Sanford Health Network

Community Health Needs Assessment

2012-2013

dba Sanford Jackson Medical Center EIN# 46-0388596

SANFORD HEALTH

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rev. 6/10/13

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Purpose

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

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

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

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

Acknowledgements

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

Sanford Enterprise Steering Group:

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

Sanford Sioux Falls Network Steering Group:

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

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:

- Sara Anderson, Home Health Advisory Group, Jackson, MN
- Holli Arp, SW Regional Director, U of M Extension, Jackson, MN
- Heidi Bargfrede, Administrative Clerk, Jackson, MN
- Terri Bargfrede, Insurance Agent, American Family Insurance, Jackson, MN
- Wanda Benda, Retired, Jackson, MN
- Mary Bezdicek, Fiscal Officer, Cottonwood-Jackson Community Health Service, Jackson, MN
- Eileen Bisaillon, Retired, Lakefield, MN
- John Buschena, Engineering Mangaer, AGCO, Jackson, MN
- Deb Craven, Administrative Loan Assistant, Bank Midwest, Jackson, MN
- Gail Eike, CFO, Sanford Jackson, Jackson, MN
- Janice Fransen, Jackson County Coordinator, Jackson, MN
- Jeff Goulet, Purchsing Manager, AGCO, Jackson, MN
- Sister Edith Mary Hart, DO, Sacred Heart Mercy Health Care Clinic, Jackson, MN
- Julie Hendrickson, Social Worker, Jackson County Dept. of Human Services, Jackson, MN
- Pam Heser, Executive Director, Jackson Area Chamber of Commerce, Jackson, MN
- Eric Hullstrom, Pastor, Salem & Belmont Lutheran Churches, Jackson, MN
- Jeff Johnson, Health Care Foundation, Jackson, MN
- Jeff Johnson, Emergency Mangement Director, County Veterans Service Office, Jackson, MN
- Steve Kapplinger, Senior Solutions Architect, AGCO, Jackson, MN
- Cindy Knabe, Public Health Nurse, Cottonwood-Jackson Community Health Service, Jackson, MN
- Donna Lappe, Public Health Nurse, Cottonwood-Jackson Community Health Service, Jackson, MN
- Todd Meyer, Superintendent, Jackson County Central Schools, Jackson, MN
- Tracy Mitchell, Public Health Nurse, Cottonwood-Jackson Community Health Service, Jackson, MN
- Holly Nestegard, Director of Pharmacy, Sanford Jackson, Jackson, MN
- Sister Raphael Paradis, Administrator, Sacred Heart Mercy Health Care Clinic, Jackson, MN
- Susan Pirsig, City of Jackson Economic Develoopment Coordinator, Jackson, MN
- Pam Pronk, Preschool Aid, Early Childhood Family Education Program, Jackson, MN
- Katja Randolph, Quality Engineer, AGCO, Jackson, MN
- Ken Karp, Project Team Lead, AGCO, Jackson, MN
- Kelly Rasche, Lakefield City Clerk, Lakefield, MN
- Ana Rooda, Lakefield, MN
- Angela Schlager, Nurse Assistant, Cottonwood-Jackson Community Health Service, Jackson, MN
- Rosemary Schultz, Jackson County Commissioner/Retired Teacher, Lakefield, MN
- Andrea Sether, Administrative Assistant, City of Jackson, Jackson, MN
- Pat Stewart, Administrator, Cottonwood-Jackson Community Health Service, Jackson, MN
- Jennifer Tewes, Site Supervisor, Sanford Jackson, Jackson, MN
- Darci Thurmer, Pubic Health Nurse, Cottonwood-Jackson Community Health Service, Jackson, MN
- Bonnie Traetow, Director, Family Services Network, Jackson, MN
- Tom Turner, Product Manager, AGCO, Jackson, MN
- Amy Voss, Dean of Students/Athletic Director, Jackson County Central High School, Jackson, MN
- Anita Whisney, School Readiness Coordinator, Jackson County Central Schools, Jackson, MN
- Chris, Homemaker, Jackson, MN

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Executive Summary

Purpose

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

Study Design and Methodology

The following qualitative data sets were studied:

- Community Health Needs Assessment of Community Leaders

The following quantitative data sets were studied:

- 2011 County Health Profiles for Jackson and Cottonwood Counties
- Aging Profiles for Jackson and Cottonwood Counties
- Diversity Profiles for Jackson and Cottonwood Counties

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

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

Key Findings – Primary Research

Sanford Jackson Medical Center distributed the Community Health Needs Assessment survey tool to key stakeholder groups as a method of gathering input from a broad cross section of the Jackson community.

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

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

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

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

Respondents had very high levels of agreement that the people in the community are friendly, helpful and supportive. There are quality school systems and programs for youth, the community has a family-friendly environment, and is a good place to raise kids. Also, the community is a safe place to live, provides convenient access to work and activities, and there are many recreational and sports activities available.

Respondents were most concerned about cost of health care and/or insurance along with cost and/or availability of elder care. Respondents were also concerned with issues regarding availability of affordable housing, resources to meet the needs of the aging population, and problems associated with mental health care systems/policies. Environmental issues regarding water/air/noise pollution levels were not a large concern; however, youth concerns included bullying and changes in family composition (e.g. divorce, single parenting). A concern with substance abuse was also noted.

Among health and wellness concerns, respondents were most concerned about the costs associated with health insurance, costs of prescription drugs, and adequacy of health insurance. Respondents were also concerned about cost of health care, availability and/or cost of dental and/or vision insurance coverage, and availability of doctors/nurses and/or specialists. Drug use and abuse along with physical health issues, particularly obesity and chronic disease (e.g. diabetes, heart disease, and multiple sclerosis) are concerns. Respondents were least concerned about patient confidentiality and access to emergency services.

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

Respondents agreed that there are quality school systems and programs for youth, and that the community is a safe place to live and has a family-friendly environment.

With respect to economic issues, respondents had moderate levels of concern with respect to the availability of employment opportunities and availability of affordable housing. Respondents were least concerned with homelessness and hunger.

Respondents were least concerned with traffic congestion, driving habits and environmental pollution.

The top three reasons respondents gave for their choice of primary health care provider were location, quality of services, and availability of services. Sixty-six percent (66%) of respondents drive less than 20 miles to access medical care.

A majority of respondents said they had paid for health care costs over the last 12 months by health insurance through an employer. Personal income was also used.

Respondents were asked which provider they used for their primary health care. Fifty-six percent (56%) of respondents said they use Sanford Health as their primary health care provider.

Key Findings – Secondary Research

HEALTH OUTCOMES

The Morbidity health outcomes indicate that Minnesota and Cottonwood County citizens report more days of poor health than the national benchmark; however, Jackson County reports slightly better health days.

Minnesota and Jackson and Cottonwood counties report more mentally unhealthy days than the national benchmark.

Jackson and Cottonwood counties have a higher percentage of low birth weight than the national benchmark.

HEALTH FACTORS

The Health Behavior outcomes indicate that Minnesota and Jackson County have higher percentages of adult smokers than the national average. Adult obesity is also higher in the state of Minnesota and in Jackson and Cottonwood counties. Jackson and Cottonwood counties have a higher percentage of physical inactivity than the national benchmark or the state of Minnesota.

Minnesota, Jackson County and Cottonwood County all have a higher percentage of binge drinking reports than the national benchmark.

Sexually transmitted infections rank substantially higher than the national average for Minnesota and Jackson County. The teen birth rate is higher than the national benchmark in Minnesota and Cottonwood County, but is lower in Jackson County.

The Clinical Care outcomes indicate that Jackson County has a higher percentage of uninsured adults and youth compared to the national benchmark, while Minnesota and Cottonwood County have a lower and equal percentage respectively.

The ratio of population to mental health providers is much higher in Jackson and Cottonwood counties than Minnesota and the national benchmark. Preventable hospital stays are higher than the national benchmark in Minnesota, but are only slightly higher than the national benchmark in Jackson and Cottonwood counties.

Diabetes screening in Minnesota and in Jackson County is lower than the national benchmark. The rate of diabetes screening is higher in Cottonwood County than the national benchmark. Cottonwood County ranks higher than the national benchmark for mammography screenings, while both Minnesota and Jackson County are under the national benchmark.

The Social and Economic Factors outcomes indicate that Minnesota and Jackson and Cottonwood counties all have a higher high school graduation average than the national benchmark; however, Jackson and Cottonwood counties have a lower percentage of post-secondary education than the national benchmark or Minnesota. The unemployment rate was higher in Minnesota and Cottonwood County than the national benchmark during 2009, while Jackson County was comparable to the national average. The percentage of child poverty is higher in Jackson and Cottonwood counties than Minnesota and the national benchmark.

The percentage of children in single parent households is higher than the national benchmark but lower than Minnesota for Jackson and Cottonwood counties.

The Physical Environment outcomes indicate that there is no air pollution or ozone pollution in this area. Access to healthy food is ranked far below the national benchmark. Access to recreational facilities ranks lower than the national benchmark in Minnesota and in Jackson and Cottonwood counties.

Youth account for 21% of the population in Jackson County and 25% of the population in Cottonwood County. Elderly account for 21% of the population in Jackson County and for 19% of the population in Cottonwood County. Seventy-one percent (71%) of Jackson County is rural compared to 29% of Minnesota and 21% as the national benchmark. Sixty-six percent (66%) of Cottonwood County is rural compared to 29% in Minnesota as a whole.

Only 2% of Jackson and Cottonwood counties and 4% of Minnesotans are not proficient in English compared to the national benchmark, which is 9%. Minnesota at 6%, and Jackson and Cottonwood counties at 7% and 8% respectively have a low illiteracy rate compared to the national benchmark of 15%.

The population for Cottonwood and Jackson counties is 21% older than 65 years of age, which is substantially greater than Minnesota (13%) and the national benchmark (13%).

The majority of individuals in this region own their homes with the percentage of home ownership in Jackson County being 78% and in Cottonwood County, 77%.

According to the 2010 Census Data, the population of working age in the labor force is 71% in Minnesota, 68% in Jackson County, and 64% in Cottonwood County. The percentage of those who are living at less than 100% of the Federal poverty level is 11% in Minnesota and Cottonwood County, and 9% in Jackson County. The percentage of those with income less than 200% of the Federal poverty level is 26% in Minnesota, 31% in Cottonwood County, and 28% in Jackson County.

The median household income is highest in Minnesota at $57,243 annually compared to $40,292 in Cottonwood County and $46,869 in Jackson County.

The population distribution from the 2010 U.S. Census Summary by race demonstrates that Minnesota is predominantly white followed by those of Black and Hispanic origin, respectively. In Jackson County, the white population totals 9,830 in all age groups with Hispanic origin being the second leading population with 277

individuals. In Cottonwood County, the white population totals 10,773 in all age groups with Hispanic origin in second place with 720 individuals.

Implementation Strategy

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

- Dental services for youth
- Engage youth in health careers (Area Health Education Center - AHEC)
- Sexually transmitted disease

Implementation Strategy: Dental Services for Youth

- Reach out to Amos S. Deinard, MD with University of Minnesota who is working with project for education of providers of varnish application on teeth.
- Visit with local dentists and community health and gain support
- Training of staff
- Marketing to patients

Implementation Strategy: Engage Youth in Health Careers (Area Health Education Center, AHEC)

- State level - Reach out to Minnesota Area Health Education Center (AHEC) program office to determine programs that may be beneficial to youth in Jackson County.
- Local level – Relationship building with high school career counselor.

Implementation Strategy: Sexually Transmitted Disease

- Partner with schools for education of youth
- Education to staff
- Marketing opportunities to public

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

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

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

Our Values:

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

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

Guiding Principles:

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

Description of the Hospital

Sanford Jackson Medical Center provides high quality, affordable and compassionate health care services for families throughout Jackson County, MN and the surrounding area.

The 20-bed hospital offers professional medical staff trained in the latest protocols for medical and surgical care, as well as a highly trained emergency staff available 24 hours per day.

Jackson and Lakefield ambulance professionals serve the area and the on-site heliport offers airlift service for transporting critically ill patients when needed. As a member of Sanford Health, the patients are assured that when it is necessary they will be transferred to a tertiary care facility, Sanford USD Medical Center.

A variety of surgical procedures are performed daily in the surgical suite at Sanford Hospital Jackson. The medical staff performs major and minor surgery, including orthopedic surgery.

Laboratory and X-ray services are available 24 hours a day, with staff serving both the hospital and the attached medical clinic.

Description of the Community Served

Charming and welcoming, the city of Jackson is located in southwestern Minnesota at the intersection of Interstate 90 and U.S. Hwy. 71, nestled in a valley of the west fork of the Des Moines River. With a population of 3,299, Jackson is the largest city and the county seat of Jackson County. In 2010 the county was designated as "the healthiest county in Minnesota" and routinely ranks in the top 10. A beautiful and historic county courthouse is centrally located on a downtown hillside, and a historic downtown district features a variety of strong retail and service-based businesses, including a classic sidewalk movie theatre offering the latest releases. Jackson also boasts a 300-acre industrial park with strong and expanding industrial residents, such as AGCO, Pioneer Seed, Technical Services for Electronics, Accent, Ziegler, Last Deck, HitchDoc, and USF Holland; and 500 adjacent acres are ready for industrial development. Outdoor enthusiasts will find within the city a beautiful and expanding biking and walking trail system, a disc golf course, a skate park, baseball and softball complexes, numerous other parks, and fishing opportunities along the river…presently being restored with riffles and pools. Beyond all that, Jackson's best feature is its warm and welcoming people…ordinary people doing extraordinary things.

Mission Statement:

The city of Jackson, Minnesota, is a welcoming community that promotes a healthy, active lifestyle for all ages; that values its youth; that celebrates cultural diversity; that experiences and nurtures a learning environment; and that capitalizes on the Interstate to expand its manufacturing, ag services and emerging technologies base and to its vibrant downtown and unique attractions.

Study Design and Methodology

In May 2011 Sanford Health convened key health care leaders and other not-for-profit leaders in the Fargo Moorhead community to establish a Fargo Moorhead Community Health Needs Assessment Collaborative. A primary goal of this collaborative is to craft standardized tools, indicators and methodology that can be used by all group members when conducting assessments and also be used by all of the Sanford medical centers across

the enterprise. After much discussion it was determined that the Robert Wood Johnson Framework for county profiles would be our secondary data model.

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

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

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

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

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

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

The following qualitative data sets were studied:

- Survey of Key Stakeholders

The following quantitative data sets were studied:

- 2011 County Health Profiles for Jackson and Cottonwood Counties
- Aging Profiles for Jackson and Cottonwood Counties
- Diversity Profiles for Jackson and Cottonwood Counties

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 Health Steering Committee performed the asset mapping and reviewed the findings. The group conducted an informal Gap Analysis to determine what needs remained after resources were thoroughly

researched. Once gaps were determined the group proceeded to the prioritization process. The multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

2011 County Health Profiles

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

Aging Profiles

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

Diversity Profiles

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

Limitations

The Sanford Jackson Medical Center Community Health Needs Assessment Collaborative attempted to convene nearly 100 key community and county stakeholders for the purpose of determining the needs of the community. The general survey was completed by 69 community members through random selection and provided a high confidence level.

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

Primary Research

Summary of the Survey Results

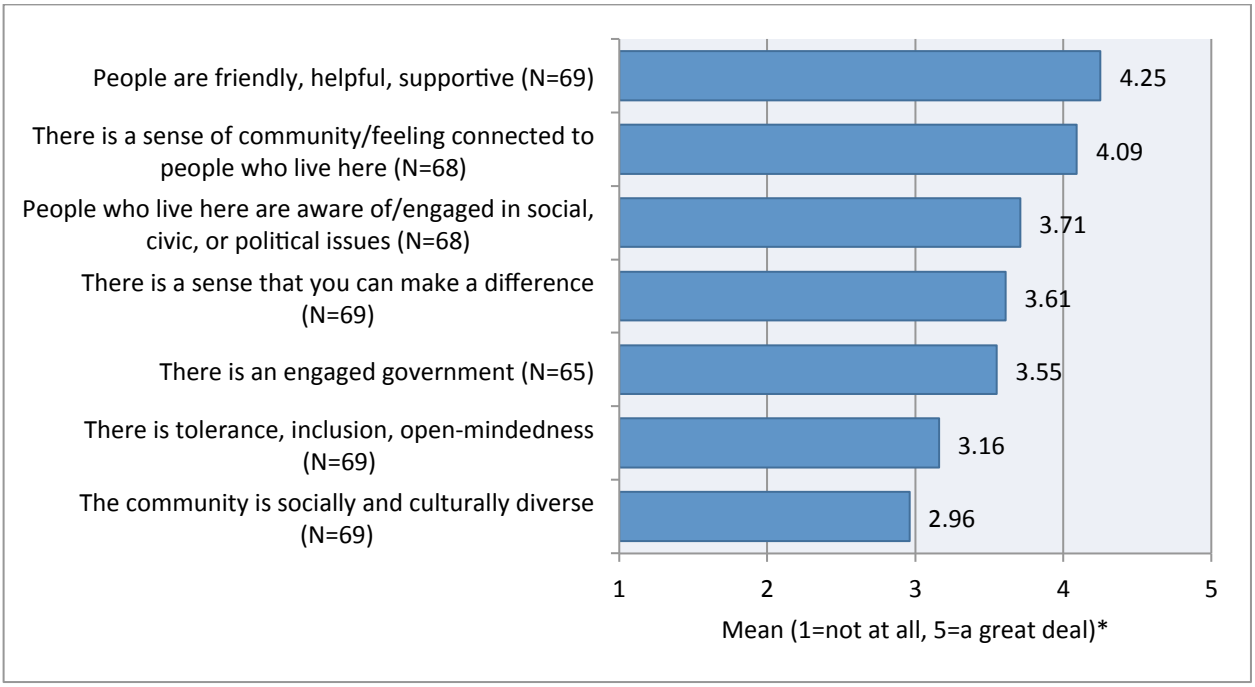
Respondents had very high levels of agreement that the people are friendly, helpful and supportive in the community. There are quality school systems and programs for youth, the community has a family-friendly environment and is a good place to raise kids. Also, the community is a safe place to live, provides convenient access to work and activities and there are many recreational and sports activities available.

Community Assets/Best Things about the Community

Using a 1 to 5 scale, with 1 being "not at all" and 5 being "a great deal," respondents were asked to rate their level of agreement with various statements regarding PEOPLE, SERVICES AND RESOURCES, QUALITY OF LIFE, GEOGRAPHIC SETTING, ACTIVITIES

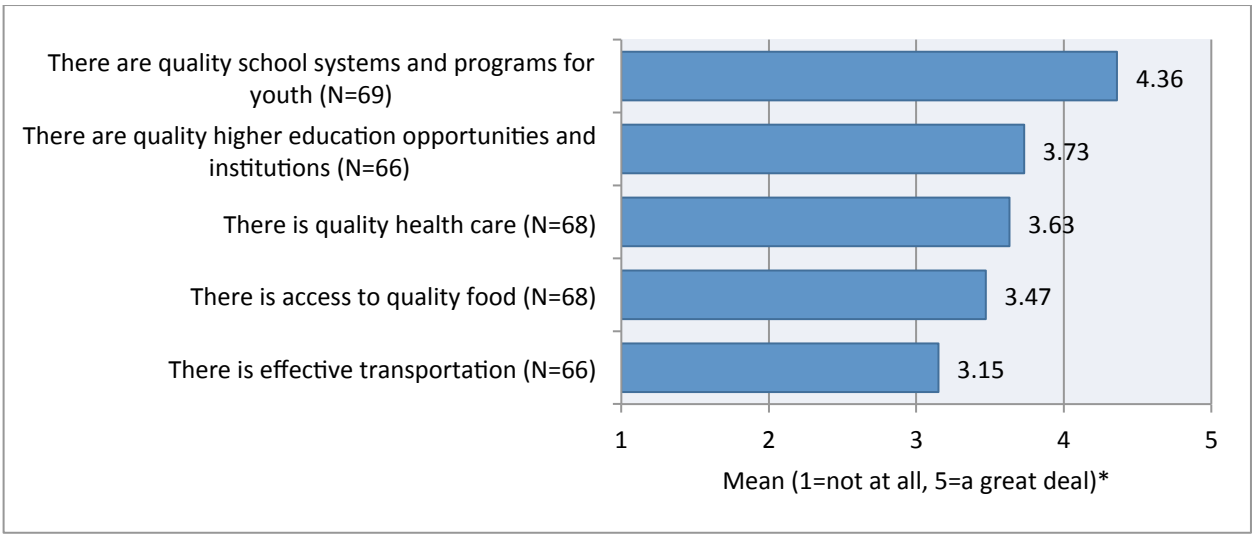
People

Figure 1. Respondents' level of agreement with statements about their community regarding PEOPLE



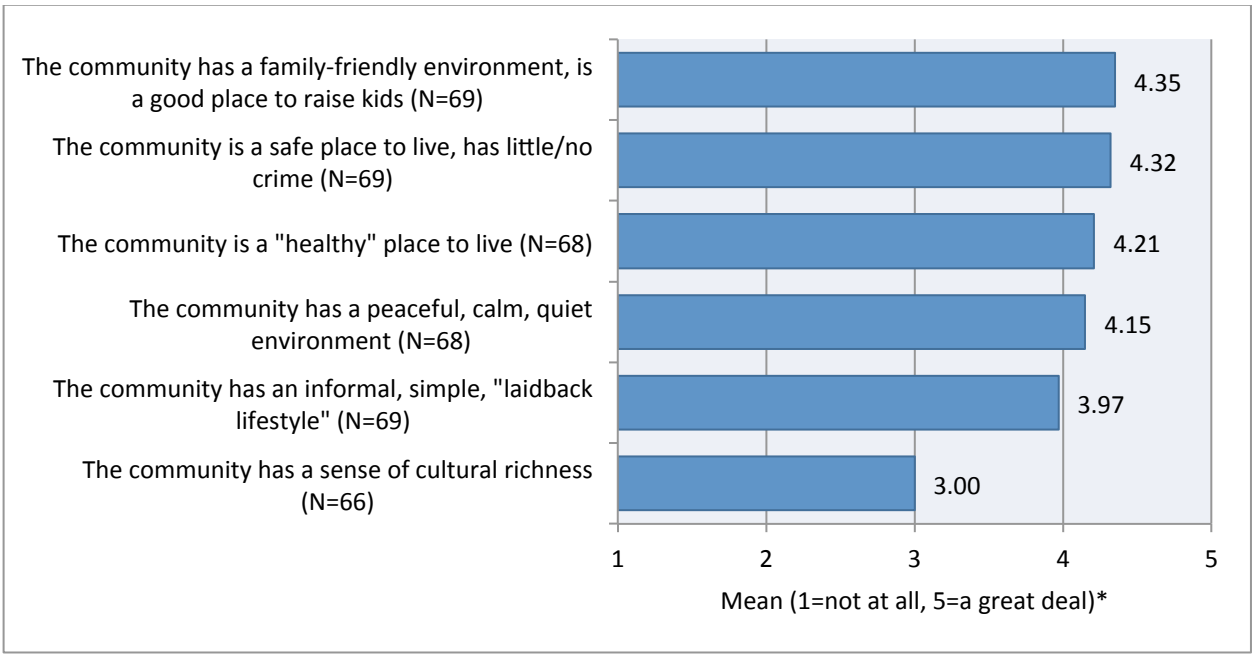
Services and Resources

Figure 2. Respondents' level of agreement with statements about their community regarding SERVICES AND RESOURCES



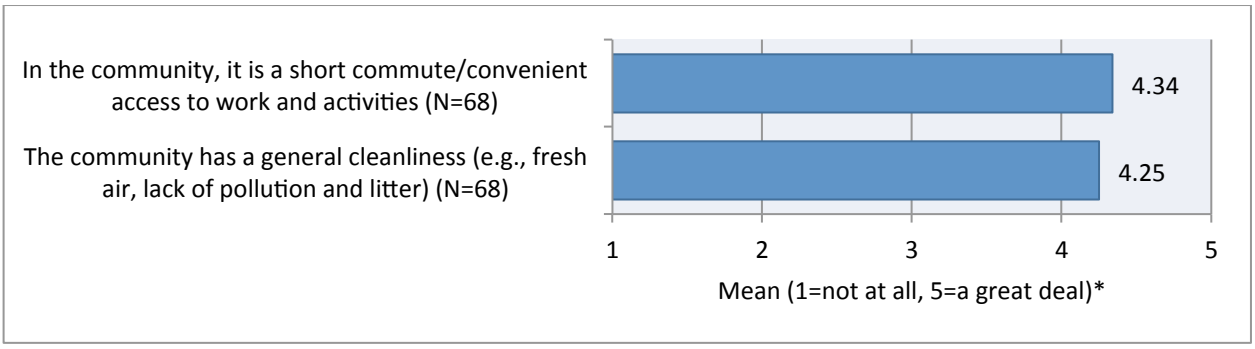
Quality of Life

Figure 3. Respondents' level of agreement with statements about their community regarding QUALITY OF LIFE



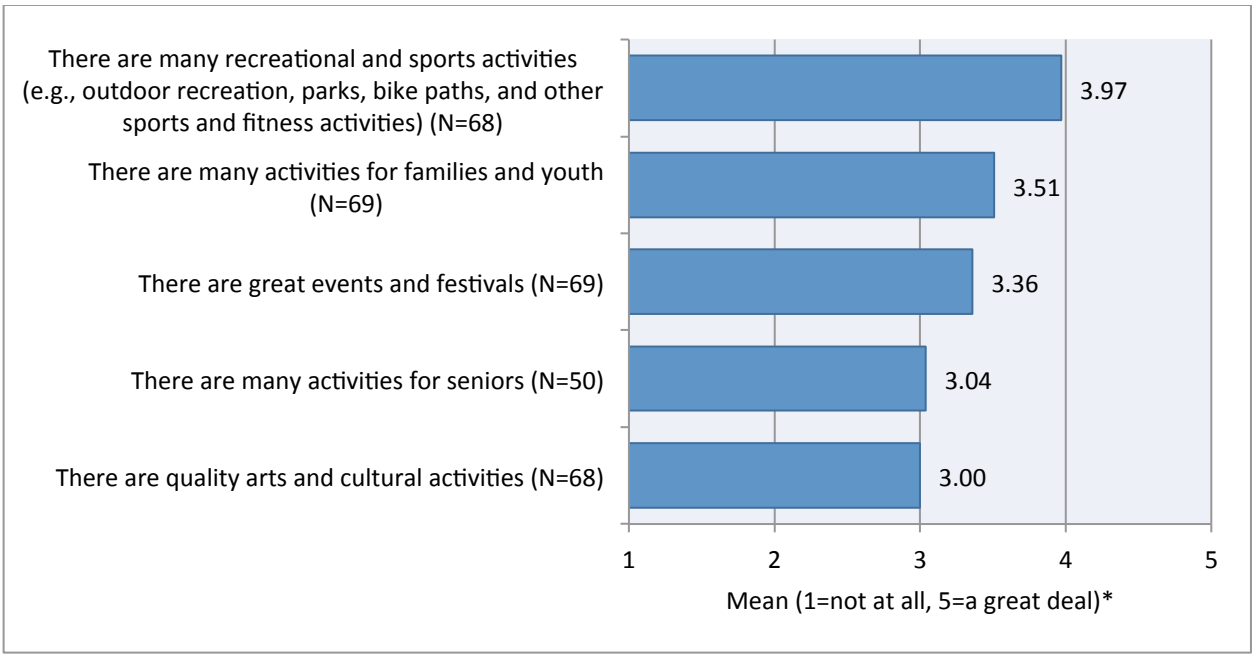
Geographic Setting

Figure 4. Respondents' level of agreement with statements about the community regarding the GEOGRAPHIC SETTING



Activities

Figure 5. Respondents' level of agreement with statements about the community regarding ACTIVITIES

