Perham Health - 2016
Community Health Needs Assessment and Report

Implementation 2017-2019
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Acknowledgements

Perham Health acknowledges and thanks the following individuals or groups for their input, expertise and collaboration regarding the 2016 Perham Area Community Health Needs Assessment.

These community-focused efforts determine and guide the Implementation Strategies to foster improved community health and wellness.

The following agencies or individuals contributed to the collective process:

- Diane Thorson, Otter Tail County Public Health Director
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- Perham Police Department
- New York Mills Police Department
- Otter Tail County Sheriff’s Department
- City of Perham – Economic Development Director & City Manager
- Perham Chamber of Commerce
- Land of the Dancing Sky Area Agency on Aging
- Otter Tail County Department of Social Services
- Perham Area Community Center
- New York Mills Public School
- Perham Area Public School
- Frazee Public School
- Perham Area Ministerial Association
• Perham School Wellness Committee
• Lakeland Mental Health Center
• Human Resource Directors with: Lund’s, KLN, Bongards, Arvig, Perham Health
• Productive Alternatives, Crisis Stabilization Unit/Services
• Mobile Mental Health Crisis Response Team
• Rethink Mental Health – Perham Community
• Community Mission – Richville United Methodist Church
• United Way of East Otter Tail County
• Kinship of Perham
• Boys & Girls Club of Perham
• Someplace Safe
• Perham Health - Partners in Care Council
• Perham Area Community Members and Stakeholders completing the survey
• Perham Health Senior Leadership Team, Medical Staff, Department Managers and Staff
• Sanford Health

“Community is...

a caring and respectful connection of people working together to solve problems.

It’s a fine human endeavor; as worthy of respect as a good poem, symphony or field goal.”

Mary Pipher,
Author/Psychologist

The Shelter of Each Other
Perham Health
Community Health Needs Assessment
2016

Purpose

The purpose of a community health needs assessment is to develop a comprehensive view of the population’s health. This includes the prevalence of disease, including lifestyle habits and economic or environmental influences that also determine individual and community health.

Community input, along with relevant data helps to:

➢ Identify health outcome trends or needs in the community.
➢ Engage community members and agencies to mutually address identified needs.
➢ Identify available resources that support health and wellness.
In 2012, Perham Health, in collaboration with community partners and stakeholders, completed its first Community Health Needs Assessment. This provided a valuable roadmap for all community partners to collectively advance positive change for individual and public/community health.

The 2012 Community Health Needs Assessment Report is also available for viewing on the Perham Health website.

In 2015-2016, Perham Health partnered again with community agencies and members for a second Community Health Needs Assessment to identify health status, trends and needs of the Perham Health service area. This process continues to provide valuable information for all stakeholders to address community needs as we collectively nurture a healthy community.

A community health needs assessment also functions to help align community needs with a responsive Community Investment/Community Benefit Program. As a non-profit health care organization, Perham Health provides various health-related services to the community and individuals without financial reimbursement for these services. Community outreach programs, care to the uninsured and underinsured, education and workforce development are some examples of community betterment services included in the Perham Health Community Investment/Community Benefit Program.
What is a Healthy Community?

An essential base to a Community Health Needs Assessment is to ask the valuable question: What is a healthy community?

One of the first steps in this process is for individuals and community agencies to recognize that health and wellness is influenced far beyond the walls of a health care organization.

Within similar understanding, health is not just the absence of illness. As an individual and a community; health is created by an environment that supports the physical, emotional and spiritual well-being of those living, working and playing in that same environment.
Lifestyle choice and behavior continues to remain the most significant factor that impacts individual health; therefore effecting community health.

Availability and consumption of healthy foods, environmental supports that naturally invite physical activity into daily routine, and preventive health care delivery are practical and sustainable models for a healthy community. Communities and health care institutions can leverage for these supports; yet their effectiveness is dependent upon patient/individual engagement and action.

There is sincere hope the information presented in the 2016 Perham Community Health Needs Assessment will further invoke energy and creativity for improvement by all stakeholders of health; individual and community. Health starts where we live, learn, work and play.

The information gathered in the Perham Health Community Health Needs Assessment illustrates what we know about physical, social and behavioral factors for health in the community; along with health outcomes related to those factors. The assessment process further invokes discussion and goal-setting to address what we can do as we join forces, to create and sustain healthier lives.
History of Perham Health

The original hospital in Perham (known as St. James Hospital) was opened in 1902 by the Franciscan Sisters, an order of Catholic Sisters headquartered in Little Falls, MN. For over 60 years, the Franciscan Order ran the hospital and provided care to community and neighboring residents. In 1968, the Memorial Hospital and Homes Association took over the hospital facilities and operations. Thereafter, the Perham Hospital District was formed in 1976 to assure the continued success of the community hospital and nursing home.

For the past century, many changes have evolved in health care. Keeping step with these changes, Perham Health has gained new services, doctors, innovative technologies, and facilities. Perham Health has a large network of medical professionals and services from our affiliation with Sanford Health. In concert with the Sanford affiliation and a rural community that prides itself on progressive ideas and services; Perham Health has earned a reputation of health care innovation and leadership for the region.

In order to continue to promote health and wellness, we began construction on a new facility in 2009. The $38 million facility covers 120,000 square feet and provides patients and their families with the support and care they need in a comfortable healing environment. The building is designed to support patient and family-centered care, future growth, energy efficiency, and sustainable practices. The new Perham Health facility opened its doors in January 2012, during our 110th year of operation.
Perham Health - Description

Perham Health is a public, non-profit health care organization owned and governed by 10 rural townships and 3 communities (Perham, Dent and Richville) all within a geographic area known as a Hospital District.

Perham Health is fully owned by the Perham Hospital District and includes a twenty-five bed critical access hospital, three primary care clinics, a ninety-six bed skilled nursing facility, retail pharmacy with durable medical equipment, home care agency and market-rate senior housing building. In addition, Perham Health manages an ambulance service (Perham Area Emergency Services) and all Perham Area EMS employees employed through Perham Health. Within all entities noted prior; Perham Health has 565 employees and is a significant contributor to the economic and social vitality of the communities served.

Perham Health has a management agreement with Sanford Health and has had this type of arrangement or its predecessors for 30+ years. The CEO (Chief Executive Officer) and the Leadership Team of Perham Health are employed by Sanford, and by contract, must represent the best interests of the Hospital District.

The primary duty of the Perham Hospital District Board of Trustees is to see that the healthcare needs of the district are met and the operations of the Perham Hospital District are sustainable and successful. In summary, the Board of Trustees retains a governance role while Sanford upholds a management role.

Perham Health leases physicians from Sanford to work in Perham’s hospital and three medical clinics. The physician group serving Perham Health includes nine family medicine physicians, one internal medicine/pediatric physician, seven mid-level providers (FNP or PA), one emergency services physician, one obstetrician, two surgeons, and three doctors of chiropractic. Visiting specialists include oncology, psychiatry, psychology, cardiology, urology, orthopedics and diabetic education.

The primary clinic is located in Perham with two satellite clinic offices located in the towns of Ottertail (10 miles south of Perham) and New York Mills (10 miles east of Perham).
Description of Community Served

Perham Health is located in the city of Perham (population 2,985)\(^1\), in the northern portion of Otter Tail County in west central Minnesota. The Perham Hospital District encompasses an area covering approximately 180 square miles, with an estimate of 15,000 people living within the Hospital District area. The service area expands beyond the District borders with estimation of an additional 10,000 people. Geographically, the Perham Health service area involves an approximate 20-25 mile radius from Perham circling the northern portion of Otter Tail County and extending into portions of Becker, Wadena and Hubbard Counties.

According to 2010 U. S. Census Data, the population in the District’s primary service area has increased approximately 3% since 2000. The Minnesota State Demographic Center projects continuation of this growth pattern, estimating another 3-5% population increase for Otter Tail and Becker County by 2020.

Perham offers a vast amount of job opportunities in the agriculture, manufacturing, and tourism industries. Health care, child care, education and social service jobs are also areas of job growth for the Perham area. Employment in Perham grew by 13.6% in a five year span. Economic development reports for the Perham area note 3,886 jobs available.\(^2\) All of these factors influence Perham Health services and its health care impact for the greater community.

Statistics gathered for the 2010 Census found the elderly dependency ratio (the # of individuals age 65+ divided by the # of individuals, ages 15-64 – typical working age population) for Otter Tail County was 34.25, compared to the MN state ratio of 19.20.\(^3\) The number of Minnesotans turning 65 in the decade spanning 2010 to 2020 will be greater than the past four decades combined.

\(^1\) U.S. Census Bureau, 2010
\(^3\) Source – Minnesota Department of Health Statistics - 2012
At the same time, around 2020, Minnesota’s 65+ population is expected to eclipse the ages 5-17, K-12 population, for the first time in history. In 2020, the elderly dependency ratio is expected to be 44.25 in Otter Tail County and 24.72 in Minnesota.

By 2030, more than 1 in 5 Minnesotans will be an older adult. Most of the baby boom generation will be over 85, a category currently described as the “oldest old”. The elderly dependency ratio for Otter Tail County in 2030 is anticipated to rise to 63.80 and 33.96 for the state of Minnesota. Due to increased longevity, Minnesota’s fastest growing population segment is that of people over 80, a group that requires the highest level of support to maintain health, independence and quality of life. The effects of these trends are highly pertinent to community services and resources, further impacting health care, work force needs and economic revenues.

Number of People Served

As a rural hospital, much like a majority of Minnesota rural health care providers today, Perham Health serves a significantly high percentage of elderly. 75% of the hospital admissions (excluding OB and newborns) for Fiscal Year 2015 were ages 65 years old and above, with the greatest majority within that category older than seventy years of age (69%). Management of chronic diseases becomes more challenging for the elderly; as is clearly reflected in the hospital admission primary diagnoses data for Perham Health. Heart disease, chronic obstructive pulmonary disease, stroke and pneumonia are the primary diagnoses within this age group necessitating hospitalization at Perham Health in 2015.
The following information provides a snapshot of services to provide further data and understanding of how many people were served by Perham Health for Fiscal Years 2012 through 2015.

### Perham Health Utilization Statistics Fiscal Years 2012-2015

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<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>Nursing Home</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident Days</td>
<td>32,995</td>
<td>33,066</td>
<td>32,975</td>
<td>33,229</td>
</tr>
<tr>
<td>Long-Term Occupancy %</td>
<td>94.0%</td>
<td>94.8%</td>
<td>94.1%</td>
<td>94.6%</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits</td>
<td>14,315</td>
<td>14,480</td>
<td>15,215</td>
<td>13,576</td>
</tr>
<tr>
<td><strong>Out-Patient Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy Visits</td>
<td>23,887</td>
<td>22,294</td>
<td>24,053</td>
<td>21,554</td>
</tr>
<tr>
<td>Occupational/Speech Therapy Visits</td>
<td>13,662</td>
<td>16,221</td>
<td>15,749</td>
<td>12,232</td>
</tr>
<tr>
<td>Clinic Visits</td>
<td>38,479</td>
<td>37,605</td>
<td>37,149</td>
<td>36,404</td>
</tr>
<tr>
<td>Laboratory Visits</td>
<td>225,943</td>
<td>205,440</td>
<td>191,290</td>
<td>201,484</td>
</tr>
<tr>
<td>Radiology Visits</td>
<td>13,917</td>
<td>12,785</td>
<td>12,600</td>
<td>11,659</td>
</tr>
<tr>
<td><strong>Hospital/In-Patient Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Dept. Visits</td>
<td>6,563</td>
<td>6,035</td>
<td>5,548</td>
<td>5,498</td>
</tr>
<tr>
<td>Patient Days – Acute</td>
<td>2,174</td>
<td>2,013</td>
<td>2,101</td>
<td>2,237</td>
</tr>
<tr>
<td>Patient Days – Swing Bed</td>
<td>523</td>
<td>290</td>
<td>299</td>
<td>255</td>
</tr>
<tr>
<td>Patient Days – Newborn</td>
<td>294</td>
<td>295</td>
<td>258</td>
<td>250</td>
</tr>
<tr>
<td>Acute Admissions</td>
<td>636</td>
<td>590</td>
<td>661</td>
<td>701</td>
</tr>
<tr>
<td>Acute average length of stay</td>
<td>3.41</td>
<td>3.39</td>
<td>3.16</td>
<td>3.19</td>
</tr>
<tr>
<td>In-Patient Lab Services</td>
<td>34,597</td>
<td>28,400</td>
<td>32,635</td>
<td>26,472</td>
</tr>
<tr>
<td>In-Patient Surgeries</td>
<td>147</td>
<td>126</td>
<td>126</td>
<td>162</td>
</tr>
<tr>
<td>Same-day Surgeries</td>
<td>1,409</td>
<td>1,233</td>
<td>1,151</td>
<td>1,188</td>
</tr>
</tbody>
</table>
Study Design and Methodology

The Perham area community health needs assessment was conducted during FY 2015. Surveying the community at large, information gleaned from focus groups with community stakeholders and analyzing health statistical data was a cooperative project with individuals and groups as noted in the acknowledgements section.

Survey Instrument

Staff from the public health agencies of Becker, Clay, Otter Tail and Wilkin counties in Minnesota developed the questions for the survey instrument with technical assistance from the Minnesota Department of Health Center for Health Statistics. Existing items from the Behavior Risk Factor Surveillance System (BRFSS) survey and from recent county-level surveys in Minnesota were used to design some of the items on the survey instrument. The survey was formatted by the survey vendor Survey Systems, Inc. of New Brighton, MN.

The survey tool can be seen as Appendix H in this Community Health Needs Assessment Report. A review of the categories and questions may provide better understanding when reviewing results of the survey for our service area.

Sample

A two-stage sampling strategy was used for obtaining probability samples of adults living in each of the five counties. A separate sample was drawn for each county. For the first stage of sampling, a random sample of county residential addresses was purchased from a national sampling vendor (Marketing Systems Group of Horsham, PA). Address-based sampling was used so that all households would have an equal chance of being sampled for the survey. Marketing Systems Group obtained the list of addresses from the U.S. Postal Service. For the second stage of sampling, the “most recent birthday” method of within-household respondent selection was used to specify one adult from each selected household to complete the survey.
Survey Administration

An initial survey packet that included a cover letter, the survey instrument, and a postage-paid return envelope was mailed August 19-20, 2015, to 1,600 sampled households in each of the five counties. About 10 days after the first survey packets were mailed (September 1), a reminder postcard was sent to all sampled households, reminding those who had not yet returned a survey to do so, and thanking those who had already responded. Two weeks after the reminder postcards were mailed (September 11 and 14), another full survey packet was sent to all households that still had not returned the survey. The remaining completed surveys were received over the next six weeks, with the final date for the receipt of surveys being October 21, 2015.

Completed Surveys and Response Rate

Completed surveys were received from 1,920 adult residents of the five counties; thus, the overall response rate was 24.0% (1920/8000). Otter Tail County residents surveyed provided the highest response rate of the five counties. County-specific response rates were:

<table>
<thead>
<tr>
<th>County</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>BECKER, MN</td>
<td>22.9%</td>
</tr>
<tr>
<td>CLAY, MN</td>
<td>21.6%</td>
</tr>
<tr>
<td>OTTER TAIL, MN</td>
<td>27.3%</td>
</tr>
<tr>
<td>WILKIN, MN</td>
<td>26.3%</td>
</tr>
<tr>
<td>RICHLAND, ND</td>
<td>21.9%</td>
</tr>
</tbody>
</table>
Data Entry and Weighting

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

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

Community Stakeholder Involvement

The survey results, along with relevant health data were reviewed with community, county and regional stakeholders at a one-half day retreat in March 2016; co-hosted by Perham Health and Otter Tail County Public Health. Areas of discussion also included: 1) forces of change (trends, events or factors) that have occurred recently, that may affect public health and the community. Review of community resources and assets also occurred as stakeholders shared anecdotal and numerical data affecting overall community health.

