MAYO CLINIC

Community Health Needs Assessment 2022

Mayo Clinic Health System-Red Wing, Cannon Falls and Lake City

MAYO CLINIC
HEALTH SYSTEM

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Executive Summary

Enterprise Overview

MAYO CLINIC

Mayo Clinic is a not-for-profit organization with a mission to inspire hope and promote health through integrated clinical practice, education, and research. Mayo Clinic serves more than 1.4 million patients annually from every U.S. state and communities throughout the world, offering a full spectrum of care from health information, preventive, and primary care to the most complex medical care. Mayo Clinic has locations in Rochester, MN; Scottsdale and Phoenix, AZ; Jacksonville, FL; and many Mayo Clinic Health System sites in Minnesota and Wisconsin.

COMMITMENT TO COMMUNITY

Through its interdisciplinary expertise in medical practice, research and education, Mayo Clinic serves communities everywhere. Mayo Clinic reinvests its net operating income to advance breakthroughs in diagnoses, treatments and cures for all varieties and complexity of human disease and quickly translates this new knowledge to advance the practice of medicine. One example illuminating this is how Mayo Clinic responded to the COVID-19 pandemic, which intensified existing community health needs. Mayo Clinic's front-line and virtual reams cared for more than 160,000 patients with COVID-19 in 2021. Mayo staff tested more than 1.1 million people for COVID-19, administered more than 500,000 COVID-19 vaccinations, and provided more than 19,000 monoclonal

antibody infusions. In addition to its extensive medical, public health, and research response, Mayo Clinic also cared for broader aspects of community need, including assistance to local non-profits, schools and government agencies, human service collaborative efforts and small local businesses to help stabilize and sustain the economies of its local communities.
Mayo Clinic Health System

Entity Overview

Mayo Clinic Health System (MCHS) was created to fulfill Mayo Clinic's commitment to bring quality health care to local communities. MCHS has a physical presence in 44 communities and consists of 53 clinics, 16 hospitals and other facilities that serve the health care needs of people in Iowa, Minnesota, and Wisconsin. The more than 900 community-based providers, paired with the resources and expertise of Mayo Clinic, enable patients in the region to receive the highest-quality physical and virtual health care close to home. MCHS is recognized as one of the most successful regional health care systems in the U.S.

MCHS was developed to bring a new kind of health care to communities. By putting together integrated teams of local doctors and medical experts, we have opened the door to information sharing in a way that allows us to keep our family, friends, and neighbors healthier than ever before.

The system also provides patients with access to cutting-edge research, technology, and resources. Our communities have the peace of mind that their neighbors are working together around the clock on their behalf.

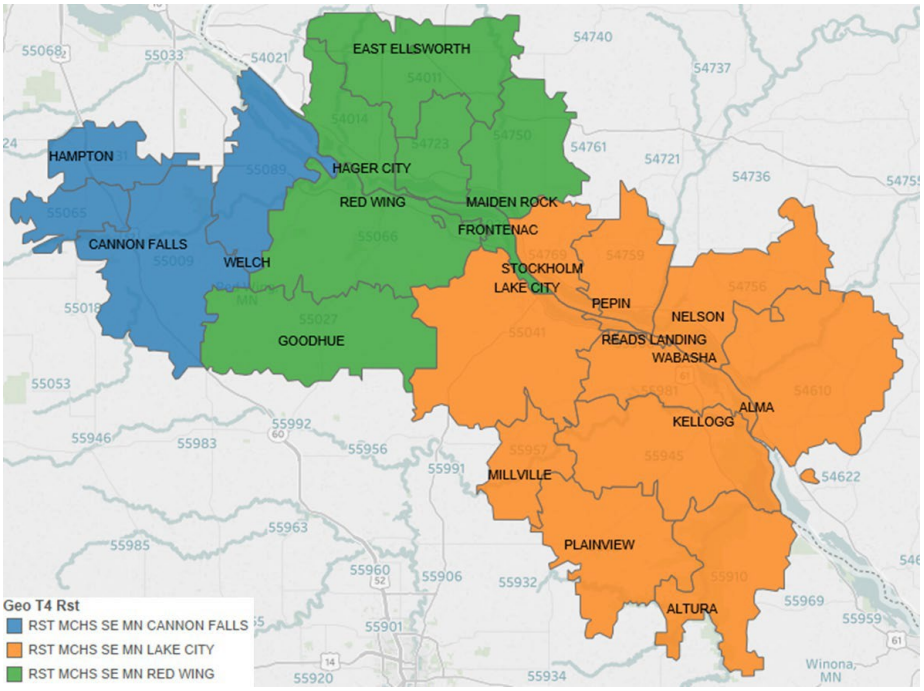
Mayo Clinic Health System in Cannon Falls (MCHS-Cannon Falls), Mayo Clinic Health System in Lake City (MCHS-Lake City) and Mayo Clinic Health System in Red Wing (MCHS-Red Wing) are part of the Southeast Minnesota region of the Mayo Clinic Health System (MCHS), which also includes hospitals in Austin (Mower County) and Albert Lea (Freeborn County), Minnesota.

This CHNA only applies to MCHS-Cannon Falls, MCHS-Lake City and MCHS-Red Wing, which supports the community through a broad range of inpatient, outpatient, and specialty services. For purposes of this CHNA, the community for the three hospitals is defined as Goodhue County as Cannon Falls, Red Wing, and part of Lake City are all located in Goodhue County.

Our Community

GEOGRAPHIC AREA

The population estimate of Goodhue County in July 2021 was 47,968. Cannon Falls, Red Wing and part of Lake City are all in Goodhue County. The service area of the three hospitals is outlined in the map below.



Cannon Falls

Mayo Clinic Health System in Cannon Falls is a 15-bed critical-access hospital and hospital-based clinic located in Cannon Falls, Minn. The medical center employs 12 clinical providers and has an additional 27 specialists who travel to Cannon Falls regularly to see specialty care patients.

Mayo Clinic Health System in Cannon Falls serves Cannon Falls and the surrounding area within Goodhue County.

Lake City

Mayo Clinic Health System in Lake City has Lake City and Plainview locations. Mayo Clinic Health System in Lake City is a campus comprised of an 18-bed critical-access hospital, a hospital-based clinic, and a 90-bed long-term care center located in Lake City, Minn. The medical center employs eight providers and has an additional 28 specialists who travel to Lake City to see specialty care patients.

The majority of Lake City's service area includes Goodhue and Wabasha counties (Lake City is in both counties) in southeastern Minnesota. Even though Goodhue County is defined as the community, Wabasha County was also considered as part of the assessment as MCHS-Lake City provides services to patients who reside in Wabasha County.

Red Wing

Mayo Clinic Health System in Red Wing has locations in Red Wing and Zumbrota, Minn., and Ellsworth, Wis. Mayo Clinic Health System in Red Wing comprises a 50-bed hospital, multi-specialty clinic, and senior living community. The medical center employs 65 clinical providers and 60 specialists who offer specialty care to community patients.

The majority of Red Wing's service area includes Goodhue County in southeastern Minnesota and, to a lesser extent, Pierce County in west-central Wisconsin.

Demographics

According to the U.S. Census Bureau, the July 2021 population estimate for Goodhue County is 47,968. A 2021 estimate reports that 22.1 percent of the population is under 18 years old, and 20.5 percent is 65 years old or older. The median household income (in 2020 dollars) is $69,334, and an estimated 7.2 percent of individuals live below the poverty level.

CHNA Demographic Data Summary for Service Area				
Estimated as of July 1, 2021				
MCHS Site	**Cannon Falls**	**Lake City**	**Red Wing**	
City pop. estimate as of July 2021	4,237	5,297	16,763	U.S. Census Bureau - https://www.census.gov/quickfacts
Median household income (2016-2020 in 2020 dollars)	$65,655	$60,481	$57,056	U.S. Census Bureau - https://www.census.gov/quickfacts
% Persons in poverty	7.5%	9.3%	11.8%	U.S. Census Bureau - https://www.census.gov/quickfacts
Median age	37.8	50.4	42.7	https://datausa.io/profile/geo
Market area population 2021	13,582	24,471	33,777	Sg2
% Female population	49.1%	49.3%	49.9%	Sg2
% Male population	50.9%	50.7%	50.1%	Sg2
% Under 18 years	21.7%	18.8%	21.9%	Sg2
% 65 years & older	18.2%	26.8%	20.0%	Sg2

Summary of the Health Needs Assessment

Every three years, MCHS partners with community stakeholders to conduct the Community Health Needs Assessment in each community where MCHS has a hospital.

In 2021, MCHS-Cannon Falls, MCHS-Lake City, and MCHS-Red Wing partnered with Goodhue County Health and Human Services, United Way of Goodhue, Wabasha, and Pierce Counties, and the city of Red Wing to create a joint Community Health Needs Assessment.

Appendix A: Goodhue County 2021 CHNA

In 2021, MCHS in Southeast Minnesota coordinated efforts with the public health departments in Freeborn, Mower, and Goodhue Counties to develop and disseminate a mailed survey.

In addition to the random mailed survey, a concerted effort was made to reach underrepresented groups. The survey was given to target populations (convenience sample). Together with other feedback mechanisms, we were able to solicit feedback from typically underserved or at-risk populations and gain general perspectives about social and environmental health issues.

Key Informant Interviews were conducted in each community through an online survey and community engagement events.

Through this process, the following priorities for MCHS hospitals in Red Wing, Cannon Falls, and Lake City (all located in Goodhue County) were identified:

1. Mental Health
2. Substance Misuse
3. Social Connection and Inclusion

Mental Health – Health Conditions

According to Healthy People 2030, about half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. Mental disorders affect people of all ages and racial/ethnic groups, but some populations are disproportionately affected by these conditions. Mental Health was the top health concern mentioned in key informant interviews, with 81% of those interviewed identifying it as a top issue. Concerns about access to mental health care and how the COVID-19 pandemic exacerbated mental health issues were frequently raised.

Based on input from the community, a priority will be placed on promoting well-being with a particular focus on awareness of mental health resources, building resilience, and improving mental health for all.

Priority Health Topic	MCHS Resources	Community Resources
Mental Health Focus on awareness of mental health resources, and resilience projects for youth, seniors, and rural and diverse populations.	• MCHS Resiliency program • The Road to Better Health • Women's Morning of Health • CARE Clinic • 12 Strategies for Healthy Aging newsletters	• United Way Goodhue County partnership as part of the Mental Health Coalition • Directory, 211, Fast Track, Telemedicine, Aunt Bertha • Make it OK • CARE Clinic • Every Hand Joined

Substance Misuse

Drug and alcohol use includes the harmful risk behaviors of binge drinking, any drinking among pregnant people and people under age 21, and any use of tobacco, e-cigarettes or vapes, marijuana, or other drugs. Drug and Alcohol Use also includes substance use

disorders. According to Healthy People 2030, "substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths. Effective treatments for substance use disorders are available, but very few people get the treatment they need."

Priority Health Topic	MCHS Resources	Community Resources
Substance Misuse Focus includes prescription drugs, vaping, and marijuana.	• Serve to Convene or Engage services • Fountain Centers	• T 21 Tobacco is a key focus area for SHIP- Live Well Goodhue County • Support Groups

Social Connection and Inclusion

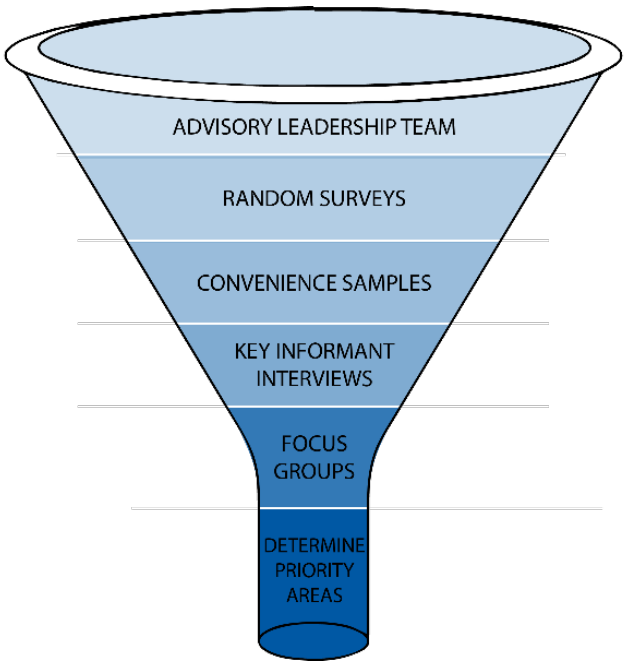
People's relationships and interactions with family, friends, co-workers, and community members can majorly impact their health and well-being. Positive home, work, and community relationships can help reduce adverse health impacts. Some people face discrimination, bullying, and social isolation and often do not get the support they need to achieve optimal health. Key informants and community members who mentioned this as a top health concern noted that both the COVID-19 pandemic and the murder of George Floyd highlighted how important social and community support are to health.

Social and community support is about the connection between characteristics of the contexts within which people live, learn, work, and play and their health and well-being. This includes topics like cohesion within a community, civic participation, discrimination, conditions in the workplace, and incarceration.

Priority Health Topic	MCHS Resources	Community Resources
Social Connection and Inclusion	• Support Groups • Care Clinic • Diversity and Inclusion Education Collateral	• Green Spaces • Inclusive Library • Community Splashpad

Assessing the Needs of the Community

Mayo Clinic Health System's community assessment process was led by the Southeast Minnesota Community Engagement Staff. The team followed a systematic approach to evaluate the health needs of our communities and determine health priorities.



Like the approach used in 2019, we attempted to standardize language around top issues that emerged in the communities. In 2022, we used Healthy People 2030 topics: https://health.gov/healthypeople/objectives-and-data/browse-objectives.

Community Input

Mayo Clinic Health System has a long history of engaging the community to identify local healthcare needs and build partnerships. Our leadership and staff serve on local boards, including economic development and Chamber of Commerce committees, service organizations, community college foundation and other initiatives important to the community.

Process and Methods

Primary data collected for the assessment included key informant interviews, county-wide mailed surveys, convenience sample surveys, online survey, and community engagement events. Mayo Clinic Health System thanks our partners in Goodhue County Health and Human Services, the United Way of Goodhue Wabasha and Pierce Counties, and the City of Red Wing for assisting the CHNA committee and our community with their input.

Surveys

Survey instrument

The survey instrument used for the project was adapted from the joint survey conducted in 2021 in Goodhue, Mower, and Freeborn Counties. The county public health agencies and Mayo Clinic Health System worked together in 2021 to select the survey content from the counties' previous surveys with technical assistance from the Minnesota Department of Health Center for Health Statistics. The survey was formatted by the vendor, Survey Systems, Inc. of Shoreview, Minnesota, as a scannable, self-administered English-language questionnaire.

Sample

A two-stage sampling strategy was used for obtaining probability samples of adults living in Goodhue, Mower, or Freeborn Counties. For the first stage of sampling, a random sample of residential addresses for each county was purchased from a national sampling vendor (Marketing Systems Group of Horsham, Pennsylvania). Address-based sampling was used so that all households would have an equal chance of being sampled for the survey, and marketing Systems Group obtained the list of addresses from the US Postal Service. For the second stage of sampling, the "most recent birthday" method of within-household respondent selection was used to specify one adult from each selected household to complete the survey.

Survey administration

An initial survey packet was mailed to 4,800 sampled households in Goodhue, Mower, and Freeborn counties on September 30, 2021, that included a cover letter, the survey instrument, and a postage-paid return envelope. One week after the first survey packets were mailed (October 11), a postcard was sent to all sampled households, reminding those who had not yet returned a survey to do so, and thanking those who had already responded. Two weeks after the reminder postcards were mailed (October 25), another complete survey packet was sent to all households that had still not returned the survey. The remaining completed surveys were received over the next six weeks, with the final date for the receipt of surveys being December 23, 2021.

Completed surveys and response rate

Completed surveys were received from 934 adult residents of Goodhue, Mower, and Freeborn Counties for an overall response rate of 19.5% (934/4800). There were 318 completed surveys received from adult residents of Goodhue County. The county-level response rates are as follows: Goodhue County: 19.9%; Mower County: 18%; Freeborn County: 19.4%. So, few respondents aged 18–24 returned completed surveys that results are reported only for adults aged 25 and over.

Data entry and weighting

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

To ensure that the county-level survey results represent each county's adult population, the data were weighted when analyzed. The weighting accounts for the sample design by adjusting for the number of adults living in each sampled household. The weighting also includes a post-stratification adjustment so that the gender and age distribution of the survey respondents mirrors the gender and age distribution of the adult population aged 25 and over in each county, according to US Census Bureau American Community Survey 2015-2019 five-year estimates.

The Minnesota Department of Health and its senior research scientist assisted in compiling the data by county.

Convenience sample survey instrument

The same survey instrument used for the random sample mailed survey was used to survey a convenience sample of adults in the GCHHS lobby, C.A.R.E. Clinic, and food shelves.

Convenience sample

To reach adults who have typically been under-represented in mailed survey results, a convenience sample approach was used. Receptionists at the GCHHS lobby and C.A.R.E. Clinic and food shelf volunteers distributed copies of the survey to adults waiting for services. GCHHS hired an interpreter from Hispanic Outreach to interpret the survey for C.A.R.E. Clinic clients

who spoke Spanish. The interpreter was at C.A.R.E. Clinic for a total of seven hours in November 2021.

While only 6% of the mailed survey responses were from people of color in 2021, 27% of the convenience sample of adults at the GCHHS lobby, C.A.R.E. Clinic, and food shelves were from people of color. While only 15% of the mailed survey responses were from people with a household income of less than $25,000, 80% of the convenience sample adults who completed a survey at the GCHHS lobby, C.A.R.E. Clinic, and food shelves had a household income of less than

$25,000. Because the survey respondents were not randomly selected, it is not appropriate to generalize this convenience sample to the entire population of people with a low income or the whole population of communities of color.

Convenience Sample Survey Administration

A total of 129 gift cards for $5 were distributed as incentives for people to complete the survey. There were 67 gift cards from Walmart in Red Wing and the rest were from local grocery stores: 30 from Family Fare in Cannon Falls and Red Wing, 13 from Nilssen's in Zumbrota, ten from Island Market in Pine Island, and nine from Kenyon Markey in Kenyon. Receptionists at the GCHHS lobby and volunteers at C.A.R.E. Clinic and the food shelves initialed for gift cards distributed.

C.A.R.E. Clinic patients received Walmart gift cards. Food shelf clients received gift cards for their local grocery store. GCHHS lobby customers received their choice of Walmart or local grocery store gift cards. Surveys were all completed between October 2021 and January 2022.

Completed convenience sample surveys

A total of 130 surveys were completed. C.A.R.E. Clinic returned 14 completed surveys. GCHHS lobby returned 57 completed surveys. Pine Island Sharing Shelves returned ten completed surveys, Zumbrota Area Emergency Food Shelf returned 17 completed surveys, All Seasons Food Shelf (Kenyon) returned four completed surveys, Red Wing Area Food Shelf returned 14 completed surveys, and Cannon Falls Food Shelf returned 14 completed surveys. A response rate cannot be calculated because this was a convenience sample; everyone who wished to fill out a survey could do so.

Convenience sample data entry and weighting

Survey Systems, Inc scanned the responses from the completed surveys into an electronic file. The data were not weighted for gender or age when analyzed. As a result, the convenience sample over-represents the responses of females (76% of the sample) and under-represents those under the age of 25 (6% of the sample).

Appendix B: Southeast Tri-County Health Survey

Key Informant Interviews

Key informant interviews were conducted in the late winter and early spring of 2022 by members of the MCHS administrative leadership at each site and the Goodhue County Health and Human Services Healthy Communities leadership team. These one-on-one interviews followed the same format but allowed individuals to report their perceptions of community needs and share insight into current strategies being used.

A total of 21 Key Informant interviews were conducted in the communities of Goodhue County. Representatives from the following community stakeholder groups participated:

- Goodhue County Health and Human Services - Public Health
- C.A.R.E. Clinic
- Hispanic Outreach
- United Way of Goodhue, Wabasha, and Pierce Counties
- Goodhue County Sheriff
- Police Department (Cannon Falls, Lake City, Red Wing)
- Cannon Falls EMS, Lake City Ambulance Director
- City Official (Cannon Falls, Lake City, Red Wing)
- School District (Cannon Falls, Lake City, Red Wing)
- Chamber of Commerce (Cannon Falls, Lake City, Red Wing)
- Lake City Community Center
- Red Wing Community Education
- Local Church leaders
- Red Wing Area Seniors
- Red Wing Family YMCA

Key Informant Surveys

Interviewees in each of the three communities were asked to complete online surveys before the interview:

- Of the issues that impact health in our community, what are the top three that are the most important related to your sector?

- For each concern selected, please answer questions on who is affected, why you believe this is a concern, contributing factors, resources available, and suggestions.
- Interviewees in each of the three communities were asked the same series of questions:
- What are the top three concerns facing people in our County?
- What makes you believe these are concerns and who is affected by them?
- What do you think could be done to address these concerns? The most frequently mentioned issues included:
- Mental Health – including affordability and a lack of services were mentioned.
- Housing and Homes - not enough housing, needing more affordable housing, and homelessness services were mentioned.
- Drug and Alcohol Use - alcohol, illegal drugs, smoking, vaping, and their relationship to crime and recovery programs.
- Obesity and physical activity are general concerns with obesity in children need to encourage more physical activity, and lack of overall health.
- Economic Concerns: Poverty, low wages, and the COVID-19 pandemic affecting the economy.

As part of the key informant interview, participants were asked if they were aware of programs to address community needs. Limited input was provided on MCHS programs to address priority needs identified in the 2019 CHNA. MCHS published its 2019 CHNA reports for Cannon Falls, Red Wing, and Lake City in December of that year and posted links to the reports on the external website. To date, no written public comments have been received regarding the reports or the corresponding implementation plans.

