2019-2021
Community Health Needs Assessment
Lake Region Healthcare

Lake Region
HEALTHCARE

August 7, 2019

Dear Community Members,

Lake Region Healthcare (LRH) is pleased to present you with the 2019 Community Health Needs Assessment (CHNA). This assessment is completed every three years and represents a collaborative effort to identify the unmet health needs in our community.

I'd like to thank the many stakeholders and community members who participated in our surveys, focus group interviews and data analysis. Together we have identified the following as top concerns for people in our region:

- Mental Health
- Substance Abuse
- Lack of Awareness of Available Resources
- Chronic Disease – Obesity, Cancer, Heart Disease, Diabetes

Over next few months we will be setting goals and strategies to address these priority issues facing our community which are outlined in this CHNA document.

We are committed to improving the health of people in our region by continually working with our community partners to understand the barriers preventing people from achieving their optimal health and addressing these barriers in a person-centered approach. We hope the result of this assessment and pursuant strategies to address the identified needs will be a marked and measurable improvement in the lives of the people we serve.

Sincerely,

Kyle Richards, CEO

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Introduction

Lake Region Healthcare's commitment to creating a healthy community through effective hospital-community partnerships is an essential part of our mission. We have a proud history of investing in community health and wellness programs and partnering with County, State and other organizations to identify and address the most urgent health needs in the communities we serve.

The Patient Protection and Affordable Care Act (PPACA) of 2010 require all non-profit hospitals conduct a community health needs assessment (CHNA) at least once every three years and to develop an implementation strategy to meet the needs identified by the CHNA.

Internal Revenue Service Section 501(r)(3) and Revenue Ruling 69-545 stipulate that each non-profit hospital must have the following components to be in compliance:

1. CHNA report that defines the community it serves, describes the needs identified, prioritizes the needs, identifies resources available to meet the needs and evaluates impact of any actions taken to address the needs identified in the most recently completed CHNA.
2. Implementation strategy plan that describes how the hospital plans to address the needs identified in the CHNA including what resources the hospital plans to commit. The implementation plan must also include an explanation as to why the hospital will not address an identified need, if any.
3. The CHNA must be adopted by an authorized body of the hospital facility and publicized by the end of the applicable taxable year.
4. The implementation plan must be adopted by an authorized body of the hospital facility and reported on the IRS Form 990 by the fifteenth day of the fifth month after the taxable year ends.

The regulations also require that the hospital takes into account input from persons who represent the broad interest of the community including the local public health department, members of the medically underserved, low-income and minority populations or organizations representing their interest and written comments received on the hospital's most recently completed CHNA and implementation strategy.

Methodology

For the Community Health Needs Assessment process, Lake Region Healthcare referred to the Mobilizing for Action through Planning and Partnerships (MAPP) framework for guidance.[1] This community-wide planning and action-oriented process was developed by the National Association of County and City Health Officials in partnership with the Public Health Practice

Program Office of the Centers for Disease Control and Prevention. MAPP is a community-driven process rooted on partnership development, assessment of needs and assets and strategic planning on how to efficiently use available resources to address the prioritized health needs.

The MAPP process consists of the following four assessments:

1. Community Themes and Strengths
2. Local Public Health System Assessment
3. Forces of Change
4. Community Health Status
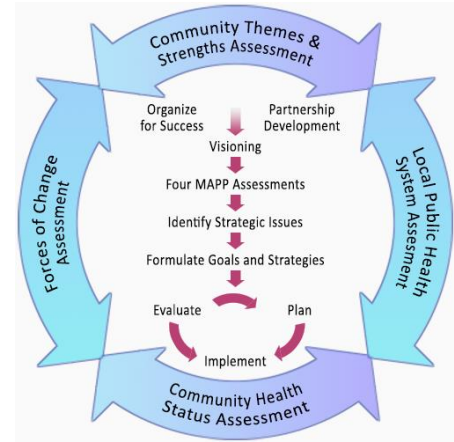
For this cycle of the CHNA, we completed two of the four assessments – (1) Community Themes and Strengths and (2) Community Health Status.

Input from community partners and stakeholders, especially public health and those representing the underserved and low-income populations were taken into account.

Planning (Feb - March)	Form work group	Kick-off meeting	Present process to LRHC Board	
Assessment (March - May)	Define service areas	Collect and analyze primary and secondary data	Gather input from community - focus groups	Evaluate progress on 2016 action plan
Prioritization (May - June)	Set criteria and method for prioritizing needs	Assess community assets and resources	Prioritize health needs	
Documentation/ Aproval (July - August)	CHNA Report	Present to LRHC Board for approval	Publicize CHNA Report	
Strategic Planning (November)	Choose strategies or programs	Set SMART objectives	Develop evaluation plan	
Documentation/ Approval (December)	Implementation Plan	Present to LRHC Board for approval	Publicize Implementation Plan	

Data Limitations and Gaps

Although special consideration for the inclusion of low income and underserved population representation was given in the sampling, there are still notable limitations to the data evaluated.

PartnerSHIP 4 Health Community Health Assessment Survey and MN Student Survey – Results are based on information reported directly by the respondent, so it may be subject to a number of sources of possible error. It is also possible that the people who choose to respond to the surveys are different from those who do not.

Focus Group – We used purposive sampling to identify focus group participants. The perspectives captured simply represent the partners who agreed to participate.

Secondary data – We relied heavily on several local, state and national entities with publicly available data. Al limitations inherent in these sources remain present for this assessment.

Community

Otter Tail County, established in 1868, is 1972 square mile community located in West Central Minnesota. It is home to 58,345 residents, two state parks – Maplewood and Glendalough – and over 1,000 of Minnesota's lakes. Its county seat, Fergus Falls, with 13,783 residents, is where Lake Region Healthcare, is one of two hospitals located in the county.
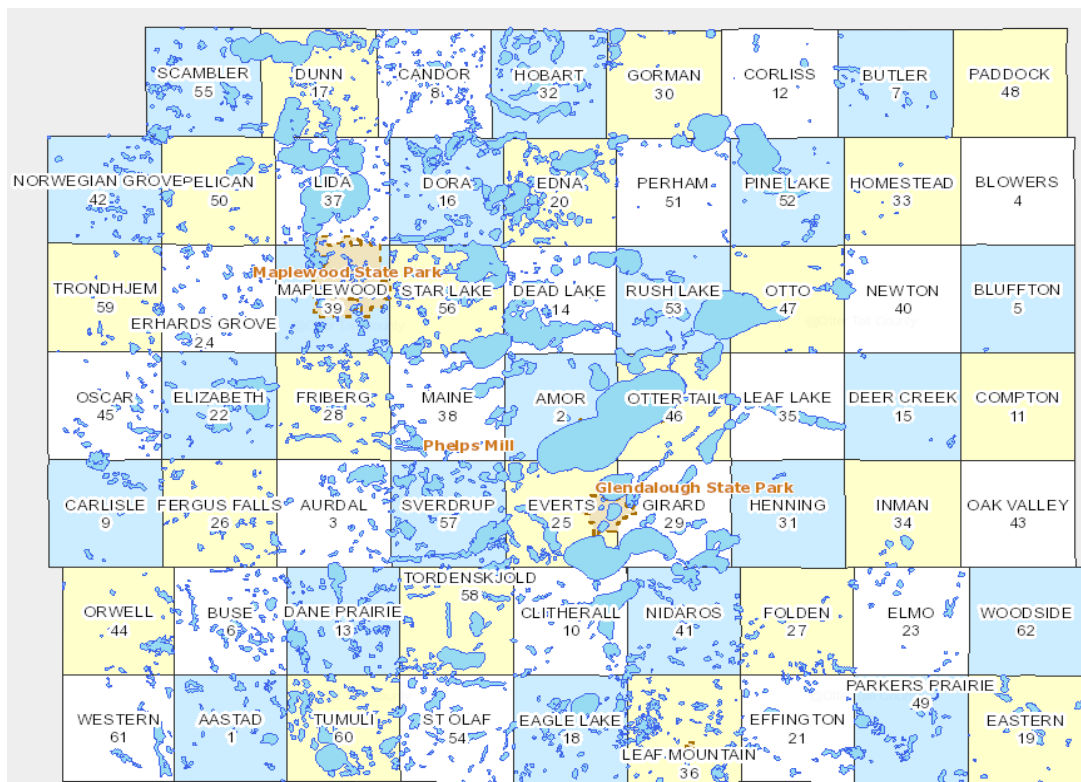
Lake Region Healthcare is a non-profit integrated healthcare system with a 108-bed hospital comprised of an 80-bed acute hospital and 14-bed psychiatric unit. In addition, Lake Region Healthcare multi-specialty clinic, cancer care center, assisted living facility and a group fitness facility in our main campus in Fergus Falls, MN. Expanded clinic hours are offered at our west-side Walk-In clinic and clinic services are provided in Ashby, Battle Lake and Barnesville.

Barnesville, a city in Clay County, is centrally located between Fargo-Moorhead and Fergus Falls. Located on the edge of the Red River Valley, the city is surrounded by beautiful terrain including flat fields, rolling hills, creeks and lakes. Barnesville Area Clinic is a full-service outreach facility that joined Lake Region Healthcare in 2014.

Lake Region Healthcare provides a full array of primary and secondary patient services to rural West Central Minnesota covering most of Otter Tail County and portions of Grant, Clay and Wilkin Counties.

Lake Region Healthcare has a Level III Trauma designation and is designated as an Acute Stroke Ready Hospital by MN Department of Health through MN Statutes 2013 144.492-494. Lake Region Healthcare is accredited by the Joint Commission and also received their Gold Seal of Approval demonstrating our compliance to the most stringent standards of performance. Notably, in 2017, it was named as one of the top 100 Rural & Community Hospitals in the United States by The National Rural Health Association's Rural Health Policy Institute, iVantage Health Analytics and The Chartis Center for Rural Health.

Lake Region Healthcare is the largest employer in Otter Tail County. With around 90 medical staff and over 900 employees, all teams are dedicated to serving patients and the extended community with integrity, teamwork, compassion and excellence. Lake Region Healthcare is governed by a 13-member Board of Trustees. These trustees are dedicated community members who care deeply about the health care services and people served by Lake Region Healthcare. Lake Region Healthcare works closely with other organizations and agencies within the community such as Otter Tail County Public Health and Human Services, senior centers, Skilled Nursing Facilities, mental health providers, group homes, assisted living facilities and other community resources.

> *"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."*
>
> **- Preamble of the Constitution of the World Health Organization**

For more than 100 years, Lake Region Healthcare has been dedicated to providing high-quality, affordable health care services and to improving the health and well-being of the communities we serve. We believe good health is a fundamental right shared by all and we recognize that health extends beyond the clinic

and hospital walls. An individual's health and well-being is influenced by a multitude of factors such as genetics, individual behavior and a host of social, economic and environmental factors.[2] Therefore, creating a healthy community begins with a healthy environment – access to affordable fresh fruits and vegetables, safe and successful schools, clean air and clean and safe parks and playgrounds – and being mindful of the community's social and economic well-being. Lake Region Healthcare understands that in order to improve the health of our community, we need to address the continuum of care from wellness and prevention through disease management and long-term care.

Lake Region Healthcare's work in the community mirrors our care teams' approach to medicine – focused on prevention and evidence-based practices. We strongly believe that solid community partnerships are essential to succeed in improving population health. We have worked for many years side-by-side our partner organizations, aligning our goals and resources to address serious public health issue such as obesity, access to care and end-of-life discussions. These partnerships, combined with the knowledge we gather through the CHNA, allow us to develop strategies aimed at making long-term, sustainable changes. It also allows us to deepen the already strong relationships we have with other organizations that are working to improve the health of our community. This work is reflected in Lake Region Healthcare's mission, vision and values.

Mission: To help improve the health of people in our region.

Vision: To be Minnesota's preeminent regional healthcare partner.

Values: *Integrity* – We communicate honestly, behave ethically and act responsibly as individuals and as an organization. We do the right thing even when no one is watching.

Teamwork – We contribute our individual best efforts to work as a group toward a common vision. We collaborate to provide superior care to our patients and partner to improve the health of our community.

Compassion – We provide care with kindness and consideration of each person's emotional, spiritual and physical needs. We create an environment conducive to healing, growth and well-being for all, including those with whom we work.

Excellence – We seek to be the best at everything we do.

A Summary of Community Benefit Financials from Fiscal Year 2018 Form 990 Schedule H:
- Financial Assistance $395,000
- Bad Debt Expense $2,866,793
- Unreimbursed Medicaid $8,856,375

Community Health Status Assessment

The Community Health Status Assessment (CHSA) intends to create a picture of the overall health status of the community and to determine how healthy our residents are. This is accomplished by collating data on several health indicators and comparing it to state or national data.

Data for the CHSA was obtained from the following data sources:

1. U.S. Census Bureau
2. MN Center for Health Statistics County Health Tables, 2017
3. American Community Survey
4. MN Compass
5. MIT Living Wage Calculator
6. MN State Demographic Center
7. MN Department of Human Services Medical Programs
8. MN Department of Public Health
9. MN Public Health Data Access
10. MN Environmental Public Health Tracking Program
11. MN Department of Human Services Minnesota's Child Maltreatment Report
12. MN Department of Human Services Minnesota's Out-of-Home Care and Permanency Report
13. MN Department of Economic Development, Labor Information Office, Local Area Unemployment Statistics
14. MN Department of Education, Data Center
15. PartnerSHIP 4 Health Community Health Assessment Survey, 2018
16. MN Student Survey, 2016
17. County Health Rankings, 2019

County Health Rankings model © 2014 UWPHI
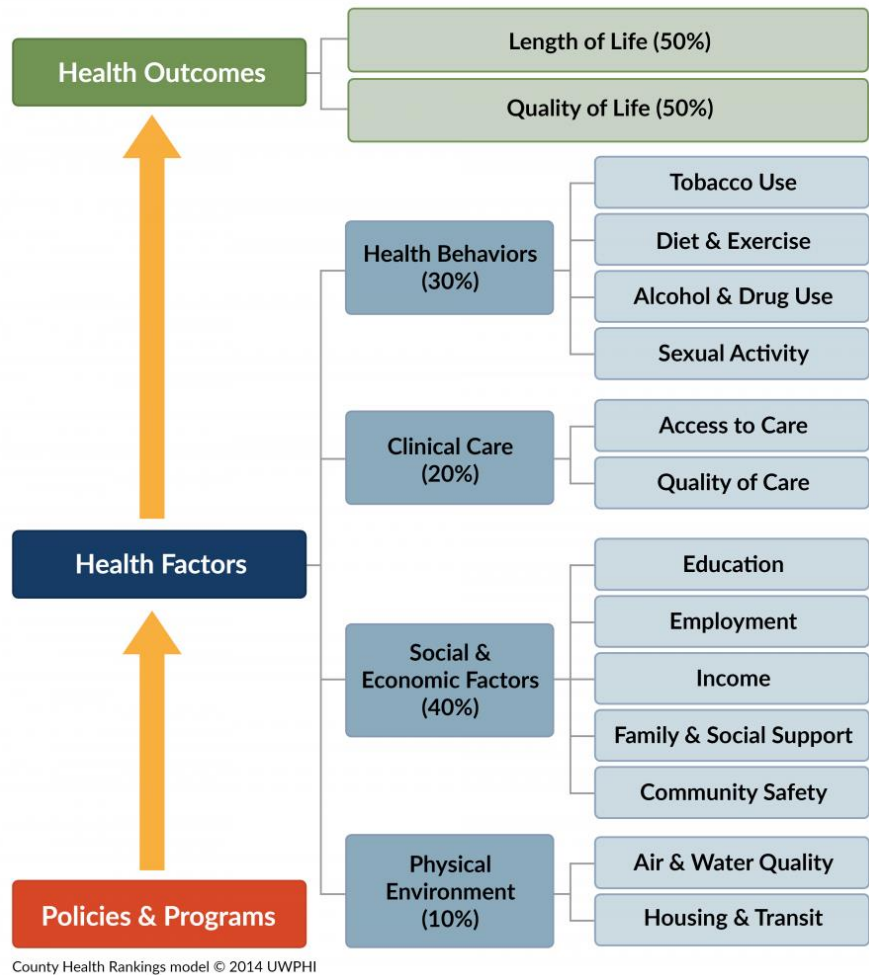
Demographics

Population

Otter Tail County is home to 58,345 people according to the US Census Bureau, an increase of 1.8% from the 2010 data. It is the 17th most populated county in Minnesota and borders Becker, Clay, Douglas, Grant, Todd, Wadena and Wilkin Counties. The most populous city is Fergus Falls, the county seat, where 24% of Otter Tail County residents reside. Based on the reporting and projections of the MN State Demographic Center, population growth in the state of MN has stagnated over the past couple of decades and will continue to level off over the next three decades. Across the state, population growth declined after a 12.4% increase between 1990 and 2000 to just 5.1% between 2010 and 2017. A fairly even distribution of females (49.7%) and males (50.3%) spans the county.

Figure 1: *Population Trends (1960-2010) and Projections (2020-2050), Otter Tail County*
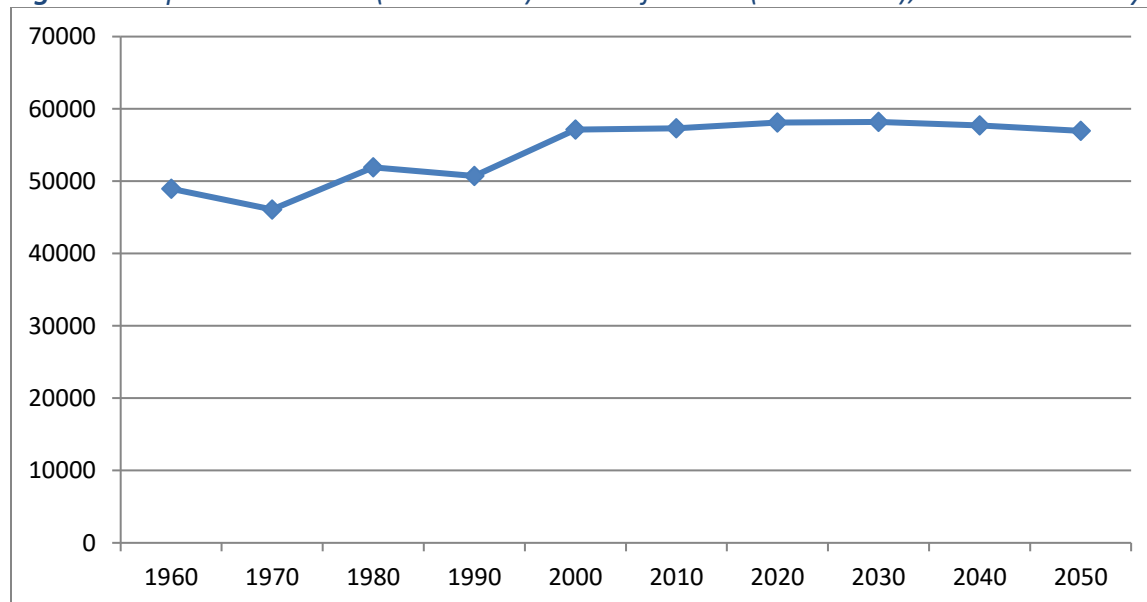
Source of Decennial Population Trend: MN Population of Counties by Decennial Census, 1900-1990. Compiled and edited by Richard Forstall, Population Division, US Bureau of Census. Retrieved from:
https://www.census.gov/population/www/censusdata/cencounts/files/mn190090.txt;US Census Bureau, US Census 2000 and 2010, Table DP-1.
Source of Population Projection: MN State Demographic Center. County Population Projections. December 2017. Retrieved from:
https://mn.gov/admin/demography/data-by-topic/population-data/our-projections/.

