



**Sanford Health of Northern Minnesota
Community Health Needs Assessment
2012-2013**

dba Sanford Bagley Medical Center EIN# 41-1266009

Sanford Bagley Medical Center

Community Health Needs Assessment
2012-2013

rev. 6/7/13

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Sanford Bagley Medical Center Community Health Needs Assessment 2012-2013

Purpose

Sanford Bagley 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 Bagley 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 Bemidji Region Steering Group:

- *Enterprise Lead:* Carrie McLeod, MBA, MM, LRD, CDE; Office of Health Care Reform, Community Benefit/Community Health Improvement
- Joy Johnson, Chief Operating Officer, Sanford Bemidji
- Kim Thebaut, Director, Quality and Risk, Sanford Bemidji
- Kirby Johnson, CEO, Sanford Bagley Medical Center
- Lindsey Wangberg, Regional Marketing Director, Sanford Bemidji
- Sara Lusignan, Corporate Controller, Sanford Bemidji
- Warren Larson, Bemidji Marketing/Community Relations Coordinator

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
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- Ashley King, Bemidji Co-Lead, Intern in Bemidji
- JoAnn Kunkel, CFO, Sanford Health
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- Martha Leclerc, MS; Vice President, Office of Health Reform and Strategic Payment
- Doug Nowak, MBA; Executive Director, Decision Support
- Heather Vanmeveren, CPA; Director of Accounting

Sanford Fargo Region Steering Group:

- *Enterprise Lead:* Carrie McLeod, MBA, MM, LRD, CDE; Office of Health Care Reform, Community Benefit/Community Health Improvement
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- Jac McTaggart, CEO, Hillsboro Medical Center
- Angela Novak, MBA; VP, Sanford Health Marketing
- Heather Rye, MBA, PHR; HR Advisor, Sanford Health Network Fargo
- Les Wietstock, MSA; CFO Sanford Health Network Fargo

We express our gratitude to the following individuals and groups for their participation in this study.

We extend special thanks to the city mayors, city council/commission members, physicians, nurses, school superintendents and school board members, parish nurses, representatives from the Native American community, Faith Community Leaders, as well as legal services, mentally and physically disabled, social services, non-profit organizations, and financial services for their participation in this work. Together we are reaching our vision “to improve the human condition through exceptional care, innovation and discovery.”

Our Guiding Principles:

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

The following key community stakeholders participated in this assessment work:

- Clark Chamber, Ancillary Director, Sanford Bagley, Bagley, MN
- Heather Galli, Owner, Galli Furniture, Bagley, MN
- David Galloway, Chiropractor, Bagley Chiropractic, Bagley, MN
- Aaron Kaiser, Branch Manager, Riverwood Bank, Bagley, MN
- Greg Leintz, Owner, Galens Super Valu, Bagley, MN
- Marsha Leintz, Nurse, Sanford Bagley, Bagley, MN
- Les Liljedahl, President/CEO, First National Bank, Bagley, MN
- Darol Melby, Rotary Club, Bagley, MN
- Jill Nelson, Dentist, Bagley, MN
- Charlene Olson, Clearwater County Treasurer, Bagley, MN
- Allen Paulson, Clearwater County Auditor, Bagley, MN
- Al Rasmussen, Project Director, University of Minnesota, Bagley, MN
- Rachel Rosenbush, Accounting Analyst, Sanford Bagley, Bagley, MN
- Leroy Sundbom, Financial Associate, Clearbrook, MN
- Don Trez, Bagley, MN

Sanford Bagley Medical Center Community Health Needs Assessment 2012-2013

Executive Summary

Purpose

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

Study Design and Methodology

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

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

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

The following qualitative data set was studied:

- Community Health Needs Assessment of Community Leaders

The following quantitative data sets were studied:

- 2011 County Health Profiles for Beltrami and Clearwater Counties
- Aging Profiles for Beltrami and Clearwater Counties
- Diversity Profiles for Beltrami and Clearwater 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 Bagley/Bemidji CHNA Steering Group performed the resource identification and asset mapping exercise to determine the availability of key services within the community that can meet the unmet needs. 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 Bagley distributed the community health needs assessment survey tool that was developed by the Greater Fargo-Moorhead Community Health Needs Assessment Collaborative to key stakeholder groups as a method of gathering input from a broad cross section of the community.

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

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

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

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

Respondents had very high levels of agreement that their community has quality school systems and programs for youth, there is quality health care, the community is a good place to raise kids, and people are friendly, helpful and supportive. However, respondents agreed the least that there is tolerance, inclusion, and open-mindedness in their community and that there are quality higher education opportunities and institutions.

Respondents were most concerned about substance abuse, child abuse and neglect, property crimes and domestic violence, and the cost and availability of services for the elderly and resources to meet the aging population. Respondents were also concerned with issues regarding youth (e.g. teen pregnancy, bullying, truancy), child care, and changes in the family composition. Environmental issues regarding garbage and litter, water quality, air quality, and noise levels were not a large concern.

Among health and wellness concerns, respondents were most concerned about the costs associated with health insurance, health care, use of emergency services for primary care, adequacy of health insurance (e.g. amount of co-pays and deductibles, consistency of coverage) and the cost of prescription drugs. Respondents were also concerned about physical health issues, particularly obesity, poor nutrition and eating habits, and inactivity or lack of exercise, as well as chronic disease (e.g. diabetes, health disease, multiple sclerosis) cancer and depression were also among the top health and wellness concerns among respondents. Respondents were least concerned about the provider not taking new patients and the availability of bilingual providers and/or translators.

Respondents had a high level of concern with economic issues related to poverty, low wages, and the cost of health care and/or insurance. Respondents had moderate levels of concern with homelessness, hunger, the availability of employment opportunities, and economic disparities between higher and lower classes. Respondents were least concerned with the availability of affordable housing.

Respondents were most concerned with availability of good walking or biking options. Respondents were least concerned with traffic congestion.

Respondents were not very concerned with environmental issues in their community.

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

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

More than 50% of respondents said they had a cancer screening or cancer care in the past year. The most common reason for not having done so was because it was not necessary or that the doctor had not recommended it. Fear, cost and the inability to access care were not considered primary concerns.

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

Respondents were asked which provider they used for their primary health care. Seventy-six percent (76%) of respondents said they use Sanford Health as their primary health care provider and 21% said they use other providers.

Key Findings – Secondary Research

Health Outcomes

The Mortality health outcomes indicate that the state of Minnesota and Clearwater County have fewer premature deaths than the national benchmark. Beltrami County, Minnesota has a much higher rate than the national benchmark.

The Morbidity health outcomes indicate that Minnesota and Beltrami County citizens report more days of poor health than the national benchmark; however, Clearwater County reports better health days. Minnesota, Beltrami County and Clearwater County report more physically unhealthy days than the national benchmark.

Minnesota, Beltrami County, and Clearwater County report more mentally unhealthy days than the national benchmark.

Minnesota has a higher percentage of low birth weight than the national benchmark; however, Beltrami County has a lower percentage of low birth weight than the national benchmark. Clearwater County data was not available for birth weight.

Health Factors

The Health Behavior outcomes indicate that the state of Minnesota and Beltrami County have higher percentages of adult smokers than the national benchmark. Adult obesity is also higher in the state of Minnesota, and in Beltrami and Clearwater Counties. Beltrami County and the state of Minnesota have lower percentages of physical inactivity than the national benchmark, while Clearwater County sits at the same level as the national benchmark.

Minnesota and Beltrami have a substantially higher percentage (20% in MN and 22% in Beltrami vs. the national rate at 8%) of binge drinking reports than the national benchmark. The state of Minnesota and is near the national benchmark for motor vehicle deaths; however, Beltrami County has more than twice the national benchmark. There was no data available for Clearwater County regarding the motor vehicle crash death rate.

Sexually transmitted infections rank substantially higher than the national benchmark for Minnesota, Beltrami and Clearwater counties. The teen birth rate is also substantially higher in Minnesota, Beltrami County and Clearwater County than the national benchmark.

The Clinical Care outcomes indicate that Minnesota and Beltrami County have lower percentages of uninsured adults while Clearwater County has a slightly higher percentage. The percentage of uninsured youth is the same in Beltrami County as the national benchmark, but is higher in Clearwater County and lower in Minnesota as a whole.

The ratio of population to primary care physicians is nearly the same in Minnesota as the national benchmark. The Beltrami and Clearwater County ratio are substantially higher than the national benchmark. The ratio of population to mental health providers is much more favorable in Minnesota and in Beltrami County than the national benchmark; however, it is significantly less favorable in Clearwater County. The number of professionally active dentists is lower than the national benchmark in Minnesota and Beltrami County. There is no data available for Clearwater County. Preventable hospital stays are higher than the national benchmark in Minnesota, Beltrami and Clearwater counties.

Diabetes screening in Minnesota is slightly lower than the national benchmark and is significantly lower than the national benchmark in Beltrami and Clearwater counties. Clearwater County ranks higher than the national benchmark for mammography screenings, while Minnesota is slightly under the national benchmark and Beltrami County is significantly lower.

The Social and Economic Factor outcomes indicate that Minnesota and Beltrami and Clearwater counties all have a lower high school graduation benchmark than the national benchmark; however, Minnesota has a higher percentage of post-secondary education. Both Beltrami and Clearwater counties have a lower benchmark of post-secondary education than the national benchmark and the state as a whole. The unemployment rate was substantially higher in Minnesota, Beltrami and Clearwater counties than the national benchmark. The percentage

of child poverty is substantially higher in Beltrami and Clearwater counties than the national benchmark; however, Minnesota as a state is sitting at the same benchmark as the nation for childhood poverty.

Inadequate social support in Beltrami County is slightly higher than the national benchmark; however Minnesota as a state is at the national benchmark.

The percentage of children in single parent households is higher than the national benchmark in Minnesota, Beltrami and Clearwater counties. The number of homicide deaths in Minnesota is higher than the national benchmark, and in Beltrami County the rate is nearly nine times that of the national benchmark.

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

Youth account for 25% of the population in Beltrami County and 24% of the population in Clearwater County. Elderly account for 13% of the population in Beltrami County and for 19% of the population in Clearwater County. Sixty-nine percent (69%) of Beltrami County is rural compared to 29% of Minnesota and 21% as the national benchmark. Clearwater County is 100% rural.

Only 4% of Minnesotans and 1% of the Beltrami and Clearwater County population is not proficient in English compared to the national benchmark which is 9%. Minnesota at 6%, and Beltrami and Clearwater counties at 6% and 8% respectively, have low illiteracy rates compared to the national benchmark of 15%.

