Sanford Health Network

Community Health Needs Assessment

2012-2013

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Sanford Canby Medical Center

Community Health Needs Assessment 2012-2013

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Sanford Canby Medical Center
Community Health Needs Assessment
2012-2013

Purpose

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

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

The 2010 PPACA enactment 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 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 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 not-for-profit status.

Acknowledgements

Sanford Health would like to acknowledge and thank the following individuals for their input into the Community Health 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
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Sanford Sioux Falls Network Steering Group:

- *Enterprise Lead:* Carrie McLeod, MBA, MM, LRD,CDE; Office of Health Care Reform, Community Benefit/Community Health Improvement
- *Sioux Falls Region Co-Lead:* Bruce Viessman, CFO, Sanford Health Network Sioux Falls
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Sanford Canby Medical Center Steering Group:

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- Lori Sisk, Hospital and Home Care CNO
- Allison Nelson, CFO
- Nancy Salmon, LTC Administrator
- Sally Vogt, Clinic Administrator
- Julie Schlecht, LTC CNO

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:

- Susan Alley, Nurse, Sanford Canby, Canby, MN
- Jason Anderson, Physical Therapist, Sanford Canby, Canby, MN
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- Marian Monroe, Housekeeping/Laundry Manager, Sanford Canby, Canby, MN
- Allison Nelson, CFO, Sanford Canby, Canby, MN
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- Dennis Steffen, Farmer/Hospital Board Member, Canby, MN
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- Megan Syltie, General Manager, Canby Inn & Suites, Canby, MN
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- LTC Nurse, Canby, MN
- Home Care Nurse, Canby, MN
- Member of Chamber of Commerce, Canby, MN

Sanford Canby Medical Center
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 not-for-profit status.

Study Design and Methodology

The following qualitative data sets were studied:

- Canby Community Health Needs Assessment of Community Leaders

The following quantitative data sets were studied:

- 2011 County Health Profile for Yellow Medicine County - 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 for Yellow Medicine County - 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 for Yellow Medicine County - 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.

Key Findings - Primary Research

Sanford Canby Medical Center 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 Canby 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.

Summary of the Survey Results

Respondents had very high levels of agreement that the people in their community are friendly, helpful and supportive, there is quality health care, the community is a good place to raise kids, and is a safe and healthy place to live with quality higher education opportunities, school systems and programs for youth. They also had a sense that you can make a difference and become engaged in social, civic and political issues. However, respondents agreed the least that there are quality arts and cultural activities in their community.

Respondents were most concerned about substance abuse, issues regarding the aging population (e.g. availability and cost of long-term care and availability of resources to help the elderly stay in their homes). Economic issues with availability of employment opportunities, affordable housing, low wages and cost of living were felt to be of concern. 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 youth). Environmental issues regarding water quality, air quality, and noise levels were not a large concern.

Among health and wellness concerns, respondents were most concerned about the costs associated with health insurance, health care cost, availability of prevention programs and services, 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), cancer, stress 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.

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

Key Findings - Secondary Research

Health Outcomes

The Mortality health outcome indicates that Yellow Medicine County has more premature deaths that the Minnesota and the national benchmarks.

The Morbidity health outcomes indicate that Minnesota citizens self-report more days of poor health (average number of physically unhealthy days reported in past 30 days unhealthy days reported in past 30 days age-adjusted 2003-2009) than the national benchmark; however, Yellow Medicine County reports slightly higher poor health.

Minnesota self-reports more mentally unhealthy days (average number of mentally unhealthy days reported in past 30 days unhealthy days reported in past 30 days age-adjusted 2003-2009) than the national benchmark. Yellow Medicine County has a higher rate for mentally unhealthy days than the state of Minnesota and the national benchmark.

Minnesota has a higher percentage of low birth weight than the national benchmark. Yellow Medicine County has a slightly higher rate than the national benchmark and slightly lower than the state of Minnesota.

Health Behaviors

The Health Behavior outcomes indicate that Minnesota has a higher percentage of adult smokers (19% vs. 15%) than the national benchmark. Yellow Medicine County has no smoking data. Adult obesity is also higher in the state of Minnesota (26%) and in Yellow Medicine County (2%) than the national benchmark (25%).

Yellow Medicine County has the same percentage of physical inactivity as the national benchmark (20%). The state of Minnesota is lower at 17%.

Minnesota has a much higher rate of binge drinking reports (20%) than the national benchmark (8%). There are no statistics for Yellow Medicine County.

Motor vehicle crash death rates are higher than the national benchmark (12.0) in Minnesota (12.9) and Yellow Medicine County was significantly higher at 31.1%.

Sexually transmitted infections rank substantially higher than the national benchmark (83.0) for Minnesota (276.1), and for Yellow Medicine County (100.4).

The teen birth rate is higher in Minnesota (27.5) and Yellow Medicine County (26.1) than the national benchmark (22.0).

Clinical Care

The Clinical Care outcomes indicate that Yellow Medicine County has the same percentage of uninsured adults as the national benchmark (13%). Minnesota is slightly lower at 11%. The percentage of uninsured youth is lower in Minnesota (6%), and Yellow Medicine County is the same as the national benchmark (7%).

The ratio of population to primary care physicians is higher in Minnesota (636:1) than the national benchmark (631:1). Yellow Medicine County's ratio is more favorable (764:1).

The ratio of population to mental health providers is much lower in Minnesota (1,306:1) than the national benchmark (2,242:1). Yellow Medicine County has a much higher ratio (3,309:1).

The number of professionally active dentists in Minnesota (61) is lower than the national benchmark (69.0). There is no data for Yellow Medicine County.

Preventable hospital stays are higher than the national benchmark (52.0) in Minnesota (56.5.) and in Yellow Medicine County (68.3).

Diabetes screening in Minnesota as a whole (88%) is slightly lower than the national benchmark (89%). The rate of diabetes screening is also lower in Yellow Medicine County (83%) than the national benchmark.

The national benchmark (74%) for mammography screenings is slightly higher than Minnesota (73%) and Yellow Medicine County (73%).

Social and Economic Factors

The Social and Economic Factors outcomes indicate that Minnesota (87%) has a lower high school graduation rate than the national benchmark (92%); however, Yellow Medicine County has a higher benchmark at 95%. Minnesota has a higher post-secondary education level than the national benchmark and Yellow Medicine County (at 68%) is exactly the same as the national benchmark.

The unemployment rate was substantially higher nationally (5.3%) during 2009, while Minnesota (8.0%) and Yellow Medicine County (6.7%) were all substantially higher.

The percentage of child poverty in Minnesota, Yellow Medicine County and the national benchmark are exactly the same at 11%.

Inadequate social support in Minnesota is exactly the same as the national benchmark - 14%. There was no data for Yellow Medicine County.

The percentage of children in single parent households is higher in Minnesota (25%) than the national benchmark (20%), but is the same in Yellow Medicine County (20%).

The number of homicide deaths in Minnesota (2.5) is higher than the national benchmark (1.0). There was no data available for Yellow Medicine County for this indicator.

Physical Environment

The Physical Environment outcomes indicate that there is no air pollution or ozone pollution in this area. Access to healthy food is ranked below the national benchmark (92%) in both Minnesota (54%) and Yellow Medicine Co. (71%).

Access to recreational facilities ranks lower than the national benchmark for Minnesota (12.0) and for Yellow Medicine County (10%).

Population by Age

The population for this area is relatively young with only 4% older than 85 years of age and only 19% older than 65 years of age.

The gender distribution is approximately 50-50 in Yellow Medicine County.

Housing

The majority of individuals in Yellow Medicine County own their homes at 79%.

Economic Security

According to the 2010 Census Data, the population of working age in the labor force is 71% in Minnesota. Yellow Medicine County is at 67%. The percentage of those who are living at less than 100% of the Federal poverty level range is 11% in Minnesota, with 26% living at less than 200% of the Federal poverty level. Both rates are slightly higher in Yellow Medicine County.

The median annual household income in Minnesota is $57,243. Yellow Medicine County falls below that level at $50,288 annual income.

Diversity Profile

The population distribution by race demonstrates that Yellow Medicine County and the state of Minnesota are predominantly white, followed by the Hispanic origin of any race. Blacks rank third in Minnesota and last in Yellow Medicine County as the leading race by population. American Indians rank third in Yellow Medicine County while they rank last in the state of Minnesota.

Implementation Strategy

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

- Obesity issues
- Provision of local Oncology services

Implementation Strategy: Develop formal program to address obesity issues

- Appoint overall planning committee to execute program goals.
- Increase physical activity in various settings within the community.
- Improvement in dietary behaviors of the community through the use of multiple resources.
- Support the community obesity issues through the use of social and behavioral approaches.

Implementation Strategy: Provide local Oncology services through outreach

- Enhance current telemedicine capabilities/frequency in conjunction with onsite oncologist presence.
- Provide local additional chemotherapy services.

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

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

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

Our Values:

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

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

Guiding Principles:

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

Description of Sanford Canby Medical Center

Sanford Canby Medical Center (SCMC) is a community-based Critical Access Hospital which exists to serve the needs of over 6,000 people in its market area. The Sanford Canby Medical Center operates a 25-bed acute care hospital, an attached 7-practitioner medical clinic (Rural Health Clinic), an attached skilled nursing facility, an attached senior housing/assisted living facility, a dental clinic, home health care service, a dialysis unit, ambulance service and wellness center. Sanford Canby also has beds designated for swing bed services and owns its own ambulance service. The organization is certified and a participating provider in Medicare and Medicaid programs.

Our professional staff includes four family practice physicians, one internal medicine physician, one surgeon, and one family nurse practitioner. Outreach services are provided for cardiology, orthopedics, GI, OB/GYN, ophthalmology and urology.

Description of the Community Served

Canby is located in southwestern Minnesota in Yellow Medicine County. The population of Canby is approximately 1,800. The nearest tertiary center is in Sioux Falls, SD, which is approximately 108 miles south of Canby, meaning that area residents must travel over 1 ½ hours to receive care in the nearest tertiary hospital. The medical center is located in a Medically Underserved Area, as designated by the Federal Health Resources and Services Administration (HRSA). Medically Underserved Areas/Populations are areas or populations designated by HRSA as having: too few primary care providers, high infant mortality, high poverty and/or high elderly population. This is a direct indication of the critical need for the services provided by SCMC and the health status of the patients who depend upon it. We serve an increasing elderly population who are often unable to travel any distance for routine health care services, and in the absence of local services, neglect health care needs until it reaches catastrophic or emergency levels of need. Our community is home to Del Clark Lake, a community golf course, walking/biking trails, and Minnesota West Community College. Sanford Canby is very active in the local chamber of commerce and works with the community to strengthen its assets. K-12 education is provided by an independent school district, as well as grades 1-6 at St. Peter's Catholic School.

Study Design and Methodology

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.

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Limitations

The Sanford Health Community Health Needs Assessment Steering Group attempted to survey key community leaders and stakeholders for the purpose of determining the needs of the community. While 143 surveys were returned, there were still many key stakeholders who did not complete the survey.

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

Primary Research

Sanford Canby Medical Center 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 Canby community. The findings discussed in this section are a result of the analysis of the survey qualitative data.

Summary of the Survey Results

Respondents had very high levels of agreement that the people in their community are friendly, helpful and supportive, there is quality health care, the community is a good place to raise kids, and is a safe and healthy place to live with quality higher education opportunities, school systems and programs for youth. They also had a sense that you can make a difference and become engaged in social, civic and political issues. However, respondents agreed the least that there are quality arts and cultural activities in their community.

Respondents were most concerned about substance abuse, issues regarding the aging population (e.g. availability and cost of long-term care and availability of resources to help elderly stay in their homes). Economic

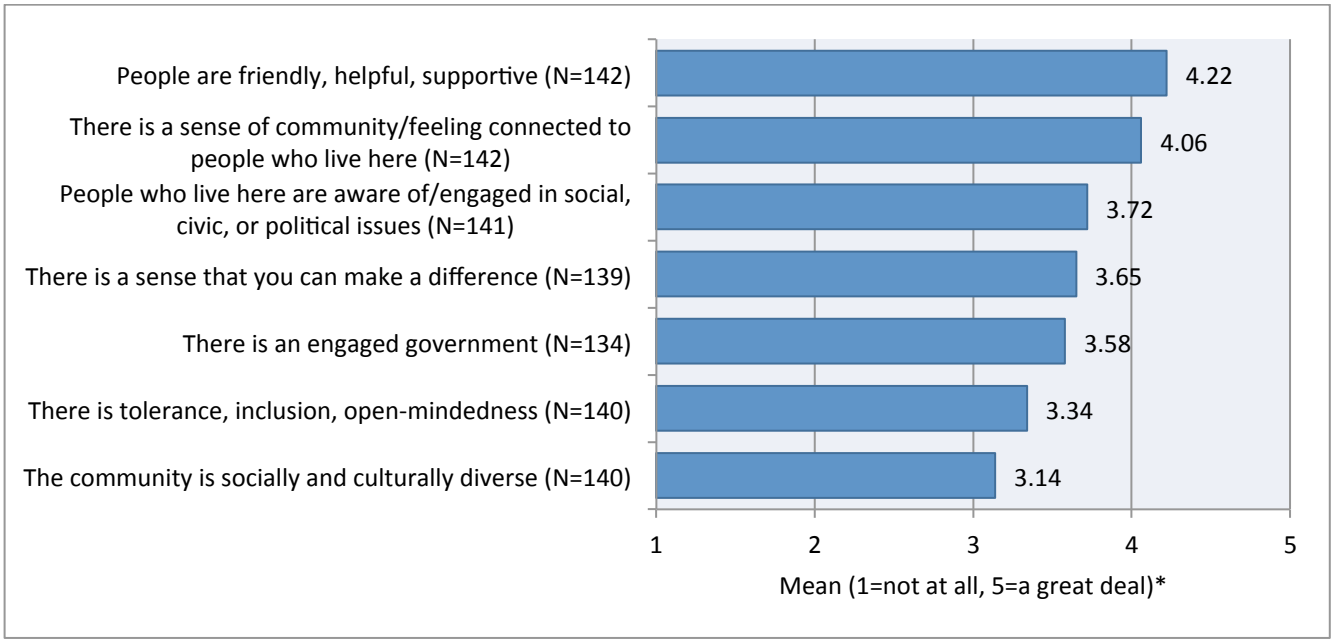
issues with availability of employment opportunities, affordable housing, low wages and cost of living were felt to be of concern. Respondents were also concerned with issues regarding children and youth (e.g. availability and cost of quality child care, bullying, availability and cost of services for youth). Environmental issues regarding water quality, air quality, and noise levels were not a large concern.

Among health and wellness concerns, respondents were most concerned about the costs associated with health insurance, health care cost, availability of prevention programs and services, 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), cancer, stress 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.

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

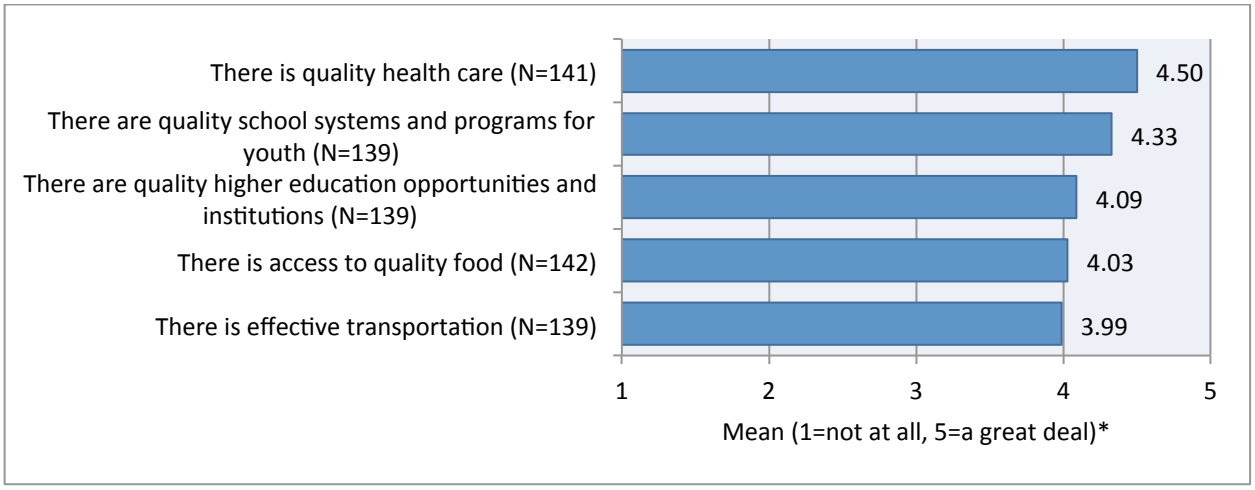
Community Assets/Best Things about the Community

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



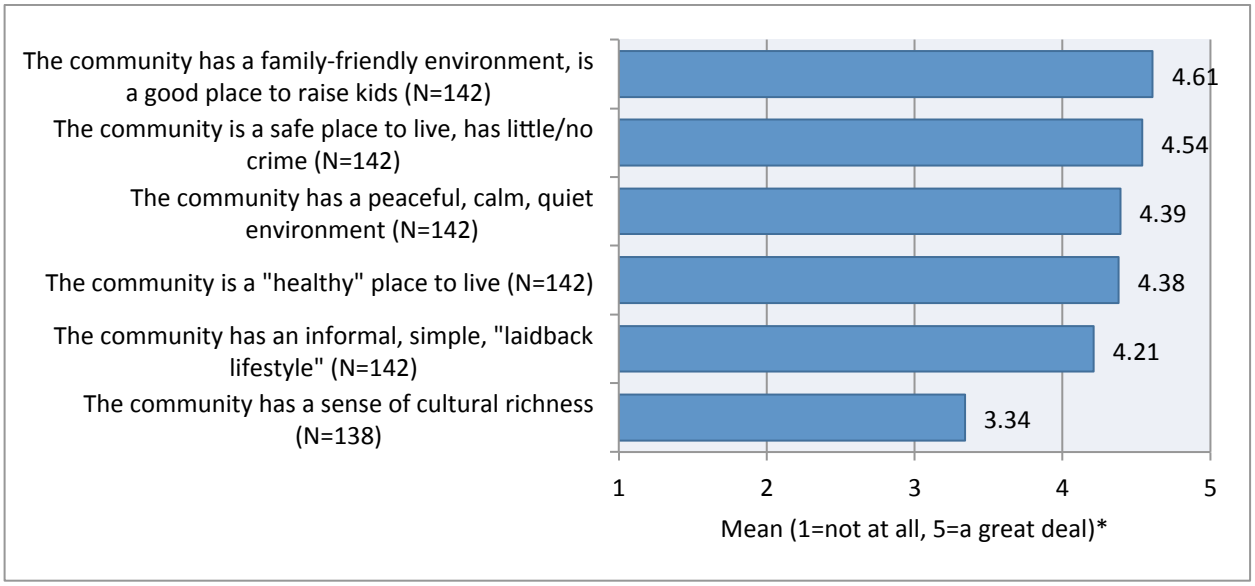
*Means exclude "do not know" responses.

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



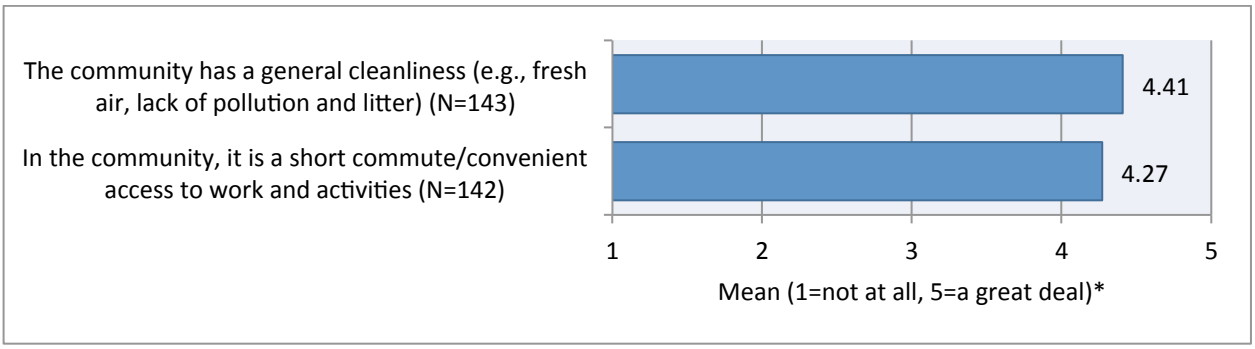
*Means exclude "do not know" responses.

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



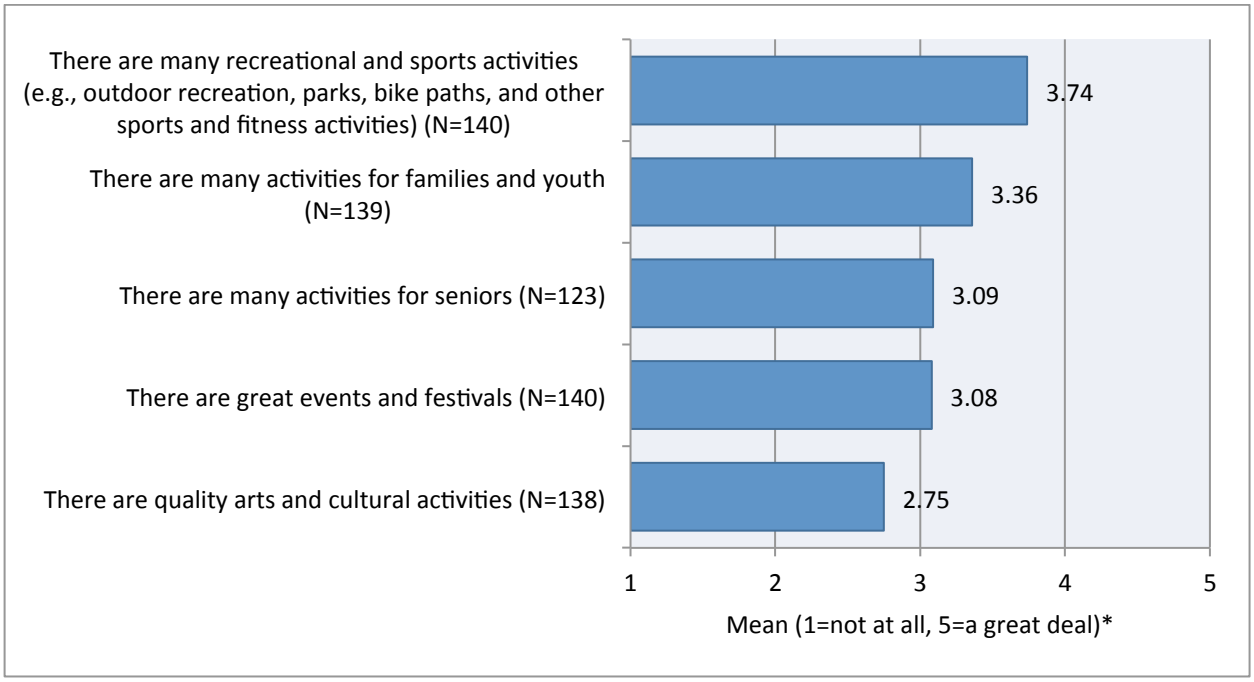
*Means exclude "do not know" responses.

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



*Means exclude "do not know" responses.

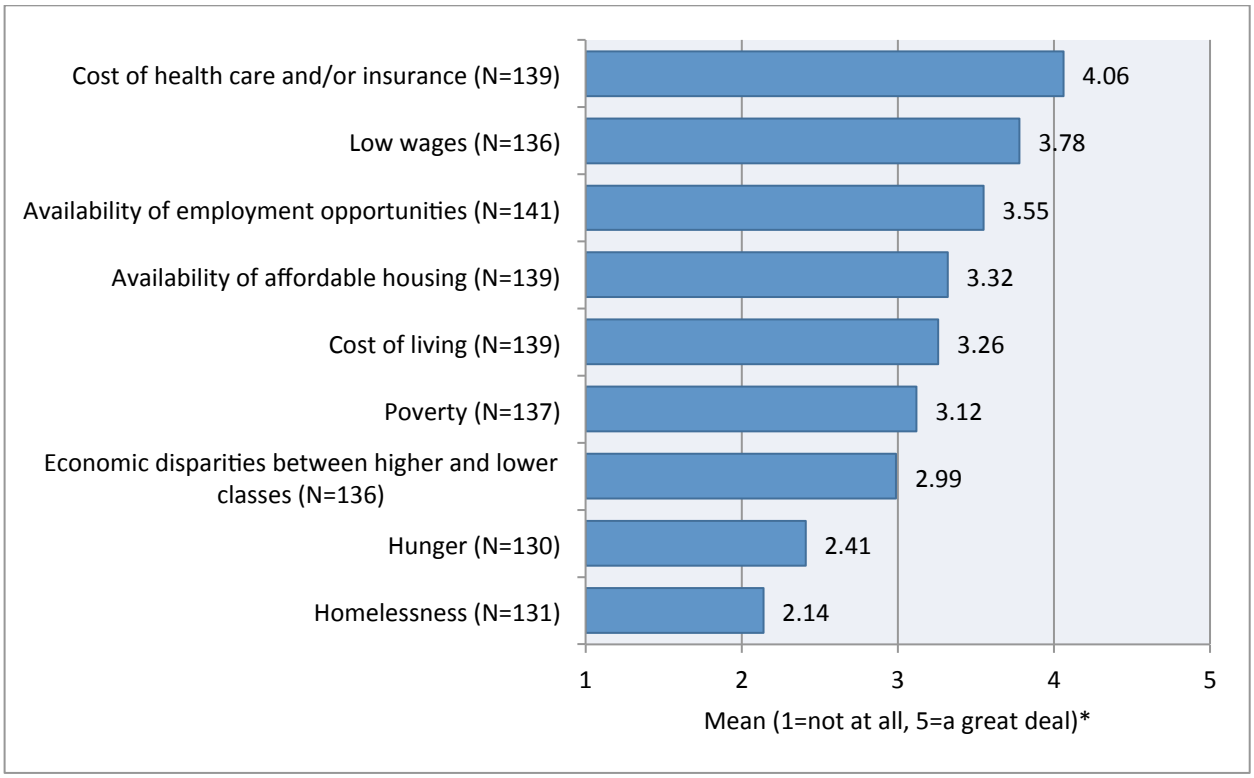
Figure 5. Level of agreement with statements about the community regarding ACTIVITIES



*Means exclude "do not know" responses.