Age

The proportion of residents by age group follows the same pattern as the statewide average with the largest group made up of individuals between the ages of 20 through 64 years old. The percentage of the elderly, ages 65 and over, in Otter Tail County is one and a half times that of the statewide average. According to the US Census Bureau, beginning 2030, all baby boomers will be older than 65, projecting that 20% of Americans will be of retirement age. By 2035, for the first time in US history, the number of adults 65 years and older will outnumber the total count of children. [3]

Figure 2: *Population by Age, Otter Tail County and MN (2017)*
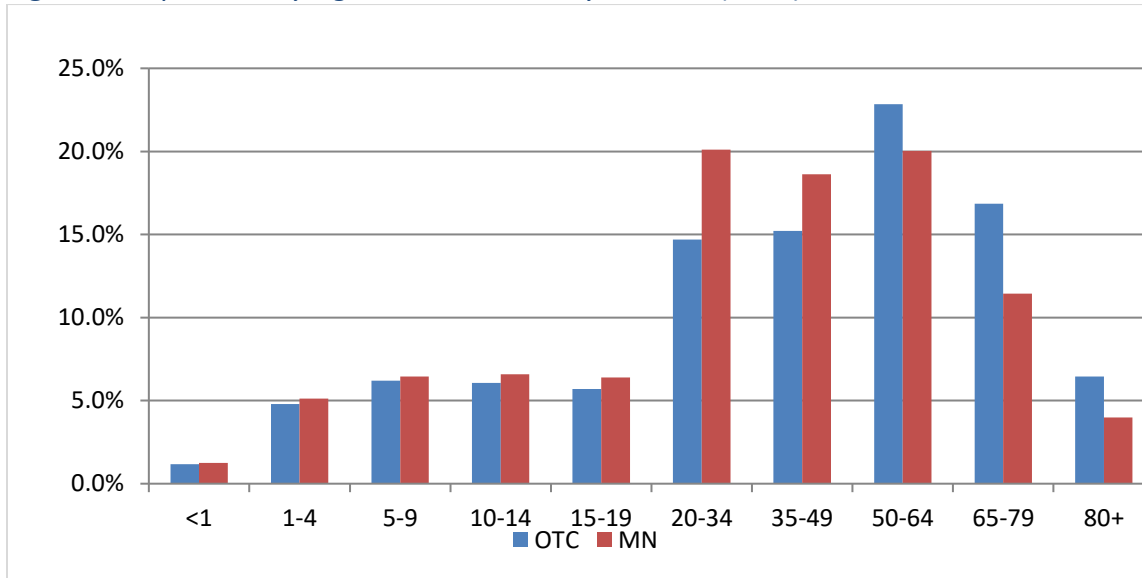
Source: US Census Bureau, Population Division. June 2018. Annual Estimates of the Resident Population for Selected Age Groups by Sex: April 1, 2010 to July 1, 2017. Table PEPANNRES.

The growing aging population was identified as one of the health-related issues facing our community during the focus group sessions. Prevalence of chronic conditions increases with age as well as need for long-term care and other social services. This poses challenges not only to the healthcare delivery system but also the community as a whole and its capacity to meet the growing and complex needs of our elderly residents.

Figure 3: *Age Demographics, Otter Tail County (2017)*
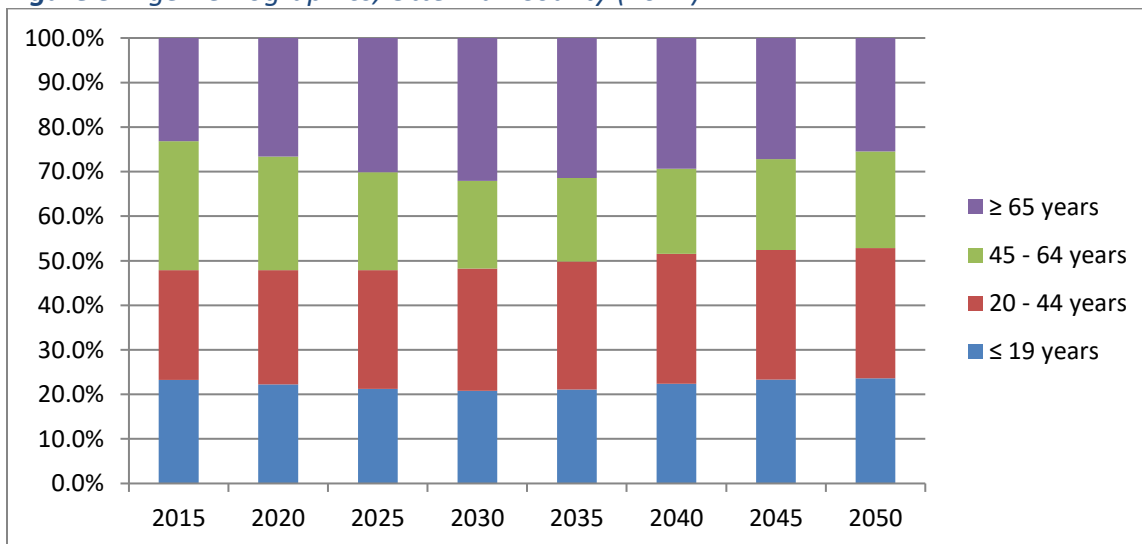
Source: Source of Population Projection: MN State Demographic Center. County Population Projections. December 2017. Retrieved from: https://mn.gov/admin/demography/data-by-topic/population-data/our-projections/.

Race

Otter Tail County's residents are primarily white, non-Hispanic (93.2%). This is a higher proportion than Minnesota (81%). However, the county has experienced growth in diversity over the last few years. The percentage of Otter Tail County residents who are foreign-born has more than doubled between 2014 (1.5%) and 2017 (4%). This increasing trend in racial and ethnic diversity is seen nationwide. The US Census Bureau projects that by 2030, immigration would be the primary driver of population growth in the country. This is not due to an increase in migration but due to the expected increase in the number of deaths as the population ages.[3]

Figure 4: *Race and Ethnicity, Otter Tail County (2017)*
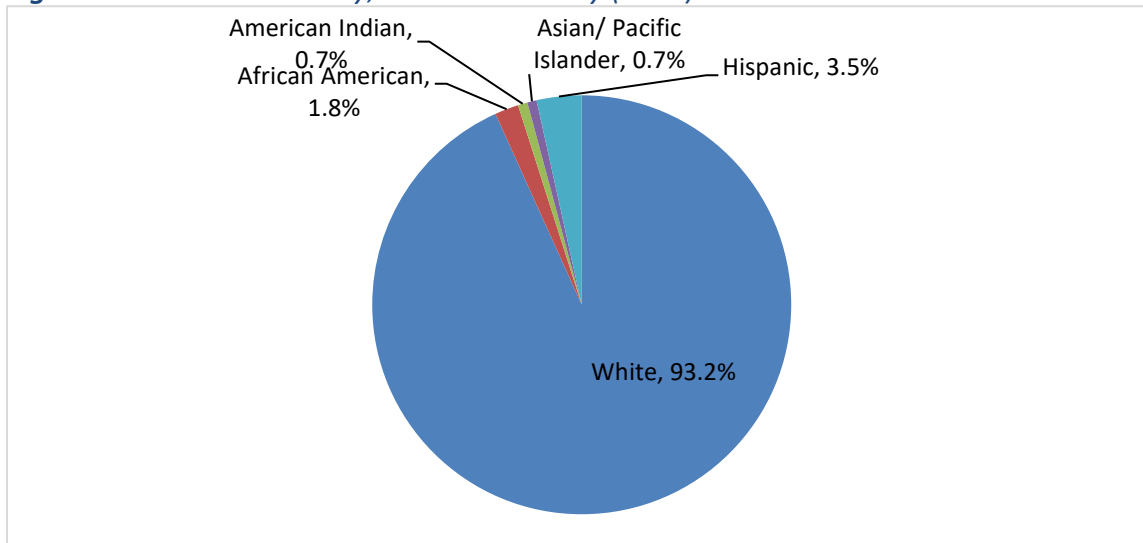
Source: 2017 MN County Health Tables. 2017 Data by State, County and Community Health Board. December 31, 2018.
Note: Annual Estimates 2017 are bridge-race Vintage 2017 postcensal estimates of the July 1 resident population.

Figure 5: *Non-White Residents and Foreign-Born Residents, Otter Tail County (2013-2017)*
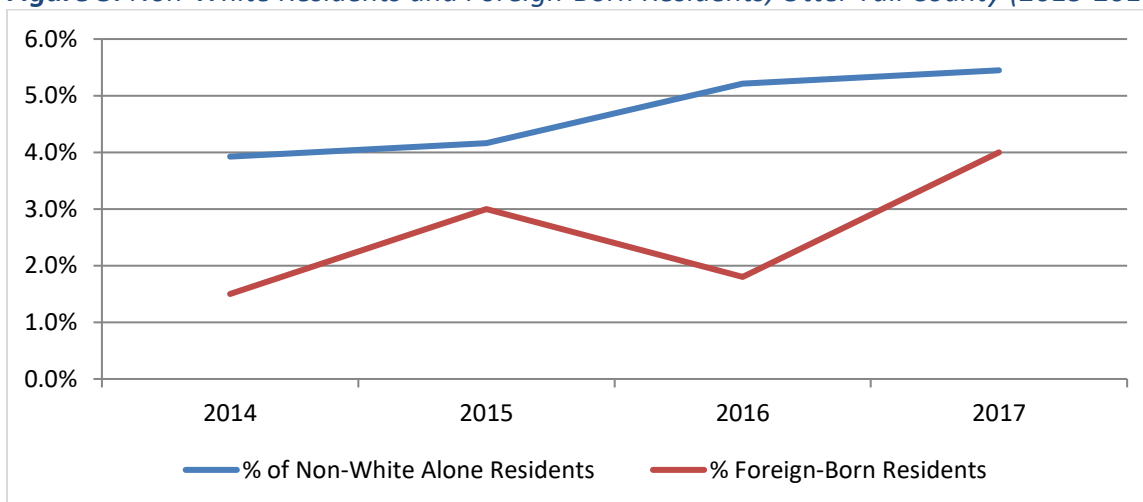
Source: US Census Bureau, 2017 American Community Survey 1 Year Supplemental Estimates w/ a Population Threshold of 20,000 or More. Tables K200201 and K200503.
*Non-White residents include foreign-born residents.

Social and Economic Factors

Educational Attainment

In Otter Tail County, 10.1% of its residents 25 years and older have no high school diploma. This percentage is higher compared to Barnesville (7.3%) and MN (7.2%). Furthermore, Otter Tail County and Barnesville have lower percentages of residents who have a Bachelor's degree or higher (25.3% and 28.2%, respectively), compared to the state (34.8%).

Figure 6: *Educational Attainment, Otter Tail County and Barnesville (2013-2017)*
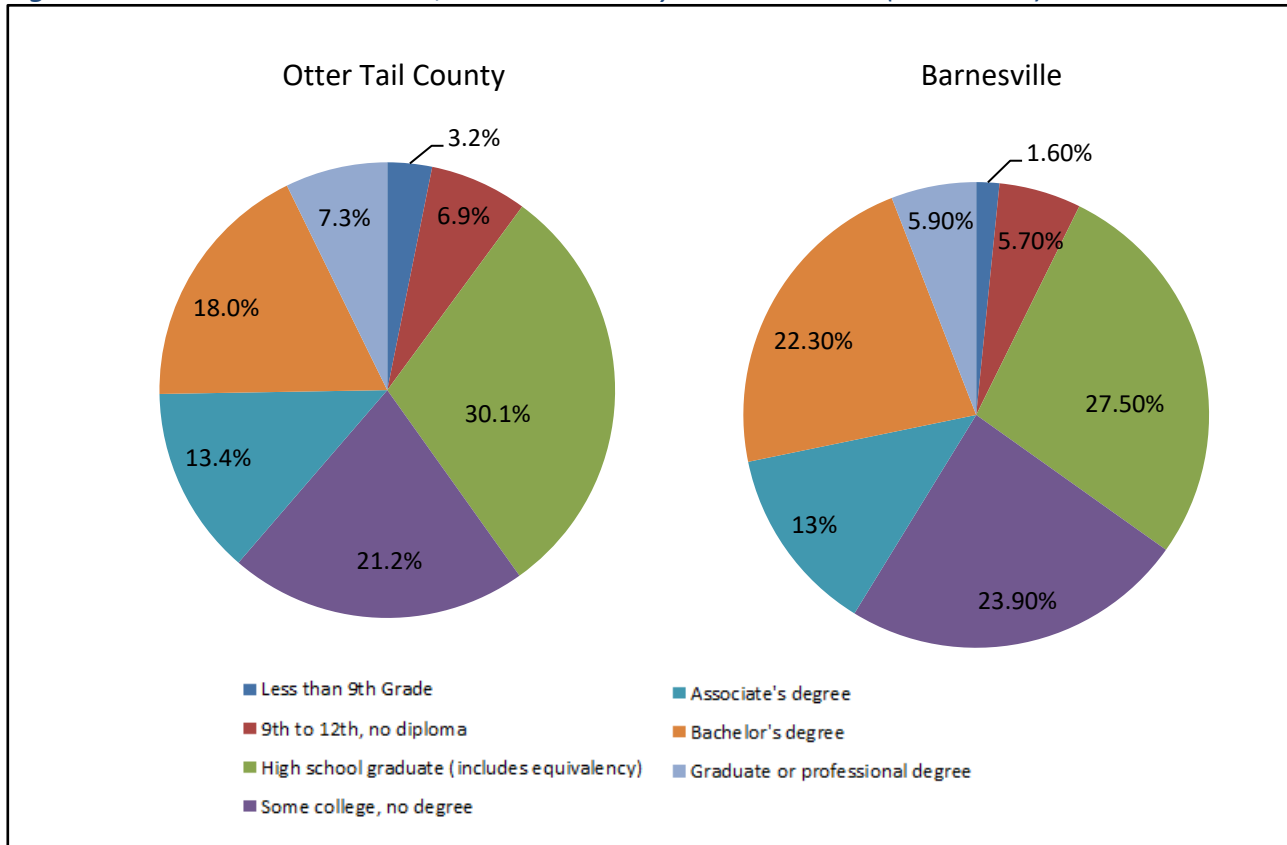
Source: US Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Table S1501.

Education is an upstream Social Determinant of Health (SDOH). It is strongly associated with an individual's health outcome and thus represents an area of opportunity to improve population health and promote health equity.[4,5] Studies have shown that education influences not only one's socioeconomic status but also their access to health care, level of health literacy, social network and cognitive functioning. Individuals with less education face serious social and health disadvantage. Compared to their more educated peers, adults with less education are more likely to engage in risky behaviors and live shorter and unhealthier lives. [6] This life expectancy gap has been widening since 1960s and those without a high school diploma are the most at risk.[7]

Income and Poverty

Median household income in Otter Tail County according to the 2013-2017 American Community Survey (ACS) is $55,181, a 3.4% increase from the 2012-2016 ACS. However, it is still lower that the state average of $65,699. Barnesville's median household income on the other hand is higher than both Otter Tail and the state at $68,313. Notably, poverty was an issue recognized by several focus group participants as a concern in the community.

Table 1: *Median Household vs. Per Capita Income, Otter Tail County, Barnesville and MN (2013-2017)*

	Otter Tail County	Barnesville	Minnesota
Median Household Income	$55,181	$68,313	$65,699
Per Capita Income	$29,932	$29,972	$43,259

Source: US Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Tables DP03 and B19049.

Median household income reports only the amount of resources available to the household. It is not adjusted for household size or cost of living which does not make it the best indicator for how well everyone is faring economically in the community. According to the Living Wage Calculator,[8] developed by Dr. Amy Glasmeier and the Massachusetts Institute of Technology, in order for a family of 4 consisting of 2 adults and 2 children to meet minimum standards of living in Otter Tail County, they must make at least $65,705, which is lower than the median household income. And for an adult to make ends meet in Otter Tail County, the minimum income is $22,730. In 2017, 16.3% of households were making less than $20,000 while 56.1% were making less than $60,000. In other words, by definition, less than half (~43.9%) of households in Otter Tail County actually meet the minimum standards of living.

Figure 7: *Household Income Distribution, Otter Tail County (2017)*
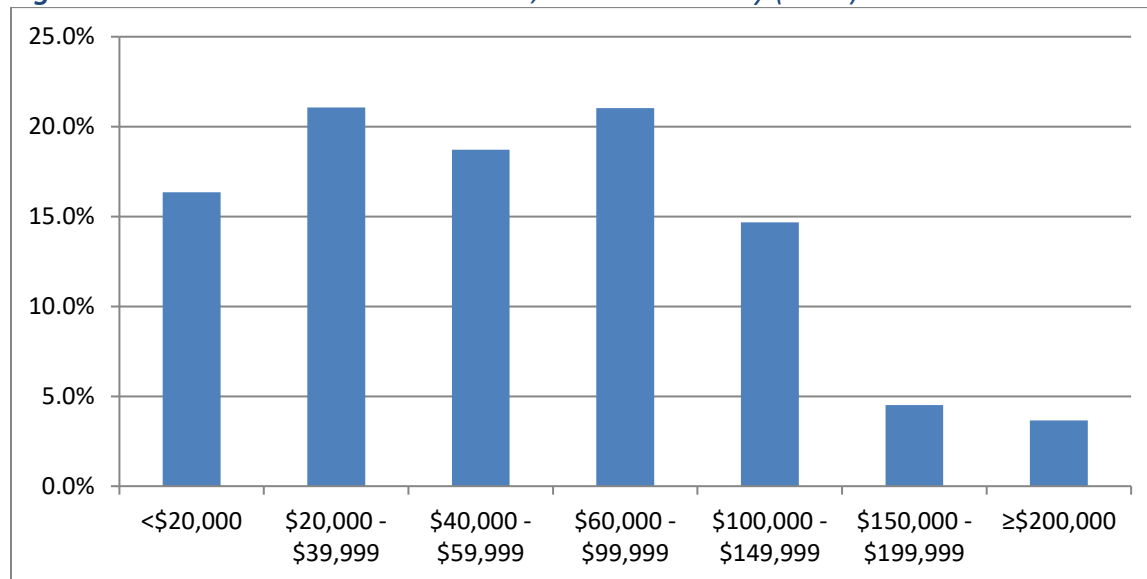
Source: US Census Bureau, 2017 American Community Survey 1-Year Estimate. Table K201901.

