Implementation Strategy Planning Report

Wishek Hospitals and Clinics

Facilitated by
Ken Hall, JD
Karin Becker, PhD candidate
Center for Rural Health
The University of North Dakota School of Medicine and Health Sciences

Funded by
The Department of Health and Human Services,
Health Resources and Services Administration, Federal Office of Rural Health Policy, North Dakota Medicare Rural Hospital Flexibility Grant Program
Introduction

Wishek Hospital & Clinics (WH&C), which includes a Critical Access Hospital (CAH), held a strategic planning workshop in Wishek, ND on October 3, 2013. Two representatives from the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences facilitated the meeting, which was attended by members of the hospital’s administrative staff.

The strategic planning workshop was a continuation of the overall Community Health Needs Assessment (CHNA) process, which is a requirement of the Affordable Care Act (ACA). The legislation mandates that non-profit hospitals conduct a CHNA at least every three years, examine input from community representatives, publicly disseminate the results, prioritize community health needs, and develop a written implementation strategy (a health improvement plan) to help meet the needs identified in the CHNA. With assistance from the Center for Rural Health, WH&C conducted the needs assessment portion of the process in 2011.

The purpose of the workshop was to initiate a more formalized strategic planning process resulting in a plan that helps address the identified significant community health needs. Strategic planning is a technique to assist a group to analyze current conditions and then develop strategies to address a set of issues and/or concerns. Workshop facilitators used a logic model as a framework for evaluating, analyzing, and organizing ideas to address the enumerated significant needs. Logic models are widely practiced in social science research to state future goals, outline responsibilities and actions needed to achieve the goals, and demonstrate a program’s progress.

To begin the strategic planning workshop, the facilitators from the Center for Rural Health shared findings from the 2011 CHNA report with the workshop participants. Data analyzed during the CHNA process included primary data (a community health survey and key informant interviews) and secondary data (analysis of County Health Rankings and other data sources). Where available, the secondary data were updated with 2013 figures so that participants had the most up-to-date snapshot of the area’s population health. The corresponding PowerPoint presentation is attached as Appendix A.

Through a voting and discussion process, participants prioritized several community health needs as being significant. These included an elevated rate of diabetics, an elevated rate of adult obesity, an elevated rate of physical inactivity, and limited access to recreational facilities. The group then collectively decided that because these needs were interrelated and overlapped considerably with one another, they should be collapsed into a broader need articulated as
“wellness.” The bulk of the remaining workshop then focused on ideas for a wellness campaign that would address all of the significant needs identified.

As part of the prioritization process, the group acknowledged that several of the needs that were identified in the 2011 assessment have been met, or are being met, through implementation strategies already enacted by the hospital. For example, the Wishek area was able to recruit two internal medicine physicians with the assistance of St. Alexius Medical Center. Dr. Joe and Dr. Raju began practicing in the area on July 1, 2013 and are obligated to stay for three years as a part of their J-I status. They both plan to focus on having positions in the hospitalist area. Additionally, WH&C has increased its efforts to disseminate information more robustly, which was an area of need noted in the assessment. Earlier this year WH&C implemented an area newsletter that is delivered to all post office addresses in the communities it serves with rural health clinics (Wishek, Napoleon, Kulm, and Gackle), as well as in Linton, Strasburg, Ashley, Lehr, and Fredonia. The WH&C website also has had a major makeover and is positioned to add information on a regular basis.

The workshop focused on generating ideas and strategies to address identified significant needs through a wellness campaign. To initiate the brainstorming process using the logic model, participants were presented with the need for a wellness campaign as the beginning point on a continuum. The end point was the outcome, or a vision of what the future would look like if that need was addressed. Participants were handed sticky notes and asked to write down desired outcomes, that is, goals or changes they would like to see related to this need. One facilitator organized the sticky notes into thematic categories and read them to the group as the other facilitator typed them into a laptop, and a table showing the logic model continuum was projected onto a screen so all could see. The outcomes were reviewed collectively so participants could discuss them.

Working backwards from the stated outcomes or goals, participants were then asked as a group to brainstorm activities that could help achieve the outcomes. Once a list of activities was produced and discussed, resources were identified to accomplish the activities, including people, organizations, existing infrastructure and programs, and potential financial resources. Finally, to complete the logic model, a list of outputs, or evidence that the activity was accomplished, was discussed but not produced as the activity needs to be enacted first. The output column in the table will be completed later. The brainstorming table, in draft form, is included in this report for informational purposes as Appendix B.

