

**Fillmore-Houston  
Community Health Service  
Community Health Improvement Plan (CHIP)  
2025-2030**



**Public Health**  
Prevent. Promote. Protect.

Prepared by the Fillmore-Houston Performance Management Team

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Reviewed and Revised:

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Fillmore-Houston CHS Administrator:

Fillmore-Houston Joint Board of Health Chairperson:

## **Organization Jurisdiction**

The Fillmore-Houston Community Health Service (FHCHS) covers the entire areas of Fillmore and Houston County. Fillmore and Houston County are located in the very Southeast corner of Minnesota bordering on Wisconsin and Iowa. This area is 1,413.36 square miles and is comprised of 21 cities and 42 townships.

The FHCHS service area encompasses approximately 16,888 households. Minnesota State Demographer Estimates from 2024 indicate that the total population for both counties is approximately 39,854 people with Fillmore County having 21,502 residents and Houston County having 18,352 residents. Youth aged birth to 18 comprise 24.5% of the Fillmore and 21.6% of the Houston County population. Adults aged 65 and older constitute 21.8% of Fillmore and 23.2% of the Houston County population respectively (US Census, 2023). People with disabilities comprise 11% of the Fillmore-Houston Community Health Service area (Minnesota Compass, 2025).

The population of the Fillmore-Houston CHS services is predominantly white (94.3%) followed by people who define themselves as two or more races (2.5%). People noting their race as Black or African American, American Indian and Alaskan Native, Asian or Pacific Island, or another race alone are each 1.0% or less of the CHB population. Fillmore County also has and provides services to nine Old Order Amish communities. Approximately 10% of Fillmore County residents live within the Amish community.

As of 2023, approximately 94.3% of Minnesotans over age 25 are high school graduates or hold a bachelor's degree or higher. Exploration of the U.S. Census Data estimates from 2023 identified that 92.8% of Fillmore County and 94.4% of Houston County residents over age 25 are high school graduates or have a higher degree. Within Fillmore County 5.2% of residents speak a language other than English with 2.6% speaking English less than "very well." Approximately 3.5% of Houston County residents speak a language other than English with 1.5% saying they speak English less than "very well." Languages spoken within the area include English, Palatine German (Pennsylvania Dutch/German), Spanish, Somali, and Hmong (Minnesota Compass, 2025).

Effective July 2025, the Minnesota unemployment rate was 3.9% while the Fillmore and Houston County unemployment rates were respectively 3.2% and 3.0%. Minnesota 2023 per capita income based upon U.S. Census estimates was \$46,350. The Fillmore County per capita income was \$37,134 and the Houston County per capita income was \$41,820. The percentage of people whose income was below the poverty level in Minnesota was 9.2%. Approximately 8.9% of Fillmore County and 6.5% Houston County residents reported living in poverty in the past twelve months. The impact of poverty within the FHCHS is greatest among children of single parent households and people over age 65. (US Census, 2023). Employment, income, and poverty are interrelated economic characteristics that play a role in both individual and community health.

Measures of length of life in a community indicate whether people are dying too early, prompting discussion of possible reasons and action strategies . The crude birth rate in Minnesota is 11.2 births per 1,000 population as compared with 12.1 and 9.1 births per 1,000 population in Fillmore and Houston counties. The 2023 premature death (<75 years) and age-adjusted rate in Minnesota was 271.00 deaths per 100,000 people. The age-adjusted death rate in Fillmore and Houston County were respectively 217.00 and 272.90 deaths per 100,000 population. The leading causes of death, many of which are preventable, in the area were heart disease, cancer, residual/unknown, Alzheimer’s disease, Chronic Obstructive Pulmonary Disease (COPD), unintentional injury, stroke, and COVID.

### **Health Equity**

Health equity is the state in which all people have the opportunity to be the healthiest they can be. As defined by the Minnesota Department of Health “health inequity is a difference in health status between more and less social and economically advantaged groups, caused by systemic differences in social conditions and process that effectively determine health. Health inequities are avoidable, unjust, and therefore actionable.” The health inequities identified through the community health improvement process were age, socio-economic status, and culture.

Social Vulnerability (SV) refers to a community’s capacity to prepare for and respond to the stress of hazardous events ranging from natural disasters to human-generated events. The Social Vulnerability Index (SVI) is based upon sixteen census-derived factors surrounding the themes of economic data, education, family characteristics, housing, language, ethnicity, and vehicle access. Areas denoted with darker shading indicate higher SVI scores. Approximately 75% of the geographical area of Fillmore County has higher overall social vulnerability as represented in light blue and/or dark blue. The highest levels are along the southern edge of Fillmore County. Upon examination, 75% of the geography of Houston County has SVI areas that are light blue. Figures 1 and 2 below illustrate the higher impacted SVI areas within both counties.

Figure 1: Social Vulnerability Index of Fillmore County, Minnesota.

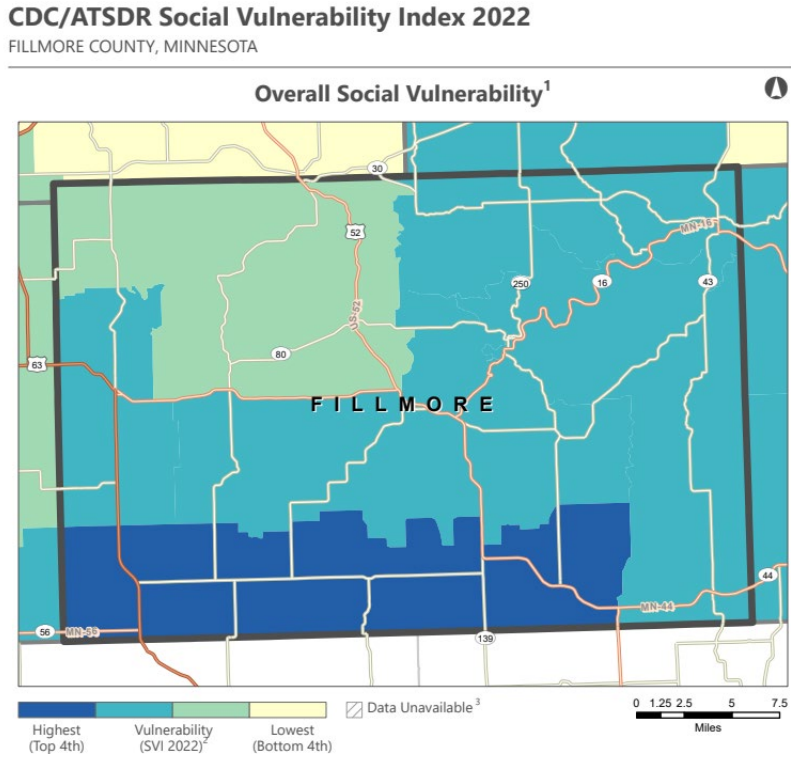
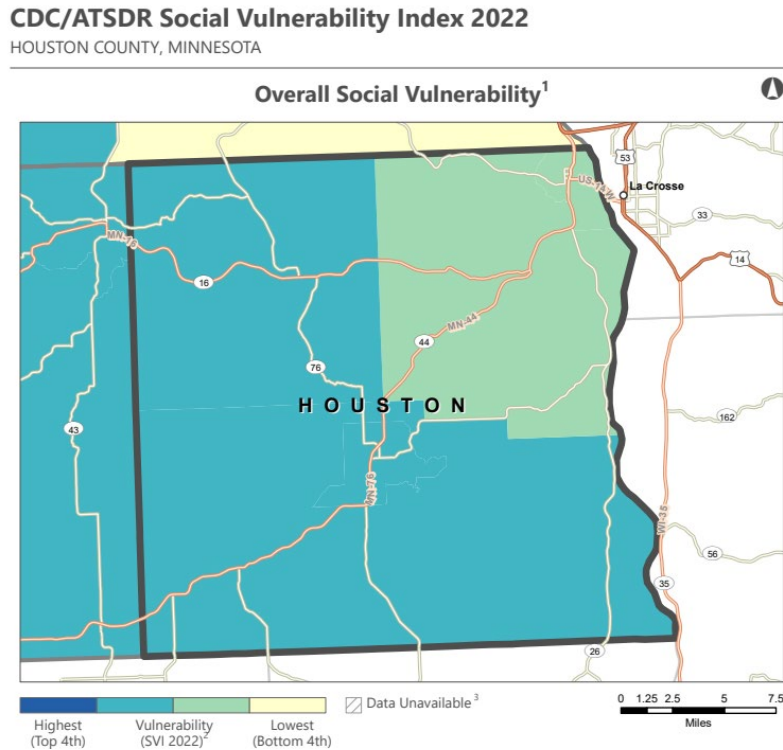


Figure 2: Social Vulnerability Index of Houston County, Minnesota.



