxation and breathing techniques to help you cope with labor, the role of your spouse, partner or labor companion, use and choice of medications and medical procedures, Cesarean birth, your recovery, care for your baby after birth, your baby's safety and resources available. A hospital birth center tour is also included. Various other classes surrounding child care, new mothers and wellness are available.

Screening Services

Colonoscopy Saturdays

Symptoms of colon cancer are often silent, making regular screening important. Everyone should have a colonoscopy every 10 years, beginning at age 50, or earlier if there is a family history of colon cancer. To help ease fears and make colonoscopies more comfortable, doctors use deep sedation so patients are completely unaware of the procedure. The sedation wears off quickly and patients are ready to go home quicker than in the past. Patients are provided with prep kits and boxed lunches and snacks for their drivers. Please plan to have a driver bring you home.

Healthy Communities Partnership

The Healthy Communities Partnership, sponsored by the Penny George Institute for Health and Healing and by the George Family Foundation, works with communities to get healthy and stay healthy. The program is open to anyone 18 years of age and older. The program includes:

- Annual health screenings for 3 years
- Blood sugar and cholesterol level checks
- Body Mass Index (BMI) testing

- Blood pressure and pulse reading
- On-line health risk assessment and coaching
- Coaching and follow-up with wellness specialists

Mammography for Low Income/Uninsured

Buffalo Hospital partners with SAGE (Minnesota Department of Health's comprehensive breast and cervical cancer screening program) to host this free mammography event twice a year, spring and fall. Free activities and pampering for this event include: seated massages, reflexology, treats, gift bags and pink boas.

Sleep Studies

Sleep is essential for a person's health and it's just as important as exercise and stress management. If a person is not getting adequate sleep it could lead to an array of serious medical conditions including obesity, diabetes, depression and heart disease. Participating in a sleep study can help determine reasons for sleep deprivation and a provider will work with you to find a resolution. A painless and thorough procedure is used to diagnose and treat sleep problems. An evaluation with a doctor will review your current physical health and sleep complaint. After the initial evaluation the doctor may recommend an overnight sleep study. After the doctor evaluates the results of the study, treatment options will be discussed.

Cancer Survivorship Services

Connect Retreat

This 3 day retreat is for cancer survivor women giving them an opportunity to relax, reflect, refresh and rejoice. The need for cancer survivors is often common and strong. Participants often desire a connection with their spirituality and they gain useful information, resources, tools, and techniques for survival. They often simply gain a deeper connection with themselves. Massage and other body connection activities such as reiki, healing touch and ear candling are available for an additional fee.

STAR Program

The STAR (Survivorship Training and Rehabilitation) Program, offered through Sister Kenny Rehabilitation Institute, addresses the unique needs that affect cancer survivors, including lymphedema,, fatigue, musculoskeletal pain, joint stiffness, weakness, cognitive problems, balance problems and issues with communication, swallowing or eating.

Other Services

Buffalo Hospital Foundation

The Buffalo Hospital Foundation hosts several events throughout the year that support and strengthen the local community. The mission of the foundation is to be a catalyst for innovative services and facilities to improve community health. Events are continually changing to meet the needs of the community. Please visit the Buffalo Hospital website for more details and listings of upcoming events.

HeartSafe Communities Services

HeartSafe Communities is designed to make the community a safer place to live, work and play by being prepared to reduce the number of deaths and disabilities associated with Sudden Cardiac Arrest. Consultants are available to assist in purchasing AEDs (Automated External Defibrillators) and their related supplies. Consultants also provide CPR and AED training with this service. Medical direction and support is included.

Cardiac Rehab

Returning to your normal activities following heart-related procedures or surgery can be overwhelming. The cardiac rehab staff is skilled in helping individuals transition back into normal routine. Patients in cardiac rehab will be asked to do various exercises while being continuously monitored. Trained staff will evaluate the patient's medications and provide education on risk factors for heart disease, diet, how the heart works, and more. Cardiac Rehab requires a physician's order.

Allina Care Navigation

One call puts patients, families and providers in touch with a care navigator 24 hours a day, seven days a week. Care navigation registered nurses and social workers assess the callers' needs and provide information and options. Our care navigators help empower and guide patients and their loved ones through the complex options of hospitals, clinics, skilled nursing facilities, home and community resources. Collaborating with families, doctors, health providers and community agencies, our care navigators look at the big picture. They will coordinate and provide options to support and improve health, wellness and lifestyle now and in the long term. Please call 651-635-9173

Advance Care Planning

Advance care planning helps you and your loved ones gain a better sense of your values, preferences and wishes related to health care. It provides information to others about your health care wishes in case illness or injury prevents you from telling them yourself. A trained ACP facilitator will assist patients in communicating their health care wishes with family and loved ones and then put those wishes in writing through an individual session or group session. A basic session can be arranged through the Buffalo Hospital, 763-684-7704. A disease-specific or chronic condition session can be arranged through the Allina Care Navigation Help Desk, 651-635-9173. There is no cost for this service.