Income disparity in Otter Tail County is evident when looking at the median household income distribution. Although a majority of Otter Tail County households fall within the middle of the spectrum, the distribution is slightly skewed towards the lower income side with 56.1% of households making less than $60,000. The Gini index is a statistical measure of distribution from 0 to 1 often used to gauge income inequality. A higher value means greater income equality. In 2017, income inequality in Otter Tail County was .4308 according to the Gini calculation (ACS 2013-2017). Income inequality had a 0.29% growth from 2012 to 2017, further increasing the Gini index, meaning that over the 5-year period the income distribution became more skewed. However, the Gini index for Otter Tail County is slightly lower than the state average of 0.4501 which means that the income gap is wider across the state than in our county.

Figure 8: Poverty Status in Past 12 Months, Otter Tail County and MN (2017)
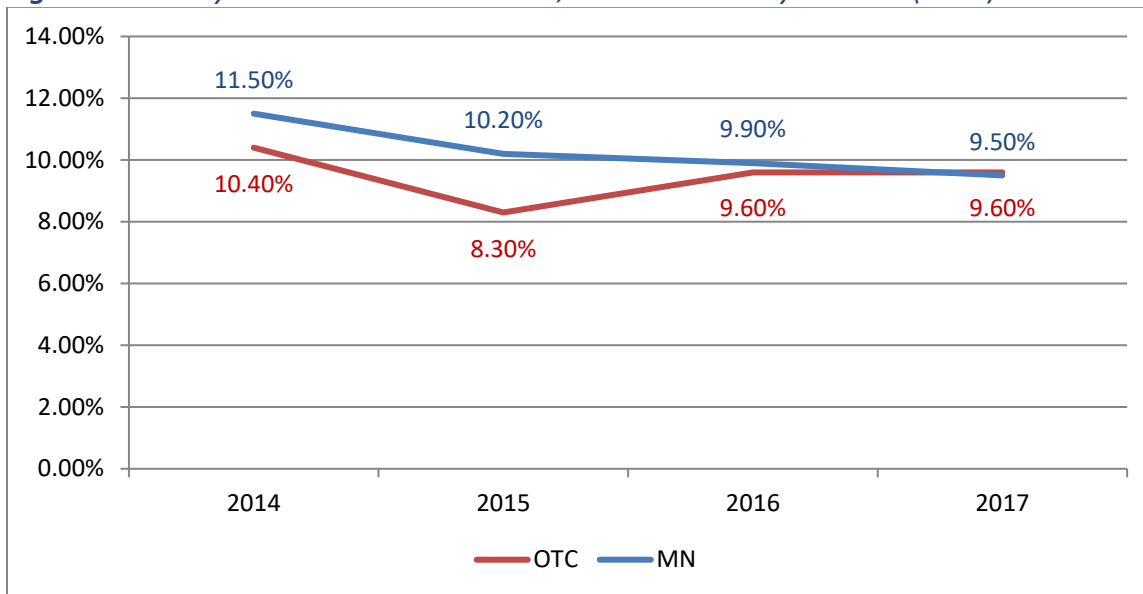
Source: US Census Bureau, 2017 American Community Survey 1-Year Estimate. Table K201701.

The percentage of residents in Otter Tail County living below poverty level in the past 12 months (9.6%) is comparable to the statewide average of 9.5%. This is a 1.3% increase compared to county poverty ratings in 2015. It is important to note that the poverty threshold is based on three times the cost of a minimum food diet in 1963 and updated for inflation using the Consumer Price Index. It is not adjusted based on geographic location which influences cost of living and does not take into account other basic needs such as clothing, shelter, childcare, transportation and utilities.[9] This may lead to underestimating the level of poverty in the community.

Figure 9: *Poverty by Race, Otter Tail County and MN (2013-2017)*
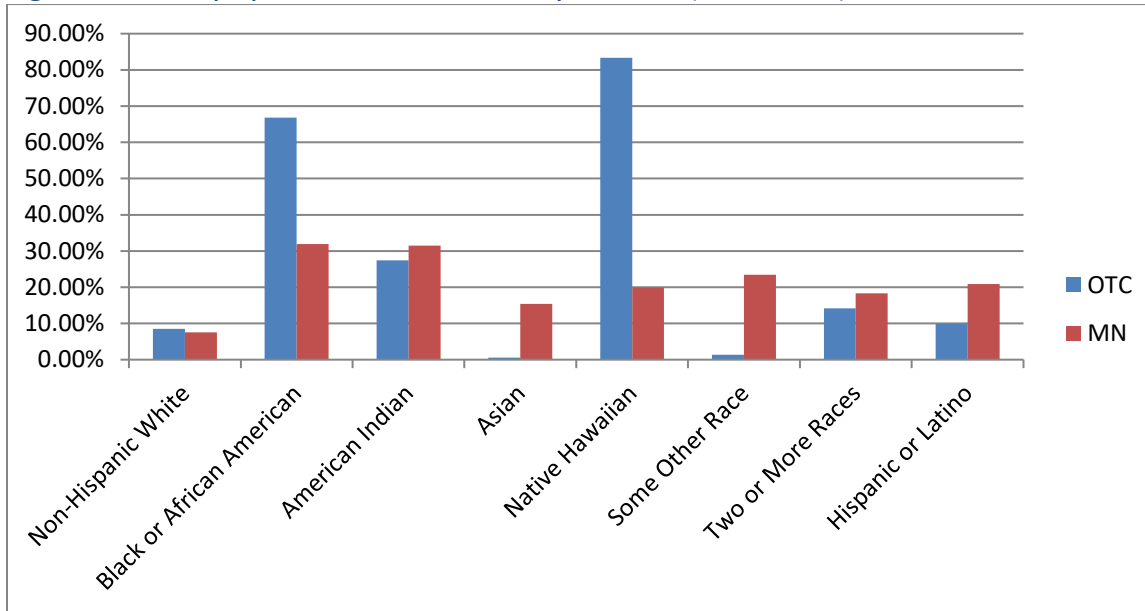
When analyzed by race and ethnicity, rates of poverty in Otter Tail County among the racial and ethnic minority groups are generally higher than non-Hispanic White. This is especially true for the county's Native Hawaiian (83.3%) and African American (66.8%) residents.

Figure 10: *Poverty Status, by Age Group (2017)*

The largest proportion of our community living in poverty is individuals between the ages of 18-64 years old. But as Figure 11 shows, the percentage of Otter Tail County residents ages 65 and older who are living in poverty is nearly double that of the state average (11.2%). This reiterates the issue of an aging population and its social implications (See section on Educational

Attainment). Meanwhile, the poverty rate for children, particularly those under 5 years of age is also high. Acute needs of children in poverty include hunger, homelessness, poor physical and behavioral health, disruption in education, and toxic stress. Without intervention, these acute needs become chronic, which further impact the individual's long-term health outlook.[10] As a growing aggregate group, the potential impact on the long-term health of the community is high, given that children living in poverty are less likely to graduate high school.

In general, individuals living at or below poverty level struggle to meet basic needs and therefore tend to be in poorer health, are food insecure, experience chronic stress, live in unsafe and under-resourced neighborhoods, and experience substandard housing and more frequent moves. When evaluated locally, in focus group sessions, participants were vocal about Otter Tail County families being "*just a crisis away*" from falling into poverty. For instance, one participant stated, "*You're doing okay but then all of a sudden your car breaks down and you can't afford to fix your car. Can't get to work…There's a huge gap between your median income in OTC compared to what they say is enough money for you to have some relative stability*." In the literature, this concept is well-documented as the cliff effect or benefits effect which is defined by the National Center for Children in Poverty as the situation wherein "work doesn't pay" because an increase in a family's income does not necessarily improve their financial situation and at times actually makes them worse off.[10] That is, as a family begins to achieve increased income, in many instances this inadvertently causes them to surpass the income limits set by the state, disincentivizing some to work or accept promotions. When household income exceeds the threshold set by the state, they immediately become ineligible to receive food stamps, child care and housing subsidies, Medicaid and other public benefits on which they had come to rely.[11] This is a significant issue for many low-income families as it is a barrier to economic self-sufficiency.

Table 2: *Educational Attainment and Poverty Status, Otter Tail County, Barnesville and MN (2013-2017)*

Educational Attainment	Otter Tail	Barnesville	MN
Less than high school	19.8%	4%	24.6%
Bachelor's degree	3.7%	3.2%	3.1%

Source: US Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Table S1701.

Table 2 gives credence to the benefits of higher education and one's economic stability. For Otter Tail County and Minnesota, poverty rate decreases among those with higher educational attainment. However, it is interesting to note that this pattern is not followed in Barnesville, where the largest percentage of poverty is among high school graduates.

Health Insurance

Access to quality, affordable, and timely health care is critical for an individual to achieve the best possible health outcome. Identified by our focus group participants are four common barriers to accessing health care in our community: no insurance, underinsured, high cost of care, and lack of transportation.

Figure 11: Health Coverage, Otter Tail County (2013-2017)
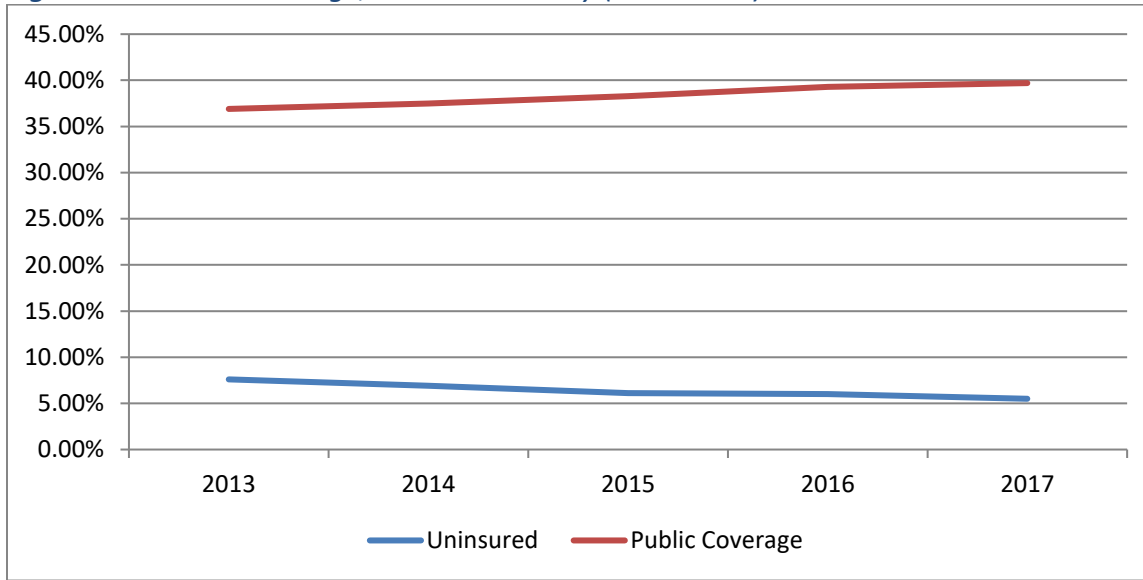
Source: US Census Bureau, American Community Survey 5-Year Estimates. Tables DP03

The percentage of OTC residents who do not have insurance has consistently decreased since 2013 while the percentage of those who are on public coverage has increased. Gains in health coverage may be attributed in part to the Affordable Care Act (ACA) passed in 2010 and which took effect in 2014. The law aimed to make health insurance more affordable to more people by allowing states to expand Medicaid coverage to cover many low-income individuals and provided health insurance marketplace subsidies to individuals below 400% of the Federal Poverty Level.[12] In addition, by implementing the individual mandate which required people to have health insurance or pay a penalty, the law attempted to encourage enrollment, especially among the young and healthy, to keep the health insurance market stable and functional.

As part of the Tax Cuts and Jobs Act passed by Congress in 2017, the individual mandate penalty will be eliminated beginning calendar year 2019. The impact of this individual mandate repeal on health insurance enrollment and premiums is uncertain. The Congressional Budget Office and Joint Committee on Taxation estimated that the it will increase the number of uninsured by 4 million in 2019 and by 13 million in 2027 and increase average premiums by approximately 10%.[13]

Unemployment

A healthy economy is a driving force for opportunity and upward mobility. Access to economic opportunities is an indicator of health and well-being because it influences one's income and access to resources, which in turn improves one's quality of life.

Unemployment rate, an economic indicator, has steadily declined since 2010 throughout MN and Otter Tail County. According to MN Employment and Economic Development, the unemployment rate in MN is at an 18-year low. As mentioned in various focus groups, several participants thought that in general there were more vacancies than people to fill them. Although in some instances, especially for positions that require certification or licensure, there are no qualified applicants, so jobs go unfilled. One focus group participant remarked, "*I've heard a lot of employers say that they would leave the job vacant just because the applicant pool is so bad.*" The lack of workforce is a challenge because it limits our ability to serve our community. As a focus group participant said, "*There are beds sitting empty in facilities that they can't fill because they don't have the staff to take care of the people.*"

The tight labor market also has resulted in more full-time opportunities for individuals with a high school diploma/GED or less from 49% in 2009 to 57% in 2016.[14] However, wage and employment prospects are still generally better for those with higher educational attainment.[15]

Figure 12: Unemployment Rate, Otter Tail County and MN (2010-2018)
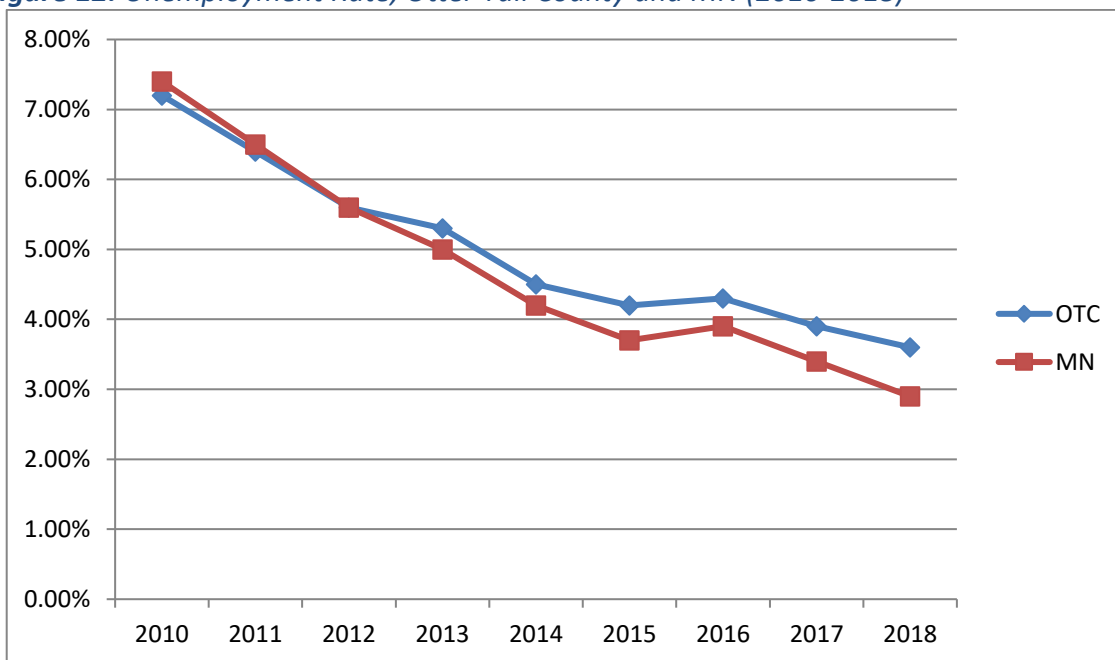
Source: MN Department of Economic Development, Labor Information Office, Local Area Unemployment Statistics. Retrieved from: https://apps.deed.state.mn.us/lmi/laus/Default.aspx
*Unemployment rate is not seasonally-adjusted.

Food Insecurity

According to the USDA, [16] food insecurity means food intake or eating pattern is interrupted due to lack of money and other resources. Food insecurity may be affected by multiple factors such as income, employment and disability and can therefore be long-term or temporary.[17] In Otter Tail County, adults earning less than $20,000 (previously highlighted in report section Income and Poverty as "unable to make ends meet") were 3 times more likely to be worried that food would run out (34.2%) compared to the county average of 10.9%. Similarly, 31.5% of adults reported that food did not last compared to the county average of 9.9%.

Figure 13: *Food Insecurity by Income, Otter Tail County (2018)*

Health Outcomes

Leading Causes of Death

According to the vital statistics data, cancer and heart disease are the top two leading causes of death in the state of MN. In Otter Tail County, heart disease leads cancer by a slim margin as the top cause of death. However, when looking at premature deaths which is a measure of years of potential life lost due to death occurring before the age of 75, cancer leads heart disease by a significant margin as the top cause of premature death. As illustrated in Figure 14, In five of nine groups, rates of death were higher than the state: Heart Disease, Alzheimer's, stroke, suicide, and influenza. Meanwhile, in 3 of nine groups, rates of death were lower than the state: cancer, accidents, and Diabetes; 1 group was equal: CLRD. Similarly, as described in Figure 15, Heart Disease and Suicide were higher than the MN State rate.