In addition, the following data sets were reviewed to assist in the Community Health Needs Assessment process:

- Community Health Needs Assessment Surveys of Otter Tail County residents
- 2015-16 County Health, Aging and Diversity Profiles for Otter Tail County
- Statewide Health Assessment Data from MN Department of Health
- Top diagnoses/profiles for all inpatients at Perham Health, 2015
- Perham Health Quality Performance Data
- 2010 Census Findings
- 2016 Robert Wood Johnson Foundation “County Health Rankings and Profiles”

4 www.countyhealthrankings.org/minnesota
Key Findings

Survey Responses

The survey provided information related to top health concerns of respondents own perceived health status accompanied by assessment of each respondents’ health-sustaining behaviors. This data was further evaluated and compared with local, county and state health data.

The survey provides opinion in level of agreement regarding community needs and assets. Likewise, various questions prompted community opinion in level of concern about health, health care access, economic issues, services and resources, transportation, environmental pollution, youth concerns and safety concerns; all part of the equation for health and wellness. Perceived health status accompanied by assessment of each respondents’ health-sustaining behaviors was also surveyed.

The information was reviewed and presented at various stakeholder focus groups and the March 2016 stakeholder retreat.

Top Areas that Otter Tail County residents/survey respondents report they are most concerned about:

<table>
<thead>
<tr>
<th>Community Health Concern</th>
<th>% of survey respondents Stating Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to affordable health insurance</td>
<td>73.8%</td>
</tr>
<tr>
<td>Access to affordable health care</td>
<td>70.2%</td>
</tr>
<tr>
<td><strong>Mental Health Issues</strong></td>
<td></td>
</tr>
<tr>
<td>• Perceived presence of illegal drug use, prescription drug abuse and alcoholism</td>
<td>70.8%</td>
</tr>
<tr>
<td>• Stress</td>
<td>56.0%</td>
</tr>
<tr>
<td>• Domestic Violence</td>
<td>53.3%</td>
</tr>
<tr>
<td><strong>Physical Health Determinants/Issues</strong></td>
<td></td>
</tr>
<tr>
<td>• Obesity</td>
<td>61.3%</td>
</tr>
<tr>
<td></td>
<td>55.2%</td>
</tr>
</tbody>
</table>
Demographic characteristics of the 426 survey respondents (27.3% return rate) from Otter Tail County include:

* 58.7% female
* 41.3% male
* 68.8% with some college education or higher
* 50% in age group 65+ years old
* 61% with income greater than $40,000
* 51.7% are retired
* 84.7% have lived in the county for more than 5 years
* 85.9% own their home

State, County and Local Health Assessment Data

County Health Rankings

The County Health Rankings report ranks Minnesota counties according to their summary measure of health outcomes and health factors. Counties also receive a rank for mortality, morbidity, health behaviors, clinical care, social and economic factors and the physical environment. Within this model of understanding; it can be further implied how each factor contributes to the overall health of individuals and communities. Numerically understood, 80% of health outcomes are determined by health behaviors, social and economic factors and physical environment; while 20% is determined by clinical care.

The County Health Rankings help counties and local communities understand influential factors that determine individual and community health. Measures that affect the future health of communities, such as high school graduation rates, access to healthy foods, rates of smoking, obesity and teen births.

Comparative data is presented in this report between MN population and Otter Tail County population focused on the above-noted characteristics and measurements of a collective population. National benchmarks for these measurements are also noted. Further
detail is provided in Appendices B and C, attached to this report. On-line information is available at: [www.countyhealthrankings.org](http://www.countyhealthrankings.org)

Due to the Perham Health service area encompassing areas of surrounding counties of Becker, Wadena and Hubbard; data from those counties in their County Health Ranking Report may also be mentioned when relevant. The narrative information provided in the body of this report serves as a general summary.

**Health Outcomes**

The Mortality (length of life) Health Outcomes data indicate that Otter Tail County statistically denotes more premature deaths than the national benchmark.\(^5\)

The Morbidity (quality of life) Health Outcomes data reports that Otter Tail County population has slightly higher prevalence of adults with diabetes than both MN and the national benchmark.\(^6\)

**Health Factors**

The Health Behavior factors indicate Minnesota and Otter Tail County have a higher percentage of adult smokers than the national benchmark.\(^7\) Adult obesity is higher in both the state of Minnesota and county of Otter Tail than the national benchmark. In assessing a weight that is considered healthy for an individual’s height, health care professionals commonly use a mathematical formula (kg/m\(^2\)) that ratios an individual’s weight and height resulting in a number known as the Body Mass Index (BMI). Based on an individual’s BMI, an individual can fall into one of five categories: Underweight (BMI<18.5), Normal/Healthy Weight (18.5<BMI<24.9), Overweight (25<BMI<29.9), Obese (30.0<BMI<39.9), and Extremely Obese (40<BMI). According to the National Diabetes Surveillance System, 27% of the population in Otter Tail County identifies as obese with a BMI of 30 or greater. Furthermore, the average

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\(^5\) Measurement is years of potential life lost before age 75 per 100,000. Otter Tail County 6,500; MN 5,100; National Benchmark 5,200.

\(^6\) Measurement is percentage of adults aged 20 and above with diagnosed diabetes. Otter Tail County 10%, compared to MN 8%, National Benchmark 9%.

\(^7\) Measurement is percentage of adults who currently smoke and have smoked at least 100 cigarettes in their lifetime. Otter Tail County reports, 15%, MN reports 16%, and National Benchmark is 14%.
BMI for citizens in the Perham Hospital District is considered 30.37 making a majority of the population that Perham Health serves either overweight or obese.

Of significant concern for both Minnesota and Otter Tail County is the percentage of adults reporting binge drinking and heavy drinking, considerably higher than the national benchmark.\(^8\) Alcohol is consumed by more people than any other drug, including tobacco. Alcohol use contributes to injury, unplanned pregnancy, poor birth outcomes and childhood development, violence, infectious disease, and chronic disease. The younger a person begins drinking regularly, the greater the chance that person will develop a clinically defined alcohol disorder like alcoholism. Youth who start drinking before age 15, compared to those who start at 21, are far more likely to be injured while under the influence of alcohol, to be in a motor vehicle crash after drinking, or to engage in a physical fight after drinking. About 90 percent of the alcohol consumed by those under 21 occurs via binge drinking. Minnesota’s rate of binge drinking is higher than in most of the rest of the U. S.; although it remains lower than the rates in the surrounding states of South Dakota, North Dakota and Wisconsin.\(^9\)

Correspondingly, the motor vehicle crash death rate for Minnesota (31%) and Otter Tail County (30%) is significantly higher than the national benchmark (14%)\(^10\). In Minnesota, motor vehicle-related injuries are the leading cause of injury-related death for individuals up to the age of 44. Those at greatest risk of injury from traffic crashes are 20-to-24 year old drivers, elderly drivers, male drivers, unbelted

\(^8\) Binge drinking is defined as five or more drinks at one time for men; four or more drinks at one time for women. Otter Tail County reports 19%, MN reports 21% and National Benchmark is 12%.
\(^9\) [www.health.state.mn.us/healthymnpartnership](http://www.health.state.mn.us/healthymnpartnership)
\(^10\) Percent of motor vehicle deaths with alcohol involvement
occupants and unrestrained children. Teenagers and young adults still pay the heaviest price in terms of both deaths and injuries, including traumatic brain injuries and spinal cord injuries.\textsuperscript{11}

Teen birth rate is marginally higher (combined average of data from Otter Tail, Becker, Hubbard and Wadena Counties) than the national benchmark; and significantly higher in the overall state of Minnesota than the national benchmark.\textsuperscript{12} Teen parents and their children face a number of unique challenges. Teen mothers are less likely to graduate from high school, and are more likely to remain unmarried, live in poverty, have large families, and receive government assistance than women who become parents after adolescence. Teen mothers are also less likely to receive timely and consistent prenatal care.\textsuperscript{13}

Clinical Care outcomes note that diabetic screening in Minnesota align with the national benchmark; while Ottertail County data notes a significantly higher percentage of diabetic Medicare enrollees receiving diabetic screening.

The data in this report mirrors community concerns relative to physician availability and access. Accessibility in this report is measured by ratio of population to primary care physicians. In Otter Tail County that ratio is 1 primary care physician for 1,920 people. The national benchmark is 1 physician for every 1,040 people. Statewide, MN data reports 1,100 people for every primary care physician; much closer to the national benchmark. Significant efforts continue for recruitment of primary care physicians to serve this rural community.

Cancer, heart disease, and stroke are the leading causes of death in Minnesota, although the mortality rate for all three diseases has declined over the past ten years. These three diseases have been the leading causes of death in Minnesota for decades. In 2000, cancer surpassed heart disease as the leading cause of death in Minnesota and remains in that pattern.\textsuperscript{14} Unintentional injury, pneumonia, Alzheimer’s disease and diabetes are also significantly represented within mortality statistics for Minnesota and Otter Tail County.

\textsuperscript{11} MN Dept of Health, Health Promotion and Chronic Disease Division. \url{www.health.state.mn.us}

\textsuperscript{14} Minnesota Department of Health, Center for Health Statistics. 
\url{http://www.health.state.mn.us/divs/chs/vitalsigns/2010natmorttrends.pdf}
Chronic diseases and injuries are among the most common and costly health problems facing our state today. The patient population served by Perham Health mirrors these findings.

Management and improvement of individual and community health is influenced by many factors demanding a merger of patient responsibility, health care support and community engagement. Sustainable health demands a balance of all these factors.

The following page provides information with a graphic that clarifies specific influences of health behaviors, clinical care, social and economic factors and the physical environment. It can also provide clearer understanding of data in the County Health Ranking Report with relevance to: 1) length of life, 2) quality of life, 3) health behaviors, and 4) clinical care.
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County Health Rankings model ©2012 UWPHI
Health Needs Identified

2016 Community Health Needs Assessment Key Findings
The survey responses, state, county and local data along with focus group discussions provided a robust platform for community input.

The following needs/concerns were brought forward as focus areas:
- Aging population implications
- Mental Health concerns
- Physical Health management
- Rural transportation challenges

Addressing the Needs

<table>
<thead>
<tr>
<th>Identified Concerns</th>
<th>How Perham Health is Addressing the Need</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aging Population</strong></td>
<td>• Nursing home care provided at Perham Living</td>
</tr>
<tr>
<td>• Long-term care needs</td>
<td>• Short-term rehabilitative care provided in Transitions; post-acute unit at Perham Living</td>
</tr>
<tr>
<td>• Caregiver support</td>
<td>• Home care services available in all home/apartment/assisted-living settings;</td>
</tr>
<tr>
<td>• Transportation</td>
<td>• Memory care services/living supports</td>
</tr>
<tr>
<td>• Access to specialized medical care in local setting</td>
<td>• Adult day services</td>
</tr>
<tr>
<td>• Affordable Housing with services</td>
<td>• Caregiver support meetings</td>
</tr>
<tr>
<td></td>
<td>• Hospice Care Contracts for care in all settings</td>
</tr>
<tr>
<td></td>
<td>• Perham Health/Living contract (within city limits) for van transportation serving elder population.</td>
</tr>
<tr>
<td></td>
<td>• Education/resource/referral to community supports from Perham Health Medical Social Services.</td>
</tr>
<tr>
<td></td>
<td>• Further information can be reviewed with Appendix A – Demonstrating Impact and Implementation Strategies &amp; Action Plan 2017-2019, pages 27-34 of this report.</td>
</tr>
<tr>
<td><strong>Mental Health Concerns</strong></td>
<td>• Contract with Mobile Mental Health Crisis Response Team for Emergency Department situations.</td>
</tr>
<tr>
<td>• Access to mental health services; crisis and prevention/maintenance</td>
<td>• Psychologist, Psychiatric nurse practitioner available with Perham Health clinic</td>
</tr>
<tr>
<td>• Suicide prevention</td>
<td>• Primary care screenings for depression.</td>
</tr>
<tr>
<td>• Teen suicide</td>
<td>• Perham Area Rethink Mental Health education on suicide and mental health management</td>
</tr>
<tr>
<td>• Mental health needs coupled with drug/alcohol use/abuse</td>
<td>• Perham Health provides staff education about resiliency.</td>
</tr>
<tr>
<td>• Alcohol use/abuse</td>
<td>• 28.6% of respondents report binge drinking</td>
</tr>
<tr>
<td>• 28.6% of respondents report binge drinking</td>
<td>• Inadequate coping/resiliency skills</td>
</tr>
</tbody>
</table>
18% of survey respondents report symptoms of depression, 15.4% report symptoms of anxiety.

- Mental health resources and education provided by Perham Health at community health fairs.
- Suicide prevention education provided to Perham Health staff and community.
- Further information can be reviewed with Appendix A – Demonstrating Impact and Implementation Strategies & Action Plan 2017-2019, pages 27-34 of this report.

<table>
<thead>
<tr>
<th>Physical Health Management Needs</th>
<th>Collaboration with Partnership 4 Health for community fitness/healthy lifestyle initiatives.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Rising rate of obesity</td>
<td>• Installation of exercise signs around the hospital walking path to promote greater community usage.</td>
</tr>
<tr>
<td>42.1% of survey respondents are overweight by reported BMI, 29.9% are obese by BMI. Perham Health data mirrors same percentage regarding patients having BMI in obese category (30%)</td>
<td></td>
</tr>
<tr>
<td>• Type II Diabetes prevalence</td>
<td>• Partnership with Stratis Health and county health endeavors to positively impact chronic disease management.</td>
</tr>
<tr>
<td>36% of survey respondents report no diabetic screening</td>
<td></td>
</tr>
<tr>
<td>• Poor Nutrition and eating habits</td>
<td></td>
</tr>
<tr>
<td>• Inactivity and lack of exercise</td>
<td></td>
</tr>
<tr>
<td>• Chronic disease</td>
<td>• Further information can be reviewed with Appendix A – Demonstrating Impact and Implementation Strategies &amp; Action Plan 2017-2019, pages 27-34 of this report.</td>
</tr>
<tr>
<td>38.6% of respondents report diagnosis of high blood pressure; 35.3% report diagnosis of high cholesterol.</td>
<td></td>
</tr>
<tr>
<td>• No identification of a primary care provider</td>
<td></td>
</tr>
<tr>
<td>38.9% of survey respondents do not have a primary care provider</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transportation Needs</th>
<th>Perham Health/Living contract (within city limits) for van transportation serving elder population.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No rural public transit system</td>
<td></td>
</tr>
<tr>
<td>• Elder population transportation needs for medical appointments and daily living errands</td>
<td></td>
</tr>
<tr>
<td>• Linkage with Otter Tail County Senior Transportation Program, area medical transport agencies</td>
<td></td>
</tr>
</tbody>
</table>

This information further directed the Perham Health Strategic Team and community partners to determine which community health needs would be addressed within a corresponding action plan/implementation strategy. As part of the process, community resources were reviewed and are included as Appendix F.

