Sanford Health Network
Community Health Needs Assessment
2012-2013

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Sanford Luverne Medical Center

Community Health Needs Assessment
2012-2013

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Purpose

Sanford Luverne Medical Center is part of Sanford Health, an integrated health system headquartered in the Dakotas and the largest rural not-for-profit health care system in the nation with locations in 126 communities in eight states.

Sanford Luverne Medical Center has undertaken a community health needs assessment as required by the Patient Protection and Affordable Care Act and as part of the IRS 990 requirement for a not-for-profit health system to address issues that have been assessed as unmet needs in the community.

PPACA requires that each hospital must have: (1) conducted a community health needs assessment in the applicable taxable year; (2) adopted an implementation strategy for meeting the community health needs identified in the assessment; and (3) created transparency by making the information widely available. For tax exempt hospital organizations that own and operate more than one hospital facility, as within Sanford Health, the new tax exemption requirements will apply to each individual hospital. The first required needs assessment falls within the fiscal year July 1, 2012 through June 30, 2013.

The purpose of a community health needs assessment is to develop a global view of the population's health and the prevalence of disease and health issues within our community. Findings from the assessment serve as a catalyst to align expertise and develop a Community Investment/Community Benefit plan of action. There is great intrinsic value in a community health needs assessment when it serves to validate, justify and defend not-for-profit status and create opportunity to identify and address public health issues from a broad perspective.

A community health needs assessment is critical to a vital Community Investment/Community Benefit Program that builds on community assets, promotes collaboration, improves community health, and promotes innovation and research. A community health needs assessment also serves to validate progress made toward organizational strategies and provides further evidence for retaining not-for-profit status.

Acknowledgements

Sanford Health would like to acknowledge and thank the Steering Committees and the Greater Fargo Moorhead Community Health Needs Assessment Collaborative for their expertise while performing the assessment and analysis of the community health data. The assessment provides support for the future directions of our work as the region's leading health care system.

Sanford Enterprise Steering Group:
- *Enterprise Lead:* Carrie McLeod, MBA, MM, LRD,CDE; Office of Health Care Reform, Community Benefit/Community Health Improvement
- *Sioux Falls Region Co-Lead:* Bruce Viessman, CFO, Sanford Health Network Sioux Falls
- Mike Begeman, Chief of Staff/Vice President of Public Affairs
- Maxine Brinkman, CPA; Director of Financial Decisions and Operations Support
- Michelle Bruhn, CPA; CFO, Health Services Division
- Randy Bury, COO, Sanford Medical Center USD
- Jane Heilman, BA; Senior Corporate Communication Strategist
- Kristie Invie, BS, MBA; Vice President for Clinical Performance
- Joy Johnson, Bemidji Region Co-Lead, VP, Business Development and Marketing, Bemidji
- Ashley King, Bemidji Co-Lead, Intern in Bemidji
- JoAnn Kunkel, CFO, Sanford Health
- Tiffany Lawrence, CPA; Fargo Region Co-Lead, CFO, Sanford Medical Center Fargo
- Martha Leclerc, MS; Vice President, Office of Health Reform and Strategic Payment
- Doug Nowak, MBA; Executive Director, Decision Support
- Heather Vanmeveren, CPA; Director of Accounting

Sanford Sioux Falls Network Steering Group:
- *Enterprise Lead:* Carrie McLeod, MBA, MM, LRD,CDE; Office of Health Care Reform, Community Benefit/Community Health Improvement
- *Sioux Falls Region Co-Lead:* Bruce Viessman, CFO, Sanford Health Network Sioux Falls
- Michelle Bruhn, CPA; CFO, Health Services Division
- Mike Daly, Director, Public Affairs
- Doug Nowak, Executive Director, Decision Support
- Jeff Rotert, COO/CFO, Sanford Worthington Medical Center
- Cindy Schuck, Manager, Accreditation Standards Program
- Dan Staebell, Communications Department
- Justin Tiffany, Project Specialist, Health Network, Sanford Medical Center

Sanford Luverne Steering Group:
- Tammy Loosbrock, CEO
- Stan Knobloch, CFO
- Nyla Sandbulte, CNO
- Nancy Drenth, Ancillary Services Director
- Laurie Jensen, Director of Clinic Operations
- Diane Westenberg, Marketing coordinator
- Joyce Eickhoff, Executive Assistant
- Sanford Luverne Department managers

We express our gratitude to the following individuals and groups for their participation in this study.
We extend special thanks to the city mayors, city council/commission members, physicians, nurses, school superintendents and school board members, Faith and Community Leaders, as well as legal services, social services, non-profit organizations, and financial services for their participation in this work. Together we are reaching our vision "to improve the human condition through exceptional care, innovation and discovery."

Our Guiding Principles:
- All health care is a community asset
- Care should be delivered as close to home as possible
- Access to health care must be provided regionally
- Integrated care delivers the best quality and efficiency
- Community involvement and support is essential to success
- Sanford Health is invited into the communities we serve

The following key community stakeholders participated in this assessment work:
- Kevin Aaker, Owner, Luverne Body Shop, Luverne, MN
- Linda Bakken, Early Childhood Teacher, Luverne Public Schools, Luverne, MN
- Barbara Berghorst, Finance Director, City of Luverne, Luverne, MN
- George Berndt, Superintendent, Ellsworth Public School, Ellsworth, MN
- Jane Blank, Office Manager, Rock County Eye Clinic, Luverne, MN
- Greg Burger, President/CEO, Minnwest Bank, Luverne, MN
- Connie Connell, Retired Social Worker, Luverne, MN
- Jeff De Boer, VP, M & H Hardware, Edgerton, MN
- Kayla DeJong, School Psychologist, SW/WC Service Cooperative, Luverne, MN
- Lori Ehde, Editor, Rock County Star Herald, Luverne, MN
- Gary Fisher, Superintendent, Luverne Schools, Luverne, MN
- Dawn Gruys, Hair Stylist, Dawn & Co., Edgerton, MN
- Jim Harner, Retired High School Principal, Luverne, MN
- Todd Holthaus, Principal, Hills-Beaver Creek Schools, Beaver Creek, MN
- Janet S. Howard, Public Health Supervisor, Nobles Co. Community Servcies, Worthingon, MN
- Lisa Huisman, City Council Member, Ellsworth, MN
- David Jahn, Missionary, AGWM, Sioux Falls, SD
- Tanya Krueger, School Psychologist, Adrian Public School, Brandon, SD
- Jane Wildung Lanphere, Executive Director, Chamber of Commerce, Luverne, MN
- Jessica Lingen, ER Nurse, Pipestone County Medical Center, Edgerton, MN
- Raevetete Loonan, DV/SA Services Coordinator, Luverne, MN
- Alene Lopau, Owner, Retail Farm & Home Store, Luverne, MN
- George McDonald, Optometrist, Pearle Vision, Sioux Falls, SD
- Patti Olson, Underwriting Supervisor, CWG, Luverne, MN
- Steve Perkins, Community Activist, Healthcare/Agriculture, Luverne, MN
- Tim Plimpton, President, Exchange State Bank, Hills, MN
- Eugene Pragoe, Real Eestate Broker, Luverne, MN
- Cary Radisewitz, Sales Manager, American Family Insurance, Luverne, MN
- Holly Sammons, Economic Development Director, Luverne, MN
- Melanie Wagner, School Nurse, Adrian, MN
- Mike Werner, Administrator, Parkview Manor, Ellsworth, MN
- Cynthia Wolf, Site Coordinator & EMT, Adrian Ambulance Service, Adrian, MN

Sanford Luverne Medical Center
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Executive Summary

Purpose

The purpose of a community health needs assessment is to develop a global view of the population's health and the prevalence of disease and health issues within the community. Findings from the assessment serve as a catalyst to align expertise and develop a Community Investment/Community Benefit plan of action. There is great intrinsic value in a community health needs assessment when it serves to validate, justify and defend not-for-profit status and create opportunity to identify and address public health issues from a broad perspective. A community health needs assessment is critical to a vital Community Investment/Community Benefit Program that builds on community assets, promotes collaboration, improves community health, and promotes innovation and research. A community health needs assessment also serves to validate progress made toward organizational strategies and provides further evidence for retaining our not-for-profit status.

Study Design and Methodology

The following qualitative data sets were studied:
- Community Health Needs Assessment of Community Leaders
- July 2011 Community Assessment and Focus Group Summary Report

The following quantitative data sets were studied:
- 2011 County Health Profiles for Rock County
- Aging Profiles for Rock County
- Diversity Profiles for Rock County

Asset mapping was conducted by reviewing the data and identifying the unmet needs from the various surveys and data sets. The process implemented in this work was based on the McKnight Foundation model - Mapping Community Capacity by John L. McKnight and John P. Kretzmann, Institute for Policy Research at Northwestern University.

Each unmet need was researched to determine what resources were available in the community to address the needs. The steering group performed the asset mapping and reviewed the findings. The group conducted an informal gap analysis to determine what needs remained after resources were thoroughly researched. Once gaps were determined, the group proceeded to the prioritization process. The multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

Key Findings – Primary Research

Community Health Needs Assessment of Community Leaders
Sanford Luverne distributed the Community Health Needs Assessment survey tool that was developed by the Greater Fargo-Moorhead Community Health Needs Assessment Collaborative to key stakeholder groups as a method of gathering input from a broad cross section of the Rock County community.

The Internal Revenue Code 501 (r) statute requires that a broad base of key community stakeholders have input into the needs of the community. Those community members specified in the statute include: persons who represent the broad interests of the community served by the hospital facility including those with special expertise in public health; Federal, tribal, regional, state and or local health or other departments or agencies with information relevant to the health needs of the community served; leaders, representatives, or members of medically underserved, low-income, and minority populations.

Sanford extended a good faith effort to engage all of the aforementioned community representatives in the survey process. The list of individuals who agreed to take the survey and also submit their names are included in the acknowledgement section of this report. In some cases there were surveys that were submitted without names or without a specified area of expertise or affiliation. We worked closely with public health experts throughout the assessment process.

Public comments and response to the community health needs assessment and the implementations strategies are welcome on the Sanford website under "About Sanford" in the Community Health Needs Assessment section.

The findings discussed in this section are a result of the analysis of the survey qualitative data.

Respondents had very high levels of agreement that their community has quality educational opportunities and programs, there is access to quality health care, and there is quality food. Respondents felt strongly that the community was a safe place to live, family friendly, had a healthy environment and a laidback lifestyle and is peaceful and quiet. The respondents agreed that people within the community are helpful and supportive, there is a sense of engagement within the community, and that people fell connected to the people that live within the community. Respondents also had a high level of agreement that the community is clean, convenient access to work and activities, and that there are many recreational/sports activities available.

Respondents were most concerned about changes in family composition among the youth. Respondents were also concerned with issues regarding substance abuse within the community. Respondents were concerned about cost and/or availability of elder care and resources to meet the needs of the aging population. Environmental issues regarding water quality, air quality, and noise levels were not a large concern.

Among health and wellness concerns, respondents were most concerned about the costs associated with health insurance, health care, and prescription drugs. Respondents were also concerned about physical health issues, particularly obesity, poor nutrition and eating habits, and inactivity or lack of exercise. The adequacy of health and dental insurance (e.g. amount of co-pays and deductibles), access to health insurance coverage (e.g. pre-existing conditions), and availability of non-traditional hours (ex: evenings and weekends), as well as the prevalence of cancer and chronic disease, and mental health treatment and programs were also among the top health and wellness concerns among respondents. Respondents were least concerned about providers not taking new patients, confidentiality, and distance to health care services.

Respondents mentioned the community is a great place to live and raise a family with a sense of support for each other. Respondents had fairly high levels of agreement that people in their community are friendly, helpful, and supportive and that there is a sense of community or feeling connected to people who live here. Among

issues regarding people in the community, respondents agreed that the least concern is that the community is socially and culturally diverse.

Respondents had moderate levels of concern with respect to the cost of living, poverty, and economic disparities between higher and lower classes. Respondents were least concerned with homelessness and hunger.

Respondents were most concerned with the obesity. Respondents were least concerned with traffic congestion and prostitution.

The levels of concern among respondents regarding substance use were fairly high. Respondents were most concerned about drug and alcohol use and abuse; and moderately concerned about the presence of drug dealers in the community and smoking.

The top three reasons respondents gave for their choice of primary health care provider were location, quality of services, and availability of services.

Fifty-eight percent (58%) of the respondents said they had not had a cancer screening or cancer care in the past year. The most common reasons for not having a screening were because the doctor had not suggested it or because it was not necessary. Fear, cost, and unfamiliarity with recommendations were also reasons respondents gave.

A majority of respondents said they had paid for health care costs over the last 12 months by health insurance through an employer. Medicare, personal income, private health insurance, and military/veterans health care benefits were also used.

Respondents were asked which provider they used for their primary health care. Eighty-five percent (85%) of the respondents said they use Sanford Health as their primary health care provider. Nine percent (9%) said they use Avera health system. Five percent (5%) used other or multiple systems.

July 2011 Community Assessment and Focus Group Summary Report

Sanford Luverne also conducted a survey in the spring of 2011, random stratified sample within the Sanford Luverne service area about utilization and perception of local health care services. As part of this process, four focus groups were also held. The findings discussed in this section are a result of the analysis of the survey qualitative data.

Respondents reported 66% had received hospital care in the prior three years, 61% of those respondents who received care utilized Sanford Luverne for most of the care. Seventy-four percent (74%) selected Sanford Luverne based on proximity to home. Sixty-eight percent (68%) would select Sanford Luverne for future hospitalizations.

Respondents reported 95% had seen a primary care provider in the prior three years, with 77% of the respondents who saw a provider reporting Sanford Luverne as their provider of choice. Of the respondents that sought care outside of Luverne, 20% did so due to quality of staff.

Respondents reported 80% had seen a health care specialist in the prior three years; with 50% being dentist visits. Of the respondents who saw a health care specialist, 60% received care at Sanford Sioux Falls, 40% through outreach at Sanford Luverne. Sixty-one percent (61%) reported they would use an after-hours clinic if available locally.

Respondents rated Sanford Luverne at 3.04 out of 4.00 with 4.00=Excellent, 3.00=Good, 2.00=Fair, and 1.00=Fair. Overall, the clinic scored 3.01. Overall outpatient services scored 3.4 with hospice scoring the best at 3.65, physical therapy at 3.58, and occupational therapy at 3.57. Sleep studies scored the lowest at 2.92.

Sixty-one percent (61%) of respondents thought lower cost of care would improve the community's access to health care services, 50% reported an after-hours clinic would improve local access, and 35% wanted more services within the community on nutrition/weight management.

Respondents viewed the community favorably in community health. Fifty-eight percent (58%) rated the community as a healthy community. Sixty-three percent (63%) felt cancer was the most serious health concern in the community, followed by heart disease and alcohol/substance abuse.

Key Findings – Secondary Research

Health Outcomes

The Mortality health outcomes indicate that Minnesota as a state and Rock County have less premature deaths than the national benchmark.

The Morbidity health outcomes indicate that Minnesota citizens and Rock County citizens report more days of poor mental and physical health than the national benchmark.

Minnesota and Rock County have a slightly higher percentage of low birth weight than the national benchmark.

Health Factors

The Health Behavior outcomes indicate that Minnesota has higher percentages of adult smokers than the national average, but the data for Rock County was unreliable or missing. Adult obesity is also higher in Minnesota and Rock County. Minnesota has a lower percentage of physical inactivity compared to the national benchmark and Rock County is the same as the national benchmark.

Minnesota and Rock County have a higher percentage of binge drinking reports than the national benchmark. Motor vehicle crash death rates are higher in Minnesota than the national benchmark.

Sexually transmitted infections rank substantially higher than the national average for Minnesota; however, significantly lower than the national average for Rock County. The teen birth rate is higher in Minnesota and Rock County than the national benchmark.

The Clinical Care outcomes indicate that Rock County has a higher percentage of uninsured adults and youth than the national benchmark, while Minnesota as a state has slightly less than the national average.

The ratio of population to primary care physicians is slightly less in Rock County than the national or state benchmark. The ratio of population to mental health providers is higher in Rock County but much lower in Minnesota than the national benchmark. The number of professionally active dentists is lower than the national benchmark in Minnesota. Preventable hospital stays are similar in Rock County to the national benchmark but higher in Minnesota.

Diabetes screening rates in Minnesota and Rock County are similar to the national benchmark. Rock County ranks higher than the national benchmark for mammography screenings, while Minnesota is slightly under the national benchmark.

Implementation Strategy

The following unmet needs were identified through a formal community health needs assessment, resource mapping and prioritization process:
- After-hours access/walk-in clinic
- Increase knowledge and awareness of services available within the community

Implementation Strategy: After-Hours Access/Walk- In Clinic
- Complete after-hours volume analysis
- Complete proforma and business plan
- Sanford Health Network level review of proforma and business plan
- FY 14 budget developed to include initiative

Implementation Strategy: Lack of knowledge on services available within the community
- Develop Rock County Collaborative of key stakeholders
- Develop tool with available resources
- Design/print resource materials with Sanford marketing
- Share resource tool with key community stakeholders/access points to care

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Sanford Health, has long been dedicated to excellence in patient care, is on a journey of growth and momentum with vast geography, cutting edge medicine, sophisticated research, advanced education and a health plan. Through relationships built on trust, successful performance, and a vision to improve the human condition, Sanford seeks to make a significant impact on health and healing. We are proud to be from the Midwest and to impact the world. The name Sanford Health honors the legacy of Denny Sanford's transformational gifts and vision.

Our Mission: *Dedicated to the Work of Health and Healing*
We provide the best care possible for patients at every stage of life, and support healing and wholeness in body, mind and spirit.

Our Vision: *To improve the Human Condition through Exceptional Care, Innovation and Discovery*
We strive to provide exceptional care that exceeds our patients' expectations. We encourage diversity in thought and ideas that lead to better care, service and advanced expertise.

Our Values:
- **Courage**: *Strength to persevere, to use our voice and take action*
- **Passion:** *Enthusiasm for patients and work, commitment to the organization*
- **Resolve:** *Adherence to systems that align actions to achieve excellence, efficiency and purpose*
- **Advancement:** *Pursuit of individual and organizational growth and development*
- **Family:** *Connection and commitment to each other*

Our Promise: *Deliver a flawless experience that inspires*
We promise that every individual's experience at Sanford—whether patient, visitor or referring physician—will result in a positive impact, and for every person to benefit from a flawless experience that inspires.

Guiding Principles:
- *All health care is a community asset*
- *Care should be delivered as close to home as possible*
- *Access to health care must be provided regionally*
- *Integrated care delivers the best quality and efficiency*
- *Community involvement and support is essential to success*
- *Sanford Health is invited into the communities we serve*

Description of Sanford Luverne Medical Center

Sanford Luverne Medical Center (SLMC) is a 25-bed Critical Access Hospital that provides inpatient, acute and long-term care. In addition, SLMC offers a broad range of outpatient services which includes Sanford Luverne Clinic a medical clinic operating as a hospital department. SLMC provides health care services to over 10,000 residents of Rock County and portions of Murray, Nobles and Pipestone counties in southwest Minnesota. The nearest tertiary care center, Sanford USD Medical Center, is approximately 35 miles west in Sioux Falls, South Dakota. The average daily census at SLMC in the last fiscal year was 6.4, outpatient encounters totaled 28,697. Sanford Luverne currently employs approximately 250 employees. Seven family physicians, a nurse practitioner, and a surgeon with Sanford Luverne Clinic provide healthcare to individuals of all ages. Several specialty physicians provide outreach clinics at SLMC on a twice-monthly or monthly basis. As a member of the Sanford Health Network, SLMC offers consulting specialists who provide services in Luverne that include general and specialized surgery, allergy/asthma, cardiology, oncology, ophthalmology, otolaryngology, radiology, urology, obstetrics/ gynecology, pathology, orthopedics, vascular and pulmonology.

Description of the Community Served

The 2010 US Census reports a city population of 4,745, a 2.8% increase over the 2000 Census. Sanford Luverne is located in Rock County, total population 9,687. Luverne is the county seat for Rock County. The population over the age of 65 is 18.9% as compared to the 2010 Minnesota state average of 12.9%. This is important because residents generally begin to require more care as they age, meaning SLMC is responding to a higher level of medical needs for this population. Sanford Luverne provides service to additional residents from portions of Murray, Nobles, and Pipestone counties in southwest Minnesota, which equates to health services provided for over 10,000 people in southwest Minnesota. Luverne is predominantly a farming community with other larger employers in finance, processing plants, healthcare and education.

Study Design and Methodology

In May 2011 Sanford Health convened key health care leaders and other not-for-profit leaders in the Fargo Moorhead community to establish a Fargo Moorhead Community Health Needs Assessment Collaborative. A primary goal of this collaborative is to craft standardized tools, indicators and methodology that can be used by all group members when conducting assessments and also be used by all of the Sanford medical centers across the enterprise. After much discussion it was determined that the Robert Wood Johnson Framework for county profiles would be our secondary data model.

The Internal Revenue Code 501 (r) statute requires that a broad base of key community stakeholders have input into the needs of the community. Those community members specified in the statute include: persons who represent the broad interests of the community served by the hospital facility including those with special expertise in public health; Federal, tribal, regional, state and or local health or other departments or agencies with information relevant to the health needs of the community served; leaders, representatives, or members of medically underserved, low-income, and minority populations.

Sanford extended a good faith effort to engage all of the aforementioned community representatives in the survey process. The list of individuals who agreed to take the survey and also submit their names are included in the acknowledgement section of this report. In some cases there were surveys that were submitted without names or without a specified area of expertise or affiliation. We worked closely with public health experts throughout the assessment process.

Public comments and response to the community health needs assessment and the implementations strategies are welcome on the Sanford website under "About Sanford" in the Community Health Needs Assessment section.

A sub group of this collaborative met with researchers from the North Dakota State University Center for Social Research to develop a survey tool for our key stakeholder groups. The survey tool incorporated the University of North Dakota's Center for Rural Health community health needs assessment tool and the Fletcher Allen community health needs assessment tool. North Dakota State University and the University of North Dakota Center for Rural Health worked together to develop additional questions and to ensure that scientific methodology was incorporated in the design.

Finally, it was the desire of the collaborative that the data would be shared broadly with others and that if possible it would be hosted on a web site where there could be access for a broad base of community, state and regional individuals and groups.

This community health needs assessment was conducted during FY 2012 and FY 2013. The main model for our work is the Association for Community Health Improvement's (ACHI) Community Health Needs Assessment Toolkit.

The following qualitative data sets were studied:
- Survey of Key Stakeholders
- July 2011 Community Assessment and Focus Group Summary Report

The following quantitative data sets were studied:
- 2011 County Health Profiles for Rock County
- Aging Profiles for Rock County
- Diversity Profiles for Rock County

Asset mapping was conducted by reviewing the data and identifying the unmet needs from the various surveys and data sets. The process implemented in this work was based on the McKnight Foundation model - Mapping Community Capacity by John L. McKnight and John P. Kretzmann, Institute for Policy Research at Northwestern University.

Each unmet need was researched to determine what resources were available in the community to address the needs. The Sanford Rock Rapids Executive leadership and management team performed the asset mapping and reviewed the findings. The group conducted an informal gap analysis to determine what needs remained after resources were thoroughly researched. Once gaps were determined the group proceeded to the prioritization process. The multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

2011 County Health Profiles
The County Health Profiles are based largely on the County Health Rankings from the Mobilizing Action Toward Community Health (MATCH), a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. State and national benchmarking required additional data sources, including the U.S. Census Bureau, Small Area Health Insurance Estimates, and the Centers for Disease Control and Prevention's National Center for Health Statistics – the Health Indicators Warehouse.

Aging Profiles
The Aging Profiles are based on data from the U.S. Census Bureau, 2010 Census Summary File 1, and 2006-2010 American Community Survey Five-Year Estimates (sample data). The estimates presented are meant to give

perspective on characteristics across age categories; however, because they are based on sample data, one should use caution when interpreting small numbers. Blank values reflect data that is missing or not available.

Diversity Profiles

The Diversity Profiles are based on data from the U.S. Census Bureau, 2010 Census Summary File 1, and 2006-2010 American Community Survey Five-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across race and ethnic categories; however, because they are based on sample data, one should use caution when interpreting small numbers. Blank values reflect data that is missing or not available.

Limitations

The Sanford Luverne planning committee attempted to survey 100 key community and county stakeholders for the purpose of determining the needs of the community. There were 34 members of this key stakeholder group who completed the survey.

The survey asked for individual perceptions of community health issues and is subjective to individual experiences which may or may not be the current status of the community.

Primary Research

Summary of the Survey Results

Respondents had very high levels of agreement that their community has quality educational opportunities and programs, there is access to quality health care, and there is access to quality food. Respondents felt strongly that the community was a family friendly, healthy environment with a laidback lifestyle and is peaceful and quiet. The respondents agreed that people within the community are helpful and supportive, there is a sense of engagement within the community, and that people fell connected to the people that live within the community. Respondents also had a high level of agreement that the community is clean, convenient access to work and activities, and that there are many recreational/sports activities available.

Respondents were most concerned about changes in family composition among the youth. Respondents were also concerned with issues regarding substance abuse within the community. Respondents were concerned about cost and/or availability of elder care and resources to meet the needs of the aging population. Environmental issues regarding water quality, air quality, and noise levels were not a large concern.

Among health and wellness concerns, respondents were most concerned about the costs associated with health insurance, health care, and prescription drugs. Respondents were also concerned about physical health issues, particularly obesity, poor nutrition and eating habits, and inactivity or lack of exercise. The adequacy of health and dental insurance (e.g. amount of co-pays and deductibles), access to health insurance coverage (e.g. pre-existing conditions), and availability of non-traditional hours (ex: evenings and weekends), as well as the prevalence of cancer and chronic disease, and mental health treatment and programs were also among the top health and wellness concerns among respondents. Respondents were least concerned about providers not taking new patients, confidentiality, and distance to health care services.

Using a 1 to 5 scale, with 1 being "not at all" and 5 being "a great deal," respondents were asked to rate their level of agreement with various statements about their community regarding people, services and resources, and quality of life.

Respondents indicated the top five community assets or best things about the community were: the community is a good place to raise kids, people are friendly, helpful, and supportive, there are quality school systems and programs for youth, the community has a peaceful, calm, quiet environment and the community is a "healthy" place to live.

Overall, respondents had moderately high levels of agreement regarding positive statements that reflect the people in their community *(Figure 1).*
- Respondents had a high level of agreement that people are friendly, helpful, and supportive.
- On average, respondents also had a fairly high level of agreement that there is a sense of community or feeling connected to people who live here.
- Although still a moderate level of agreement, respondents agreed the least that there is social and cultural diversity and tolerance, inclusion, and open-mindedness in their community.

Figure 1. Level of agreement with statements about the community regarding PEOPLE
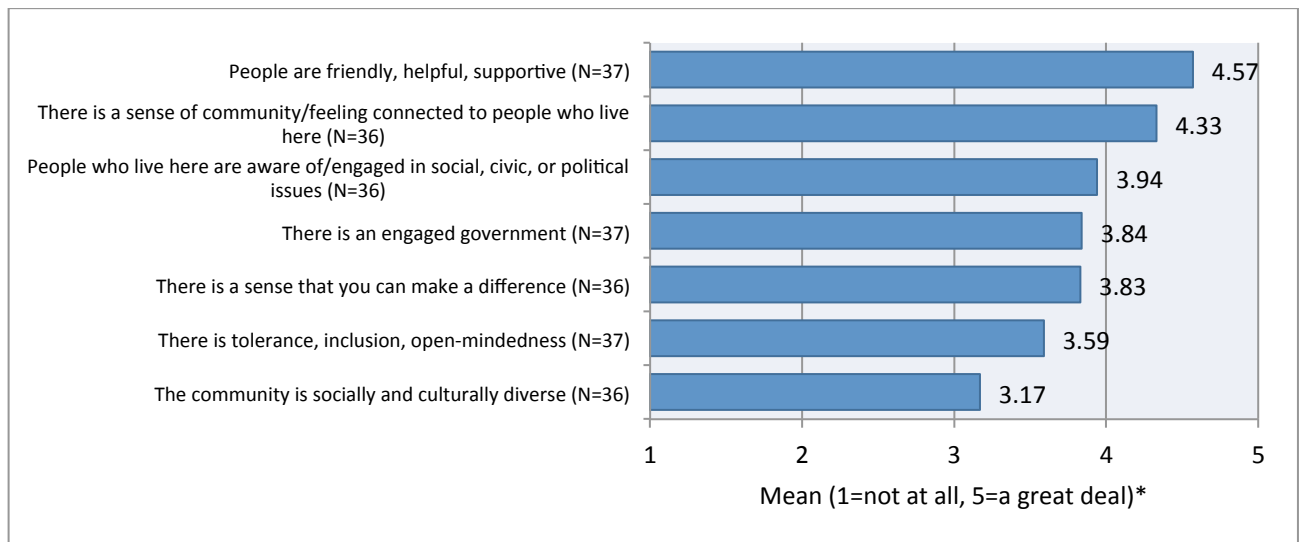
*Means exclude "do not know" responses

Services and Resources

Respondents had high levels of agreement that there are quality school systems and programs for youth in their community as well as quality health care *(Figure 2).*

Although still a moderate level of agreement, respondents agreed the least that there is effective transportation within the community.

Figure 2. Level of agreement with statements about the community regarding SERVICES AND RESOURCES
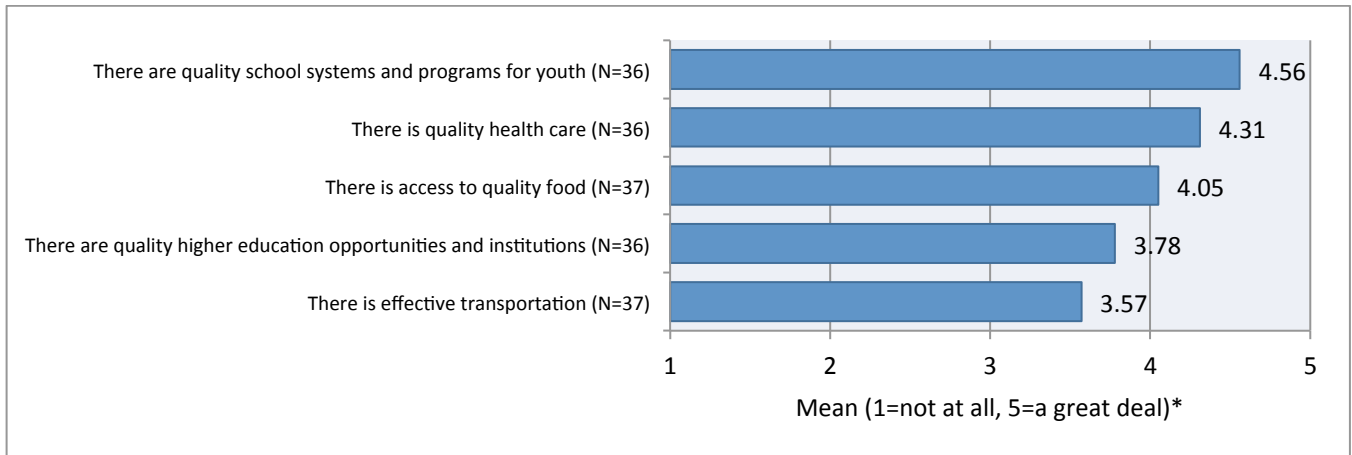
*Means exclude "do not know" responses.