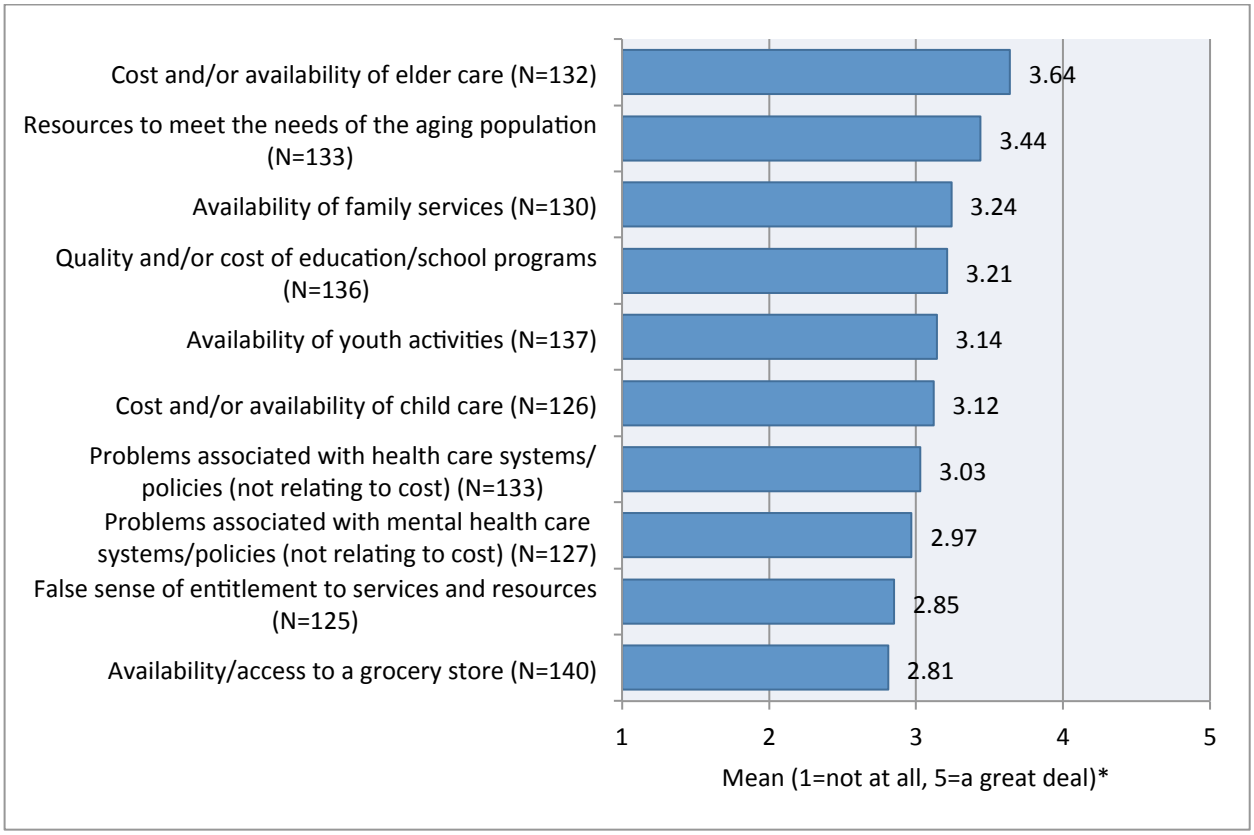
General Concerns about the Community

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



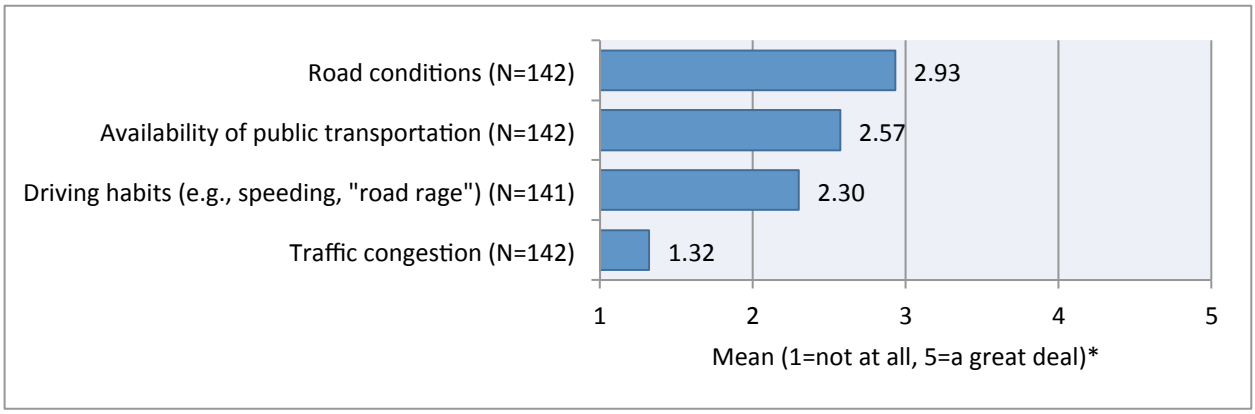
*Means exclude "do not know" responses.

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



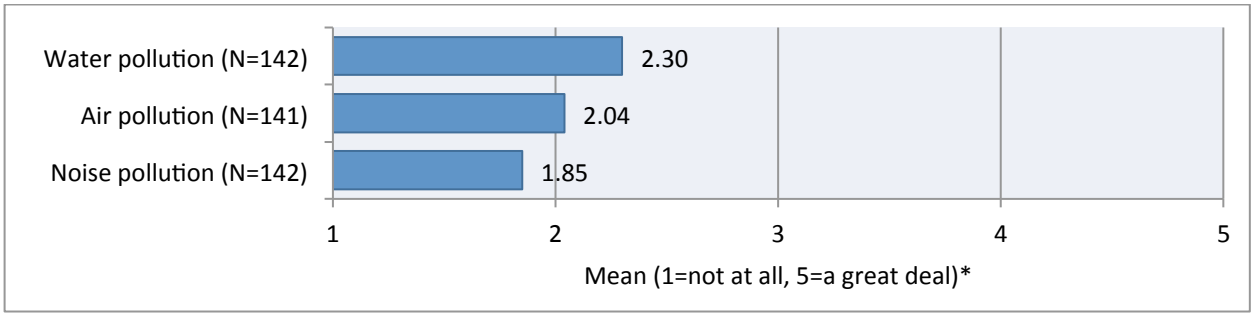
*Means exclude "do not know" responses.

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



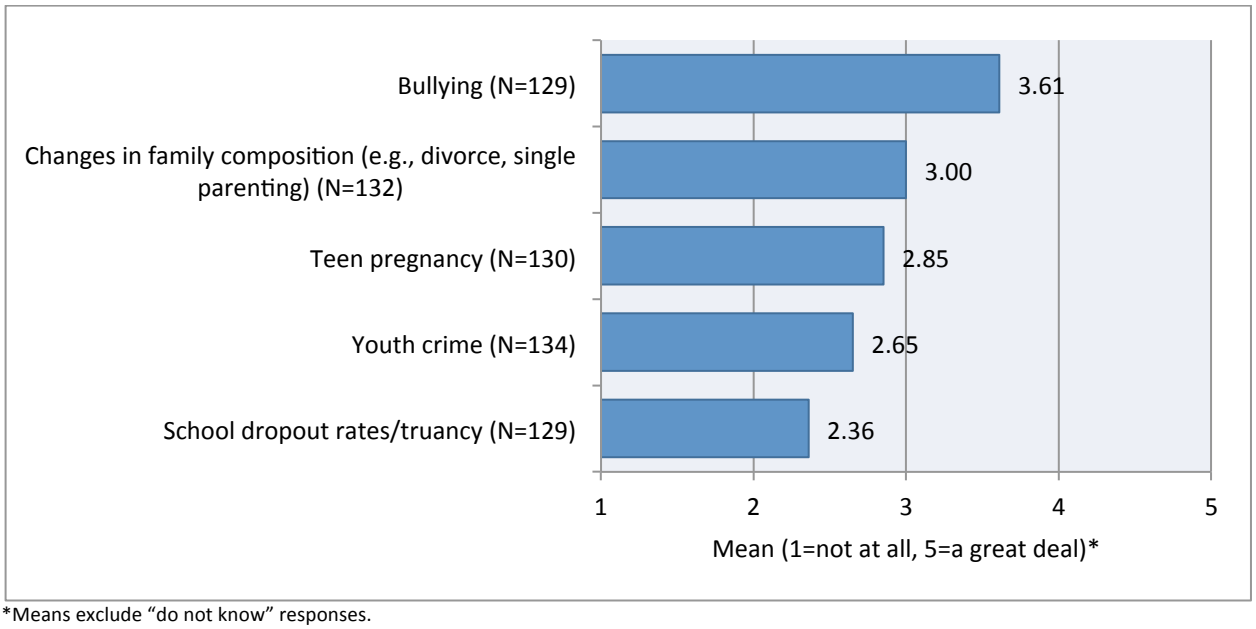
*Means exclude "do not know" responses.

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



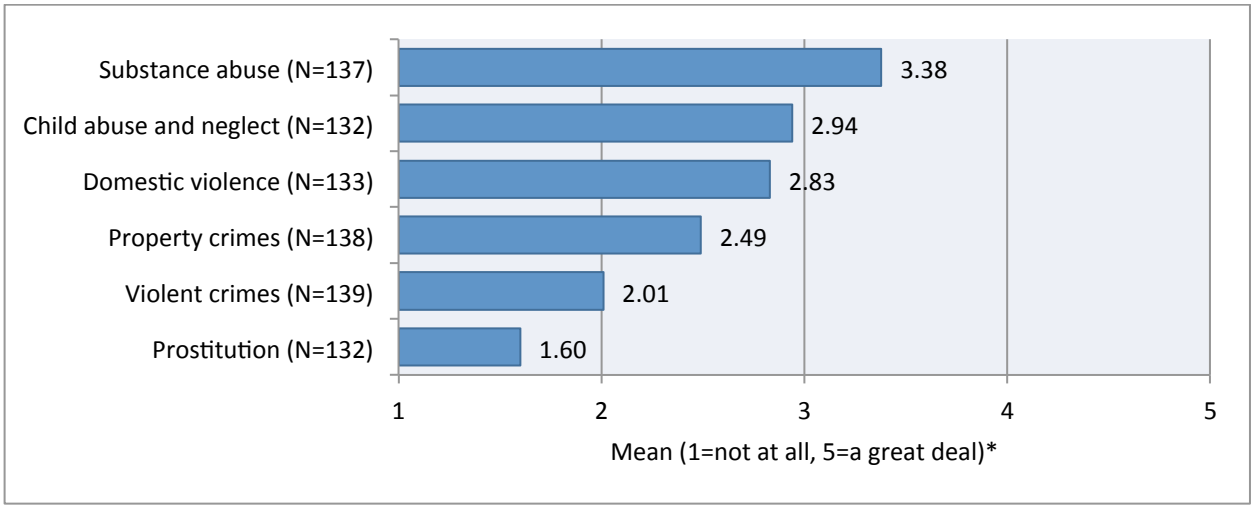
*Means exclude "do not know" responses.

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



*Means exclude "do not know" responses.

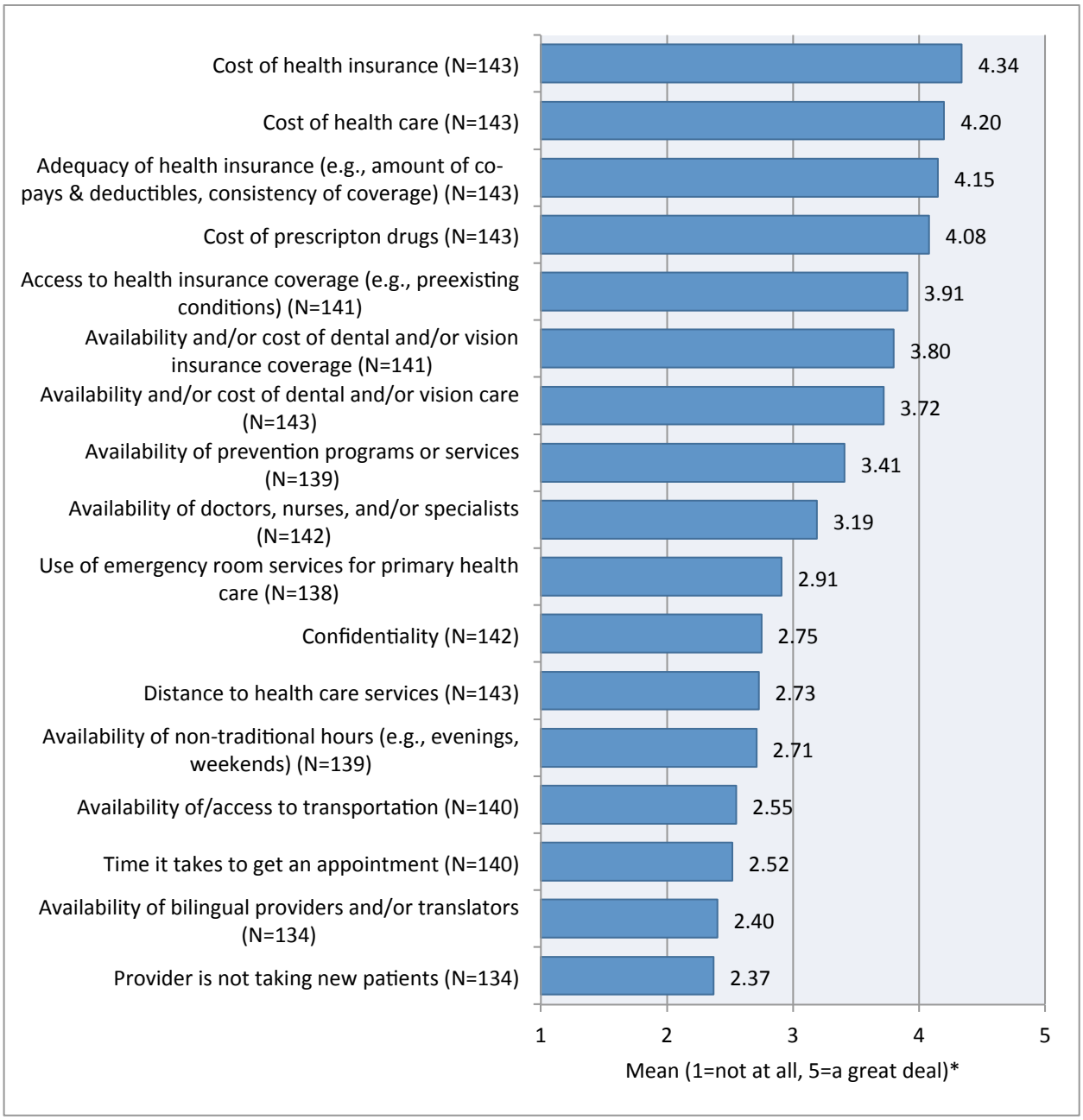
Figure 11. Level of concern with statements about the community regarding SAFETY CONCERNS



*Means exclude "do not know" responses.

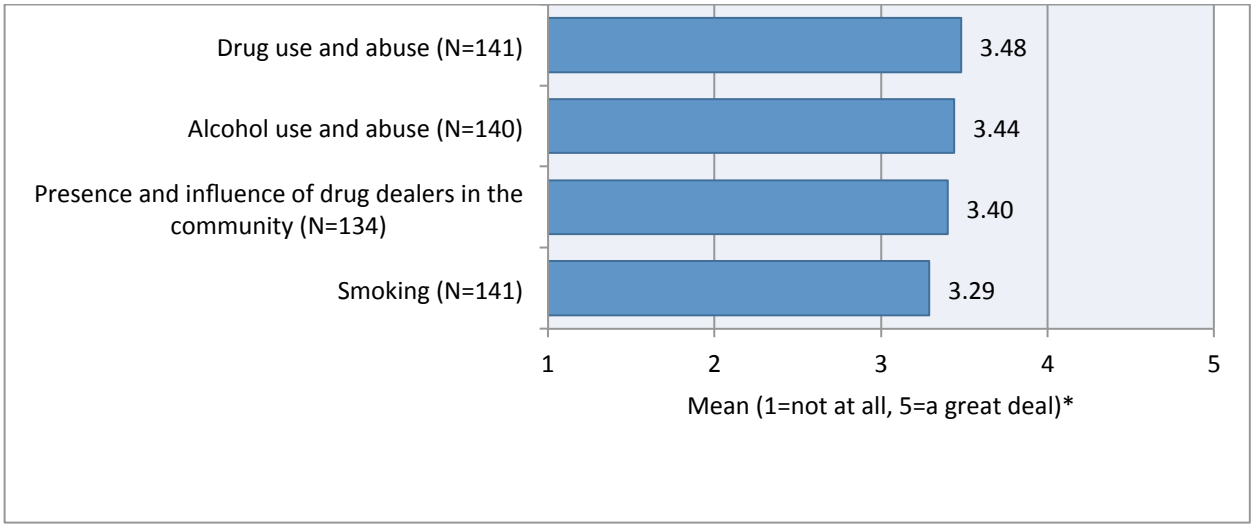
Community Health and Wellness Concerns

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



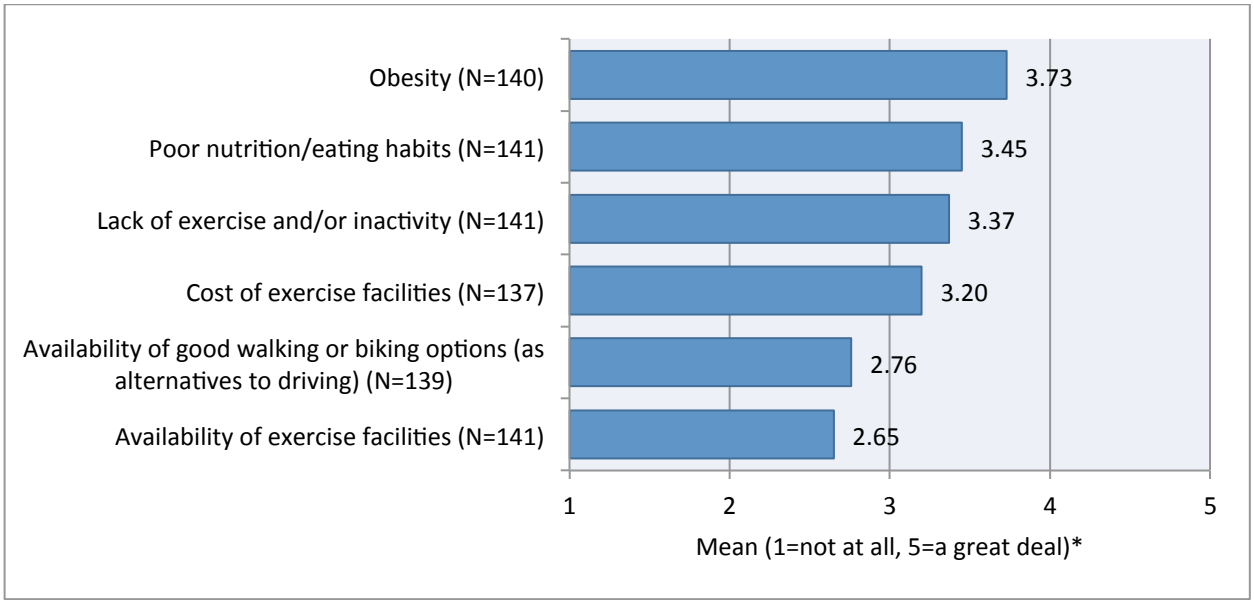
*Means exclude "do not know" responses.

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



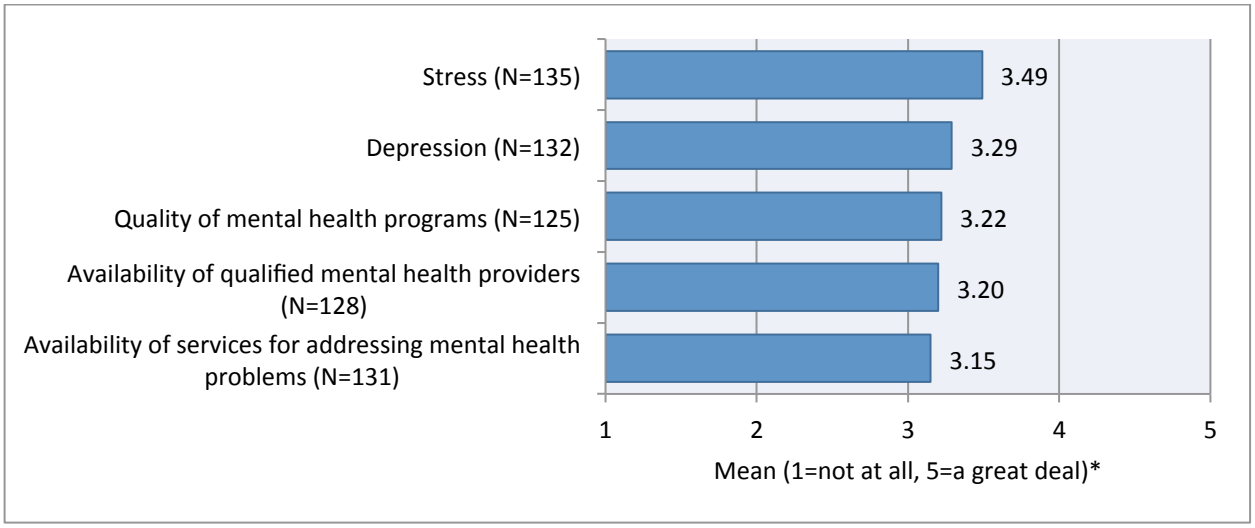
*Means exclude "do not know" responses.

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



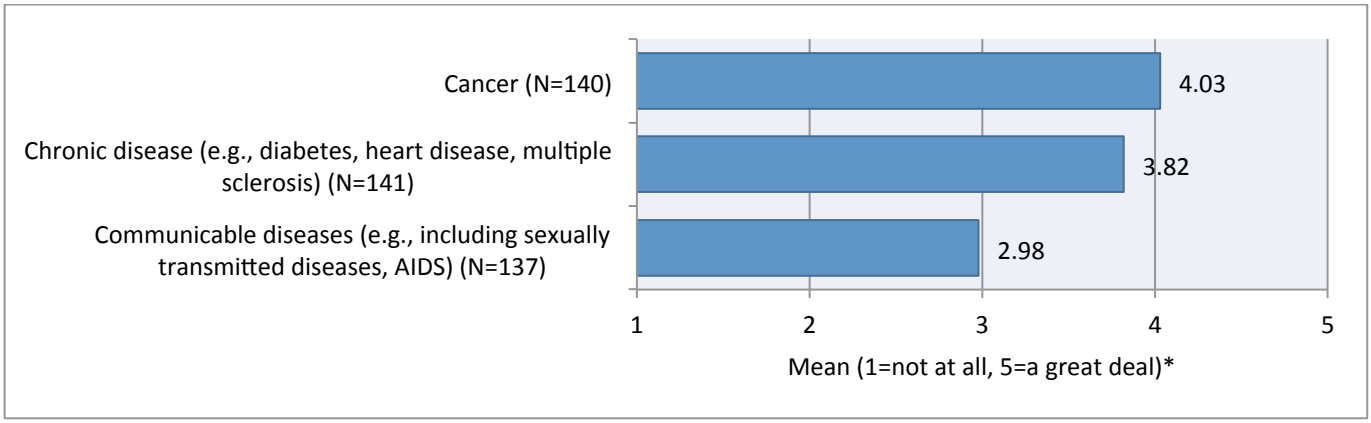
*Means exclude "do not know" responses.

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



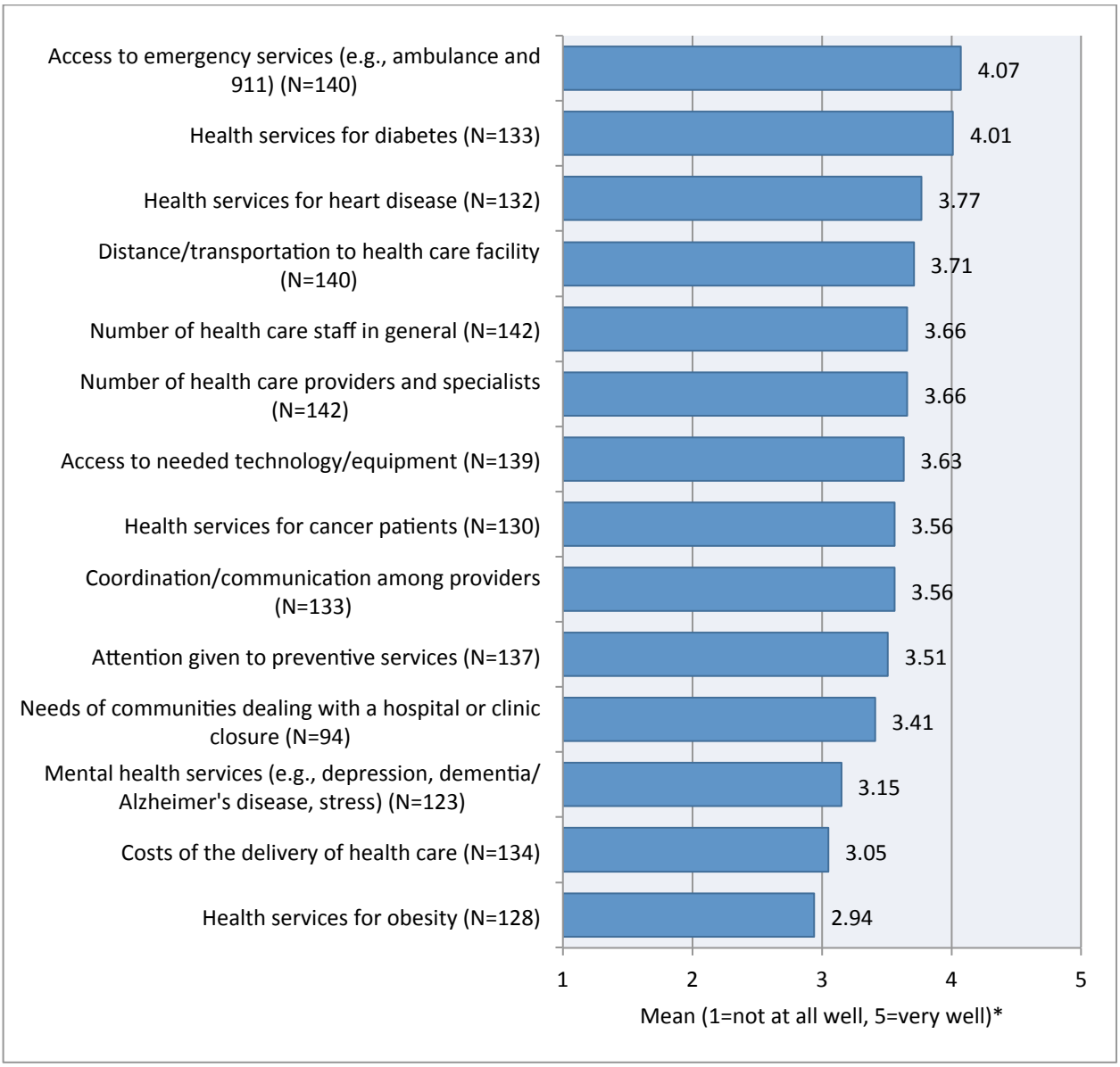
*Means exclude "do not know" responses.

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



*Means exclude "do not know" responses.

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

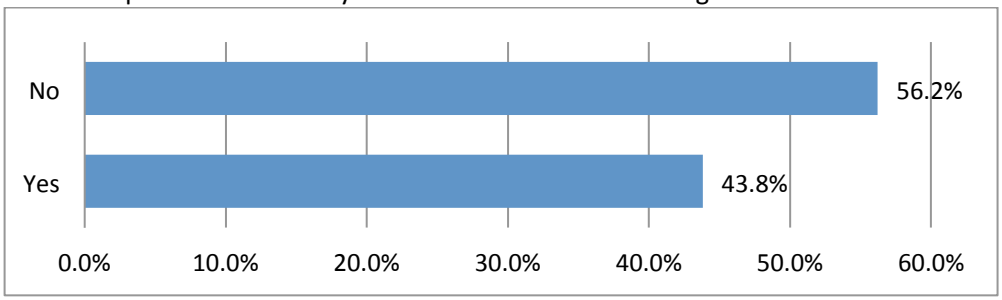


*Means exclude "do not know" responses.

