To be the healthiest communities in which to live, learn, work, and play.
The Wabasha County Community Health Improvement Plan is posted online at www.co.wabasha.mn.us
# Table of Contents

2013-2014 Core Team Members 3

Planning participant listing 4

Wabasha County-description of the people and place 5

The community Health Needs Assessment process 7

Community Assets 8

Top Ten Health Needs Identified 8

Community Prioritization Process 10

Community Health Priorities 10

Community Health Improvement Plans 10

- Senior Needs 12
- Prevention and Wellness-Obesity 17
- Improve Access to Mental Health Services 22

Appendix A
- Wabasha County People and Place 26

Appendix B
- Key Health Findings 32

Appendix C
- Decision Making Grid 36
CORE TEAM MEMBERS

2013-2014 Core Team Members

Fit City of Wabasha/Kellogg- Carol Scott
St. Elizabeth Medical Center- Jenny Schlagenhaft
Wabasha County Human Services- Terry Smith
Wabasha County Public Health- Judy Barton, Jodi Johnson
Wabasha County Advisory Committee- Rita Fox

The development of this community health improvement plan was led by core team members. This plan would not have been possible without input and guidance from the community members and partners identified on the next page.
Wabash County and St. Elizabeth Medical Center would like to thank the following organizations and participants for being part of the planning sessions that led to the community health priorities as outlined in this report.

Becky Rietmann- Health and Human Services Advisory Committee
Colleen Hansen- Three Rivers Community Action Council
Terry Smith- Wabasha County Social Services
Rita Fox- Community Volunteer, Health and Human Services Advisory Co.
Jan Wilke- Winona State University Nursing Professor
JM Moravec- ACE Brain Fitness
Debbie Peterson- Elder Network
David Schmidt- Wabasha City Administrator
Lynn Sandstrom- Wabasha County Public Health
Mary Arens- Health and Human Services Advisory Committee, Community Volunteer
Cheri Wright- Wabasha/Kellogg Chamber of Commerce
Lynn Schoen- Schoen Dental Clinic
Kathleen Evers- Wabasha County Public Health
Susan Dailey- Mayo Health Systems
Emily Durand- Health Partners
Kim Scanlan- Three Rivers Community Action Council
Tammy Fiedler- Wabasha County Public Health
Jan Rombalski- Buffalo County Health Director
Bridget Hoffman- Wabasha County Coordinator
Nicole Graner- St. Elizabeth Medical Center
Deb Roschen- Wabasha County Commissioner
Kathy Brehmer- Wabasha County Public Health
Jodi Johnson- Wabasha County Public Health
Rollin Hall- Wabasha Mayor
Becky Luekstein- Ministry Health Care Board member
Carol Scott- Fit City of Wabasha/Kellogg
Janet Schmidt- Wabasha County Public Health
Debbie Stegemann- Wabasha County Public Health
Maureen Nelson- United Way of Goodhue/Wabasha/Pierce
Cea Grass- South Country Health Alliance
Mary Orban- Minnesota Department of Health
Pastor - Faith Lutheran Church
Kim McCoy- Stratus Health
Wabasha County

This Community Health Improvement Plan encompasses the geographic area of Wabasha County which is located in South East Minnesota. Wabasha County has 550 square miles and a population of 21,676 residents, 8,277 households, and 5,876 families. This is a 2.7% decrease in population from the previous census done in 2000. The population density is 41 people per square mile. The racial makeup of the county is 97.97% White, 0.25% Black or African American, 0.27% Native American, 0.43% Asian, 0.62% from other race, and 0.45% from two or more races. 1.68% of the population is Hispanic or Latino of any race.

The county is made up of several small and rural communities with the county seat located in the city of Wabasha. Other incorporated towns include, Plainview, Lake City, Mazeppa, Hammond, Millville, Kellogg, Weaver, Theilman, Zumbro Falls, Bellchester, Oak Center and Reads Landing. Due to the proximity to the city of Rochester and the number of Wabasha County residents who work, shop, and seek their entertainment and recreation in Rochester, Wabasha County is consider a Metropolitan Statistical Area of Rochester. Within Wabasha County agriculture and agri-businesses are the primary sources of employment.

Wabasha County has an aging population with the percent of people 65 and older at 17%, the state average is 12.9%. 0ur 65 and older dependency ration per 100 population of 15-64 is 26.6% compared to the state average of 19.2%. Of the elderly 28.9% live alone.

6.1% of our population are children under 5 and 25.5% of our population are children are 0-19. Wabasha County’s Child dependency ration under age 15/100 ages 15-64 is 29.5% compared to the state average of 29.9%. We have a higher than state percentage of births to unmarried mothers and births to teen Moms ages 18-19, however a lower than state average of births to Moms under the age of 18.

Wabasha County total dependency age ratio is 56.1%, which is 5% higher than the state average, and a 6% increase from 2006. 10.7% of our children below the age of 18 are living in poverty and 25.3% of our total population is living at or below 200% poverty. Educational attainment of the population 25 plus who live in poverty is: 25% have less than a high school degree, 34% have a high school diploma or GED, 30% have some college or Associates Degree, and 11% have a Bachelors Degree or higher.

The percentage of Wabasha County residents with no insurance is 11%, compared with 9.1% state average. Another 12% of Wabasha County residents report they are underinsured. Availability of providers to our residents shows that primary care physicians (841.1 residents/physician), dentists (3,618 residents/dentist) and mental health providers (21,873 to 1) is well below the state average for all three provider types.

Leading causes of death to Wabasha County residents are:
- Heart Disease- 24%
- Cancer - 23.5%
- Unintentional Injury- 8%
According to the 2012 County Health Rankings 12% of our adult population consider themselves in poor/fair health (National is 10% and state is 11%), 3.7% consider themselves in poor physical health (National is 2.6% and state is 3%) and 4% of our adult population reported having poor mental health (National 2.3% and state 2.7%)

The Wabasha County Community Health Needs Assessment process began in the summer of 2013 with the establishment of a leadership team. Team members included:

- Jenny Schlagenhaft, Director of Community Relations, Saint Elizabeth’s Medical Center.
  Jenny has been employed with Saint Elizabeth’s for 10 years. She has worked in health care public relations and communications for more than 32 years. She is actively involved in community partnerships that emphasize community health and promote wellness and prevention.

- Kim McCoy, MPH, MS, Program Manager, Stratis Health.
  Kim provides leadership on public health and health care quality initiatives throughout Minnesota. She works with communities to facilitate collaborative assessment and planning. Kim brings together people from different settings and disciplines to develop innovative ideas and implement evidence-based best practices to improve health and health care. Kim holds an M.S. in Health Services Research and an M.P.H. in Public Health Administration from the University of Minnesota. Stratis Health has the expertise and experience with a wide array of health care improvement services. They are well-integrated with the Minnesota health care community to facilitate improvements for people and communities especially in reducing health disparities among vulnerable populations. Stratis Health knows the rural community and has led rural health quality work aimed at improving rural care delivery to assist critical access hospitals in addressing their unique challenges and opportunities.