Quality of Life
Respondents had a very high level of agreement that their community has a family friendly environment and is a good place to raise kids *(Figure 3)*. Respondents had high levels of agreement with the remaining components of quality of life issues in their community. Means ranged from 4.62 to 4.22 with respect to the community being a healthy place to live; the community being a safe place to live with little or no crime; the community having a peaceful, calm, and quiet environment; and the community having many recreational, exercise, and sports activities/opportunities. The respondents gave the lowest score (3.56) to the cultural richness of the community

Figure 3. Level of agreement with statements about the community regarding QUALITY OF LIFE
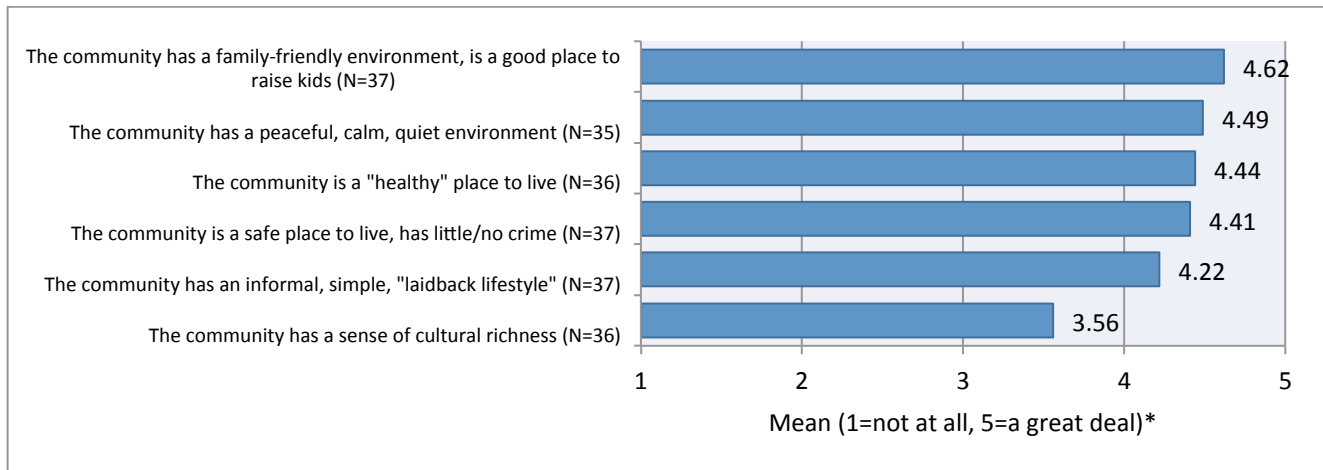
*Means exclude "do not know" responses.

General Concerns about the Community

Respondents had high levels of agreement that people in their community are friendly, helpful and supportive and that there is a sense of community or feeling connected to people who live here. Among issues regarding people in the community, respondents agreed the least that there is tolerance, inclusion, and open-mindedness in their community and that the community is culturally diverse.

Using a 1 to 5 scale, with 1 being "not at all" and 5 being "a great deal," respondents were asked to rate their level of concern with various statements regarding ECONOMIC ISSUES, TRANSPORTATION, ENVIRONMENT, CHILDREN AND YOUTH, THE AGING POPULATION, and SAFETY in their community.

Economic Issues
Respondents had moderately high levels of concern with cost of health care and/or insurance and moderate concerns regarding affordable housing and employment opportunities. Respondents were least concerned with homelessness.

Overall, respondents had a moderate level of concern with economic issues in their community *(Figure 4).*
   • On average, respondents were most concerned with the cost of health care and/or insurance.
   • Respondents were least concerned with homelessness within the community.

Figure 4. Level of concern with statements about the community regarding ECONOMIC ISSUES
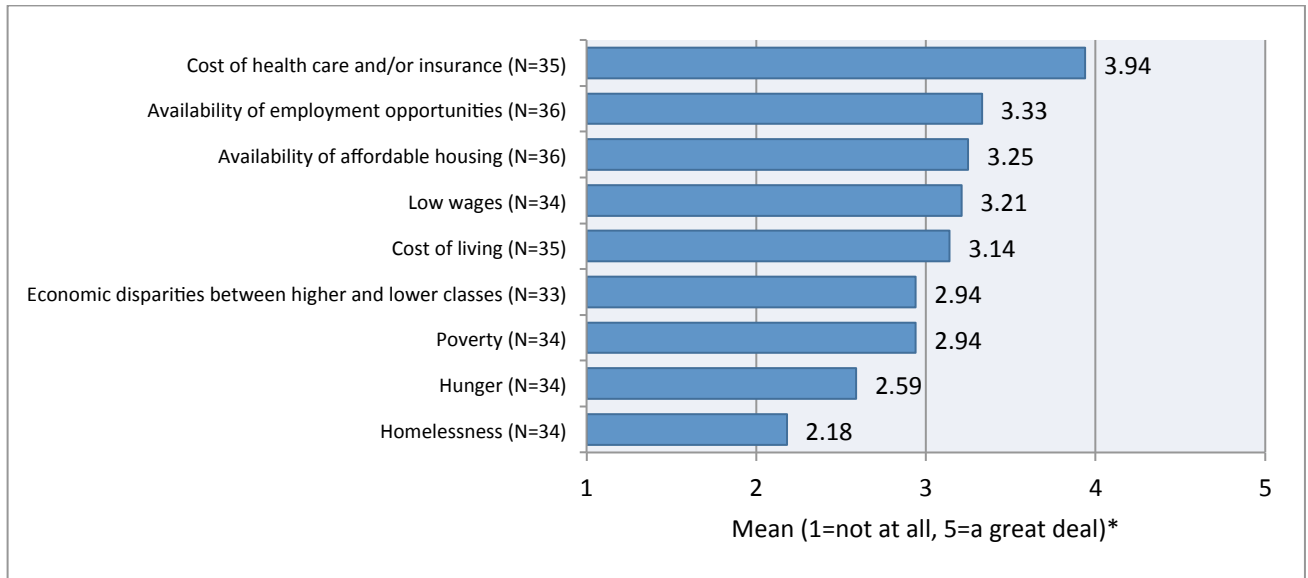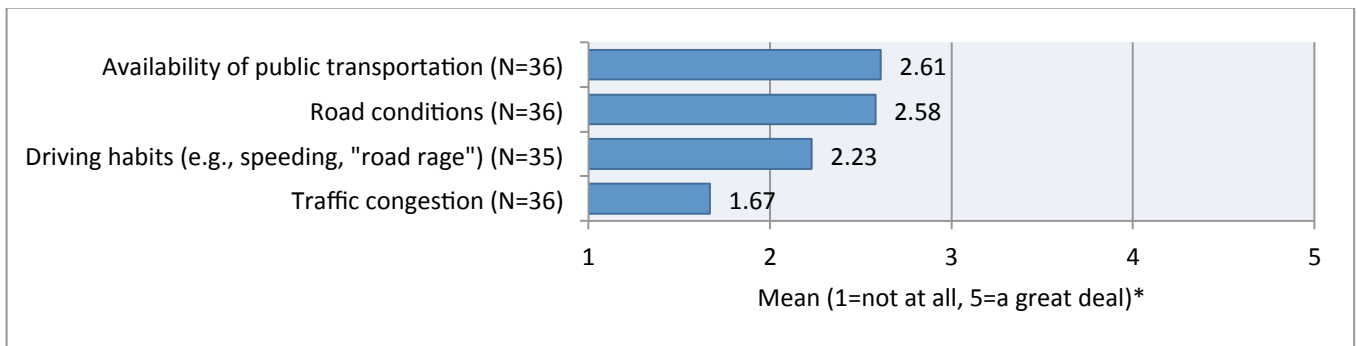

*Means exclude "do not know" responses.

Transportation

Respondents were most concerned with the availability of public transportation. Respondents were least concerned with traffic congestion.

Overall, respondents had a moderately low level of concern with transportation issues in their community (*Figure 5*).

- On average, respondents had moderate low concern regarding availability of public transportation, road conditions and driving habits.
- On average, respondents had low levels of concern with traffic congestion.

Figure 5. Respondents' level of concern with statements about their community regarding TRANSPORTATION
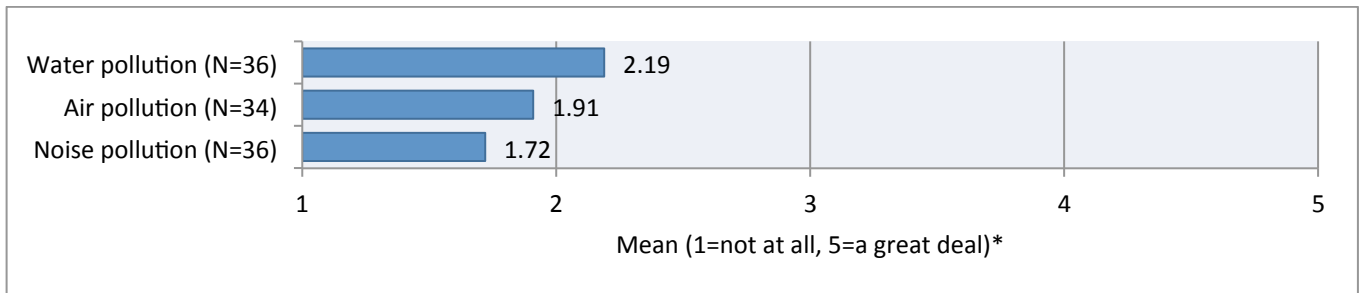

*Means exclude "do not know" responses.

Environment

Respondents on average had moderate to low concern with environmental issues in their community.

Overall, respondents were not that concerned with environmental issues in their community (*Figure 6*).
- On average, respondents had a higher level of concern with water pollution

Figure 6. Respondents' level of concern with statements about their community regarding ENVIRONMENTAL POLLUTION
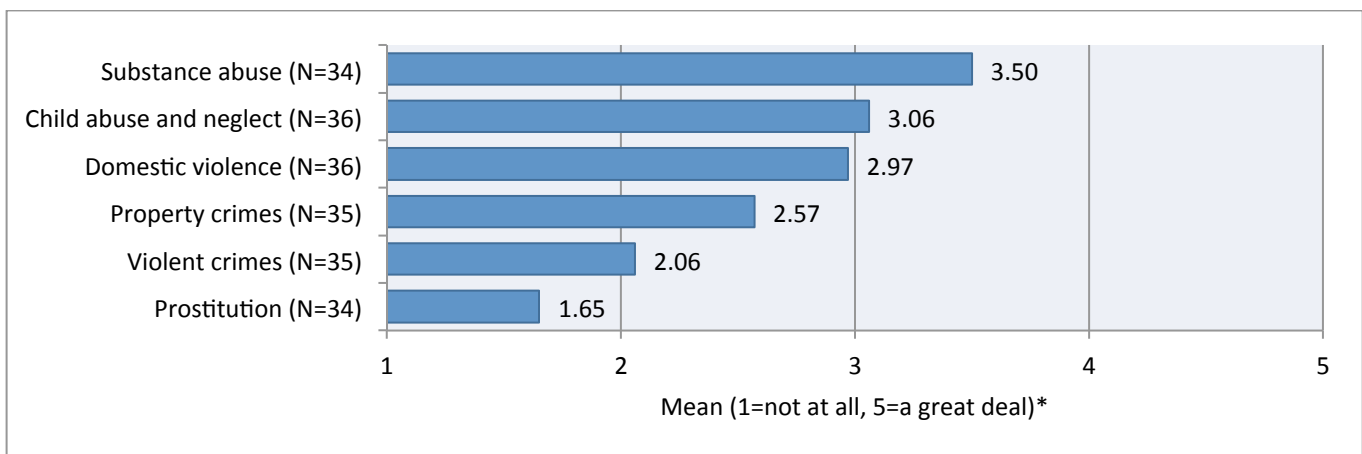

*Means exclude "do not know" responses.

Safety

Regarding safety issues in their community, respondents were most concerned with substance abuse, child abuse and neglect and domestic violence. Respondents were least concerned with prostitution.

Overall, respondents had a moderate level of concern with safety issues in their community (*Figure 7*).
- On average, respondents were most concerned with substance abuse, followed by child abuse and neglect and domestic violence.
- On average, respondents had low levels of concern about violent crimes and prostitution.

Figure 7. Respondents' level of concern with statements about their community regarding SAFETY

*Means exclude "do not know" responses.

The Aging Population

Four percent (4%) of the population in this area is older than 85 years of age, and 19% is older than 65 years of age. The state of Minnesota has 13% over 65 and 2% over the age of 85 years of age (*Figure 8).*

The gender distribution in Rock County is 49% male and 51% female; in the state of Minnesota it is evenly split at 50-50.

Figure 8. County Age and Demographic profile

|	Rock County	Minnesota
Total population	9,678	5,303,925
Percent ages 65 and older	19%	13%
Percent 85 and older	4%	2%
Percent male	49%	50%
Percent female	51%	50%

Children and Youth

Regarding children and youth, respondents were most concerned with the changes in family composition (e.g. divorce, single parent, etc.), and teen pregnancy. Respondents were least concerned with school dropout rates/truancy.

Overall, respondents had a moderate level of concern with issues relating to children and youth in their community (*Figure 9*).

- On average, respondents were most concerned about the changes in family composition (e.g. divorce, single parent, etc).
- Respondents had a moderate level of concern regarding bullying and teen pregnancy.
- Respondents had a moderately low level of concern with youth crime and school dropout rates/truancy.

Figure 9. Respondents' level of concern with statements about their community regarding YOUTH CONCERNS
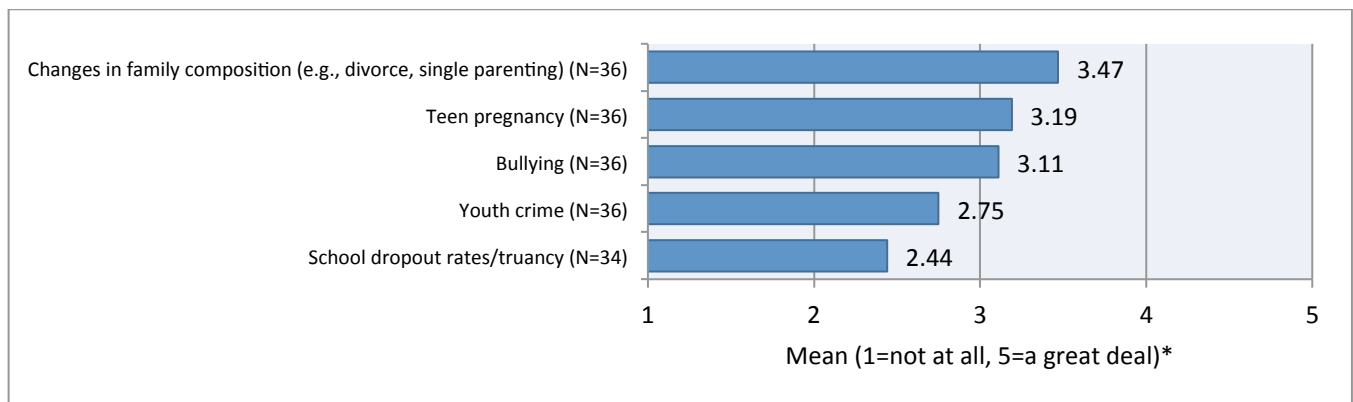
*Means exclude "do not know" responses.

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Using a 1 to 5 scale, with 1 being "not at all" and 5 being "a great deal," respondents were asked to rate their level of concern with various health and wellness issues with respect to access to health care, physical and mental health, and substance use and abuse.

The top six health and wellness concerns among community leaders were:
- Cost of health insurance
- Cost of health care
- Adequacy of health insurance coverage
- Cost of prescription drugs
- Obesity
- Availability and/or cost of dental/vision coverage
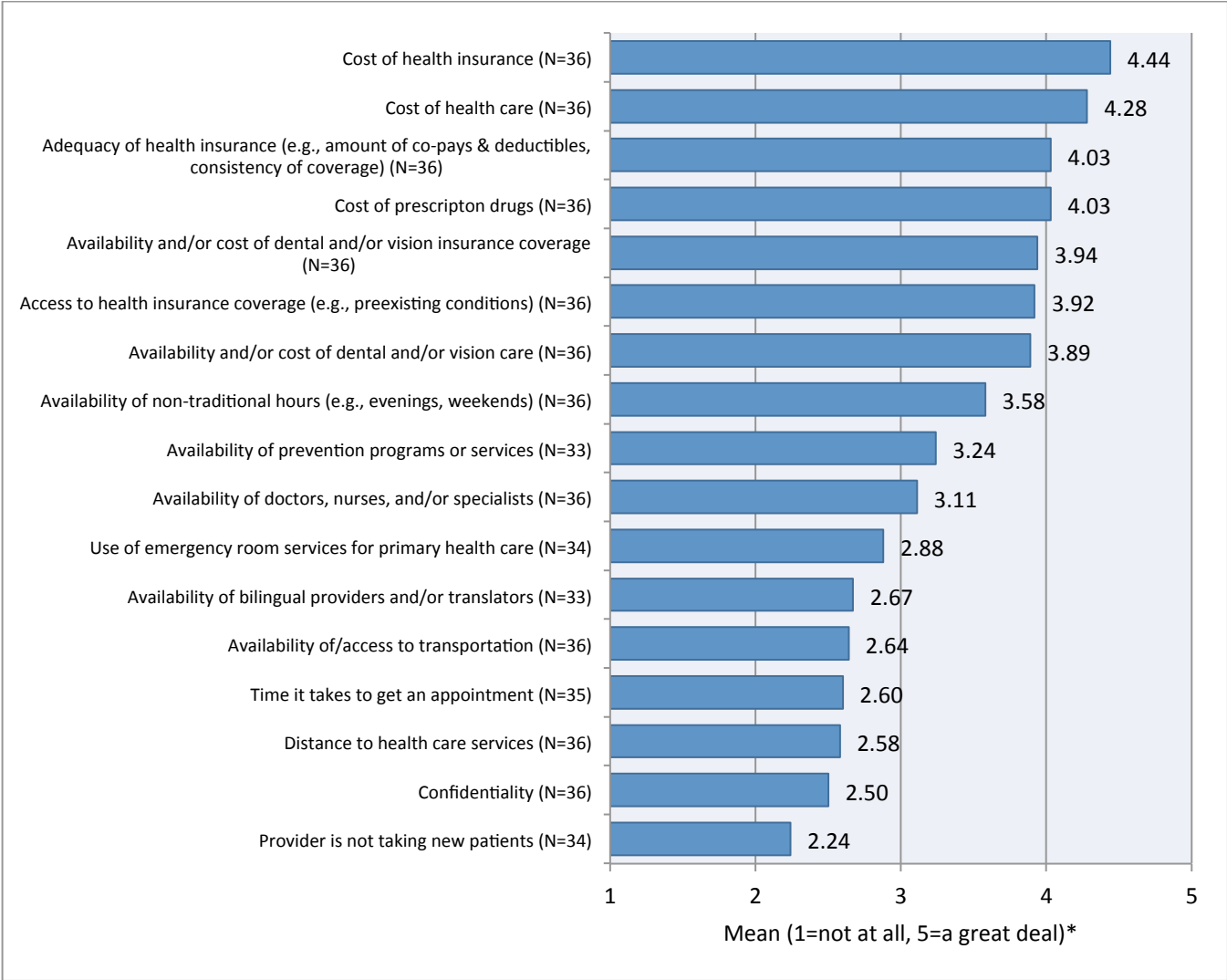- Access to health insurance coverage

Access to Health Care
Respondents had high levels of concern with respect to costs associated with health and wellness in their community. Cost of health insurance, cost of health care, adequacy of health insurance, and cost of prescription drugs were the top four concerns *(Figure 10).*

Respondents also had concerns with respect to availability and cost of dental and vision care, access to health insurance coverage, availability of and cost of dental and vision insurance coverage, and availability of non-traditional hours (evenings and weekends). Availability of prevention, providers and specialists, and availability of mental health were all well above average in level of concern.

Respondents had lowest levels of concern with patient confidentiality and providers not taking new patients.

Figure 10. Level of concern with statements about the community regarding ACCESS TO HEALTH CARE


Statement	Mean (1=not at all, 5=a great deal)*
Cost of health insurance (N=36)	4.44
Cost of health care (N=36)	4.28
Adequacy of health insurance (e.g., amount of co-pays & deductibles, consistency of coverage) (N=36)	4.03
Cost of prescripton drugs (N=36)	4.03
Availability and/or cost of dental and/or vision insurance coverage (N=36)	3.94
Access to health insurance coverage (e.g., preexisting conditions) (N=36)	3.92
Availability and/or cost of dental and/or vision care (N=36)	3.89
Availability of non-traditional hours (e.g., evenings, weekends) (N=36)	3.58
Availability of prevention programs or services (N=33)	3.24
Availability of doctors, nurses, and/or specialists (N=36)	3.11
Use of emergency room services for primary health care (N=34)	2.88
Availability of bilingual providers and/or translators (N=33)	2.67
Availability of/access to transportation (N=36)	2.64
Time it takes to get an appointment (N=35)	2.60
Distance to health care services (N=36)	2.58
Confidentiality (N=36)	2.50
Provider is not taking new patients (N=34)	2.24

Mean (1=not at all, 5=a great deal)*

*Means exclude "do not know" responses.

**Physical and Mental Health**

Regarding physical and mental health issues, respondents had the highest levels of concern with obesity, poor nutrition and eating habits, lack of exercise and inactivity and mental health issues. Respondents were least concerned with availability of good walking or biking options *(Figures 11 and 12).*

Figure 11. Level of concern with statements about the community regarding PHYSICAL HEALTH
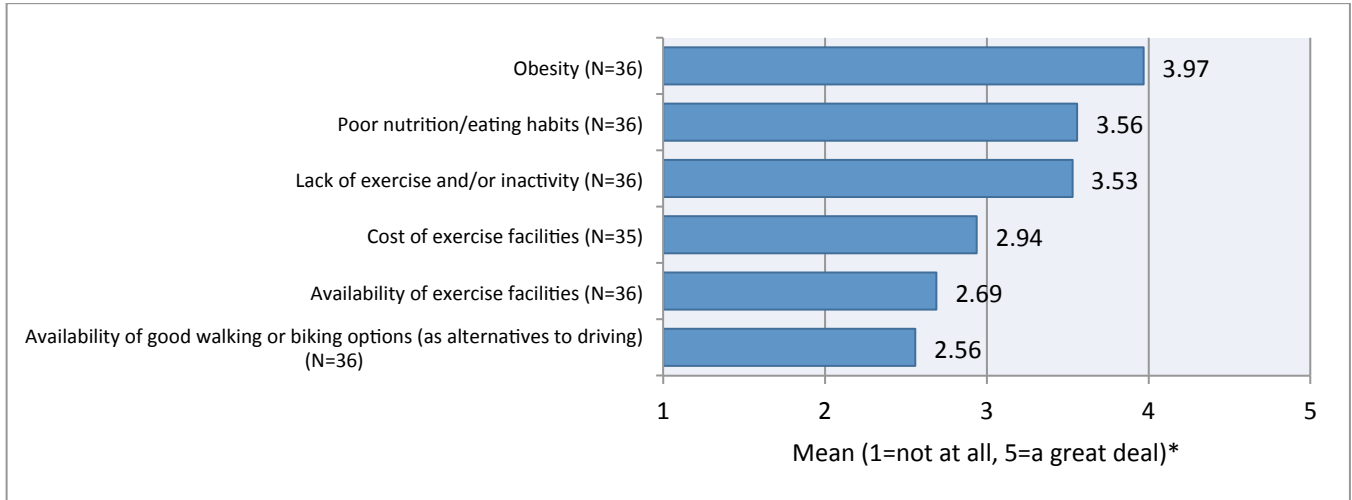
*Means exclude "do not know" responses.

Figure 12. Level of concern with statements about the community regarding MENTAL HEALTH
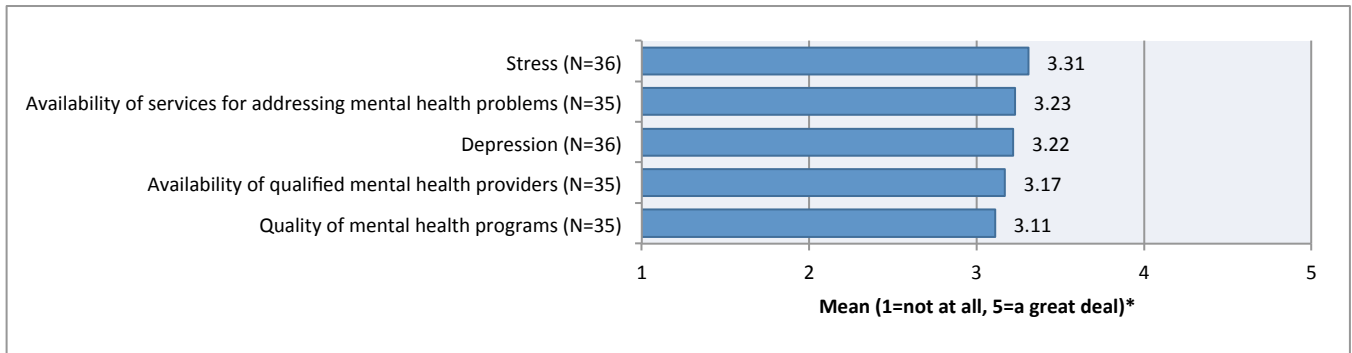
*Means exclude "do not know" responses.

Substance Use and Abuse

The levels of concern among respondents regarding drug use and abuse and alcohol use and abuse issues in their community were moderately high *(Figure 13)*. Respondents were most concerned about drug use and abuse. Although still moderate, respondents were least concerned about presence and influence of drug dealers in the community and smoking.

Figure 13. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE
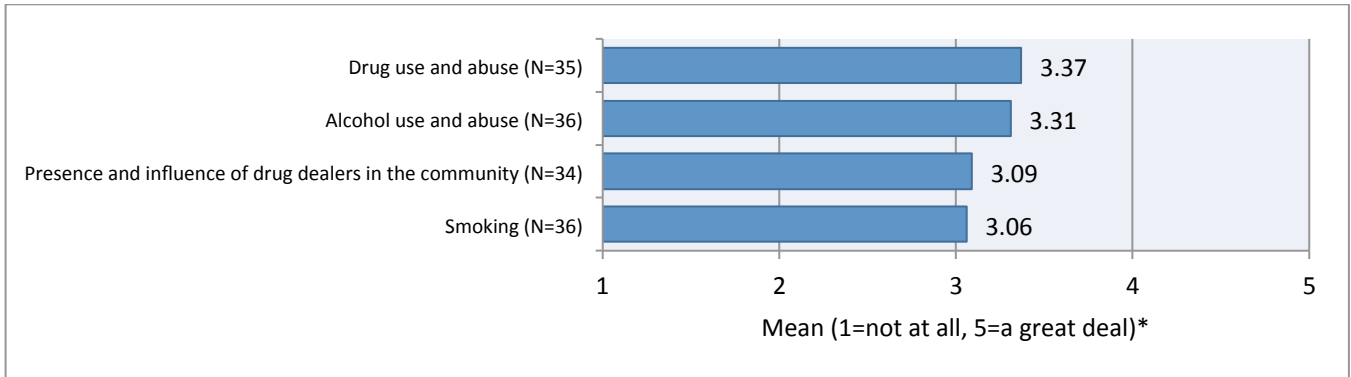
*Means exclude "do not know" responses.

Personal Heath Care Information

The top three reasons respondents gave for their choice of primary health care provider were location, quality of services, and availability of services.

Fifty-eight percent (58%) of the respondents said they had not had a cancer screening or cancer care in the past year. The most common reasons for not having a screening were because the doctor had not suggested it or because it was not necessary. Fear, cost, and unfamiliarity with recommendations were also reasons respondents gave *(Figure 14)*.

Respondents were asked whether they had a cancer screening or cancer care in the past year, and if they had not, reasons for not having done so.

- Three of five respondents said they had not had a cancer screening or cancer care in the past year.

Figure 14. Whether respondents had a cancer screening or cancer care in the past year
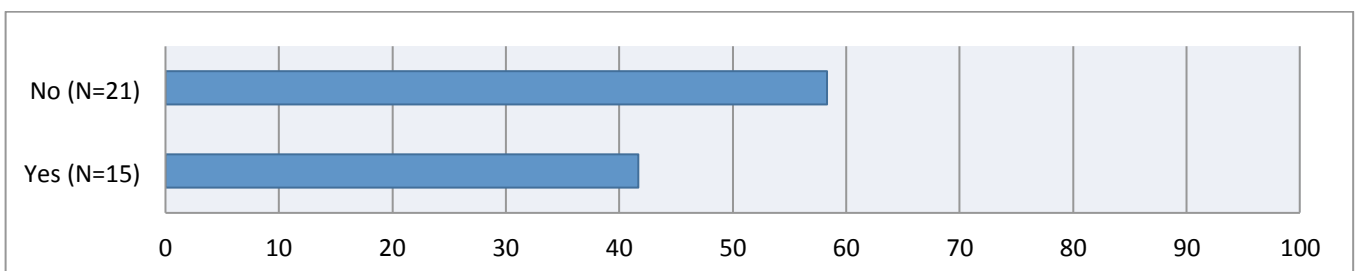
*Means exclude "do not know" responses.

Cancer Screening

Among respondents who had not had a cancer screening or cancer care in the past year, two in five said they had not done so because their doctor had not suggested it or that it wasn't necessary. Cost, fear, and unfamiliarity with the recommendations were also reasons for some respondents *(Figure 15)*.

Figure 15. Respondents cited reason for not having cancer screening or cancer care in the past year
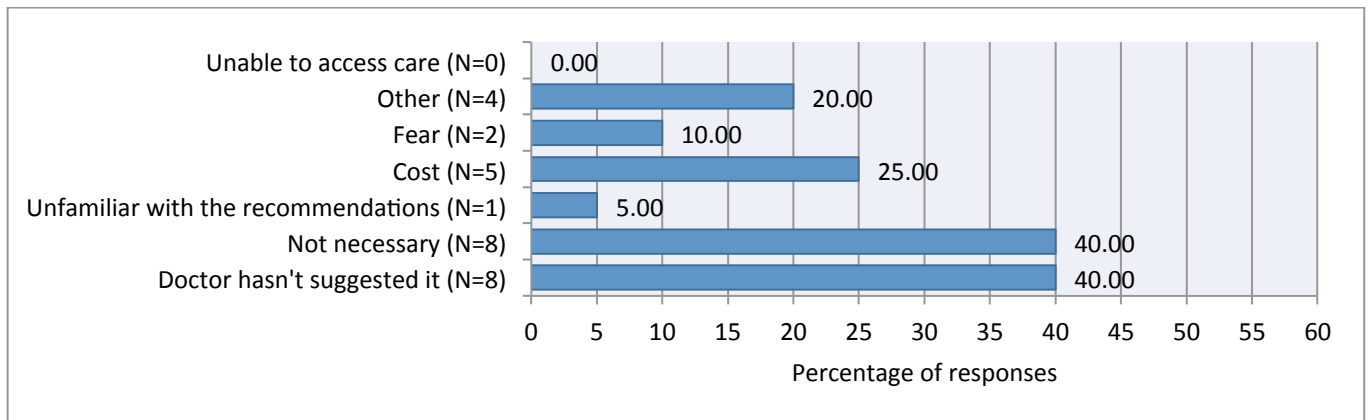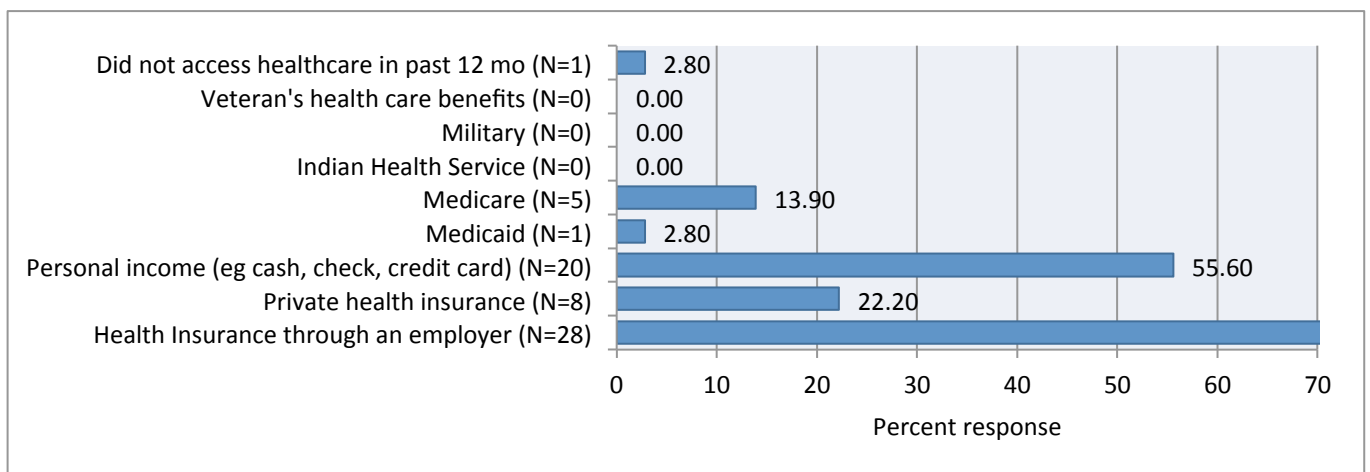

*Means exclude "do not know" responses.