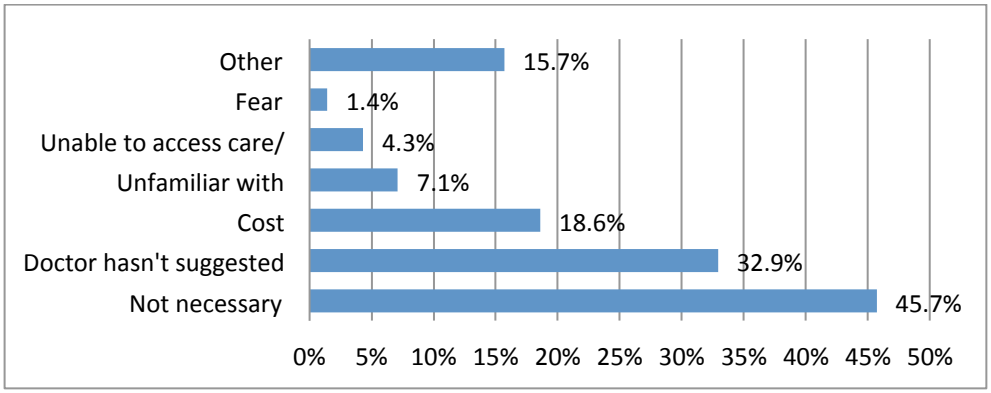
Personal Health Care Information

Cancer Screening

56% of respondents said they had not had cancer screening or cancer care within the past year.

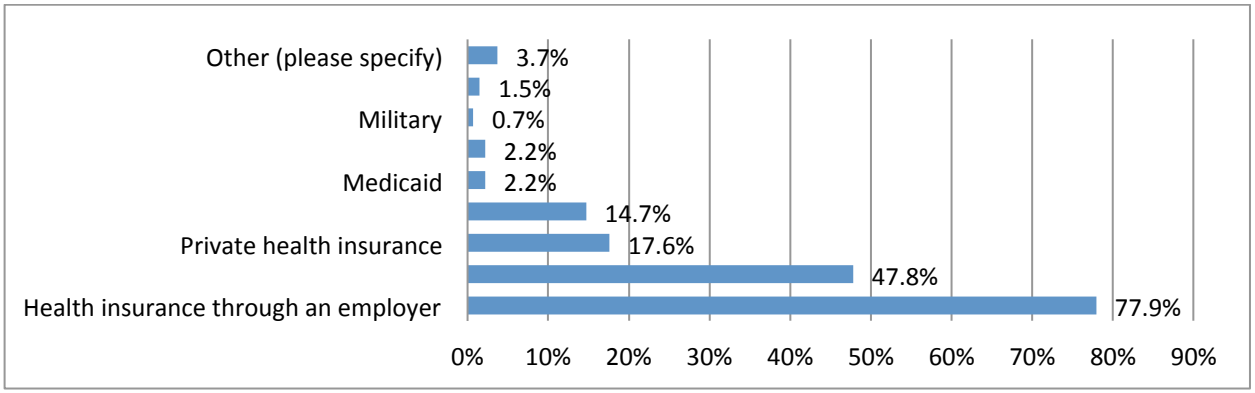


Among respondents who have not had a cancer screening or cancer care in the past year, 46% said it was not necessary and 32% had not done so because their doctor had not suggested it. Access and unfamiliarity with recommendations were not reasons that the majority of respondents gave.



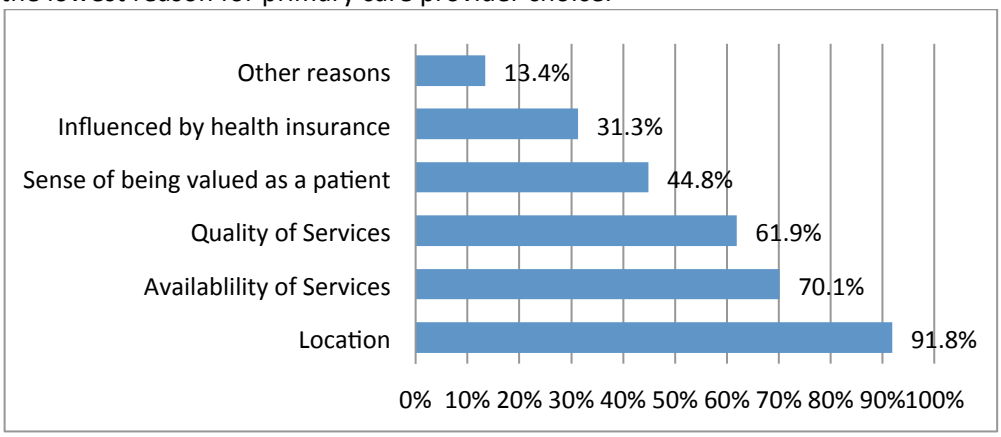
Health Care Coverage

A majority of respondents (77.9%) said they had paid for health care costs over the last 12 months by health insurance through an employer. Medicare, personal income and private health insurance and veteran's health care benefits were also used.



Primary Care Provider

The top reasons respondents gave for their choice of primary health care provider were location, quality of services, availability of services and the sense of being valued as a patient. Influence by health insurance ranked the lowest reason for primary care provider choice.

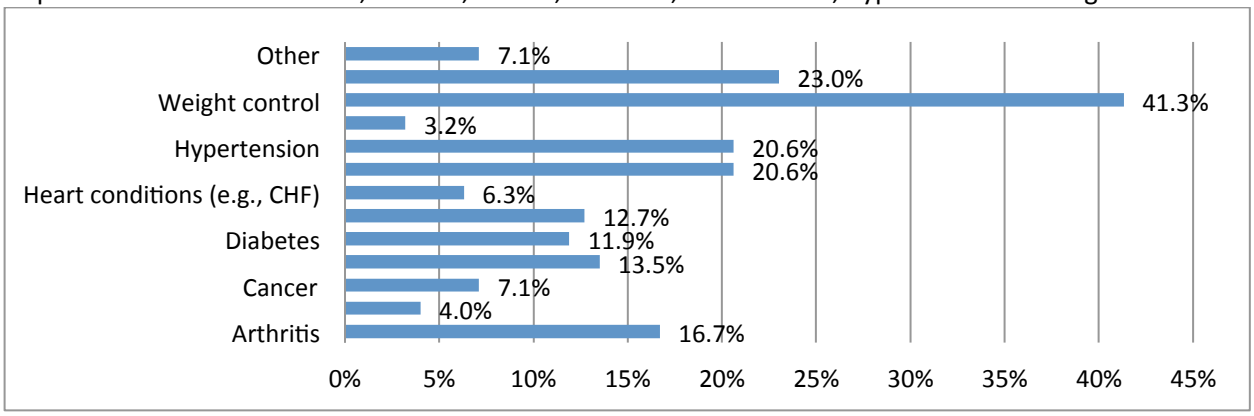


Respondent's Primary Care Provider

Respondents were asked which provider they used for their primary health care. Ninety-one percent (91%) of the respondents said they use Sanford Health as their primary health care provider.

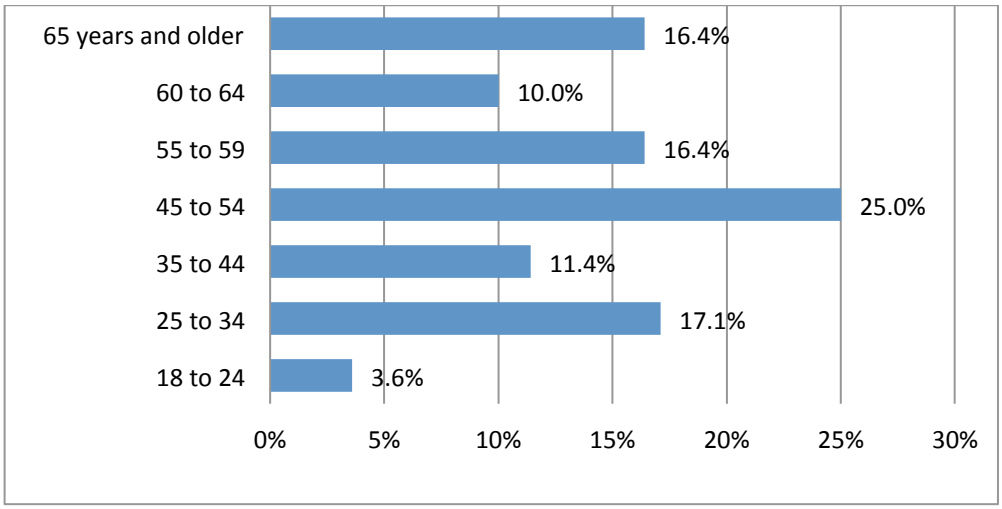
Respondents Representing Chronic Disease

Respondents were asked to select their personal general health conditions/diseases. Weight Control received the most responses with 41.3% of the participants selecting this condition. The chronic diseases found among respondents included arthritis, asthma, cancer, diabetes, heart failure, hypertension and high cholesterol.

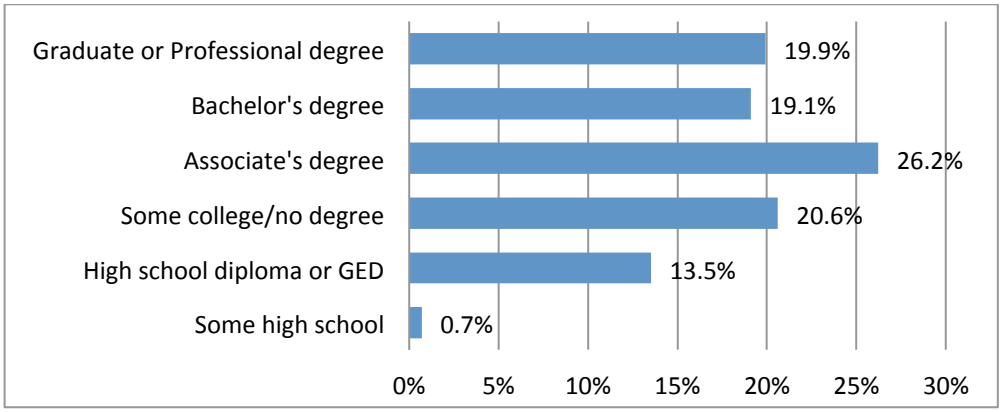


Demographic Information

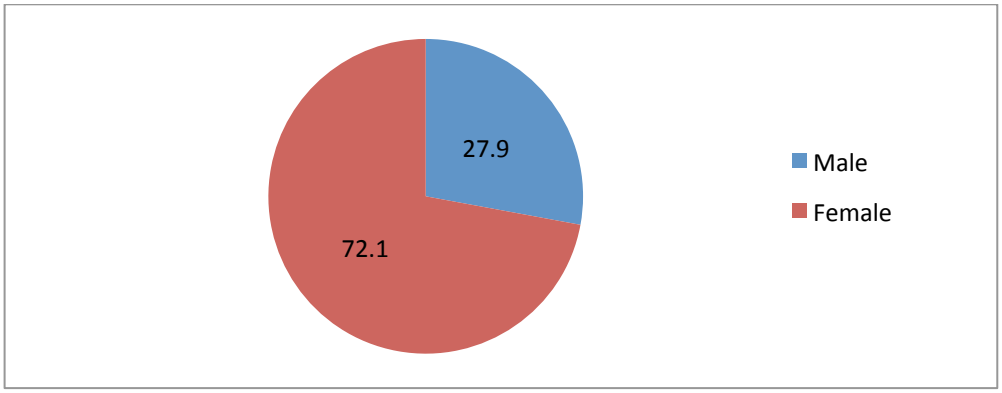
The majority of the respondents were 45-54 years old.



Most respondents had an Associate degree or higher, including 19.9 percent who had a graduate or professional degree.



72.1% of the respondents were female.



Secondary Research

Health Outcomes

Mortality

The Mortality health outcome indicates that Yellow Medicine County has more premature deaths that the Minnesota and the national benchmarks. Map 1 in the Appendix, provides a county view of the premature deaths in the five-state region.

		Yellow Medicine	National Benchmark	Minnesota
Premature death	Years of potential life lost before age 75 per 100,000 population (age adjusted), 2005-2007	7,253	5,564	5,272

Morbidity

The Morbidity health outcomes indicate that Minnesota citizens self-report more days of poor health (average number of physically unhealthy days reported in past 30 days unhealthy days reported in past 30 days age-adjusted 2003-2009) than the national benchmark; however, Yellow Medicine County reports slightly higher poor health.

Minnesota self-reports more mentally unhealthy days (average number of mentally unhealthy days reported in past 30 days unhealthy days reported in past 30 days age-adjusted 2003-2009) than the national benchmark. Yellow Medicine County has a higher rate for mentally unhealthy days than the state of Minnesota and the national benchmark.

Minnesota has a higher percentage of low birth weight than the national benchmark. Yellow Medicine County has a slightly higher rate than the national benchmark and slightly lower than the state of Minnesota. Maps 2-5 in the Appendix, provide county views of the morbidity indicators within the five-state region.

		Yellow Medicine	National Benchmark	Minnesota
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	13%	10%	11%
Poor physical health	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	3.6	2.6	3.1
Poor mental health	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	4.4	2.3	2.8
Low birth weight	Percent of live births with low birth weight (<2,500 grams), 2001-2007	6.4%	6.0%	6.5%

Health Factors

Health Behaviors

The Health Behavior outcomes indicate that Minnesota has a higher percentage of adult smokers (19% vs. 15%) than the national benchmark. Yellow Medicine County has no smoking data. Adult obesity is also higher in the state of Minnesota (26%) and in Yellow Medicine County (2%) than the national benchmark (25%).

Yellow Medicine County has the same percentage of physical inactivity as the national benchmark (20%). The state of Minnesota is lower at 17%.

Minnesota has a much higher rate of binge drinking reports (20%) than the national benchmark (8%). There are no statistics for Yellow Medicine County.

Motor vehicle crash death rates are higher than the national benchmark (12.0) in Minnesota (12.9) and Yellow Medicine County was significantly higher at 31.1%.

Sexually transmitted infections rank substantially higher than the national benchmark (83.0) for Minnesota (276.1), and for Yellow Medicine County (100.4).

The teen birth rate is higher in Minnesota (27.5) and Yellow Medicine County (26.1) than the national benchmark (22.0).

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

		Yellow Medicine	National Benchmark	Minnesota
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	-	15%	19%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008	27%	25%	26%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	20%	20%	17%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking**, 2003-2009	-	8%	20%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	31.3	12.0	12.9
Sexually transmitted infections	Number of Chlamydia cases (new cases reported) per 100,000 population, 2008	100.4	83.0	276.1
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	26.1	22	27.5

Clinical Care

The Clinical Care outcomes indicate that Yellow Medicine County has the same percentage of uninsured adults as the national benchmark (13%). Minnesota is slightly lower at 11%. The percentage of uninsured youth is lower in Minnesota (6%), and Yellow Medicine County is the same as the national benchmark (7%).

The ratio of population to primary care physicians is higher in Minnesota (636:1) than the national benchmark (631:1). Yellow Medicine County's ratio is more favorable (764:1).

The ratio of population to mental health providers is much lower in Minnesota (1,306:1) than the national benchmark (2,242:1). Yellow Medicine County has a much higher ratio (3,309:1).

The number of professionally active dentists in Minnesota (61) is lower than the national benchmark (69.0). There is no data for Yellow Medicine County.

Preventable hospital stays are higher than the national benchmark (52.0) in Minnesota (56.5.) and in Yellow Medicine County (68.3).

Diabetes screening in Minnesota (88%) is slightly lower than the national benchmark (89%). The rate of diabetes screening is also lower in Yellow Medicine County (83%) than the national benchmark.

The national benchmark (74%) for mammography screenings is slightly higher than Minnesota (73%) and Yellow Medicine County (73%).

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

		Yellow Medicine	National Benchmark	Minnesota
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	13%	13%	11%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	7%	7%	6%
Primary care physicians	Ratio of total population to primary care physician, 2008	764:1	631:1	636:1
Mental health providers	Ratio of total population to mental health providers, 2008	3,309:1	2,242:1	1,306:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	-	69.0	61.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	68.3	52.0	56.5
Diabetes screening	Percent of Medicare enrollees with diabetes that receive HbA1c screening, 2006-2007	83%	89%	88%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	73%	74%	73%

Social and Economic Factors

The Social and Economic Factors outcomes indicate that Minnesota (87%) has a lower high school graduation rate than the national benchmark (92%); however, Yellow Medicine County has a higher benchmark at 95%. Minnesota has a higher post-secondary education level than the national benchmark and Yellow Medicine County (at 68%) is exactly the same as the national benchmark.

The unemployment rate was substantially higher nationally (5.3%) during 2009, while Minnesota (8.0%) and Yellow Medicine County (6.7%) were all substantially higher.

The percentage of child poverty in Minnesota, Yellow Medicine County and the national benchmark are exactly the same at 11%.

Inadequate social support in Minnesota is exactly the same as the national benchmark - 14%. There was no data for Yellow Medicine County.

The percentage of children in single parent households is higher in Minnesota (25%) than the national benchmark (20%), but is the same in Yellow Medicine County (20%).

The number of homicide deaths in Minnesota (2.5) is higher than the national benchmark (1.0). There was no data available for Yellow Medicine County for this indicator.

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

		Yellow Medicine	National Benchmark	Minnesota
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007	95%	92%	87%
Same college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	68%	68%	72%
Unemployment	Percent of population ages 16 and older that is unemployed by seeking work, 2009	6.7%	5.3%	8.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	11%	11%	11%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	-	14%	14%
Children in single-parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	20%	20%	25%
Homicide rate	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 20010-2007	-	1.0	2.5

Physical Environment

The Physical Environment outcomes indicate that there is no air pollution or ozone pollution in this area. Access to healthy food is ranked below the national benchmark (92%) in both Minnesota (54%) and Yellow Medicine Co. (71%).

Access to recreational facilities ranks lower than the national benchmark for Minnesota (12.0) and for Yellow Medicine County (10%).

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

		Yellow Medicine	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	71%	92%	54%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	10.0	17.0	12.0

Demographics

		Yellow Medicine	National Benchmark	Minnesota
Youth	Percent of total population ages 0-17, 2009	23%	24%	24%
Elderly	Percent of total population ages 65 and older, 2009	21%	13%	13%
Rural	Percent of total population living in a rural area, 2000	82%	21%	29%
Non English proficient	Percent of total population that speaks English less that "very well," 2005-2009	1%	9%	4%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	7%	15%	6%

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

Population by Age

The population for this area is relatively young with only 4% older than 85 years of age and only 19% older than 65 years of age.

The gender distribution is approximately 50-50 in Yellow Medicine County.

	Yellow Medicine	Minnesota
Total Population	10,438	5,303,925
Percent ages 65 and older	19%	13%
Percent ages 85 and older	4%	2%
Percent male	51%	50%
Percent female	49%	50%

Housing

	Yellow Medicine	Minnesota
Percent of occupied housing that is owner-occupied	79%	73%
Percent of occupied housing that is renter-occupied	21%	27%

Economic Security

Based on 2010 Census data

According to the 2010 Census Data, the population of working age in the labor force is 71% in Minnesota. Yellow Medicine County is at 67%. The percentage of those who are living at less than 100% of the Federal poverty level range is 11% in Minnesota, with 26% living at less than 200% of the Federal poverty level. Both rates are slightly higher in Yellow Medicine County.

The median annual household income in Minnesota is $57,243. Yellow Medicine County falls below that level at $50,288 annual income.

	Yellow Medicine	Minnesota
Percent of working-age population in labor force	67%	71%
Percent of total population with income less than 100% of poverty	13%	11%
Percent of total population with income less than 200% of poverty	29%	26%
Median household income (by age of householder)	$50,288	$57,243
Owner-occupied housing units (by age of householder)	3,350	1,548,127
Percent spending 30% or more of income toward housing costs	17%	28%
Renter-occupied housing units (by age of householder)	863	537,790
Percent spending 30% or more of income toward housing costs	40%	46%

Diversity Profile

The population distribution by race demonstrates that Yellow Medicine County and the state of Minnesota are predominantly white, followed by Hispanic origin of any race. Blacks rank third in Minnesota and last in Yellow Medicine County as the leading race by population. American Indians rank third in Yellow Medicine County while they rank last in the state of Minnesota.

	Yellow Medicine	Minnesota
Total Population	10,438	5,303,925
White alone	9,806	4,524,062
Black alone	16	274,412
American Indian alone	314	60,916
Asian alone	33	214,234
Hispanic Origin – of any race	397	250,258

Health Needs Identified

The identified needs from the surveys and analysis of secondary data indicated the following needs:

- Need for Local Chemotherapy
- Handicap Accessibility
- Workforce
- Physical Health/Obesity/Nutrition Education
- Better Emergency Room Facility

Community Assets/Prioritization Process

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

Each unmet need was researched to determine what resources were available in the community to address the needs. The Sanford Canby Community 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.

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.

An informal gap analysis was conducted at the conclusion of the asset mapping work. The gap analysis determined that there were three main areas on which to focus attention. A multi-voting prioritization process determined the priority of the remaining needs.

The priorities that remain include:

- Physical Health/Obesity/Nutrition Education
- Need for Local Chemotherapy
- Better Emergency Room Facility

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

IMPLEMENTATION STRATEGY

2013 Community Health Needs Assessment
Sanford Canby Medical Center
Implementation Strategy

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

- Obesity Issues
- Provision of Local Oncology Services

Implementation Strategy: Develop formal program to address obesity issues

- Appoint overall planning committee to execute program goals.
- Increase physical activity in various settings within the community.
- Improvement in dietary behaviors of the community through the use of multiple resources.
- Support the community obesity issues through the use of social and behavioral approaches.

Implementation Strategy: Provide local oncology services through outreach

- Enhance current telemedicine capabilities/frequency in conjunction with on-site oncologist presence.
- Provide local additional chemotherapy services.

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

Yellow Medicine County

Minnesota

HEALTH OUTCOMES		ellow Medicir	*National Benchmark	Minnesota
Mortality				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	7,253	5,564	5,272
Morbidity				
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	13%	10%	11%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	3.6	2.6	3.1
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	4.4	2.3	2.8
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	6.4%	6.0%	6.5%
HEALTH FACTORS				
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	20%	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	31.3	12.0	12.9
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	100.4	83.0	276.1
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	26.1	22.0	27.5
Clinical Care				
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	13%	13%	11%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	7%	7%	6%
Primary care physicians	Ratio of total population to primary care physicians, 2008	764:1	631:1	636:1
Mental health providers	Ratio of total population to mental health providers, 2008	3,309:1	2,242:1	1,306:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	-	69.0	61.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	68.3	52.0	56.5
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	83%	89%	88%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	73%	74%	73%

2011 County Health Profile (Page 2)

Yellow Medicine County
Minnesota

HEALTH FACTORS (continued)		ellow Medicir	*National Benchmark	Minnesota
Social and Economic Factors				
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007	95%	92%	87%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	68%	68%	72%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	6.7%	5.3%	8.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	11%	11%	11%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	-	14%	14%
Children in single-parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	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				
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	71%	92%	54%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	10.0	17.0	12.0

Demographics		ellow Medicir	United States	Minnesota
Youth	Percent of total population ages 0-17, 2009	23%	24%	24%
Elderly	Percent of total population ages 65 and older, 2009	21%	13%	13%
Rural	Percent of total population living in a rural area, 2000	82%	21%	29%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	1%	9%	4%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	7%	15%	6%

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

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

 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

Yellow Medicine County
Minnesota

CHARACTERISTICS	Total	AGE	
		Less than 65 Years	Ages 65 and Older
Population[1]			
Total population	10,438	8,407	2,031
Percent ages 65 and older	19%	-	100%
Percent ages 85 and older	4%	-	21%
Percent male	51%	53%	44%
Percent female	49%	47%	56%
Living Arrangements			
Total households (by age of householder)[1]	4,292	3,024	1,268
Percent with family households (i.e., at least two people who are related)	66%	72%	52%
Percent with householder living alone	29%	22%	47%
Grandparents living with their grandchildren*[2]	72	28	44
Percent who are responsible for their grandchildren	68%	86%	57%
Housing[1]			
Percent of occupied housing that is owner-occupied	79%	78%	82%
Percent of occupied housing that is renter-occupied	21%	22%	18%
Economic Security[2]			
Percent of working-age population in labor force	67%	84%	16%
Percent of total population with income less than 100% of poverty	13%	14%	6%
Percent of total population with income less than 200% of poverty	29%	28%	34%
Median household income (by age of householder)	$50,288	$46,182	$30,449
Owner-occupied housing units (by age of householder)	3,350	2,268	1,082
Percent spending 30% or more of income toward housing costs	17%	17%	15%
Renter-occupied housing units (by age of householder)	863	659	204
Percent spending 30% or more of income toward housing costs	40%	42%	35%

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.