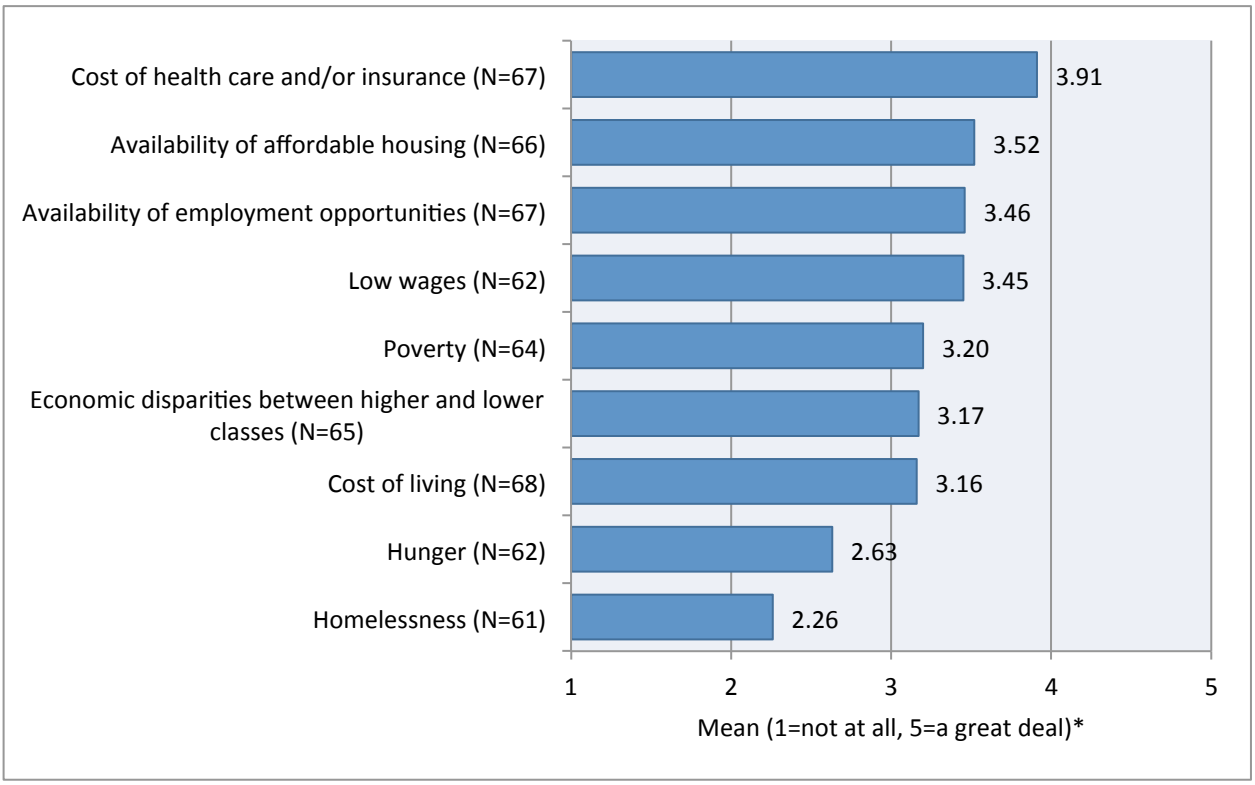


General Concerns about the Community

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

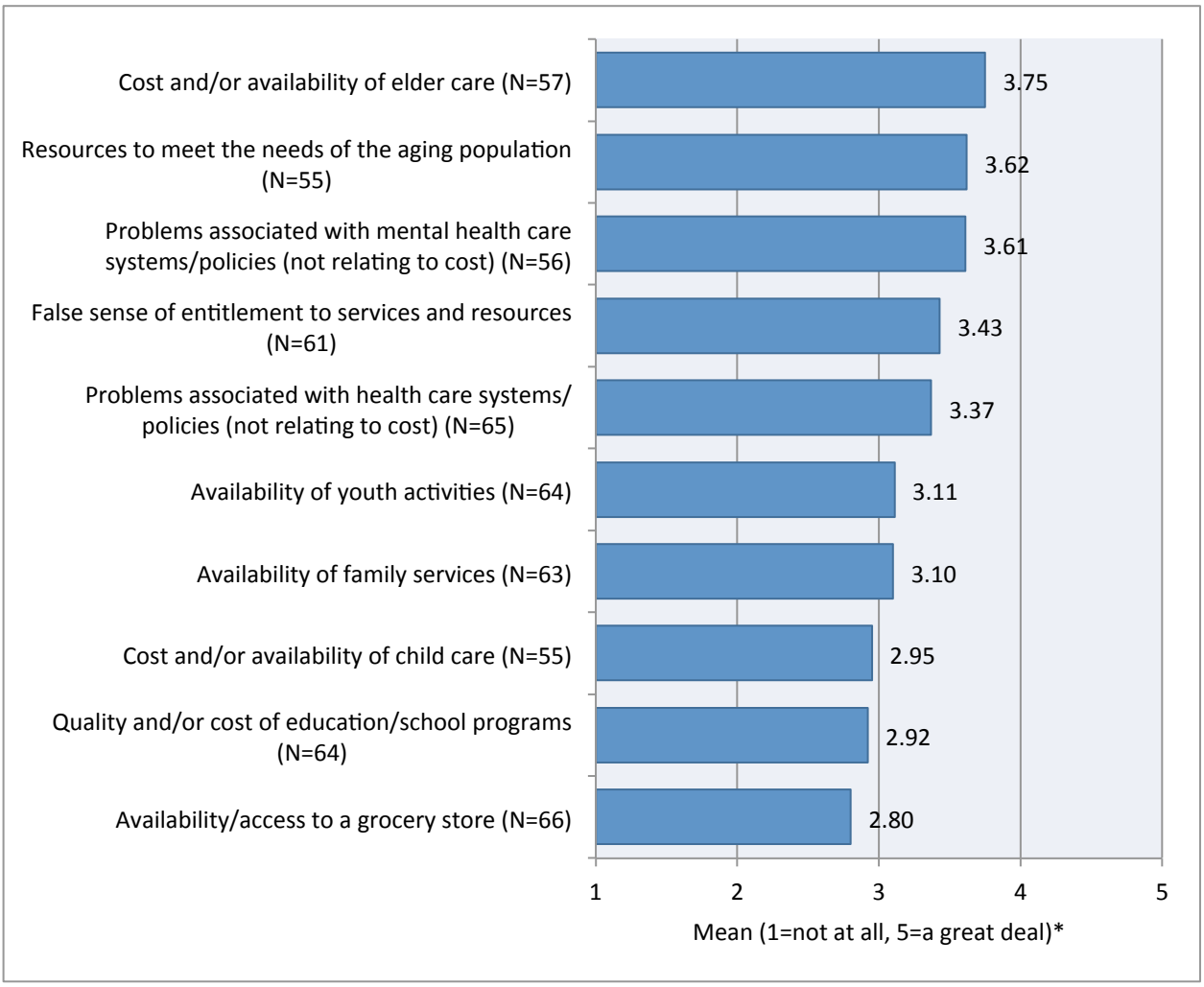
Economic Issues

Figure 6. Respondents' level of concern with statements about the community regarding ECONOMIC ISSUES



Services and Resources

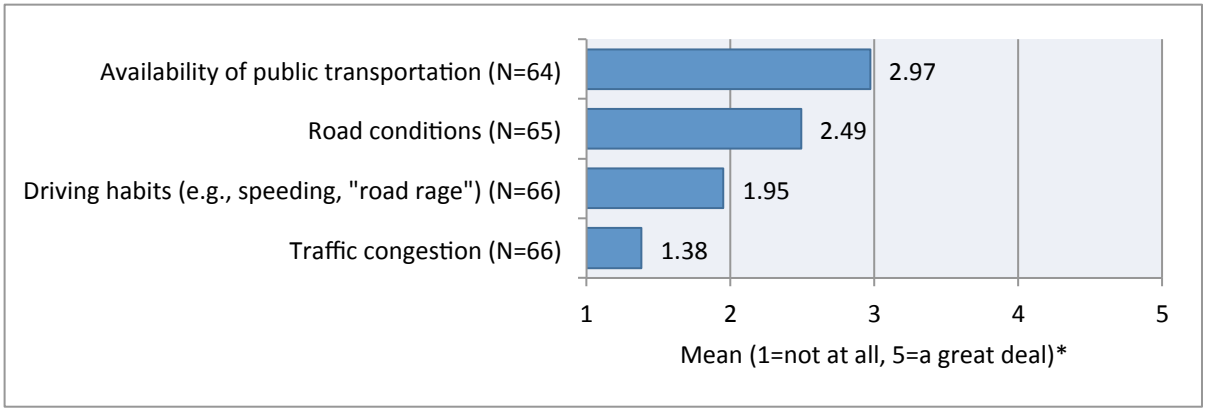
Figure 7. Respondents' level of concern with statements about the community regarding SERVICES AND RESOURCES



*Means exclude "do not know" responses.

Transportation

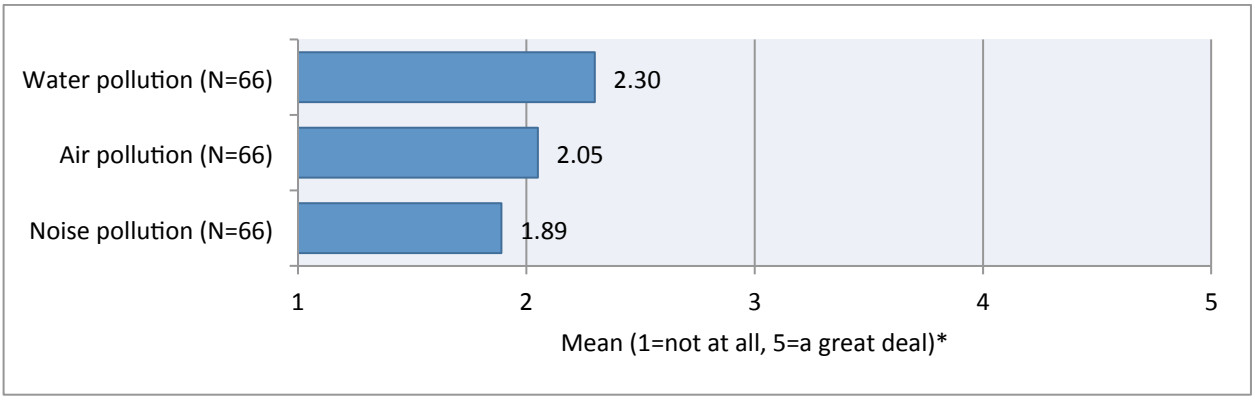
Figure 8. Respondents' level of concern with statements about the community regarding TRANSPORTATION



*Means exclude "do not know" responses.

Environment

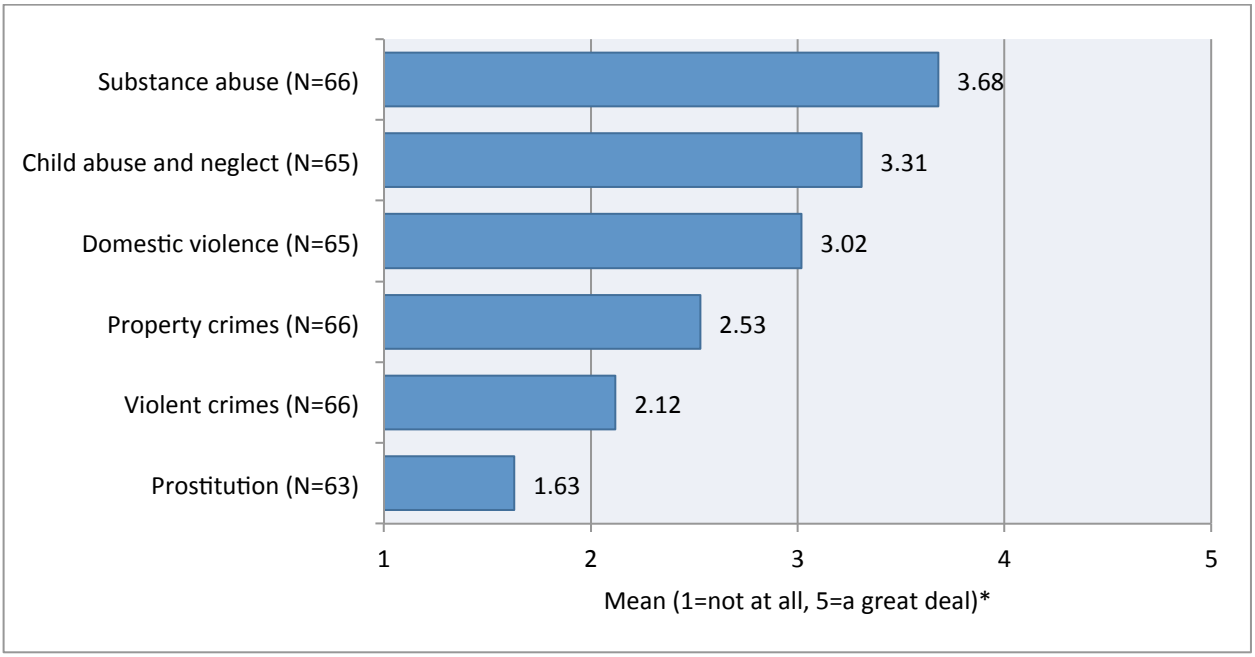
Figure 9. Respondents' level of concern with statements about the community regarding ENVIRONMENTAL POLLUTION



*Means exclude "do not know" responses

Safety

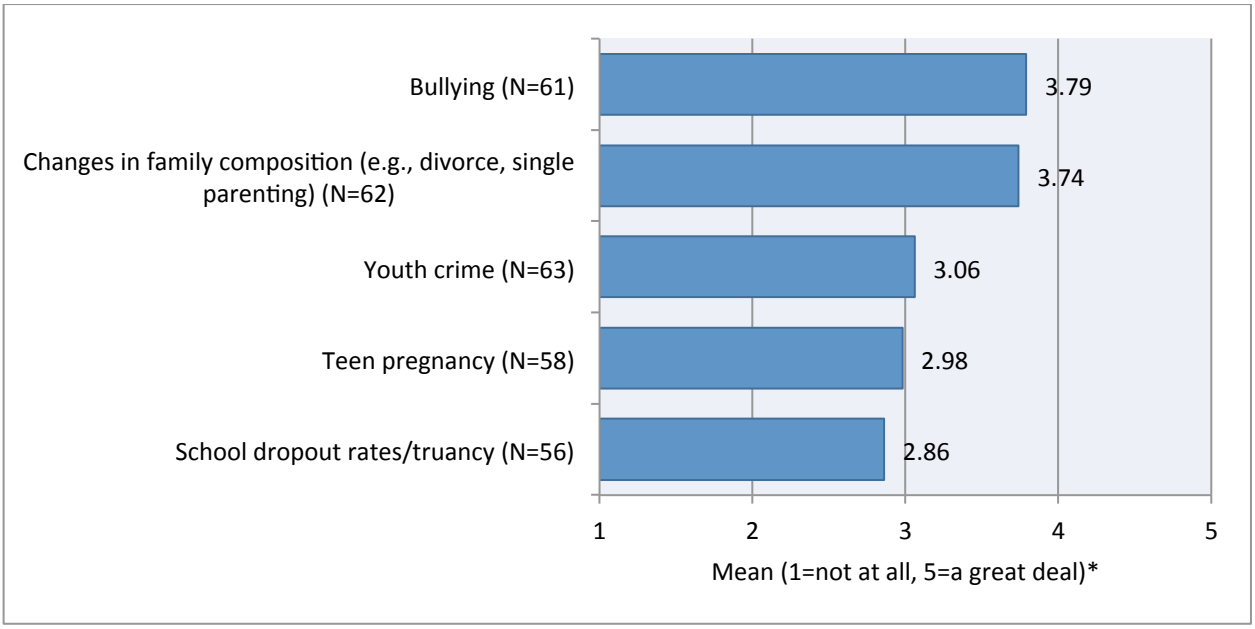
Figure 11. Respondents' level of concern with statements about the community regarding SAFETY CONCERNS



*Means exclude "do not know" responses.

Children and Youth

Figure 10. Respondents' level of concern with statements about the community regarding YOUTH CONCERNS



*Means exclude "do not know" responses.

Community Health and Wellness Concerns

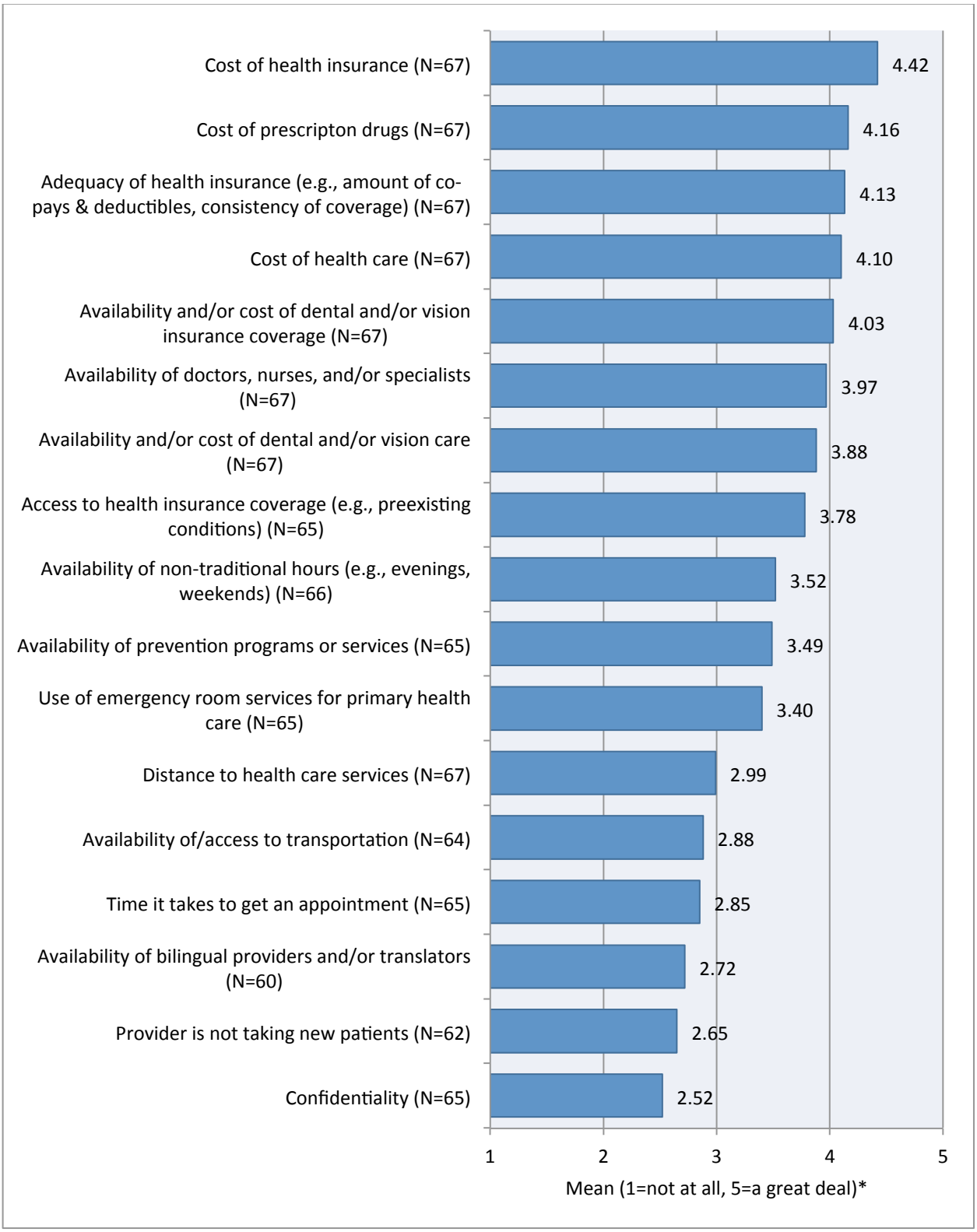
Using a 1 to 5 scale, with 1 being "not at all" and 5 being "a great deal," respondents were asked to rate their level of concern about health and wellness issues in their community regarding ACCESS TO HEALTH CARE, SUBSTANCE USE AND ABUSE, PHYSICAL HEALTH, MENTAL HEALTH, and ILLNESS.

The top five health and wellness concerns among community leaders were:

- cost of health insurance
- cost of prescription drugs
- adequacy of health insurance
- cost of health care
- availability and/or cost of dental and/or vision insurance coverage

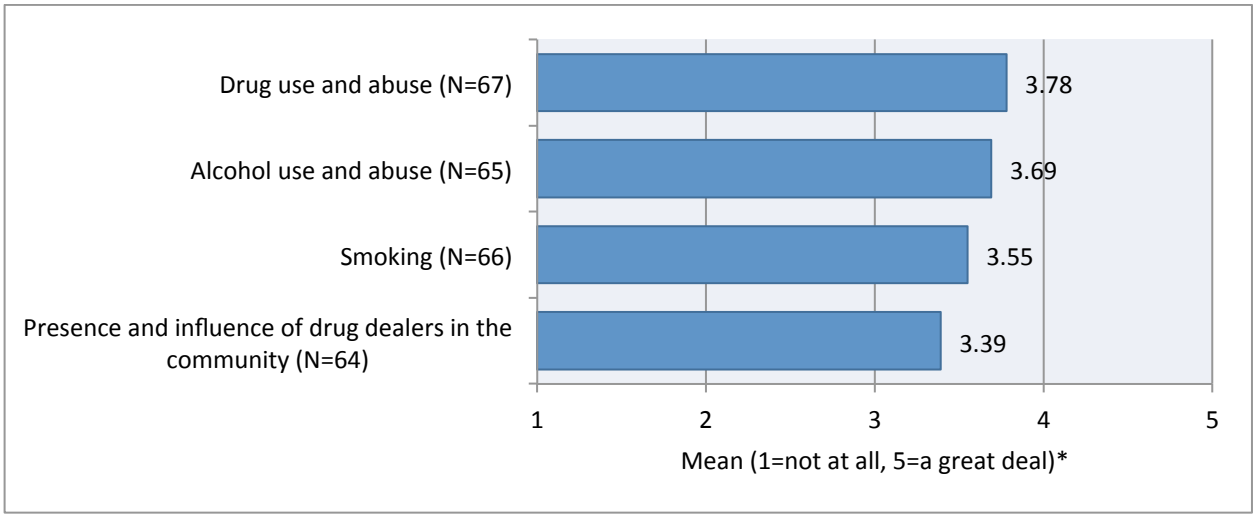
Access to Health Care

Figure 12. Respondents' level of concern with statements about the community regarding ACCESS TO HEALTH CARE



Substance Use and Abuse

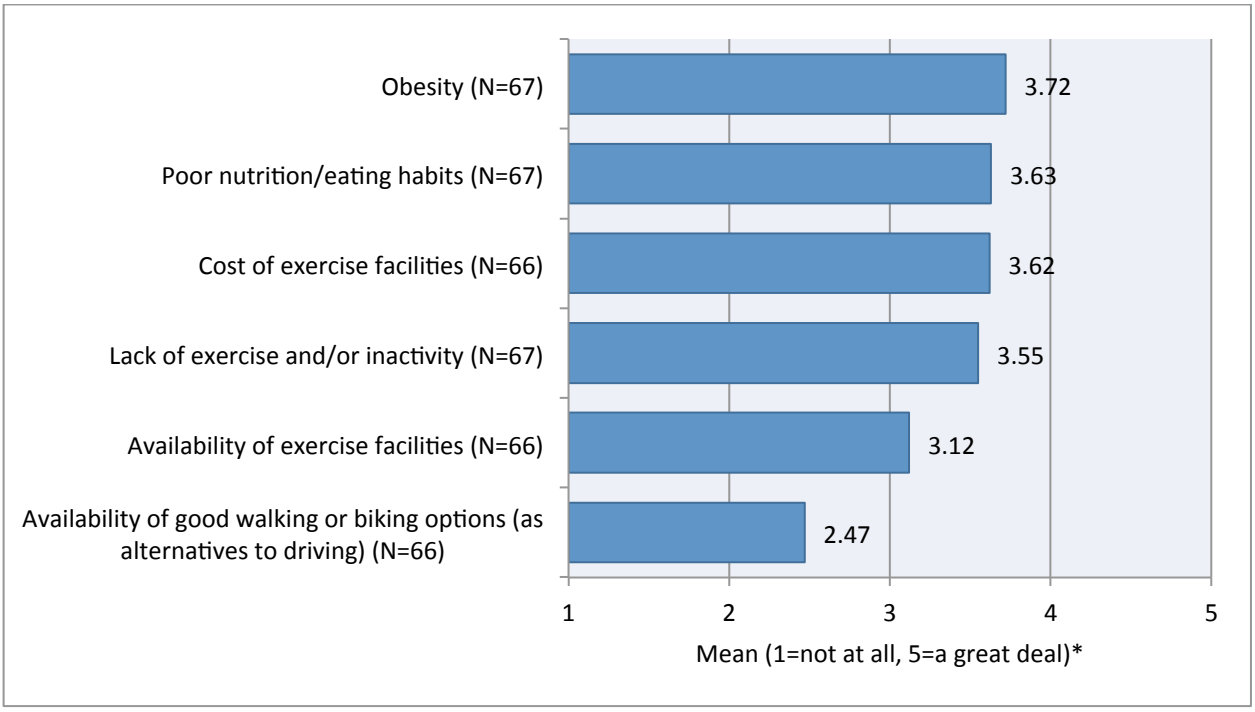
Figure 13. Respondents' level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE



*Means exclude "do not know" responses.

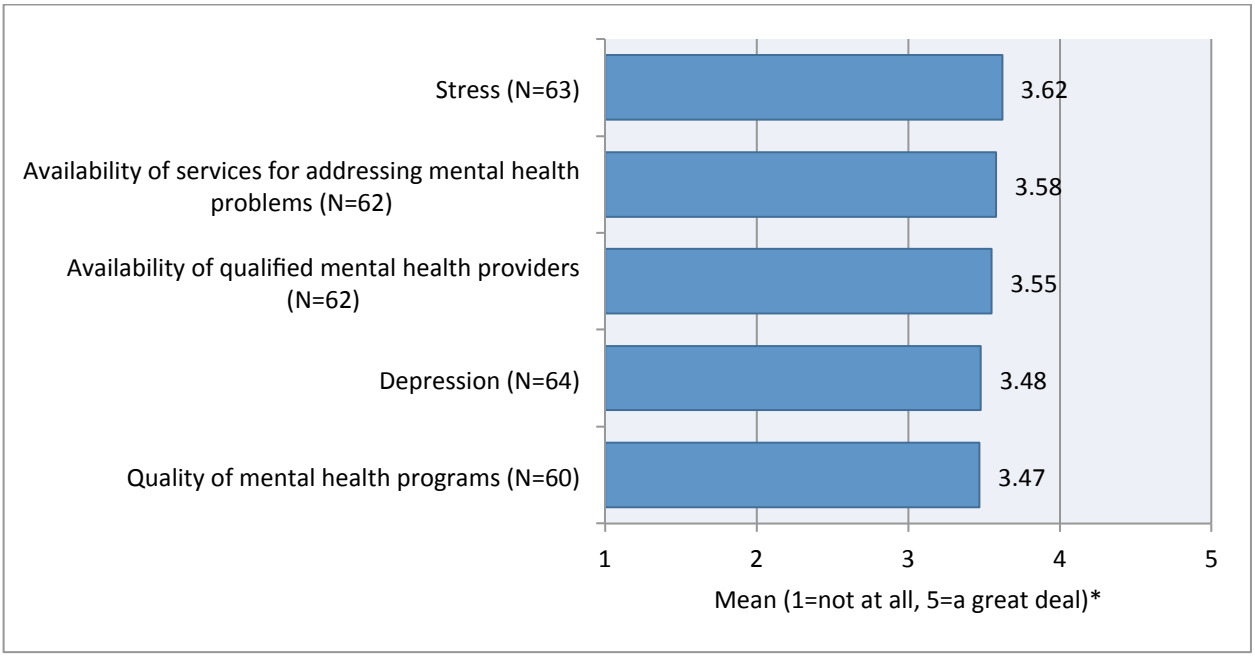
Physical and Mental Health

Figure 14. Respondents' level of concern with statements about the community regarding PHYSICAL HEALTH



*Means exclude "do not know" responses.

Figure 15. Respondents' level of concern with statements about the community regarding MENTAL HEALTH



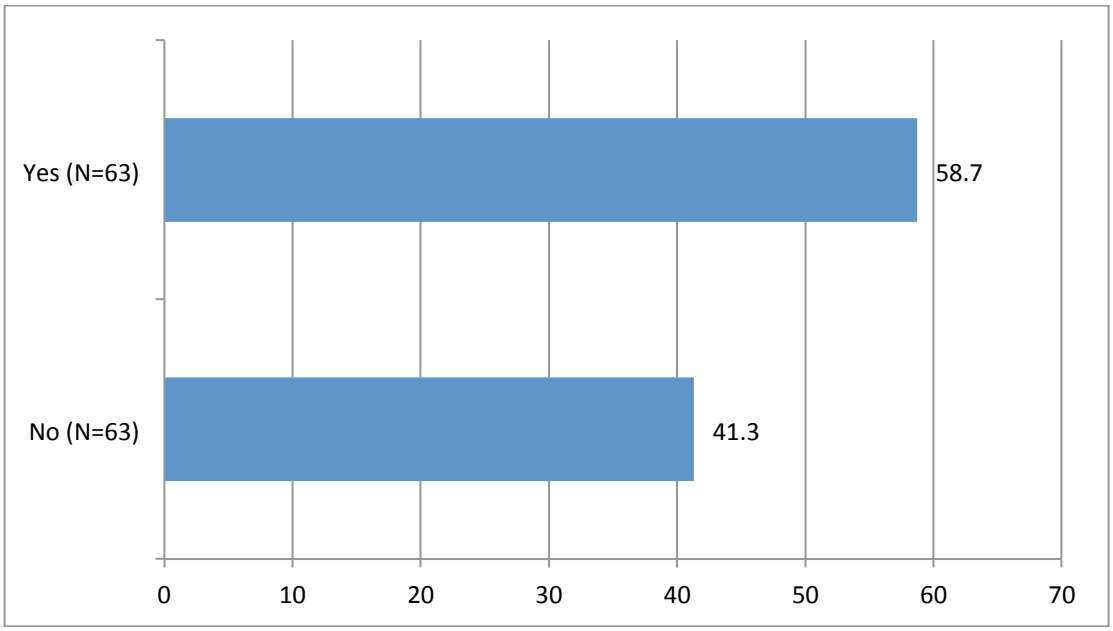
*Means exclude "do not know" responses.

Personal Heath Care Information

Cancer Screening

58.7% of respondents have had cancer screening or cancer care in the past year (see fig.14).