Health Care Coverage

Respondents were asked how they had paid for health care costs, for themselves or family members, over the last 12 months. A majority of respondents said they had paid for health care costs over the last 12 months by health insurance through an employer. Personal income, private insurance, Medicaid, and Medicare were also used *(Figure 16)*.

Figure 16. Methods respondents have used to pay for health care costs over the last 12 months
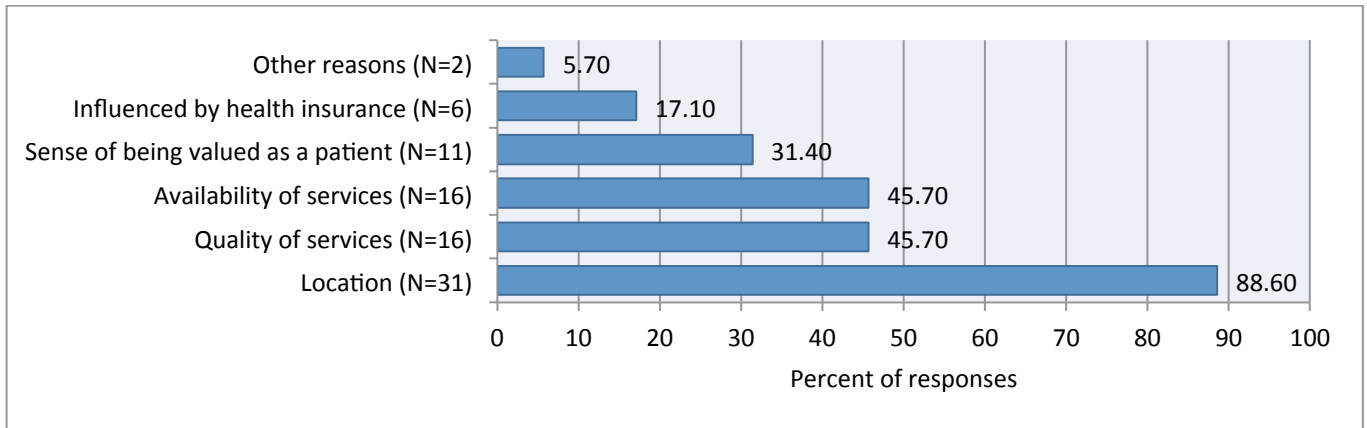

*Means exclude "do not know" responses.

Primary Care Provider

The top three reasons respondents gave for their choice of primary health care provider were location, quality of services, and availability of services (*Figure 17)*. Influenced by health insurance was not an issue in choosing a provider for most respondents.

Figure 17. Respondents' reasons for choosing primary health care provider

*Means exclude "do not know" responses.

Respondent's Primary Health Care Provider

Respondents were asked which provider they used for their primary health care. Eighty five percent (85%) of the respondents said they use Sanford Health as their primary health care provider. Nine percent (9%) said they use Avera health system. Five percent (5%) used other or multiple systems (*Figure 18*).
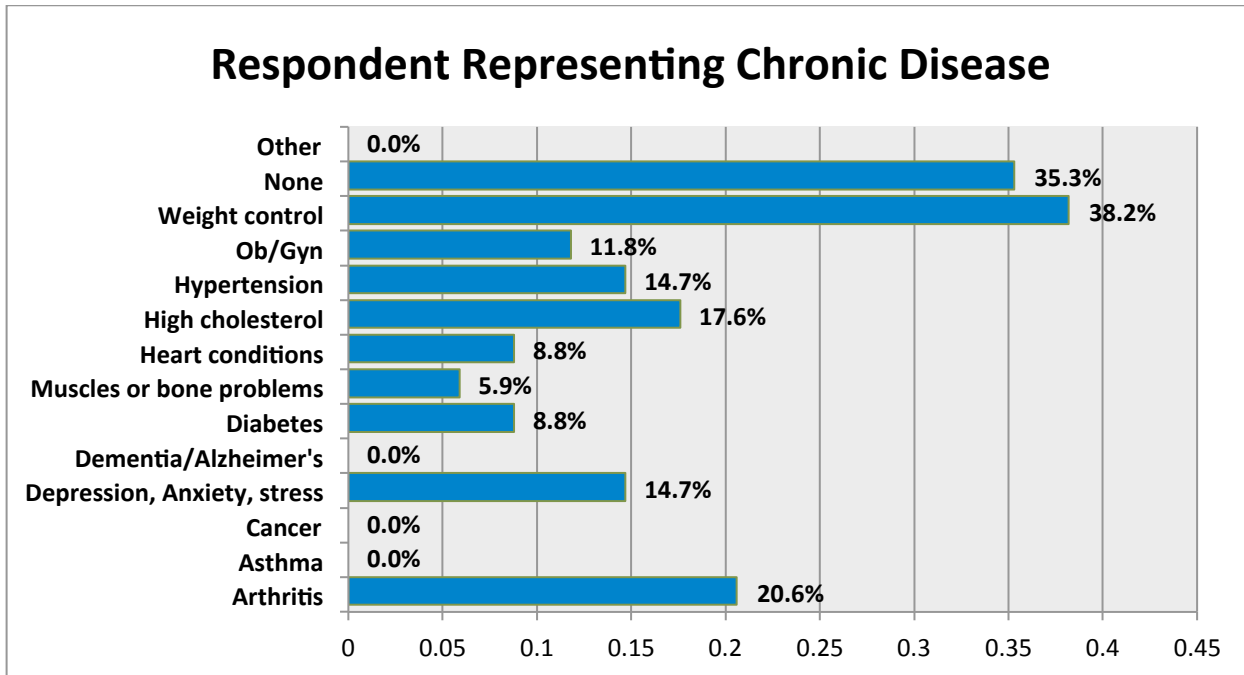
Figure 18. Respondent's primary health care provider
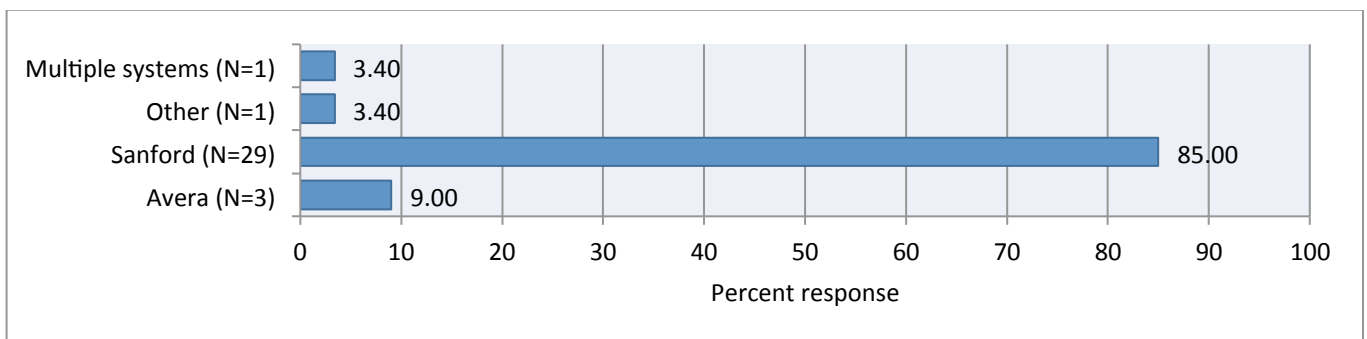
*Means exclude "do not know" responses.

Respondents Representing Chronic Disease

Respondents were asked to select their personal general health conditions/diseases. Weight control received the most responses with 38.2% of participants selecting this condition. The chronic diseases found in the highest percentages among respondents include arthritis, hypertension, depression, anxiety, stress and hypercholesterolemia. (Figure 19)

Figure 19. Respondent's health/chronic diseases

Respondent Representing Chronic Disease

Category	Percentage
Other	0.0%
None	35.3%
Weight control	38.2%
Ob/Gyn	11.8%
Hypertension	14.7%
High cholesterol	17.6%
Heart conditions	8.8%
Muscles or bone problems	5.9%
Diabetes	8.8%
Dementia/Alzheimer's	0.0%
Depression, Anxiety, stress	14.7%
Cancer	0.0%
Asthma	0.0%
Arthritis	20.6%

Demographic Information

Of the respondents who took part, 61.1% were female, 38.9% were male, and 100% were white. Respondents' age distribution ranged from 25 years to over 65 years old. Respondents between the ages of 25-34 were 13.9%, between the ages of 35-44 were 11.1%, between the ages of 45-54 were 36.1%, between 55-59 were 8.3%, between 60-64 were 13.9%, and 16.7% were 65 years and older. Respondents' education: 5.6% had high school education or GED equivalent, 8.3% have had some college with no degree, 19.4% have an Associate level degree, 30.6% have a Bachelor's degree, and 36.1% have a graduate or professional level degree.

Community Assessment and Focus Group Report – July 2011

Community Assessment Survey
In February 2011, The National Rural Health Resource Center (the Center) conferred with leaders from Sanford Luverne Medical Center to discuss the objectives of a regional community health needs assessment survey. A survey instrument was developed to assess the health care needs and preferences in the service area. The survey instrument was designed to be easily completed by respondents. Responses were electronically scanned to maximize accuracy. The survey was designed to assemble information from local residents regarding:
- Demographics of respondents
- Utilization and perception of local health services
- Perception of community health

Sanford Luverne Medical Center provided the Center with a list of inpatient hospital admissions. Zip codes with the greatest number of admissions were stratified in the initial sample selection. Each area would be represented in the sampling proportionately to both the overall served population and the number of past admissions. Eight hundred (800) residents were selected randomly from Prime Net Data Source, a marketing organization. Although the survey samples were proportionately selected, actual surveys returned from each population area varied. This may result in slightly less proportional results.

Two hundred eighty-one (281) of the mailed surveys were returned providing a 36% response rate. Based on the sample size, surveyors are 95% confident that the responses are representative of the service area population, with a margin of error of 4.68%.

Key Findings from Survey
Key findings provide the reader with an overview of the most frequent responses for each question. Percentages indicated in the key findings below are based upon the total number of responses for each individual question, as some respondents did not answer all questions, as a result the denominator can vary between questions. (N=281)

Demographics
- 60% (n= 168) of respondents reside in Luverne
- 21% (n= 60) of respondents were aged 56-65 years old
- 73% (n= 204) of respondents were female

Use of Health Care Services
- 18% (n= 50) of respondents delayed/did not get medical services when needed in the past 3 years
- Of the respondents who delayed/did not receive medical services, 48% (n= 31/64) did not because it cost too much (respondents were asked to select three that apply). Note: an additional 14 respondents answered this question compared to those that reported a delay in medical services above.

Hospital Utilization
- 66% (n= 184) of respondents received hospital care in the last three years
- 61% (n= 113/184) of respondents who received hospital care in the last three years utilized Sanford Luverne for care
- Of the respondents who utilized hospital services within the last three years, 74% (n= 156/210) selected the facility based on proximity to home (respondents were asked to select three that apply, so percentages do not equal 100%; note an additional 26 respondents answered this question who previously did not report receiving hospital care)

- 68% (n=143) of respondents would select Sanford Luverne for future hospitalizations; 55% (n=115) would select Sanford USD - Sioux Falls (respondents were asked to select all that apply, so percentages do not equal 100%)

Primary Care Utilization
- 95% (n=268) of respondents have seen a primary health care provider in the last three years
- 77% (n= 195/252) of respondents who saw a primary health care provider, saw one at Sanford Luverne; note that 16 respondents did not answer this question who previously indicated having received primary care services in the last three years
- Of respondents that saw a health care provider, 72% (n= 192/268) chose that provider because it was closest to home (respondents were asked to select three that apply, so percentages do not equal 100%)
- If respondents sought primary care services outside of Luverne, 20% (n=54/210) did so due to the quality of staff (respondents were asked to select all that apply, so percentages do not equal 100%)

Specialty Care Utilization
- 80% (n=226) of respondents have seen a health care specialist in the last three years
- Of the respondents who saw a health care specialist, 50% (n= 113/226) saw a dentist (respondents were asked to select all that apply, so percentages do not equal 100%)
- Of the respondents who saw a health care specialist, 60% (n= 135/226) received specialty care at Sanford-Sioux Falls and 40% (n=90/226) received care at Sanford Luverne (respondents were asked to select all that apply, so percentages do not equal 100%)
- If respondents left the area for specialty care services, 37% (n=64/174) left because services were not provided at Sanford Luverne (respondents were asked to select all that apply, so percentages do not equal 100%)
- 61% (n= 105/174) of all respondents would use acute care hours/after hours clinical services if available locally

Perception of Sanford Luverne
The overall quality of care (care from physicians, lab/x-ray, etc.) provided at Sanford Luverne Hospital received an average weighted score of 3.04 out of 4.00, with facility appearance receiving the top average weighted score of 3.37 on a 4.00 scale with 4.00 = Excellent, 3.00 = Good, 2.00 = Fair, and 1.00 = Poor.

- The overall quality of care provided at Sanford Luverne Clinic received an average weighted score of 3.01 out of 4.00, with facility appearance receiving the top average weighted score of 3.35 using the same weighted scoring system
- The overall quality of services (radiology, sleep studies, etc.) at Sanford Luverne hospital and clinic were rated using the same average weighted scoring system. The overall quality of services scored a 3.40. The Hospice program received the top score of 3.65.

Awareness of Services
- 52% (n= 146) of respondents rate their knowledge of the health services available at Sanford Luverne Medical Center as Fair
- Word of mouth was rated as the most frequent method in how respondents learn of community health services available at 79% (n= 194/245) (respondents were asked to select all that apply, so percentages do not equal 100%)
- 61% (n= 142/231) of respondents thought lower cost of care would improve their community's access to health care services, as well as 50% (n=116/231) report acute care/after hours clinic care would improve local access (respondents were asked to select all that apply, so percentages do not equal 100%)
- 35% (n=81/196) of respondents think health education services offered in the community on nutrition/weight management would be helpful (respondents were asked to select all that apply, so percentages do not equal 100%)

- 51% (n=125/237) would like to receive information on health education through pamphlets or other printed materials (respondents were asked to select all that apply, so percentages do not equal 100%)
- 57% (n= 159) of survey respondents identified local health care services to be very important to the economic well-being of the area

Community Health
- 58% (n= 162) of respondents rated their community as being a healthy community
- 63% (n= 165/264) of respondents thought cancer was one of the most serious health-related concerns in their community (respondents were asked to select three that apply, so percentages do not equal 100%)
- 59% (n= 157/266) of respondents reported that access to health care and other services were the most important factors contributing to a healthy community (respondents were asked to select three that apply, so percentages do not equal 100%)
- 81% (n=229) of respondents are unaware of businesses that Sanford Luverne could partner with on a community health coalition

Health Insurance
- 37% (n=103) of respondents indicate Medicare health insurance covered the majority of household's medical expenses and 1% (n=4) report having no health insurance
- 47% (n=132) rate their health insurance as Good on a scale of Excellent, Good, Fair, or Poor
- Of the respondents that indicated they do not have health insurance, 69% (n=11/16) do not because they cannot afford to pay insurance costs (respondents were asked to select all that apply, so percentages do not equal 100%). Note: an additional 12 respondents answered this question compared to the 1% (n=4) that indicated no health insurance above.
- 40% (n=112) of respondents are unaware of programs that help people pay for health care bills

Focus Group
Four focus groups were held in April 2011. Focus group participants were identified as people living in Luverne and the surrounding area. A total of 24 people participated. The focus groups were designed to represent various consumer groups of local health services including senior citizens, caregivers, business owners, clergy and health care providers. Each focus group session was approximately 60 minutes in length and included the same questions. The questions and discussions at the focus groups were led by Kami Norland of the National Rural Health Resource Center. Of the 24 focus group participants, there were 19 females and 5 males. The ages ranged from 20-75+ years old.

Key Focus Group Findings
Sanford Luverne is providing high quality, personalized health care services. Community members prefer to receive health care services within Luverne when possible and think an after-hours or urgent care clinic would increase their local utilization of health care. Increasing the marketing of existing services and making the current health resource directory more widely accessible would also increase local utilization. A health care barrier is the lack of availability of mental/behavioral health services. Focus group participants appreciate and value the personalized care they receive at Sanford Luverne.

Secondary Research

The 2011 County Profiles are based largely on the County Health Rankings from the Mobilizing Action Toward Community Health (MATCH), a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. State and National Benchmarking required additional data sources including the U.S. Census Bureau, Small Area Health Insurance Estimates, and the Centers for Disease Control and Prevention's National Center for Health Statistics – the Health Indicators Warehouse. The County Profile Data is included in the Appendix.

Health Outcomes

Mortality
The Mortality health outcomes indicate that Minnesota as a state and Rock County have fewer premature deaths than the national benchmark.

		Rock County	National Benchmark	MN
Premature death	Years of potential life lost before age 75 per 100,000 (age-adjusted), 2005-2007	5,396	5,564	5,272

Morbidity
The Morbidity health outcomes indicate that Minnesota citizens and Rock County residents report more days of poor mental and physical health than the national benchmark.

Minnesota and Rock County have a slightly higher percentage of low birth weight than the national benchmark.

		Rock County	National Benchmark	MN
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	--	10%	11%
Poor physical health days	Average number of physical unhealthy days reported in past 30 days (age-adjusted), 2003-2009	3.8	2.6	3.1
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.7	2.3	2.8
Low birth weight	Percent of live births with low birth weight (<2,500 grams), 2001-2007	6.5%	6.0%	6.5%

Health Factors

Health Behaviors
The Health Behavior outcomes indicate that Minnesota has a higher percentage of adult smokers than the national benchmark. Adult obesity is also higher in Minnesota and Rock County. Rock County has a similar percentage of physical inactivity as the national benchmark; however, Minnesota as a state is better than the national benchmark.

Minnesota and Rock County have a higher percentage of binge drinking reports than the national benchmark. Motor vehicle crash death rates are higher than the national benchmark in Minnesota.

Sexually transmitted infections rank substantially higher than the national average for Minnesota; however, significantly lower than the national average for Rock County. The teen birth rate is higher in Minnesota and Rock County than the national benchmark.

Sexually transmitted infections rank substantially lower than the national average for Minnesota and the national benchmark.

The teen birth rate is higher in Iowa than the national benchmark but is lower in Rock County. Maps 6-12 in the Appendix provide county views of the Health Behavior indicators within southwestern Minnesota.

		Rock County	National Benchmark	MN
Adult smoking	Percent of adults who currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	--%	15%	19%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008	28%	25%	26%
Physical inactivity	Percent of adults reporting no leisure physical activity, 2008	20%	20%	17%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking, (consuming >4 for women and >5 for men on a single occasion) 2003-2009	11%	8%	20%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	Unreliable or missing data	12.0	12.9
Sexually transmitted infections	Number of Chlamydia cases (new cases reported) per 100,000 population 2008	31.7	83.0	276.1
Teen birth rate	Number of teen births per 100,000 females ages 15-19, 2001-2007	26.7	22.0	27.5

Clinical Care
The Clinical Care outcomes indicate that Rock County has a slightly higher percentage of uninsured adults and youth than the national benchmark, while Minnesota as a state has a lower percentage than the national benchmark.

The ratio of population to primary care physicians is significantly better in Rock County than the national or state benchmark. Minnesota and the national benchmark are similar. The ratio of population to mental health providers is much higher in Rock County, but lower in the state of Minnesota than the national benchmark. The number of professionally active dentists is lower than the national benchmark in Minnesota. Preventable hospital stays are slightly higher than the national benchmark in Rock County and higher than the national benchmark in Minnesota.

Diabetes screening in Minnesota and Rock County is similar to the national benchmark. Rock County ranks higher than the national benchmark for mammography screenings, while Minnesota is slightly under the national benchmark.

		Rock County	National Benchmark	MN
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	14%	13%	11%
Uninsured youth	Percent of youth ages 0-18 without health insurance.	8%	7%	6%
Primary Care Physicians	Ratio of population to primary care physicians, 2008	473:1	631:1	636:1
Mental Health Providers	Ratio of total population to mental health providers, 2008	3,151:1	2,242:1	1,306:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	--	69.0	61.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	52.7	52.0	56.5
Diabetes screening	Percent of Medicare enrollees with diabetes that receive HbA1c screening, 2006-2007	89%	89%	88%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	76%	74%	73%

Social and Economic Factors

The Social and Economic Factors outcomes indicate that Rock County has a higher high school graduation rate than the national benchmark; however, Minnesota has a lower percentage than the national benchmark. Rock County has a similar percentage of post-secondary education as the national benchmark, but Minnesota has a higher percentage of adults with some post-secondary education.

The unemployment rate was slightly higher in Rock County than the national benchmark during 2009; however, significantly above the national benchmark for the state of Minnesota.

The percentage of child poverty is equal to the national benchmark for Rock County and for Minnesota.

In Minnesota, inadequate social support is similar to the national benchmark. The Rock County data is unreliable or missing.

The percentage of children in single parent households is slightly lower in Rock County than the national benchmark and Minnesota is higher than the national benchmark.

The number of homicide deaths in Rock County is not available data is unreliable or missing. The number for Minnesota is almost 2.5 times the national benchmark for 2001-2007.

Maps 21-27 in the Appendix provide county views of the Social and Economic indicators within the five-state region.

		Rock County	National Benchmark	MN
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years 2006-2007	95%	92%	87%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	68%	68%	72%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work 2009	5.5%	5.3%	8.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	11%	11%	11%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	--	14%	14%
Children in single parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	18%	20%	25%
Homicide rates	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	Unreliable or missing data	1.0	2.5

Physical Environment

The Physical Environment outcomes indicate that there is no air pollution or ozone pollution in this area. Access to healthy food is ranked significantly below the national benchmark for Rock County, and lower than the benchmark for Minnesota.

Access to recreational facilities ranks higher than the national benchmark for Rock County but lower than the benchmark for Minnesota data in 2008.

Maps 28-31 in the Appendix provide county views of the Physical Environment indicators within the five-state region.

		Rock County	National Benchmark	MN
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	10
Air pollution-ozone	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0
Access to healthy foods	Percent of zip codes with a healthy food outlet (i.e. grocery store or produce stand/farmers market), 2008	13%	92%	54%
Access to recreational facilities	Number of recreational facilities per 100,000 population 2008	21.0	17.0	12.0

Demographics

Youth account for 26% of the population in Rock County and elderly account for 19% of the population. Fifty-four percent (54%) of Rock County is rural compared to 29% in Minnesota and 21% as the national benchmark. Only 1% of Rock County residents and 4% of Minnesotans are not proficient in English compared to the national benchmark which is 9%. Rock County and Minnesota have a low illiteracy rate compared to the national benchmark of 15%.

Maps 32-36 in the Appendix provide county views of the demographics within the five-state region.

		Rock County	National Benchmark	MN
Youth	Percent of total population ages 0-17, 2009	26%	24%	24%
Elderly	Percent of total population ages 65 and older, 2009	19%	13%	13%
Rural	Percent of total population living in rural area, 2000	54%	21%	29%
Not English Proficient	Percent of total population that speaks English less than "very well". 2005-2009	1%	9%	4%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	7%	15%	6%

Population Age

County Aging Profile data is included in the Appendix. The population for this area is older than for the state of Minnesota. Rock County has 4% older than 85 years of age and 19% older than 65 years of age. The state of Minnesota has 13% over 65 and 2% over the age of 85 years of age.

The gender distribution is 49% male and 52% female in Rock County and 50-50 in the state of Minnesota.

	Rock County	Minnesota
Total population	9,687	5,303,925
Percent ages 65 and older	19%	13%
Percent 85 and older	4%	2%
Percent male	49%	50%
Percent female	51%	50%

Based on 2010 Census data

Housing

A significant number of individuals (77%) in this region own their homes.

	Rock County	Minnesota
Percent of occupied housing that is owner-occupied	77%	73%
Percent of occupied housing that is renter-occupied	23%	27%

Based on 2010 Census data

Economic Security

According to the 2010 Census Data, the population of working age in the labor force is 71% in Minnesota and 69% in Rock County. The percentage of those who are living at less than 100% of the Federal poverty level is 11% in Minnesota and 10% in Rock County. Twenty-nine percent of Rock County and 26% of Minnesotans are at less than 200% of the Federal poverty level.

The median household in Minnesota is $57,243 with Rock County significantly less at $45,411 annual income.

	Rock County	Minnesota
Percent of working age population in the labor force	69%	71%
Percent of total population with income less than 100% of poverty	10%	11%
Percent of total population with income less than 200% of poverty	29%	26%
Median household income	$45,411	$57,243
Owner occupied housing units	3,082	1,548,127
Percent spending 30% or more income toward housing costs	18%	28%
Renter occupied housing units	803	537,790
Percent renters spending 30% or more of income toward housing costs	35%	46%

Diversity Profile

The population distribution by race demonstrates that Rock County is significantly white (96.7%), followed by Hispanic. Minnesota is slightly more diverse with 85% white followed by Black, Hispanic, and Asian. (See Diversity Profile in the Appendix.)

	Rock County	Minnesota
Total population	9,687	5,303,925
White alone	9,365	4,524,062
Asian alone	53	214,234
Black alone	59	274,412
Hispanic origin – of any race	197	250,258
American Indian	34	60,916

Health Needs Identified

The following needs were identified from the surveys and analysis of secondary data:
- After Hours Access/Walk in clinic
- Dialysis Services
- Increase knowledge and awareness of services available within the community
- Obesity specific to poor nutrition, inactivity and chronic disease and care coordination for these services
- Mental health and care coordination for mental health services

Community Assets/Prioritization Process

A review of the primary and secondary research concerns was conducted followed by an asset mapping exercise to determine what resources were available to address the needs. An informal gap analysis was conducted at the conclusion of the asset mapping work. Identified needs that were related to other groups within the community will be shared with that group.

Table 1 in the Appendix display the concerns and assessed needs that were determined by the assessment and includes the assets in the community that address the needs.

The priorities that remain include:
- After Hours Access/Walk in clinic
- Dialysis Services
- Increase knowledge and awareness of services available within the community

The Sanford Luverne leadership team is establishing key initiative strategies to address the first three identified needs. Sanford Luverne leadership will be partnering with system leadership from Sanford Health to work on the system level priorities of obesity and mental health.

Table 2 in the Appendix displays the unmet needs that were determined after the asset mapping exercise and the prioritized list of remaining needs.

IMPLEMENTATION STRATEGY

2013 Community Health Needs Assessment
Sanford Luverne Implementation Strategy

The following unmet needs were identified through a formal community health needs assessment, resource mapping and prioritization process:

- After-hours access/walk-in clinic
- Increase knowledge and awareness of services available within the community

Implementation Strategy: After-Hours Access/Walk- In Clinic

- Complete after-hours volume analysis
- Complete proforma and business plan
- Sanford Health Network level review of proforma and business plan
- FY 14 budget developed to include initiative

Implementation Strategy: Lack of knowledge on services available within the community

- Develop Rock County Collaborative of key stakeholders
- Develop tool with available resources
- Design/print resource materials with Sanford marketing
- Share resource tool with key community stakeholders/access points to care

2013 Community Health Needs Assessment
Enterprise Implementation Strategy

The following unmet needs were identified through a formal community health needs assessment, resource mapping and prioritization process:
- Mental Health Services
- Obesity

Implementation Strategy: Mental Health Services - Sanford One Mind
- Completion (to the extent resources allow) of full integration of Behavioral Health services in all primary care clinics in Fargo and Sioux Falls
- Completion (to the extent resources allow) of full integration of Behavioral Health services or access to Behavioral Health outreach in all regional clinic sites in the North, South and Bemidji regions
- Complete presentation of outcomes of first three years of integrated Behavioral Health services
- Implementation of integrated Behavioral Health into clinics in new regions
- Design Team for Inpatient Psychiatric Unit, Partial Hospitalization and Clinic Space for Fargo presents recommendations for design of new spaces
- Design Team for Sioux Falls Inpatient Psychiatric Units and Partial Hospitalization

Implementation Strategy: Obesity
- Medical Management for Obesity
  o Develop CME curriculum for providers and interdisciplinary teams across the enterprise inclusive of medical, nutrition, nursing, and Behavioral Health professionals
- Develop community education programming
  o Include the following program options in the curriculum to create awareness of existing resources:
    ➢ Family Wellness Center
    ➢ Honor Your Health Program
    ➢ WebMD Fit Program
    ➢ Bariatric Services
    ➢ Eating Disorder Institute
    ➢ Mental Health/Behavioral Health
    ➢ Profile
- Actively participate in community initiatives to address wellness, fitness and healthy living

APPENDIX

2011 County Health Profile

An adaptation of the County Health Rankings Project for the Fargo-Moorhead
Community Health Needs Assessment Collaborative

Rock County

Minnesota

HEALTH OUTCOMES		Rock	*National Benchmark	Minnesota
Mortality				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	5,396	5,564	5,272
Morbidity				
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	-	10%	11%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	3.8	2.6	3.1
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.7	2.3	2.8
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	6.5%	6.0%	6.5%

HEALTH FACTORS

Health Behaviors		Rock	*National Benchmark	Minnesota
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	-	15%	19%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008	28%	25%	26%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	20%	20%	17%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking**, 2003-2009	11%	8%	20%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	-	12.0	12.9
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	31.7	83.0	276.1
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	26.7	22.0	27.5

Clinical Care		Rock	*National Benchmark	Minnesota
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	14%	13%	11%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	8%	7%	6%
Primary care physicians	Ratio of total population to primary care physicians, 2008	473:1	631:1	636:1
Mental health providers	Ratio of total population to mental health providers, 2008	3,151:1	2,242:1	1,306:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	-	69.0	61.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	52.7	52.0	56.5
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	89%	89%	88%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	76%	74%	73%

HEALTH FACTORS (continued)

		Rock	*National Benchmark	Minnesota

Social and Economic Factors

		Rock	*National Benchmark	Minnesota
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007	95%	92%	87%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	68%	68%	72%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	5.5%	5.3%	8.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	11%	11%	11%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	-	14%	14%
Children in single-parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	18%	20%	25%
Homicide rate	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	-	1.0	2.5

Physical Environment

		Rock	*National Benchmark	Minnesota
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	0
Air pollution-ozone	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0
Access to healthy foods	Percent of zip codes with a healthy food outlet (i.e., grocery store or produce stand/farmers' market), 2008	13%	92%	54%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	21.0	17.0	12.0

Demographics

		Rock	United States	Minnesota
Youth	Percent of total population ages 0-17, 2009	26%	24%	24%
Elderly	Percent of total population ages 65 and older, 2009	19%	13%	13%
Rural	Percent of total population living in a rural area, 2000	54%	21%	29%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	1%	9%	4%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	7%	15%	6%

*The national benchmark is the 90th percentile (i.e., 10% of counties nationwide ranked better). **Binge drinking is defined as consuming more than 4 (for women) or 5 (for men) alcoholic beverages on a single occasion in the past 30 days. Heavy drinking is defined as drinking more than 1 (for women) or 2 (for men) alcoholic beverages per day on average. - Blank values reflect unreliable or missing data.