Through collaborative brainstorming, participants identified clear and measurable action steps that can be taken to address the needs identified through the assessment. A further step of
delineating who will be responsible for what activity and assigning a timeline to the tasks will help convey ownership.

**Priority Need: Wellness Campaign**

**Outcome Goals and Anticipated Impact**

- Have a staff member/instructor who promotes wellness in the community
- Increase community support and collaboration related to community wellness

**Specific Actions and Activities**

- Engage with employers in the area to offer blood pressure checks, promote awareness of physical therapy services, and offer prevention education services (e.g., prevention of diabetes, chronic disease, and back injury)
- Offer one or more cooking classes to educate participants about healthy eating and diabetic meals
- Dedicate half page in WH&C’s periodic newsletter, as well as space on WH&C website, to a “Wellness Update”
- Use WH&C newsletter and website to educate community members about services and facilities available within the community and from consumers’ health insurance companies
- Send WH&C staff member to annual Blue Cross Blue Shield of North Dakota wellness program
- Participate in Taste of Wishek event in June to highlight alternative, healthy cooking and baking options
- Partner with senior center and other community organizations to possibly offer dinner and dance class to encourage wellness and healthy recipes
- Engage with county extension service and public health to find ways to promote community wellness events and activities
## Resources to Commit

- Work with local wellness-related organizations
- WH&C newsletter and website
- WH&C staff time to plan wellness events
- WH&C financial resources for Taste of Wishek and/or other community events

## Accountable Parties

- Various administrative personnel at WH&C

## Partnerships/Collaboration

- Various local city and county public and private entities
The intervening time until the next CHNA is conducted provides the timeline for implementing these activities. Since WH&C’s most recent assessment was conducted in 2011, the next assessment will need to be completed no later than 2014. In the meantime, the activities set forth in the implementation strategy should be undertaken.

Summary and Next Steps

The strategic planning session was the starting point to begin the CHNA implementation strategy as required under the ACA. Participants met for approximately three hours and engaged in thoughtful discussions related to the goals and future of WH&C. Specific outcomes, activities, resources, and potential collaborators were generated from the previously prioritized needs as identified in the CHNA. The strategic planning process being used by WH&C is a tool to foster collaboration and increase the scope and reach of WH&C’s services. By identifying common values and focusing on efforts and activities to build a healthier community, WH&C has the opportunity to establish stronger relationships that can benefit the communities involved and local organizations.

Although the logic model provides initial structure and framework, a complete strategic planning process will require a number of additional sessions involving WH&C and possibly other collaborators.
Appendix A
Power Point Presentation

Wishek Hospital & Clinics
Needs Assessment Review/
Implementation Strategy Planning

Ken Hall, JD
Karin Becker, PhD candidate

Center for Rural Health

Established in 1980, at The University of North Dakota (UND) School of Medicine and Health Sciences in Grand Forks, ND
One of the country’s most experienced state rural health offices
UND Center of Excellence in Research, Scholarship, and Creative Activity
Home to seven national programs
Recipient of the UND Award for Departmental Excellence in Research

Focus on
- Educating and Informing
- Policy
- Research and Evaluation
- Working with Communities
- American Indians
- Health Workforce
- Hospitals and Facilities

ruralhealth.und.edu
Agenda

1. Overview of new IRS regulations.
   - New updates regarding implementation strategy.
2. Review of CHNA methodology and findings.
   - Potential needs.
3. Prioritization of needs.
4. Implementation planning.
   - Brainstorming session to address significant needs.

Goal: Identify specific steps required to meet community health needs and be in compliance with ACA.

Timeline

- ACA 2010
- CHNA 2011
- Strategic Planning Oct. 2013
- Implement Programs 2013-14
- Next CHNA 2014
Affordable Care Act

Mandates Community Health Needs Assessment (CHNA) be conducted every 3 years by all non-profit hospitals

Enforced by: IRS
Penalties:
  • $50,000 excise tax per year of non-compliance.
  • Puts tax exempt status in jeopardy.