Appendix A of the 2016 Community Health Needs Assessment Report summarizes the 2013-2015 focus areas, strategies and their impact. Please review Appendix A “Demonstrating Impact” to assist in greater understanding of areas that will be addressed and/or expanded within the 2017-2019 Implementation Strategies.
The implementation strategy developed from this Community Health Needs Assessment is aligned with the mission and values of Perham Health; along with the Vision 2020 Strategic Initiatives (see Appendix D). The Perham Health implementation strategy naturally incorporates priority areas for public health, Healthy People 2020\(^\text{15}\), as we work collaboratively with Otter Tail County Public Health and other health partners to capitalize on successful efforts to dramatically change the trajectory of individual and community health.

\(^{15}\) http://www.health.state.mn.us/healthynpartnership/hm2020/
Focus Area: Physical Health

Physical health consists of many components including physical activity, nutrition and diet, rest and sleep, along with self-care. Physical health is critical for overall well-being and is the most visible of the various dimensions of health, which also include social, intellectual, emotional, spiritual and environmental health.

Perham Health has set strategy to help the community improve their physical health and chronic health conditions. These endeavors are in partnership with other community supports to nurture and sustain a “culture of wellness” throughout the community.

Focus Area: Mental Health

Mental health includes emotional, psychological and social well-being. It affects how people respond to daily stress, life situations and ability to be self-aware. Mental health problems are common and people with mental health imbalance can manage life well with available supports. Many factors contribute to mental health problems, including: 1) biological factors, such as genes or brain chemistry; 2) life experiences, such as trauma or abuse; 3) family history of mental health instability.

Perham Health has prioritized mental health issues as a major focus to set strategy toward increased education for the community about mental health challenges, and to continue in efforts to maximize linkages and accessibilities to mental health resources and treatment options. We recognize that regional and state efforts are necessary to leverage
demands for mental health services beyond our community; yet community members need access to these supports. Perham Health representatives will work with these entities to advocate for rural mental health service needs.

**Focus Area: Population Aging**

The population is aging. This is a natural occurrence. But, what is unusual is the number of people entering into ages 65 and beyond, as compared to number of people younger than that. As baby boomers reach retirement age, Minnesota’s senior population will double. This creates a population challenge of disproportionate numbers of people not in the work force. The increased senior population also creates demand for expanded medical and support services to help people live not only a longer life, but also a fulfilling life.

Perham Health, as a rural health care facility, will continue to serve a high percentage of seniors and elders. Based on the demographic shifts of collective population aging, it is anticipated by 2020, 44% of the population in Otter Tail County will be age 65 and above; as compared to statewide 25% of the population age 65 and above by 2020. Clearly, rural populations are experiencing “population aging” more intensely. Design of supports and services must mirror present and future needs.

Perham Health will continue with expansions of services for the aging population in the Perham area. Health care management for chronic diseases for elderly is addressed also in the focus area of physical health. Perham Health will partner with regional/state resources and initiatives to assist the community in “aging readiness” efforts.
Implementation Strategies

Action Plan

FY 2017-2019

Focus Area: Physical Health

Projected Impact: Improve the physical health of Perham area community.

Goal: Build support for healthy lifestyle changes, especially for those at high risk for Type 2 Diabetes, Heart Disease and Stroke.

<table>
<thead>
<tr>
<th>Actions/Tactics</th>
<th>Measureable Outcomes</th>
<th>Dedicated Resources</th>
<th>Leadership</th>
<th>Community Partnerships (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement evidence-based pre-diabetes screening process.</td>
<td>Increase screening, counseling/education, and referrals for patients with pre-diabetes, obesity and/or hypertension indicators.</td>
<td>Perham Health Clinic providers, nursing staff, management.</td>
<td>Perham Health Clinic</td>
<td>PartnerSHIP 4 Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Perham Health Leadership Team</td>
<td>Stratis Health</td>
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<td></td>
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<td></td>
<td></td>
<td>Sanford Health</td>
</tr>
<tr>
<td>Explore opportunities to increase patient accessibility to medical providers thru technology, to better manage health challenges.</td>
<td>Increased usage of video visits, e-visits, and/or phone visits.</td>
<td>Perham Health Clinic providers, nursing staff, management. Information Technology.</td>
<td>Perham Health Leadership Team</td>
<td>Sanford Health</td>
</tr>
<tr>
<td>Encourage patients to solidify a health care partnership with a primary care provider.</td>
<td>38.9% of respondents with the 2015 Otter Tail County survey reported they do NOT have a primary care provider. Increase primary provider accessibility with ongoing provider recruitment.</td>
<td></td>
<td>Perham Health Leadership Team</td>
<td>Sanford Health</td>
</tr>
<tr>
<td>Actions/Tactics</td>
<td>Measureable Outcomes</td>
<td>Dedicated Resources</td>
<td>Leadership</td>
<td>Community Partnerships (if applicable)</td>
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</tr>
<tr>
<td>Monitor measures of these seven health criteria: diabetes, vascular, hypertension, colorectal, mammography, asthma control, and depression.</td>
<td>By January 1, 2020 these quality measures will be within the Sanford Quality Measures, see Appendix E.</td>
<td>Perham Health Clinic providers, nursing staff, management. Medical Home/RN Health Coach support.</td>
<td>Perham Health Leadership Team</td>
<td>Sanford Health Stratis Health</td>
</tr>
<tr>
<td>Obesity Management and Education</td>
<td>Reduce Perham Health patient BMI (Body Mass Index) by 5% within 5 year span</td>
<td>Perham Health providers, nursing staff, management. Population Health Workgroup in clinic setting. Medicare Intensive Behavior Therapy coverage for dietitian visits.</td>
<td>Perham Health Leadership Team and Directors</td>
<td></td>
</tr>
<tr>
<td>Research option of “Putting Health on the Menu” for area restaurants, etc. Partner with Perham Area Community Education; i.e. nutrition and cooking classes. Expansion of Perham Health Wellness group for education to staff. Evaluate ways to expand it to the community.</td>
<td>Promote healthy lifestyle habits with community partners to support unified message for health behaviors.</td>
<td>Perham Health Wellness group Involvement in Safe Routes to School Partnership and activities. “Happy Healthy Mama” group meetings, 2x/month</td>
<td>Perham Health Leadership Team and Directors</td>
<td>PartnerSHIP 4 Health Perham Chamber of Commerce Perham Area Community Education Community business &amp; industry employers with workplace wellness programs.</td>
</tr>
</tbody>
</table>

Dedicated to health and wellness throughout life.
Focus Area: Mental Health

Projected Impact: Improved understanding about mental health challenges, mental health treatment, and community responses that can provide support.

Goal: Increase education for the community about mental health challenges and maximize accessibility to mental health resources and treatment options.

<table>
<thead>
<tr>
<th>Actions/Tactics</th>
<th>Measureable Outcomes</th>
<th>Dedicated Resources</th>
<th>Leadership</th>
<th>Community Partnerships (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnership with Mobile Mental Health to expand services in Perham Health ED.</td>
<td>24 hour access available effective November 1, 2016 Promote community utilization of Mobile Mental Health Unit before accessing ED.</td>
<td>Perham Health Leadership Team, Perham Health ED manager, Perham Health Social Services Director</td>
<td></td>
<td>Lakeland Mental Health – Mobile Mental Health Crisis Unit</td>
</tr>
<tr>
<td>Partnership with Alzheimer’s Association</td>
<td>Network for accessibility to consultation, dementia education resources &amp; community referrals.</td>
<td>Perham Health Leadership Team, Perham Health Social Services Director</td>
<td></td>
<td>Alzheimer’s Association, Regional Unit</td>
</tr>
<tr>
<td>Community Paramedic Program utilization</td>
<td>Prevent unnecessary ED visits related to mental health management.</td>
<td>Perham Health Leadership Team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health support for individuals (ages 5-18) with autism or related diagnosis.</td>
<td>Partner with community group to provide clinical component of community autism center currently being considered.</td>
<td>Perham Health Leadership Team</td>
<td></td>
<td>Community Autism Services: Bright Futures Boys &amp; Girls Club of Perham</td>
</tr>
<tr>
<td>Actions/Tactics</td>
<td>Measureable Outcomes</td>
<td>Dedicated Resources</td>
<td>Leadership</td>
<td>Community Partnerships (if applicable)</td>
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<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Community, county, regional &amp; state mental health resource knowledge and advocacy.</td>
<td>Maintain and/or expand active network of resources for referrals and supports related to mental health care. Engage regional partners to discuss collaborative improvement in regional access to mental health services. Evaluate and identify opportunities for increasing local access to outpatient mental health services.</td>
<td>Perham Health Leadership Team</td>
<td>Otter Tail County Vulnerable Adult Protection Team</td>
<td>Sanford Health</td>
</tr>
<tr>
<td>Mental Health community education.</td>
<td>Promote education and discussions about mental health to reduce public stigma.</td>
<td>Perham Health Leadership Team</td>
<td>Sanford Health</td>
<td>Make it OK campaign* See Appendix G</td>
</tr>
<tr>
<td>Tele-mental health Services</td>
<td>Increase accessibility and utilization of tele-mental health services.</td>
<td>Perham Health Leadership Team</td>
<td>Sanford Health</td>
<td></td>
</tr>
</tbody>
</table>

*See Appendix G*
Focus Area: Population Aging

Projected Impact: The Perham community will provide supports for the aging population and their families so each individual may age well and live well.

Goal: Promote or expand senior services that provide a comprehensive range of care options; best suited to their medical and social needs, desires and resources.

<table>
<thead>
<tr>
<th>Actions/Tactics</th>
<th>Measureable Outcomes</th>
<th>Dedicated Resources</th>
<th>Leadership</th>
<th>Community Partnerships (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Care Planning</td>
<td>Develop an advance care planning program and provide education to community, providers, and staff. Designate and train ACP certified facilitators for all settings within the Perham Health continuum of care. Research utilization of POLST (Physician Orders for Life Sustaining Treatment)</td>
<td></td>
<td>Perham Health Leadership Team&lt;br&gt;Perham Living Leadership&lt;br&gt;Perham Health Strategic Team for Advanced Care Planning</td>
<td>Sanford Health Hospice</td>
</tr>
<tr>
<td>Maximize early Medicare enrollee supports available for health promotion, disease prevention and detection.</td>
<td>Research feasibility for increased utilization of the Medicare funded IPPE (Initial Preventive Physical Examination)</td>
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<tr>
<td>Actions/Tactics</td>
<td>Measureable Outcomes</td>
<td>Dedicated Resources</td>
<td>Leadership</td>
<td>Community Partnerships (if applicable)</td>
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<tr>
<td>Partnership with Alzheimer’s Association</td>
<td>Network for accessibility to consultation, dementia education resources &amp; community referrals.</td>
<td>Perham Health Leadership Team</td>
<td>Perham Health Social Services Director</td>
<td>Alzheimer’s Association, Regional Unit</td>
</tr>
<tr>
<td>Elderly Housing with Services</td>
<td>Expand options and increase community utilization; including Adult Day Services, Assisted Living Memory Care (Northwinds).</td>
<td>Perham Health Leadership Team</td>
<td>Perham Living-Home Health Care Leadership</td>
<td></td>
</tr>
<tr>
<td>Post-Acute Care Rehabilitation Services</td>
<td>Increase utilization of Transitions – Post Acute Care services at Perham Living for ease of community patients and families receiving care locally.</td>
<td>Perham Health Leadership Team</td>
<td>Perham Health Therapy</td>
<td>Sanford Health</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>Regional network of acute care providers</td>
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<td></td>
<td></td>
<td>Stratis Health</td>
</tr>
<tr>
<td>Geriatric Clinic</td>
<td>Explore feasibility of a geriatric-based clinic on the Perham Living campus.</td>
<td>Perham Health Leadership Team</td>
<td>Perham Living Leadership</td>
<td>Sanford Health</td>
</tr>
<tr>
<td>Silos to Circles Collaborative</td>
<td>Organize stakeholder involvement in education &amp; public messaging about area senior needs. Establish a user-friendly “help me find it” navigation process for seniors to attain services.</td>
<td>Perham Health &amp; Living Leadership</td>
<td></td>
<td>Land of the Dancing Sky Area Agency on Aging</td>
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<td>Senior Linkage Line</td>
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<td></td>
<td>Otter Tail County Social Services</td>
</tr>
</tbody>
</table>
Appendix A

Demonstrating Impact

Review of 2013-2015 Strategies
Demonstrating Impact

The 2013 Community Health Needs Assessment provided focus on the following needs:

- Obesity and implications to other chronic health conditions.
- Fragmented or minimal mental health services.
- Access to specialized health care services.

Implementation strategies for 2013-2016, were broad-based for community impact and sustainability. Expansion in these areas will continue with the 2017-2019 Implementation Strategies as the 2016 assessment uplifts focus on similar concerns/needs.

<table>
<thead>
<tr>
<th>Implementation Strategy: Obesity</th>
<th>Impact of the Strategy to Address Obesity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Expand Medical Home model of care for wellness/prevention and health accountability.</td>
<td>• Population Health Workgroup formed in clinic setting.</td>
</tr>
<tr>
<td>• Promote Health Care Team to use “Behavioral/Motivational Health” Interview Model.</td>
<td>• Initiated Medicare Intensive Behavior Therapy coverage for dietitian visits for healthy weight loss.</td>
</tr>
<tr>
<td>• Expand school/hospital/community partnerships with Minnesota SHIP initiatives.</td>
<td>• Collaboration with Partnership 4 Health for community fitness/healthy lifestyle initiatives and promotions.</td>
</tr>
<tr>
<td>• Expand community partnerships to make environmental adaptations to encourage active lifestyles; i.e. bike and walking paths.</td>
<td>• Involvement in Safe Routes to School</td>
</tr>
<tr>
<td>• Community education to impact Baby/Early Childhood nutrition habits</td>
<td>• Development of “Happy Healthy Mama” 2x/month meetings – group support and education for parents and young families regarding healthy lifestyle habits.</td>
</tr>
<tr>
<td>• Develop a Medication Adherence Program</td>
<td>• Collaboration with community workplace wellness initiatives.</td>
</tr>
<tr>
<td>• Expand nutrition education at health facility and in the community.</td>
<td>• Installation of exercise signs around the hospital walking path to promote greater community usage of the area.</td>
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<tr>
<td></td>
<td>• Host Farmers’ Market in hospital parking lot for healthy food accessibility.</td>
</tr>
<tr>
<td></td>
<td>• Sponsorship of Mature Mile/5K for promotion of physical activity options no matter what age.</td>
</tr>
<tr>
<td></td>
<td>• Patient accessibility to Nutrition Therapy.</td>
</tr>
<tr>
<td></td>
<td>• Implementation of Diabetes Prevention Program</td>
</tr>
<tr>
<td>Implementation Strategy: Mental Health</td>
<td>Impact of the Strategy to Address Mental Health</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>• Partner with Minnesota Consortium for Advanced Rural Psychology Training (MCARPT) as training site.</td>
<td>• Contracted with Mobile Mental Health Crisis Response/Lakeland Mental Health to provide on-call assistance for patients in mental health crisis entering Perham Health emergency department.</td>
</tr>
<tr>
<td>• Research feasibility of tele-mental health services.</td>
<td>• Interviews/articles with local media venues about mental health and emotional wellness.</td>
</tr>
<tr>
<td>• Maintain active role in Minnesota Hospital Association Mental Health Task Force to partner in solutions to address limited mental health services for rural areas.</td>
<td>• Perham Health hosted 3-day WRAP (Wellness Recovery Action Plan) Seminar, focused on emotional wellness tools and strategies. Collaborative event with Becker, Clay, Otter Tail, Wilkin Adult Mental Health Initiative.</td>
</tr>
<tr>
<td>• Increase collaborative role with local, county and regional mental health service providers.</td>
<td>• Perham Health sponsored and hosted suicide prevention training for staff. QPR- Question, Persuade and Refer.</td>
</tr>
<tr>
<td>• Partner with Sanford Health for expansion of Behavioral Health outreach, integrated in clinic setting.</td>
<td>• Promoted Make it OK campaign(^1) at public health events — capturing ways to normalize conversation about mental illness.</td>
</tr>
<tr>
<td></td>
<td>• Developed Perham Area Rethink Mental Health Team.</td>
</tr>
<tr>
<td></td>
<td>• Active role in county/community Vulnerable Adult Team</td>
</tr>
<tr>
<td></td>
<td>• Tele-Psychiatry availability implemented and utilized thru clinic.</td>
</tr>
<tr>
<td></td>
<td>• Additional hours added for clinic psychologist.</td>
</tr>
<tr>
<td></td>
<td>• Improved processes in all Perham Health care settings to screen depression and other mental health conditions.</td>
</tr>
</tbody>
</table>

\(^1\) Example of effective public messaging utilized, is shown as Appendix C
Partnered with Alzheimer’s Association for a 4 month series of community education related to dementia. Kick-off of education series was Glen Campbell movie: “I'll Be Me”.