Source: The overall format and content of the County Health Profiles is based largely on County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/. Additional data sources include the U.S. Census Bureau, Small Area Health Insurance Estimates, http://www.census.gov/sahie/ and the Centers for Disease Control and Prevention's National Center for Health Statistics - the Health Indicators Warehouse, http://healthindicators.gov and "Health, United States, 2010," Table 109, http://www.cdc.gov/nchs/hus.htm.

Disclaimer: The data displayed are from the source indicated; we do not vouch for the accuracy of the data or ensure they are the most recent available. The information is intended for personal, non-commercial use. It can be shared freely if it is not used for profit and appropriate acknowledgments are given. The 2011 County Health Profile was prepared by researchers at North Dakota State University in Fargo for the 2011-2013 Fargo-Moorhead Community Health Needs Assessment Collaborative. December 2011

Definitions of Health Variables

| Definitions of Health Variables from the *County Health Rankings* *2011 Report* Variable	Definition
Poor or Fair Health	Self-reported health status based on survey responses to the question: "In general, would you say that your health is excellent, very good, good, fair, or poor?"
Poor Physical Health Days (in past 30 days)	Estimate based on responses to the question: "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?"
Poor Mental Health Days (in past 30 days)	Estimate based on responses to the question: "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?"
Adult Smoking	Percent of adults that report smoking equal to, or greater than, 100 cigarettes and are currently a smoker
Adult Obesity	Percent of adults that report a BMI greater than, or equal to, 30
Excessive Drinking	Percent of as individuals that report binge drinking in the past 30 days (more than 4 drinks on one occasion for women, more than 5 for men) or heavy drinking (defined as more than 1 (women) or 2 (men) drinks per day on average
Sexually Transmitted Infections	Chlamydia rate per 100,000 population
Teen Birth Rate	Birth rate per 1,000 female population, ages 15-19
Uninsured Adults	Percent of population under age 65 without health insurance
Preventable Hospital Stays	Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees
Mammography Screening	Percent of female Medicare enrollees that receive mammography screening
Access to Healthy Foods	Healthy food outlets include grocery stores and produce stands/farmers' markets
Access to Recreational Facilities	Rate of recreational facilities per 100,000 population
Physical Inactivity	Percent of adults aged 20 and over that report no leisure time physical activity
Primary Care Provider Ratio	Ratio of population to primary care providers
Mental Health Care Provider Ratio	Ratio of population to mental health care providers
Diabetes Screening	Percent of Medicare enrollees with diabetes that receive HbA1c screening
Binge Drinking	Percent of adults that report binge drinking in the last 30 days. Binge drinking is consuming more than 4 (women) or 5 (men) alcoholic drinks on one occasion.

Aging Profile

2010 Demographic and Socio-Economic Profile
for the Aging Population Ages 65 and Older

Rock County
Minnesota

CHARACTERISTICS	Total	AGE Less than 65 Years	AGE Ages 65 and Older
Population [1]			
Total population	9,687	7,852	1,835
Percent ages 65 and older	19%	-	100%
Percent ages 85 and older	4%	-	21%
Percent male	49%	51%	43%
Percent female	51%	49%	57%
Living Arrangements			
Total households (by age of householder) [1]	3,918	2,754	1,164
Percent with family households (i.e., at least two people who are related)	68%	76%	50%
Percent with householder living alone	29%	21%	49%
Grandparents living with their grandchildren* [2]	31	13	18
Percent who are responsible for their grandchildren	35%	69%	11%
Housing [1]			
Percent of occupied housing that is owner-occupied	77%	78%	76%
Percent of occupied housing that is renter-occupied	23%	22%	24%
Economic Security [2]			
Percent of working-age population in labor force	69%	85%	18%
Percent of total population with income less than 100% of poverty	10%	9%	10%
Percent of total population with income less than 200% of poverty	29%	27%	39%
Median household income (by age of householder)	$45,411	$48,039	$26,734
Owner-occupied housing units (by age of householder)	3,082	2,147	935
Percent spending 30% or more of income toward housing costs	18%	18%	19%
Renter-occupied housing units (by age of householder)	803	537	266
Percent spending 30% or more of income toward housing costs	35%	33%	41%

Note: *The age categories for this indicator are grandparents ages 35 to 59 and grandparents ages 60 and older.

Source: U.S. Census Bureau, [1] 2010 Census Summary File 1 and [2] 2006-2010 American Community Survey 5-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across age categories; however, because they are based on sample data, one should use caution when interpreting small numbers. - Blank values reflect data that are missing or not applicable.

Disclaimer: The data displayed are from the source indicated; we do not vouch for the accuracy of the data or ensure they are the most recent available. The information is intended for personal, non-commercial use. It can be shared freely if it is not used for profit and appropriate acknowledgments are given. The Aging Profile was prepared by researchers at North Dakota State University in Fargo for Sanford Health. May 2012

Diversity Profile

2010 Demographic and Socio-Economic Profile
for Racial and Ethnic Populations

Rock County

Minnesota

CHARACTERISTICS	Total	RACE				ETHNICITY
		White alone	Black alone	American Indian alone	Asian alone	Hispanic Origin - of any race
Population [1]						
Total population	9,687	9,365	59	34	53	197
Percent ages 0 to 17	26%	25%	32%	41%	34%	51%
Percent ages 18 to 44	28%	28%	39%	41%	55%	39%
Percent ages 45 to 64	27%	28%	27%	12%	9%	10%
Percent ages 65 and older	19%	20%	2%	6%	2%	1%
Median age (in years)	41.4	42.4	27.5	21.5	29.3	17.8
Living Arrangements						
Total households [1]	3,918	3,836	26	12	14	43
Percent with householder living alone	29%	29%	42%	42%	14%	12%
Percent with families with children ages 0 to 17	29%	29%	19%	42%	57%	63%
Grandparents living with their grandchildren [2]	31	27	0	4	0	0
Percent who are responsible for grandchildren	35%	26%	-	100%	-	-
Housing [1]						
Percent occupied housing that is owner-occupied	77%	78%	15%	50%	43%	44%
Percent occupied housing that is renter-occupied	23%	22%	85%	50%	57%	56%
Educational Attainment [2]						
Percent of persons ages 25 and older with high school degree or higher	89%	89%	49%	100%	80%	100%
Percent of persons ages 25 and older with Bachelor's degree or higher	17%	17%	20%	0%	0%	19%
Economic Security [2]						
Unemployment rate	2%	2%	0%	0%	0%	0%
Median household income	$45,411	$45,570	$6,726	$60,250	$36,250	$27,188
Percent of households with income <$25,000	25%	25%	72%	0%	33%	6%
Percent of persons with income <100% poverty	10%	9%	47%	0%	24%	8%
Percent of children ages 0 to 17 in families with income <100% poverty	14%	14%	33%	-	39%	0%
Percent of elderly ages 65 and older with income <100% poverty	11%	11%	-	0%	-	-

Source: U.S. Census Bureau, [1] 2010 Census Summary File 1 and [2] 2006-2010 American Community Survey (ACS) 5-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across race and ethnic categories; however, because they are based on sample data, one should use caution when interpreting small numbers. - Blank values reflect data that are missing or not applicable. Racial categories not represented include Native Hawaiian and Other Pacific Islander alone, Some Other Race alone, and Two or More races.
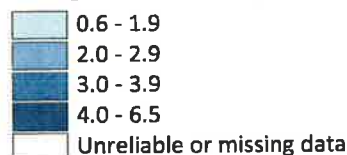
Disclaimer: The data displayed are from the source indicated; we do not vouch for the accuracy of the data or ensure they are the most recent available. The information is intended for personal, non-commercial use. It can be shared freely if it is not used for profit and appropriate acknowledgments are given. The Diversity Profile was prepared by researchers at North Dakota State University in Fargo for Sanford Health. May 2012

Map 1

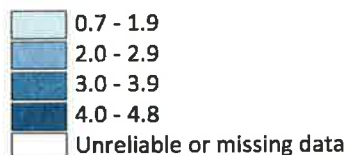# Premature Death - A health outcome measure focusing on mortality

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
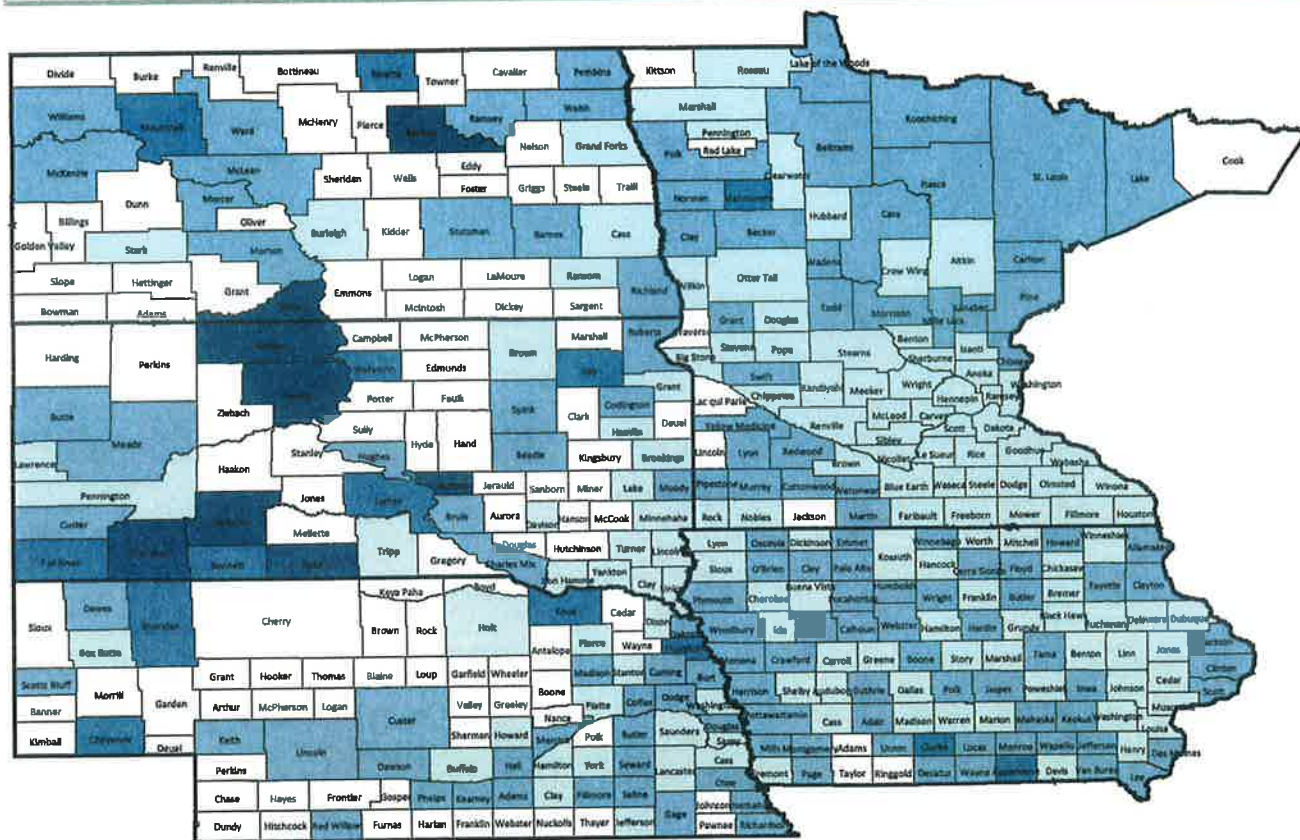
Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007

- 3,624 - 5,999
- 6,000 - 8,899
- 8,900 - 14,999
- 15,000 - 24,829
- Unreliable or missing data
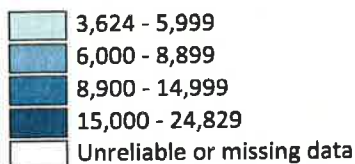
CONTEXT

What It Is: Premature death is represented by the years of potential life lost before age 75 (YPLL-75). Every death occurring before the age of 75 contributes to the total number of years of potential life lost. For example, a person who dies at age 25 contributes 50 years of life lost, whereas a person who dies at age 65 contributes 10 years of life lost to a county's YPLL. The YPLL measure is presented as a rate per 100,000 population and is age-adjusted to the 2000 U.S. population.

Where It Comes From: Data on deaths, including age at death, are based on death certificates and are routinely reported to the National Vital Statistics System (NVSS) at the National Center for Health Statistics, part of the Centers for Disease Control and Prevention (CDC). NVSS calculates age-adjusted YPLL rates based on three-year averages to create more robust estimates of mortality, particularly for counties with smaller populations.

Importance: Age-adjusted YPLL-75 rates are commonly used to represent the frequency and distribution of premature deaths. Measuring YPLL allows communities to target resources to high-risk areas and further investigate the causes of death.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

Map 2

Poor or Fair Health - A health outcome measure focusing on morbidity

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Percent of adults reporting fair or poor health (age-adjusted), 2003-2009

- 3.5% - 8.9%
- 9.0% - 11.9%
- 12.0% - 16.9%
- 17.0% - 29.1%
- Unreliable or missing data
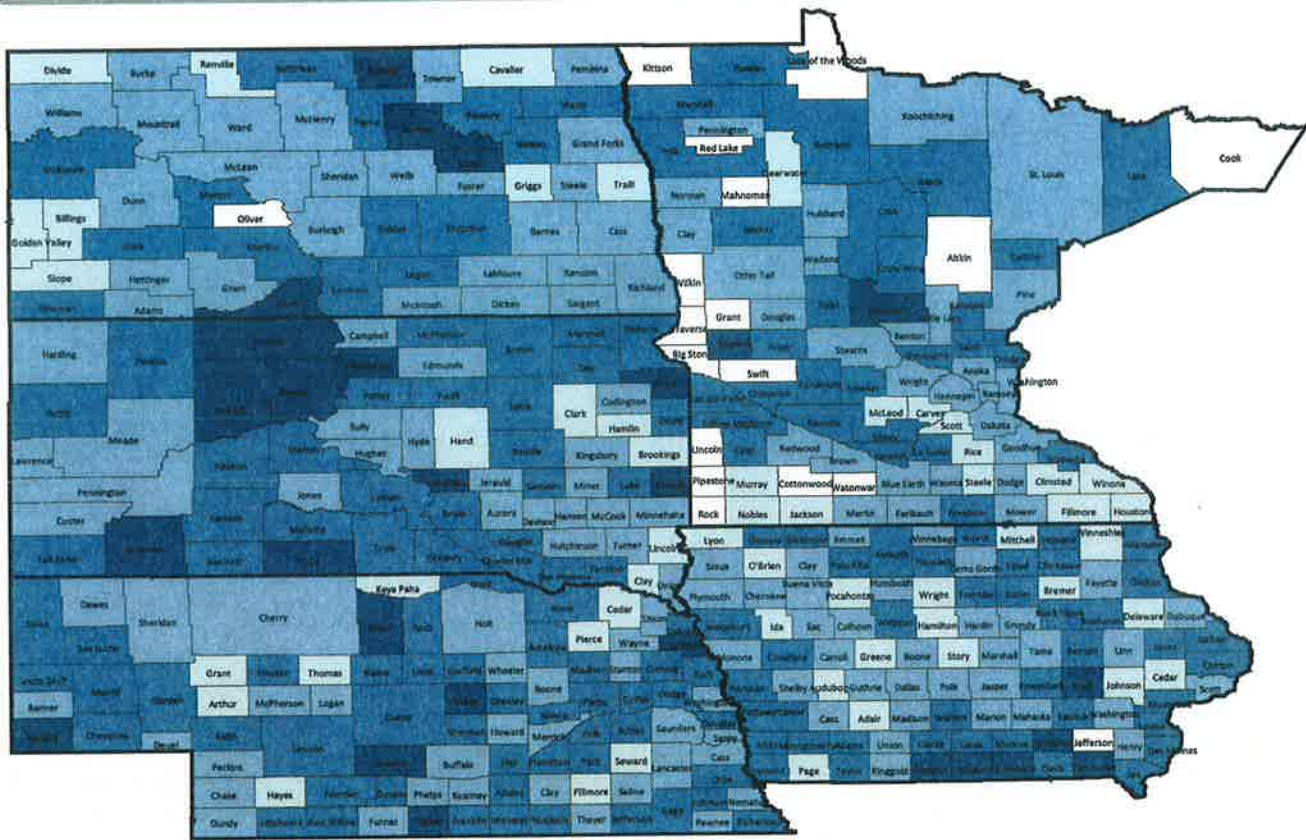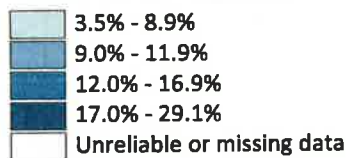
CONTEXT

What It Is: Self-reported health status is a general measure of health-related quality of life in a population. This measure is based on survey responses to the question: "In general, would you say that your health is excellent, very good, good, fair, or poor?" The value reported is the percent of adult respondents who rate their health "fair" or "poor." The measure is age-adjusted to the 2000 U.S. population.

Where It Comes From: This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population ages 18 and older living in households with a land-line telephone. Seven years of data are used to generate more stable estimates of self-reported health status.

Importance: Self-reported health status is a widely used measure of people's health-related quality of life. In addition to measuring how long people live, it is important to also include measures of how healthy people are while alive – self-reported health status has been shown to be a very reliable measure of current health.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 3

Poor Physical Health Days - A health outcome measure focusing on morbidity

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009

- 0.6 - 1.9
- 2.0 - 2.9
- 3.0 - 3.9
- 4.0 - 6.5
- Unreliable or missing data

CONTEXT

What It Is: The poor physical health days measure is based on responses to the question: "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?" Presented is the average number of days a county's adult respondents report that their physical health was not good. The measure is age-adjusted to the 2000 U.S. population.

Where It Comes From: This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population ages 18 and older living in households with a land-line telephone. Seven years of data are used to generate more stable estimates of poor physical health days.
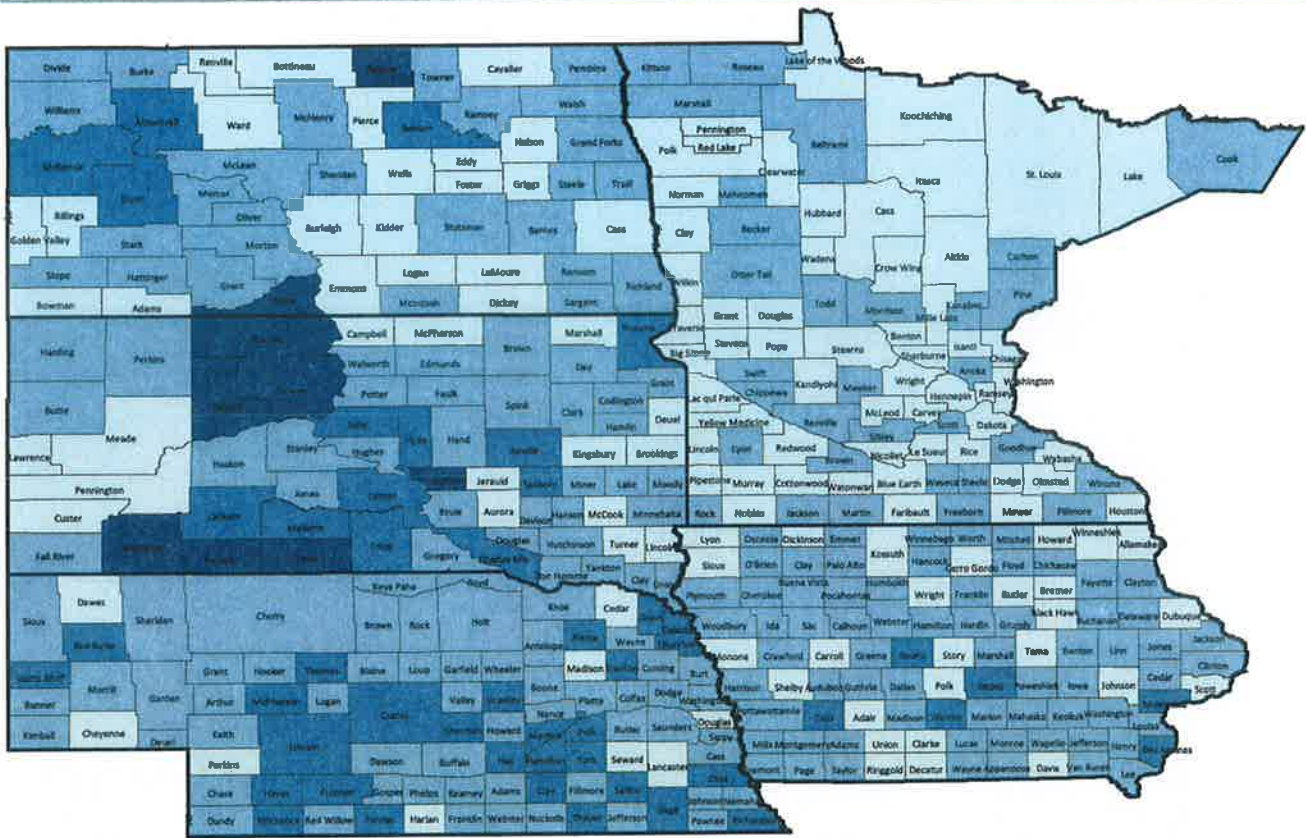
Importance: In addition to measuring how long people live, it is also important to include measures of how healthy people are while alive – people's reports of days when their physical health was not good are a reliable estimate of their recent health.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 4

Poor Mental Health Days - A health outcome measure focusing on morbidity

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009

- 0.7 - 1.9
- 2.0 - 2.9
- 3.0 - 3.9
- 4.0 - 4.8
- Unreliable or missing data

CONTEXT

What It Is: The poor mental health days measure is based on responses to the question: "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?" Presented is the average number of days a county's adult respondents report that their mental health was not good. The measure is age-adjusted to the 2000 U.S. population.

Where It Comes From: This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population ages 18 and older living in households with a land-line telephone. NCHS used seven years of data to generate more stable estimates of poor mental health days.

Importance: Overall health depends on both physical and mental well-being. Measuring the number of days when people report that their mental health was not good, i.e., poor mental health days, represent an important facet of health-related quality of life. The County Health Rankings considers health-related quality of life to be an important health outcome.
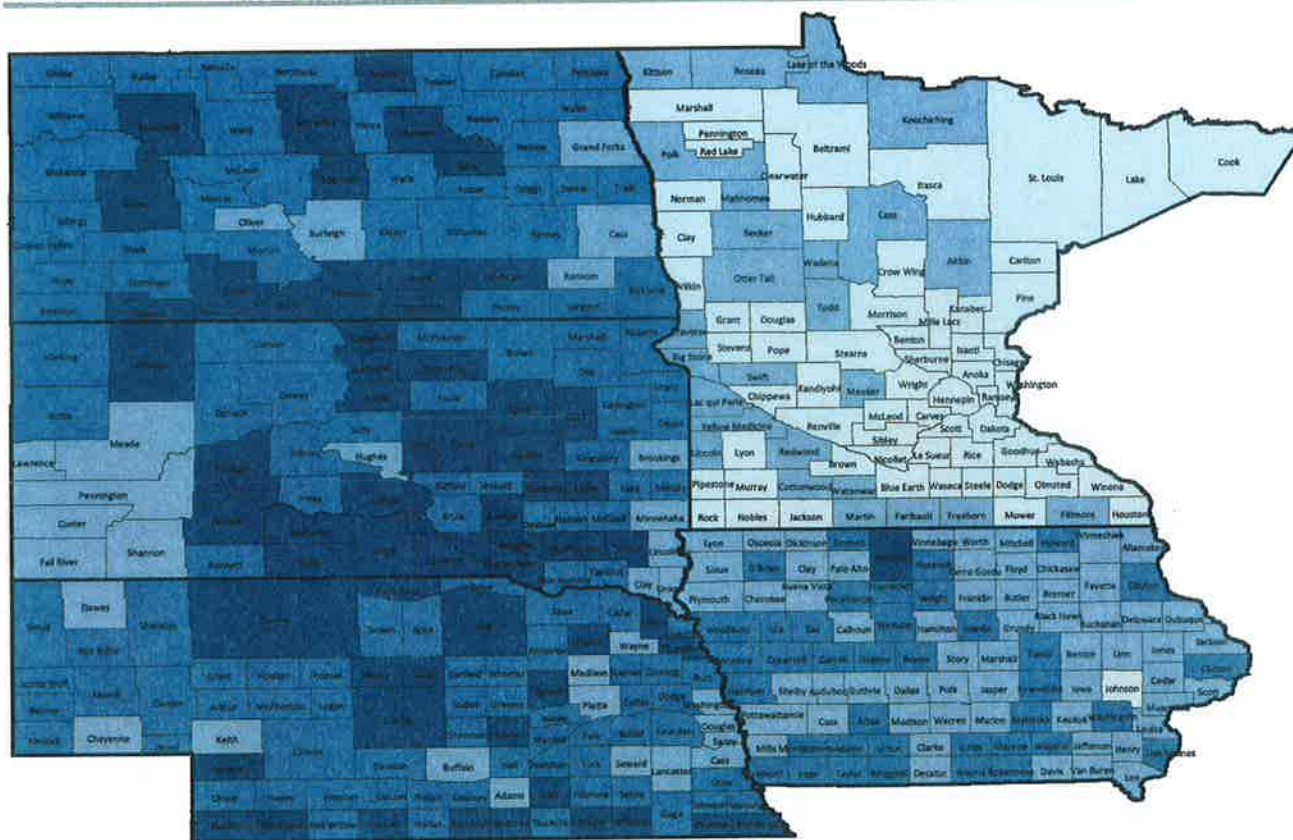
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 5

Low Birthweight - A health outcome measure focusing on morbidity

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Percent of live births with low birthweight (<2,500 grams), 2001-2007

- 4.7% - 5.9%
- 6.0% - 6.9%
- 7.0% - 7.9%
- 8.0% - 9.1%
- Unreliable or missing data
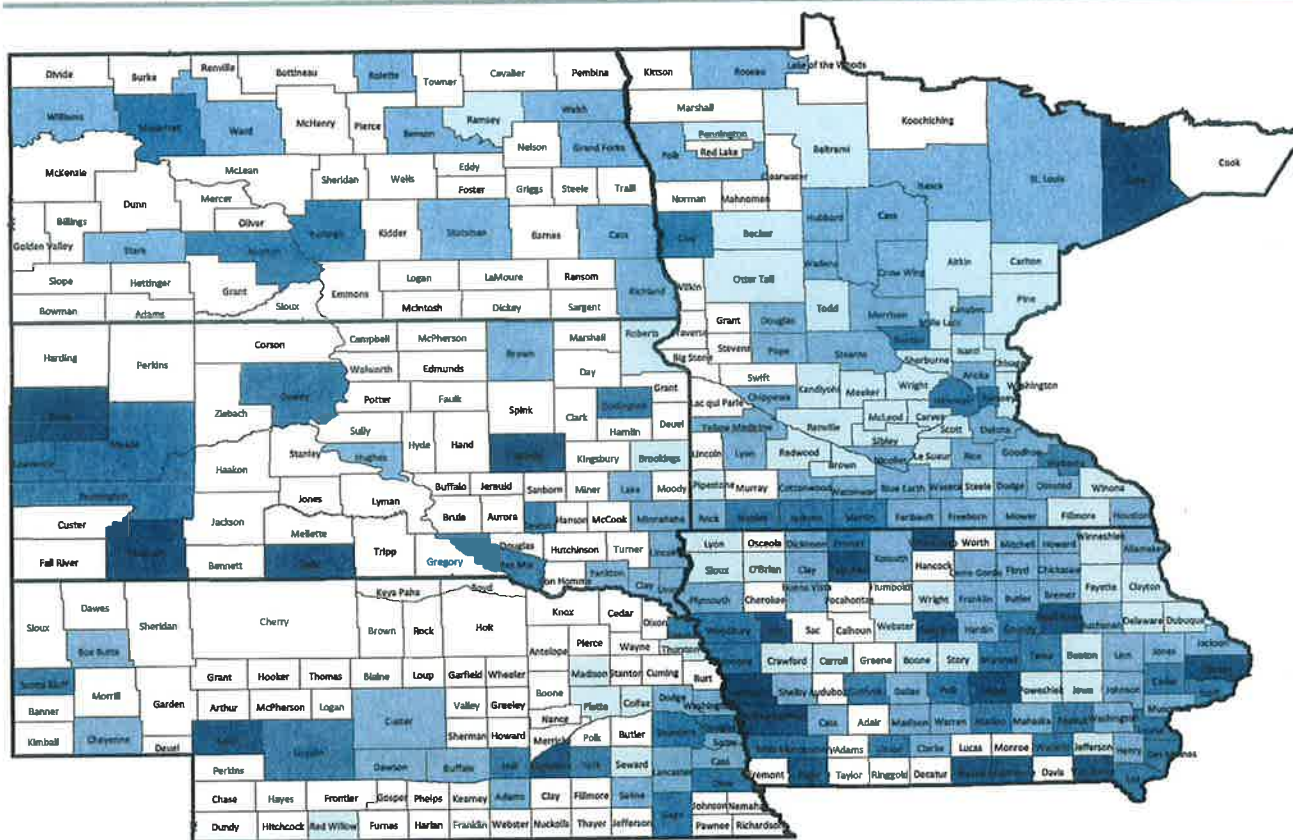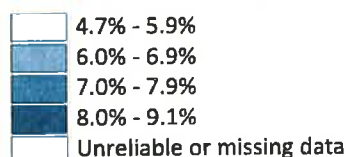
CONTEXT

What It Is: Low birthweight is the percent of live births for which the infant weighed less than 2,500 grams (approximately 5 lbs., 8 oz.).

Where It Comes From: Data on births, including weight at birth, are based on birth certificates and are routinely reported to the National Vital Statistics System (NVSS) at the National Center for Health Statistics (NCHS), part at the Centers for Disease Control and Prevention (CDC). NCHS provides this measure based on the percent of live births with low birthweight for a seven-year period. They use seven-year averages to create more robust estimates, particularly for counties with smaller populations.