Need: (1) CHNA Report
     (2) Implementation Strategy

Affordable Care Act – 2013 Regulation

IRS REG-106499 (April 5, 2013):

• IRS relaxes stance on penalties: No penalty if failures to meet requirements were minor, inadvertent, and due to reasonable cause.

• Errors/omissions not willful or egregious will be excused if corrected and disclosed.
Affordable Care Act – 2013 Regulation

• Must *identify* “significant” needs, *prioritize* significant needs, and identify *measures and resources* to address those needs.

  • Determine whether need is significant “based on all the facts and circumstances present in community.”

Affordable Care Act – 2013 Regulation

• Examples of prioritization criteria include:
  • Burden, scope, severity, or urgency of the health need
  • Estimated feasibility and effectiveness of possible interventions
  • Health disparities associated with need
  • Importance the community places on addressing the need
  • But: Hospital “may use any criteria it deems appropriate.”
Affordable Care Act – 2013 Regulation

• Must make CHNA report widely available to public.
  • Conspicuously post report on hospital’s website (or link to other website with report).
  • Report must remain on the website until two subsequent reports have been posted.
  • Must make a paper copy available for public inspection at hospital without charge.
  • May post draft of report without starting 3-year cycle.

Affordable Care Act – 2013 Regulation
Implementation Strategy – Basics
For each significant health need, must:
1. Describe how hospital plans to address need
   a) Describe actions and anticipated impact.
   b) Identify programs and resources to commit.
   c) Describe collaboration with other facilities/organizations.
2. Or: Identify need as one hospital does not intend to address and explain why.
   • Brief explanation is sufficient.
Hospital must adopt implementation strategy in same taxable year CHNA is conducted.
CHNA Review

- Goal was to present snapshot of community health
- Mixed methods research design:
  - Primary data—
    - 1:1 interviews
    - Survey
  - Secondary data
    - Compilation of county specific, state and national health indicators and outcomes for LaMoure, Logan, and McIntosh counties

Wishek Hospital & Clinics Service Area Strengths

- Engaged community:
  - Approx. 235 people participated in assessment—from Wishek, Kulm, Napoleon, and Gackle plus surrounding areas.
- Expressions of appreciation for hospital and caregivers:
  - Convenience, pride in being able to have clinic and hospital in area. Sustainability.
  - I have received quality care for the minor illnesses/problems I have.
  - A main reason I own a home here is local health care services.
  - The clinic is a vital part of the city of Napoleon.
  - We are fortunate to have a hospital in our small community. Without it our community would not thrive.
  - We love Wishek hospital employees; they are kind, friendly, and helpful.
  - The courtesy and friendliness of employees are an added bonus.
Prioritization Process for Today

- As a group, review community health needs identified from data and results
- Review of secondary data
  - County Health Rankings
- Review of primary data
  - Survey results
  - Findings from interviews
- Looking at all health needs, not just those you would expect a hospital to address
- After identifying the needs, work on prioritizing needs
- **Goal:** Compile list of prioritized needs for Wishek Hospital & Clinics

Secondary Data: County Health Rankings

Measures/outcomes noted in red means they are worse than the **state average**.

Measures/outcomes noted in blue means they are worse than the **national benchmark**.
## Secondary Data: County Health Rankings

<table>
<thead>
<tr>
<th>Ranking: Outcomes</th>
<th>LaMoure County</th>
<th>Logan County</th>
<th>McIntosh County</th>
<th>National Benchmark</th>
<th>North Dakota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor or Fair Health</td>
<td>16th</td>
<td>NR</td>
<td>29th</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>Poor Physical Health Days (past 30 days)</td>
<td>2.4</td>
<td>2.8</td>
<td>2.7</td>
<td>2.6</td>
<td>2.7</td>
</tr>
<tr>
<td>Poor Mental Health Days (past 30 days)</td>
<td>1.9</td>
<td>3.0</td>
<td>2.8</td>
<td>2.3</td>
<td>2.5</td>
</tr>
<tr>
<td>% Diabetic</td>
<td>9%</td>
<td>11%</td>
<td>11%</td>
<td>-</td>
<td>8%</td>
</tr>
</tbody>
</table>