Children's Bike Rodeos

Buffalo Hospital's emergency department teams up with local police, sheriff's office and fire department to help children learn the importance of bike riding safety. This is a fun event to teach and remind children to be safe while having fun on their bike. If a child hits their head on a sidewalk or street, there is potential for a brain injury so bike safety is very important. Children can bring their bike and enjoy many fun activities, including learning the rules of the road, a bicycle obstacle course, helmet fittings, carnival games and prizes and lunch.

To learn more about these programs, please call us at 763-684-7025.

To sign up for the free *"Choose Wellness"* e-newsletter, go to buffalohospital.org

Allina Health

BUFFALO HOSPITAL

303 Catlin Street
Buffalo, MN 55313
763-682-1212

buffalohospital.org

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BUFFALO HOSPITAL
NORTHWEST REGIONAL

Appendix K

Wright County Inventory

Community Health Needs Assessment
and Implementation Plan 2014–2016

BUFFALO HOSPITAL

Wright County Health and Wellness Resource Guide

Compliments of Buffalo Hospital
Engagement and Wellness
763-684-7025

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Food Shelves and Clothing

(All area food shelves check with each other to check for abusers)

Food Shelf – Call Wright County for locations: 763-682-7400

ANNANDALE

www.annandalefoodshelf.org | Phone: 320-274-3663
Emergency only phone: 320-274-7155

- Available to Annandale, Maple Lake, South Haven and Silver Creek Annandale School District resident in need of emergency food
- Clothing, some household items for people in need may be available
- FREE will offering is asked

BUFFALO

www.buffalofoodshelf.com
Phone: 763-684-1699 (Leave message and they will return call)

- Serving those that reside in the 55313 zip code area in need of food
- Food available
- Address verification required, dated in the last 30 days

CLEARWATER – CLEAR LAKE

Phone: 320-558-2954 (Leave message and they will return call)

- Serving Clearwater and Clear Lake area resident in need of food
- Come and fill out application
- Bring picture ID and proof of residence

COKATO – DASSEL AREA

Elim Mission Church: 320-286-2662

- For emergency only
- Proof of residence and children's birth certificate may be required

Save & Share Thrift Shop: 320-286-5895

DELANO

Phone: 763-972-3723 or Jeanie at 763-972-3360

- Available for all Delano area residents in need of emergency food

ELK RIVER

www.caerfoodshelf.org | Phone: 3763-441-1020

- Available to residents with an Elk River or Otsego address
- Emergency food
- Address verification required, dated in the last 30 days
- Clothing available

HANOVER

http://www.stpaulsinhanover.org/food.htm | Phone: 763-498-8311

- Available to resident in Albertville, part of Corcoran, Hanover, Loretto, and St. Michael areas only
- Emergency food

MONTICELLO

Phone: 763-295-4031
Food Shelf

- By appointment only
- Available to resident in Monticello and Silver Creek that are in Monticello School area
- Emergency food

Clothing Center

- Food shelf clients receive voucher for free clothing at the clothing center. Others may shop for a small cost.
- Clothing for emergency or disaster relief will be provided free.

ROCKFORD

www.riverworksonline.org | Phone: 763-477-6098

- Serving Rockford and Greenfield area
- Food and clothing

Waverly Shirley Legatt at 763-658-4414

- Emergency food
- Available to Howard Lake, Montrose and Waverly area. Other towns may be served, depending on individual situation.
- Clothing

LOVE INC. – HEARTLAND

www.loveincheartland.org | Phone: 7763-972-6547

- Residents in Delano, Howard Lake, Rockford, Waverly, and Watertown
- Back to school supplies
- Bedding
- Resume skills
- Furniture

Food Programs (other)

NUTRITION ASSISTANCE PROGRAM FOR SENIORS (NAPS)

Second Harvest at 800-365-0270 or 651-484-8241

- For Seniors 60 years or older, residents of MN – low income seniors who meet federal income guidelines
- Must be pre-registered for the program

FARE FOR ALL

www.fareforall.org | Phone: 763-450-3880, 763-682-4864 or 1-800-582-4291

WIC – WCCA
Phone: 320-963-6500
- Pregnant mothers
- Infants

BUFFALO VALLEY GRAINS
www.buffalovalleygrains.com | Phone: 763-684-8115
- Organic grains
- Gluten-free flours and grains