<table>
<thead>
<tr>
<th>Implementation Strategy: Access to Specialized Health Care Services</th>
<th>Impact of the Strategy to Address Access to Specialized Health Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Research feasibility of offering dialysis locally.</td>
<td>- Partnered with Sanford Health and community stakeholders to research feasibility of local dialysis unit. Confirmed present structure of medical mandates demanded by dialysis medical care prevents ability for Perham Health to expand into this specialty care.</td>
</tr>
<tr>
<td>- Research feasibility of offering chemotherapy locally.</td>
<td>- In June of 2015, Infusion Therapy services became available in the hospital setting for outpatient management. A variety of infusions are offered to treat arthritis, osteoporosis, anemia, kidney disease, bone and wound infections, and supportive therapy for cancer treatments including blood product transfusions. Chemotherapy is not offered at this time but currently being explored.</td>
</tr>
<tr>
<td>- Secure outreach visits from specialists; i.e. nephrology, orthopedic surgery.</td>
<td>- Additional hours of availability for nephrology, orthopedic, psychology, tele-psychiatry and dietitian appointments at clinic.</td>
</tr>
<tr>
<td></td>
<td>- Additional access to Sleep Medicine assessments and support.</td>
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<tr>
<td></td>
<td>- Additional Coumadin education delivered via ITV.</td>
</tr>
</tbody>
</table>
County Health Rankings

The County Health Rankings report ranks Minnesota counties according to their summary measure of health outcomes and health factors. Counties also receive a rank for mortality, morbidity, health behaviors, clinical care, social and economic factors and the physical environment. Within this model of understanding; it can be further implied how each factor contributes to the overall health of individuals and communities. Numerically understood, 80% of health outcomes is determined by health behaviors, social and economic factors and physical environment; while 20% is determined by clinical care.

Demographics

<table>
<thead>
<tr>
<th>Population Age</th>
<th>MN</th>
<th>Otter Tail County MN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>5,457,173</td>
<td>57,635</td>
</tr>
<tr>
<td>Percent ages 65 and older</td>
<td>14.3%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Percent below 18 years of age</td>
<td>23.5%</td>
<td>21.4%</td>
</tr>
<tr>
<td>Percent female</td>
<td>50.3%</td>
<td>49.7%</td>
</tr>
<tr>
<td>Percent of population living in rural area</td>
<td>26.7%</td>
<td>73.6%</td>
</tr>
<tr>
<td>Percent not proficient in English</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>White alone</td>
<td>81.4%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Asian alone</td>
<td>4.7%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Black alone</td>
<td>5.7%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Hispanic origin – of any race</td>
<td>5.1%</td>
<td>3.1%</td>
</tr>
<tr>
<td>American Indian</td>
<td>1.3%</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

Based on 2014 Census data

Economic Security

<table>
<thead>
<tr>
<th></th>
<th>MN</th>
<th>Otter Tail County MN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of total population with income less than 100% of poverty</td>
<td>11.52%</td>
<td>11.04%</td>
</tr>
<tr>
<td>Percent of total population with income less than 200% of poverty</td>
<td>27.09%</td>
<td>30.26%</td>
</tr>
<tr>
<td>Median household income</td>
<td>$76,190</td>
<td>$63,019</td>
</tr>
</tbody>
</table>

US Census Bureau, American Community Survey. 2010-14

Health Outcomes

<table>
<thead>
<tr>
<th>Length of Life</th>
<th>National Benchmark</th>
<th>MN</th>
<th>Otter Tail County MN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premature death</td>
<td>Years of potential life lost before age 75 per 100,000 (age-adjusted), 2011-2013</td>
<td>5,200</td>
<td>5,100</td>
</tr>
<tr>
<td>Premature age-adjusted mortality</td>
<td>Number of deaths among residents under age 75 per 100,000 population (age-adjusted), 2011-2013</td>
<td>270</td>
<td>260</td>
</tr>
<tr>
<td>Child mortality</td>
<td>Number of deaths among children under age 18 per 100,000, 2010-2013</td>
<td>40</td>
<td>40</td>
</tr>
</tbody>
</table>
## Quality of Life

<table>
<thead>
<tr>
<th>Quality of Life</th>
<th>National Benchmark</th>
<th>MN</th>
<th>Otter Tail County MN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor or fair health</td>
<td>12%</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>Poor physical health days</td>
<td>2.9</td>
<td>2.8</td>
<td>2.6</td>
</tr>
<tr>
<td>Poor mental health days</td>
<td>2.8</td>
<td>2.9</td>
<td>2.7</td>
</tr>
<tr>
<td>Low birth weight</td>
<td>6.0%</td>
<td>6.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Frequent physical distress</td>
<td>9%</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Frequent mental distress</td>
<td>9%</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Diabetes prevalence</td>
<td>9%</td>
<td>8%</td>
<td>10%</td>
</tr>
<tr>
<td>HIV prevalence</td>
<td>41</td>
<td>158</td>
<td>10</td>
</tr>
</tbody>
</table>

## Health Factors

<table>
<thead>
<tr>
<th>Health Behaviors</th>
<th>National Benchmark</th>
<th>MN</th>
<th>Otter Tail County MN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult smoking</td>
<td>14%</td>
<td>16%</td>
<td>15%</td>
</tr>
<tr>
<td>Adult obesity</td>
<td>25%</td>
<td>26%</td>
<td>27%</td>
</tr>
<tr>
<td>Physical inactivity</td>
<td>20%</td>
<td>20%</td>
<td>22%</td>
</tr>
<tr>
<td>Excessive drinking</td>
<td>12%</td>
<td>21%</td>
<td>19%</td>
</tr>
<tr>
<td>Alcohol-impaired driving deaths</td>
<td>14%</td>
<td>31%</td>
<td>30%</td>
</tr>
<tr>
<td>Sexually transmitted infections</td>
<td>134.1</td>
<td>348.4</td>
<td>136.2</td>
</tr>
<tr>
<td>Teen birth rate</td>
<td>19</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td>Clinical Care</td>
<td>National Benchmark</td>
<td>MN</td>
<td>Otter Tail County MN</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>--------------------</td>
<td>--------</td>
<td>----------------------</td>
</tr>
<tr>
<td><strong>Uninsured</strong></td>
<td>Percentage of population under age 65 without health insurance, 2013</td>
<td>11%</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Primary Care Physicians</strong></td>
<td>Ratio of population to primary care physicians, 2013</td>
<td>1,040:1</td>
<td>1,100:1</td>
</tr>
<tr>
<td><strong>Mental Health Providers</strong></td>
<td>Ratio of total population to mental health providers, 2015</td>
<td>370:1</td>
<td>490:1</td>
</tr>
<tr>
<td><strong>Dentists</strong></td>
<td>Ratio of population to dentists, 2014</td>
<td>1,340:1</td>
<td>1,500:1</td>
</tr>
<tr>
<td><strong>Preventable hospital stays</strong></td>
<td>Number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees, 2013</td>
<td>38</td>
<td>41</td>
</tr>
<tr>
<td><strong>Diabetic monitoring</strong></td>
<td>Percentage of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring, 2013</td>
<td>90%</td>
<td>89%</td>
</tr>
<tr>
<td><strong>Mammography screening</strong></td>
<td>Percent of female Medicare enrollees that receive mammography screening, 2006-2007</td>
<td>90%</td>
<td>89%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social and Economic Factors</th>
<th>National Benchmark</th>
<th>MN</th>
<th>Otter Tail County MN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High school graduation</strong></td>
<td>Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2012-2013</td>
<td>93%</td>
<td>81%</td>
</tr>
<tr>
<td><strong>Some college</strong></td>
<td>Percent of adults ages 25-44 with some post-secondary education, 2010-2014</td>
<td>72%</td>
<td>74%</td>
</tr>
<tr>
<td><strong>Unemployment</strong></td>
<td>Percent of population ages 16 and older that is unemployed but seeking work, 2014</td>
<td>3.5%</td>
<td>4.1%</td>
</tr>
<tr>
<td><strong>Child poverty</strong></td>
<td>Percent of children ages 0-17 living below the Federal Poverty Line, 2014</td>
<td>13%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Inadequate inequality</strong></td>
<td>Ratio of household income at the 80th percentile to income at the 20th percentile, 2010-2014</td>
<td>3.7</td>
<td>4.4</td>
</tr>
<tr>
<td><strong>Children in single parent households</strong></td>
<td>Percent of children in families that live in a household headed by a parent with no spouse present, 2010-2014</td>
<td>21%</td>
<td>28%</td>
</tr>
<tr>
<td><strong>Social associations</strong></td>
<td>Number of membership associations per 10,000 population, 2013</td>
<td>22.1</td>
<td>13.2</td>
</tr>
<tr>
<td><strong>Violent Crimes</strong></td>
<td>Number of reported violent crime offenses per 100,000 population, 2010-2012</td>
<td>59</td>
<td>229</td>
</tr>
<tr>
<td><strong>Injury Deaths</strong></td>
<td>Number of deaths due to injury per 100,000 population, 2009-2013</td>
<td>51</td>
<td>57</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>National Benchmark</td>
<td>MN</td>
<td>Otter Tail County MN</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>--------------------</td>
<td>----</td>
<td>----------------------</td>
</tr>
<tr>
<td><strong>Air pollution-particulate matter</strong></td>
<td>9.5</td>
<td>12</td>
<td>12.4</td>
</tr>
<tr>
<td>Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Drinking water violations</strong></td>
<td>No</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>Indicator of the presence of health-related drinking water violations. Yes indicates the presence of a violation, No indicates no violation, 2013-2014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Severe housing problems</strong></td>
<td>9%</td>
<td>14%</td>
<td>12%</td>
</tr>
<tr>
<td>Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities, 2008-2012</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Food environment index</strong></td>
<td>8.3</td>
<td>8.2</td>
<td>8.3</td>
</tr>
<tr>
<td>Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best), 2012-2013</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix C

2016 MN Health Rankings

Robert Wood Johnson Foundation
INTRODUCTION

The County Health Rankings & Roadmaps program brings actionable data and strategies to communities to make it easier for people to be healthy in their homes, schools, workplaces, and neighborhoods. Ranking the health of nearly every county in the nation, the County Health Rankings illustrate what we know when it comes to what is making people sick or healthy. The Roadmaps show what we can do to create healthier places to live, learn, work, and play. The Robert Wood Johnson Foundation (RWJF) collaborates with the University of Wisconsin Population Health Institute (UWPHI) to bring this program to cities, counties, and states across the nation.

WHAT ARE THE COUNTY HEALTH RANKINGS?

Published online at countyhealthrankings.org, the Rankings help counties understand what influences how healthy residents are and how long they will live. The Rankings are unique in their ability to measure the current overall health of nearly every county in all 50 states. They also look at a variety of measures that affect the future health of communities, such as high school graduation rates, access to healthy foods, rates of smoking, obesity, and teen births. Communities use the Rankings to help identify issues and opportunities for local health improvement, as well as to garner support for initiatives among government agencies, healthcare providers, community organizations, business leaders, policy makers, and the public.

DIGGING DEEPER INTO HEALTH DATA

Although we know that a range of factors are important for good health, every state has communities that lack both opportunities to shape good health and strong policies to promote health for everyone. Some counties lag far behind others in how well and how long people live – which we refer to as a “health gap.” Find out what’s driving health differences across your state and what can be done to close those gaps. Visit countyhealthrankings.org/reports.

To further explore health gaps and other data sources in your community, check out the feature to find more data for your state and dig deeper on differences in health factors by geography or by population subgroups. Visit countyhealthrankings.org/using-the-rankings-data

1 www.countyhealthrankings.org/minnesota
MOVING FROM DATA TO ACTION

Roadmaps to Health help communities bring people together to look at the many factors that influence health and opportunities to reduce health gaps, select strategies that can improve health for all, and make changes that will have a lasting impact. The Roadmaps focus on helping communities move from awareness about their county’s ranking to actions designed to improve everyone’s health. The Roadmaps to Health Action Center is a one-stop shop of information to help any community member or leader who wants to improve their community’s health by addressing factors that we know influence health, such as education, income, and community safety.

Within the Action Center you will find:

- Online step-by-step guidance and tools to move through the Action Cycle
- **What Works for Health** — a searchable database of evidence-informed policies and programs that can improve health
- Webinars featuring local community members who share their tips on how to build a healthier community
- Community coaches, located across the nation, who provide customized consultation to local leaders who request guidance in how to accelerate their efforts to improve health. You can contact a coach by activating the Get Help button at countyhealthrankings.org

HOW CAN YOU GET INVOLVED?

You might want to contact your local affiliate of United Way Worldwide, the National Association of Counties, Local Initiatives Support Corporation (LISC), or Neighborworks— their national parent organizations have partnered with us to raise awareness and stimulate action to improve health in their local members’ communities. By connecting with other leaders interested in improving health, you can make a difference in your community. In communities large and small, people from all walks of life are taking ownership and action to improve health. Visit countyhealthrankings.org to get ideas and guidance on how you can take action in your community. Working with others, you can improve the health of your community.
HOW DO COUNTIES RANK FOR HEALTH OUTCOMES?

The green map below shows the distribution of Minnesota's health outcomes, based on an equal weighting of length and quality of life. Lighter shades indicate better performance in the respective summary rankings. Detailed information on the underlying measures is available at countyhealthrankings.org.