The social determinants of health playing a role in these inequities are job opportunities, wages, transportation options, housing, access to health care, and the availability of social support networks. Social determinants of health play a role in priorities selected through the Community Health Improvement Planning Process and require addressing during Community Health Improvement Plan strategy implementation.

### **Community Health Improvement Planning (CHIP) Process**

The Community Health Assessment and Community Health Improvement Process align with Public Health Accreditation Standard (PHAB) Domain 1, Standard 1.1 and Domain 5, Standard 5.2. The process used to complete community health improvement planning for the Fillmore-Houston CHS derived from Community Commons and Mobilizing for Action through Planning and Partnerships (MAPP 2.0). This process involved the following three steps.

1. Building a foundation for community health improvement.
2. Tell the community story through community partner, status, and context assessments.
3. Continuously improving the community.

### **Community Stakeholders**

Fillmore and Houston County engaged both individuals and organizations in the prioritization process for identifying community health needs. Individual citizens participated in the process by completing a community health assessment and both individuals and organizations engaged in the prioritization of community health needs, asset identification, and strategy development. Please see Appendix A for a comprehensive listing of participating organizations. Stakeholders invested in this process will continue to support efforts defined in the Community Health Improvement Plan (CHIP) by implementing strategies and monitoring and revising the plan annually.

### **Data Collection and Interpretation**

From 2020-2025, Fillmore and Houston County developed and implemented independent community health needs assessment processes. These assessments gathered information from individual participants regarding perceptions of community health, personal health behaviors, demographics, and public health services. Community health needs assessment information was shared with both the public and participants online and through in-person meetings.

From April to July 2025, Fillmore County completed a Community Health Needs Assessment that addressed 44 questions about health care access and status, health behaviors, transportation, emergency preparedness and response, home environment, economic stability, social support, public health priorities, factors that impact equity, and demographics. This randomized survey was mailed to 1,200 households and completed by 332 (n = 322) or 26.8% Fillmore County households who it (See Appendix B). Ten surveys were removed from analysis as 50% or more of the survey was incomplete. From July to August 2025, data was weighted by Wilder Research. Weighing is used to compensate for limitations of a sample survey such as nonresponse and under-coverage of specific populations by demographic factors. Fillmore County data was weighted by age, gender, education, and number of adults in the household.

As part of the weighting process the following groups were consolidated for analysis; 18-24 and 25-34 year olds by gender, less than high school through GED or high school graduate, trade/vocational and associate degrees, and bachelor or higher degrees. Health themes noted as opportunities to address include access to dental and eye care, healthy eating, radon awareness, adult tobacco use, volunteerism, and social connectedness.

Data collection in Houston County was completed using the 2023 United Way COMPASS Now Community Needs Assessment with a convenience sample. COMPASS data was collected through a community survey, focus groups, review of socio-economic indicators, and inventory of community resources. COMPASS was completed at random by Houston County households. Completed surveys were returned by 89 households. This assessment information is available as Appendix C.

Fillmore and Houston County supplemented adult survey information with data from the Minnesota Center for Health Statistics, 2022 Minnesota Student Survey, and the 2024 Semcac Community Needs Assessment. In 2024, Semcac completed a Community Needs Assessment and Community Action Plan. This assessment placed focus upon factors that impact health equity such as demographics, service utilization, and current housing, transportation, food, and other needs. Community members within the Semcac Service area completed this voluntary survey. A total of 757 completed surveys were returned, 113 of which were from Fillmore County and 143 from Houston County. This survey was completed by a greater proportion of adults aged 25-34. Key findings from this assessment were the need for food security, transportation, affordable health care coverage, clothing and shoe needs, and safe, affordable, and suitable housing (Semcac, 2024).

Community Health Needs Assessment and the Community Health Improvement Plan were presented to the Fillmore-Houston Community Health Board on August 26, 2025.

### **Community Engagement**

From 2020-2025, Fillmore County Public Health collaborated with 460 individuals to complete the community health improvement plan. This number in addition to the 332 county residents who completed the community health needs assessment. This five-year process gathered information from various individuals and community partners about child care, access to care, mental well-being, food security and health eating, child development, retail sale of tobacco, alcohol, and tobacco products, public health emergency preparedness and response, active living, employment, communication and information, social inclusion, social participation, housing, and transportation.

Starting in September 2023, Age-Friendly Fillmore County began collaborating with community partners to gather information about health, equity, social determinants of health, and the AARP Eight Domains of Livability. Data was collected using various strategies including focus groups, key informant interviews, community member surveys and comments, committee meetings, community charrettes, and community environmental asset and opportunity scans. There were seven focus groups held in the areas of Pilot Mound Township, Chatfield, Rushford,

Harmony, Mabel, Lanesboro, and Fountain from September 2023 to April 2024. During 2024, ten community activities using various modes of information gathering were conducted in Pilot Mound Township, Wykoff, Chatfield, Spring Valley, Harmony, Preston, Rushford, and Mabel. Participating locations included community events, food shelves, care giver classes, and county resident's homes. Community assets and supports identified during this process included: community connectedness and belonging, beautiful environment, safety, economic stability, public and private amenities, schools, places of worship, volunteerism, meals on wheels, food shelves, and spaces for recreation. These community assets and supports are available in a Community Resource Guide which available from Fillmore County Public Health and Fillmore County Social Services.

Upon completion of the community health needs assessment, additional data from local, state, and national resources was gathered to prepare for use in the asset inventory and prioritization process. Houston County Public Health held a COMPASS 2024 Focus Group Summary in June 2024. The meeting was held at Houston County Public Health and consisted of eight participants. The focus group addressed the areas of concern/challenge within the community, how these areas would be addressed, along with questions on economic development, health, safety, education, housing, the needs of vulnerable population and social connectedness within the community.

### **Prioritization Process**

In Fillmore County, the community health needs assessment survey and community engagement process were both utilized to determine the top ten priority areas. The top ten priorities identified by individuals as noted by weighted Community Health Needs Assessment data are in Table 2 by order of prioritization. The top five priority areas were mental health, access to health care, infectious disease, water quality, and healthy eating. The top three areas identified by the 17 Age-Friendly community events were health services and community supports, transportation, and housing. Health services and community supports mentioned at a higher level were places to access food, dental and mental health services, and chore services. This is also consistent with the findings in the 2024 Semcac Community Health Needs Assessment.

In Houston County, a Community Stakeholder Meeting was held in Caledonia on March 26, 2024 for COMPASS and on June 4, 2024 with the Advisory Board for the Houston County Community Needs Assessment Survey. The purpose of these meetings was to share data from the COMPASS Now 2024 Community Needs Assessment to generate, discuss, and establish top five concerns and identify community resources to support community needs. Priorities for both groups were tabulated together to create a top five list of priorities which are provided on Table 2.

