Sanford Medical Center Wheaton
Community Health Needs Assessment
2012-2013

SANFORD
HEALTH

Sanford Medical Center Wheaton

Community Health Needs Assessment

2012-2013

rev. 6/13/13

Table of Contents

Sanford Medical Center Wheaton
Community Health Needs Assessment
2012-2013

Purpose

Sanford Medical Center Wheaton 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 Medical Center Wheaton 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 Fargo Region Steering Group:
- *Enterprise Lead:* Carrie McLeod, MBA, MM, LRD, CDE; Office of Health Care Reform, Community Benefit/Community Health Improvement
- *Fargo Region Co-Lead:* Tiffany Lawrence, CPA; CFO, Sanford Medical Center Fargo
- Roger Baier, BS; CEO, Sanford Medical Center Mayville
- Maxine Brinkman, CPA; Director of Financial Decisions and Operations Support
- Joann Foltz, RN, BSN, PHN; CEO, Sanford Medical Center Wheaton
- Brenda Petersen, Human Resource Specialist, Sanford Medical Center Wheaton
- Chuck Gulsvig, Director of Public Affairs
- Mary Kara, RHIA, BS; Quality Analyst
- Jac McTaggart, CEO, Hillsboro Medical Center
- Angela Novak, MBA; VP, Sanford Health Marketing
- Heather Rye, MBA, PHR; HR Advisor, Sanford Health Network Fargo
- Les Wietstock, MSA; CFO Sanford Health Network Fargo

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, parish nurses, representatives from the Native American community, Faith Community Leaders, as well as legal services, mentally and physically disabled, 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:
- Corinne Anderson, Wheaton, MN
- Rhonda Antrim, Director, Traverse Co. Social Services, Wheaton, MN
- Shane Ayres, CFO, Sanford Wheaton, Wheaton, MN
- Dorothy Baldry, Teacher & Cancer Group Chairman, Wheaton, MN
- Marcie Conroy, Wheaton, MN
- Elwina Fischer, Wheaton, MN
- JoAnn Foltz, CEO, Sanford Wheaton, Wheaton, MN
- Bonnie Halverson, Secretary/Treasurer, Chamber of Commerce, Wheaton, MN
- Lee Hydeen-Niss, Social Worker, Traverse Co. Social Services, Wheaton, MN
- Norma Holtz, American Family Insurance, Tintah, MN
- Shirley Hormann, Cardiac Rehab, Wheaton, MN
- Bernice Johnson, Cancer Support Group, Wheaton, MN
- Michelle Johnson, Director of Nursing, Sanford Wheaton, Wheaton, MN
- Jeff Koenen, VP, Starr Bank, Wheaton, MN
- Judie Larson, City Council Member, Wheaton, MN
- Laurie Marchetti, Dental Hygienist, Marchetti Family Dentistry, Wheaton, MN
- Lillian Peterson, Wheaton, MN
- Vicky Radel, LAC, Prairie Acupuncture, Wheaton, MN
- Deb Rapp, Coordinator on Aging, Traverse Co. Social Services, Elbow Lake, MN
- Megan Rikimoto, Lab Supervisor, Sanford Wheaton, Wheaton, MN
- Leslie Schultz, Administrative Secretary, Big Stone Therapies, Wheaton, MN
- Mary Schultz, Cancer Support Group, Wheaton, MN
- Lynn Siegel, Paramedic & EMT Supervisor, Sanford Wheaton, Wheaton, MN
- Donna Wahl, Nurse, Sanford Wheaton, Wheaton, MN

Sanford Medical Center Wheaton
Community Health Needs Assessment
2012-2013

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

Sanford Health Fargo 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.

A subgroup 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.

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:
- Wheaton Community Health Needs Assessment of Community Leaders

The following quantitative data sets were studied:
- 2011 County Health Profiles for Traverse County
- Aging Profiles for Traverse County
- Diversity Profiles for Traverse 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 Wheaton Community Health Needs Assessment Collaborative 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

Sanford Health 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 Wheaton 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 friendly, helpful and supportive people; the community is a family-friendly environment; a good place to raise kids; and there is quality health care. However, respondents agreed the least that there is tolerance, inclusion, and open-mindedness in their community.

Respondents were most concerned about cost and/or availability of elder care, resources to meet the aging population, availability of family services, cost and/or availability of child care, quality and/or cost of education/school programs, problems associated with mental health care systems/policies, false sense of entitlement to services and resources, and availability of youth activities.

Respondents had moderate level of concern with availability of public transportation, cost of health care and/or insurance, availability of affordable housing, low wages, cost of living, availability of employment opportunities, poverty, and economic disparities between higher and lower classes. Respondents were also concerned with issues of children and youth (bullying and substance abuse).

Among health and wellness concerns, respondents were most concerned about the cost of health insurance, cost of prescription drugs, availability and/or cost of dental and/or vision insurance coverage, cost of health care, adequacy of health insurance, availability of doctors, nurses, and/or specialists, availability and/or cost of dental and vision care, access to health insurance coverage, and availability of prevention programs or services. Respondents were also concerned about physical health issues, particularly obesity, lack of exercise and/or inactivity, poor nutrition/eating habits, and availability of good walking or biking options. Respondents were least concerned about cost and availability of exercise facilities and traffic congestion.

Respondents were not very concerned with environmental issues in their community. Water and air pollution concerns were more of a concern than noise.

The levels of concern among respondents regarding substance use and abuse issues in their community were fairly high. Respondents were most concerned about alcohol use and abuse. Although still moderately high, respondents were least concerned about smoking.

The top three reasons respondents gave for their topics related to delivery of health care were access to emergency services, health services for heart disease, and health services for cancer patients.

Over 50% of the respondents said they had not had a cancer screening or cancer care in the past year. The most common reason for not having done so was because it was not necessary. Fear and cost were also reasons respondents gave.

Respondents were most concerned with delivery of health care in the community. Access to emergency services rated highest. Although still moderately high, respondents were concerned about health services for heart disease and cancer patients, distance/transportation to a health care facility, and attention given to preventive services. Respondents were least concerned with needs of communities dealing with a hospital or clinic closure.

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

Implementation Strategy

Implementation Strategy: Transportation
- Identify series currently available within the community
- Develop directory with resources and outsource information
- Increase volunteer driver program and work with law enforcement and Social Services for Mental Health transport

Implementation Strategy: Mental Health Services
- Define services currently available
- Develop directory of resources and information
- Distribute directory to various groups and entities

Implementation Strategy: Recruitment of Physician
- Employ another full-time Family Practice Physician

Sanford Medical Center Wheaton
Community Health Needs Assessment
2012-2013

Sanford Health, 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 the Hospital

Sanford Medical Center Wheaton is a primary care Critical Access Hospital presently licensed for 25 beds. Sanford Medical Center Wheaton serves people in Traverse County, Minnesota and surrounding areas of Big Stone and Grant counties of Minnesota and Roberts County of South Dakota with high quality, comprehensive health care services. Its goal is to improve the health and wellbeing of the population within the limits of available resources.

Sanford Wheaton is licensed by the State of Minnesota, certified for Medicare and Blue Cross, and is a member of the American Hospital Association, the MN Hospital Association, and the MN Rural Health Alliance.

Sanford Medical Center Wheaton provides the following services for patients:
- Skilled nursing, respite and acute care
- Certified CLIA clinical laboratory
- Radiology on site
  - EKG, MRI, Dexascan, Ultrasound, Mammography, Holter and event monitoring, nuclear medicine studies, stress tests, thallium studies, EEG, CAT scan
- Outpatient care
  - Antibiotic therapy
  - Infusion port care
  - Periodic infusions/injections
  - Blood transfusions
  - Respiratory therapy
  - Simple wound management
  - Colonoscopy
  - EGD
- Therapies - Physical, Occupational, Speech Language Pathology
- Swing Bed Services
  - Medicare-approved rehabilitative care
  - Orthopedic rehabilitation
  - Emphasis on strengthening
  - Assistance with activities of daily living
- Cardiac Rehab Program
- Medical Home Program
- Surgery, including ophthalmology, general, urologic and endoscopic procedures

Services provided through contract or agreement includes:
- Sanford Home Health Care
- Podiatry
- Urology
- Ophthalmology
- Orthopedics
- Audiology
- Oncology
- Sleep Studies
- Surgery
- Beltone Hearing Aid Service

Sanford Medical Center Wheaton's professional staff is made up of providers who operate Sanford Wheaton Clinic. The clinic is staffed by two physicians, two family nurse practitioners, and a physician assistant.

Study Design and Methodology

In May 2011 Sanford Health Fargo 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 assure 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:
* Wheaton Community Health Needs Assessment of Community Leaders

The following quantitative data sets were studied:
* 2011 County Health Profiles for Traverse County
* Aging Profiles for Traverse County
* Diversity Profiles for Traverse 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 need. The Wheaton Community Health Needs Assessment Collaborative performed the asset mapping and reviewed the findings. The group conducted an informal gap analysis to determine what need 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.

Wheaton Community Health Needs Assessment of Community Leaders

The purpose of the community survey was to explore the views of key leaders in the Wheaton area (e.g. health professionals, social workers, educators, elected leadership, and non-profit leaders) regarding the resident population's health and the prevalence of disease and health issues within the community.

The survey instrument was the same instrument developed in collaboration with the FMCHNAC and used in the generalizable survey of residents of the Fargo-Moorhead metro area of Cass and Clay counties, with 30 questions focusing on community assets, general concerns about communities, community health and wellness concerns, and demographic information.

The community leaders' version of the survey also included a set of questions at the end relating to the respondent's name, title, affiliation, area of expertise, city/town, and state. These questions were included to fulfill the current interpretation of IRS requirements for non-profit hospitals conducting community health needs assessments as part of the new compliance requirements imposed by PPACA enacted on March 23, 2010.

The list of community leaders was generated by members of the Collaborative. Collaborative members e-mailed those community leaders with instructions for them to fill out the survey via the Internet-based survey tool. Data was collected through mid-June. A total of 42 surveys were completed. The purpose of this survey was to learn about the perceptions of area key stakeholders regarding the prevalence of disease and health issues in their community.

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. Racial categories not represented include Native Hawaiian and Other Pacific Islander alone, Some other race alone, and Two or More races.

Limitations

The Wheaton Community Health Needs Assessment Collaborative attempted to convene nearly 100 key community and county stakeholders for the purpose of determining the needs of the community. There were 42 members of this key stakeholder group who completed the survey and focus group questions.

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 educational opportunities and programs, the community is a good place to raise kids, and there is quality health care. However, respondents agreed the least that there is tolerance, inclusion, and open-mindedness in their community.

Respondents were most concerned about domestic violence and issues regarding the aging population (e.g. availability and cost of long-term care, availability of resources to help elderly stay in their homes, and availability of resources for family and friends caring for elders). Respondents were also concerned with issues regarding children and youth (e.g. availability and cost of quality child care, bullying, availability and cost of services for at-risk youth, and child abuse and neglect). Environmental issues regarding garbage and litter, 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 insurance (e.g. amount of co-pays and deductibles) and access to health insurance coverage (e.g. pre-existing conditions), as well as chronic disease (e.g. diabetes, health disease, multiple sclerosis) and depression were also among the top health and wellness concerns among respondents. Respondents were least concerned about patient confidentiality and distance to health care services.

Community Assets/Best Things about the Community

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: there are quality higher education opportunities and institutions, the community is a good place to raise kids, there are

quality school systems and programs for youth, there is quality health care, and people are friendly, helpful, and supportive.
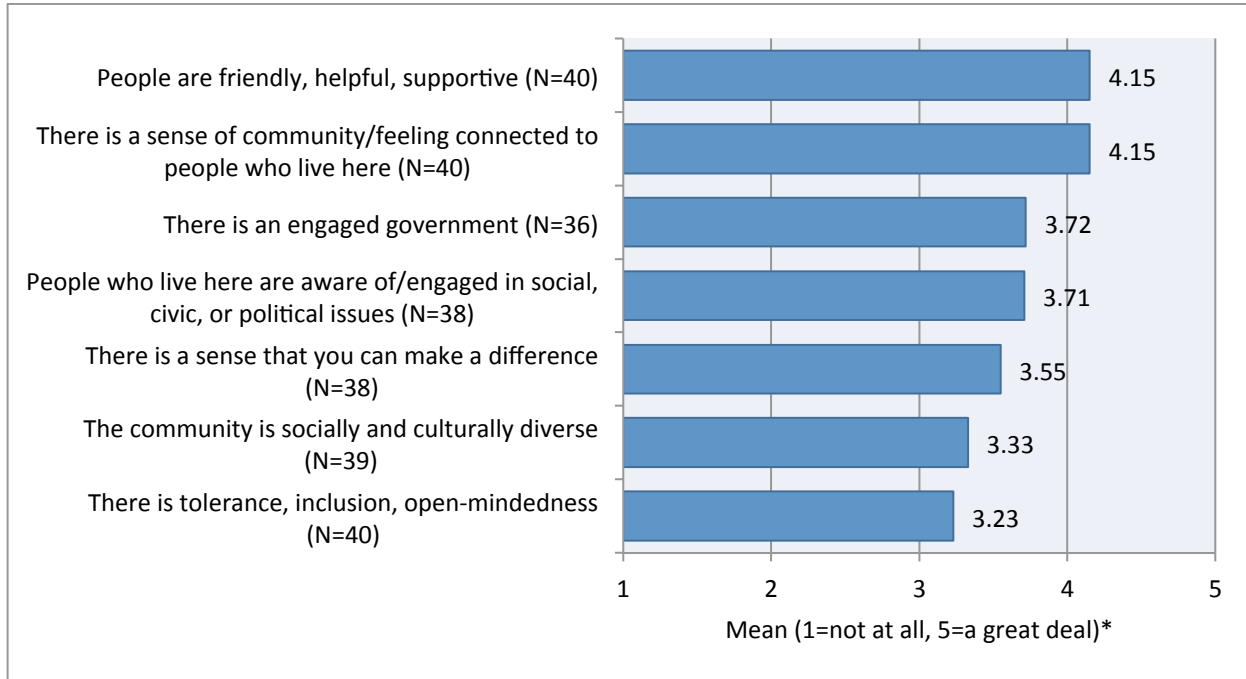
Overall, respondents had moderately high levels of agreement regarding positive statements that reflect the people in their community *(Figure 1).*
- On average, respondents agreed the most that people in their community are friendly, helpful, and supportive.
- Respondents also had a fairly high level 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 tolerance, inclusion, and open-mindedness in their community.

Respondents were asked to rate their level of agreement with various statements regarding PEOPLE, SERVICES AND RESOURCES, QUALITY OF LIFE, GEOGRAPHIC SETTING, and ACTIVITIES in their community.
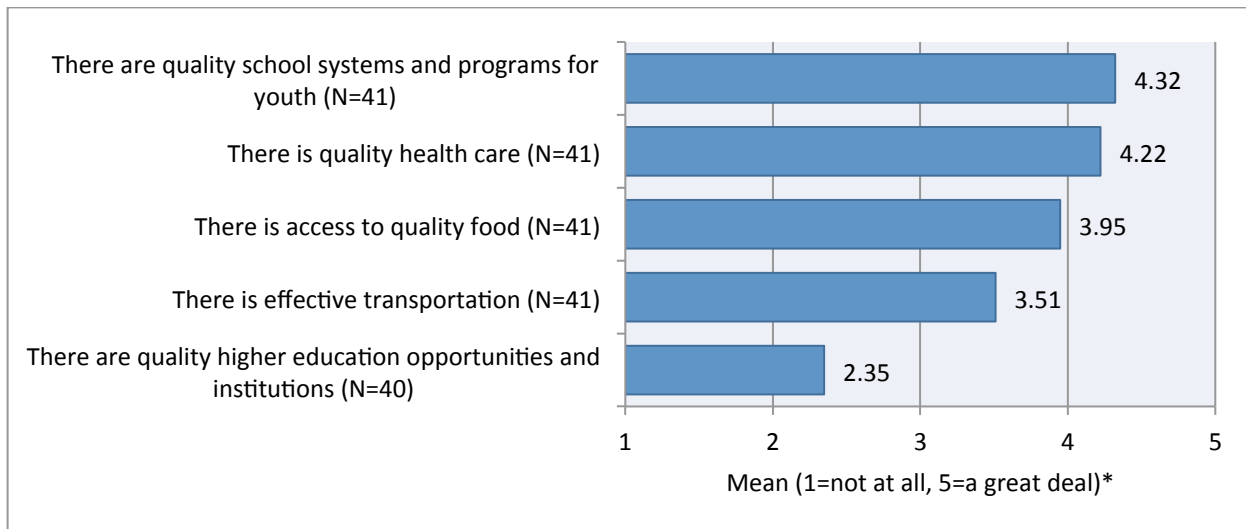
People

Figure 1. Level of agreement with statements about the community regarding PEOPLE

People are friendly, helpful, supportive (N=40) — 4.15
There is a sense of community/feeling connected to people who live here (N=40) — 4.15
There is an engaged government (N=36) — 3.72
People who live here are aware of/engaged in social, civic, or political issues (N=38) — 3.71
There is a sense that you can make a difference (N=38) — 3.55
The community is socially and culturally diverse (N=39) — 3.33
There is tolerance, inclusion, open-mindedness (N=40) — 3.23

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

*Means exclude "do not know" responses.

Services and Resources

Figure 2. Level of agreement with statements about the community regarding SERVICES AND RESOURCES

There are quality school systems and programs for youth (N=41) — 4.32
There is quality health care (N=41) — 4.22
There is access to quality food (N=41) — 3.95
There is effective transportation (N=41) — 3.51
There are quality higher education opportunities and institutions (N=40) — 2.35

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

*Means exclude "do not know" responses.

<u>Quality of Life</u>

Figure 3. Level of agreement with statements about the community regarding QUALITY OF LIFE

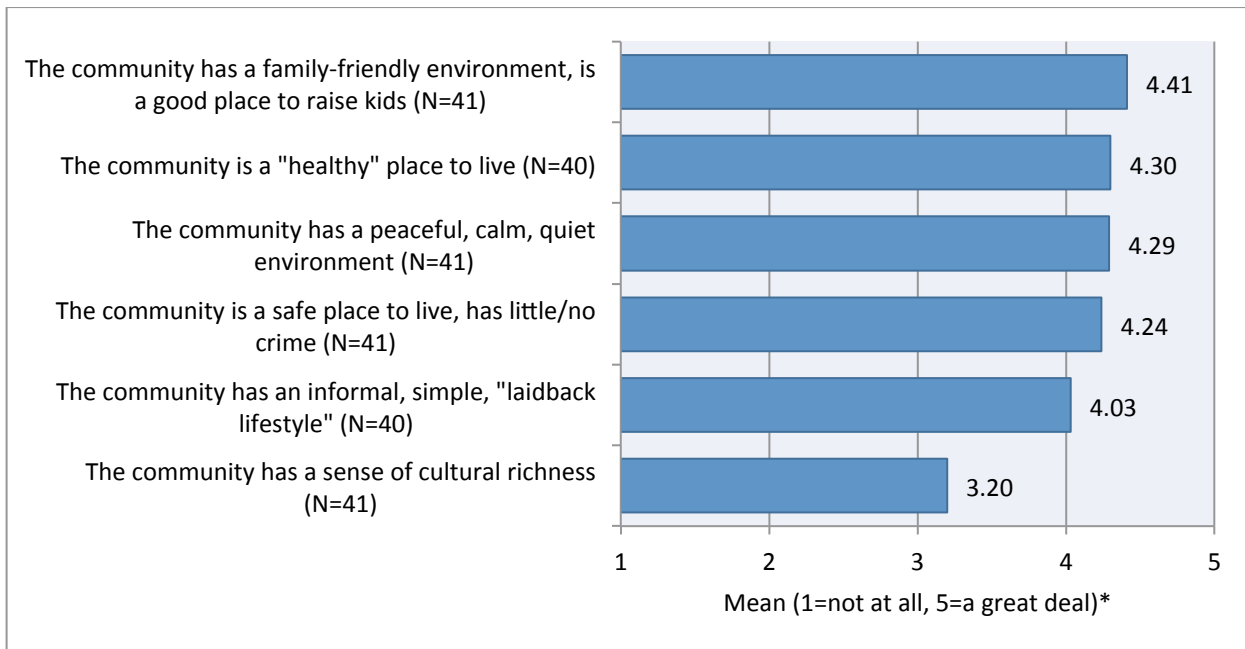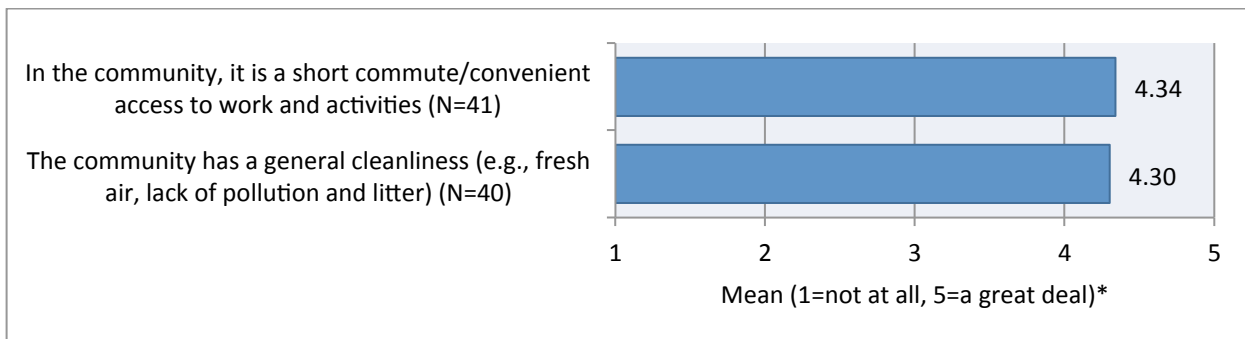
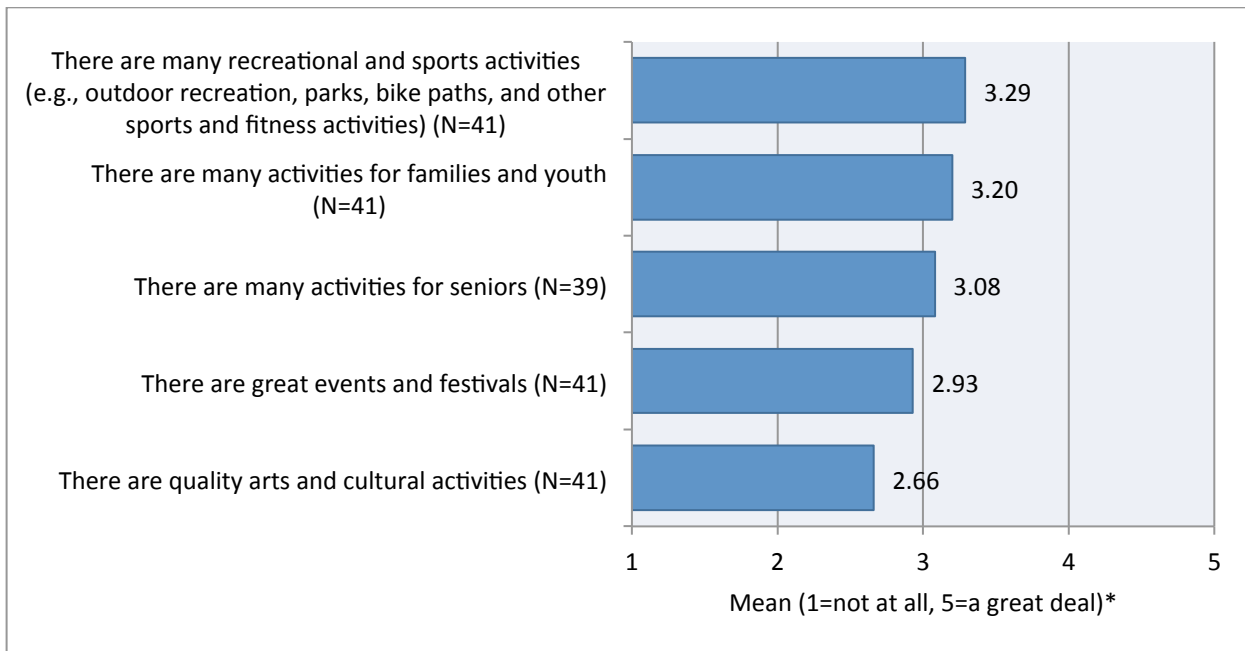*Means exclude "do not know" responses.

<u>Geographic Setting</u>

Figure 4. Level of agreement with statements about the community regarding the GEOGRAPHIC SETTING

*Means exclude "do not know" responses.

Activities

Figure 5. Level of agreement with statements about the community regarding ACTIVITIES

There are many recreational and sports activities (e.g., outdoor recreation, parks, bike paths, and other sports and fitness activities) (N=41) — 3.29

There are many activities for families and youth (N=41) — 3.20

There are many activities for seniors (N=39) — 3.08

There are great events and festivals (N=41) — 2.93

There are quality arts and cultural activities (N=41) — 2.66

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

*Means exclude "do not know" responses.