The population for this area is relatively young with only 2-3% older than 85 years of age. In Beltrami County only 13 % are older than 65 years of age. In Clearwater County 19% are older than 65 years of age.

The gender distribution is 50-50 in Beltrami and Clearwater counties. Minnesota as a state is 45% male and 55% female.

The majority of individuals in this region own their homes with ownership in Minnesota at 73%, Beltrami County 70%, and Clearwater County 80%.

According to the 2010 Census Data, the population of working age in the labor force ranges from 69-77% in Minnesota as a whole, 66% in Beltrami County, and 65% in Clearwater County. The percentage of those who are living at less than 100% of the poverty level is 20% in Beltrami County and 16% in Clearwater County. In Beltrami County 41% and in Clearwater County 42 % are at less than 200% of the poverty level.

The median annual household income in Minnesota is \$57,243. In Beltrami County the annual income is \$43,394 and Clearwater County has an annual income of \$39,310.

The population distribution from the 2010 U.S. Census Summary by race demonstrates Minnesota, Beltrami County and Clearwater County are predominantly white followed by American Indian with a population of 9,004 in Beltrami County and 782 in Clearwater County. Hispanic origin is the third leading population. Asian origin is fourth in Beltrami and there are slightly more black Americans in Clearwater County than Asian Americans. American Indians rank fifth in Minnesota (60,916 total population) as the leading race by population.

Implementation Strategy

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

- Obesity

Implementation Strategy: Obesity

- Participate and help develop a comprehensive weight management program within the Bagley and Bemidji regions using an interdisciplinary team inclusive of medical, nutrition, Behavioral Health and fitness professionals, as well as helping our appropriate patients gain access to weight loss surgery services.
- Continue promoting and increasing community members in the involvement of our Silver Sneakers program to promote and incentivize Medicare-eligible customers.
- Implement Sanford Frontiers weight management program within the Bagley region.
- Actively participate with community wellness, fitness and healthy living entities to promote and support fitness and active living by sponsoring walking, screening and educational programs.

Sanford Bagley Medical Center

Community Health Needs Assessment 2012-2013

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

Our Mission: *Dedicated to the Work of Health and Healing*

We provide the best care possible for patients at every stage of life, and support healing and wholeness in body, mind and spirit.

Our Vision: *To improve the Human Condition through Exceptional Care, Innovation and Discovery*

We strive to provide exceptional care that exceeds our patients' expectations. We encourage diversity in thought and ideas that lead to better care, service and advanced expertise.

Our Values:

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

Our Promise: *Deliver a flawless experience that inspires*

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

Guiding Principles:

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

Description of Sanford Bagley Medical Center

Sanford Bagley Medical Center in Bagley, MN, originally founded in 1949, is built on a tradition of ensuring that every community member has access to the highest quality care close to home.

The 25-bed Critical Access Hospital includes:

- 24-hour Emergency Department
- Ambulance Service
- Bagley and Clearbrook Clinic
- Inpatient and Outpatient Surgery
- Outpatient IV therapy
- Laboratory Services
- Radiology Services (including: X-ray, Digital Mammography, Bone Densitometry, CT Scan, MRI, Ultrasound and Nuclear Medicine)
- Respiratory Therapy
- Sleep Studies
- Cardiac and Pulmonary Rehabilitation
- Stress Tests
- Physical and Occupational Therapy
- Dietitian Services
- Swing Bed
- Respite Care
- Fitness Center

As part of an integrated health system, Sanford Bagley, formerly Clearwater Health Services, employs approximately 80 people and 5 physicians/advanced practice providers. As caregivers, neighbors and friends, Sanford Bagley employees are dedicated to improving the health and wellness of the people of Clearwater County. Beyond providing medical care, Sanford Bagley supports and partners with local organizations to provide health care awareness, education and prevention for the communities it serves.

Description of the Community Served

Bagley is a charming and progressive community located 240 miles northwest of Minneapolis and 28 miles west of Bemidji, MN. It provides a small town flavor and friendliness while at the same time providing many cultural options not always thought of for northern Minnesota. From state parks to sporting events, you will find an activity that meets your needs with trails to hike, bike or snowmobile, skiing, canoeing, golfing, sailing or fishing.

With a population over 1,200, the community serves as a hub for residents of Clearwater County with a combined county population of approximately 8,250. Bagley is an active community with citizens who are fully invested in their education system, health care and volunteer opportunities. It is also home to large variety of businesses, including TEAM electronics and several nonprofit agencies.

Study Design and Methodology

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

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

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

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

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

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

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

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

The following qualitative data sets were studied:

- Community Health Needs Assessment Survey of Bemidji Community Leaders

The following quantitative data sets were studied:

- 2011 County Health Profiles for Beltrami and Clearwater counties
- Aging Profiles for Beltrami and Clearwater counties
- Diversity Profiles for Beltrami and Clearwater 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 Bemidji Community Health Needs Assessment Steering Group performed the asset mapping and reviewed the findings. The group conducted an informal gap analysis to determine what need remained after resources were thoroughly researched. Once gaps were determined the group proceeded to the prioritization

process. The multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

Bagley Community Health Needs Assessment Survey of Community Leaders

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

The survey instrument was developed in collaboration with the FMCHNAC and used to survey of residents of the Bemidji, Beltrami and Clearwater Counties. Thirty questions were included in the survey focusing on community assets, general concerns about communities, community health and wellness concerns, and demographic information.

The community leaders' survey also included a set of questions at the end relating to the respondent's name, title, affiliation, area of expertise, city/town, and state. These questions were included to fulfill the current interpretation of IRS requirements for non-profit hospitals conducting community health needs assessments as part of the new compliance requirements imposed by the PPACA law on March 23, 2010. The community leaders who chose to include their names are included in the acknowledgement section of this report. Data was collected through mid-June. A total of 19 surveys were completed.

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 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 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

At the time of this CHNA there were multiple assessments being conducted in the community of Bemidji for the community and surrounding area. While there is great collaboration within the community partnerships, there was not one tool selected for the assessment due to the timing of each respective survey launch, and the required

data by each separate group. In the future there is great opportunity to build the survey tools together and to collaborate to determine critical data needs.

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

Sanford Bagley distributed the community health needs assessment survey tool that was developed by the Greater Fargo-Moorhead Community Health Needs Assessment Collaborative to key stakeholder groups as a method of gathering input from a broad cross section of the community. The findings discussed in this section are a result of the analysis of the survey qualitative data.

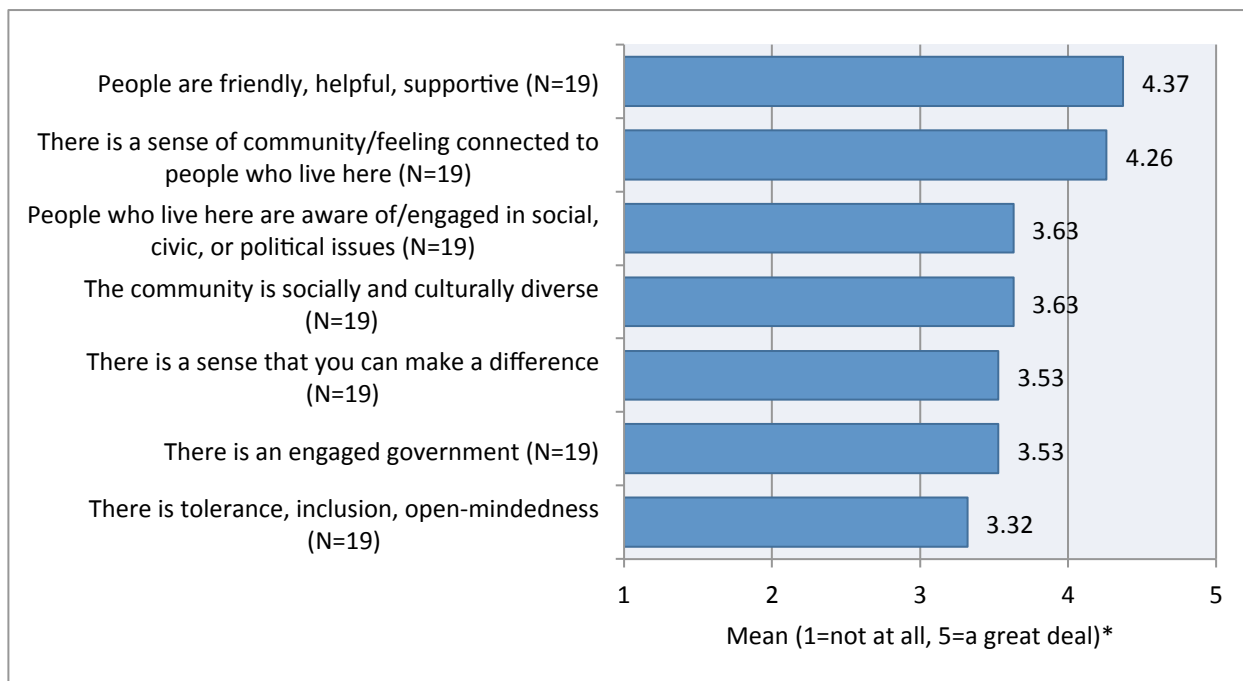
Community Assets/Best Things about the Community

Respondents had very high levels of agreement that their community is made up of friendly, helpful and supportive people, there is a sense of community and feeling connected to people who live here, there is a quality school system and programs for youth, and there is quality health care. However, respondents agreed the least that there is tolerance, inclusion, and open-mindedness in the community.