Table 2. Community Health Assessment Data: Top Five to Ten Public Health Issues  
 Prioritization Meeting Data

	Fillmore	Houston
1	Mental Health (63.8%)	Mental Health
2	Access to Health Care (49.9%)	Healthy Eating
3	Infectious Disease (42.3%)	Active Living
4	Water Quality (42.1%)	Access to Dental Services
5	Healthy Eating (38.9%)	Environmental
6	Pregnancy and Parenting (36.4%)	
7	Disasters (36.1%)	
8	Alcohol and Drug Use (32.7%)	
9	Dental Health (32.1%)	
10	Active Living (32.1%)	

**Health Priority Justification**

The Fillmore-Houston CHS convened a workgroup to review internal and external data resources and prioritization results from both the community health needs assessment and community prioritization meeting process. The work group selected healthy eating and access to care as priorities. Priority selection justification is based upon community health needs assessment results, community prioritization results, other reliable data sources, and community assets. Selection of these priorities for the community health improvement plan in no way limits efforts to address other identified priorities. Many of these other priorities are being addressed in some capacity through other efforts within the Fillmore-Houston CHB.

The Minnesota Statewide Improvement Framework 2025-2029 establishes equitable access and care as one of the top three priorities to address the health of Minnesotans. Example population health indicators for this priority include the number of people foregoing care due to cost, fair treatment, and the availability and proximity to providers. These priorities also align with the National Prevention Strategic Directions of Healthy and Safe Environments and Clinical and Community Preventative Services and the priority of Healthy Eating. The Fillmore-Houston CHS and Healthy People 2030 both address access to care and healthy eating as objectives. Healthy People 2023 focuses on improving health by helping people get timely, high-quality health care services which can reduce morbidity, mortality, and associated health care costs. Healthy People addresses the need to eat nutritious foods as means of reducing the risk of chronic disease. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health. Other social determinants included in this plan address availability of resources to meet daily needs like economic stability, health care provider access, and food sourcing options.

### **Fillmore-Houston Priority 1: Healthy Eating**

A healthful diet reduces the risks of developing chronic diseases, pregnancy complications, developmental problems, and early death. Results from local Community Health Needs Assessments and Minnesota Student Survey note the need for increasing consumption of fruits and vegetables among both adults and youth. Addressing healthy eating via improving access is one of two primary priorities of the Fillmore-Houston Community Health Service.

For infants, breastfeeding is a method to obtain nourishing, affordable, and culturally relevant food. Breastfeeding initiation by Fillmore and Houston WIC participants is 83%, which is slightly below the Minnesotan rate of 83.5%. Fewer Fillmore-Houston CHS WIC participants (12.1%) breastfed for a 12 month duration compared to Minnesota WIC participants (14.7%). As infants grow into children and adults, fruit and vegetable intake is one measure of healthy eating. Fillmore (86.4%) and Houston County (86.5%) 11th graders' recommended consumption of five daily servings of fruits and vegetables is below the Minnesota average (88.9%) and only about 1 in 3 adults are eating at least five servings of fruits and vegetables five or more days of the week. This presents an opportunity to increase healthy eating through the lifecycle.

The number of children eligible for free and reduced lunch in Fillmore County, while below the Minnesota average of 43%, has jumped substantially from 19% in 2024 to 36% in 2025. The number of children eligible for free and reduced lunch in Houston County went from 26% in 2024 to 44% in 2025 (County Health Rankings and Roadmaps, 2025). Sixty-four percent of Fillmore and 61% of Houston households are eligible for SNAP versus 58% of all Minnesotans. An estimated 10.4% of Minnesota households experience food insecurity, which means their access to adequate food is limited by lack of money or other resources and this is linked increased risk for obesity and other preventable chronic diseases. Approximately 9.8% of Fillmore and 8.8% of Houston households experience food insecurity (Feeding America, 2023).

According to the USDA Food Access Research Atlas (2019), residents living in the southern and western portions of Fillmore County lack transportation access and are more than twenty miles from the nearest supermarket, putting them at risk for food insecurity. In Houston County, food insecurity is greater in the land tract surrounding Caledonia due to lower income and an urban distance of more than a mile from a supermarket.

Semcac conducted a convenience sample of 113 Fillmore and 143 Houston County adult residents. Fillmore County residents top three concerns about food were food security, accessing or preparing well-balanced nutritious meals, and access to a food shelf. Houston County participants' top three priorities were food security, accessing and preparing nutritious meals, and free or reduced lunches for children (Semcac, 2024).

Factors that influence healthy eating include knowledge and attitudes, cooking skills, access to cooking supplies and kitchen equipment, food and agricultural policies, food assistance programs, access to retailers who sell healthy foods, having access to healthy, safe and affordable food, and being surrounded by a culture that supports healthy food consumption. Implementation strategies addressing these factors and are described under Appendix D.

## Fillmore-Houston Priority 2: Access to Dental and Health Care

Access to care is crucial for achieving optimal health outcomes, reducing health disparities, and ensuring individuals and communities are healthy and thrive. For the purposes of this plan, the scope of health care access pertains to physical, dental, eye, or mental health. Factors that play a role in health care include timeliness, healthy equity, affordability, medical debt, access to preventative services, transportation, insurance coverage, provider availability, provider reimbursement, and social acceptance. Improving health care access is one of the two the health priority of the Fillmore-Houston Community Health Service.

Within the Fillmore-Houston Community Health Service area there is a need for health care providers. There are a total of ten primary clinics and no hospital in each county. Each county has one clinic that provides eye care. Table 3 reflects the need for providers in each county based upon the patient to provider ratio for primary, dental, and mental health care. The patient to provider ratios in both counties are significantly higher than those of Minnesota and the United States. It is important to note that many of the current providers are of or nearing retirement age and rural recruitment of younger providers may pose a challenge. Patients have experienced appointment unavailability and providers refusing their insurance. This is especially true for people enrolled with Medicaid and Medicare insurance. Both the Fillmore and Houston County Health Department assist community members with reducing barriers associated with identifying providers, getting transportation to appointments, and applying for insurance.

Table 3: Patient to Dental, Mental, and Primary Care Provider Ratios in Fillmore and Houston County. (County Health Care Rankings and Roadmaps, 2025)

	<b>Fillmore County</b>	<b>Houston County</b>	<b>Minnesota</b>	<b>United States</b>
<b>Dentist Ratio</b>	1,780:1	1,880:1	1,290:1	1,360:1
<b>Mental Health Provider Ratio</b>	2,390:1	2,320:1	280:1	300:1
<b>Primary Care Physician Ratio</b>	3,550:1	1,710:1	1,130:1	1,330:1

Access to preventative services, such as routine physicals and vaccinations, maintains health of the public. Individuals with access to these resources are more likely to receive necessary care early thus improving health care outcomes, assisting them with disease or illness management, and reducing health care costs. Preventative screening is crucial for identification and treatment of diabetes, cancer, and cardiovascular disease which contribute to the leading causes of death in Fillmore and Houston County. Vaccinations play a critical role in reducing both individual illness and community outbreaks which are preventable. Maintaining good oral hygiene and care can reduce the risk of heart disease, diabetes, infection, and complications with pregnancy. It also helps with speech development and socialization.

Fillmore County residents were asked if any time in the past 12 months someone in their household needed care and did not get it or delayed getting it. It was noted that 28.5% reported having no or delayed dental care, 16% of Fillmore County residents reported having no or a delayed annual physical, 15.9% reported having no or a delayed eye exam, and 12.1% they delayed or did not receive a vaccination they needed. The primary reason for delays in care was cost. Unlike medical coverage, more households lack dental and eye care coverage unless it is rolled into their traditional health care insurance. (Fillmore County Community Health Needs Assessment, 2025).