General Concerns about the Community

Respondents were asked to rate their level of concern with various statements regarding ECONOMIC ISSUES, SERVICES AND RESOURCES, TRANSPORTATION, ENVIRONMENTAL POLLUTION, YOUTH CONCERNS, and SAFETY CONCERNS in their community.
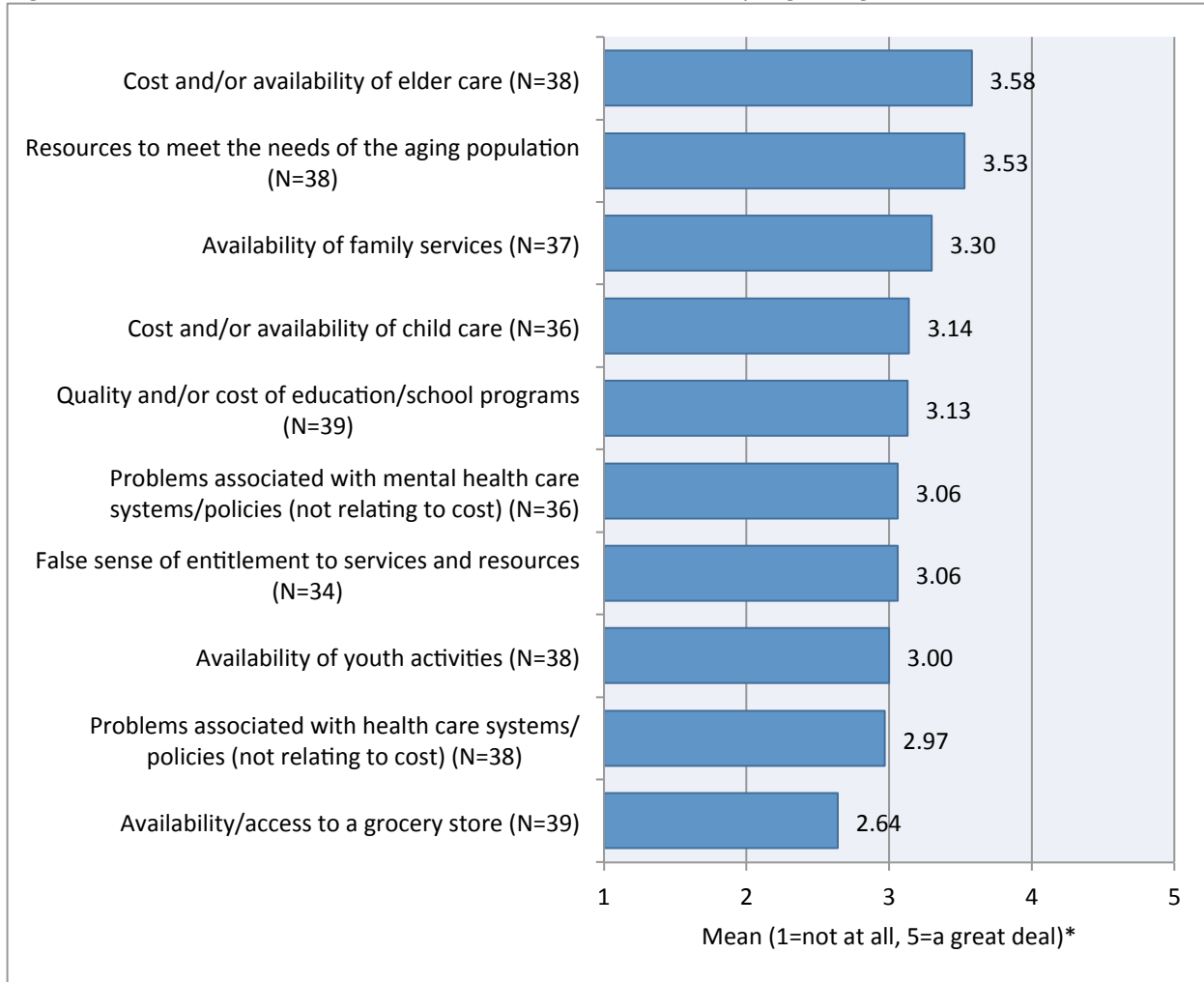
Economic Issues

Figure 6. Level of concern with statements about the community regarding ECONOMIC ISSUES
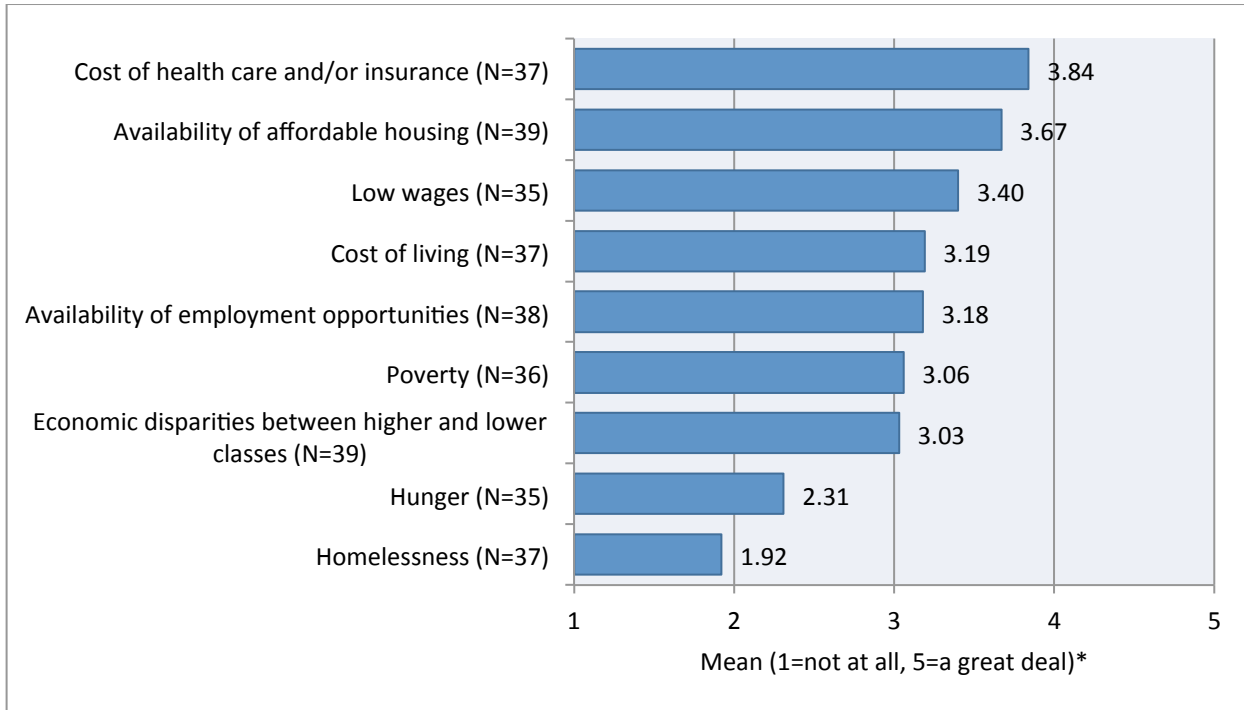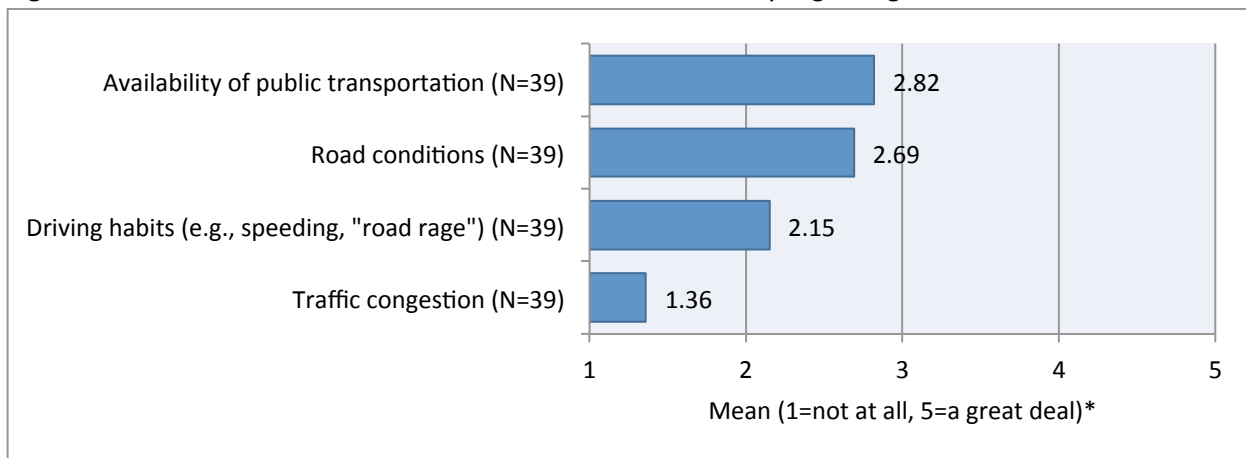
Services and Resources

Figure 7. Level of concern with statements about the community regarding SERVICES AND RESOURCES

Cost and/or availability of elder care (N=38): 3.58

Resources to meet the needs of the aging population (N=38): 3.53

Availability of family services (N=37): 3.30

Cost and/or availability of child care (N=36): 3.14

Quality and/or cost of education/school programs (N=39): 3.13

Problems associated with mental health care systems/policies (not relating to cost) (N=36): 3.06

False sense of entitlement to services and resources (N=34): 3.06

Availability of youth activities (N=38): 3.00

Problems associated with health care systems/policies (not relating to cost) (N=38): 2.97

Availability/access to a grocery store (N=39): 2.64

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

*Means exclude "do not know" responses.

Transportation

Figure 8. Level of concern with statements about the community regarding TRANSPORTATION

Availability of public transportation (N=39): 2.82

Road conditions (N=39): 2.69

Driving habits (e.g., speeding, "road rage") (N=39): 2.15

Traffic congestion (N=39): 1.36

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

*Means exclude "do not know" responses.

Environment

Figure 9. Level of concern with statements about the community regarding ENVIRONMENTAL POLLUTION
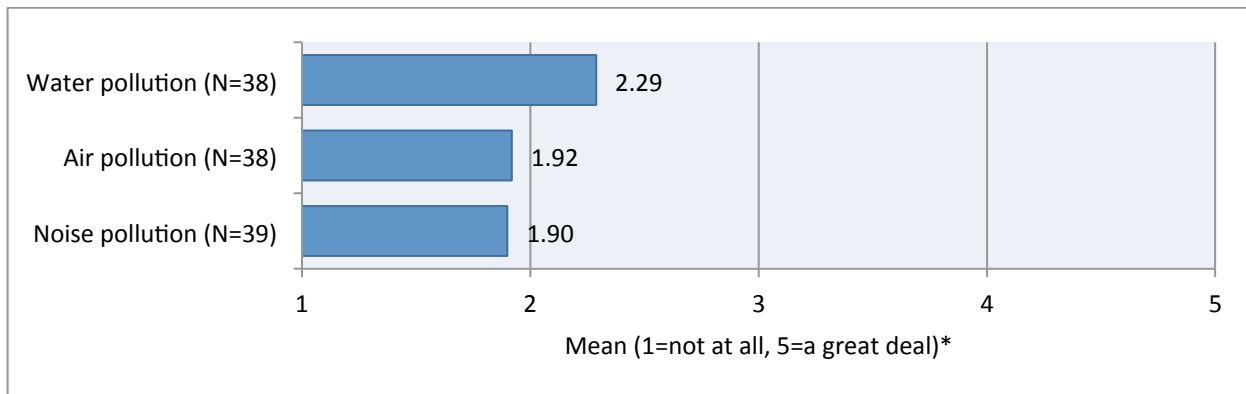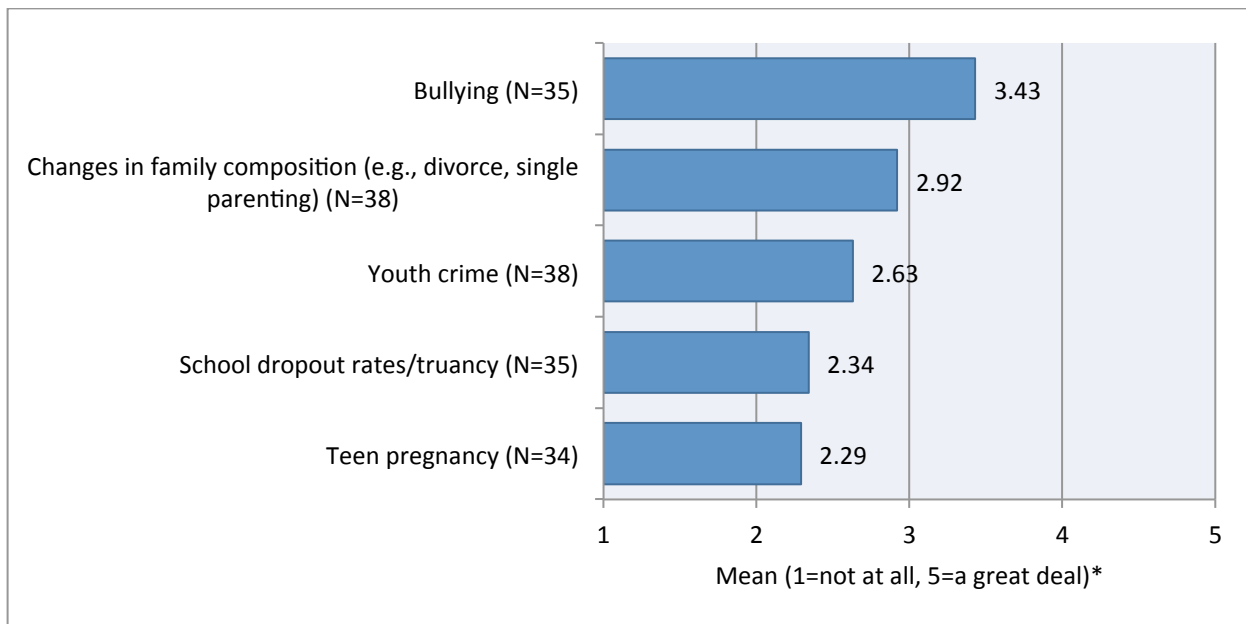

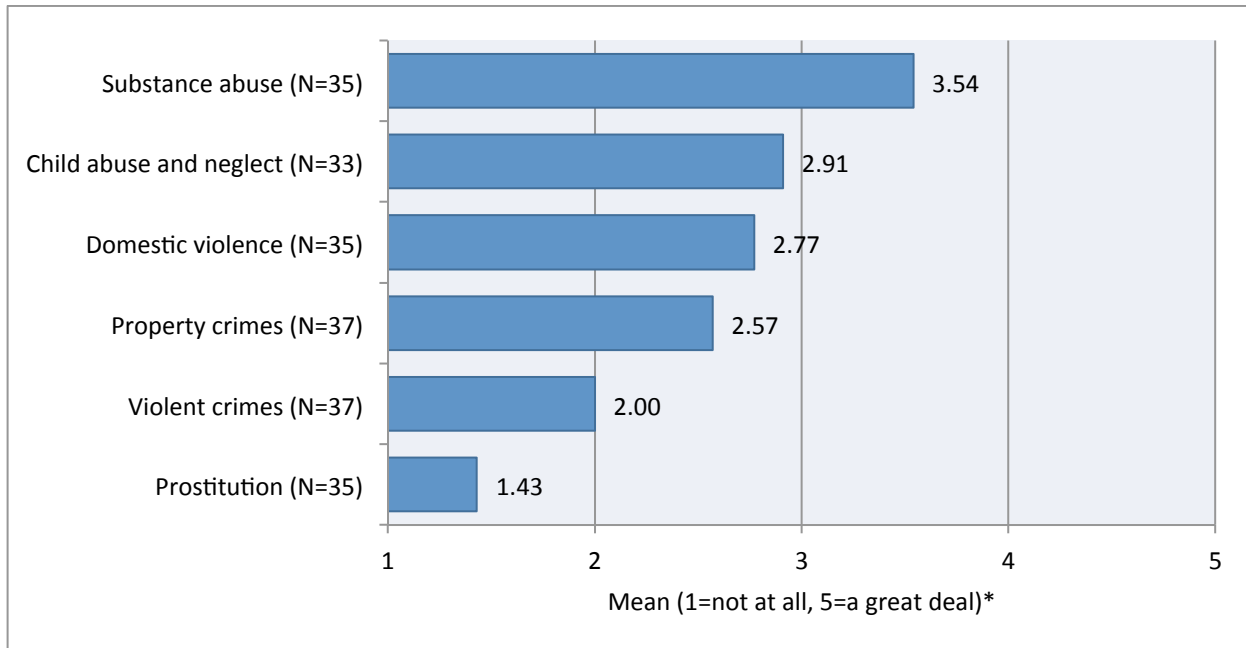*Means exclude "do not know" responses.

Youth

Figure 10. Level of concern with statements about the community regarding YOUTH CONCERNS

*Means exclude "do not know" responses.

Figure 11. Level of concern with statements about the community regarding SAFETY CONCERNS
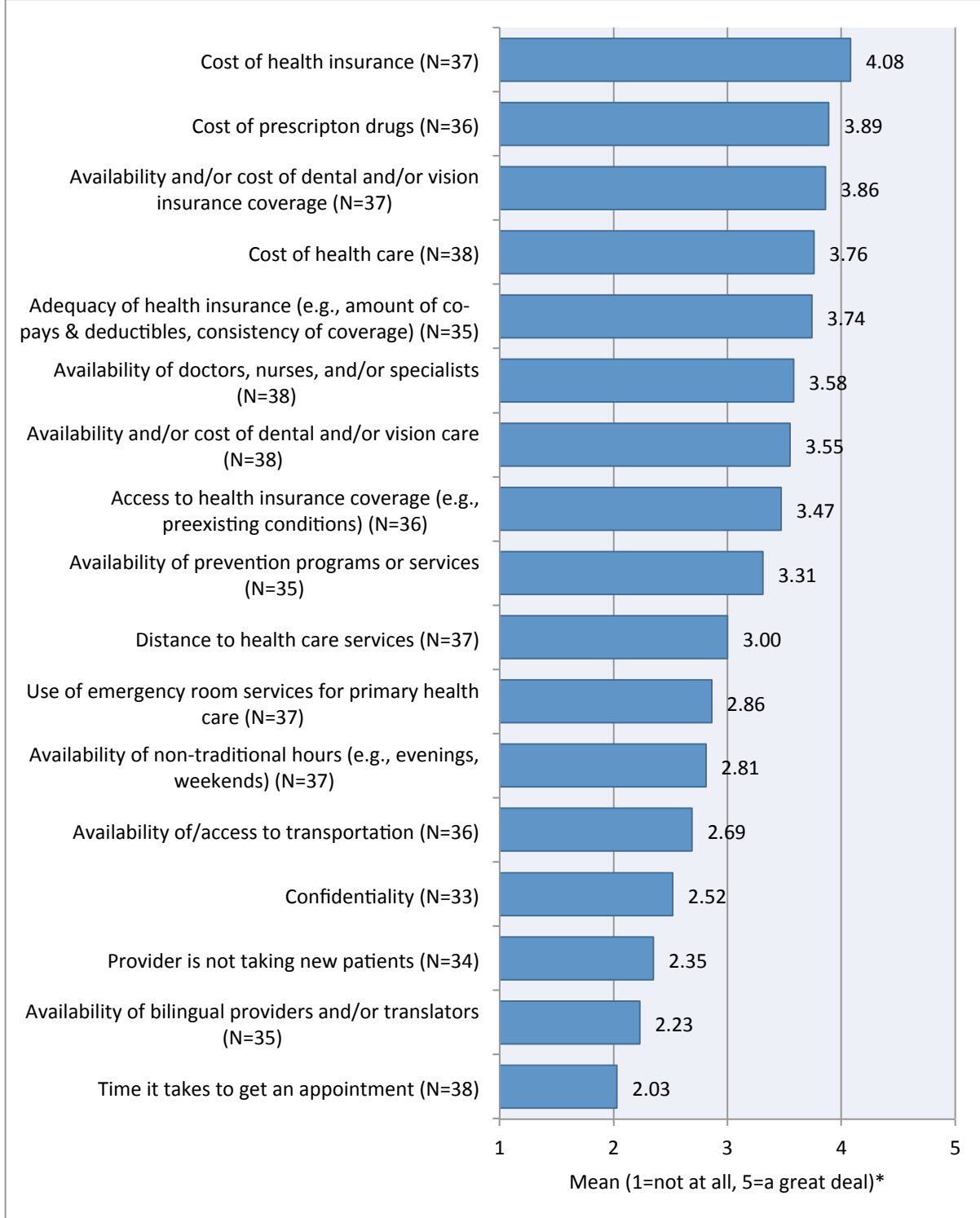

*Means exclude "do not know" responses.

Community Health and Wellness Concerns

Respondents were asked to rate their level of concern about health and wellness issues in their community regarding ACCESS TO HEALTH CARE, SUBSTANCE USE AND ABUSE, PHYSICAL AND MENTAL HEALTH, and ILLNESS.
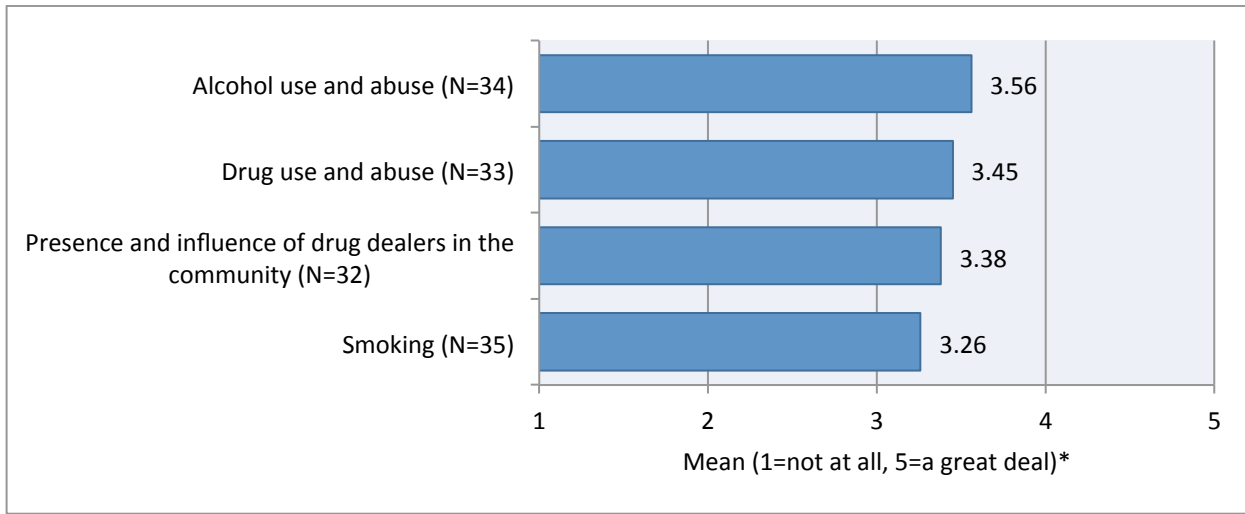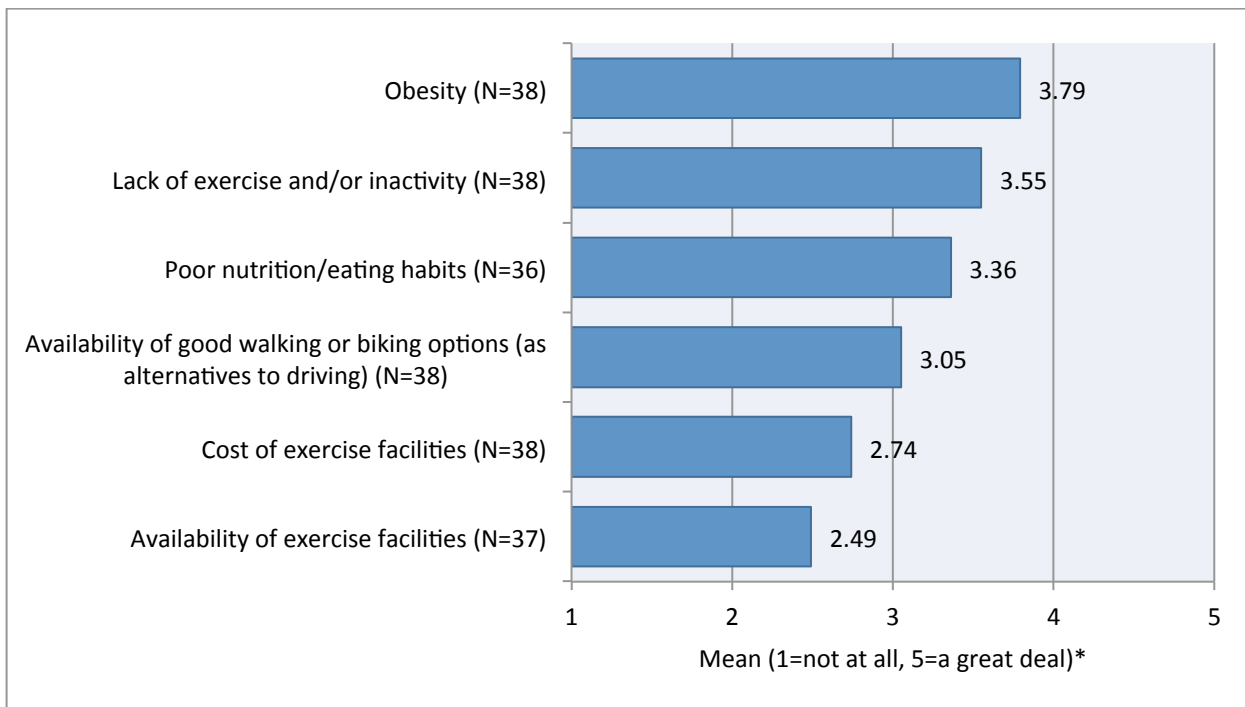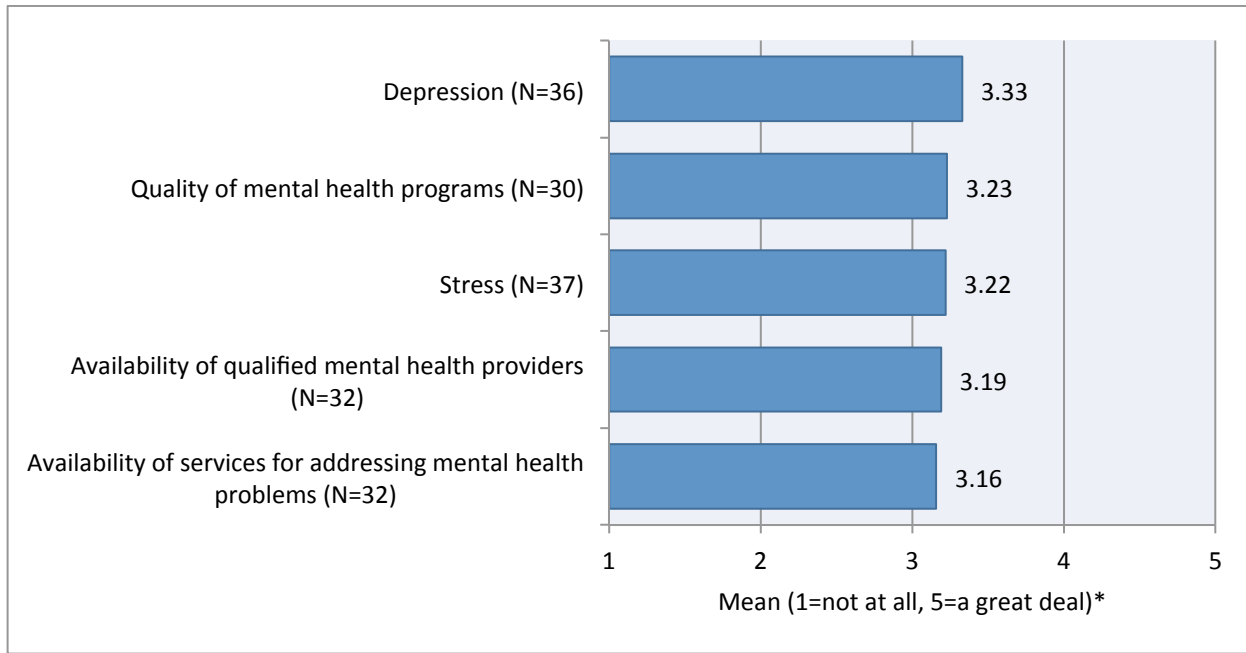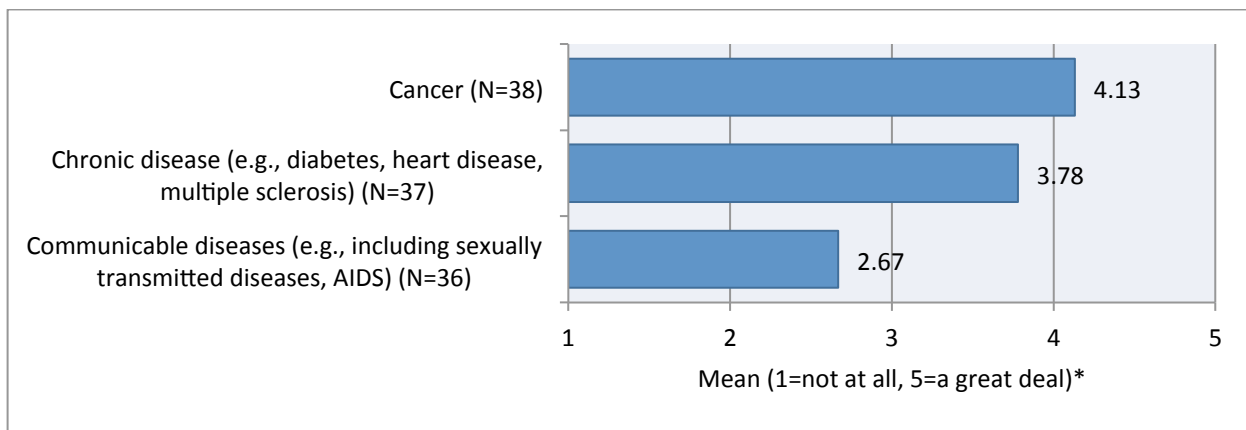
Access to Health Care

Figure 12. Level of concern with statements about the community regarding ACCESS TO HEALTH CARE

Cost of health insurance (N=37) 4.08
Cost of prescripton drugs (N=36) 3.89
Availability and/or cost of dental and/or vision insurance coverage (N=37) 3.86
Cost of health care (N=38) 3.76
Adequacy of health insurance (e.g., amount of co-pays & deductibles, consistency of coverage) (N=35) 3.74
Availability of doctors, nurses, and/or specialists (N=38) 3.58
Availability and/or cost of dental and/or vision care (N=38) 3.55
Access to health insurance coverage (e.g., preexisting conditions) (N=36) 3.47
Availability of prevention programs or services (N=35) 3.31
Distance to health care services (N=37) 3.00
Use of emergency room services for primary health care (N=37) 2.86
Availability of non-traditional hours (e.g., evenings, weekends) (N=37) 2.81
Availability of/access to transportation (N=36) 2.69
Confidentiality (N=33) 2.52
Provider is not taking new patients (N=34) 2.35
Availability of bilingual providers and/or translators (N=35) 2.23
Time it takes to get an appointment (N=38) 2.03

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

*Means exclude "do not know" responses.

Substance Use and Abuse

Figure 13. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE

Alcohol use and abuse (N=34) — 3.56
Drug use and abuse (N=33) — 3.45
Presence and influence of drug dealers in the community (N=32) — 3.38
Smoking (N=35) — 3.26

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

*Means exclude "do not know" responses.