HOHL GROWN FARM
hohlgrown@gmail.com | Phone: 612-799-7599 or 763-477-4629
- Organic
- Sustainable farming

SWEET BEET FARM
www.sweetbeetfarm.com | Phone: 612-219-1853
- Purchase a share each year
- Delivery to Buffalo drop site
- Seasonal vegetables

SLEEPY ROOT FARM
www.sleepyrootfarm.com | Phone: 651-239-3860
- Chemically-free vegetables, fruits and herbs

THREE WILLOWS FARM
threewillowsfarm@gmail.com | Phone: 763-276-0578 or 763-276-0579
- Beef
- Pork
- Chickens
- Eggs & Milk

TRUE COST FARM
www.truecostfarm.com
Phone: 612-568-4686
- Sustainable farming
- Beef
- Pork
- Chicken

Clothing/Furniture

Monticello Help Center 763-295-4031
Family Service Center, Waverly 763-658-4414
We Care We Share, Annandale.....................320-274-8881
Wise Penny Thrift Shop, Buffalo 763-682-4178

Health and Mental Health Support

HEALTH CARE CLINICS

Mid-Minnesota Family Practice Center
- St. Cloud .... 320-240-3157 or 1-800-575-2982

St. Mary's Health Care Clinics .... www.stmaryshealthclinics.org
- 10 Clinics in the metro area 651-287-7777

MINI-CLINICS IN LOCAL STORES

Fairview Express Care .... www.fairview.org
- Elk River Coburn's 763-389-7686

Minute Clinic .... www.minuteclinic.com | 1-866-389-2727
- Buffalo Cub Foods
- St. Michael CVS/Pharmacy
- Otsego Target 763-252-1315

NOW Clinic
- Albertville 763-315-5000
- Elk River 763-257-8080

IMMUNIZATIONS FOR ADULTS

Wellness on Wheels 763-682-7717
- Tetanus, Diphtheria, Pertussis
- Pneumococcal
- Human Papillomavirus
- Varicella
- Hepatitis A
- Hepatitis B
- Mumps, Measles, Rubella

MAMMOGRAM & PAP TEST

Sage Program........ 1-888-643-2584 or 763-682-7717

FAMILY PLANNING

Wright County Community Action........ 1-320-963-6500
Planned Parenthood Minnesota........www.ppmns.org/4now | 1-800-230-PLAN
Birthright 763-295-2232

IMMUNIZATIONS – ALL AGES

Wright County Public Health 763-682-7717

WELL-CHILD CHECKUPS (6 MONTHS TO 21 YEARS)

Wright County Public Health 763-682-7717
Sherburne County Public Health 763-241-2764

ONE CALL FOR HELP

United Way........ www.unitedwayhelps.org | 211 or 1-800-543-7709
- Food & clothing help

Neighborhood Health Care Network .... 651-489-2273 or 1-866-489-4899

DENTAL RESOURCES

Ronald McDonald Dental Van 763-682-7456
- Kids & Pregnant Women Only

School of Dentistry U of M........ 612-624-8400
Community Dental Clinic St. Cloud Tech........ 320-308-5310
Children's Dental Services, Minnetonka........ 612-746-1530
Herzing University of Dental Hygiene........ 763-231-3174
Area Dental Care Resource List .... www.cdf-mn.org.healthcare/dental.htm

VISION RESOURCES

Glasses .... www.zennioptical.com

InfantSee .... www.infantsee.org
- Vision checks for babies 6-12 months

PRESCRIPTION RESOURCES

www.HelpingPatients.org
www.ppax.org 1-800-333-2433
www.MinnesotaRxConnect.com
www.familywize.org

COUNSELING/MENTAL HEALTH

Catholic Charities 1-800-830-8254
Central MN Mental Health Center, Buffalo........ 763-682-4400
Central MN Mental Health Center, Monticello........ 763-295-4001
Crisis Connection 612-379-6363
Emergency Psychiatric Services 1-800-635-8008
Family Counseling Center........ 763-682-5420
Four County Crisis Response Team........ 1-800-635-8008 or 320-253-5555
- Non-emergency:........ 320-257-6088

Lutheran Social Services........ 1-888-881-8261
Minnesota Mental Health........ www.mnmentalhealth.org | 320-253-4136
- Early Childhood
- Children
- Adult

STARS Mental Health .... 763-271-5322 or 1-877-333-0083
Wright County Human Services 763-682-7400