![Map of Minnesota with county rankings](image)

<table>
<thead>
<tr>
<th>County</th>
<th>Rank</th>
<th>County</th>
<th>Rank</th>
<th>County</th>
<th>Rank</th>
<th>County</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atkin</td>
<td>72</td>
<td>Fillmore</td>
<td>9</td>
<td>Martin</td>
<td>49</td>
<td>Rock</td>
<td>36</td>
</tr>
<tr>
<td>Anoka</td>
<td>40</td>
<td>Freeborn</td>
<td>45</td>
<td>McLeod</td>
<td>12</td>
<td>Roseau</td>
<td>38</td>
</tr>
<tr>
<td>Becker</td>
<td>71</td>
<td>Goodhue</td>
<td>17</td>
<td>Meeker</td>
<td>28</td>
<td>Scott</td>
<td>3</td>
</tr>
<tr>
<td>Beltrami</td>
<td>86</td>
<td>Grant</td>
<td>52</td>
<td>Mille Lacs</td>
<td>77</td>
<td>Sherburne</td>
<td>18</td>
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<tr>
<td>Benton</td>
<td>57</td>
<td>Hennepin</td>
<td>46</td>
<td>Morrison</td>
<td>65</td>
<td>Slade</td>
<td>31</td>
</tr>
<tr>
<td>Big Stone</td>
<td>33</td>
<td>Houston</td>
<td>5</td>
<td>Mower</td>
<td>53</td>
<td>St Louis</td>
<td>76</td>
</tr>
<tr>
<td>Blue Earth</td>
<td>43</td>
<td>Hubbard</td>
<td>60</td>
<td>Murray</td>
<td>58</td>
<td>Stearns</td>
<td>25</td>
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<tr>
<td>Brown</td>
<td>24</td>
<td>Isanti</td>
<td>34</td>
<td>Nicolet</td>
<td>13</td>
<td>Steele</td>
<td>39</td>
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<tr>
<td>Carlton</td>
<td>61</td>
<td>Itasca</td>
<td>75</td>
<td>Nobles</td>
<td>42</td>
<td>Stevens</td>
<td>4</td>
</tr>
<tr>
<td>Carver</td>
<td>1</td>
<td>Jackson</td>
<td>80</td>
<td>Norman</td>
<td>83</td>
<td>Swift</td>
<td>27</td>
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<tr>
<td>Cass</td>
<td>85</td>
<td>Kanabec</td>
<td>56</td>
<td>Olmsted</td>
<td>8</td>
<td>Todd</td>
<td>50</td>
</tr>
<tr>
<td>Chippewa</td>
<td>70</td>
<td>Kandiyohi</td>
<td>32</td>
<td>Otter Tail</td>
<td>51</td>
<td>Traverse</td>
<td>37</td>
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<tr>
<td>Chisago</td>
<td>26</td>
<td>Kittson</td>
<td>30</td>
<td>Pennington</td>
<td>67</td>
<td>Wabasha</td>
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<td>Clay</td>
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<td>Koochiching</td>
<td>79</td>
<td>Pine</td>
<td>82</td>
<td>Wadena</td>
<td>74</td>
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<tr>
<td>Clearwater</td>
<td>84</td>
<td>Lac qui Parle</td>
<td>22</td>
<td>Pipestone</td>
<td>55</td>
<td>Waseca</td>
<td>19</td>
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<tr>
<td>Cook</td>
<td>78</td>
<td>Lake</td>
<td>81</td>
<td>Polk</td>
<td>69</td>
<td>Washington</td>
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</tr>
<tr>
<td>Cottonwood</td>
<td>43</td>
<td>Lake of the Woods</td>
<td>7</td>
<td>Pope</td>
<td>68</td>
<td>Watonwan</td>
<td>32</td>
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<tr>
<td>Crow Wing</td>
<td>59</td>
<td>Le Sueur</td>
<td>21</td>
<td>Ramsey</td>
<td>66</td>
<td>Wilkin</td>
<td>10</td>
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<td>Dakota</td>
<td>11</td>
<td>Lincoln</td>
<td>46</td>
<td>Red Lake</td>
<td>20</td>
<td>Winona</td>
<td>41</td>
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<tr>
<td>Dodge</td>
<td>14</td>
<td>Lyon</td>
<td>48</td>
<td>Redwood</td>
<td>64</td>
<td>Wright</td>
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<td>Douglas</td>
<td>16</td>
<td>Mahnomen</td>
<td>87</td>
<td>Remville</td>
<td>73</td>
<td>Yellow Medicine</td>
<td>47</td>
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<tr>
<td>Faribault</td>
<td>54</td>
<td>Marshal</td>
<td>29</td>
<td>Rice</td>
<td>35</td>
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<td></td>
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</tbody>
</table>

www.countyhealthrankings.org/minnesota
HOW DO COUNTIES RANK FOR HEALTH FACTORS?

The blue map displays Minnesota’s summary ranks for health factors, based on weighted scores for health behaviors, clinical care, social and economic factors, and the physical environment. Lighter shades indicate better performance in the respective summary rankings. Detailed information on the underlying measures is available at countyhealthrankings.org.
## 2016 COUNTY HEALTH RANKINGS: MEASURES AND NATIONAL/STATE RESULTS

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>US Median</th>
<th>State Overall</th>
<th>State Minimum</th>
<th>State Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEALTH OUTCOMES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premature death</td>
<td>Years of potential life lost before age 75 per 100,000 population</td>
<td>7.700</td>
<td>5.100</td>
<td>3.200</td>
<td>11.000</td>
</tr>
<tr>
<td>Poor or fair health</td>
<td>% of adults reporting fair or poor health</td>
<td>16%</td>
<td>12%</td>
<td>9%</td>
<td>22%</td>
</tr>
<tr>
<td>Poor physical health days</td>
<td>Average # of physically unhealthy days reported in past 30 days</td>
<td>3.7</td>
<td>2.8</td>
<td>2.3</td>
<td>4.4</td>
</tr>
<tr>
<td>Poor mental health days</td>
<td>Average # of mentally unhealthy days reported in past 30 days</td>
<td>3.7</td>
<td>2.9</td>
<td>2.4</td>
<td>4.1</td>
</tr>
<tr>
<td>Low birthweight</td>
<td>% of live births with low birthweight (&lt; 2500 grams)</td>
<td>8%</td>
<td>6%</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td><strong>HEALTH FACTORS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health behaviors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult smoking</td>
<td>% of adults who are current smokers</td>
<td>18%</td>
<td>26%</td>
<td>13%</td>
<td>25%</td>
</tr>
<tr>
<td>Adult obesity</td>
<td>% of adults that report a BMI ≥ 30</td>
<td>31%</td>
<td>23%</td>
<td>23%</td>
<td>34%</td>
</tr>
<tr>
<td>Food environment index</td>
<td>Index of factors that contribute to a healthy food environment, (0-10)</td>
<td>7.1</td>
<td>8.2</td>
<td>6.1</td>
<td>9.3</td>
</tr>
<tr>
<td>Physical inactivity</td>
<td>% of adults aged 20 and over reporting no leisure-time physical activity</td>
<td>28%</td>
<td>20%</td>
<td>10%</td>
<td>25%</td>
</tr>
<tr>
<td>Access to exercise</td>
<td>% of population with adequate access to locations for physical activity</td>
<td>62%</td>
<td>84%</td>
<td>2%</td>
<td>100%</td>
</tr>
<tr>
<td>Excessive drinking</td>
<td>% of adults reporting binge or heavy drinking</td>
<td>17%</td>
<td>21%</td>
<td>18%</td>
<td>25%</td>
</tr>
<tr>
<td>Alcohol-impaired driving</td>
<td>% of driving deaths with alcohol involvement</td>
<td>31%</td>
<td>31%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Sexually transmitted</td>
<td>% of newly diagnosed chlamydia cases per 100,000 population</td>
<td>287.7</td>
<td>348.4</td>
<td>51.7</td>
<td>535.6</td>
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<tr>
<td>Teen births</td>
<td>% of births per 1,000 female population ages 15-19</td>
<td>48</td>
<td>12</td>
<td>9</td>
<td>88</td>
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<tr>
<td><strong>CLINICAL CARE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured</td>
<td>% of population under age 65 without health insurance</td>
<td>17%</td>
<td>9%</td>
<td>6%</td>
<td>16%</td>
</tr>
<tr>
<td>Primary care physicians</td>
<td>Ratio of population to primary care physicians</td>
<td>1,990.1</td>
<td>1,100.1</td>
<td>920.1</td>
<td>420.1</td>
</tr>
<tr>
<td>Dentists</td>
<td>Ratio of population to dentists</td>
<td>2,590.1</td>
<td>1,500.1</td>
<td>1,260.1</td>
<td>1,120.1</td>
</tr>
<tr>
<td>Mental health providers</td>
<td>Ratio of population to mental health providers</td>
<td>1,060.1</td>
<td>490.1</td>
<td>10,680.1</td>
<td>230.1</td>
</tr>
<tr>
<td>Preventable hospital stays</td>
<td>% of hospital stays for ambulatory-care sensitive conditions per 1,000</td>
<td>66</td>
<td>41</td>
<td>28</td>
<td>68</td>
</tr>
<tr>
<td>Medicare enrollees</td>
<td>% of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring</td>
<td>85%</td>
<td>89%</td>
<td>67%</td>
<td>95%</td>
</tr>
<tr>
<td>Mammography screening</td>
<td>% of female Medicare enrollees ages 67-69 that receive mammography screening</td>
<td>61%</td>
<td>65%</td>
<td>50%</td>
<td>79%</td>
</tr>
<tr>
<td><strong>SOCIAL AND ECONOMIC FACTORS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school graduation</td>
<td>% of ninth-grade cohort that graduates in four years</td>
<td>86%</td>
<td>83%</td>
<td>64%</td>
<td>97%</td>
</tr>
<tr>
<td>Some college</td>
<td>% of adults ages 25-64 with some post-secondary education</td>
<td>56%</td>
<td>74%</td>
<td>43%</td>
<td>82%</td>
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<tr>
<td>Unemployment</td>
<td>% of population aged 16 and older unemployed but seeking work</td>
<td>6.0%</td>
<td>4.1%</td>
<td>2.5%</td>
<td>10.3%</td>
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<tr>
<td>Children in poverty</td>
<td>% of children under age 18 in poverty</td>
<td>23%</td>
<td>15%</td>
<td>6%</td>
<td>33%</td>
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<tr>
<td>Income inequality</td>
<td>Ratio of household income at the 80th percentile to income at the 20th percentile</td>
<td>4.4</td>
<td>4.4</td>
<td>3.2</td>
<td>5.4</td>
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<tr>
<td>Children in single-parent households</td>
<td>% of children that live in a household headed by a single parent</td>
<td>32%</td>
<td>28%</td>
<td>15%</td>
<td>53%</td>
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<tr>
<td>Social associations</td>
<td>% of membership associations per 10,000 population</td>
<td>13.0</td>
<td>13.2</td>
<td>6.9</td>
<td>41.0</td>
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<tr>
<td>Violent crime</td>
<td># of reported violent crime offenses per 100,000 population</td>
<td>199</td>
<td>229</td>
<td>0</td>
<td>787</td>
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<tr>
<td>Injury deaths</td>
<td># of deaths due to injury per 100,000 population</td>
<td>74</td>
<td>57</td>
<td>39</td>
<td>102</td>
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<tr>
<td><strong>PHYSICAL ENVIRONMENT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Air pollution – particulate matter</td>
<td>Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)</td>
<td>11.9</td>
<td>12.0</td>
<td>10.4</td>
<td>13.3</td>
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<tr>
<td>Drinking water violations</td>
<td>Indicator of the presence of health-related drinking water violations</td>
<td>NA</td>
<td>NA</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Severe housing problems</td>
<td>% of households with overcrowding, high housing costs, or lack of</td>
<td>14%</td>
<td>34%</td>
<td>7%</td>
<td>18%</td>
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<tr>
<td>Driving alone to work</td>
<td>% of workforce that drives alone to work</td>
<td>80%</td>
<td>78%</td>
<td>69%</td>
<td>86%</td>
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<tr>
<td>Long commute – driving alone</td>
<td>Among workers who commute in their car alone, % commuting &gt; 30 minutes</td>
<td>29%</td>
<td>30%</td>
<td>11%</td>
<td>54%</td>
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www.countyhealthrankings.org/minnesota
### 2016 COUNTY HEALTH RANKINGS: DATA SOURCES AND YEARS OF DATA

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Years of Data</th>
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<tr>
<td><strong>HEALTH OUTCOMES</strong></td>
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<tr>
<td>Length of Life</td>
<td>National Center for Health Statistics – Mortality files</td>
<td>2011-2013</td>
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<tr>
<td>Quality of Life</td>
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<td></td>
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<tr>
<td>Poor or fair health</td>
<td>Behavioral Risk Factor Surveillance System</td>
<td>2014</td>
</tr>
<tr>
<td>Poor physical health days</td>
<td>Behavioral Risk Factor Surveillance System</td>
<td>2014</td>
</tr>
<tr>
<td>Poor mental health days</td>
<td>Behavioral Risk Factor Surveillance System</td>
<td>2014</td>
</tr>
<tr>
<td>Low birthweight</td>
<td>National Center for Health Statistics – Natality files</td>
<td>2007-2013</td>
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<tr>
<td><strong>HEALTH BEHAVIORS</strong></td>
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<tr>
<td>Tobacco Use</td>
<td>Adult smoking</td>
<td>2014</td>
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<tr>
<td>Diet and Exercise</td>
<td>Adult obesity</td>
<td>2012</td>
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<td></td>
<td>Food environment index</td>
<td>2013</td>
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<tr>
<td></td>
<td>Physical inactivity</td>
<td>2012</td>
</tr>
<tr>
<td></td>
<td>Access to exercise opportunities</td>
<td>2010 &amp; 2014</td>
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<td>Alcohol and Drug Use</td>
<td>Excessive drinking</td>
<td>2014</td>
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<td></td>
<td>Alcohol-impaired driving deaths</td>
<td>2010-2014</td>
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<td>Sexual Activity</td>
<td>Sexually transmitted infections</td>
<td>2013</td>
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<td>Teen births</td>
<td>2007-2013</td>
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<td><strong>CLINICAL CARE</strong></td>
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<td>Access to Care</td>
<td>Uninsured</td>
<td>2013</td>
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<td></td>
<td>Primary care physicians</td>
<td>2013</td>
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<td></td>
<td>Mental health providers</td>
<td>2015</td>
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<td>Quality of Care</td>
<td>Preventable hospital stays</td>
<td>2013</td>
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<tr>
<td></td>
<td>Diabetic monitoring</td>
<td>2013</td>
</tr>
<tr>
<td></td>
<td>Mammography screening</td>
<td>2013</td>
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<td><strong>SOCIAL AND ECONOMIC FACTORS</strong></td>
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<td></td>
</tr>
<tr>
<td>Education</td>
<td>High school graduation</td>
<td>2012-2013</td>
</tr>
<tr>
<td></td>
<td>Some college</td>
<td>2010-2014</td>
</tr>
<tr>
<td>Employment</td>
<td>Unemployment</td>
<td>2014</td>
</tr>
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<td>Income</td>
<td>Children in poverty</td>
<td>2014</td>
</tr>
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<td></td>
<td>Income inequality</td>
<td>2010-2014</td>
</tr>
<tr>
<td>Family and Social Support</td>
<td>Children in single-parent households</td>
<td>2010-2014</td>
</tr>
<tr>
<td></td>
<td>Social associations</td>
<td>2013</td>
</tr>
<tr>
<td>Community Safety</td>
<td>Violent crime</td>
<td>2010-2012</td>
</tr>
<tr>
<td></td>
<td>Injury deaths</td>
<td>2009-2013</td>
</tr>
<tr>
<td><strong>PHYSICAL ENVIRONMENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Air and Water Quality</td>
<td>Air pollution - particulate matter</td>
<td>2011</td>
</tr>
<tr>
<td></td>
<td>Drinking water violations</td>
<td>FY2013-14</td>
</tr>
<tr>
<td>Housing and Transit</td>
<td>Severe housing problems</td>
<td>2008-2012</td>
</tr>
<tr>
<td></td>
<td>Driving alone to work</td>
<td>2010-2014</td>
</tr>
<tr>
<td></td>
<td>Long commute – driving alone</td>
<td>2010-2014</td>
</tr>
</tbody>
</table>

1. Not available for AK and HI.
Appendix D

Perham Health Vision 2020

Strategic Initiatives
PERHAM HEALTH

VISION 2020 STRATEGIC INITIATIVES

To achieve our vision and our five principle strategies, we will complete the following strategic initiatives by January 1, 2020.