Importance: Low birthweight represents two factors: maternal exposure to health risks and an infant's current and future morbidity, as well as premature mortality risk. The health consequences of low birthweight are numerous.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

Map 6

Adult Smoking - A health factor measure focusing on health behaviors
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
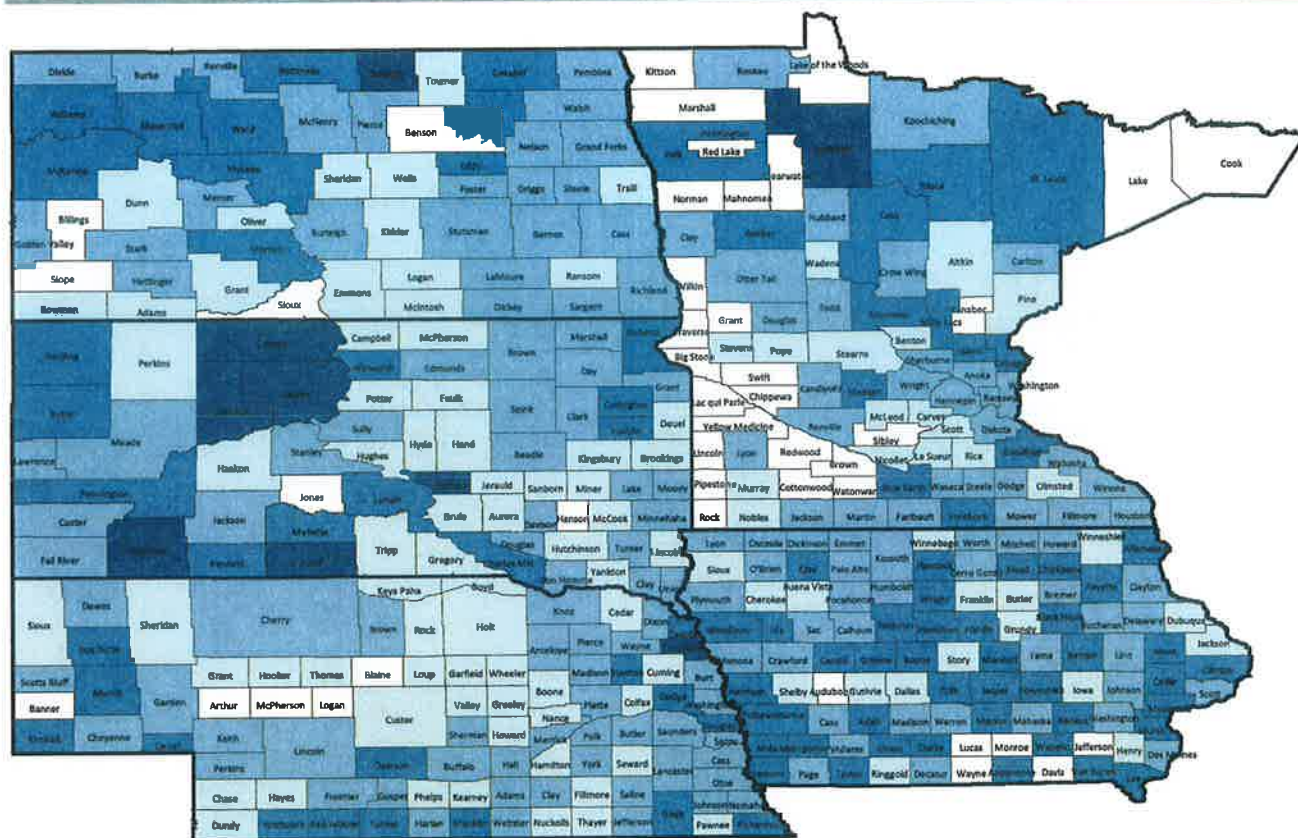
Percent of adults that currently smoke and have smoked at least 100 cigarettes in lifetime, 2003-2009

- 3.6% - 15.9%
- 16.0% - 20.9%
- 21.0% - 29.9%
- 30.0% - 48.5%
- Unreliable or missing data
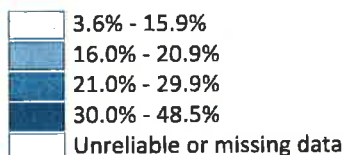
CONTEXT

What It Is: Adult smoking prevalence is the estimated percent of the adult population that currently smokes every day or "most days" and has smoked at least 100 cigarettes in their lifetime.

Where It Comes From: This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population ages 18 and older living in households with a land-line telephone. The estimates are based on seven years of data.

Importance: Each year approximately 443,000 premature deaths occur in the U.S. primarily due to smoking. Cigarette smoking is identified as a cause in multiple diseases including various cancers, cardiovascular disease, respiratory conditions, low birthweight, and other adverse health outcomes. Measuring the prevalence of tobacco use in the population can alert communities to potential adverse health outcomes and can be valuable for assessing the need for cessation programs or the effectiveness of existing programs.
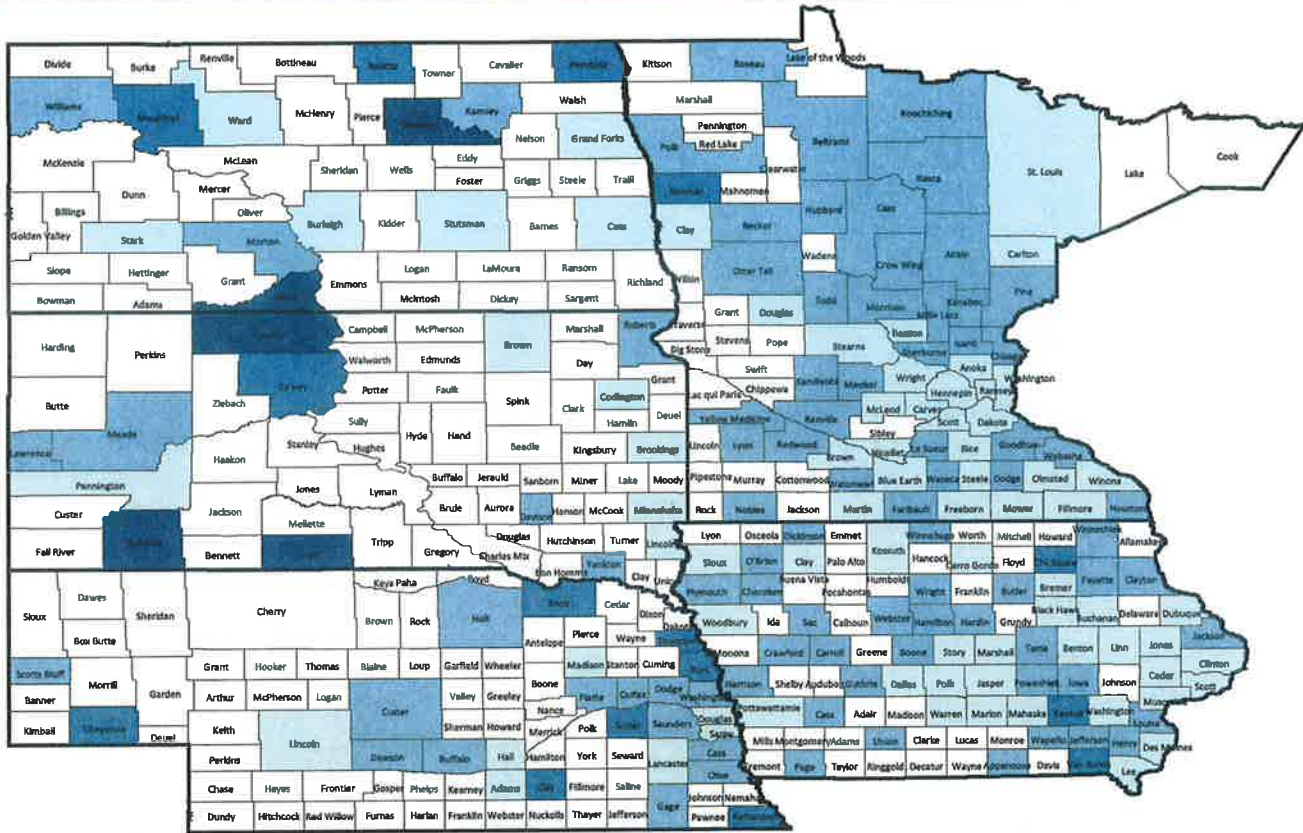
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

Map 7

Adult Obesity - A health factor measure focusing on health behaviors

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008

- 22.5% - 27.9%
- 28.0% - 29.9%
- 30.0% - 33.9%
- 34.0% - 41.0%
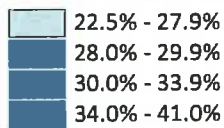
CONTEXT

What It Is: The adult obesity measure represents the percent of the adult population (age 20 and older) that has a body mass index (BMI) greater than or equal to 30 kg/m2.

Where It Comes From: Estimates of obesity prevalence by county were calculated by the CDC's National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, using multiple years of Behavioral Risk Factor Surveillance System (BRFSS) data. BRFSS data are representative of the total non-institutionalized U.S. population ages 18 and older living in households with a land-line telephone.

Importance: Obesity is often the end result of an overall energy imbalance due to poor diet and limited physical activity. Obesity increases the risk for health conditions such as coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep apnea and respiratory problems, and osteoarthritis.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 8

Physical Inactivity - A health factor measure focusing on health behaviors
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Percent of adults reporting no leisure time physical activity, 2008

	14.6% - 19.9%
	20.0% - 25.9%
	26.0% - 29.9%
	30.0% - 35.7%
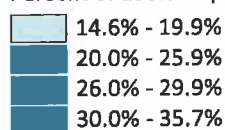
CONTEXT

What It Is: Physical inactivity is the estimated percent of adults ages 20 and older reporting no leisure time physical activity.

Where It Comes From: Estimates of physical inactivity by county were calculated by the CDC's National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, using multiple years of Behavioral Risk Factor Surveillance System (BRFSS) data. BRFSS data are representative of the total non-institutionalized U.S. population ages 18 and older living in households with a land-line telephone.

Importance: Regular physical activity is one of the most important things one can do for their health. It can help control weight, reduce risk of cardiovascular disease, reduce risk for type 2 diabetes and metabolic syndrome, reduce risk of some cancers, strengthen bones and muscles, improve mental health and mood, improve ability to do daily activities and prevent falls in older adults, and increase chances of living longer (Centers for Disease Control and Prevention, http://www.cdc.gov/ physicalactivity/everyone/health/index.html).

- Data were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www. countyhealthrankings.org/.

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Map 9

Excessive Drinking - A health factor measure focusing on health behaviors
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Percent of adults reporting binge drinking and heavy drinking, 2003-2009

- 7.5% - 14.9%
- 15.0% - 19.9%
- 20.0% - 24.9%
- 25.0% - 35.9%
- Unreliable or missing data
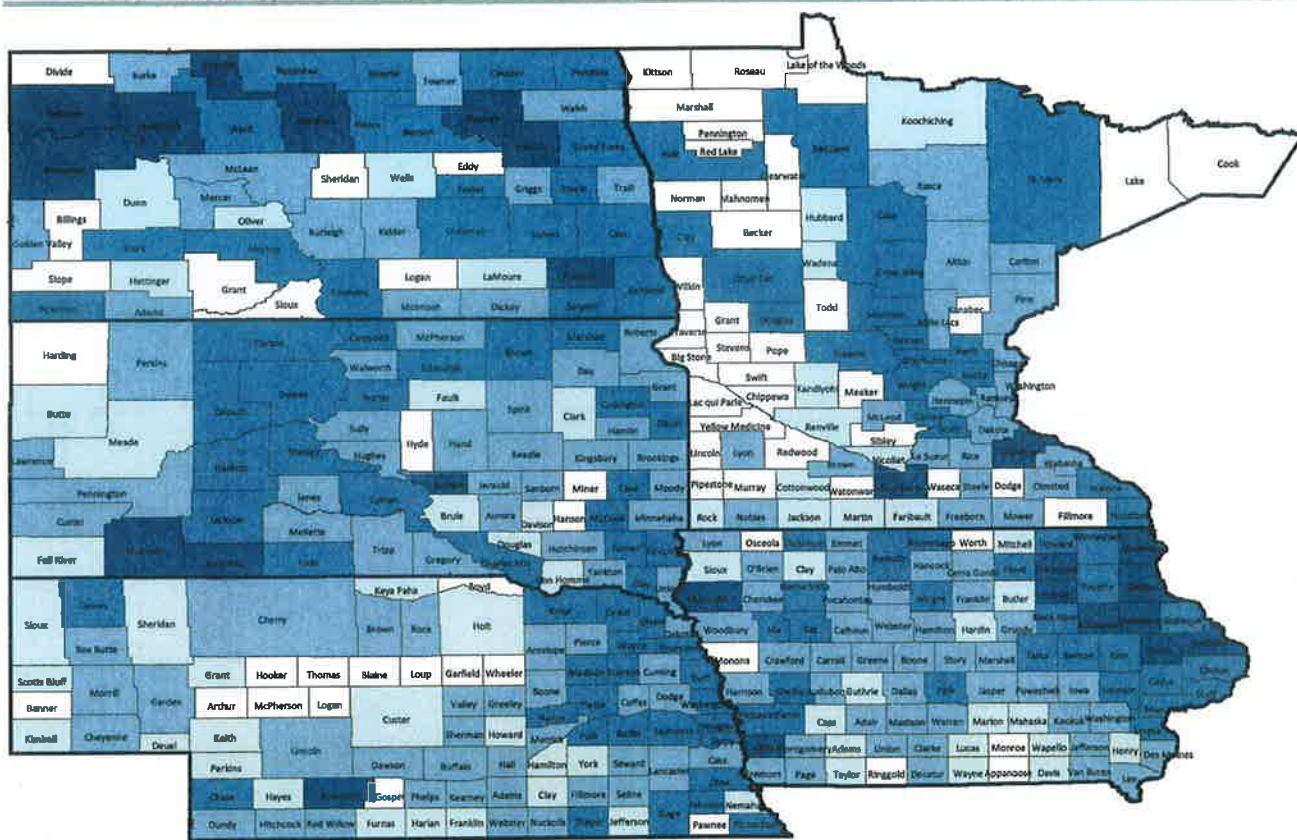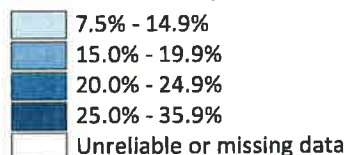
CONTEXT

What It Is: The excessive drinking measure reflects the percent of the adult population that reports either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than 1 (women) or 2 (men) drinks per day on average.

Where It Comes From: This measure was calculated by the National Center for Health Statistics using data obtained from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population ages 18 and older living in households with a land-line telephone. The estimates are based on seven years of data.

Importance: Excessive drinking is a risk factor for a number of adverse health outcomes such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 10

Motor Vehicle Crash Death Rate - A health factor measure focusing on health behaviors

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Motor vehicle crash deaths per 100,000 population, 2001-2007

- 7.1 - 17.9
- 18.0 - 31.9
- 32.0 - 59.9
- 60.0 - 135.7
- Unreliable or missing data
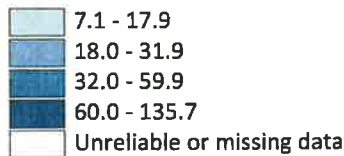
CONTEXT

What It Is: Motor vehicle crash deaths are measured as the crude mortality rate per 100,000 population due to on- or off-road accidents involving a motor vehicle. Motor vehicle deaths includes traffic and non-traffic accidents involving motorcycles and 3-wheel motor vehicles; cars; vans; trucks; buses; street cars; ATVs; industrial, agricultural, and construction vehicles; and bikes and pedestrians when colliding with any of the vehicles mentioned. Deaths due to boating accidents and airline crashes are not included in this measure.

Where It Comes From: These data were calculated by National Center for Health Statistics (NCHS), part of the Centers for Disease Control and Prevention (CDC), based on data reported to the National Vital Statistics System (NVSS). NCHS used data for a seven-year period to create more robust estimates of cause-specific mortality, particularly for counties with smaller populations.

Importance: A strong association has been demonstrated between excessive drinking and alcohol-impaired driving, with approximately 17,000 Americans killed annually in alcohol-related motor vehicle crashes.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

Map 11

Sexually Transmitted Infections - A health factor measure focusing on health behaviors

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Number of chlamydia cases (new cases reported) per 100,000 population, 2008

- 15.4 - 176.9
- 177.0 - 399.9
- 400.0 - 1,015.9
- 1,016.0 - 2,326.8
- Unreliable or missing data
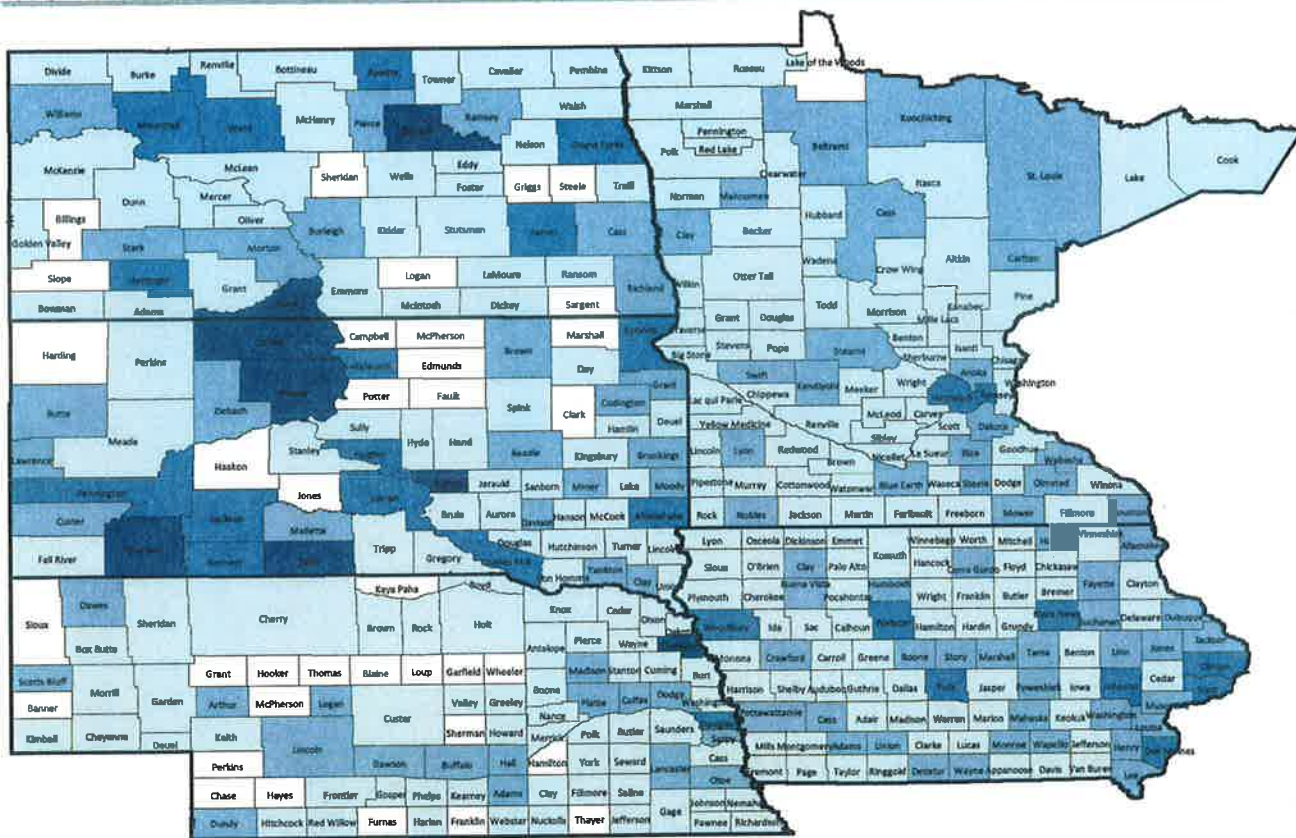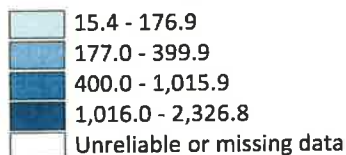
CONTEXT

What It Is: The Sexually Transmitted Infection (STI) rate is measured as chlamydia incidence (the number of new cases reported) per 100,000 population.

Where It Comes From: The county-level measures were obtained from the CDC's National Center for Hepatitis, HIV, STD, and TB Prevention.

Importance: Chlamydia is the most common bacterial STI in North America and is one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain. STIs in general are associated with a significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, involuntary infertility, and premature death. However, increases in reported chlamydia infections may reflect the expansion of chlamydia screening, use of increasingly sensitive diagnostic tests, an increased emphasis on case reporting from providers and laboratories, improvements in the information systems for reporting, as well as true increases in disease.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 12

Teen Birth Rate - A health factor measure focusing on health behaviors
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
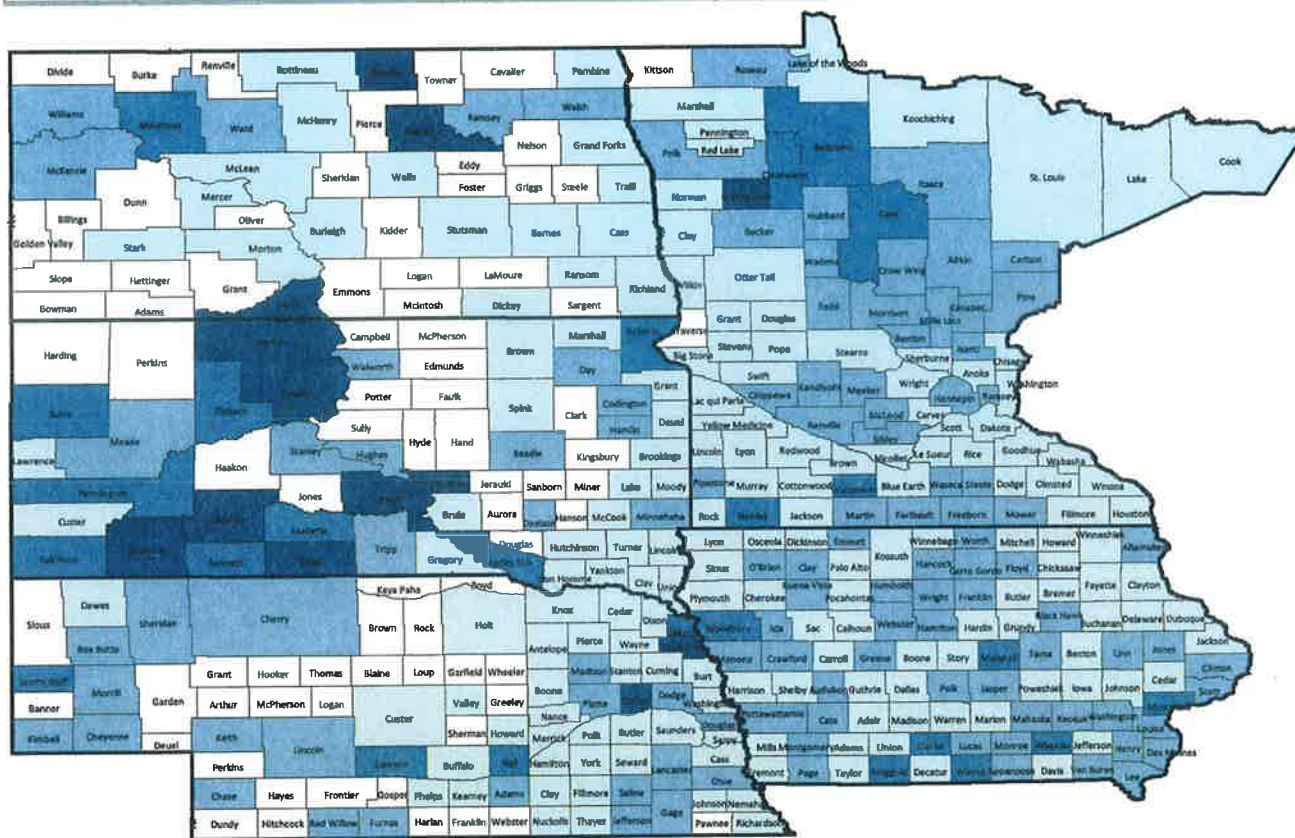
Number of teen births per 1,000 females ages 15 through 19, 2001-1007

- 8.1 - 28.9
- 29.0 - 45.9
- 46.0 - 79.9
- 80.0 - 137.8
- Unreliable or missing data
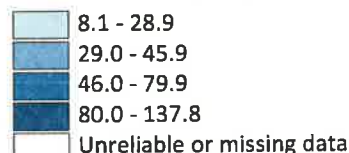
CONTEXT

What It Is: Teen births are reported as the number of births per 1,000 female population ages 15 through 19.

Where It Comes From: Teen birth rates were obtained from the National Vital Statistics System (NVSS) at the National Center for Health Statistics, part of the Centers for Disease Control and Prevention (CDC).

Importance: Teen pregnancy is associated with poor prenatal care and pre-term delivery. Pregnant teens are more likely than older women to receive late or no prenatal care, have gestational hypertension and anemia, and achieve poor maternal weight gain. They are also more likely to have a pre-term delivery and low birth weight, increasing the risk of child developmental delay, illness, and mortality.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

Map 13

Uninsured Adults - A health factor measure focusing on clinical care
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
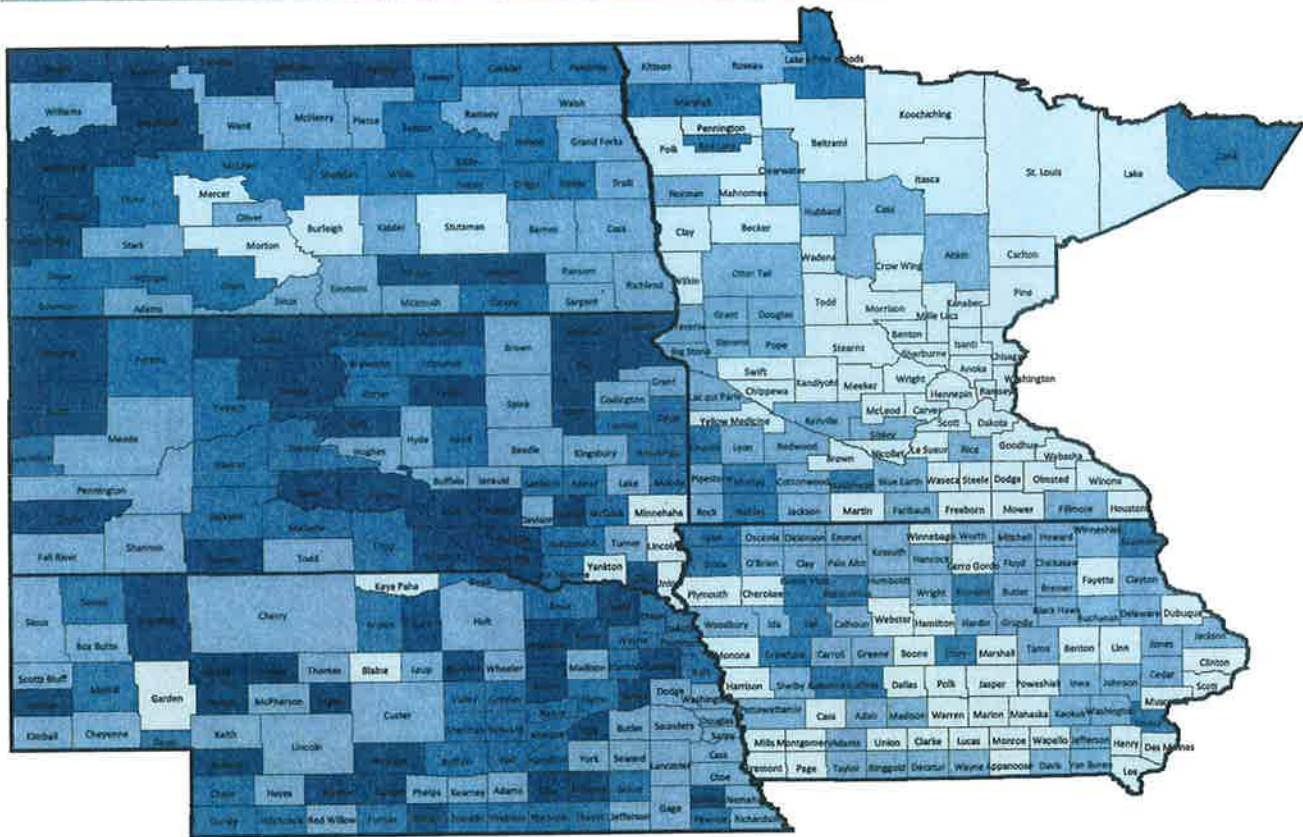
Percent of adult population ages 18 through 64 without health insurance, 2007

- 8.3% - 12.9%
- 13.0% - 16.9%
- 17.0% - 20.9%
- 21.0% - 27.5%
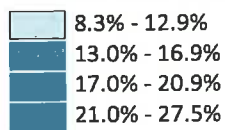
CONTEXT

What It Is: The uninsured adults measure represents the estimated percent of the adult population under age 65 that has no health insurance coverage.

Where It Comes From: The Small Area Health Insurance Estimates from the U.S. Census Bureau provide annual estimates of the population without health insurance coverage for all U.S. states and their counties. The estimates used are for the most recent year for which reliable county-level estimates are available.

Importance: Lack of health insurance coverage is a significant barrier to accessing needed health care.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

Map 14

# Uninsured Youth - A health factor measure focusing on clinical care

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
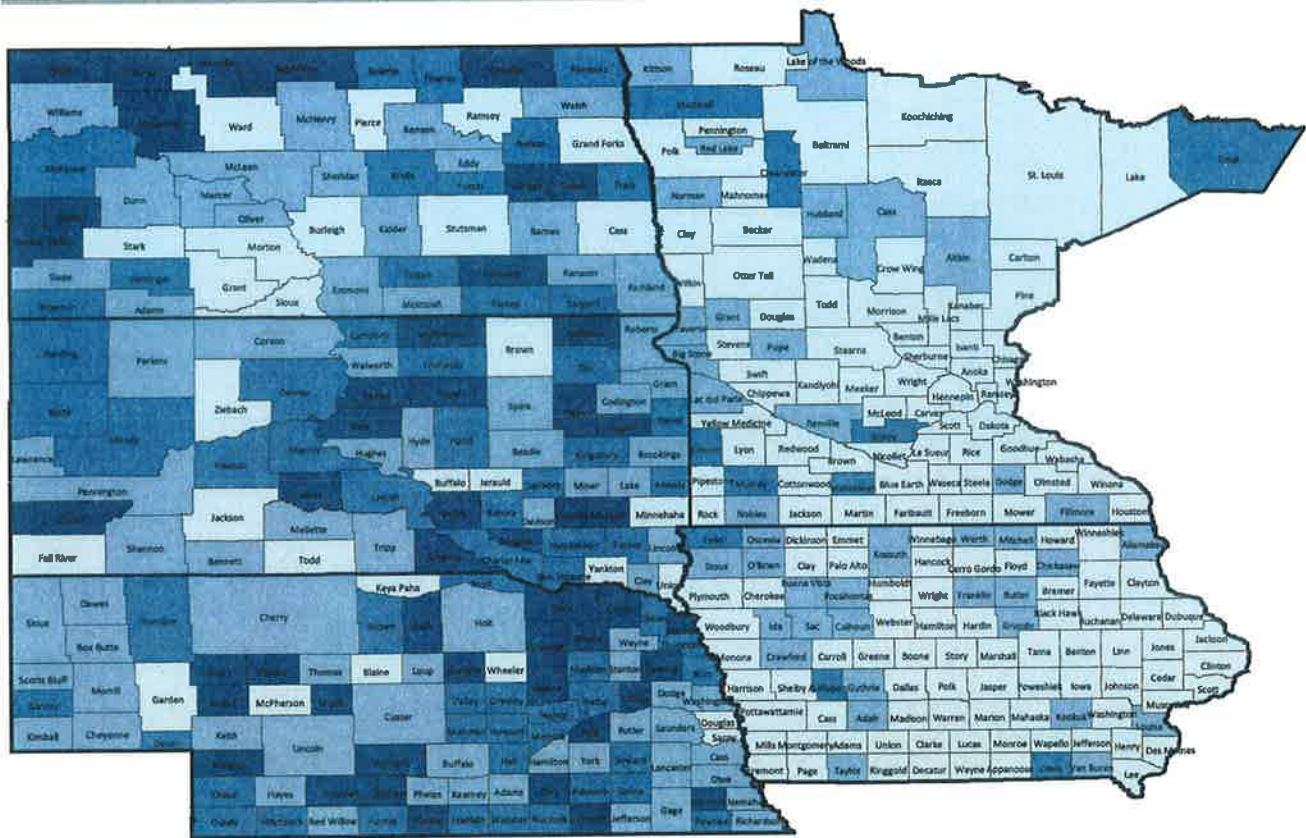
Percent of youth ages 0 through 18 without health insurance, 2007

- 4.1% - 7.9%
- 8.0% - 10.9%
- 11.0% - 13.9%
- 14.0% - 20.5%
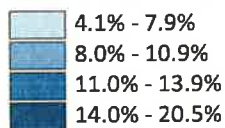
CONTEXT

What It Is: The uninsured youth measure represents the estimated percent of the children ages birth through 18 that has no health insurance coverage.

**Where It Comes From:** The Small Area Health Insurance Estimates from the U.S. Census Bureau provide annual estimates of the population without health insurance coverage for all U.S. states and their counties. The estimates used are for the most recent year for which reliable county-level estimates are available.