Appendix C: CHNA Key Informant Interview Summary

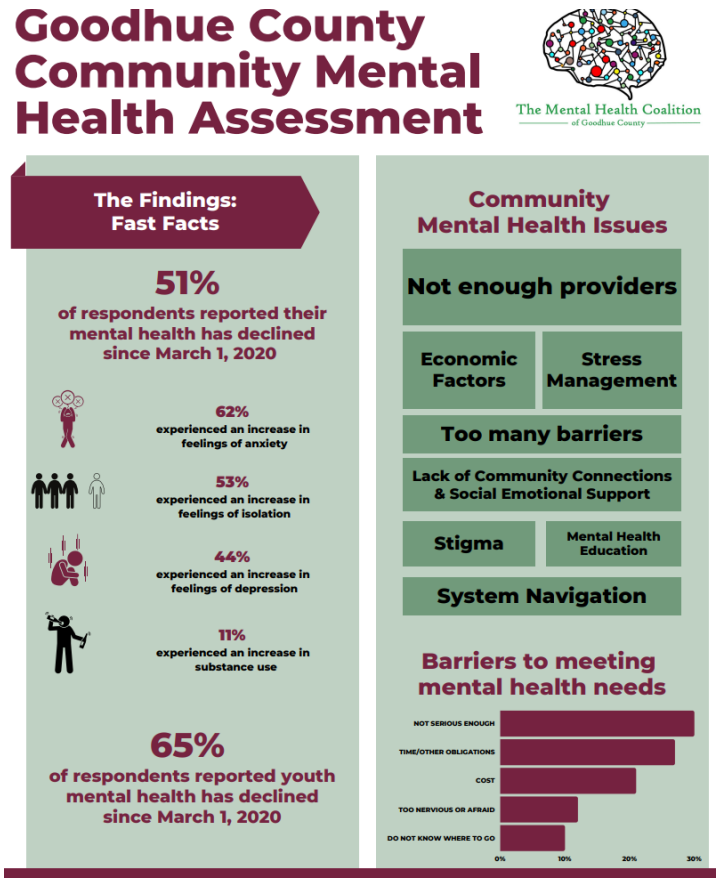
Hanlon Method

In March 2022, the Community Health Assessment committee prioritized twenty-one health topics using the Hanlon Method. This method allowed members to rate health issues based on size, seriousness, inequity, and effectiveness of interventions. Size is the number of people potentially or affected by the health topic. Seriousness refers to the impact this health topic has on disability, premature death, social burdens, or health care costs. Inequity refers to the presence of differences in health status by gender, race, income, etc. that are unjust (arbitrary, unnecessary, avoidable). The effectiveness of intervention refers to effective ways to reduce the problem. The core group of committee members looked at the results and narrowed the list of health issues down to fifteen.

Appendix D: Goodhue County Community Partnership Report

Online Survey

In April 2022, an online survey was conducted to gather further feedback from the community on the top fifteen health issues. The survey consisted of two questions, “in thinking about your health and well-being, what concerns you most,” and “in thinking about the community’s health and well-being, what concerns you most.” Respondents were able to select up to three health issues for each question. The survey was promoted through social media and had over 1100 responses. Survey results were looked at by the core group of the community health assessment committee and then narrowed the list of health issues down to ten.



Appendix E: Goodhue County Mental Health Coalition Presentation

Community Engagement Events

The CHA Core Group hired an intern to help engage community members on the CHNA plan and share the top ten health issues. The intern's primary responsibility was to travel throughout the county to attend community events, festivals, or other activities and talk to residents about what top health issues they think are affecting their community.

The intern collected this data through interactive activities, incentives, and a dot-voting system to help narrow our top ten health issues down to the top three that will be included in the implementation plan.

Through the engagement plan, community members were asked at events to pick and put a sticky dot next to their top health issue.

The events around the county where this feedback was collected were:

- Cannon Falls Father's Day pancake feed
- Red Wing Juneteenth celebration
- Lake City Water Ski days
- Red Wing Music in the Park
- Zumbrota Music in the Park
- Cannon Falls Open Air Fair
- Red Wing Farmers Market
- Pine Island Farmers Market
- Red Wing River City Days
- Cannon Falls Chamber Fun Fest
- Goodhue County Fair
- Kenyon Rose Fest

The results from these community engagement events were reviewed with core group partners and Mayo Clinic Health System leadership and the top three assessed needs were selected.

As demonstrated in the graph below, health outcomes are influenced by a variety of factors, 80% of which are outside of clinical care.

Appendix F: Goodhue County Community Engagement Summary

Source: https:www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model

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Addressing the Needs of the Community

Identified Health Needs

Identified Health Needs Listing in the Order of Importance

- Mental Health
- Substance misuse
- Social Connection and Inclusion

After reviewing the assessment outcomes with Goodhue Public Health, community partners and Red Wing, Cannon Falls and Lake City MCHS leadership, the top three issues were identified.

Mental Health

According to Healthy People 2030, about half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. Mental disorders affect people of all ages and racial/ethnic groups, but some populations are disproportionately affected by these conditions. Mental Health was the top health concern mentioned in key informant interviews, with 81% of those interviewed identifying it as a top issue. Concerns about access to mental health care, and how the COVID-19 pandemic exacerbated mental health issues were frequently brought up.

The Minnesota Department of Health defines mental health as more than the absence of disease. “Everyone has a state of mental health, and this can change across the lifespan. Not having a mental illness, does not guarantee good mental health. Similarly, having a mental illness does not guarantee poor mental health. It includes life satisfaction, self-acceptance, sense of purpose, identity, feeling connected and belonging, empowerment, and resilience, which is the ability to bounce back after setbacks.”

Substance Misuse

Drug and Alcohol Use includes the harmful risk behaviors of binge drinking, any drinking among pregnant people and people under age 21, and any use of tobacco, e-cigarettes or vapes, marijuana, or other drugs. Drug and Alcohol Use also includes substance use disorders. Drug and Alcohol Use was one of the most frequently mentioned health concerns, mentioned by 29% of key informants interviewed in 2022. One key informant said, “We see a frequent connection between alcohol and drug use and criminal behavior. Substance abuse impacts educational achievement, family functioning, social development, traffic safety and most areas of life.” Responding to Drug and Alcohol Use includes both “preventing drug and alcohol misuse and helping people with substance use disorders get the treatment they need” (Healthy People 2030). Opioid-involved overdose deaths spiked to never-before-seen levels in Goodhue County in 2021. According to Healthy People 2030, “substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths. Effective treatments for substance use disorders are available, but very few people get the treatment they need.” 479 Goodhue County residents received chemical dependency treatment in 2021.

Substance misuse is a serious health challenge. It includes the use of illegal drugs and the inappropriate use of legal substances, such as alcohol and tobacco. Drug Misuse is defined by the World Health Organization as the use of a substance for a purpose not consistent with legal or medical guidelines. Reducing substance misuse improves overall health and impacts mental well-being and chronic disease prevention.

Social Connection and Inclusion

People’s relationships and interactions with family, friends, co-workers, and community members can have a major impact on their health and well-being. Positive relationships at home, work, and in the community can help reduce negative health impacts. Some people face discrimination, bullying, and social isolation and often do not get the support they need to achieve optimal health. Key informants and other community members who mentioned this as a top health concern mentioned that both the COVID-19 pandemic and the murder of George Floyd highlighted how important social and community support are to health. One key informant talked about how the events of the last two years

heightened the “me” vs. “we” culture in the community and that makes it difficult to create communities of inclusiveness where people have a sense of belonging.

Social and community support is about the connection between characteristics of the contexts within which people live, learn, work, and play and their health and well-being. This includes topics like cohesion within a community, civic participation, discrimination, conditions in the workplace, and incarceration.

Health Needs Not Addressed

The assessment process identified needs that will not be addressed in this Community Health Needs Assessment.

Access to Care

MCHS Red Wing, Cannon Falls and Lake City will continue to evaluate and improve access to care throughout the county. MCHS partners with the CARE Clinic to provide medical, mental health and dental services at no /reduced costs to community members living in poverty. MCHS provides the facility for the CARE Clinic to operate and additional services to assist the continuity of care between the CARE Clinic and MCHS.

MCHS will continue to work with the Mental Health Coalition Service Array Focus group, 211, Fast Track, and other community efforts to increase access to care by providing information on where and how to navigate healthcare options, ensuring those services are accommodating and accessible.

Socio-economic Factor- Housing

While this is not an area of MCHS expertise, it is important to the community, and we will therefore play a supporting role. MCHS can support programs and partner with organizations that focus on housing, such as the Affordable Housing Coalition in Goodhue County and the Homeless initiative of Goodhue County. MCHS will also engage in United Way’s Poverty Simulation to increase awareness of the effects of poverty on health.

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Evaluation of Prior CHNA and Implementation Strategy

Impact of 2019-2022 Implementation

The 2019 CHNA Priorities are: Mental well-being, Chronic Disease Prevention and Substance Misuse

- Mental Well-Being – Improve mental well-being throughout the community.
- Chronic Disease Prevention – Educate the community on healthy behaviors to promote disease prevention.
- Substance Misuse – Reduce substance misuse by providing education, collaboration, and advocacy around substance misuse in the community.

Mental Well-Being

The following efforts were implemented to impact mental well-being and related health concerns:

Women & Well-Being Webinar – designed to educate women on health and wellness – a program intended for a multigenerational audience – informs women of the importance of emotional well-being and feeling safe in a medical setting.

Discover Gratitude (virtual program): Invited educators, social service agencies, and community members to participate in this free, self-guided virtual program that helps improve mental well-being through daily journaling, emphasizing gratitude for the positive.

Cannon Falls Community Health & Wellness Fair: MCHS providers joined community members in a COVID-safe outdoor venue and promoted practices to lessen Anxiety and Decrease Isolation. 45 participants picked up educational material on Anxiety, and the school contacted us for additional information.

Mental Health Conveners: Promoted mental well-being activities and access to care through online and printed resource materials distributed to schools throughout Goodhue County.

Community meetings for underserved populations: Coordinated meetings with Hispanic Outreach and the CARE Clinic to share resources and explore obstacles for community members who found barriers in obtaining health care.

Cancer Webinar: Promoted participation in a webinar focusing on care for the caregiver during a Cancer diagnosis.

Chronic Disease Prevention

The following efforts have been implemented to impact chronic disease prevention and related health concerns:

Virtual Wellness Campaign: Invited community members through well-being at work, county SHIP partners and educators to participate in this free weekly webinar with self-guided programming to improve mental well-being and exercise. Programs focused on daily challenges and exercise. 59 participants from the county received weekly webinar links and reminders. Gratitude journals and calendars with daily activities were available as a free download.

Farmers Market: Participated and promoted farmer's markets in Cannon Falls, Lake City, Goodhue, and Red Wing; received funding to build their Power of Produce programs and to encourage healthy food choices for youth. The funds were used to incentivize vegetables and fruits at the local stands. Farmer’s Markets were conducted through Pre Order pick up, scheduled times to shop, and COVID-safe shopping in 2020.

Goodhue Wabasha County Public Health Flu Vaccination: Promoted flu vaccinations to community groups with education on symptoms, vaccine safety, availability, and community collaboration. Flyers were distributed in Spanish to county and community partners.

Substance Misuse

The following efforts have been implemented to impact substance misuse and related health concerns:

Preliminary meetings to discuss potential programming: Meetings have been held with Recovery Corps to evaluate current services in the county and determine if a Site Partner, Recover Navigator, or Opioid Response Project Coordinator would be appropriate in Goodhue County. Several leaders attended a Recovery Corps presentation and continue to develop a local committee to evaluate services and needs Recover Corps could meet.

Hope and Harbor Homeless Shelter modified programming in 2020 to meet additional substance misuse programming, education, and counseling in a safe, sustainable shelter. The shelter changed from an overnight site to a 24-hour-a-day site.

2019 CHNA – COVID 19

COVID-19 emerged as the leading community health priority in 2020

In February 2020, the COVID-19 virus became a pandemic throughout the U.S. and in Minnesota. Mayo Clinic responded to this challenge in a multitude of ways to protect the health of its local and regional communities as well as contribute to the national and global response, including:

- Restructuring patient care services to ensure capacity for intensive care for community needs. This required significant interruptions to normal operations as non-emergency care services were deferred to increase COVID-19 response capacity.
- Expanding virtual care capabilities to advance home care and treatment to safely improve access for community and rural patients.
- Rapid development and dissemination of public and consumer information about the COVID-19 virus to help the public (consumers, government, peer medical providers, etc.) understand the risks and take actions to prevent and/or care for the infection.
- Development and dissemination of rapid COVID-19 testing resources to strengthen efforts of local public health and other healthcare organizations in serving community needs.
- Refocused research efforts to bring a greater understanding, therapies, and potential vaccine solutions for the COVID-19 virus, including antibody testing capabilities, blood plasma therapies and effectiveness and safety of various pharmaceutical treatments.
- Sharing knowledge and collaborating broadly with other academic health centers and businesses to expand understanding and resources to address and contain the disease. Examples include using AI to model and forecast hotspots across the U.S. and developing tools to standardize

contact tracing and exposure management. These systems were also shared with Public Health departments to inform changing health safety policies as the pandemic has evolved locally.

At the local level, community engagement efforts shifted to educating and communicating about COVID-19. These activities included the following:

- Community liaison role with public health officials and community partners: Communicated frequently – weekly or more – with established communication networks to share accurate, timely information. Staff served as a community contact to share feedback, questions, and concerns with the clinical practice.
- Mayo Clinic Health System Leadership presentations: Placed Mayo Clinic Health System leaders at key community events (e.g., Chamber of Commerce, Economic Development) to answer community questions related to COVID-19.
- COVID-19 community e-news: Shared up-to-date, accurate, relevant information with more than 100 key community stakeholders and established networks, often several times a week, depending on the urgency of the communication.
- Targeted outreach to priority populations: Worked with community partners to coordinate efforts to meet the needs of Low English Proficiency (LEP) populations to provide educational resources in translated languages.
- COVID-19 Virtual Community Forums: Hosted a series of webinars/virtual Q&A with medical professionals to provide accurate information on COVID-19 and answer questions from the community. Over the course of three events, more than 350 attended.

These efforts, combined with the capacity challenges of local non-profits and other sectors, delayed some of the 2020 community health improvement (implementation plan) strategies.

Appendix A

Goodhue County 2021 Community Health Needs Assessment

Introduction

The 2021 Goodhue County Community Health Needs Assessment Survey was conducted to learn about the health of Goodhue County adults. Similar surveys were previously conducted in 2015 and 2018. The data presented in this summary offers some key highlights from the survey findings in the areas of obesity, chronic disease, mental health, access to care, healthy eating, food security, physical activity, tobacco and alcohol use, and driving behaviors. Goodhue County Health and Human Services (GCHHS) requested analyses from the Minnesota Department of Health to monitor differences based on demographic and health status categories found in the 2018 survey. There were not enough responses from people of color in 2018 or 2021 to monitor differences by race/ethnicity. There were also not enough responses from adults aged 18–24 in 2018 or 2021, so the youngest age group analyzed was 25–34. Exploratory analyses were conducted on some new 2021 survey questions to identify potential differences. This summary includes differences for the following demographic and health status categories on some key questions:

- Gender
- Age (adults ages 25–34, 35–44, 45–54, 55–64, 65–74, and 75+)
- Annual household income (less than $35,000, $35,000–$49,999, $50,000–$74,999, $75,000–$99,999, $100,000–$149,999, and $150,000 or more)
- History of mental illness
- Weight status based on self-reported BMI (not overweight or obese, overweight but not obese, and obese)

In addition, survey results were compared to a 2021 convenience sample of 130 adults who completed the same survey in settings where they receive services:

- Adults who filled out the survey in the GCHHS lobby, C.A.R.E. Clinic or a food shelf

The percentages referenced in this summary are rounded to the nearest whole number.

Interpretation and limitations

In this summary, a threshold of 10 percentage points or more is used to identify potential differences between groups. However, caution should be used when interpreting the findings and reporting differences between population groups, as some estimates are based on the

perceptions and experiences of relatively few individuals. Community residents, specifically from groups underrepresented in the survey, such as people of color and adults aged 24 and younger, should be engaged in reviewing and interpreting the survey results to ensure the findings align with the lived experience of Goodhue County residents. Additional data collection activities (e.g., interviews, focus groups, and other surveying) should be used to examine the potential differences more closely between groups suggested by these findings and topics of interest to community residents.

A note about health equity

GCHHS is interested in understanding health inequities in the county. The Minnesota Department of Health defines health equity as "the opportunity for every person to realize their health potential—the highest level of health possible for that person—without limits imposed by structural inequities."[1] Health inequities arise from disparities or differences in health between groups because of varying social, economic, environmental, geographic, and political conditions, also known as the social determinants of health. Certain health disparities are the consequence of genetic or biological differences between groups, while health inequities result from social conditions that can be changed through the implementation of policies and practices.

The data referenced in this summary and the full survey results offer a starting point to identify potential health disparities between groups and consider the need for additional research to better understand and address health inequities. As previously noted, there are limitations to these survey data. Therefore, the discussion focused on health inequities should be informed by other data collection activities, analysis of the factors that influence health in Goodhue County (e.g., geography, employment, and access to resources and services), and feedback from community residents, particularly groups who were not well represented among the survey respondents.

[1] Minnesota Department of Health. (2014). Advancing Health Equity Legislative Report. Retrieved from the Minnesota Department of Health website: https://www.health.state.mn.us/communities/equity/reports/index.html

Overall, potential differences between groups

This section highlights some potential differences between respondent groups that are described in greater detail in the following "key findings" section of the summary.

Overweight/obesity

- Respondents from the convenience sample, who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or at a food shelf, were about as likely as the general population of adults 25+ to have been **told by a health care professional that they are obese,** but more likely to have a self-reported **body mass index (BMI) that puts them in the obese category**.

Chronic conditions

- **High blood pressure/hypertension** was more often reported among respondents who are obese or overweight, aged 65+, and from households making $35,000–$49,999.
- **Asthma** was more often reported by respondents from the convenience sample, who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf, than the general population of adults 25+.
- **High cholesterol or triglycerides** was more often reported by respondents from the convenience sample, who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf.
- **Diabetes** was more often reported among respondents with household incomes between $100,000 and $149,000.

Mental health

- The reported **number of mentally unhealthy days** was higher among respondents from the convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf; respondents who reported any history of mental illness; and respondents who only sometimes, rarely, or never get the social and emotional support they need.
- **Depression** was more often reported among respondents who are female, respondents from households that make less than $35,000, and respondents who rent rather than own their home. Respondents who participated in the convenience sample survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf were nearly twice as likely as the general population of adults 25+ to report depression.
- **Anxiety or panic attacks** were reported more than twice as often by respondents from the convenience sample, who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf, than the general population of adults 25+. Respondents from households that make

less than $35,000 and those who rent rather than own their home were also more likely to report anxiety or panic attacks.

Access to care

- Respondents from the convenience sample, who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or at a food shelf, were more likely than the general population of adults 25+ to **have delayed or not sought both medical and mental health care**.
- Among both the general population of adults 25+ and the convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or at a food shelf the most common reason for **delaying or not seeking medical care** was respondents not thinking the issue was serious enough.
- While the most common reason for **delaying or not seeking mental health care** among the general population of adults 25+ was respondents not thinking the issue was serious enough, among the convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or at a food shelf, the most common reason was feeling too nervous or afraid.

Food security

- Concerns about **running out of food** before having money to buy more were most often reported among respondents from households that make less than $35,000 and those who rent rather than own their home. Respondents from the convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf were more likely than any subgroup within the general population of adults 25+ to report often or sometimes worrying about running out of food.

Eating habits

- **Eating a home-cooked meal at least seven times a week** was most likely to be reported by respondents aged 55–64, and least likely among those aged 45–54.

Physical activity

- Respondents aged 25–34, those whose household income is between $50,000 and $74,999, and those who are not overweight were the most likely to report getting at least 30 minutes of **moderate physical activity** at least five days a week.
- Respondents aged 25–34, those whose household income is between $50,000 and $74,999 or $150,000 or more, and those who are not overweight were the most likely to report getting at least 20 minutes of **vigorous physical activity** at least three days a week.

- **Lack of time** and **lack of self-discipline or willpower** were self-identified most often as a big problem preventing respondents from being more physically active. Respondents aged 35–44, those with the highest household incomes, and those who only sometimes receive the social or emotional support they need were most likely to say that lack of time is a big problem.

- Respondents with lower household incomes were most likely to identify **illness, injury, or disability** as a big problem preventing them from being more physically active.

- Respondents from the convenience sample, who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or at a food shelf, were more likely than the general population of adults 25+ to say that **cost** is a big problem preventing them from being more physically active.

- Respondents from the convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or at a food shelf, and respondents aged 45–54 were most likely to identify **not having anyone to exercise with** as a big problem preventing them from being more physically active.

Tobacco use

- Respondents who participated in the convenience sample survey in the GCHHS lobby, at C.A.R.E. Clinic, or at a food shelf, were more likely than the general population of adults 25+ to report **current tobacco use** of some kind.

- **Current cigarette smoking** was most likely to be reported among respondents with household incomes below $50,000 and those who rent rather than own their homes. Respondents who participated in the convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf were more likely than those in the general population to report that they currently smoke cigarettes.

Alcohol use

- **Binge drinking** was reported at a higher rate among the general population of adults 25+ than the convenience sample who took the survey in the GCHHS lobby, at the C.A.R.E. Clinic, or a food shelf.

Driving behaviors

- Younger respondents were more likely to report that they **read or send texts** while driving.

Key findings

Caution should be used when interpreting any potential differences encompassing adults aged 25–34, as these estimates are based on the responses of a relatively small number of residents.

Overweight/obesity

Obesity

Nineteen percent of respondents reported that they have been told by a healthcare professional that they are obese. That is slightly more than the rate in 2018.

Thirty-five percent of respondents were categorized as obese based on their body mass index (BMI), which was calculated using respondents' self-reported weight and height. Thirty-six percent of respondents in 2018 were categorized as obese based on BMI.

Thirty-four percent of respondents were categorized as overweight but not obese, based on BMI, and 31% were categorized as not overweight or obese. These rates are similar to 2018 (36% and 28%, respectively).

Potential differences between population groups

- Nineteen percent of respondents in the convenience sample, who took the survey **in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf,** reported that they have been told by a health care professional that they are obese, compared to 25% of the convenience sample in 2018.

- Almost half of the respondents in the convenience sample who took the survey **in the GCHHS lobby, at the C.A.R.E. Clinic or a food shelf** were categorized as obese (46%), based on their calculated BMI. This rate was 57% for the convenience sample in 2018.