 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

Yellow Medicine 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	10,438	9,806	16	314	33	397
Percent ages 0 to 17	24%	22%	44%	35%	42%	51%
Percent ages 18 to 44	29%	29%	44%	36%	24%	36%
Percent ages 45 to 64	28%	29%	13%	23%	24%	11%
Percent ages 65 and older	19%	20%	0%	6%	9%	1%
Median age (in years)	42.9	44.3	19.5	26.5	31.5	17.5
Living Arrangements						
Total households [1]	4,292	4,098	4	123	10	90
Percent with householder living alone	29%	30%	25%	31%	40%	18%
Percent with families with children ages 0 to 17	27%	26%	75%	37%	50%	63%
Grandparents living with their grandchildren [2]	72	62	0	10	0	0
Percent who are responsible for grandchildren	68%	74%	-	30%	-	-
Housing [1]						
Percent occupied housing that is owner-occupied	79%	80%	50%	75%	10%	63%
Percent occupied housing that is renter-occupied	21%	20%	50%	25%	90%	37%
Educational Attainment [2]						
Percent of persons ages 25 and older with high school degree or higher	90%	91%	65%	88%	75%	35%
Percent of persons ages 25 and older with Bachelor's degree or higher	18%	18%	0%	13%	65%	2%
Economic Security [2]						
Unemployment rate	5%	5%	71%	12%	0%	24%
Median household income	$50,288	$50,815	$13,173	$36,667	$85,625	$20,865
Percent of households with income <$25,000	25%	24%	100%	45%	31%	64%
Percent of persons with income <100% poverty	13%	10%	79%	25%	47%	71%
Percent of children ages 0 to 17 in families with income <100% poverty	23%	17%	100%	41%	73%	77%
Percent of elderly ages 65 and older with income <100% poverty	7%	7%	-	0%	-	0%

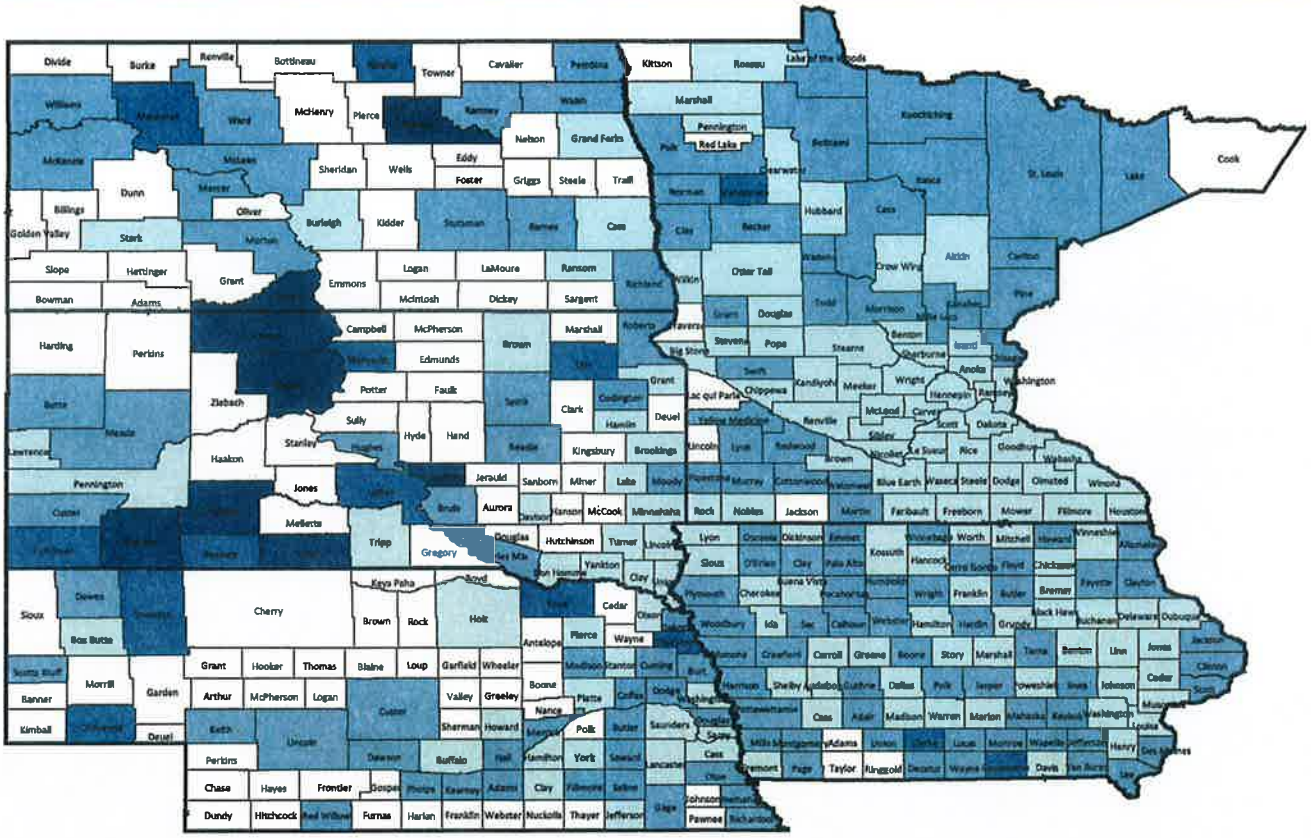
Source: U.S. Census Bureau, [1]2010 Census Summary File 1 and [2]2006-2010 American Community Survey (ACS) 5-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across race and ethnic categories; however, because they are based on sample data, one should 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.

 The Diversity Profile was prepared by researchers at North Dakota State University in Fargo for Sanford Health. May 2012

Map 1

Premature Death - A health outcome measure focusing on mortality

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



Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007

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

CONTEXT

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

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

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

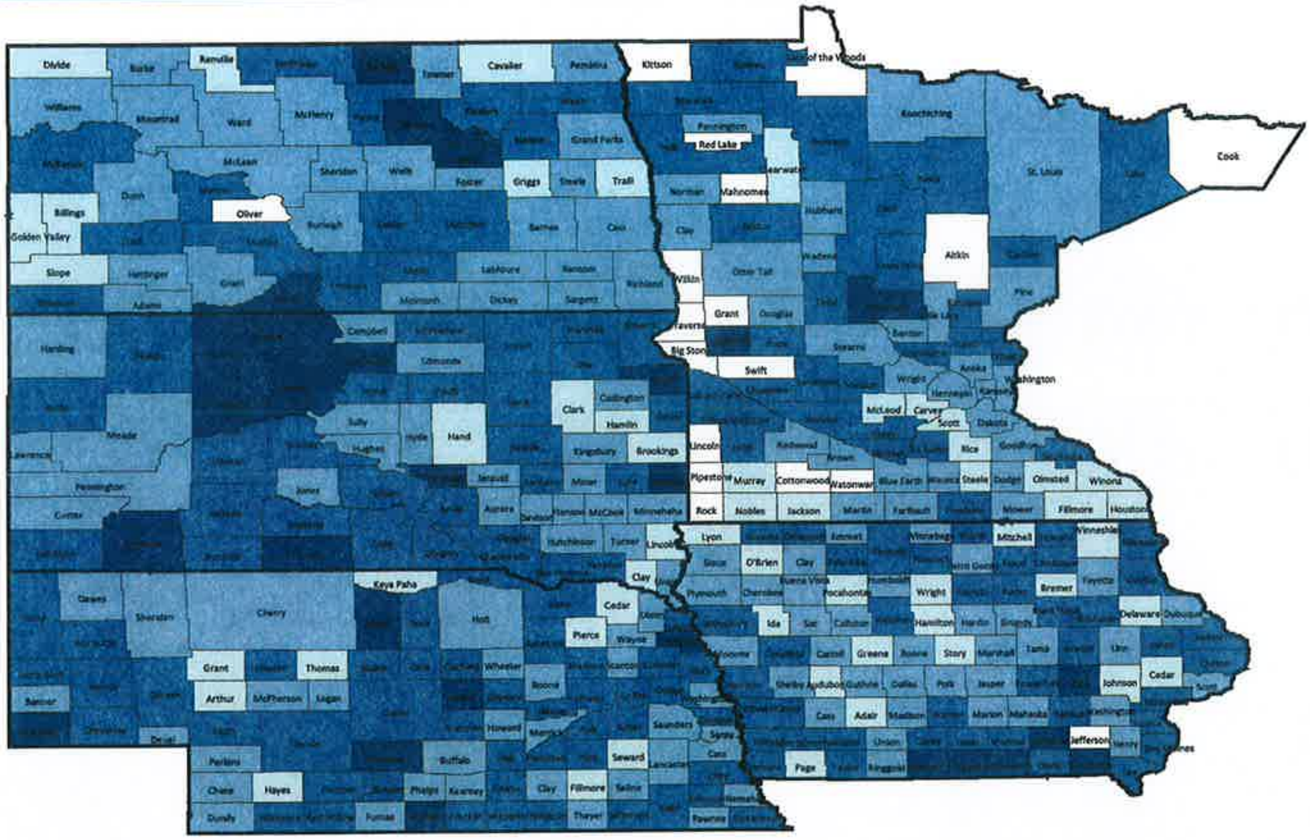
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

 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

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

Map 2

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.

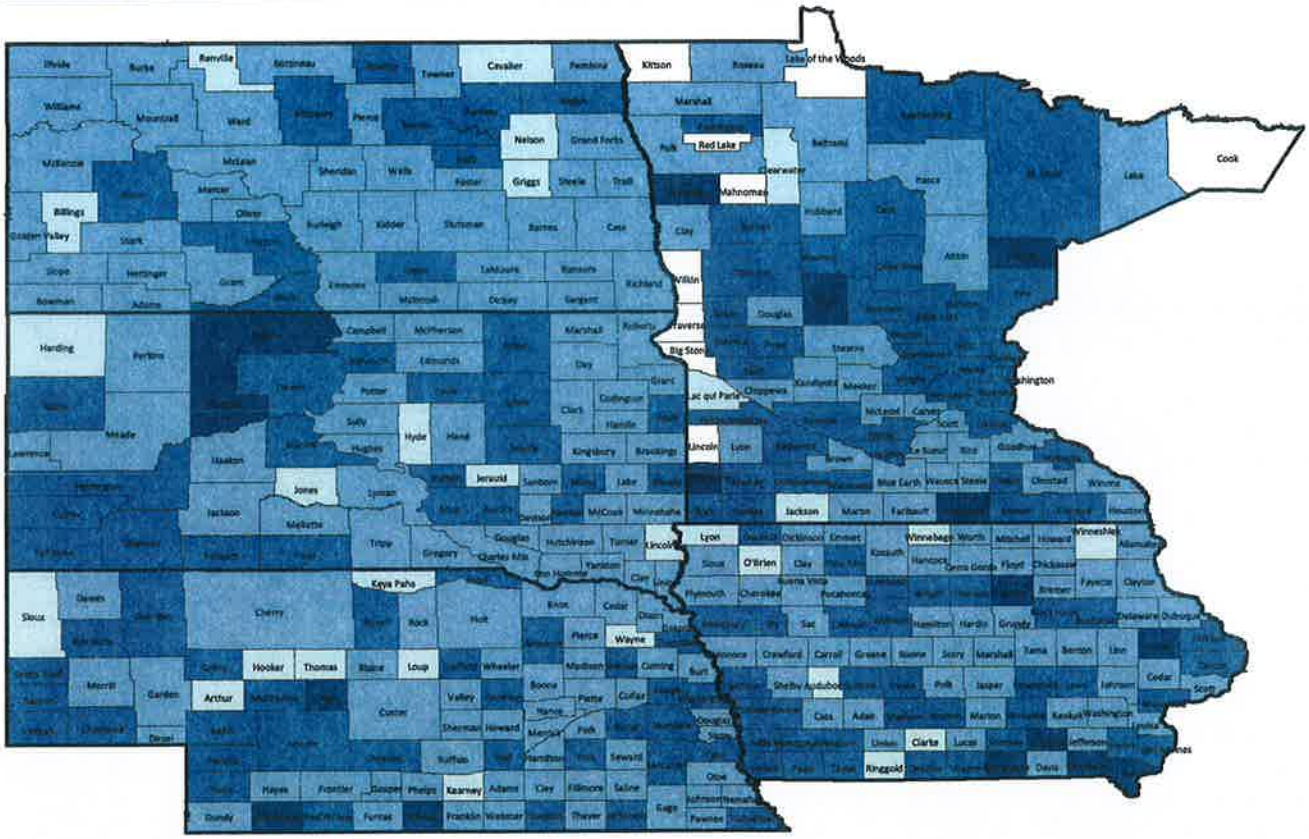
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

 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 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.

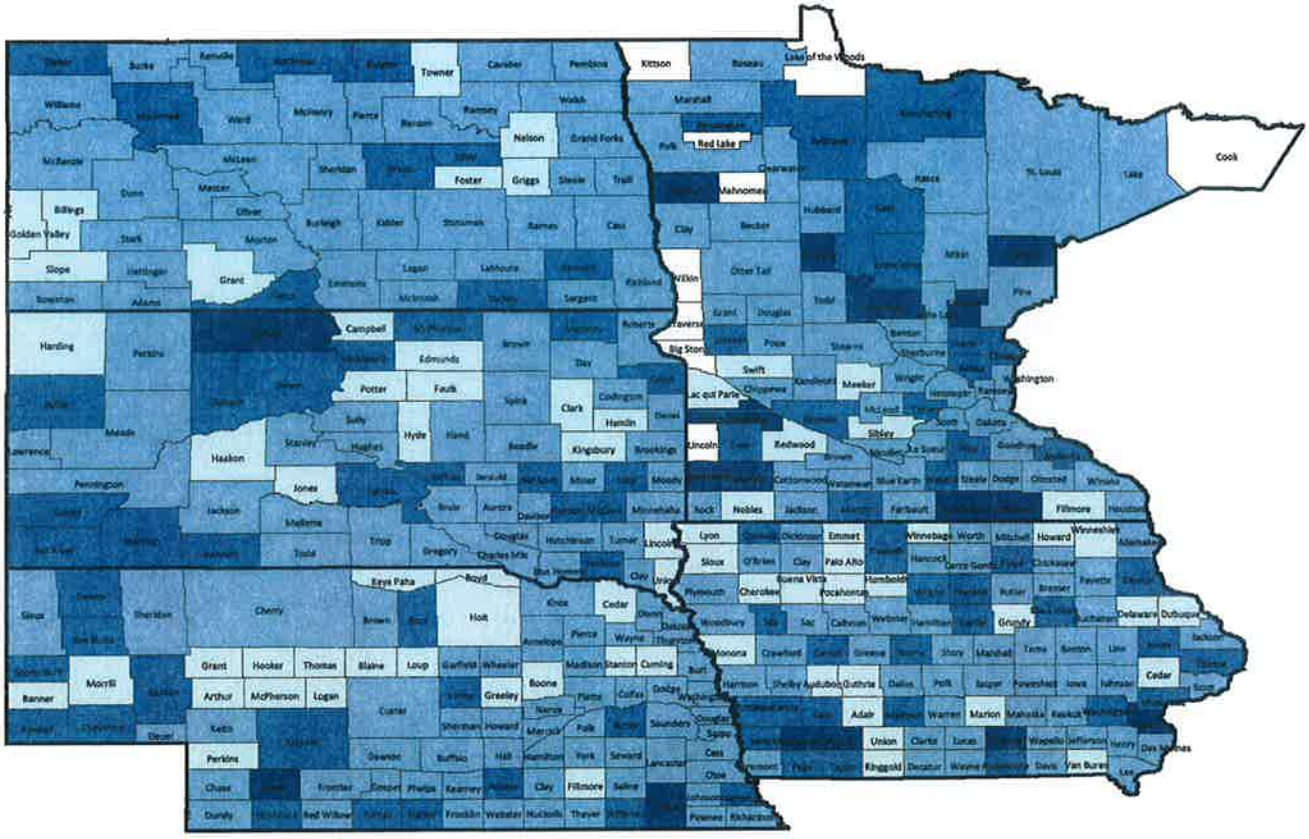
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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

Importance: Overall health depends on both physical and mental well-being. Measuring the number of days when people report that their mental health was not good, i.e., poor mental health days, represent an important facet of health-related quality of life. The County Health Rankings considers health-related quality of life to be an important health outcome.

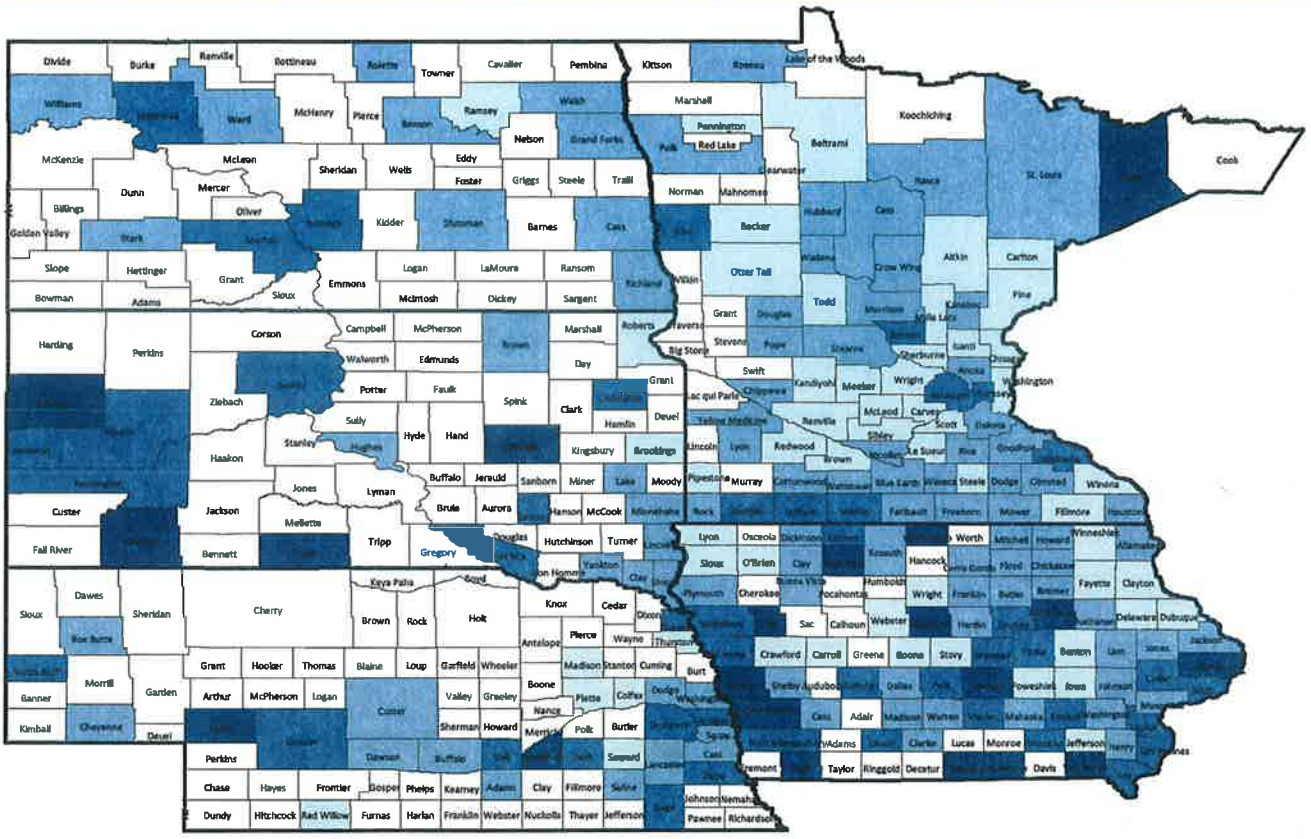
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

 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

Low Birthweight - A health outcome measure focusing on morbidity

Map 5

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.

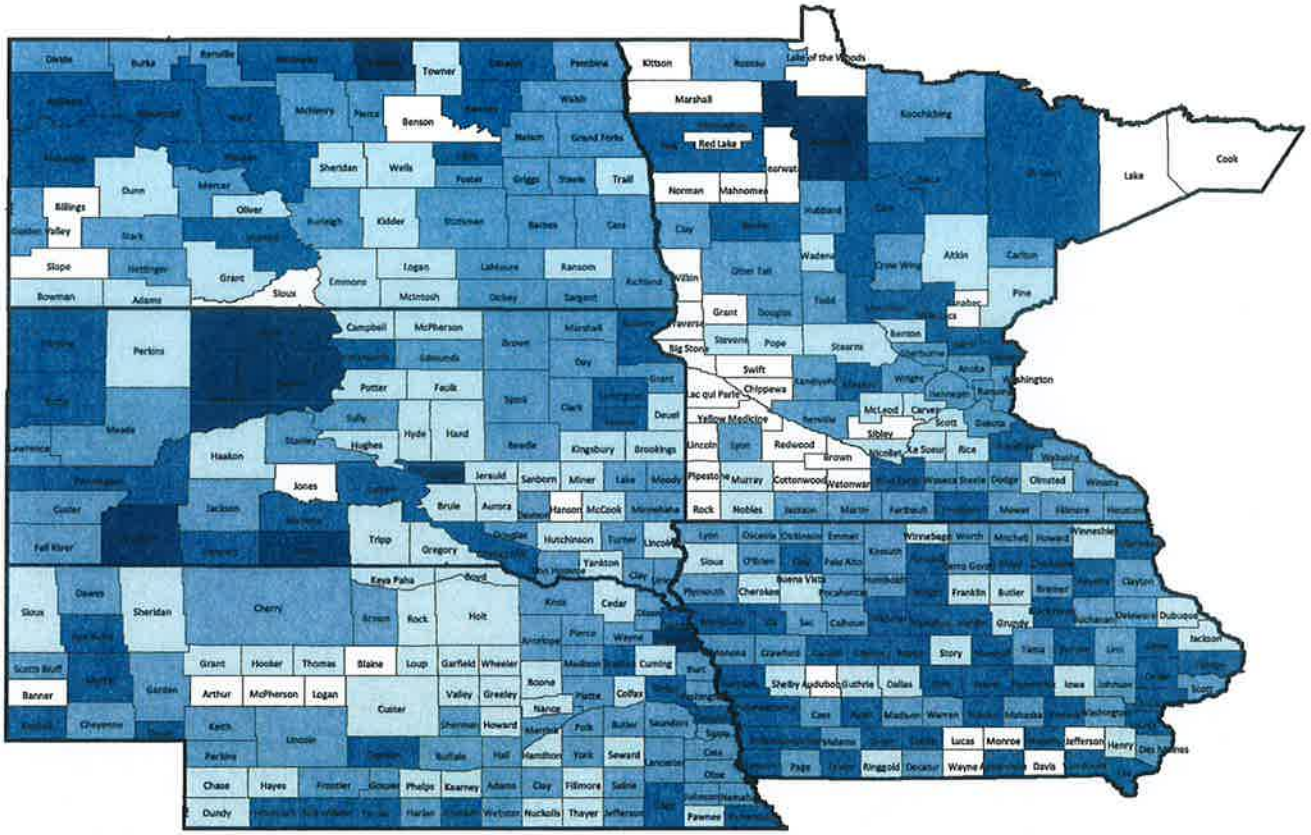
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

 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 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.

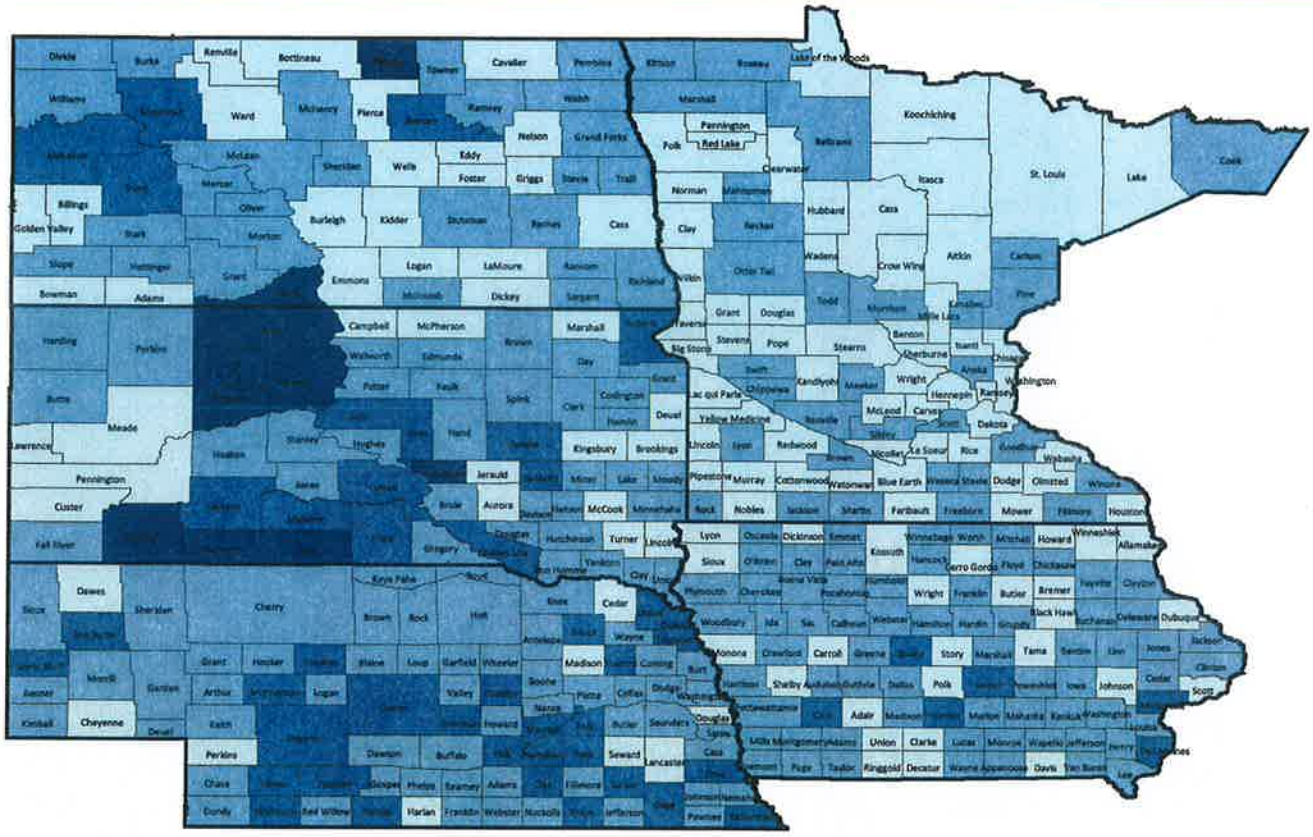
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

 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 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.

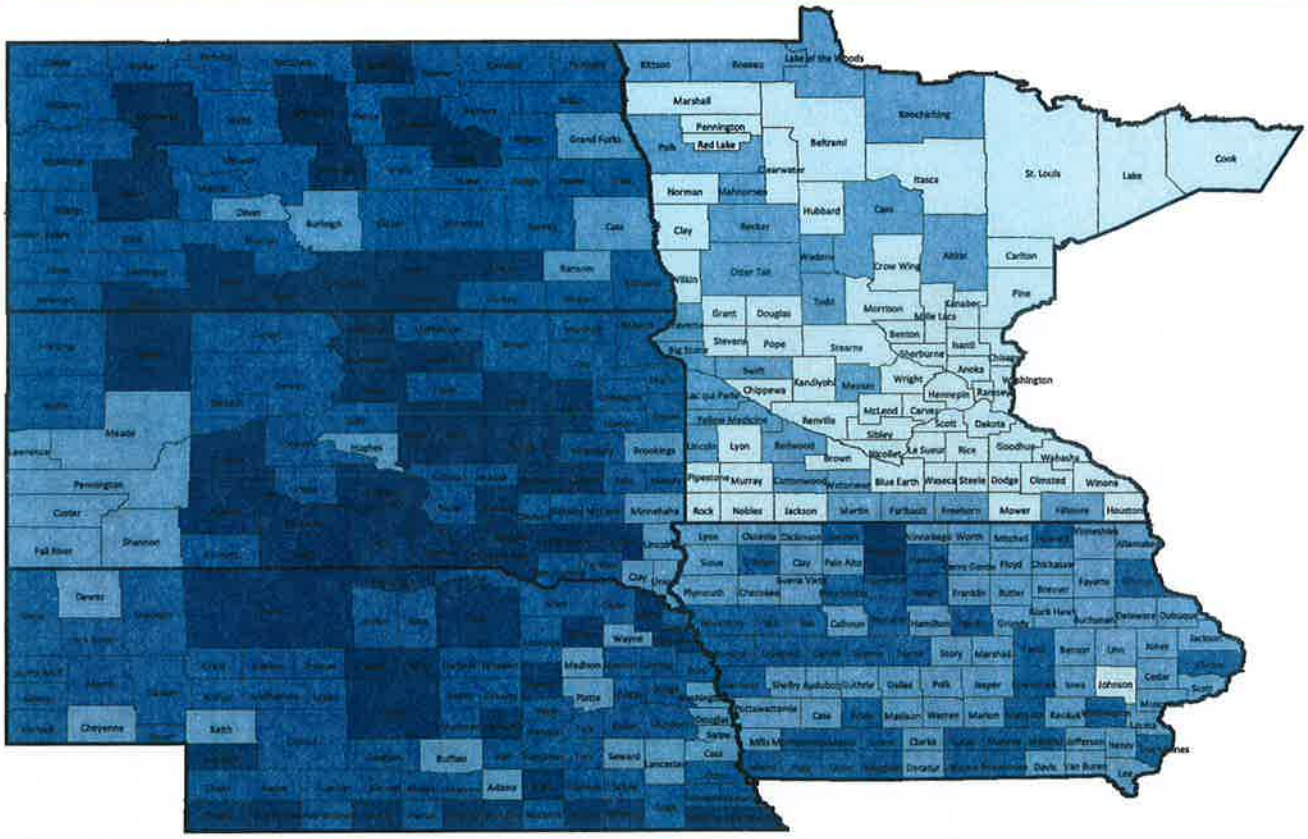
Importance: Obesity is often the end result of an overall energy imbalance due to poor diet and limited physical activity. Obesity increases the risk for health conditions such as coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep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

 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

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.