Importance: Children without health insurance are more likely than others to receive late or no care for health problems, putting them at greater risk for hospitalization. In addition to resulting in reduced access to health care, a lack of health insurance can also negatively influence children's school attendance and participation in extracurricular activities, and increase parental financial and emotional stress. (Child Trends DataBank, http://www.childtrendsdatabank. org/?q=node/297)

- Data were obtained from the Small Area Health Insurance Estimates (SAHIE), a program of the U.S. Census Bureau, http://www.census.gov/ did/www/sahie/.

Map 15

Primary Care Physicians - A health factor measure focusing on clinical care

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
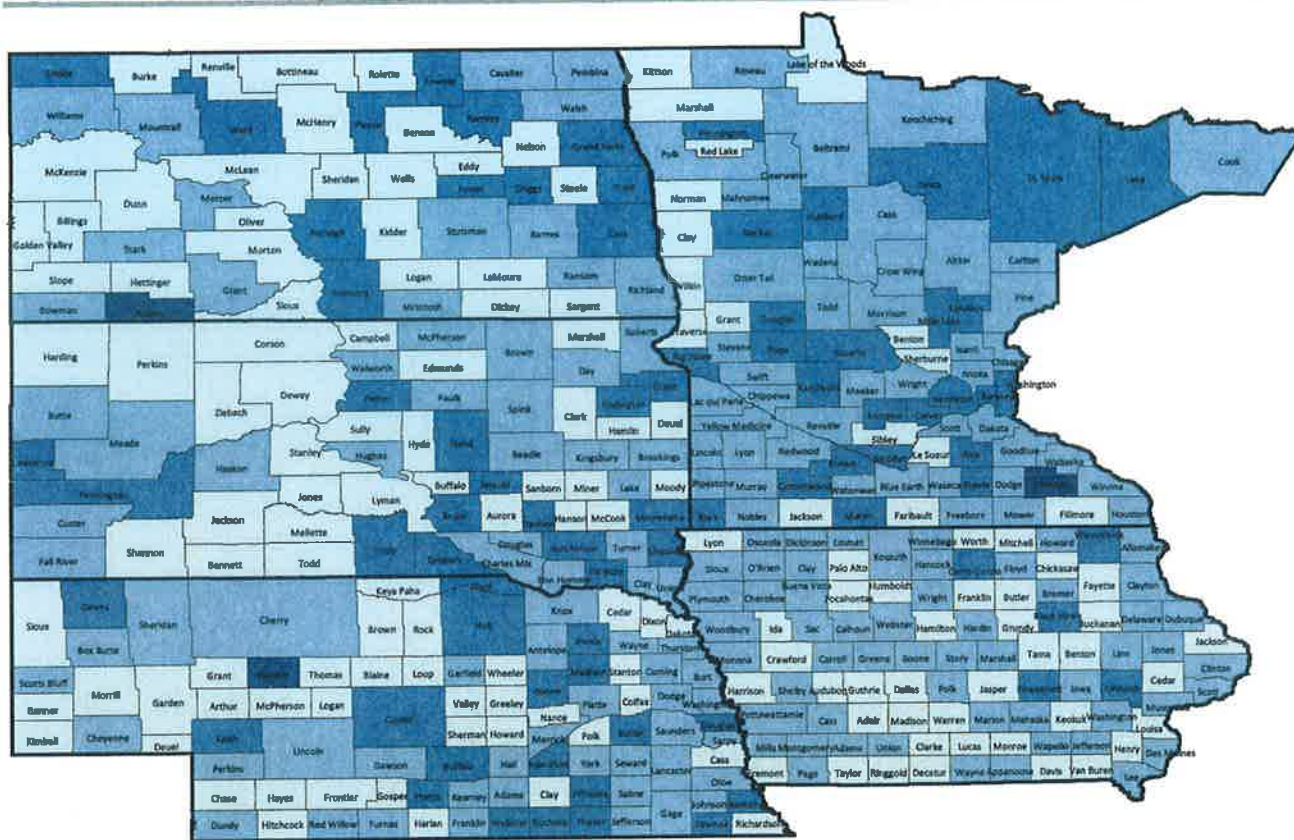
Number of primary care physicians per 100,000 population, 2008

- 0.0 - 60.9
- 61.0 - 139.9
- 140.0 - 339.9
- 340.0 - 793.0
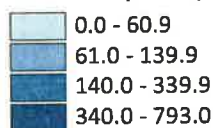
CONTEXT

What It Is: Primary care physicians include practicing physicians specializing in general practice medicine, family medicine, internal medicine, pediatrics, and obstetrics/gynecology. The measure represents the number of providers per 100,000 population.

Where It Comes From: The data on primary care physicians were obtained from the Health Resources and Services Administration's Area Resource File (ARF). The ARF data on practicing physicians come from the AMA Master File (2008), and the population estimates are from the U.S. Census Bureau's 2008 population estimates.

Importance: Having access to care requires not only having financial coverage but also access to providers. While high rates of specialist physicians has been shown to be associated with higher, and perhaps unnecessary, utilization, having sufficient availability of primary care physicians is essential so that people can get preventive and primary care, and when needed, referrals to appropriate specialty care.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 16

Mental Health Providers - A health factor measure focusing on clinical care
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Number of mental health providers per 100,000 population, 2008

- 0.0 - 10.9
- 11.0 - 31.9
- 32.0 - 57.9
- 58.0 - 155.1
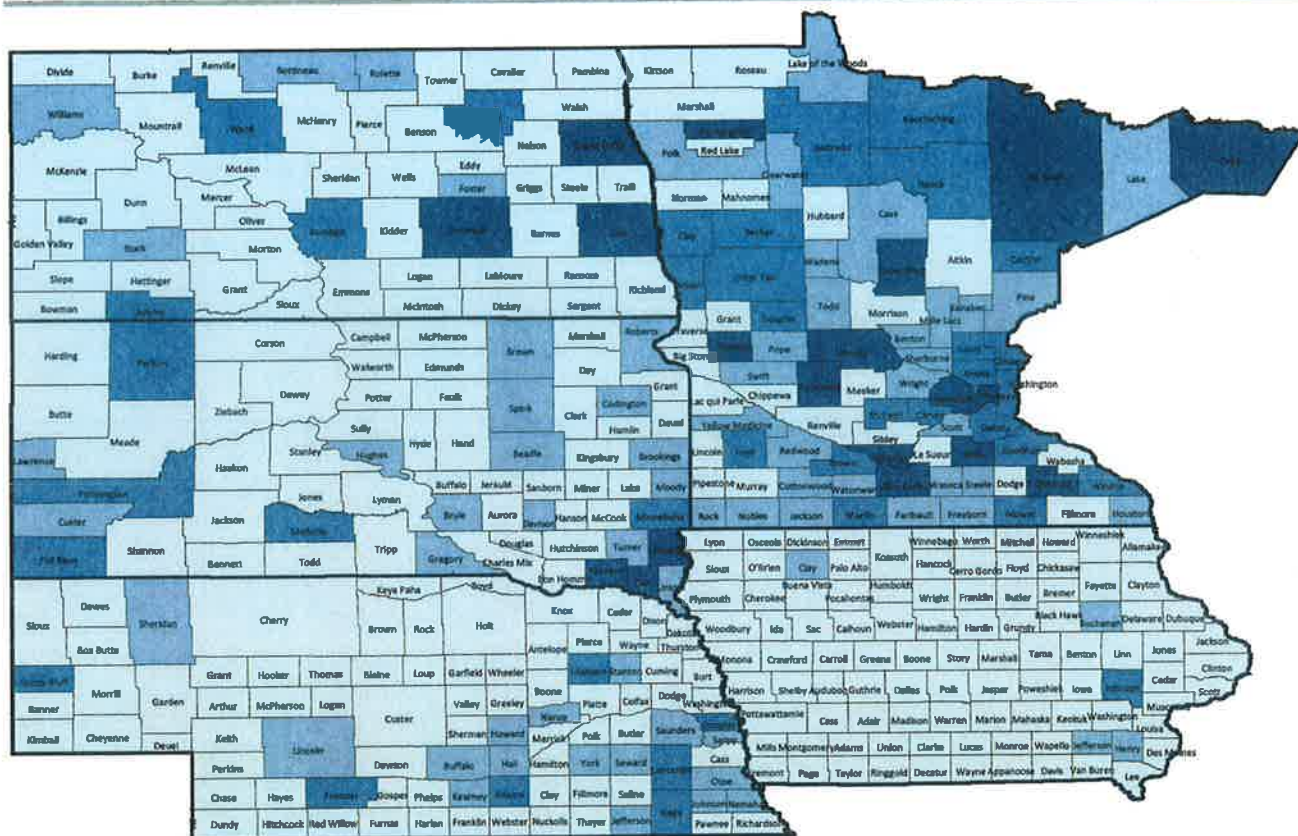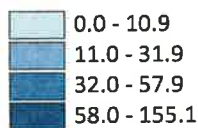
CONTEXT

What It Is: Mental health providers include psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists who meet certain qualifications and certifications. This measure represents the number of mental health providers per 100,000 population.

Where It Comes From: Data on mental health providers were obtained from the Health Resources and Services Administration's (HRSA) Area Resource File (ARF).

Importance: Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender. A key disparity often hinges on a person's financial status; formidable financial barriers block off needed mental health care from too many people regardless of whether one has health insurance with inadequate mental health benefits, or is one of the 44 million Americans who lack any insurance. (David Satcher, M.D., Ph.D., Surgeon General, http://www.surgeongeneral.gov/library/mentalhealth/home.html)

- Data were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project
- a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 17

Dentist Rate - A health factor measure focusing on clinical care
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Number of professionally active dentists per 100,000 population, 2007

- 0.0 - 15.9
- 16.0 - 37.9
- 38.0 - 60.9
- 61.0 - 149.9
- Unreliable or missing data
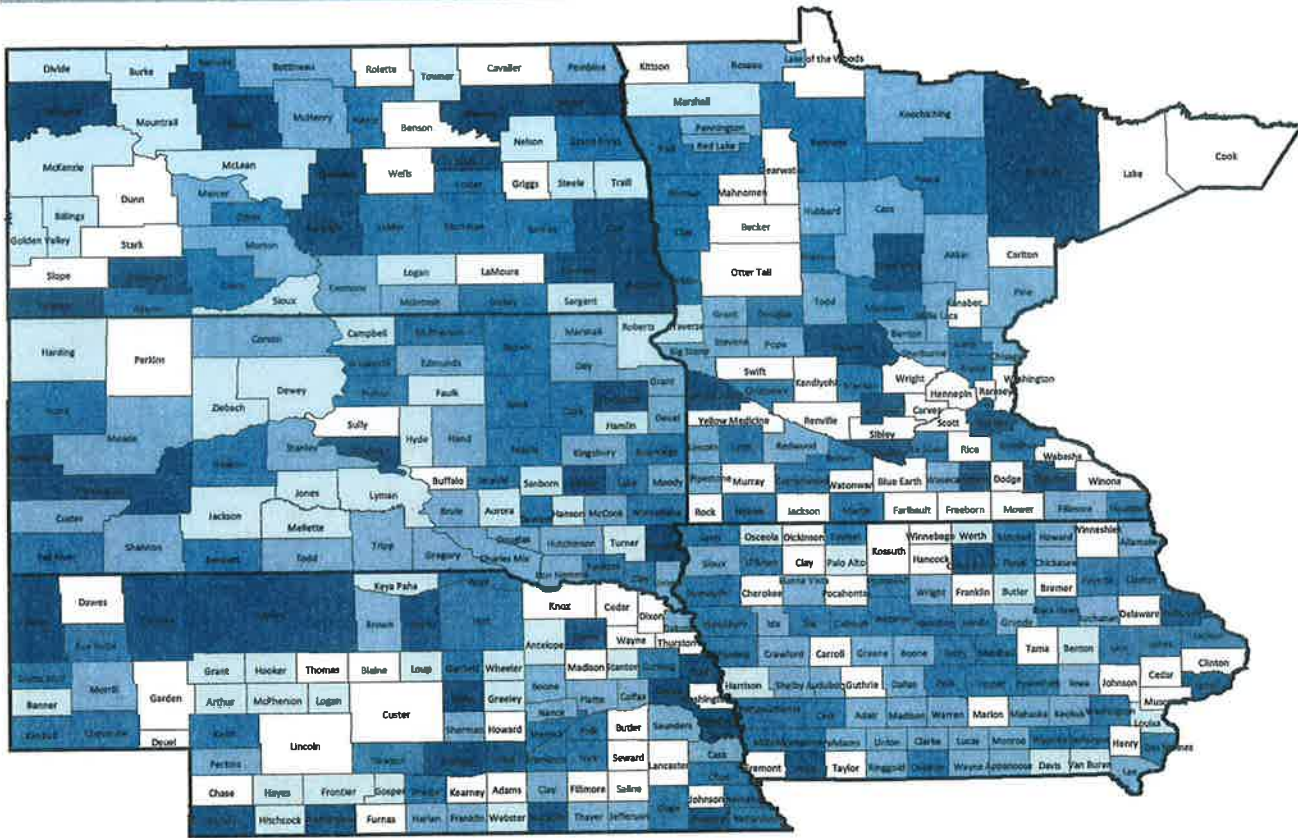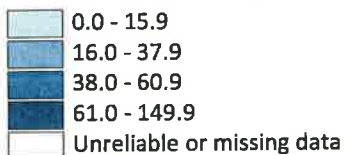
CONTEXT

What It Is: The dentist rate is defined as the number of professionally active dentists per 100,000 population. Professionally active dentist occupation categories include active practitioners; dental school faculty or staff; armed forces dentists; government-employed dentists at the federal, state, or local levels; interns and residents; and other health or dental organization staff members.

Where It Comes From: Data on the number of dentists are tracked by the American Dental Association (ADA) and the American Medical Association (AMA). County-level data are housed in the Health Resources and Services Administration's Area Resource File (ARF) and made available through the Health Indicators Warehouse developed by the National Center for Health Statistics.

Importance: Today, thanks to fluoride, healthier lifestyles and quality dental care, more people than ever before are keeping their natural teeth throughout their lifetime. Yet for those who live in areas where a dentist is not available or those who cannot afford treatment, getting dental care can be difficult (American Dental Association, http://www.ada.org).

- Data were obtained from the Health Indicators Warehouse at http://healthindicators.gov/ which is maintained by the Centers for Disease Control and Prevention's National Center for Health Statistics.

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Map 18

Preventable Hospital Stays - A health factor measure focusing on clinical care

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007

- 28.9 - 60.9
- 61.0 - 79.9
- 80.0 - 116.9
- 117.0 - 205.8
- Unreliable or missing data
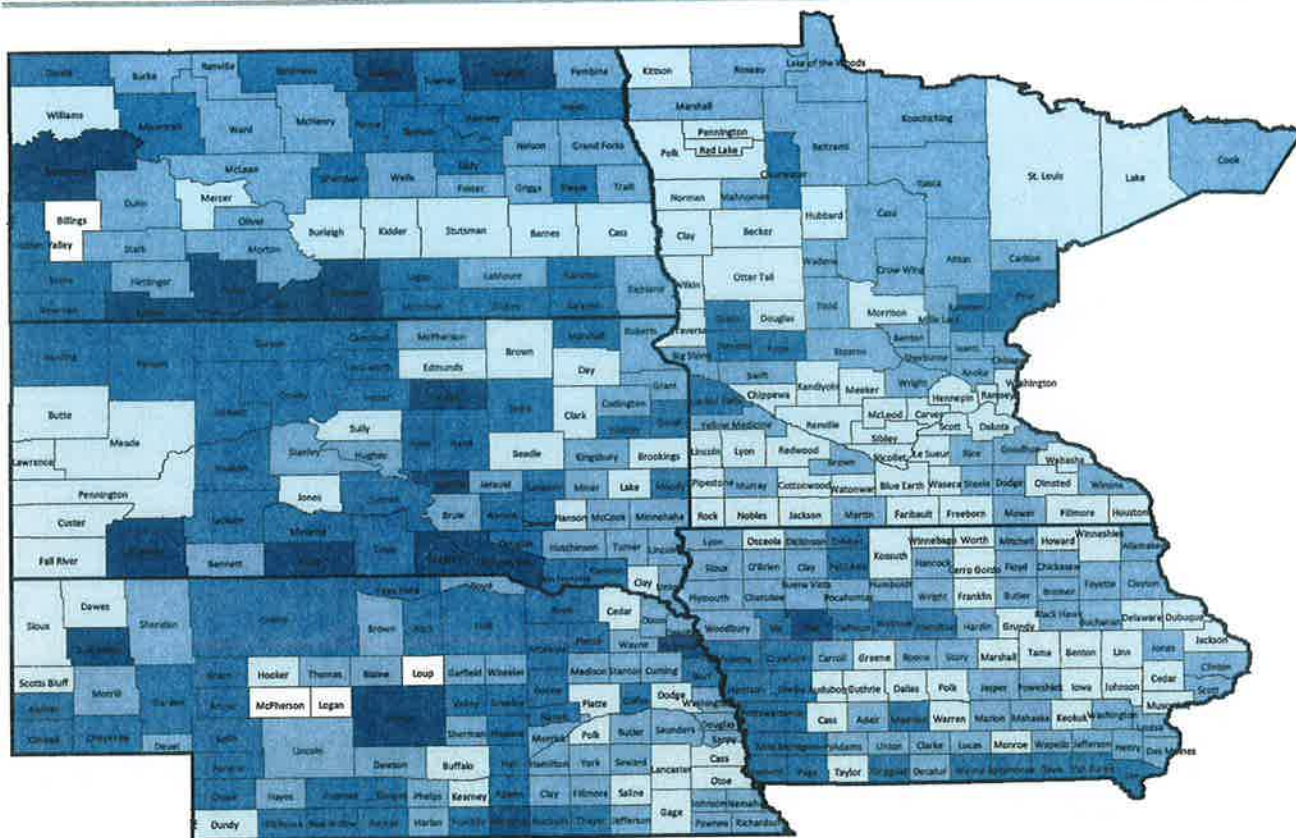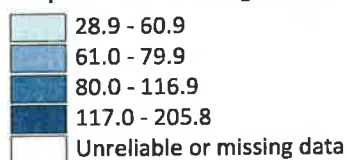
CONTEXT

What It Is: Preventable hospital stays are measured as the hospital discharge rate for ambulatory care-sensitive conditions per 1,000 Medicare enrollees.

Where It Comes From: Estimates of preventable hospital stays were calculated by the authors of the Dartmouth Atlas of Health Care using Medicare claims data.

Importance: Hospitalization for diagnoses amenable to outpatient services suggests that the quality of care provided in the outpatient setting was less than ideal. The measure may also represent the population's tendency to overuse the hospital as a main source of care.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 19

Diabetic Screening - A health factor measure focusing on clinical care
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007

- 31.4% - 52.9%
- 53.0% - 80.9%
- 81.0% - 88.9%
- 89.0% - 100.0%
- Unreliable or missing data
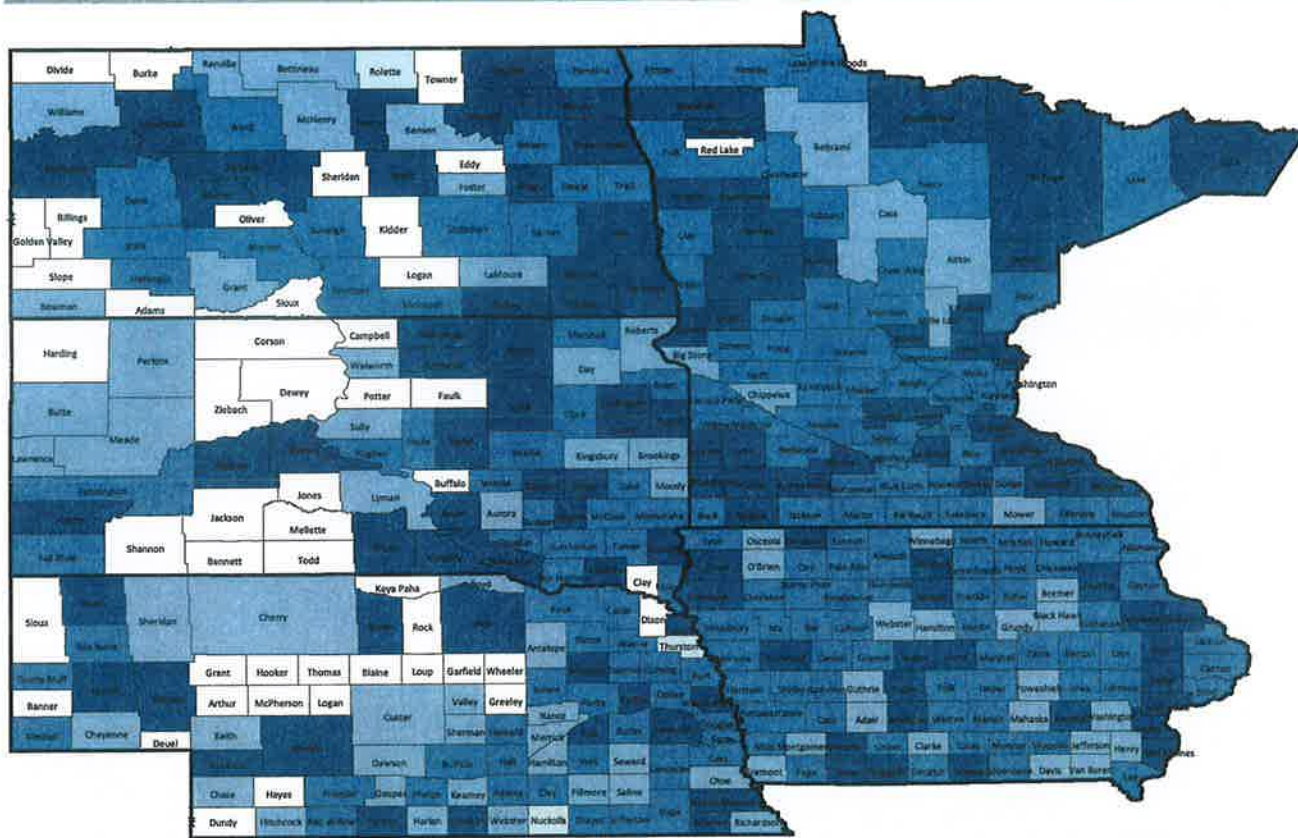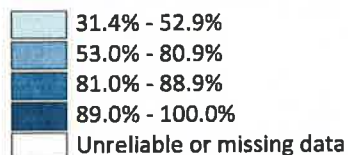
CONTEXT

What It Is: Diabetic screening is calculated as the percent of diabetic Medicare patients whose blood sugar control was screened in the past year using a test of their glycated hemoglobin (HbA1c) levels.

Where It Comes From: Estimates of diabetic screening were calculated by the authors of the Dartmouth Atlas of Health Care using Medicare claims data.

Importance: Regular HbA1c screening among diabetic patients is considered the standard of care. It helps assess the management of diabetes over the long term by providing an estimate of how well a patient has managed his or her diabetes over the past two to three months. When hyperglycemia is addressed and controlled, complications from diabetes can be delayed or prevented.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 20

Mammography Screening - A health factor measure focusing on clinical care
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Percent of female Medicare enrollees that receive mammography screening, 2006-2007

- 40.0% - 59.9%
- 60.0% - 69.9%
- 70.0% - 79.9%
- 80.0% - 100.0%
- Unreliable or missing data
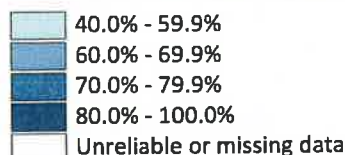
CONTEXT

What It Is: This measure represents the percent of female Medicare enrollees ages 40 through 69 that had at least one mammogram over a two-year period.

Where It Comes From: Estimates were calculated by the authors of the Dartmouth Atlas of Health Care using Medicare claims data.

Importance: Evidence suggests that mammography screening reduces breast cancer mortality, especially among older women. A physician's recommendation or referral—and satisfaction with physicians—are major facilitating factors among women who obtain breast cancer screening. The percent of women ages 40 through 69 receiving a mammogram is a widely endorsed quality of care measure.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 21

High School Graduation - A health factor measure focusing on educaton

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007

- 40.0% - 59.0%
- 60.0% - 79.0%
- 80.0% - 89.0%
- 90.0% - 100.0%
- Unreliable or missing data
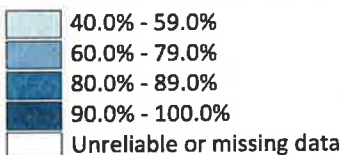
CONTEXT

What It Is: High school graduation, commonly referred to as the averaged freshman graduation rate, is reported as the percent of a county's ninth-grade cohort in public schools that graduates from high school in four years.

Where It Comes From: Estimates of high school graduation are based on the restricted-use versions of the LEA Universe Survey Dropout and Completion data and the Public Elementary/Secondary School Universe Survey data. These data were requested from NCES for the school year 2006-07.

Importance: The relationship between more education and improved health outcomes is well known, with years of formal education correlating strongly with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

Map 22

Some College - A health factor measure focusing on education
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
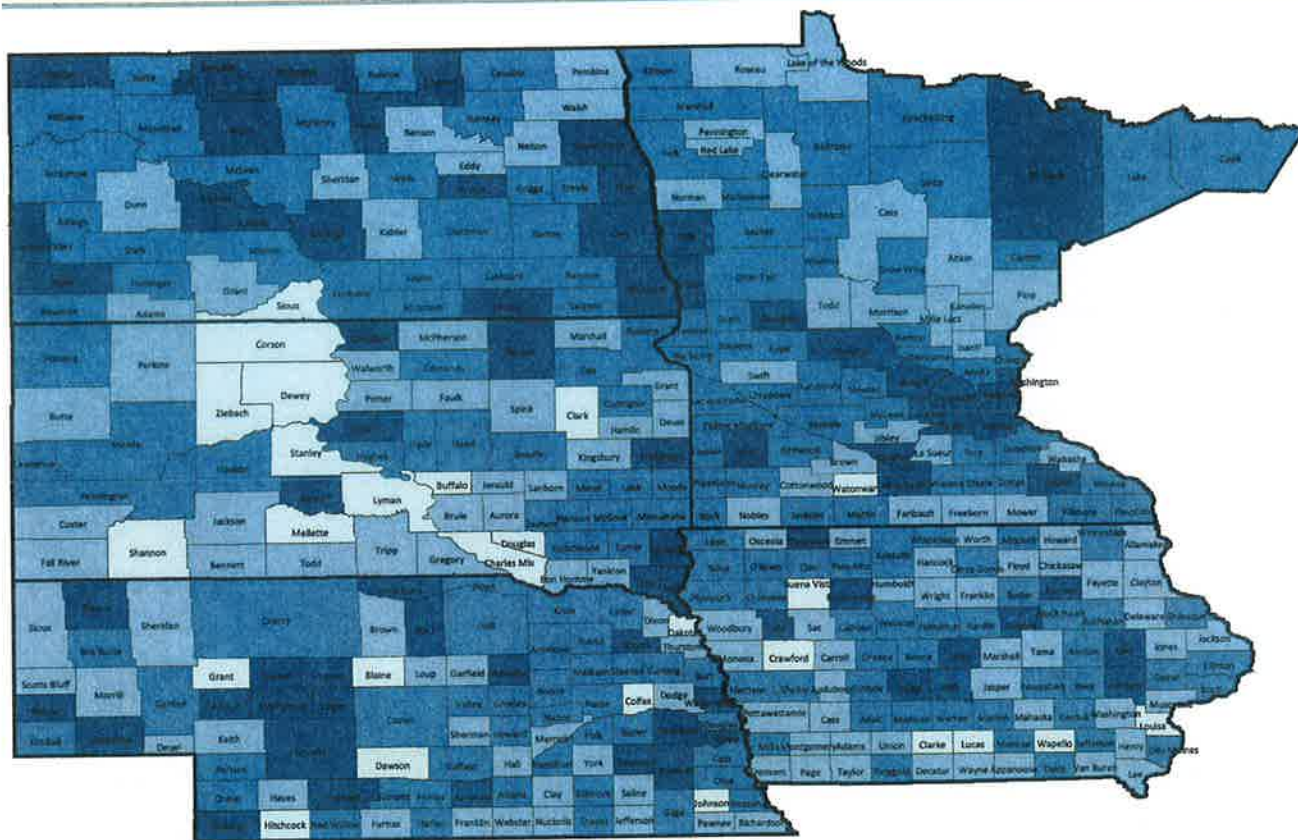
Percent of adults ages 25 through 44 with some post-secondary education, 2005-2009
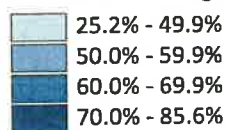
- 25.2% - 49.9%
- 50.0% - 59.9%
- 60.0% - 69.9%
- 70.0% - 85.6%

CONTEXT

What It Is: This measure represents the percent of the population ages 25 through 44 with some post-secondary education, such as enrollment at vocational/technical schools, junior colleges, or four-year colleges. It includes individuals who pursued education following high school but did not receive a degree.

Where It Comes From: Estimates of the population ages 25 through 44 with some post-secondary education were calculated using the 5-year estimates from the U.S. Census Bureau's American Community Survey (ACS).

Importance: The relationship between higher education and improved health outcomes is well known, with years of formal education correlating strongly with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 23

Unemployment - A health factor measure focusing on labor
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
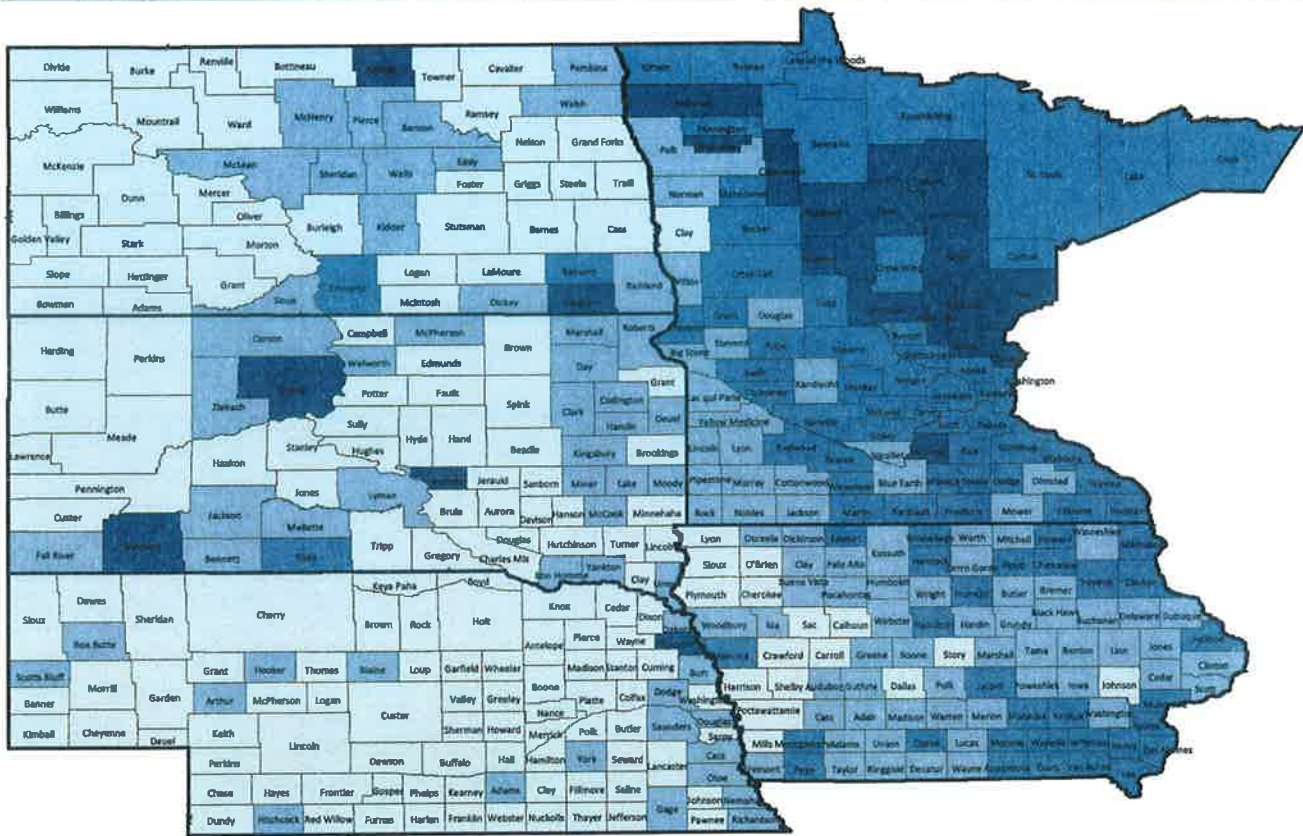
Percent of population ages 16 and older that is unemployed but seeking work, 2009

- 2.4% - 4.9%
- 5.0% - 6.9%
- 7.0% - 9.9%
- 10.0% - 15.1%
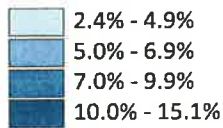
CONTEXT

What It Is: Unemployment is measured as the percent of the civilian labor force ages 16 and older that is unemployed but seeking work.