Note: Throughout the rest of the report, results are sometimes disaggregated by whether respondents are obese, overweight but not obese, or not overweight or obese. This disaggregation for analysis is based on BMI calculations, using self-reported height and weight, and not based on whether respondents indicated that a health professional had diagnosed them as overweight or obese.

Chronic conditions

High blood pressure/hypertension

Thirty-one percent of respondents reported that they have been told by a healthcare professional that they had high blood pressure/hypertension. Similarly, 32% of respondents reported high blood pressure/hypertension in 2018.

Potential differences between population groups

- The prevalence of high blood pressure generally increased with age. **Respondents aged 65–74** were most likely to report high blood pressure/hypertension (61%) followed by

respondents aged 75+ (58%), 55–64 (35%), and 45–54 (26%), in contrast to those aged 35–44 (8%) and 25–34 (6%). These results may indicate a decrease in rates of high blood pressure/hypertension in the 35–44 age group (from 22% to 8%) since 2018. In 2018, respondents aged 75+, 65–74, 55–64, 45–54, and 35–44 were all more likely to report high blood pressure/hypertension (66%, 51%, 46%, 26%, and 22%, respectively) than those aged 25–34 (0%).

- Respondents from **households that make $35,000–$49,999** were more likely to report having high blood pressure/hypertension (46%) than other respondents. Those with household incomes of $150,000 or more were less likely than other respondents to report hypertension (8%). These results are similar to 2018 when 46% of respondents with the lowest household income reported hypertension (46% for incomes under $25,000 and 43% for incomes from $25,000 to $34,999).

- Respondents who are **obese** were more likely to report high blood pressure/hypertension (45%) than all respondents (31%), those who are not overweight or obese (16%), or those who are overweight (28%). This is similar to 2018 when the high blood pressure/hypertension rates were 47% for obese respondents, 27% for overweight respondents, and 16% for respondents who were not overweight or obese.

High cholesterol or triglycerides

Thirty-two percent of respondents reported that they have been told by a health care professional that they had high cholesterol or triglycerides. This is somewhat higher than in 2018 when 26% of respondents reported having high cholesterol/triglycerides.

Potential differences between population groups

- Eighteen percent of respondents in the convenience sample who took the survey **in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf** reported having been told by a health care professional that they had high cholesterol/ triglycerides, substantially less than the general population of adults 25+. In 2018, 17% of the convenience sample reported the same.

Asthma

Nine percent of respondents reported that they have been told by a healthcare professional that they have asthma. This is similar to 2018 when 8% of respondents reported having asthma.

Potential differences between population groups

- Twenty-two percent of respondents in the convenience sample who took the survey **in the GCHHS lobby, at the C.A.R.E. Clinic, or a food shelf** reported that they have been told by a

health care professionals they have asthma. Twenty-three percent of the convenience sample in 2018 reported the same.

Heart trouble or angina

Eight percent of respondents reported that they have been told by a healthcare professional that they have heart trouble or angina, which is similar to the rate reported in 2018 (10%) and similar to the 2021 convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf (9%).

Diabetes and pre-diabetes

Nine percent of respondents reported that they have been told by a healthcare professional that they have diabetes, which is similar to the rate reported in 2018 (8%). Twelve percent reported that they have been told they have pre-diabetes, which is the same as the rate in 2018.

Potential differences between population groups

- Adults with **household incomes from $100,000 to $149,999** were more likely to report having diabetes than other respondents. Over twice as many adults with that income level reported having diabetes (22%) than the general population of adults 25+. Respondents with household incomes under $35,000 reported the next highest rate of diabetes, at 14%. In 2018, the highest rate of diabetes was reported by those adults whose household income was below $25,000 (17%) or between $25,000 and $34,999 (21%).

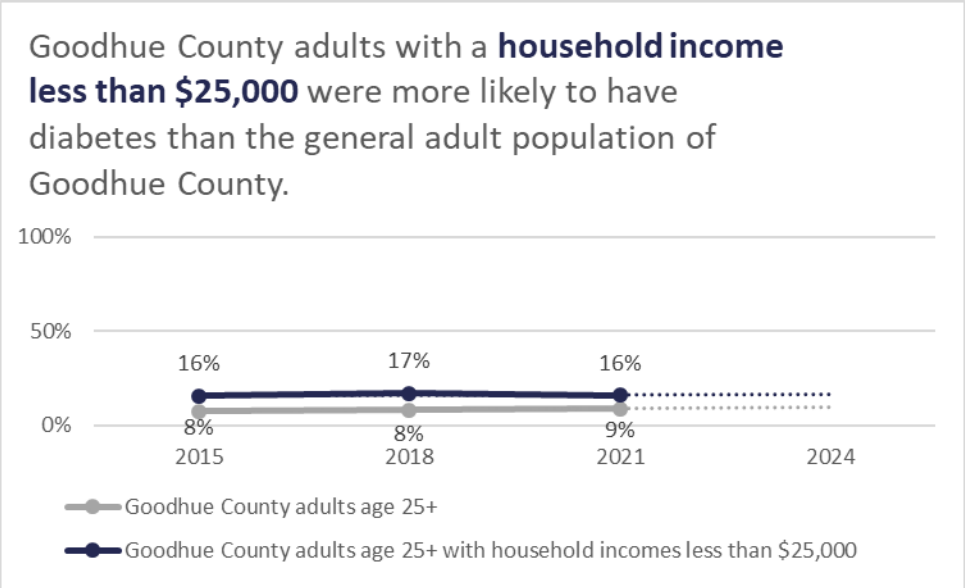


Figure 1. The diabetes rates for adults with a household income of less than $25,000 is a Community Health Objective in the 2018–2023 Goodhue County Community Health Improvement Plan, Priority 3: Engage Priority Populations.

Mental health

Any mental health problem

More than one in four respondents indicated a history of mental illness[2] in 2021 (30%), as well as in 2018 (28%).

Potential differences between population groups

- More than half of the respondents in the convenience sample who took the survey **in the GCHHS lobby, at the C.A.R.E. Clinic, or a food shelf** reported having a history of mental illness (53%). In 2018, the rate among respondents in the convenience sample was 56%.
- Forty-one percent of respondents with a **household income of less than $35,000** reported a history of mental illness, which is similar to the rate reported for respondents with a household income of $25,000 or less in 2018 (37%).

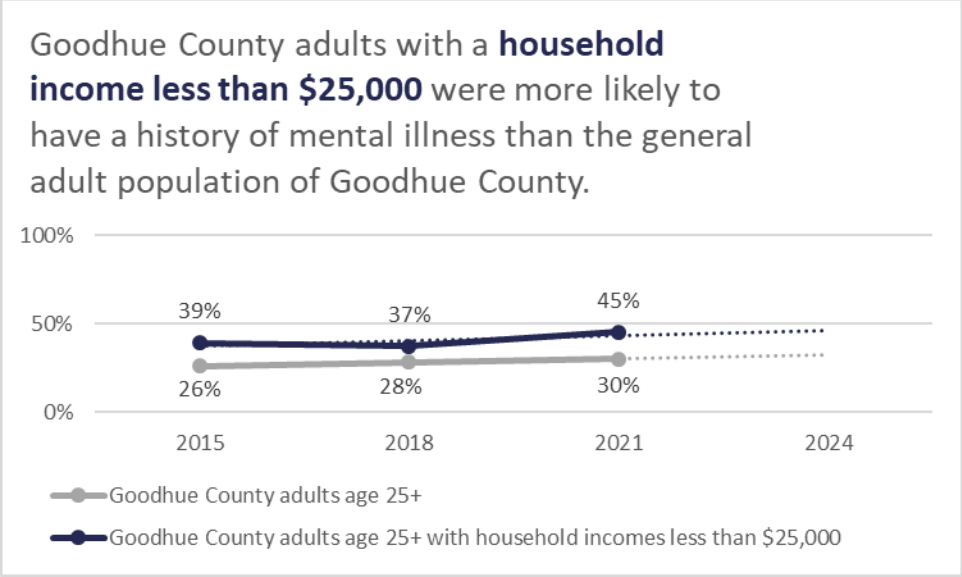


Figure 2. History of mental illness in adults is a Poverty-Related Disparity in the 2018–2023 Goodhue County Community Health Improvement Plan, Priority 1: Talk about the Impact of Poverty on Health.

- Respondents who report they always **get the social and emotional support they need**, and also those who report they never do, were less likely to have a history of mental illness (20% and 18%, respectively). Those who sometimes get the support they need were more likely to report a history of mental illness (47%).

[2] Respondents were categorized as having a history of mental illness if they reported that they had ever been told by a health care provider that they had depression, anxiety or panic attacks, or another mental health problem.

- Nearly half (47%) of respondents who **rent** rather than own their home reported a history of mental health problems.

Mentally unhealthy days

Forty-eight percent of respondents reported their mental health was not good on one or more days during the past 30 days, up from 40% in 2018. Among respondents in the convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf, 68% reported one or more mentally unhealthy days, a similar proportion as in 2018 (66%). Convenience sample respondents were much more likely to report their mental health was poor for all of the past 30 days (15%) compared to the general population of adults 25+ (4%).

Potential differences between population groups

- Adults with a **history of mental illness** were only slightly more likely to report any number of mentally unhealthy days, but they were much less likely to report having had zero mentally unhealthy days (34%) than those with no history of mental illness (61%).

- Similarly, respondents were more likely to report having 10–19 mentally unhealthy days when they also reported **getting the social and emotional support they need** only sometimes (21%), rarely (33%), or never (30%)—compared to 10% of respondents overall.

- Adults with a **household income between $75,000 and $99,999** were more likely to report one to nine mentally unhealthy days (48%) compared with the general population of adults 25+ (32%), and less likely to report zero days.

- Respondents generally reported similar numbers of mentally unhealthy days regardless of how much **moderate physical activity** they reported. Those reporting zero days of physical activity were the only group showing substantial difference versus the general population of adults 25+; they were less likely to report between one and nine mentally unhealthy days.

- Goodhue County adults age 25+ self-reported an average number of 3.8 mentally unhealthy days in the last 30 days which is similar to 2018. In contrast, respondents in the convenience sample who took the survey **in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf** reported 9.1 mentally unhealthy days on average.

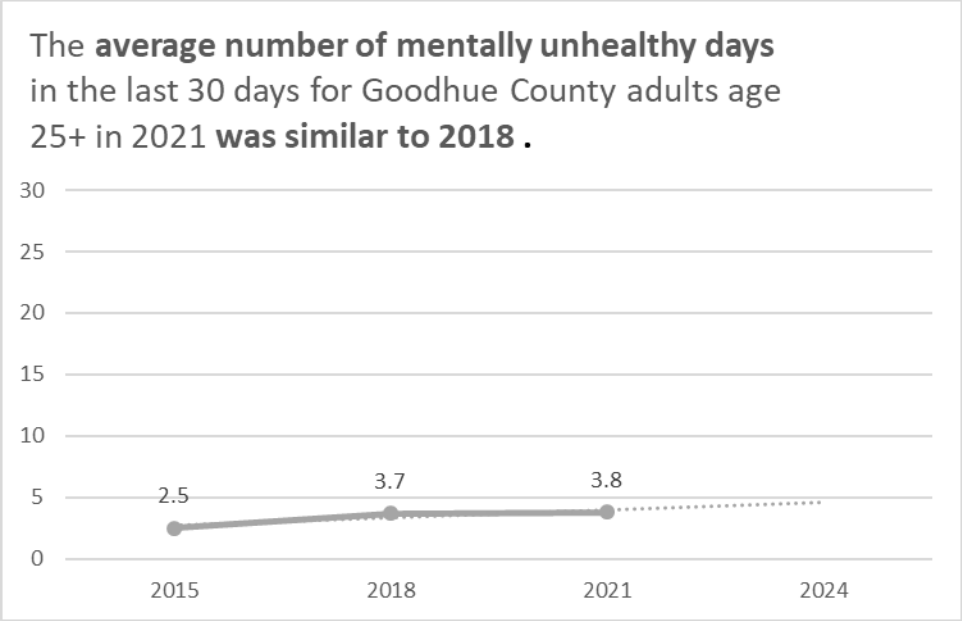


Figure 3. The average number of mentally unhealthy days for adults is a Community Health Objective in the 2018–2023 Goodhue County Community Health Improvement Plan, Priority 2: Reduce Barriers to Mental Health Care.

Depression

Twenty-four percent of respondents reported that they have been told by a healthcare professional that they had depression. This is similar to 20% of respondents in 2018.

Potential differences between population groups

- **Female** respondents were more likely to report depression (29%) than male respondents (19%). This was also true in 2018 when 25% of female respondents and 14% of male respondents reported depression.

- The prevalence of depression was highest among **respondents with household incomes less than $35,000** (38%), in contrast to those with household incomes from $50,000 to $74,999 (11%). Rates for respondents with household incomes of $35,000–$50,000 and above $75,000 were all similar to the general population of adults 25+ rate. This differs from 2018 when reported rates of depression were highest for respondents in households making less than $25,000 per year (33%) and decreased as household incomes increased.

- Respondents in the convenience sample who took the survey **in the GCHHS lobby, at C.A.R.E. Clinic, or at a food shelf** were almost twice as likely to report depression (47%) compared to the general population of adults 25+ (24%). Similarly, in 2018, 46% of the convenience sample but only 20% of the general population of adults 25+ reported depression.

- Respondents who are **obese** were more likely to report depression (31%) than those who are overweight (20%) and not overweight or obese (22%). Similarly, in 2018, 25% of respondents who were obese reported depression, but only 13% of those who were overweight and 19% of those who were not overweight or obese.

- Respondents who reported getting the **social and emotional support they need** only some of the time were more likely to report depression (40%).

- **Renters** were more likely to report depression (40%) than those respondents who own their homes (22%).

Anxiety or panic attacks

Twenty-one percent of respondents reported that they have been told by a healthcare professional that they had anxiety or panic attacks. This is slightly higher than 17% of respondents who reported the same in 2018.

Potential differences between population groups

- Respondents in the convenience sample who took the survey **in the GCHHS lobby, at C.A.R.E. Clinic, or at a food shelf** were much more likely to report anxiety or panic attacks (45%) than the general population of adults 25+ (21%). In 2018, 43% of respondents in the convenience sample reported having been told they had anxiety or panic attacks.

- Respondents with **household incomes under $35,000** were more likely to report anxiety or panic attacks (32%) than those at any other level of household income.

- **Females** were more likely to report anxiety or panic attacks (27%) than males (14%).

- Respondents who reported getting the **social and emotional support they need** only some of the time were more likely to report anxiety or panic attacks (37%) than those reporting any other levels of support.

- **Renters** were much more likely to report anxiety or panic attacks (43%) than those respondents who own their homes (18%).

Attitudes toward mental illness

In both 2018 and 2021, respondents were asked whether they **agreed or disagreed that people are generally caring and sympathetic to people with mental illness**. In 2021, 38% of respondents agreed or strongly agreed. Similarly, 42% of respondents with a history of mental illness agreed or strongly agreed in 2021. In comparison, 59% of respondents from the convenience sample who took the survey in the GCHHS lobby, at the C.A.R.E. Clinic, or a food shelf agreed or strongly agreed. All of these responses are similar to those in 2018.

Respondents were asked whether they **agreed or disagreed that they are more comfortable helping a person who has a physical illness than a person who has a mental illness** in both

2021 and 2018. Fifty-six percent of all 2021 respondents and 50% of respondents from the convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf agreed or strongly agreed. In contrast, only 43% of respondents with a history of mental illness agreed or strongly agreed. This may show a decrease in stigma among those with mental illness since 2018 when more respondents with mental illness agreed or strongly agreed (53%). However, this may show an increase in stigma among the convenience sample from 37% feeling more comfortable helping a person with a physical illness than a person who has a mental illness in 2018 to 50% in 2021.

Respondents were also asked whether they **agreed or disagreed that people with mental illness do not try hard enough to get better**. Responses across different groups may show a slight increase in stigma since 2018. Fourteen percent of all respondents agreed or strongly agreed, compared to 10% in 2018. Eleven percent of respondents with a history of mental illness agreed or strongly agreed, compared to 8% in 2018. And 18% of convenience sample respondents who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf agreed or strongly agreed, compared to 12% in 2018.

Access to care

Seeing a health professional for medical care

Sixty-six percent of respondents reported having a general health exam within the last year, which is about the same as in 2018. Four percent of respondents indicated that their last general health exam was five or more years ago, and 3% reported that they have never had a general health exam.

Twenty-one percent of respondents reported that in the past 12 months they delayed or did not get medical care when they thought they needed it, which is somewhat lower than in 2018 (28%). The most commonly reported reason for delaying getting medical care was respondents thinking the issue was not serious enough (32%), followed by the cost of care (30%). These were also the most common reasons in 2018 (52% and 37%, respectively).

Potential differences between population groups

- For respondents in the convenience sample who took the survey **in the GCHHS lobby, at C.A.R.E. Clinic, or at a food shelf** the most common reason for delaying medical care was thinking the issue was not serious enough (32%), followed by difficulty getting an appointment (21%). Compared to respondents in the general population of adults 25+, convenience sample respondents were more likely to report lack of insurance (13% versus 1%) and transportation issues (13% versus 4%) as reasons for delaying care, but less likely to report cost as a reason (13% versus 30%).

Seeing a health professional for mental health

Thirteen percent of respondents who wanted to talk with or seek help from a health professional about mental health issues reported delaying or not seeking care in the last 12 months. This was slightly higher than the rate in 2018 (9%). The most commonly reported reason for delaying or not getting mental health care was respondents thinking the issue was

not serious enough (38%), followed by other reasons (35%) and cost (31%). The percentage of respondents delaying or not seeking care because they felt too nervous or afraid decreased from 31% in 2018 to 16% in 2021, returning to the same value as in 2015. The 2021 survey also showed decreases in how many respondents reported not knowing where to go for care (4%, versus 18% in 2018) and mental health not being covered by insurance (4%, versus 17% in 2018). Insurance coverage decreased as an issue, from 30% reporting in 2018 that they delayed or did not seek help because it was not covered by insurance to 16% in 2021.

Potential differences between population groups

- Twenty-six percent of respondents in the convenience sample who took the survey **in the GCHHS lobby, at the C.A.R.E. Clinic, or a food shelf** reported delaying or not seeking mental health support in the last 12 months, which is similar to the 24% who reported the same in the convenience sample in 2018. The most common reason for delaying or not seeking care among convenience sample respondents was being too nervous or afraid (31%), followed by not knowing where to go and being unable to get an appointment (25% each). More convenience sample respondents reported feeling nervous or afraid in 2021 than in 2018 (15%), and fewer reported thinking the issue was not serious enough (9% in 2021 versus 19% in 2018).

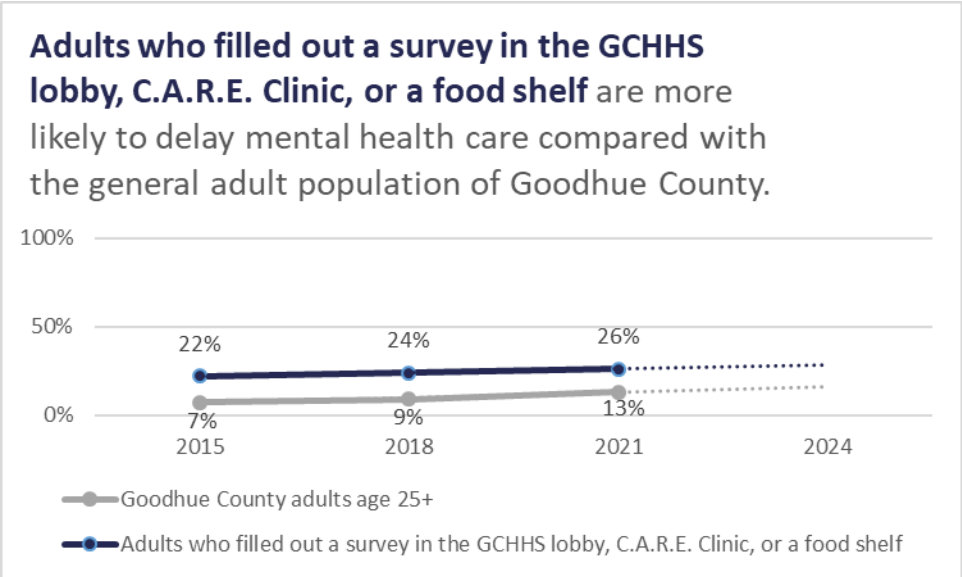


Figure 4. The percentage of adults who delayed mental health care is a Community Health Objective in the 2018–2023 Goodhue County Community Health Improvement Plan, Priority 2: Reduce Barriers to Mental Health Care

COVID-19 vaccination

Eighty-nine percent of respondents reported receiving a COVID-19 vaccination at any point in the past.

Potential differences between population groups

- Only 36% of convenience sample respondents, who took the survey **in the GCHHS lobby, at the C.A.R.E. Clinic, or at a food shelf**, reported getting a COVID-19 vaccine.

- Respondents with a **household income below $35,000** were least likely to report vaccination (75%), and those with incomes above $150,000 were most likely (100%).

Food security

Concerns about running out of food

Nine percent of respondents indicated that during the past 12 months they "often" or "sometimes" worried that their food would run out before they had money to buy more, which is slightly higher than the 6% of respondents who did so in 2018.

Potential differences between population groups

- Respondents whose **household income is less than $35,000** were more likely to report that they "often" or "sometimes" worried that their food would run out before they had money to buy more (24%), followed by those whose household income is between $35,000 and $49,999 (16%).

- Respondents in the convenience sample who took the survey **in the GCHHS lobby, at C.A.R.E. Clinic, or at a food shelf** were much more likely than the general population of adults 25+ to report that they "often" or "sometimes" worried that their food would run out before they had money to buy more in both 2021 (62%) and 2018 (67%).

- The vast majority of **obese** respondents (89%) did not indicate food insecurity. The obesity rate among those who "never" worried about running out of food was similar to the general population of adults 25+ obesity rate in 2021 (35%) and 2018 (36%). Very few respondents indicated they "often" worried about food security in 2021. However, a majority of the small percentage of respondents who reported "often" or "sometimes" had concerns about running out of food were obese (57%). This is similar to 2018, when the obesity rate for respondents who "often" or "sometimes" worried that their food would run out was 62%, compared to an obesity rate among the general population of adults 25+ of 36%.