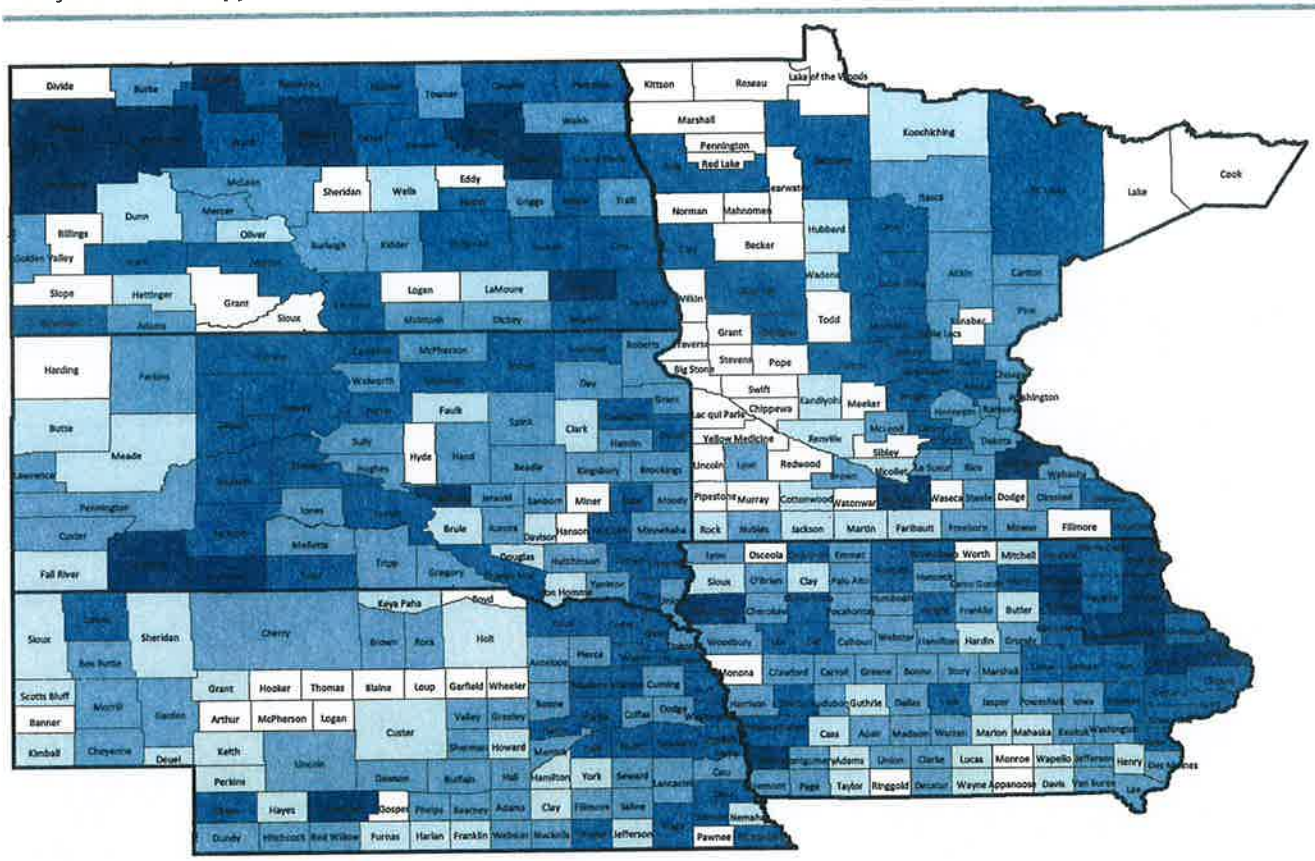
Importance: Regular physical activity is one of the most important things one can do for their health. It can help control weight, reduce risk of cardiovascular disease, reduce risk for type 2 diabetes and metabolic syndrome, reduce risk of some cancers, strengthen bones and muscles, improve mental health 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/.

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.

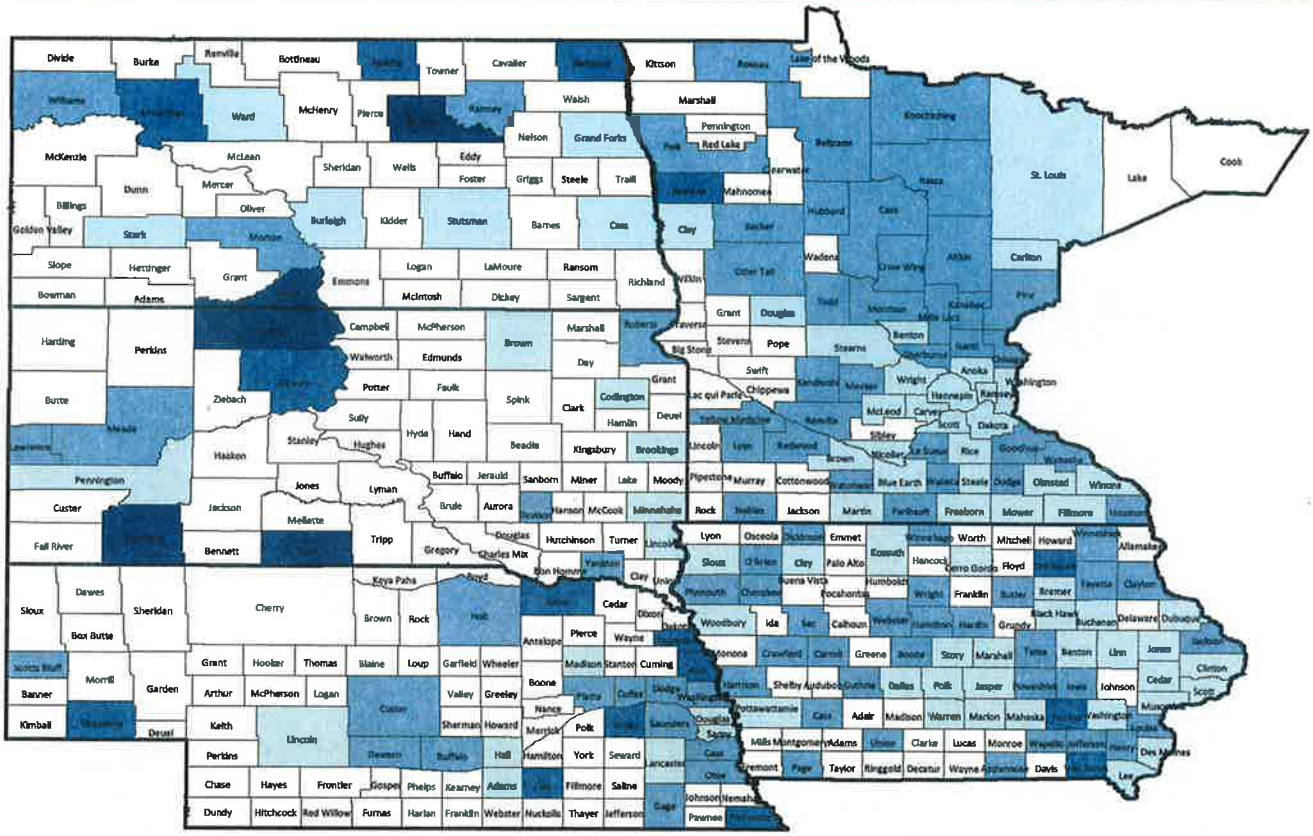
Importance: Excessive drinking is a risk factor for a number of adverse health outcomes such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and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

 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

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/.

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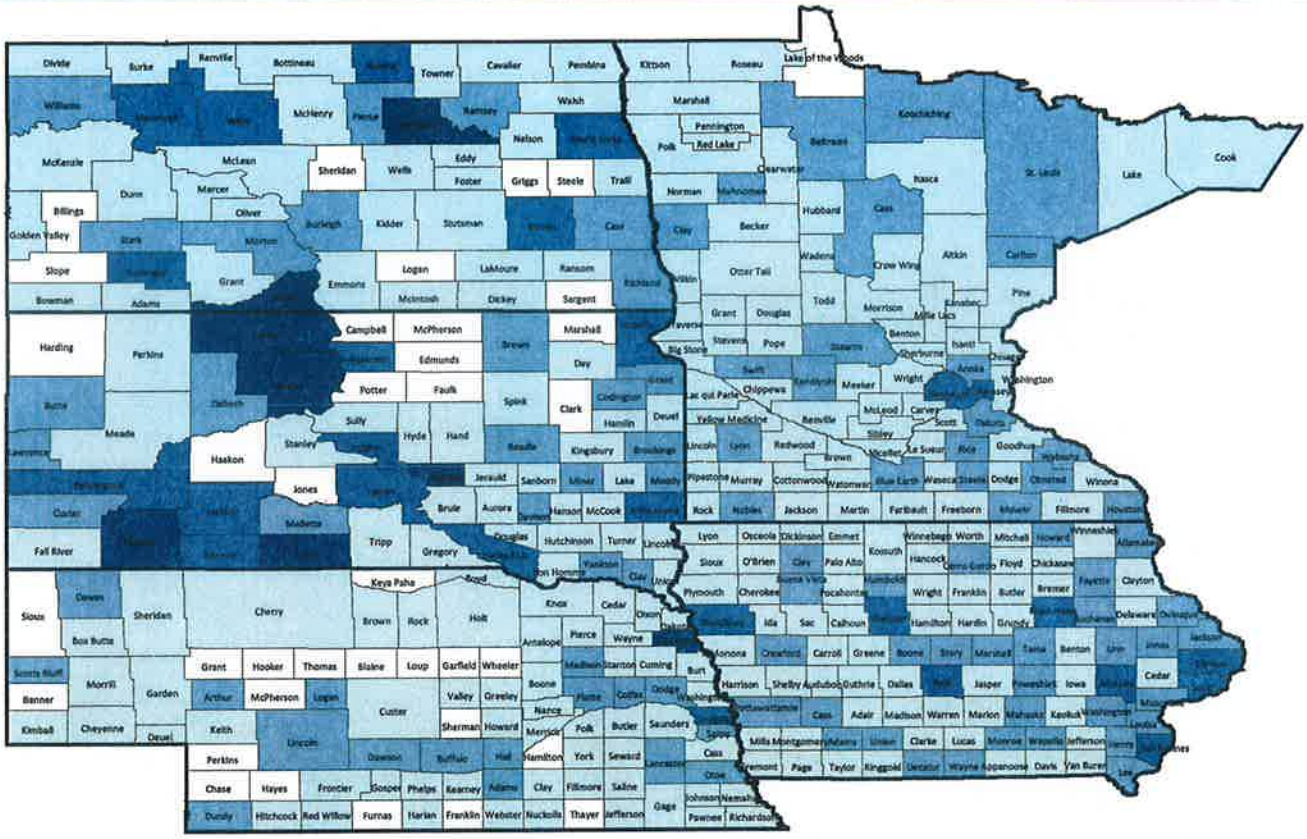
Sexually Transmitted Infections - A health factor measure focusing on health behaviors

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.

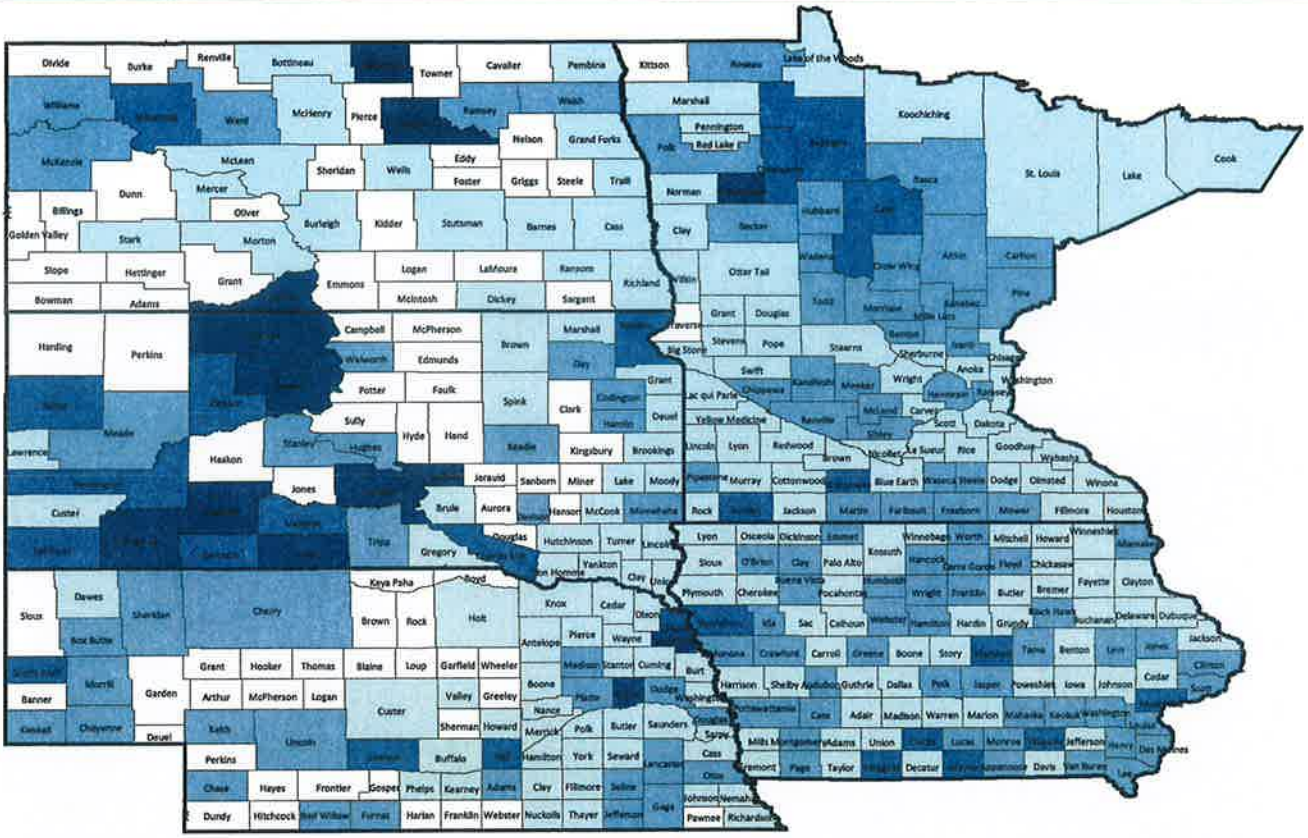
Importance: Chlamydia is the most common bacterial STI in North America and is one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain. STIs in general are associated with a significantly increased risk of morbidity and mortality, including 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/.

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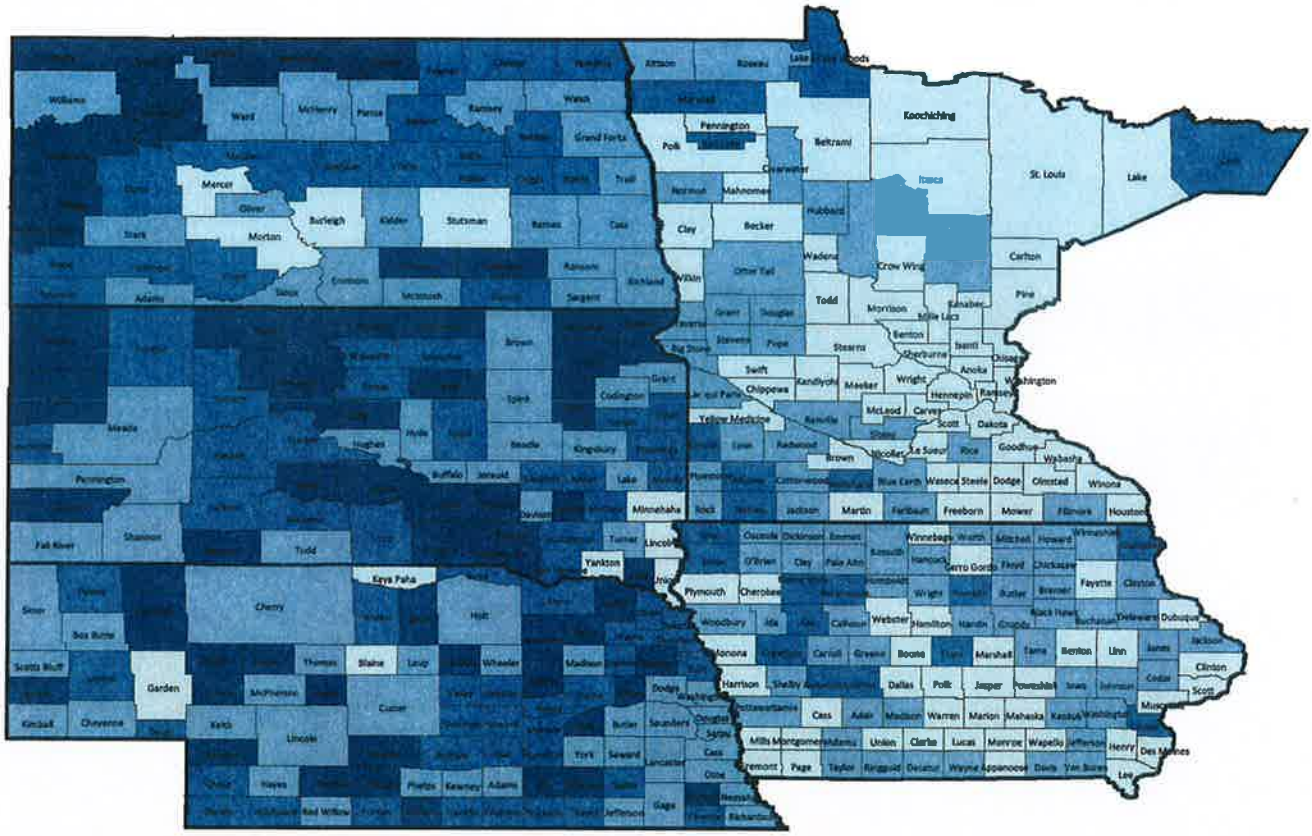
Uninsured Adults - A health factor measure focusing on clinical care

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.

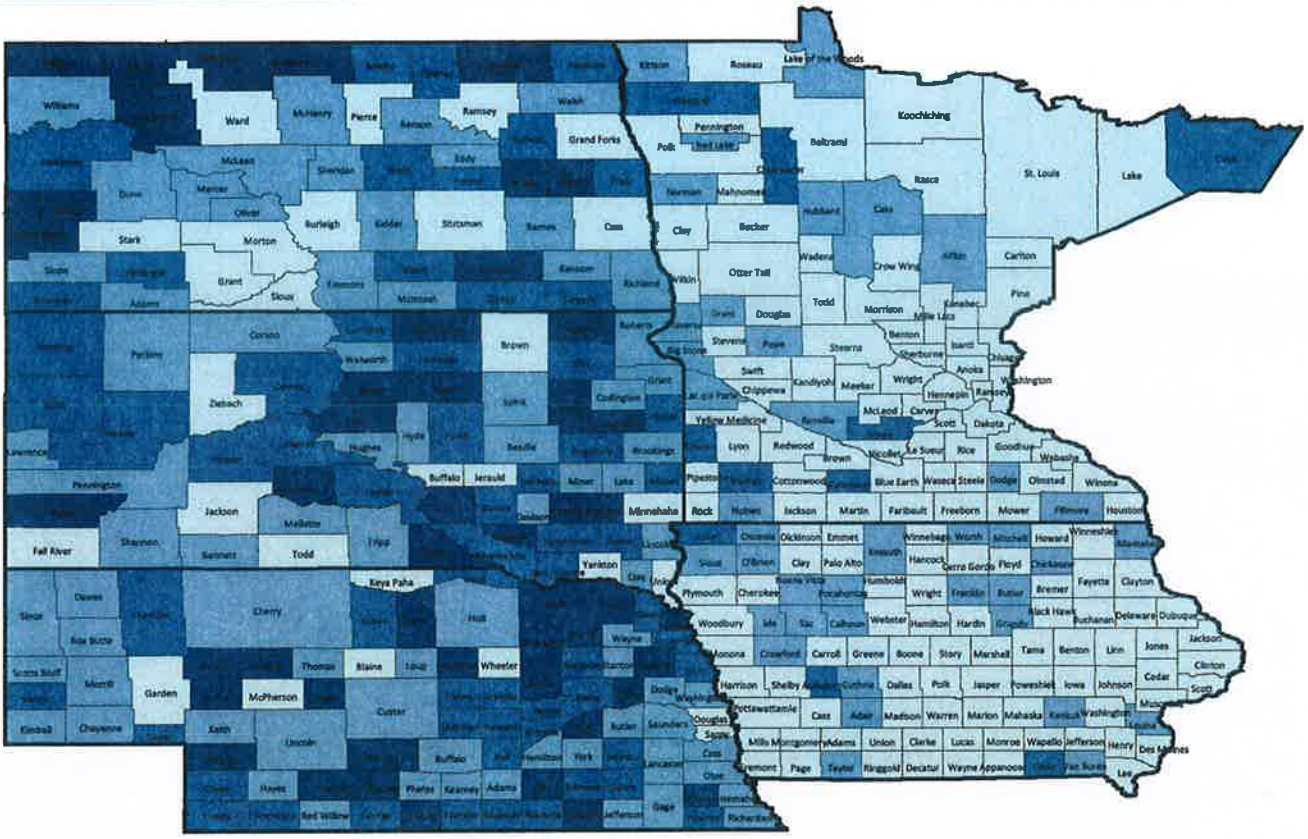
Importance: Lack of health insurance coverage is a significant barrier to accessing needed health care.

- 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/.

Uninsured Youth - A health factor measure focusing on clinical care

Map 14

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



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

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

CONTEXT

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

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

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

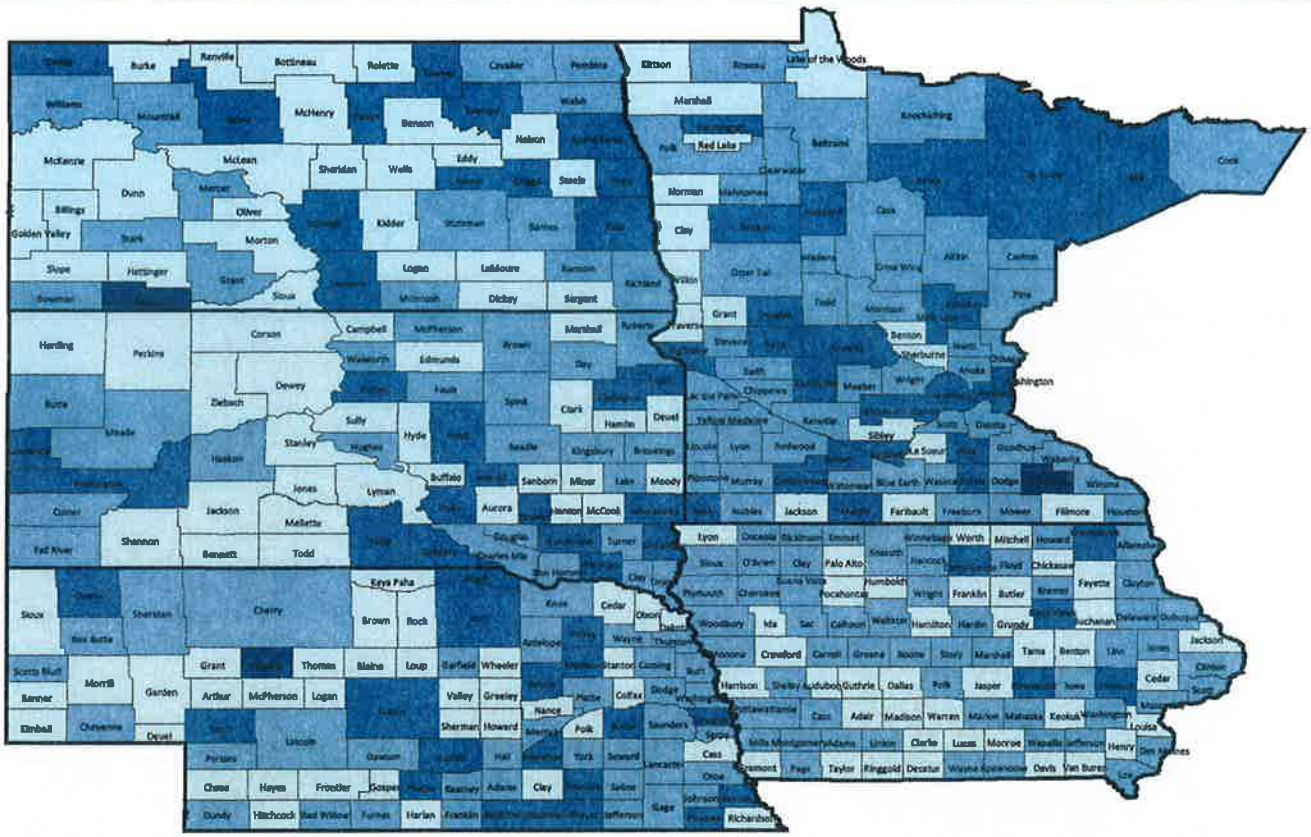
- Data were obtained from the Small Area Health Insurance Estimates (SAHIE), a program of the U.S. Census Bureau, http://www.census.gov/did/www/sahie/.