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

People

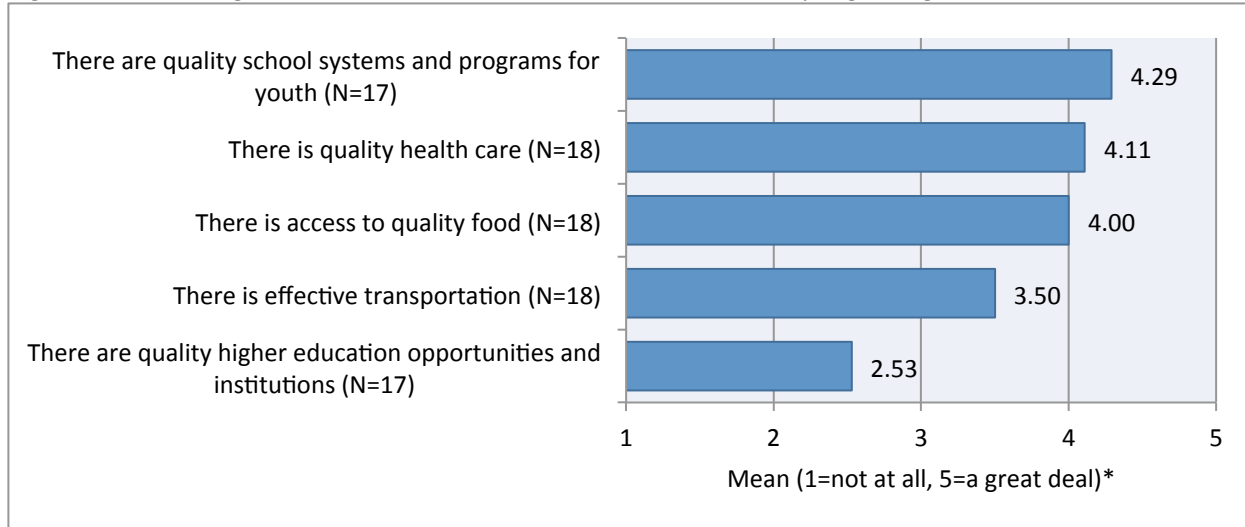
Figure 1. Level of agreement with statements about the community regarding PEOPLE



*Means exclude "do not know" responses.

Services and Resources

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

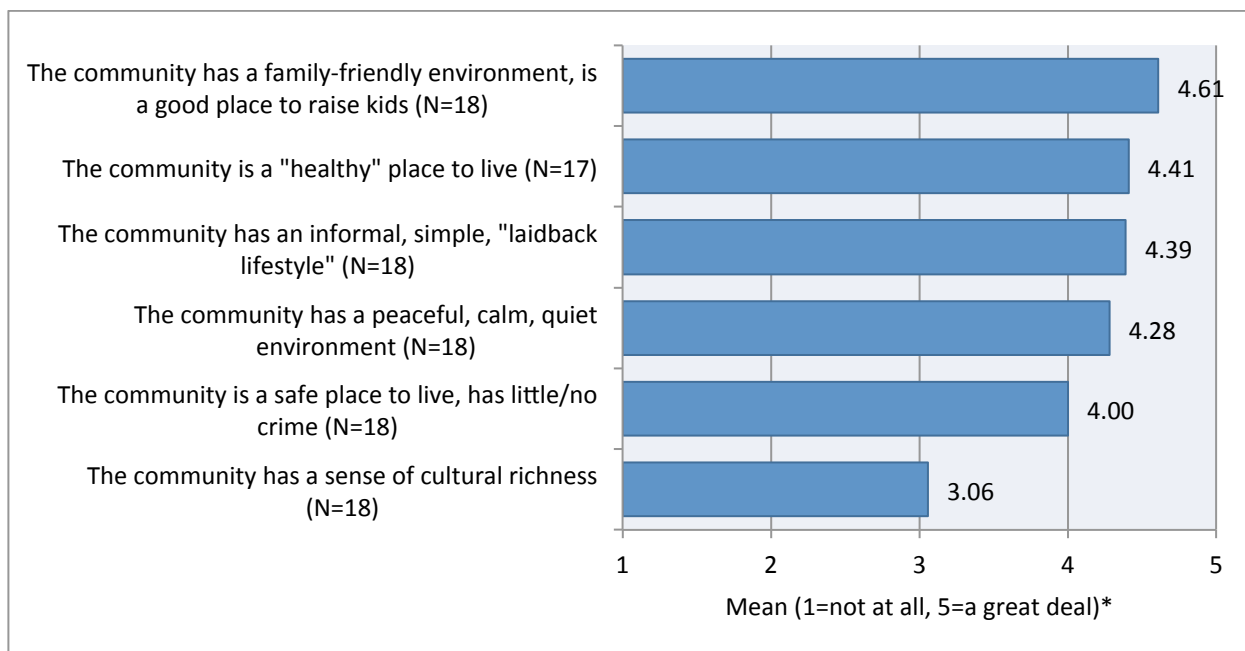


*Means exclude "do not know" responses.

Respondents had high level of agreement that this community is a family-friendly environment and a good place to raise kids, is a health place to live, has an informal, laidback lifestyle, is peaceful, calm, quiet and is a safe place to live. While still moderate agreement, the respondents agreed the least that this community has a sense of cultural richness.

Quality of Life

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

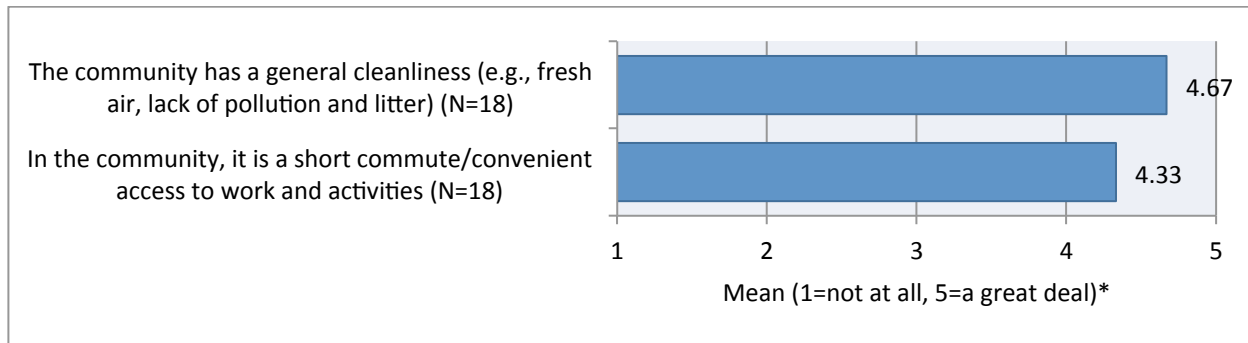


*Means exclude "do not know" responses.

Respondents had a high level of agreement that the community has a general cleanliness and a short commute with access to work and activities.

Geographic Setting

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

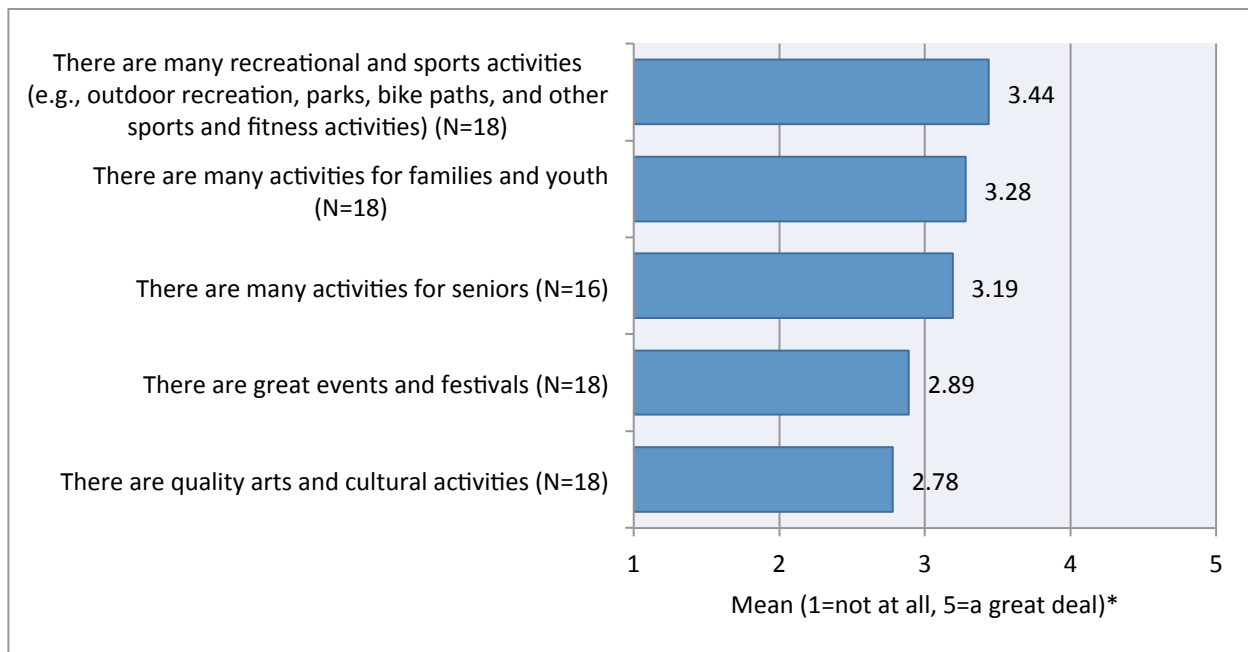


*Means exclude "do not know" responses.

Activities

Respondents had a moderate level of agreement that there are many recreational activities, sports activities, activities for family and youth, and activities for seniors. Respondents agreed the least that there are great events and festivals and quality art and cultural activities.

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



*Means exclude "do not know" responses.