CLINICS – LOCAL

Albertville-St. Michael Clinic 763-684-8300
Allina Annandale 320-274-3744
Allina Buffalo 763-682-5225
Allina Cokato........ 320-286-2123
Allina St. Michael........ 763-744-4000
Buffalo Clinic 763-682-1313
Clearwater Clinic 320-558-2293
Monticello Clinic........ 763-295-2921
New River Physicians, Monticello........ 763-295-3100
NOW Medical, Albertville 763-315-5000
NOW Medical, Rogers 952-593-9818
Ridgeview Delano 763-972-9172
Ridgeview Howard Lake........ 320-543-2591
Urgent Care, Buffalo 763-684-3696
Urgent Care, Monticello........ 763-271-3896

Medical Skin Care Center of Buffalo Clinicwww.minnesotaskin.com | 763-684-3700
- Microdermabrasion
- Chemical Peel
- Dermal Fillers
- Vascular Lesion Treatments
- Varicose Veins Procedure
- Hair Removal

Recover Health 320-774-0777
- Medicare Services (Nursing care, Daily activities assistance)
- Personal Care Services
- Therapy Services (Physical, occupational, speech, and respiratory therapies)

CLINICS – LOW COST

Mid MN Family Practice Center, St. Cloud 1-800-575-2982

St. Mary's Health Clinics 651-690-7029

HOSPITALS

Buffalo Hospital
- Pre-Diabetes Classes..763-682-5225
- Community Wellness Programs
- Wellness Campaigns
- Fitness Services
- Rehabilitation Services at Sister Kenny Rehabilitation
- Nutrition Services

New River Medical Center, Monticello 763-295-2945

Ridgeview Medical Center, Waconia 952-442-2191

St. Cloud Hospital 1-800-835-6652

OTHER

Help Me Grow..763-682-6361 or 1-800-286-6331
- Infant and Children

Medical Referral Line 1-866-489-4899

Minnesota Care 763-682-7414

SAGE – Breast Cancer Screening..1-888-643-2584

Senior Drug Program & Senior Linkage Line 1-800-333-2433

WOW Van – Wright County Public Health..763-682-7717

Housing

WRIGHT COUNTY HOUSING RESOURCES

ASSISTED LIVING	LOCATION	PHONE	UNITS
Centennial Villa	Annandale	320-274-5031	2
Lake Ridge Manor	Buffalo	763-682-1434	3
Park Terrace Assisted Living & Memory Care Buffalo www.elimcare.org	Buffalo	763-951-7859	4
Sunrise – Buffalo www.sunriseassistedliving.com	Buffalo	763-682-5489	6
Sunrise Cottages (AL, ML) www.sunriseassistedliving.com	Buffalo	763-682-9366	4
Brookridge www.cokato-senior-care.org	Cokato	320-286-3196	1
Legacy of Delano (AL, ML)	Delano	763-972-2333	5
Legacy of St. Michael (I, AL, ML) www.twdcc.com/legacystmichael	St. Michael	763-497-0171	7
St. Benedict Senior Community/			
The Village (I)	Monticello	763-295-4051	6
The Court (AL)	Monticello	763-295-4051	4
The Court Memory Care (ML)	Monticello	763-295-4051	1
Lighthouse at Waconia	Waconia	952-442-1261	1
Assisted Living Services of Winsted	Winsted	320-485-4271	4

I=Independent Living, AL=Assisted Living, ML=Memory Loss

LOW INCOME	LOCATION	PHONE	UNITS
Pheasant Ridge Apts	Albertville	763-295-5804	2
Annandale Square Apts.	Annandale	320-274-5206	3
Buffalo Court (families/children)	Buffalo	763-684-1907	4
Lakeside West & Lakeside East	Buffalo	763-682-2485	3
Maple Dell	Buffalo	952-935-0359	1
Maria Villa	Buffalo	763-512-7721	1
Clearwater Parkview	Clearwater	763-633-1955	1
Clearwater River Apts.	Clearwater	952-935-0359	1
Cokato Park View	Cokato	763-263-1955	2
Golf View Apts.	Cokato	320-286-4480	4
Delano FourPlex	Delano	763-232-1256	4