Figure 14: *Leading Causes of Death per 100,000 Persons, Age-Adjusted, Otter Tail County and MN (2013-2017)*
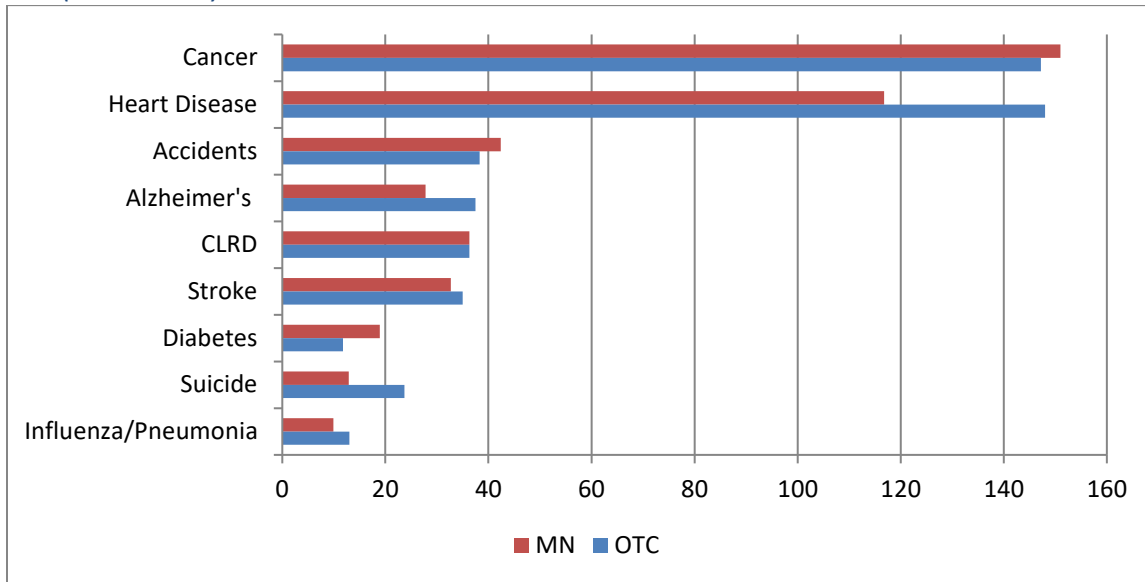
Source: 2017 MN County Health Tables. (December 2018). 2017 Data by State, County and Community Health Board. Mortality.
*Data age-adjusted to the 2000 US standard population
**CLRD – Chronic Lower Respiratory Disease

Figure 15: *Premature Deaths per 100,000 Persons, Age-Adjusted, Otter Tail County and MN (2013-2017)*
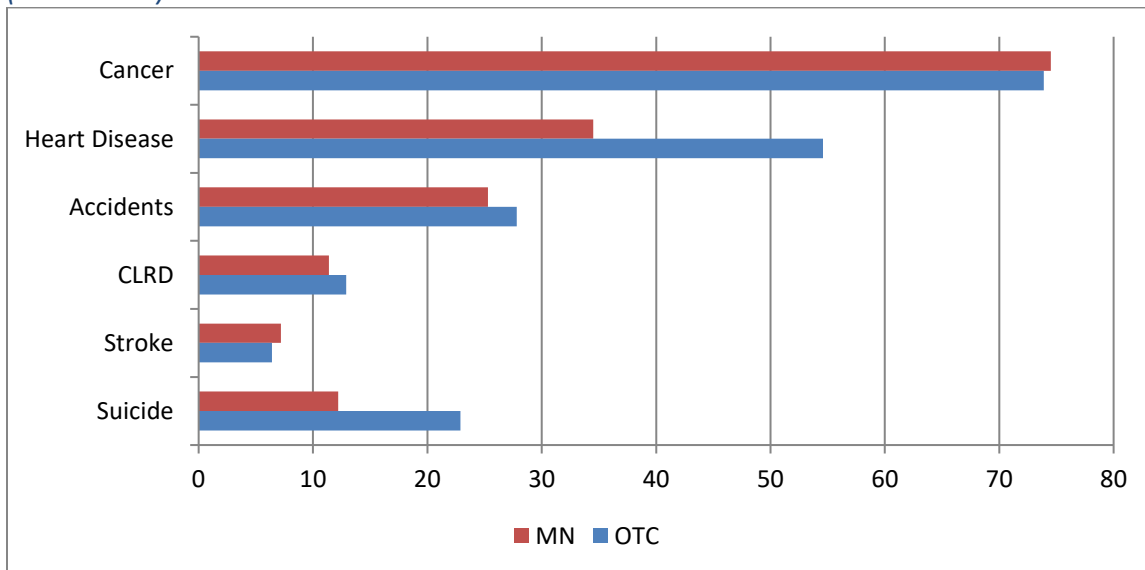
Source: 2017 MN County Health Tables. (December 2018). 2017 Data by State, County and Community Health Board. Mortality.
*Data age-adjusted to the 2000 US standard population
**CLRD – Chronic Lower Respiratory Disease

Suicide

According to the data brief from MDH released on December 2018, age-adjusted suicide rate in Otter Tail County between 2013 through 2017 was 22.8, second only to Itasca county. This serious public health issue even more so disproportionately affects rural communities

compared to their urban counterparts. In 2015, the age-adjusted suicide rate per 100,000 population ins rural counties nationwide was 17.6 compared to 12.5 among urban counties.[18] In MN, a similar trend is observed wherein age-adjusted suicide rate in Greater Minnesota was 15.4 in 2017 compared to 12.8 in the 7-County Metro.[19] There are many barriers faced by rural communities, such as limited access to mental health services, social isolation and stigma associated with seeking help or treatment, all raised in the focus group sessions. These statistics complement observational data collected from focus group participants indicating that declining mental health is one of the top issues facing our community.

Prevalence of suicide in the County is troubling. The daily activity report from the Otter Tail County Sheriff's Department reports that there were 6 deaths attributed to suicide in 2018 and 61 suicide attempts or threats. Suicide rates also vary by age. In the County, suicide rate was highest among middle-aged white men between the ages of 45-64 years old. For Greater MN, firearm was the most common mechanism for suicide followed by suffocation and poisoning.

Figure 16: Number of Deaths by Suicide, by Age and Gender, Otter Tail County (2013-2017)
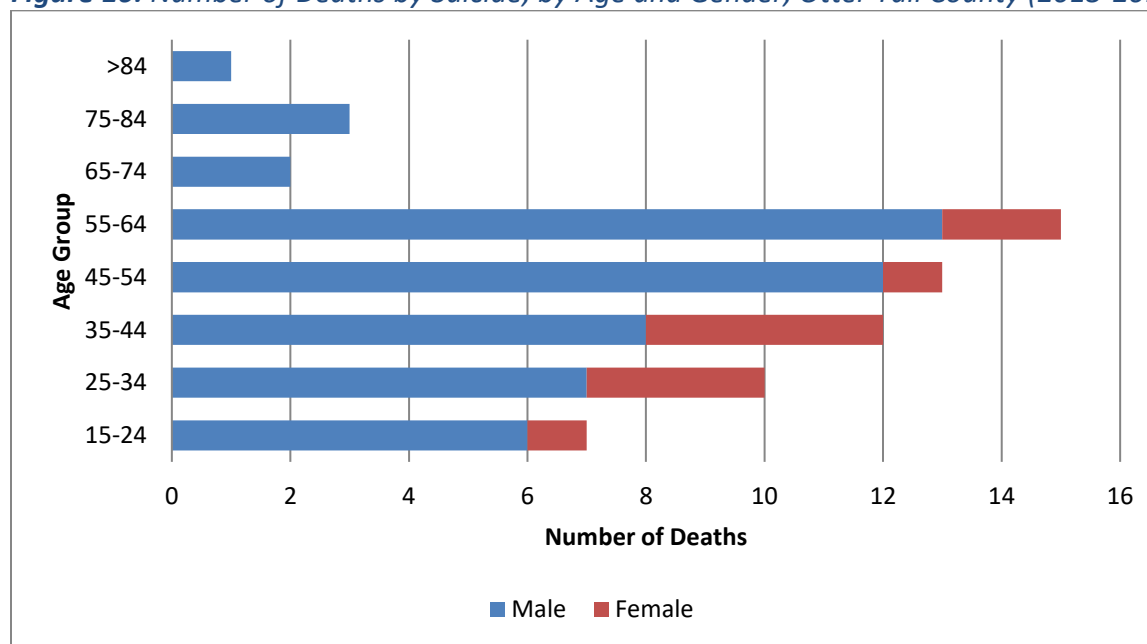
Source: MN Department of Health. (December 2018). Suicide in Minnesota, 1999-2017.

Of high importance, is that risk for suicide is not limited to adults. Results from the MN Student Survey indicate high suicide ideation among Otter Tail County youths, particularly among female students. The issue of suicide becomes even more exacerbated as students age. In the survey administered in 2016, 14.7% of Otter Tail County 11th graders who answered the survey indicated attempting suicide during the past year while 5% actually attempted suicide. Both percentages are higher than state averages of 12% and 3%, respectively.

Figure 17: *Percentage of Students who Attempted Suicide, Otter Tail County (2016)*
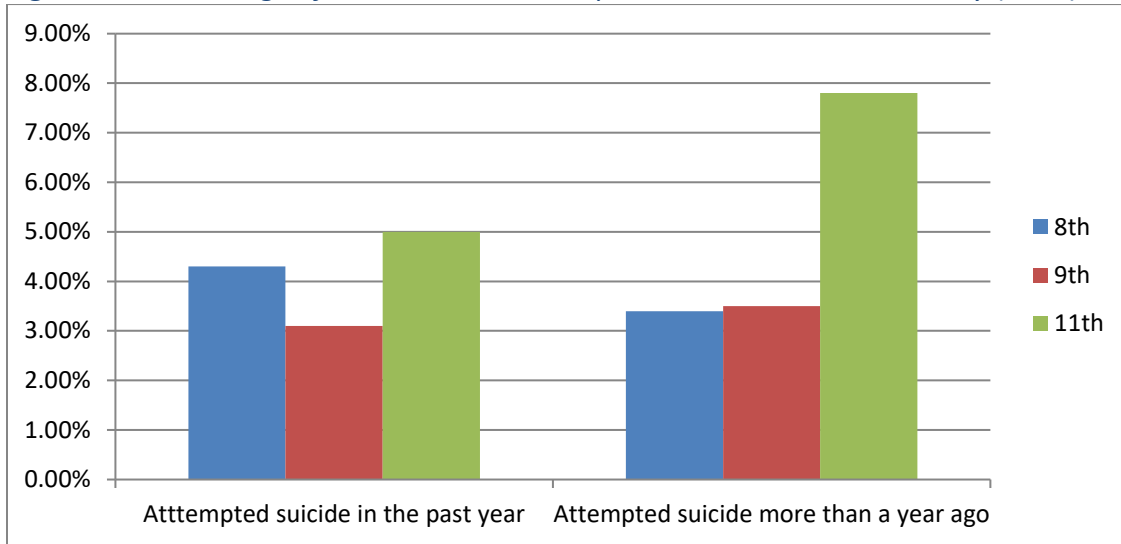
Source: MN Department of Education, Health, Human Services and Public Safety. (2016). 2016 MN Student Survey.

Table 3: *Suicide Attempts, by Sex, 11th Graders, Otter Tail County vs. MN (2016)*

Description	% Female OTC Students	% Male OTC Students	Total % OTC Students	Total % MN Students
Seriously attempted suicide during the last year	16.6%	12.8%	14.7%	12.0%
Seriously attempted suicide more than a year ago	25.6%	10.9%	18.4%	- -
Actually attempted suicide during the last year	6.2%	3.8%	5.0%	3.0%
Actually attempted suicide more than a year ago	9.5%	5.7%	7.8%	- -

Source: MN Department of Education, Health, Human Services and Public Safety. (2016). 2016 MN Student Survey.

Heart Disease

In 2017, based on the number of deaths, heart disease was the leading cause of death in Otter Tail County, claiming the lives of 154 residents according to the MN County Health Tables. Heart disease or cardiovascular disease includes a range of problems that affect the heart such as heart attack, atherosclerosis, stroke, heart failure, arrhythmia, heart infections, cardiomyopathy, and heart valve problems.[20] According to the CDC, common risk factors for heart disease are tied to lifestyle choices such as smoking, poor diet, physical inactivity and excessive alcohol use. Medical conditions that also pose as risk factors include diabetes, high blood pressure, high LDL cholesterol and being overweight or obese. [21] At Lake Region Healthcare, heart failure accounts for 21.74% of all-cause readmission rate and is the third most common diagnosis identified as a potentially preventable admission based on 3M's methodology.

Cancer

The incidence rate of cancer as an overarching diagnosis is slightly higher in Otter Tail County compared to the MN statewide average. The prevalence of cancer diagnoses in MN and Otter Tail can be ranked as follows: 1. cancer of the lungs and bronchus, 2. colorectal, 3. melanoma and, 4. bladder cancer. When stratified by sex, cancer of the lungs and bronchus (54/100,000) was also the most common cancer in men while breast cancer (115.4/100,000) was the most common type of cancer to affect women.

Figure 18: *Cancer Incidence per 100,000 Population, by Site, Otter Tail County and MN (2011-2015)*
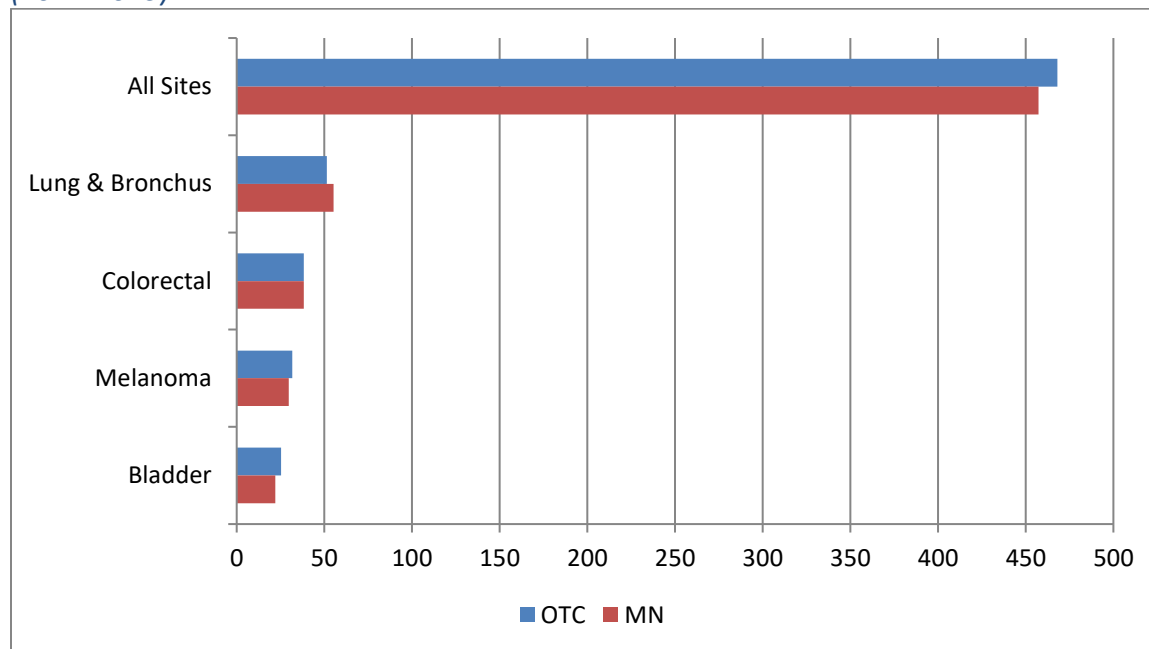
Source: MN Department of Health, MN Public Health Data Access, MN Environmental Public Health Tracking Program. Retrieved from: https://data.web.health.state.mn.us/cancer_query

Morbidity

Studies suggest that income and health are inextricably linked by several clinical, social, behavioral, and environmental factors.[22] By way of example, individuals of higher income are reported to have better health outcomes and live longer than those of lower income.[23] This national trend is reflected through subjective reports of perceived health in our own data as Figure 19 shows, the percentage of adults reporting their health to be excellent or very good, decreases as their income decreases. Those making $120,000 or more were 3 times more likely to perceive their health be excellent or very good compared to adults making $20,000 or less.

Figure 19: *Percentage of Adults who Perceive They are of Excellent or Very Good Health, by Income, Otter Tail County (2018)*
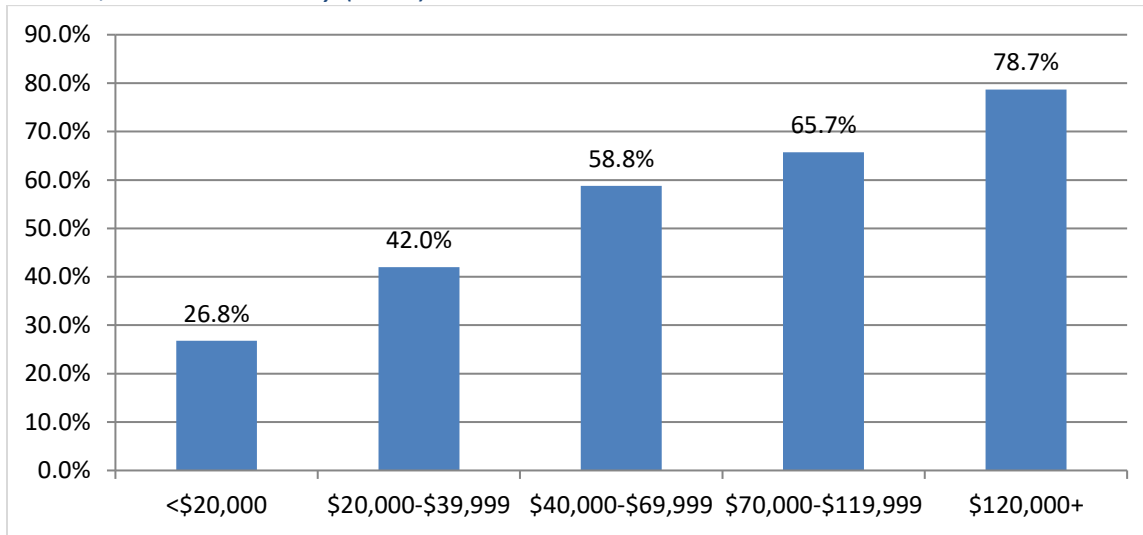
Source: Partnership4Health Community Health Board. (2018). Community Health Needs Assessment Survey

Health Behavior

Tobacco Use

Overall, 7.2% of Otter Tail County residents report to be current smokers. The prevalence of current smokers among adults making less than $40,000 is over 3 times higher than those making $40,000 or more (Figure 20). These observations may be due to marketing and advertisement strategy. It has been reported that marketing and advertisements of tobacco products disproportionately target vulnerable groups such as youth, racial/ethnic minorities and people who are low-income or have lower levels educational attainment.[24]

Figure 20: *Adult Current Smokers, Otter Tail County (2018)*
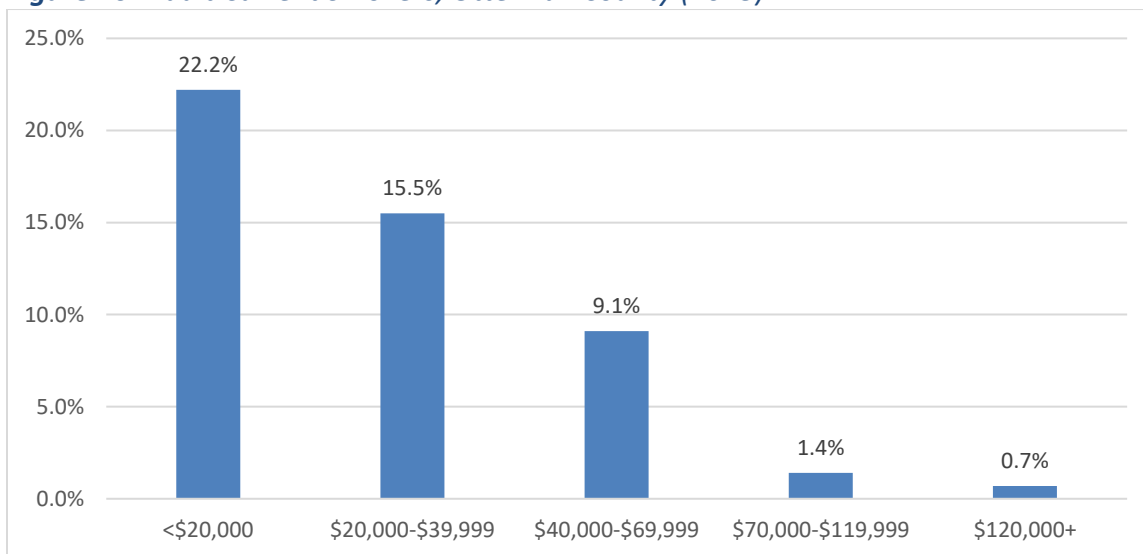
Source: Partnership4Health Community Health Board. (2018). Community Health Needs Assessment Survey

Although there has been considerable progress made in reducing youth's use of cigarettes,[25] there's still plenty of work that needs to be done. In Otter Tail County, 24.9% of 11th graders have used tobacco in their lifetime compared to the statewide average of just 15.8%. Tobacco use continues to grow also due to the growing market for alternative tobacco products such as e-cigarettes which creates another complex public health challenge. According to the Surgeon General's Advisory, e-cigarettes have been the most commonly used tobacco product among US youths since 2014.[25] This pattern is also observed among Otter Tail County youths as seen in Figure 21.