- Mary Orban, Regional Consultant, Minnesota Department of Health.
  Mary has more than 28 years working in public health at the local and state levels. Mary has worked for local public health departments in Rice and Mower counties and in Michigan for a variety of program areas, including providing home visiting services to families. During the past 11 years, Mary has worked for MDH as the public health nurse consultant for the Southeast and part of South Central regions.

- Judy Barton, RN, PHN, Director of Wabasha County Public Health Department.
  Judy has been a registered nurse for 38 years with 34 of those years in public health. She has been a public health director/community health administrator responsible for Community Health Needs Assessment and planning for the past 30 years. She has served on several state-wide public health committees throughout her career.

The leadership team then invited more than 400 community members representing a broad spectrum of the county to participate in a Wabasha County Health Needs Assessment titled: “Call for Action & Collaboration” a two-part workshop series. Attendees included representatives from the following organizations:

Wabasha County Public Health, Wabasha County Social Services, Wabasha County, City of Wabasha, Three Rivers Community Action, Saint Elizabeth’s Medical Center, United Way, Dental Clinics, Wabasha County Public Health Advisory Committee, Hospice, Elder Network, Churches, Senior Advocacy, South Country Health Alliance, Common Closet, Wellness Center, Lake City Medical Center, Health Partners, MN Department of Health, and Stratus Health.
Additional outreach activities that served to broaden the scope of the assessment process included discussions with providers and public health officials in Goodhue County, Minnesota, and Pepin and Buffalo Counties in Wisconsin, all neighboring counties.

**The Assessment Process- Process Overview**

The leadership team agreed to adopt and follow the Minnesota Department of Health Community Health Assessment Model as a framework for evaluating and analyzing county health needs.

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**Organize and Plan**

Face-to-face meetings and conference calls were used to establish the structure, time frames and responsibilities for leadership team members. Minnesota Department of Health and Stratis Health representatives served in a consulting capacity, which local public health and hospital leaders took direct action to gather and analyze county data.

**Data Gather and Analysis**

- Once the basic work plan was established, team members launched a thorough process of collecting and analyzing critical data sets and health indicators categorized under six primary themes:
  1. People and Place
  2. Opportunity for Health
  3. Healthy Living
  4. Chronic Disease and Conditions
  5. Infectious Disease
  6. Injury and violence
- The evaluation of the data gathered resulted in the creation of two summary reports:
  1. Wabasha County Profile: People and Place (Appendix A)
  2. Call for community Action and Collaboration: Key Health Findings (Appendix B)

A formal presentation of these resources and data sets was shared with key stakeholders during the two Community Health Needs Assessment workshops to engage community leaders, providers and citizens in a rigorous process of gaining feedback and prioritizing county-specific health needs.

Following the formal presentation of data and findings, workshop participants were engaged in large-group and small-group discussions facilitated by a Stratis Health consultant. Using standard quality improvement tools, including the Minnesota Technology of Participation facilitation process, Affinity Diagram, Nominal Group Technique and the Decision Matrix,
participants offered feedback and rankings that resulted in the development of the following:

A vision for a healthy community
The top 11 health needs based on data presented
A preliminary list of community resources and assets
The prioritization of the top four health needs in Wabasha County
A jump start of the implementation process by identifying preliminary strategies under each broad theme that can be taken to improve community health

Following the workshops, a progress report and invitation to participate as an implementation plan work team member were created and disseminated to workshop participants and all key stakeholders within the county. This report was also publicized in our local weekly newspapers.

Community Assets Identified
Prior to the identification of health needs, workshop participants were guided through a large group visioning process. Members were asked to envision a “healthy community.” The vision exercise was a precursor to the identification of existing community assets. This listing was categorized to fully understand the diversity of skills, abilities, talents, and resources.

- Individual Talents/Skills within our communities:
  Advocates, health educators, coach, dispenser of information, information and referral resources, team builder, story teller, listener, organizer, socialization, problem solver, proof reading, research, research translator, finance analysis, project planner, small scale farmer, swimming and gymnastics instructor, quilter, grant writer, nursing

- Organizational Resources:
  Fundraising, staffing, facilities, leadership, experience, grant funding, community planning, education/support for seniors, aging in place resources and facilities, caring for the sick and elderly, social hub for community, opportunities for volunteers, resources for fulfilling immediate needs for people in the community, access/knowledge of community resources, government programs, strong focus on prevention and wellness, food shelf, access to health, schools, government agencies, civic groups, faith communities, hospitals, nursing homes, dental offices, fitness center, libraries, service organizations, funding agents, non-profits, fire/police/ambulance, businesses, providers, insurers, Chamber of Commerce, and health relation associations

- Other Partners/Resources:
  Mentorship Program, physicians, chiropractors, Mayo Clinic Health System, Area Agency on Aging, mental health providers, law enforcement, Catholic charities, emergency medical services, city/county officials, day care providers, media, pharmacies, clergy, senior dining, consumers, housing authorities, food shelves, libraries, transportation, and sexual assault services

Top 10 Health Needs Identified
Higher Percentage than the state average of Older Adults
The aging population is rising resulting in a greater number of seniors living alone. Statistics find an increasing prevalence of age-related issues such as arthritis, disability and mobility limitations, dementia, Alzheimer’s disease, falls, and medication
management issues. A growing demand for family caregiver supports, affordable
independent senior housing and in home assistance was noted.

**Insufficient access to Mental Health services, especially specialty mental health prescribers.**
The population is experiencing a higher number of mentally unhealthy days. Teen girls
have a high level of suicidal thoughts and seniors have a rising depression rate. There is a
high level of risky behaviors reported by teens, such as cutting/intentional injuries and
bullying.

**Declining immunization rate & reemergence of vaccine preventable Infectious Diseases**
Declining immunization rates among older children has been found as well as an
increasing prevalence of re-emerging communicable diseases, such as pertussis
(Whooping Cough).

**Unique Environmental Health risks**
There is a higher than state average level of radon and lead in homes and nitrate levels in
ground water.

**Lack of access to Oral Health**
Lack of access to dental services for the low-income population and many dentists don’t
accept Medicaid patients. One of the top health issues among children is prevalence of
cavities. More children and adults need an annual dental exam and cleaning.

**Chronic Disease/Nutrition/Physical Activity**
The county mirrors the national epidemic with a rising prevalence of overweight and
obesity in all populations. Lack of physical activity and healthy eating was reported
among all populations.

**Self reported substance abuse**
Self-reported behaviors find a high binge drinking rate among teens and adults and
increase use of alcohol among seniors. Rising rates of smoking among young adults was
also among the findings.

**Unintentional Injury and Violence**
Wabasha County residents have a high prevalence of accidental falls, traumatic brain
injuries (TBI) and poor motor vehicle behaviors (seat belt use, DWI/DUI, speed, and
inattentive driving.

**Adolescent Sexual Health**
There is a high incidence of sexual intercourse among 9th and 12th grade students. A
higher teenage birth rate was reported. The sexually-transmitted disease rate (Chlamydia)
is also high.