ASSURING ACCESS TO A FULL SPECTRUM OF COST-EFFECTIVE, QUALITY CARE

- **Quality** - Implement annual quality initiatives across the continuum of care.
- **Patient Safety** - Implement MHA’s Calls to Action, National Patient Safety Goals and Joint Commission Sentinel Event Alerts as they become available and are applicable to our services.
- **Maximize Local Services** - Better educate our patient and referral partners as to what can be done locally so if they leave town for care, they may return here for services that can be provided safely and effectively.
- **Cost of Care** - Continually evaluate and seek opportunities to reduce cost in order to be a high value organization.
- **Shared Savings/Payer Contracting** - Evaluate shared savings models as they become available with consideration of the appropriate level of risk for our size organization.
- **Swing Bed Strategy** - Conduct an evaluation of how we utilize swing beds and transition beds and determine an optimal strategy.
- **Revenue Cycle Management** - Continue decreasing accounts receivable days until we are within industry standards.
- **Perham Living Financial Health** - Study, identify, and implement strategies to reduce the operational loss at the Perham Living campus.
- **Billing** - Identify and implement strategies to reduce the billing confusion and frustration of our patients and families.

ADVANCING PERSON-CENTERED CARE THROUGHOUT OUR CONTINUUM

- **Partners in Care** - Grow the number of patient partners we have and integrate them fully throughout our facility.
- **Person Centered Care Training** - Develop a consistent format of training new employees to our models of care and retraining existing staff as necessary.
- **Person Centered Care Progress** - Conduct a regular assessment of our progress in patient and family centered care and implement strategies for improvement.
- **Patient Satisfaction** - Implement strategies to improve our patient, resident, and client satisfaction towards a long-term goal of being at the 90th percentile.
ASSURING THAT WE ARE A PROVIDER AND EMPLOYER OF CHOICE

- **Compensation** - Complete a thorough study of our compensation system, including healthcare and community comparisons, to ensure we are able to recruit and retain staff. Transparently share our findings with staff.

- **Communication** - Explore opportunities to improve internal communication and relationships across our continuum.

- **Resiliency** - Explore strategies for increasing resiliency and decreasing burnout of employees within the demanding healthcare environment.

- **Just Culture** - Continue our transformation to a Just Culture environment.

- **Generational Understanding** - Increase the organization’s understanding of the many generations in our workplace and implement strategies to help the different generations work optimally together.

- **National Recognition** - Explore and determine the feasibility of pursuing the Baldrige Award, Pathways to Excellence, or other national recognition for our organization.

- **Employee Retention** - Develop and promote programs to enhance employee retention, such as employee scholarships, career planning, education and training, and individual employee development plans.

ADVANCING POPULATION HEALTH INITIATIVES

- **Physician Recruitment** - Recruit and retain the appropriate number of permanent and outreach providers as identified in the Provider Development Plan and to assure adequate access for our patients. Consider ways for Perham Health to supplement Sanford’s recruiting efforts.

- **Complement of Local and Outreach Providers** - Evaluate the appropriate and desired level of each local and outreach specialty and work towards achieving the determined level.

- **Continuum of Services** - Periodically evaluate and identify gaps in our service continuum and work to develop the service, partner for the service, or other strategies to fill those gaps.

- **Infusion Therapy** - Fully develop and grow our new infusion therapy program.

- **Growing Home and Community Based Services** - Identify and implement new business opportunities that will allow people to remain independently in their own homes.

- **Assisted Living** - Implement a memory care assisted living.

- **Perham Living Therapy/Entrance Project** - Complete the proposed therapy and front entrance project for the Perham Living campus.

- **Housing with Services** - Explore additional market-rate senior housing.

- **Adult Day Services** - Expand adult day services with the goal of making this program financially sustainable.
• **Community Health** - Conduct a second assessment of the health status of our community in partnership with other area service providers. Identify and implement opportunities for improvement.

• **Mental Health Access** - Engage regional partners in a discussion of how we can improve regional access to mental health services.

• **Mental Health Services** - Evaluate and identify opportunities for increasing local access to outpatient mental health services.

• **Geriatric Clinic** - Explore the feasibility of a geriatric-based clinic on the Perham Living campus.

• **Community Paramedic** - Implement a community paramedic program and evaluate ways it may help us achieve other strategic goals, such as mental health access, reducing readmissions, etc.

• **Wellness** - Further develop our employee wellness program and, if successful, evaluate ways to expand it to the community.

---

**IMPLEMENTING BEST PRACTICES TO ASSURE OPTIMAL OUTCOMES**

• **Care Transitions** - Improve care transitions and handoffs between the various parts of our continuum.

• **Sanford Management Agreement** - Share the new agreement transparently to calm fears and assure alignment of everyone toward the same goals.

• **Sanford Relationship** - Evaluate annually the Sanford relationship and transparently share the value of the relationship internally and externally. As part of that evaluation, review the service matrix to ensure we are fully leveraging the resources of the Sanford system.

• **Post-Acute Electronic Solutions** - Explore with Sanford opportunities to integrate our post-acute continuum into our electronic medical record.

• **Branding** - Maintain our co-branding with Sanford and work to improve our internal scripting and understanding of the brand concepts and decrease external confusion.

• **Marketing Strategy** - Explore better utilization of our success in patient and family centered care in our marketing strategy.

• **Team Based Care** - Determine the appropriate team-based model of primary care delivery for our facility and implement throughout the clinics. Educate the public on team-based care.

• **Telehealth** - Explore opportunities to increase the services provided locally through the use of video visits, e-visits, and/or phone visits.

• **Practice Efficiency** - Focus on increasing the efficiency of providers and reducing variation in care delivery.

• **Clinic/Hospital Integration** - Explore ways to further integrate the clinic and hospital organizations.

• **Advance Care Planning** - Develop an Advanced Care Planning program that includes training, certified facilitators, and considerations of POLST.
If we successfully implement our Vision 2020 Strategic Plan, we will achieve the following outcomes and measures by January 1, 2020.

### Assuring Access to a Full Spectrum of Cost-Effective, Quality Care

- **EBIDA** - Will be maintained above the CLA benchmark for CAH.
- **Days Cash on Hand** - Will achieve and maintain 120 days cash on hand.
- **Accounts Receivable Days** - Will be below 55 by January 1, 2020.
- **Debt Service Coverage** - Will be maintained above 2.0.
- **Operating Income** - Will be maintained between 3-5%.
- **PL National Quality Indicators** - Will achieve a five star rating on the quality component of the CMS Nursing Home Compare by January 1, 2020.
- **PL Minnesota Quality Indicator Score** - Will achieve and maintain a quality score five points above the Minnesota average on the 35 point scale.
- **PH Hospital Quality** - We will be at or above target on 60% of the Sanford quality measures.
- **PH Clinic Quality** - The following seven chronic disease measures will be within Sanford standards by 1-1-2020: diabetes, vascular, hypertension, colorectal, mammography, asthma control, and depression.

### Advancing Person-Centered Care Throughout Our Continuum

- **PH Hospital Patient Satisfaction** - "Overall Score" and "Likelihood to recommend" top box score will be 90.0% by January 1, 2020.
- **PH Clinic Patient Satisfaction** - "Overall Score" and "Likelihood to recommend will both be at or above the 50th percentile by January 1, 2020. In addition, two questions will be selected each year and the target will be to get above the 90th percentile by year-end on those specific questions.
- **PL Nursing Home Resident Quality of Life Survey** - "Overall Score" and "Likelihood to recommend" will be maintained above the 90th percentile.

### Assuring That We Are a Provider and Employer of Choice

- **PH Hospital Market Share** - Market share for our primary service area will stay above the following: 40% OB, 45% General Medicine, 20%, General Surgery. Market share for the Perham zip code will remain above: 55% OB, 65% General Medicine, 35% General Surgery.
• **PL Long-Term Care Occupancy** - Occupancy in the five long-term-care households will be at 99%.

• **PL Transitions Occupancy** - Occupancy of transitions will be above 80%.

• **PH Turnover** - Achieve and maintain a turnover rate of 15% or less.

• **PL Turnover** - Achieve and maintain a turnover rate of 25% or less.

• **PL Just Culture** - Overall Perception of safety will remain above 90%.

• **PH Hospital Just Culture** - Overall perception of safety will increase to 70%.

• **PH Clinic Just Culture** - Overall perception of safety will increase to 75%.

• **PH Retention** - Will be measured and goal set after the fiscal year ends.

• **PL Retention** - Will be measured and goal set after the fiscal year ends.

• **Employee Satisfaction** - Increase the overall employee satisfaction score each year over the prior year during the term of this strategic plan.

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**ADVANCING POPULATION HEALTH INITIATIVES**

• **Provider FTEs** - Increase or maintain the net provider FTE each year of the strategic plan.

• **BMI** - The percent of patients meeting the obesity definition in the 0 –17 and 18 – 64 categories will decline 5% by January 1, 2020. There will be no increases in the age 65+ category.

• **Chronic Disease** - The following seven measures will be within Sanford standards by January 1, 2020: diabetes, vascular, hypertension, colorectal, mammography, asthma control, and depression.

• **Access** - The four access related questions on Press Ganey will be above the 50th percentile by January 1, 2020.

---

**IMPLEMENTING BEST PRACTICES TO ASSURE OPTIMAL OUTCOMES**

• **Prevention of ED Visits** - During the course of this strategic plan we will begin a community paramedic program. One of the many goals of the program is to prevent unnecessary ED visits. While it’s too early to set a goal, we will track and report the number of ED visits prevented.

• **Readmission Rate Overall** - Will be measured and goal set after the fiscal year ends.

• **Readmission Rate NH Residents** - Will be measured and goal set after the fiscal year ends.

• **Readmission Rate Home Care Clients** - Will be measured and goal set after the fiscal year ends.
Appendix E

Perham Health Clinical Care
Quality Measures with
Sanford Health
<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
</table>
| Optimal Diabetes Goal (60%) | • Age 18-75  
• A1C <8.0  
• BP <140/90  
• Tobacco Free (smoking and smokeless)  
• If known vascular disease: ASA or antiplatelet on med list/allergy list  
• Statin recommendations or accepted contraindication:  
  o On statin if age 40-75 unless untreated LDL <70, or <40 if have vascular disease  
  o On statin if age 21-39 if LDL ≥190 or known vascular disease (unless untreated LDL <40)  
  o Age 18-20 do not need a statin to meet the measure in any situation |
| Optimal Vascular Goal (75%) | • Age 18-75  
• BP <140/90  
• Tobacco free (smoking and smokeless)  
• Statin recommendations or accepted contraindication:  
  o On statin or has statin allergy/contraindication, unless untreated LDL <40  
  o Age 18-20 do not need a statin to meet the measure in any situation  
• ASA or antiplatelet on med list or allergy list |
| Optimal Asthma Adult Goal (70%) | • Age 5-50  
• Asthma Control Test (ACT) score ≥ 20 and completed within the last year  
• <2 patient-reported ED visits & inpatient hospitalizations related to asthma combined in the last 12 months |
| Optimal Asthma Peds Goal (75%) | • Ages 5-50  
• Written asthma self-management plan within the past year that includes:  
  o Information on medication doses and purposes of medications  
  o Information on how to recognize and what to do during an exacerbation |
| Depression Remission Goal (11%) | • Age 18+  
• Percentage of adults patients who have reached remission at six months (+/- 30 days) after an PHQ-9 score greater than nine with a visit diagnosis of depression. Remission is defined as a PHQ-9 score less than five. |
| Colorectal Cancer Screening Goal (80%) | • Ages 50-75  
• Up to date with appropriate colorectal cancer screening:  
  o Colonoscopy within ten years  
  o Stool Blood Tests within the last 12 months |
| Breast Cancer Screening Goal (85%) | • Women Ages 40-75 years of age  
• Mammogram in the last two years |
| Hypertension Goal (90%)     | • Age 18-59  
• <140/<90  
• Age 60+ WITH Diabetes, Vascular, or Renal Diseases  
  • <140/<90  
• Age 60+ WITHOUT Diabetes, Vascular, or Renal Diseases  
  • <150/<90 |
Appendix F

Perham Area

Community Resources
Community Resources in Otter Tail County and Neighboring Communities

**Home Health Care, Chores, Homemaking Services**

**Home Health Care**

**Perham Living – Home Health Care**  www.perhamhealth.org  
Phone: 218-347-1880  
Address: 665 3rd St SW, Perham, MN 56573  
**Ecumen Community Home Health** (branch office of PLHC)  
Phone: 218-847-7158  
Address: Detroit Lakes, MN

**Accra Home Health Care Services**  
Phone: 218-736-0246 or 877-736-0246  
Address: 119 E Lincoln, Fergus Falls  
(branch office in Moorhead, MN)  
Phone: 218-233-1000

**Caring Hands Home Care Inc.**  
Phone: 218-837-5572  
Address: P.O. Box 197, Sebeka, MN 56477

**Lake Country Home Care, LLC**  
Phone: 218-385-3422  
Address: 95 Miller St. East  New York Mills, MN 56567
New Dimensions Home Health Care  www.newdimensionsshhc.com
Phone: 218-739-5856
Address: 312 N Tower Rd, Fergus Falls, MN 56537

Lakeland Hospice and Home Care  www.lakelandhospicehomecare.org
Phone: 218-998-1400 or 888-820-7885
Address: 120 S Union Ave, Fergus Falls, MN 56537-2517

Sanford Home Care
Phone: 218-863-2273
Address: PO Box 645, 211 East Mill, Pelican Rapids, MN 56572

Tender Hearts Home Care
Phone: 218-385-3466 or 877-362-9784
Address: 42690 CTY HWY 67, New York Mills, MN 56567

Essentia Home Health
Phone: 218-847-0808
Address: 1027 Washington Ave., Detroit Lakes, MN 56501

Harmony Home Health Care, LLC
Phone: 218-998-3750 or 218-205-0575

<table>
<thead>
<tr>
<th>Homemaking and Errand Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Tidy Homemaking</td>
</tr>
<tr>
<td>Phone: 218-205-4330</td>
</tr>
<tr>
<td>Address: 450 1st Ave S., Perham, MN 56573</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ghost Runner Errand Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.ghostrunner-mn.com">www.ghostrunner-mn.com</a></td>
</tr>
<tr>
<td>Phone: 218-346-2650 or Cell: 218-371-9491</td>
</tr>
<tr>
<td>Address: 745 West Main St., Perham, MN 56573</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neighbor to Neighbor; A Living at Home/Block Nurse Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: 218-334-3559</td>
</tr>
<tr>
<td>Address: PO Box 141, Frazee, MN 56544</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Helping Hands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: 218-731-7185</td>
</tr>
<tr>
<td>Address: 36591 Co Rd 14, PO Box 61, Richville, MN 56576</td>
</tr>
</tbody>
</table>
Emergency Response Systems

Medical Alert Line (Arvig)
Phone: 1-866-937-4227

Lifeline
Phone: 1-800-543-3546

Tri County Home Monitoring System
Phone: 1-218-631-3510

Essentia Home Health
Phone: 1-218-847-0808
1027 Washington Ave.
Detroit Lakes, MN 56501

Pioneer Link
Phone: 218-998-2628

Hospice care is designed to provide end of life care and support to patients and their families.