East Riverview Apts.	Delano (Caretakers)	612-685-5032	38
Honeytree Apts.	Delano	612-986-7787	25
Howard Lake Apts.	Howard Lake	320-274-5871	24
Howard Lake 5-Plex	Howard Lake	763-232-1256	5
Hillside Terrace I & II #28	Monticello	763-295-5804	48
Ridgemont Apts.	Monticello	320-295-3736	48
Ridgeway Apts.	Monticello	763-295-5081	44
*Terrace View Apts.	Monticello	763-263-1955	26*
HALTER Oaks Apts.	Rockford	800-676-6505	24
Rockford 4-Plex	Rockford	763-232-1256	4
Walnut Place Townhomes	Rockford	763-477-4681	30
Waverly 3-Plex (314 Elm Ave.)	Waverly	763-232-1256	3

** Units – May not all be subsidized housing*

SENIOR HOUSING	LOCATION	PHONE	UNITS
Cottages of Albertville	Albertville	763-497-0858	44
Centennial Villa (ML)	Annandale	320-274-5031	40
Cottages of Annandale	Annandale	320-274-2818	36
*Goldendale Apts.	Annandale	320-274-5871	24*
Knollwood Square Apts.	Annandale	320-274-2506	17
*Oakdale Apts.	Annandale	952-935-0359	18*
Autumn Winds Apts.	Big Lake	763-441-1733 or 1-888-424-1733	25
*Barrington Apts. www.barrington@tiestalle.com	Buffalo	763-274-2700	20*
*Lake Ridge Manor	Buffalo	763-682-6763, ext. 27	39*
*Lakeside East Apts.	Buffalo	763-682-2485	39*
Park Lane Apts.	Buffalo	763-682-1131	48
Village Place Apts.	Buffalo	763-682-4128	48
Woodmere Apts.	Buffalo	763-682-3240	54
*Cokato Senior Apts. I, II, III, IV	Cokato	320-286-2758	83*
Edgewood Gables	Cokato	320-286-2159	30
Heritage Place (ML)	Cokato	320-286-2158	10
*Crow River Villa	Delano	763-972-29454	30*
Delano Commons	Delano	763-972-2930	29
*Ridge Manor Apts.	Delano	763-972-2945	16*
*Heritage Square	Howard Lake	320-543-3331	24*
Howard Lake Apts.	Howard Lake	320-274-5871	24

Shoreline Commons	Howard Lake	320-543-2663	24
*Maple Manor	Maple Lake	320-963-5283	62*
*Broadway Square Apts.	Monticello	763-263-1955	28*
*Cedar Crest Apts.	Monticello	763-295-4242	38*
Mississippi Shores	Monticello	763-295-2787	49
Ridgemont Apts.	Monticello	763-295-3736	48
*River Park View	Monticello	763-263-1955	31*
St. Benedict Senior Community	Monticello	763-295-4051	60
The Village (St. Benedict's)	Monticello	763-295-4051	60
*Rosehaven I, II	Montrose	763-675-3303	30*
*Rockford Manor Apts.	Rockford	651-433-3247	24*
Autumn Trails of Rogers	Rogers (Hennepin)	651-645-7271	20
*Pleasant Place Apts.	Rogers (Hennepin)	763-428-4494	24*
Cottages of St. Michael	St. Michael	763-497-4901	28
Ridge Drive Apts. I, II	St. Michael	952-941-7347	42
Elim Meadows	Watertown (Carver)	952-955-3784	11
*Waverly Community Homes #200	Waverly	1-888-203-9301	16*

I=Independent Living, AL=Assisted Living, ML=Memory Loss
**Units – May not be subsidized housing*

HOUSING ASSISTANCE AND REPAIR

Wright County Community Action, Box 787, Maple Lake, MN 55358
PHONE: 320-963-6500
FAX: 320-963-5745
WEBSITE: www.wccaweb.com
SERVICES PROVIDED: Repairs and weatherization – Insulation, weather stripping and emergency fund for fuel. (Service is available for low income seniors).

Section 8: Housing/General: 612-370-3000 Rental Only	320-252-0880
Homes Plus, Seniors	-800-333-2433
MFIP emergency Assistance	763-682-7414
Project Off-Streets for Youth	612-252-1200
Wright County Community Action	320-963-6500
Wright County Human Services	763-682-7400

Law and Legal Services

DOMESTIC VIOLENCE

Anna Marie's.....www.annamaries.org | 320-253-6900
Safe at Home .....651-201-1399 or 1-866-723-3035
(domestic violence survivors program)
Emergency Only.....911
First Call For Help 211

LAW ENFORCEMENT

Annandale Police 320-274-3278
Buffalo Police 763-682-5976
Howard Lake Police.....320-543-3111
Minnesota State Patrol.....320-255-4224
Wright County Sheriff.....763-682-1162

LEGAL SERVICES

Attorney Referral, MN State Bar.....1-800-292-4152
Central MN Legal Services.....1-800-622-773