Figure 16. Whether respondents had a cancer screening or cancer care in the past year

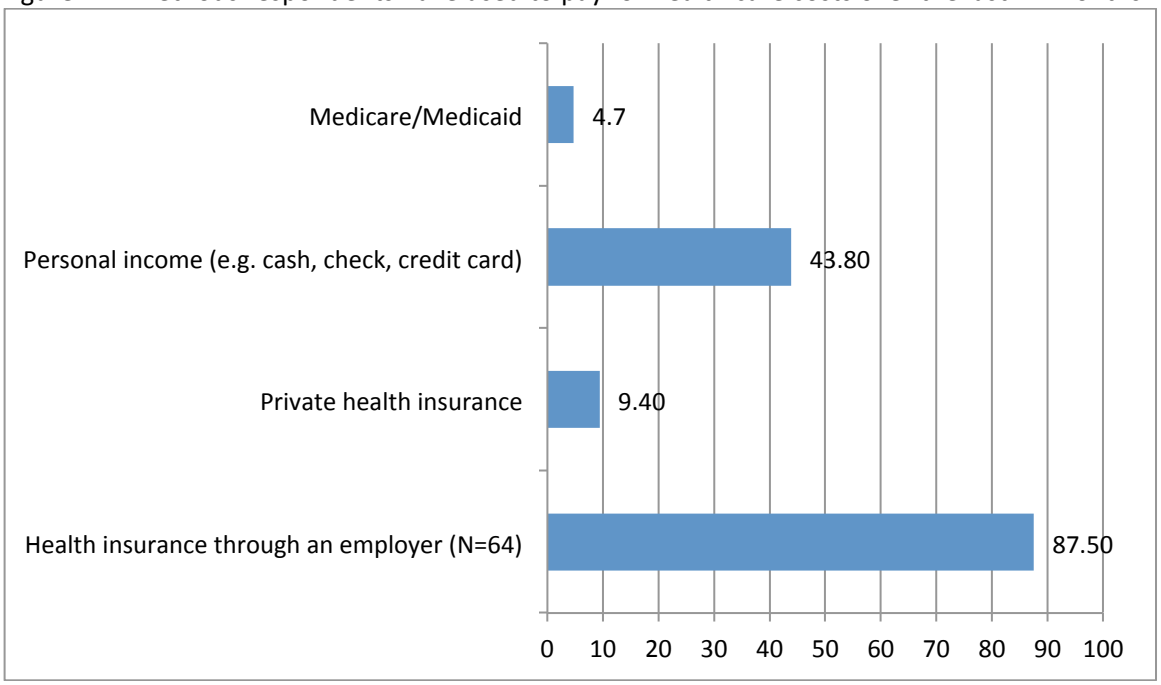


Among respondents who had not had a cancer screening or cancer care in the past year, 84% said they had not done so because it was not necessary or their doctor had not suggested it. Unfamiliarity with recommendations was also cited as a reason.

Health Care Coverage

Respondents were asked how they had paid for health care costs, for themselves or family members, over the last 12 months. A majority of respondents said they had paid for health care costs over the last 12 months by health insurance through an employer. Private insurance and personal income were also used.

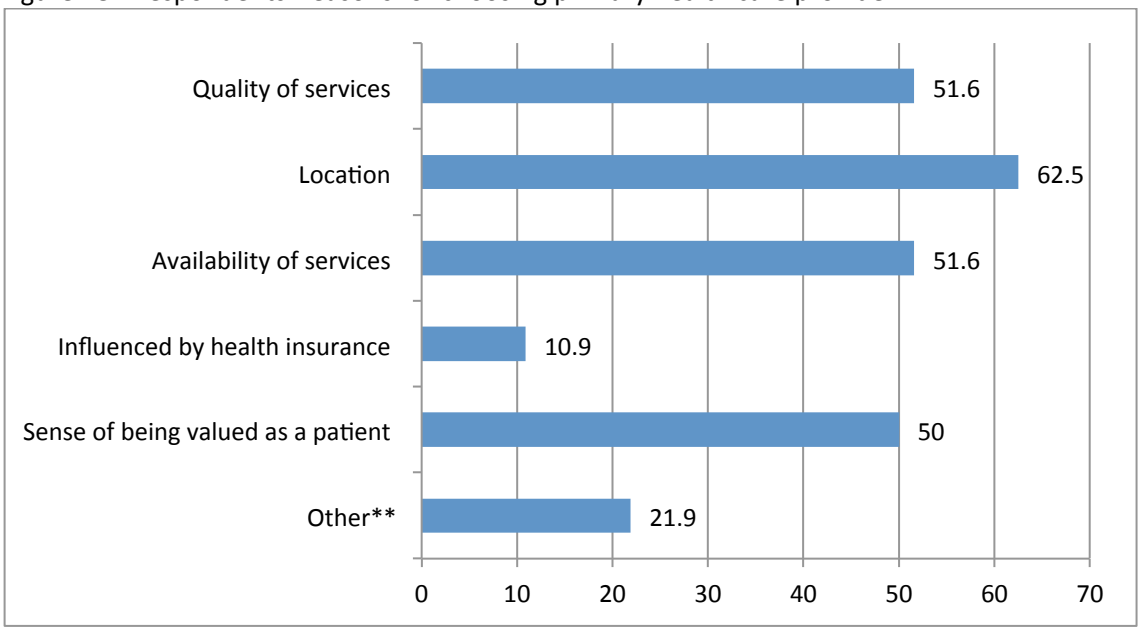
Figure 17. Methods respondents have used to pay for health care costs over the last 12 months



Primary Care Provider

The top three reasons respondents gave for their choice of primary health care provider were location, quality of services and availability of services. (*Figure 16)*

Figure 18. Respondents' reasons for choosing primary health care provider

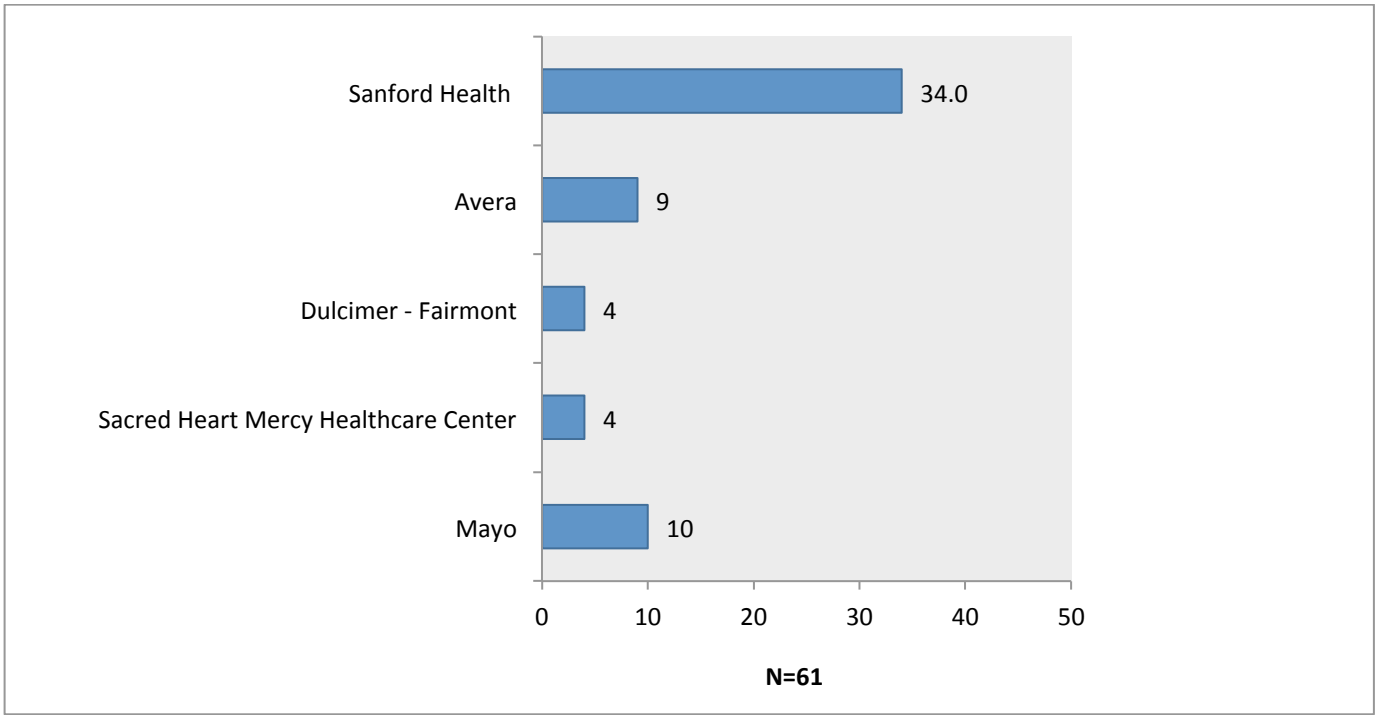


*Percentages do not equal 100.0 due to multiple responses.

Respondent's Primary Health Care Provider

Respondents were asked which provider they used for their primary health care. Fifty-six percent (56%) of respondents said they use Sanford Health as their primary health care provider. (*Figure 17*)

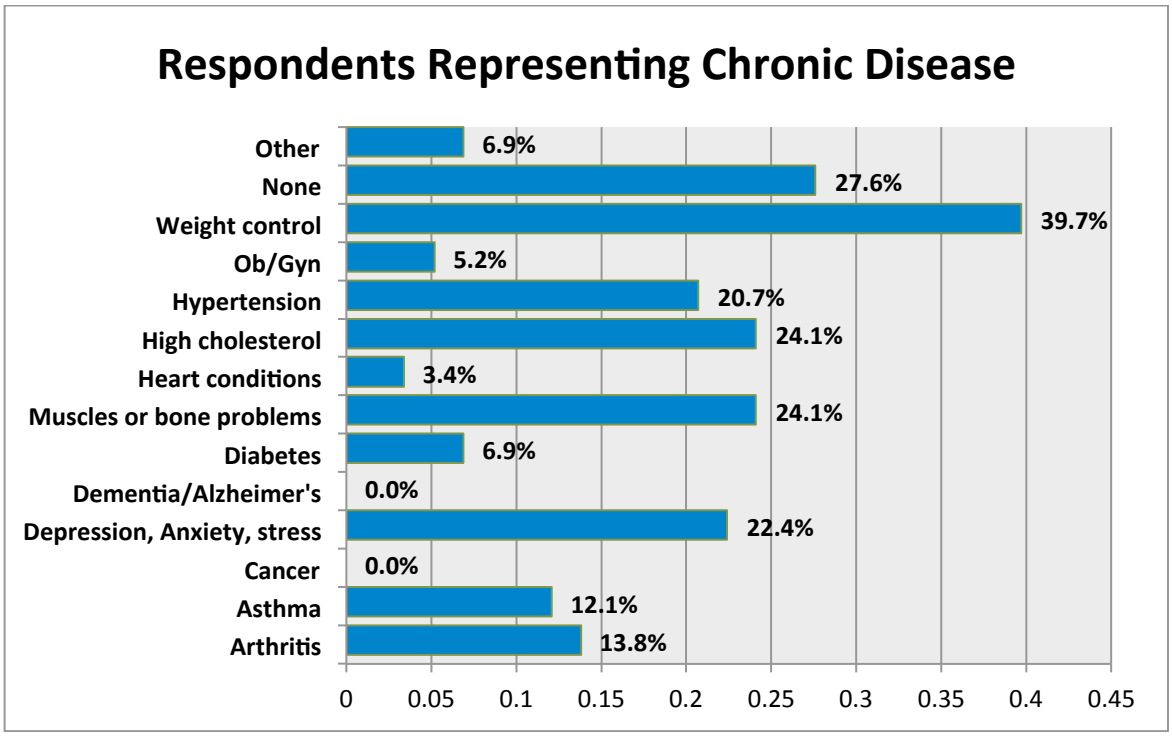
Figure 19. Respondents' primary health care provider



Respondents Representing Chronic Disease

Respondents were asked to select their personal general health conditions/diseases. Weight control received the most responses with 39.7% of participants selecting this condition. The chronic diseases found in the highest percentage among respondents include, depression, anxiety or stress, muscle and bone problems, and hypercholesterolemia. (Figure 20)

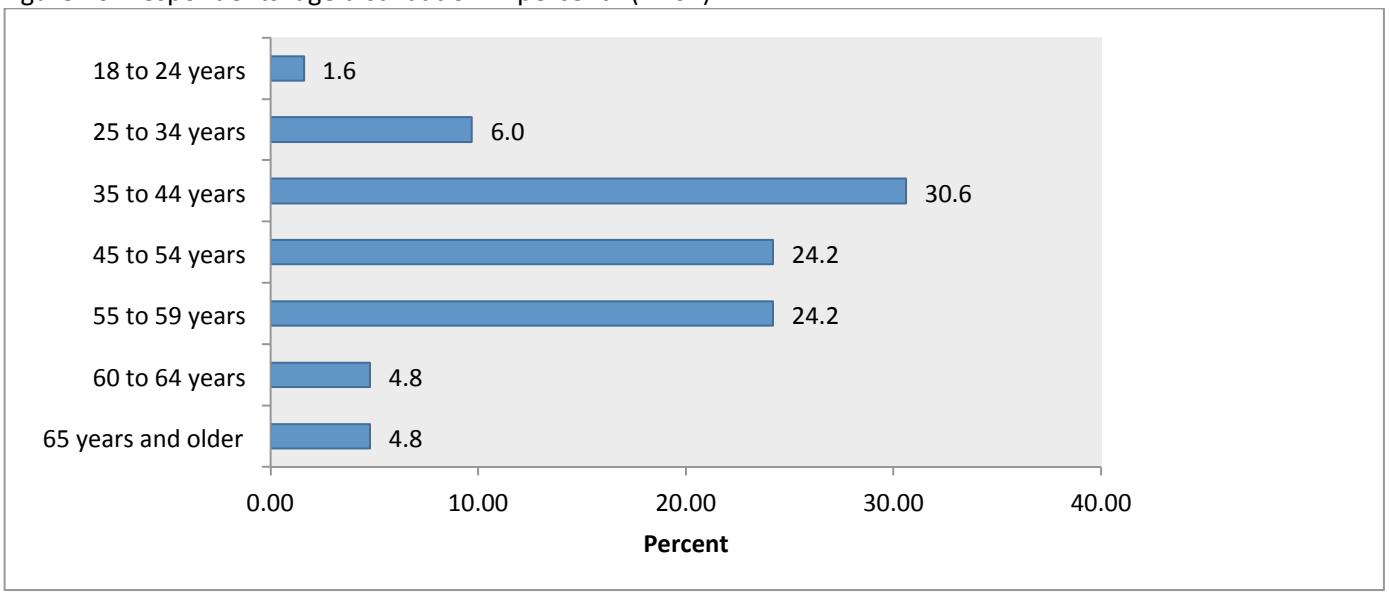
Figure 20. Respondent's health/chronic diseases



Demographic Information

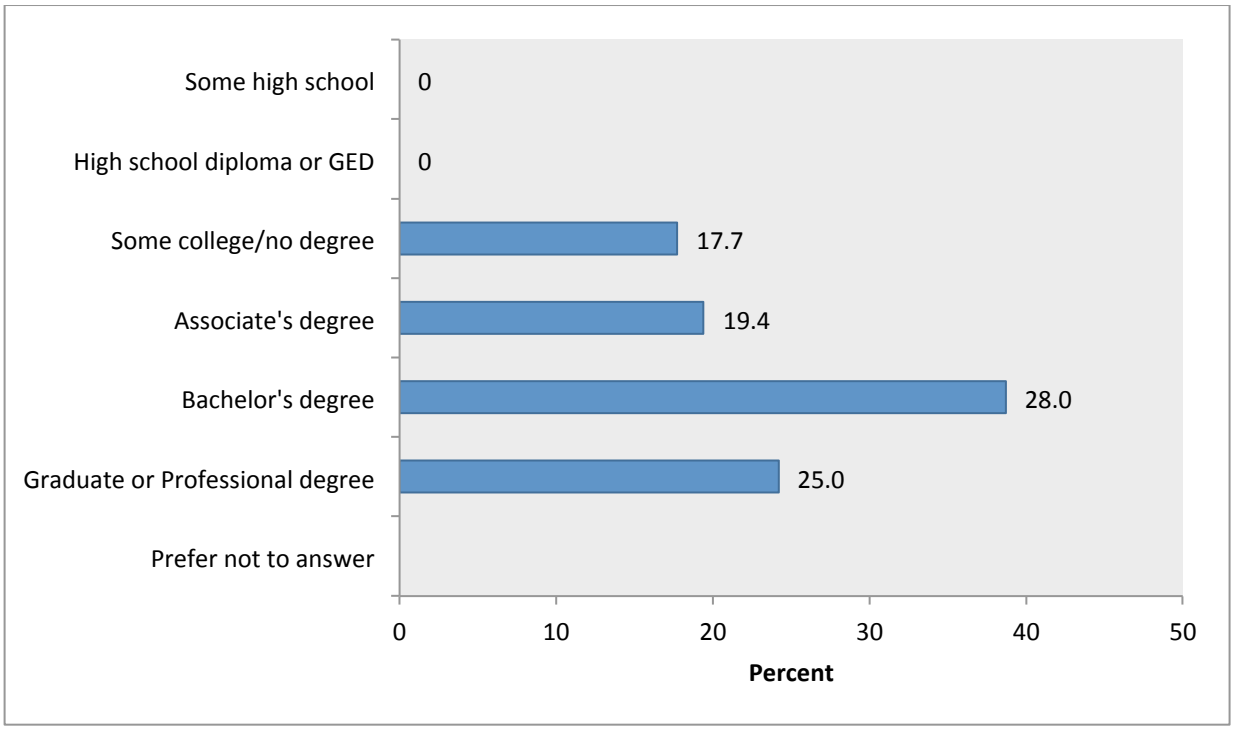
The majority of respondents are 35 to 44 years old.

Figure 20. Respondents' age distribution in percent. (N=62)



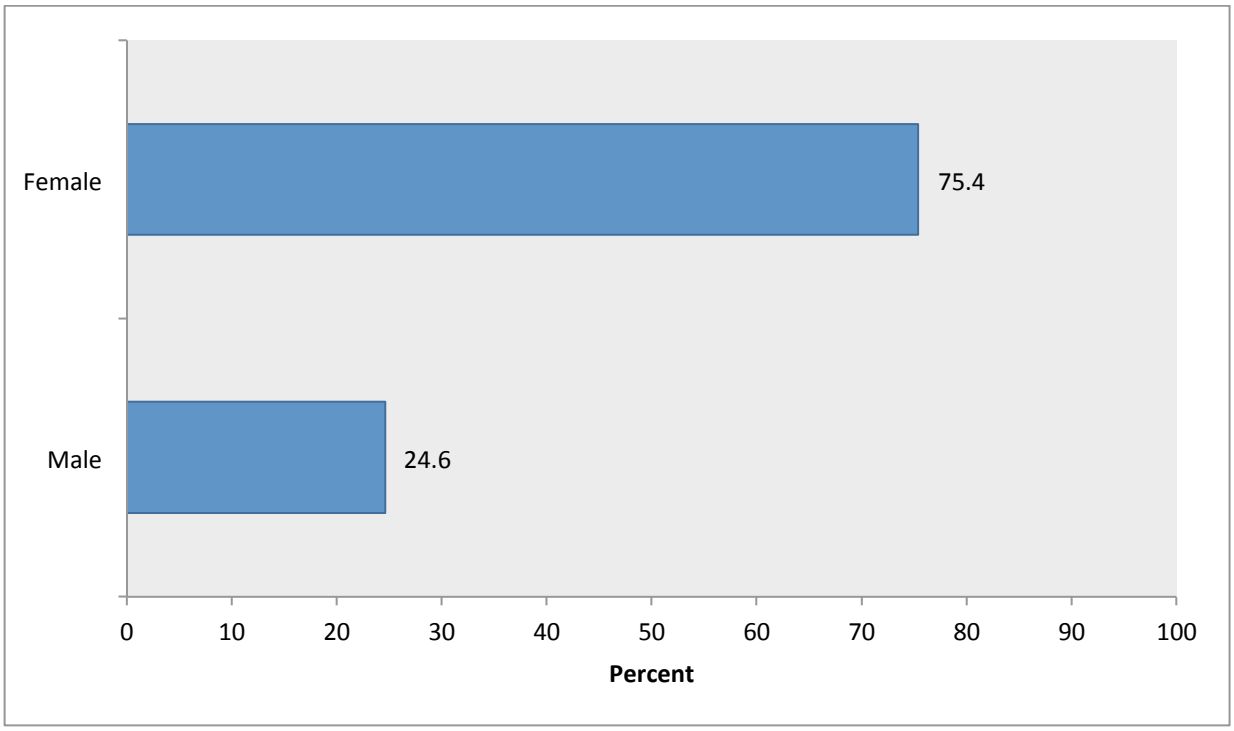
Most respondents have a Bachelor's degree or higher, including a high percent who have a graduate or professional degree.

Figure 21. Respondents' education (N=62)



The majority of respondents are female.

Figure 22. Respondents' gender distribution



Secondary Research

Health Outcomes

The Morbidity health outcomes indicate that Minnesota and Cottonwood County citizens report more days of poor health than the national benchmark; however, Jackson County reports slightly better health days.

Minnesota and Jackson and Cottonwood counties report more mentally unhealthy days than the national benchmark.

Jackson and Cottonwood counties have a higher percentage of low birth weight than the national benchmark.

Mortality

		National Benchmark	MN	Jackson MN	Cottonwood MN
Premature death	Years of potential life lost before age 75 per 100,000 (age-adjusted), 2005-2007	5,564	5,272	-	7,277

Morbidity

		National Benchmark	MN	Jackson MN	Cottonwood MN
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	10%	11%	4%	-
Poor physical health days	Average number of physical unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.6	3.1	1.9	3.6
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.3	2.8	2.7	2.6
Low birth weight	Percent of live births with low birth weight (<2,500 grams), 2001-2007	6.0%	6.5%	7.0%	6.2%

Health Factors

The Health Behavior outcomes indicate that Minnesota and Jackson County have higher percentages of adult smokers than the national average. Adult obesity is also higher in the state of Minnesota and Jackson and Cottonwood counties. Jackson and Cottonwood counties have a higher percentage of physical inactivity than the national benchmark or the state of Minnesota.

Minnesota and Jackson and Cottonwood counties all have a higher percentage of binge drinking reports than the national benchmark.

Sexually transmitted infections rank substantially higher than the national average for Minnesota and Jackson County. The teen birth rate is higher than the national benchmark in Minnesota and Cottonwood County, but is lower in Jackson County.

Health Behaviors

		National Benchmark	MN	Jackson MN	Cottonwood MN
Adult smoking	Percent of adults who currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	15%	19%	16%	-
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008	25%	26%	28%	28%
Physical inactivity	Percent of adults reporting no leisure physical activity, 2008	20%	17%	20%	22%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking, (consuming >4 for women and >5 for men on a single occasion) 2003-2009	8%	20%	13%	12%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	12.0	12.9	-	-
Sexually transmitted infections	Number of Chlamydia cases (new cases reported) per 100,000 population 2008	83.0	276.1	111.8	53.2
Teen birth rate	Number of teen births per 100,000 females ages 15-19, 2001-2007	22.0	27.5	17.8	26.4

Clinical Care

The Clinical Care outcomes indicate that Jackson County has a higher percentage of uninsured adults and youth compared to the national benchmark, while Minnesota and Cottonwood County have a lower and equal percentage, respectively.

The ratio of population to mental health providers is much higher in Jackson and Cottonwood counties than Minnesota and the national benchmark. Preventable hospital stays are higher than the national benchmark in Minnesota, but are only slightly higher than the national benchmark in Jackson and Cottonwood counties.

Diabetes screening in Minnesota and in Jackson County is lower than the national benchmark. The rate of diabetes screening is higher in Cottonwood County than the national benchmark. Cottonwood County ranks higher than the national benchmark for mammography screenings, while both Minnesota and Jackson County are under the national benchmark.

		National Benchmark	MN	Jackson MN	Cottonwood MN
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	13%	11%	14%	13%
Uninsured youth	Percent of youth ages 0-18 without health insurance.	7%	6%	8%	7%
Primary Care Physicians	Ratio of population to primary care physicians, 2008	631:1	636:1	-	591:1
Mental Health Providers	Ratio of total population to mental health providers, 2008	2,242:1	1,306:1	5,410:1	5,616:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	69.0	61.0	-	53.2
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	52.0	56.5	53.7	52.7
Diabetes screening	Percent of Medicare enrollees with diabetes that receive HbA1c screening, 2006-2007	89%	88%	85%	92%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	74%	73%	68%	79%

Social and Economic Factors

The Social and Economic Factors outcomes indicate that Minnesota and Jackson and Cottonwood counties all have a higher high school graduation average than the national benchmark; however, Jackson and Cottonwood counties have a lower percentage of post-secondary education than the national benchmark or Minnesota. The unemployment rate was higher in Minnesota and Cottonwood County than the national benchmark during 2009, when Jackson County was comparable to the national average. The percentage of child poverty is higher in Jackson and Cottonwood counties than Minnesota and the national benchmarks.

The percentage of children in single parent households is higher than the national benchmark but lower than Minnesota for Jackson and Cottonwood counties.

		National Benchmark	MN	Jackson MN	Cottonwood MN
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years 2006-2007	92%	87%	95%	95%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	68%	72%	64%	54%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work 2009	5.3%	8.0%	5.5%	6.5%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	11%	11%	12%	16%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	14%	14%	8%	-

		National Benchmark	MN	Jackson MN	Cottonwood MN
Children in single parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	20%	25%	17%	23%
Homicide rates	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	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 far below the national benchmark. Access to recreational facilities ranks lower than the national benchmark for Minnesota and Jackson and Cottonwood counties.

		National Benchmark	MN	Jackson MN	Cottonwood MN
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	0	0
Air pollution-ozone	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0	0
Access to healthy foods	Percent of zip codes with a healthy food outlet (i.e. grocery store or produce stand/farmers market), 2008	92%	54%	40%	67%
Access to recreational facilities	Number of recreational facilities per 100,000 population 2008	17.0	12.0	9.0	9.0

Demographics

Youth account for 21% of the population in Jackson County and 25% of the population in Cottonwood County. Elderly account for 21% of the population in Jackson County and for 19% of the population in Cottonwood County. The rural population of Jackson County is 71% compared to 29% of Minnesota and 21% as the national benchmark. Cottonwood County has a rural population of 66% compared to 29% of Minnesota.

Only 2% of Jackson and Cottonwood counties and 4% of Minnesotans are not proficient in English compared to the national benchmark of 9%. Minnesota at 6%, and Jackson and Cottonwood counties at 7% and 8% respectively have a low illiteracy rate compared to the national benchmark of 15%.

The population for Cottonwood and Jackson counties is 19-21% older than 65 years of age, which is substantially greater than Minnesota (13%) and the national benchmark (13%).

		National Benchmark	MN	Jackson MN	Cottonwood MN
Youth	Percent of total population ages 0-17, 2009	24%	24%	21%	25%
Elderly	Percent of total population ages 65 and older, 2009	13%	13%	21%	19%
Rural	Percent of total population living in rural area, 2000	21%	29%	71%	66%
Not English Proficient	Percent of total population that speaks English less than "very well". 2005-2009	9%	4%	2%	2%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	15%	6%	7%	8%

Population Age

The population for Cottonwood and Jackson County is 21% older than 65 years of age which is substantially greater than Minnesota (13%) and the national benchmark (13%).

	MN	Jackson MN	Cottonwood MN
Total population	5,303,925	10,266	11,687
Percent ages 65 and older	13%	20%	21%
Percent male	50%	51%	49%
Percent female	50%	49%	51%

Based on 2010 Census data

Housing

The majority of individuals in this region own their homes with the percentage of home ownership in Jackson County being 78% and in Cottonwood County, 77%.

	MN	Jackson MN	Cottonwood MN
Percent of occupied housing that is owner-occupied	73%	78%	77%
Percent of occupied housing that is renter-occupied	27%	22%	23%

Based on 2010 Census data

Economic Security

According to the 2010 Census Data, the population of working age in the labor force is 71% in Minnesota, 68% in Jackson County and 64% in Cottonwood County. The percentage of those who are living at less than 100% of the Federal poverty level is 11% in Minnesota and Cottonwood County and 9% in Jackson County. The percentages of those with income less than 200% of the Federal poverty level are 26% in Minnesota, 31% in Cottonwood County, and 28% in Jackson County.

The median annual household income is highest in Minnesota at $57,243 compared to $40,292 in Cottonwood County and $46,869 in Jackson County.

	MN	Jackson MN	Cottonwood MN
Percent of total population with income less than 100% of poverty	11%	9%	11%
Percent of total population with income less than 200% of poverty	26%	28%	31%
Median household income	$57,243	$46,869	$40,292
Owner occupied housing units	1,548,127	3,560	3,909
Percent spending 30% or more income toward housing costs	28%	19%	23%
Renter occupied housing units	537,790	971	1,003
Percent renters spending 30% or more of income toward housing costs	46%	29%	33%

Diversity Profile

The population distribution from the 2010 U.S. Census Summary by race demonstrates that Minnesota is predominantly white followed by those of black and Hispanic origin respectively. In Jackson County, the white population totals 9,830 in all age groups with Hispanic origin as the second leading population with 277 individuals. In Cottonwood County, the white population totals 10,773 in all age groups with Hispanic origin in second place with 720 individuals.

	MN	Jackson MN	Cottonwood MN
Total population	5,303,925	10,266	11,687
White alone	4,524,062	9,830	10,773
Asian alone	214,234	140	317
Black alone	274,412	47	87
Hispanic origin – of any race	250,258	277	720
American Indian	60,916	24	27

Health Needs Identified

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

- Access to Health Care
- Aging /Baby Boomers
- Children and Youth
- Mental Health/Health factors
- Physical Health/Obesity
- Physician Recruitment/Retention

Community Assets/Prioritization Process

A review of the primary and secondary research concerns was conducted followed by an asset mapping exercise to determine what resources were available to address the needs. An informal Gap Analysis was conducted at the conclusion of the asset mapping work.