Hospice of the Red River Valley  www.hrrv.org
800-237-4629
1701 38th Street S Suite 101
Fargo, ND 58103
&
Hospice of the Red River Valley – DL Office
1102 W River Rd
Detroit Lakes, MN 56501
Phone: 218-847-9493

Lakeland Hospice and Home Care  www.lakelandhospicehomecare.org
P.O. Box 824
Fergus Falls, MN 56573
Phone: 218-998-1400 or 1-888-820-7885

Legacy Home Care/Hospice
Phone: 218-631-7480
Fax: 218-632-1336
Address: 201 Shady Lane Dr Wadena, MN 56482

Elderly Subsidized Rental Housing & Housing with Services

Elderly Subsidized Rental Housing (Some with customized services)
Perham
Lakeland Apartments
Phone: 218-346-7045
Address: 2111 2nd Ave SE

New York Mills
Finlandia
Phone: 800-728-5401
Address: 107 Edgewood St.

Kaleva Apartments
Phone: 218-385-3273 or 385-2884
Address: 205 Walker Ave N

Heritage Manor
Phone: 218-385-2005
Address: 105 Edgewood St., PO Box 188

Scandia Apartments
Phone: 218-385-2802
Address: 104 Edgewood

Battle Lake
Summit Village
Phone: 1-800-728-5401
Address: 102 Madison

Henning
Our Home Your Home
Phone: 218-583-4428
Address: 609 Front Street,

Willow Creek Senior Community
Phone: 218-548-6683
Address: 500 Willow Creek Drive

Adult Day Services

735 Third St SW
Perham, MN 56573
218-347-1940
Elderly Housing with Services

Perham
Briarwood
Phone: 218-347-1865
Address: 630 5th St SW

St. James Manor
Phone: 218-347-1779
Address: 415 8th Ave SW

Prairie View Assisted Living
Phone: 218-346-3080
Address: 821 7th Ave SW and
Phone: 218-346-3167
Address: 825 7th Ave SW and
Phone: 218-346-2770
Address: 826 7th Ave SW

7th Heaven Assisted Living
Phone: 218-346-7077
Address: 210 7th Ave SE

Some Place Special
Phone: 218-346-2431
Address: 449 West Main

Thomas House I
Phone: 218-346-3064
Address: 701 3rd Ave SW

Thomas House II
Phone: 218-346-3862
Address: 738 3rd Ave SW

Hadley House
Phone: 346-4475
Address: 908 Coney Street West

New York Mills
Home Sweet Home Assisted Living
Phone: 218-385-2660
Address: 412 Hummingbird Lane

Frazee
Frazee Care Center – Assisted Living
Phone: 218-334-4501 or 877-528-2874
Address: 219 West Maple

**Vergas**

**Vergas Assisted Living**
Phone: 218-334-4501 or 877-528-2874
Address: 405 E Frazee Ave

---

**Nursing Homes**

**Perham Living**
Phone: 218-347-1887
735 3rd Street SW
Perham

**Elders Home**
Phone: 218-385-2005
215 South Tousley, P.O. Box 188
New York Mills

**Frazee Care Center**
Phone: 218-334-4501 or 877-528-2874
311 West Maple
Frazee

**Battle Lake Good Samaritan Center**
Phone: 218-864-5231
605 N Lake Ave
Battle Lake

**Broen Memorial Home**
Phone: 218-998-7300
824 South Sheridan
Fergus Falls

**Pioneer Care Center**
Phone: 218-739-7700
1006 South Sheridan
Fergus Falls

**Minnesota Veterans Home**
Phone: 218-736-0400
1821 North Park
Fergus Falls

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**Golden Living Center of Henning**
Phone: 218-583-2965
907 Marshall Avenue
Henning

St. Williams Nursing Home
Phone: 218-338-4671
Address: Parkers Prairie

Pelican Valley Health Center
Phone: 218-863-2991
211 East Mill Ave
Pelican Rapids

**General Resources**

Otter Tail County Financial Services
Phone: 218-385-5450
Address: 118 N Main, New York Mills, MN 56567 and
Otter Tail County Financial Services www.co.otter-tail.mn.us
Phone: 218-998-8230
Address: 535 West Fir, Fergus Falls, MN 56537
Services: Food Stamps, General Assistance, Medical Assistance, Minnesota
Supplemental Assistance, Prescription Drug Program

Otter Tail County Human Services www.co.otter-tail.mn.us
Phone: 218-385-5450
Address: 118 N Main, New York Mills, MN 56567 and
Otter Tail County Human Services www.co.otter-tail.mn.us
Phone: 218-998-8150
Address: 530 West Fir, Fergus Falls, MN 56537
Services: Information on housing and other options, referrals, Long Term Care
Consultations to assess needs and discuss options, Vulnerable Adult services,
and information about programs to help pay for community based services.

First Call for Help
Phone: 218-736-2856 or 1-800-543-7709
Services: Comprehensive Information and referral services for of Minnesota.

Legal Services of Northwest Minnesota www.lsnmlaw.org
Phone: 1-800-450-2552
Address: 1114 Broadway, Alexandria, MN 56308
Services: Handle cases for 60+ seniors regarding such things as Medicare,
Medical Assistance, Insurance, Social Security, Supplemental Security Income,
Consumer complaints, Living Wills, Advanced Directives. (Not criminal cases or
fee-generating cases.)

Otter Tail Public Health Dept www.co.otter-tail.mn.us
Phone: 218-998-8320  
Address: 560 West Fir, Fergus Falls, MN 56537  
Services: PCA Assessments, Nursing Home telephone consultations, information on prescription drug plans, patient rights, health care directives, scams prevention.

Mahube- OTWA Community Action Partnership  
Phone: 218-739-3011  
Address: 125 W Lincoln Ave #4 Fergus Falls, MN 56537  
Services: Budget Counseling, Fuel Assistance, Home Modification aid, Income Tax Form Completion assistance, weatherization, Retired and Senior Volunteer Program (RSVP), Head Start, Family Dev. & Housing, Child Care & Kinship Support, Family Health

Senior Linkage Line www.mnaging.org  
Phone: 1-800-333-2433  
Services: Information and referral services and advocacy for seniors

Social Security Administration www.ssa.gov/chicago/minnesota.htm  
Phone: 1-800-772-1213  
Address: 1023 W Lincoln, Fergus Falls, MN 56537  
Services: Social Security benefit info, Medicare, Supplemental Security Income

Veteran Services  
Phone: 218-385-5540  
Address: 118 N Main, New York Mills, MN 56567  
Phone: 218-998-8605  
Address: Court House, Fergus Falls, MN 56537  
Services: Assistance for eligible veterans to secure benefits, transport veterans to and from Veteran's Hospital appointments

Vulnerable Adult Reporting  
Phone: 218-998-8166  
Services: To make a confidential Vulnerable Adult report for concerns you may have about a person experiencing abuse, neglect, self-neglect, or financial exploitation

West Central Area Agency on Aging  
Phone: 218-739-4617 or 800-333-2433  
Address: 313 S Mill Street, Fergus Falls, MN 56537  
Services: Links people to information and assistance that they need.

Respite Care www.caregiversupportandrespite.org  
Phone: 1-800-488-4146
Services: Provided by Lutheran Social Service MN; short-term, non-medical respite care for those 60 and over, caregiver support groups and community education

**Office of Ombudsman for Long-Term Care**
Phone: 1-800-657-3591 or 320-273-2364.
Services: A state organization to investigate concerns, mediates disputes, advocate for seniors and provide information.
Regional Advocate: Ann Holme
Phone: 1-800-657-3591 or 320-273-2364
Home Medical Equipment and Services

Perham Health Medical Accessories  
1000 Coney Street West  Perham, MN  
218-347-1582

HealthCare Accessories  
3223 32nd Ave S Fargo, ND  
701-293-8211

Arrowhealth Medical Supply  
Phone: 218-847-2837 or 1-877-386-5757  
Address: 495A Hwy 10E Detroit Lakes MN 56501

Lincare Inc. In-Home Respiratory Care Company  
Phone: 218-847-5649  
219 W Front St, Detroit Lakes MN 56501

ProvidaCare Medical Supply  
Phone: 218-844-CARE (2273) or 1-877-474-4056  
601 Highway 10 East  
Detroit Lakes, MN 56501

HERO (Healthcare Equipment Recycling Organization)  
www.fmhero.org  
Phone: 701-212-1921 or 888-524-2827  
5012 53rd St S, Suite C  
Fargo, ND 58104

Mental Health and Chemical Dependency Services/Resources

Perham Health Clinic  
Phone: 218-347-1200  
Perham  
Services: Psychology-Behavioral Health, call for appointments

Prairie St. John’s  
Phone: 1-877-333-9565  
510 4th Street South  
Fargo, ND 58103  
Services: support for psychiatric conditions and addictions

Eastern Otter Tail Community Support Program  
Phone: 218-338-5945  
Services: Outreach services supporting adults with mental illness
Mobile Mental Health Crisis Response  
Phone: 1-800-223-4512  
Services: Phone or face-to-face crisis intervention for adults & children

Lake Region Bridgeway Unit  
Phone: 218-736-8000 or 218-736-8208  
Address: 712 S Cascade Fergus Falls MN  
Services: Treating depression, manic-depressive anxiety, panic disorders, and disorders disrupting contact with reality.

Lakeland Mental Health Center  
Phone: 218-847-1676  
Address: 714 Washington Ave, Detroit Lakes, MN and  
Phone: 218-736-6987  
Address: 126 Alcott Ave E Fergus Falls MN  
Services: Individual, group, family, and marital therapy; and professional home based services; court evaluation; day treatment, family rehabilitation, domestic violence, chemical dependency outpatient treatment, and employee assistance programs.

Lutheran Social Services of Minnesota  
Phone: 218-847-0629  
Address: 211 W. Holmes, Detroit Lakes, MN and  
Phone: 218-736-5431  
Address: 731 Western Ave Fergus Falls MN  
Services: Provide Family Resource workers, Intensive In-Home Treatment, couples, family, individual, and group therapy, and classes.

Otter Tail County Human Services  
Phone: 218-998-8150  
Address: 530 Fir Ave West Fergus Falls MN  
Services: Provides consultation, information & referral; plans and arranges for the delivery of mental health services with Otter Tail County.

Alcoholics Anonymous (AA)  
Phone: 1-877-833-2327  
Nutrition and Services

Home Delivered Meals

Meals On Wheels by Nutrition Services Inc.
Phone: 218-347-1558  Perham Health Dietary Dept.
Services: Meals delivered within Perham city limits and regional nutrition services at 1-877-677-3319
Services: Home delivered meal per day M-F available in areas covered.

Mom’s Meals
Phone: 866-204-6111 or fax 515-382-3789
Web Site: http://www.momsmeals.com
Services: ready to heat and eat meals shipped directly to customer’s doorstep, remain fresh in refrigerator for two full weeks.

Congregate Dining

Senior Dining by Nutrition Services Inc.
Perham (346-2262), Heritage Manor (385-2005), New York Mills (385-2024), Kaleva (385-3273), Battle Lake (864-8768), Vergas (342-2810) and Pelican Rapids (863-5225). **Contact the congregate site between 10:30am and 1:00pm.
Phone: 1-877-677-3319, or 320-677-3319 for other locations or information.
Services: Noon meal 3-5 times per week in a congregate setting, planned presentations and fellowship.

Grocery Programs

FARE for all
Phone: 218-736-5016 or 1-800-582-4291
Services: Discounted food packages.

NAPS (Nutrition Assistance Program for Seniors)
Phone: 800-365-0270
Services: If you are 60 years of age or older and meet an income requirement, you are eligible for a monthly free food box.
Transportation

**Local**

**Perham**

**Otter Express**

Phone: 866-998-3002

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**County-wide**

*Note: If Medicaid is to be the pay source, use an approved carrier and get preauthorization from the financial worker or Managed Care Provider.*

**Medi Van**

Phone: 1-800-422-0976

Address: Detroit Lakes

Purpose: 24 hour door to door, for local or distant medical appointments.

**Care A Van**

Phone: 1-877-832-0168

2010 E State Hwy 210

Fergus Falls **and**

Phone: 1-800-500-6699

Address: Fargo/Moorhead

**Peoples Express**

Phone: 1-800-450-0123

12182 US Hwy 10

Wadena

Purpose: 24 hour door to door, for local or distant medical appointments.

**Otter Tail County Volunteer Transportation Program**

Phone: 866-998-3002

Purpose: Local or distant health related appointments.

**Veterans Service Office Hospital Transport Van**

Phone: 218-998-8605

Clientele: All Veterans only. Not handicapped accessible. Ambulatory only.

Purpose: To Veterans Hospitals in Fargo, St. Cloud, and Minneapolis
Vision/Hearing Assistance/Dental

** For other resources, please refer to the yellow pages in local phone book under such headings as eye, physician, optometrist, hearing aids and dentists.

**Visual**

**Minnesota State Services for the Blind**
Phone: 1-218-236-2422 or 1-800-657-3755
Address: 715 11th St N Ste 205 Moorhead MN 56560
Clientele: Any age with visual impairments
Services: Low vision equipment such as magnifiers, talking book library, radio talking book; adjustment to blindness, rehabilitation counseling, independent living skills training, Braille training.
Cost: Most services, aids, and devices are free.

**The Store**
Phone: 1-800-652-9000
Address: 2200 University Ave W Ste 240 St. Paul MN 55114-1840
Services: Variety of equipment and assistance device, mail order catalog available.

**Hearing**

**Family Service Center of Clay County; Deaf and Hard of Hearing Services**
Phone: 218-291-5880 or 1-800-456-7589 or TTY 866-488-3829
Address: 715 11th Street North, Suite 204, Moorhead, MN 56560
Services: Referral, consultation, library, equipment demonstration, interpreter referral, and free telephone related equipment distribution to eligible individuals

**Dental**

Individual dentists may be contacted for services, making sure to note the type of payment source involved. For information regarding the availability of special clinics that may be scheduled for Medical Assistance recipients, please contact Otter Tail County Public Health at 218-998-8320.

For a more detailed and expansive list of services available in Otter Tail County and the surrounding areas, please access information at: http://www.co.otter-tail.mn.us/humanservices/seniordirectory/default.php
Appendix G

Mental Health

Messaging/Education Sample

Make It OK Campaign
Mental Illnesses.
1 in 4 will have some kind of mental illness in their lifetime.

Just how common is 1 in 4?
Just as common as iPhone® customers.
1 in 4

More common than grey cars
1 in 6

60 Million Americans are affected each year.

More common than people with tattoos
1 in 7

A public survey showed most people thought mental illnesses were related to:

STRESS
LACK OF WILLPOWER
WEAKNESS

THIS IS STIGMA.

1 in 10

More common than left-handed people

How can we fix it? Talking.
The more we talk, the more we’ll realize that these illnesses are not unique and that they are treatable.
It’s how we’ll make it ok.