**Red = Worse than ND average**  
**Blue = Worse than national benchmark**

## Secondary Data: County Health Rankings

<table>
<thead>
<tr>
<th>Ranking: Factors</th>
<th>LaMoure County</th>
<th>Logan County</th>
<th>McIntosh County</th>
<th>National Benchmark</th>
<th>North Dakota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Behaviors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Smoking</td>
<td>25%</td>
<td>16%</td>
<td>13%</td>
<td>13%</td>
<td>19%</td>
</tr>
<tr>
<td>Adult Obesity</td>
<td>27%</td>
<td>33%</td>
<td>32%</td>
<td>15%</td>
<td>35%</td>
</tr>
<tr>
<td>Physical Inactivity</td>
<td>38%</td>
<td>35%</td>
<td>36%</td>
<td>11%</td>
<td>26%</td>
</tr>
<tr>
<td>Excessive Drinking (binge/heavy drinking)</td>
<td>12%</td>
<td>-</td>
<td>19%</td>
<td>7%</td>
<td>22%</td>
</tr>
<tr>
<td>Sexually Transmitted Infections</td>
<td>193</td>
<td>101</td>
<td>36</td>
<td>92</td>
<td>357</td>
</tr>
</tbody>
</table>

**Red = Worse than ND average**  
**Blue = Worse than national benchmark**
# Secondary Data: County Health Rankings

<table>
<thead>
<tr>
<th></th>
<th>LaMoure County</th>
<th>Logan County</th>
<th>McIntosh County</th>
<th>National Benchmark</th>
<th>North Dakota</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured Adults</td>
<td>13%</td>
<td>23%</td>
<td>18%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>133:1</td>
<td>100:1</td>
<td>933:1</td>
<td>1,067:1</td>
<td>1,197:1</td>
</tr>
<tr>
<td>Dentist Ratio</td>
<td>-</td>
<td>2,072:1</td>
<td>2,903:1</td>
<td>1,516:1</td>
<td>1,886:1</td>
</tr>
<tr>
<td>Preventable Hospital Stays</td>
<td>59</td>
<td>75</td>
<td>70</td>
<td>47</td>
<td>59</td>
</tr>
<tr>
<td>Diabetic Screening</td>
<td>89%</td>
<td>98%</td>
<td>87%</td>
<td>90%</td>
<td>86%</td>
</tr>
<tr>
<td>Mammography Screening</td>
<td>85%</td>
<td>61%</td>
<td>65%</td>
<td>73%</td>
<td>71%</td>
</tr>
<tr>
<td><strong>Physical Environment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited Access to Healthy Foods</td>
<td>27%</td>
<td>31%</td>
<td>7%</td>
<td>1%</td>
<td>9%</td>
</tr>
<tr>
<td>Access to Recreational Facilities</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>16</td>
<td>12</td>
</tr>
</tbody>
</table>

Red = Worse than ND average  
Blue = Worse than national benchmark

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## Survey results

- Responses from 192 community members  
- Responses from 43 health care professionals  

- Although we are focusing on needs, process revealed much positive feedback  

- CM = Community members  
- HCP = Health care professionals
Survey results – Potential Health Concerns

Top 3 Community Health Concerns of Community Members
1. Shortage of providers/specialists
2. Higher costs for consumers
3. Continued emergency services

Top 3 Community Health Concerns of Health Care Professionals
1. Higher costs for consumers
2. Shortage of providers/specialists
3. Cancer

Survey results (CM) – Potential Health Concerns

- Shortage of providers/specialists: 156
- Higher costs for consumers: 134
- Continued emergency services: 132
- Not enough health care staff in general: 123
- Hospital closure: 120
- Cancer: 117
- Heart Disease: 109
- Diabetes: 108
- Access to needed technology/equipment: 106
- Mental health: 100
- Focus or prevention: 98
- Distance/transportation to facility: 94
- Obesity: 94
Survey results (HCP) – Potential Health Concerns

Survey results – Barriers to Care
Community Members’ Recommendations to Remove Barriers to Using Local Care

1. More doctors
2. Evening or weekend hours
3. Collaboration with competition

Health Care Professionals’ Recommendations to Remove Barriers to Using Local Care

1. More doctors
2. Evening or weekend hours
3. Collaboration with competition
   Telehealth
Survey results – Improve Collaboration?

Improve collaboration?

- Both community members and health care professionals saw need for improved collaboration with **schools/health wellness education**.