Physical Health

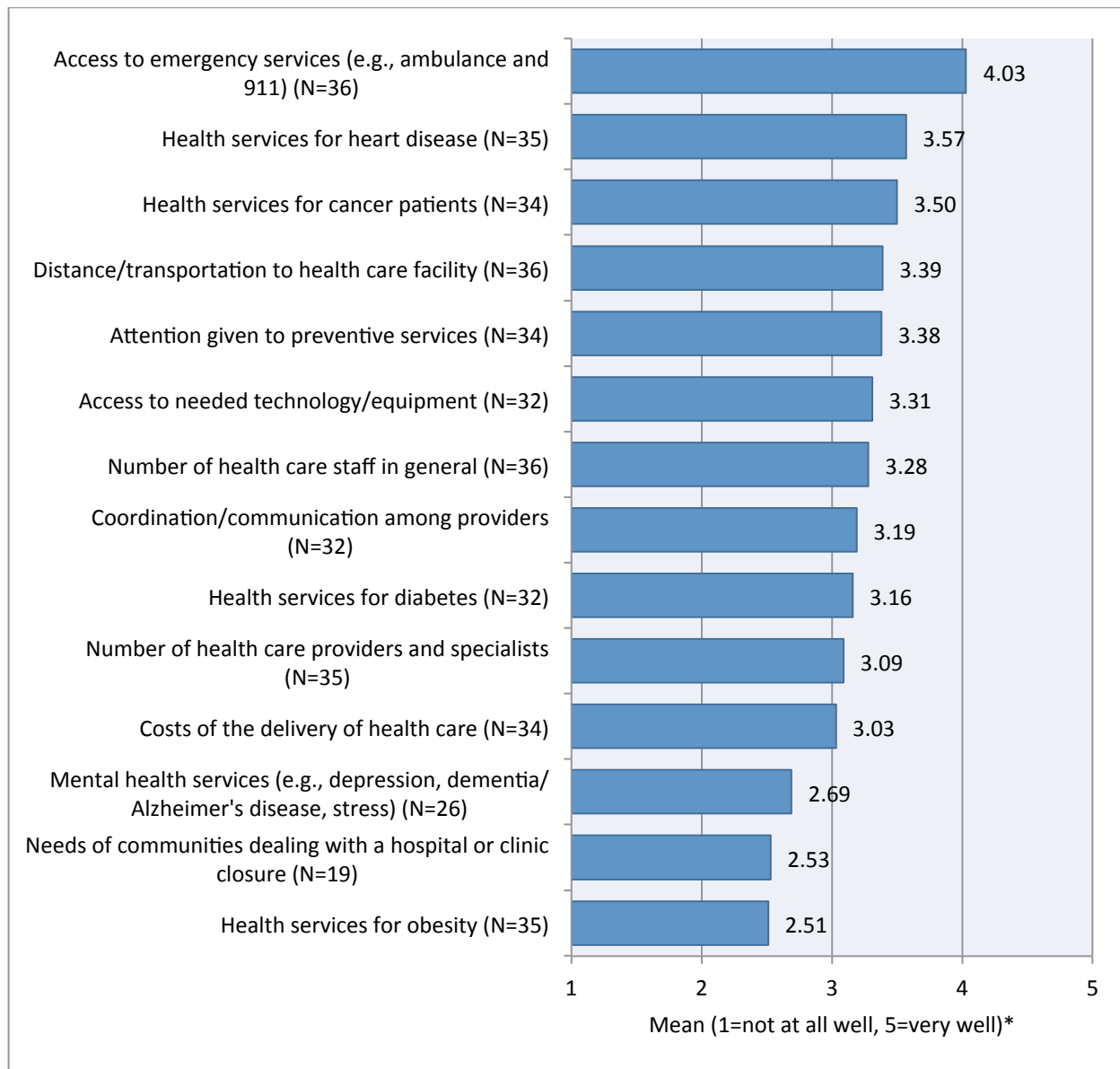**Figure 14.** Level of concern with statements about the community regarding PHYSICAL HEALTH

Obesity (N=38) — 3.79
Lack of exercise and/or inactivity (N=38) — 3.55
Poor nutrition/eating habits (N=36) — 3.36
Availability of good walking or biking options (as alternatives to driving) (N=38) — 3.05
Cost of exercise facilities (N=38) — 2.74
Availability of exercise facilities (N=37) — 2.49

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

*Means exclude "do not know" responses.

Mental Health

Figure 15. Level of concern with statements about the community regarding MENTAL HEALTH

	Mean
Depression (N=36)	3.33
Quality of mental health programs (N=30)	3.23
Stress (N=37)	3.22
Availability of qualified mental health providers (N=32)	3.19
Availability of services for addressing mental health problems (N=32)	3.16

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

*Means exclude "do not know" responses.

Illness

Figure 16. Level of concern with statements about the community regarding ILLNESS

	Mean
Cancer (N=38)	4.13
Chronic disease (e.g., diabetes, heart disease, multiple sclerosis) (N=37)	3.78
Communicable diseases (e.g., including sexually transmitted diseases, AIDS) (N=36)	2.67

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

*Means exclude "do not know" responses.

Delivery of Health Care in the Community

Respondents were asked to rate how well DELIVERY OF HEALTH CARE topics are being addressed in their community. Respondents rated the least addressed concerns to be obesity and mental health services.

Figure 17. How well topics related to DELIVERY OF HEALTH CARE in the community are being addressed

Topic	Mean
Access to emergency services (e.g., ambulance and 911) (N=36)	4.03
Health services for heart disease (N=35)	3.57
Health services for cancer patients (N=34)	3.50
Distance/transportation to health care facility (N=36)	3.39
Attention given to preventive services (N=34)	3.38
Access to needed technology/equipment (N=32)	3.31
Number of health care staff in general (N=36)	3.28
Coordination/communication among providers (N=32)	3.19
Health services for diabetes (N=32)	3.16
Number of health care providers and specialists (N=35)	3.09
Costs of the delivery of health care (N=34)	3.03
Mental health services (e.g., depression, dementia/ Alzheimer's disease, stress) (N=26)	2.69
Needs of communities dealing with a hospital or clinic closure (N=19)	2.53
Health services for obesity (N=35)	2.51

Mean (1=not at all well, 5=very well)*

*Means exclude "do not know" responses.

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

More than 50% of respondents said they had not had a cancer screening or cancer care in the past year. The most common reason for not having done so was because the doctor had not recommended it. Fear, unfamiliarity with recommendations, and not knowing who to see were not considered to be the main reasons respondents gave.

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. Over 50% said they had not had a cancer screening or cancer care in the past year.

Figure 18. Whether respondents had a cancer screening or cancer care in the past year
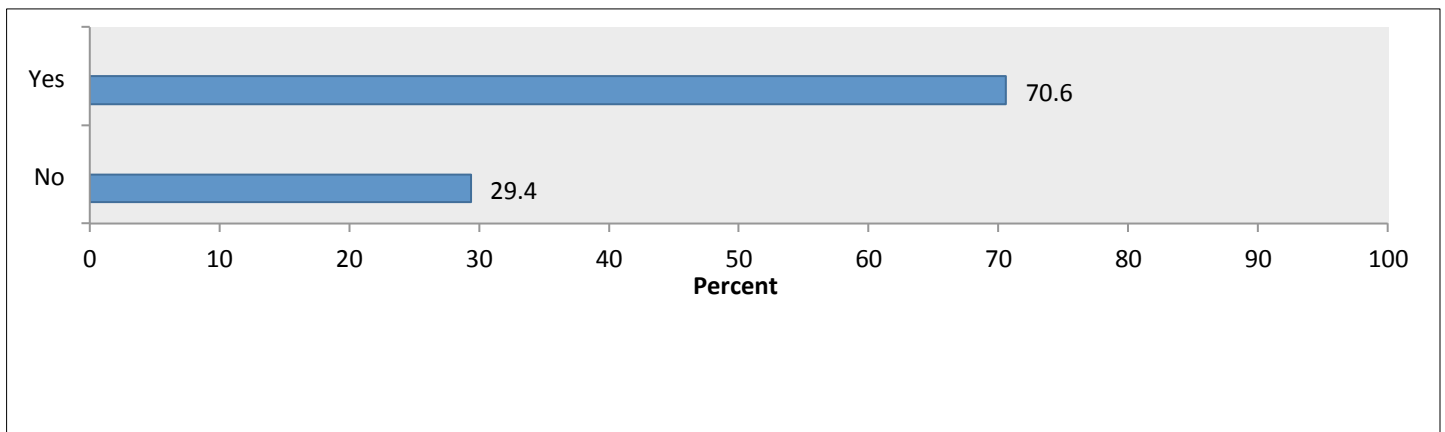
Cancer Screening

Among respondents who had not had a cancer screening or cancer care in the past year, 50% said they had not done so because it was not necessary or their doctor had not suggested it. Ten percent (10%) said it was a cost factor. Fear was not considered a reason for respondents to not have the screenings. (Figure 19)

Figure 19. Reasons among respondents who have not had a cancer screening or cancer care in the past year.
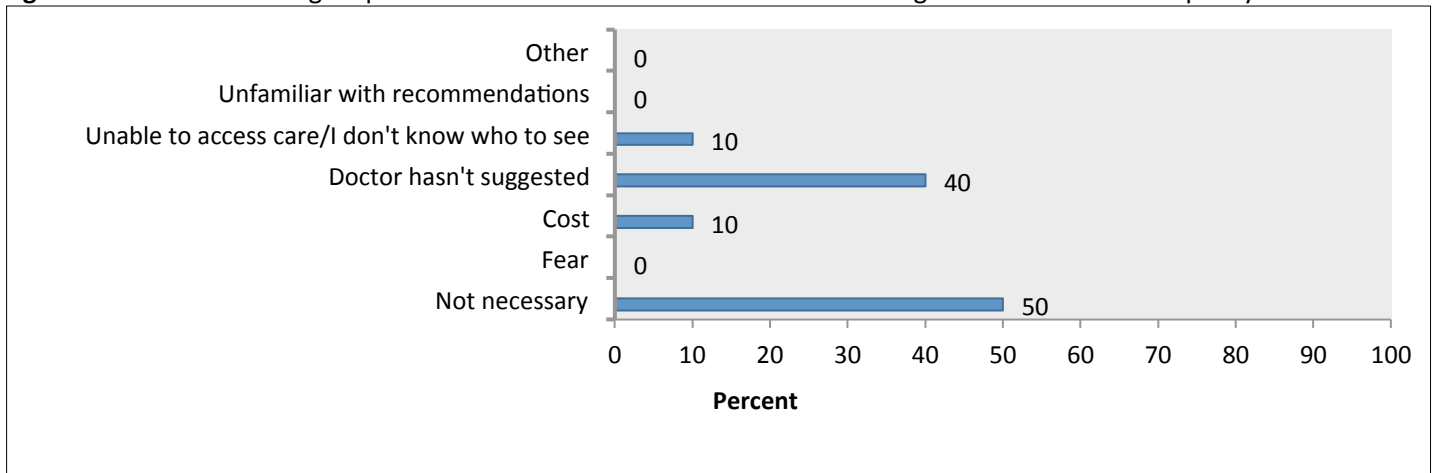
Health Care Coverage

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 and private health insurance were also used.

Figure 20. Methods respondents have used to pay for health care costs over the last 12 months.

Health insurance through an employer — 61.8
Medicare — 35.3
Personal income (e.g., cash, check, credit) — 50
Private health insurance — 32.4
Medicaid — 2.9
Did not access health care in last 12 months — 0
Other** — 0

Percent*
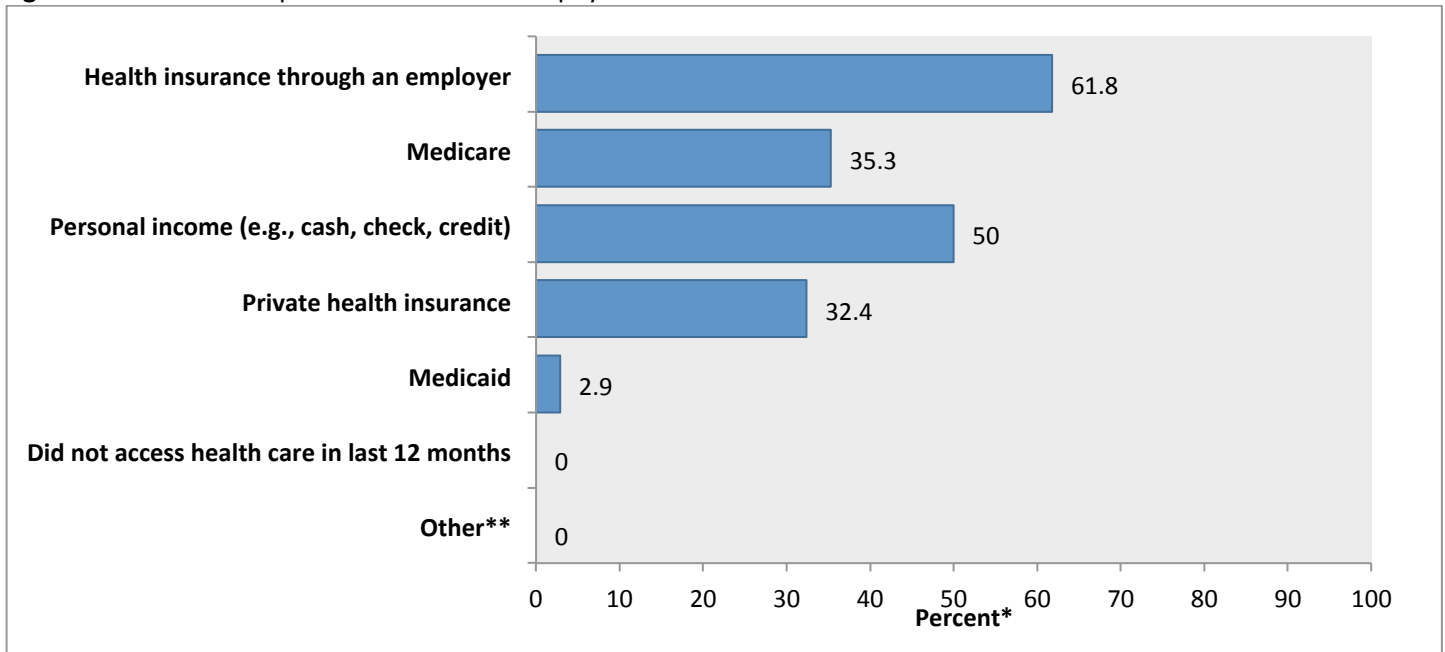
Primary Care Provider

The top three reasons respondents gave for their choice of primary health care provider were location, availability of services, and quality of services (Figure 21). Being valued as a patient was important to 33.3% of respondents.

Figure 21. Respondents' reasons for choosing primary health care provider

Quality of services — 36.1
Location — 91.7
Availability of services — 41.7
Influenced by health insurance — 2.8
Sense of being valued as a patient — 33.3
Cost —
Other** — 11.1

Percent*
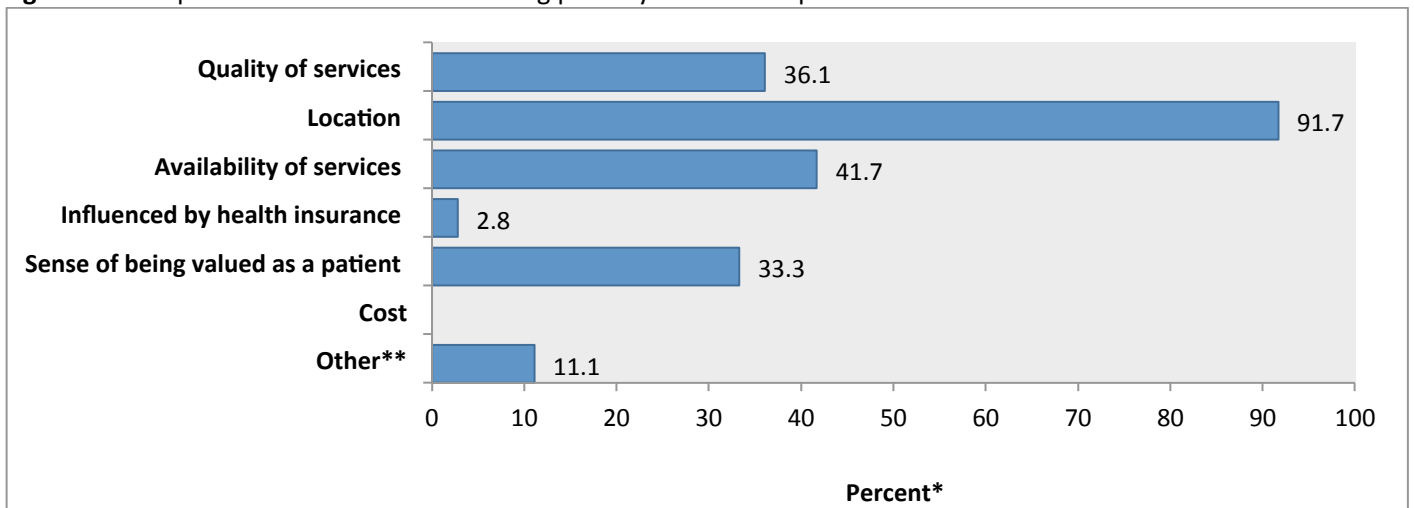
Respondent's Primary Health Care Provider

Respondents were asked which provider they used for their primary health care. Over 95% of respondents said they use Sanford Wheaton as their primary health care provider

Figure 22. Respondents' primary health care provider
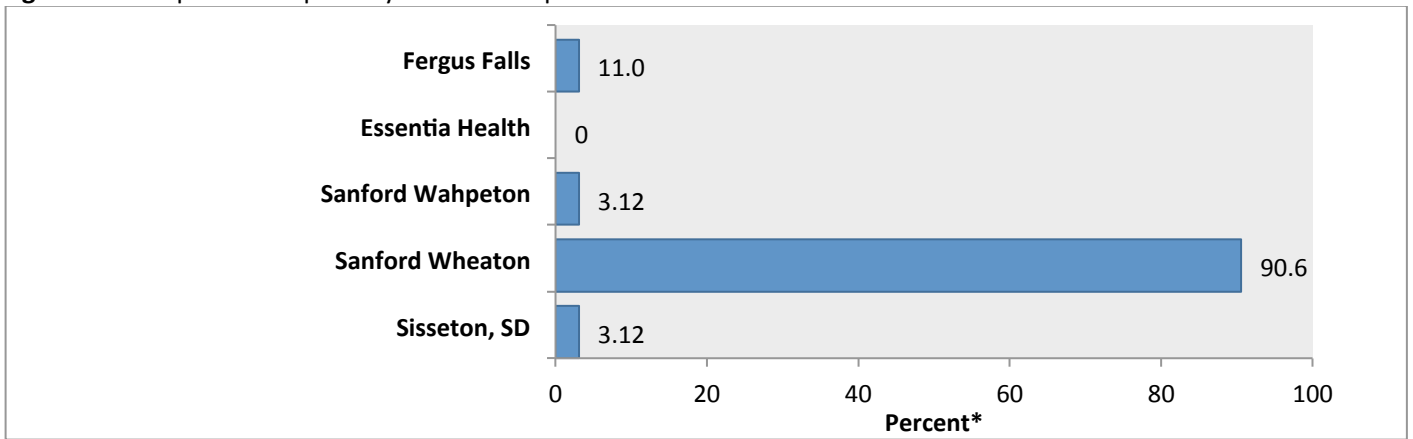
Respondents Representing Chronic Disease

Respondents were asked to select their personal general health conditions/diseases. Weight control and arthritis received the most responses with 40% of participants selecting this condition. The chronic diseases found among respondents include arthritis, asthma, cancer, heart disease, diabetes, hypertension, hypercholesterolemia, and depression, anxiety or stress. The highest occurrence of these chronic diseases includes arthritis, hypertension, hypercholesterolemia, and cancer. (Figure 23)

Figure 23. Respondent's health/chronic diseases
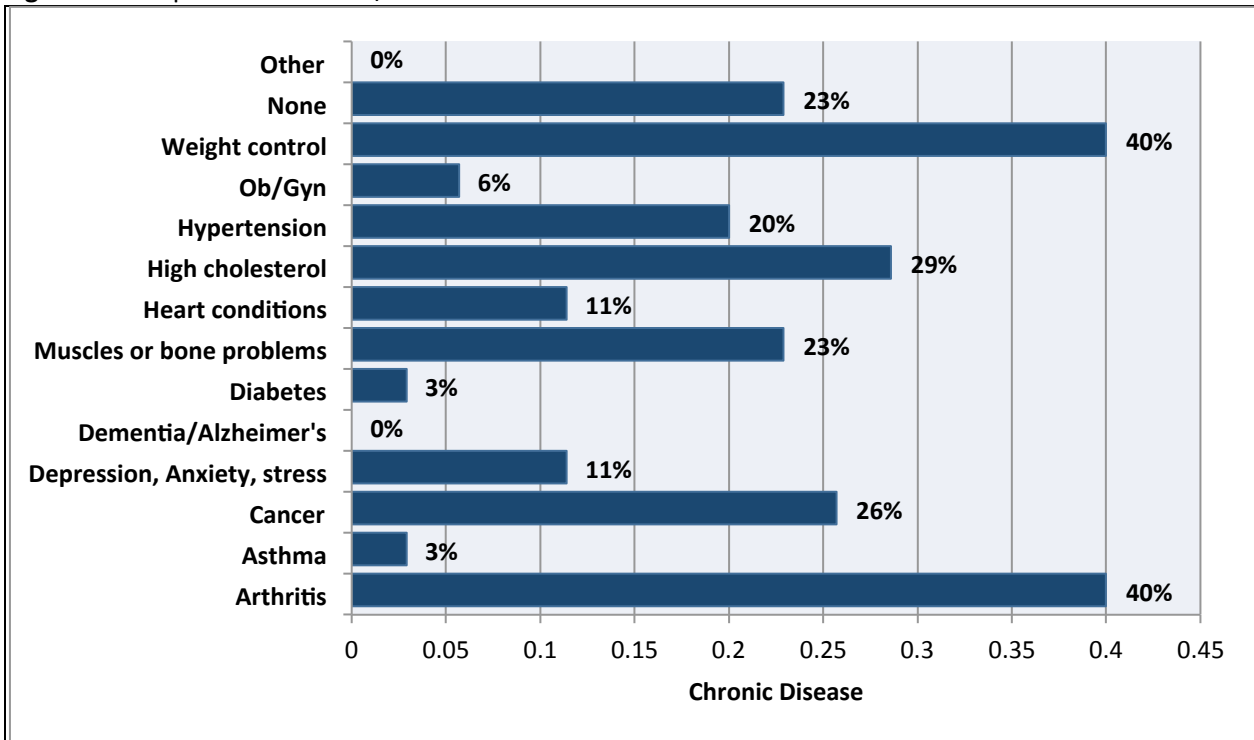
The majority of respondents are 65 years and older.

Figure 24. Respondents' age distribution
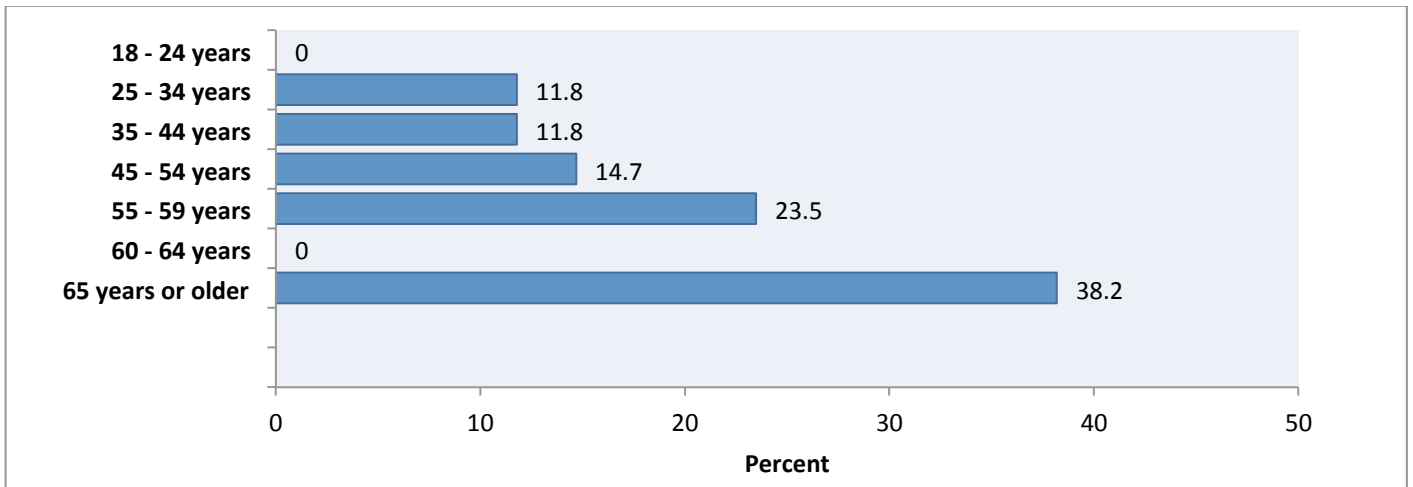
Most respondents have a high school degree or higher, including 34% with Bachelor's or Graduate's degree.

Figure 25. Respondents' education
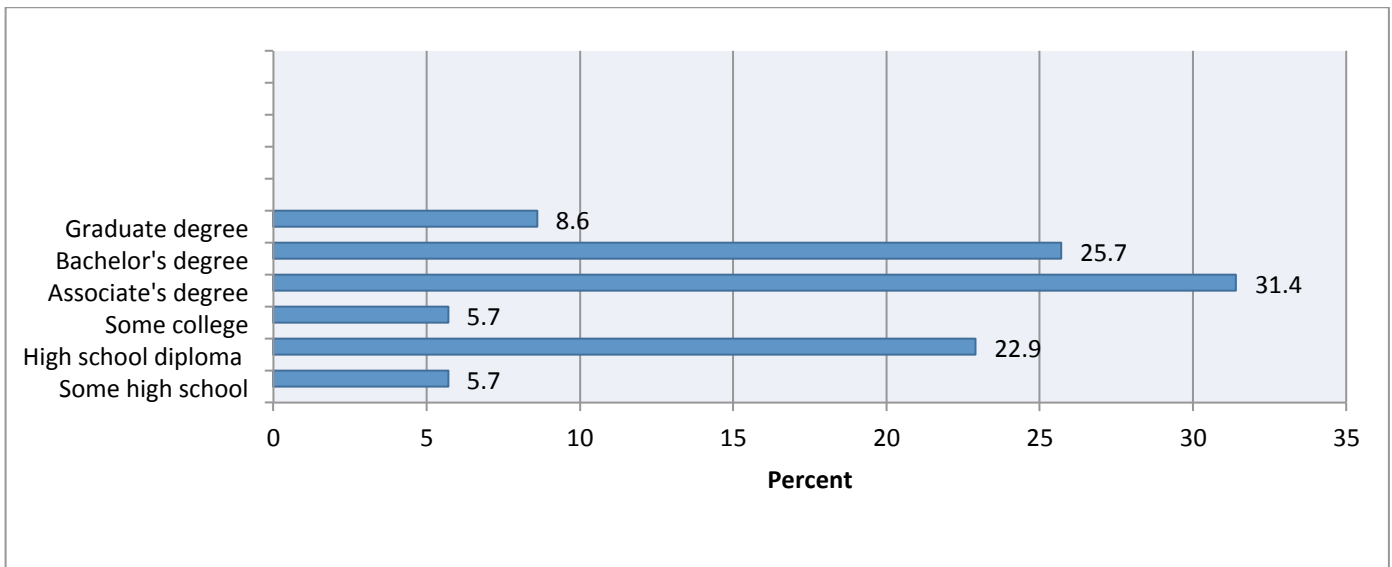
Figure 26. Respondents' gender distribution
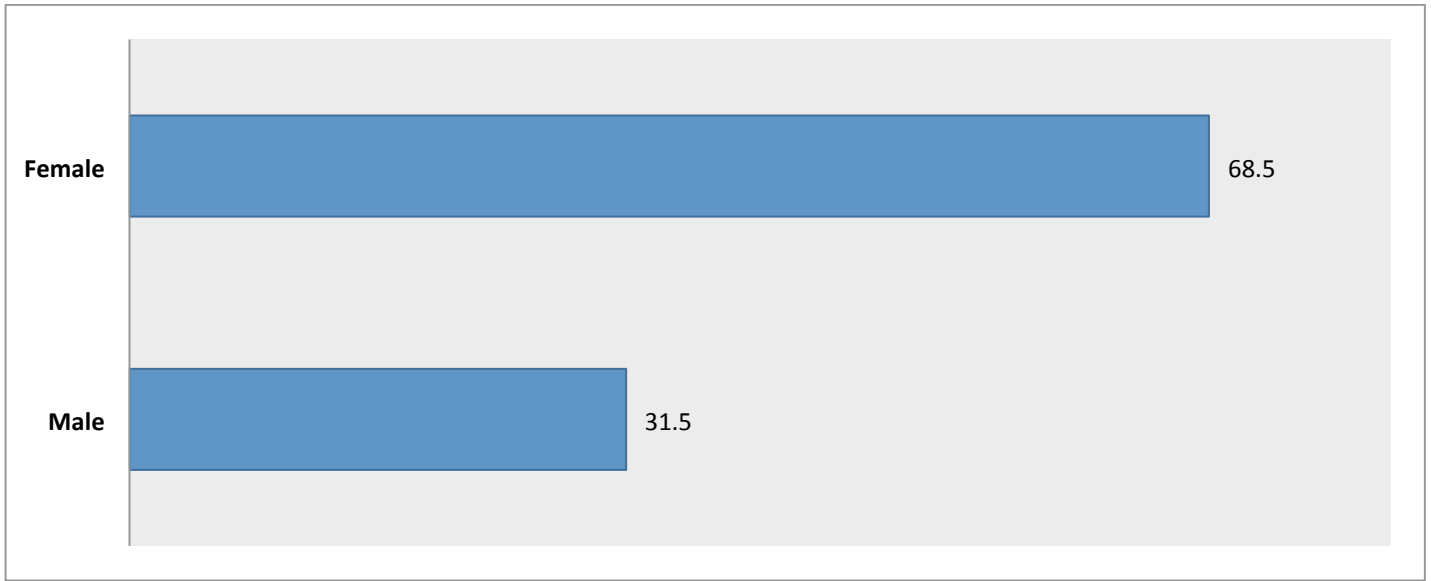
Secondary Research

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.