**Maternal/Infant Child Health issues**
A high percentage of births to unmarried mothers have been recorded and a high number
of grandparents are living with and responsible for grandchildren.

**Access to Transportation**
There are limited transit services in the Wabasha County but a growing need for
transportation to medical appointments, services and job-seeking activities. Low-income
people lack funds to pay for gas/and or car repairs.
Health Priorities

Upon a thorough review and discussion of key findings, the facilitator led key stakeholders through a prioritization and ranking process using a problem importance index with the following criteria: (See appendix C)

- Percent of the county residents that are impacted by this issue
- Practical/realistic to address issue
- Cost to address or cost of not addressing – cost/benefit relationship Available resources – including state, federal or local funding and staffing
- Severity of the impact of the issue
- Barriers to addressing the impact
- Level of community Support

Based on criteria, the following top four most critical health needs in Wabasha County were identified:

1. **SENIOR HEALTH**: Improving the health and well-being of aging population thus allowing them to remain in their own homes.
2. **PREVENTION & WELLNESS**: Reducing obesity and promoting healthy habits (nutrition and physical activity) to prevent and or manage chronic diseases.
3. **MENTAL HEALTH**: Improving access to mental health services
4. **ORAL HEALTH**: Improving oral health and access to affordable dental services

**Developing the Community Health Improvement Plan**

After the two Community Health Needs Assessment workshops and the prioritization of needs in Wabasha County the leadership team distributed a progress report to key stakeholders and invited them to confirm the priorities and to offer feedback and input.

Following the solicitation of feedback and support from key stakeholders the leadership team put out a call to community organizations and citizens for workgroup members and team leaders for each of the four priority areas. The work teams were responsible to develop and implement a Wabasha County Community Health Needs Assessment Improvement plan in their priority area that would achieve county-wide health improvement.

The leadership team was able to recruit volunteers for all priority areas, except oral health. It was decided that initially the leadership team would move forward with the other 3 priority areas and attempt to recruit team members for the oral health priority in year 2 of the implementation phase.

Stratus health held two educational sessions with team leaders on goal setting, methods setting, evidence based practices, and how to move the team forward as progress is made.

Each priority area team then met, studied further data and narrowed their focus for initial goals and methods.
The Senior Needs team decided to focus first on fall prevention. Wabasha County has a higher percentage of their elderly residing in Nursing Facilities than the statewide average. In addition the number one reason for admission to our Nursing Facilities was injuries as a result of a fall.

The Prevention and Wellness team decided to initially focus on childhood obesity and reducing the incidence of Childhood Obesity in Wabasha County by implementing the 5-2-1-0- program in our schools, and expanding to other areas in the future.

The Mental Health team focused on access to Mental Health care, particularly mental health specialist who can prescribe. In addition the need for in home therapy for our high risk families was identified and will be address in year two of this 5 year plan.
Senior Needs Community Health Improvement Plan

Date Created: January 6, 2014          Date Reviewed/Updated: 5/8/14, 9/5/14

**PRIORITY AREA:** Senior Needs

**GOAL:** Improve the health, function and quality of life of older adults to keep them safely in their homes.

**PERFORMANCE MEASURES**

**How We Will Know We are Making a Difference**

<table>
<thead>
<tr>
<th>Short Term Indicators</th>
<th>Source</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>By end of 2014, attendees at fall/prevention educational program assessed with a risk of falls will have an individual action plan developed</td>
<td>Count of action plans developed</td>
<td>At conclusion of each educational program</td>
</tr>
<tr>
<td>By end of 2015, Number of individuals continuing to follow fall prevention action plan will be 50%</td>
<td>Staff tracking of plan compliance</td>
<td>Annual</td>
</tr>
<tr>
<td>By end of 2015, Increase the % of seniors who are actively engaged in programs/services that promote physical activity, balance improvement and fall reduction by 5%</td>
<td>Attendance records</td>
<td>Annual</td>
</tr>
<tr>
<td>By end 2014, Attendees at Living Well with Chronic Diseases series will have an individual action plan developed</td>
<td>Count of action plans developed</td>
<td>At conclusion of series</td>
</tr>
<tr>
<td>By end of 2015, Number of individuals continuing to follow action plan to manage chronic diseases will be 50%</td>
<td>Staff tracking of plan compliance</td>
<td>Annual</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Long Term Indicators</th>
<th>Source</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 2017, experience 5% fewer falls in Wabasha county in older adults</td>
<td>MN Dept of Health</td>
<td>Annual</td>
</tr>
</tbody>
</table>

**OBJECTIVE #1:** Increase awareness among seniors and their caregivers of fall risk factors, factors contributing to decline in physical mobility, importance of exercise and balance, and fall prevention strategies

**BACKGROUND ON STRATEGY**

Source: Falls Free: Promoting a National Falls Prevention Action Plan by the National Council on the Aging
Preventing Falls: How to Develop Community based Fall Prevention Programs for Older Adults by CDC and Healthy People 2020

**Evidence Base:** Yes

**Policy Change (Y/N): N**

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<table>
<thead>
<tr>
<th>Activity</th>
<th>Target Date</th>
<th>Resources Required</th>
<th>Lead Person/ Organization</th>
<th>Anticipated Product or Result</th>
<th>Progress Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop education program for seniors to address fall risk factors,</td>
<td>June 2014</td>
<td>Staff time</td>
<td>Jodi Johnson, WCPH</td>
<td>Increased awareness of fall risk factors, factors contributing to decline in physical mobility, importance of exercise and balance, and fall prevention strategies</td>
<td></td>
</tr>
<tr>
<td>factors contributing to decline in physical mobility, importance of</td>
<td></td>
<td>Volunteer time</td>
<td>Rita Fox, SEMC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>exercise and balance, and fall prevention strategies</td>
<td></td>
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</tr>
<tr>
<td>Develop a pre and post test for participants in educational programs to</td>
<td>June 2014</td>
<td>Staff time</td>
<td>Jodi Johnson, WCPH</td>
<td>Post test will show increased awareness over pre test of risk factors, factors contributing to decline in physical mobility, importance of exercise and balance and of fall prevention strategies</td>
<td></td>
</tr>
<tr>
<td>measure increased awareness</td>
<td></td>
<td>Volunteer time</td>
<td>Rita Fox, SEMC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present educational program to seniors and their caregivers at three</td>
<td>January 2015</td>
<td>Staff time</td>
<td>Jodi Johnson, WCPH</td>
<td>Increased awareness of fall risk factors, factors contributing to decline in physical mobility, importance of exercise and balance, and fall prevention strategies</td>
<td></td>
</tr>
<tr>
<td>different sites where seniors gather in Wabasha County</td>
<td></td>
<td>Volunteer time</td>
<td>Rita Fox, SEMC</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Lap top with LCD</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Information packets</td>
<td></td>
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</tbody>
</table>
**OBJECTIVE #2:** Assess individual seniors for risk of falls