 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

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

Map 15

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



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

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

CONTEXT

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

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

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

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

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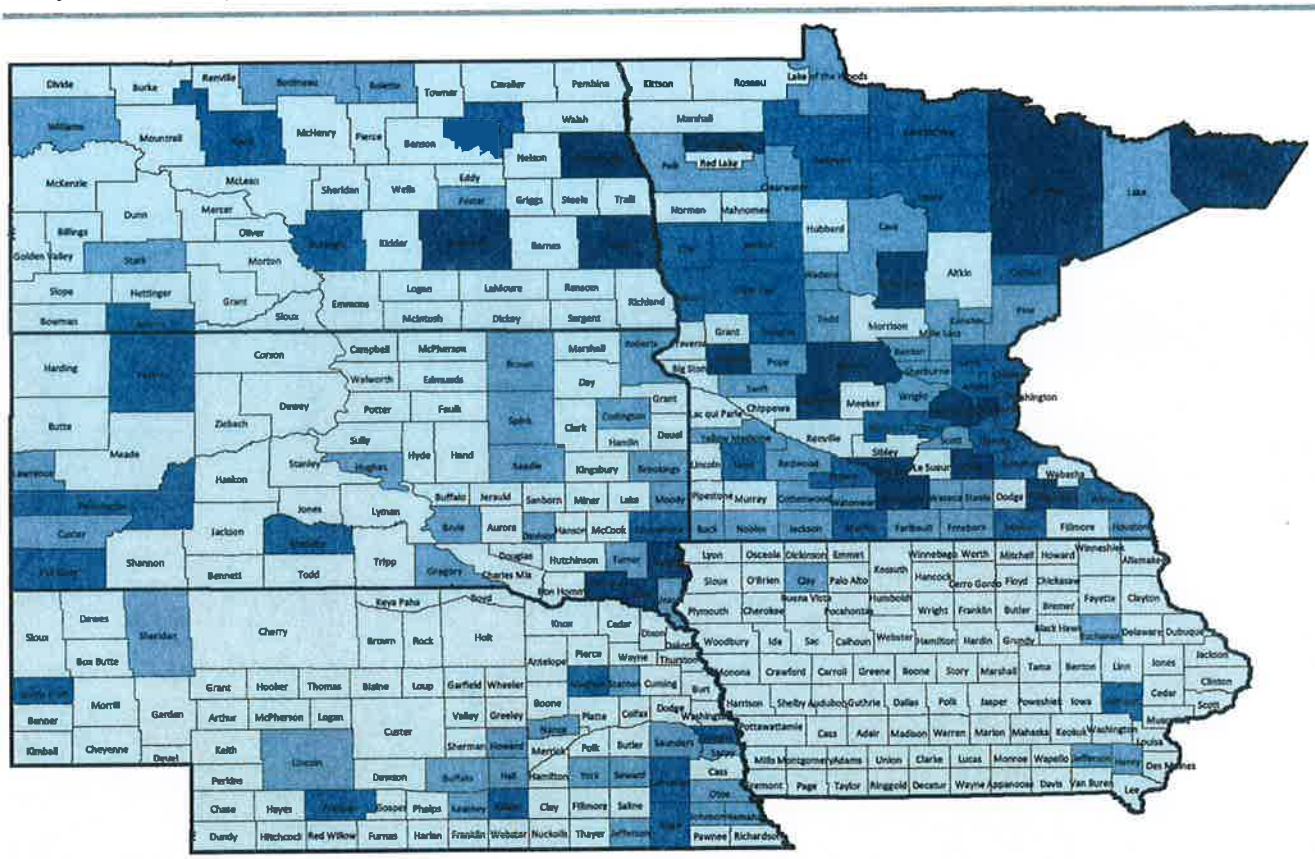
Map 16

Mental Health Providers - A health factor measure focusing on clinical care

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



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

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

CONTEXT

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

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

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

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

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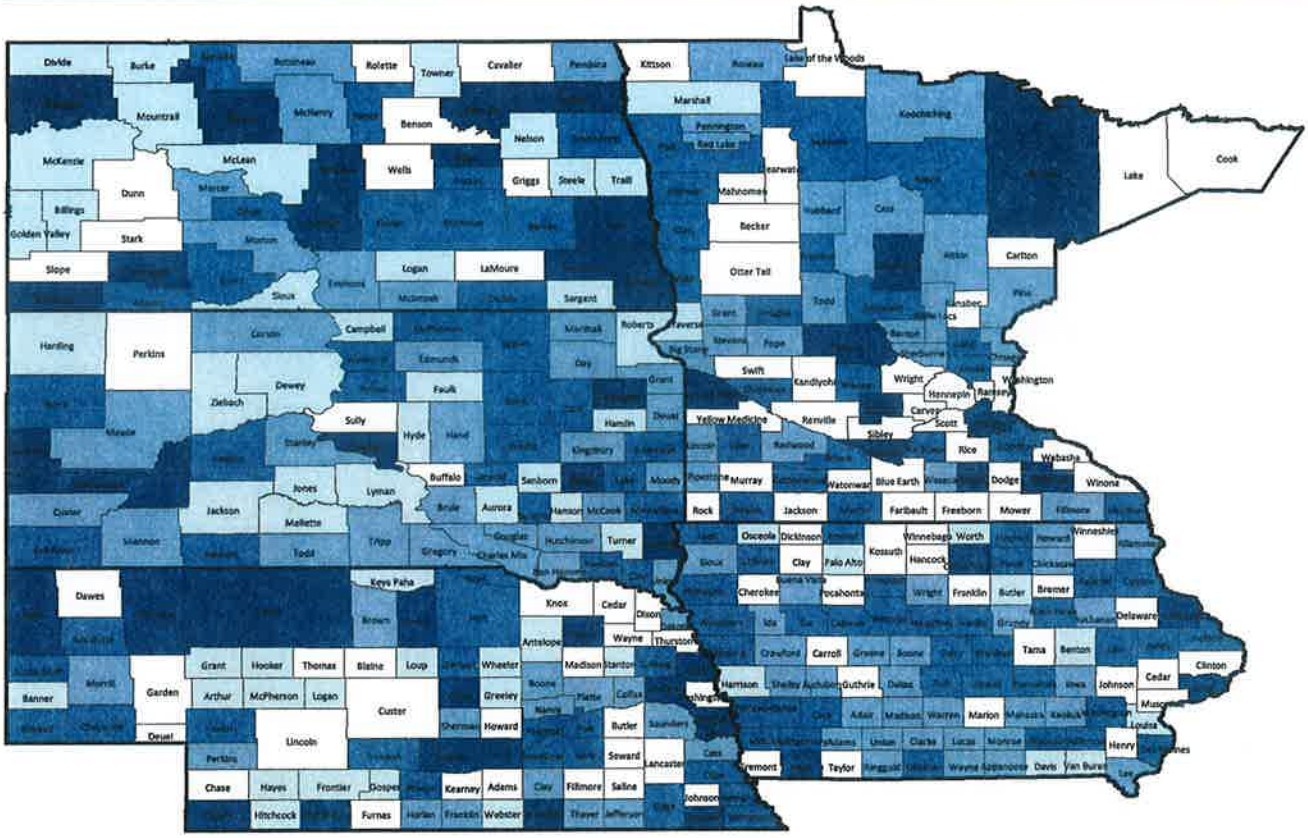
Map 17

Dentist Rate - A health factor measure focusing on clinical care

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



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

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

CONTEXT

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

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

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

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

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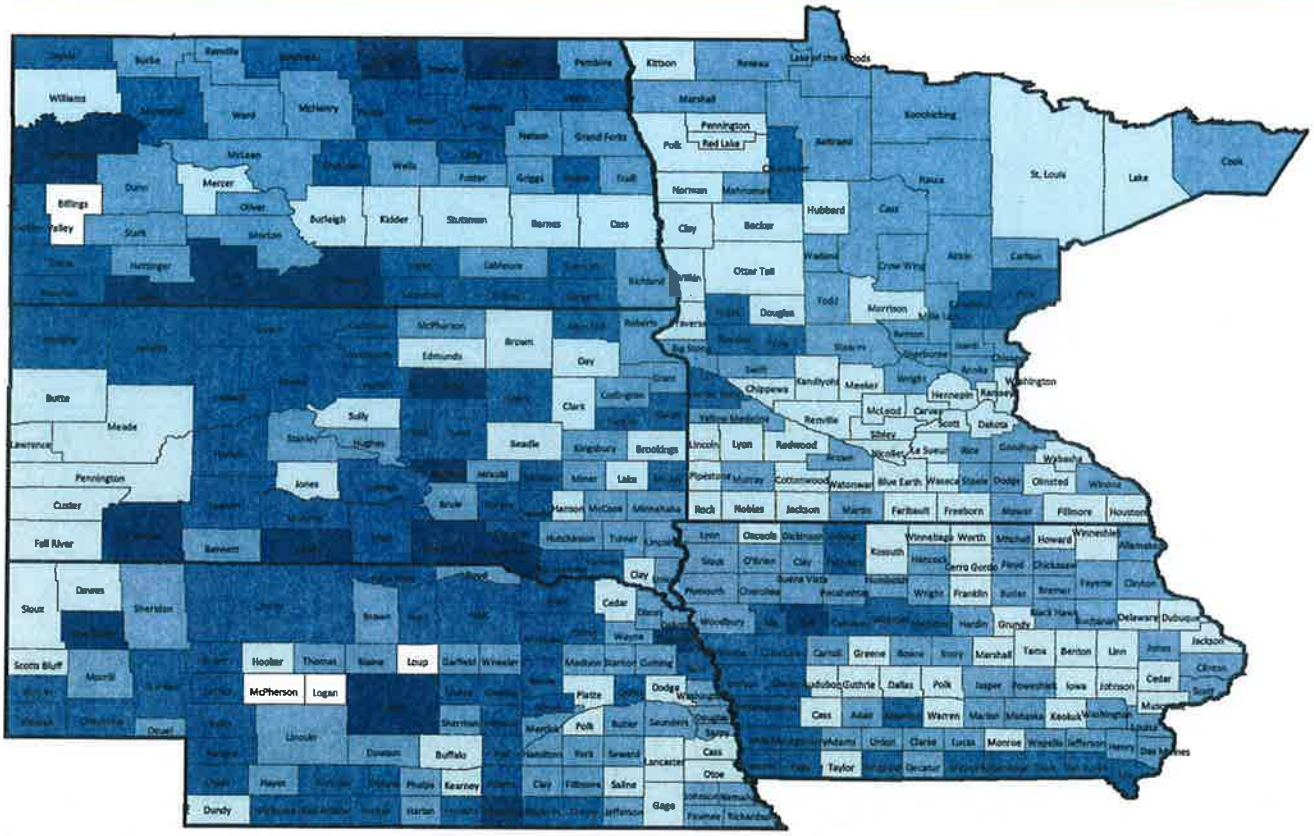
Map 18

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

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



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

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

CONTEXT

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

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

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

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

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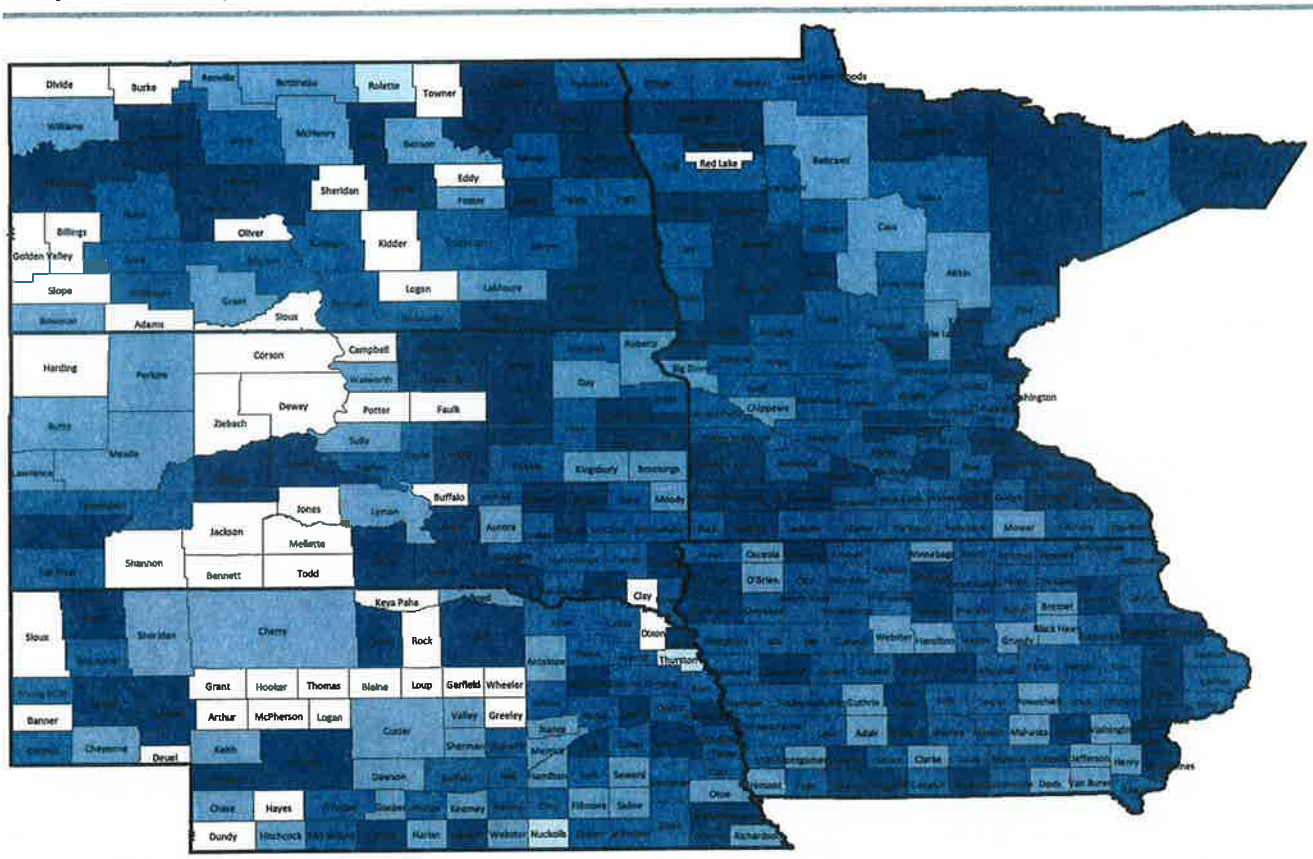
Map 19

Diabetic Screening - A health factor measure focusing on clinical care

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



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

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

CONTEXT

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

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

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

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

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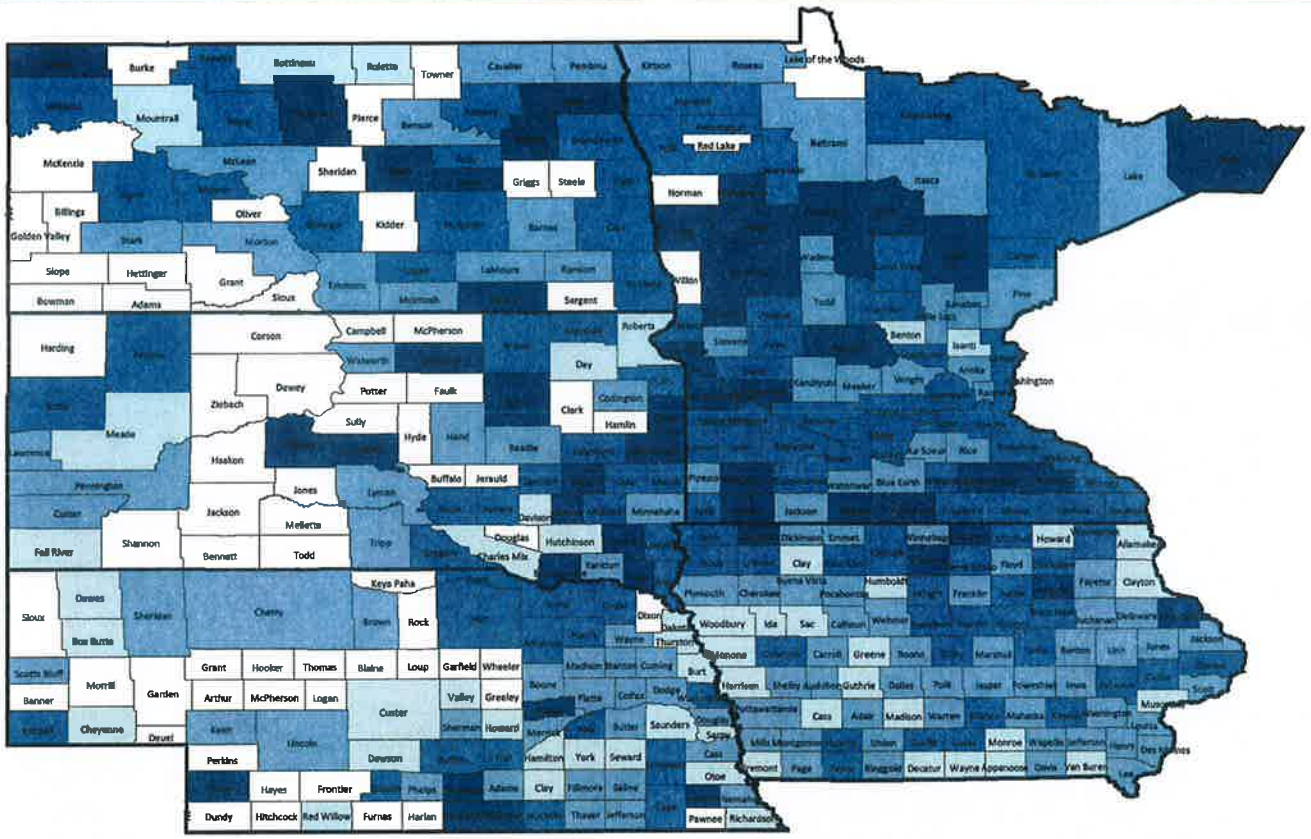
Mammography Screening - A health factor measure focusing on clinical care

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.

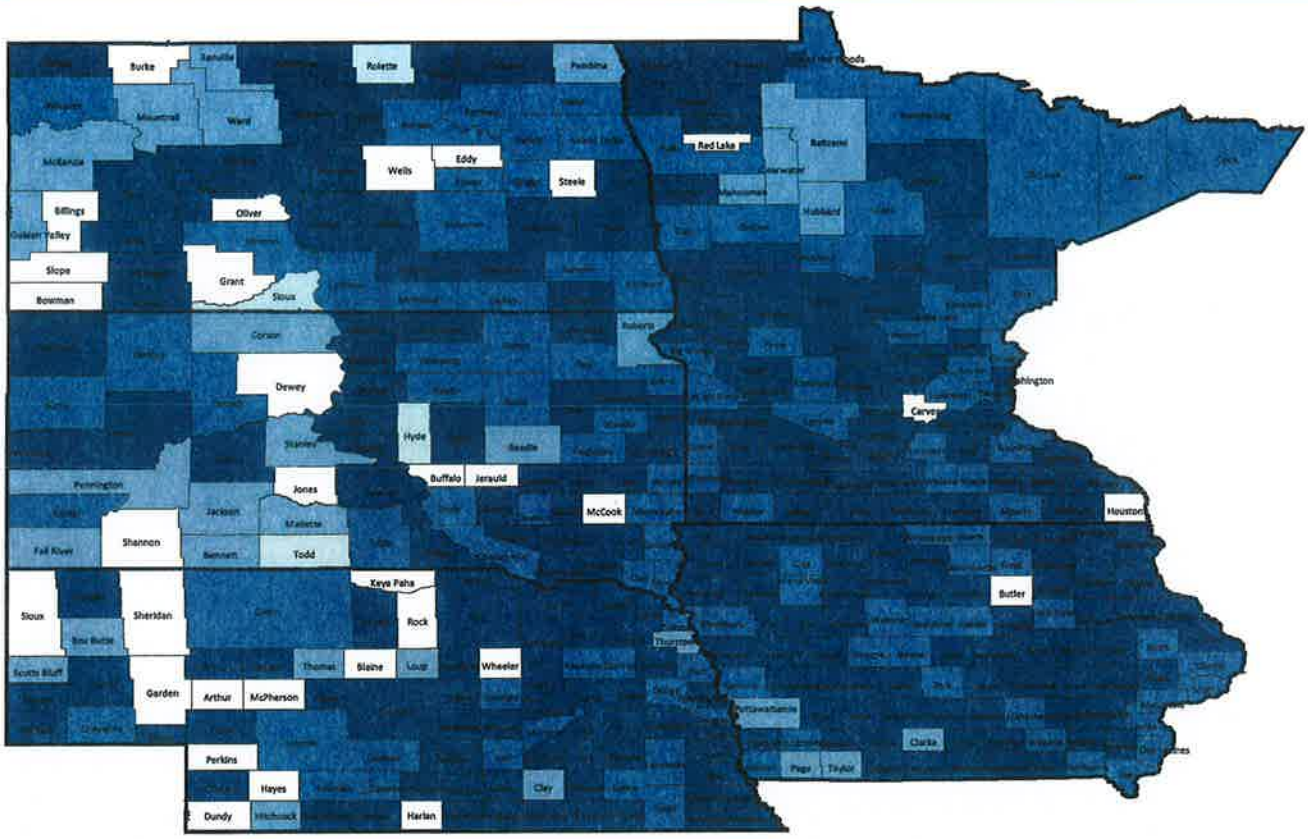
Importance: Evidence suggests that mammography screening reduces breast cancer mortality, especially among older women. A physician's recommendation or referral—and satisfaction with physicians—are major facilitating factors among women who obtain breast cancer screening. The percent of women ages 40 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/.

High School Graduation - A health factor measure focusing on educaton

Map 21

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/.

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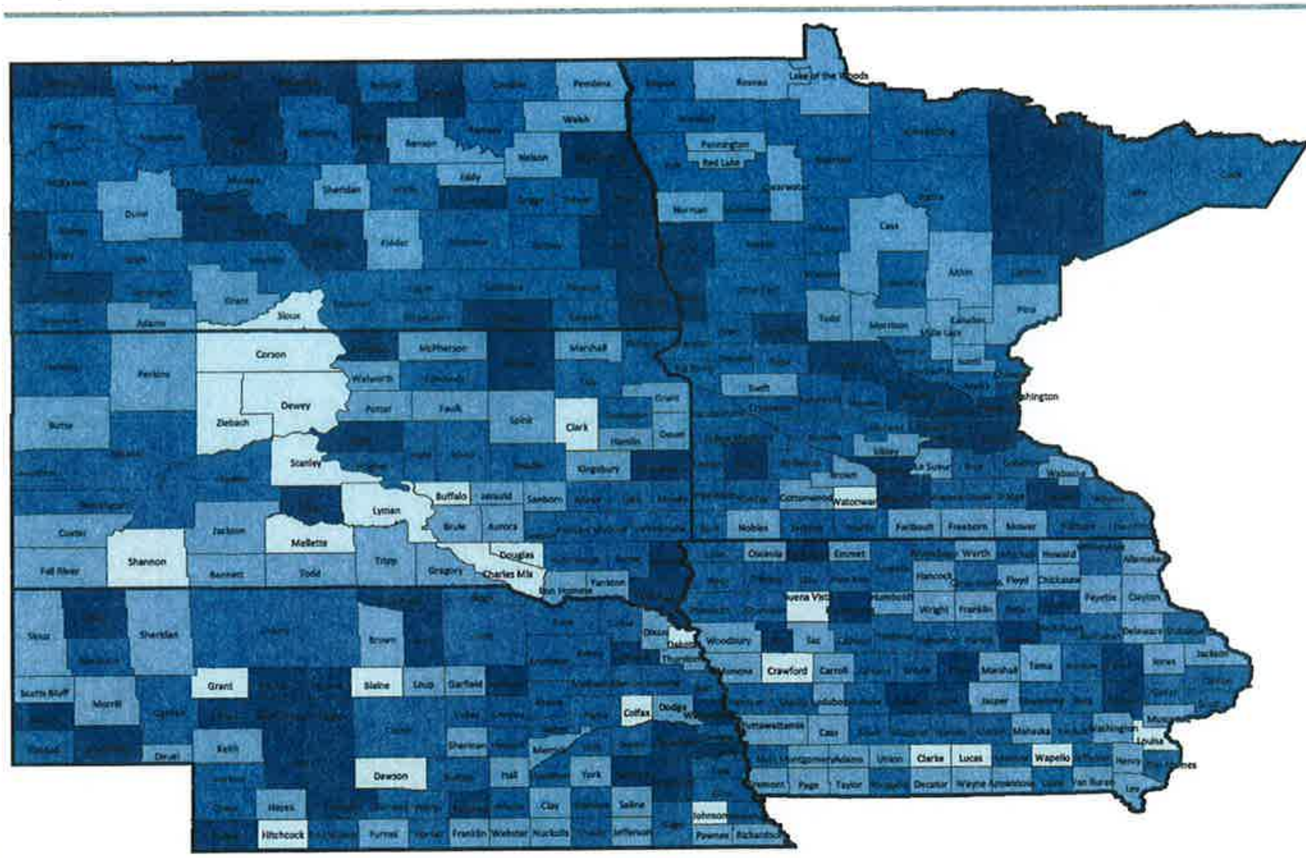
Some College - A health factor measure focusing on education

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).

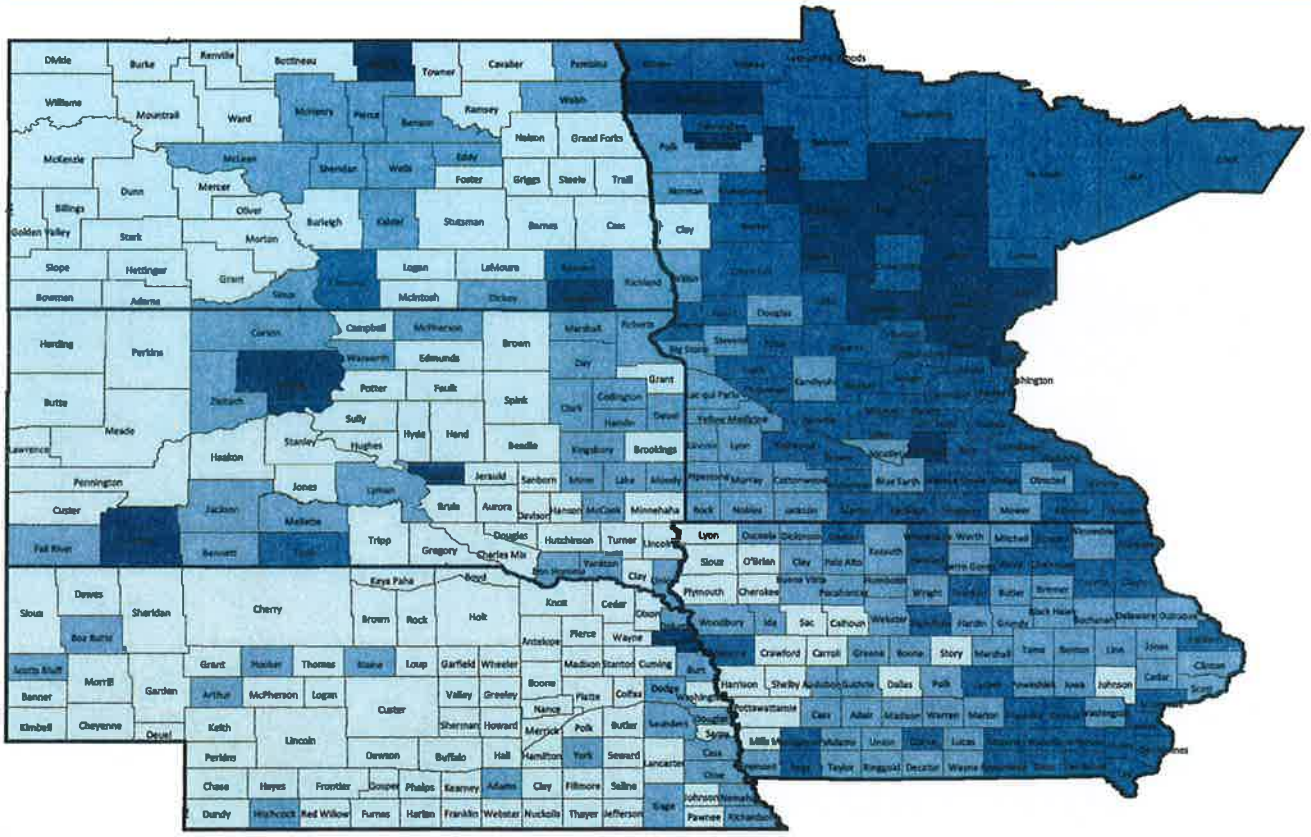
Importance: The relationship between higher education and improved health outcomes is well known, with years of formal education correlating strongly with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles.