- In all other categories, more respondents said collaboration was fine as it is than said there was need for improved collaboration.

- Many community members said they did not know whether improved collaboration was needed.

Survey results (CM) – Improve Collaboration?

![Survey results chart](image-url)
Survey results (HCP) – Improve Collaboration?

Results of key informant interviews/surveys

Other concerns
(listed in no particular order)

1. Need for information dissemination
2. Transportation and highway concerns
3. Emphasis on prevention
Comments

Need for information dissemination

- It would be good to publicize information on who physicians in Wishek are and what they do. This information should be put in the local newspaper on a quarterly basis.
- More advertisements for services they provide would benefit communities.
- The need to educate the community on services offered and also on the limitations of Wishek's hospital so patients understand why it operates in a certain way (for example, cannot provide OB because...).
- There needs to be a way to provide evaluation of services and customer feedback on a regular basis.
- What is the vision of Wishek? How will we know what the outcome of this needs assessment is?

Comments

Transportation and highway concerns

- ND department of transportation needs to be much more prompt to correct areas of highway that have been affected by high water flooding. It seems to take way too long to build a section of highway up. For example, Highway 13 from Lehr to Wishek is a disaster in how the road construction is being handled. No good detour - it affects delivery of health care, trying to get to Wishek hospital/clinic from the East can be quite stressful - both for employees and for patients.
- Road conditions are a barrier - ambulance is taking patients to other communities.
- The highway is a barrier - water over highway in places, or being torn up by road construction from Kulm to Wishek.
- Transportation at assisted living area.


Comments

Emphasis on prevention

- I have not had any medical care in 17 years, it is too expensive and not an option. It would be nice to have information on free preventative services available locally for all ages, not just children and the elderly. The economic toll on people right now is great, too much at times.
- More prevention - exercise is a necessity, access to machines night and day - special diets to improve health status.
- Prevention will increase awareness and help prevent many health issues.

Needs That Emerge from Data

CRH created an initial list based on information gathered

What other needs does group perceive based on information presented?

Next step: Prioritize these needs to provide Wishek Hospital & Clinics with guidance in meeting community needs
### Potential Community Health Needs - Wishes Hospital & Clinics Service Area

<table>
<thead>
<tr>
<th>Identified Need</th>
<th>Vote</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Secondary data: Death rate of patients</td>
<td>[ ]</td>
</tr>
<tr>
<td>2. Secondary data: Diabetes rate of 50%</td>
<td>[ ]</td>
</tr>
<tr>
<td>3. Secondary data: Diabetes rate of 30%</td>
<td>[ ]</td>
</tr>
<tr>
<td>4. Secondary data: Diabetes rate of 20%</td>
<td>[ ]</td>
</tr>
<tr>
<td>5. Secondary data: Diabetes rate of 10%</td>
<td>[ ]</td>
</tr>
<tr>
<td>6. Secondary data: Diabetes rate of 0%</td>
<td>[ ]</td>
</tr>
<tr>
<td>7. Secondary data: Diabetes rate of 90%</td>
<td>[ ]</td>
</tr>
<tr>
<td>8. Secondary data: Diabetes rate of 80%</td>
<td>[ ]</td>
</tr>
<tr>
<td>9. Secondary data: Diabetes rate of 70%</td>
<td>[ ]</td>
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<tr>
<td>10. Secondary data: Diabetes rate of 60%</td>
<td>[ ]</td>
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<td>11. Secondary data: Diabetes rate of 50%</td>
<td>[ ]</td>
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<tr>
<td>12. Secondary data: Diabetes rate of 40%</td>
<td>[ ]</td>
</tr>
<tr>
<td>13. Secondary data: Diabetes rate of 30%</td>
<td>[ ]</td>
</tr>
<tr>
<td>14. Secondary data: Diabetes rate of 20%</td>
<td>[ ]</td>
</tr>
<tr>
<td>15. Secondary data: Diabetes rate of 10%</td>
<td>[ ]</td>
</tr>
<tr>
<td>16. Secondary data: Diabetes rate of 0%</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

* = LaMoure County worse than state average  
# = Logan County worse than state average  
Δ = McIntosh County worse than state average  