MISSING CHILDREN

Find the Children.....1-888-477-6721
Jacob Wetterling Resource Center.....320-325-4673
Missing Children MN.....612-334-9449 or 1-888-786-9355
National Center for Missing & Exploited Children 1-800-843-5678

SENIOR SUPPORT

SENIOR PROGRAMS

60+ and Healthy Clinics .....763-682-7456, or 800-362-3667, ext. 7456
- Foot care
- Blood pressure
- Education

Faith in Action 763-234-3586
Homes Plus, Seniors.....1-800-333-2433
Recover Health Agency.....320-774-0777
- Medicare Services
  - Nursing care
  - Daily activities assistance
- Personal Care Services
- Therapy Services
  - Physical, occupational, speech, and respiratory therapies

Senior Linkage Line 1-800-333-2433
Social Security 1-800-772-1213
United Way.....211
From a cell phone, call: 651-291-0211
Wright County Senior Transportation 763-684-2343
- Howard Lake.....320-543-2444

SENIOR SERVICES

Faith in Action 763-234-3586

Support

CHEMICAL DEPENDENCY

1-800-ALCOHOL (referrals).....1-800-252-6465
24 hr. emergency.....1-800-635-8008
Al-Anon Hotline.....1-800-344-2666
Syringe Access Information.....1-800-248-2437
Alcoholics Anonymous (A.A.).....952-922-0880
Central MN Mental Health Center, Buffalo.....763-682-4400
Central MN Mental Health Center, Monticello.....763-295-4001
Detox.....320-252-6654
Maple Lake & Prairie House Recovery Center.....320-963-6865
M.E.A.D.A. 763-682-7713
Narcotics Anonymous Helpline.....952-939-3939
New Beginnings at Waverly 1-800-487-8758

CRIME VICTIMS

Central MN Sexual Assault Center .....320-251-4357 or 1-800-237-5090
cmsa@cmsac.org
Crime Victim Assistance (Wright County) 763-682-7349
Safe at Home .....651-201-1399 or 1-866-723-3035
(domestic violence survivors program)

EATING DISORDERS

Melrose Institute, Park Nicollet 952-993-6200
Eating Disorder Program, St. Cloud 320-229-4918
National Eating Disorders Hotline 1-800-931-2237

EDUCATIONAL SERVICES

Dassel-Cokato ALC 320-286-4100
Delano ALP 763-972-3365
Early Childhood Family Education 763-682-8780
Family Education Centers (Parenting) 763-682-7464
GED-Adult Education .... 763-682-8770 or 763-272-2040
Head Start
- Head Start 320-963-6500
- Migrant & Seasonal Early Head Start .... 763-272-2965 or 1-800-201-3461

PACER 1-800-53PACER
Phoenix, Buffalo ALP 763-682-8680
Teen Parent Program, Wright Technical Center 763-682-2792
The Knight's Academy, St. Michael ALP 763-497-6575
Parenting Through Divorce 763-682-7394
Resource Training & Solutions (Family Education) 1-888-447-7032
Turning Point, Monticello ALP 763-272-3200
Wright County Early Intervention Project 763-682-8722
Wright Technical Center of Buffalo 763-682-2792

GAY/LESBIAN SUPPORT

PFLAG Helpline (for parents) 612-852-1660
Youth & AIDS Project 612-627-6820

STDS & HIV/AIDS

MN AIDS Hotline 1-800-248-2437
Hennepin County Public Health Clinic, Minneapolis 612-543-5555
STD Hotline .... 1-800-783-2287 West Suburban Teen Clinic, Excelsior
952-474-3251
Wright County Public Health 763-682-7456

SUICIDE

American Suicide Foundation (Survivors) 1-888-333-2377
SAVE .... 952-946-7998 or 1-800-784-2433
- Teen Suicide Prevention
- Symptoms of Depression in Teens

Suicide Crisis Hotline, Local 1-800-635-8008
Suicide Prevention Lifeline National 1-800-273-8255
Suicide Prevention Lifeline Spanish 1-888-628-9454

SUPPORT GROUPS

Diabetes Support Group
- Cub Food, Buffalo
- Third Wednesday of each month
- 6:30-7:30 p.m.