- 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/.

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).

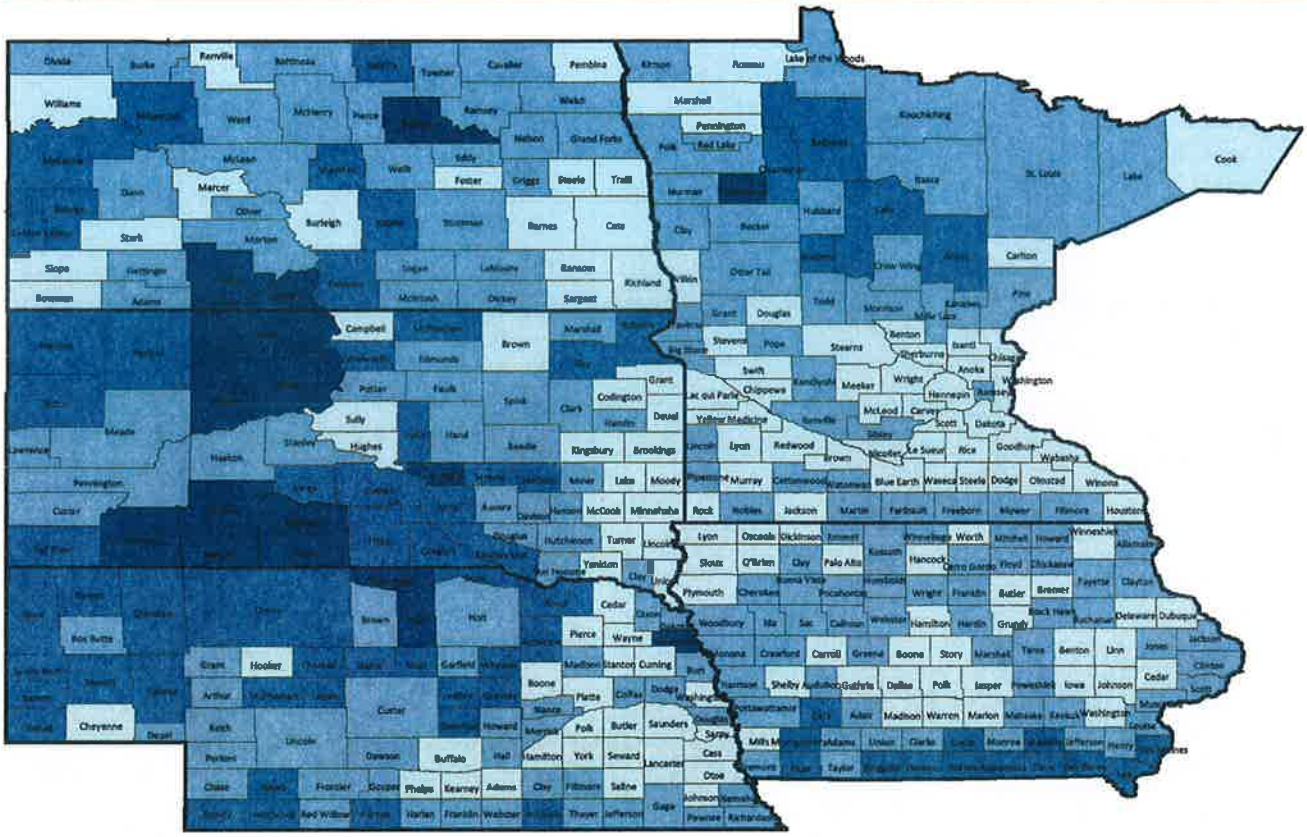
Importance: Unemployment may lead to physical health responses ranging from self-reported physical illness to mortality, especially suicide. It has also been shown to lead to an increase in unhealthy behaviors related to alcohol and tobacco consumption, diet, exercise, and other health-related behaviors, 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/.

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

Map 24

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.

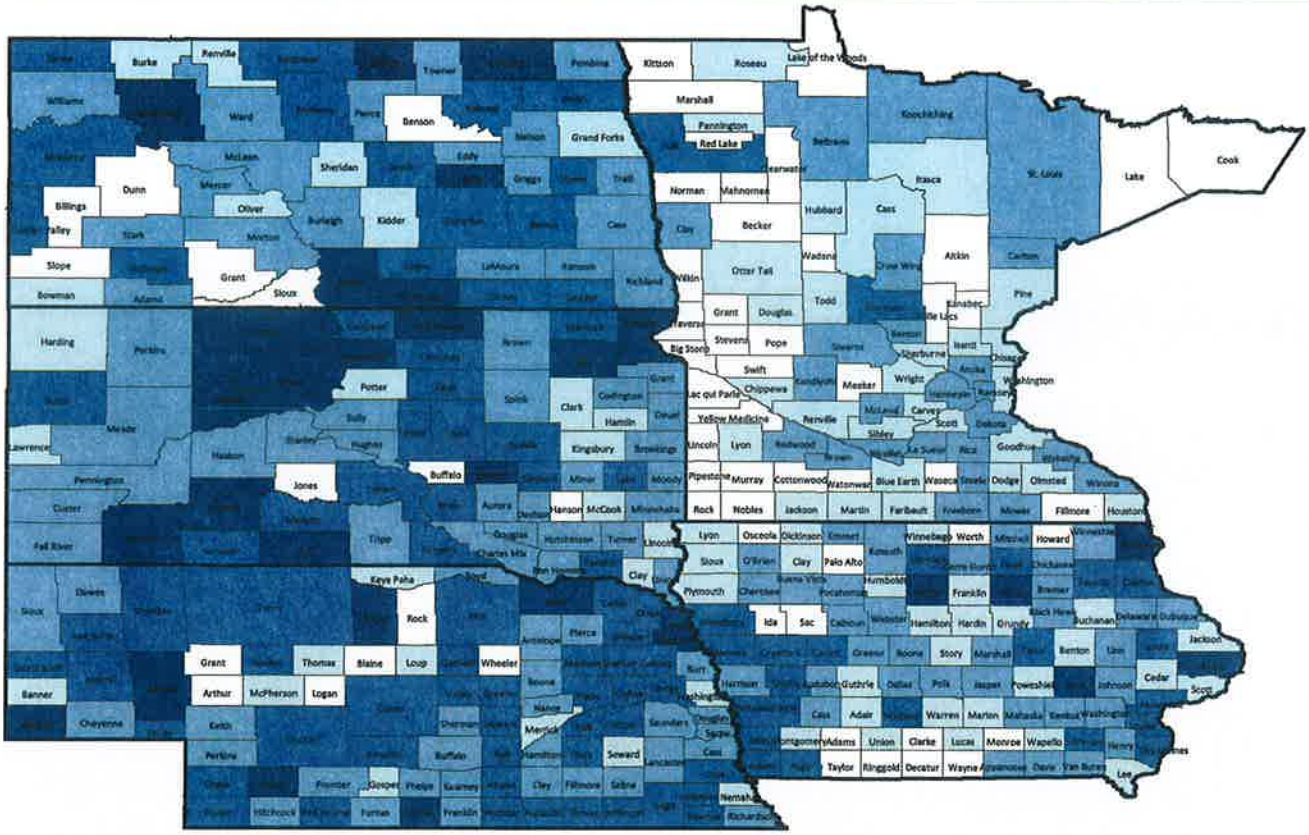
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

 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

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

Map 25

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/.

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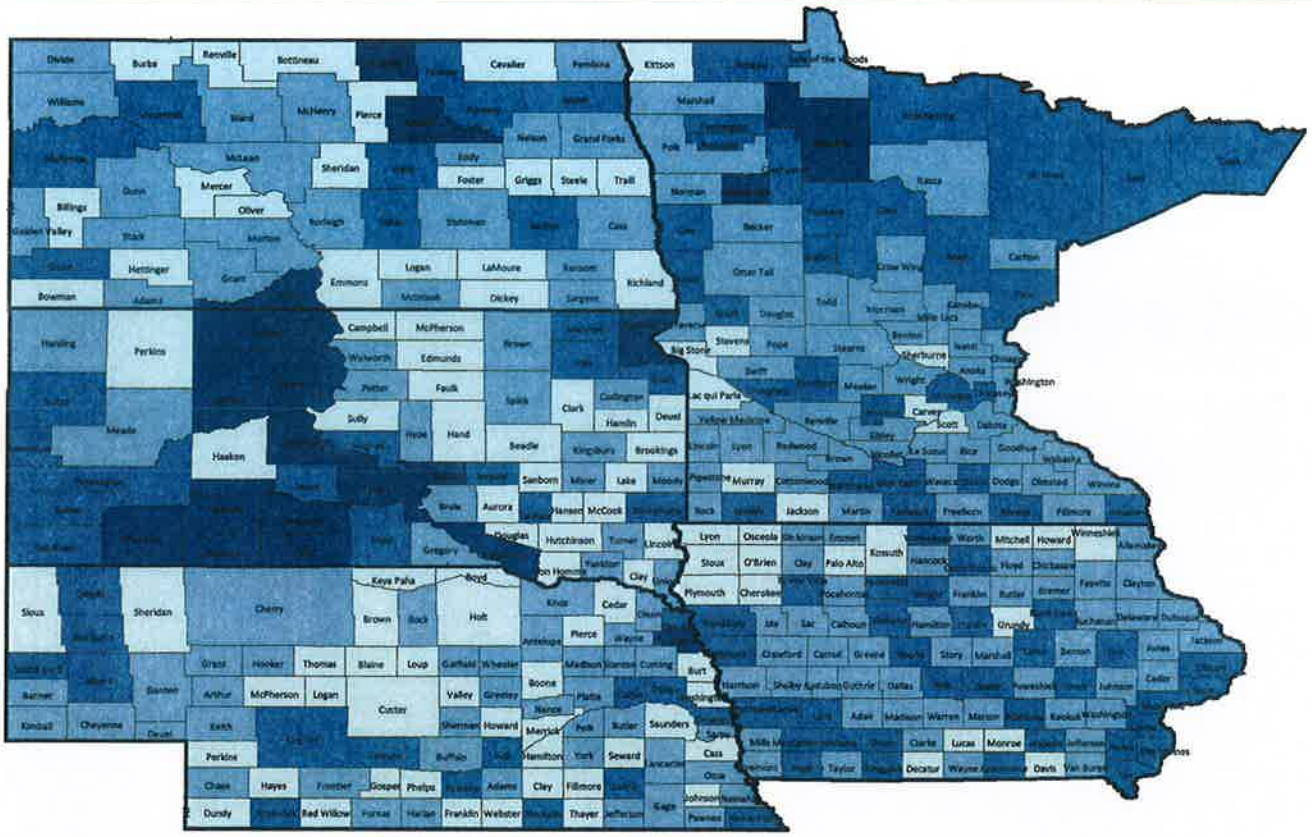
Children in Single-Parent Households - A health factor measure focusing on families

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



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

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

CONTEXT

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

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

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

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

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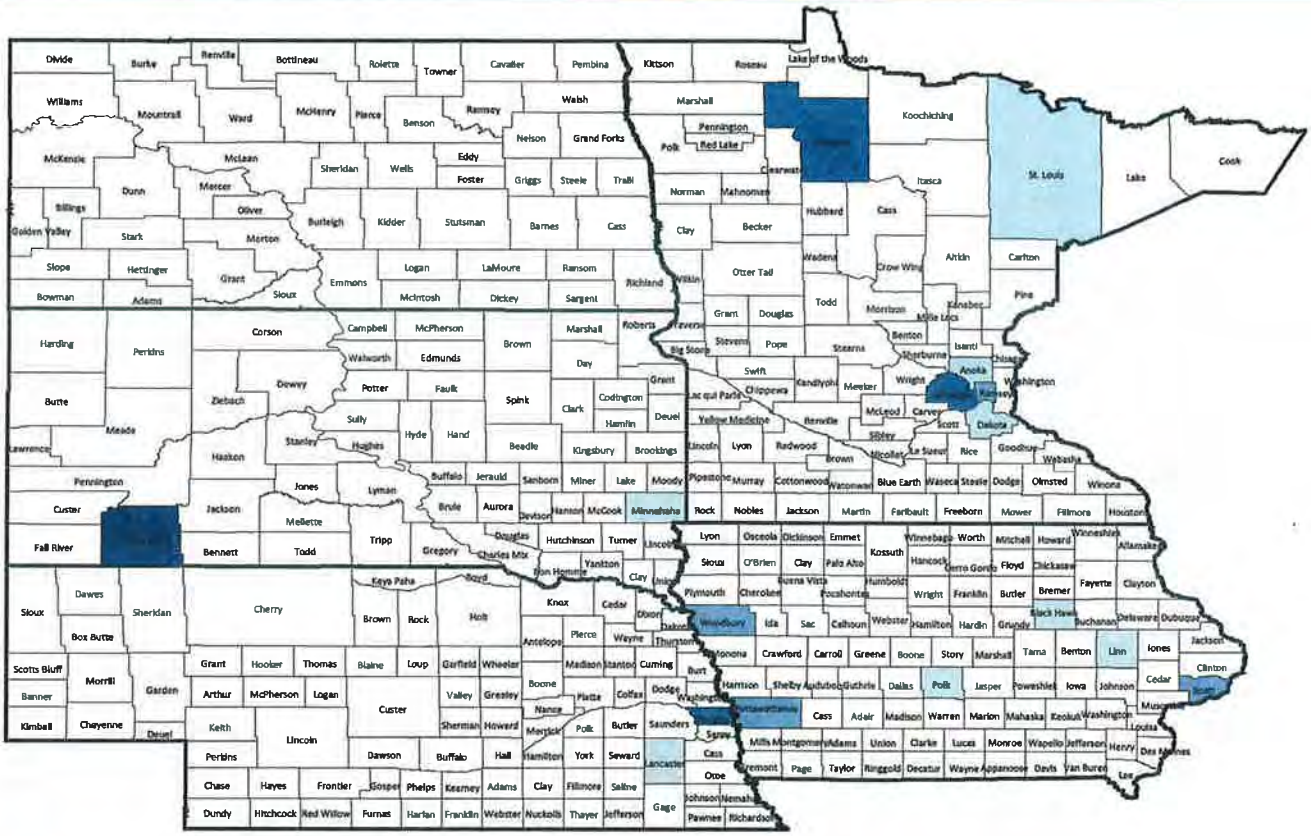
Map 27

Homicide Rate - A health factor measure focusing on violent crime

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



Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007

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

CONTEXT

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

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

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

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

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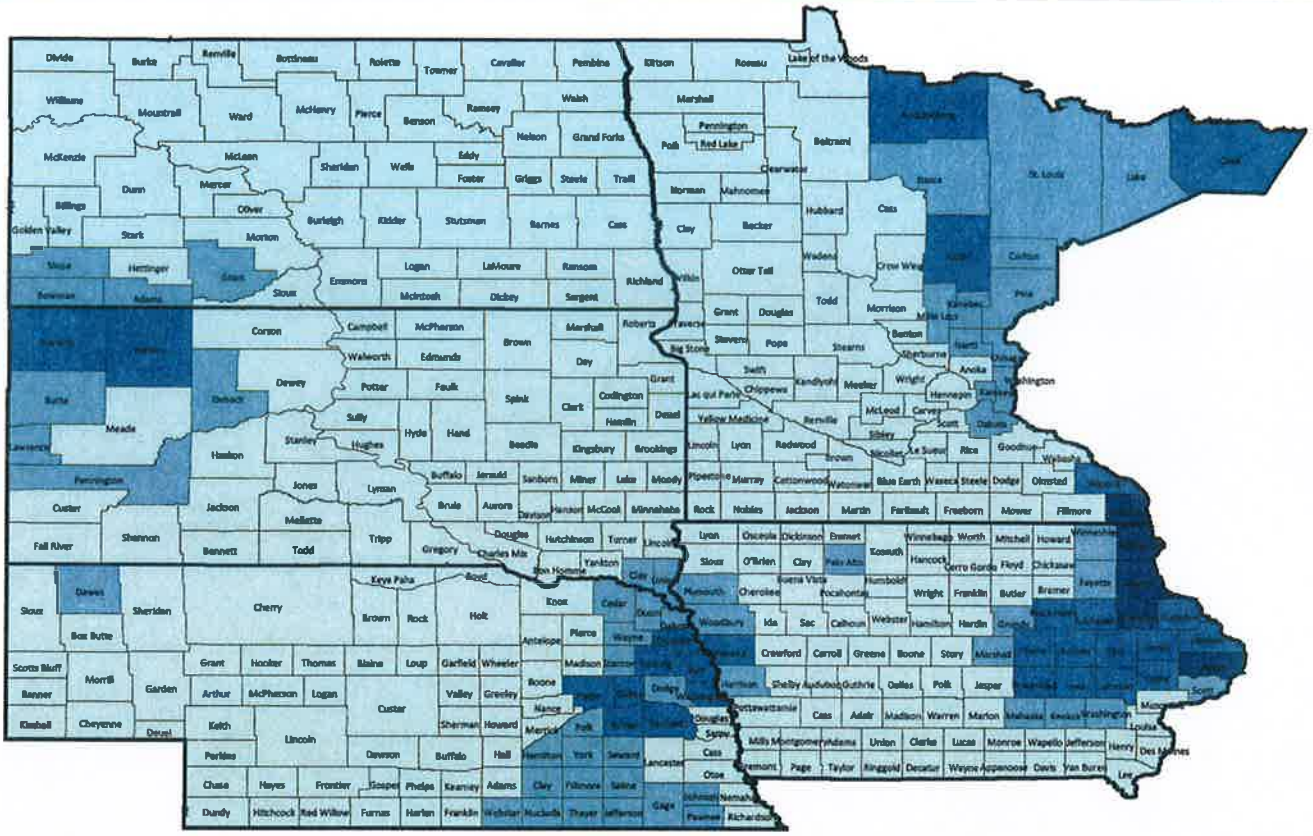
Map 28

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

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



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

- 0
- 1
- 2
- 3 - 4

CONTEXT

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

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

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

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

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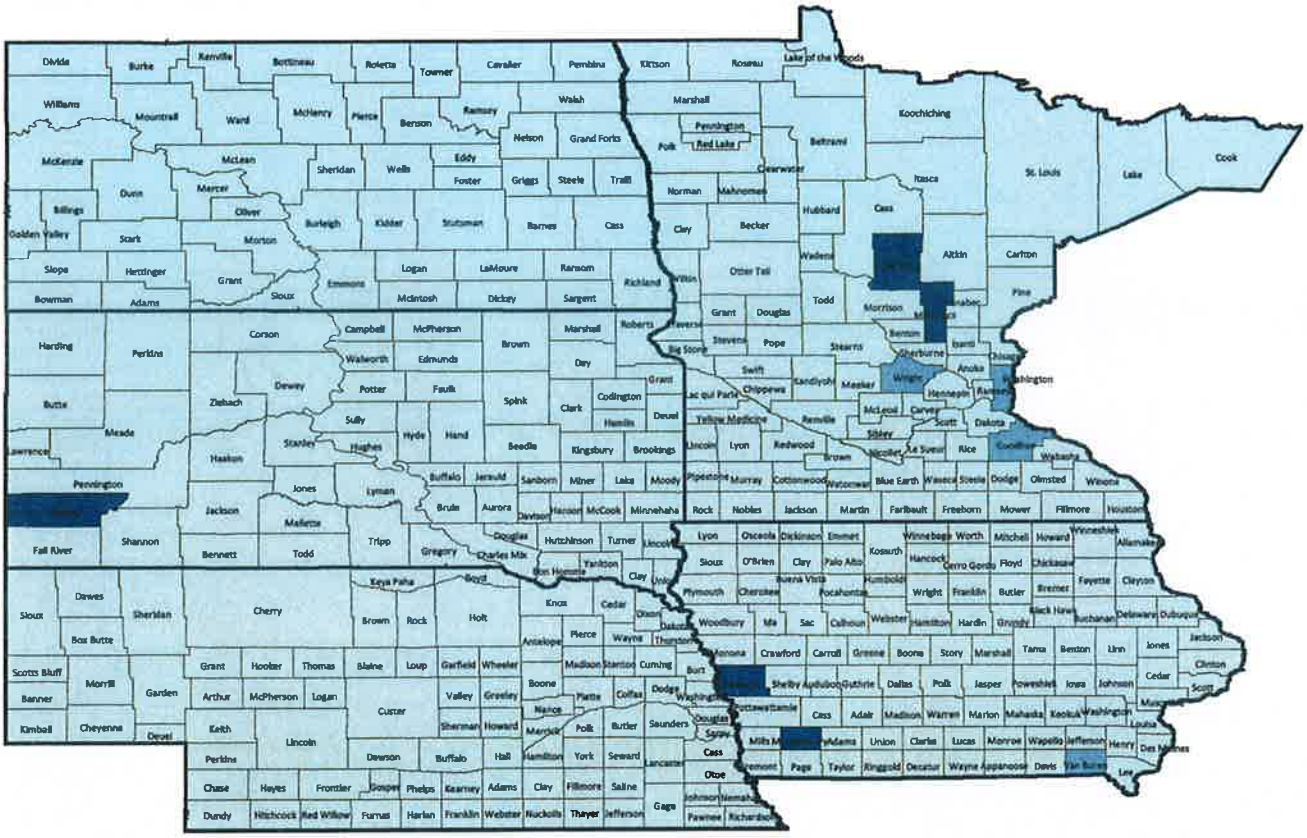
Air Pollution-OzoneDays - A health factor measure focusing on physical environment

Map 29

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.

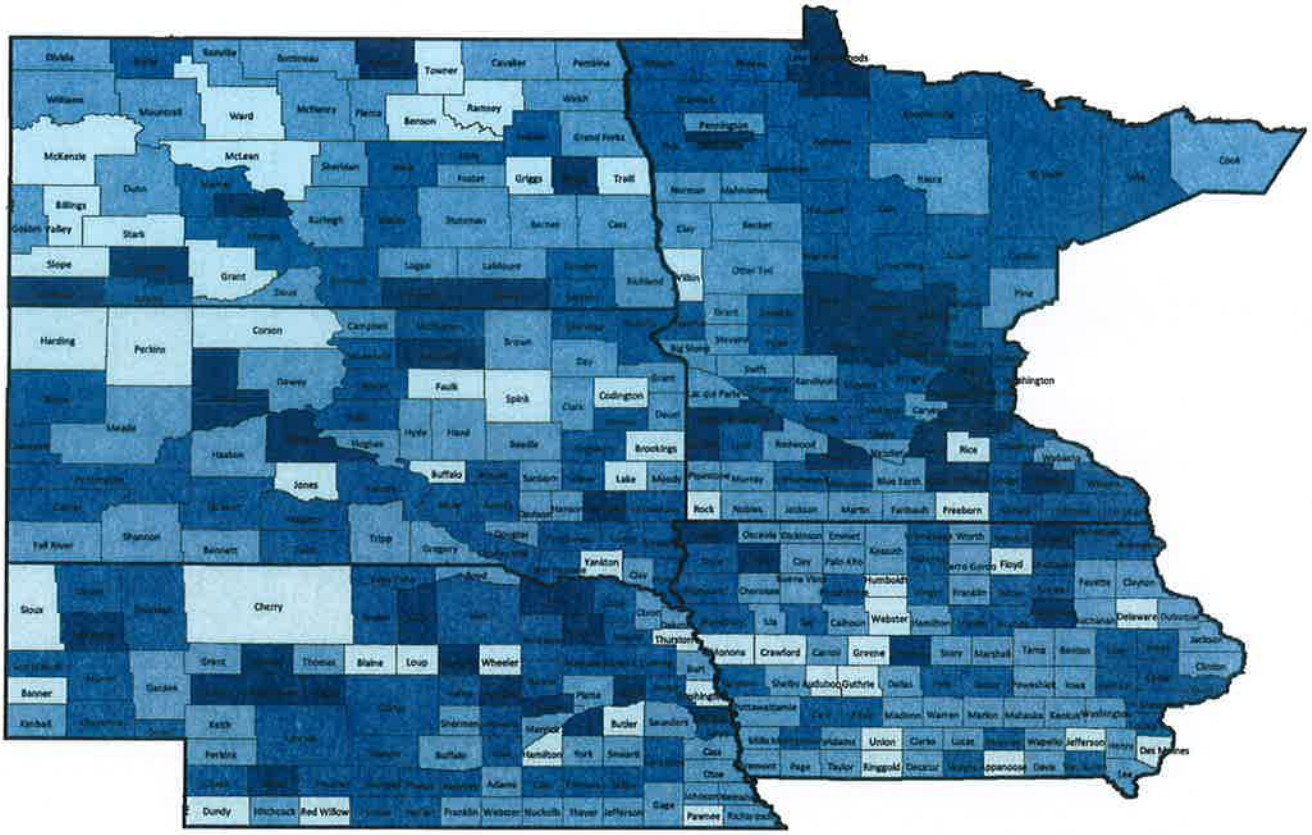
Importance: The relationship between elevated air pollution—particularly fine particulate matter and ozone—and compromised health has been well documented. The negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.

- 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/.

Access to Healthy Foods - A health factor measure focusing on physical environment

Map 30

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/.