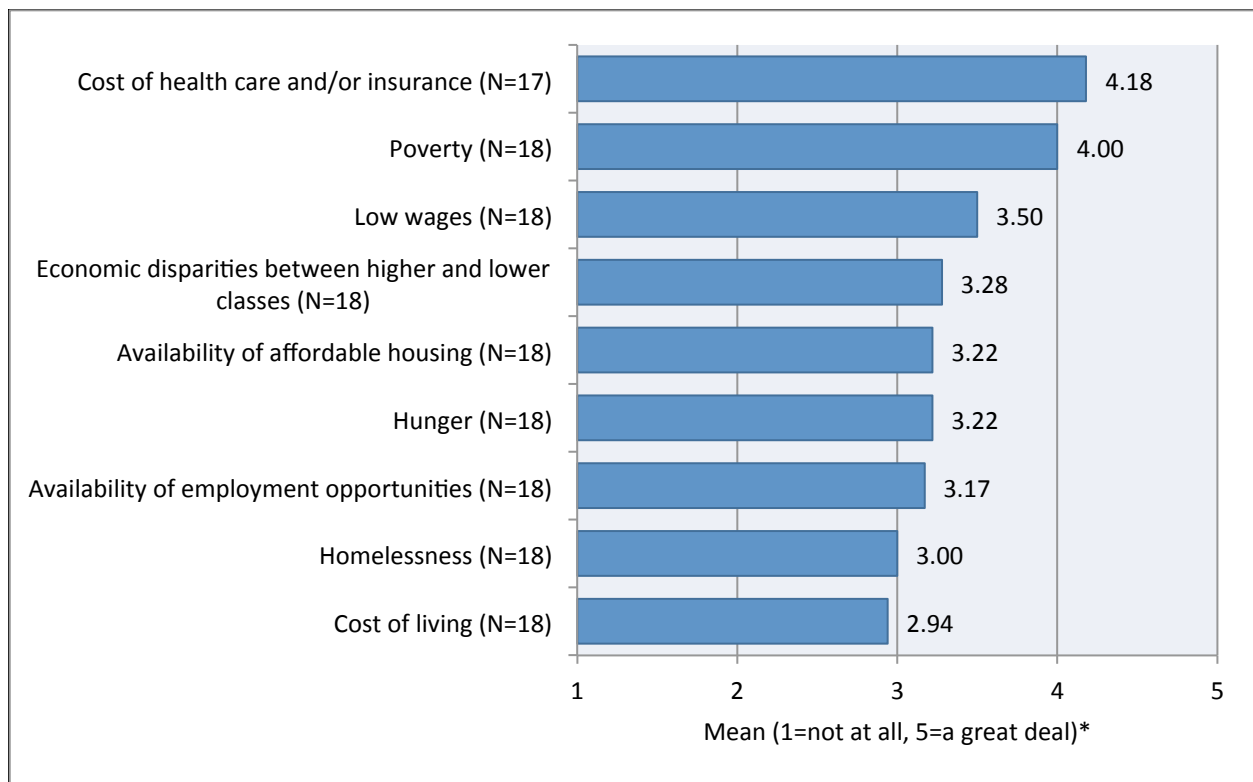
General Concerns about the Community

Respondents were most concerned about substance abuse, cost of health care and insurance, and changes in family composition. Environmental issues regarding garbage and litter, water quality, air quality, and noise levels were not a large concern.

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

Economic Issues

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

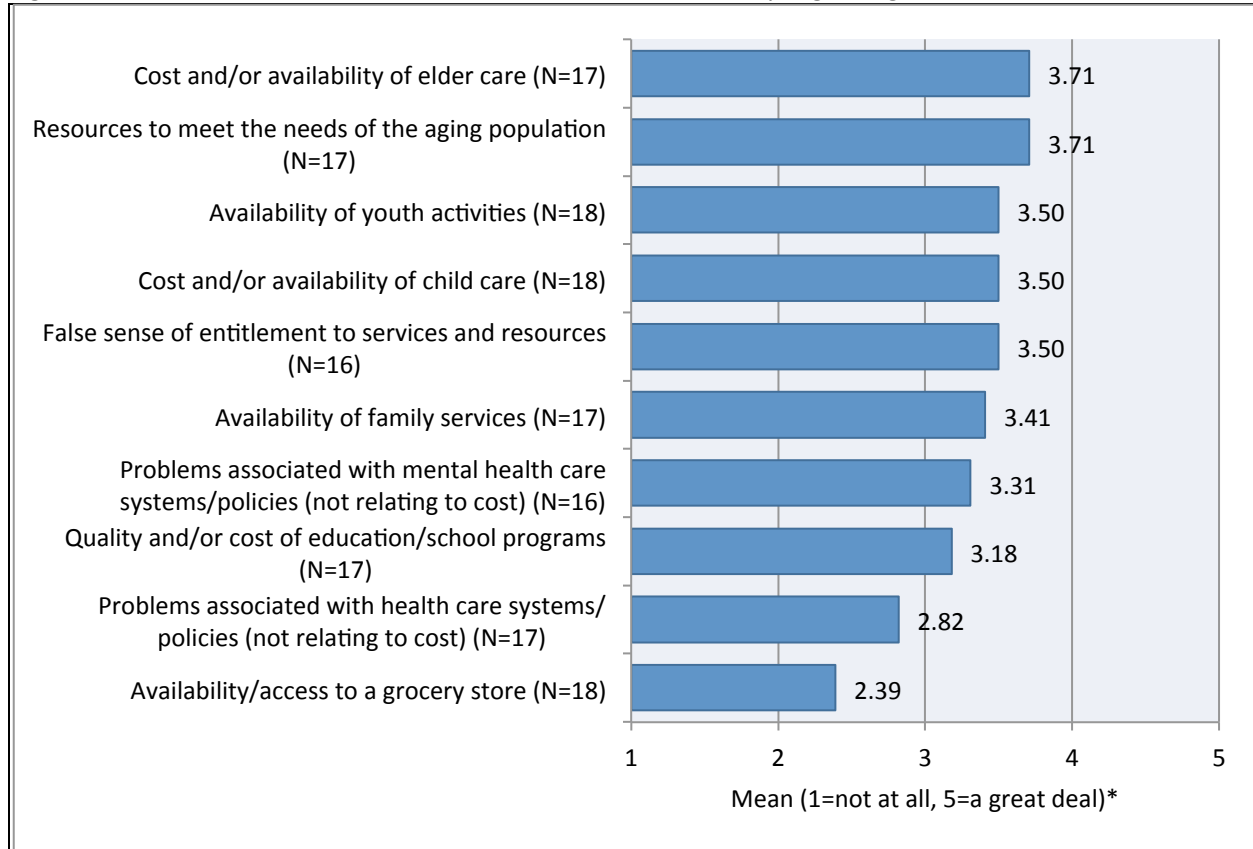


*Means exclude "do not know" responses.

Respondents were most concerned about the cost and or availability of elder care and resources to meet the needs of the aging population. There was moderate concern about the availability of youth activities, adequate childcare, and a false sense of entitlement. Respondents were the least concerned about access to a grocery store and problems associated with health care systems and policies not related to cost.

Services and Resources

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

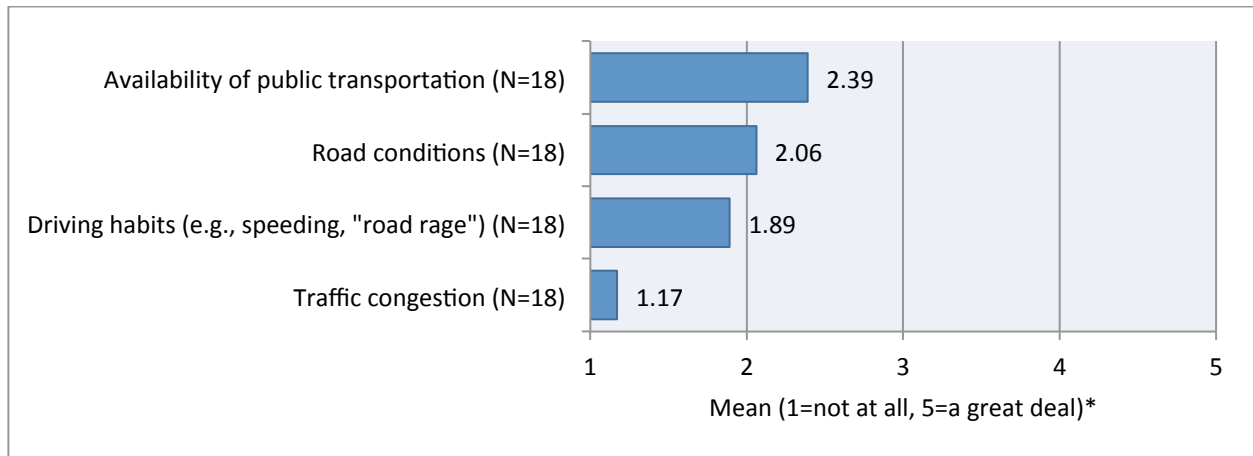


*Means exclude "do not know" responses.

Respondents did not express a high level of concern over transportation issues in the community.

Transportation

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

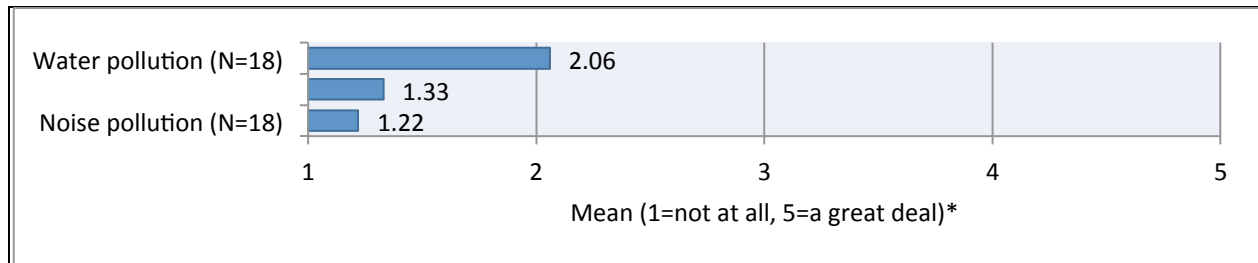


*Means exclude "do not know" responses.

Environment

Respondents did not express a high level of concern about the environmental pollution in the community.

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

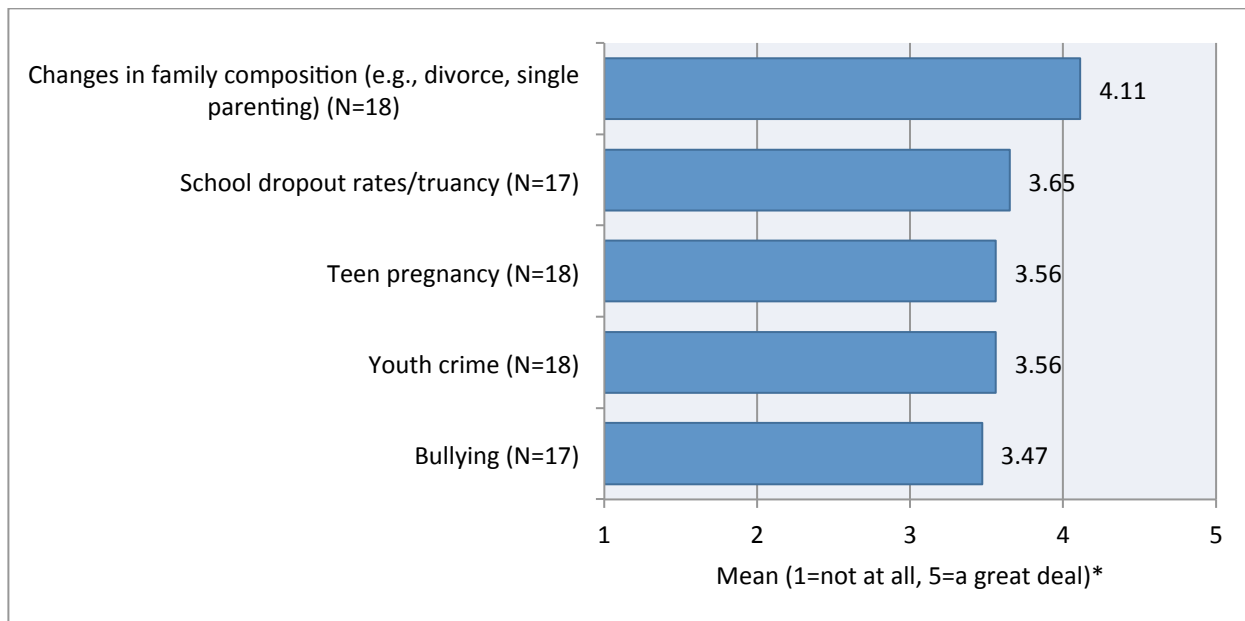


*Means exclude "do not know" responses.