**BACKGROUND ON STRATEGY**
Source: Falls Free: Promoting a National Falls Prevention Action Plan by the National Council on the Aging
Preventing Falls: How to Develop Community based Fall Prevention Programs for Older Adults by CDC and Healthy People 2020
Evidence Base:
Policy Change (Y/N): N

**ACTIONS PLAN**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Target Date</th>
<th>Resources Required</th>
<th>Lead Person/Organization</th>
<th>Anticipated Product or Result</th>
<th>Progress Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research and select assessment tools for self assessment of fall risk, balance and mobility</td>
<td>May 2014</td>
<td>Staff time, Volunteer time</td>
<td>Jodi Johnson, WCPH, Rita Fox, SEMC</td>
<td>Identification of seniors at risk for falls</td>
<td></td>
</tr>
<tr>
<td>Research and select tool for individual goal/action planning</td>
<td>May 2014</td>
<td>Staff time, Volunteer time</td>
<td>Jodi Johnson, WCPH, Rita Fox, SEMC</td>
<td>Tools track compliance with action plan</td>
<td></td>
</tr>
<tr>
<td>Conduct assessments with seniors at the educational programs</td>
<td>January 2015</td>
<td>Staff time, Volunteer time</td>
<td>Jodi Johnson, WCPH, Rita Fox, SEMC</td>
<td>Identification of seniors at risk for falls</td>
<td></td>
</tr>
</tbody>
</table>
| Meet with seniors with assessment scores showing any risk of falls to provide education on interventions to prevent falls, on available resources and to develop their own action plan | January 2015| Staff time, Volunteer time | Jodi Johnson, WCPH, Rita Fox, SEMC | *Increased awareness of resources  
*Actions plans developed |                  |
| Develop plan for follow up with seniors who initiated an action plan     | January 2015| Staff time, Volunteer time | Jodi Johnson, WCPH, Rita Fox, SEMC | Participation and progress toward goals |                  |
**OBJECTIVE #3: Increase the % of seniors who are actively engaged in programs/services that promote physical activity, balance improvement and fall reduction**

**BACKGROUND ON STRATEGY**
Source: Falls Free: Promoting a National Falls Prevention Action Plan by the National Council on the Aging
Preventing Falls: How to Develop Community based Fall Prevention Programs for Older Adults by CDC and Healthy People 2020
Evidence Base: Matter of Balance workshops for the elderly
Policy Change (Y/N): N

<table>
<thead>
<tr>
<th>ACTION PLAN</th>
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</thead>
<tbody>
<tr>
<td><strong>Activity</strong></td>
</tr>
</tbody>
</table>
| Develop list of local resources/services for improving exercise, mobility and balance | May 2014 | Staff time
Volunteer time | Jodi Johnson, WCPH
Rita Fox, SEMC | *Increased awareness of resources
*Use of resources in action plans | |
| Host one “Matter of Balance” workshop with trained outside facilitators | October 2014 | Staff time
Volunteer time
Facilitator expenses
Laptop with LCD | Jodi Johnson, WCPH
Rita Fox, SEMC | Increased participation in programs and services to improve balance | |

**OBJECTIVE #4: Provide one Living with Chronic Disease Series**

**BACKGROUND ON STRATEGY**
Source: Falls Free: Promoting a National Falls Prevention Action Plan by the National Council on the Aging
Preventing Falls: How to Develop Community based Fall Prevention Programs for Older Adults by CDC and Healthy People 2020
Evidence Base: Stanford University Chronic Disease Self-management Program
Policy Change (Y/N): N

<table>
<thead>
<tr>
<th>ACTION PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity</strong></td>
</tr>
</tbody>
</table>
| Sponsor facilitator training for two individuals for Living with Chronic Disease | Date of next facilitator training | Staff time
Volunteer time
Mileage | Jodi Johnson, WCPH
Rita Fox, SEMC | Ability to host Living Well series | |
<table>
<thead>
<tr>
<th>Training expenses</th>
<th>January 2014</th>
<th>Staff time</th>
<th>Jodi Johnson, WCPH Facilitators</th>
<th>*Increase awareness of benefits of self management of chronic disease</th>
<th>*Action plans track progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Host one six week series of Living Well with Chronic Disease</td>
<td>December 2014</td>
<td>Volunteer time</td>
<td>Rita Fox, SEMC Facilitators</td>
<td>Room rental</td>
<td>Informational handouts</td>
</tr>
</tbody>
</table>
**Prevention & Wellness Community Health Improvement Plan**

Date Created: November 1, 2013   Date Reviewed/Updated: May 2014

**PRIORITY AREA:** Prevention & Wellness

**GOALS:** Help children and families eat healthier and be more active through the implementation of 5-2-1-0 Let’s Go!

**PERFORMANCE MEASURES**

How We Will Know We are Making a Difference

<table>
<thead>
<tr>
<th>Short Term Indicators</th>
<th>Source</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>5= By 2015, increase the number of children and adults eating at least 5 servings of fruits and vegetables daily by 5%.</td>
<td>Student Survey</td>
<td>Annual</td>
</tr>
<tr>
<td>2= By 2015, increase the proportion of children/adolescents who view television, videos or play video games for no more than 2 hours a day.</td>
<td>Student Survey</td>
<td>Annual</td>
</tr>
<tr>
<td>1= By 2015, increase the proportion of children and adults who meet current Federal physical activity guidelines for aerobic physical activity by 5%.</td>
<td>Student Survey</td>
<td>Annual</td>
</tr>
<tr>
<td>0=Increase access to water and low-fat milk in schools, childcare and homes; limit or eliminate sugary beverages</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Long Term Indicators</th>
<th>Source</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 2017, experience no increase in the percentage of overweight children/adolescents.</td>
<td>Student Survey</td>
<td>Annual</td>
</tr>
<tr>
<td>By 2017, experience no increase in the percentage of overweight adult.</td>
<td>BRFS</td>
<td>Annual</td>
</tr>
</tbody>
</table>

**OBJECTIVE #1: Implement 5-2-1-0 Goes to School**

**BACKGROUND ON STRATEGY**

Source: Healthy People 2020 and 5-2-1-0 Let’s Go!