HEALTH OUTCOMES

The Mortality health outcomes indicate that Minnesota as a state has fewer premature deaths than the national benchmark. Traverse County, Minnesota results are unavailable for the indicator due to the sample size.

Map 1 in Appendix provides a county view of the premature deaths within the five-state region.

Mortality

		National Benchmark	Minnesota	Traverse County
Premature death	Years of potential life lost before age 75 per 100,000 (age adjusted), 2005-2007	–	–	–

The Morbidity health outcomes indicate that North Dakota and Minnesota citizens report more days of poor health than the national benchmark. Minnesota reports more physically unhealthy days than the national benchmark. Traverse County is unavailable for the indicator due to the sample size for physically unhealthy days.

Minnesota reports more mentally unhealthy days than the national benchmark. Traverse County is unavailable for the indicator due to the sample size for mentally unhealthy days.

Minnesota has higher percentages of low birth weight. Traverse County is unavailable for the indicator due to the sample size for low birth weight.

Maps 2-5 in the Appendix provide county views of the Morbidity indicator within the five-state region.

Morbidity

		National Benchmark	Minnesota	Traverse County
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted) 2003-2009	10%	12%	_
Poor physical health days	Average number of physical unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.6	2.7	_
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.3	2.5	_
Low birth weight	Percent of live births with low birth weight grams (<2,500 grams), 2001-2007)	6.0%	6.4%	_

HEALTH FACTORS

The Health Behavior outcomes indicate that Minnesota has higher percentages of adult smokers than the national benchmark. Adult obesity is also higher in Minnesota. Traverse County has a higher percentage than the state of Minnesota and the national benchmark.

Minnesota has a lower percentage of adults reporting no leisure time physical activity compared to the national benchmark. Traverse County exceeds the national benchmark of percentage of adults reporting no leisure time.

Minnesota has a higher percentage of binge drinking reports than the national benchmark. Traverse County is unavailable for the indicator due to the sample size for binge drinking.

The state of Minnesota is near the national benchmark for motor vehicle deaths. Traverse County is unavailable for the indicator due to the sample size for motor vehicle deaths.

Sexually transmitted infections rank substantially higher than the national benchmark for Minnesota but lower in Traverse County than the national benchmark. The teen birth rate is higher in Minnesota than the national benchmark. Traverse County is unavailable for the indicator due to the sample size for sexually transmitted infections.

Maps 6-12 in the Appendix provide county views of the Health Behavior indicators within the five-state region.

Health Behaviors

		National Benchmark	Minnesota	Traverse County
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	25%	26%	27%
Physical Inactivity	Percent of adults reporting no leisure physical activity, 2008	20%	17%	22%
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	8%	20%	
Motor vehicle crash Death rate	Motor vehicle crash death 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	83.0	276.1	54.6
Teen birth rate	Number of teen birth per 100,000 females ages 15-19, 2001-2007	22.0	27.5	_

The Clinical Care outcomes indicate that Minnesota has a lower percentage of uninsured adults than the national benchmark. Traverse County has a higher percentage of uninsured adults than the national benchmark. Minnesota has a lower percentage of uninsured youth than the national benchmark, but Traverse County has a higher percentage.

The ratio of population to primary care physicians is higher in Minnesota than the national benchmark.

The ratio of total population to mental health providers is higher in Traverse County than the national benchmark. Minnesota as a whole is lower than the national benchmark.

The number of professionally active dentists in Minnesota is lower than the national benchmark.

Preventable hospital stays are higher than the national benchmark in Minnesota, but is lower in Traverse County.

Diabetes screening in Minnesota is slightly lower than the national benchmark.

The rate of diabetes screening is higher in Traverse County than the national benchmark. Traverse County ranks high than the national benchmark for mammography screenings, while Minnesota is lightly under the national benchmark.

Maps 13-20 in the Appendix provide county views of the Clinical Care indicators within the five-state region.

Clinical Care

		National Benchmark	Minnesota	Traverse County
Uninsured Adults	Percent of adult population ages 18-64 without health insurance, 2007	13%	11%	17%
Uninsured Youth	Percent of youth ages 0-18 without health insurance.	7%	6%	10%
Primary Care Physicians	Ratio of total population to mental health providers, 2008	631:1	636:1	_
Mental Health Providers	Ratio of total population to mental health providers, 2008	2,242:1	1,306:1	3,602:0
Dentist Rate	Number of professionally active dentist per 100,000 population, 2007	69.0	61.0	0.0
Preventable Hospital Stays	Hospitalization discharges for ambulatory care-sensitive condition per 1,000 Medicare Enrollees, 2006-2007	52.0	56.5	49.7
Diabetes Screening	Percent of Medicare enrollees with diabetes that receive HbA1c screening, 2006-2007	89%	88%	94%
Mammography Screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	74%	73%	78%

The Social and Economic Factor outcomes indicate that Minnesota and Traverse County all have a lower high school graduation rates than the national benchmark.

The unemployment rate in 2009 was substantially higher than the national benchmark in Minnesota and Traverse County. The unemployment rate in 2012 was substantially better than the national benchmark for Minnesota.

The percentage of child poverty is the same in Minnesota as the national benchmark, and higher in Traverse County than the national benchmark.

Inadequate social support ranks the same in Minnesota as the national benchmark.

The percentage of children in single parent households is higher than the national benchmark in Minnesota and reports the same in Traverse County.

The number of homicide deaths in Minnesota is higher than the national benchmark.

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

Social and Economic Factors

		National Benchmark	**Minnesota**	**Traverse County**
High School Graduation	Percent of ninth-grade cohort in public schools that graduate from high school in four years 2006-2007	92%	87%	100%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	68%	72%	67%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work 2009, May 2012	5.3% 7.9%	8.0% 5.2%	7.1%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	11%	11%	16%
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	20%	25%	20%
Homicide rates	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	1.0	2.5	_

The Physical Environment outcomes indicate that there is no air pollution or ozone pollution in this area. Access to healthy food is ranked far below the national benchmark. In this rural area there can be a far distance to travel to grocery stores, and there are food deserts in some communities where only a gas station convenience store is close to home. Access to recreational facilities ranks lower than the national benchmark for Minnesota.

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

Physical Environment

		National Benchmark	**Minnesota**	**Traverse County**
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	92%	54%	50%
Access to recreational facilities	Number of recreational facilities per 100,000 population 2006	17.0	12.0	0.0

Youth account for 21% of the population in Traverse County. Elderly account for 28% of the population in Traverse County. One hundred percent (100%) of Traverse County is rural compared to 29% of Minnesota and 21% of the United States population.

Only 1% of Traverse County residents are not English proficient. Four percent (4%) of Minnesotans are not proficient in English compared 9% of the United States population as a whole.

Minnesota (at 6%) and Traverse County (at 8%) have low illiteracy rates compared to the United States as a whole (15%).

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

Demographics

		United States	Minnesota	Traverse County
Youth	Percent of total population ages - 0-17, 2009	24%	24%	21%
Elderly	Percent of total population ages 65 and older, 2009%	13%	13%	28%
Rural	Percent of total population living in a rural area, 2000	21%	21%	100%
Not English Proficient	Percent of total population that speaks English less than "very well", 2005-2009	9%	9%	1%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	15%	15%	8%

Traverse County is predominantly an elderly population with 26% of the population 65 years of age and older. Six percent (6%) of the population is 85 years of age or older.

The gender distribution is 50-50 in Traverse County and across the state of Minnesota.

Population by Age

	Minnesota	Traverse County
Total population	5,303,925	3558
Percent ages 65 and older	13%	26%
Percent 85 and older	2%	6%
Percent male	50%	50%
Percent female	50%	50%

The majority of individuals (81%) in Traverse County own their homes.

Housing

	Minnesota	Traverse County
Percent of occupied housing that is owner-occupied	73%	81%
Percent of occupied housing that is renter-occupied	27%	19%

Based on 2010 Census data

According to the 2010 Census Data, the population of working age in the labor force ranges from 69-77% in Minnesota. The percentage of those who are living at less than 100% of the Federal poverty level range between 11–13 % in Minnesota, with 26-30% at the less than 200% of the Federal poverty level.

The median household is highest in Minnesota at $57,243 annual income.

Economic Security

	Minnesota	Traverse County
Percent of working age population in the labor force	71%	61%
Percent of total population with income less than 100% of poverty	11%	9%
Percent of total population with income less than 200% of poverty	26%	32%
Median household income	$57,243	$41,287
Owner occupied housing units	1,548,127	1,314
Percent spending 30% or more income toward housing costs	28%	18%
Renter occupied housing units	537,790	322
Percent renters spending 30% or more of income toward housing costs	46%	35%

The population distribution from the 2010 U.S. Census Summary by race demonstrates that Minnesota is predominantly white. Traverse County is also predominantly white. American Indians rank second in Traverse County with 139 persons.

Diversity Profile

	Minnesota	Traverse County
Total population	5,303,925	3,558
White alone	4,524,062	3,352
Asian alone	214,234	4
Black alone	274,412	13
Hispanic origin - of any race	250,258	50
American Indian	60,916	139

Health Needs Identified

The identified needs were identified from the surveys and analysis of secondary data:
- Access to Health Care
- Aging / Baby Boomers
- Children and Youth
- Economic Issues
- Environment
- Mental Health
- Physical Health/Obesity
- Safety
- Substance Use and Abuse

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.

Table 1 in the Appendix displays 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:
- Transportation
- Mental health and care coordination for mental health services
- Recruitment of physician

The Wheaton Community Health Needs Assessment Collaborative is establishing key initiative strategies to address all three of the above listed concerns. Leadership from Sanford Health will serve on all three key initiative groups.

Sanford Medical Center Wheaton will specifically address transportation and mental health and execute the implementation strategy.

The Prioritization Worksheet (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
Wheaton Implementation Strategy

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

- Transportation
- Mental Health Services
- Recruitment of Physician

Implementation Strategy: Transportation

- Identify series currently available within the community
- Develop directory with resources and outsource information
- Increase volunteer driver program and work with law enforcement and Social Services for Mental Health transport

Implementation Strategy: Mental Health Services

- Define services currently available
- Develop directory of resources and information
- Distribute directory to various groups and entities

Implementation Strategy: Recruitment of Physician

- Employ another full-time Family Practice Physician

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
  - Develop CME curriculum for providers and interdisciplinary teams across the enterprise inclusive of medical, nutrition, nursing, and Behavioral Health professionals
- Develop community education programming
  - 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

Traverse County

Minnesota

HEALTH OUTCOMES		Traverse	*National Benchmark	Minnesota
Mortality				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	-	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	-	2.6	3.1
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	-	2.3	2.8
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	-	6.0%	6.5%

HEALTH FACTORS

		Traverse	*National Benchmark	Minnesota
Health Behaviors				
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	27%	25%	26%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	22%	20%	17%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking**, 2003-2009	-	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	54.6	83.0	276.1
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	-	22.0	27.5
Clinical Care				
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	17%	13%	11%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	10%	7%	6%
Primary care physicians	Ratio of total population to primary care physicians, 2008	-	631:1	636:1
Mental health providers	Ratio of total population to mental health providers, 2008	3,602:0	2,242:1	1,306:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	0.0	69.0	61.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	49.7	52.0	56.5
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	94%	89%	88%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	78%	74%	73%

HEALTH FACTORS (continued)		**Traverse**	***National Benchmark***	**Minnesota**

Social and Economic Factors

		Traverse	National Benchmark	Minnesota
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007	100%	92%	87%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	67%	68%	72%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	7.1%	5.3%	8.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	16%	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	20%	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

		Traverse	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	50%	92%	54%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	0.0	17.0	12.0

Demographics

		Traverse	**United States**	**Minnesota**
Youth	Percent of total population ages 0-17, 2009	21%	24%	24%
Elderly	Percent of total population ages 65 and older, 2009	28%	13%	13%
Rural	Percent of total population living in a rural area, 2000	100%	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	8%	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

Traverse County

Minnesota

CHARACTERISTICS	Total	AGE Less than 65 Years	AGE Ages 65 and Older
Population [1]			
Total population	3,558	2,621	937
Percent ages 65 and older	26%	-	100%
Percent ages 85 and older	6%	-	23%
Percent male	50%	52%	43%
Percent female	50%	48%	57%
Living Arrangements			
Total households (by age of householder) [1]	1,524	935	589
Percent with family households (i.e., at least two people who are related)	64%	73%	49%
Percent with householder living alone	33%	23%	49%
Grandparents living with their grandchildren* [2]	47	32	15
Percent who are responsible for their grandchildren	79%	88%	60%
Housing [1]			
Percent of occupied housing that is owner-occupied	81%	81%	81%
Percent of occupied housing that is renter-occupied	19%	19%	19%
Economic Security [2]			
Percent of working-age population in labor force	61%	82%	17%
Percent of total population with income less than 100% of poverty	9%	10%	7%
Percent of total population with income less than 200% of poverty	32%	31%	35%
Median household income (by age of householder)	$41,287	$42,427	$27,042
Owner-occupied housing units (by age of householder)	1,314	823	491
Percent spending 30% or more of income toward housing costs	18%	17%	20%
Renter-occupied housing units (by age of householder)	322	238	84
Percent spending 30% or more of income toward housing costs	35%	36%	32%

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

Traverse County

Minnesota

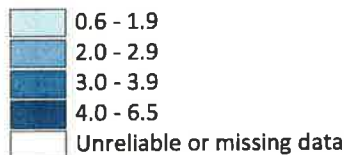| CHARACTERISTICS	Total	RACE White alone	RACE Black alone	RACE American Indian alone	RACE Asian alone	ETHNICITY Hispanic Origin - of any race
Population [1]						
Total population	3,558	3,352	13	139	4	50
Percent ages 0 to 17	22%	21%	23%	37%	25%	44%
Percent ages 18 to 44	24%	23%	54%	41%	25%	38%
Percent ages 45 to 64	28%	28%	23%	17%	25%	16%
Percent ages 65 and older	26%	28%	0%	6%	25%	2%
Median age (in years)	47.6	49.1	24.5	24.9	33.5	20.0
Living Arrangements						
Total households [1]	1,524	1,468	3	39	1	12
Percent with householder living alone	33%	33%	33%	23%	0%	33%
Percent with families with children ages 0 to 17	23%	23%	33%	44%	0%	42%
Grandparents living with their grandchildren [2]	47	25	0	22	0	0
Percent who are responsible for grandchildren	79%	60%	-	100%	-	-
Housing [1]						
Percent occupied housing that is owner-occupied	81%	83%	33%	38%	100%	25%
Percent occupied housing that is renter-occupied	19%	17%	67%	62%	0%	75%
Educational Attainment [2]						
Percent of persons ages 25 and older with high school degree or higher	88%	89%	-	79%	-	60%
Percent of persons ages 25 and older with Bachelor's degree or higher	15%	15%	-	0%	-	40%
Economic Security [2]						
Unemployment rate	3%	3%	-	0%	-	18%
Median household income	$41,287	$41,691	-	$33,750	-	$153,274
Percent of households with income <$25,000	30%	30%	-	38%	-	28%
Percent of persons with income <100% poverty	9%	8%	-	41%	0%	0%
Percent of children ages 0 to 17 in families with income <100% poverty	9%	5%	-	46%	-	0%
Percent of elderly ages 65 and older with income <100% poverty	7%	7%	-	-	-	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.

Map 1

Premature Death - A health outcome measure focusing on mortality

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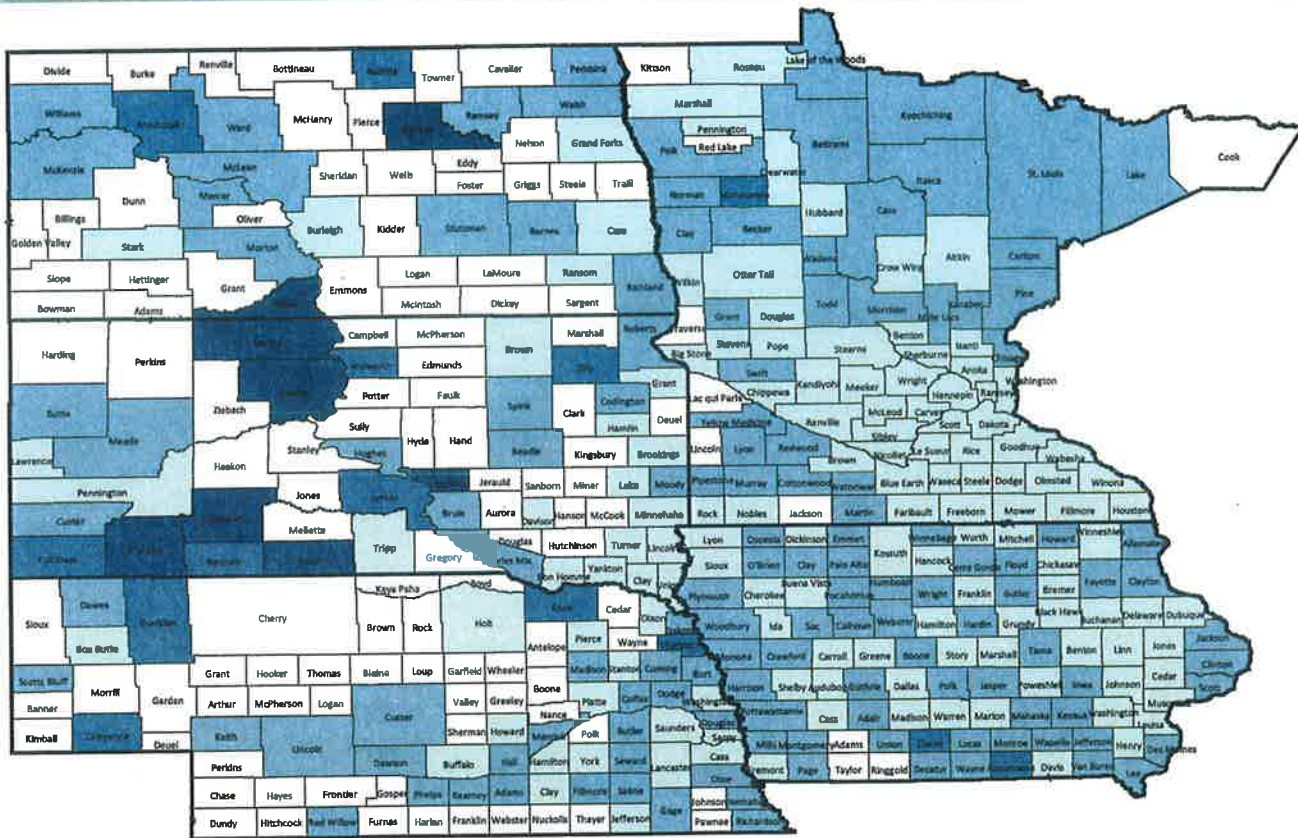
Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007

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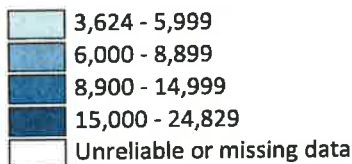
CONTEXT

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/.
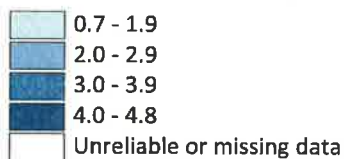
Map 2

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
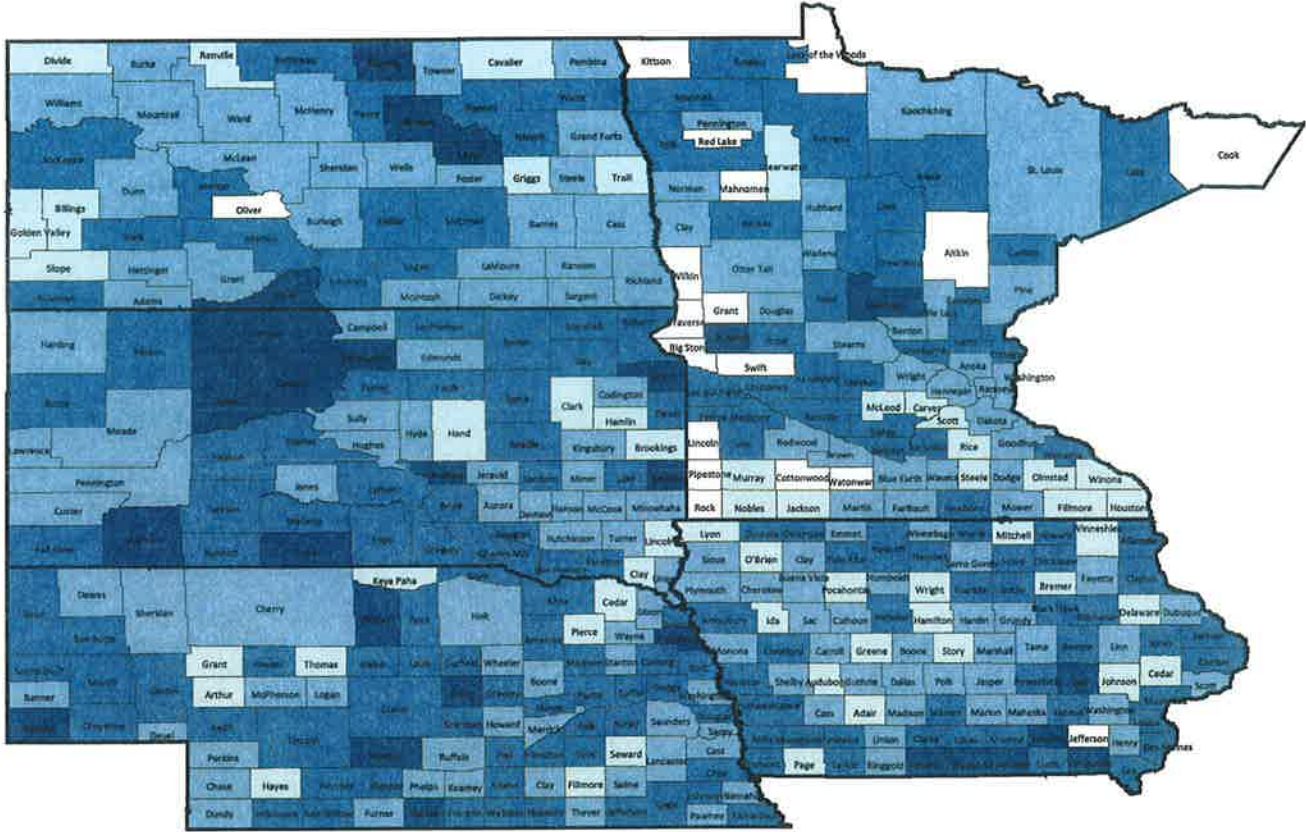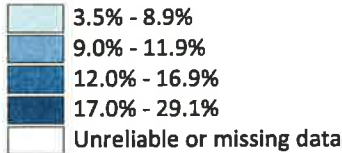
CONTEXT

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.
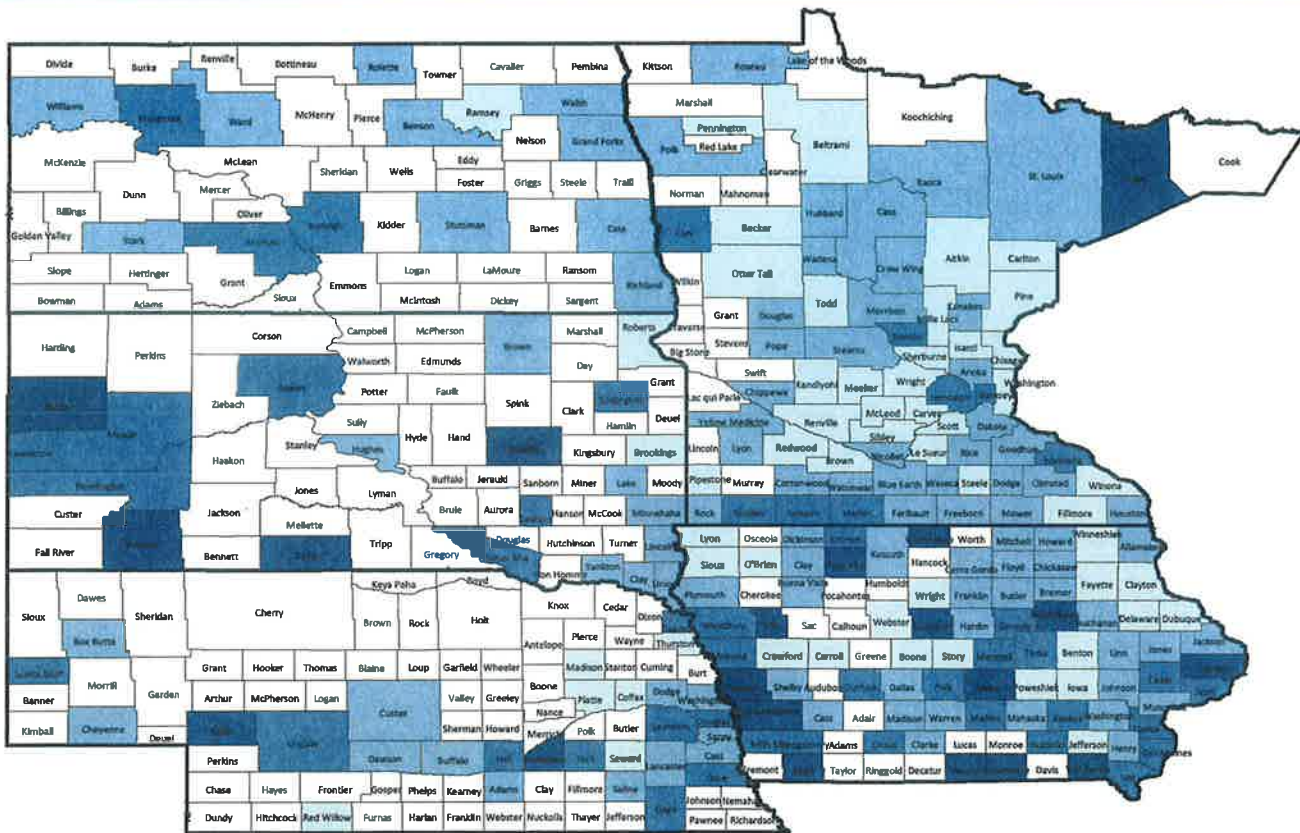
Where It Comes From: This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized 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/.

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/.