Table 1 in the Appendix displays the concerns and assessed needs that were determined by the assessment and includes the assets in the community that address the needs and the prioritized list of remaining needs.

The priorities that remain include:

- Obesity specific to poor nutrition, inactivity and chronic disease and care coordination for these services
- Mental health and care coordination for mental health services
- Lack of dental healthcare for children
- Engage youth in careers - Physician Recruitment/Retention
- Health factors – specifically related to sexually transmitted disease

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

Sanford Jackson Medical Center will specifically address health factors related to sexually transmitted disease, physician recruitment/retention, and lack of dental healthcare of children as we execute the implementation strategy.

IMPLEMENTATION STRATEGY

2013 Community Health Needs Assessment

Sanford Jackson Implementation Strategy

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

- Dental services for youth
- Engage youth in health careers (Area Health Education Center - AHEC)
- Sexually transmitted disease

Implementation Strategy: Dental Services for Youth

- Reach out to Amos S. Deinard, MD with University of Minnesota who is working with project for education of providers of varnish application on teeth.
- Visit with local dentists and community health and gain support
- Training of staff
- Marketing to patients

Implementation Strategy: Engage Youth in Health Careers (Area Health Education Center, AHEC)

- State level - Reach out to Minnesota Area Health Education Center (AHEC) program office to determine programs that may be beneficial to youth in Jackson County.
- Local level – Relationship building with high school career counselor.

Implementation Strategy: Sexually Transmitted Disease

- Partner with schools for education of youth
- Education to staff
- Marketing opportunities to public

SANFORD HEALTH

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

Jackson County
Minnesota

HEALTH OUTCOMES		Jackson	*National Benchmark	Minnesota
Mortality				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	-	5,564	5,272
Morbidity				
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	4%	10%	11%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	1.9	2.6	3.1
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.7	2.3	2.8
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	7.0%	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	16%	15%	19%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008	28%	25%	26%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	20%	20%	17%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking**, 2003-2009	13%	8%	20%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	-	12.0	12.9
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	111.8	83.0	276.1
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	17.8	22.0	27.5
Clinical Care				
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	14%	13%	11%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	8%	7%	6%
Primary care physicians	Ratio of total population to primary care physicians, 2008	-	631:1	636:1
Mental health providers	Ratio of total population to mental health providers, 2008	5,410:1	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	53.7	52.0	56.5
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	85%	89%	88%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	68%	74%	73%

2011 County Health Profile (Page 2)

Jackson County
Minnesota

HEALTH FACTORS (continued)		Jackson	*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	64%	68%	72%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	5.5%	5.3%	8.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	12%	11%	11%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	8%	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	17%	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	40%	92%	54%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	9.0	17.0	12.0

Demographics		Jackson	United States	Minnesota
Youth	Percent of total population ages 0-17, 2009	21%	24%	24%
Elderly	Percent of total population ages 65 and older, 2009	21%	13%	13%
Rural	Percent of total population living in a rural area, 2000	71%	21%	29%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	2%	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

2011 County Health Profile

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

Cottonwood County
Minnesota

HEALTH OUTCOMES		Cottonwood	*National Benchmark	Minnesota
Mortality				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	7,277	5,564	5,272
Morbidity				
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	-	10%	11%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	3.6	2.6	3.1
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.6	2.3	2.8
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	6.2%	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	28%	25%	26%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	22%	20%	17%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking**, 2003-2009	12%	8%	20%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	-	12.0	12.9
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	53.2	83.0	276.1
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	26.4	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	591:1	631:1	636:1
Mental health providers	Ratio of total population to mental health providers, 2008	5,616:1	2,242:1	1,306:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	53.2	69.0	61.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	52.7	52.0	56.5
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	92%	89%	88%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	79%	74%	73%

2011 County Health Profile

Cottonwood County
Minnesota

HEALTH FACTORS (continued)		Cottonwood	*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	54%	68%	72%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	6.5%	5.3%	8.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	16%	11%	11%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	-	14%	14%
Children in single-parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	23%	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	67%	92%	54%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	9.0	17.0	12.0

Demographics		Cottonwood	United States	Minnesota
Youth	Percent of total population ages 0-17, 2009	25%	24%	24%
Elderly	Percent of total population ages 65 and older, 2009	19%	13%	13%
Rural	Percent of total population living in a rural area, 2000	66%	21%	29%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	2%	9%	4%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	8%	15%	6%

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

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

 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

Jackson County

Minnesota

CHARACTERISTICS	Total	AGE	
		Less than 65 Years	Ages 65 and Older
Population[1]			
Total population	10,266	8,222	2,044
Percent ages 65 and older	20%	-	100%
Percent ages 85 and older	4%	-	21%
Percent male	51%	52%	44%
Percent female	49%	48%	56%
Living Arrangements			
Total households (by age of householder)[1]	4,429	3,074	1,355
Percent with family households (i.e., at least two people who are related)	66%	72%	52%
Percent with householder living alone	31%	24%	47%
Grandparents living with their grandchildren*[2]	114	89	25
Percent who are responsible for their grandchildren	39%	31%	64%
Housing[1]			
Percent of occupied housing that is owner-occupied	78%	77%	81%
Percent of occupied housing that is renter-occupied	22%	23%	19%
Economic Security[2]			
Percent of working-age population in labor force	68%	83%	19%
Percent of total population with income less than 100% of poverty	9%	9%	11%
Percent of total population with income less than 200% of poverty	28%	27%	34%
Median household income (by age of householder)	$46,869	$45,852	$31,027
Owner-occupied housing units (by age of householder)	3,560	2,362	1,198
Percent spending 30% or more of income toward housing costs	19%	16%	26%
Renter-occupied housing units (by age of householder)	971	747	224
Percent spending 30% or more of income toward housing costs	29%	23%	49%

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

Aging Profile

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

Cottonwood County
Minnesota

CHARACTERISTICS	Total	AGE: Less than 65 Years	AGE: Ages 65 and Older
Population[1]			
Total population	11,687	9,205	2,482
Percent ages 65 and older	21%	-	100%
Percent ages 85 and older	4%	-	20%
Percent male	49%	51%	43%
Percent female	51%	49%	57%
Living Arrangements			
Total households (by age of householder)[1]	4,857	3,252	1,605
Percent with family households (i.e., at least two people who are related)	64%	71%	52%
Percent with householder living alone	32%	24%	48%
Grandparents living with their grandchildren*[2]	89	53	36
Percent who are responsible for their grandchildren	13%	23%	0%
Housing[1]			
Percent of occupied housing that is owner-occupied	77%	77%	79%
Percent of occupied housing that is renter-occupied	23%	23%	21%
Economic Security[2]			
Percent of working-age population in labor force	64%	81%	20%
Percent of total population with income less than 100% of poverty	11%	12%	7%
Percent of total population with income less than 200% of poverty	31%	29%	39%
Median household income (by age of householder)	$40,292	$37,980	$27,407
Owner-occupied housing units (by age of householder)	3,909	2,535	1,374
Percent spending 30% or more of income toward housing costs	23%	23%	23%
Renter-occupied housing units (by age of householder)	1,003	702	301
Percent spending 30% or more of income toward housing costs	33%	23%	58%

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

Jackson 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	10,266	9,830	47	24	140	277
Percent ages 0 to 17	23%	22%	32%	54%	29%	49%
Percent ages 18 to 44	29%	28%	60%	38%	44%	36%
Percent ages 45 to 64	29%	30%	2%	8%	23%	13%
Percent ages 65 and older	20%	21%	6%	0%	4%	1%
Median age (in years)	44.1	45.2	26.5	17.5	29.8	18.1
Living Arrangements						
Total households[1]	4,429	4,321	11	3	49	58
Percent with householder living alone	31%	31%	18%	0%	22%	9%
Percent with families with children ages 0 to 17	26%	25%	18%	67%	47%	62%
Grandparents living with their grandchildren[2]	114	69	0	0	31	14
Percent who are responsible for grandchildren	39%	43%	-	-	0%	100%
Housing[1]						
Percent occupied housing that is owner-occupied	78%	79%	9%	33%	55%	52%
Percent occupied housing that is renter-occupied	22%	21%	91%	67%	45%	48%
Educational Attainment[2]						
Percent of persons ages 25 and older with high school degree or higher	90%	91%	100%	56%	59%	56%
Percent of persons ages 25 and older with Bachelor's degree or higher	16%	16%	50%	0%	39%	9%
Economic Security[2]						
Unemployment rate	3%	3%	0%	0%	4%	10%
Median household income	$46,869	$46,463	-	-	$186,429	$43,438
Percent of households with income <$25,000	23%	24%	0%	0%	0%	42%
Percent of persons with income <100% poverty	9%	9%	0%	0%	0%	29%
Percent of children ages 0 to 17 in families with income <100% poverty	9%	7%	-	-	0%	37%
Percent of elderly ages 65 and older with income <100% poverty	11%	11%	-	-	-	0%

Source: U.S. Census Bureau, [1]2010 Census Summary File 1 and [2]2006-2010 American Community Survey (ACS) 5-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across race and ethnic categories; however, because they are based on sample data, one should use caution when interpreting small numbers. - Blank values reflect data that are missing or not applicable. Racial categories not represented include Native Hawaiian and Other Pacific Islander alone, Some Other Race alone, and Two or More races.

 The Diversity 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

Cottonwood 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	11,687	10,773	87	27	317	720
Percent ages 0 to 17	24%	22%	30%	37%	29%	48%
Percent ages 18 to 44	27%	26%	48%	37%	33%	41%
Percent ages 45 to 64	28%	28%	18%	22%	31%	9%
Percent ages 65 and older	21%	23%	3%	4%	7%	2%
Median age (in years)	44.2	45.9	28.5	39.3	33.2	18.6
Living Arrangements						
Total households[1]	4,857	4,600	36	10	105	158
Percent with householder living alone	32%	33%	42%	20%	29%	11%
Percent with families with children ages 0 to 17	26%	25%	22%	20%	32%	63%
Grandparents living with their grandchildren[2]	89	79	0	0	0	0
Percent who are responsible for grandchildren	13%	15%	-	-	-	-
Housing[1]						
Percent occupied housing that is owner-occupied	77%	80%	11%	50%	50%	43%
Percent occupied housing that is renter-occupied	23%	21%	89%	50%	50%	57%
Educational Attainment[2]						
Percent of persons ages 25 and older with high school degree or higher	85%	87%	-	100%	33%	29%
Percent of persons ages 25 and older with Bachelor's degree or higher	16%	16%	-	0%	5%	0%
Economic Security[2]						
Unemployment rate	4%	3%	0%	5%	48%	0%
Median household income	$40,292	$41,279	-	-	$39,688	$35,018
Percent of households with income <$25,000	29%	28%	-	100%	26%	28%
Percent of persons with income <100% poverty	11%	9%	11%	44%	8%	51%
Percent of children ages 0 to 17 in families with income <100% poverty	14%	12%	0%	0%	5%	57%
Percent of elderly ages 65 and older with income <100% poverty	7%	7%	-	-	-	0%

Source: U.S. Census Bureau, [1]2010 Census Summary File 1 and [2]2006-2010 American Community Survey (ACS) 5-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across race and ethnic categories; however, because they are based on sample data, one should use caution when interpreting small numbers. - Blank values reflect data that are missing or not applicable. Racial categories not represented include Native Hawaiian and Other Pacific Islander alone, Some Other Race alone, and Two or More races.

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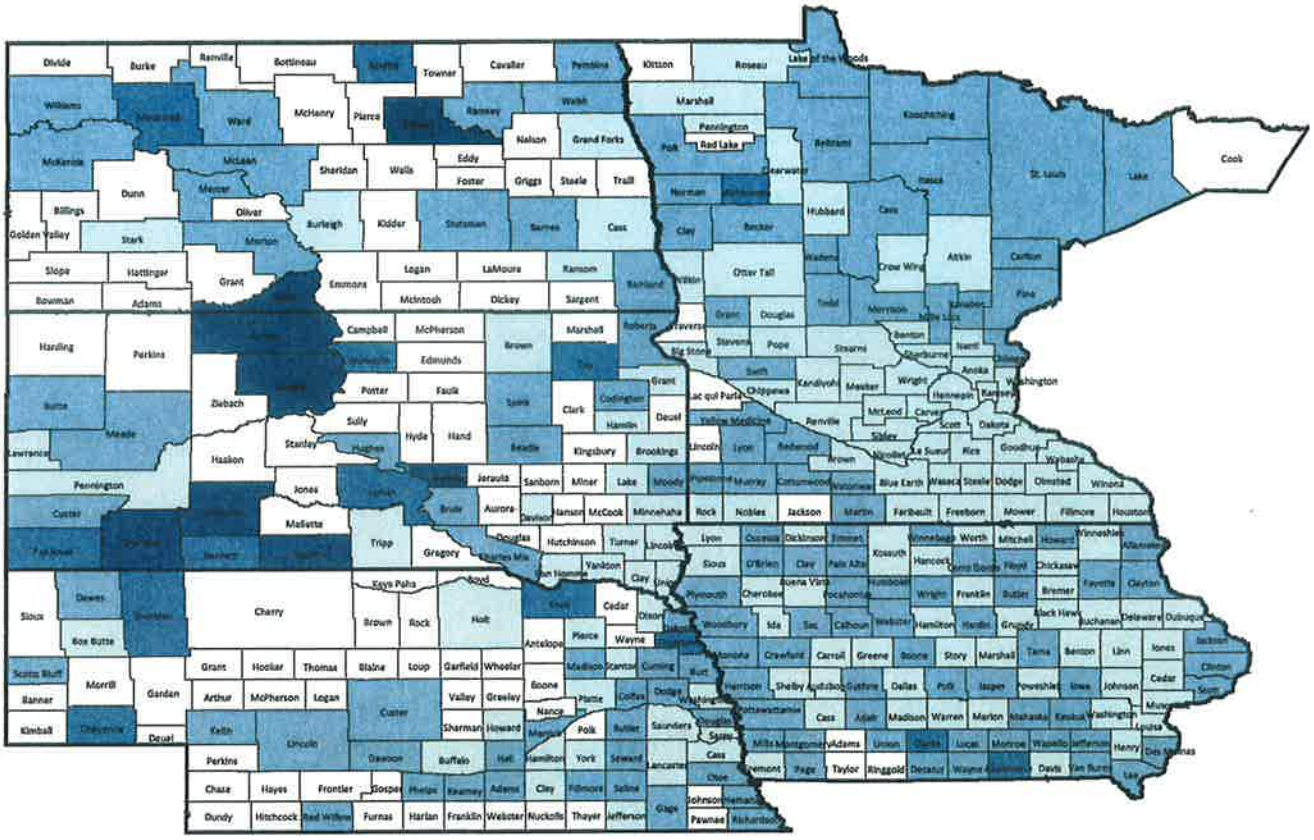
Map 1

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

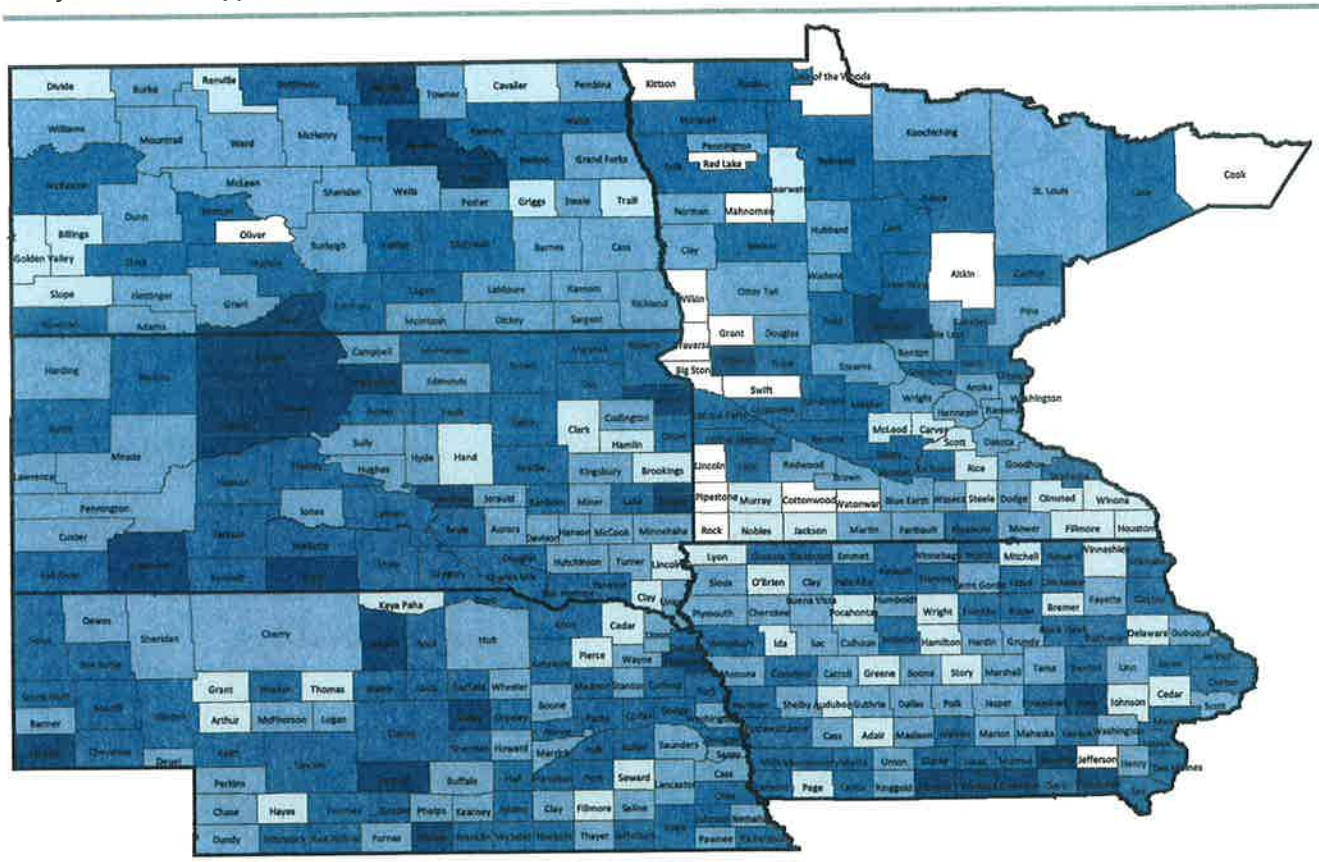
What It Is: Premature death is represented by the years of potential life lost before age 75 (YPLL-75). Every death occurring before the age of 75 contributes to the total number of years of potential life lost. For example, a person who dies at age 25 contributes 50 years of life lost, whereas a person 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



Map 2

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

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

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.

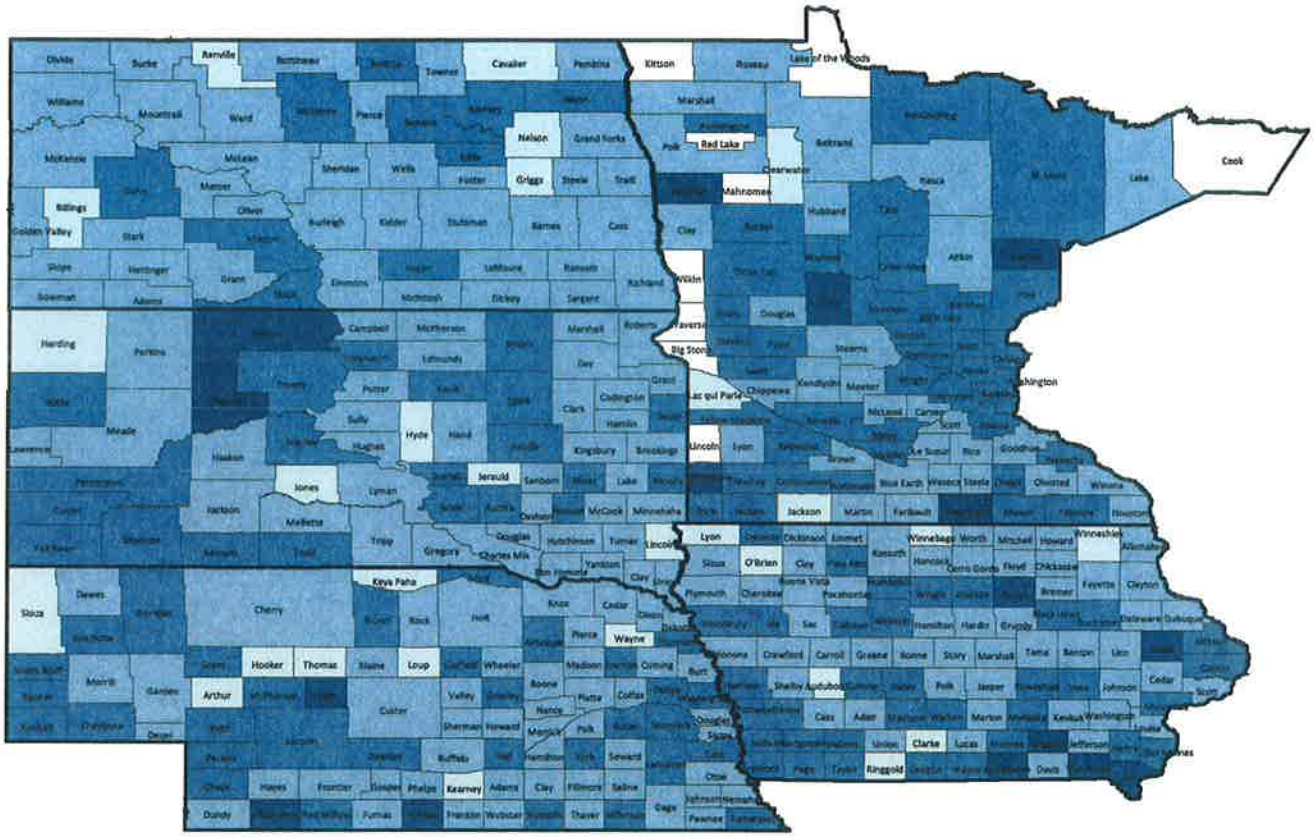
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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

Map 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.

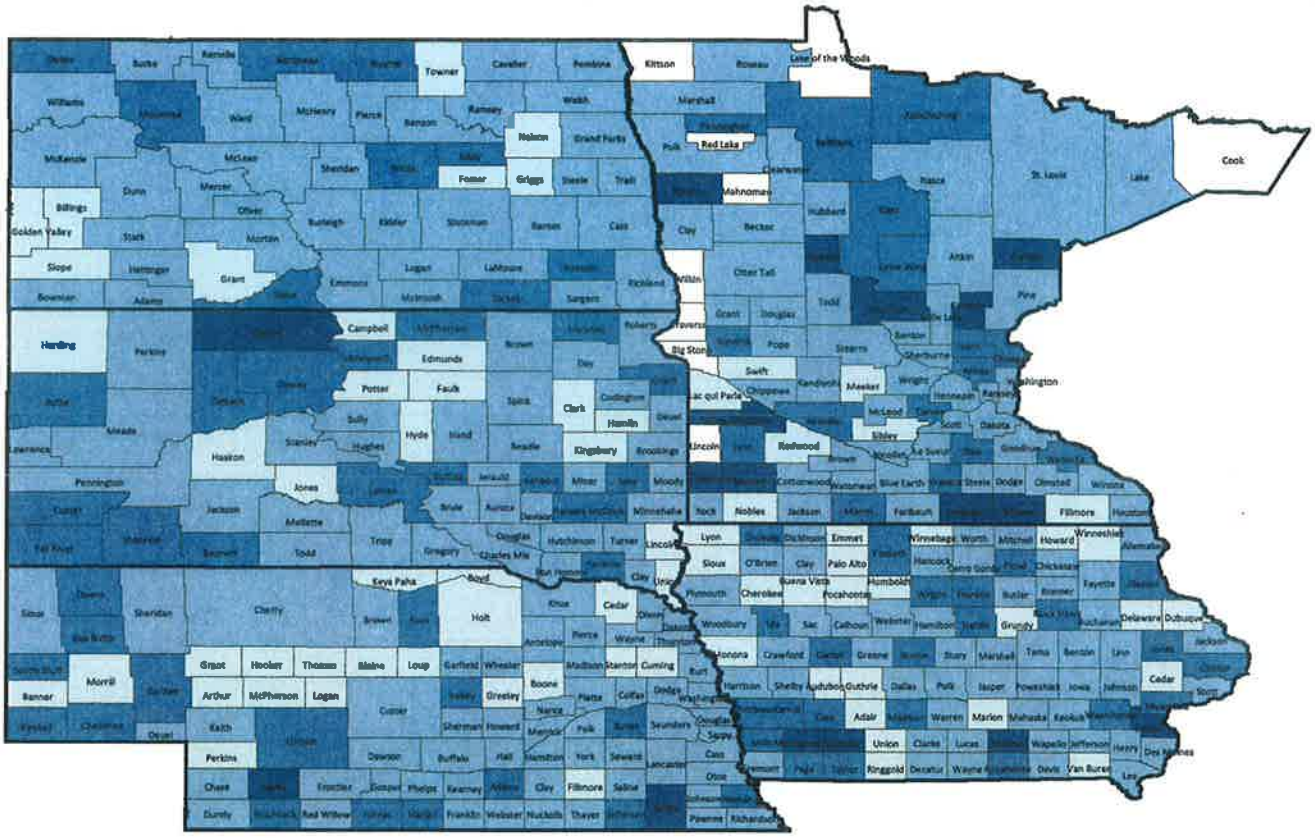
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

 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.

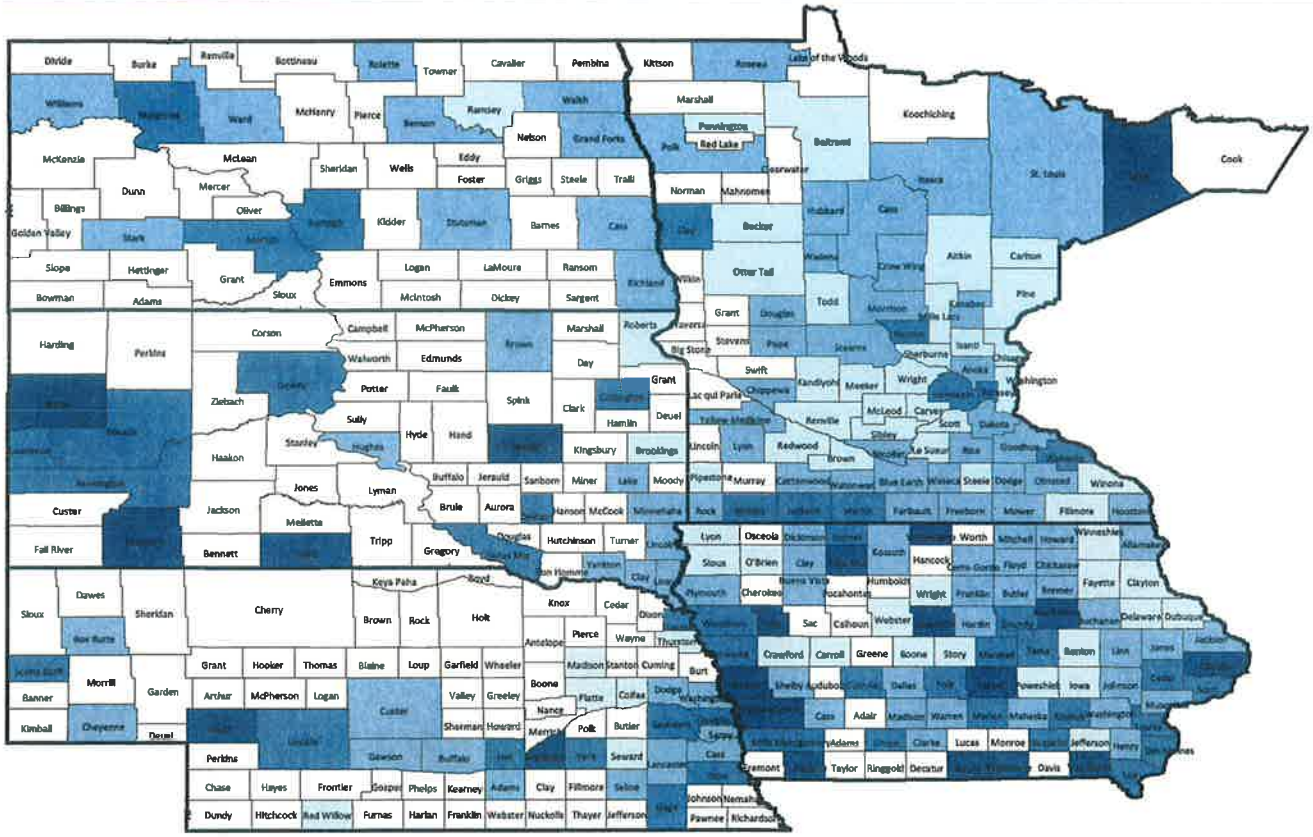
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

 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/.