Evidence Base: 5-2-1-0 obesity prevention program

Policy Change (Y/N): N

**ACTION PLAN**
<table>
<thead>
<tr>
<th>Activity</th>
<th>Target Date</th>
<th>Resources Required</th>
<th>Lead Person/Organization</th>
<th>Anticipated Product or Result</th>
<th>Progress Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sponsor 4-week 5210 campaign for k-5 graders at Wabasha-Kellogg and St. Felix School</td>
<td>March 2014</td>
<td>School tool kit with student and parent packets&lt;br&gt;Staff Time&lt;br&gt;Volunteer Time</td>
<td>Julie Jacobs, SEMC&lt;br&gt;Ashley Marx, W-K School&lt;br&gt;Carrie Williams, St. Felix School&lt;br&gt;Kim Ihrke, PEM School</td>
<td>• Increased awareness of 5210 messages&lt;br&gt;• Logs track weekly participation and progress toward goals&lt;br&gt;• Recognition and rewards for students who meet desired participation goals</td>
<td></td>
</tr>
<tr>
<td>Sponsor 4-week 5210 campaign for k-5 graders at Plainview-Elgin-Millville School</td>
<td>October 2014</td>
<td>School tool kit with student and parent packets&lt;br&gt;Staff Time&lt;br&gt;Volunteer Time</td>
<td>Julie Jacobs, SEMC&lt;br&gt;Ashley Marx, W-K School&lt;br&gt;Carrie Williams, St. Felix School&lt;br&gt;Kim Ihrke, PEM School</td>
<td>• Increased awareness of 5210 messages&lt;br&gt;• Logs track weekly participation and progress toward goals&lt;br&gt;• Recognition and rewards for students who meet desired participation goals</td>
<td></td>
</tr>
<tr>
<td>Develop 5210 maintenance program</td>
<td>May 2014</td>
<td>School tool kit with family resources&lt;br&gt;Staff Time&lt;br&gt;Volunteer Time</td>
<td>Julie Jacobs, SEMC&lt;br&gt;Jenny Schlagenhaft, SEMC&lt;br&gt;Parent/teacher organizations</td>
<td>• Maintenance program is developed&lt;br&gt;• 5210 practices continue at home with leadership from parents</td>
<td></td>
</tr>
<tr>
<td>In collaboration with school wellness committees, establish and revise school policies that promote System/Policy/Environment (SPE) changes that encourage 5210 practices</td>
<td>Oct 2014</td>
<td>School tool kit with SPE resources&lt;br&gt;Staff Time</td>
<td>Julie Jacobs, SEMC&lt;br&gt;Jenny Schlagenhaft, SEMC&lt;br&gt;Ashley Marx, W-K School&lt;br&gt;Carrie Williams, St. Felix School&lt;br&gt;Kim Ihrke, PEM School</td>
<td>• A minimum of two SPE changes are approved and accepted by leadership</td>
<td></td>
</tr>
</tbody>
</table>

**OBJECTIVE #2: Implement 5-2-1-0 Health Care**

**BACKGROUND ON STRATEGY**
Source: Healthy People 2020 and 5210 Let’s Go
Evidence Base: 5-2-1-0 program
Policy Change (Y/N): Y, requires local medical clinics to incorporate the parent questionnaire into well-child visits.

**ACTION PLAN**
<table>
<thead>
<tr>
<th>Activity</th>
<th>Target Date</th>
<th>Resources Required</th>
<th>Lead Person/Organization</th>
<th>Anticipated Product or Result</th>
<th>Progress Notes</th>
</tr>
</thead>
</table>
| 5210 Healthy Habits Questionnaires, which are distributed to every parent during well-child primary care clinic appointments at Wabasha Clinic, prompts discussion and education between provider and parents | Feb 2014 | Healthcare tool kit with educational resources | Jenny Schlagenhaft, SEMC, Anna Arens, Wabasha Clinic | • Questionnaires are being distributed, completed and submitted to providers  
• Meaningful conversations and action planning takes place during clinic appointment  
• Action steps are tracked in patient record | |
| Distribute 5210 Healthy Habits Questionnaires to WIC clients and lead discussion and education between public health nurses and parents | March 2014 | Healthcare tool kit with questionnaire and educational resources | Jenny Schlagenhaft, SEMC, Tammy Fiedler, WCPH WIC coordinator | • Questionnaires are being distributed, completed and submitted to providers  
• Meaningful conversations and action planning takes place during clinic appointment  
• Action steps are tracked in patient record | |
| Post 5210 posters with key messages in every exam room at Wabasha Clinic and WIC | February 2014 | 5210 Posters | Anna Arens, Wabasha Clinic, Tammy Fiedler, WCPH | • | |
| Investigate the clinic practices for measuring and calculating BMI at every well-child visit | February 2014 | Staff Time | Anna Arens, Wabasha Clinic | • All providers are consistently calculating BMI and when score falls outside of desirable, a specific set of practices, recommendations and referrals are made/followed to ensure BMI improvement. | |
## OBJECTIVE #3: Implement 5-2-1-0 Early Childhood

### BACKGROUND ON STRATEGY
Source: Healthy People 2020 and 5210 Let’s Go
Evidence Base: 5-2-1-0
Policy Change (Y/N): Y

### ACTION PLAN

<table>
<thead>
<tr>
<th>Activity</th>
<th>Target Date</th>
<th>Resources Required</th>
<th>Lead Person/Organization</th>
<th>Anticipated Product or Result</th>
<th>Progress Notes</th>
</tr>
</thead>
</table>
| Introduce 5210 toolkit to all licensed childcare providers in Wabasha County | June 2014   | Early childhood tool kit Staff Time Volunteer Time Printing Postage                | Carol Scott, SEMC Shannan Bleed, Wabasha County Social Services | • Every licensed childcare provider receives a toolkit  
  • A minimum of 50% of the providers complete an internal audit/assessment of their program.  
  • A minimum of 25% of the providers implement at least two 5210 practices by end of 2014 |                |

## OBJECTIVE #4: Implement 5-2-1-0 Communities

### BACKGROUND ON STRATEGY
Source: Healthy People 2020 and 5210 Let’s Go
Evidence Base: 5210 Let’s Go
Policy Change (Y/N): N

### ACTION PLAN

<table>
<thead>
<tr>
<th>Activity</th>
<th>Target Date</th>
<th>Resources Required</th>
<th>Lead Person/Organization</th>
<th>Anticipated Product or Result</th>
<th>Progress Notes</th>
</tr>
</thead>
</table>
| Develop comprehensive communication plan across all sectors that builds awareness of the key messages of 5210: Tactics may include – social media, websites, posters, brochures, press releases, events, public service announcements, etc. | June 2014   | 5210 tool kits and resources Publicity/Media support Staff Time Volunteer Time     | Jenny Schlagenhaft, SEMC Carol Scott, SEMC Fit City Collaborative                          | • Children and families are exposed to 5210 messages where they live, learn, work and play.  
  • Community- |                |
<table>
<thead>
<tr>
<th>Fit City Restaurant Challenge is sponsored and features the 5210 commitment</th>
<th>May 2014</th>
<th>Fit City Restaurant Challenge materials 5210 tool kits Staff Time Volunteer Time Media support</th>
<th>Fit City Collaborative</th>
<th>At least 7 restaurants in Wabasha participate in Fit City 5210 Restaurant Challenge  At least 25% of patrons select the 5210 featured entrée and submit scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>In partnership with Scheel’s grocery store in Wabasha, adopt 5210 messages in grocery store signage, recipes and advertising</td>
<td>February 2015</td>
<td>5210 tool kits Staff Time Volunteer Time</td>
<td>Julie Jacobs Bob Scheel and staff</td>
<td>Store signage, advertising and recipes incorporate 5210 brand</td>
</tr>
</tbody>
</table>
PRIORITY AREA: Mental Health