The recommendation for all people is to see a dental provider at least every six months for preventative care. Both Fillmore and Houston County have a significant number of children enrolled with Medicaid or without insurance coverage who have not seen a dentist in a year or more. This is validated by 2022 Minnesota Student Survey results regarding access to routine dental care and dental treatment. Between roughly 9% to 17% of 9<sup>th</sup> and 11<sup>th</sup> grade youth have not had the recommended dental preventative care as noted in Table 4. It was also noted that in Houston County a higher number of Houston County youth were unable to get dental treatment for dental problems as compared to the Minnesota average (Minnesota Student Survey, 2022)

Table 4: Frequency of dental appointments among 9<sup>th</sup> and 11<sup>th</sup> grade youth in Fillmore and Houston County (Minnesota Student Survey, 2022)

	Fillmore Grade 9	Houston Grade 9	Minnesota Grade 9	Fillmore Grade 11	Houston Grade 11	Minnesota Grade 11
During the last year	84.6%	86.2%	81.0%	83.3%	91.7%	78.8%
Between 1 and 2 years ago	10.3%	12.1%	12.1%	5.0%	6.3%	13.1%
More than 2 years ago	3.8%	1.7%	5.5%	8.3%	1.4%	6.7%
Never	1.3%	0.0%	1.4%	3.3%	0.7%	1.3%

Access to care is more than visiting a doctor, dentist, or therapist; it encompasses the availability, affordability, and acceptability of healthcare services. Improving access is essential for fostering a healthier society, reducing disparities, and ensuring that all individuals can achieve their best possible health outcomes. Addressing the barriers to access is a critical step toward achieving health equity and improving the overall health of communities. Both the Fillmore and Houston County Health Department assist community members with reducing barriers associated with identifying providers, getting transportation to appointments, and applying for insurance. As a Community Health Service, the goal is to continue to address barriers and disparities associated with medical, dental, and mental health care access.

### **Community Health Improvement Plan Implementation**

Fillmore and Houston work with local partners identified within the CHIP to propel efforts forward that will address health eating and access to care. This work occurs with individual partners or small partner work groups. These partnership contributions assist with service linkages and improving the CHIP priority areas. Implementation plans are available in Appendix D and Appendix E.

### **Community Health Improvement Plan Updates**

The plan undergoes annual review and revision by internal performance management teams and external advisory committees and partners working on strategies. Partners working on specific strategies assist by providing current localized data and outcome reports. Updates to the plan occur in both the CHIP and associated appendices, which address strategy implementation, action steps, data updates, outcomes, revisions, and revision justifications. Resources for assessing benchmarks and indicators for both health priorities are located in Appendix F. Sharing of CHIP updates occurs with governing bodies and advisory committees via annual reporting and ongoing programmatic updates. Annual updates are located in Appendix D and Appendix E.

## Appendix A: Fillmore-Houston CHS Community Health Improvement Plan Stakeholders

Fillmore County Organizations	Houston County Organizations
Age-Friendly Fillmore County (220)	ABLE Inc.
Bridges Health	Caledonia School District
Children’s Dental Health Services	City of Caledonia
Cities of Chatfield, Fountain, Harmony, and Mabel	Gundersen Health System (Emplify)
Copewell Participants (49)	Houston County Board of Commissioners
Chatfield Food Shelf	Houston County Public Health & Human Services
Chatfield School District	Houston County Public Health Advisory Board
Fillmore-Central School District	La Crescent Food Shelf
Fillmore County Board of Commissioners	Mayo Health System
Fillmore County Family Services Collaborative	Minnesota Department of Health
Fillmore County Public Health Hazard Risk Assessment Participants (21)	Semcac
Fillmore County In-Home Child Care Providers (15)	<p><i>Please note that many of these community coalitions, collaboratives, or groups are comprised of various sectors that include health care, government, public safety, faith communities, schools, workforce development, and more.</i></p>
Fillmore County Public Health Advisory Committee	
Fillmore County Public Health	
Fillmore County Public Health Dental Clinic Clients (56)	
Fillmore-Houston Toward Zero Deaths Coalition	
Follow-Along Program Participants (40)	
Good Shepherd Child Care	
Harmony Care Giver Class	
Harmony Kids Learning Center	
Healthy Food for All Summit Participants (27)	
Kingsland School District	
Lanesboro Child Care Center	
Lanesboro School District	
Mabel-Canton School District	
Mabel Food Shelf	
Nisse Treehouse Child Care and Preschool	
One Block at a Time Child Care and Preschool	
Pilot Mound Township	
Rochester Community and Technical College	
Root River Trail Towns (9)	
Rushford-Peterson School District	
St. John’s Lutheran Church – Food Shelf	

## Appendix B: Fillmore County Community Health Needs Assessment Weighted Results 2025

### FILLMORE COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT 2025

#### HEALTH CARE ACCESS AND HEALTH STATUS

1. During the **past 12 months**, has there been a time you or someone in your household needed care for any of these reasons and did not get it or delayed getting it?

	Yes	No
Annual or routine checkup	16.0%	79.3%
Dental care	28.5%	68.0%
Emergency medical care	1.6%	90.4%
Eye care	15.9%	77.8%
Family planning services	1.2%	88.7%
Immunization	12.1%	80.4%
Medications or prescriptions	8.5%	84.7%
Mental health care	7.6%	84.8%
Preventative health screening	8.3%	84.3%

2. Why did you or your household member delay or not get the health care services you needed? (Mark all that apply)

- Appointment unavailable **(6.9%)**
- Could not find a provider **(5.4%)**
- Fear of the unknown or what others think **(4.0%)**
- Feeling that the treatment may not help **(7.8%)**
- Insurance did not cover the services **(16.4%)**
- It costs too much **(23.1%)**
- Lack of insurance **(5.7%)**
- Lack of or problems with transportation **(3.6%)**
- Provider refused insurance type **(6.2%)**
- Work, family, or other obligations **(8.5%)**
- Other (Please specify): **(3.7%)**

3. For each of the following statements, please mark which is the closest to how you have been feeling over the **past two weeks**.

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
I have felt cheerful, in good spirits, and hopeful.	20.4%	58.1%	16.9%	4.2%	0.3%
I have felt calm and relaxed.	17.4%	57.0%	14.1%	8.2%	0.3%
I have felt active and vigorous.	15.7%	45.0%	22.4%	12.1%	2.2%
I have participated in daily activities that are interesting and please me.	28.3%	46.5%	17.4%	4.7%	1.6%
I have opportunities to interact with others.	43.2%	37.0%	12.9%	4.2%	1.6%
I have felt safe in my home.	85.3%	13.1%	1.0%	0.2%	0.4%
I have felt safe in my community.	75.1%	18.3%	6.1%	0.1%	0.1%
I have felt welcome in my community.	66.6%	20.4%	9.9%	1.7%	0.6%

## HEALTH BEHAVIORS

4. 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 only light sweating and a small increase in breathing or heart rate.

Number of days

- 0 (7.4%)
- 1 (6.0%)
- 2 (14.6%)
- 3 (20.2%)
- 4 (10.2%)
- 5 (16.2%)
- 6 (9.2%)
- 7 (15.5%)

5. 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.

Number of days

- 0 (19.5%)
- 1 (19.7%)
- 2 (21.3%)
- 3 (11.5%)
- 4 (11.3%)
- 5 (7.4%)
- 6 (3.4%)
- 7 (5.7%)

6. When you think about opportunities in your community that would help you to be more physically active, pick the one option you feel would best support you.