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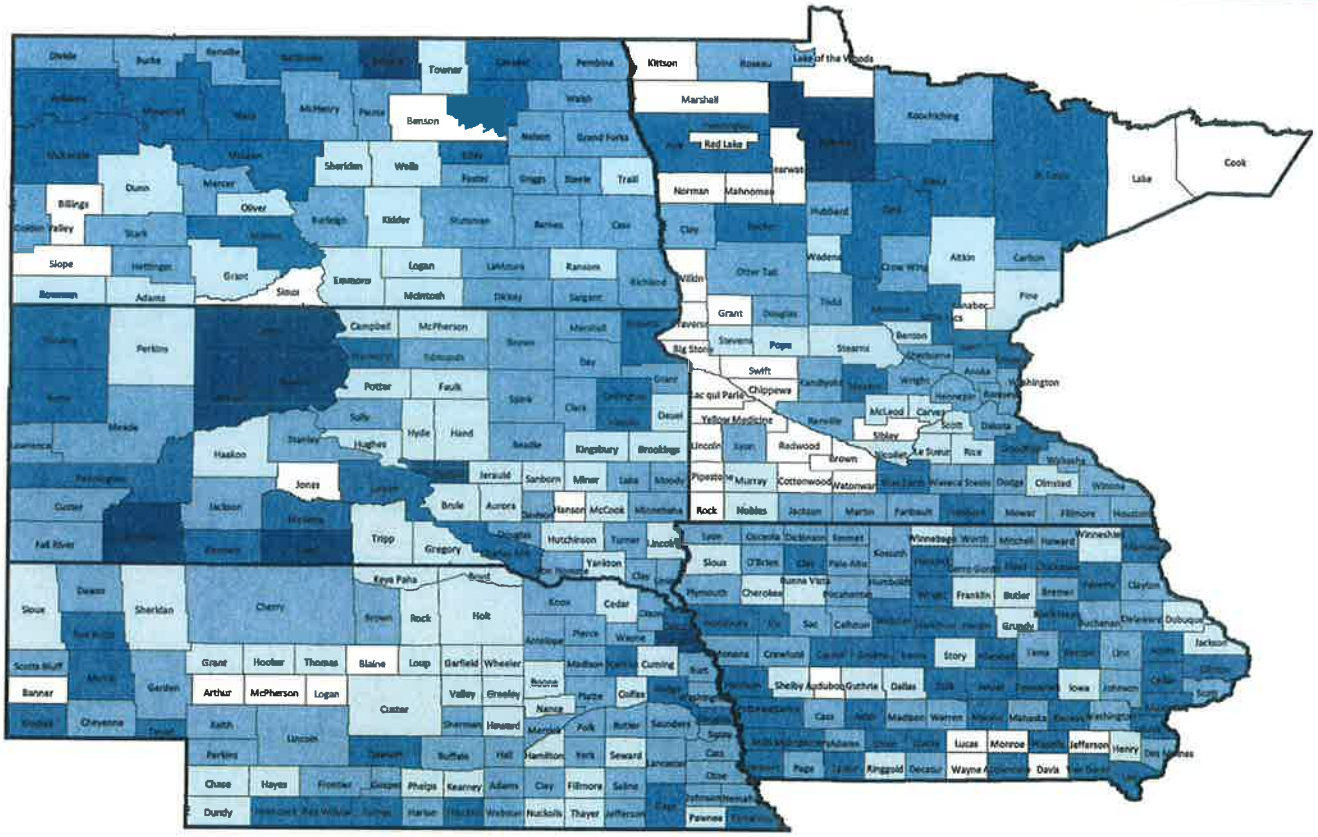
Adult Smoking - A health factor measure focusing on health behaviors

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/.

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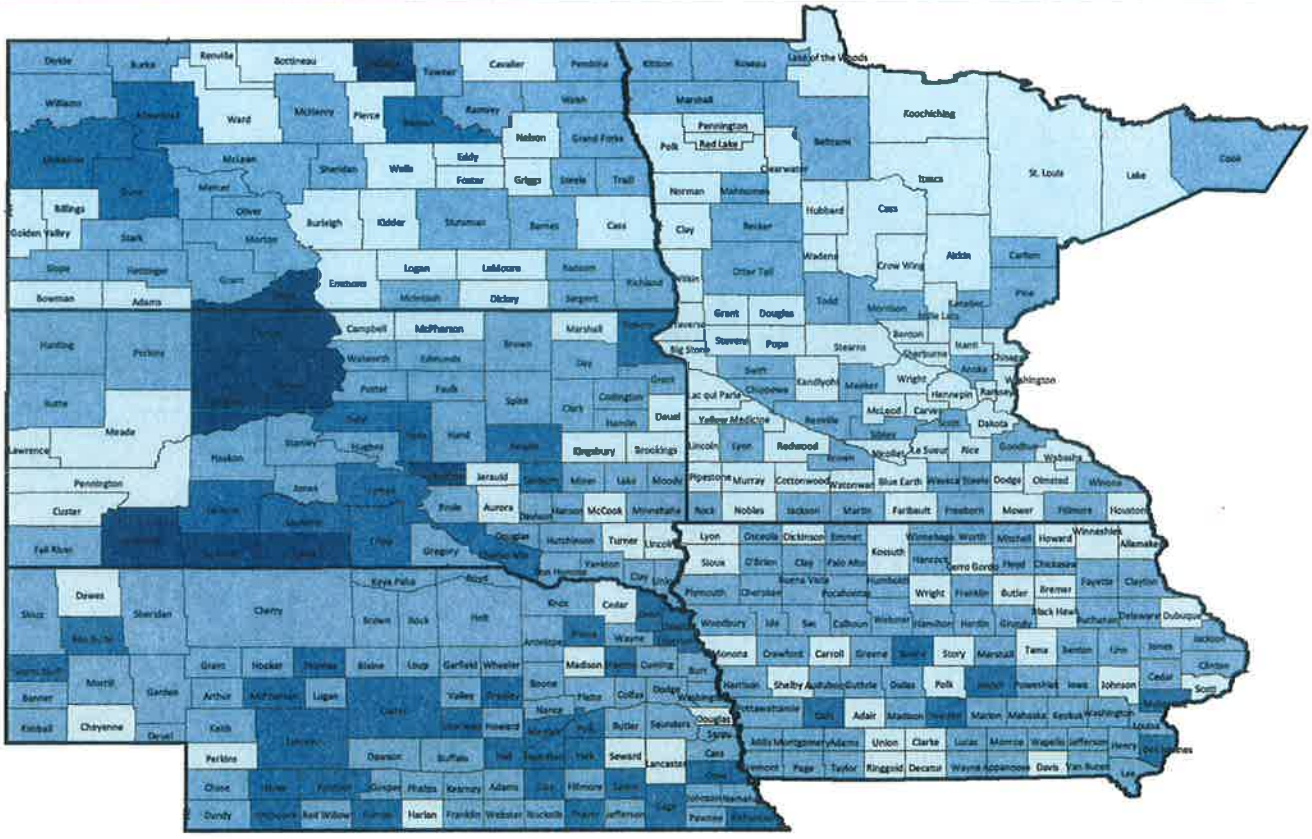
Map 7

Adult Obesity - A health factor measure focusing on health behaviors

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



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

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

CONTEXT

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

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

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

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

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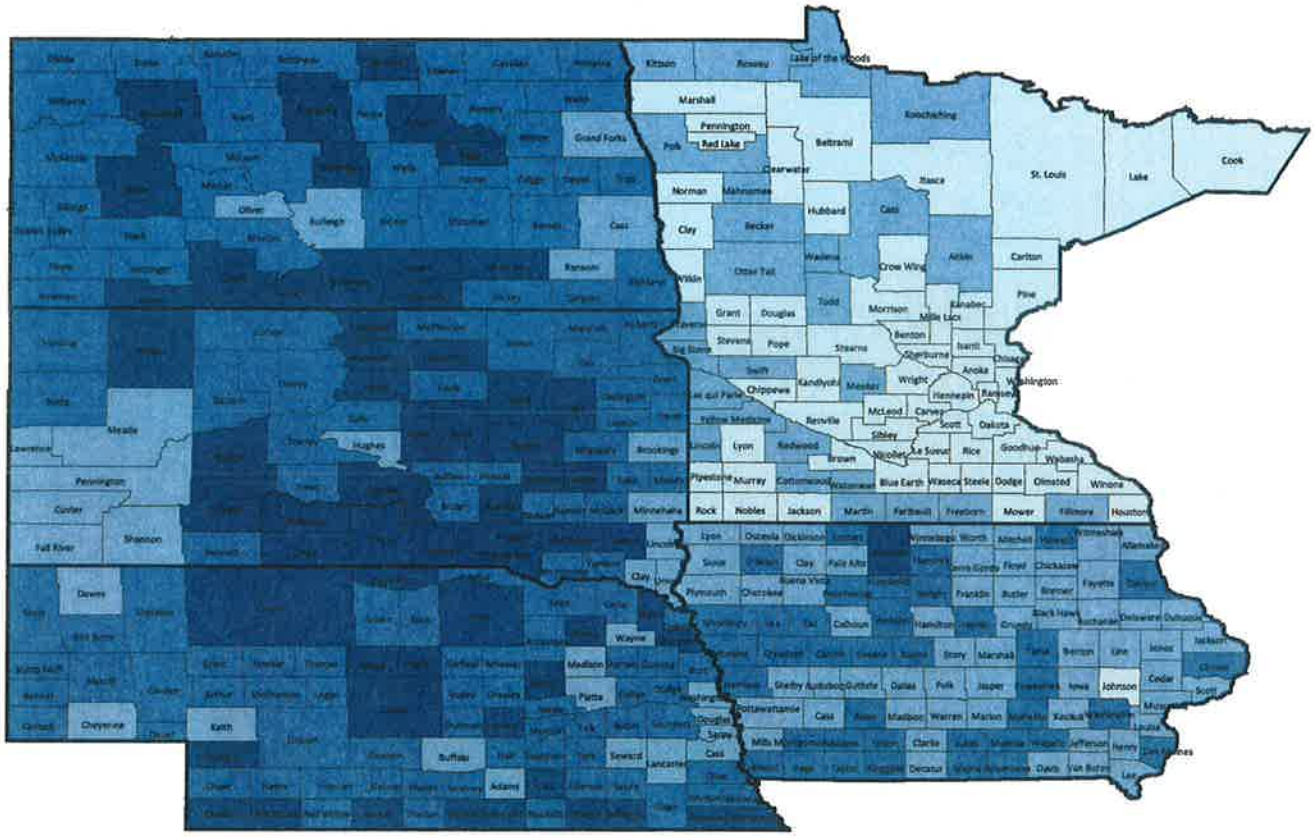
Physical Inactivity - A health factor measure focusing on health behaviors

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



Percent of adults reporting no leisure time physical activity, 2008

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

CONTEXT

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

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

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

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

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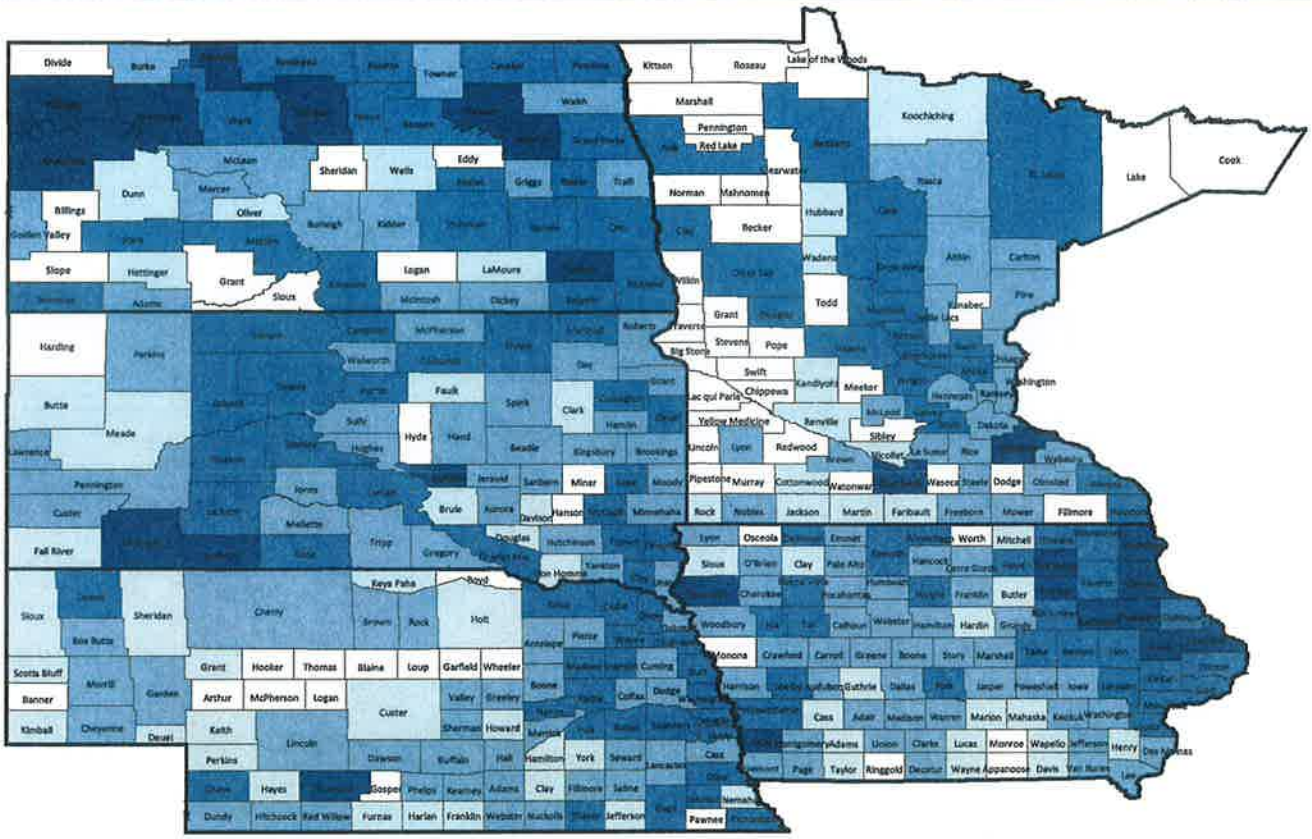
Map 9

Excessive Drinking - A health factor measure focusing on health behaviors

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



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

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

CONTEXT

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

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

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

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

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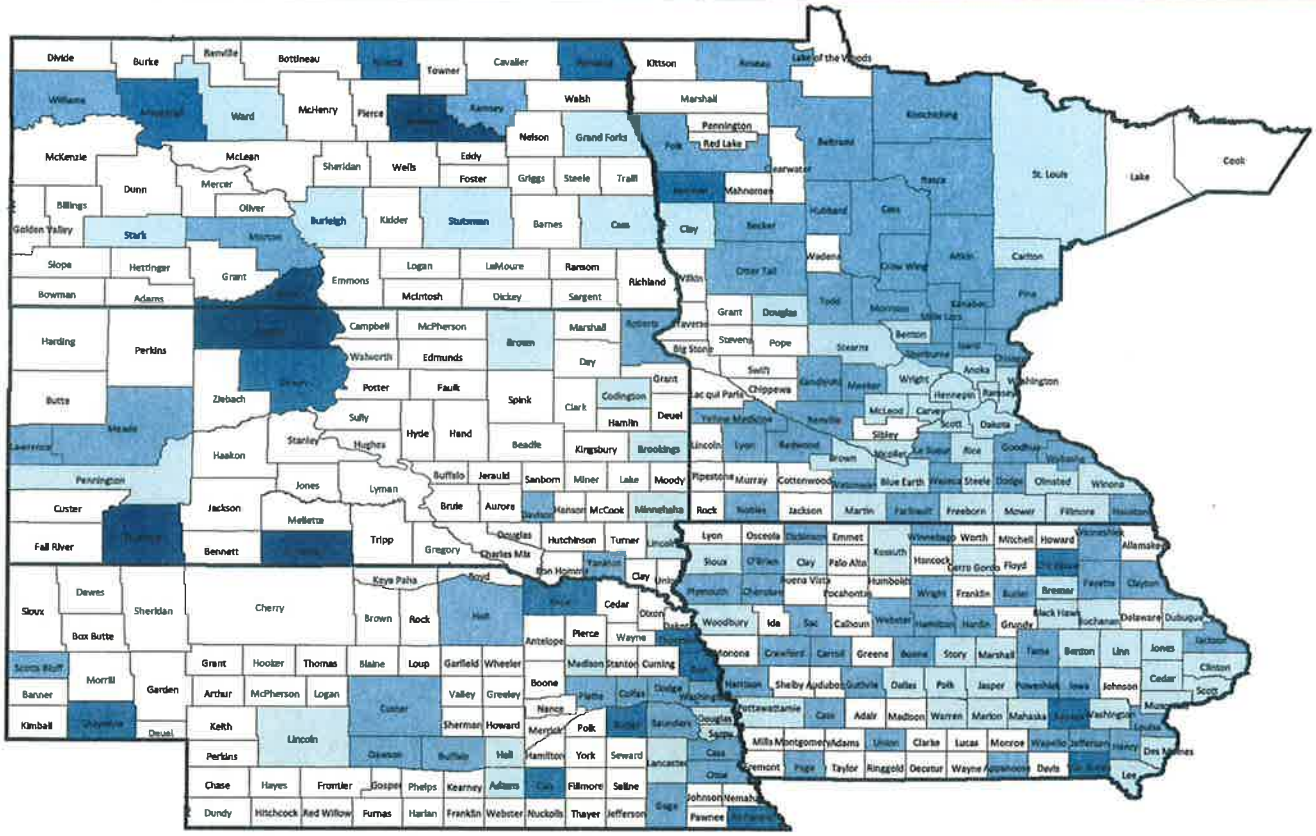
Motor Vehicle Crash Death Rate - A health factor measure focusing on health behaviors

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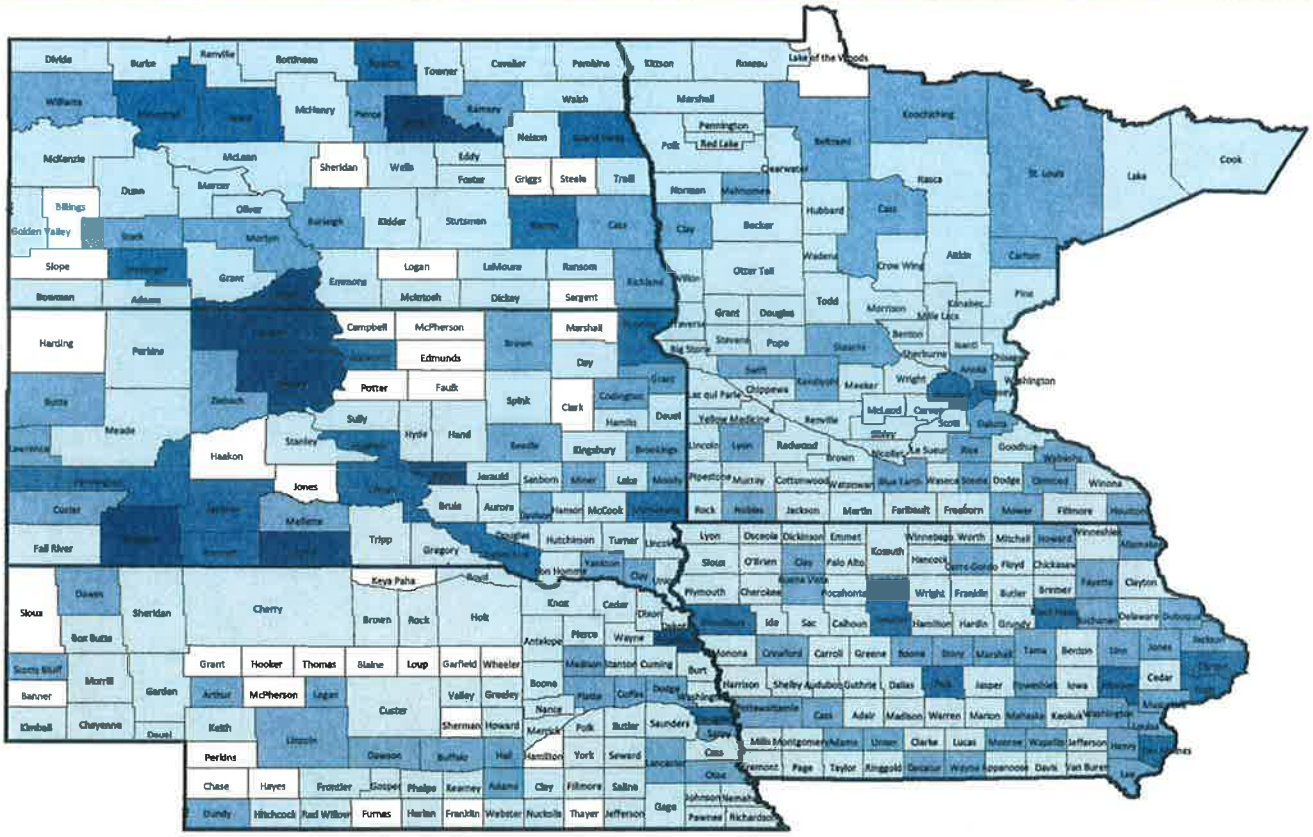
Sexually Transmitted Infections - A health factor measure focusing on health behaviors

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/.

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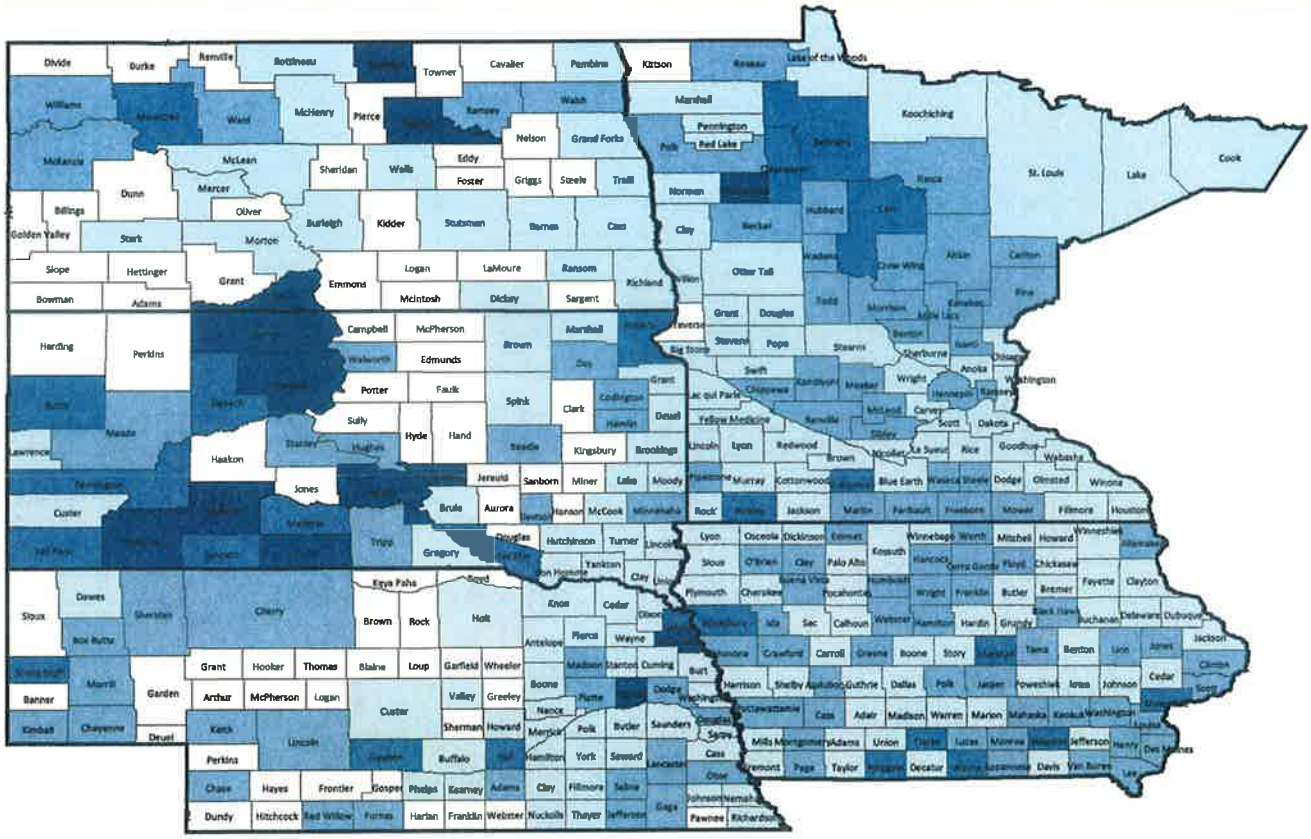
Map 12

Teen Birth Rate - A health factor measure focusing on health behaviors

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



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

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

CONTEXT

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

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

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

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

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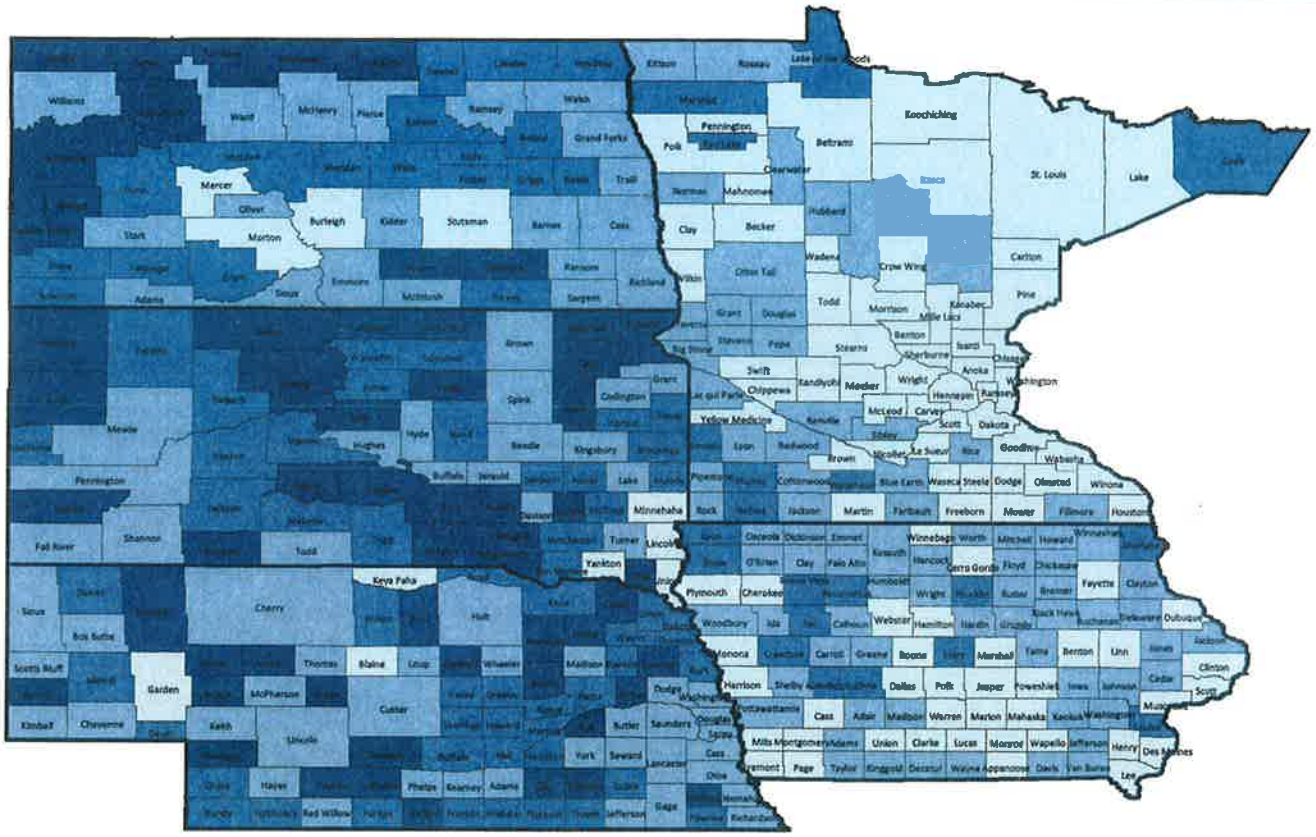
Uninsured Adults - A health factor measure focusing on clinical care

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/.