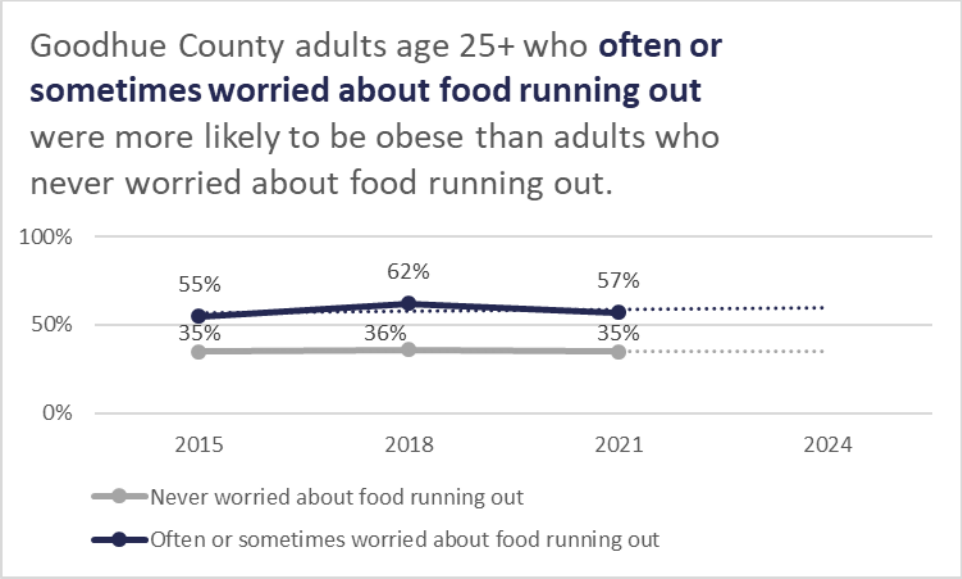


Figure 5. The obesity rate for adults who worry about food running out is a Poverty-Related Disparity in the 2018–2023 Goodhue County Community Health Improvement Plan, Priority 1: Talk about the Impact of Poverty on Health.

- Some **older** respondents were less likely to report that they "often" or "sometimes" worried that their food would run out before they had money to buy more. Six percent of respondents aged 65–74 indicated those worries, although no respondent aged 75+ did so.

- Respondents who are **renters** were much more likely than homeowners to report "often" or "sometimes" worrying that their food would run out. While only 5% of homeowners indicated those worries, 40% of renters did so.

- Respondents with a **history of mental health problems** reported they "often" or "sometimes" worried that their food would run out (17%), much more often than those with no mental health problems (5%).

Use of community food shelves

Four percent of respondents indicated that during the past 12 months they had used a community food shelf at least once. This is a similar response to 2018 when 3% reported food shelf use.

Potential differences between population groups

- Respondents in the convenience sample who took the survey **in the GCHHS lobby, at the C.A.R.E. Clinic, or a food shelf** were much more likely than the general population of adults 25+ to report food shelf use in the past 12 months in both 2021 (61%) and 2018 (66%). Note that this finding is likely affected by the data collection sites for the

convenience sample—nearly half of convenience sample surveys were completed at food shelves—and so may not be comparable to the general population of adults 25+.

Eating habits

Fruit and vegetable consumption

Thirty-eight percent of respondents reported eating five or more servings of fruits and vegetables (including juices) the prior day. About the same number (37%) reported eating between three and four servings, and 23% reported eating between one and two servings. Two percent reported eating zero servings. In 2018, 34% of respondents reported eating five or more servings the prior day and 34% reported eating between three and four.

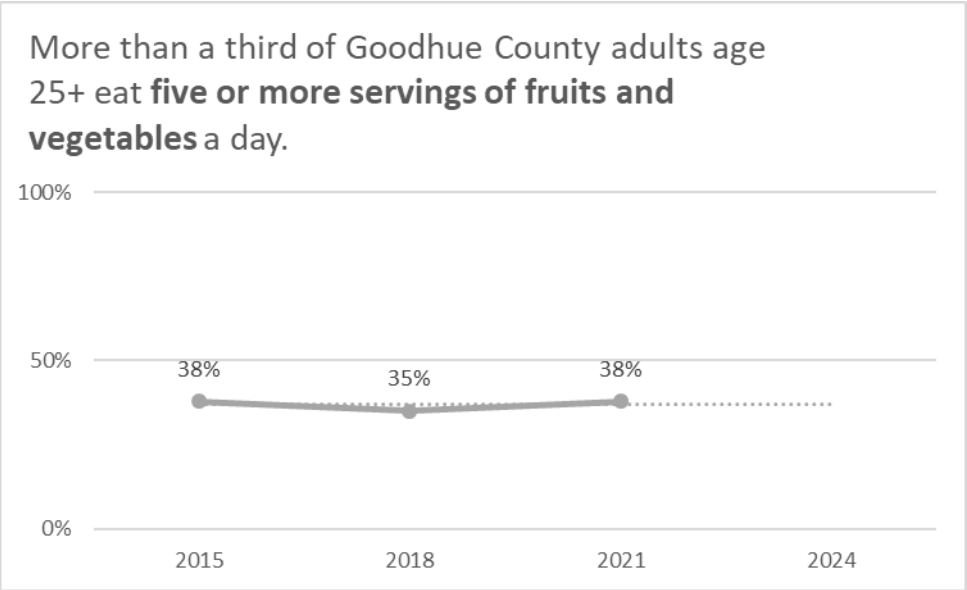


Figure 6. Adult fruit and vegetable consumption is a Community Health Objective in the 2018–2023 Goodhue County Community Health Improvement Plan, Priority 3: Engage Priority Populations.

Potential differences between population groups

- Respondents in the convenience sample who took the survey **in the GCHHS lobby, at C.A.R.E. Clinic, or at a food shelf** reported slightly higher rates of eating at least five servings of fruits and vegetables the prior day (41%) but lower rates of eating three to four servings a day (21%) than the general population of adults 25+ of Goodhue County. However, convenience sample respondents were more likely to report they ate zero servings of fruits and vegetables yesterday (13%), compared to 2% in the general population of adults 25+.

- Respondents **aged 65–74** were less likely to report eating at least five servings of fruits and vegetables the prior day (28%). This group was also slightly more likely to report eating zero servings of fruits and vegetables (7%, versus 2% overall).

- **As income increases, fruit and vegetable consumption increases.** Overall, 76% of respondents reported at least three or more servings per day. Fewer of those with household incomes of less than $35,000 (61%) or $35,000–$49,999 (68%) reported three or more servings per day. More respondents with household incomes of $75,000–$99,999 (80%), $100,000–$149,999 (78%), and $150,000 or more (81%) reported eating three or more servings per day.

Eating a home-cooked meal

Over 98 percent of respondents reported eating a home-cooked meal at least once in a typical week. Almost half reported eating a home-cooked meal seven or more times a week (45%). This was similar to 2018 when 99% of respondents reported eating a home-cooked meal at least once in a typical week, and 48% of respondents reported doing so seven or more times a week. Respondents in the convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf reported similar rates of eating home-cooked meals.

Potential differences between population groups

- Respondents aged **55–64** were the most likely (65%) to report eating a home-cooked meal seven or more times in a typical week, followed by respondents aged 65–74 (47%), respondents aged 35–44 (44%), and respondents aged both 25–34 (42%). In 2018, respondents aged 25–34 were the most likely (59%) to report eating a home-cooked meal seven or more times in a typical week. The rate increased for respondents aged 55–64 (46% to 65%) but decreased for those aged 25–34 (59% to 42%), 45–54 (42% to 29%), and 75 or older (53% to 39%) from 2018 to 2021.

Visiting a farmer's market

Respondents were asked how frequently they visit a farmer's market or fruit and vegetable stand during the growing season. A similar proportion of respondents visit at least once per month from the general population of adults 25+ (60%) and from the convenience sample who took the survey in the GCHHS lobby, at the C.A.R.E. Clinic, or a food shelf (56%). However, respondents from the general population sample were more likely to visit at least once per week (22%) versus the convenience sample (13%).

In 2018, respondents from the general adult population were more likely to have visited a farmer's market at least once per month (73%), and about as likely to have visited weekly (24%). Responses from the 2018 convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf were similar to those in 2021.

Consuming sugary drinks

Respondents were asked how frequently they consume a variety of different sugary drinks. In

general, rates of daily consumption are low. Respondents in the convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf were less likely than those in the general population of adults 25+ to report never consuming sugary drinks.

Fruit drinks

Three percent of respondents in the general population of adults 25+ and 8% in the convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf reported daily consumption of fruit drinks. The rate for the general population in 2018 was the same, but for the convenience sa,mple was somewhat higher (15%).

More than three-quarters (78%) of the general population reported never consuming these drinks, versus 56% in the convenience sample. Respondents in the 2018 convenience sample were somewhat less likely to report never consuming fruit drinks (46%), while the 2018 general population respondents were similar to 2018.

In 2021, respondents with household incomes below $35,000 were less likely to report never consuming fruit drinks (67%), and more likely to report drinking them two to four times per week (25%, versus 11% for the general population of adults 25+ overall).

Sports drinks

One percent of respondents in the general population of adults 25+ and 6% in the convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf reported daily consumption of sports drinks. Rates were similar for both groups in 2018.

Seventy-six percent of the general population reported never consuming these drinks, versus 60% in the convenience sample. The rate was somewhat higher for the 2018 general adult population 25+ (81%) and similar to 2021 in the 2018 convenience sample.

Respondents in 2021 with household incomes below $35,000 were less likely to report consuming sports drinks once per week than the overall sample (5% versus 16%), and more likely to report drinking them five to six times per week (18% versus 3%).

Regular soda or pop

Thirteen percent of respondents in the general population of adults 25+ and 25% of the convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf reported daily consumption of regular soda or pop. These rates are the same as in 2018.

Almost half (48%) of the general population reported never consuming these drinks, versus 26% in the convenience sample. This is slightly lower than in 2018 for the general population (54%) and similar to 2018 for the convenience sample (27%).

Respondents to the 2021 survey who had household incomes below $35,000 were less likely to report never consuming regular soda or pop (37%) and more likely to report drinking them five to six times per week (26% versus 5%). Respondents with household incomes over $150,000 were more likely to report never drinking regular soda or pop (69%). Although responses to this item had the most variation in terms of income of all the sugary drink responses, that variation did not indicate a consistent pattern.

Energy drinks

Four percent of respondents in the general population of adults 25+ and 3% in the convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf reported daily consumption of energy drinks. Rates were similar for both groups in 2018.

The vast majority (88%) of the general population reported never consuming these drinks, versus 78% in the convenience sample. These rates are somewhat lower than in 2018 for both the general population (94%) and the convenience sample (85%).

Respondents in 2021 with household incomes below $35,000 were more likely to report consuming energy drinks five to six times per week (14% versus 3%). Those with incomes from $75,000 to $99,999 were more likely to report drinking them once per week (16% versus 4%).

Attitudes about fruits and vegetables

Cost of fruits and vegetables

Survey respondents were asked whether they viewed the cost of fruits and vegetables where they usually shop (i.e., whether they are too expensive) as a "big problem," a "small problem," or "not a problem." Thirty percent of respondents described the cost as either a big problem or a small problem. Respondents from the convenience sample, who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf, were much more likely to say the expense of fruits and vegetables was a problem (65%).

Difficulty in preparing fruits and vegetables

Survey respondents were asked whether they viewed the difficulty of preparing fruits and vegetables as a "big problem," a "small problem," or "not a problem." Seventeen percent of respondents described this difficulty as either a big problem or a small problem. Respondents from the convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf were more likely to say the difficulty of preparing fruits and vegetables was a problem (29%).

Physical activity

Moderate physical activity

Almost 90% of respondents reported that they get at least 30 minutes of moderate physical activity (i.e., activities that cause only light sweating and a small increase in breathing or heart rate) at least once in a typical week. Fifty-nine percent reported getting at least 30 minutes of moderate physical activity between one and four days a week, and 30% reported getting at least 30 minutes between five and seven days a week. These rates were similar to 2018.

Potential differences between population groups

- Respondents aged **25–34** were more likely than other age groups to report getting at least 30 minutes of moderate physical activity five or more days a week (44%). Respondents aged 35–44 and 45–54 were the least likely (21% each). These percentages are similar to 2018.

- Respondents whose **household income is between $50,000 and $74,999** were the most likely to report getting at least 30 minutes of moderate physical activity five or more days a week (47%) compared to those at other income levels, with those making between $35,000 and $49,999 the least likely to report the same (20%). In 2018, respondents whose household income was between $35,000 and $49,999 were the most likely to report that they do not get at least 30 minutes of moderate physical activity at all—zero days—in a typical week (20%). In 2021, respondents with household incomes below $35,000 were most likely to report zero days of activity (22%).

- Respondents who are **not overweight** were the most likely to report getting at least 30 minutes of moderate physical activity five or more days a week (46%), compared to 25% of overweight respondents and 21% of obese respondents. Respondents who are not overweight were also the least likely to report not getting at least 30 minutes of moderate physical activity at all during a typical week (2%), compared to 7% of overweight respondents and 23% of obese respondents. In 2018, respondents who were not overweight were the most likely to report not getting at least 30 minutes of moderate physical activity at all during a typical week (14%), slightly more than overweight (10%) and obese (11%) respondents.

- Respondents with a **history of mental health problems** were less likely to report five or more days of moderate physical activity per week (20%) compared to the general population of adults 25+ (30%).

- Respondents who sometimes or rarely **get the social or emotional support they need** were also less likely to report five or more days of moderate physical activity per week (19% and 17%, respectively) compared to the general population of adults 25+ (30%). Those who rarely get the support they need were the most likely to report zero days of moderate physical activity (26%) compared to the general population of adults 25+ (11%).

Vigorous physical activity

Twenty-nine percent of respondents reported that they get at least 20 minutes of vigorous physical activity (i.e., activities that cause heavy sweating and a large increase in breathing or heart rate) at least three days a week, while 30% reported getting one to two days and 41% reported not getting at least 20 minutes of vigorous activity at all in a typical week. These rates were similar to 2018.

Potential differences between population groups

- Respondents aged **25–34** were the most likely to report getting at least 20 minutes of vigorous physical activity three or more days in a typical week (57%), followed closely by those aged 35–44 (35%). In 2018, respondents aged 25–34 were less likely to report getting at least 20 minutes of vigorous physical activity three or more days in a typical week, but

still the most likely group (40%). Respondents aged **75 or older** were the least likely to report getting at least 20 minutes of vigorous physical activity three or more days in a typical week (12%) and were the most likely to report not getting any vigorous physical activity (74%). Respondents aged 75 or older were much more likely to report not getting any vigorous activity in a typical week in 2021 than in 2018 (58%).

- Respondents whose **household income is between $50,000 and $74,999** were the most likely to report getting at least 20 minutes of vigorous physical activity three or more days a week (43%) compared to those at other income levels, with those making between $35,000 and $49,999 the least likely to report the same (16%). Respondents whose household income is less than $35,000 were the most likely to report that they did not get at least 20 minutes of vigorous physical activity at all during a typical week (64%).

- Respondents who are **overweight but not obese** were the most likely to report getting at least 20 minutes of vigorous physical activity at least three days a week (41%), compared to 27% of respondents who are not overweight and 21% of respondents who are obese. Respondents who are obese were the most likely to report zero days of 20 minutes of vigorous physical activity in a typical week (50%), which is slightly higher than the rate for obese respondents in 2018 (45%).

- Respondents with a **history of mental health problems** were less likely to report three or more days of vigorous physical activity per week (19%) and more likely to report zero days (55%).

- Respondents who sometimes or rarely **get the social or emotional support they need** were less likely to report three or more days of vigorous physical activity per week (14% and 18%, respectively) and more likely to report zero days (54% and 59%).

Factors preventing physical activity

Respondents were asked whether different factors prevented them from being more physically active. Respondents rated the different factors as a "big problem," a "small problem," or "not a problem."

Twenty-two percent of respondents said that **lack of time** is a big problem preventing them from being more active, the same percentage as **lack of self-discipline or willpower**. The **cost** of fitness programs, gym memberships, or admission fees was another commonly indicated problem (19%). **Fear of injury** (4%) and not having a **safe place to exercise** (2%) were the factors least likely to be identified as a big problem. These responses are similar to those from 2018.

Potential differences between population groups

- The cost was most likely to be selected as a big problem preventing them from being more active (39%) by respondents in the convenience sample who took the survey **in the GCHHS**

lobby, at C.A.R.E. Clinic, or a food shelf. The convenience sample was more likely to say cost is a big problem than those in the general population of adults 25+. Those in the convenience sample (20%) were also more likely than the general population of adults 25+ (10%) to say that long-term illness, injury, or disability was a big problem. Those in the convenience sample were somewhat less likely (13%) than the general population of adults 25+ (22%) to say that lack of time was a big problem.

- **Younger respondents** were more likely to say that lack of time is a big problem preventing them from being more physically active. Forty-seven percent of respondents aged 35–44 said lack of time is a big problem, compared to 6% of respondents aged 65–74 and 6% of those aged 75+.

- Respondents with **higher household incomes** were more likely to say that lack of time is a big problem preventing them from being more physically active. Thirty-three percent of respondents whose household income is $150,000 or higher said lack of time is a big problem.

- Respondents with **lower household incomes** were more likely to say that illness, injury, or disability is a big problem preventing them from being more physically active. Almost a quarter (24%) of respondents whose household income is below $35,000 said illness, injury, or disability is a big problem.

- Respondents who are **obese** were the most likely to say that illness, injury, or disability is a big problem preventing them from being more physically active (19%), compared to respondents who are overweight (7%), and those who are not obese or overweight (2%).

- While 7% of the general population of adults 25+ said that not having someone to exercise with is a big problem preventing them from being more physically active, 17% of respondents whose **household income is between $100,000 and $149,999** said that not having anyone to exercise with is a big problem.

- Respondents who sometimes **get the social or emotional support they need** were more likely to cite lack of time (42%), cost (31%), and having no one to exercise with (20%, versus 7% overall) as big problems.

Tobacco use

Any tobacco use

Twenty percent of respondents reported that they currently use some sort of tobacco product, which is slightly higher than the rate in 2018 (17%).

Potential differences between population groups

- Nearly half (46%) of the respondents in the convenience sample who took the survey **in the GCHHS lobby, at the C.A.R.E. Clinic, at a food shelf** reported that they currently use tobacco. The rate for the convenience sample in 2018 was 50%.

- Most respondents were similarly likely to report current tobacco use regardless of household income level. Only those whose **household income is greater than $150,000** were the exception; none of those respondents are current tobacco users. This differs from 2018 when those whose household income was less than $25,000 or between $25,000 and $34,999 were most likely to report being a current tobacco product user (30% and 29%, respectively).

Smoking

Eleven percent of respondents reported that they are a current cigarette smoker, similar to 7% in 2018. Sixty-three percent reported that they have never been a cigarette smoker.

Among current cigarette smokers, a much smaller percentage reported having tried to quit smoking within the past 12 months in 2021 than in 2018 (36% versus 57%).

Potential differences between population groups

- Thirty-six percent of the respondents in the convenience sample who took the survey **in the GCHHS lobby, at C.A.R.E. Clinic, or a food shelf** reported that they currently smoke cigarettes, which is more than the general population of adults 25+ but less than the rate for the convenience sample in 2018 (48%). Among those in the convenience sample who reported they currently smoke cigarettes, 50% reported having tried to quit in the last 12 months, compared to 71% in the 2018 convenience sample.

- Respondents whose **household income is less than $35,000** and those whose household income is between **$35,000 and $49,999** were the most likely to report being a current cigarette smoker (26% and 23%, respectively). No respondents whose household income is greater than $150,000 reported being a current cigarette smoker, and this group was most likely to report having never been a smoker (86%).

- **Older respondents** were slightly more likely to be former smokers (39% of those aged 65–74 and 37% of those aged 75 or older). Respondents aged 25–24 (15%) and aged 45–54 (16%) were least likely to be former smokers.

- Respondents who are **renters** were much more likely than homeowners to report being current smokers (40% versus 8%) and were less likely than homeowners to have never smoked (43% versus 65%).

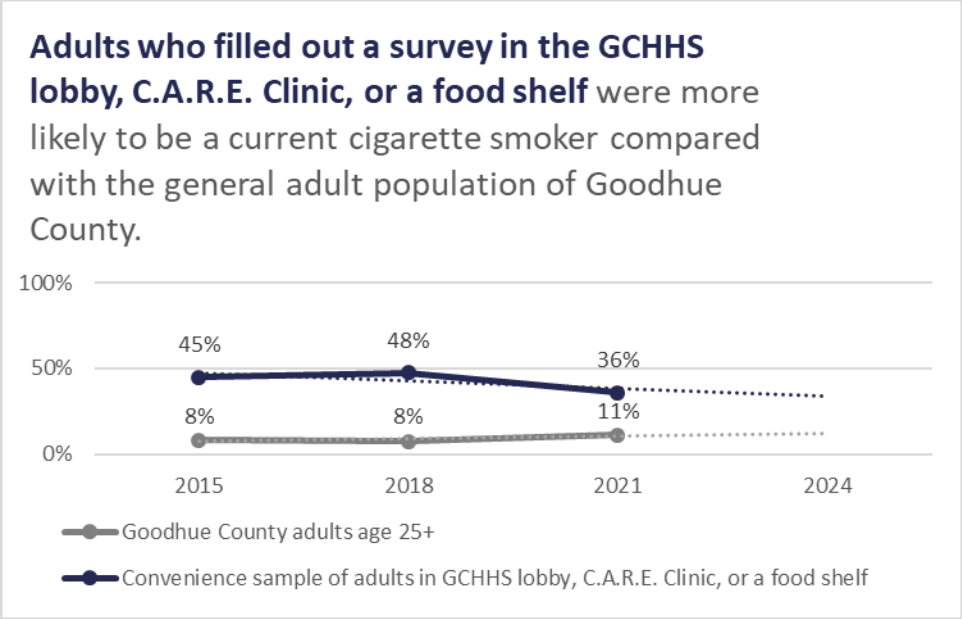


Figure 7. The adult smoking rate is a Poverty-Related Disparity in the 2018–2023 Goodhue County Community Health Improvement Plan, Priority 1: Talk about the Impact of Poverty on Health.