- Access to safe and well-maintained sidewalks. (16.6%)
- Community-based programs that provide opportunities to learn about and practice being active. (6.7%)
- Park and recreation opportunities for all ages. (5.5%)
- Public facilities that open their spaces for low-cost or no-cost physical activity. (16.5%)
- Safe intersections and designated spaces on roads where sidewalks are absent. (5.4%)
- Trails that can be used for multiple purposes throughout the entire year. (25.2%)

7. During an **average week**, how many days do you eat at least five servings of fruits and vegetables? A serving is defined as 1 cup of leafy greens, 1 cup of fresh, frozen, or cooked fruits and vegetables, 1 medium piece of fruit, or ½ cup of dried fruits or vegetables.

Number of days

- 0 **(12.2%)**
- 1 **(5.8%)**
- 2 **(18.0%)**
- 3 **(19.3%)**
- 4 **(12.4%)**
- 5 **(14.0%)**
- 6 **(7.1%)**
- 7 **(9.4%)**

8. When you think about opportunities in your community that would help you eat better, pick the one option you feel would best support you.

- Access to nutrition education and support such as Meals on Wheels, Senior Dining, SNAP, WIC. **(7.0%)**
- Community-based programs that offer opportunities to learn about and practice healthy eating. **(4.2%)**
- Community-based gardens. **(9.7%)**
- Farmer’s markets. **(30.3%)**
- Food shelves or food pantries. **(0.8%)**
- Healthy food prompts at businesses that sell food. **(9.0%)**
- Paid subscription for fresh fruits and vegetables from a local producer. **(9.8%)**

9. How often do you currently use any of the following tobacco or nicotine products?

	Every day	Some days	Not at all
Cigarettes	10.4%	2.3%	83.9%
Cigars, cigarillos, or little cigars	0.0%	1.6%	94.2%
Dissolvable strip or pill	0.0%	0.0%	95.8%
E-cigarettes: E-Juice, Electronic Nicotine Delivery Systems, or Vapes	0.9%	1.7%	95.3%
Pipes	0.1%	0.4%	94.4%
Snuff, snus, pouch, dip, or chewing tobacco	1.6%	1.6%	93.1%
Any other type of tobacco product	0.0%	0.9%	94.9%
Tobacco-free nicotine products: Lucy, On, Syx, or Velo	3.4%	0.0%	92.4%

10. Do the tobacco or nicotine product(s) you use contain any of the following?

- Menthol **(1.1%)**
- A flavor other than menthol **(6.9%)**
- Non-menthol **(11.3%)**
- Not applicable: I don’t use these products **(77.8%)**

11. During the **past 12 months**, have you stopped using tobacco or nicotine products for one day or longer because you are trying to quit?
- Yes **(8.4%)**
  - No **(13.7%)**
  - Not applicable: I don't use these products **(76.8%)**
12. How often do you have drinks containing alcohol? A standard alcoholic beverage is defined as a 12-ounce beer, 5-ounce glass of wine, or a drink with a 1.5 ounce shot of liquor.
- Monthly or less **(19.6%)**
  - 2-4 times a month **(18.8%)**
  - 2-3 times a week **(11.7%)**
  - 4 or more times a week **(8.5%)**
  - Not Applicable: I don't use these products **(40.4%)**
13. How many cans of beer, glasses of wine, or drinks with liquor do you have on a typical day?
- I don't drink **(49.0%)**
  - 1 **(28.1%)**
  - 2 **(9.7%)**
  - 3 **(3.6%)**
  - 4 **(0.9%)**
  - 5 **(0.4%)**
  - 6 **(0.1%)**
  - 7 **(0.9%)**
  - 8 **(0.0%)**
  - 9 **(0.0%)**
  - 10 or more **(0.0%)**
14. How many times in the **past 12 months** have you had 4 or more drinks in a day (females) or 5 or more drinks in a day (males). A drink is a 12-ounce beer, 5-ounce glass of wine, or 1.5 ounce shot.  
Number of times
- Never **(60.1%)**
  - Once or Twice **(24.7%)**
  - Monthly **(7.3%)**
  - Weekly **(4.9%)**
  - Daily or Almost Daily **(1.4%)**

15. How often do you use any of the following hemp or cannabis (marijuana) products?

	Every day	Some days	Not at all
Cannabis/Marijuana: Pot, Hash, or Hash Oil	1.1%	3.5%	93.2%
Hemp or Cannabis Consumables: Edibles, Drinks, Etc.	0.0%	6.3%	91.4%
Hemp or Cannabis Topicals: Lotions, Salves, Etc.	0.0%	2.8%	94.9%
Medical Cannabis: Prescribed by an Approved Medical Provider	0.1%	1.1%	96.5%
Synthetic Marijuana: K2 or Gold	0.0%	0.0%	97.2%
Vaping Device or E-Cigarette with Marijuana, THC, Hash Oil, or THC Wax	0.0%	1.1%	96.4%

16. How often do you use any of the following substances for **non-medical purposes**?

	Every day	Some days	Not at all
Cocaine or crack	0.0%	0.0%	96.7%
Fentanyl/Fentanyl-laced pills (Blues, M30s, Perc30s, Xanax bars, or Z-Bars)	0.0%	0.0%	96.7%
Hallucinogens (Ecstasy, MDMA, Mushrooms, or PCP)	0.0%	0.0%	96.7%
Heroin	0.0%	0.0%	96.4%
Inhalants (Glue, Markers, Spray Paint, or Whip-Its)	0.0%	0.0%	96.6%
Pain relievers (Acetaminophen with Codeine, Oxycodone, or Vicodin)	1.0%	5.6%	90.5%
Stimulants (Adderall, ADHD Drugs, Methamphetamines, Ritalin, or Speed)	0.0%	1.2%	95.3%
Synthetics (Bath Salts, K2, Spice, Etc.)	0.0%	0.4%	96.3%
Tranquilizers or sedatives (Ativan, Benzos, Kratom, Valium, Xanax, Etc.)	0.0%	0.5%	96.1%

17. During the **past 12 months**, have you stopped using cannabis or other substances for one day or longer because you are trying to quit?

- Yes (**0.5%**)    No (**7.4%**)    Not applicable: I don't use these products (**86.9%**)

## TRANSPORTATION

18. How often do you do the following when traveling in a vehicle?

	Always	Sometimes	Never	I don't drive
Get a sober ride to my location after drinking alcohol.	33.1%	8.6%	26.6%	19.7%
Get a sober ride to my location after using products containing cannabis.	16.2%	0.9%	28.8%	22.5%
Make or answer a phone call without holding the phone while driving.	25.8%	30.3%	27.0%	12.7%
Read or send written texts or emails without holding the phone.	12.5%	22.5%	49.7%	9.8%
Surf the internet or use apps or social media without holding the phone while driving.	4.1%	5.6%	73.5%	10.4%
Wear a seat belt when driving.	86.4%	1.2%	0.3%	10.0%
Wear a seat belt when riding as a passenger.	92.9%	3.2%	1.1%	0.4%

19. How do you get around for things like shopping, doctor visits, running errands, or going other places? (Check all that apply)
- Drive yourself **(86.2%)**
  - Have friends or family drive you **(27.6%)**
  - Ride a bike **(6.6%)**
  - Take a taxi or cab **(9.3%)**
  - Use public transportation **(1.7%)**
  - Use specialized transportation service available for older adults or people living with disabilities **(0.7%)**
  - Walk **(14.6%)**
  - Other (Please specify): **(5.3%)**

20. How often does lack of transportation prevent you from accessing the following:

	Daily	Weekly	Monthly	Never
Child care	0.0%	0.5%	1.7%	91.4%
Elder care	0.0%	0.3%	0.0%	93.5%
Errands or chores	0.9%	1.3%	2.4%	91.2%
Medical or dental appointments	0.0%	0.4%	2.2%	93.4%
School	0.0%	0.0%	0.0%	93.7%
Senior dining	0.2%	0.0%	0.0%	93.4%
Social or recreational functions	0.0%	1.1%	2.1%	92.5%
Work	0.5%	0.3%	1.7%	92.5%