GOAL: Improve access to mental health services for all ages in Wabasha County

PERFORMANCE MEASURES
How We Will Know We are Making a Difference

<table>
<thead>
<tr>
<th>Short Term Indicators</th>
<th>Source</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meetings will be held with Mental Health providers for discussion of issues and steps that need to be taken to address the issues</td>
<td>Meeting dates and attendance by county and mental health staff</td>
<td>Annually</td>
</tr>
<tr>
<td>Partnerships with neighboring counties with similar mental health access issues will be developed to address the shortage of mental health providers in our rural counties</td>
<td>Evidence of counties partnering, (ie partnership agreements, joint ventures, etc.)</td>
<td>Annually</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Long Term Indicators</th>
<th>Source</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase access to specialty providers of mental health services with prescribing authority</td>
<td>Actual increase in numbers as evidenced by community resources review.</td>
<td>Annually</td>
</tr>
<tr>
<td>Increased in Mental Health services available to children in Wabasha County</td>
<td>Actual increase as evidenced by community resources review</td>
<td>Annually</td>
</tr>
<tr>
<td>Improvement in response to Mental Health Crisis’s in Wabasha County</td>
<td>Survey of Law Enforcement, local ER, and jail staff</td>
<td>Every other year.</td>
</tr>
</tbody>
</table>
### OBJECTIVE #1: Increase access to Mental Health Specialist with prescribing authority

**BACKGROUND ON STRATEGY** Evidence shows mental health can be improved through prevention and by ensuring access to appropriate, quality mental health services.

**Source:** 2020 healthy people  
**Evidence Base:** Y  
**Policy Change (Y/N):** Y

**ACTION PLAN**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Target Date</th>
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<th>Lead Person/Organization</th>
<th>Anticipated Product or Result</th>
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</tr>
</thead>
</table>
| Meet with Local SS Directors and State Mental Health Consultant for the SE Regional Hub to look at way of improving access to Mental Health Specialist prescribers for residents of our SE Hub. | Jan-July 2014 | County staff time, HVMHC staff time | Terry Smith-WCSS  
Judy Barton-WCPH | Collaboration of the SE Regional Hub resulting in increased access to mental health prescribers | |
| SE regional hub to develop a joint mental health prescriber team to serve all 5 counties with services both on site and via ITV. | Aug-Dec, 2014 | Financial support from each of the counties to assist with administrative costs for HVMHC | Terry Smith-WCSS  
Judy Barton-WCPH  
County SS Directors from Houston, Fillmore, Winona, and Goodhue Counties | Addition of 3 mental health nurse practitioners or physician assistants. This staff would be employed by and housed at Hiawatha Valley Mental Health Center. | |
| Arrange for an ITV station in each county and at the base at the HVMHC in Winona and phase in use of ITV psychiatry/prescribing by county as funding becomes available. | Dec. 2014 | County dollars to help support ITV equipment at each site. | Terry Smith-WCSS  
Judy Barton-WCPH  
County SS Directors from Houston, Fillmore, Winona, and Goodhue Counties | Ability to access via ITA a prescriber as needed from any of the five counties without resident needing to drive to Winona. | |

### OBJECTIVE #2: Increase mental health services to high risk children, risk can be due to psycho-social or health risk factors

**ACTION PLAN**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Target Date</th>
<th>Resources Required</th>
<th>Lead Person/Organization</th>
<th>Anticipated Product or Result</th>
<th>Progress Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a team of stakeholders to meet around the issue of</td>
<td>Jan. 2014</td>
<td>Stakeholders staff time</td>
<td>John Dahlstrom-WCSS</td>
<td>Identification of top needs and prioritization of</td>
<td>March 2014 3 meetings held. Top 3</td>
</tr>
<tr>
<td>Activity</td>
<td>Target Date</td>
<td>Resources Required</td>
<td>Lead Person/ Organization</td>
<td>Anticipated Product or Result</td>
<td>Progress Notes</td>
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</tr>
<tr>
<td>Collaborate with SE Regional Hub to research opportunities to develop a 24/7 mobile crisis intervention team which would respond to an individual’s mental health crisis. This would allow for more appropriate assessment and referral of the individual vs law enforcement handling these crisis’s alone.</td>
<td>4/1/14</td>
<td>Staff Time</td>
<td>John Dahlstrom-WCSS</td>
<td>SE Hub collaborative approach to Mental Health crisis.</td>
<td></td>
</tr>
<tr>
<td>Research and apply for grant funding to develop and</td>
<td>12/31/14</td>
<td>Staff time to research and write grant for</td>
<td>Lynn Skinner</td>
<td>Grant approved for funding of a</td>
<td></td>
</tr>
<tr>
<td>Implementation</td>
<td>Date</td>
<td>Funding, able and willing mental health provider (center)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>----------</td>
<td>----------------------------------------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Implement Mobile Crisis Team in the SE Regional Hub service area as per grant requirements.</td>
<td>12/31/2015</td>
<td>Lynn Skinner County SS Directors</td>
<td>Fully functioning mobile crisis team which will respond when requested anywhere within the SE Hub</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix A- Wabasha County People and Place

Wabasha County
People and Place

POPULATION STATISTICS

- 2010 Actual Census Population  21,676
- 2006 Estimated Population  22,286
- Percentage of population decrease from 2006 to 2010  2.7%
- State Averaged a 2.6% gain during this timeframe
- Neighboring counties growth or loss
  - Winona- 4% gain
  - Fillmore-1.5% loss
  - Houston-4% loss
  - Goodhue-.5% gain
Mothers and Children

Percent of Births to unmarried mothers
• 2006-2010 Wabasha County 30.2%
• 2001-2005 Wabasha County 26.2%
• 2006-2010 State 32.9%
• 2001-2005 27.9%

Teen Birth Rate - # of births /1000 females in the specific age group (2008-2010)
• Wabasha County 15-17 * 18-19 15-19
  * 11.5 52.6 22.2
• State of MN 15-17 * 18-19 15-19
  * 16.0 43.6 24.6

Teen Pregnancy Rate - # of pregnancies /1000 females in the specific age group (2008-2010)
• Wabasha County 15-17 * 18-19 15-19
  * 61.1 26.0
• State of MN 16.0 58.1 33.2

Children Continued

School Enrollment PreK-12
• 2010-2011 4491
• 2007-2008 4601
• % loss of students in our schools 2.7%

Percentage of children under age 5
• Wabasha County (1,332) 6.1%
• State of MN (355,504) 6.7%

Percentage of children 0-19
• Wabasha County (5534) 25.5%
• State of MN (1,431,221) 27%

Child Dependancy Ratio under age 15/100 pop ages 15-64
• Wabasha County 2010 29.5%
• State of MN 2010 29.9%
### Our Elderly Residents

<table>
<thead>
<tr>
<th>Total dependancy ratio-(under 15, over 65)/100 pop of 15-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wabasha County 2010</td>
</tr>
<tr>
<td>State of MN 2010</td>
</tr>
<tr>
<td>Wabasha County 2006</td>
</tr>
<tr>
<td>State of MN 2006</td>
</tr>
</tbody>
</table>

### General Statistics and Financial Statistics

**Percent of 25+ yo with <or=to HS Education**
- Wabasha County (2005-2009): 50.2%
- State of MN(2005-2009): 37.1%

**Percent of under 18 years living in poverty**
- Wabasha County: 10.7%
- State of MN: 13.9%

**Percent of all people living at or below 200% Poverty**
- Wabasha County: 25.3%
- State of Mn: 25.5%
Poverty Status of Families with children under 18 y.o in Wabasha County

- All families: 7.2%
- Married Couple Families: 3.6%
- Female household families (no husband present): 15.1%

Educational attainment of the population 25+ with poverty status in the last 12 months for Wabasha County residents.