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 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 househol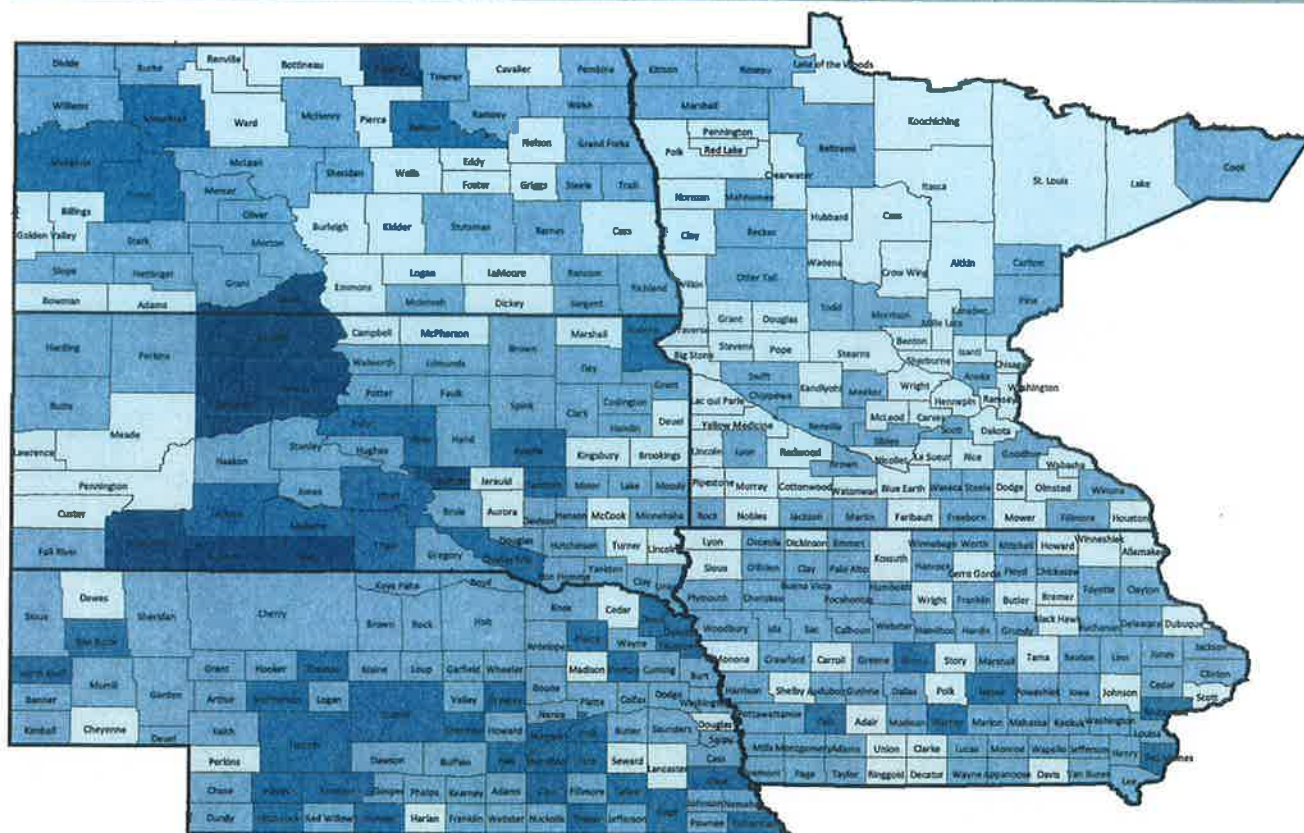ds with a land-line telephone. NCHS used seven years of data to generate more stable estimates of poor mental health days.

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/.

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
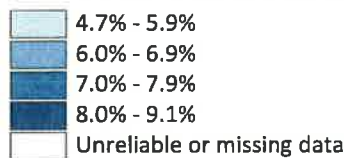
CONTEXT

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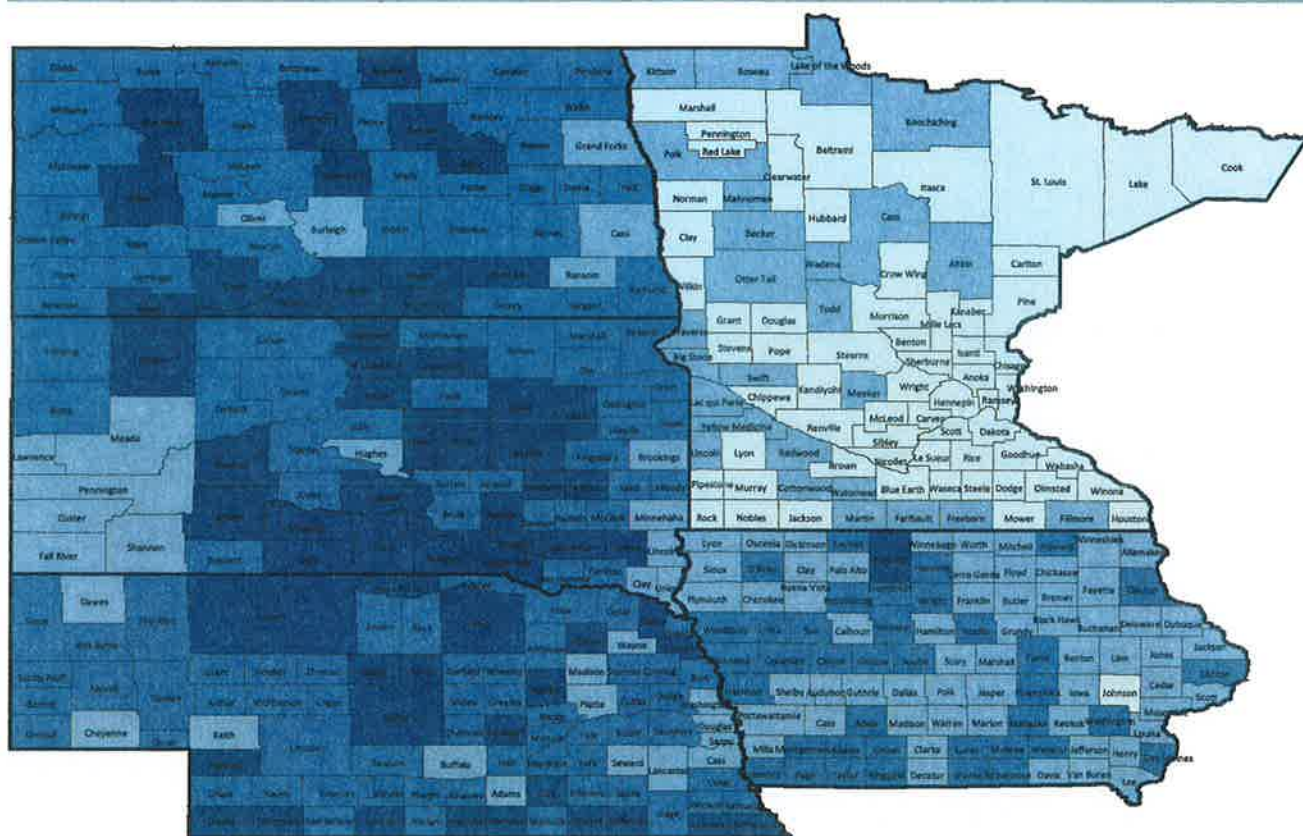
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

Map 6

# Adult Smoking - A health factor measure focusing on health behaviors

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
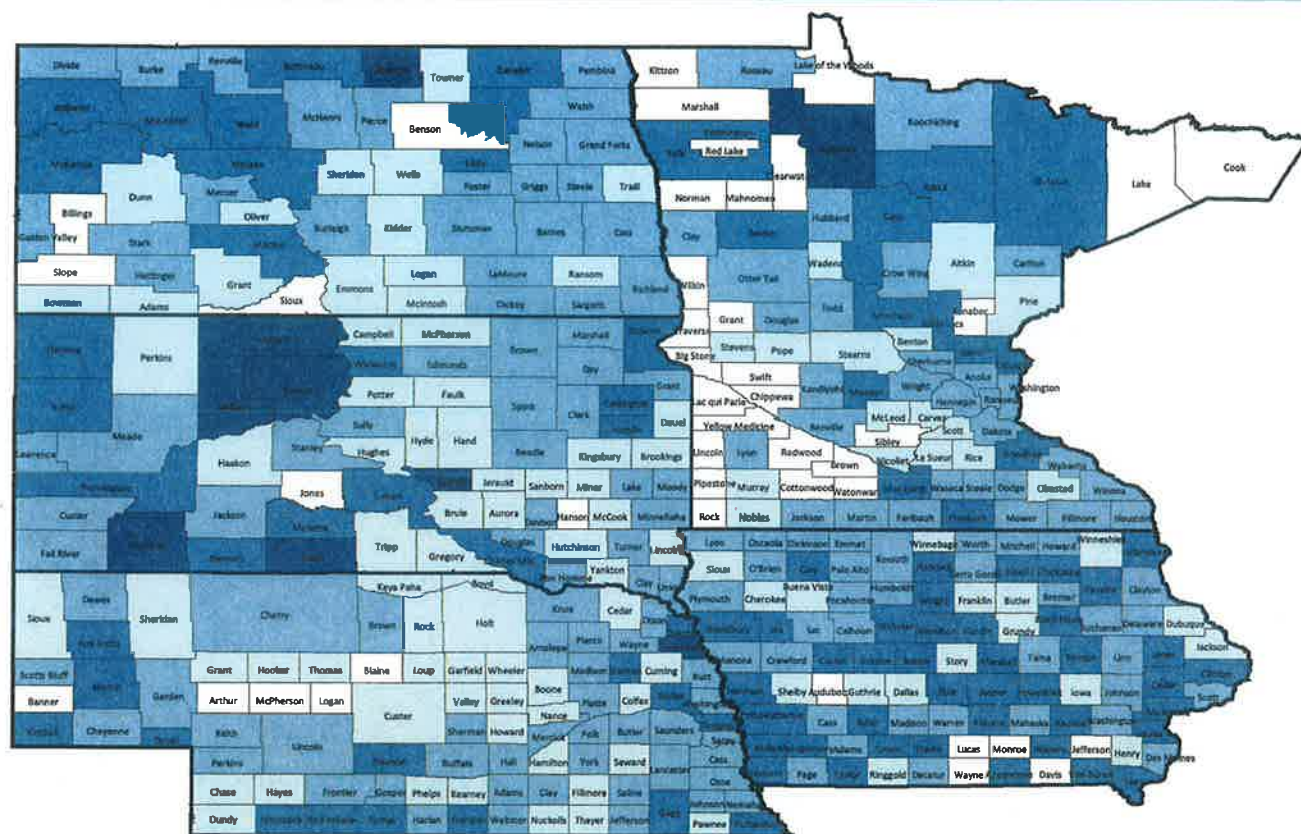
Percent of adults that currently smoke and have smoked at least 100 cigarettes in lifetime, 2003-2009

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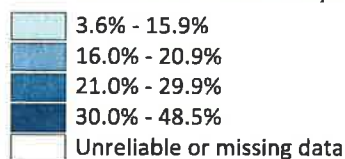
CONTEXT

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.
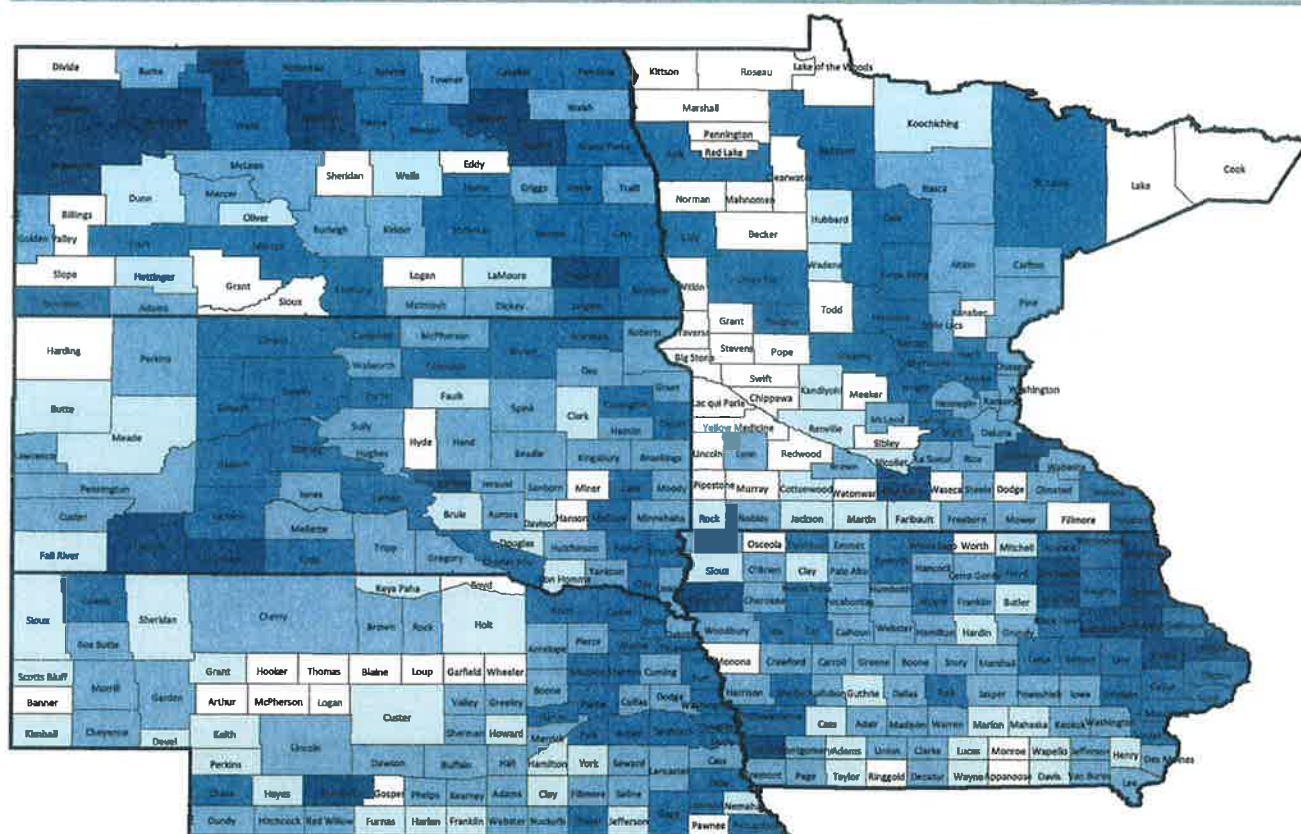
Importance: Each year approximately 443,000 premature deaths occur in the U.S. primarily due to smoking. Cigarette smoking is identified as a cause in multiple diseases including various cancers, cardiovascular disease, respiratory conditions, low birthweight, and other adverse health outcomes. Measuring 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%
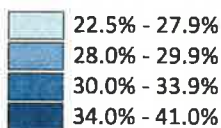
CONTEXT

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/.

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 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%
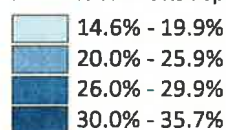
CONTEXT

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/.

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 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
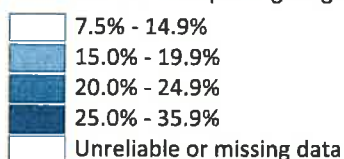
CONTEXT

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/.

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
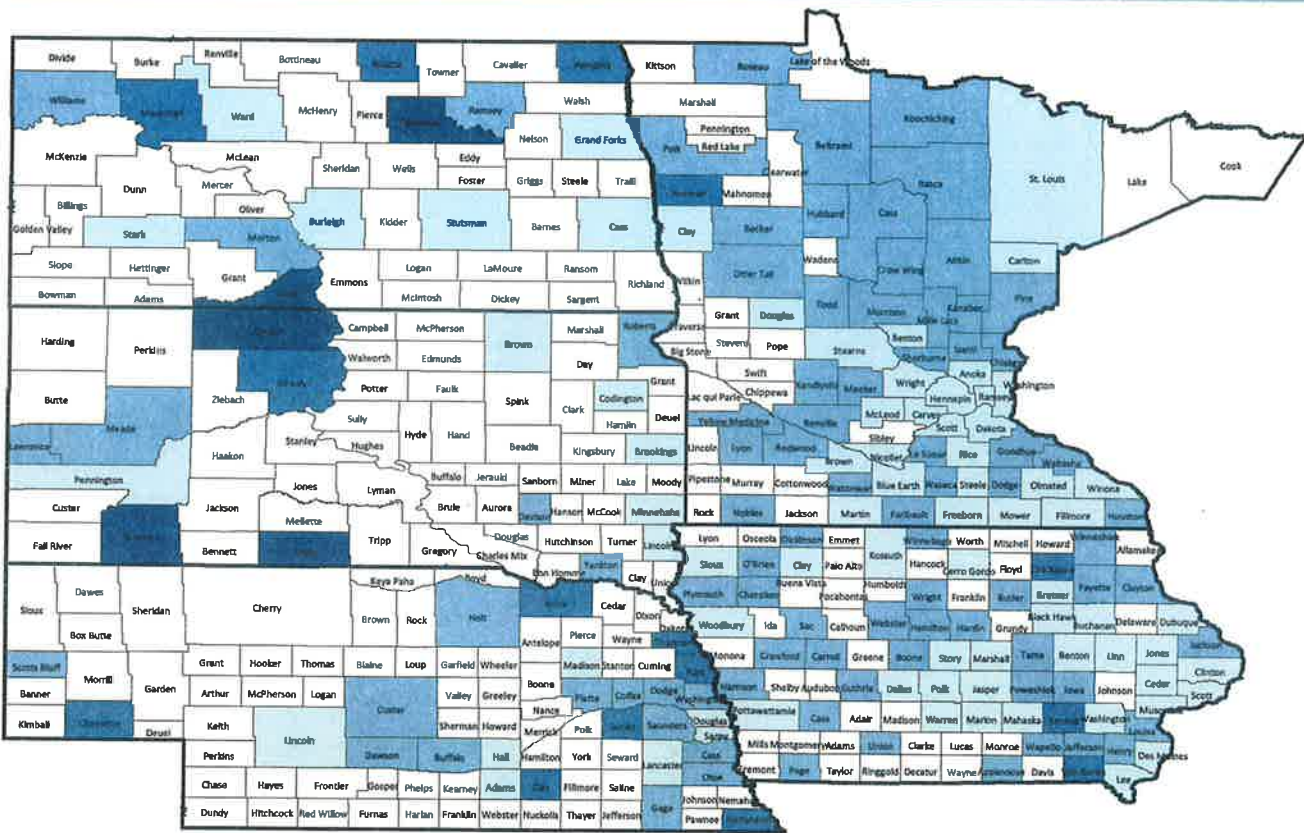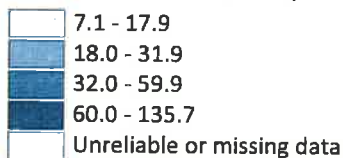
CONTEXT

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
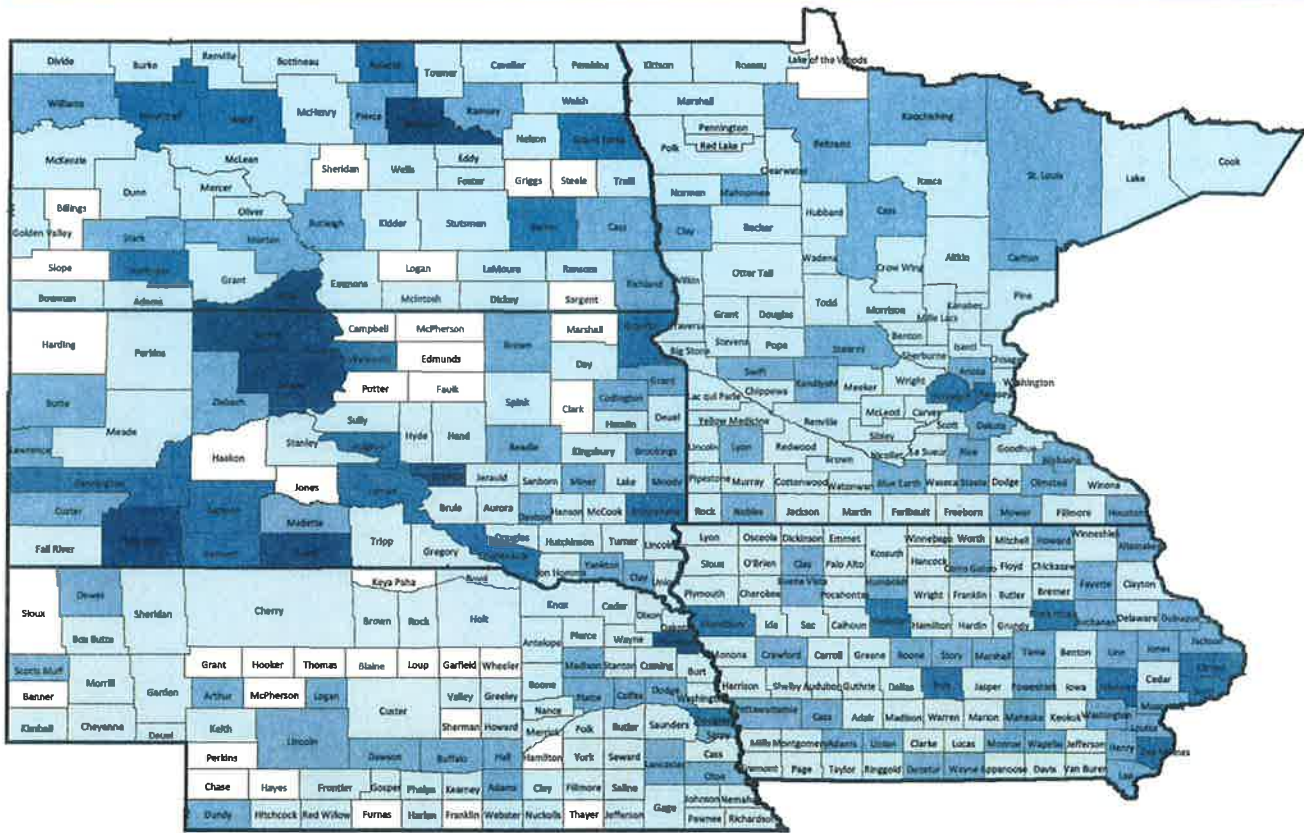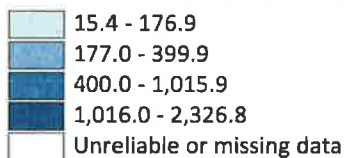
CONTEXT

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/.

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
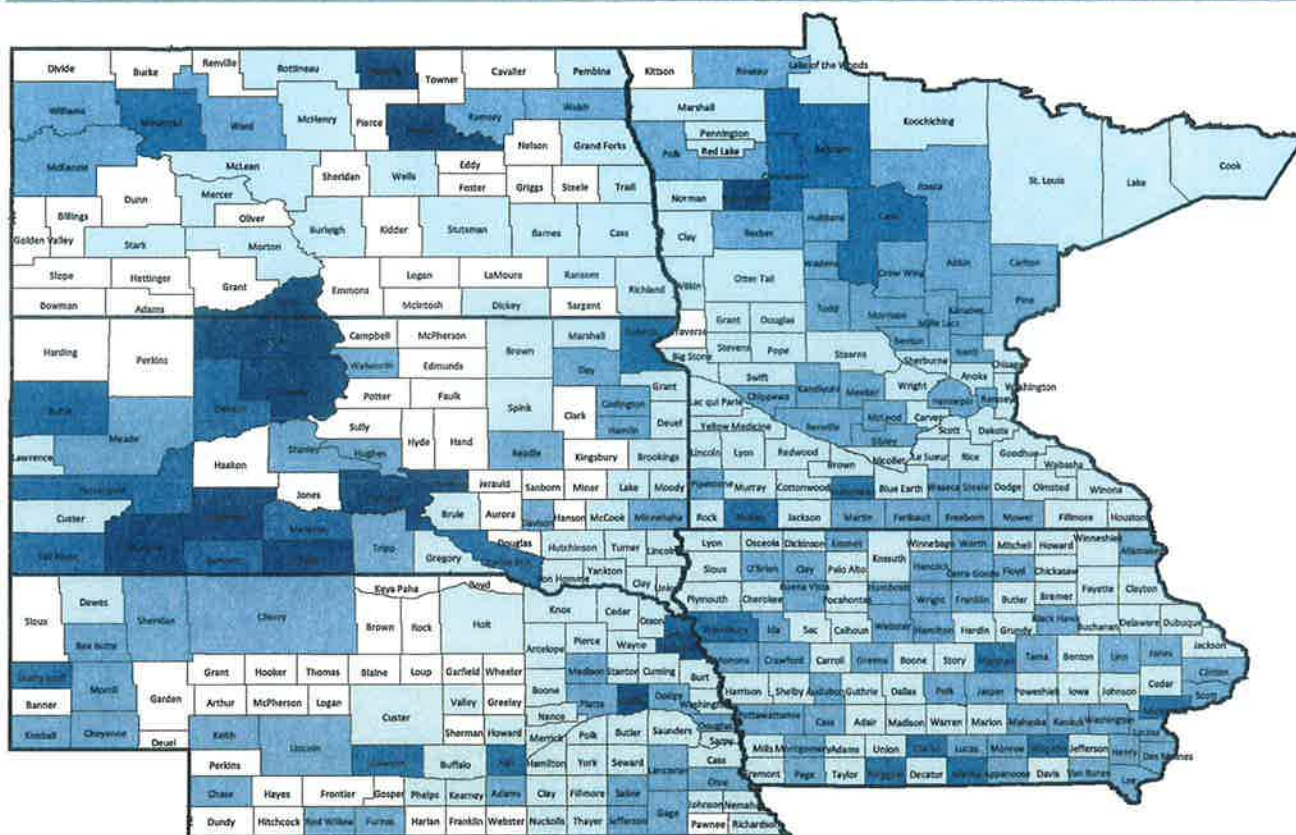
Number of teen births per 1,000 females ages 15 through 19, 2001-1007

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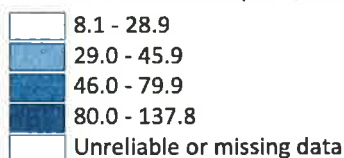
CONTEXT

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
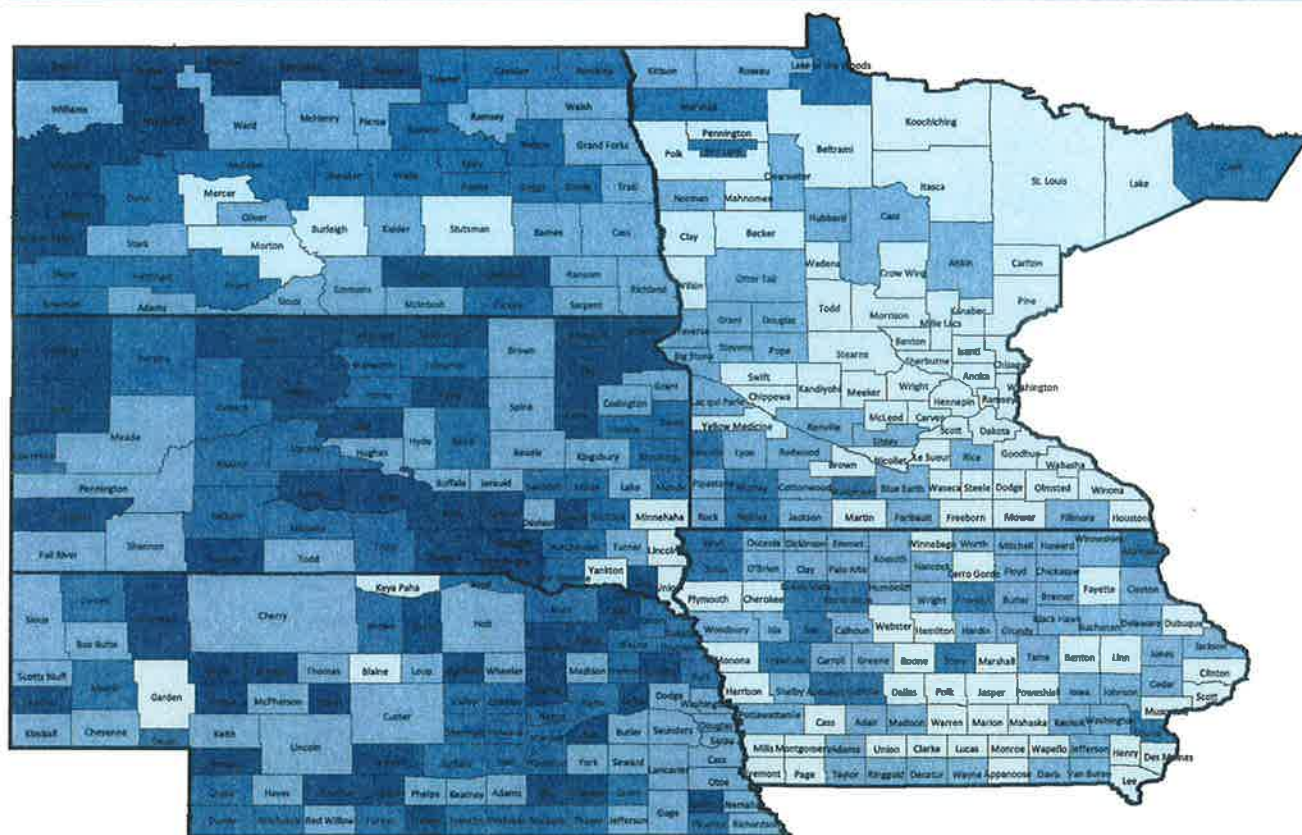
Percent of adult population ages 18 through 64 without health insurance, 2007

- 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/.