Although marketed as a safer alternative to regular cigarettes, studies have shown that e-cigarettes are harmful. Just like cigarettes, e-cigarettes contain the highly addictive nicotine and other potentially harmful additives such as solvents and toxicants, which can damage adolescent brain development and affect their physical and mental health. [25] Also, use of e-cigarettes among youth is associated with the use of other tobacco products including cigarettes.[25]

Figure 21: *Tobacco Use Among 11th Graders, Otter Tail County and MN (2016)*
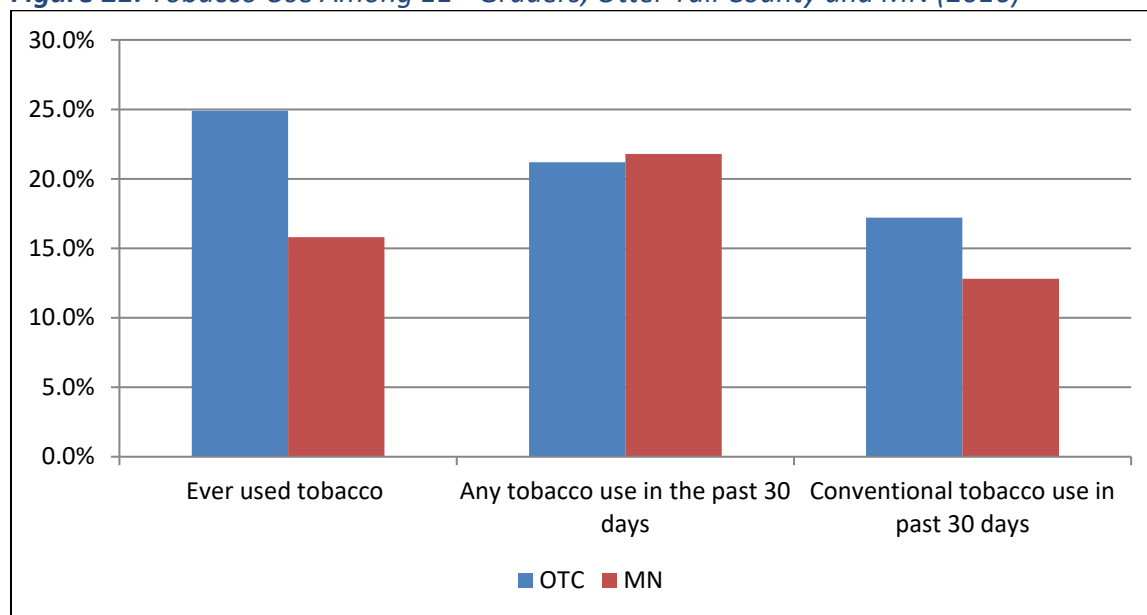
Source: MN Department of Education, Health, Human Services and Public Safety. (2016). 2016 MN Student Survey.

In an effort to curb this growing issue, Otter Tail County took the proactive step of becoming the first county in Minnesota to pass the Tobacco 21 (T-21) ordinance, which began to be phased in on January 1, 2019. The T-21 ordinance raises the legal purchasing age of tobacco products from 18 to 21. A grandfathering clause was included in the ordinance which allows persons born on or before December 31, 2000 to purchase tobacco products.

Figure 22: *Type of Tobacco Used by 11th Graders, Otter Tail County (2016)*

Source: MN Department of Education, Health, Human Services and Public Safety. (2016). 2016 MN Student Survey.

Obesity, Physical Activity, Nutrition

Obesity, physical activity and nutrition have been in the national spotlight for quite some time due to the prevalence of obesity across all age groups. Obesity continues to be a concern in our community. In the 2018 PartnerSHIP 4 Health survey, 39.3% of adults were considered to be obese and 72.5% of adults were either overweight or obese. These numbers are alarmingly high and can have a significant impact on our health, the health care system, and the economy.

Figure 23: *Weight Status of Youth, Otter Tail County and MN (2016)*

Source: MN Department of Education, Health, Human Services and Public Safety. (2016). 2016 MN Student Survey.

According to the State of Obesity 2018 report,[26] obesity increases the risk for developing a wide-range of complex health problems such as type 2 diabetes, high blood pressure, heart disease, stroke, sleep apnea, certain types of cancer and depression. In addition, the obesity epidemic increases health care cost with one study claiming that per capita medical spending for individuals with obesity is 42% more than individuals of normal weight. If the rising obesity trend continues, obesity-related medical cost is projected to rise to $66 billion per year by 2030.[27]

Based on the MN Student survey, obesity rate is higher in Otter Tail County than the state average. This is especially evident among 11th graders (16.3%) compared to just 11.3% statewide. As Figure 23 shows, proportion of students who are either overweight or obese is larger among 11th graders compared to 8th and 9th graders both in Otter Tail County and the state. This trend may correspond to the greater intake of fruit and vegetables (Fig. 24) as well as the greater physical inactivity (Fig. 25) among 11th graders compared to 8th and 9th graders.

Figure 24: *Vegetable and Fruity Consumption by Youth, Otter Tail County (2016)*

Source: MN Department of Education, Health, Human Services and Public Safety. (2016). 2016 MN Student Survey.

Figure 25: *Physical Activity Among Youths, Otter Tail County and MN (2016)*
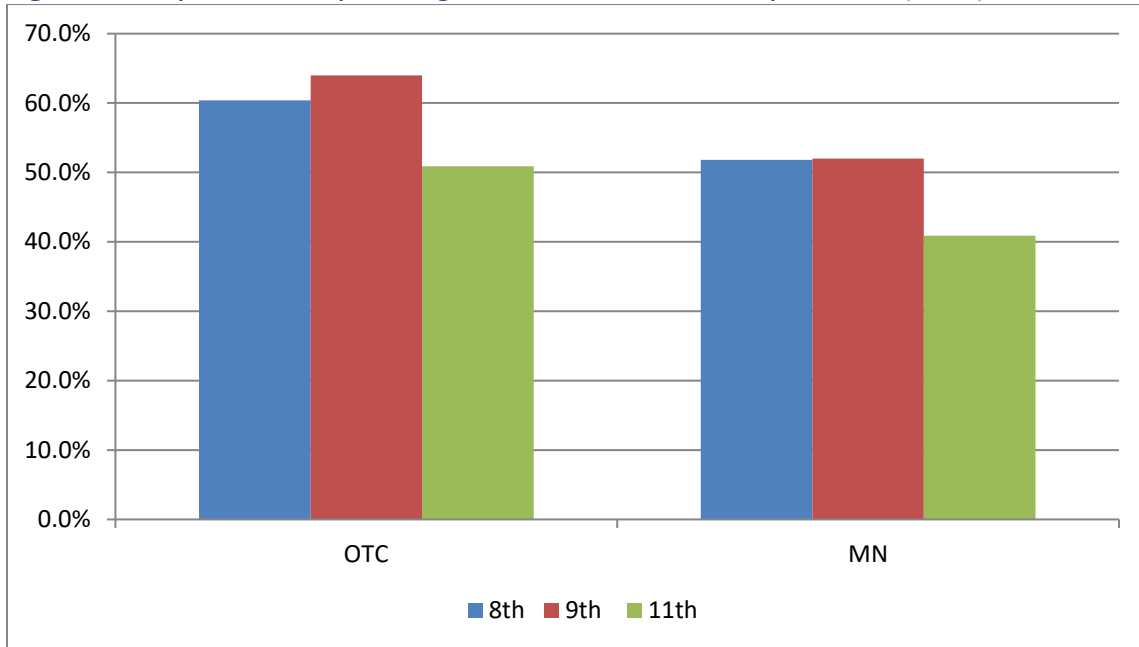
Source: MN Department of Education, Health, Human Services and Public Safety. (2016). 2016 MN Student Survey.

Bullying

Bullying is another concern that affects Otter Tail County youth according to the 2016 MN Student Survey. Overall electronic bullying seems to be more common, especially among 11th graders where its occurrence (13.8%) in the past 30 days is almost double that of physical form (7.1%) of bullying.

Figure 26: *Percentage of Students Bullied, Otter Tail County and MN (2016)*

Source: MN Department of Education, Health, Human Services and Public Safety. (2016). 2016 MN Student Survey.

When analyzed by sex, there is a difference in forms of bullying experienced by students. Electronic bullying is more prevalent among females where they are more than twice as likely to be electronically bullied compared to their male counterpart – a pattern not unique to Otter Tail County. Conversely, male students tend to experience more physical bullying than female students.

Table 4: Bullying Among Youth, by Sex, Otter Tail County (2016)

	Bullied Electronically		Pushed, Shoved, Slapped or Kicked at School	
	Female	Male	Female	Male
8th	21.5%	7.0%	11.6%	19.6%
9th	18.0%	9.6%	9.9%	13.5%
11th	19.0%	8.3%	3.3%	11.0%

Source: MN Department of Education, Health, Human Services and Public Safety. (2016). 2016 MN Student Survey

Substance Use

Although other drugs are emerging, alcohol still continues to be the drug of choice in Otter Tail County. According to the MN Student Survey, 23.9% of 8th graders have had alcohol in their lifetime. The percentage goes up as they get older. Among 9th and 11th graders, 38.6% and 46.7%, respectively have ever had alcohol. Alcohol use in the past 30 days and binge drinking among 11th graders are higher in Otter Tail compared to MN's average.
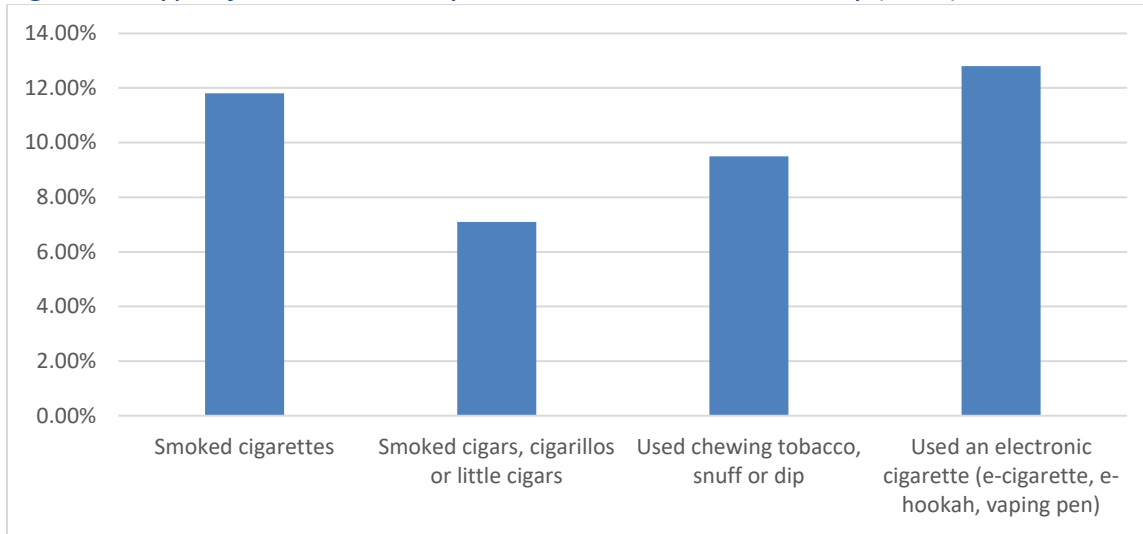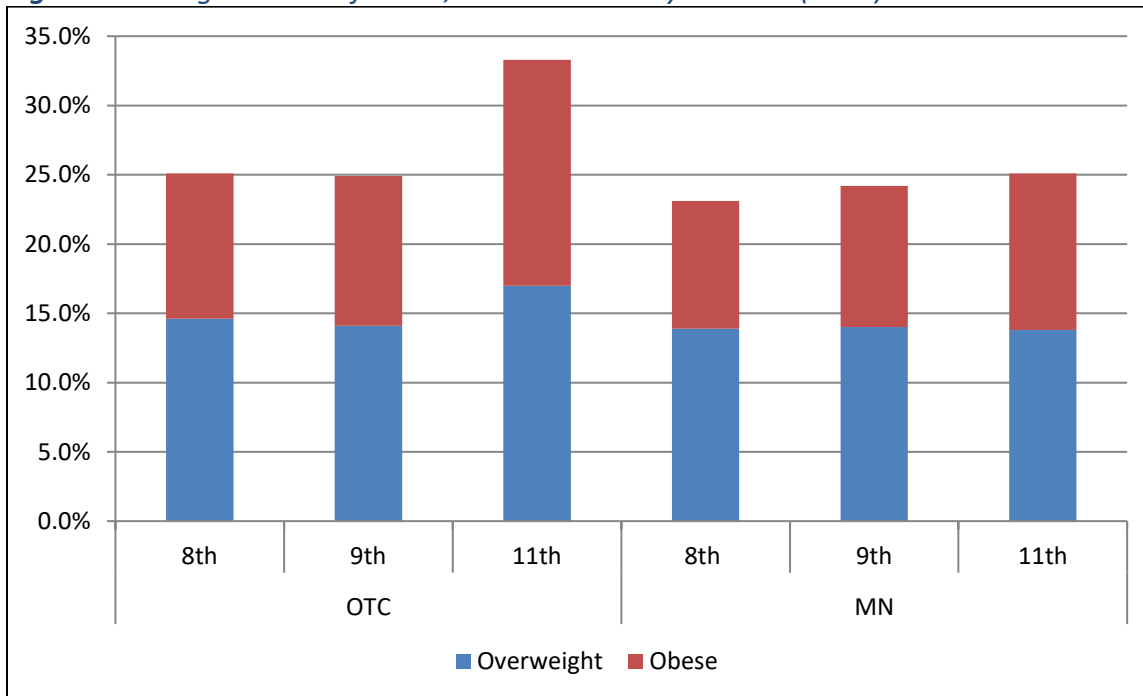
Figure 27: Alcohol Use Among 11th Graders, Otter Tail County and MN (2016)
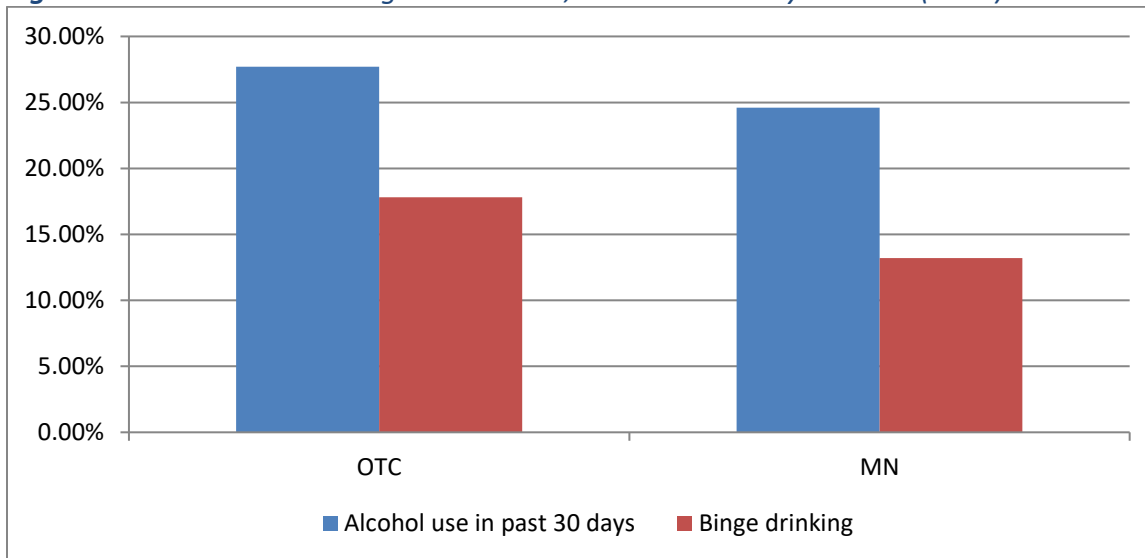
Source: MN Department of Education, Health, Human Services and Public Safety. (2016). 2016 MN Student Survey

After alcohol, marijuana is the 2nd most prevalently used substance among high school students. There seems to be perception that smoking marijuana is socially acceptable and pose very little risk. Among 11th graders, 18.8% perceive smoking marijuana once or twice per week

to pose no risk while 5.5% and 9.5%, respectively believe that their parents and friends would not find it wrong at all for them to be smoking marijuana.