Respondents expressed a high level of concern about changes in the family composition, and moderate concerns about school dropout rates, truancy, teen pregnancy, youth crime and bullying.

Youth

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

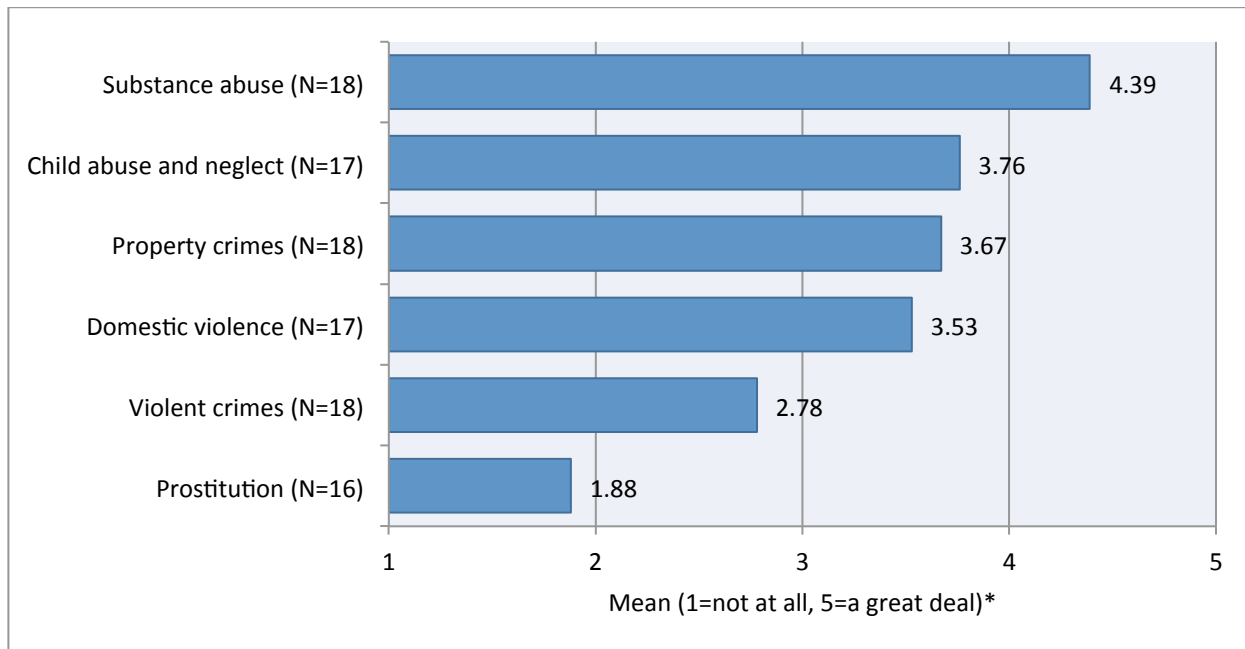


*Means exclude "do not know" responses.

Respondents were highly concerned over substance abuse in the community, as well as child abuse, property crimes and domestic violence. Respondents were the least concerned over prostitution in the community.

Safety

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



*Means exclude "do not know" responses.

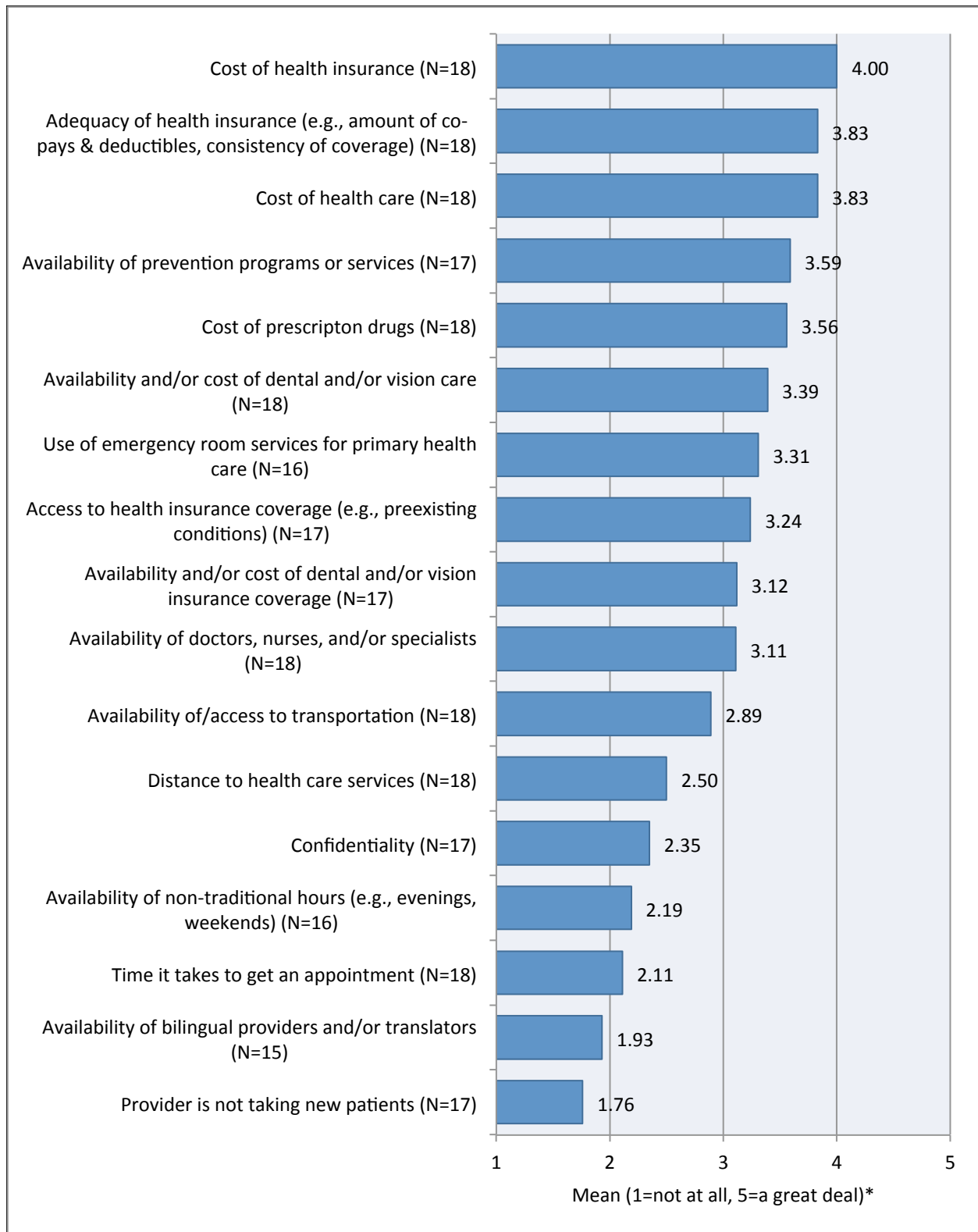
Community Health and Wellness Concerns

Among health and wellness concerns, respondents were most concerned about the costs associated with health insurance, health care, adequacy of health insurance (e.g., amount of co-pays and deductibles, consistency of coverage), and the cost of prescription drugs. Respondents were also concerned about physical health issues, particularly obesity, poor nutrition and eating habits, and inactivity or lack of exercise, as well as chronic disease (e.g. diabetes, heart disease, multiple sclerosis), cancer, and the availability of qualified mental health providers and mental health program. Respondents were least concerned about the provider not taking new patients and the availability of bilingual providers and/or translators.

Access to Health Care

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.

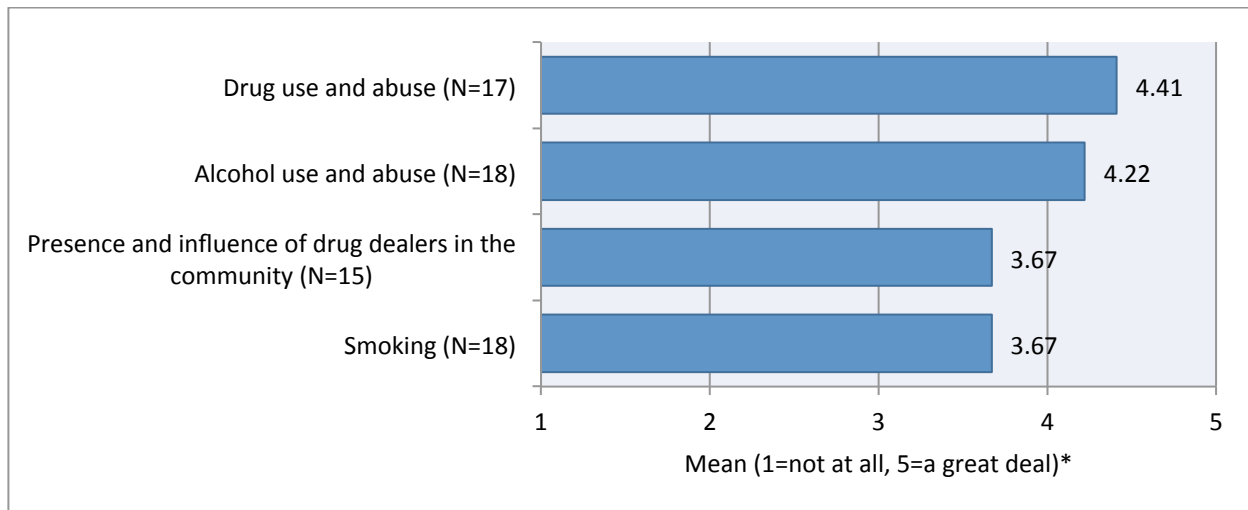
Figure 12. Level of concern with statements about the community regarding ACCESS TO HEALTH CARE



Substance Use and Abuse

Respondents were highly concerned about drug abuse and alcohol abuse in the community. There was moderate concern about the influence of drug dealers in the community and smoking.