- Less than high school: 25%
- High school grad or GED: 34%
- Some college or Associates Degree: 30%
- Bachelors Degree or higher: 11%

Median Income by Educational Attainment and Gender in 25+ population for Wabasha County residents

- Less Than high school graduate - Male: $26,475 Female: $15,530
- High School or GED - Male: $33,137 Female: $20,743
- Some College or Associate Degree - Male: $39,962 Female: $27,030
- Bachelors Degree - Male: $51,489 Female: $35,338
- Graduate or professional degree - Male: $62,484 Female: $51,245

Employment and Earnings
Access to Medical Care

Health Insurance:
- Percent of county residents with no health insurance: 11%
- Percent of MN residents with no health insurance: 9.1%
- Percent of county residents under insured: 12%
- People with incomes $25,000-$37,999 who do not have Health insurance: 13.8%

Health Care Providers in Wabasha County:
- Primary Care Physicians: 841:1 (State is 636:1)
- Dentists: 3,618:1 (State is 2,126:1)
- Mental Health Providers: 21,873:1 (State is 1,306:1)

HEALTH OF OUR PEOPLE

2010 LEADING CAUSES OF DEATH TO WABASHA COUNTY RESIDENTS

1. Heart Disease: 24.0%
2. Cancer: 23.5%
3. Unintentional Injury: 8.0%

Years of Potential Life Lost Due to the 3 Leading Causes

<table>
<thead>
<tr>
<th>Cause</th>
<th>to age 65</th>
<th>to age 75</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Heart Disease</td>
<td>90</td>
<td>250</td>
</tr>
<tr>
<td>2. Cancer</td>
<td>100</td>
<td>265.5</td>
</tr>
<tr>
<td>3. Unintentional injury</td>
<td>107.5</td>
<td>264</td>
</tr>
</tbody>
</table>

All causes of death Years of potential life lost
- 597.5
- 1,198
How do Wabasha County Residents view their health?

According to the 2012 County Health Rankings:

• 12% of our adult population consider themselves in poor/fair health (National 10%, State 11%)

• 3.7% consider themselves in poor physical health (National 2.6%, State 3%)

• 4% of our adult population reported having poor mental health (National 2.3%, State 2.7%)
Appendix B-Wabasha County CHIP

**Help us Improve the Health of Wabasha County Residents...**

_A Call for Community Action and Collaboration._

**KEY FINDINGS**

The following list of themes, with specific needs, challenges, and health impacts, were identified during a preliminary assessment of county data and statistics collected from a variety of sources. Themes align with Healthy People 2020 topics and objectives.

<table>
<thead>
<tr>
<th>THEME</th>
<th>DESCRIPTION OF NEEDS/CHALLENGES/HEALTH IMPACTS</th>
<th>SUPPORTING DATA</th>
</tr>
</thead>
</table>
| Older Adults     | • Aging population is rising  
• High Elderly Age Dependency Ratio  
• Rising percent of seniors living alone  
• Increasing prevalence of arthritis, including disability and mobility limitations  
• Rising prevalence of dementia, including Alzheimer’s disease  
• High prevalence of falls  
• Increase in medication management issues  
• Growing demand for family caregiver supports  
• Growing demand for affordable independent senior housing  
• Potential need for more healthcare workers (providers/mid-levels/other), which are difficult to recruit to rural areas  
• Growing need for in-home assistance (chore services, companionship, transportation)  
• Need for improved coordination of services | • Projected that number of seniors to double in next 20 years  
• 28.9% of seniors live alone.  
• Elderly Age Dependency ratio is 26%  
• 32.9% of 65+ report having a disability  
• 21.3% of 65+ report ambulatory limitations  
• In MN, 827,000 adults have arthritis  
• 25% increase in Alzheimer’s disease by 2025  
• Fatal falls rate in Wabasha County 84.8/100,000 (7 deaths due to falls in 2010)  
• Demand for 243 additional senior housing (market rate, affordable) units by 2016.  
• Demand for 86 congregate, 84 assisted living, and 75 memory care units by 2016  
• 40% of Three Rivers Community Action (TRCA) respondents report needing help with personal care or household assistance so they can remain at home.  
*Statistics in bold are county/regional data |