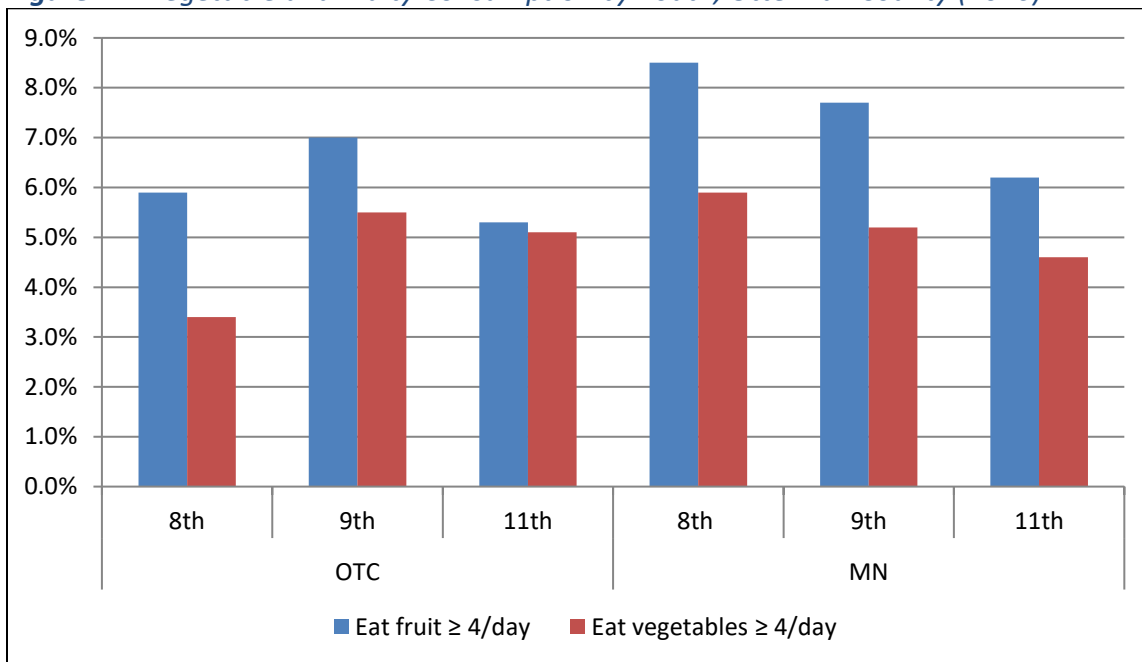***Figure 28:** Substance Use Among 11th Graders, Otter Tail County and MN (2016)*
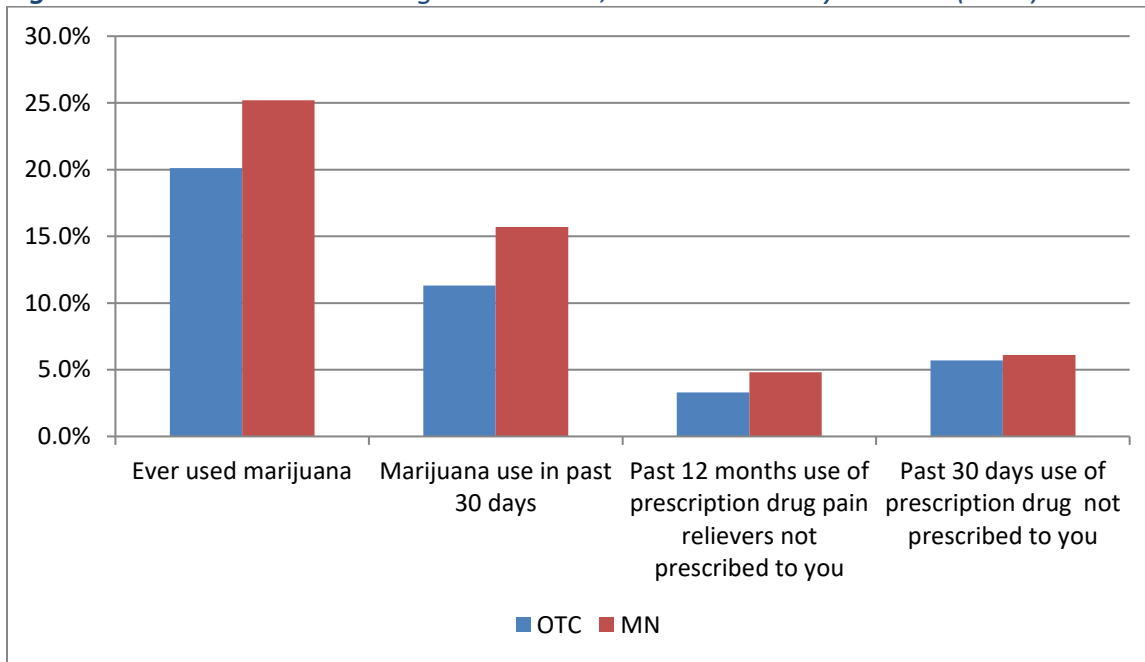
Source: MN Department of Education, Health, Human Services and Public Safety. (2016). 2016 MN Student Survey

Although at a much lower prevalence than alcohol and marijuana, Otter Tail youths are also using prescription drugs, including opioids, not prescribed to them. Chemical dependence is one of the issues that was brought up in several focus group sessions.

Sexual Behavior

There were close to 44% of 11th graders who were sexually active, higher than state average (35.3%) and a five-fold increase compared to 9th graders (8.2%). And among those who are sexually active, 34% never talked to their partner about protecting themselves from sexually transmitted infections while 28% never talked about preventing pregnancy. The most common method used to prevent pregnancy among 11th graders was condoms (46,7%), followed by birth control pills (20%) and withdrawal (16.1%). This illustrates a gap and opportunity to improve sexual health education among high school students.

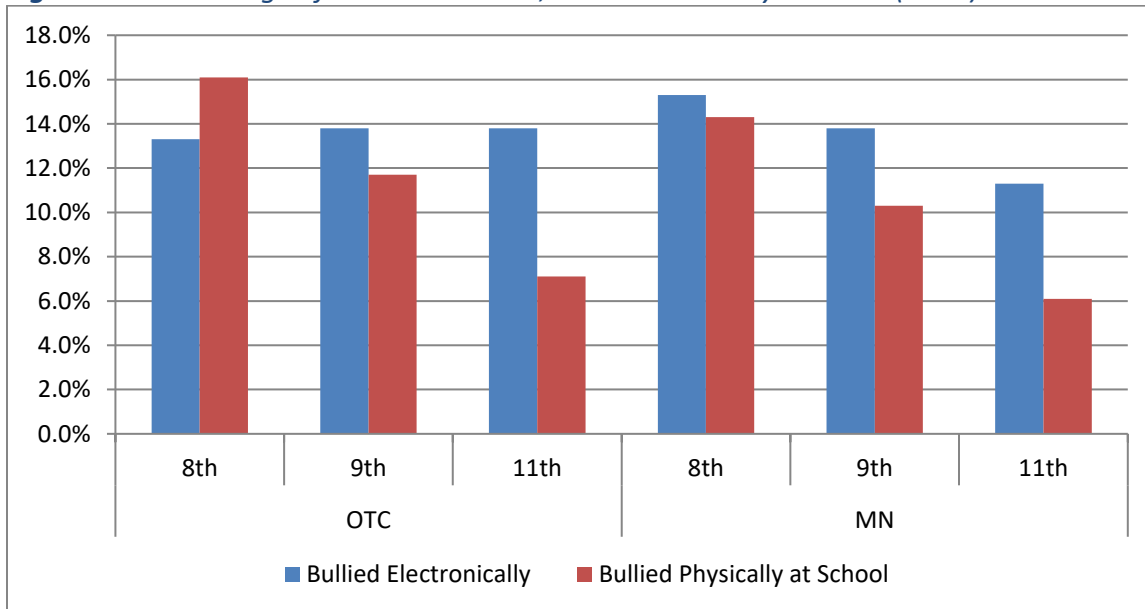*Figure 29:* *Sexual Behaviors Among 11th Graders, Otter Tail County and MN (2016)*
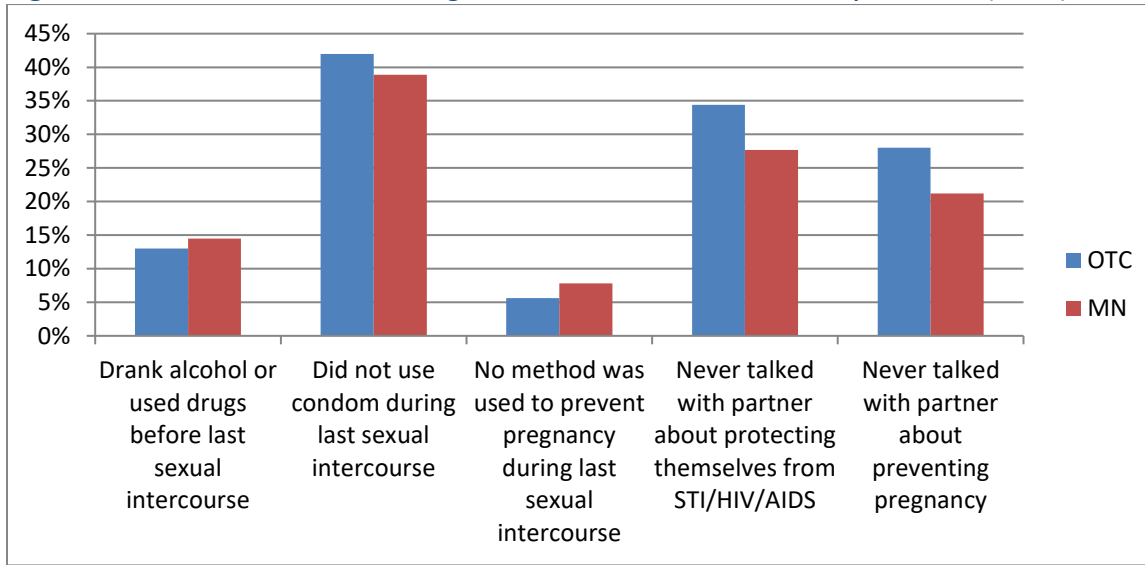
Source: MN Department of Education, Health, Human Services and Public Safety. (2016). 2016 MN Student Survey

Child Well-Being

In 1995, the Centers for Disease Control and Prevention and Kaiser Permanente collaborated on the Adverse Childhood Experience (ACE) study which assessed association between childhood experience of abuse, neglect and household dysfunction with behavior, overall health and well-being throughout the lifespan. The findings of the study demonstrated that there is a strong graded relationship between childhood exposure to trauma and adoption of risky behaviors and development of adverse health outcomes such as chronic diseases and social, behavioral and emotional problems, as adults.[28]

The three types of ACEs include

ABUSE
Physical
Sexual
Emotional

NEGLECT
Physical
Emotional

HOUSEHOLD DYSFUNCTION
Mental Illness   Incarcerated Relative
Witness Domestic Abuse Substance Abuse
Divorce

https://www.shastacapcc.org/ace-study
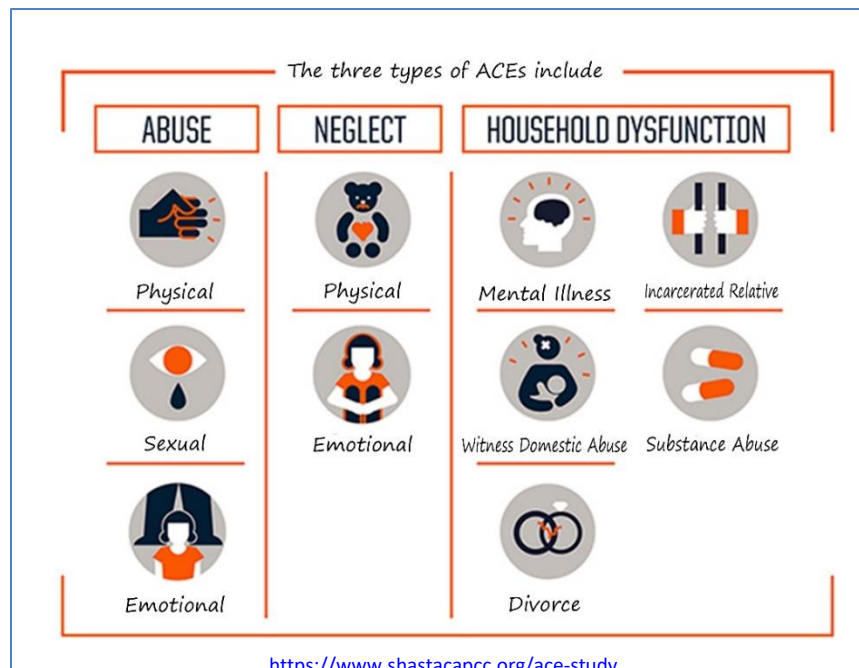
Children age 8 and younger represented the majority of the alleged victims of maltreatment. This may be because they are more dependent on adults for their care making them more vulnerable to abuse or they are more likely to be in contact with mandated reporters and therefore increase the prospect of reporting suspected maltreatment (MN Maltreatment Report, 2017).

Figure 30: *Number of Alleged Victims, by Age Group, Otter Tail County and MN (2017)*
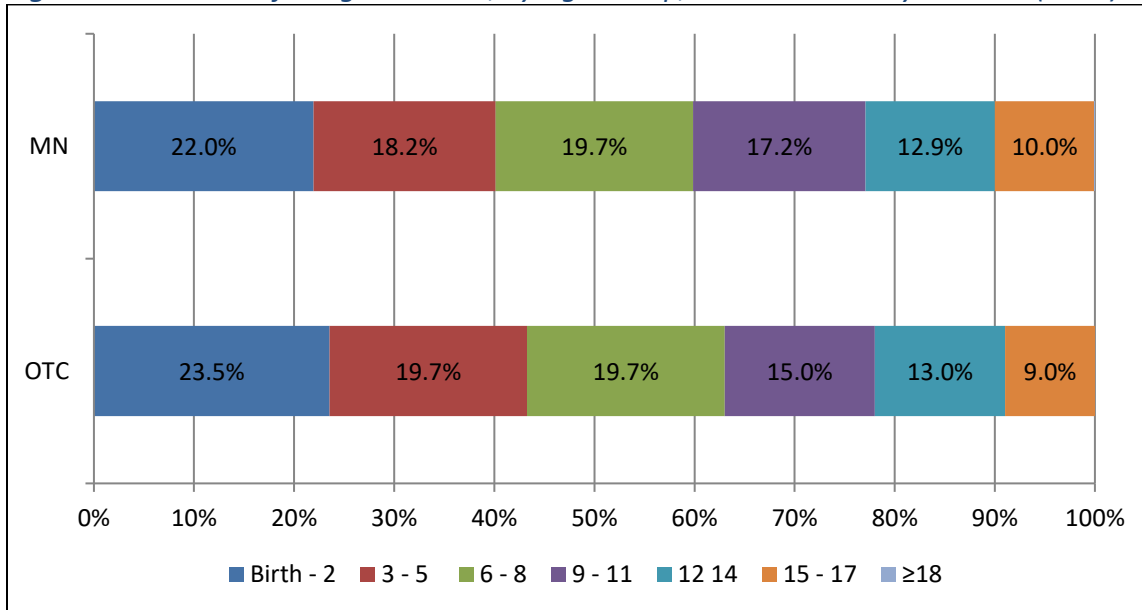
Source: MN DHS. (November 2018). Minnesota's Child Maltreatment Report, 2017. Children and Family Services.

Figure 31: *Number of Alleged Victims by Maltreatment Type, Otter Tail County (2017)*
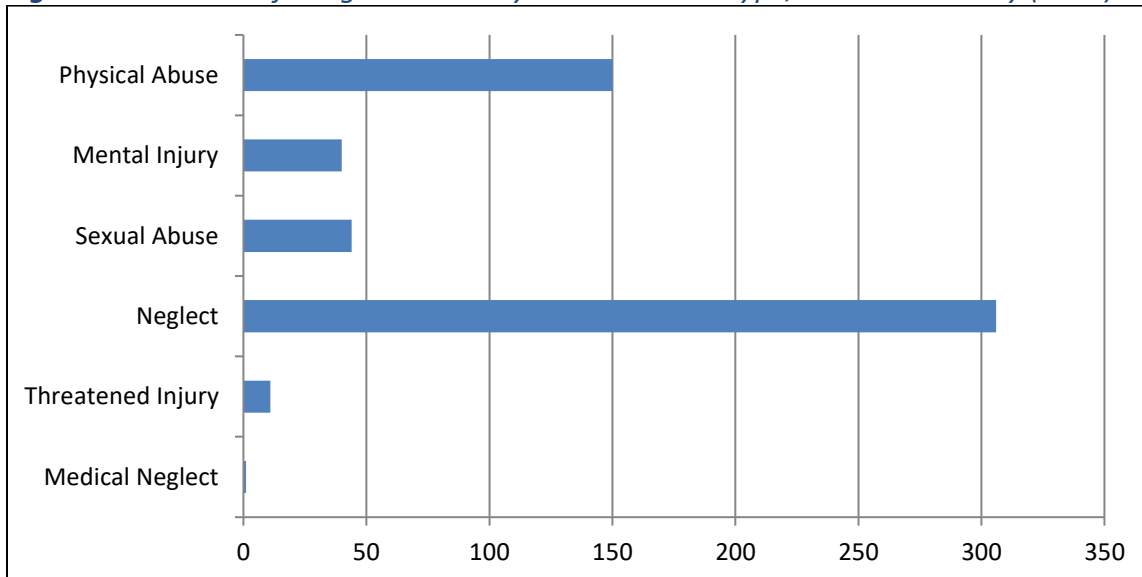
Source: MN DHS. (November 2018). Minnesota's Child Maltreatment Report, 2017. Children and Family Services.

According to the MN Maltreatment Report (2017), maltreatment allegations involving chronic and severe use of controlled substance and alcohol and prenatal exposure more than doubled since 2013 statewide. In Otter Tail County, neglect, which includes prenatal exposure to controlled substances and/or alcohol, represents the bulk of maltreatment allegations.

Physical Environment

Lead and Radon

Lead exposure increases the risk for children to develop cognitive and behavioral problems and learning and other developmental delays. In 2014, 66.8% of Otter Tail County children less than 3 years of age were tested for blood lead levels in 2014. Of those tested, 0.7% had elevated blood lead levels.

Radon is a colorless and odorless cancer-causing gas that is found naturally in most soil types. It can travel from the soil into the home through cracks, gaps or water supply.[29] Behind cigarette smoking, Radon is the next leading cause of lung cancer and 20,000 lung cancer deaths each year are attributed to Radon exposure.[30] According to the US Environmental Protection Agency (EPA), a level of 4pCi/l or higher is considered unacceptable. 59.5% of properties tested in Otter Tail County had an unacceptable Radon level of between 2010 and 2016.

Housing

A household is considered cost-burdened if it spends 30% or more of its income on housing expenses. In Otter Tail a quarter of households are considered cost-burdened while close to half of the renters are spending a third of their income on rent. This limits the household's discretionary spending.

Figure 32: *Cost-Burdened Household, Otter Tail County and Barnesville (2013-2017)*
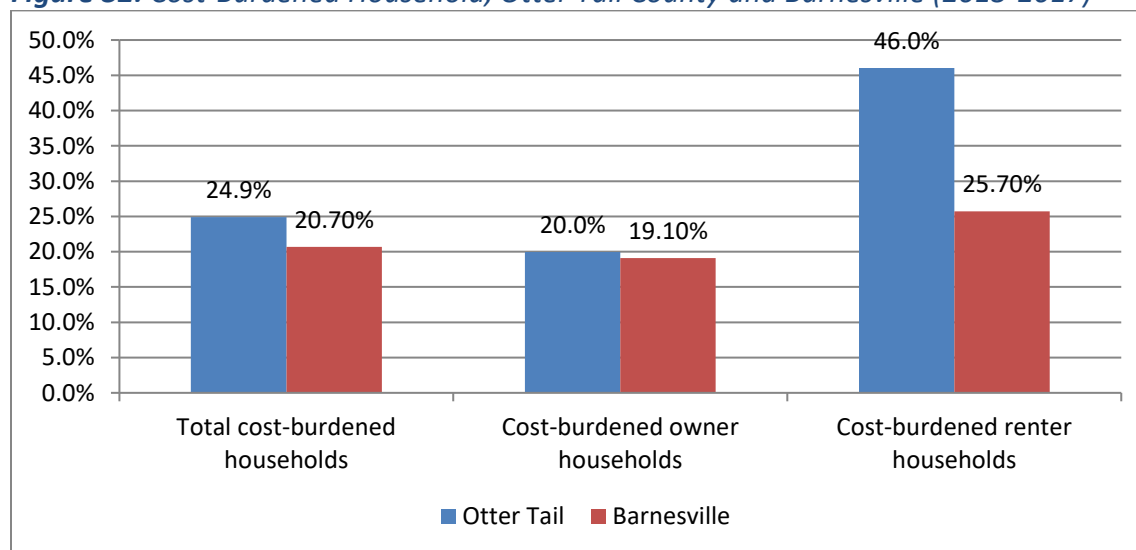
Source: MN Compass. (n.d.). Housing: Otter Tail County and Barnesville, MN. Retrieved from: https://www.mncompass.org/profiles/county/otter-tail.

Community Themes and Strengths Assessment

The purpose of the Community Themes and Strengths Assessment is to gather input from community members to develop an in-depth understanding of issues they feel are important and their concerns. Primary data collection is a key component of the community health needs assessment process. It provides additional information to augment data collected through secondary data sources. It also allows for better community engagement in the process and ensures that community members' voices are heard and that their input is incorporated in the assessment. Lake Region Healthcare chose to use the focus group approach to a) engage the community, b) generate novel solutions to perceived problems, and c) prioritize issues ranked as having the greatest impact on the health of the community.