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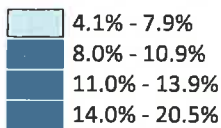
Uninsured Youth - A health factor measure focusing on clinical care
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Map 14
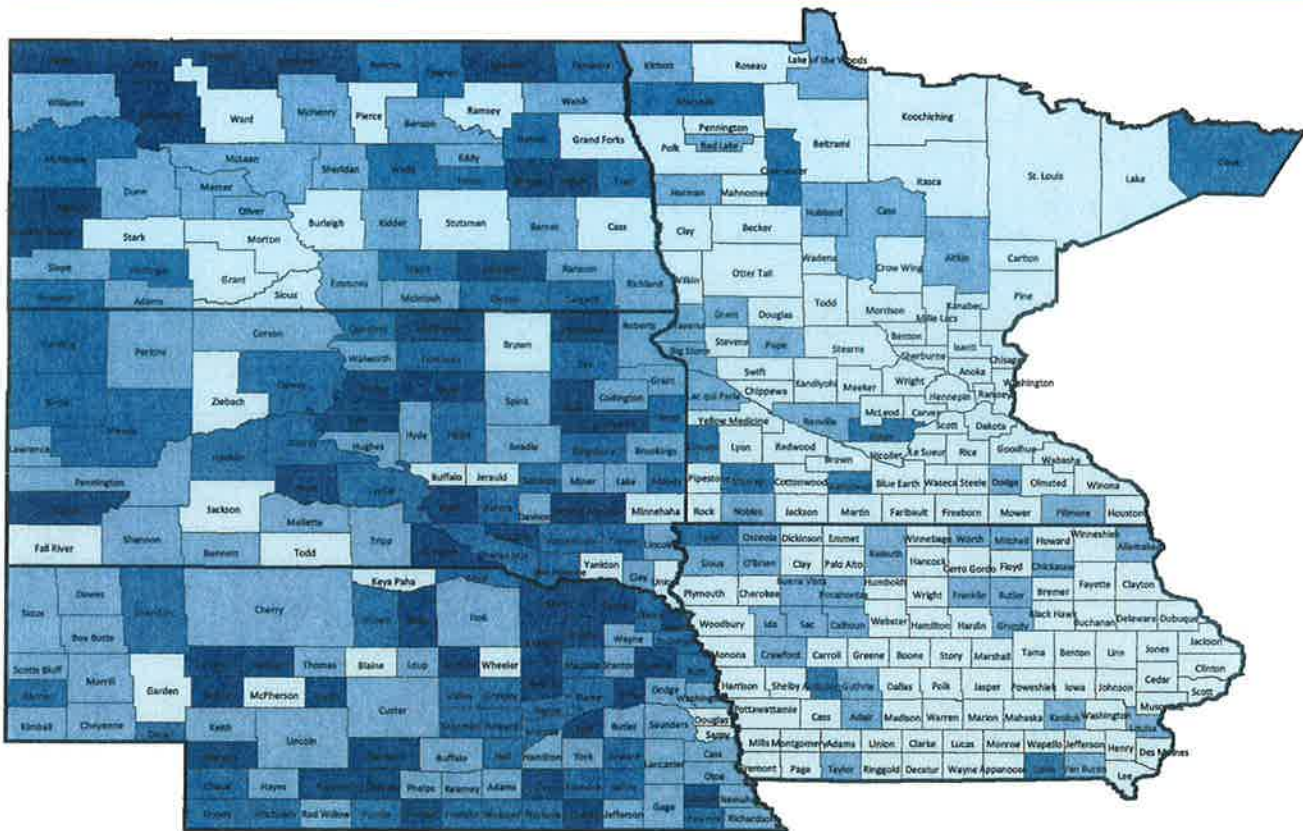
Percent of youth ages 0 through 18 without health insurance, 2007

- 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
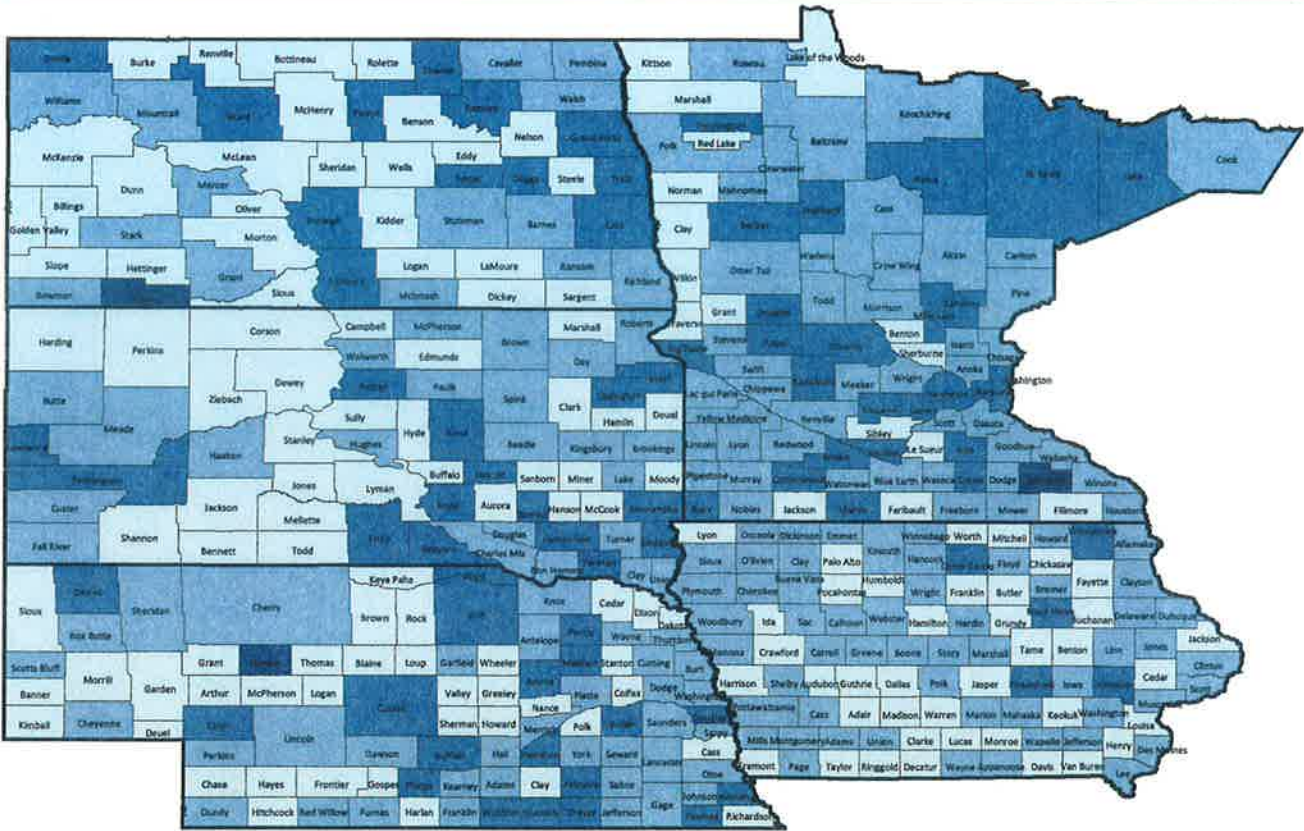
Number of primary care physicians per 100,000 population, 2008

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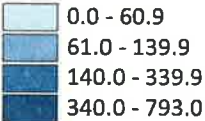
CONTEXT

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/.

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
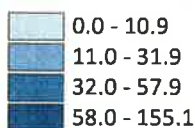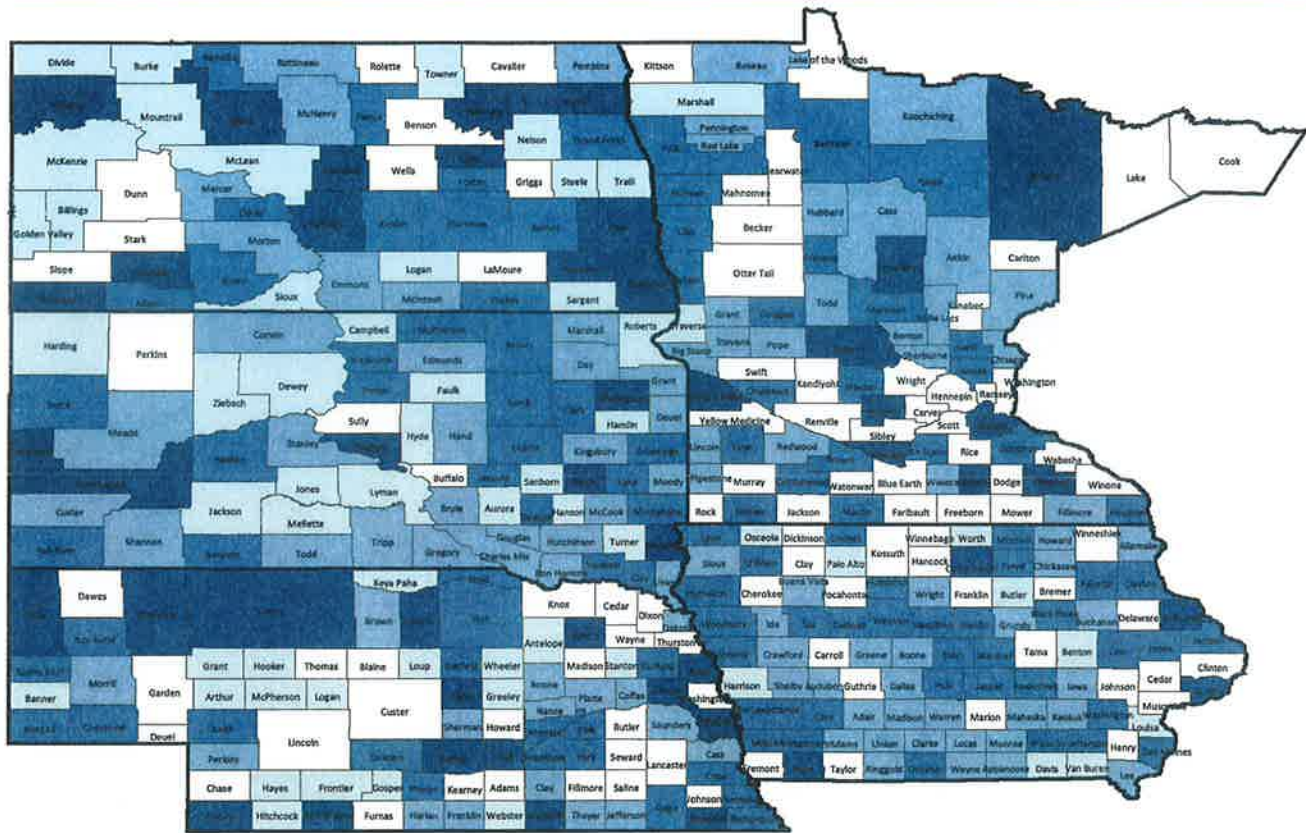
Map 16

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
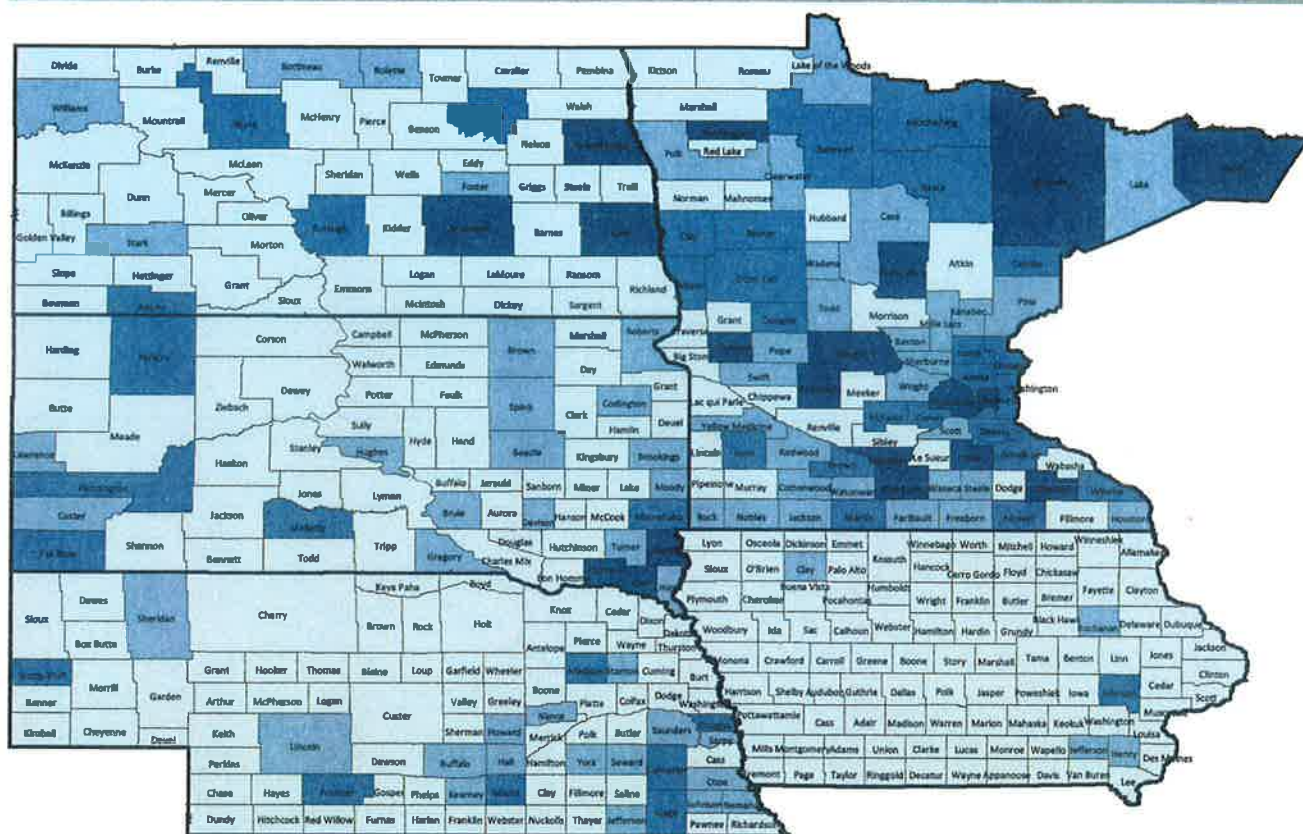
CONTEXT

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/.

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 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
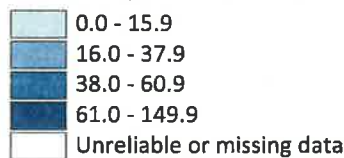
CONTEXT

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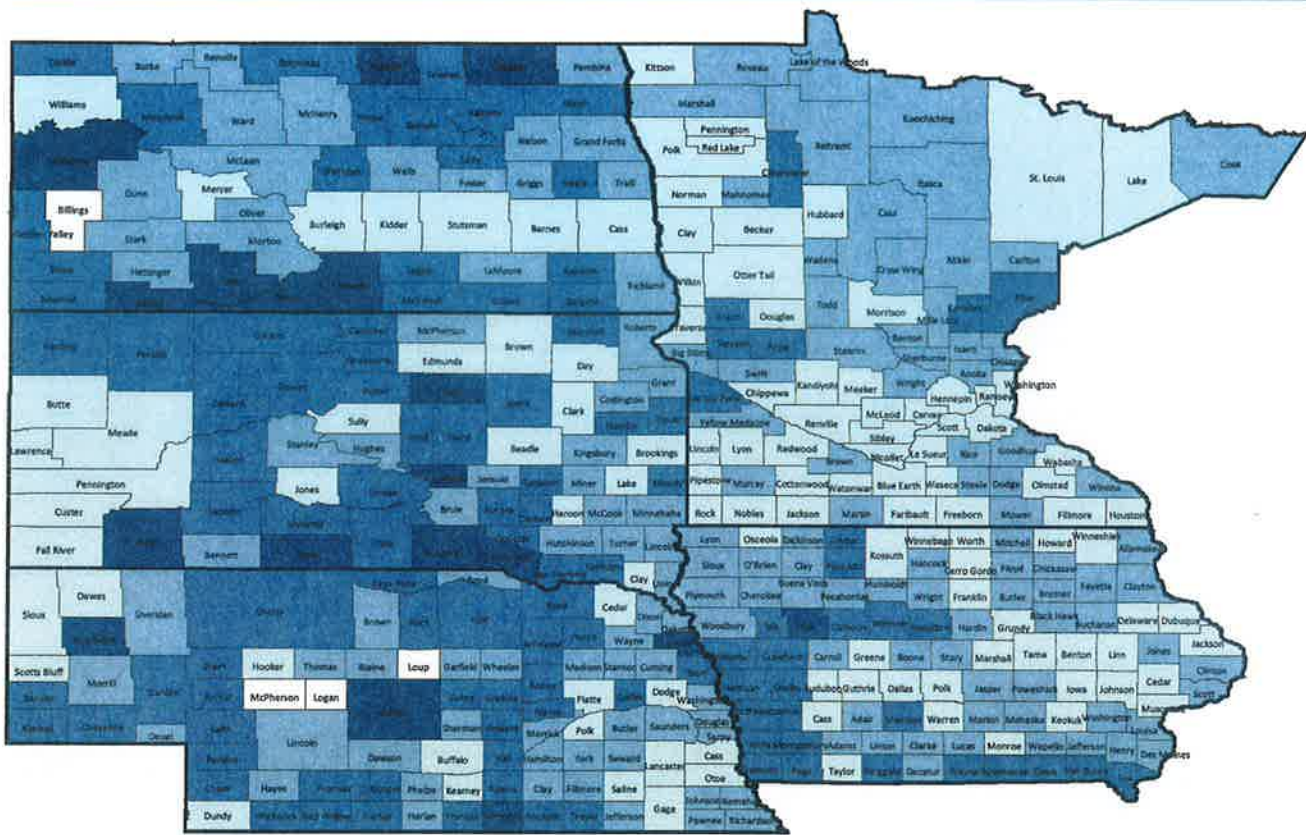
Importance: Today, thanks to fluoride, healthier lifestyles and quality dental care, more people than ever before are keeping their natural teeth throughout their lifetime. Yet for those who live in areas where a dentist is not available or those who cannot afford treatment, getting dental care can be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

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 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
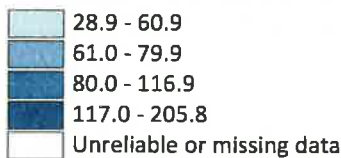
CONTEXT

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/.
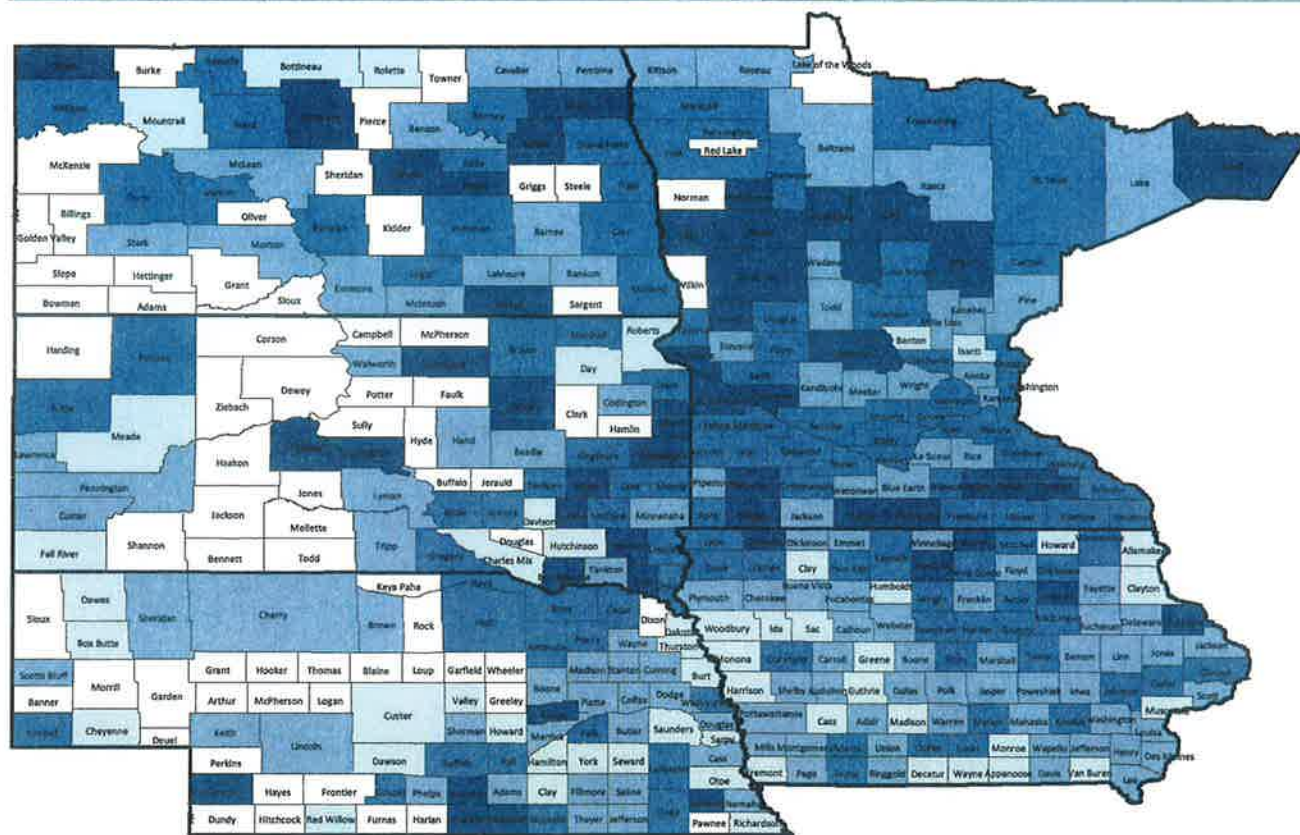
Disclaimer: The data displayed are from the source indicated; we do not vouch for the accuracy of the data or ensure they are the most recent available. The information is intended for personal, non-commercial use. It can be shared freely if it is not used for profit and appropriate acknowledgments are 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 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
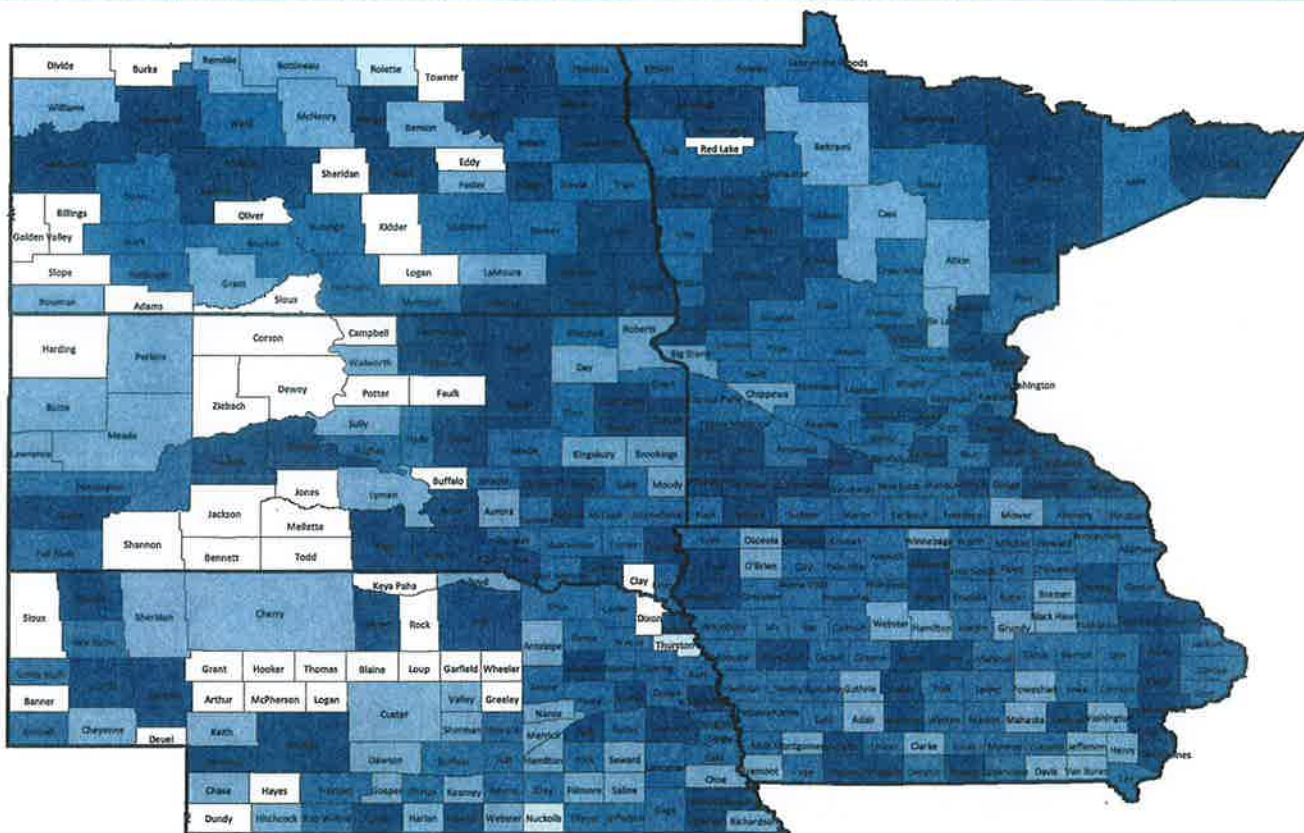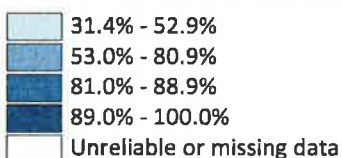
CONTEXT

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/.

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 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/.

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

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/.

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 22

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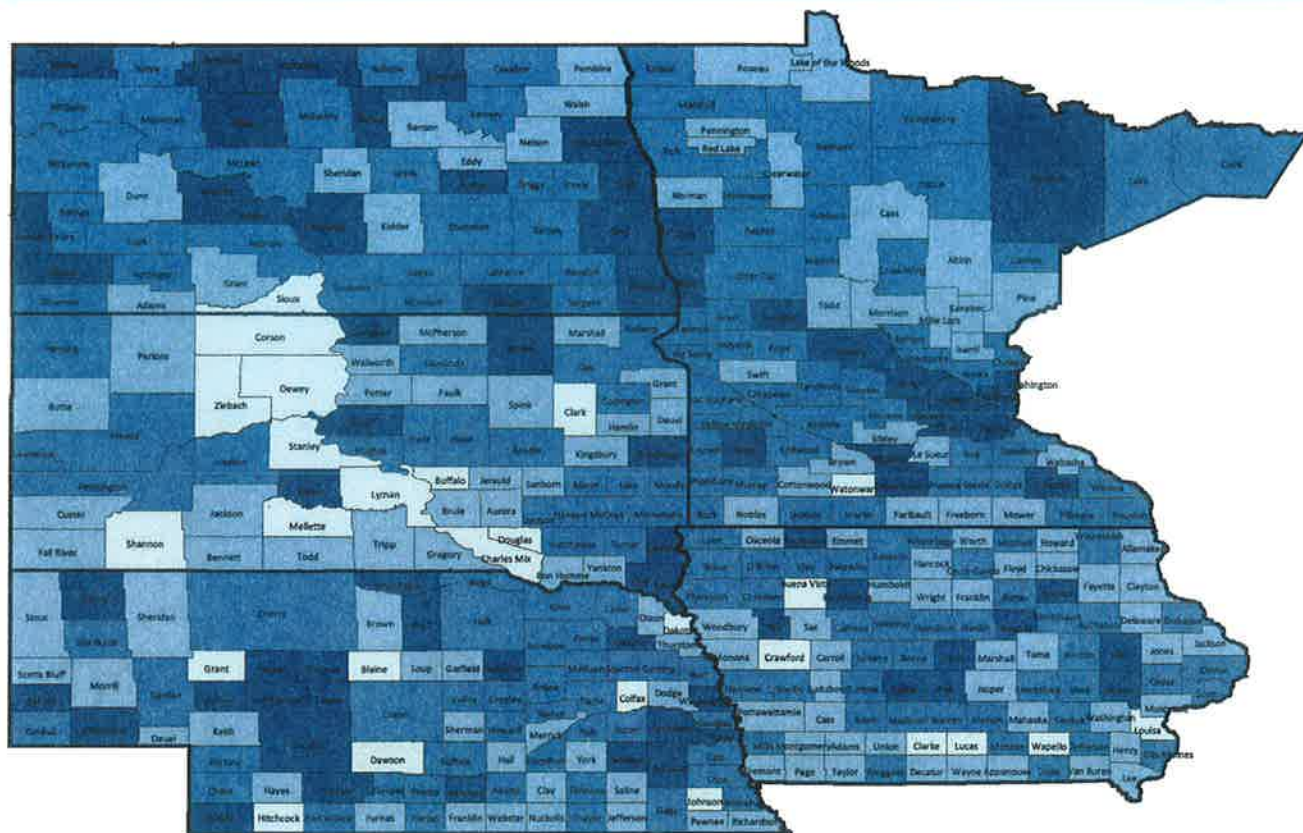
Percent of adults ages 25 through 44 with some post-secondary education, 2005-2009
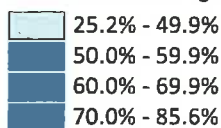
- 25.2% - 49.9%
- 50.0% - 59.9%
- 60.0% - 69.9%
- 70.0% - 85.6%

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/.