#### EMERGENCY PREPAREDNESS AND RESPONSE

21. If something unpredictable were to happen tomorrow such as a tornado, flood, or community disaster. (Mark all that apply).
- I have an emergency or evacuation plan for my household. **(48.3%)**
  - I have an emergency supply kit (Three-days of food, water, medications, hygiene supplies, etc.). **(30.0%)**
  - I have a contact list of people I can call to get help. **(60.8%)**
  - I have an emergency or crank radio with batteries. **(20.5%)**
  - I am willing to volunteer to help others. **(67.4%)**
  - I can count on my community to respond. **(60.2%)**
  - I can count on my community to fully recover. **(39.1%)**

22. Thinking about the various disasters that impact health, choose the top ten you feel are most important for the local public health department to be ready to respond to? (Select Up to Ten)
- Active Shooter **(49.6%)**
  - Biological (Infectious Disease) **(48.9%)**
  - Biological (Non-Infectious Disease) **(14.5%)**
  - Civil Unrest **(16.7%)**
  - Cyber Attack **(24.0%)**
  - Drought **(22.3%)**
  - Epidemic/Pandemic **(49.2%)**
  - Explosives Attack **(22.4%)**
  - Extreme Cold **(41.9%)**
  - Extreme Heat **(31.0%)**
  - Fire **(64.2%)**
  - Financial Crisis **(24.8%)**
  - Foodborne/Waterborne Disease **(52.2%)**
  - Hazardous Materials Exposure **(34.8%)**
  - Ice Storm/Blizzard **(57.5%)**
  - Land Subsidence **(18.3%)**  
(Cave Collapse/Landslides/Sink Holes)
  - Radiological Release **(18.1%)**
  - Straight Line Winds/Tornado **(75.0%)**
  - Terrorism **(27.7%)**
  - Transportation-Related Event **(9.4%)**
  - Utility Outage or Failure **(68.0%)**  
(Electrical/Fuel/Phone/Sewer/Water)
  - Wildfire **(33.3%)**

**HOUSING ENVIRONMENT**

23. Check if any of these options are needed to help your household live independently.
- Easier access into or within the home (ramps or wider doorways) **(4.5%)**
  - Bathroom modifications (grab bars, higher toilet, shower installation) **(10.0%)**
  - Putting a bedroom, bathroom, or kitchen on the first floor **(3.0%)**
  - Improving lighting **(4.4%)**
  - Installing a medical emergency response system that notifies others in case of an emergency **(6.8%)**
  - A differently sized-home that is affordable, accessible, and easier to maintain **(7.0%)**
  - Other (Please specify): **(4.8%)**
24. In the **past 12 months**, have you fallen at home or in the community?  Yes **(39.1%)**  No **(39.1%)**
25. In your home, do you **currently** have . . .

	Yes	No
A working carbon monoxide detector	72.9%	24.2%
A working fire extinguisher	66.8%	29.9%
A working smoke detector	88.0%	9.3%
Many extension cords because you need more electrical outlets	20.8%	74.9%
Old paint, cleaners, chemicals, or tires that need to be disposed of	26.3%	67.6%

26. Please share if you have the following at your home:

	Yes	No	I don't know
Alternate power source or generator	24.5%	70.9%	1.1%
Asbestos	3.9%	72.5%	18.3%
Electrical power	88.1%	9.6%	2.3%
Functional plumbing	96.3%	1.4%	0.1%
Functional septic system or sewer	92.6%	3.0%	1.7%
Heat	96.7%	1.1%	2.2%
Hot water	96.4%	1.2%	2.4%
Lead paint or pipes	4.6%	68.3%	22.9%
Mold	3.2%	69.2%	23.7%
Pests such as bats, insects, or rodents	31.4%	63.0%	2.5%
Private well water that has been tested for contaminants	35.2%	53.0%	5.7%
Radon levels above 4 pCi/L	2.2%	44.7%	45.5%
Structural damage	2.5%	84.9%	9.3%
Water leaks or damage	4.6%	83.8%	8.0%
Working appliances	96.4%	1.2%	2.5%

## ECONOMIC STABILITY AND VITALITY

27. Thinking about employment and volunteering . . .

	Yes	No
Do you want help finding a job?	1.1%	95.3%
Do you want help keeping work?	3.7%	92.4%
Do you want help with job-related training?	2.8%	93.5%
Are you currently volunteering in your community?	31.8%	64.7%
Are you interested in starting to volunteer in your community?	22.2%	71.0%
Would you like to be connected to volunteer opportunities in your community?	18.5%	72.5%

28. How hard is it for you to pay for the basics like clothing, food, health care, housing, and utilities?

Would you say it is:  Very hard (4.3%)  Somewhat hard (28.9%)  Not hard at all (63.6%)

29. In the **past 12 months**, have you been unable to pay for any of the following? (Mark all that apply)

- Child care (1.7%)
- Credit cards (7.2%)
- Elder care (0.2%)
- Food (6.1%)
- Health care insurance or expenses (8.0%)
- Housing (Mortgage or Rent) (5.4%)
- Loans (5.7%)
- Pet care (3.6%)
- Taxes (2.6%)
- Utilities (5.9%)
- Vehicle gas, insurance, or repairs (8.1%)
- Other (Please specify): (2.1%)

## SOCIAL SUPPORT

30. Do you have serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition?  Yes **(6.0%)**  No **(89.2%)**
31. Do you have difficulty doing errands alone such as visiting a doctor's office or shopping because of a physical, mental, or emotional condition?  Yes **(4.5%)**  No **(91.0%)**
32. When thinking about people who help support you would you say . . .

	All of the Time	Most of the Time	Some of the Time	A Little of the Time	None of the Time
I have good friends who provide me with the emotional support I need and with whom I can share my successes and problems.	51.3%	28.9%	9.7%	4.8%	2.9%
I have someone I can go to in my community if there is a sudden need for financial help like an unexpected \$500 bill.	41.7%	15.3%	7.2%	4.9%	25.8%
I have someone I can go to in my community if there is a sudden need for social support like helping with emergency child care or transportation help	46.6%	20.5%	8.2%	6.9%	14.4%

33. Below is a list of activities that are difficult for some people. Please check which answer best describes how difficult each activity is for you.

	Not Difficult	Somewhat Difficult	Very Difficult	Unable to Do
Activities of daily living like eating, bathing, dressing, and moving around the home	88.6%	7.8%	1.0%	0.4%
Being social or having companionship with others	83.1%	10.9%	3.3%	2.6%
Doing housework	79.1%	14.7%	3.3%	0.5%
Finding a person to help me with repairs	75.2%	18.5%	4.1%	0.2%
Managing medications	89.6%	6.3%	0.1%	0.9%
Managing money	83.0%	12.8%	1.5%	0.4%
Preparing meals	83.4%	13.1%	0.6%	0.4%
Shopping for personal items	88.0%	8.7%	0.1%	1.0%

## PUBLIC HEALTH PRIORITIES

34. From the list below, select **up to ten** priorities you feel public health should add

- Access to Health Care **(49.9%)**
- Air Quality **(20.3%)**
- Alcohol and Drug Use **(32.7%)**
- Chronic Conditions **(18.8%)**
- Dental Health **(32.1%)**
- Disasters **(36.1%)**
- Foodborne Diseases **(24.6%)**
- Infectious Diseases **(42.3%)**
- Injury Prevention **(11.3%)**
- Mental Health **(63.9%)**
- Nutrition **(38.9%)**
- Physical Activity **(32.1%)**
- Pregnancy and Parenting **(36.4%)**
- Public Health Nuisances **(15.6%)**
- Reproductive Health **(22.0%)**
- Tobacco Use **(24.0%)**
- Traffic Safety **(14.4%)**
- Vectorborne Diseases **(9.5%)**
- Waiver Services **(4.6%)**
- Waterborne Diseases **(20.0%)**
- Water Quality **(42.1%)**