E-cigarettes, vaping, and JUUL

Two percent of respondents reported being a current user of e-cigarettes, including vaping pens, JUUL, or similar. This is the same as in 2018. Note, in both years the survey only had adult respondents ages 25 years and older. There were not enough responses from ages 18 to 24 to monitor rates of e-cigarette, vaping, and JUUL use for young adults.

In 2021, respondents who reported using e-cigarettes were also asked if they used tobacco at the time they first used an e-cigarette. Seventy-three percent of the general population of adults 25+ respondents reported they were, while 88% of the convenience sample who took the survey in the GCHHS lobby, at C.A.R.E. Clinic, at a food shelf did so.

Potential differences between population groups

- Fourteen percent of the respondents in the convenience sample who took the survey **in the GCHHS lobby, at C.A.R.E. Clinic, or at a food shelf** reported that they currently use e-cigarettes which is similar to the rate for the convenience sample in 2018 (15%) and higher than the general adult population age 25+ (2%).

Alcohol use

Heavy drinking

Fifteen percent of respondents reported heavy drinking in the past 30 days (i.e., 60 or more drinks for males and 30 or more drinks for females). This is somewhat higher than the 2018 rate

(10%).

Potential differences between population groups

- Respondents from the convenience sample who took the survey **in the GCHHS lobby, at C.A.R.E. Clinic, or at a food shelf** were somewhat less likely to report heavy drinking in the past 30 days (7%).

Binge drinking

Thirty-four percent of respondents reported binge drinking in the past 30 days (i.e., five or more drinks in a day for males and four or more drinks in a day for females). This is up somewhat from 26% in 2018.

Potential differences between population groups

- Respondents from the convenience sample who took the survey **in the GCHHS lobby, at C.A.R.E. Clinic, or at a food shelf** were less likely to report binge drinking in the past 30 days (22%).

- **Male** respondents were somewhat more likely to report binge drinking in the past 30 days (37%) than female respondents (31%). The rate of reported binge drinking for female respondents increased by more than ten percentage points from 2018 to 2021 (20% to 31%).

- **Respondents who are not overweight or obese** were the most likely to report binge drinking in the past 30 days (41%), a substantial increase from 2018 (12%).

Driving behaviors

Distracted driving

Among respondents who drive, only 1% of respondents reported that they "often" read or send texts while driving, which is the same rate reported in 2018. Twenty-nine percent of respondents reported "sometimes" reading or sending texts while driving, which is somewhat lower than in 2018 (34%).

Ten percent of respondents reported that they "often" make or answer phone calls while driving, which is slightly less than in 2018 (15%). Sixty-three percent of respondents reported "sometimes" making or answering phone calls, which is slightly higher than in 2018 (58%).

Potential differences between population groups

- Respondents aged **25–34**, **35–44, and 45–54** were all more likely to report "sometimes" reading or sending texts while driving (42%, 42%, and 44%, respectively). This differs from 2018 when 61% of respondents aged 25–34 reported "sometimes" reading or sending texts, while other age brackets did so at rates below 40%. Only 3% of respondents aged 75

or older reported “sometimes” reading or sending texts while driving.

- Respondents in the convenience sample who took the survey **in the GCHHS lobby, at C.A.R.E. Clinic, or at a food shelf** were more likely to report never reading or sending texts while driving (78%) and less likely to report doing so “sometimes” (19%). The same is true of responses about making or answering phone calls while driving: convenience sample respondents reported doing so “sometimes” much less often (39% versus 63%), and never doing so much more often (52% versus 26%).

Seatbelt use

Ninety-two percent of respondents indicated that they “always” wear a seatbelt when driving or riding in a vehicle, which is the same as in 2018. Only 1% of respondents in both 2021 and 2018 reported that they “never” wear a seatbelt when driving or riding in a vehicle.

Home safety

Radon testing

In 2021, respondents were asked whether their household air has ever been tested for the presence of radon. Thirty-nine percent of respondents indicated their home has been tested for radon.

Potential differences between population groups

- Respondents in the convenience sample who took the survey **in the GCHHS lobby, at C.A.R.E. Clinic, or at a food shelf** were less likely to report radon testing (10%).
- Respondents with **household incomes under $35,000 or between $35,000 and $49,999** were less likely to report radon testing (17% and 26%, respectively). Those with household incomes above $150,000 were most likely to report radon testing (64%).
- Respondents who are **renters** were much less likely to report home radon testing (3%) than homeowners (44%).

Appendix B

September 2021

Dear Southeastern Minnesota Resident:

This is your opportunity to help improve the health of your community!

Freeborn, Mower, and Goodhue Counties, in partnership with Mayo Clinic Health System, are conducting the 2021 Community Health Needs Assessment Survey. Your household has been randomly selected to participate.

This survey helps us gather information to complete an in-depth assessment of our community's health and determine how to direct resources in the future. This information is used by many organizations including local counties and Mayo Clinic Health System to design programs to support community health and wellness.

Participation in this survey is completely voluntary. All answers to the questions are strictly confidential and no identifying information will be linked to any of the responses. We do track which surveys have been completed through the identifying number on each survey. This allows us to remove addresses from the mailing list for reminder notices once we receive the completed survey.

Only a limited number of randomly selected addresses are receiving this mailing. The study will be more meaningful if someone from your household completes the survey and mails it back. To get a mix of the population, **please give the survey to the ADULT (age 18 or older) in your household who has most recently had a birthday.** Please complete the enclosed survey form and return it in the postage-paid envelope provided.

By completing this survey, your household will make a valuable contribution to improving the health of people living in your community. If you have any questions, please contact Sue Yost – Freeborn County (507-377-5273), Megan Roschen – Goodhue County (651-385-6140), Chris Weis – Mower County (507-437-9701), or Ilaya Hopkins – Mayo Clinic (507-266-4536).

Thank you very much for your participation.

Sincerely,

Sue Yost
Public Health Director
Freeborn County
Public Health

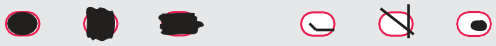
Nina Arneson
Director
Goodhue County
Health and Human Services

Crystal Peterson
Director
Mower County
Health and Human Services

Robert Albright Jr. D.O.
Regional Vice President
Mayo Clinic Health System
Southeast Minnesota

2021 Community Health Needs Assessment Survey

SURVEY INSTRUCTIONS



Correct marks Incorrect marks

- Please use #2 pencil or blue or black pen to complete this survey.
- Do not use red pencil or ink.
- Do not use X's or check marks to indicate your responses.
- Fill response ovals completely with heavy, dark marks.

Please give this survey to the adult (age 18 or over) in the household who has most recently had a birthday.

1. In general, would you say that your health is:

Excellent ○ Very good ○ Good ○ Fair ○ Poor ○

2. Have you ever been told by a doctor or other health care professional that you had any of the following health conditions?

	No	Yes	Yes, but only during pregnancy
a. High blood pressure/hypertension	○	○	
b. Pre-hypertension	○	○	○
c. Diabetes	○	○	
d. Pre-diabetes	○	○	○
e. Overweight	○	○	
f. Cancer	○	○	
g. Chronic lung disease (including COPD, chronic bronchitis or emphysema)	○	○	
h. Heart trouble or angina	○	○	
i. Stroke or stroke-related health problems	○	○	
j. High cholesterol or triglycerides	○	○	
k. Arthritis	○	○	
l. Depression	○	○	
m. Anxiety or panic attacks	○	○	
n. Other mental health problems	○	○	
o. Obesity			
p. Asthma			
q. COVID-19			

3. What kind of place do you usually go to when you are sick or need advice about your health?

- ○ A doctor's office
- ○ A clinic
- ○ A free clinic
- ○ A tribal clinic
- ○ Some other health center
- ○ An emergency room
- ○ An urgent care clinic
- ○ Schedule telehealth or virtual visit
- ○ No usual place
- ○ Some other place _____

	Within 1 year	Within 2 years	Within 5 years	Five or years ago	Never
a. … a flu shot?	○	○	○	○	○
b. … a dental exam or your teeth cleaned?	○	○	○	○	○
c. … a hearing test?	○	○	○	○	○
d. … an eye exam?	○	○	○	○	○
e. … your blood pressure checked?	○	○	○	○	○
f. … your blood cholesterol checked?	○	○	○	○	○
g. … your blood sugar checked?	○	○	○	○	○
h. … any screening for skin cancer?	○	○	○	○	○
i. … any screening for colon cancer? *Examples are fecal occult blood test, proctoscopic exam, sigmoidoscopy, colonoscopy or barium enema*	○	○	○	○	○
j. … COVID-19 vaccine	○	○	○	○	○
k. … a prostate exam (men only)?	○	○	○	○	○
l. … a Pap test (women only)?	○	○	○	○	○
m. … a mammogram (women only)?	○	○	○	○	○
n. … a general health exam?	○	○	○	○	○

5. Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

Write the number in the boxes, then fill in the appropriate circle beneath each box.

days

6. During the past 12 months, was there a time when you thought you needed medical care but did not get it or delayed getting it?

○ Yes ○ No ▶ **IF NO, GO TO QUESTION 8**

7. Why did you not get or delay getting the medical care you thought you needed? *(Mark ALL that apply)*

- ○ I could not get an appointment
- ○ I had transportation problems I
- ○ was too nervous or afraid
- ○ I did not think it was serious enough
- ○ It cost too much
- ○ I did not have insurance
- ○ My insurance did not cover it
- ○ I could not take time off from work
- ○ I had family obligations
- ○ I did not know where to go
- ○ My clinic was closed due to COVID-19
- ○ I was in isolation or quarantine due to COVID-19
- ○ Other reason_____

8. During the past 12 months, was there a time when you thought you needed dental care but did not get it or delayed getting it?

○ Yes ○ No ▶ **IF NO, GO TO QUESTION 10**

9. Why did you not get or delay getting the dental care you thought you needed?*(Mark ALL that apply)*

- ○ I could not get an appointment
- ○ I had transportation problems I
- ○ was too nervous or afraid
- ○ It cost too much
- ○ I did not have insurance
- ○ The dentist wouldn't accept my insurance
- ○ I did not know where to go
- ○ I could not take time off from work
- ○ I had family obligations
- ○ My clinic was closed due to COVID-19
- ○ I was in isolation or quarantine due to COVID-19
- ○ Other reason_____

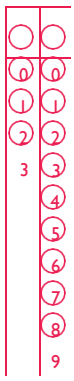
10. In the past 12 months, have you experienced feelings of hopelessness, anxiety or loss of interest in things you used to enjoy?

○ Yes ○ No

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

Write the number in the boxes, then fill in the appropriate circle beneath each box.

days



12. During the past 12 months, was there a time when you wanted to talk with or seek help from a health professional about mental health issues, but did not go, or delayed talking with someone?

○ Yes ○ No ▶ **IF NO, GO TO QUESTION 14**

13. Why did you not get or delay getting the mental health care you thought you needed? *(Mark ALL that apply)*

- ○ I could not get an appointment
- ○ I had transportation problems
- ○ I was too nervous or afraid
- ○ I did not think it was serious enough
- ○ It cost too much
- ○ I did not have insurance
- ○ My insurance did not cover it
- ○ I did not know where to go
- ○ I could not take time off from work
- ○ I had family obligations
- ○ My clinic was closed due to COVID-19
- ○ I was in isolation or quarantine due to COVID-19
- ○ Other reason_____

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

0 1 2 3 4 5 6 7 8 9 10 11 12+ **servings**

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

0 1 2 3 4 5 6 7 8 9 10 11 12+ **servings**

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

0 1 2 3 4 5 6 7 8 9 10 11 12+ **servings**

17. How often did you drink the following beverages in the past week?

	Never or less than 1 time per week	1 time per week	2-4 times per week	5-6 times per week	1 time per day	2-3 times per day	4 or more times per day
a. Fruit drinks (such as Snapple, flavored teas, Capri Sun, and Kool-Aid)	○	○	○	○	○	○	○
b. Sports drinks (such as Gatorade; PowerAde); these drinks usually do not have caffeine.	○	○	○	○	○	○	○
c. Regular soda or pop (include all kinds such as Coke, Pepsi, 7-Up, Sprite, root beer)	○	○	○	○	○	○	○
d. Energy drinks (such as Rockstar, Red Bull, Monster, and Full Throttle); these drinks ○ usually have caffeine	○	○	○	○	○		○

18. In an average week, how many times do you do the following?

	0	1-2	3-4	5-6	7 or more
a. Eat at or get food from a fast food place (McDonald's, KFC, Taco Bell, pizza places, etc.)	○	○	○	○	○
b. Eat at or get food from a restaurant that is not a fast food place	○	○	○	○	○
c. Eat a home-cooked meal					

19. During the growing season, how often do you or others in your household buy or get food from a Farmer's market or a fruit/vegetable stand?

Never or less than one time per month	About one time per month	About two or three times per month	About one time per week	Two or more times per week
○	○	○	○	○

20. During the past 12 months, how often did you worry that your food would run out before you had money to buy more?

○ Often ○ Rarely
○ Sometimes ○ Never

21. During the past 12 months, have you used a community food shelf program or a community food box program?

○ Yes ○ No

22. How much of a problem are the following factors for you in terms of preventing you from eating more fruits and vegetables?

	Not a problem	A small problem	A big problem
a. The fresh fruits and vegetables where I usually shop are too expensive			
b. Fruits and vegetables are difficult to prepare	○	○	○

23. During the past 30 days, other than your regular job, did you participate in any physical activity or exercise such as running, calisthenics, golf, gardening or walking for exercise?

○ Yes ○ No

24. During an average week, other than your regular job, how many days do you get at least 30 minutes of moderate physical activity? *Moderate activities cause*

○ ○ ○ ○
○ ○ ○ ○

25. During an average week, other than your regular job, how many days do you get at least 20 minutes of vigorous physical activity? *Vigorous activities cause heavy sweating and a large increase in breathing or heart rate.*

○ ○ ○ ○
○ ○ ○ ○ ○

o nl y li g ht s w e at in g and a small increase in

breathing or heart rate.

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

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

26. Please indicate whether you use the following resources and facilities in your community.

	I use this	I do not use this	My community does not have this
a. Walking paths or trails			
b. Bicycle paths, shared use paths or bike lanes			
c. Public swimming pools or water parks			
d. Public recreation or community centers			
e. Parks or sports fields			
f. Schools, colleges or universities that are open for public use for exercise or physical activity			
g. A shopping mall or store for physical activity or walking			
h. Health club, fitness or wellness center (YMCA, Curves, Snap Fitness, Anytime Fitness, etc.)			
i. Nearby waterways, such as creeks, rivers, and lakes for water-related activities (canoeing, swimming, kayaking, etc.)			

27. Where do you usually exercise or do physical activities? *(Mark ALL that apply)*

- At home
- At work
- At a health club, fitness center, or gym
- At a public recreation facility or community center
- Somewhere outdoors (park, trails, etc.)
- Some other place
- Not applicable-I do not do or I am unable to do physical activities

28. How much of a problem are the following factors for you in terms of preventing you from being more physically active?

	Not a problem	A small problem	A big problem
a. Lack of time			
b. Lack of programs, leaders or facilities			
c. Lack of support from family or friends			
d. No one to exercise with			
e. The cost of fitness programs, gym memberships or admission fees			
f. Public facilities (schools, sports fields, etc.) are not open or available at the times I want to use them			
g. Not having sidewalks			
h. Traffic problems (excessive speed, too much traffic)			
i. Long-term illness, injury or disability			
j. Fear of injury			
k. Distance I have to travel to fitness, community center, parks or walking trails			
l. No safe place to exercise			
m. The weather			
n. I don't like to exercise			
o. Lack of self-discipline or willpower			
p. I don't know how to get started			
q. Other reasons			

29. How often do you get the social and emotional support you need?

Always Usually Sometimes Rarely Never

30. How much do you agree or disagree with these statements?

	Strongly agree	Agree	Disagree	Strongly disagree

a. I am comfortable when mothers breastfeed their babies near me in a public place, such as a mall, bus station, etc.

b. Public buildings need to have a room where mothers can breastfeed and pump milk for their babies.

31. How much do you agree or disagree with these statements?

	Strongly agree	Agree	Disagree	Strongly disagree
a. I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness.	○	○	○	○
b. People are generally caring and sympathetic to people with mental illness.	○	○	○	○
c. People with mental illness do not try hard enough to get better.				

32. Have you smoked at least 100 cigarettes in your entire life? (100 cigarettes = 5 packs)

○ Yes ○ No ▶ **GO TO QUESTION 35**

33. Do you now smoke cigarettes every day, some days, or not at all?

○ Every day ○ Some days ○ Not at all ▶ **GO TO QUESTION 35**

34. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit?

○ Yes ○ No

35. Have you ever used an electronic cigarette, vaping device, Mod, JUUL, or other electronic nicotine device even just one time in your entire life?

○ Yes ○ No ▶ **IF NO, GO TO QUESTION 37**

36. Were you a tobacco user (cigarette, cigar, little cigar, pipe, snuff, snus, chewing tobacco, etc.) at the time you first used an e-cigarette or other electronic nicotine delivery device?

○ Yes ○ No

37. How often do you use any of the following products?

	Every day	Some days	Not at all
a. Cigars, cigarillos, or little cigars			
b. Pipes	○	○	○
c. Snuff, snus or chewing tobacco			
d. E-cigarettes (vaping pen, JUUL, etc.)	○	○	○
e. Any other type of tobacco product			
f. Marijuana	○	○	○

38. Does anyone, including yourself, smoke tobacco (not including e-cigarettes) regularly inside your home? ○ Yes ○ No

39. During the past 30 days, have you had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?

○ Yes ○ No ▶ **GO TO QUESTION 43**

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

Days

41. During the past 30 days, on the days when you drank, about how many drinks did you drink on average?
(A drink is one can of beer, one glass of wine, or a drink with one shot of liquor.)

○ 1 drink
○ 2 drinks
○ 3 drinks
○ 4 drinks
○ 5 drinks
○ 6 drinks
○ 7 drinks
○ 8 drinks
○ 9 drinks
○ 10 drinks or more

42. Considering all types of alcoholic beverages, how many times during the past 30 days did you have...?

FOR FEMALES: 4 or more drinks on one occasion

Times

FOR MALES: 5 or more drinks on one occasion

Times

43. Has your household air ever been tested for the presence of radon?

○ Yes ○ No ○ I don't know

---

44. Do you ever drive a car or other vehicle?

○ Yes ○ No ▶ GO TO QUESTION 46

▼

45. When DRIVING a car or other vehicle, how often do you…	Often	Sometimes	Never	Not applicable: I don't have a cell phone
a.....read or send text messages?				
b.....make or answer a phone call?	○	○	○	○
c.....do other activities such as eat, read, apply makeup or shave?				
d.....drive when you have perhaps had too much to drink?	○	○	○	

46. How often do you wear a seat belt when you drive or ride in a car?

○ Always ○ Most of the time ○ Sometimes ○ Seldom ○ Never

47. Do you ever use public transportation such as *Hiawathaland Transit, SMART* or any other kind of bus transit?

○ Yes
○ No

48. What is the main way you usually get around for things like work, shopping, medical visits, etc.? (Mark ONLY ONE answer)

○ My own vehicle (car, truck, van, motorcycle)
○ Get rides from family/friends
○ Public transportation such as Hiawathaland Transit or SMART (or any other kind of bus transit)
○ Carpool or vanpool
○ Bicycle
○ Walk
○ I don't have any regular transportation
○ Other transportation method _____

---

49. In the past 12 months, has someone living in your home made you fearful through action, tone of voice, threats, or destroying your property?

○ Yes ○ No

50. During the past 12 months, did you seriously think about killing yourself?

○ Yes ○ No

---

51. Are you:

○ Male ○ Female ○ Intersex

52. What is your gender identity?

○ Male
○ Female
○ Transgender
○ Not sure
○ Please describe:_____

53. What is your sexual orientation?

○ Heterosexual or Straight
○ Gay, Lesbian, or homosexual
○ Bisexual
○ Please describe:_____

54. **Your age group:**

- ◯ 18-24
- ◯ 25-34
- ◯ 35-44
- ◯ 45-54
- ◯ 55-64
- ◯ 65-74
- ◯ 75 or older

55. **Are you a member of any of the following ethnic or cultural groups?**

- ◯ Hispanic or Latino/Latina
- ◯ Somali
- ◯ Sudanese
- ◯ Burmese
- ◯ Karen
- ◯ Other _____

56. **Which of the following best describes you?** *(Mark ALL that apply)*

- ◯ American Indian
- ◯ Asian or Pacific Islander
- ◯ Black, African or African American
- ◯ White
- ◯ Other _____

57. **How tall are you without shoes?**

Feet: 0 1 2 3 4 5 6 7

Inches: 0 1 2 3 4 5 6 7 8 9 10 11

58. **Approximately how much do you weigh?** _____ Pounds

59. **Including yourself, how many adults (age 18 or older) live in your household?**

Number of adults:

1 2 3 4 5 6 7 8 9 0 1 2 or more

60. **How many children (under age 18) live in your household?**

Number of children:

0 1 2 3 4 5 6 7 8 9 0 1 2 or more

61. **What is the highest level of education you have completed?** *(Please mark only ONE)*

- ◯ Did not complete 8th grade
- ◯ Did not complete high school
- ◯ High school diploma/GED
- ◯ Trade/Vocational school
- ◯ Some college
- ◯ Associate degree
- ◯ Bachelor's degree
- ◯ Graduate/Professional degree

62. **Household income per year:**

- ◯ Less than $10,000
- ◯ $10,000 - $14,999
- ◯ $15,000 - $24,999
- ◯ $25,000 - $34,999
- ◯ $35,000 - $49,999
- ◯ $50,000 - $74,999
- ◯ $75,000 - $99,999
- ◯ $100,000 - $149,999
- ◯ $150,000 - $199,999
- ◯ $200,000 or more

63. **Are you currently...** *(Mark ALL that apply)*

- ◯ Employed
- ◯ Self-employed or farmer
- ◯ Serving in the Armed Forces
- ◯ Unemployed or out of work due to COVID
- ◯ Unemployed or out of work for reasons other than COVID
- ◯ A homemaker or stay-at-home parent
- ◯ A student
- ◯ Retired
- ◯ Unable to work because of a disability

64. **Do you rent or own your current housing?**

- ◯ Rent
- ◯ Own
- ◯ Other _____

65. **How much is your current monthly rent or mortgage?**

_____

6	6	6
7	7	7
8	8	8
9	9	9

Thank you for completing this survey!