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 23

Unemployment - A health factor measure focusing on labor

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
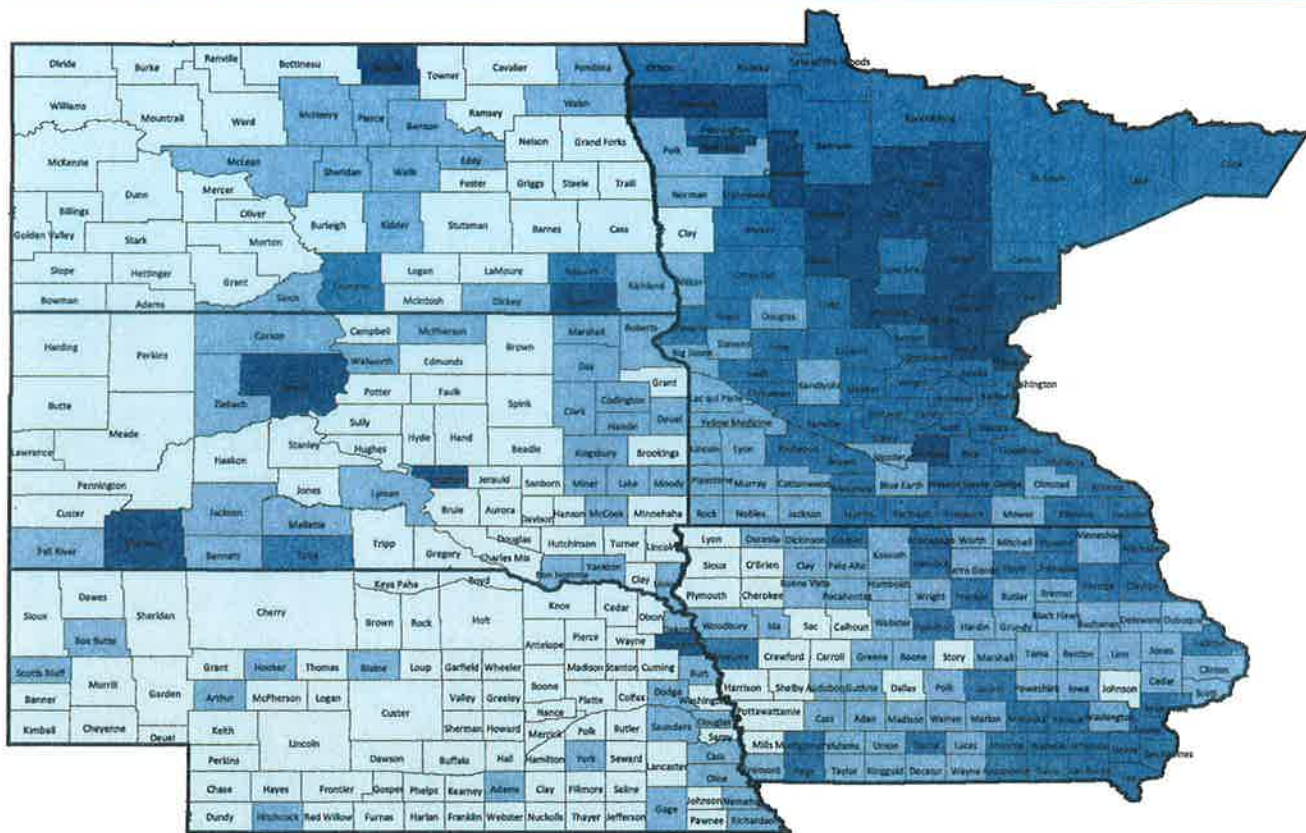
Percent of population ages 16 and older that is unemployed but seeking work, 2009

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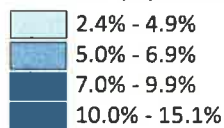
CONTEXT

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/.

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
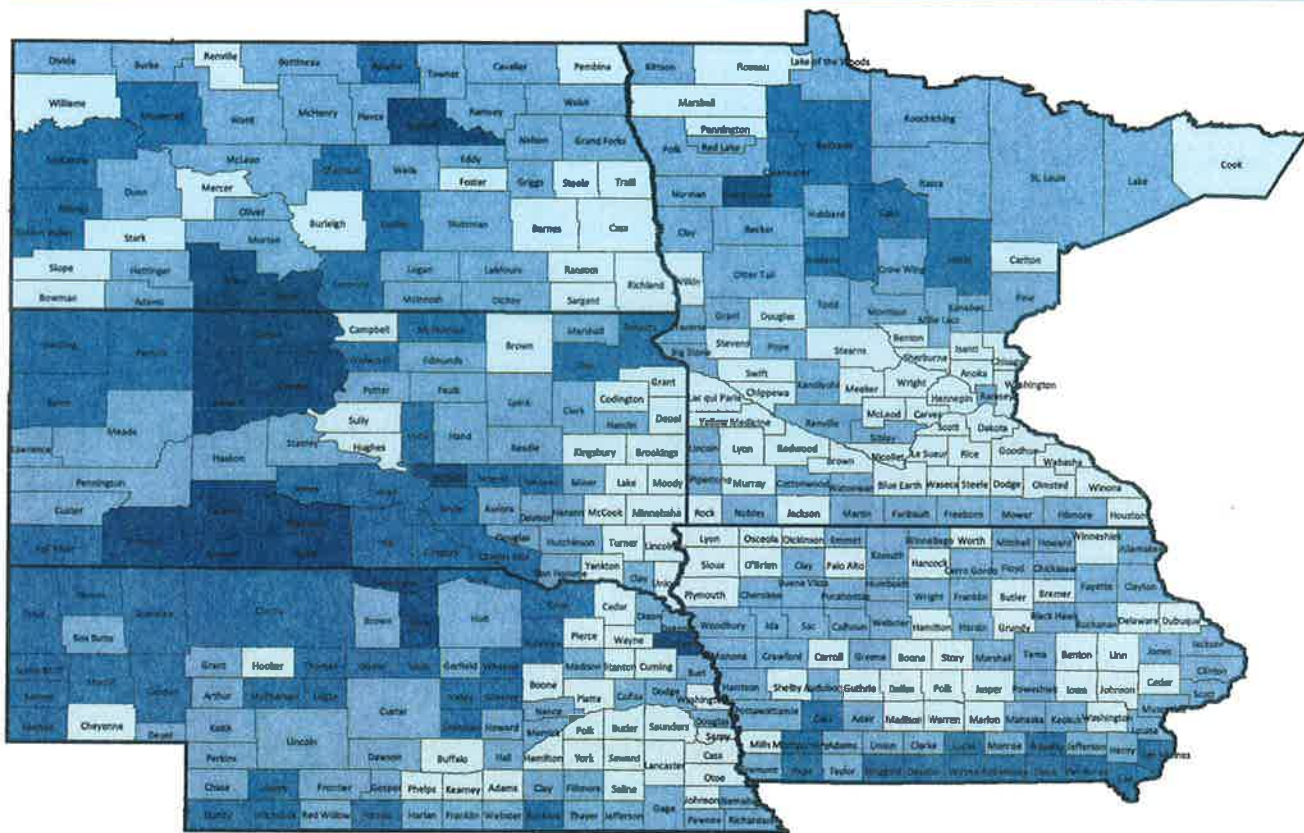
Percent of children ages 0 through 17 living below the Federal Poverty Line, 2008

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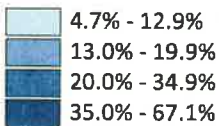
CONTEXT

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/.

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 25

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

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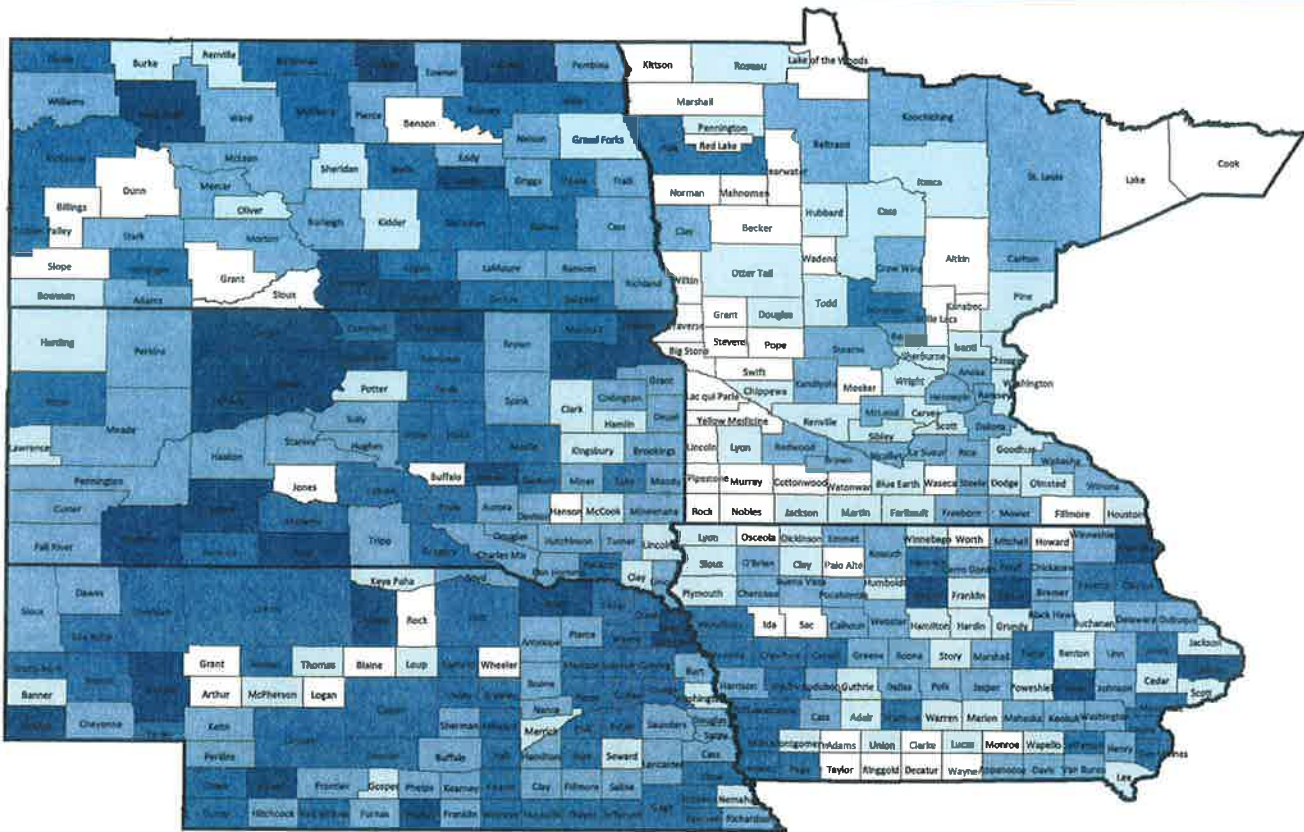
Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009

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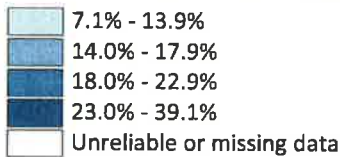
CONTEXT

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
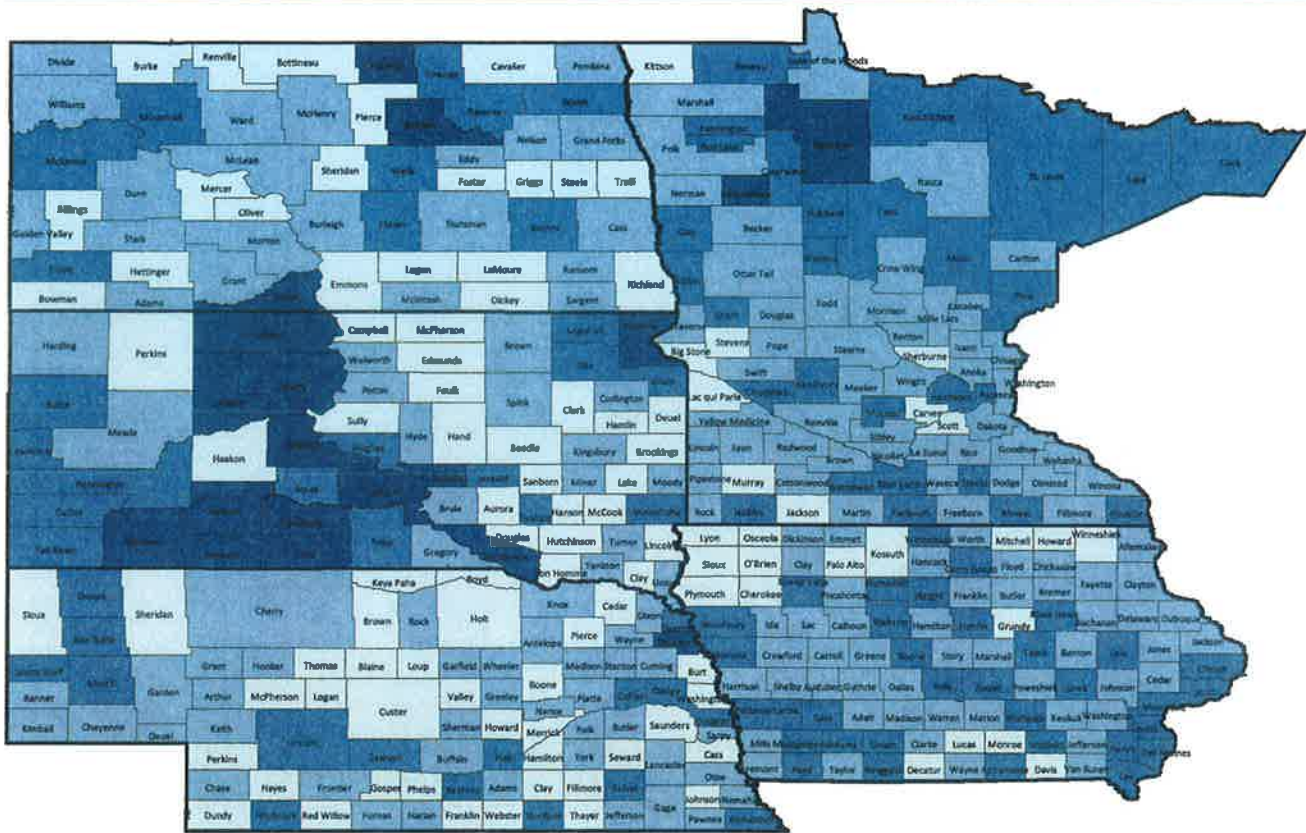
Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009

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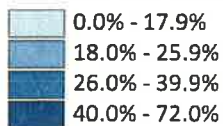
CONTEXT

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/.

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 27

Homicide Rate - A health factor measure focusing on violent crime

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
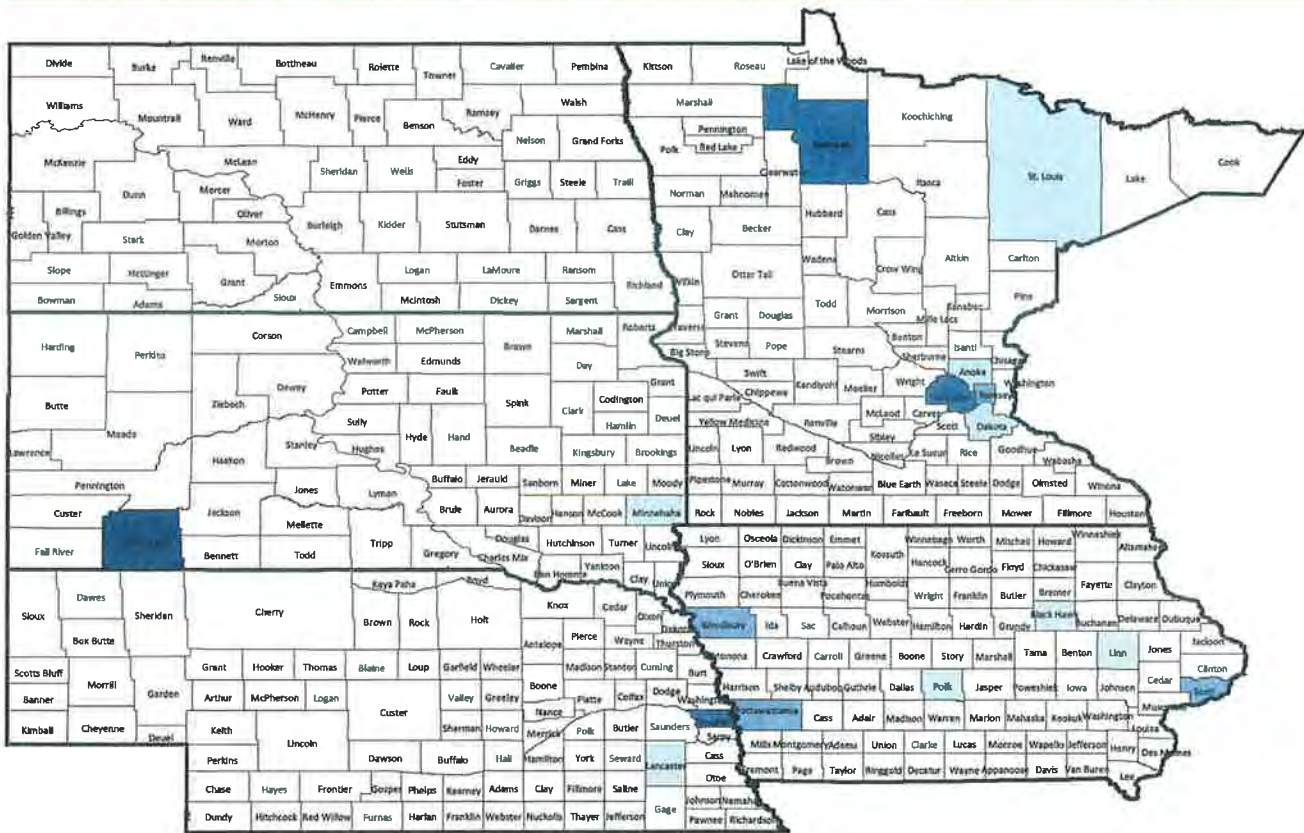
Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007

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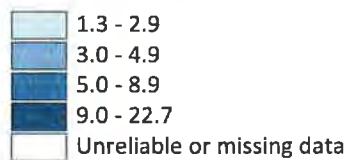
CONTEXT

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/.

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 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

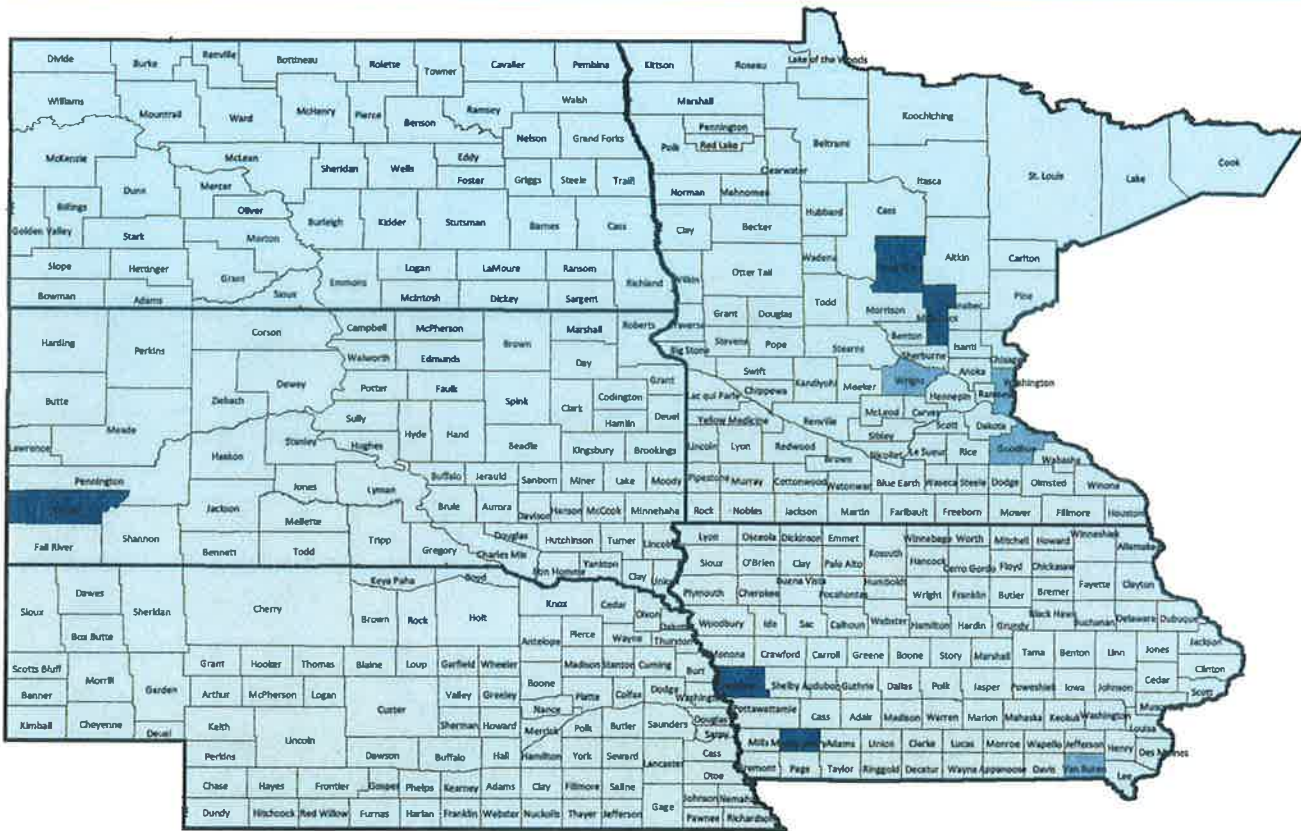**Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006**

- 0
- 1
- 2
- 3 - 4
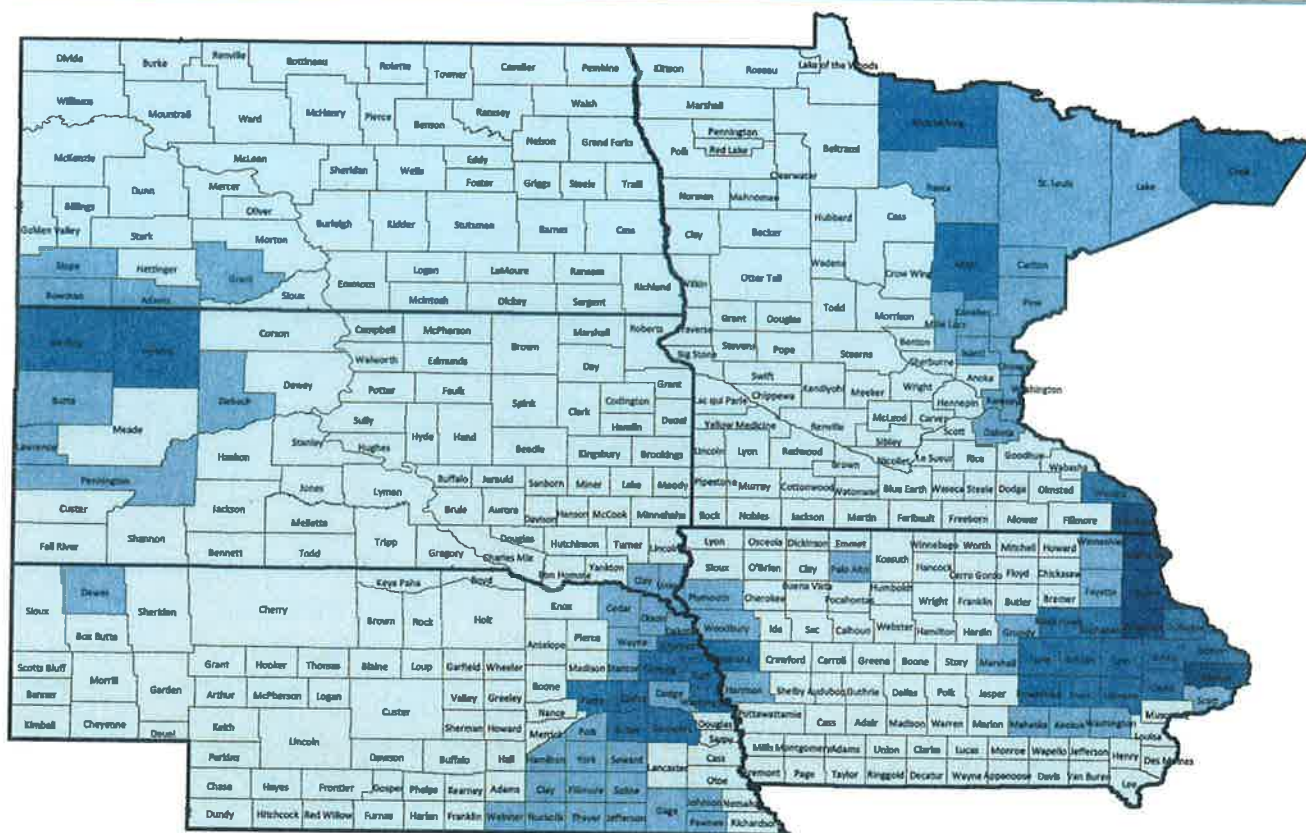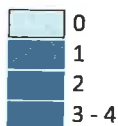
CONTEXT

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/.

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 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/.