Where It Comes From: Data on unemployment is obtained from the Bureau of Labor Statistics (BLS), Local Area Unemployment Statistics (LAUS).

Importance: Unemployment may lead to physical health responses ranging from self-reported physical illness to mortality, especially suicide. It has also been shown to lead to an increase in unhealthy behaviors related to alcohol and tobacco consumption, diet, exercise, and other health-related behaviors, which in turn can lead to increased risk for disease or mortality. Because employee-sponsored health insurance is the most common source of health insurance coverage, unemployment can also limit access to health care.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 24

Children in Poverty - A health factor measure focusing on income and poverty

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
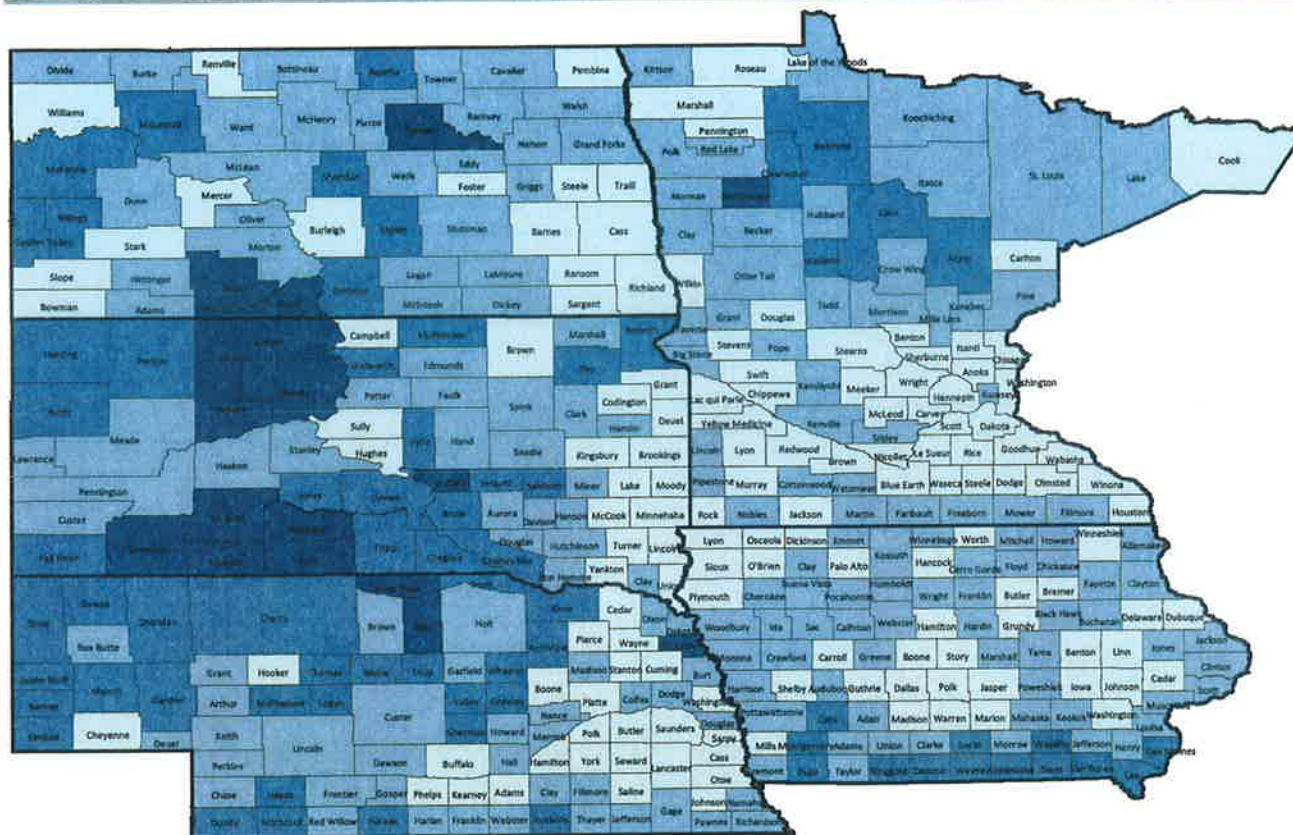
Percent of children ages 0 through 17 living below the Federal Poverty Line, 2008

- 4.7% - 12.9%
- 13.0% - 19.9%
- 20.0% - 34.9%
- 35.0% - 67.1%

CONTEXT

What It Is: Children in poverty is the percent of children under age 18 living below the Federal Poverty Line (FPL).

Where It Comes From: Children in poverty estimates are provided by the Small Area Income and Poverty Estimates (SAIPE) program through the U.S. Census Bureau.

Importance: Poverty can result in negative health consequences, such as increased risk of mortality, increased prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors. While negative health effects resulting from poverty are present at all ages, children in poverty experience greater morbidity and mortality due to an increased risk of accidental injury and lack of health care access. Children's risk of poor health and premature mortality may also be increased due to the poor educational acheivement associated with poverty. The children in poverty measure is highly correlated with overall poverty rates.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 25

Inadequate Social Support - A health factor measure focusing on social networks

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
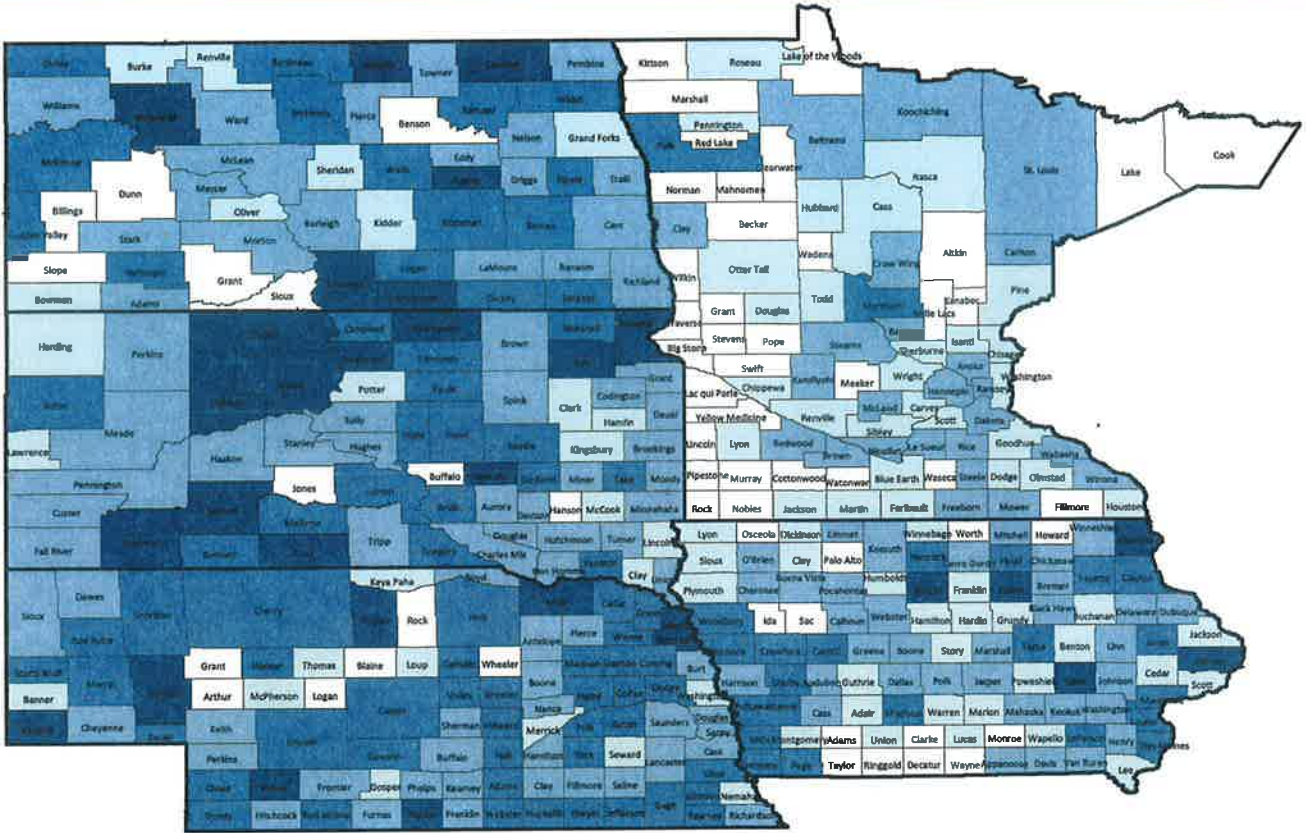
Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009

- 7.1% - 13.9%
- 14.0% - 17.9%
- 18.0% - 22.9%
- 23.0% - 39.1%
- Unreliable or missing data
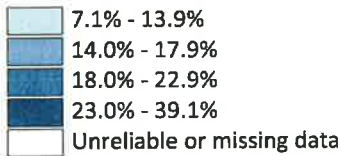
CONTEXT

What It Is: The social and emotional support measure is based on responses to the question: "How often do you get the social and emotional support you need?" The value presented is the percent of the adult population that responds that they "never," "rarely," or "sometimes" get the support they need.

Where It Comes From: This measure was calculated by the National Center for Health Statistics using data obtained from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. The estimates are based on seven years of data.

Importance: Poor family support, minimal contact with others, and limited involvement in community life are associated with increased morbidity and early mortality. Furthermore, social support networks have been identified as powerful predictors of health behaviors, suggesting that individuals without a strong social network are less likely to participate in healthy lifestyle choices.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

Map 26

Children in Single-Parent Households - A health factor measure focusing on families

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
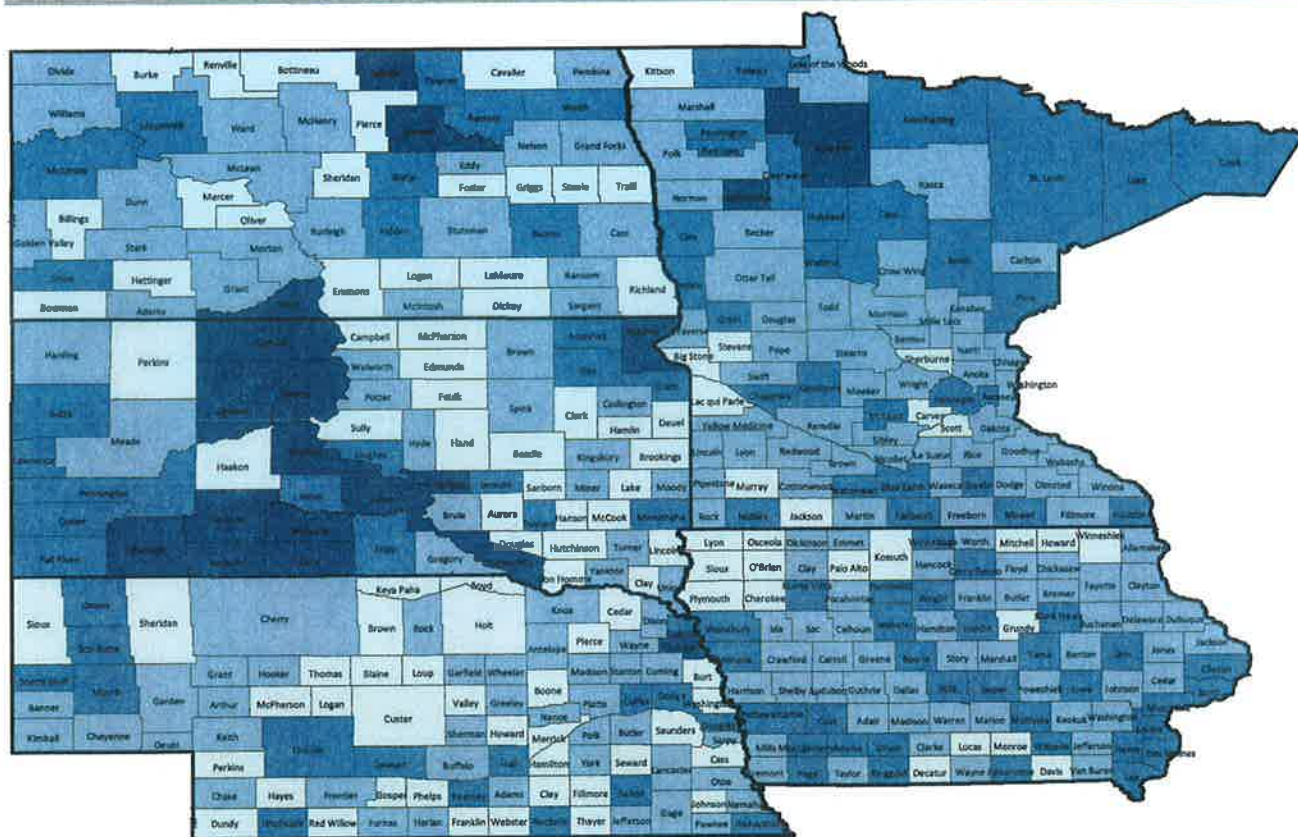
Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009

- 0.0% - 17.9%
- 18.0% - 25.9%
- 26.0% - 39.9%
- 40.0% - 72.0%
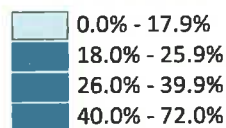
CONTEXT

What It Is: The single-parent household measure is the percent of all children in family households that live in a household headed by a single parent (male or female householder with no spouse present).

Where It Comes From: Estimates of the percent of children in single-parent households were calculated using data from the U.S. Census Bureau's American Community Survey (ACS) 5-year estimates.

Importance: Adults and children in single-parent households are both at risk for adverse health outcomes such as mental health problems (including substance abuse, depression, and suicide) and unhealthy behaviors such as smoking and excessive alcohol use.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 27

Homicide Rate - A health factor measure focusing on violent crime
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
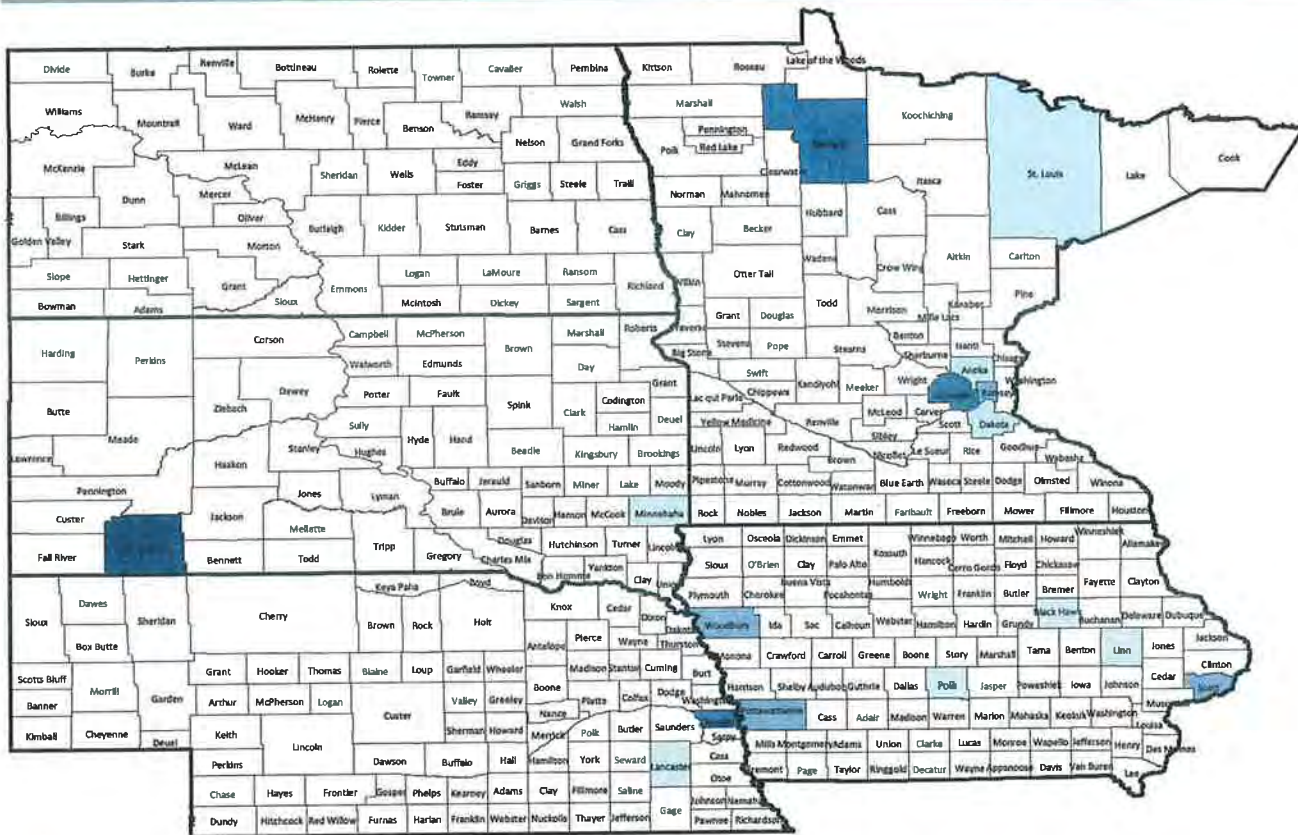
Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007

- 1.3 - 2.9
- 3.0 - 4.9
- 5.0 - 8.9
- 9.0 - 22.7
- Unreliable or missing data
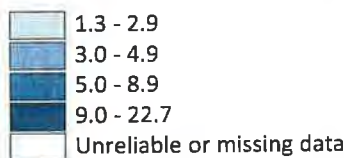
CONTEXT

What It Is: Homicide is represented as a crude death rate due to murder or non-negligent manslaughter per 100,000 population.

Where It Comes From: These data were calculated by National Center for Health Statistics (NCHS) at the Centers for Disease Control and Prevention (CDC) using data from the National Vital Statistics System (NVSS). NCHS used data for a seven-year period to create more robust estimates of cause-specific mortality, particularly for counties with smaller populations.

Importance: Because homicide is one of the five offenses that comprise violent crime, a homicide rate is used as a proxy when violent crime data are not available.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

Map 28

Air Pollution-Particulate Matter Days - A health factor measure focusing on physical environment

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006

- 0
- 1
- 2
- 3 - 4
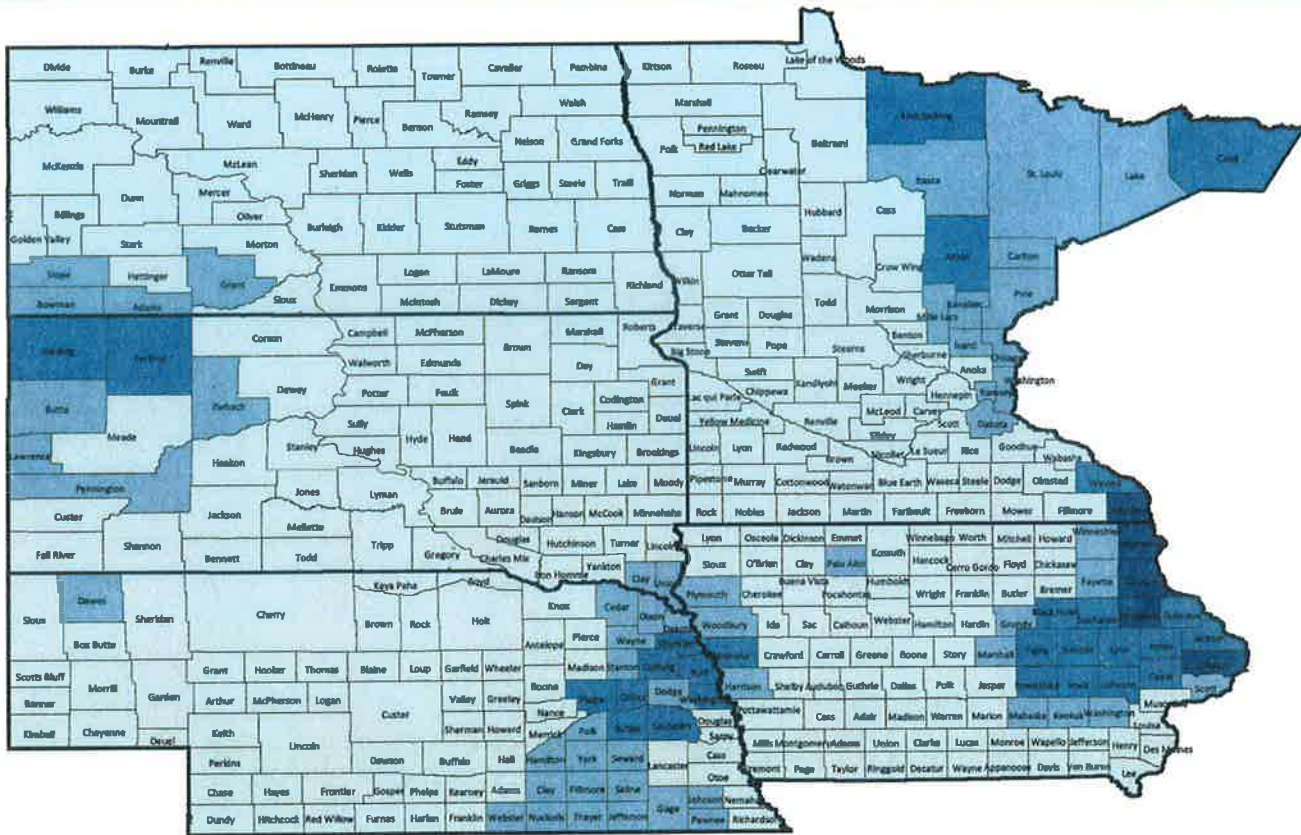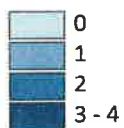
CONTEXT

What It Is: The air pollution—particulate matter measure represents the annual number of days that air quality was unhealthy for sensitive populations due to fine particulate matter (FPM, < 2.5 μm in diameter).

Where It Comes From: The Public Health Air Surveillance Evaluation (PHASE) project, a collaborative effort between the Centers for Disease Control and Prevention (CDC) and the EPA, used Community Multi-Scale Air Quality Model (CMAQ) output and air quality monitor data to create a spatial-temporal model that estimated fine particulate matter concentrations throughout the year. The PHASE estimates were used to calculate the number of days per year that air quality in a county was unhealthy for sensitive populations due to FPM.

Importance: The relationship between elevated air pollution—particularly fine particulate matter and ozone—and compromised health has been well documented. The negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 29

Air Pollution-OzoneDays - A health factor measure focusing on physical environment

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006

- 0
- 1
- 2
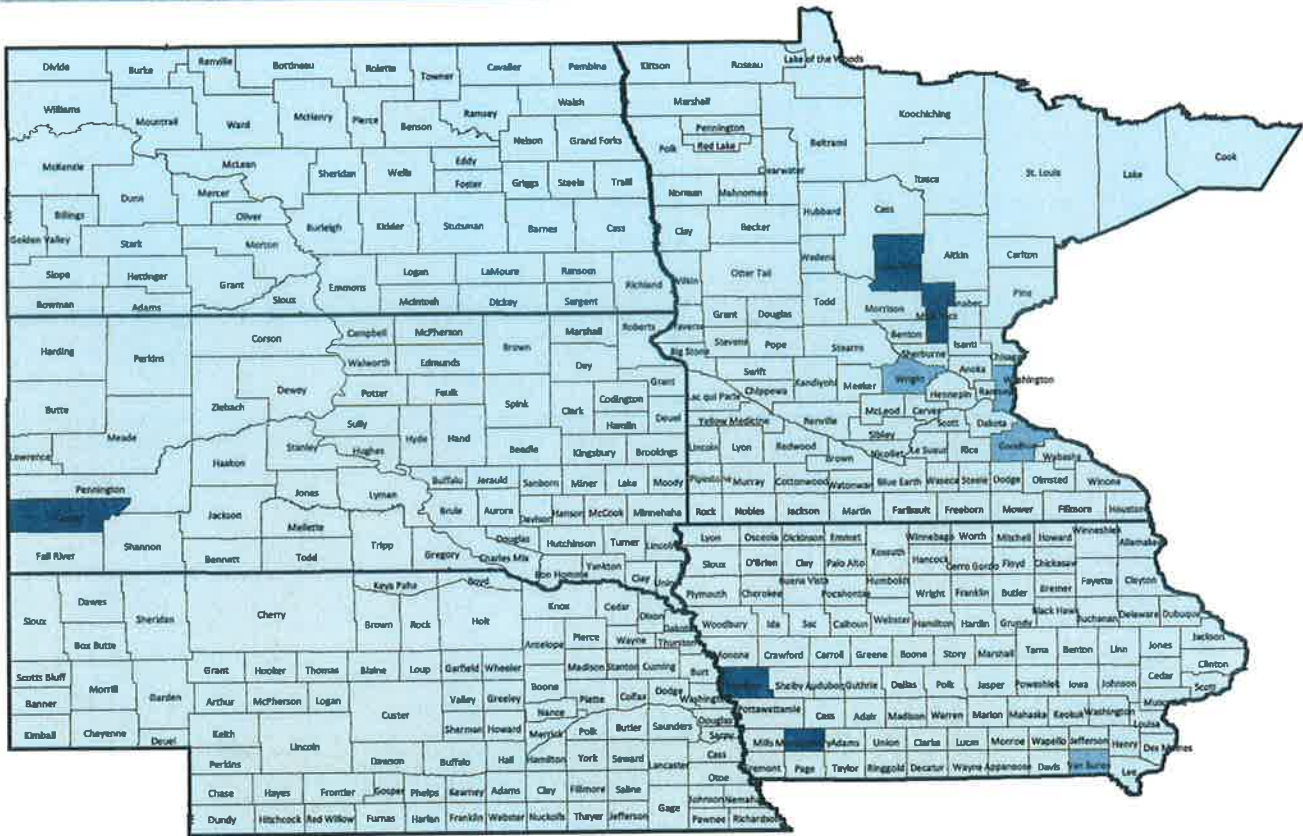
CONTEXT

What It Is: The air pollution—ozone measure represents the annual number of days that air quality was unhealthy for sensitive populations due to ozone levels.

Where It Comes From: The Public Health Air Surveillance Evaluation (PHASE) project, a collaborative effort between the Centers for Disease Control and Prevention (CDC) and the EPA, used Community Multi-Scale Air Quality Model (CMAQ) output and air quality monitor data to create a spatial-temporal model that estimated daily ozone concentrations throughout the year. The PHASE estimates were used to calculate the number of days per year that air quality in a county was unhealthy for sensitive populations due to ozone.

Importance: The relationship between elevated air pollution—particularly fine particulate matter and ozone—and compromised health has been well documented. The negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

Map 30

Access to Healthy Foods - A health factor measure focusing on physical environment
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
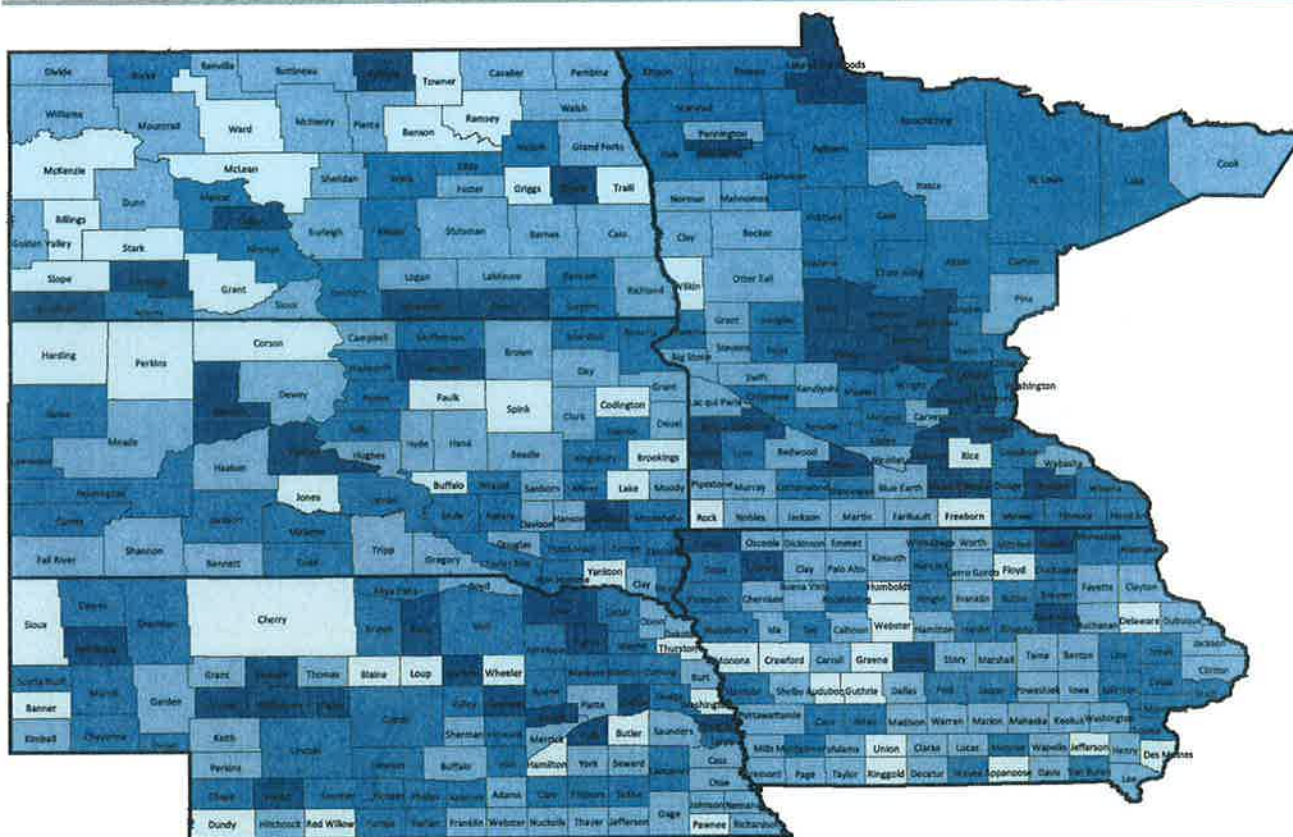
Percent of zip codes with healthy food outlets (i.e., grocery store or produce stand/farmers' market), 2008

- 0.0% - 24.9%
- 25.0% - 42.9%
- 43.0% - 69.9%
- 70.0% - 100.0%
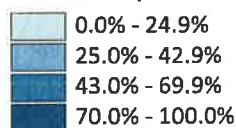
CONTEXT

What It Is: Access to healthy foods is measured as the percent of zip codes in a county with a healthy food outlet, defined as a grocery store or produce stand/farmers' market.

Where It Comes From: The measure is based on data from the U.S. Census Bureau's Zip Code Business Patterns. Healthy food outlets include grocery stores and produce/farmers' markets, as defined by their North American Industrial Classification System (NAICS) codes.