Appendix C

Key Informant Interview Summary

Dec. 2021-Feb 2022

Demographic Information:

- 21 interviews were compiled. Participants indicated they were 35-74, with one interviewee 25-34.
- Thirteen were male, and eight were female.
- Occupations listed included education, government, health care, business, and service.
- All interviewees were white, with one being Black, African, or African American, and no Hispanic or Latino origin.

Interviewees were asked to complete online surveys before the interview:

> Of the issues that impact health in our community, what are the top three most important related to your sector? For each concern selected, please answer questions on who is affected, why you believe this is a concern, contributing factors, resources available, and suggestions.
>
> For the online survey, the top three issues were selected from the Healthy People 2030 list, https://health.gov/healthypeople/objectives-and-data/browse-objectives.

A summary of the answers is as follows:

Mental Health and Mental Disorders were a clear concern, including access and barriers to treatment. Affordability for treatment was also mentioned. Mental health issues related to an aging population were cited. Other top concerns included Housing and Homes, Drug and Alcohol Use, Overweight and Obesity, Economic Stability (Poverty), and Preventive Care.

Mental Health

Mental Health and Mental Disorders was the most frequently mentioned health concern by a wide margin. It was mentioned by 81% of key informants (17 of 21). Concerns around affordability and a lack of services were mentioned, with the COVID-19 pandemic having an effect. One informant said there should be more encouragement to our state government to budget more for mental health treatment, and that there needs to be insurance coverage for early intervention and help for mental health professionals to work with people. Currently, a person must be at a critical point in their mental health crisis to get qualified for help that the insurance will cover.

Housing

Of 21 key informants, 6 (29%) chose Housing as one of their top three concerns, making it one of the most frequently mentioned health concerns. Concerns about homelessness numbers increasing, not enough housing, and housing not being affordable. One informant said there needs to be one central location for people experiencing homelessness to receive services.

Drug and Alcohol Use

Drug and Alcohol Use was one of the most frequently mentioned health concerns. Of 21 key informants, 6 (29%) chose Drug and Alcohol use as one of their top three concerns. Key informant interviews suggest the drug and alcohol issue could be measured by arrest reports, increasing alcohol sales, drug court participation, local recovery programs (AA), and the number of people talking to pastors about substance abuse concerns. Resources mentioned by key informants included adult substance abuse treatment providers, recovery groups, and drug courts. Key informants identified gaps in adolescent treatment services, upstream interventions, and treatment and recovery groups in rural towns such as Lake City and Goodhue. Key informants suggested more support for adolescents and families of drug users, including more recovery groups.

Overweight and Obesity

Of 21 key informants, 6 (29%) chose Overweight and obesity as one of their top three concerns, making it one of the most frequently mentioned health concerns. Key informants mentioned sedentary lifestyles and technology, such as video games and video conferences, as a contributor to overweight and obesity. Key informants identified the price of healthy foods as a barrier, as well as a lack of culturally diverse options at local food shelves.

Poverty

Of 21 key informants, 4 (19%) chose Economic Stability as one of their top three concerns. Informants shared concerns about the community being unable to afford to live on low wages, income rates going in the wrong direction, and the COVID-19 pandemic affecting the economy.

Preventive Care

Of 21 key informants, 4 (19%) chose Preventative Care as one of their top three concerns. Key informants said some people may not see the value in it, but preventive care is important to catch illness early. Barriers to preventive care identified by key informants included accessibility, lack of healthcare education, a lack of financial means to access it, and a lack of understanding of what is covered by insurance. Key informants also acknowledged that chronic disease prevention can be an expensive service to provide.

Discrimination and Social Connection

Of 21 key informants, 3 (14%) chose Social and Community Context as one of their top three concerns. One informant stated that the COVID-19 pandemic has heightened the ability for individuals to become antagonistic and more of a "me" vs. "we" culture in our communities. This makes it hard to get various stakeholders to pull together and act as a community to help improve local inclusiveness. Informants also stated that Minnesota is focusing more on racial equality. This allows us to do more at the local level as well. We need to demonstrate and showcase areas of success and hope to build on that with private/public partnerships and find ways to continue to partner between organizations.

Education Access and Quality

Of 21 key informants, 3 (14%) chose Education Access and Quality as one of their top three concerns. One informant said with the changes in communication due to COVID-19, education needs to continue to expand and be offered over multiple platforms. There are ways to educate our youth through programs and virtual opportunities and these efforts need to be supported to be effective in delivery.

Trust in Public Health

Of 21 key informants, 2 (10%) chose Emergency Preparedness as one of their top three concerns. One informant said with the COVID-19 pandemic our community members are trusting us less, and not following preparedness guidance, and are sick of hearing about it.

Physical Activity

Of 21 key informants, 2 (10%) chose Physical Activity as one of their top three concerns. There were concerns about obesity in our children. One informant said, in a virtual world with video games and phone addictions, there needs to be more encouragement of physical activity.

Violent Crime and Child Abuse

Violence Prevention was mentioned as a top health concern by one key informant. The concern was around violence in many forms such as assault, domestic assault, threats, intimidation, etc. With increasing gun violence nationwide we would be wise to acknowledge and prevent it before it escalates on a more local level.

Healthcare Access and Quality

Health Care Access and Quality were not selected as top health concerns by any key informants.

Appendix D

COMMUNITY PARTNER ASSESSMENT

2022 REPORT

Overview of MAPP

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is not an agency-focused assessment process; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems.

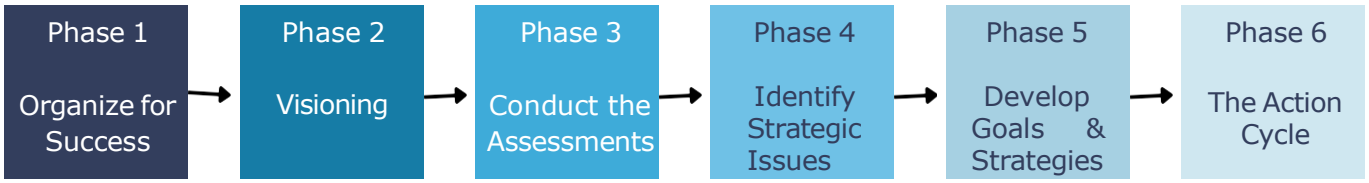
In 2019, the National Association of County and City Health Officials (NACCHO) began a redesign of the MAPP process. This redesign was focused on the following principles:

- Equity
- Inclusion
- Trusted Relationships
- Community Power
- Strategic Collaboration and Alignment
- Data and Community Informed Action
- Full Spectrum Actions
- Flexible
- Continuous

In 2022, Goodhue County Health and Human Services (GCHHS) was selected to participate in a national pilot of the MAPP redesign, called MAPP 2.0. GCHHS was one of two health departments in the country to pilot the new Community Partner Assessment as part of Phase 2 in MAPP 2.0.

More information about MAPP and the redesign process can be found in NACCHO's MAPP Evolution Blueprint Executive Summary.

Original MAPP Framework



MAPP 2.0 Framework

Community Partner Assessment: Goals & Intentions

The CPA is an assessment process that allows all of the community partners involved in MAPP to critically look at 1) their own individual systems, processes, and capacities and 2) their collective capacity as a network/across all community partners to address health inequities. This tool helps identify the range of actions that are currently being taken and could be taken moving forward to address health inequity at the individual to systemic and structural levels.

CPA Goals

The goals of the Community Partner Assessment are to:

- Describe why community partnerships are critical to community health improvement (CHI) and how to build or strengthen relationships with community partners and organizations
- Name the specific roles of each community partner to support the local public health system and engage communities experiencing inequities produced by systems
- Assess each MAPP partner's capacities, skills, and strengths to improve community health, and health equity, and advance MAPP goals
- Document the landscape of MAPP community partners, including grassroots and community power-building organizations, to summarize collective strengths and opportunities for improvement
- Identify who else to involve in MAPP moving forward, along with ways to improve community partnerships, engagement, and community power-building

Methods

The CPA consisted of an online survey and four community partner meetings in May-July 2022. More than forty organizations participated in the CPA in some way. Some participated in the survey, some attended meetings, and others participated in both.

Survey

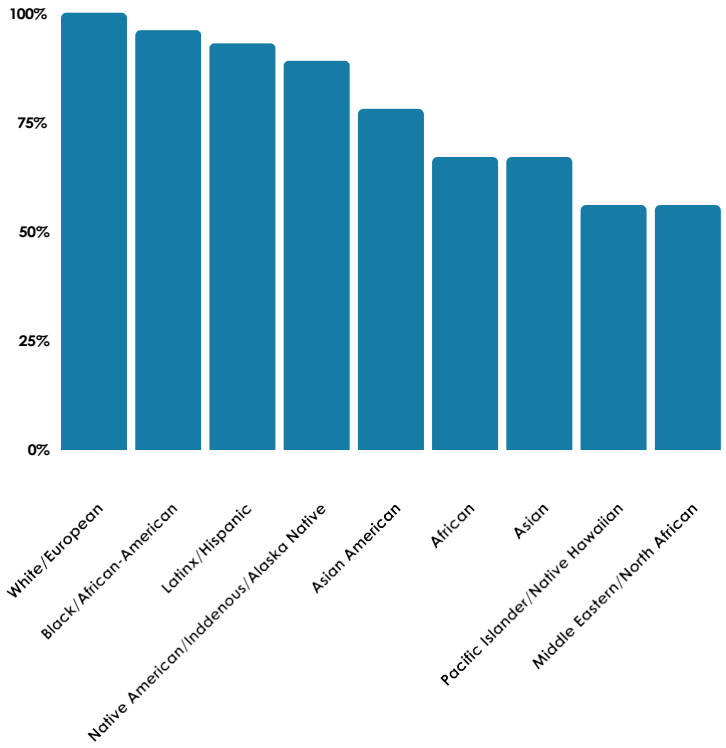
Twenty-seven partner organizations participated in the CPA Survey in June 2022. The CPA survey consisted of fifty-nine questions on the following topics: about the organization, interest in participating in the community health improvement process, demographics of people served, topic area focuses, organizational commitment to equity, who the organization is accountable to, capacities as they relate to the 10 Essential Public Health Services, general capacities and strategies, data access and systems, community engagement practices, policy, advocacy, and communication.

Partner Discussion Meetings

Thirty-two partner organizations participated in one to four virtual meetings to build connections, and learn about what is needed in Goodhue County to address health inequities and improve community health. Meeting topics included: the local public health system, understanding upstream and downstream approaches, community engagement, partnerships, organizational reflections on equity practices, and reflections on lessons learned.

About Our Community Partner Organizations

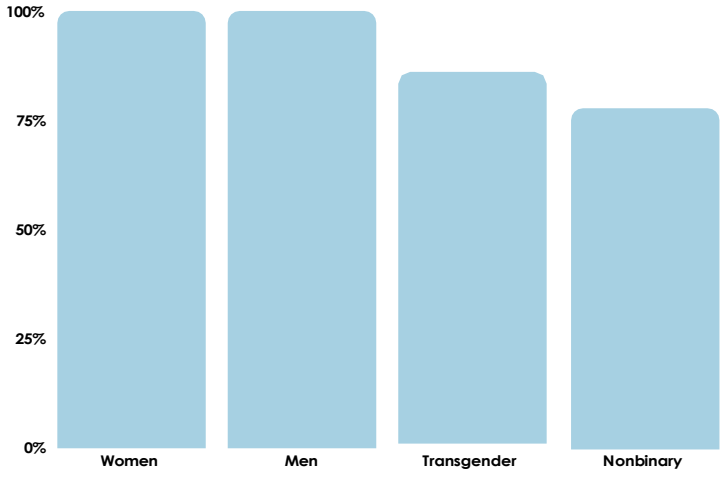
Percent of organizations who work with racial/ethnic groups



Over half of partner organizations stated that they work with all racial and ethnic populations, however, several noted that the number of non-White clients served is relatively small.

Percent of organizations who work with gender/sex identities

The majority of partner organizations stated that they are open to all but recognized that Goodhue County is a rural community and gender identities are not always spoken of openly.



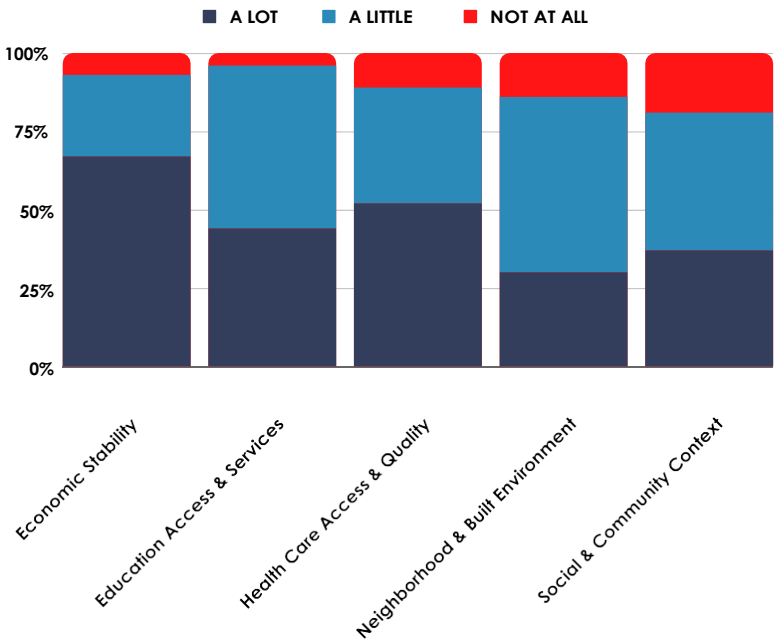
Other population groups served by partner organizations

Populations who are low-income, experience housing instability, and are disabled are among those served by many of the partner organizations.

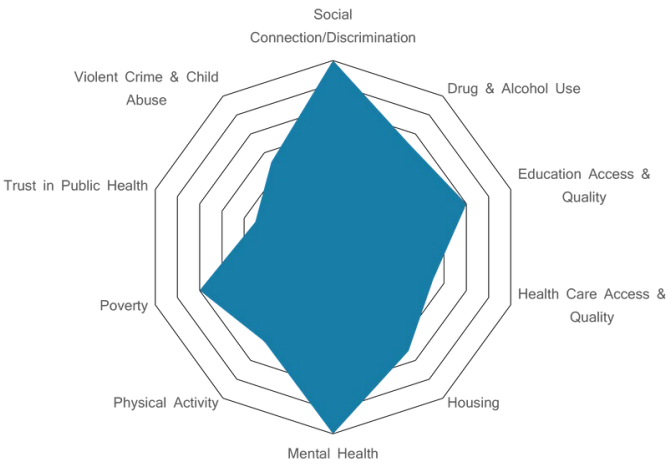
Organizational Focus on Social Determinants of Health

Healthy People 2030 defines social determinants of health as "the conditions in the environments where people are born, live, work, play, worship, and age that affect a wide range of health, functioning and quality-of- life outcomes and risks."

Over half of partner organizations work "a lot" on Economic Stability and Health Care Access & Quality. Nineteen percent do not work on social & community context at all.

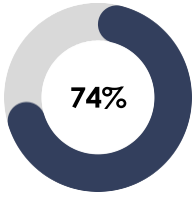


Organizational Focus on Health Issues

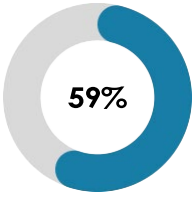


Of the top ten health issues in Goodhue County, we have many partners working on mental health and social connection, while very few are working on trust in public health, health care access, and physical activity.

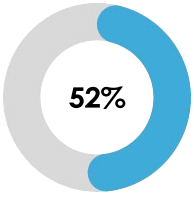
Partner Commitment to Health Equity



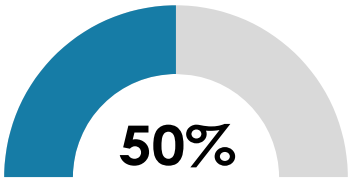
Partners that have at least one individual dedicated to addressing equity in their organization



Partners that have a team dedicated to addressing equity in their organization



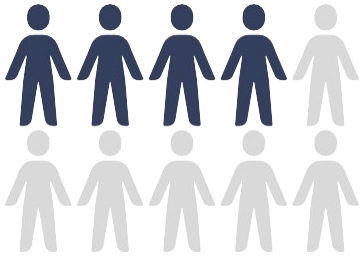
Partners that have advancing equity included in all or most staff job requirements



Partners that have an advisory board of community members, stakeholders, youth, or others who are impacted by the organization

Partner Demographic Reflection

Four out of every ten partner organizations have leadership, management, and staff that reflect the demographics of the community they serve



Partner Capacity

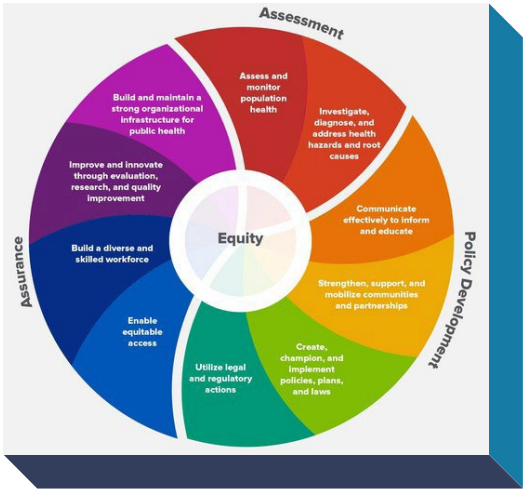
37%

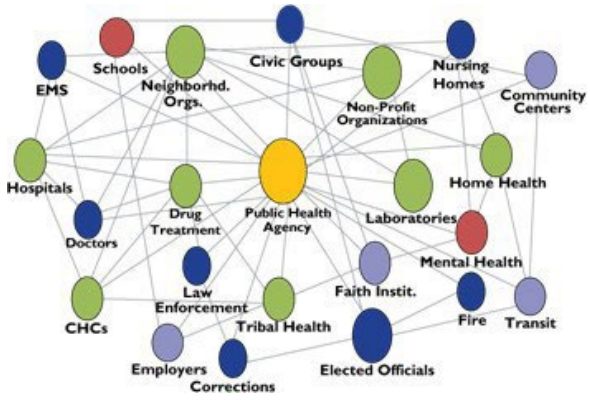
Partners that have sufficient capacity to support their work

The 10 Essential Public Health Services

The 10 Essential Public Health Services describe the public health activities that all communities should undertake. They are:

- Assess and monitor population health status, factors that influence health, and community needs and assets
- Investigate, diagnose, and address health problems and hazards affecting the population
- Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it
- Strengthen, support, and mobilize communities and partnerships to improve health
- Create, champion, and implement policies, plans, and laws that impact health
- Utilize legal and regulatory actions designed to improve and protect the public's health
- Assure an effective system that enables equitable access to the individual services and care needed to be healthy
- Build and support a diverse and skilled public health workforce
- Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement
- Build and maintain a strong organizational infrastructure for public health

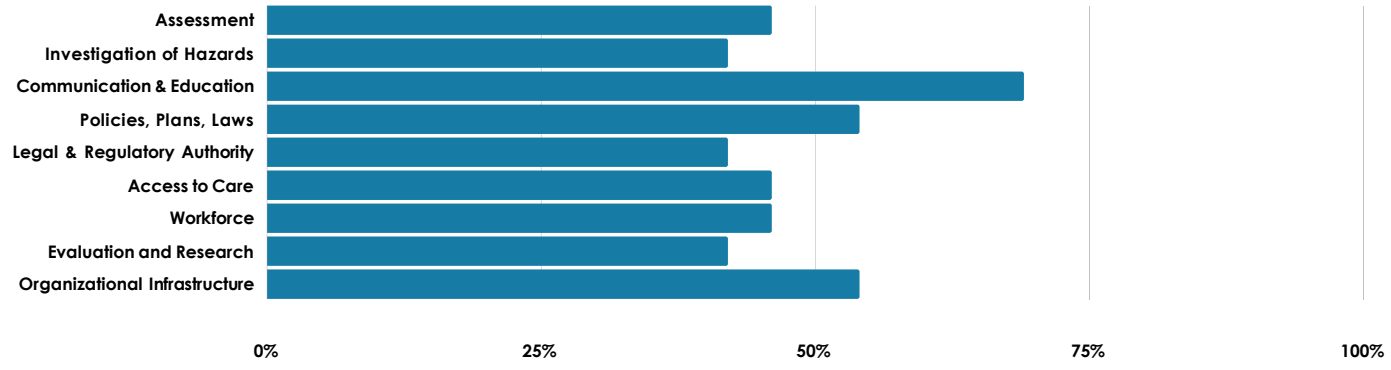




As the local public health system consists of a broad group of community members, this depicts an idea of what entities contribute to the local public health system.

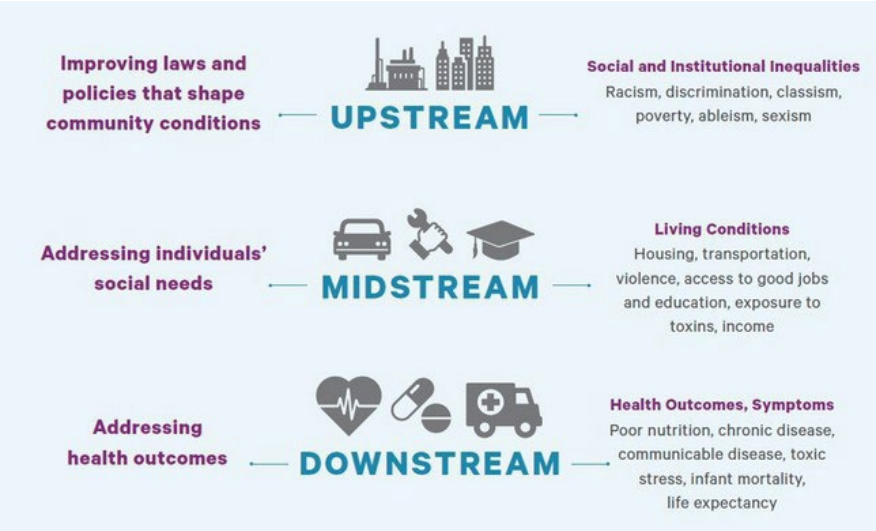
The public health system in Goodhue County is a network of entities with different roles, relationships, and interactions that all contribute to the delivery of the 10 Essential Public Health Services, and the community's health and well-being.