_To be the healthiest communities in which to live, learn, work, and play._

_The Wabasha County Community Health Improvement Plan is posted online at www.co.wabasha.mn.us_
<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Immunizations &amp; Infectious Diseases</th>
<th>Environmental Health</th>
<th>Oral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Higher number of mentally unhealthy days</td>
<td>• Declining immunization rates among older children</td>
<td>• High level of radon and lead in homes</td>
<td>• Lack of access to dental services for low-income population</td>
</tr>
<tr>
<td>• High level of suicidal thoughts among teen girls</td>
<td>• Increase prevalence of emerging communicable diseases such as pertussis (Whooping Cough)</td>
<td>High nitrate levels in ground water.</td>
<td>• Many dentists don’t accept Medicare/Medicaid patients</td>
</tr>
<tr>
<td>• Rising depression rates among seniors</td>
<td></td>
<td></td>
<td>• Lack of oral health prevention/education screening and services</td>
</tr>
<tr>
<td>• High level of risky behaviors reported by teens (cutting/intentional injuries, bullying)</td>
<td></td>
<td></td>
<td>• More children and adults need annual dental exam</td>
</tr>
<tr>
<td>• Increasing need for better access to full continuum of mental health services</td>
<td></td>
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</tr>
<tr>
<td>• County rankings respondents report having four mentally unhealthy days in the last 30 (compared to 2.7 in state and 2.3 nationally)</td>
<td>• Reported Pertussis cases in 2011-0 in 2012 – 10</td>
<td>• County average radon level 6.9 pCi/l, national average is 1.3.</td>
<td>• 12 dentists per 10,000</td>
</tr>
<tr>
<td>• 23% of 9th grade females thought about killing themselves in last year; 7% of 9th grade females tried to kill themselves.</td>
<td>• Reported Pertussis cases in SE MN in 2011-55 in 2012- 407</td>
<td>• 56% of children under 3 tested for blood lead levels had an elevated rate, state average is 36%</td>
<td>• 78.8% of adults 18+ report visiting a dentist or dental clinic within the past year for any reason.</td>
</tr>
<tr>
<td>• 18% of 9th grade girls have hurt themselves through burns, cutting, or bruises.</td>
<td>• MN state 13-17 yo vaccine rates do not reach the 2010 National goal of 90%. Varicella is 81.9, Tdap 82.5, Meningocacal 63.1, Female HPV 3 doses 34.8</td>
<td>• See map for nitrate levels throughout the county.</td>
<td>• 45.3% of TRCA respondents reported need for a nearby dentist to accept MA and MN Care.</td>
</tr>
<tr>
<td>• 44-55% of youth has bullied or has been bullied.</td>
<td>• 2010 national adult average for Tdap vaccination is 6% yet the source infectant for infants who have gotten pertussis is Parent 47%, Siblings 20%, Grandparents 8%</td>
<td></td>
<td>• Dental caries, or tooth decay, a preventable condition, remains the most common chronic</td>
</tr>
<tr>
<td>• Total number of county residents receiving mental health services in 2010 – 304/10,000.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• 23% of 9th grade females thought about killing themselves in last year; 7% of 9th grade females tried to kill themselves.</td>
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<td>• County rankings respondents report having four mentally unhealthy days in the last 30 (compared to 2.7 in state and 2.3 nationally)</td>
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<td></td>
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</tr>
</tbody>
</table>
| Chronic Disease/ Nutrition/Physical Activity/ Substance Abuse | One of the top health issues among children is prevalence of cavities. The national prevalence rate is 25% in children aged 6 to 11, and 59% in adolescents aged 12 to 19 years.
- At 55%, Minnesota’s third grade caries experience (history of dental caries) does not meet the Healthy People target of 42%.
- About 18% of third grade students have untreated tooth decay.
- The state average school sealant rate is 64%, however, WC schools do not offer sealant.
- 62% of population lives in rural areas with private wells that most likely do not have the optimal amount of fluoride to prevent tooth decay in children.
| Rising prevalence of overweight and obesity in all populations
- Lack of physical activity among all populations
- Lack of healthy eating among all populations
- High binge drinking rate among teens and adults
- Increase use of alcohol among seniors
- Rising rates of smoking among young adults |
| Disease of children ages 6 to 19. |
| 26% obesity rate in adults
- 63% adults obese or overweight
- 16% 9th graders overweight
- 16% 9th graders obese
- 20.2% of WIC children overweight and 14% obese
- 1 in 3 adults don’t get enough physical activity
- 41% of 9th graders spend six or more hours per week—screen time
- 85% of Minnesotans do not eat enough fruits and vegetables to meet daily recommendations
- 37.7% of TRCA respondents with limited income said they need help on how to shop for well-balanced, nutritious meals
- 20% of MN adults report binge drinking
- 17% of 9th graders engaged in binge drinking in last two weeks. |
| Unintentional Injury and Violence | High prevalence of accidental falls
- High rate of traumatic brain injuries (TBI)
- Poor motor vehicle behaviors (seat belt use, DWI/DUI, speed, and inattentive driving) |
| Fatal falls rate in Wabasha County 84.8/100,000 (7 deaths due to falls in 2010)
- TBI prevalence is 41 (rate 177/100,000) state rate is 92.1/100,000. Major causes of TBI in our county are falls (44.6%), struck by or against something (23%), Motor vehicle 10.5%), motorcycle (7%), ATV (3.5%) |
<table>
<thead>
<tr>
<th>Adolescent Health</th>
<th>Wabasha County higher than state average in fatal and serious injury MV accidents due to: Alcohol 79/100,000 state 35/100,000 Wabasha County highest in region, Inattentive driving 53/100,000 state 40, No seat belt 61/100,000 state 28/100,000 Speed 83/100,000 state 36/100,000</th>
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</table>
|                        | • High incidence of sexual intercourse among 9th and 12th grade students  
|                        | • Higher teenage birth rate  
|                        | • Higher SDT rate (Chlamydia)  
|                        | 9th graders – 23% males and 15% females have had sex one or more times.  
|                        | 12th graders – 67% males and 66% females have had sex one or more times.  
|                        | 9th graders – 30% never use condom  
|                        | 12th graders – 23% never use condom  
|                        | Teen Birth Rate for 18-19 yrs 52.6, state 43.6  
|                        | 52 cases of Chlamydia reported in 2010  
| Maternal/Infant Child Health | • High percentage of births to unmarried mothers  
|                        | • High number of grandparents living with and responsible for grandchildren  
|                        | 30.2% of births born to unmarried mothers  
|                        | 17.1% of children born with no father listed on birth certificate  
|                        | 12% of children born to mothers who smoked during pregnancy  
|                        | 199 grandparents in Wabasha County are living with/responsible for grandchildren  
| Transportation (Health Determinant) | • Limited transit services in county  
|                        | • Limited volunteer driver programs  
|                        | • Low-income lack funds to pay for gas and/or car repairs  
|                        | • Growing need for transportation to medical appointments, services, and job-seeking activities  
|                        | 75.2% of TRCA Community Partners survey respondents report need for transportation for adults to access services; 63.1% reported need for transportation to look for a job, maintain a job, or access training.  
| Others (Audience Feedback) |                                                                 |
|                         | Summary of data sources: Minnesota Department of Health; Centers for Disease Control; Minnesota Department of Human Services; Student Survey; County Health Rankings; Three Rivers Community Action (TRCA) Needs Assessment; Saint Elizabeth’s Medical Center; US Census; EPA, and WONDER. |
## Appendix C

### Wabasha County Community Health Assessment and Planning

#### Decision-making Criteria

<table>
<thead>
<tr>
<th>Issues</th>
<th>numbers of people affected</th>
<th>seriousness of issue</th>
<th>availability of community/financial resources to address need</th>
<th>impact on low-income population</th>
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<tbody>
<tr>
<td>Increasing prevalence of Alzheimer's</td>
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<td>Lack of services to meet elder care needs</td>
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<td>Lack of affordable, independent senior housing</td>
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<tr>
<td>Increased alcohol abuse among seniors</td>
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<td>Increased births to single moms</td>
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<td>High prevalence of smoking during pregnancy</td>
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<td>High prevalence of grandparents raising grandchildren</td>
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<td>Lack of access to dental care</td>
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<tr>
<td>Lack of transportation to medical appointments</td>
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<td>Lack of transportation to job seeking opportunities</td>
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<tr>
<td>Low immunization rates for young adults and adults</td>
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<tr>
<td>High rates of sexual activity by teens</td>
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<td>Low rates of condom use by teens</td>
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<td>High rates of teens who have been bullied or bullied others</td>
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<tr>
<td>High rates of binge drinking among teens</td>
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<td>High rates of DUIs among teens</td>
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<td>High rates of suicidal intention among teens – esp girls</td>
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<td>High obesity rates among adults</td>
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<tr>
<td>High obesity rates among children and teens</td>
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<td>Lack of physical activity by adults</td>
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<td>Inadequate nutrition among adults</td>
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<tr>
<td>High mortality due to falls</td>
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<td>High prevalence of traumatic brain injury</td>
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<td>Lack of access to mental health care</td>
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