Make It OK.org

Appendix H

Survey Document
1. In general, would you say that your health is:
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor

2. Have you ever been told by a doctor, nurse, or other health care professional that you had any of the following health conditions?
   - High blood pressure/hypertension
   - Diabetes
   - Cancer
   - Chronic lung disease (including COPD, chronic bronchitis or emphysema)
   - Heart trouble or angina
   - Stroke or stroke-related health problems
   - PAD (peripheral artery disease) or claudication (leg cramps during exercise)
   - High cholesterol or triglycerides
   - Asthma
   - Arthritis
   - Depression
   - Anxiety
   - Panic attacks
   - Alzheimer’s disease
   - Other mental health problems

3. How long has it been since you last visited a doctor or other health care professional for a routine check-up?
   - Within the past year
   - Within the past 2 years
   - 5 or more years ago

4. Do you have one person who you think of as your personal doctor or health care provider?
   - Yes, only one person
   - Yes, more than one person
   - No

5. What kind of place do you usually go to when you are sick or need advice about your health? (Please mark only ONE)
   - Physician’s office
   - Public Health department or clinic
   - Some other free or discounted clinic
   - Hospital emergency room
   - Urgent care clinic
   - No usual place

6. How long has it been since you last visited a dentist or dental clinic for any reason?
   - Within the past year
   - Within the past 2 years
   - 5 or more years ago

7. Where do you get most of your health-related information? (Mark ALL that apply)
   - Government websites (e.g., local public health, CDC)
   - Non-government websites (e.g., WebMD)
   - Television
   - Magazines, newspapers, or books
   - Doctor or other healthcare professional
   - Family or friends
   - Telephone helpline
   - Other: ___________________________
8. What is the best way for you to access technology for health information? (Mark ALL that apply)
   - Personal computer or tablet
   - Public computer (e.g., library, community center)
   - Smart phone
   - Other: ____________________________
   - None

9. Do you currently have any of the following types of health insurance? (Please mark yes or no for each.)
   - Yes
   - No
   a. Health insurance or coverage through your employer or your spouse/partner, parent, or someone else's employer
   b. Health insurance coverage bought directly by yourself or your family (not through an employer)
   c. Indian or Tribal Health Service
   d. Medicare
   e. Medicaid, Medical Assistance (MA), or Prepaid Medical Assistance Program (PMAP)
   f. Minnesotacare
   g. CHAMPUS, TRICARE, or Veteran's benefits
   h. Other health insurance or coverage (Please specify) ____________________________
   i. NO health insurance coverage

10. Do you have any insurance that covers dental care or other oral health needs??
    - Yes
    - No
    - Don't know

11. Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

12. Over the past two weeks, how often have you been bothered by any of the following problems?
    a. Little interest or pleasure in doing things
       - Not at all
       - Several days
       - More than half the days
       - Nearly every day
    b. Feeling down, depressed or hopeless
       - Not at all
       - Several days
       - More than half the days
       - Nearly every day

13. A serving of vegetables—not including French fries—is one cup of salad greens or a half cup of vegetables. How many servings of vegetables did you have yesterday?

14. A serving of fruit is a medium-sized piece of fruit or a half cup of chopped, cut or canned fruit. How many servings of fruit did you have yesterday?

15. A serving of 100% fruit juice is 6 ounces. How many servings of fruit juice did you have yesterday?

16. During the past 30 days, other than your regular job, did you participate in any physical activity or exercises such as running, calisthenics, golf, gardening, or walking for exercise?
    - Yes
    - No
17. During an **average week**, other than your regular job, how many days do you get at least 30 minutes of moderate activity? Moderate activities cause only light sweating and a small increase in breathing or heart rate.

- 0 days  
- 1 day  
- 2 days  
- 3 days  
- 4 days  
- 5 days  
- 6 days  
- 7 days

18. During an **average week**, other than your regular job, how many days do you get at least 30 minutes of vigorous activity? Vigorous activities cause heavy sweating and a large increase in breathing and heart rate.

- 0 days  
- 1 day  
- 2 days  
- 3 days  
- 4 days  
- 5 days  
- 6 days  
- 7 days

Below is a list of preventive screenings and procedures that you may have had in the past 12 months. Please tell us

a) whether or not you had each of the procedures in the past 12 months, and

b) if you did **not** have the procedure, why not? (Mark ALL that apply)

<table>
<thead>
<tr>
<th><strong>19a. Have you had this procedure in the past 12 months?</strong></th>
<th><strong>19b. If you <strong>have not</strong> had this procedure in the past 12 months, why not?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Screenings</strong></td>
<td><strong>(Mark ALL that apply for each procedure)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>Blood pressure screening</td>
<td>(Y)</td>
</tr>
<tr>
<td>Blood sugar screening</td>
<td>(Y)</td>
</tr>
<tr>
<td>Bone density test</td>
<td>(Y)</td>
</tr>
<tr>
<td>Cardiovascular screening</td>
<td>(Y)</td>
</tr>
<tr>
<td>Cholesterol screening</td>
<td>(Y)</td>
</tr>
<tr>
<td>Dental screening and X-rays</td>
<td>(Y)</td>
</tr>
<tr>
<td>Flu shot</td>
<td>(Y)</td>
</tr>
<tr>
<td>Glaucoma test</td>
<td>(Y)</td>
</tr>
<tr>
<td>Hearing screening</td>
<td>(Y)</td>
</tr>
<tr>
<td>Immunizations (e.g., tetanus, hepatitis A or B)</td>
<td>(Y)</td>
</tr>
<tr>
<td>Pelvic exam (<strong>women only</strong>)</td>
<td>(Y)</td>
</tr>
<tr>
<td>STD (sexually transmitted disease) screening</td>
<td>(Y)</td>
</tr>
<tr>
<td>Vascular screening (i.e., stroke or carotid artery ultrasound)</td>
<td>(Y)</td>
</tr>
</tbody>
</table>

| **Cancer Screenings**                                    | **(Mark ALL that apply for each procedure)**                 |
|                                                          | **Yes** | **No** | **Not necessary** | **Doctor hasn't suggested** | **Cost/no insurance/insurance does not cover** | **Fear of procedure or results** | **Transportation problems/can't get appointment** | **No providers offer this procedure or screening** | **Other reason** |
| Breast cancer screening (Mammogram, breast exam)         | (Y)     | (N)    | Y                | 2                          | 3                                    | 4                          | 0                          | 0                          | 0              |
| **(women only)**                                         | **Cervical cancer screening (Pap smear) (**women only**)**   | (Y)     | (N)    | Y                | 2                          | 3                                    | 4                          | 0                          | 0              |
| Colorectal cancer screening (e.g., colonoscopy, fecal occult blood test, barium enema) | (Y) | (N) | Y | 2 | 3 | 4 | 0 | 0 | 0 |
| Prostate cancer screening (PSA blood test and/or digital exam) (**men only**) | (Y) | (N) | Y | 2 | 3 | 4 | 0 | 0 | 0 |
| Skin cancer screening                                     | (Y)     | (N)    | Y                | 2                          | 3                                    | 4                          | 0                          | 0                          | 0              |
20. Have you smoked at least 100 cigarettes in your entire life? (100 cigarettes = 5 packs)
   ○ Yes   ○ No  → GO TO QUESTION 23

21. Do you now smoke cigarettes every day, some days, or not at all?
   ○ Every day   ○ Some days   ○ Not at all

22. During the past 12 months have you stopped smoking for one day or longer because you were trying to quit?
   ○ Yes   ○ No

23. Do you now use chewing tobacco or snuff every day, some days, or not at all?
   ○ Every day   ○ Some days   ○ Not at all

24. Where would you first go for help if you wanted to quit using tobacco? (Please mark only ONE)
   ○ Telephone quitline
   ○ Private counselor/therapist
   ○ Doctor or other healthcare professional
   ○ Public Health department or clinic
   ○ I don’t use any tobacco products
   ○ I don’t want to quit
   ○ Don’t know
   ○ Other: ________________________________

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

26. During the past 30 days, on the days when you drank, about how many drinks did you drink on average? (A drink is one can of beer, one glass of wine, or a drink with one shot of liquor.)
   ○ 1   ○ 2   ○ 3   ○ 4   ○ 5   ○ 6   ○ 7   ○ 8   ○ 9   ○ 10 or more drinks

27. Considering all types of alcoholic beverages, how many times during the past 30 days did you have...
   FOR FEMALES: 4 or more drinks on an occasion
   FOR MALES: 5 or more drinks on an occasion

28. Have you ever had a problem with...
   a. Alcohol use?

29. If yes, did you get the help you needed?
   ○ Yes   ○ No

30. Over the past two years...
   a. Has alcohol use had harmful effects on you or a family member?

   b. Has prescription or non-prescription drug abuse had harmful effects on you or a family member?
31. Are you:
   - Male
   - Female

32. Your age group:
   - 18 to 24 years
   - 25 to 34 years
   - 35 to 44 years
   - 45 to 54 years
   - 55 to 64 years
   - 65 to 74 years
   - 75+ years

33. Are you of Hispanic or Latino origin?
   - Yes
   - No

34. What best describes your race/ethnicity? (Mark ALL that apply)
   - White
   - Black or African American
   - American Indian or Alaska Native
   - Asian or Pacific Islander
   - Other: ______________________

35. About how much do you weigh without shoes?

   Write your weight in the boxes, then fill in the matching oval beneath each box.

   EXAMPLE
   1 2 3

   Pounds

36. About how tall are you without shoes?

   Feet
   Inches

37. Including yourself, how many adults live in your household?

   Number of adults: 1 2 3 4 5 6 7 8 9 10 11 12 or more

38. What is the highest level of education you have completed? (Please mark only ONE)
   - Did not complete 8th grade
   - Did not complete high school
   - High school diploma/GED
   - Trade/Vocational school
   - Some College
   - Associate degree
   - Bachelor's degree
   - Graduate/Professional degree

39. Household income per year?
   - Less than $20,000
   - $20,000 to $39,999
   - $40,000 to $69,999
   - $70,000 to $119,999
   - $120,000 or more

40. Are you currently...(Mark ALL that apply.)
   - Employed
   - Self-employed or farmer
   - Unemployed or out of work
   - A homemaker or stay-at-home parent
   - A student
   - Retired
   - Unable to work because of a disability
41. What is your home zip code?
Write your zip code in the boxes, then fill in the matching oval beneath each box.

42. How long have you lived in your community?
- Less than 2 years
- 2 to 5 years
- More than 5 years

43. Do you own or rent your home?
- Own
- Rent
- Other arrangement: ___________________________

44. How many children younger than 18 years of age live in your household?
- None
- 1 to 2
- 3 to 5
- 6 or more
If None, go to Q48

45. What kind of place do you usually take your child/children to when they are sick? (Please mark only ONE)
- Physician's office
- Public Health department or clinic
- Some other free or discounted clinic
- Hospital emergency room
- Urgent care clinic
- No usual place
- Other place: ___________________________

46. Are all children in your household current (up to date) on their immunizations?
- Yes, all children
- No, not all children
- Don't know

47. Do all children in your household, aged 6 months or older, get a flu shot or flu mist each year?
- Yes
- No
- Don't know
- Not applicable
Using a 1 to 4 scale, with 1 being "not at all concerned" and 4 being "very concerned," please tell us your level of concern about health and wellness issues in your community.

<table>
<thead>
<tr>
<th>Considering your community, what is your level of concern with...</th>
<th>Level of concern</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>48. ECONOMICS</strong></td>
<td></td>
</tr>
<tr>
<td>a. Availability of affordable housing</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>b. Homelessness</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>c. Hunger</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td><strong>49. TRANSPORTATION</strong></td>
<td></td>
</tr>
<tr>
<td>a. Availability of public transportation</td>
<td>1 2 3 4</td>
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<tr>
<td>b. Cost of public transportation</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>c. Driving habits (e.g., speeding, road rage)</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>d. Availability of good walking or biking options (as alternatives to driving)</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td><strong>50. ENVIRONMENTAL</strong></td>
<td></td>
</tr>
<tr>
<td>a. Water quality</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>b. Air quality</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>c. Home septic systems</td>
<td>1 2 3 4</td>
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<tr>
<td>d. Hazardous waste</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td><strong>51. CHILDREN AND YOUTH</strong></td>
<td></td>
</tr>
<tr>
<td>a. Availability of services for at-risk youth</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>b. Cost of services for at-risk youth</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>c. Youth crime</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>d. School dropout rates</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>e. School absenteeism</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>f. Teen pregnancy</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>g. Bullying</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>h. Availability of activities for children and youth</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>i. Cost of activities for children and youth</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>j. Availability of quality child care</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>k. Cost of quality child care</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>l. Availability of quality infant care (birth to 2 years)</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>m. Cost of quality infant care</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td><strong>52. THE AGING POPULATION</strong></td>
<td></td>
</tr>
<tr>
<td>a. Availability of activities for seniors</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>b. Cost of activities for seniors</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>c. Availability of resources to help the elderly stay safe in their homes</td>
<td>1 2 3 4</td>
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<tr>
<td>d. Availability of resources for family/friends caring for and making decisions for elders</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>e. Availability of resources for grandparents caring for grandchildren</td>
<td>1 2 3 4</td>
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<tr>
<td>f. Availability of long term care</td>
<td>1 2 3 4</td>
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<tr>
<td>g. Cost of long term care</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>h. Availability of memory care</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td><strong>53. SAFETY</strong></td>
<td></td>
</tr>
<tr>
<td>a. Child abuse and neglect</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>b. Elder abuse</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>c. Domestic violence</td>
<td>1 2 3 4</td>
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<tr>
<td>d. Presence of street drugs, prescription drugs, and alcohol in the community</td>
<td>1 2 3 4</td>
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<tr>
<td>e. Presence of drug dealers in the community</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>f. Presence of gang activity</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>g. Crime</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>h. Sex trafficking</td>
<td>1 2 3 4</td>
</tr>
</tbody>
</table>
54. HEALTH CARE
a. Access to affordable health care
b. Access to affordable prescription drugs
c. Access to affordable health insurance
d. Cost of affordable vision insurance
e. Cost of affordable dental insurance coverage
f. Distance to health care services
g. Providers not taking new patients
h. Coordination of care between providers and services
i. Availability of non-traditional hours (e.g., evenings, weekends)
j. Availability of transportation
k. Use of emergency room services for primary health care
l. Timely access to vision care providers
m. Timely access to dental care providers
n. Timely access to prevention programs and services
o. Timely access to bilingual providers and/or translators
p. Timely access to transportation
q. Timely access to doctors, physician assistants, or nurse practitioners
r. Timely access to physician specialists
s. Timely access to registered dietitians
t. Timely access to exercise specialists or personal trainers
u. Timely access to mental health providers
v. Timely access to substance abuse providers

55. PHYSICAL AND MENTAL HEALTH
a. Obesity
b. Poor nutrition and eating habits
c. Inactivity and lack of exercise
d. Cancer
e. Chronic disease (e.g., diabetes, heart disease, multiple sclerosis)
f. Sexually transmitted diseases (e.g., AIDS, HIV, chlamydia)
g. Infectious diseases such as the flu
h. Dementia and Alzheimer's disease
i. Depression
j. Stress
k. Suicide
l. Other psychiatric diagnoses

56. SUBSTANCE USE AND ABUSE
a. Alcohol use and abuse
b. Drug use and abuse
c. Underage drinking
d. Underage drug use and abuse
e. Smoking and tobacco use
f. Exposure to second-hand smoke

Additional comments you would like to share:

Thank you for assisting us with this important survey!