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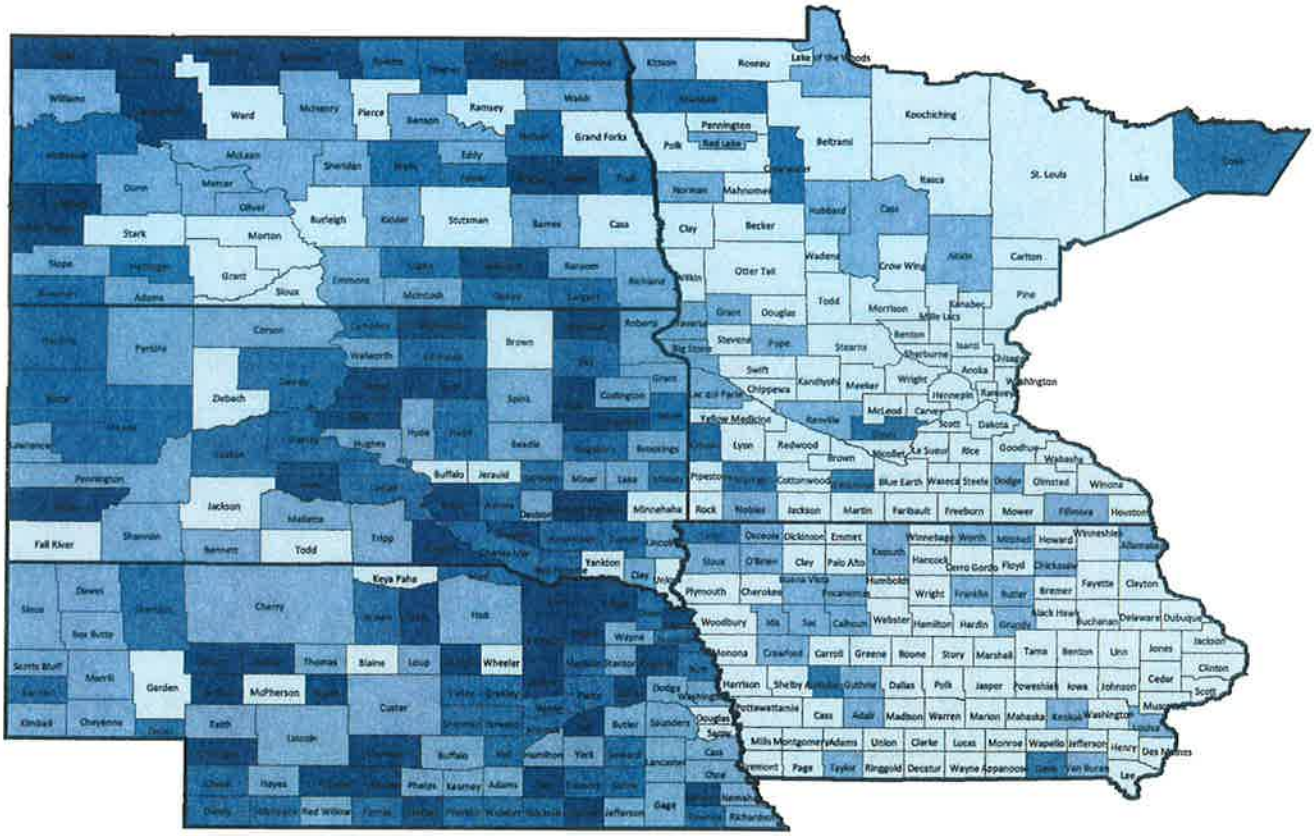
Uninsured Youth - A health factor measure focusing on clinical care

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

Map 14



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

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

CONTEXT

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

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

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

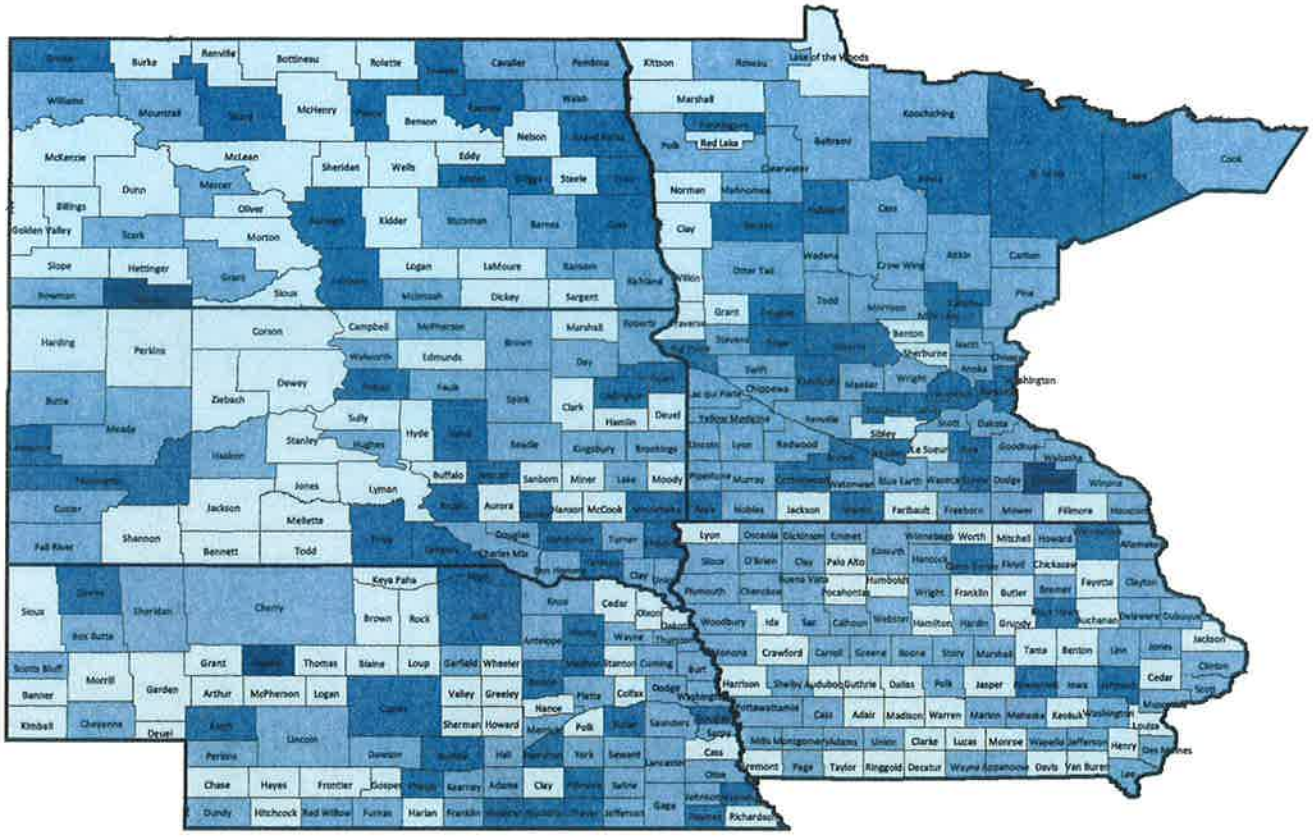
- Data were obtained from the Small Area Health Insurance Estimates (SAHIE), a program of the U.S. Census Bureau, http://www.census.gov/did/www/sahie/.

 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.

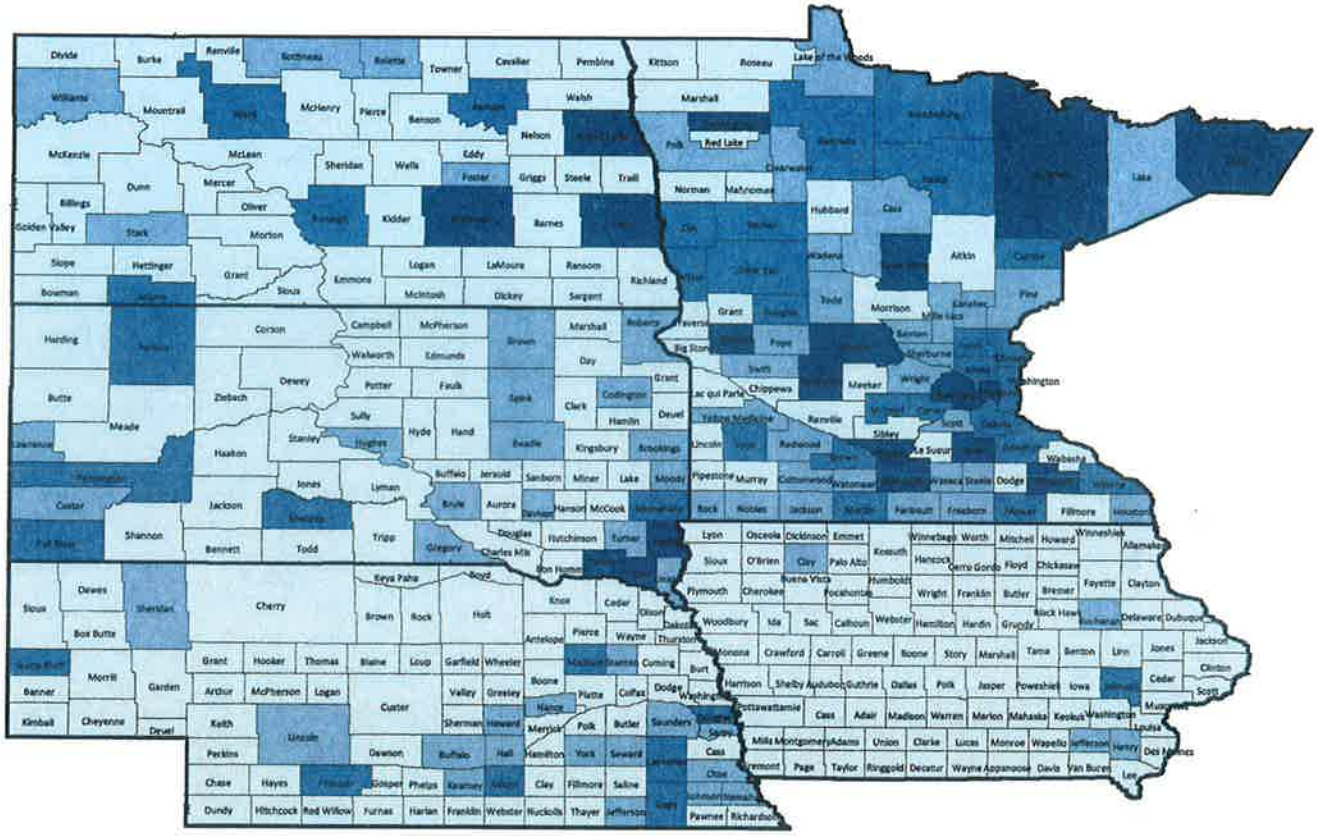
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

 This map was prepared by researchers at North Dakota State University in Fargo for the 2011-2013 Fargo-Moorhead Community Health Needs Assessment Collaborative. December 2011

Map 16

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

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



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

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

CONTEXT

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

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

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

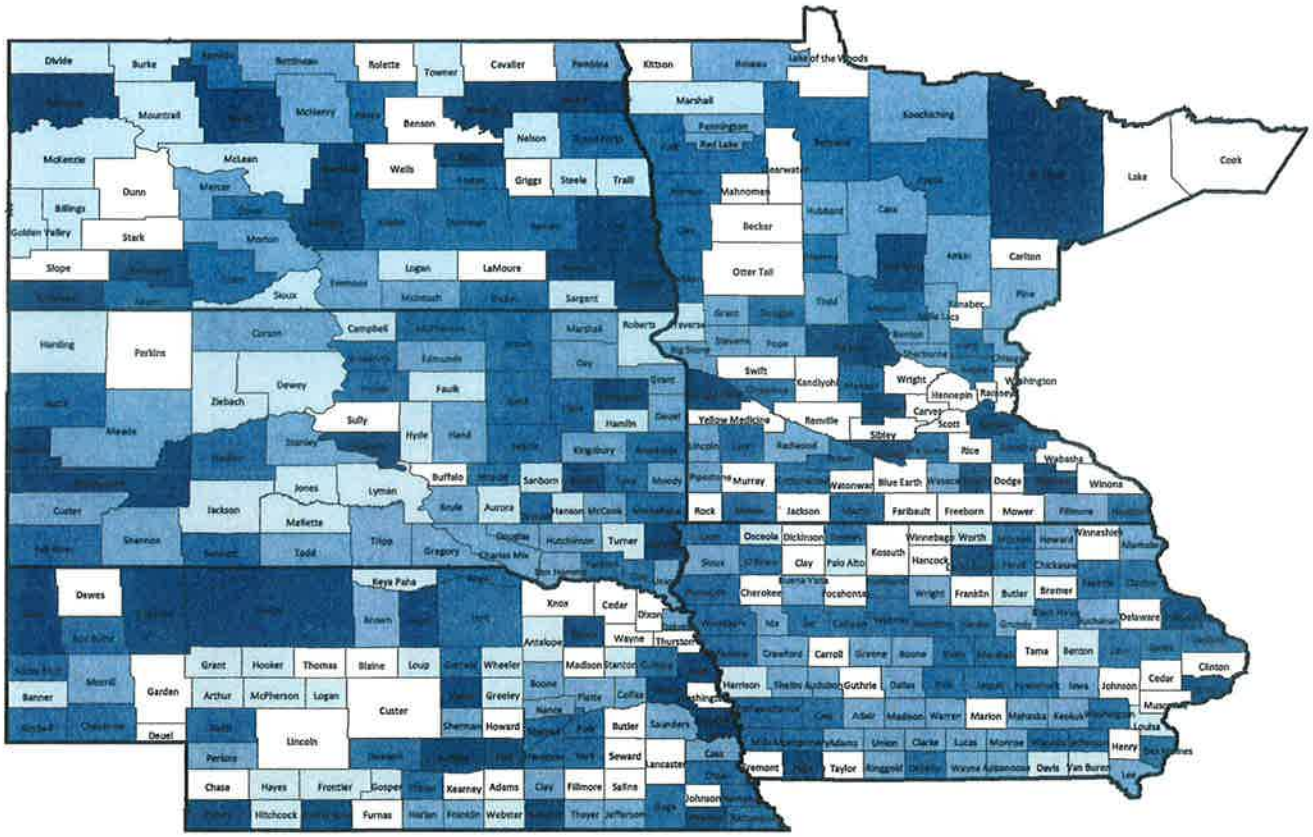
- Data were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

 This map was prepared by researchers at North Dakota State University in Fargo for the 2011-2013 Fargo-Moorhead Community Health Needs Assessment Collaborative. December 2011

Map 17

Dentist Rate - A health factor measure focusing on clinical care

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



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

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

CONTEXT

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

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

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

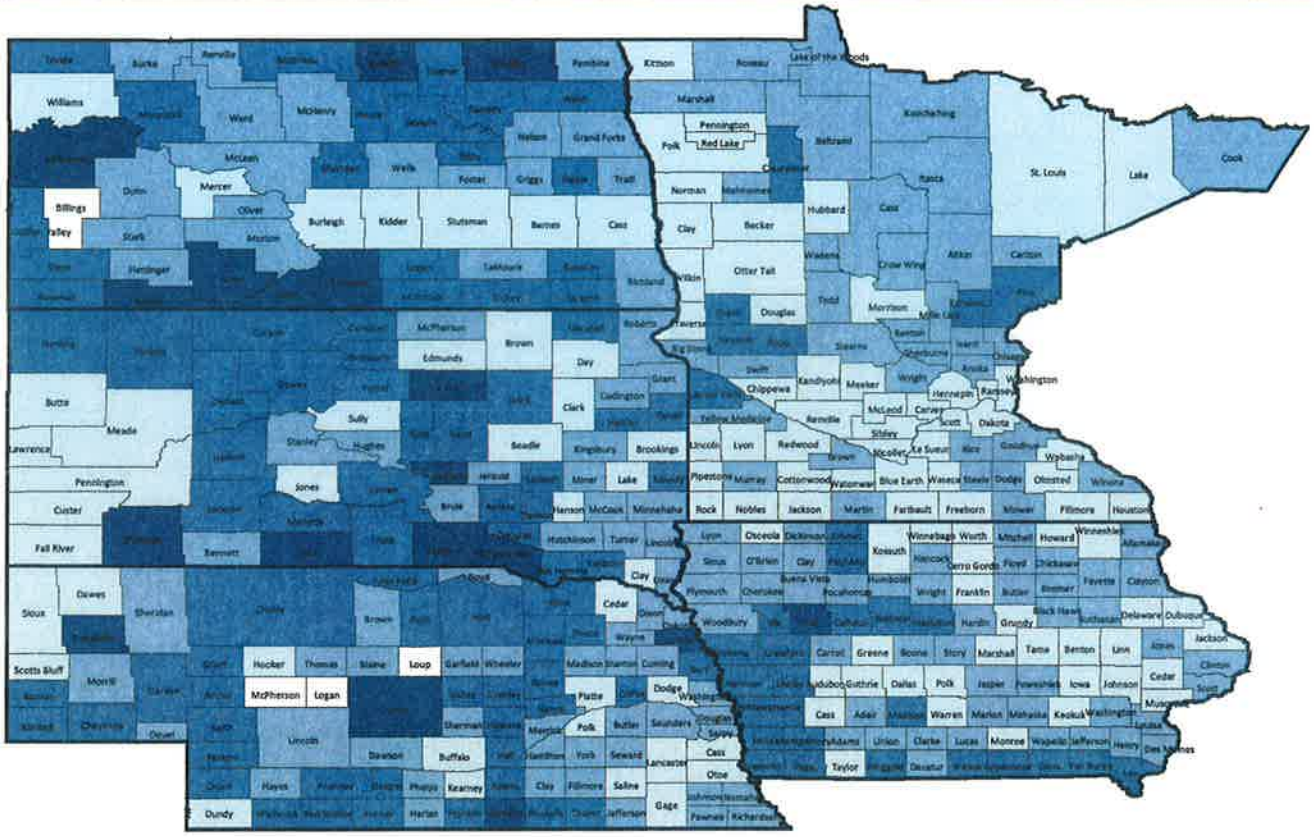
- Data were obtained from the Health Indicators Warehouse at http://healthindicators.gov/ which is maintained by the Centers for Disease Control and Prevention's National Center for Health Statistics.

 This map was prepared by researchers at North Dakota State University in Fargo for the 2011-2013 Fargo-Moorhead Community Health Needs Assessment Collaborative. December 2011

Map 18

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

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



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

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

CONTEXT

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

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

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

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

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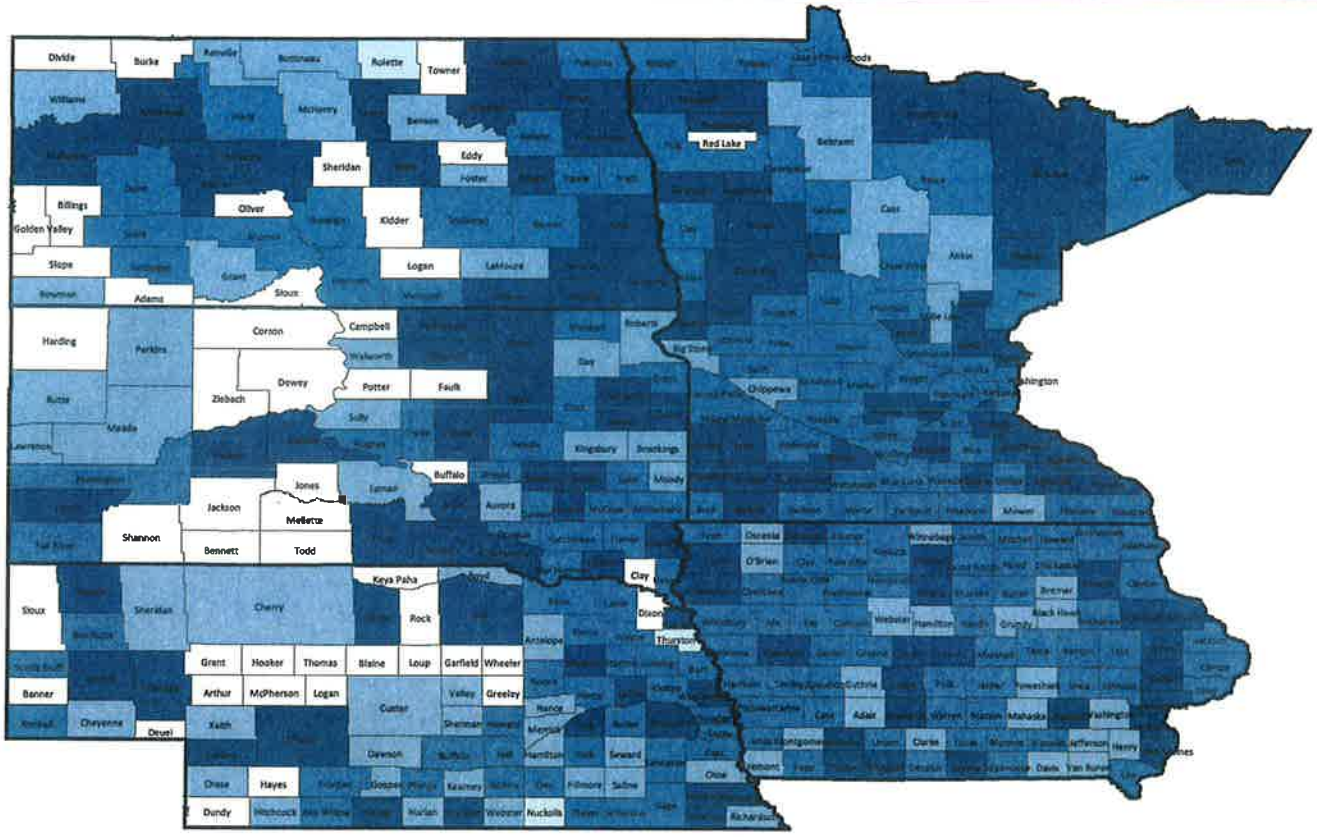
Diabetic Screening - A health factor measure focusing on clinical care

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.

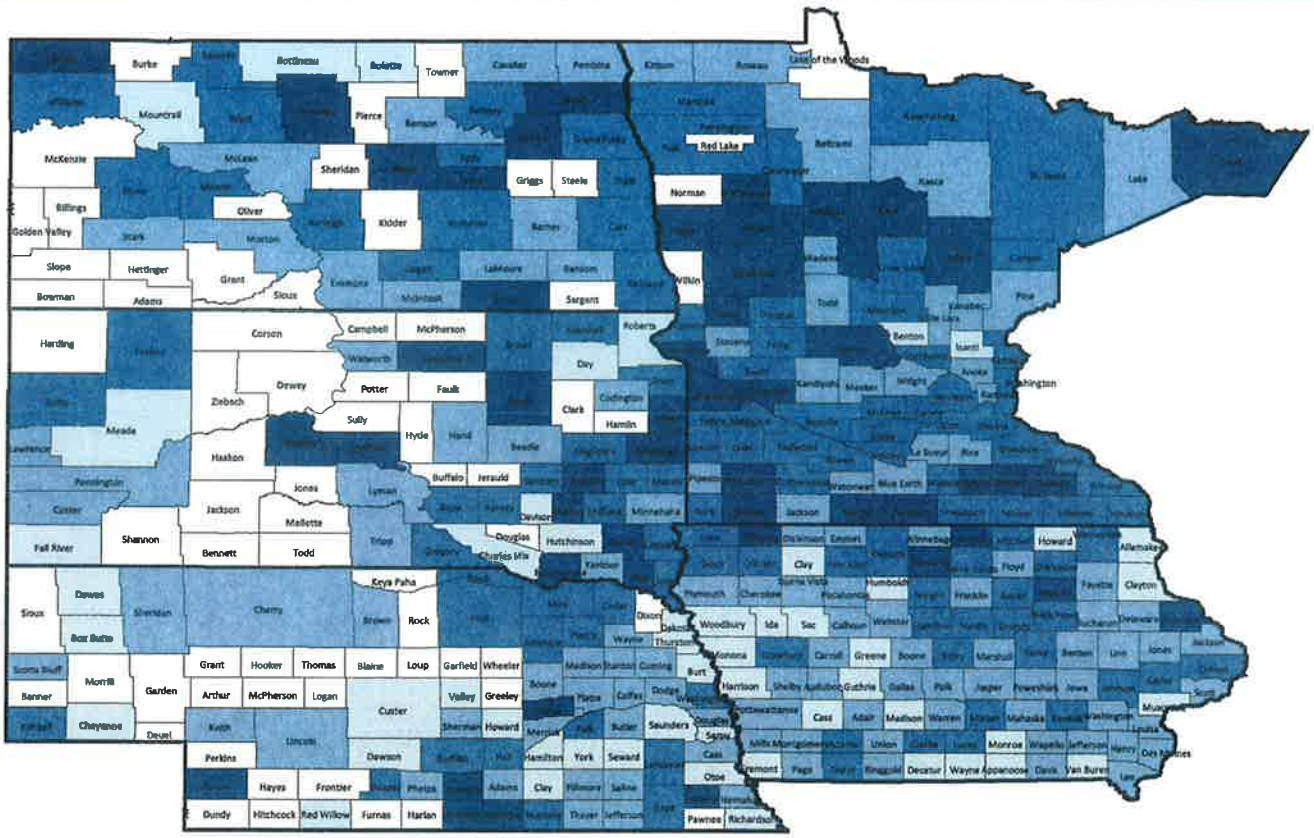
Importance: Regular HbA1c screening among diabetic patients is considered the standard of care. It helps assess the management of diabetes over the long term by providing an estimate of how well a patient has managed his or her diabetes over the past two to three months. When hyperglycemia is addressed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

 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

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.

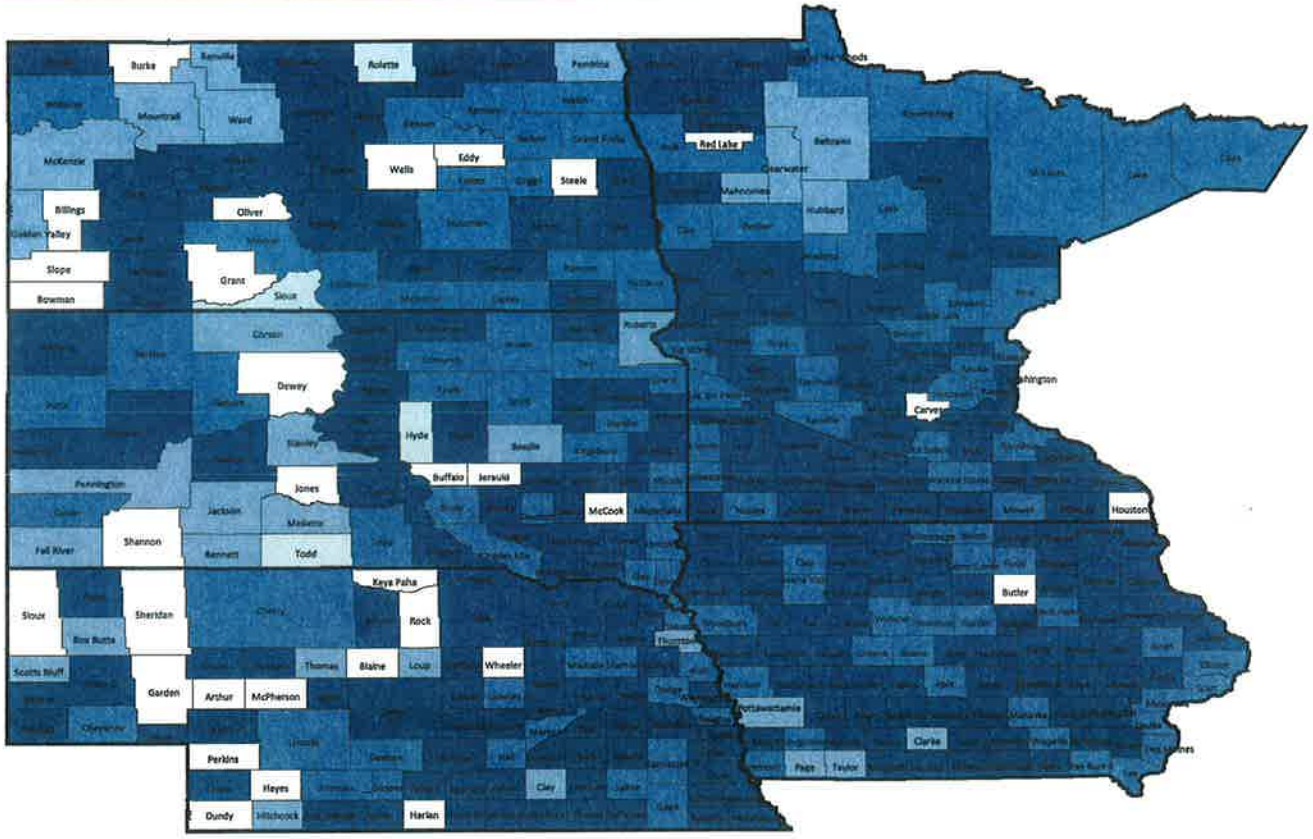
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

 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

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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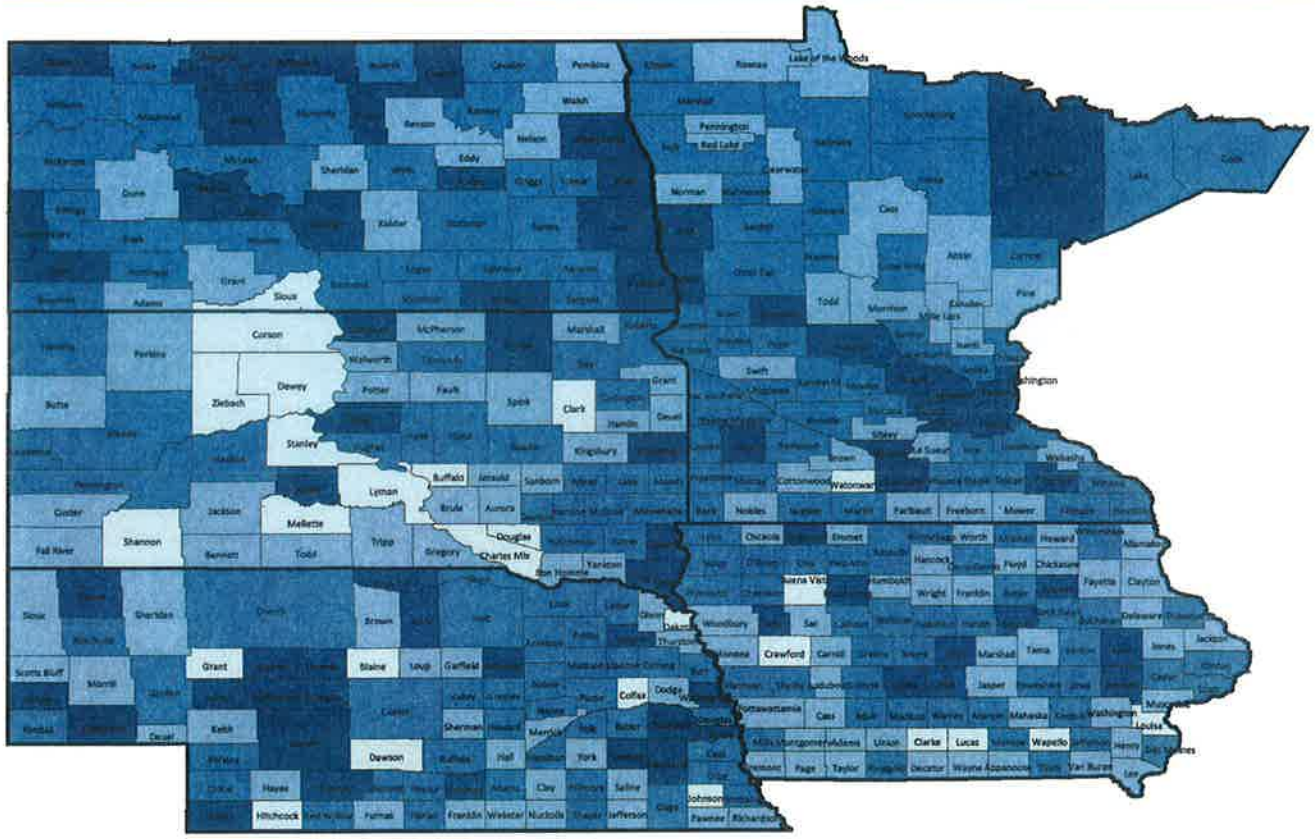
Some College - A health factor measure focusing on education