Partner Organizations that Regularly Work on the 10 Essential Public Health Services



Upstream vs. Downstream Work

In public health, there is the concept of "upstream" and "downstream" health interventions. The analogy of the river is used to describe how policies and social and institutional inequities have a profound impact on health outcomes. Upstream work focuses on improving the structures that influence health, whereas downstream work addresses individual health outcomes and symptoms.



In Goodhue County, partner organizations are heavily focused on downstream and midstream work. Many partners expressed a desire to work further upstream but felt funding, capacity, skill set, and governmental barriers prevented them from doing so.

Partner organizations participated in an activity where they put the main activities their organizations participate in on the river. This helped create a visual representation of the health work being done throughout Goodhue County.

Partner Reflections on Upstream Work

"We need to carve out time to think upstream & systemically."

"We need to find ways to coalition build for systems advocacy in our community. We can't engage in systems advocacy on our own; it requires all of us."

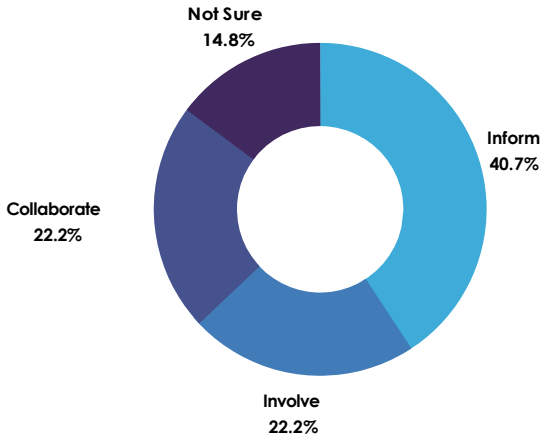
"The more you know about how to work upstream, the more you can do."

Community Engagement

The Spectrum of Community Engagement charts a pathway to strengthen our communities through participation, particularly by populations that are commonly excluded from voice and power. The more voices at the table, the more capacity we have to understand and address community health issues.

Type of Community Engagement Practices Most Often Used by Partners

Informing is the most common community engagement practice used by partners. No partner organizations said most often "consult" or "defer to."



Partnerships

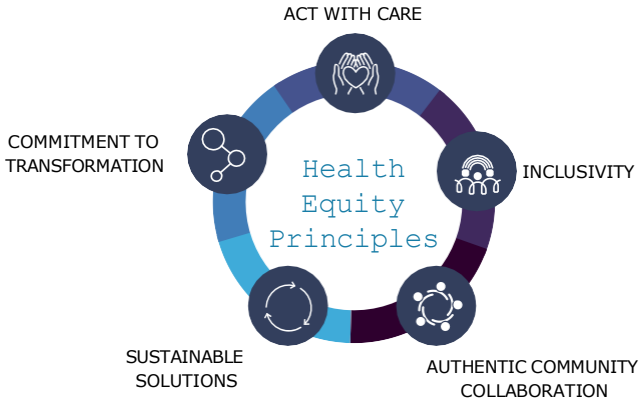
All partner organizations bring relationships with other organizations that may help advance community health goals. Some of these relationships are very trusting ones, while others may be emerging or functioning through coordination only.

66

organizations were identified by partners that they have a collaborating or partnering relationship with.

Collaborating relationships are defined as sharing innovative ideas and starting to put joint plans in writing. Partnering relationships have a shared vision, shared space/staff, shared authority and decision-making, an written plans and agreements.

Health Equity Principles



The Praxis Project created a set of principles to help guide work that supports health equity for everyone. They are: act with care, inclusivity, authentic community collaboration, sustainable solutions, and commitment to transformation. Each health equity principle has a set of indicators to access and reflect on how they embody health equity in practice and identify opportunities for growth and improvement.

Partner assessment on health equity principles

*Partner organizations exhibit this principle **70%** of the time.*

ACT WITH CARE

- Intentionally establishes timelines that enable relationship building and trust with community partners
- Conduct risk assessments to prevent unintended harm for every project Policies are
- programs are evaluated by their impact, not their intentions
- Actions explicitly address bias and stigmatized statuses

INCLUSIVITY

- Members of impacted communities are leading the decision-making process of issues that directly affect their community
- Members of impacted communities are meaningfully represented at all levels through policies
- Differential impacts that policies have are intentionally identified and named
- Community partners' identities are recognized and respected.

*Partner organizations exhibit this principle **62%** of the time.*

*Partner organizations exhibit this principle **70%** of the time.*

AUTHENTIC **COMMUNITY COLLABORATION**

- Clear, shared understanding of who the prioritized community is that is served
- Policy solutions are adjusted and tailored to accommodate the priorities of those served
- Decision-making processes value lived experience as much or greater than professional experience
- Processes for transparency and communication with community partners
- Intentionally assess and remove barriers to participation in activities
- Provide financial and logistical compensation for all community member participation

SUSTAINABLE SOLUTIONS

- The majority of funding is dedicated to asset-based programming
- Redistributed most resources, power, and opportunities directly back to the community
- Solutions address the root causes of issues facing the community
- Majority of funding specifically develops and supports community infrastructure vs. service delivery

*Partner organizations exhibit this principle **63%** of the time.*

COMMITMENT TO TRANSFORMATION

NEVER ALWAYS

Partner organizations exhibit this principle **66%** *of the time.*

- Intentionally establishes timelines that include space for self-reflection and peer-to-peer feedback
- Established accessible channels for feedback from community members and partners
- Feedback is discussed and appropriate changes are made in response
- Regularly assess organizational operations and processes for power dynamics and health equity
- Established accountability system to ensure work is aligned with community values

Lessons Learned

Community Strengths

Goodhue County is filled with a variety of people and organizations that are supporting community health and well-being. There is a strong desire among partners to collaborate and learn from each other to continue to improve. Many organizations are engaged in health equity work and others express a desire to begin this work. Goodhue County has partners working on all of the 10 Essential Public Health Services and the top ten health issues identified through the Community Health Assessment.

Organizational Capacities

Many of the organizations struggle with capacity and it prevents them from doing the upstream work that they would like to do. However, partners recognize that collaboration and networking can help expand capacity to continue to address health inequities within the community.

Systems of Power

Partners recognize that there is still a long way to go to address systems of power in the community. Power imbalances in the community and within organizations exist and they are a need for representation at all levels. Organizations need to continue to work on their internal culture to make changes throughout the community. Addressing power, privilege, and oppression is important to community health and partners need to continue to move forward to break down and improve equity.

Health Behaviors & Health Outcomes

While many partners do not consider themselves a health organization, their work still has a strong influence on it. Health is not just an individual endeavor, and the systems, environment, and resources have a critical impact on health outcomes. Every partner has a role in connecting those they serve with the resources that impact health behaviors and outcomes. Creating a sense of belonging is vital to individual and community health.

Additional Lessons

- Goodhue County has a wide variety of organizations and resources to collaborate with
- Partners don't realize the positive role they have in supporting community health
- Funding needs to be community-centric
- No organization works in a bubble
- A unified approach to addressing health issues will be important to ensure we leverage resources in a meaningful way

Next Steps

As Goodhue County moves into Phase 3 of the MAPP 2.0 process, and continuously improves the community, the information gathered in the Community Partner Assessment will help identify organizations to connect with to address the top health issues, gather further data, and advance health equity. Additionally, the CPA advances community connections and collaboration to further improve the community's health.

Acknowledgments

Participating Partners

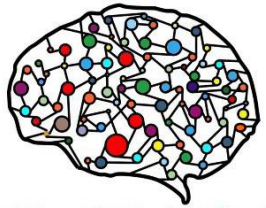
Cannon Falls Library
Cannon Falls School District
C.A.R.E. Clinic
Channel One Regional Food Bank
City of Red Wing
City of Zumbrota
Fernbrook Family Services
Goodhue County Court Services
Goodhue County Health & Human Services
Goodhue County Sheriff's Office
Hiawatha Valley Mental Health Center
Hispanic Outreach
Hope & Harbor
HOPE Coalition
Kenyon Public Library
Lake City Public Schools
Mayo Clinic Health System
NAMI Southeast MN
Olmsted Medical Center
Pine Island Schools
Prairie Island Indian Community
Red Wing Chamber of Commerce
Red Wing Community Education
Red Wing Farmers Market
Red Wing HRA
Red Wing Library
Red Wing Police Department
Red Wing School District
Red Wing YMCA
Red Wing Youth Outreach
SEMCAC Senior Dining
SEMCIL
SEMMCHRA
South Country Health Alliance
St. Luke's Church of Goodhue
Three Rivers Community Action
United Way of Goodhue, Wabasha, and Pierce Counties
University of Minnesota Extension
Workforce Development
Zumbrota Library
Zumbrota-Mazeppa School District

Community Health Assessment Core Group

Maggie Cichosz, Goodhue County Health and Human Services
Ruth Greenslade, Goodhue County Health and Human Services
Michelle Leise, City of Red Wing
Maureen Nelson, United Way of Goodhue, Wabasha, and Pierce Counties
Stephanie Olson, Mayo Clinic Health System

Community Partner Assessment Facilitators

Lead Facilitator: Maggie Cichosz
Assistant Facilitators: Ruth Greenslade, Whitney Isaacson, Gina Johnson, Michelle Leise, Maureen Nelson, Laura Smith



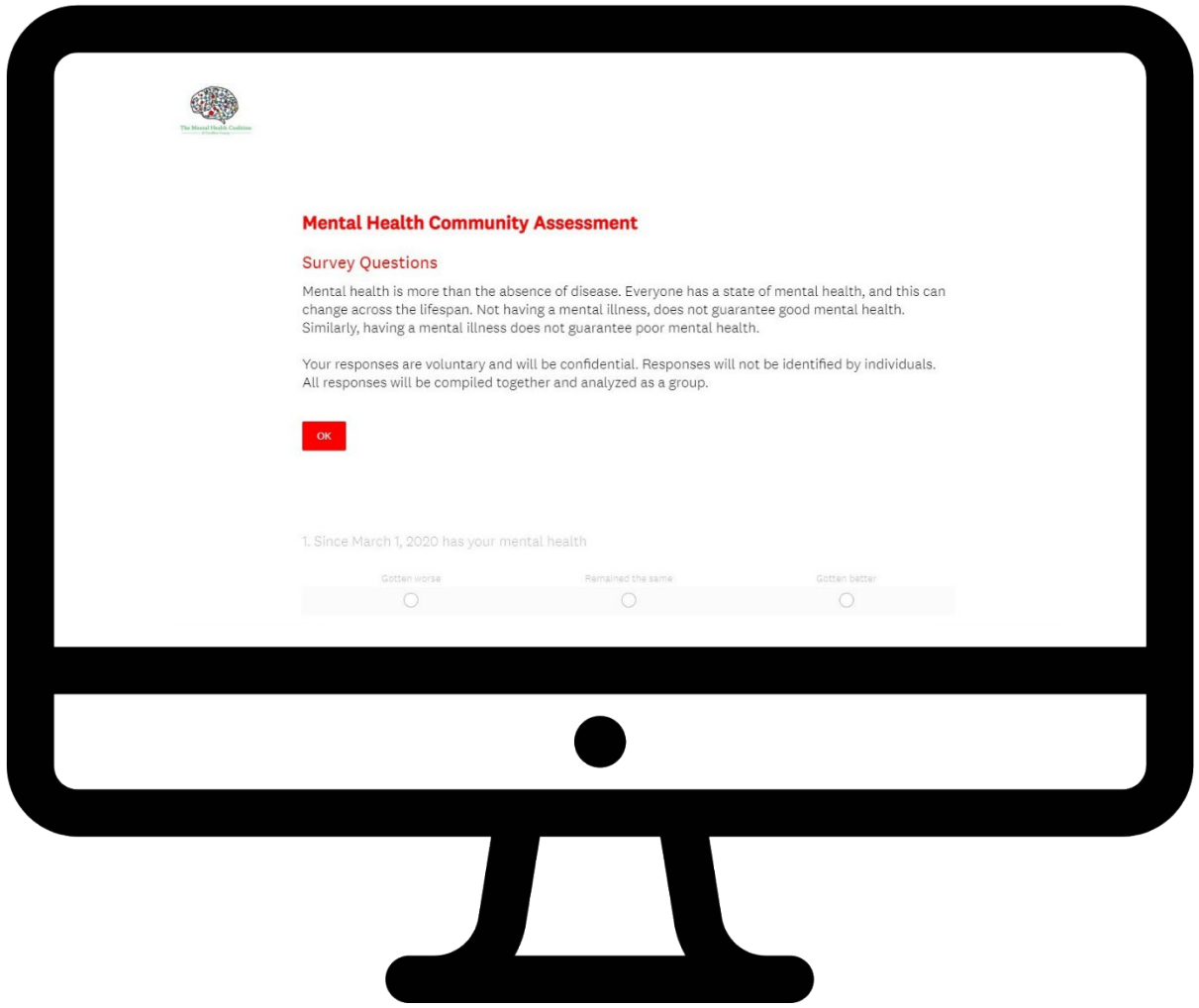
Appendix E

Mental Health Community Assessment

The Mental Health Coalition
of Goodhue County

The Survey

The Mental Health Coalition sent out an online survey in August 2021 to get a pulse on how the mental health of people who live and work in Goodhue County has been impacted since March 2020.



The Mental Health Coalition of Goodhue County

Limitations

- Convenience sample
- Only 257 respondents
- The demographics of respondents are not representative of Goodhue County.

The Mental Health Coalition
of Goodhue County

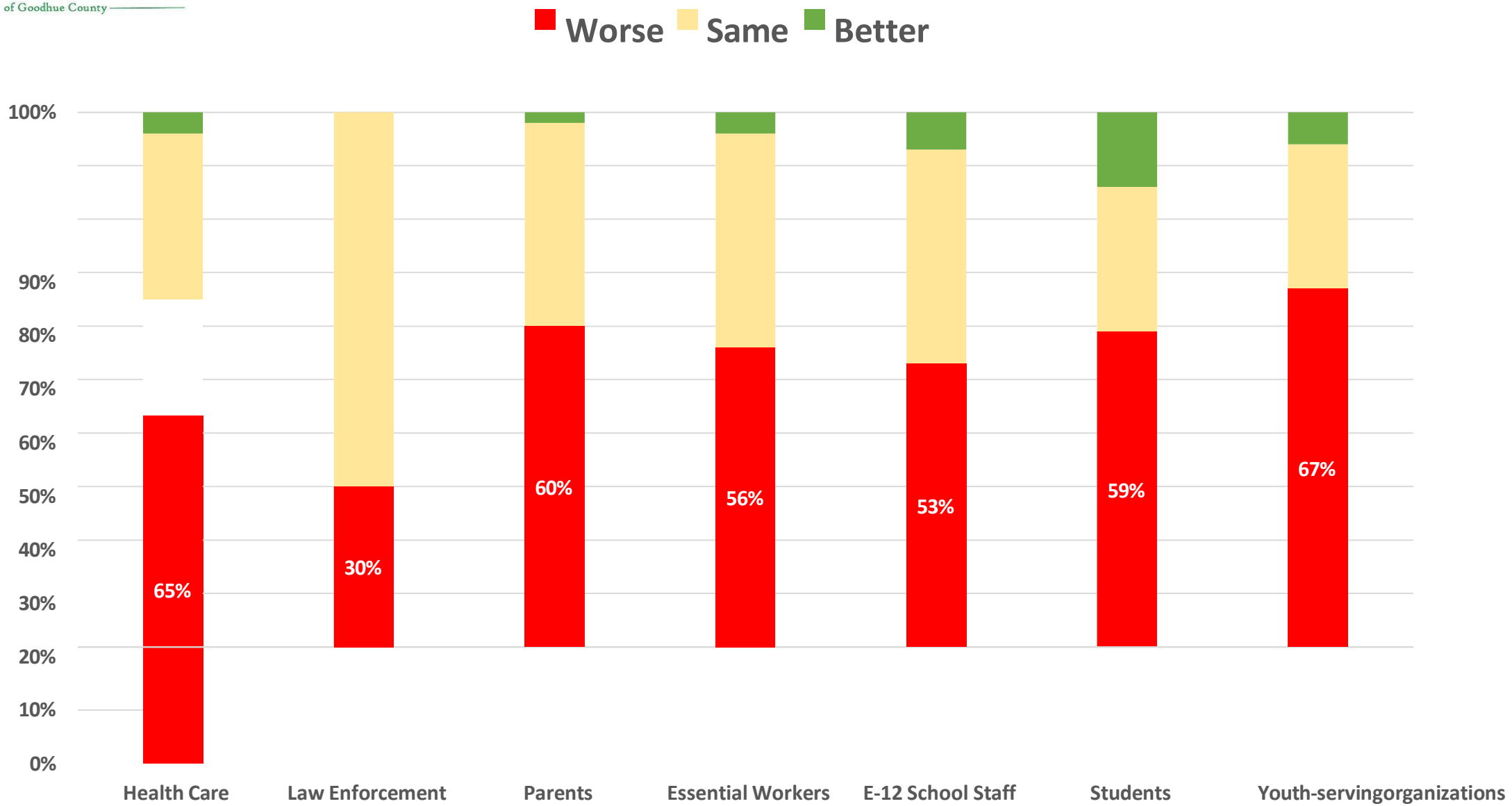
Change in Mental Health

51%

of respondents reported their mental health is worse since March 1, 2020

The Mental Health Coalition
of Goodhue County

Change in Mental Health



The Mental Health Coalition
of Goodhue County

Change in Mental Health Symptoms

62%

experienced an increase in feelings of **anxiety**.

53%

experienced an increase in feelings of **isolation.**

44%

experienced an increase in feelings of **depression.**

11%

experienced an increase in **substance use.**

The Mental Health Coalition
of Goodhue County

Stress Triggers

COVID restrictions & shutdowns

Worrying about loved ones getting sick

Missing friends and family

2020 Election

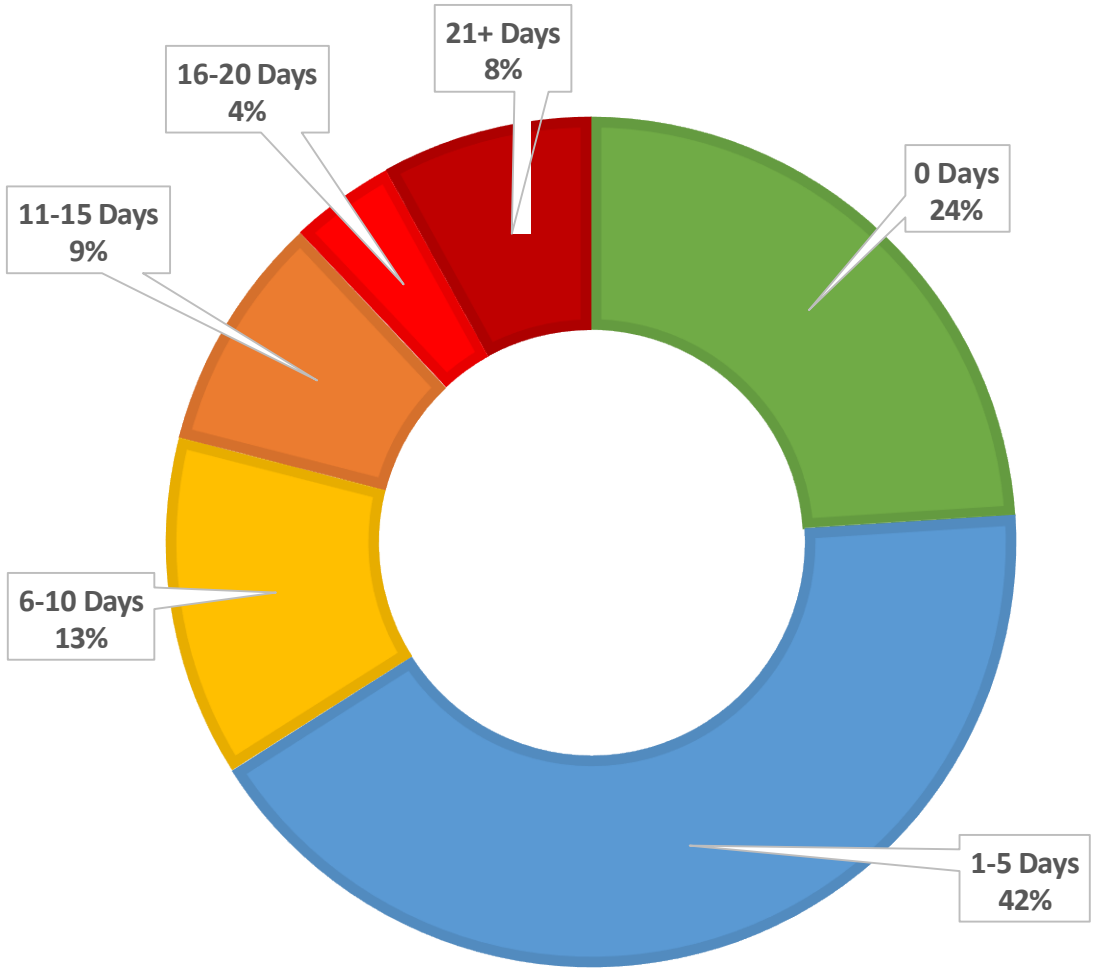
Missing events and/or milestones

Civil unrest

The Mental Health Coalition
of Goodhue County

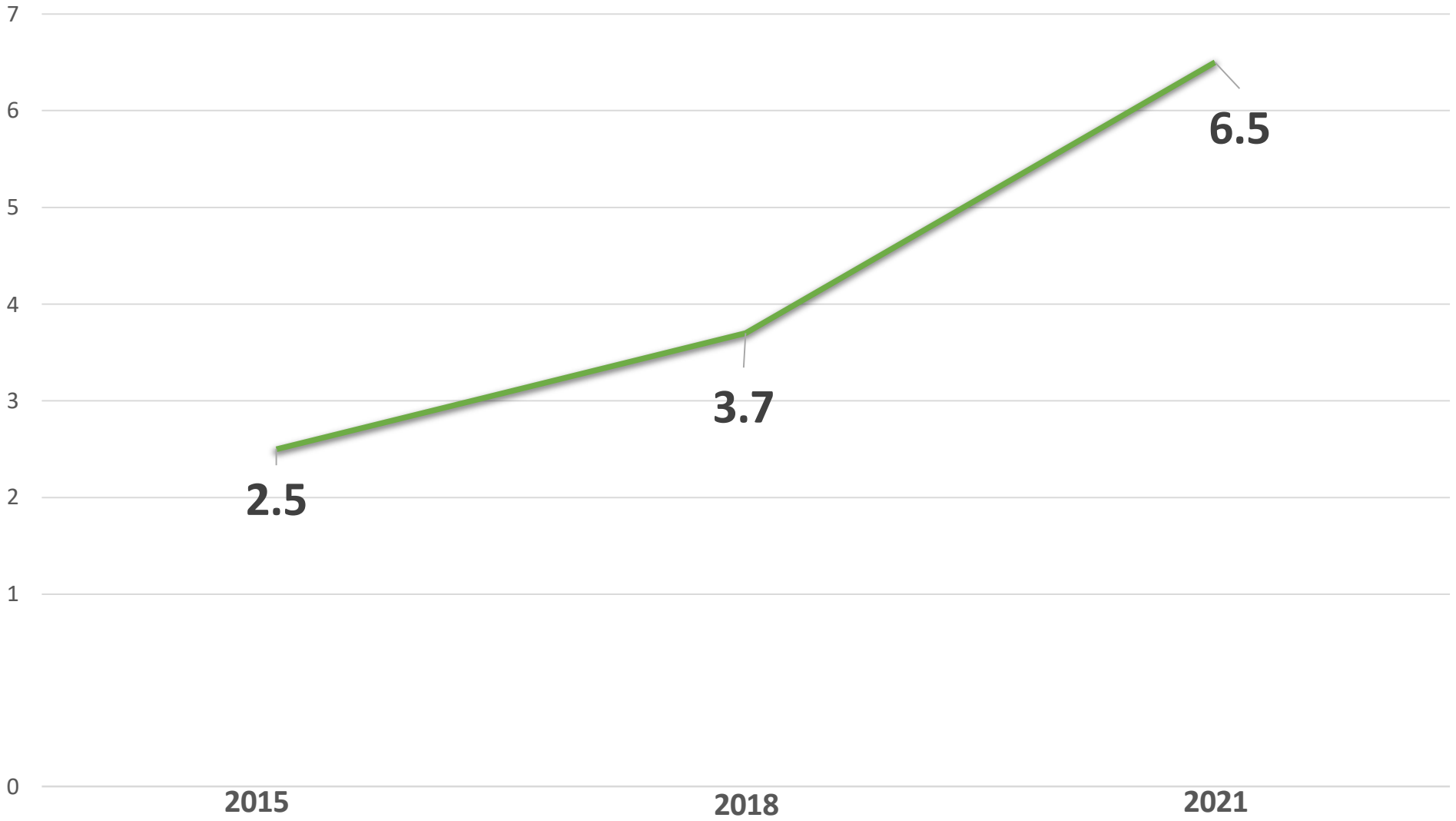
Poor Mental Health Days

The average number of mentally unhealthy days was 6.5 of the last 30 days.