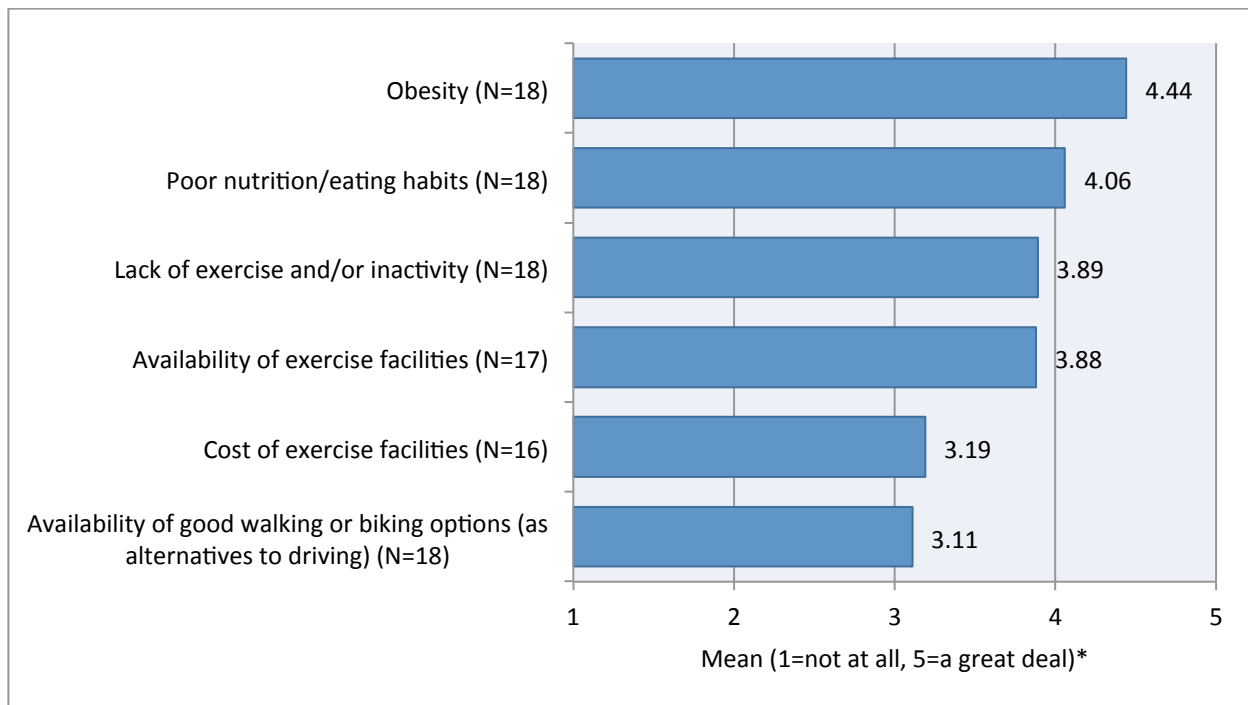
Figure 13. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE



Physical Health

The respondents were highly concerned with obesity, poor nutrition and eating habits, lack of exercise, and the availability of exercise facilities.

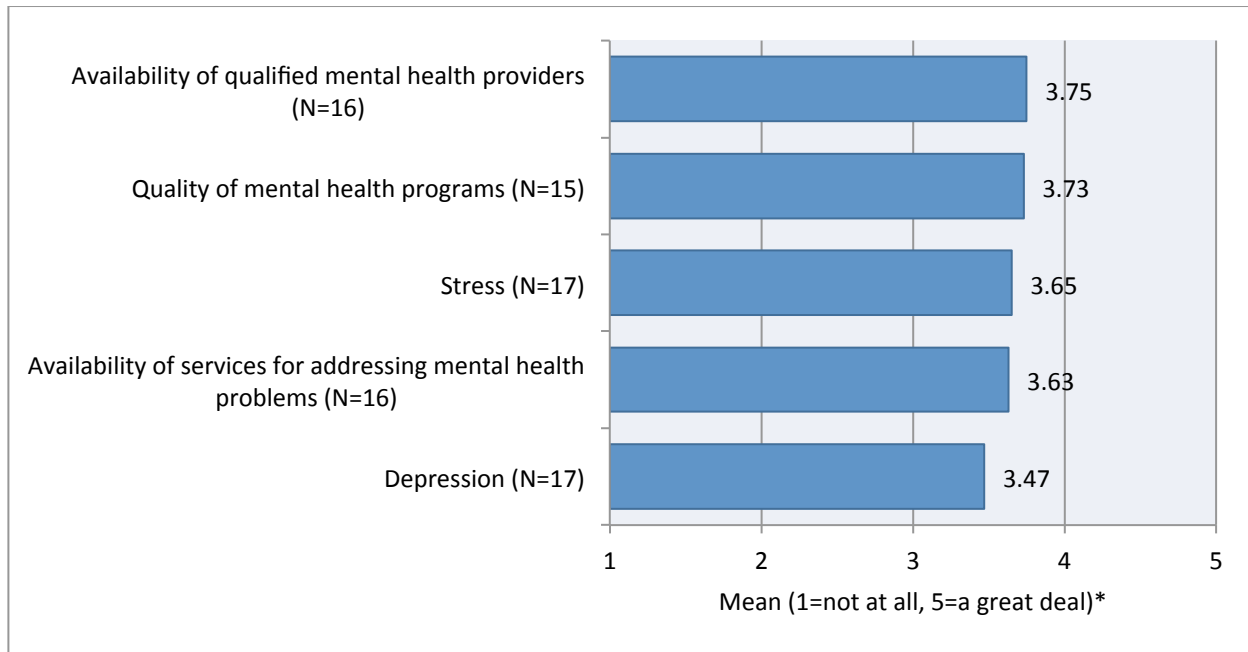
Figure 14. Level of concern with statements about the community regarding PHYSICAL HEALTH



Mental Health

Respondents were concerned about mental health services and lack of providers in the community as well as stress and depression.

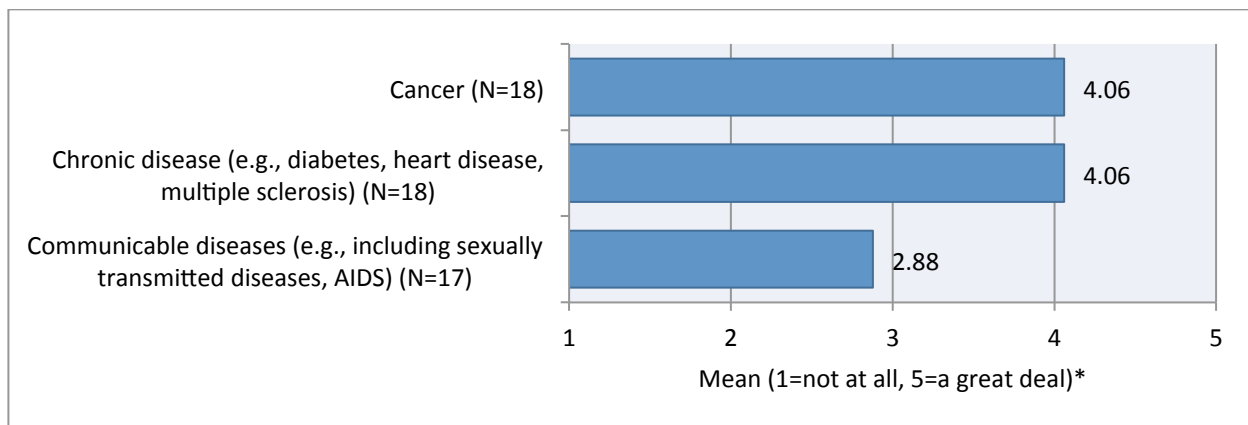
Figure 15. Level of concern with statements about the community regarding MENTAL HEALTH



Illness

Respondents were highly concerned about cancer and chronic disease in the community.