Wright County Human Services 763-682-7400
Stroke Support Group ...sisterkennyinstitute.com | 763-684-3855 or 763-684-3888

Women's and Children's Services

BIRTH CONTROL/PREGNANCY TESTING

Minnesota Family Planning Hotline 1-800-783-2287
Minnesota Family Planning Hotline .... Text – 36263
Monticello Birthright 763-295-2232
Planned Parenthood Minnesota .... www.ppmns.org/4now | 1-800-230-PLAN
West Suburban Teen Clinic, Excelsior 952-474-3251
Wright County Public Health 763-682-7456
Wright Women's Health, WCCA 320-963-6500

CHILD CARE

Child Care Assistance, Human Services 763-682-7414
Child Care Choice Referral Network 1-800-288-8549

Child Care Listing .... 763-682-7400 or 1-800-362-3667

Child Care Resource & Referral 320-251-508, ext. 501 or 1-800-288-8549, ext. 501
- Ideas for activities and teaching tools
- Support for:
  - First aid kit
  - Fire extinguisher
  - Outlet covers
  - Safety gate
  - Equipment such as a high chair or portable crib
  - Toys that teach

CRISIS NURSERY

Crisis Nursery .... 763-271-1681 or 1-800-965-1430

Kindred Minnesota, Inc. .... 763-271-1681 or 1-800-965-1430
- Crisis Nursery

NEW MOTHERS

Lactation Specialist
- New River Medical Center.. 763-271-2218
- Buffalo Hospital 763-682-1212

La Leche League ....320-252-8467 or 320-230-1515 or 320-363-1110

Nursing Mothers' Support Group 763-682-8780

Wright County Services

WRIGHT COUNTY COMMUNITY ACTION

320-963-6500

- Clothing & Food Shelf
- Energy Assistance
- Family Budgeting Services
- Family Planning
- Foreclosure Counseling
- Head Start
- Home Buyer Training
- Transitional Housing
- WIC

WRIGHT COUNTY AGENCIES

Wright County Human Services .... 763-682-7414 or 1-800-362-3667

- Financial Services.. 763-682-7414
- Social Services 763-682-7400
  - Child Protection 763-682-7449
  - Vulnerable Adult Protection... 763-682-7481
  - Adoption
  - Foster Care
  - Chemical Dependency
  - Mental Health Services
  - Transportation
    - Specialized Transportation
    - Volunteer Transportation.......................Kathy DeMars at 763-682-7487 or 800-362-3667
    - River Rider/Heartland Express...............763-263-0101 or 800-821-9719
- Public Health... 763-682-7456
  - 60+ and Healthy Clinics ....763-682-7456 or 800-362-3667, ext. 7456
  - Pregnancy Support
  - Parenting Program
  - Environmental Services
  - Wellness on Wheels Van – WOW van .... 763-682-7717 or 800-362-3667, ext. 7717
    - Food Support (Food Stamp) Benefits
    - Healthy Adult Program
    - Healthy Family Program
    - Well-Child Checkups
      - 6 month to 20 years
    - Infant & Child Weight & Height Checks
    - Dental Wellness Program
    - Immunizations
    - Cholesterol testing
    - Wellness Programs
    - Lead Poison Screening
    - Community Resources
    - Screens (Blood Pressure, Radon Testing, Well Testing Kit, Pregnancy, Diabetes
    - Child Car Seat Checks
- Live Wright.......................... joel.torkelson@co.wright.mn.us | 763-682-7909
  - Health Promotion
  - Reduce smoking
  - Reduce obesity
  - Healthy lifestyle

Wright County Government Center
- Legal clinic at the Law Library 763-682-7592

Miscellaneous

HOT LINES

Central MN Mental Health Center 1-800-635-8008
Crisis Nursery in Wright County 1-800-965-1430
Disability Linkage Line 1-866-333-2466
Domestic Abuse 1-800-439-2642
Emergency Contraception 1-888-668-2528
Gambling Addiction 1-800-437-3641
MN AIDS Line 1-800-248-2437
MN Arson Hotline 1-800-723-2020
MN Family Planning Hotline 1-800-783-2287
MN Immunization Hotline 1-800-657-3970
MN Tobacco Helpline 1-877-270-STOP
National Child Abuse Hotline 1-800-422-4453
National Runaway Hotline 1-800-621-4000
Poison Control 1-800-222-1222
Sexual Assault Center 1-800-237-5090
STD Hotline 1-800-783-2287
Suicide Crisis Hotline 1-800-635-8008
Senior Linkage Line 1-800-333-2433

ABUSE/ASSAULT/NEGLECT/PROTECTION

Anna Marie's. St. Cloud 1-800-950-2203
Alexander House 1-866-223-1111
Bridge for Runaway Youth 612-377-8800
Casa de Esperanza (Spanish) 651-772-1611
MN Domestic Violence Crisis Line 1-866-223-1111
National Child Abuse Hotline 1-800-422-4453
Parent Warm Line 612-813-6336
Rivers of Hope .... 763-295-3433 or 1-800-439-2642
Wright County Child Protection 763-682-7400
Wright County Vulnerable Adult 763-682-7400