Map 22

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



Percent of adults ages 25 through 44 with some post-secondary education, 2005-2009

- 25.2% - 49.9%
- 50.0% - 59.9%
- 60.0% - 69.9%
- 70.0% - 85.6%

CONTEXT

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

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

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

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

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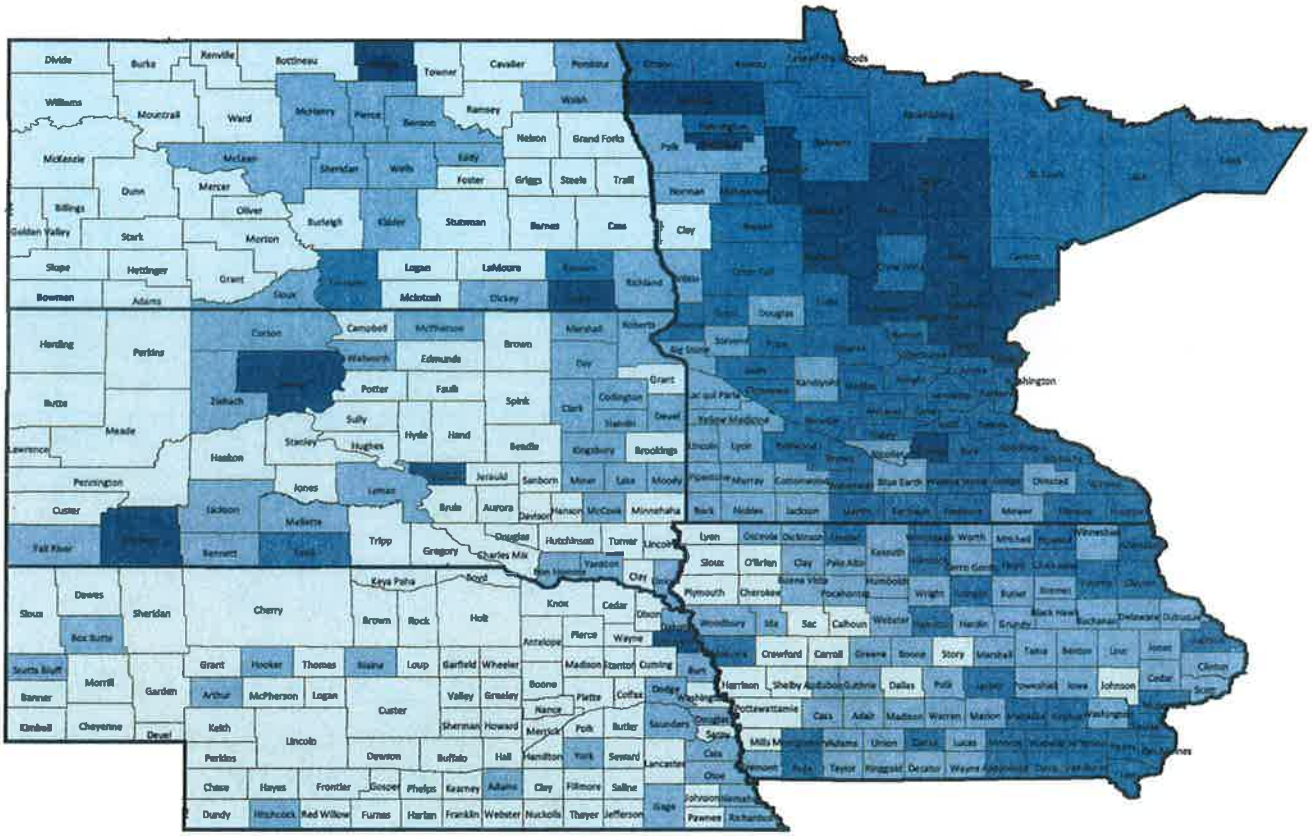
Map 23

Unemployment - A health factor measure focusing on labor

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



Percent of population ages 16 and older that is unemployed but seeking work, 2009

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

CONTEXT

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

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

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

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

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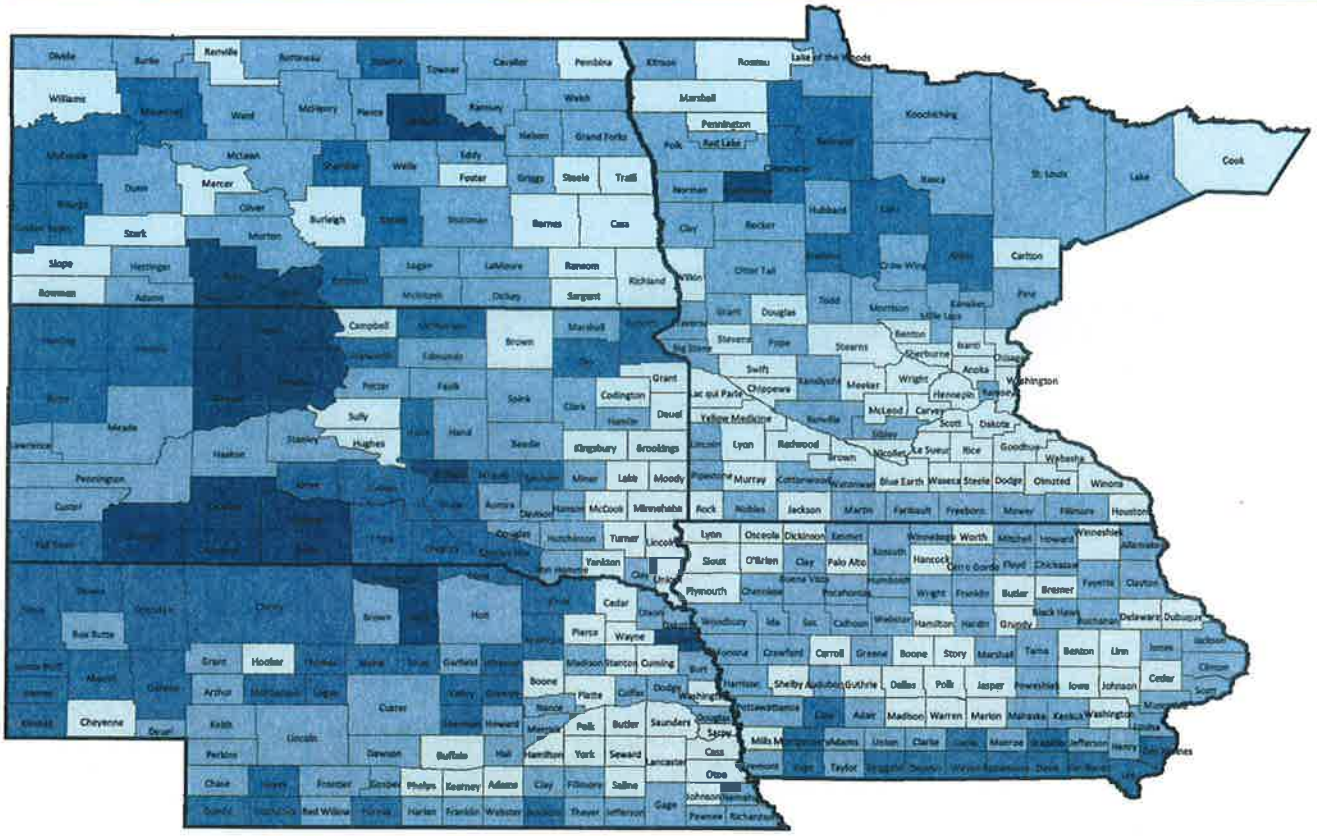
Children in Poverty - A health factor measure focusing on income and poverty

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.

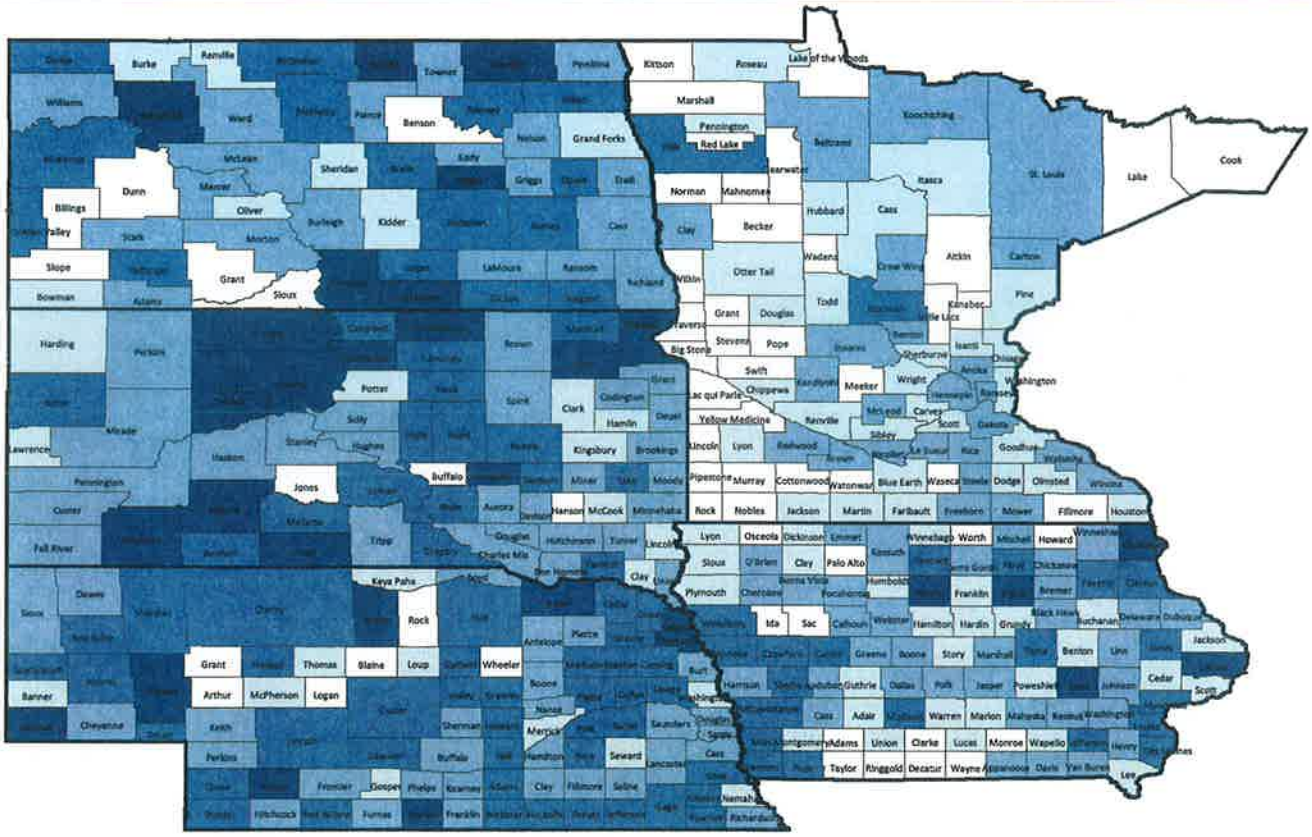
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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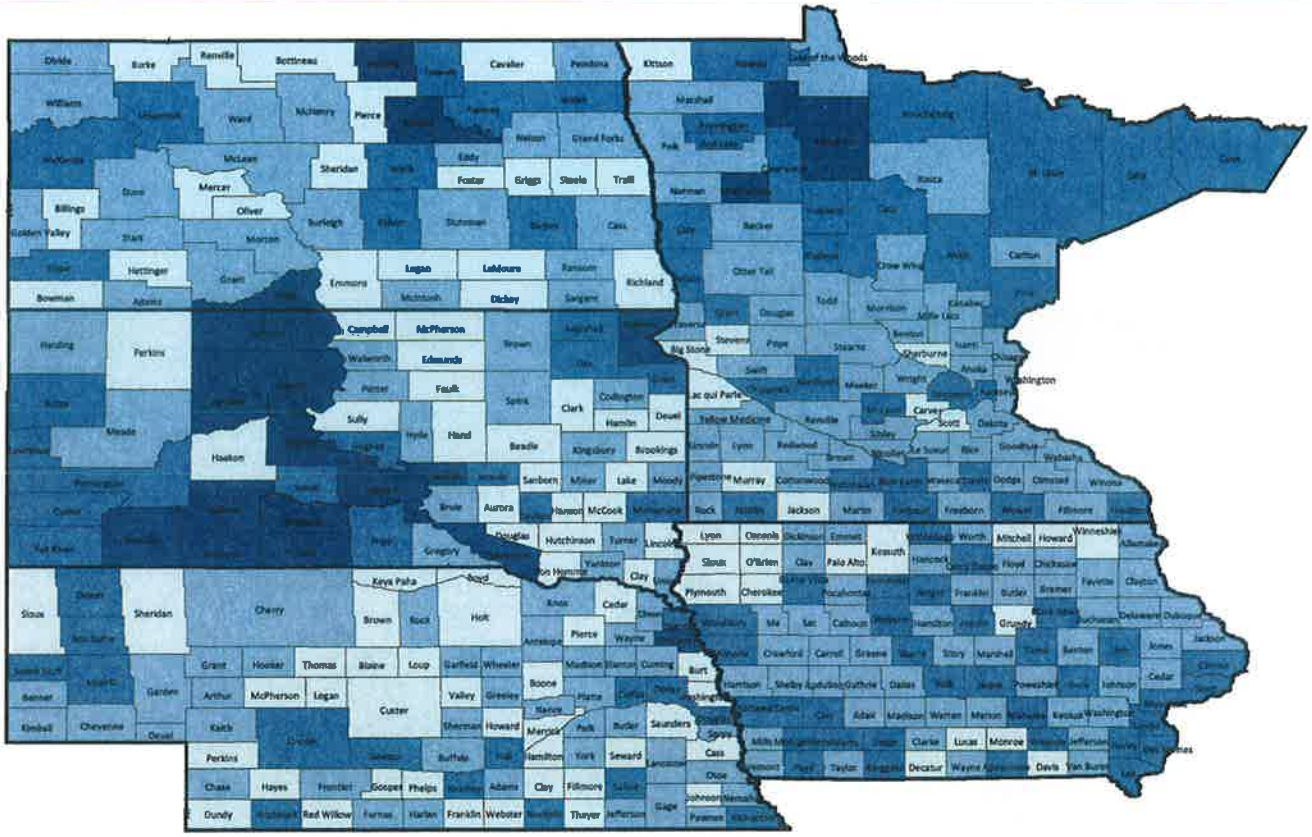
Children in Single-Parent Households - A health factor measure focusing on families

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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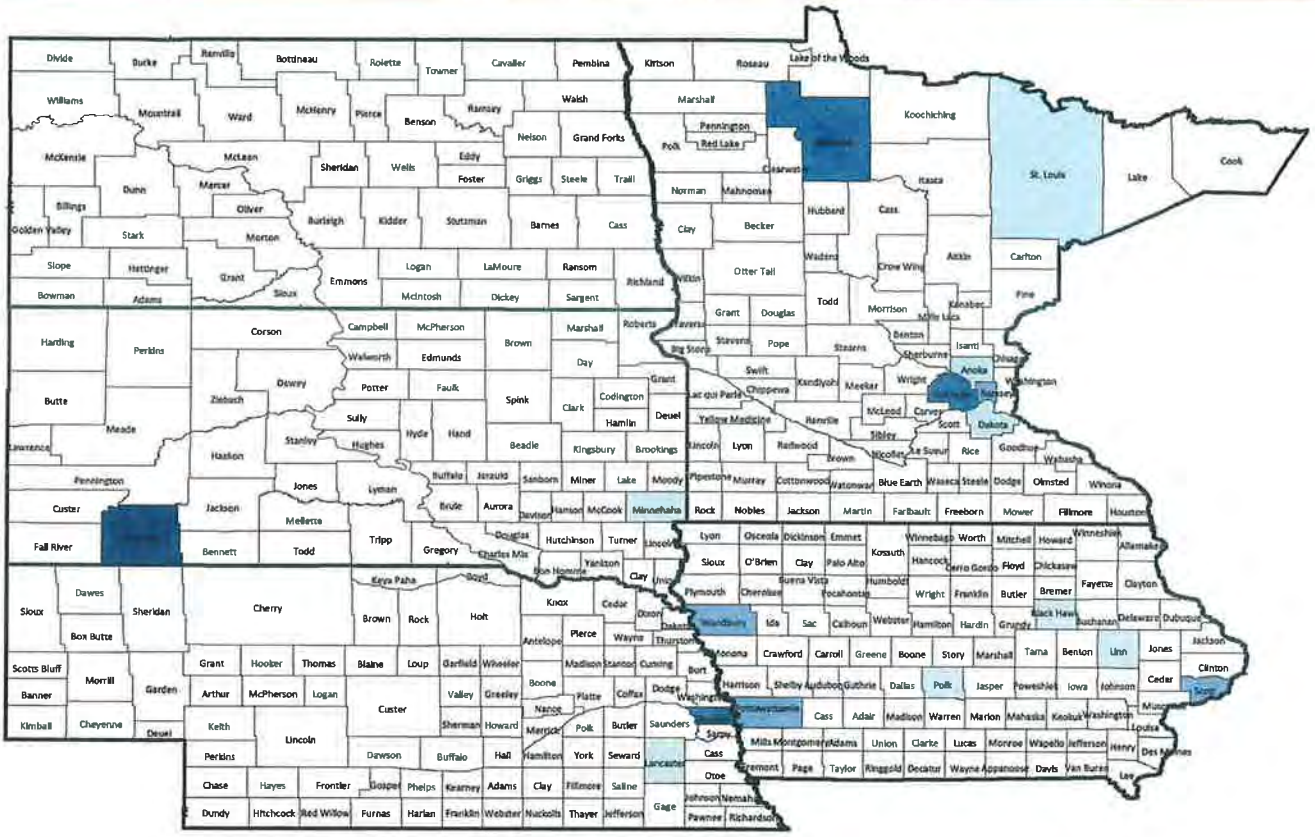
Map 27

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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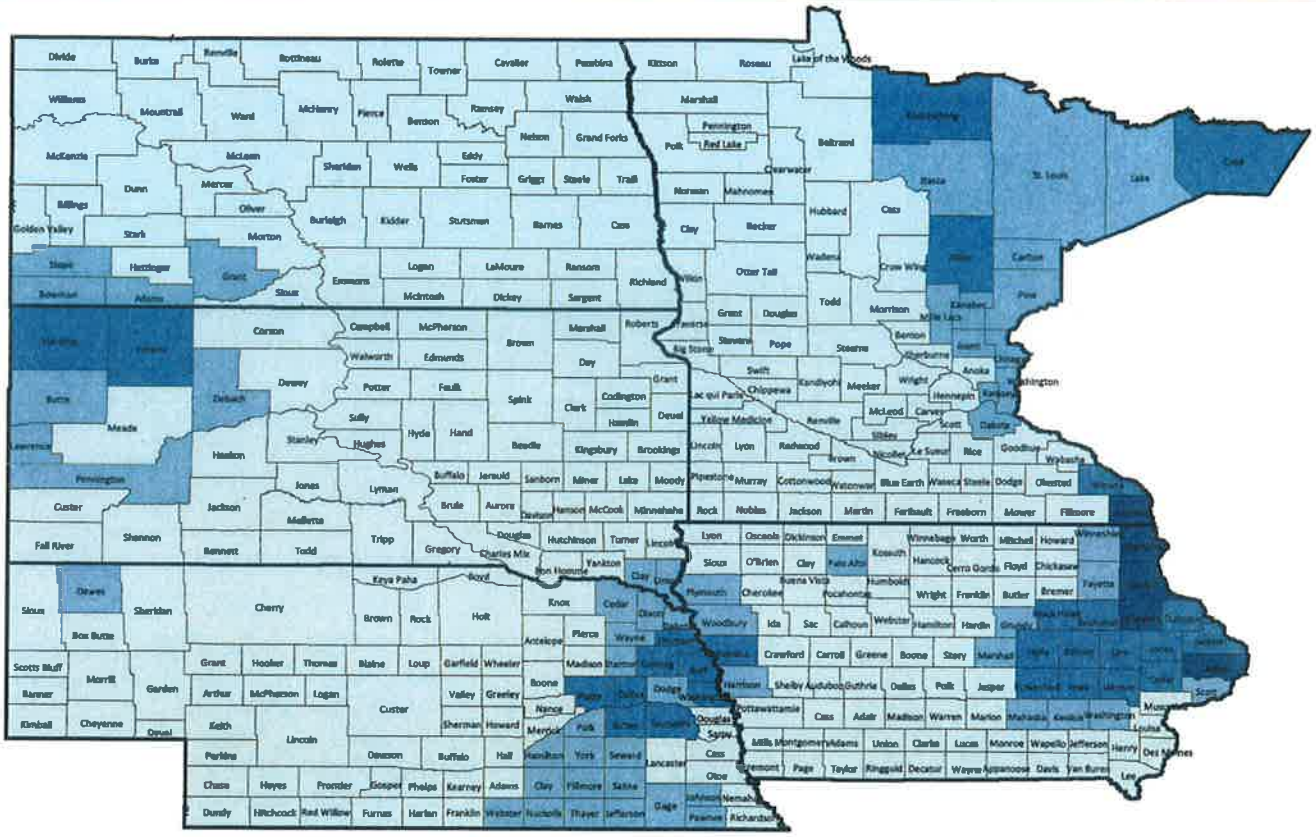
Map 28

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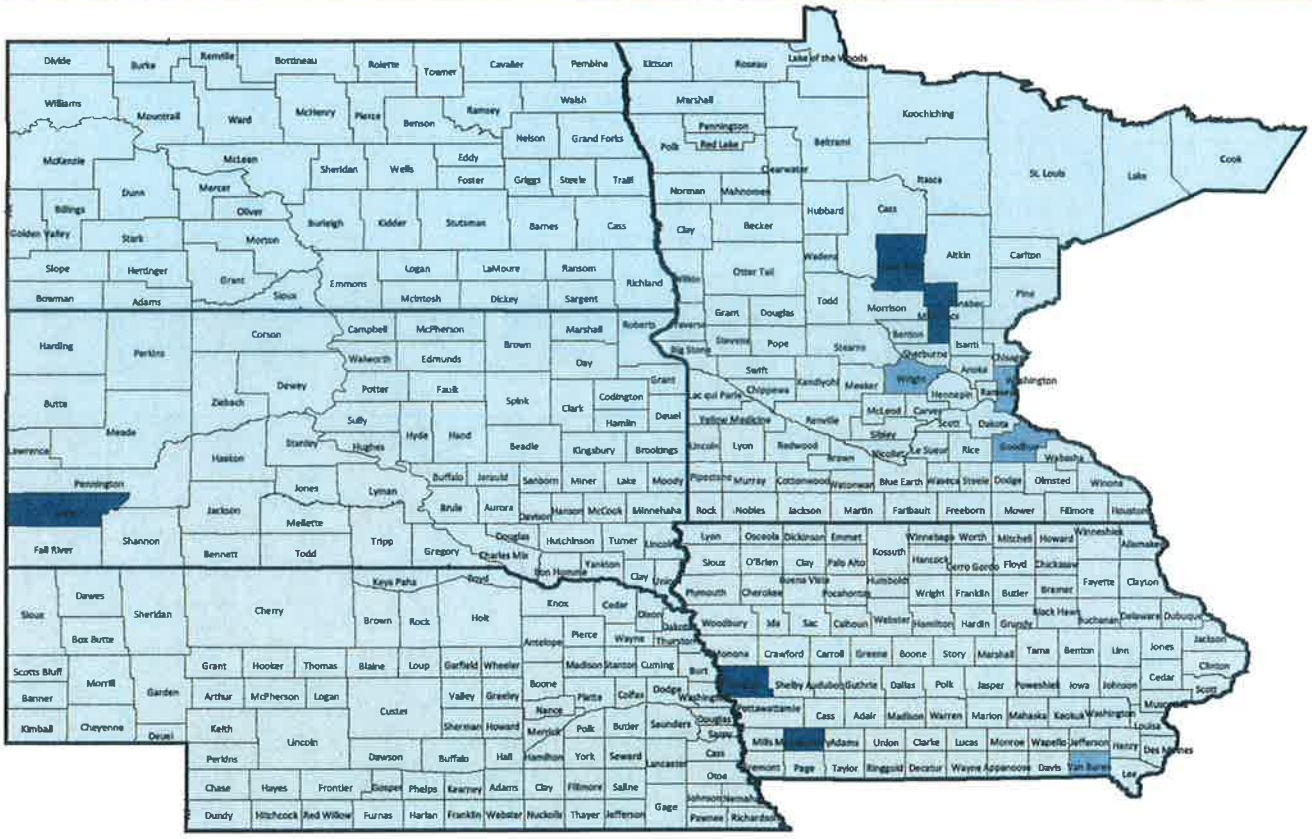
Air Pollution-OzoneDays - A health factor measure focusing on physical environment

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/.

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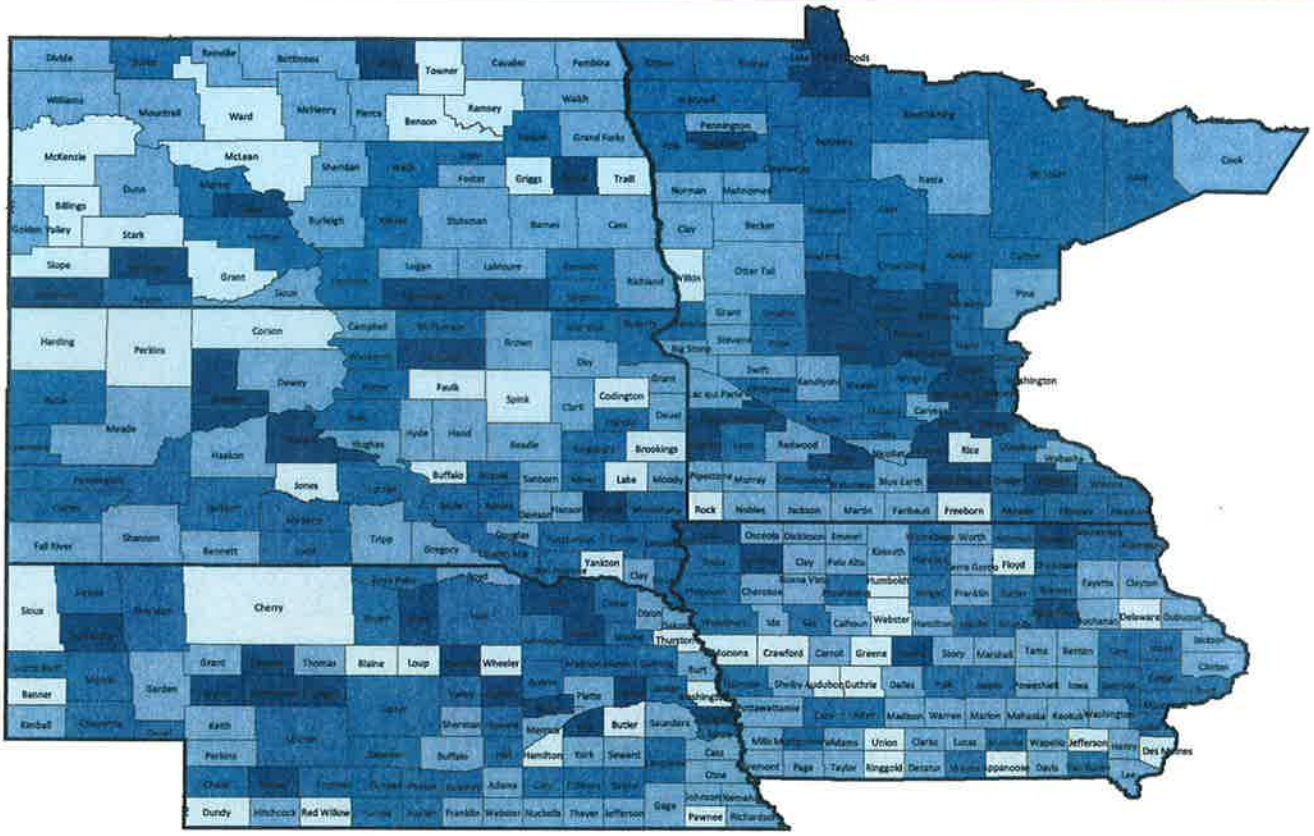
Access to Healthy Foods - A health factor measure focusing on physical environment

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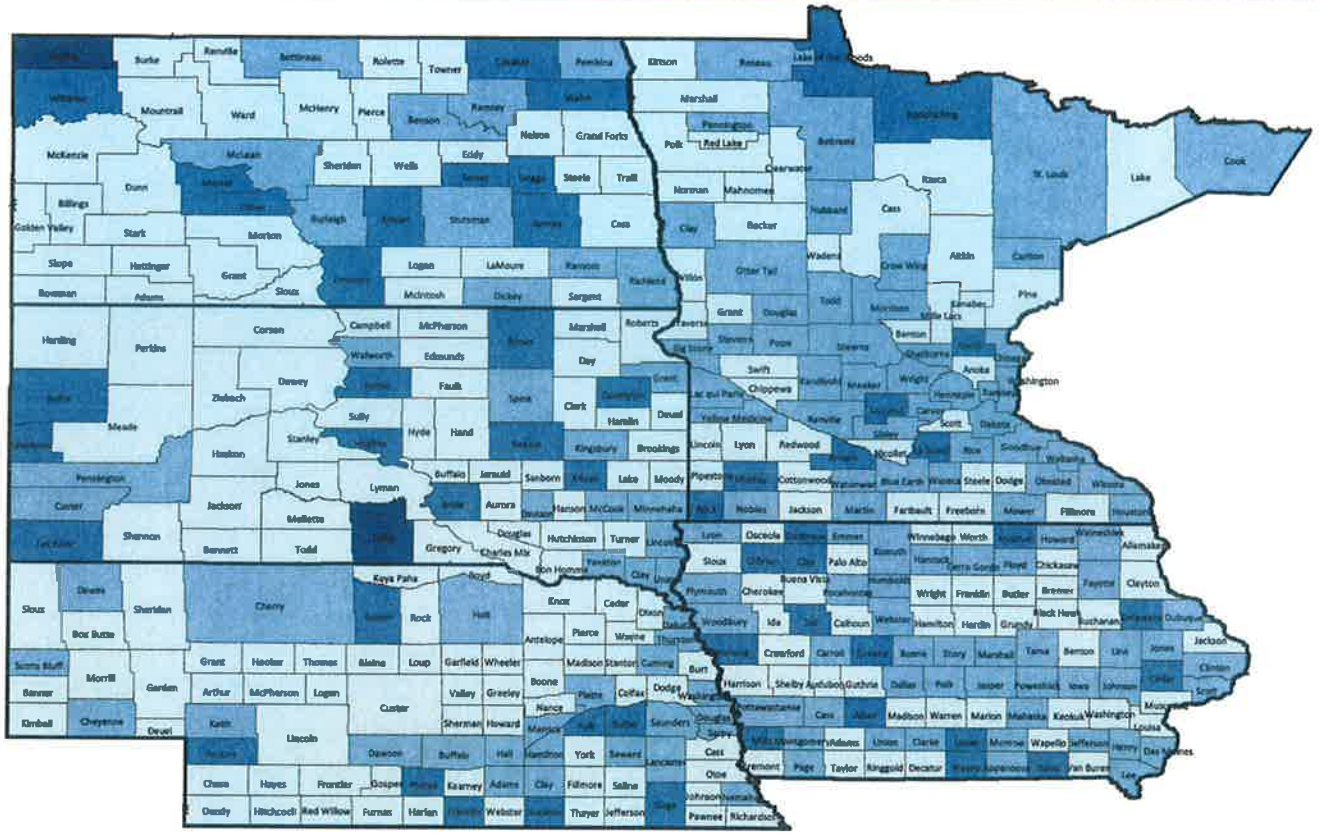
Access to Recreational Facilities - A health factor measure focusing on physical environment

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.