Methodology and Sampling:

Each focus group included 8-11 participants and lasted approximately 90 minutes, allowing for substantial, high quality collection of data while remaining productive and respectful of participants' time.

Five focus group sessions were facilitated in May 2019 with a total of forty-seven participants. Purposive sampling was the method used to select individuals invited to participate. Participants were recruited based on the organizations or agencies they worked for with the idea that they would be in a position to know the community as a whole – its needs, concerns and assets, due to the nature of their work and the numerous and diverse community members they interact with on a day-to-day basis. Directors, supervisors and staff were directly contacted and invited to participate in the focus group.

Table 5: Group and Date of Focus Group Sessions

Group	# of Participants	Date
Community Group #1	10	May 14, 2019
Community Group #2	8	May 16, 2019
Lake Region Healthcare Staff	9	May 20, 2019
Faith Leaders	9	May 23, 2019
Community Group #3	11	May 28, 2019

Table 6: Summary of Participant Characteristics (n=47)

Characteristic	Number	Percentage
Gender		
Female	28	59.6%
Male	19	40.4%
Age		
18-34	4	8.5%
35-44	14	29.8%

45-54	10	21.3%
55-64	11	23.4%
65 or older	8	17.0%
Race/Ethnicity		
White	47	100%
Sector of Work		
Healthcare	19	40.4%
Non-Profit	8	14.9%
Faith-Based	7	14.9%
Public Health	3	6.4%
School	3	6.4%
Business	2	4.3%
Public Safety	1	2.1%
Human Services	1	2.1%
Retired	4	8.5%
Area(s) of Expertise*		
Health	26	
Mental Health	14	
Children/Youth	8	
Education	4	
Aging	13	
Housing	3	
Transportation	5	
Low Income	11	
Disability	6	
Homelessness	5	
Crime	2	
Domestic Violence	4	
Veterans	3	
Immigrants	1	
Discrimination	1	
Substance Use	6	
Length of Residence		
0-2 years	4	8.5%
3-5 years	7	14.9%
6-10 years	5	10.6%
11-15 years	6	12.8%
16 years or more	25	53.2%

* Did not calculate percentages for this category because respondents were allowed to choose more than one option.

All participants were asked to sign a consent form (see Appendix B) which informed them of the purpose of the focus group, how the data collected will be used and that the session will be audio recorded. The consent form also reiterated that their participation is voluntary. Because age, gender, experience and other variables can impact perceptions and views on health,

participants were also asked to complete a demographic questionnaire (see Appendix C) to capture specific characteristics and assess such factors. Participants received a light meal as an incentive for their participation.

A modified version of the Nominal Group Technique was employed in conducting the focus groups to encourage contributions from all participants. A standard protocol was used for all focus groups (see Appendix A). Steps included:

1. An introduction of the facilitator and all participants.
2. A brief overview of the purpose of the focus group.
3. An outline of the ground rules and process to be observed during the focus group session.
4. Each participant is asked to share an idea in response to the question posed. Response is recorded on a flip chart poster. Each participant has two turns to respond to each question. Afterwards, the facilitator opens the floor and asks participants to share any additional ideas they have.
5. The ideas are clarified and grouped according to consensus. Participants are asked to agree on a final listing.
6. Participants, by raising their hands when the facilitator reads the response, get to vote on the top two ideas/responses they believe to be the most important.
7. The votes are tallied and recorded.
8. The same steps were followed for all three questions.
9. A standard script was used for the focus group (see Appendix A).

Questions asked are as follows:

1. When thinking about health, what are the greatest strengths in our community?

- Identify resources and factors that the community can use to build upon to meet the health needs of the community.

2. What are the most important health-related issues in our community?

- Identify the pressing health-related gaps and needs in the community.

3. What recommendations do you have to improve the health of our community?

- Identify potential resources, services, programs or interventions that would help advance the community's goal of better health and quality of life.

Data from all five focus groups were collected and analyzed independently and collectively. The analysis identified prevailing themes in each of the three questions and coded accordingly (see Appendix D).

Results

Because participants of the focus groups were from varying background with different life and work experiences a broad range of responses was expected. However, despite their differences, common themes across all 5 focus groups were apparent in each of the three questions.

Strengths

For strengths in the community the most common responses were:

Access to a Variety of Quality Health-Related Resources

"*Access to cancer center, walk-in, preventive and specialty care…access to care (from) prenatal all the way to end of life.*"

Focus group participants identified access to quality healthcare providers and facilities to care across the continuum available in the community from wellness and prevention to treatment and end-of-life care as a fundamental strength. The Cancer Center was especially singled out with one participant saying, "*…the fact that we have a cancer center for a town of 13,000. I think that's very unusual and we're very lucky*." Also, included in this category are access to mental health, long-term care services and services not provided by the clinic and the hospital such as health care services provided by Public Health and Mahube-Otwa. Most people do not have to leave the community to get the care they need.

Collaboration and Partnership

"*I think we have a pretty good way of knowing who the different players are to impact health. And we have good communication lines*."

Partnership and collaboration across the different agencies in the community was a key strength noted by several participants. The partnerships among the healthcare system, non-profit and community-based organizations, the County, local businesses, school and spiritual community and willingness to work together in support of various health-related initiatives was a common theme. Through these partnerships and collective action, they have been able to more effectively make an impact in their common goal of promoting and improving the overall health of the community.

Access to a Variety of Community-Based Resources and Social Services

"*I think we have a coordinated effort amongst our resources. So there's that integral relationship already established.*"

The variety of services and resources available in the community that is not traditionally tied to health was identified by focus group participants as a significant strength, "*especially for a*

community our size." These include the Food Shelf, Ruby's Pantry, Community Garden, Someplace Safe, A Place 2 Belong, United Way, Salvation Army, the County Human Services and Social Services and other non-profit agencies in the community. In addition to having these services available, there is generally an awareness among and good communication across the different agencies wherein, "*If they can't help you in this area, they will refer you to somebody who can.*"

Natural Resources

"*It's a beautiful part of Minnesota. We have clean air, lakes all around. I think Fergus Falls is relatively walkable. I think all of those things are strengths in terms of health.*"

The naturally built environment of the county was mentioned as one of the leading strengths of the community. Aside from its beauty, access to free parks, trails and lakes affords everyone an opportunity to partake in various outdoor activities and to engage in a healthy lifestyle.

Community Support and Volunteerism

"*Community support benefits the community through connection and sense of togetherness.*"

A general sense of community and willingness to help and support others are valued strengths in the community. Included in this is category are volunteerism, social connectedness, philanthropy and leadership. People in the community are innovative, generous, caring and invested in the community. In Barnesville, a participant said, "*If there is a medical emergency or fire we have a (community) fund in town to help other families.*" Another focus group participant said, "*Our community is known for innovation and we have some people who really want to do some great things and are health-driven.*"

Issues:
There were common concerns noted across the five focus groups. The most common ones are listed below:

Social Issues

"*A lot of times when I think about health, when a lot of basic needs aren't met, health you know, goes south too.*"

The most often-cited issue in the community relates to social determinants of health. Poverty, low income, lack of access to transportation, food insecurity and lack of affordable housing and childcare were some of the specific social issues identified by participants. Many expressed that these are often the drivers of health and health inequity in our community. People who live in poverty face a unique set of challenges and barriers to accessing resources that impact their

health behaviors, and ultimately their health. One participant said, "*When I think of the level of people living in poverty who have obesity, diabetes and drug addiction…People on food support programs when they make choices to extend their dollar they are choosing to buy soda instead of milk so they have weight and (other) health-related issues.*" Other examples shared by participants include an individual who may be eligible for Medical Assistance but cannot get one because they do not have transportation to get to Human Services to apply for it or people cannot apply for a job or get additional training because they do not have the means to get there. Although the county offers public transportation, it requires planning and scheduling ahead of time which limits one's ability to access same-day or urgent appointments. These factors limit the ability of people to seek out or secure needed and valuable services or participate in social opportunities.

This aligns with the County Health Rankings model which estimates the impact of clinical care on health to be just 20%. The remaining 80% of health is determined by other factors such as health behavior, socioeconomic factors and the physical environment.[31]

Mental Health

"*Mental health is the biggest issue I see in primary care.*"

One of the most common issues in the community cited by participants is the prevalence of mental health issues, limited access to psychiatry, lack of treatment facilities and stigma associated with it. Due to limited access to psychiatry, primary care providers are left managing mental health disorders or according to another participant's research, "*pastors and clergy above any other professional are the most referred to for mental health services.*" It was noted that a lack of access to mental health services is prevalent nationwide and is not just a problem in our community.

Many felt that isolation, lack of social interaction and family deterioration compound this issue, "*Many kids nowadays are so engrossed in their electronic devices that they lack basic communication skills.*" Child psychiatry was pointed out as an area where the gap in service is even bigger. Emphasized during the focus group sessions was how mental illness not only affects the individual who is suffering from the disorder, but that the difficulties associated with the illness extend to the family and the community.

Chemical Dependency

"*The amount of meth, cocaine and heroin use is astronomical. And it's in every corner...Somehow drugs have found a way to every single community in this country with no problem…(it's) overwhelming.*"

Substance use and lack of treatment services was another commonly cited concern. It's an issue that affects everyone from newborn to the elderly. Similar to mental health, participants mentioned "*the affect it has on everything and everyone in the community…It affects domestic violence. Kids witness domestic violence so it affects the entire family. There's sexual violence that's perpetrated because of drugs. Sexual exploitation because of drugs. Other general crimes such as burglaries, thefts all sorts of things. So I just think that drugs in the community are huge.*" More kids are also entering the foster system because parents are unable to care for them due to their addiction.

Although several participants expressed that mental health and chemical dependency overlap or one usually leads to the other, the consensus was that these two should be distinct issues. Increasing availability and accessibility to treatment services for both mental health and chemical dependency is imperative. In addition, emphasis on prevention efforts is critical to curb this problem.

Lack of Awareness of Available Resources

"*There's a constant need for awareness – of getting those resources or getting that awareness to the people.*"

Although the availability of a variety of resources and services was one of the main strengths of the community, a challenge that many expressed was the lack of awareness, not only by community members but by some service providers and community leaders about these resources. This hinders their ability to make the appropriate referrals or for their clients to be connected to these much needed resources or services. Complicating this issue is identifying how to effectively communicate these resources to the community because resources are constantly changing and people have different ways or preferences of receiving information.

Aging Population

"*The aging population in general is an issue for everything, I believe.*"

The growing elderly population was another concern brought up by participants. This demographic shift will increase demand for specific healthcare, social and supportive services, such as home care, long-term care end-of-life care, affordable senior housing and transportation. Social isolation and mental health issues were also brought up as challenges faced by the elderly, especially those who live in the more rural parts of the community. One participant said, it's particularly challenging "*for elderly who do not have a family to help them. They live alone and they're struggling and nobody knows it. They may even have mental issues.*" Lack of affordable senior housing was singled out in a focus group because it leads to seniors

reluctantly having to leave their friends and the community they have lived in most of their lives which contributes to the decline in their mental and cognitive health.

Lack of Workforce

"You can have all the services that you want, but if you have no staff or a quality workforce, then none of it matters."

Lack of workforce was a common theme cited by participants and perceived as a two-sided issue. That is, for some opportunities there are more vacancies than there are people available to fill them. On the other hand, especially for positions that require certification or licensure, people do not have the necessary education or skill to qualify. It was also brought up by a participant how the state of Minnesota makes it very challenging for professionals to receive their license that sometimes due to not being able to afford student loans *"they just can't go all the way to get the credentialing that's needed."* This compounds the workforce shortage which in turn limits ability and capacity to provide needed care and service to the community. As one participant said, *"There are beds sitting empty in facilities that they can't fill because they don't have the staff to take care of the people."*

Three primary factors were perceived to contribute to the workforce shortage: 1. A lack of awareness when jobs are available locally, 2. The lack of affordable childcare especially for those that are in need of assistance during "non-primary work hours", and 3) The local perception that salary in the Fargo-Moorhead area is significantly higher (than positions available locally). A lack of diversity in the workforce was also of concern, *"We know that our workforce does not represent the population that we serve. That's a really big challenge. A really big barrier to accessing care."*

Recommendations:
Most of the recommendations identified by participants relate to addressing issues of concern. Below were the most frequently cited recommendations.

Raise Awareness of the Available Resources and Services in the Community

"It would be great if there's just somebody who knew all these resources in town and would be able to be a resource for people in my position and other positions. Because I'm often just at a loss when I meet these people."

There was a strong sentiment by focus group participants that we have a lot of resources and services in the community, some of which are being underutilized due to the lack of awareness that they exist. The challenge is how to effectively inform community members about them. Specific recommendations included having a point person in the County, a *"community liaison,"*

who people can call to connect them to the appropriate place or even a database of resources that everyone can access.

Address Social Issues

"[The] mentality of creating ahead of time a comprehensive plan for a variety of these social issues would pay off for the care teams that deal with them."

This is a broad category of recommendations that encompasses addressing complex social issues collaboratively and comprehensively to effectively improve population health. Specific recommendations include developing a more complex transportation system that is affordable to ensure that it is not a limiting factor in accessing care and needed services; subsidize fruits and vegetables to make it more affordable; design health promotion interventions that target children and youth to lay the foundations of a healthy lifestyle; offer educational and supportive services such as parenting and financial management skills class to equip people with basic skills that give them and their family the opportunity to thrive.

Provide Transitional Services

"This is about developing our community and sustaining our community. Putting people back into life with their family and children and working. It's the shared idea of how the community comes around transition."

Participants identified creating a community-driven education center that would provide training and support for people who are recovering from addiction, mental health or personal issues that would help reach their potential and move them along to the path of success.

Remove Stigma Associated with Mental Health, Poverty and Addiction

"I feel like a lot of people experiencing these issues [addiction, mental health, poverty] aren't necessarily embarrassed by it. But they know the moment they go out of their circle or comfort zone that they're no longer safe….And they're definitely treated differently."

Another common theme of recommendations was the need for more education and cultural competency training about mental health, addiction and poverty. This goes for both general community members and service providers to reduce societal stigma around these issues. For service providers specifically, cultural competency training would enable them to appropriately respond to the unique needs of their clients.

Improve Social Connection

"The greatest predictor of health is the quality of our social connectedness."

Several of our focus group participants linked the lack of social connection or social isolation to a lack of basic communication skills, and the presence of family dysfunction, mental health issues, suicide and an increasing risk of dementia. Many participants asserted that teaching basic communication skills, discouraging excessive use of social media and electronics, engaging community members (especially the elderly) and promoting volunteerism would be beneficial to individual and to community health.

Update 2013-2016 Implementation Plan

Reducing Substance Use

- LRH entered into an Opioid Abuse Prevention Pilot Project through the Minnesota Department of Health on April 2018. Activities implemented are as follows:

  - Created a Controlled Substance Care Team (CSCT) consisting of internal medicine and family practice physicians, psychiatrist, RN controlled substance care coordinator, RN medical home care coordinator, social worker, pharmacists and clinic coordinator. This multidisciplinary care team reviews chronic pain patients and make appropriate recommendations to the patient's primary care provider. Recommendations can include a tapering plan, non-pharmaceutical therapies and alternative medication therapies. The CSCT also assist in referring patients to services they may need or may be helpful to reduce their dependence on opioids, allow them to manage their pain more effectively and improve their overall health. The focus of the CSCT is to care for the patient's medical as well as social needs to help reduce inappropriate use of opioids and rate opioid addiction.

  - The CSCT also encourages responsible prescribing through provider education using the CDC opioid prescribing guidelines published in 2016.

  - Started a Medication Assisted Therapy Program which is a treatment option for individuals suffering from opioid addiction. Currently we have 3 providers who are waivered to prescribe Suboxone and 30 active patients in the program. All patients in the MAT program are connected with our controlled substance care coordinator and our medical home care coordinator to provide them with the support they need in their journey to recovery.

  - Leads a county-wide opioid abuse prevention task force that meets every other month. Members include law enforcement, county attorney, county public health and human services, probation, long-term care, mental health, school

representative, Narcan trainer, local pharmacy, dentist and multiple Lake Region Healthcare staff including providers, administration, social worker, CSCT members, etc. The objective of the task force is to develop and implement effective environmental strategies to address opioid abuse and misuse, guide prevention and treatment efforts and increase community awareness and education on safe use, storage and disposal of controlled substances.

  o Began requiring all patients who are on chronic opioid therapy to sign a care plan which will be updated annually.

- LRH partnered with the Thrifty White, pharmacy located in the clinic, to house a prescription drug drop off box where anyone can safely dispose their unwanted medications.

- LRH updated its Emergency Department's Controlled Substance Prescription policy to include not refilling controlled substances prescribed for psychiatric conditions in addition to patients with chronic pain.

  - LRH is collaborating with Otter Tail County Public Health to:

  1. *Implement new legislation related to prescribing naloxone by the Community Health Board's Medical Consultant.*

  2. *Collaborate with area pharmacies in an attempt to implement new legislation related to pharmacy take back of medications to remove unused medications from homes.*

  3. *Promote the "Take It To The Box" option at local law enforcement agencies to collect unused medications in order to eliminate it from the supply stream and protect the environment from disposal of medications.*

Reducing Obesity Status

- LRH continues to enhance access to group fitness classes at LRH including CrossFit Classes.

- LRH plans and participates in community functions that promote activity such as the Streets Alive Initiative, the Corporate Cup Challenge, use of the Fergus Falls loop of North Country Trail, the Lake Region Run, and the Pebble Lake Youth Triathlon.

- LRH collaborates with community partners to continue to host the annual Community Health Challenge which focuses on the 7 dimensions of wellness – emotional, environmental, intellectual, occupational, physical, social and spiritual.

- LRH partners with the local grocery store, Service Foods, to offer the Shop with the Doc program, a free education session led by LRH physicians on what to look for and how to shop for affordable healthy foods.

- LRH is evaluating the need and feasibility for additional dietitian hours for Lifestyle Medicine and Cancer Center outpatient nutrition counseling services.

- LRH is increasing the number of healthful menu items in our cafeteria, implementing a healthy catering policy and supporting employee weight management goals and reduce risk of development of Type II Diabetes.

- LRH continues with our community garden, "Lake Region Takes Root" campaign. For the 2018 summer season, an estimated 10,600 pounds of fresh foods was harvested and shared with our local food shelf, WIC program, Salvation Army, and A Place to Belong.

- LRH continues to offer the "I Can Prevent Diabetes" (ICPD) Program free of charge. The program focuses on facilitating the adoption of a healthier lifestyle through healthful eating and increased physical activity to prevent or delay the onset of Type II diabetes. This is a 24-session lifestyle program that spans over a one year period.

- LRH continues to partner with PartnerSHIP 4 Health on various projects to "make the healthy choice the easy choice" by implementing system, policy and environmental changes. Recent projects include hosting a healthy cooking class open to the public at least once a year, becoming a member of PartnerSHIP 4 Health's worksite wellness collaborative and implementing changes to our clinic practice to improve prediabetes initiative.