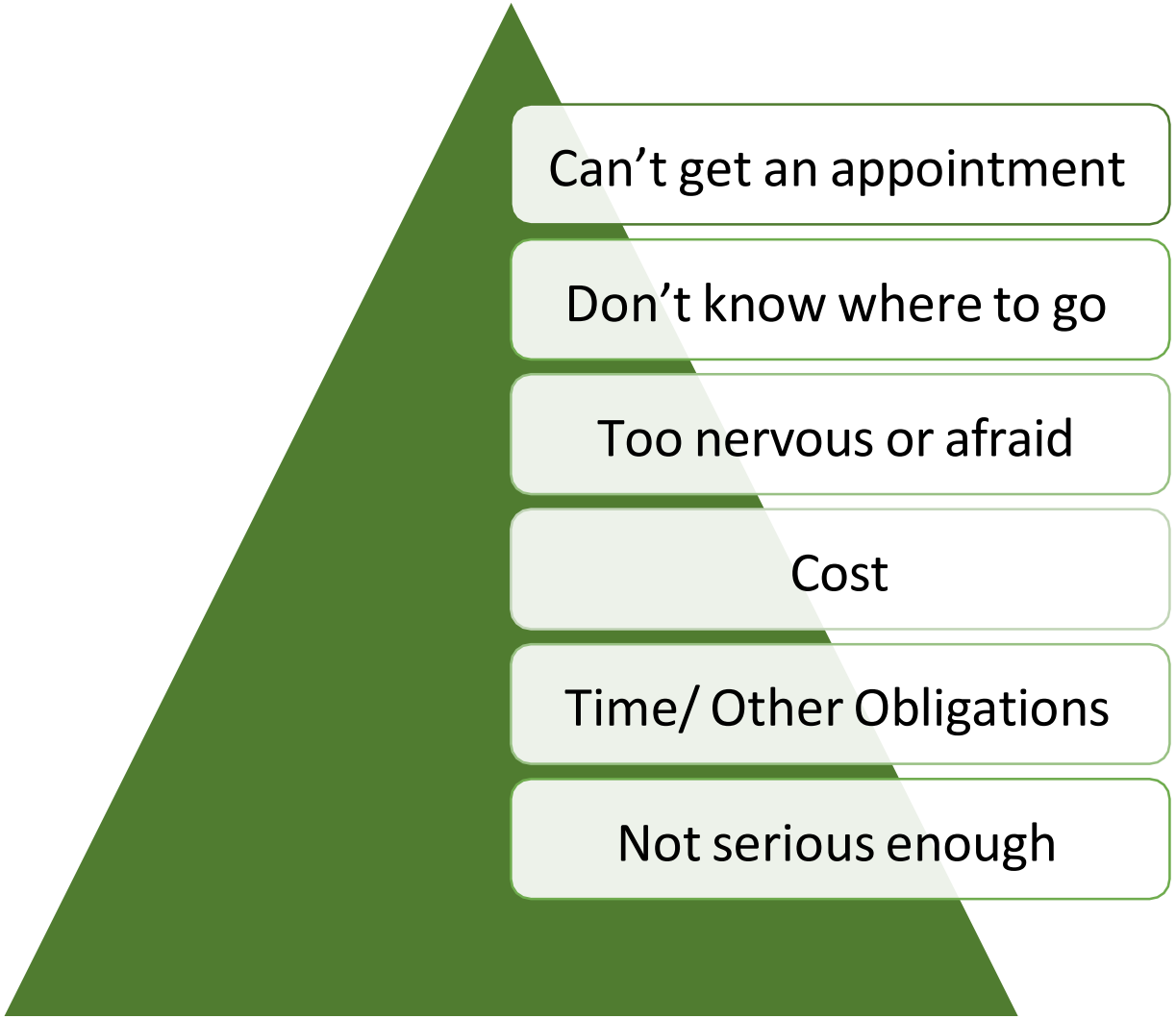
The Mental Health Coalition
of Goodhue County

Poor Mental Health Days



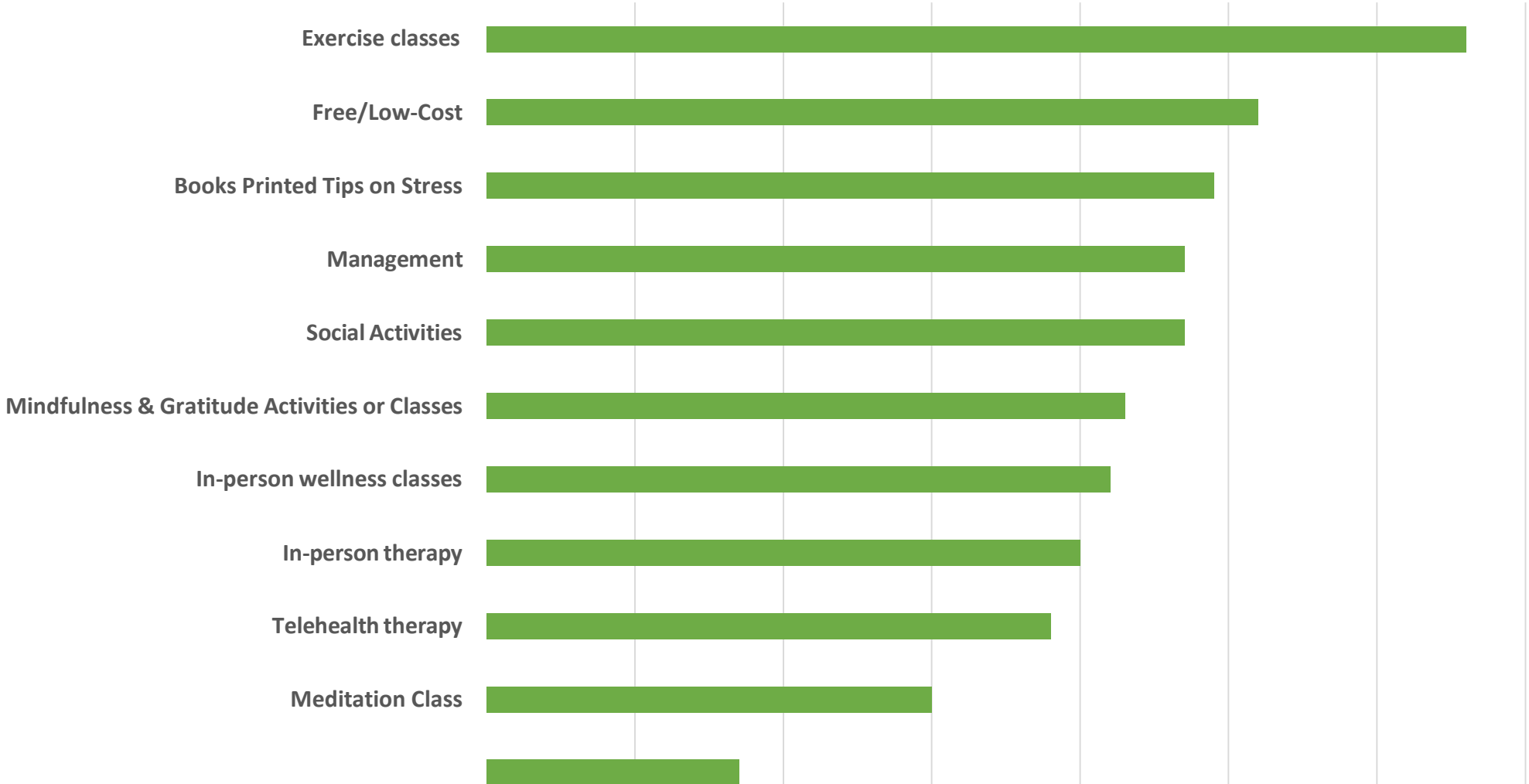
The Mental Health Coalition
of Goodhue County

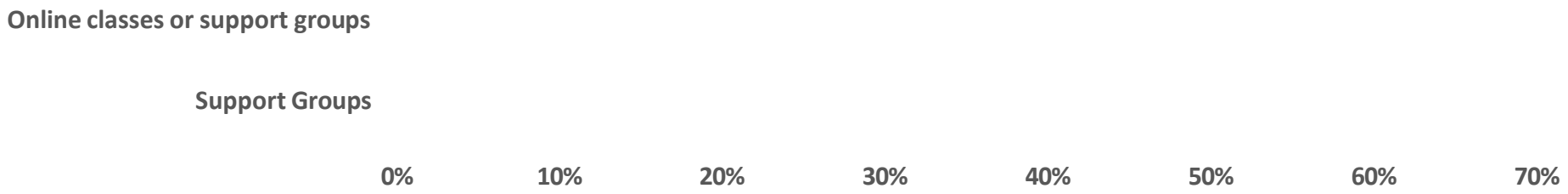
Barriers to Meeting Mental Health Needs



The Mental Health Coalition
of Goodhue County

Supports Most Likely to Use




Online classes or support groups
Support Groups
0%
10%
20%
30%
40%
50%
60%
70%

The Mental Health Coalition
of Goodhue County

Community Mental Health Issues

Not enough providers

Economic factors

Stress management

Too many barriers

Work/life balance

Stigma/ Mental health education

Lack of community connections & social support

The Mental Health Coalition
of Goodhue County

Change in Youth Mental Health

65%

of respondents feel like youth mental health is worse than it was on March 1, 2021

The Mental Health Coalition
of Goodhue County

Supports For Youth Mental Health

- Supportive and caring adults
- More activities (non-Athletics)
- More unstructured time to spend with family and friends
- Support for parents
- Job training
- Youth/Community Center
- More mental health education in schools

The Mental Health Coalition
of Goodhue County

Next Steps

The Mental Health Coalition
of Goodhue County

Questions?

Appendix F

Community Engagement Summary
June-August 2022

Engagement Strategy

The engagement strategy was an interactive tabling activity for community members to stop at and help identify what they think is the biggest health issue in the county. The activity consisted of a display board that covered the top 10 health issues in the county and asked community members to the sticky dot what they think out of the 10 is the biggest issue in the county to be addressed. Staff also distributed incentives such as facial tissue, COVID-19 test kits, and hand sanitizer.

Events

June 19th Cannon Falls Father's Day Pancake Feed and the Red Wing Juneteenth Park Celebration:

The Pancake Feed was an event by the Cannon Falls Lions Club celebrating Father's Day and taking donations for the Lions Club. The Juneteenth Celebration was an event by the City of Red Wing to share with the community the history of Juneteenth. At these events, a total of 55 community members participated in our tabling activity. The top 3 issues identified by community members were:

1. **Mental health**
2. **Housing**
3. **Discrimination and social connection**

June 25-26th Lake City Water Ski Days:

Water Ski Days are an annual festival in Lake City with a carnival, water show, parade, and lots of family fun activities. At this event, a total of 65 community members participated in our tabling activity. The top issues identified by community members were:

1. **Housing**
2. **Mental health**

June 29th Red Wing Music in the Park:

This event is a weekly concert series in the park hosted by the Red Wing Arts organization. At this event, a total of 34 community members participated in our tabling activity. The top 3 issues identified by community members were:

1. **Mental health**
2. **Drug and alcohol use**

3. **Education access and quality**

July 12th and 19th Zumbrota Music in the Park:

This event is a weekly concert series in the park hosted by the Zumbrota Lions Club. At these events, a total of 66 community members participated in our tabling activity. The top issues identified by community members were:

1. **Housing**
2. **Mental health**
3. **Poverty**
4. **Discrimination and social connection**

July 14th Cannon Falls Open Air Fair:

The fair is hosted by the Cannon Falls Chamber and offers different vendors and activities. At this event, a total of 28 community members participated in our tabling activity. The top 3 issues identified by community members were:

1. **Mental health**
2. **Housing**
3. **Drug and alcohol use**

July 16th and 23rdRed Wing Farmers Market:

The market has different local vendors and food sales. At these events, a total of 120 community members participated in our tabling activity. The top 3 issues identified by community members were:

1. **Mental health**
2. **Housing**
3. **Drug and alcohol use**

July 22nd Pine Island Farmers Market:

The market has different local vendors and food sales. At this event, a total of 59 community members participated in our tabling activity. The top 3 issues identified by community members were:

1. **Mental health**
2. **Housing**
3. **Drug and alcohol use**

August 2nd, Kenyon Night to Unite:

This event was partnered with local police to unite with community members and provide a free meal. At this event, a total of 25 community members participated in our tabling activity. The top issues identified by community members were:

1. **Mental health**
2. **Housing**

August 5-6th Red Wing River City Days:

This annual festival includes music, carnival activities, and local events. At this event, a total of 133 community members participated in our tabling activity. The top 3 issues identified by community members were:

1. **Mental health**
2. **Housing**
3. **Discrimination and social connection**

August 11th Cannon Falls Fun Fest:

The fair is hosted by the Cannon Falls Chamber and offers different vendors and activities. At this event, a total of 28 community members participated in our tabling activity. The top issue identified by community members was **mental health.**

August 1th Goodhue County Fair:

At this event, a total of 65 community members participated in our tabling activity. The top 3 issues identified by community members were:

1. **Mental health,**
2. **Drug and alcohol use**
3. **Physical activity**

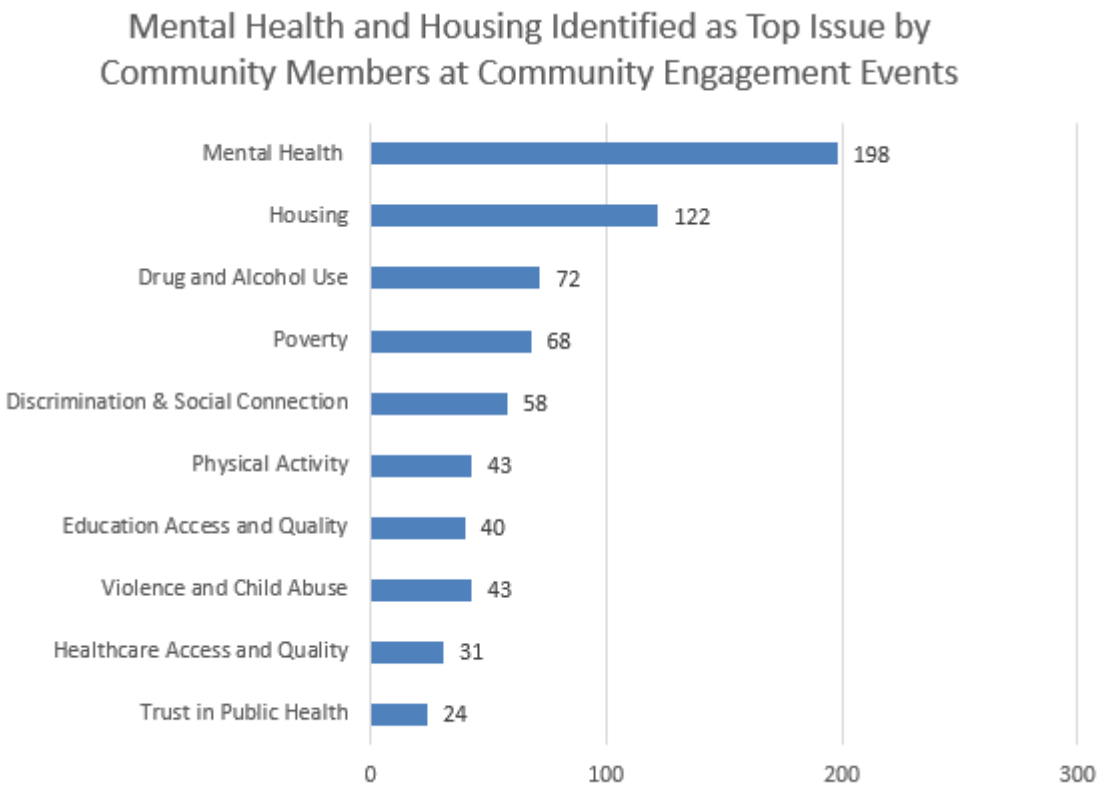
August 20th Kenyon Rose Fest:

The city of Kenyon hosts the fest and offers different vendors and activities. At this event, a total of 26 community members participated in our tabling activity. The top issue identified by community members was **mental health**.

Grand Totals

Out of 15 Community Engagement events, a total of 699 community members participated in our activity. From that total, 198 people identified mental health as their biggest health concern, 122 people identified housing as their biggest health concern, and 72 people

identified drug and alcohol use as their biggest health concern.



Total Factors and Strategies

Mental Health

The top issue identified by the community was mental health. Out of some factors and strategies provided, community members tallied what they thought was contributing to the issue and what could be done to address it.

Factors

- Not enough providers were selected by 55 people
- Past trauma was selected by 30 people
- Too much stress was selected by 28
- Loneliness was selected by 13 people

Strategies

- Increase school-based counseling was selected by 35 people
- Teach healthy coping skills was selected by 21 people
- Promote activities and opportunities for social connection was selected by 17 people
- Promote trauma-responsive schools and workplaces were selected by 10 people

Housing

The second top issue identified by the community was housing. Out of some factors and strategies provided, community members tallied what they thought was contributing to the issue and what could be done to address it.

Factors

- Not enough affordable housing was selected by 59 people
- Not enough support for those experiencing homelessness was selected by 22 people
- Not enough protections for renters were selected by 8 people
- Restriction on township zoning was selected by 1

Strategies

- Provide funding to support the development of affordable housing was selected by 26 people
- Promote re-housing programs that provide support services was selected by 11 people
- Advocate for rent regulation policies was selected by 10 people

Drug and alcohol use

The third top issue identified by the community was drug and alcohol use. Out of some factors and strategies provided, community members tallied what they thought was contributing to the issue and what could be done to address it.

Factors

- Family and/or friends use was selected by 20 people
- Stress (using as a way to cope) was selected by 12 people
- Not enough resources to prevent overdoses was selected by 7 people
- Boredom was selected by 4 people

Strategies

- Give students information and skills to prevent substance use was selected by 11 people
- Increase access to therapy was selected by 10 people
- Increase recreation opportunities was selected by 3 people
- Distribute Naloxone & train people to use it was selected by 2 people

Poverty

The fourth top issue identified by the community was poverty. Out of some factors and strategies provided, community members tallied what they thought was contributing to the issue and what could be done to address it.

Factors

- Wages are too low was selected by 20 people
- Single parents was selected by 11 people
- Lack of good jobs/job growth was selected by 7 people
- Social injustice/ discrimination was selected by 4 people
- Spiritual poverty was selected by 1 person

Strategies

- Advocate for living wage laws and minimum wage increases was selected by 14 people
- Increase financial assistance to working parents to pay for child care was selected by 9 people
- Support programs that provide job training & education for people of color was selected by 6 people
- Advocate for job growth and community development was selected by 4 people

Discrimination and social connection

The fifth top issue identified by the community was discrimination and social connection. Out of some factors and strategies provided, community members tallied what they thought was contributing to the issue and what could be done to address it.

Factors

- Lack of knowledge about other cultures was selected by 28 people
- Past events (historical trauma) was selected by 6 people
- People don't feel comfortable talking to youth was selected by 3 people
- Transportation for senior adults was selected by one person

Strategies

- Promote opportunities to learn and meet others was selected by 18 people
- Increase involvement in mentoring programs was selected by 8 people
- Increase safety, empowerment, and support for people who have experienced trauma was selected by 6 people
- Mentorship programs for special needs children was selected by 1 person