35. Which age group best describes you:

- 18-24 **(4.4%)**
- 25-34 **(17.7%)**
- 35-44 **(15.8%)**
- 45-54 **(14.4%)**
- 55-64 **(18.0%)**
- 65 or older **(28.2%)**

36. Which of the following best describes you? (Mark all that apply)

- American Indian or Alaskan Native **(0.9%)**
- Asian **(0.0%)**
- Black or African American **(0.0%)**
- Hispanic or Latino **(0.4%)**
- Middle Eastern or North African **(0.0%)**
- Native Hawaiian or Pacific Islander **(0.0%)**
- White **(98.4%)**
- Other (Please specify): **(2.3%)**

37. Which of these terms best describes you?

- Female **(49.6%)**     Male **(50.4%)**

38. What is the highest level of education you have completed?

- Less than high school **(9.8%)**  
 High school graduate or GED **(31.1%)**  
 Trade/Vocational school **(19.3%)**  
 Associate degree **(17.3%)**  
 Bachelor's degree **(15.6%)**  
 Graduate or professional degree **(7.0%)**

39. Are you currently?

- Employed **(51.0%)**  
 Self-employed **(14.7%)**  
 Unable to find work due to disability **(1.0%)**  
 Unemployed or out of work **(3.2%)**  
 Retired **(25.9%)**  
 A homemaker or stay-at-home parent **2.0%**  
 A student **(0.0%)**

40. How tall are you without shoes on? **(Multiple Responses)**

Feet \_\_\_\_\_ Inches \_\_\_\_\_

41. Approximately how much do you weigh? **(Multiple Responses)**

Weight in pounds \_\_\_\_\_

42. Including yourself, how many adults and children live in your household?

Adults over 18:	<b>Range 1 to 6</b>
Children age birth to 4:	<b>Range 0 to 3</b>
Children aged 5 to 10:	<b>Range 0 to 3</b>
Children aged 11 to 14:	<b>Range 0 to 2</b>
Children aged 15 to 17:	<b>Range 0 to 2</b>

43. Thinking about information which best describes you? (Check all that apply)

- I know where to access accurate health information. **(78.8%)**  
 I have access to the internet. **(79.2%)**  
 I would like to learn how to better use technology to communicate. **(10.6%)**  
 Information is available to me in the language or format I need. **(63.9%)**

44. What is your annual household income from all sources?

- \$14,999 or less **(6.7%)**
- \$15,000 - \$24,999 **(6.1%)**
- \$25,000 - \$34,999 **(7.3%)**
- \$35,000 - \$49,999 **(11.7%)**
- \$50,000 - \$74,999 **(18.8%)**
- \$75,000 - \$99,999 **(15.5%)**
- \$100,000 - \$149,999 **(21.1%)**
- \$150,000 - \$199,999 **(7.8%)**
- \$200,000 or more **(5.0%)**

45. What is your zip code?

- 55922 (Canton) **(5.2%)**
- 55923 (Chatfield) **(12.2%)**
- 55935 (Fountain) **(4.1%)**
- 55939 (Harmony) **(12.9%)**
- 55949 (Lanesboro and Whalan) **(7.0%)**
- 55954 (Mabel) **(10.6%)**
- 55961 (Ostrander) **(1.4%)**
- 55962 (Peterson) **(3.1%)**
- 55965 (Preston) **(6.5%)**
- 55971 (Rushford and Rushford Village) **(14.5%)**
- 55975 (Spring Valley) **(19.1%)**
- 55976 (Stewartville) **(0.6%)**
- 55990 (Wykoff) **(2.9%)**

## **Appendix C: Houston County Community Health Needs Assessment Results 2024**

2024 Compass Now Houston County results are available in an eighty page document located at: <https://www.greatriversunitedway.org/wp-content/uploads/2025/02/compass-now-2024-houston-county.pdf>

**Appendix D: Fillmore-Houston Health Priority 1 – Healthy Eating 2025-2030**

**Goal 1:** Improve access to and consumption of healthy food in Fillmore and Houston County.

**Objective 1:** By December 2026, work with at least two emergency food programs within Fillmore and Houston County to increase food security.

**Objective 2:** By December 2026, work with at least two emergency food programs or retailers within Fillmore and Houston County to increase fruit and vegetable consumption while decreasing saturated fat, sodium, and added sugar consumption.

Evidence Based Actions	Partnership Sectors	Assets and Resources	Policy, System, or Environment (PSE) Change Implementation	Health Outcomes	Progress Benchmarks <sup>B</sup> or Indicators
Partner to increase access to healthy and affordable foods.	Childcare and Education Community Gardens Elected Officials Emergency Food Programs Faith Farmers Farmer’s Markets Food Retailers Libraries Public Health Semcac Social Services U of MN Extension WIC	Back Pack Programs Food Shelves Homestyle Direct Meals on Wheels Mom’s Meals School Nutrition Senior Dining SHIP U of MN Extension WIC	Develop and share a local food resource guide.  Incorporate SuperShelf standards at food shelves.  Institute healthy food donation, handling, storage, recovery, and transport PSE with emergency food programs.	Increased food security.  Increased fruits and vegetable consumption.  Reduced consumption of sodium, saturated fat, and added sugar.	Work with at least two partners instituting nutrition PSE changes. <sup>B</sup>  Types of food access and healthy food intake PSE changes.  FHCHS Community Health Assessments  Food Access Research Atlas USDA Mapping  Healthy People 2030
Help residents to identify healthy food and beverages choices.	Emergency Food Programs Food Retailers Public Health Public Libraries Social Services WIC	Clinics Food Shelves School Nutrition SHIP U of MN Extension WIC	Counsel clients to maximize food access, healthy choice selection, and preparation.  Institute healthy nutrition prompts at points of purchase.	Increased food security.  Increased fruits and vegetable consumption.  Reduced consumption of sodium, saturated fat, and added sugar	Minnesota Food Shelf Survey Results  Minnesota Student Survey  WIC Annual Summary Reports

**Appendix D: Progress Report for Fillmore-Houston Health Priority 1 – Healthy Eating 2025-2030**

**Goal 1:** Improve access to and consumption of healthy food in Fillmore and Houston County.

**Objective 1:** By December 2026, work with at least two emergency food programs within Fillmore and Houston County to increase food security.

**Objective 2:** By December 2026, work with at least two emergency food programs or retailers within Fillmore and Houston County to increase fruit and vegetable consumption while decreasing saturated fat, sodium, and added sugar consumption.

**Benchmark 1:** Work with at least two partners in instituting nutrition PSE changes.

**Indicator Update and Analysis:**

Health Priority Strategies	Strategy/Action Steps	Strategy/Action Progress	Revision Description	Revision Rationale
Partner to increase access to healthy and affordable foods.	Develop and share a local food resource guide.  Incorporate SuperShelf standards at food shelves.  Institute healthy food donation, handling, storage, recovery, and transport PSE with emergency food programs			
Help residents to identify healthy food and beverages choices.	Counsel clients to maximize food access, healthy choice selection, and preparation.  Institute healthy nutrition prompts at points of purchase.			

**Next Steps:**

**Appendix E: Fillmore-Houston Health Priority 2 – Access to Care 2025-2030**

**Goal 2:** Improve access to health care in Fillmore and Houston County.

**Objective 3:** By December 2026, work with at least two health care organizations within Fillmore and Houston County to promote and improve access to care for primary care, dental, vision, or mental health services.