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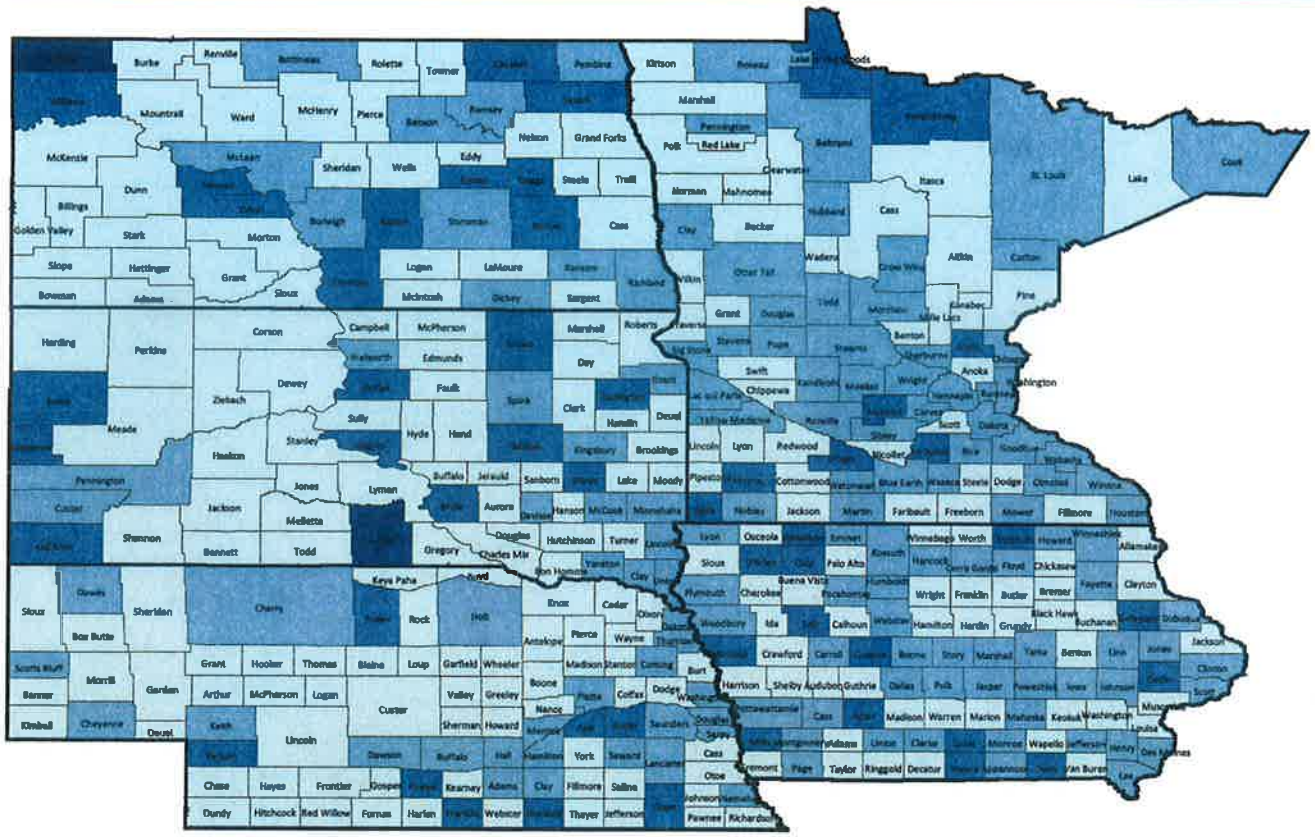
Map 31

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

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



Number of recreational facilities per 100,000 population, 2008

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

CONTEXT

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

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

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

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

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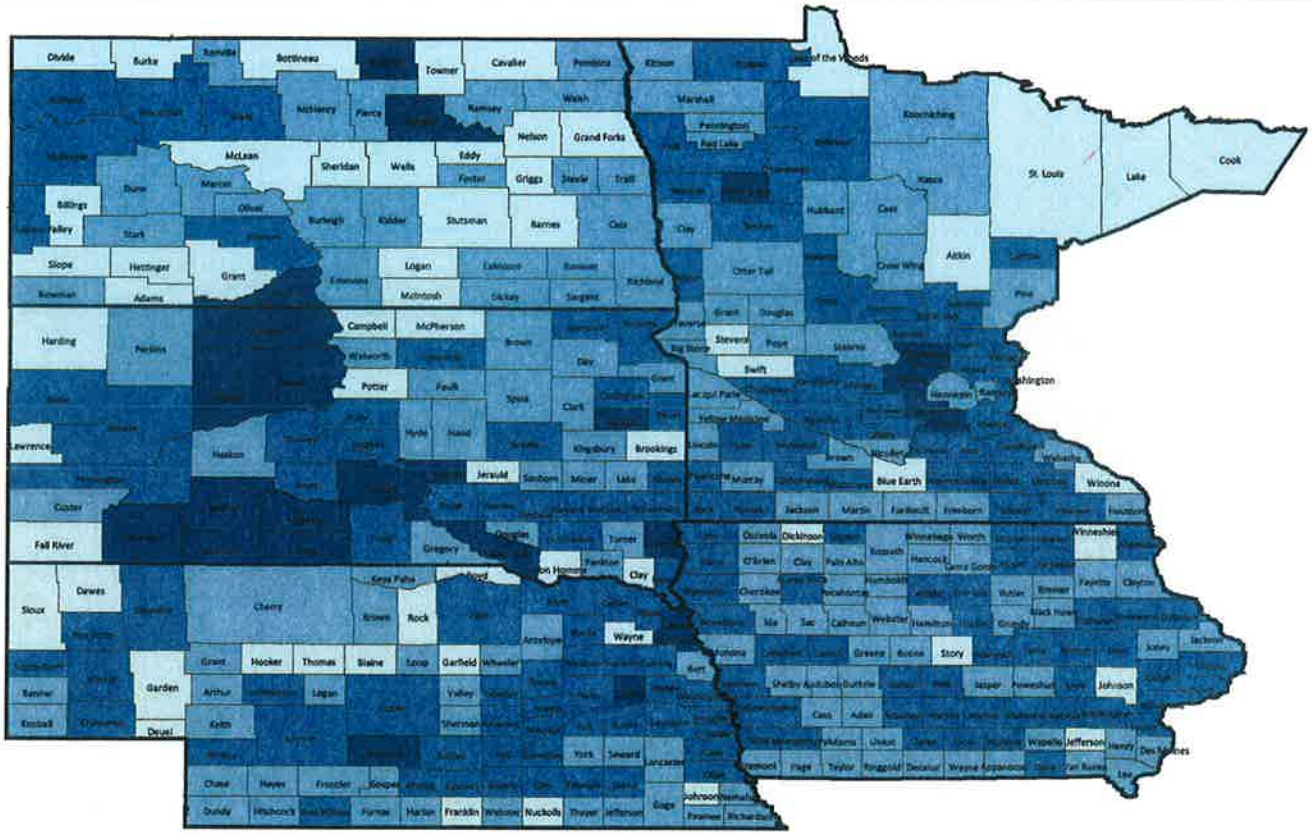
Youth - A demographic measure

Map 32

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



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

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

CONTEXT

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

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

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

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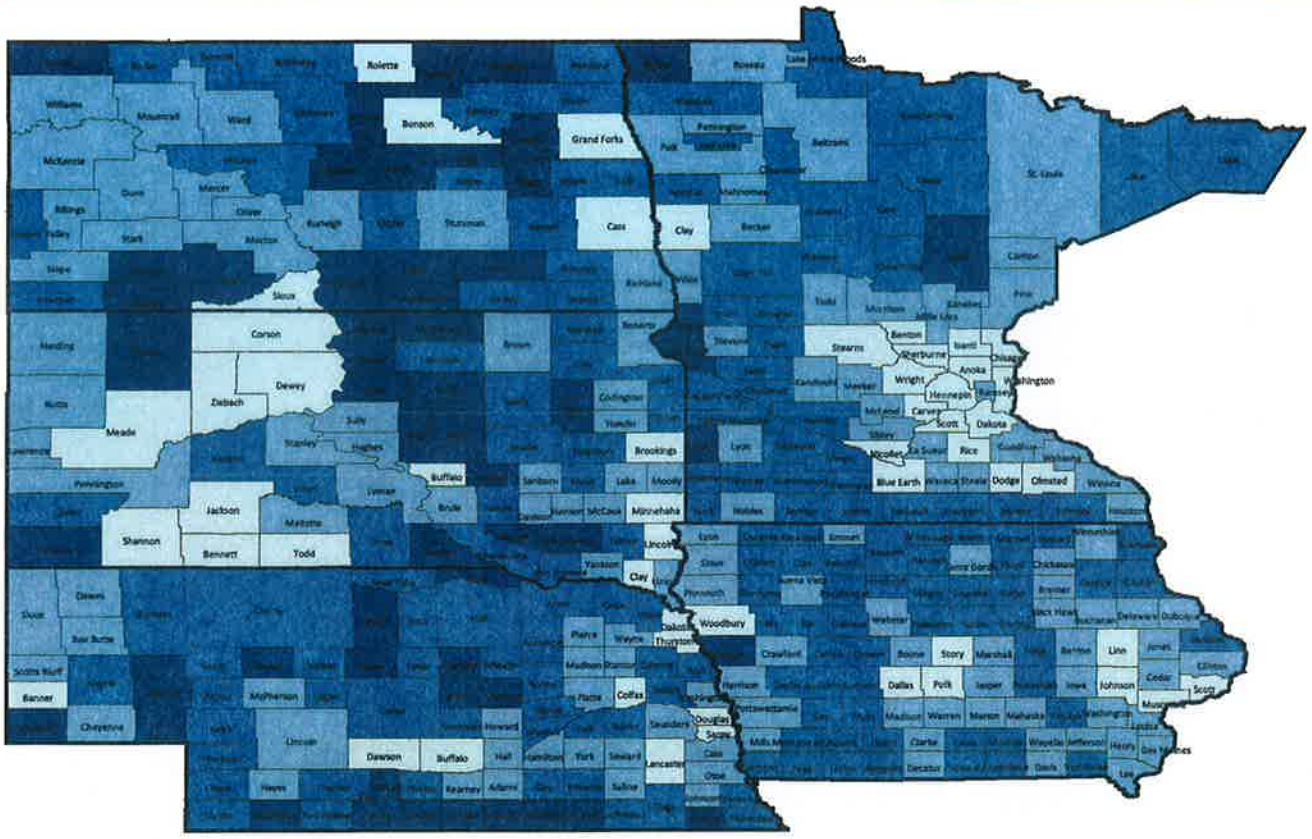
Elderly - A demographic measure

Map 33

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/.

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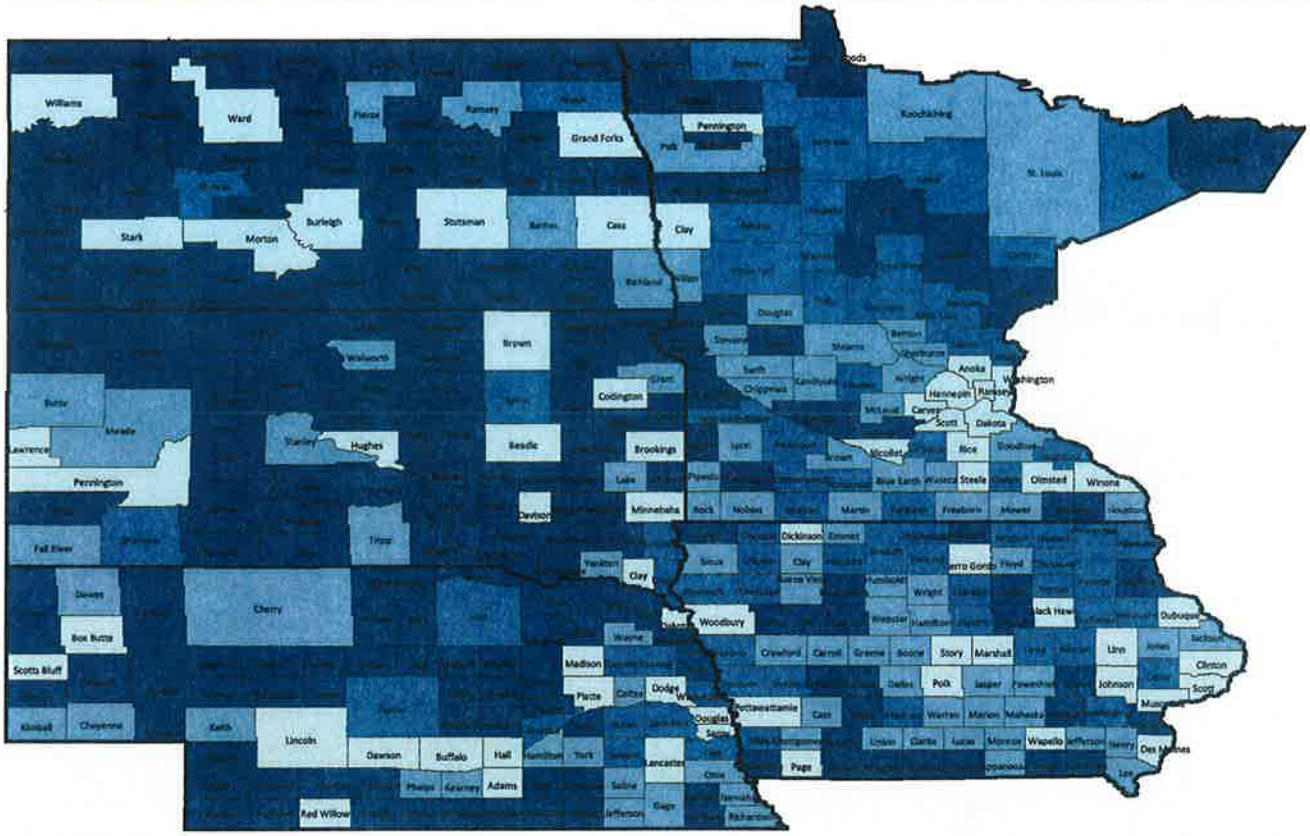
Rural - A demographic measure

Map 34

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



Percent of total population living in a rural area, 2000

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

CONTEXT

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

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

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

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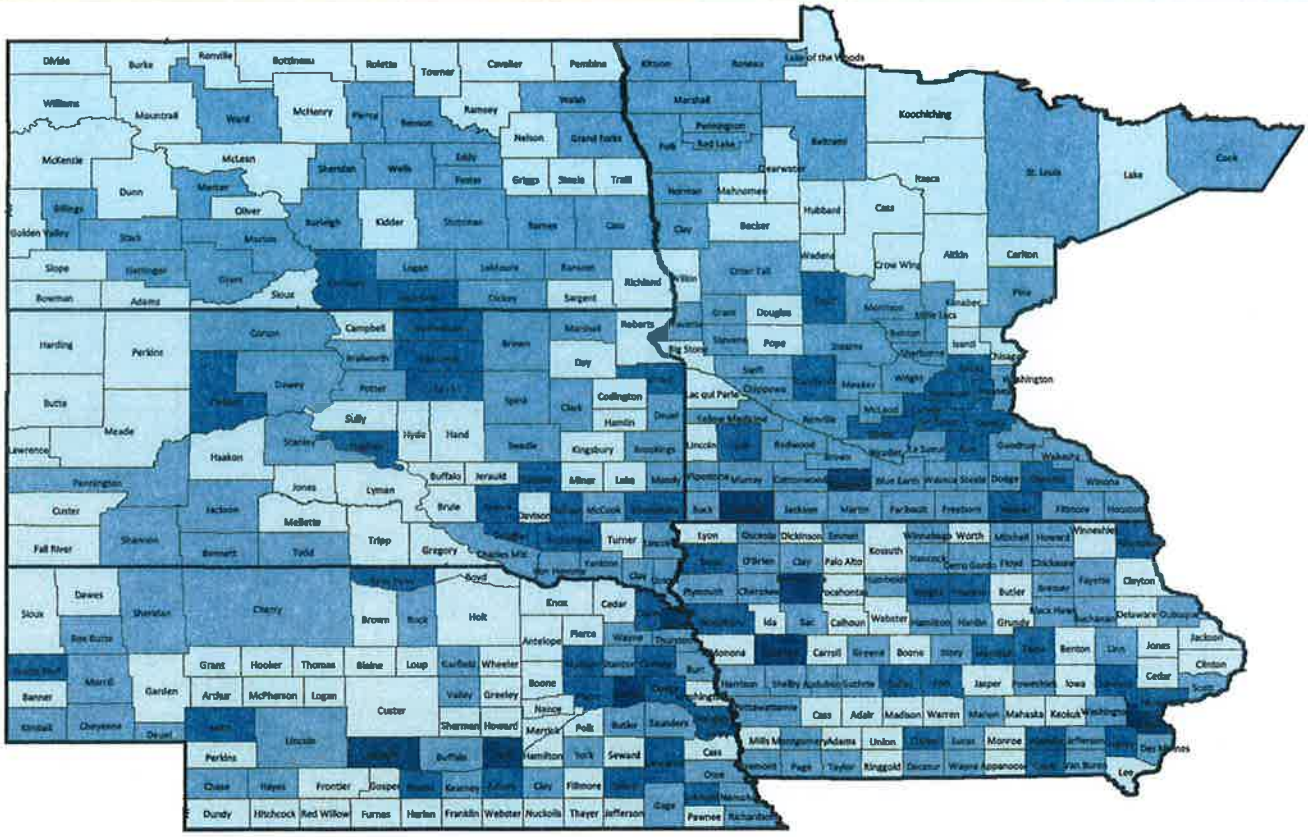
Not English Proficient - A demographic measure

Map 35

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/.

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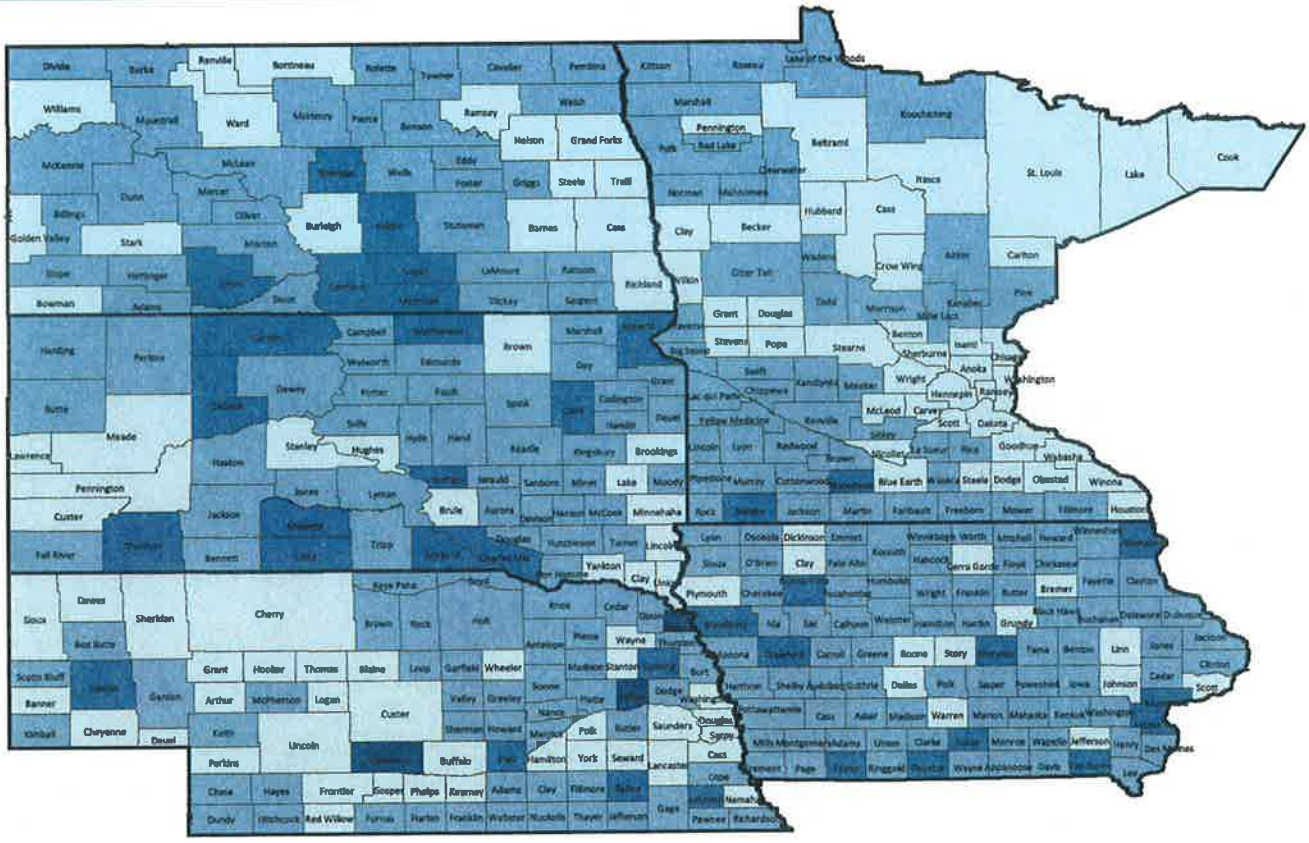
Map 36

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/.

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SANFORD HEALTH

Table 1

Community Health Needs Assessment Asset Mapping
Canby Stakeholders

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Access	• Lengthy wait for scheduled clinic appointment (long wait in the lobby or exam room) • Distance & accessibility to a quality healthcare facility • Need more specialists and primary care providers • Stay open later on certain days (clinic) • Need a quick clinic (like a pharmacy clinic)	Monitored through Press Ganey and customer service team. Local transportation available. Recruit additional outreach physicians No current need for primary care which are culturally diverse. Not enough volume to support additional hours.	X
Cancer	• People who need cancer care must drive 50-100 miles to get treatments • Concern about amount of cancer in the community • Concern about younger people getting cancer • Need cancer research	Cancer Biology Research Center SCMC could provide chemotherapy services-have certified nursing staff and pharmacy support. This could be done in conjunction with telemedicine. State of the art Digital mammography unit installed in 2011. Sage screening program available. Relay for Life Sponsors. Women's Health Night Partner with County American Cancer Society Screening GI Services available	X

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Cardiac	• Concern over cardiac care	Cardiology coverage every week Stress testing available Wellness Center CPR training available for community members Cardiac rehab program available locally.	
Child Care	• Quality of child care • Not enough child care facilities	Share with city leaders.	
Chronic Disease	• Concern about services for ALS patients	Medical Home The Sanford Project – to cure Type 1 DB in Denny Sanford's lifetime Support groups –MS, Diabetes, Low Vision, Parkinson's , Memory, Stroke. CDE Educators on staff. Offer Preventive Screenings Certified Asthma Educator on staff.	
Confidentiality	• Concern about confidentiality among community & mental healthcare providers	Will share with partnering mental health providers.	
Diabetes	• Concern about amount of diabetes in the community • Lower percentage receiving Hgb A1C than nationally	The Sanford Project – to cure Type 1 DB in Denny Sanford's lifetime	
Disabled	• Need everywhere to be handicap accessible • Need services for those with autism	Will evaluate handicapped drive by the rehab entrance. Do not feel there is an autism need.	X
Education	• Education on natural family planning • Education for young couples on how to stay committed • 90% HS graduation rates compared to 92% nation wide	Canby High School graduation rate is 100%. Share with Countryside Public Health.	
Economic Situation/ Business community	• Food costs are high locally • High gas costs • Lack of industry in this community • Need more jobs/good jobs ○ Difficult to keep young people here	SCMC is major employer. Continue to support local service developments. Employees active on local boards and service groups. Share with community leaders.	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	• Need a steak house to go with the new hotel • Need a clothing store that sells affordable clothing • Need a variety store • High unemployment rate		
Healthcare Cost/Insurance Cost	• Cost of healthcare is too high, especially for the elderly & disadvantaged • Cost continues to go up even though wages stay the same • High cost of taking children in when they are ill (even though parent has insurance) • Concern for seniors (prescription drug cost) when they fall into the "donut hole" in their insurance plan • People are not getting service because of the cost • Need more competition to keep costs down	Community care policy. Discount policy. Offer sign up for Assistance/Minnesota Care. Referrals to County agencies. Participate in the MNVFC Program. Sage Program.	
Healthy Nutrition	• Concern over poor eating habits • Education on how to make healthy meals from fresh ingredients • Only 60% have access to healthy foods	Federal lunch program available. Sanford Web MD Fit kids Congregate meal site. Prairie Five food shelf.	
Mental Health	• Limited services for mental health issues • Limited availability of mental services for nursing home residents • Lack of financial coverage for mental health services • People neglect their mental health & this can be a gateway to other significant health problems • Depression/stress (no outlets for younger adults to vent)	Sanford One Care Share data with Western Mental Health Services. Referrals to Western Mental Health Services.	
Obesity	• Concern over growing obesity problem	Sanford WebMD Fit Kids Community Fitness, bike/walking path, school walking program. SCMC Wellness Center	x

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
		Bariatric Support Group Dietitians on staff and available for counseling. Medicare obesity coverage. Support local weight watcher program.	
Physicians	• Listen to physicians – keep them satisfied so they will stay in a small town • Physicians spend more time on the computer than checking the patient • Coordination & communication between providers • Need more specialists – such as orthopedics, nephrology, dermatology, high risk OB, psychiatry, Pediatrics, PAs	Ongoing medical staff collaboration with satisfaction. Sanford One Chart implementation within the past year. Proficiency developing. Outreach physician recruitment.	
Pollution	• Canby Farmers Grain Elevator has major noise, dust & debris issues • Issues with city sewer smell in the spring • Concerned about the quality of our drinking water • Concerned about chemicals in rural water supply – cancer causing agents?	Share data with city leaders. Share data with Countryside public health.	
Poverty	• Lots of Medical Assistance patients • Lots of people on welfare – do they really need to be? • Medical costs for the uninsured	Our Medical Assistance/Minnesota care rate is only about 10% of our patient population. Community care policy. Discount policy. Offer sign up for Assistance/Minnesota Care. Referrals to County agencies. Participate in the MNVFC Program. Sage Program.	
Prevention Services	• Need to stress prevention of illness • Need more prevention programs	The Sanford Project – to cure Type 1 DB in Denny Sanford's lifetime Sanford WebMD Fit Kids Cancer Screening available	X

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
		Medical Home Wellness Center Preventive Services available.	
Physical Activity	• Concern about lack of exercise • Need better walking & biking paths • Need a longer bike path • Have nice trails but they are not used • Need a walking track • Need a dog park • Need a free exercise facility • Only 8% have access to recreational facilities	Sanford WebMD Fit Kids Medical Home Community Fitness, bike/walking path, school walking program. SCMC Wellness Center Bariatric Support Group Canby Inn and Suites has indoor pool use for nominal fee. Share with City leaders. Open gym nights. Summer recreation program.	
Substance Abuse	• Meth addiction • Alcoholism • Smoking addiction • Peer pressure re: drinking • Would like to have abstinence education	SCMC offers free smoking cessation visit to provider for all employees. Medical Home Share with Western Mental Health. Sanford One care. Share with community leaders. AA meetings available locally.	
Technology & Equipment	• Access to technology/equipment • Telehealth (access to experts via video & audio)	Develop more telemedicine services.	
Traffic/ City Infrastructure	• Need more stop signs by the schools • Too many stop signs • People drive recklessly because there is so little congestion in our community • Need to continue to upgrade streets • Need more street lights at night • Concern with city infrastructure needs	Caution light needs on State highway 75 due to health care campus being split by this highway. Share with city leaders.	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Wellness	• Need community wellness programs	Sanford WebMD Fit Kids Medical Home Community Fitness, bike/walking path, school walking program. SCMC Wellness Center Bariatric Support Group Canby Inn and Suites has indoor pool use for nominal fee. Share with City leaders. Open gym nights. Summer recreation program. CDE Educators on staff. Offer Preventive Screenings Certified Asthma Educator on staff.	
Workforce	• Not enough staff for the work (in healthcare)	Front line staff recruitment.	X

Youth	• School lunches
	  ○ Not enough healthy options are offered
	  ○ More fresh, less canned, less processed food
	  ○ Poor quality food
	  ○ Willing to pay a higher price for quality foods.
	• Peer pressure re: drinking
	• Would like to have abstinence education
	• Would like more information about programs available for young children
		Sanford WebMD Fit Kids
		Federal school lunch program.
		Share with Canby Public School Board.	

Sanford Specific	• Need a lab that is not a rural lab – so it is treated with insurance with the visit • Need better OR facilities • Need better ER (larger) • Need more specialists – such as orthopedics, nephrology, dermatology, high risk OB, psychiatry,	SCMC structured accordingly. OR remodeling included in ER architectural plan. 1960 ER – architectural plan has been developed. Has not yet reached a priority for capital. Outreach physician recruitment. Open Thursday evening and Saturday morning.	X

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	Pediatrics, PAs • Stay open later on certain days (clinic) • Need a quick clinic (like a pharmacy clinic) • Concern about privacy – being asked your age & other personal questions when registered for a clinic appointment (when others can overhear)	Redesign front desk arrangement to maximize privacy.	

SANFORD HEALTH

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**
Need more specialists	**5**	**4**	
People who need cancer care must drive 50-100 miles to get treatments	**5**	**6**	**7**
Need everywhere to be handicap accessible	**3**	**0**	
Concern over growing obesity problem	**6**	**6**	**7**
Need more prevention programs	**5**	**3**	
Not enough staff for the work (in healthcare) Not enough staff for the work (in healthcare)	**4**	**2**	
Need better ER (larger)	**7**	**7**	**7**

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