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 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
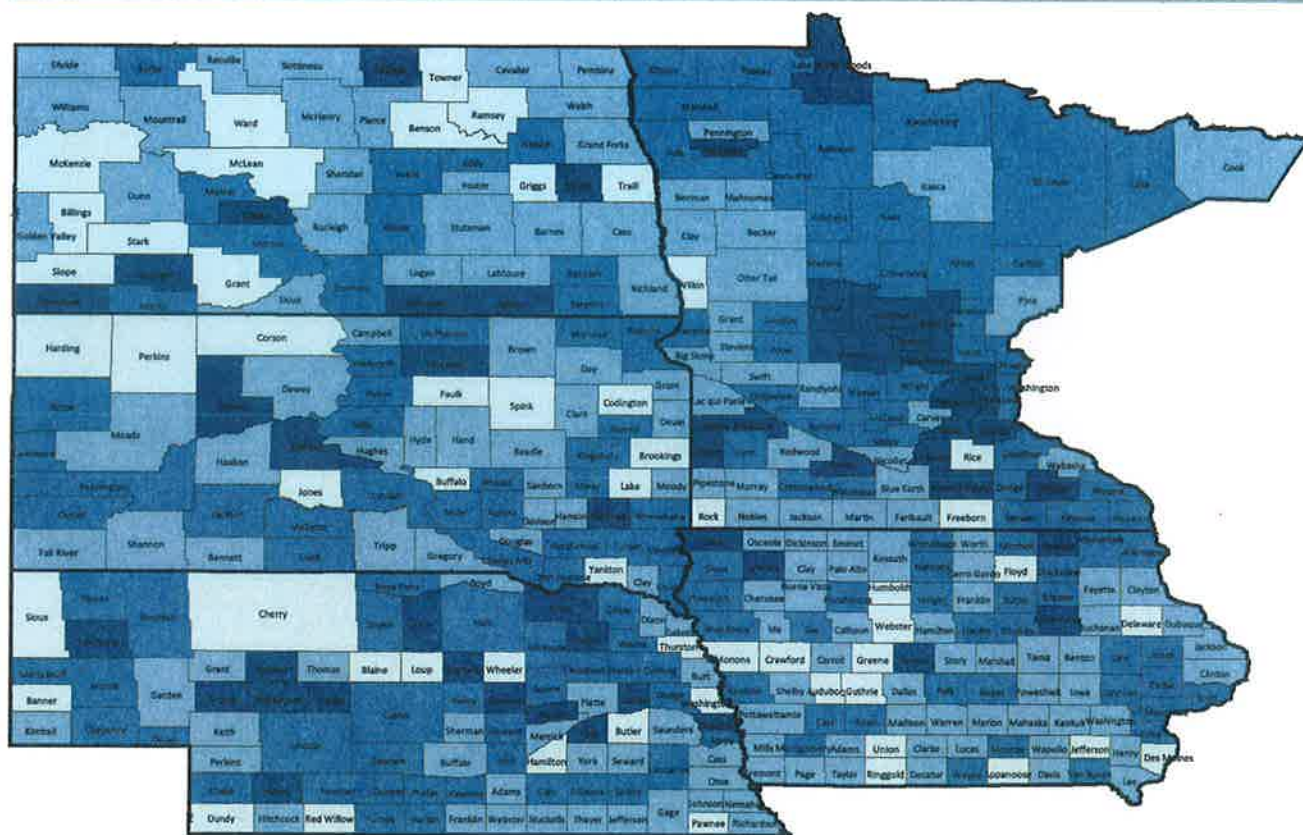
Percent of zip codes with healthy food outlets (i.e., grocery store or produce stand/farmers' market), 2008

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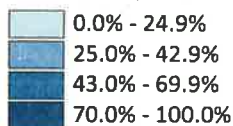
CONTEXT

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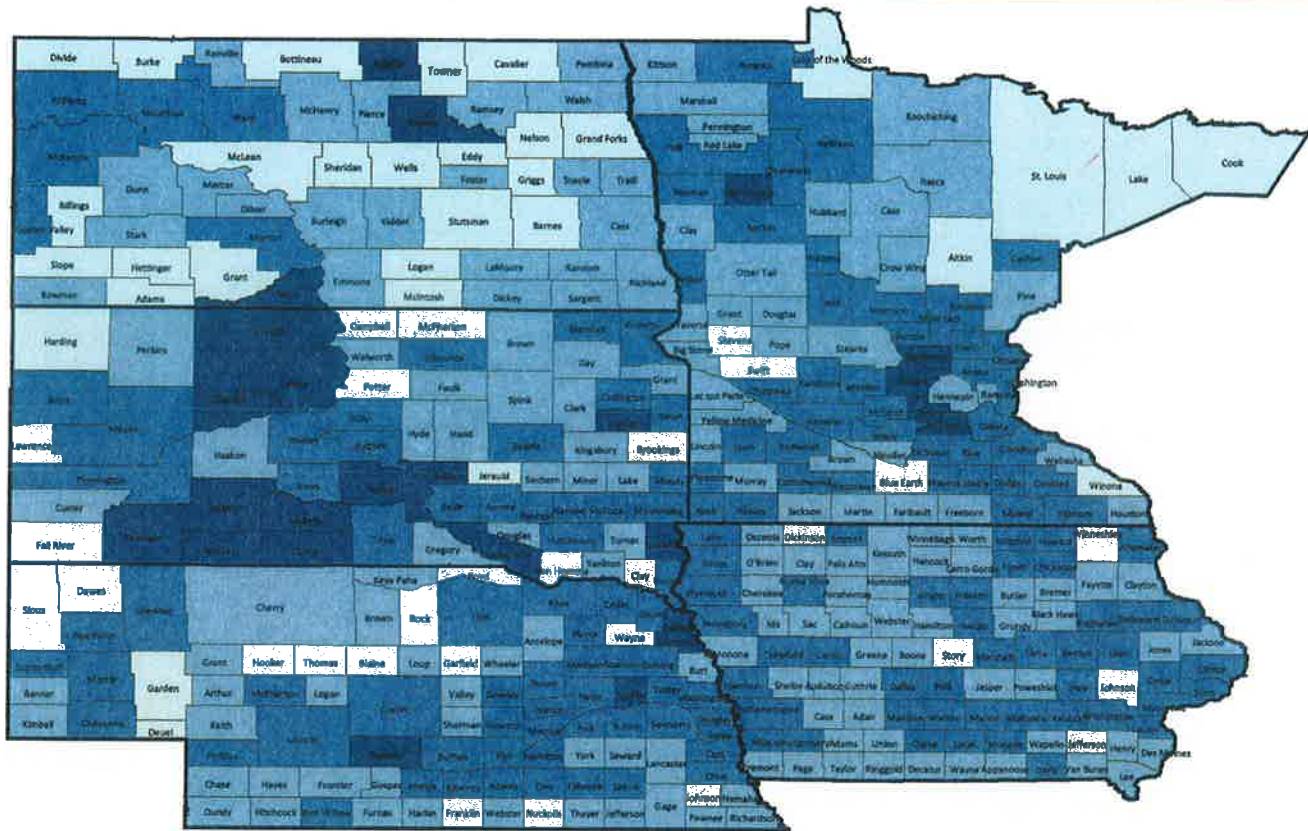
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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 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
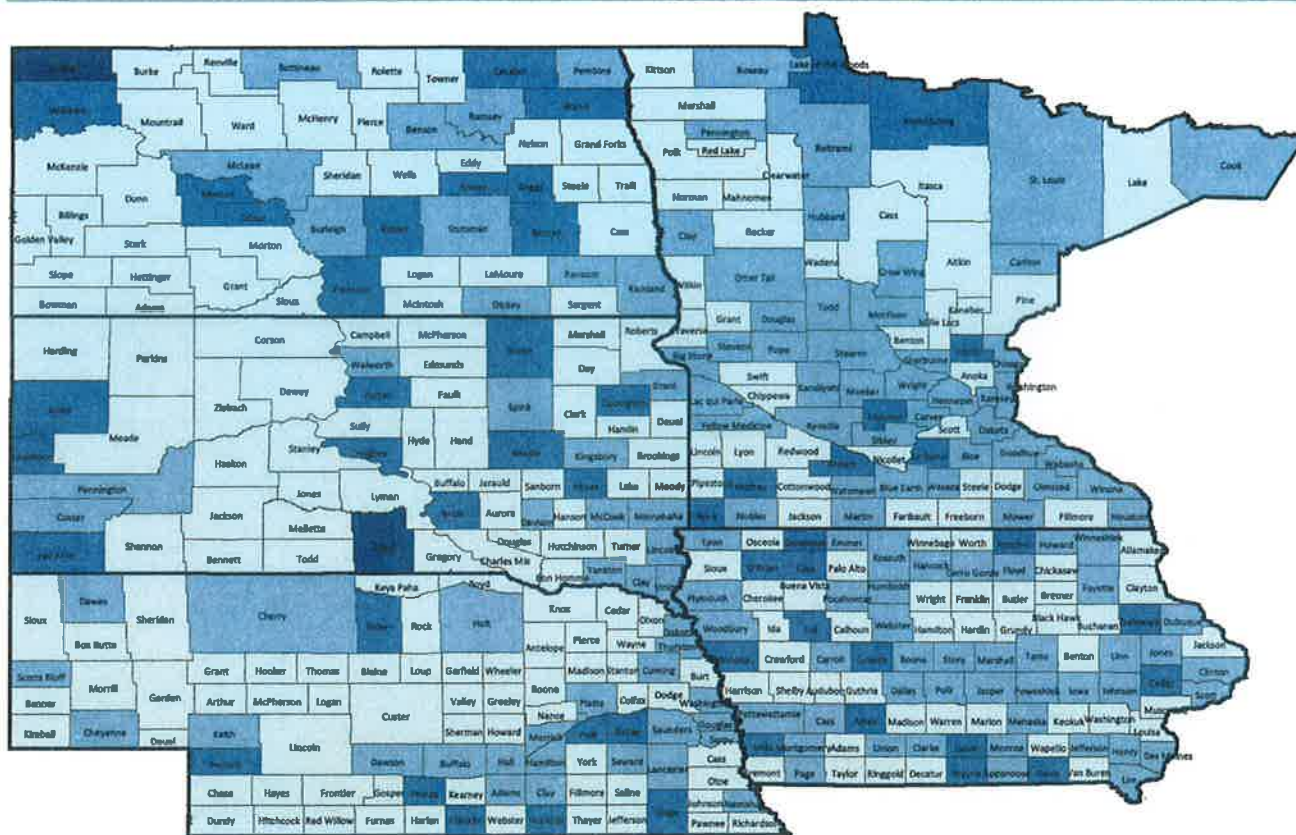
CONTEXT

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/.

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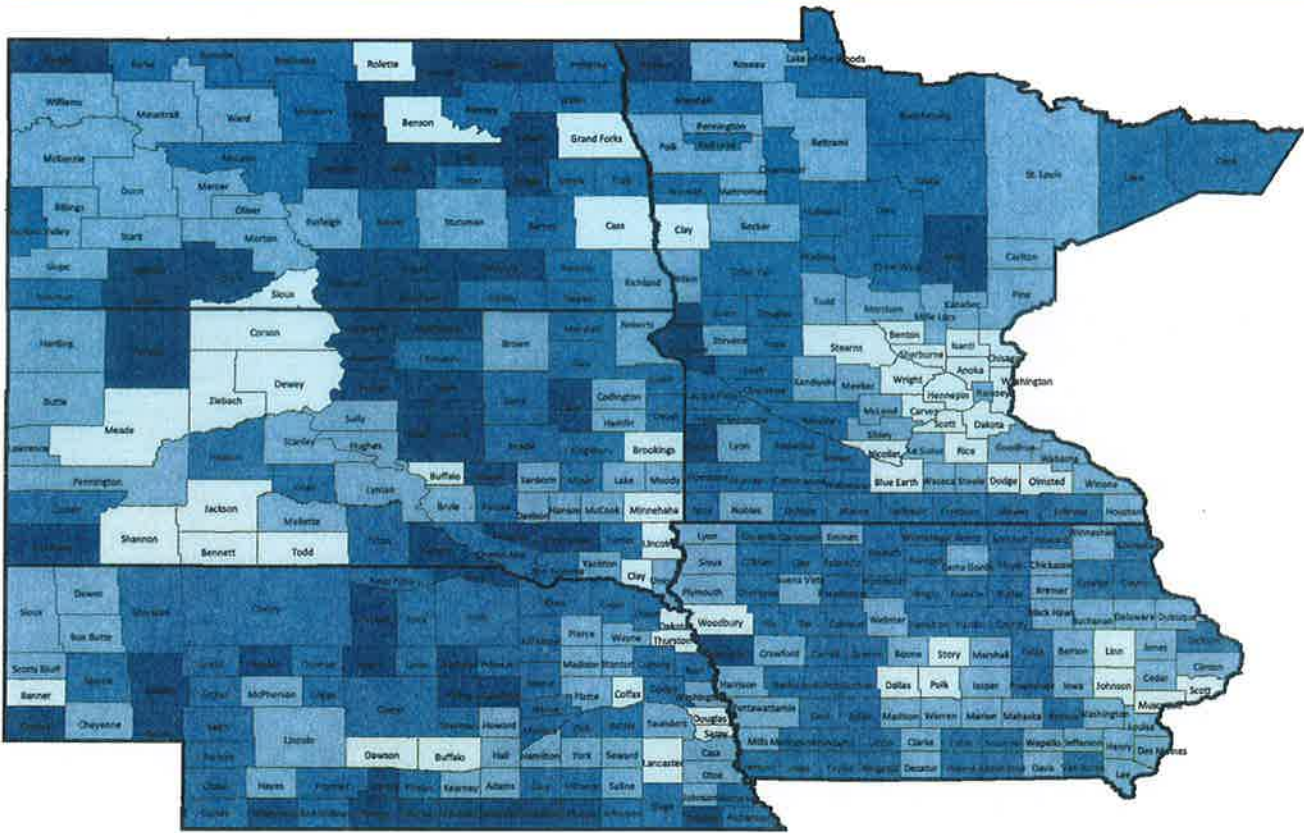
- 14.7% - 20.4%
- 20.5% - 23.4%
- 23.5% - 28.4%
- 28.5% - 40.5%
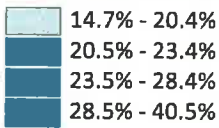
CONTEXT

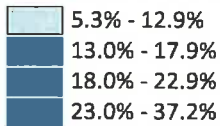**What It Is:** This measure represents the percent of a county's population that is less than 18 years of age.

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/.

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 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%
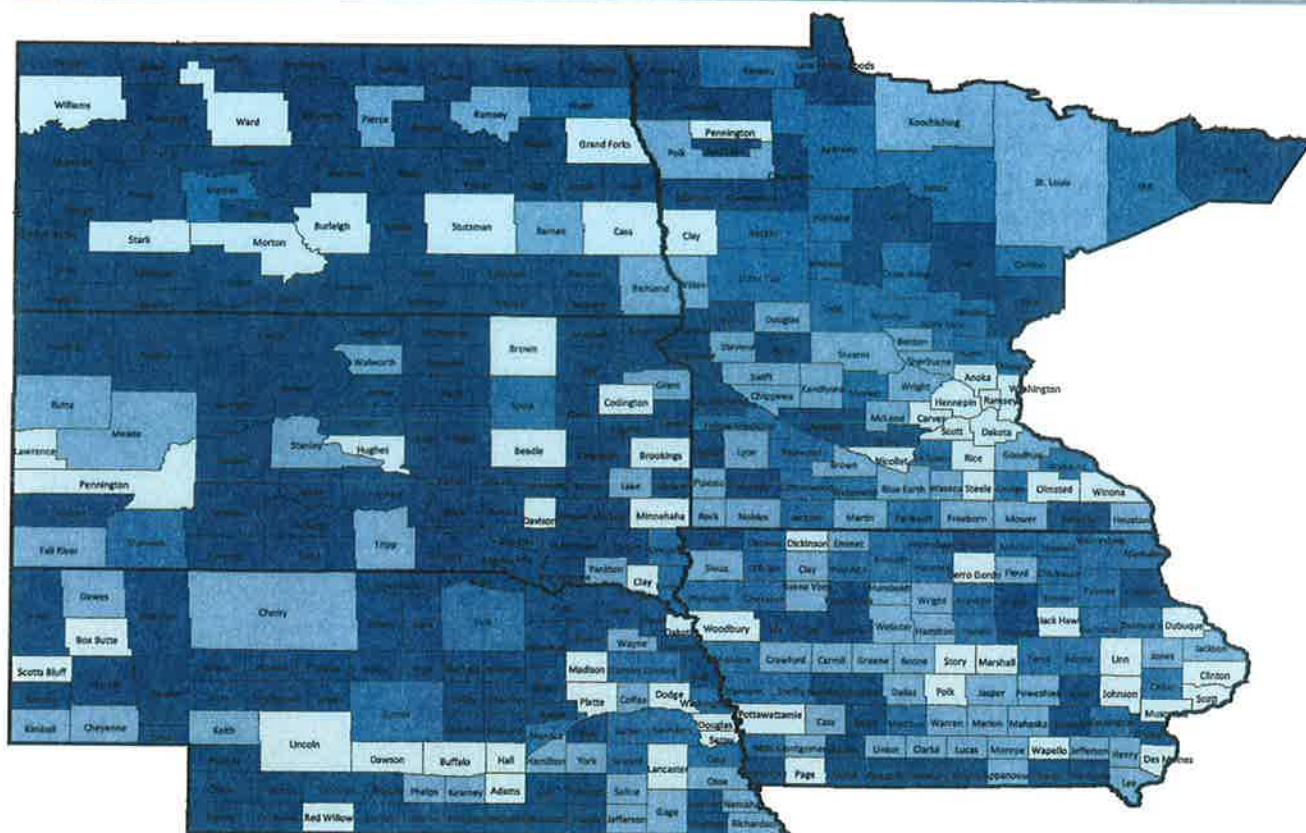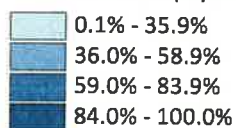- 18.0% - 22.9%
- 23.0% - 37.2%

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

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/.

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%
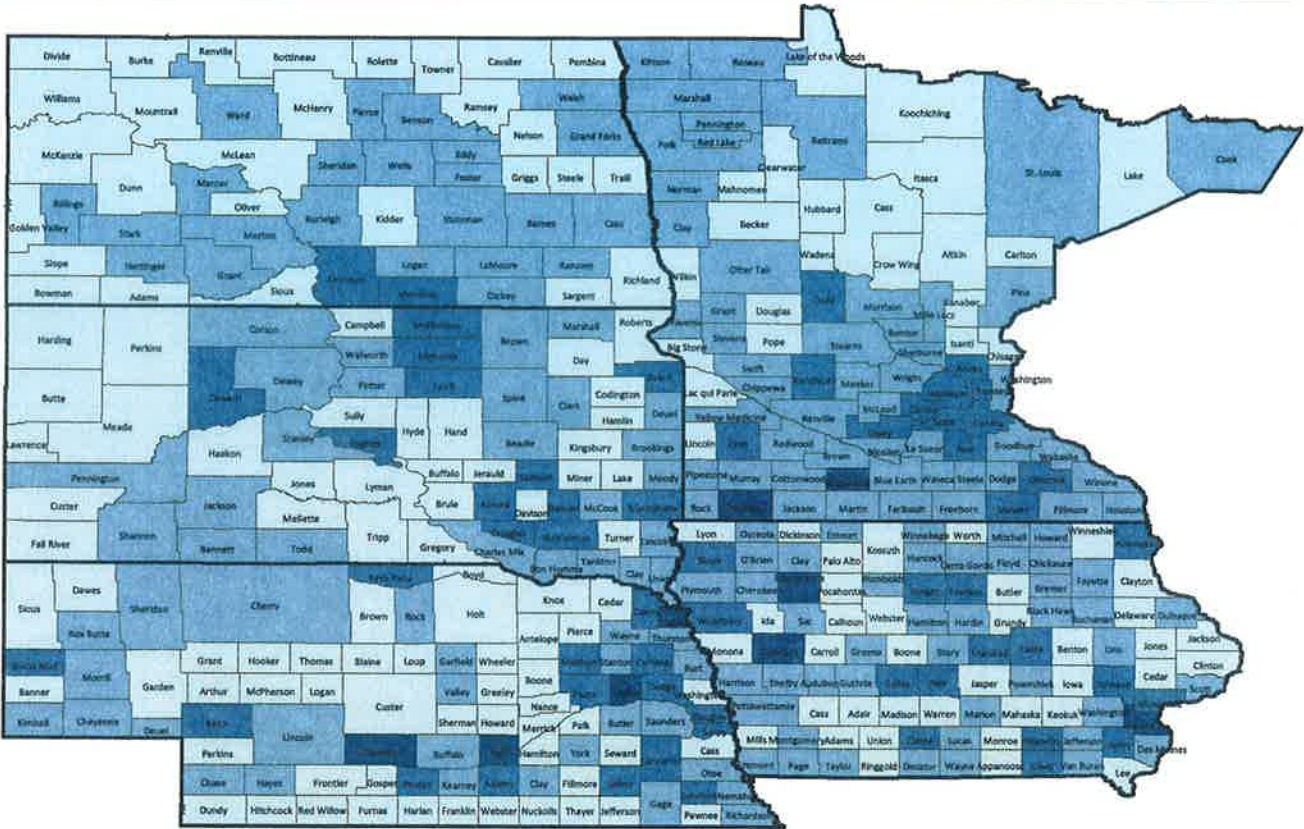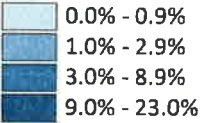
CONTEXT

What It Is: This measure represents the percent of the total population that reports speaking English less than "very well."
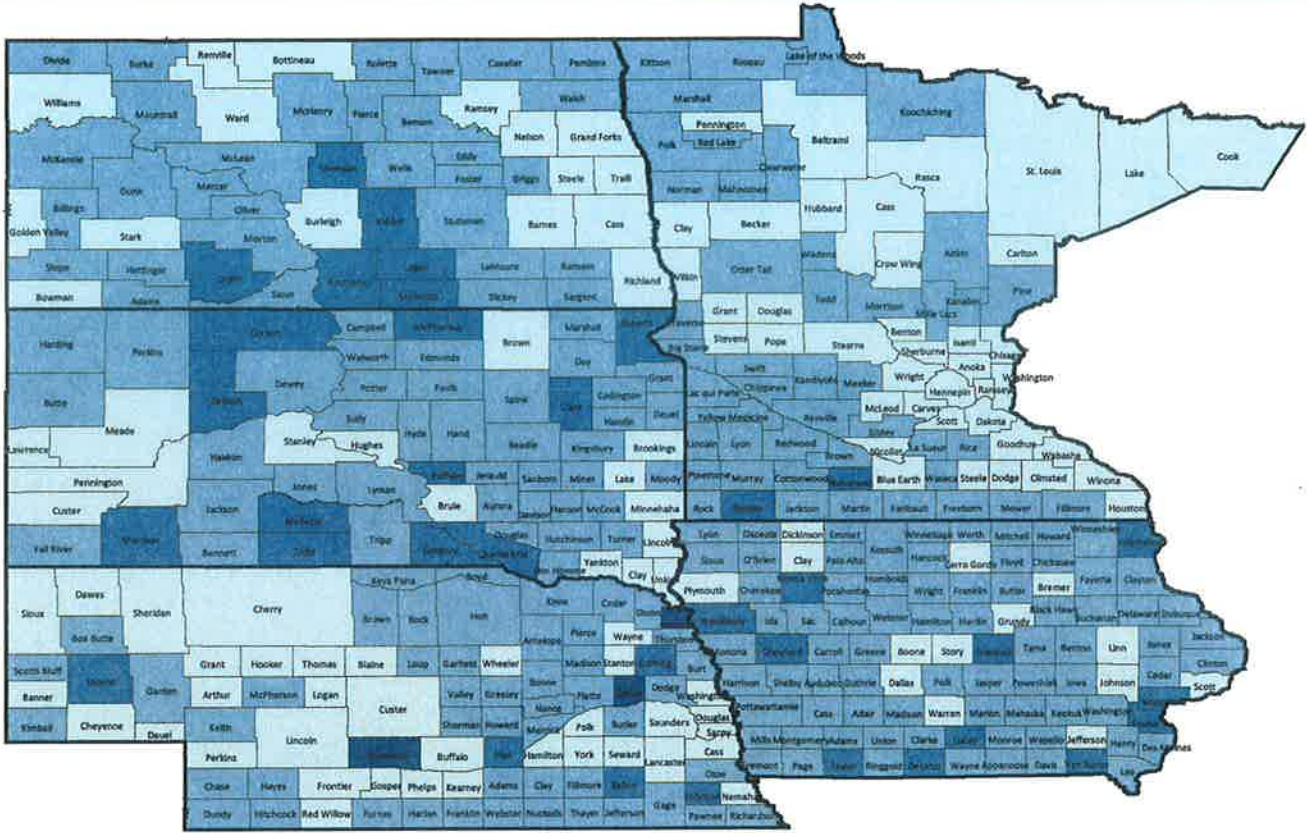
Where It Comes From: Data on spoken English proficiency come from the U.S. Census Bureau's American Community Survey 5-year estimates.

- 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%
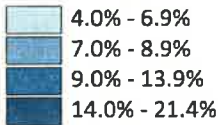
CONTEXT

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/.

SANFORD
HEALTH™

Table 1

Community Health Needs Assessment Asset Mapping

Wheaton Stakeholders

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Alternative Medicine	• Need more options for holistic care	Acupuncture Clinic - educate the acupuncturist regarding benefits of being in an approved network-- 10 visits approved if in Network Massage Therapy Chiropractic Clinic	
Chronic Conditions	• Need services for heart disease, obesity, diabetes, other chronic disease	Sanford Wheaton Clinic Home Care Public Health Diabetic Educator RN Health Coach Prime West – developing pods to manage chronic diseases Obesity - School lunch menu is changing this fall- lettuce, fruit, no desserts, or malt machines SHIP program available for obesity/tobacco	Support Groups

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Community Activities	• Need more annual community activities that get everyone involved (more than just the fair)	Hospital = Health Fair – 5K Walk/Run Cardiac Rehab Month - EMT Week - Touch a Truck Home Alone Meals for holidays Food Shelf Senior Citizen outings-monthly Rainbow Rider Services Social Service - WIC, Child Abuse Walk, Pencil Tree Project, Toys for Tots Early Childhood Mental Health Fireman's Fish Fry Farmer's Market-SHIP grant (obesity, tobacco) Community Theatre & Prairie Fire Theatre Relay for Life – Longest Day of Golf Senior Citizens Picnic/pontoon rides Sporting Events Music Events Kinship Program Gopher Theater Father's Resource Group (custody, visitations, mediation) Community Church services/Bible Schools/salad luncheons ECFE - early childhood programs	
Economic Situation/ Business community	• Need to keep industry (to keep young people in town) • Groceries are too expensive so people go out of town to shop – this takes away from the community as they then do other shopping out of town also • Need more jobs	County Food Shelf West Central Community Action Food Drop NAPS for seniors Salvation Army	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Elderly	• Concern with unsafe elderly drivers • Traverse County—Oldest/capita in state; 4th in nation	Lake Region Healthcare Driver Rehabilitation- program to evaluate for ability to safely drive Social Service will have County Car available for volunteer drivers Driver's Class to reduce insurance through Community Education Sanford Fargo Driver's Evaluation and Rehabilitation	
Healthcare Cost/Insurance Cost	• Concern about the cost of healthcare & health insurance; high deductibles; those without group health insurance	Preventative Medicine 2014 Healthcare Exchange	
Home Health	• Concern about the minimum time requirement policy for home health	Sanford Wheaton Home Care – 320-563-0078 Homemaking charge changed to 2 hour visits min.	
Mental Health	• Need mental health services • Concern with a wait of 3 months before an initial appointment	Havenwood Homes – 320-563-4366 Sanford One Care Mental Health Support Group Caregivers Support Cancer Support Regional Mental Health Service ARMHS Outpatient chemical help MH coverage 3days/week coverage from Morris	No youth program for Chemical help Not ARMHS certified Have Locus No AA

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Physicians	• Need another doctor • Need a doctor on call at all times • Need an OB/GYN • Concerned about the number of healthcare providers & specialists (because such a small community) • Concern about physicians & NPs not living in the community (therefore not being ingrained into the fabric of the community)	Recruitment Office Providers on call 24/7 Shortage of OB Provider Prenatal and postnatal education-provided at clinic	
Pollution/ Environment	• Concern with the chemicals being sprayed on crops	Public Health	
Schools	• Concern with bullying in the schools – schools not doing enough to combat this	Speakers will be at HS for teachers/students first day of school Funding available - school needs to send staff Governor's Collaborative funding - after school programs	
Transportation	• Need for transportation to medical appointments (for the elderly) • Difficulty in patients getting home after being transported by ambulance; shortage of volunteer drivers • Difficulty getting people to psychiatric hospitals after they present at the ER	Wheaton Ambulance – 320-563-8226 People's Express (West Central MN counties) – 1-800-4450-0123 (non-emergency medical transportation) Working with Social Services and Law Enforcement Rainbow Rider Prime West - volunteer drivers Mental Health Transports via Law Enforcement UCARE covers costs to and from health care services for eligible members.	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Youth	• Concern about overweight kids; need to disseminate more information on eating right & staying healthy	Sanford Clinic – 320-563-8971 Sanford WebMD Fit Kids School Nurse - School menu changing Summer Rec Program 4H programs Sports programs Swimming Pool Open Gym	
Sanford Specific	• Concern with the "new patient fee" charged • Concern over residual "Dr. Gallagher fear" influencing how care is provided • Local clinic staff could be more welcoming & (know the patient's name) - HIPPA violation	Educate receptionists through online education gc-0300, dc-0091 Volunteers at Reception Area	

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 gaps analysis worksheet)	Round 1 Vote	Round 2 Vote	Round 3 Vote
Alternative Medicine			
Chronic Conditions	X		
Community Activities			
Economic Situation/Business Community	XX		
Elderly	X		
Health Care Cost/Insurance			
Home Health			
Mental Health	XXX	XXXXX	
Physicians (Recruitment)	XXXX	XXXXX	
Pollution/Environment			
Schools			
Transportation	XXXX	XXXXX	
Youth			
Sanford-Specific	X		