Evidence Based Actions	Partnership Sectors	Assets and Resources	Policy, System, or Environment (PSE) Change Implementation	Health Outcomes	Progress Benchmarks <sup>B</sup> or Indicators
Assist residents in identifying and connecting with medical, dental, vision, and mental health providers.	Childcare and Education Emergency Food Programs Faith Families Health Care Head Start Insurance Companies Public Health Public Libraries Social Services Semcac	Age-Friendly C&TC Chiropractors Children’s Dental Health Dentists Medical Providers Medical Transportation Mental Health Teams Optometrists Parish Nurses Pharmacies RCTC School Nurses Therapists WIC ZV Medical Society	Counsel clients to encourage participation in preventative and maintenance care.  Cultivate community awareness of health conditions, preventative strategies to address them, and resources.	Increased participation in health care-related appointments for medical, dental, vision, and/or mental health care.  Reduced proportion of people who can’t get health care when they need it.	Number of youth and adults participating in preventative and maintain care events and appointments. <sup>B</sup>  Number of youth and adults receiving preventative care and/or medical, dental, vision, and/or mental health treatment. <sup>B</sup>  Healthy People 2030
Partner to address barriers to accessing to care.	Health Care Higher Education Insurance Companies Public Health Social Services	C&TC Children’s Dental Health Dentists Medical Providers Medical Transportation Mental Health Teams Optometrists Pharmacies RCTC Therapists ZV Medical Society	Establish agreements and/or policies with partners that reduce barriers to care.	Reduced proportion of people who can’t get health care when they need it.	FHCHS Community Health Assessments  Healthy People 2030  Minnesota Student Survey

**Appendix E: Fillmore-Houston Health Priority 2 – Access to Care 2025-2030**

**Goal:** Improve access to health care in Fillmore and Houston County.

**Objective 3:** By December 2026, work with at least two health care organizations within Fillmore and Houston County to promote and improve access to care for primary care, dental, vision, or mental health services.

**Benchmark 2:** Number of youth and adults participating in preventative and maintain care events and appointment.

**Benchmark 3:** Number of youth and adults receiving preventative care and/or medical, dental, vision, and/or mental health treatment.

**Indicator Update and Analysis:**

Health Priority Strategies	Strategy/Action Steps	Strategy/Action Progress	Revision Description	Revision Rationale
Assist residents in identifying and connecting with medical, dental, vision, and mental health providers.	Counsel clients to encourage participation in preventative and maintenance care.  Cultivate community awareness of health conditions, preventative strategies to address them, and resources.			
Partner to address barriers to accessing to care.	Establish agreements and/or policies with partners that reduce barriers to care.			

**Next Steps:**

**Appendix F: Fillmore-Houston CHIP Progress Benchmark and Indicator Resources**

<b>Progress Indicators or Benchmarks</b>	<b>Data Resource</b>
Fillmore-Houston Community Health Service Community Health Needs Assessment	Records on file. Current assessments provided as Appendices B and C.
Food Access Research Atlas USDA Mapping	<a href="http://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas.aspx">http://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas.aspx</a>
Healthy People 2030 – Access to Care Objectives	<a href="https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality">https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality</a>
Healthy People 2030 – Nutrition Objectives	<a href="https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/nutrition-and-healthy-eating">https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/nutrition-and-healthy-eating</a>
Minnesota Food Shelf Survey	<a href="https://www.thefoodgroupmn.org/more-minnesotans-visited-food-shelves-in-2024-than-ever-before-whats-behind-the-numbers/">https://www.thefoodgroupmn.org/more-minnesotans-visited-food-shelves-in-2024-than-ever-before-whats-behind-the-numbers/</a>
Minnesota Student Survey – Nutrition and Access to Care	<a href="https://public.education.mn.gov/MDEAnalytics/DataTopic.jsp?TOPICID=242">https://public.education.mn.gov/MDEAnalytics/DataTopic.jsp?TOPICID=242</a>
WIC Reports and Data	<a href="https://www.health.state.mn.us/people/wic/localagency/reports/index.html">https://www.health.state.mn.us/people/wic/localagency/reports/index.html</a>

## Bibliography

- AARP. (2025). *The 8 Domains of Livability: An Introduction*.  
<https://www.aarp.org/livable-communities/network-age-friendly-communities/info-2016/8-domains-of-livability-introduction.html?msockid=250c2d9626e567032c373bd527ba6664>
- Agency for Toxic Substances and Disease Registry. (2025). *SVI Interactive Map*. [Dataset].  
[https://www.atsdr.cdc.gov/place-health/php/svi/svi-interactive-map.html?CDC\\_AAref\\_Val=https://www.atsdr.cdc.gov/placeandhealth/svi/interactive\\_map.html](https://www.atsdr.cdc.gov/place-health/php/svi/svi-interactive-map.html?CDC_AAref_Val=https://www.atsdr.cdc.gov/placeandhealth/svi/interactive_map.html)
- Feeding American. (2025). *Food Security among the Overall Population in Minnesota 2022*. [Dataset]. <https://map.feedingamerica.org/county/2022/overall/minnesota>
- Fillmore County Public Health. (2025). *Community Health Needs Assessment* [Data file].
- Great Rivers United Way. (2025). *2024 Compass Now Houston County Needs Report*. [PDF File]. Retrieved from [https://www.greatriversunitedway.org/wp-content/uploads/2025/02/compass-now-2024\\_houston-county.pdf](https://www.greatriversunitedway.org/wp-content/uploads/2025/02/compass-now-2024_houston-county.pdf)
- Minnesota Department of Education. (2025). *Minnesota Student Survey Reports 2013-2022* [Dataset]. <https://www.health.state.mn.us/data/mchs/vitalstats/index.html>
- Minnesota Department of Health. (2025). *MN Vital Statistics Interactive Query Dashboards* [Dataset]. <https://www.health.state.mn.us/data/mchs/vitalstats/index.html>
- Minnesota Department of Health. (2025). *Healthy Minnesota Statewide Health Improvement Framework 2025-2029*. [PDF file]. Retrieved from <https://www.health.state.mn.us/communities/practice/healthymnpartnership/framework/shif2025.pdf>
- Minnesota Department of Health. (2025). *WIC Reports and Data* [Dataset]. <https://www.health.state.mn.us/people/wic/localagency/reports/index.html>
- Minnesota State Demographic Center Department of Administration (2025). *Population Data* [Dataset]. <https://mn.gov/admin/demography/data-by-topic/population-data/>
- Public Health Accreditation Board. (2014). *Public Health Accreditation Board Standards and Measures*. [PDF file]. Retrieved from [https://phaboard.org/wp-content/uploads/PHABSM\\_WEB\\_LR1-1.pdf](https://phaboard.org/wp-content/uploads/PHABSM_WEB_LR1-1.pdf)

- Semcac. (2025). *2024 Community Health Needs Assessment and Community Health Improvement Plan* [PDF file]. Retrieved from <https://www.semcac.org/wp-content/uploads/2024-Community-Needs-Assessment-Executive-Summary.pdf>
- United States Census Bureau. (2020). *Explore Census Data*. [Data set]. <https://data.census.gov/>
- United States Department of Agriculture. (2019). *Foods Access Research Atlas*. Retrieved August 20, 2025 from <https://www.ers.usda.gov/data-products/food-access-research-atlas/>
- United States Department of Health and Human Services. (2011). *National Prevention Strategy: America's Plan for Better Health and Wellness*. [PDF file]. Retrieved from <https://www.hhs.gov/sites/default/files/disease-prevention-wellness-report.pdf>
- National Association of County and City Health Officials. (2025). *MAPP 2.0: Mobilizing for Action through Planning and Partnerships*. <https://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/mapp/main>
- United States Department of Health and Human Services Office of Disease Prevention and Health Promotion. (2025). *Healthy People 2030* <https://odphp.health.gov/healthypeople>
- University of Wisconsin Population Health Institute. (2025). *2024 County Health Rankings* [Data set]. <https://www.countyhealthrankings.org/health-data>