Addressing Mental Health Issues Status

- LRH is improving access to mental health providers by implementing tele-psychiatry visits.

- LRH is working to improve access to services for persons in need of detoxification services.

- LRH partnered with the ParnterSHIP 4 Health to implement the THRIVE initiative which is a community resilience project that promote health through happiness and meaning by using proven mental health resiliency tools. The goal of THRIVE is to create a community that flourishes, where residents learn resiliency skills developed by practicing positive emotion, engagement, positive relationships, meaning and accomplishments. We are currently working with service groups, mental health providers, long-term care agencies, school districts and local businesses to promote improved mental well-being.

Preventing Adverse Childhood Events Status

- In collaboration with Otter Tail County Public Health, LRH is increasing awareness of ACES and their impact on health through developing a language and working with education, welfare, healthcare, and other public systems.

- In collaboration with Otter Tail County Public Health, LRH is enhancing collaboration with Lake Region Healthcare pediatric services and county programs to make referrals to the Help Me Grow Program for children to access early childhood family education.

- LRH continues to refer all new moms and their infants to Otter Tail County Public Health for a family home visit during which a public health nursing assessment is done at the first visit and additional supports such as parenting education and education on caring for babies, infant growth, child development and safe home environment are provided if needed. A referral to the Healthy Families America program is also made if deemed necessary.

- LRH is also a member of the Otter Tail Family Services Collaborative which aims to improve the social, emotional, educational and economic outcomes of all Otter Tail County children, adolescents and their families by working together to create a responsive, flexible system of education, support and services that focus positively on the needs, strengths and potential of each child and family.

Improving Chronic Disease Management Status

- LRH continues to enhance systems and processes that will greatly improve our performance in the Minnesota Community Measurement, an organization that collects, analyzes and publicly reports information on health care quality, cost and patient experience. More focused work has been done on improving optimal asthma care and colorectal cancer screening.

- LRH continues to expand the Medical Home Care Coordination program within LRH including outlying clinics. Outreach clinics in Ashby, Barnesville and Battle Lake are now certified health care homes as well. Currently, we have 230 patients enrolled in our medical home program.

- LRH continues to offer the "I Can Prevent Diabetes" (ICPD) Program free of charge. The program focuses on facilitating the adoption of a healthier lifestyle through healthful eating and increased physical activity to prevent or delay the onset of Type II diabetes. This is a 24-session lifestyle program that spans over a one year period (this implementation plan is also mentioned in Reducing Obesity Status above).

Prioritization

On June 25, 2019, the CHNA Steering Committee met to debrief on the findings of the CHNA and prioritize the identified needs. The graphic below describes the priority health needs identified during the CHNA as well as the process and criteria used to prioritize the needs.

Following the review of data, committee members asked clarifying questions, approved the proposed prioritization criteria and discussed the 2016-2018 CHNA report's identified prioritized needs and if there is an opportunity to link both efforts. Committee members agreed to take into consideration previous CHNA's prioritized needs when analyzing the data collected for the current cycle of CHNA.

Under the direction of the CHNA Steering Committee, a subset of the committee met afterwards to review and discuss the focus group results and secondary data collected against the prioritization criteria and identify the priority health issues. After thoughtful deliberation, the following were identified to be the priority health issues of Otter Tail County and Barnesville (in no particular order):

1. Mental Health
2. Substance Abuse
3. Lack of Awareness of Available Resources
4. Chronic Disease – Obesity, Cancer, Heart Disease, Diabetes

Based on the perceived impact of social issues/social determinants of health (SDOH) across the spectrum of health issues (see Appendix) and the clear concern voiced by our focus group participants, SDOH will be carefully considered and evaluated in all proposed intervention strategies.

Prioritization Process:

2016 Prioritized Needs:
1. Substance use
2. Obesity
3. Mental health
4. Adverse childhood events
5. Chronic disease management

Established Prioritization Criteria
1. Seriousness
   - Size
   - Urgency
2. Ability to Impact
   - Effective interventions
   - Resources/Capacity

2019 Prioritized Needs:
1. Mental health
2. Substance use
3. Lack of awareness of available resources
4. Chronic Disease

Focus Groups:
1. Strengths
2. Issues
3. Recommendations

Focus Group #1

Focus Group #2

Focus Group #3

Focus Group #4

Focus Group #5

Coded and grouped into categories

Prioritization Criteria
1. Seriousness
2. Ability to impact

Ranked grouped categories based on priority votes

Combined Top 5 of the Issues and Recommendations list

Supplement with Secondary Data

Assets and Resources

Below is a list of potentially available assets and resources to address the significant community needs identified through the CHNA.

- Lake Region Healthcare
- A Place2Belong
- Barnesville Area Helpers
- Barnesville Economic Development Authority
- Community Garden
- Faith Leaders
- Fergus Falls Food Shelf
- Kiwanis
- Lakeland Mental Health Center
- LB Homes
- Live Well Fergus Falls
- Local Law Enforcement
- Mahube-Otwa
- Meals on Wheels
- Someplace Safe
- Otter Tail County Public Health
- Otter Tail County Human Services
- Otter Tail County Sherriff's Office
- Otter Tail County Family Services Collaborative
- PartnerSHIP 4 Health
- PioneerCare
- Productive Alternatives, Inc
- Rotary
- Salvation Army
- Schools
- United Way of Otter Tail and Wadena County
- Valley Care and Rehab

Conclusion

In March of 2019, Lake Region Healthcare gathered to begin the community health needs assessment (CHNA) process for FY 2019 - 2021. The goal of the CHNA was to guide the focus and direction of Lake Region Healthcare in addressing the health-related needs of the Otter Tail County and Barnesville community.

This CHNA report includes both quantitative and qualitative data to shed light on the health status and health needs of the Otter Tail County and the City of Barnesville communities. Qualitative data were gathered from five focus group sessions with different members of the community. Quantitative data were collected from multiple secondary sources such as the US Census Bureau, MN County Health Tables, MN Public Health Data Access, MN Youth Survey and the PartnerSHIP4Health CHNA Survey.

After the review and analysis of all data, prevailing themes emerged which helped the CHNA Steering Committee identify Mental Health, Substance Use, Lack of Awareness of Available Services and Chronic Disease as the priority health issues in the community. Work groups will be formed around each of the identified priority health issues. Each will be tasked to define attainable goals and objectives, develop clear strategies and develop an evaluation plan to measure progress in addressing each of the identified priority health issue.

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Appendix

Appendix A: Focus Group Guide

Welcome:

Good afternoon. Thank you for agreeing to be part of the focus group. I appreciate you taking the time out of your busy schedules to participate.

Introduction:

I'm Joanna Chua, community health initiatives project coordinator for Lake Region Healthcare and I will be your facilitator. Just to give you a brief overview of the purpose of this focus group discussion – Lake Region Healthcare is in the process of conducting a community health needs assessment. As part of the assessment we are facilitating a few focus group sessions to gather community members' viewpoints on the pressing needs facing our community, Otter Tail County. Information gathered from the focus groups will be used to supplement the statistical data we collect from secondary sources. The overall results of the assessment will help guide Lake Region Healthcare's focus and direction to meet the health care needs of Otter Tail County.

Ground Rules:

- For today's discussion we will be using a modified version of the Nominal Group Technique. In this process each participant will share one response per turn to the question. We will go about it in a round-robin fashion so each participant has an opportunity to respond. Each participant will get two turns to respond to each question. Participant may "pass" your turn, and may then add a response on a subsequent turn. During the round-robin process there will be no discussions, not even questions for clarification. All responses will be recorded on the flip chart and when everyone has shared their responses, we will open it up for discussion. Afterwards, each participant will have two votes to cast on the ideas/responses you believe to be the most important for each question.
- There are no right or wrong answers. We are not evaluating or judging any one person's opinions or experiences. Rather, we are trying to capture the thinking of as many people as possible so please be honest and open with your thoughts.
- What is said in this room will stay here. Please refrain from discussing comments made by other group members outside the focus group.
- I will be audio recording the session so I can capture everything you have to say. But you can rest assured that no one will be identified by name in the report. Everyone will remain anonymous.

Questions:

1. What areas of concern/challenges do you see facing the community?
2. What do you view as the greatest assets/strengths of the community?
3. What can be done to address these needs/concerns?

Conclusion:

Thank you for participating. This has been a very successful discussion. Your thoughts and opinions will be valuable to the community health needs assessment. I hope you have found the discussion interesting. If you have any concerns or questions regarding the session or the needs assessment in general, please feel free to contact me. Again, I would like to remind you that any comments that will be included in the needs assessment report will be anonymous. Before you leave, please hand in your completed demographic questionnaire and the card requesting for a one-word description of the community.

Appendix B: Focus Group Consent Form

Lake Region HEALTHCARE

LAKE REGION HEALTHCARE
712 Cascade St S | Fergus Falls, MN 56537
218.736.8000

Community Health Needs Assessment
Focus Group Consent Form

You have been asked to participate in a focus group sponsored by Lake Region Healthcare Corporation as part of its community health needs assessment process. The purpose of the group is to gather information and to understand the perspectives of community partners and stakeholders regarding the pressing needs facing our community as well as its strengths and available resources. The information learned in the focus group will be used to help Lake Region Healthcare and other organizations in Otter Tail County better understand what residents and service providers think about the community and the needs that are present.

You can choose whether or not to participate in the focus group and stop at any time. Although the focus group session will be audio recorded, your responses will remain anonymous and no names will be included in the report.

There are no right or wrong answers to the focus group questions. We want to hear many different viewpoints and would like to hear from everyone. We hope you can be honest even when your responses may not be in agreement with the rest of the group. In respect for each other, we ask that only one individual speak at a time and that responses made by all participants be kept confidential.

If you have any questions or concerns regarding the focus group session, please contact:

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Jmchua@lrhc.org
218-739-6775

Abby Drouillard
Quality and Respiratory Care Director
Akdrouillard@lrhc.org
218-736-8361

I understand this information and agree to participate fully under the conditions stated above.

Sign name: _____   Date: _____

Print name: _____

Appendix C: Focus Group Demographic Questionnaire

Lake Region Healthcare
Focus Group Demographic Questionnaire

Gender:　☐ Female　　☐ Male　　☐ Non-binary　☐ Prefer not to answer

Age:　　☐ 18 – 34　☐ 35 – 44　☐ 45 – 54　☐ 55 – 64　☐ 65 or older

Race/Ethnicity:

☐ White　　☐ Black/African American　　☐ Asian /Pacific Islander　　☐ Native American

☐ Multiracial　☐ Hispanic/Latino　　　☐ Other:_____　　☐ Prefer not to answer

Sector of Work: *Check the one that best describes your employer.*

☐ Healthcare　　　☐ Non-Profit/Social/Community Organization　　☐ Faith-Based

☐ Public Health　☐ School　　☐ Business　　☐ Public Safety　　☐ Human Services

☐ Retired　　　　☐ Other: _____

Area(s) of Expertise: *Check all that apply.*

☐ Health　　☐ Mental Health　　☐ Children/Youth　　☐ Education　☐ Aging

☐ Housing　　☐ Transportation　　☐ Low Income　　☐ Disability　☐ Homelessness

☐ Crime　　☐ Domestic Violence　☐ Veterans　　　☐ Immigrants　☐ Discrimination

☐ Substance Use/Chemical Dependence　　　　☐ Others:_____

How long have you been living and/or working in Otter Tail County?

☐ 0 – 2 years　☐ 3 – 5 years　☐ 6 – 10 years　　☐ 11 – 15 years　　☐ 16 years or more

Appendix D: Focus Group Results

Strengths:

Response	Incidence	Priority Votes
Variety of health resources • *Access to specialties* • *Clinic* • *Health-related resources* • *Human services, care coordination and case management are available and coordinated* • *Health-related facilities* • *Large variety of services – senior living, assisted living, PT/OT* • *Local pharmacy* • *Dental, eye, nursing home, PT* • *Access to basic healthcare* • *Number of different healthcare options* • *Multiple healthcare services in the community* • *Cancer Center* • *Care options for seniors* • *Great healthcare providers* • *Mental health services in schools* • *Variety of care options for all ages* • *Good access to care both preventive and specialty* • *Cancer Center* • *Walk-in clinic* • *Care options for the aging* • *Hospital, pediatric rehab which addresses behavioral issues* • *Range of care available* • *Care for elderly especially those with dementia* • *Hospice* • *Healthcare professionals we trust* • *Addiction and recovery services* • *Awareness of mental health issues and resources*	31	30
Collaboration and Partnership • *Driven people and stakeholders* • *Community is health-focused*	13	16

• *Information is available across agencies* • *Health-related partnerships* • *County commissioners working with community to pass T-21* • *Coordination across resources* • *Willingness to work together* • *Collaboration between agencies* • *Collaboration and services offered* • *Engagement of OTC Public Health* • *Improvements and change are welcome* • *Multiple partnerships*		
Community-based Resources and Social Service • *Family-related activities* • *Access to healthy food – healthy restaurants* • *Community resources, events and activities* • *Barnesville Area Helpers* • *Fitness facilities* • *Access to insurance agents* • *Food pantry* • *Senior Center* • *Meals on Wheels* • *Activities for youth – athletics and music* • *YMCA* • *Variety of community-based and non-profit organizations* • *Law enforcement* • *Strong resources* • *Salvation Army, social clubs, Someplace Safe, Mahube, United Way – organizations that meet people's basic needs* • *A lot of resources* • *County assessment and treatment options for children* • *Strong arts and music* • *Options for arts*	20	21
Natural Resources • *Outdoor activities* • *Walking trails, parks* • *Community garden* • *Natural resources* • *Central Lake Trail, bike trails being built in North Country Trail*	8	9

Responses	Incidence	Priority Votes
• Clean environment • Physical activity opportunities		
Community and Spiritual Support • Community togetherness • Volunteers • Community support • Strong commitment in community to community • Many social clubs • Generous community • People value health and wellness • Live Well Fergus Falls • Progressive community • Many churches and spiritual support • Number of faith-based groups • Relay for Life • Open to new initiatives • Spiritual community	16	12
Workforce • Local staffing • Locally-owned and managed businesses • Quality of professionals who are experts in their fields	3	0
School • School district • School is health-focused and has physical activity facilities open to the public • Schools are open to change • Schools making healthier lunch choices • MState • Public and private education	6	3

Issues:

Responses	Incidence	Priority Votes
Mental Health • Mental health • Social isolation • Lack of resources for mental health and chemical dependency • Psychosocial distress of oncology diagnosis on patients and families • Increase in violent video games	12	14

• *Increase in electronic use, lack of communication skills* • *Senior mental health* • *Access to mental health services especially for children* • *Suicide – being alone, solation and no community support*		
Chemical Dependency • *Drugs/Opioids* • *Chemical dependency* • *Lack of quality foster care homes due to increase in drug use by parents* • *No facility for low-level offenders* • *Deterioration of family* • *Need more chemical dependency and mental health treatment services* • *Need safe places for people to go to for addiction, grief and other issues* • *No detox center or transitional housing*	11	13
Lack of Awareness of Available Resources • *Not understanding what resources are available or how to access them* • *Lack of awareness of available resources* • *Don't know how to get people the help they need when they have interrelated issues* • *Lack of participation in community events so don't know what's available* • *How we provide information regarding services may be lacking*	11	10
Social Issues/Social Determinants of Health • *Don't have safe harbor for children* • *Lack of quality foster care* • *Socio-economic status* • *Social issues* • *Accessibility for those with disabilities* • *Impact of environment on health* • *Dysfunctional families* • *Lack of transportation* • *Underlying poverty, kids are struggling* • *Health outcomes are different and predictable based on demographic difference* • *Lack of affordable housing*	23	25

• *Social determinants of health* • *Lack of affordable, accessible childcare* • *Weight and health-related issues due to poverty*		
Lack of Workforce • *Staffing* • *Workforce* • *Lack of awareness of what jobs are available* • *Training for youth especially in healthcare* • *Kids do not want to work* • *No transportation to get to work or get training*	9	5
Lack of Focus on Preventive Health • *Lack of encouragement for preventive health* • *Lack of understanding of health issues* • *Education and support for preventive opportunities* • *Obesity and lack of physical activity* • *Education regarding healthy food* • *Bullying* • *Not taking advantage of preventive care* • *Lack of fitness programs for kids* • *Lack of awareness and education on hospice care*	10	1
Lack of Access to Health-related Services • *Lack of cardiac care* • *Limited access to oral healthcare specifically to MA population* • *Lak of oral healthcare providers* • *Lack of specialists – urology, dermatology, cardiology* • *Lack of access to home health care*	5	5
Adverse Childhood Experiences and Trauma-informed Care • *ACE* • *Lack of trauma-informed services* • *Lack of training support for crisis intervention*	3	1
High Cost of Care • *Uninsured/underinsured* • *Affordability of care* • *Financial distress of oncology diagnosis* • *Cost of care* • *Services availability varies on insurance coverage*	8	3

Responses	Incidence	Priority Votes
• Lack of affordable oral healthcare • No sources of funding to access services		
Lack of Intercultural Competency • Lack of intercultural competency • Need to respond to increased cultural diversity	2	1
Lack of Physical Activity Opportunities During Winter	2	0
Aging Population • Fear of change • Elderly living alone	8	7
Stigma Associated with Mental Health, Addiction and Poverty • Pride and shame get in the way of seeking help. Afraid of judgement • Community and the individual not acknowledging that it's a problem • Stigma	7	2
Others: • Trade Fairness – local businesses are disadvantaged • City is not thinking of Barnesville as a community	2	0

Recommendations:

Responses	Incidence	Priority Votes
Raise Awareness of the Available Resources and Services in the Community • Community health liaison • Clearinghouse of resources • Raise awareness and improve communication • Resources fair • Tie services together • Parish nurses • Awareness of resources • Improve collaboration of services • Education Center • Early intervention to let people know options available to them • Increase education and knowledge on health and resources available • Empower people that they're in charge of their health	16	21

• *Healthcare networking* • *Showcase health-related organizations*		
Address Social Issues • *Affordable housing* • *More non-healthcare services* • *More early intervention services for families* • *Parenting education* • *Parent support groups* • *More and better public transportation* • *Continue community-led activities* • *Personal and financial management skills training* • *Quality childcare* • *Comprehensive plan for all social issues* • *Make healthy choices more affordable* • *Work with youth to set standards for healthy changes*	20	24
Provide Transitional Services • *Transitional services to move people through the path* • *Community-led place to build character and workforce*	2	7
Remove Stigma Associated with Mental Health, Poverty and Addiction • *Increase awareness and education in the community and schools regarding mental health, addiction and poverty*	1	6
Address Drug Abuse	1	3
Establish a Mental Health Urgent Care	2	3
Workforce Development • *Grow our own workforce* • *More high paying jobs* • *Work with school to align courses with staffing needs*	6	3
Extend Clinic Hours	1	5
Advocacy • *Communicate to Otter Tail County Family Services Collaborative*	3	4
Improve Social Connectedness • *Acceptance of differences*	7	6
Improve Access to Affordable Care • *Figuring out insurance*	2	3

• *Have fair and consistent access to care*		
Promote Preventive Services	1	1
Schools Address More Health Issues	1	0

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