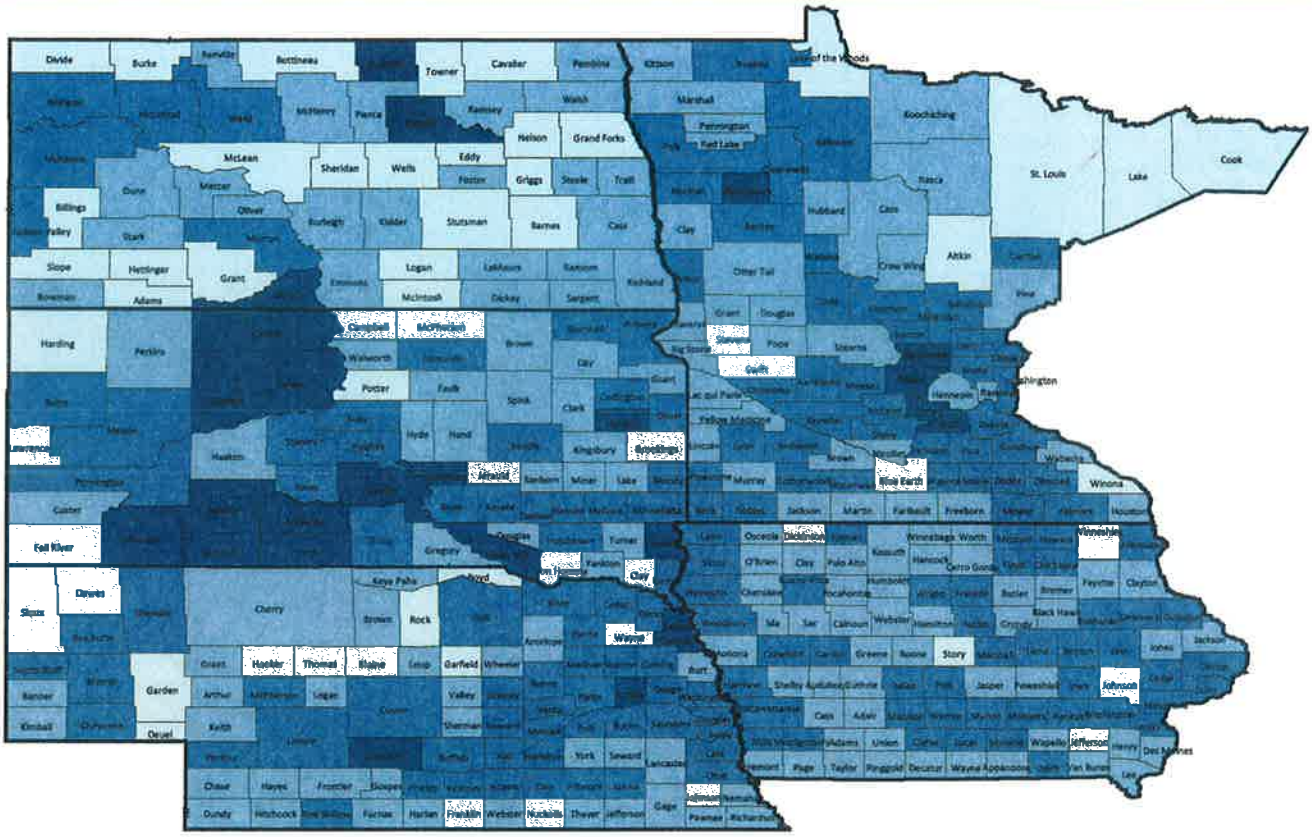
Importance: The availability of recreational facilities can influence individuals' and communities' choices to engage in physical activity. Proximity to places with recreational opportunities is associated with higher physical activity levels, which in turn is associated with lower rates of adverse health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

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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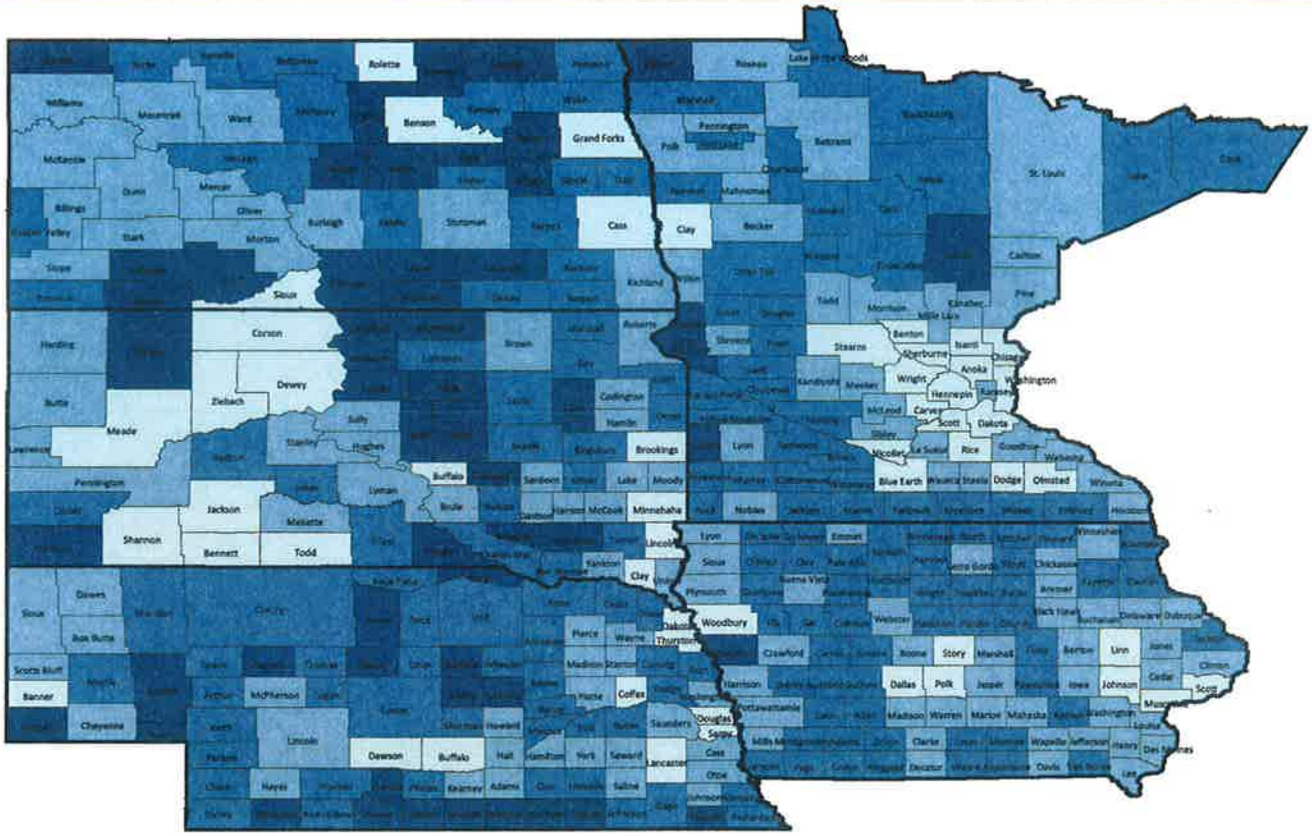
Elderly - A demographic measure

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

Map 33



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.

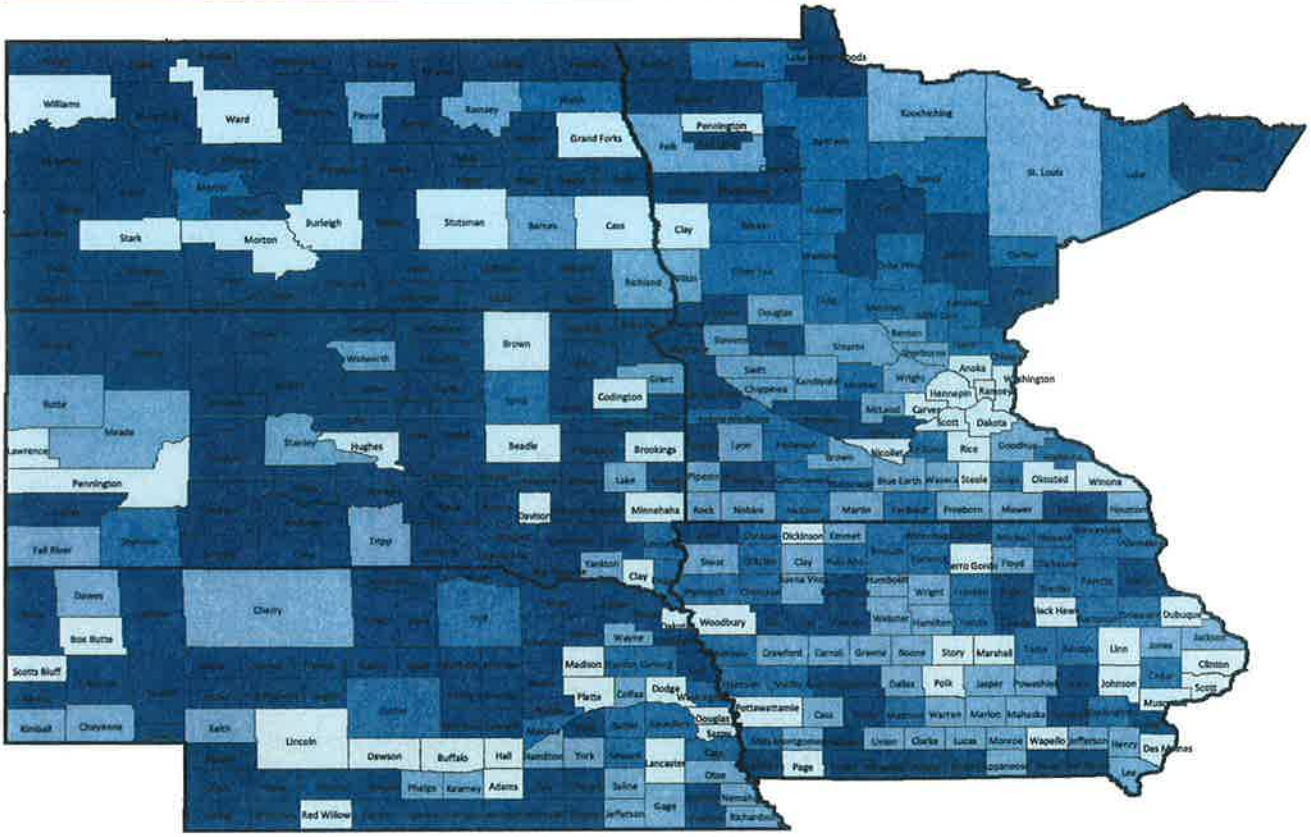
Where It Comes From: County demographic figures come from the U.S. Census Bureau's annual population estimates.

- 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/.

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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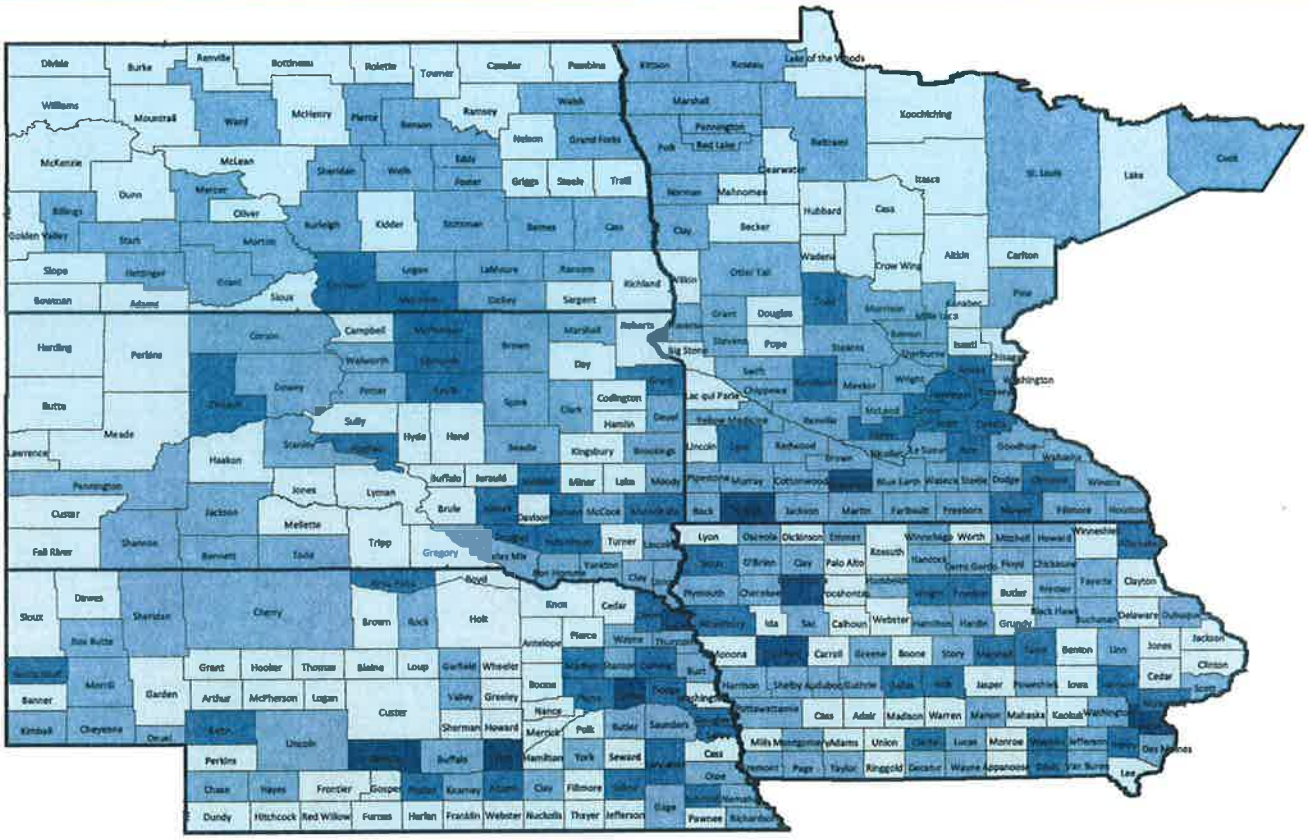
Not English Proficient - A demographic measure

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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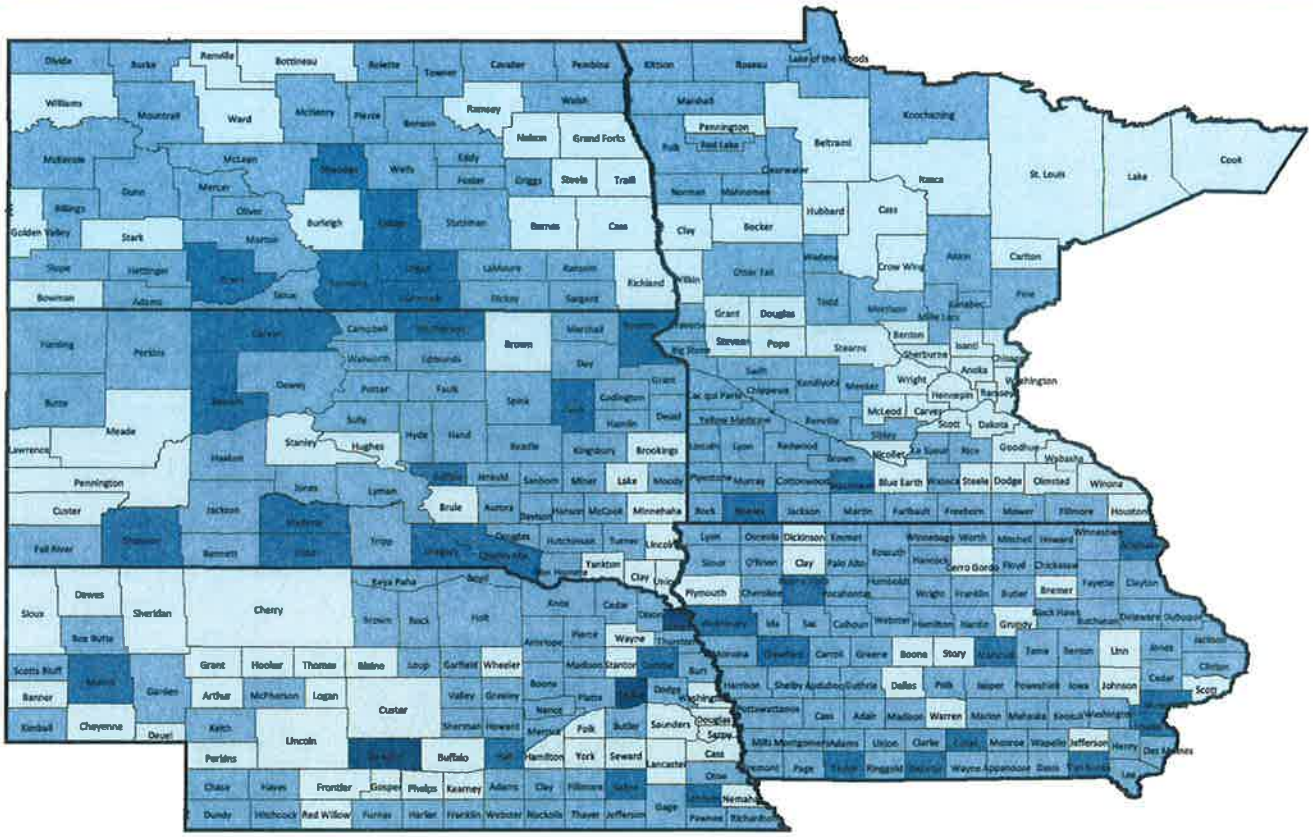
Illiteracy - A demographic measure

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



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

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

CONTEXT

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

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

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

SANFORD HEALTH

Table 1
Community Health Needs Assessment Asset Mapping
Jackson Stakeholders

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Access	• Need more primary care physicians & specialists • Concern about clinic pts. being bumped in the clinic because an emergency comes in (clinic doctors & CNPs are required to be on call for the ER) • ~~High ratio of mental health providers for population~~ • Preventable hospital stays	Actively recruiting Minnesota Health Care Homes/Sanford Medical Homes	
Chronic Disease	• Concern about lack of research being done on diseases such as Marfan's Syndrome • Only 85% have Hgb A1C screening • 68% of female Medicare enrollees have mammogram screening	Sanford Medical Homes Full time Health Care Coach as of November 2012 Involvement of SHIP in the county Dietician/Diabetes Education Mammo screening on site in Jackson/Lakefield SAGE Worksite wellness programs Sacred Heart collaboration Mobile heart screen – every 2 years to community	
City Services	• We need bike paths for children to use to get to school safely • Would be nice to have the option of public forums to address serious issues – moderated by someone with a cool head.	Parks board – bike path proposed for Springfield Parkway City Council	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Cultural Diversity	• Need education about living in a culturally diverse world	Schools Public Health	
Education	• Pre-K availability	Schools – not called "Pre K" – but we do have preschool available. This is costly to the parents.	
Elderly	• Need a fitness program for the elderly •	Curves Senior Dining could add something? Wellness centers (high school, Curves, Prairie Rehab) Southwest MN aging agency – does not offer a lot of resources Community Education – need elderly opportunity? Offer through churches - Faithfully Fit for Life though Sanford at no cost. Consider Parish Nurse?	
Emergency Care	• People who use the EC for primary care (especially at unusual times – like middle of the night) • Concern about access to emergency services • Get better equipped ER facility to lessen out servicing	Sanford generates report to Health Care Coach on "frequent fliers". HCC should contact them to encourage. ED is 24/7. We do not see long waits. Facility renovation is done. Equipment is improved.	
Healthcare Cost/Insurance Cost	• Concern about the cost of healthcare & high deductibles • 14% uninsured adults	Sanford Community Care Program – counselors on site and in Sioux Falls. Nursing staff informed of options. Can refer to county resources, SAGE, ect. Health Care Coach familiar with program	
Health Factors	• High incidence of sexually transmitted disease	School nurses Public health – primary resource. Planned Parenthood – a distance to drive for services.	#3
Housing	• Need more residential rental properties	Economic Development Vicious cycle of housing prices/needs/new people moving to Jackson.	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Healthy Nutrition	• Poor quality produce at the grocery store – too expensive also • Need a nutritionist who could assist parents & grandparents in providing meals using lower priced, healthy foods • Only 40% have access to healthy foods	Sanford WebMD Fit Kids Consulting Dietician for Sanford Jackson Senior Dining Meals on Wheels SHIP does not have dietician	
Mental Health	• Need more mental health personnel • Need a full-time CNP who can prescribe • Need short-term counseling services • Need family counseling services • Need services for emergent mental health • Need child mental health services – especially for evaluations • Need stress management groups, classes, etc. • Mental health services are not covered well in many insurance plans • Need more attention to suicide prevention	Sanford One Care – telemedicine integrated with primary care. $12 million grant from CMS to address mental health/behavioral health coordination with medical home. Triage behavioral health therapist will be shared with Worthington/Jackson/Lakefield. Anita's clinic downtown Dr. Moeller here once a month Southwest Mental Health available	
Morbidity and Mortality			
OB Services	• Need OB services in our community!	Ob/Gyn services available 3 out of 4 weeks from Worthington. Deliveries are not here. 20-30 miles for deliveries.	
Obesity	• Concern about obese kids • Too much screen time (for kids) • Concern about lack of services for obesity, diabetes – do we have any? How would we find out? • High incidence of adult obesity • As a community, we need to concentrate on healthy diet & exercise so as to lower # of those who will get a chronic illness	Sanford WebMD Fit Kids SHIP Open gym Swimming pool Biking and walking trails – Parks and Rec Ball parks, parks all through town "Any Sports Club" Frisbee Golf Dietician Curves, Prairie Rehab, School fitness center	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
		Sanford Tri For Health – annually – family oriented Lakefield 5k annually Jackson 5K annually?	
Physical Activity	• Need more family-oriented physical activities • Need more options for working out in the winter – can the schools be open more hours, especially on weekends? • Cost to work out is prohibitive if you are not a student or do not have wellness programs covered in your insurance •	See obesity above A lot is available with no cost – open gym, community education resources (zumba, swimming, ect)	
Physicians	• Turnover of physicians – make sure that issue is a big part of the interview • Encourage local high school graduates to go to medical school & come back to the community when done with their training	Collaboration with Sacred Heart is valuable Medical staff works very well together Continue contact with local med school students – often not interested in family medicine in small community. Have hosted NP/PA students for clinicals Exploring options for engaging local students in health careers. Southern MN Area Health Education Center (AHEC).	#2
Pollution	• Loud vehicles & vehicles with music pounding • Littering • Dog refuse not picked up by dog owner • Farm field run-off • Radon	City Council Economic Development	
Prevention Services	• Public does not understand the scope of services until it is crisis time & they need the services they should have had months ago • Need more preventive educational sessions. Is difficult to get groups together in a small community because size of group is not economically feasible, especially if size of group begins shrinking.	Sanford Medical Home Sanford WebMD Fit Kids Health Coaches Support Groups – reinstate? Public Health/Community Health Community Ed opportunity? Need education to the public of resources available BEFORE they need the service.	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	• More attention needs to be paid to communicable disease issues	Ask the expert – monthly in the newspaper Reach out to senior wellness – expound on that Speaking at Kiwanis, Lions, service groups, ect. Mass flu clinics in communities (Jackson and Lakefield) Promoting TDAP, flu shots, phneumovax, ect. with patients. Work site wellness	
Safety	• Need to put more emphasis on using seats belts, bike helmets, wearing visible walking clothing for at night	Bike safety? Bike helmets provided by fire department Education by providers to the patients – during well child exams	
Substance Abuse	• Concern about drug abuse problems • High percentage of binge drinking	Sanford One Care Lack of resources to get them in program if suspected alcohol abuse. AA is in town Is telemed an option for the future?	
Transportation	• Lack of public transportation at night (this can result in drinking & driving) • Transportation for the elderly late in the day • Transportation for the elderly to healthcare appointments • Need transportation for the elderly to healthcare appointments	West CAP and volunteer drivers yet drivers are limited, scheduling Difficult to get beyond Jackson – costly There are people that do not have family to drive them.	
Urgent Care	• Need a "minute clinic" so that people do not use the ER for non-emergent issues • Access to physicians & pharmacy services on evenings & weekends	Done in past and was not financially feasible. Did analysis 1 year ago – still considered not feasible. Urgent care is available in Worthington and Fairmont. Pharmacies have limited hours – scripts would have to go out of town to get script filled.	
Wellness	• Need more community wellness programs • Need more cooperation between the 3 workout facilities • Need a fitness program for the elderly	See obesity above	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Workforce	• Need to hire new faces (from outside the community). Community is too closed-minded & not welcoming to newcomers. Community is dwindling & school enrollment is down because we encourage graduates to "get out & get a good job". We do not have enticing job opportunities, plus we continue to try to "keep it local" when hiring people. • Concern about the number of qualified nurses (recruitment, retention)	Engage the school	
Youth	• Concern about alcohol & drug use • Cost & time to make healthy food in the schools is prohibitive • Need more after-school activities for youth • Concern about instability of many families & the impact this has on children's health (both physical & mental) • Concern about single parents not being able to "be there" for their kids • Concern about autism • Concern about lack of dental healthcare for kids • Concern about verbal violence in the home • Bullying • Exposure to second hand smoke / the asthma rates • Concern about obese kids – 25% of the kids at Riverside School are classified as obese this year • Concern about parents allowing kids to have too much screen time (obesity)	Sanford WebMD Fit Kids Sanford One Care Independent autism support group started – parent organized. Lack of Medicaid participation by dentist. Social worker in school shared with Family Services Network Huskies Fighting Cancer 4-H after school activities offered Library after school activities offered	#1
Sanford Specific	• Concern about staffing levels which result in poor healthcare delivery • Concern about being referred to Fairmont, Windom or Sioux Falls – why can't the physician in Jackson handle it?		

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Table 5

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**
Dental Services for Youth			#1
Explore the possibility of engaging local students in health careers (AHEC)			#2
Work with Public Health and school nurses to address Sexually transmitted disease			#3

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Table 2

Prioritization Worksheet

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100-1031919-0013 Rev. 2/13