### Prioritization Criteria

Rank health concerns based on:
- Importance
- Impact
- Severity
- Reach

Not:
- Feasibility
Strategic Planning

Beginning       End
Need           Outcome

1. Wellness Campaign
   Future vision or goal—what change would you like to see?

Logic Model

➢ Useful for stating future goals.
➢ Encourages “thinking backwards.”
➢ Identifies measurable steps taken.
➢ Outlines responsibilities and actions needed.
➢ Demonstrates program’s progress.
➢ Efficient and transparent model to chart improvement and intended change.
Logic Model

<table>
<thead>
<tr>
<th>Need</th>
<th>Resources</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>In order to accomplish our set of activities we will need the following:</td>
<td></td>
<td>In order to address our need we will accomplish the following activities:</td>
<td>Once accomplished we expect the following evidence of delivery:</td>
<td>We expect that if accomplished these activities will lead to the following changes in 1-3 years:</td>
</tr>
</tbody>
</table>

Sample Logic Model

<table>
<thead>
<tr>
<th>Need</th>
<th>Resources</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| Elevated rate of physical inactivity | • Donated fitness space  
• Instructor’s salary  
• Promotion materials | • Launch fitness program  
• Secure space for classes  
• Recruit fitness instructor  
• Design fitness flyer | • # of participants in class  
• # of flyers distributed  
• # of calls/month seeking info about it | • Change in attitude about fitness  
• Change in physical behavior  
• Increased flexibility  
• Decreased blood pressure |
### Activities
(needed to accomplish outcome)

<table>
<thead>
<tr>
<th>Need</th>
<th>Resources</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Fitness Center 2. BCBS Healthy Blue 3. Michelle 4. Cindy at Community Ed. 5. Senior Center 6. Tia Kiefer offers dance classes for kids. 7. Sarah T</td>
<td>1. Go to schools/Wishek Steel &amp; Titan to offer BP checks and inform of PT measurements 2. Offer cooking classes/educate about diabetic meals 3. Offer a dinner/dance class to promote healthy recipes/taste testing 4. Offer more square dancing clubs, ballroom dancing, dance offs, dancing with the stars</td>
<td>1. Decrease in obesity &amp; physical inactivity rate by X% 2. Weight loss/ decrease in BMI, Healthy eating &amp; diets; make ppl more aware of what they eat is who they are 3. Instructor/staff for wellness 4. Increase community support/collaboration</td>
<td></td>
</tr>
</tbody>
</table>
Next Steps

- Select activities to implement.
- Form committees to meet again.
- Follow up:
  - Keep Center for Rural health updated of progress.
  - Identify potential resources and grants.

Contact us for more information!

501 North Columbia Road, Stop 9037
Grand Forks, North Dakota 58202-9037

701.777.3848 • ruralhealth.und.edu

Ken Hall Kenneth.hall@med.und.edu
Karin Becker Karin.becker@email.und.edu
## Appendix B
### Brainstorming Document

<table>
<thead>
<tr>
<th>Need</th>
<th>Resources</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| Wellness Campaign | 1. Fitness Center  
2. BCBS Healthy Blue  
3. Michelle  
4. Cindy at Community Ed.  
5. Senior Center  
6. Tia Kiefer offers dance classes for kids.  
7. Sarah T  
8. Public health | • Go to schools/Wishek Steel & Titan to offer BP checks and inform of PT  
• Offer cooking classes/educate about diabetic meals.  
• Offer a dinner/dance class to promote healthy recipes/taste testing  
• Offer more square dancing clubs, ballroom dancing, dance offs, dancing with the stars  
• Start a community ed class through county extension office.  
• Prevention education for diabetes and chronic disease, back injury  
• Offer more screenings  
• Set up booth at Taste of Wishek in June to show alternative cooking/exercise  
• Make a call in newsletter for fitness/dance instructors  
• Dedicate half page in newsletter to “Wellness Update” and website and invite interviews with community members/leaders.  
• Sending employee to BCBS annual wellness program meeting Oct. 2013  
• “Move-on-athon” offered next May  
• Morning for Women-craft fair/physician/education | 1. Decrease in obesity & physical inactivity rate by X%;  
2. Weight loss, decrease in BMI, Healthy eating & diets; make ppl more aware that what they eat is who they are.  
3. Instructor/staff for wellness  
4. Increase community support/collaboration. |