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

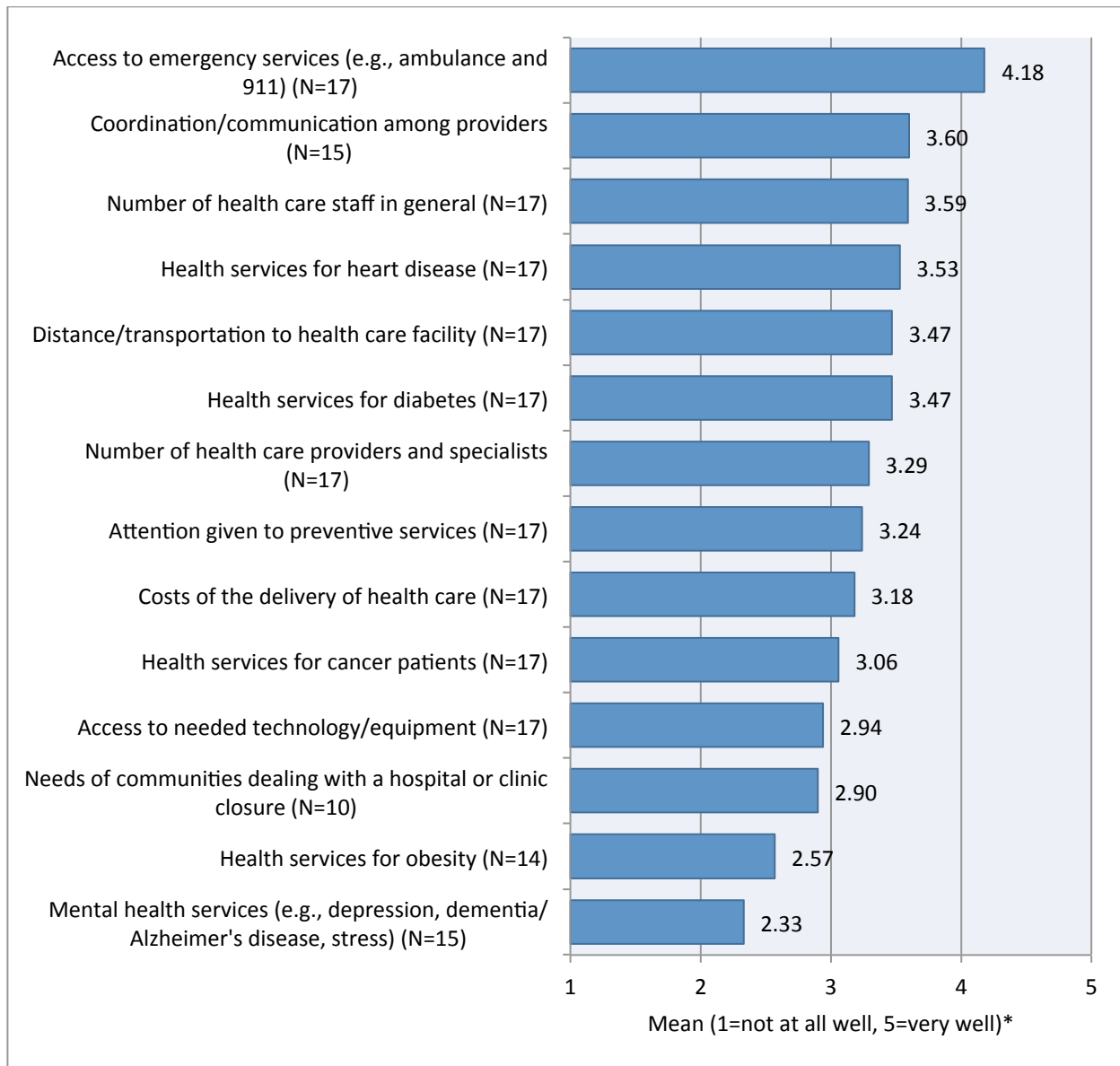


Delivery of Health Care in the Community

Respondents were highly confident about access to emergency care in the community, coordination among providers, the number of health care staff in general, services for heart disease, the distance to a health care facility, and health services for those with diabetes. Respondents were the most concerned with mental health services and health services for obesity.

Respondents were asked to rate how well DELIVERY OF HEALTH CARE topics are being addressed in their community.

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

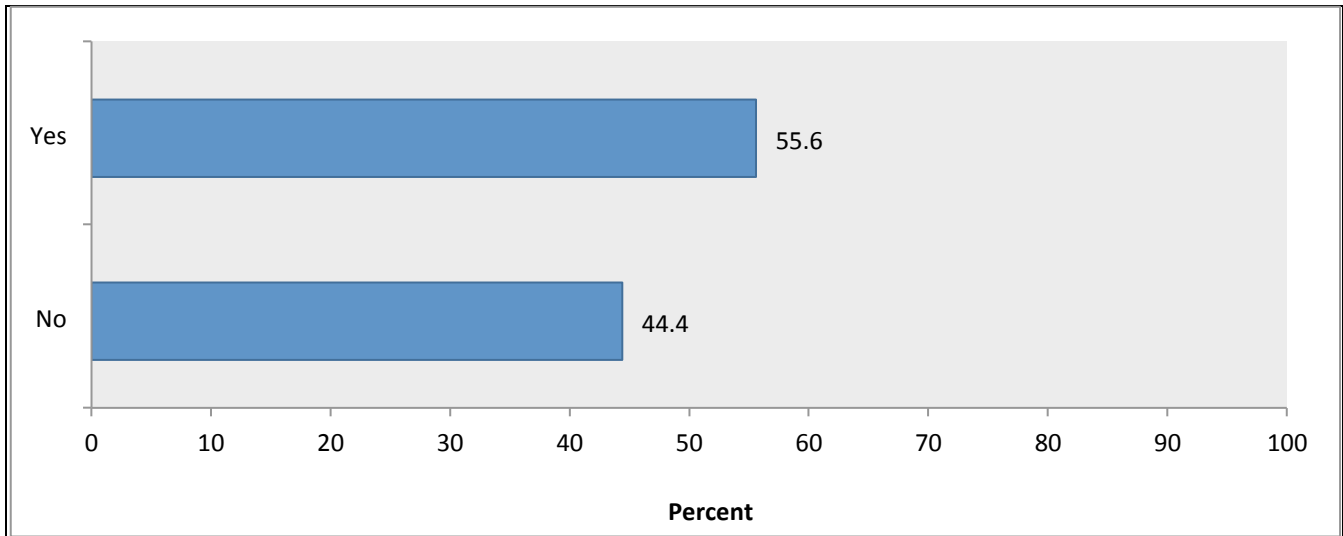


Personal Health Care Information

Cancer Screening

Over 50% of respondents did have a cancer screening or cancer care in the past year.

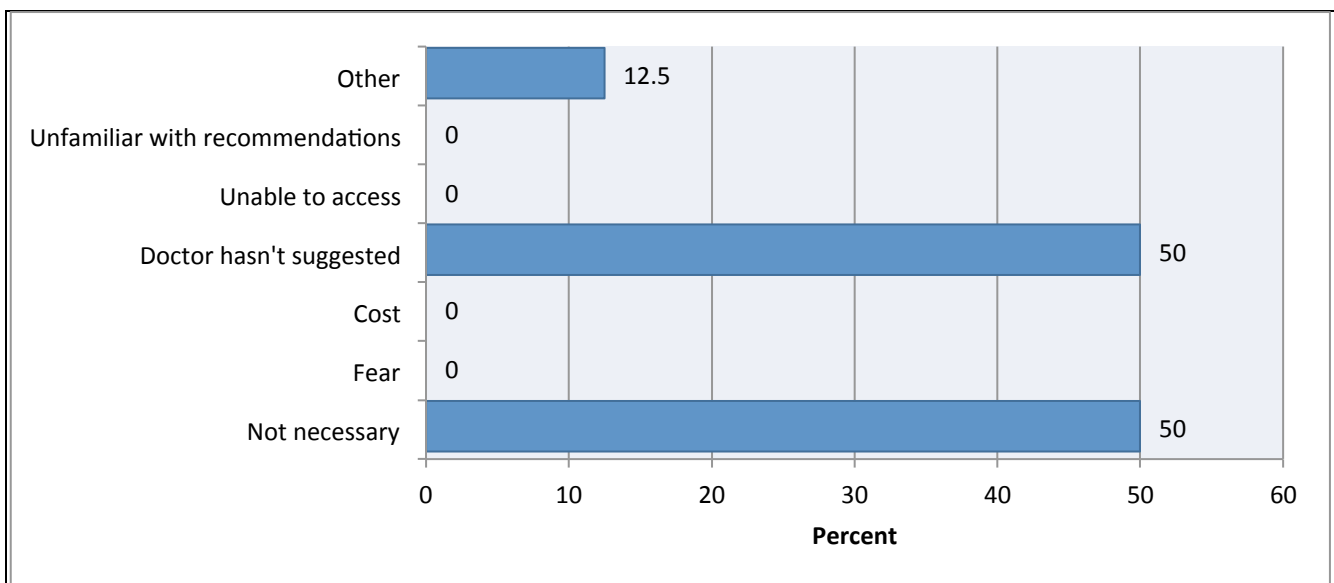
Figure 18. Whether respondents had a cancer screening or cancer care in the past year



Among respondents who had not had a cancer screening or cancer care in the past year, 50% said they had not done so because their doctor had not suggested it and 50% said they thought it was unnecessary.

- No respondents stated that cost was a factor.
- Fear was not considered a reason for respondents to not have the screening. (Figure 19)

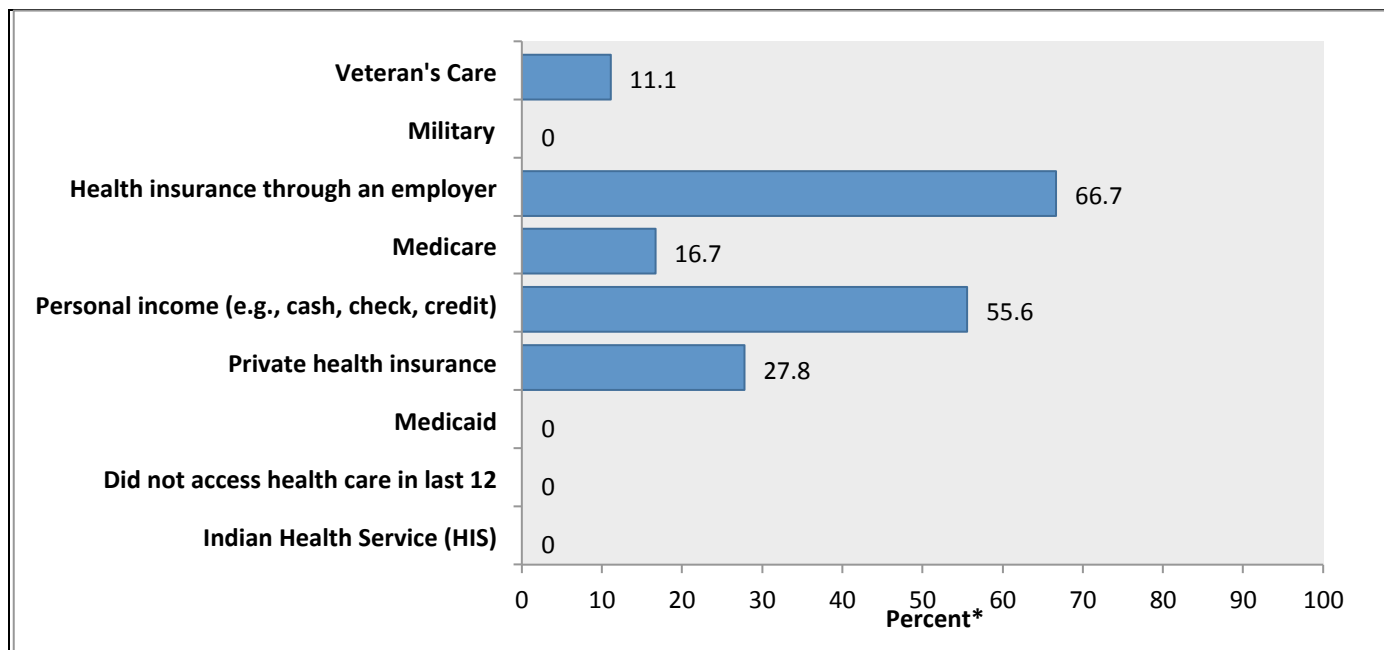
Figure 19. Reasons among respondents who have not had a cancer screening or cancer care in the past year.