BUDGETING/FINANCIAL ASSISTANCE

Social Security 1-800-772-1213
The Village Financial Resource Center 1-800-450-4019
Wright County Community Action 320-963-6500
Wright County Human Services 763-682-7414

EMERGENCY ASSISTANCE

American Red Cross Disaster Service 1-800-560-7641
Salvation Army in Wright County 763-682-8941
Wright County Community Action 320-963-6500
Wright County Human Services` 763-682-7414

EMPLOYMENT

Functional Industries 763-682-4336
Work Force Center/Jobs & Training, Monticello .. 763-271-3700 or 1-800-284-7425
Work Connection, Buffalo 763682-5524

TRANSPORTATION

River Rider Public Transportation 1-800-821-9719
Wright County Senior Transportation 763-684-2343

MISCELLANEOUS (OTHER)

Adult Disease Epidemiology (MN Department of Health)
- Reporting foodborne illness

Buffalo Adult Day Center .... www.elimcare.org/adultdaycenter | 763-684-0803

Fathers' Adoption Registry (MN Department of Health.................. 1-800-627-3529
- Register MN fathers in order to protect the father's rights in the adoption process

Follow Along Program .... 763-684-2312 or 1-800-362-3667, ext. 2312

Institute for Alternative Dispute Resolution 320-308-4962
- www.stcloudstate.edu/continuingstudies/instituteadr
- Conflict resolution with a mediator

National Pesticide Information ....Centernip.orst.edu | 1-800-858-7378
- Are pesticides safe if you are pregnant or have children

New Weigh of Life 763-271-3800
- At Monticello Clinic
- Medic Weight Management Program

United Way.. www.21unitedway.org

Calling from a land line..211

Calling from a cell phone 651-291-0211

Find local information about:

- Education
- Health Services
- Legal Heal
- Transportation
- Senior Services
- Youth Services
- Senior Services
- And much more

Bridge to Benefits .... www.bridgetobenefits.org

- Helps families determine eligibility for food support, school meal programs and health care programs, as well as Energy Assistance, Child Care Assistance and the Earned Income Tax Credit

Health Savings Account (HSA): ....www.treas.gov/offices/public-affairs/hsa

- For people enrolled in a high deductible health plan

Free Tax Preparation

- Tri-Cap .... 320-251-1612 or 1-888-765-5597 | www.tricap.org
  - Free Tax Prep
  - Financial Coaching and Credit Advice

To sign up for our free e-newsletter
"*Choose Wellness*" go to
buffalohospital.org

Allina Health

BUFFALO
HOSPITAL

303 Catlin Street
Buffalo, MN 55313
763-682-1212

buffalohospital.org

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BUFFALO HOSPITAL
NORTHWEST REGIONAL

Appendix L

CADCA's Seven Strategies for Community Change

Community Health Needs Assessment and Implementation Plan 2014–2016

CADCA's National Coalition Institute

Defining the Seven Strategies for Community Change

1. Providing Information – Educational presentations, workshops or seminars or other presentations of data (e.g., public announcements, brochures, dissemination, billboards, community meetings, forums, web-based communication).

2. Enhancing Skills – Workshops, seminars or other activities designed to increase the skills of participants, members and staff needed to achieve population level outcomes (e.g., training, technical assistance, distance learning, strategic planning retreats, curricula development).

3. Providing Support – Creating opportunities to support people to participate in activities that reduce risk or enhance protection (e.g., providing alternative activities, mentoring, referrals, support groups or clubs).

4. Enhancing Access/Reducing Barriers- Improving systems and processes to increase the ease, ability and opportunity to utilize those systems and services (e.g., assuring healthcare, childcare, transportation, housing, justice, education, safety, special needs, cultural and language sensitivity).

5. Changing Consequences (Incentives/Disincentives) – Increasing or decreasing the probability of a specific behavior that reduces risk or enhances protection by altering the consequences for performing that behavior (e.g., increasing public recognition for deserved behavior, individual and business rewards, taxes, citations, fines, revocations/loss of privileges).

6. Physical Design – Changing the physical design or structure of the environment to reduce risk or enhance protection (e.g., parks, landscapes, signage, lighting, outlet density).

7. Modifying/Changing Policies – Formal change in written procedures, by-laws, proclamations, rules or laws with written documentation and/or voting procedures (e.g., workplace initiatives, law enforcement procedures and practices, public policy actions, systems change within government, communities and organizations).