Importance: Studies have linked the food environment to consumption of healthy food and overall health outcomes.
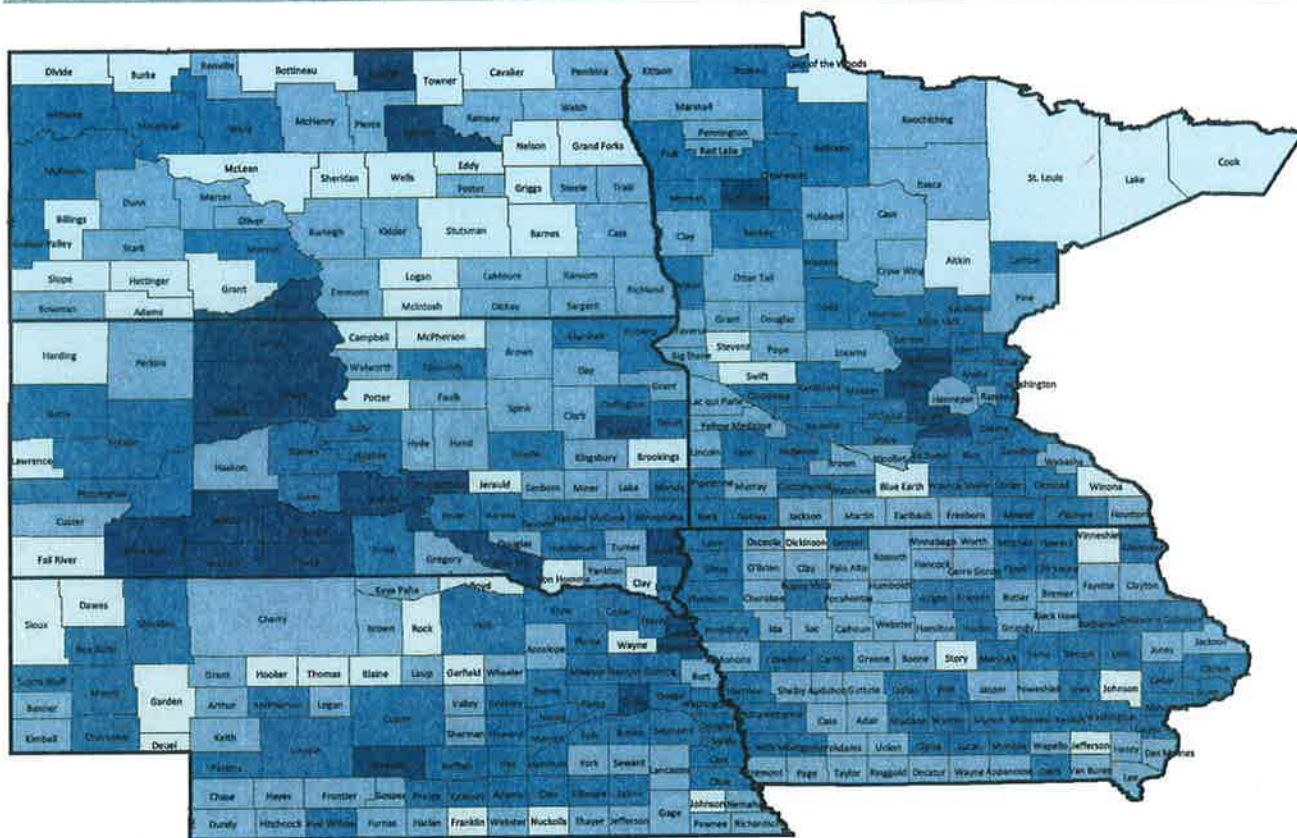
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

Map 31

Access to Recreational Facilities - A health factor measure focusing on physical environment

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Number of recreational facilities per 100,000 population, 2008

- 0 - 9
- 10 - 19
- 20 - 69
- 70 - 150
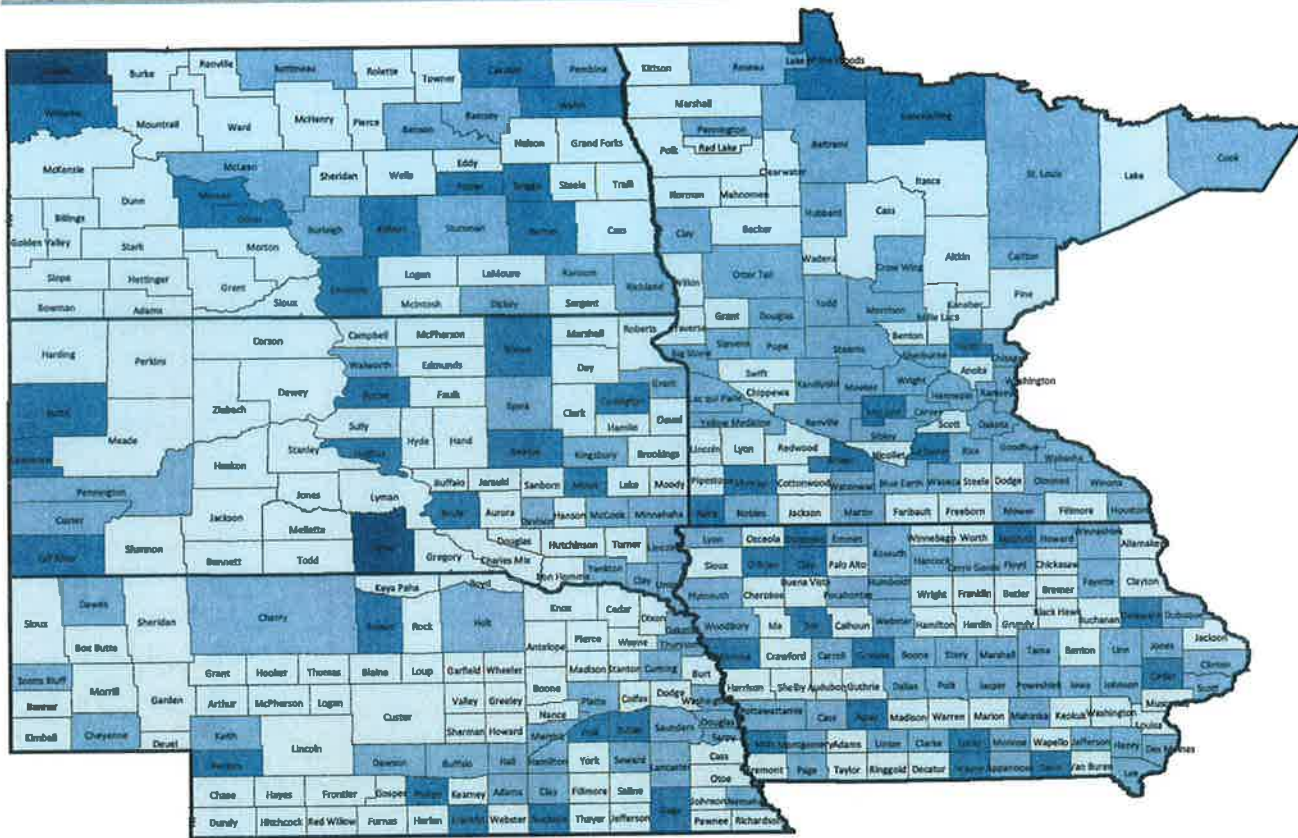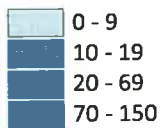
CONTEXT

What It Is: This measure represents the number of recreational facilities per 100,000 population in a given county. Recreational facilities are defined as establishments primarily engaged in operating fitness and recreational sports facilities, featuring exercise and other active physical fitness conditioning or recreational sports activities such as swimming, skating, or racquet sports.

Where It Comes From: This measure is based on a measure from United States Department of Agriculture (USDA) Food Environment Atlas, and is calculated using the most current County Business Patterns data set. Recreational facilities are identified by North American Industrial Classification System (NAICS) code 713940.

Importance: The availability of recreational facilities can influence individuals' and communities' choices to engage in physical activity. Proximity to places with recreational opportunities is associated with higher physical activity levels, which in turn is associated with lower rates of adverse health outcomes associated with poor diet, lack of physical activity, and obesity.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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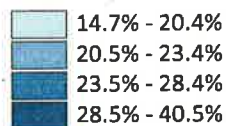
Map 32

Youth - A demographic measure
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Persons ages 0 through 17 as a percent of the total population, 2009

- 14.7% - 20.4%
- 20.5% - 23.4%
- 23.5% - 28.4%
- 28.5% - 40.5%

CONTEXT

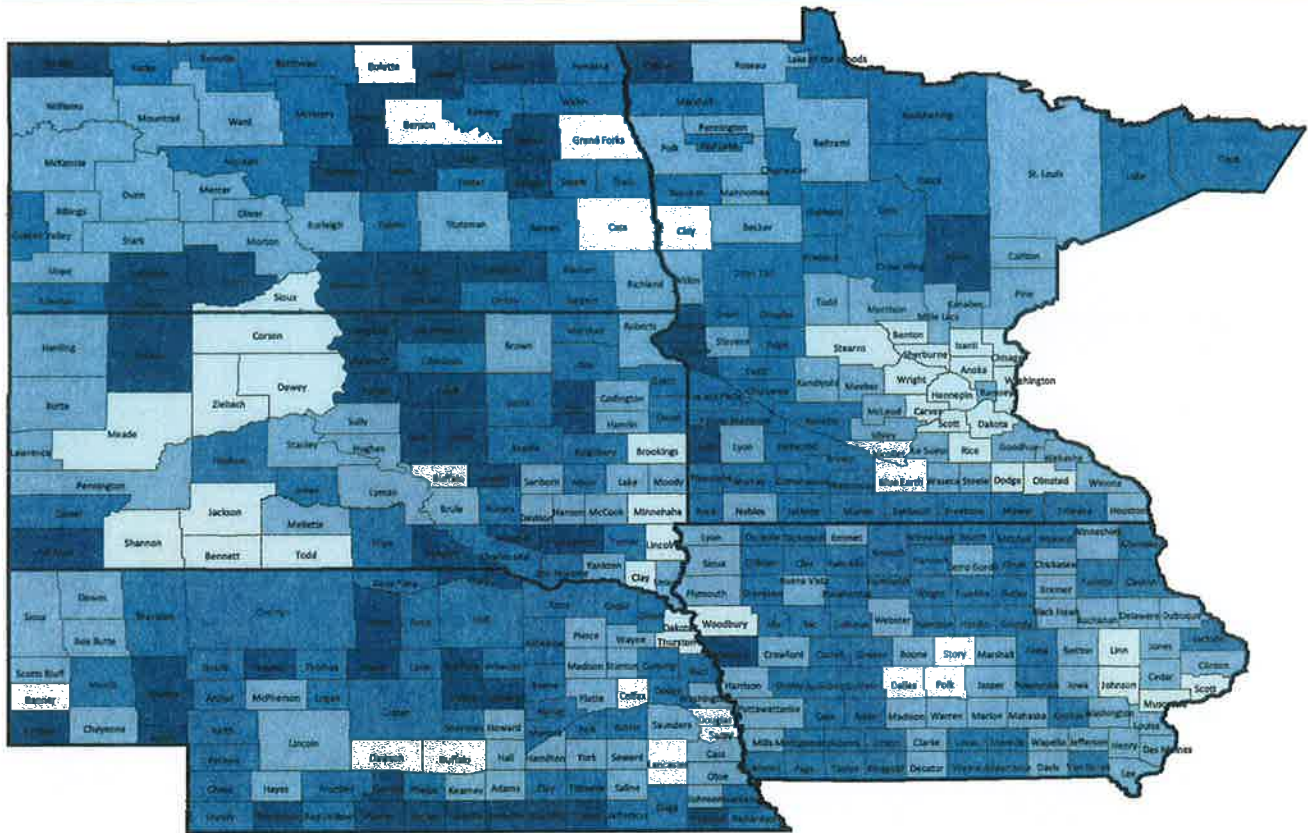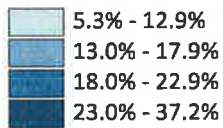**What It Is:** This measure represents the percent of a county's population that is less than 18 years of age.

Where It Comes From: County demographic figures come from the U.S. Census Bureau's annual population estimates.
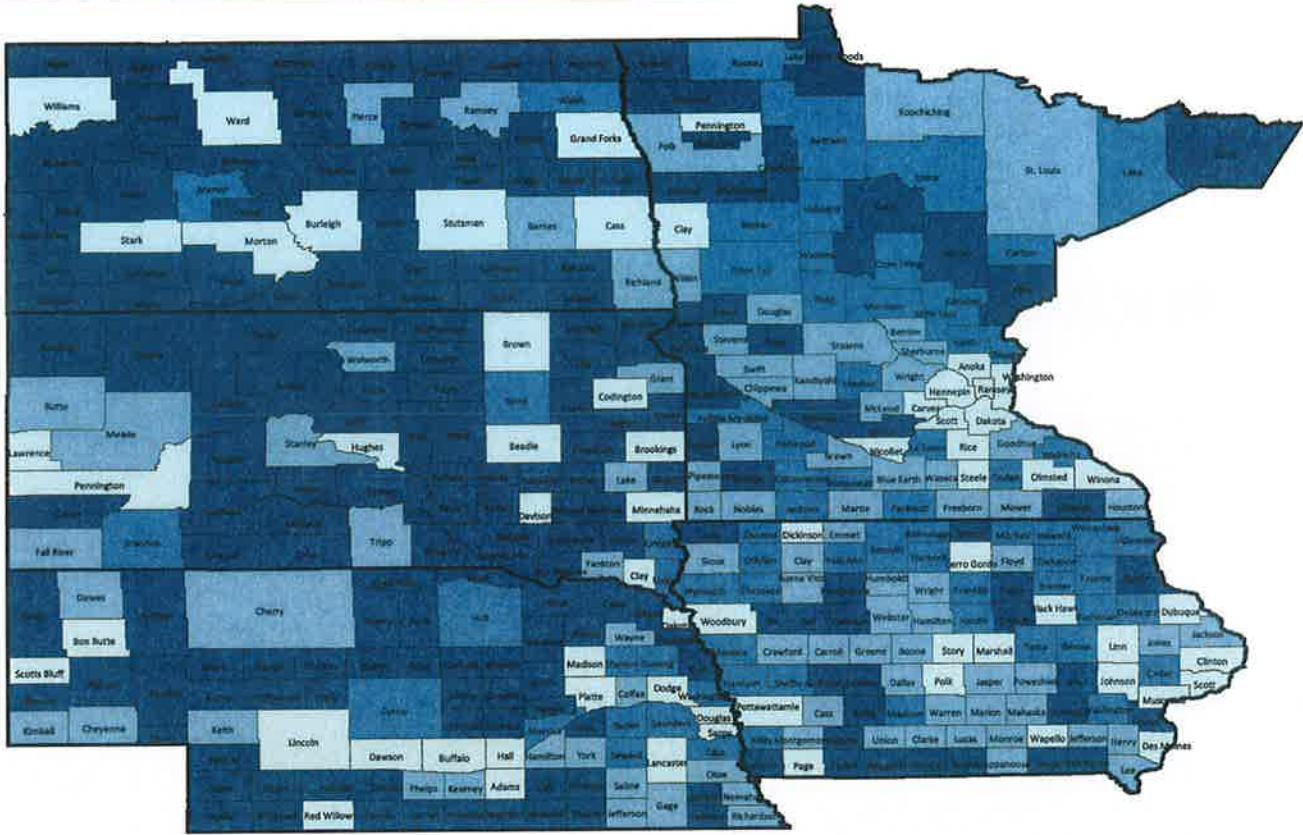
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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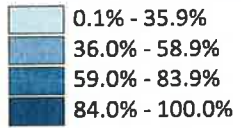
Map 33

Elderly - A demographic measure

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Persons ages 65 and older as a percent of the total population, 2009

- 5.3% - 12.9%
- 13.0% - 17.9%
- 18.0% - 22.9%
- 23.0% - 37.2%

CONTEXT

What It Is: This measure represents the percent of a county's population that is 65 years of age and older.

Where It Comes From: County demographic figures come from the U.S. Census Bureau's annual population estimates.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

Disclaimer: The data displayed are from the source indicated; we do not vouch for the accuracy of the data or ensure they are the most recent available. The information is intended for personal, non-commercial use. It can be shared freely if it is not used for profit and appropriate acknowledgments are given. This map was prepared by researchers at North Dakota State University in Fargo for the 2011-2013 Fargo-Moorhead Community Health Needs Assessment Collaborative. December 2011

Map 34

Rural - A demographic measure

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Percent of total population living in a rural area, 2000

- 0.1% - 35.9%
- 36.0% - 58.9%
- 59.0% - 83.9%
- 84.0% - 100.0%

CONTEXT

What It Is: This measure represents the percent of a county's population that lives in a rural area, which the U.S. Census Bureau defines as all territory located outside of urbanized areas and urban clusters. Urbanized areas and urban clusters are geographic areas with a core population density of at least 1,000 people per square mile that are surrounded by areas with an overall population density of at least 500 people per square mile.

Where It Comes From: This measure is calculated by the U.S. Census Bureau using data from 2000.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.
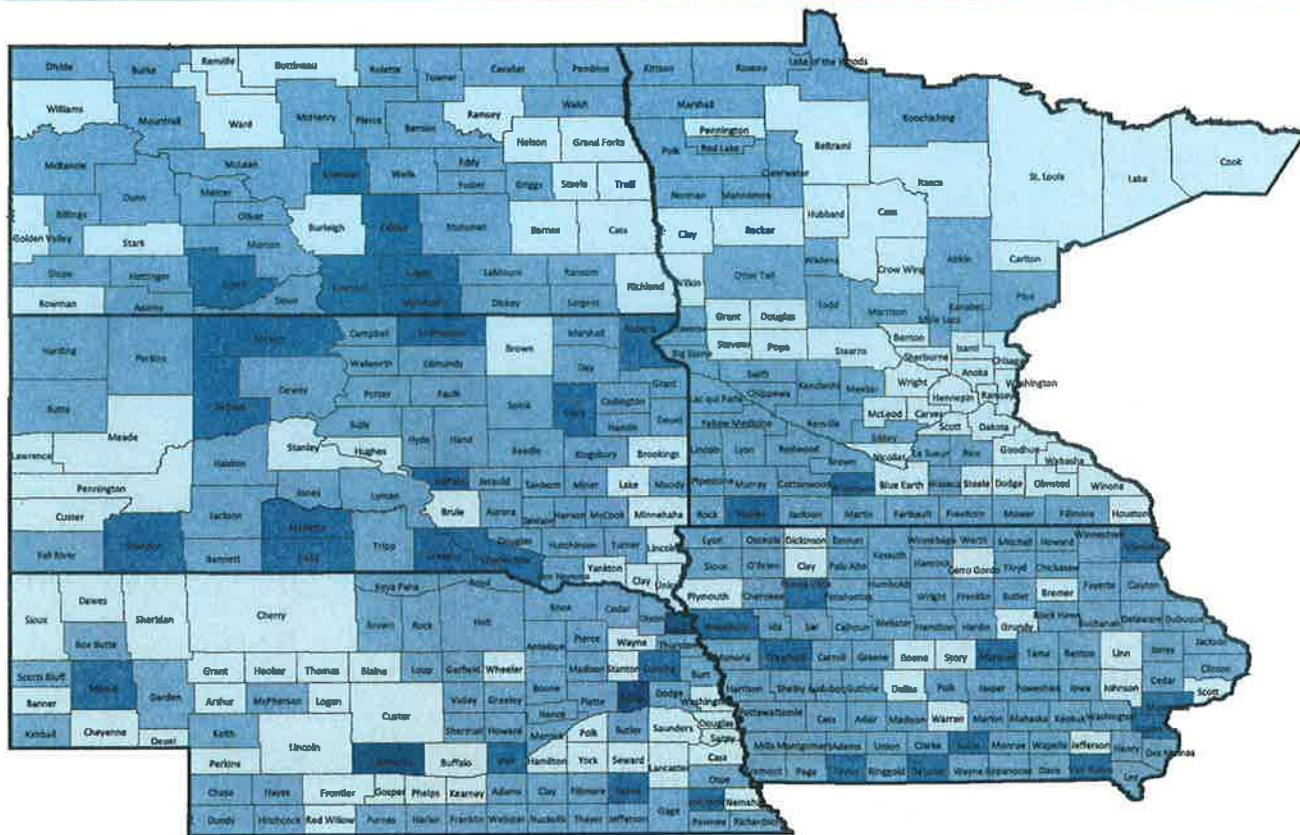
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Map 35

Not English Proficient - A demographic measure

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Percent of total population that speaks English less than "very well", 2005-2009

- 0.0% - 0.9%
- 1.0% - 2.9%
- 3.0% - 8.9%
- 9.0% - 23.0%
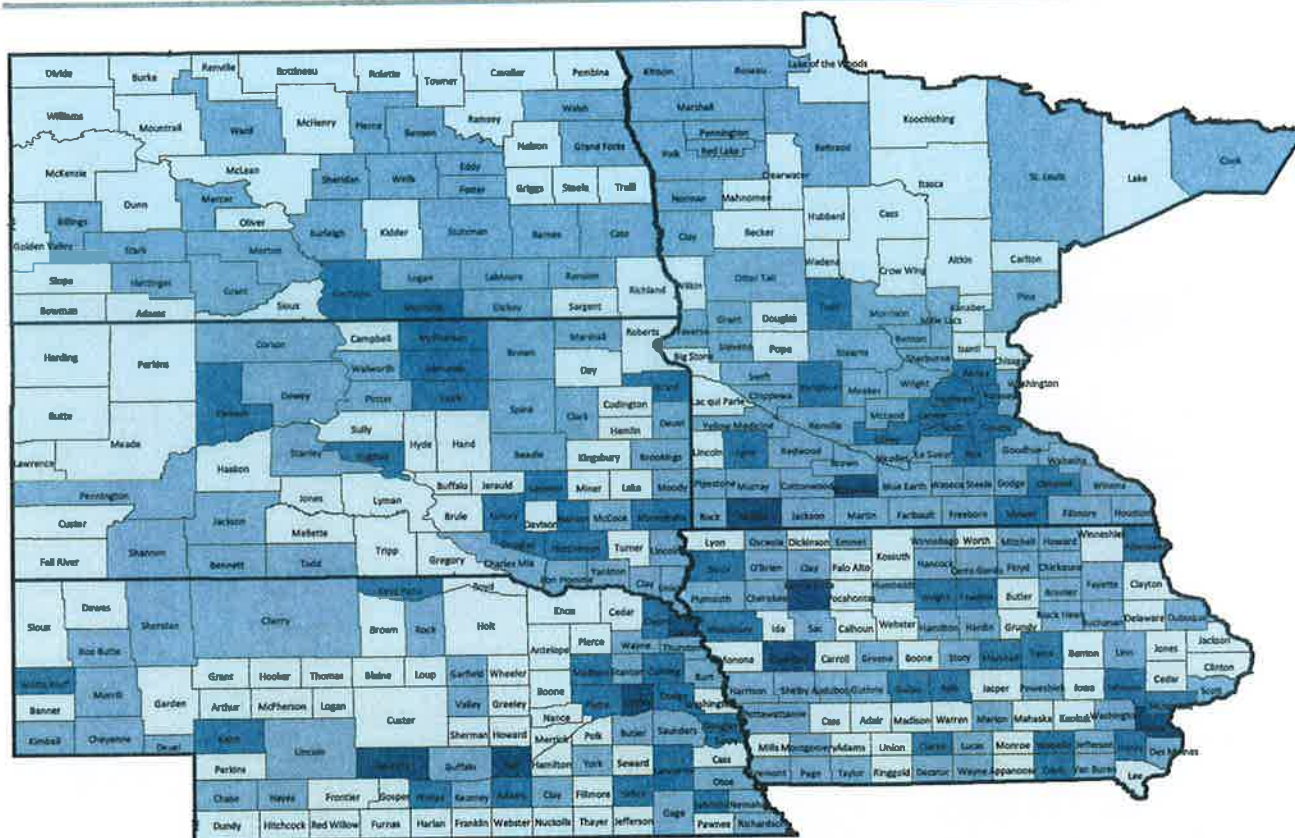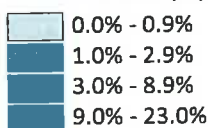
CONTEXT

What It Is: This measure represents the percent of the total population that reports speaking English less than "very well."

Where It Comes From: Data on spoken English proficiency come from the U.S. Census Bureau's American Community Survey 5-year estimates.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

Map 36

Illiteracy - A demographic measure

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Percent of population ages 16 and older that lacks basic prose literacy skills, 2003

- 4.0% - 6.9%
- 7.0% - 8.9%
- 9.0% - 13.9%
- 14.0% - 21.4%
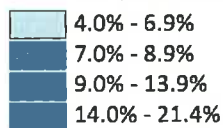
CONTEXT

What It Is: This measure reflects the percent of the population ages 16 and older that lacks basic prose literacy skills.

Where It Comes From: This measure is obtained from the National Center for Education Statistics and is based on the 2003 National Assessment of Adult Literacy.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

Table 1
Community Health Needs Assessment Asset Mapping
Luverne Stakeholders

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Access	• No services after regular hours except for the ER. Need an after-hours clinic. (multiple comments) • Need a walk-in clinic • Desire for dermatology and expanded cardiology outreach	Cardiology services offered 3x month at clinic.	X
Cancer	• Concern over cancer in the community	Sanford Cancer Biology Research Center Edith Sanford Breast Cancer Institute	
Chronic Conditions	• Several cases of ALS (men) in our community – why? • Concern about TB • Concern about lack of healthcare services for those with chronic illnesses • Concern over heart disease, alcohol/substance abuse, and obesity	Sanford Medical Home TB: Sanford Luverne Infection Control and Public Health Chronic Illness: Family Services coordinate care for qualified patients. Sanford Luverne Health Coaches coordination of care. Obesity: SHIP Grant to reduce obesity in Community Substance: CHIP, Community Health, smoking cessation	
Competition	• Concern about two healthcare facilities – can the community support two?	Currently one healthcare facility in our service area.	
Dental Care	• Dental access is limited & very expensive • Dental care for low income families, especially the children – why do they have to travel to Windom or Marshall for this care? • Concern over lack of dentist in Edgerton	2 Dentists in Luverne, 0 in Edgerton, 1 in Adrian. UCare provides mobile services in Sanford Worthington Clinic Parking Lot. Pediatric dental varnish offered in the clinic.	
Diabetes	• Need diabetic classes in the evenings or on weekends	The Sanford Project – to cure Type1 Diabetes in Denny Sanford's lifetime Sanford Medical Home Sanford Luverne has daytime Diabetic Classes. Previous evenings classes had poor attendance.	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Dialysis	• Concern about the lack of dialysis being offered in Luverne (2)		X
Economic Situation/ Business Community	• We have only one grocery store– extremely high prices.	Share with City of Luverne.	
Elderly Issues	• Concern about healthcare services for the elderly	Home Care services VNA, Good Sam, HSI. Assisted Living services available. Senior Linkage Line RSVP Volunteers Life Line Refer to monthly caregiver's support group meeting.	
Emergency Services	• Concern about those who use the ER first, then think about the clinic • Concern about an ambulance service with staff who are trained in emergency service • Concerned about keeping volunteers for the ambulance service • Concern about the confusion & delay when 911 is called (requests got routed through Sioux Falls when Beaver Creek or Luverne should have answered the call). Unnecessary delay.	EMT's/Paramedics complete continuing education hours to maintain certification Local counties continue recruiting for volunteers for ambulance services. Share with Sheriff's office.	
Healthcare Cost/Insurance Cost	• Concern about cost of healthcare services(several) • Concern about cost of insurance • Concern about the costs incurred in duplication of services • Concern over cost of prescriptions	Health reform Lewis drug prescription card UCare or MA if cannot afford and meet guidelines Sanford Luverne Health coach to help identify resources	
Health Factors	• Only 13% report access to healthy food on 2011 county health profile	Community Garden Farmer's Market Refer to County Extension Agency	
Healthy Nutrition	• Concern about improving the eating habits of children – more fresh fruits & veggies, less fatty high carb foods	Refer to local schools.	
Mental Health	• Concern over lack of mental health providers • Children who have issues in the home but don't qualify for any type of mental health counseling • Concern about the time it takes to get into see a mental health worker, availability & cost of services, coordination with	Sanford One Care Mental Health Providers: Sanford Recruiting for Triage Therapist, Psychologist, and Psychiatrist. Southwinds, Southwest Mental Health. Refer #2 to local schools. Sanford Behavioral Health Psych	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	community services • Ratio of mental health providers per population on 2011 county health profile	services available through telehealth at Sanford Luverne	
Morbidity and Mortality	• High incidence of low birth weight babies	Sanford Luverne offers prenatal care and prenatal classes.	
Pharmacy	• Need for pharmacy services in Edgerton	Refer to local pharmacies and City of Edgerton	
Physicians	• Concern about not having a physician in Edgerton • Concern about being able to attract GP physicians to our community	Edgerton has an Avera Physician. Sanford Luverne has recruited a physician starting in 2014.	
Pollution	• Concern about pollution from the ethanol plant • Concern about radon • Concern about bed bugs, rodents, garbage houses, mold • Concern about water quality	Refer to City of Luverne, Public Health	
Poverty	• Concern about the level of poverty in our community (38% of the county population)		
Physical Activity	• There is only one exercise place in town	Power Fitness and Luverne Area Aquatics and Fitness Center in Luverne. Bike Path in Luverne. Walking offered at school. Hills has fitness center. Adrian has 2 fitness centers, Edgerton has 1 fitness center. Luverne Community Education offers Fitness Classes.	
Snow Removal	•	Refer to City offices in service area.	
Substance Abuse	• Concern about substance abuse in the community	Sanford One Care Sanford Luverne CD program Drug Court Participation	
Traffic	• Lack of law enforcement officers to enforce the speed limit	Refer to county law enforcement	
Transportation	• No transportation for those who need healthcare after 4 pm. • Transportation between 8 a.m. and 4 p.m. is limited	RSVP drivers offer transportation after 4pm Wheelchair Express MediVan Heartland Express (8am-5pm)	
Wellness	• We need an effective wellness program, develop and become a model community • Concern over obesity • Need more age related health information	Sanford WebMD Fit Kids Sanford Luverne Wellness Program CHIP is addressing obesity issues Healthcare Home Certification/Health	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	• Need fitness classes for all ages • Need weight & pain control groups • Need women's issue clinic	Coaches Luverne Community Education offers classes Weight Watchers/TOPS	
Youth	• Concern about alcohol & drug issues • Concern about teenage pregnancy • Concern about STDs • Concern about large number of obese kids • Concern about lack of responsibility & accountability being taught in the schools • Concern about bullying	Sanford WebMD Fit Kids Sanford One Care Chemical Dependency Program to address youth substance abuse. Refer to area schools.	
Sanford Specific	• Suggestion that Sanford build a clinic in Edgerton MN • Need a hospital social worker	Avera presently has a clinic in Edgerton Discharge planner refers to Hospice Social Worker, Health Coach or Rock County Family Services as needed.	

6/15/12

Table 2

Prioritization Worksheet

Criteria to Identify Priority Problem
- Cost and/or return on investment
- Availability of solutions
- Impact of problem
- Availability of resources (staff, time, money, equipment) to solve problem
- Urgency of solving problem (H1N1 or air pollution)
- Size of problem (e.g. # of individuals affected)

Criteria to Identify Intervention for Problem
- Expertise to implement solution
- Return on investment
- Effectiveness of solution
- Ease of implementation/maintenance
- Potential negative consequences
- Legal considerations
- Impact on systems or health
- Feasibility of intervention

Health Indicator/Concern (from asset mapping and gap analysis worksheet)	Round 1 Vote	Round 2 Vote	Round 3 Vote
Lack of after-hours/walk-in clinic	XXXX		
Concern over lack of dialysis services within the community			XXXXX
Lack of knowledge of services available within the community	X	XXXXX	

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Concern over lack of dialysis services within the community			XXXXX
Lack of knowledge of services available within the community	X	XXXXX	