Health Care Coverage

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

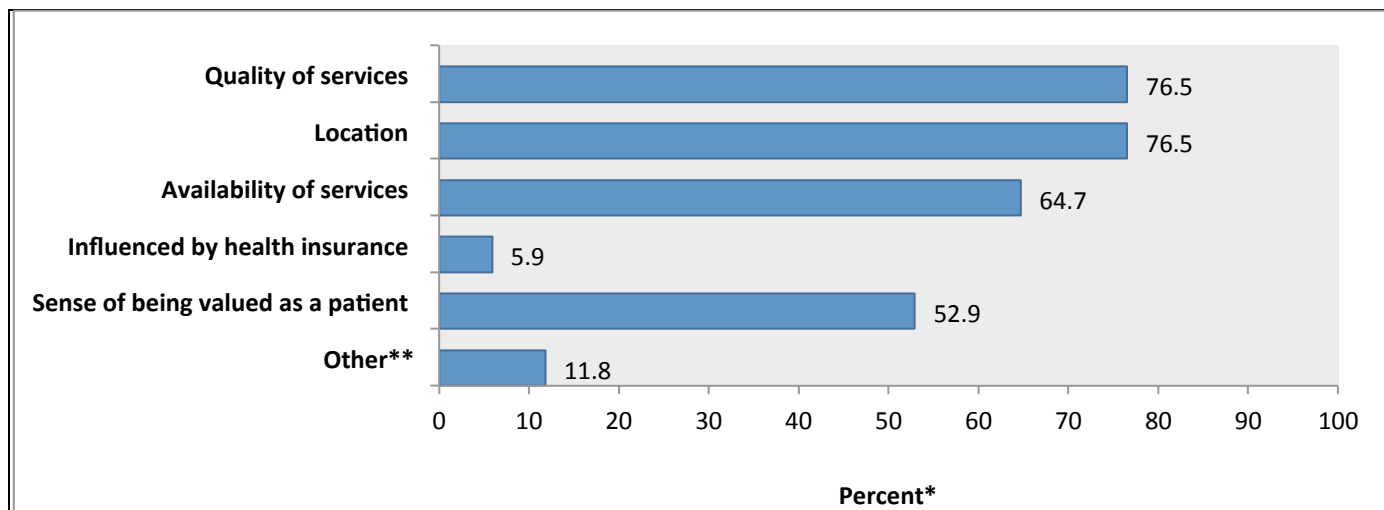
Figure 20. Methods respondents have used to pay for health care costs over the last 12 months



Primary Care Provider

The top three reasons respondents gave for their choice of primary health care provider were location, availability of services, and quality of services, (Figure 21)

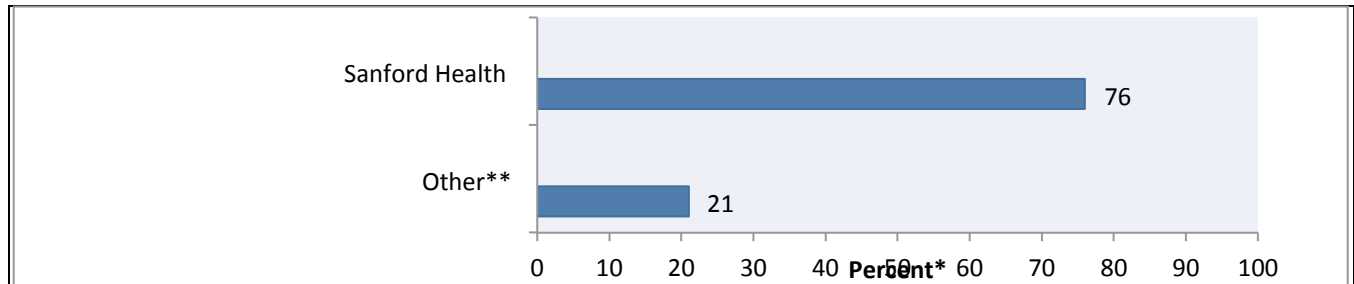
Figure 21. Respondents' reasons for choosing primary health care provider



Respondent's Primary Health Care Provider

Respondents were highly confident about access to emergency care in the community, coordination among providers, the number of health care staff in general, services for heart disease, the distance to a health care facility, and health services for those with diabetes. Respondents were the most concerned with mental health services and health services for obesity.

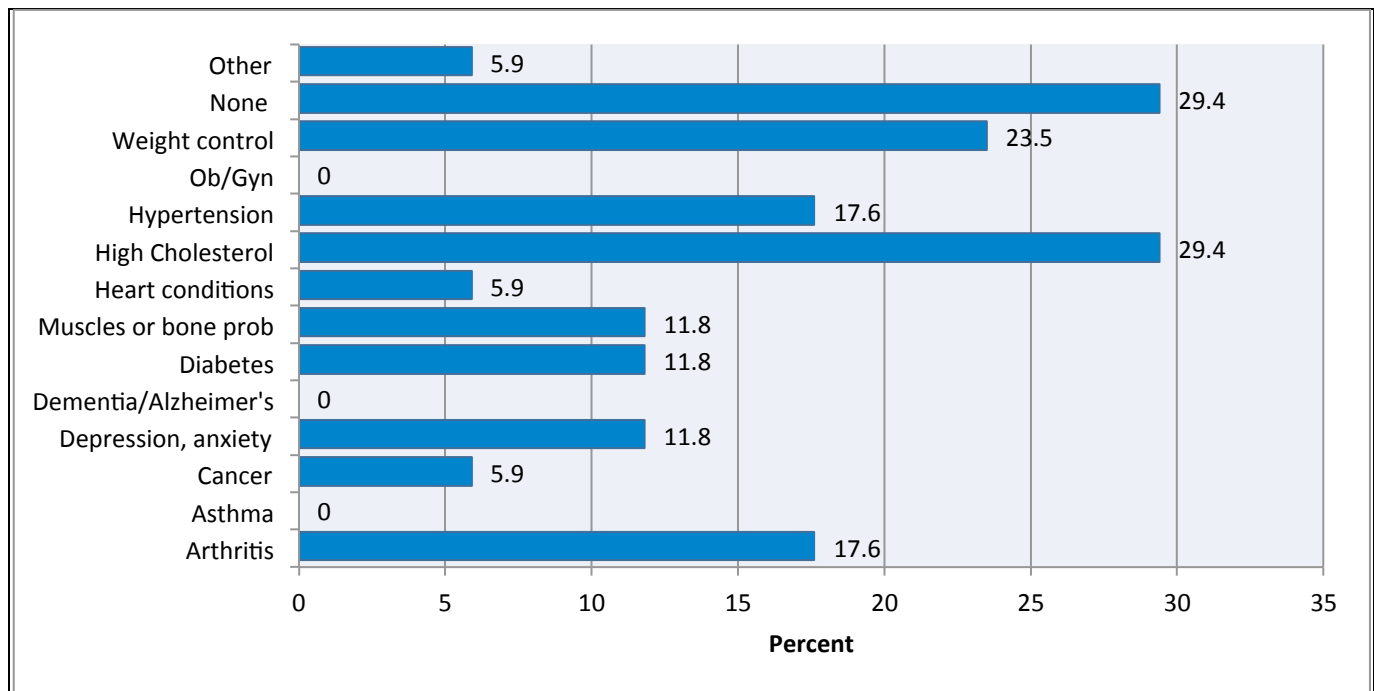
Figure 22. Respondent's primary health care provider



Respondents Representing Chronic Disease

Respondents were asked to select their personal general health conditions/diseases. The chronic diseases found among respondents include high cholesterol, hypertension, heart conditions, diabetes, arthritis and depression. (Figure 26)

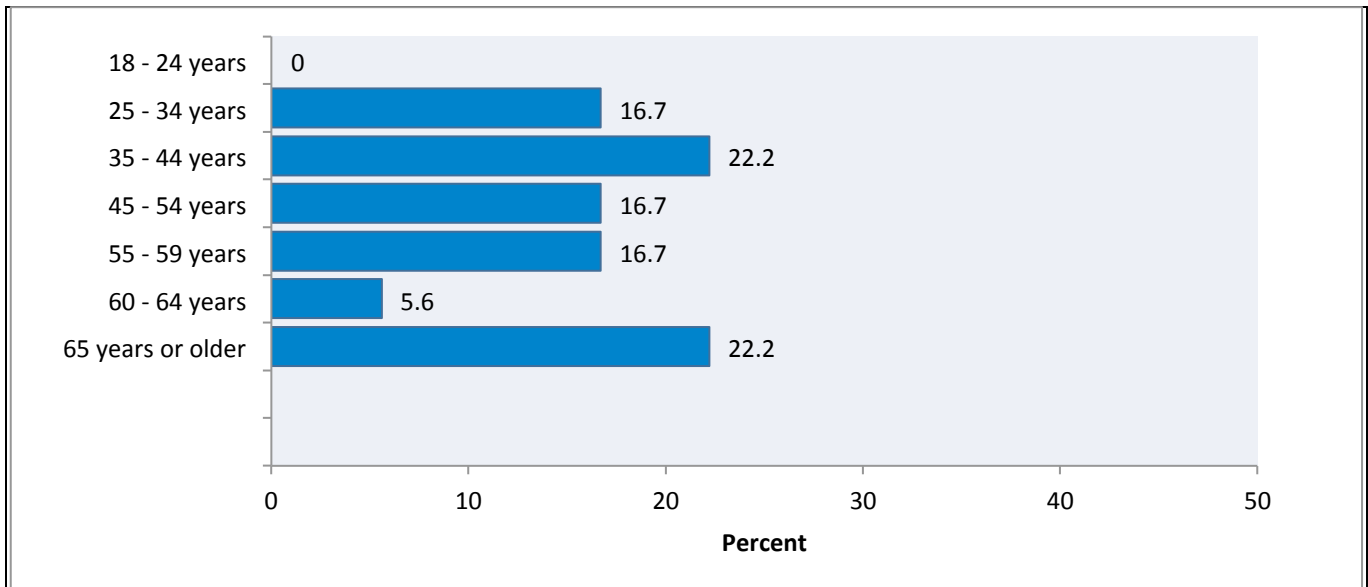
Figure 23. Respondent's health/chronic diseases



Demographic Information

The majority of respondents are 35 to 44 years old or are in the 65 years and older group.

Figure 24. Respondents' age distribution



Most respondents have a Bachelor's degree or higher, including 22% who have a graduate or professional degree.

Figure 25. Respondents' education

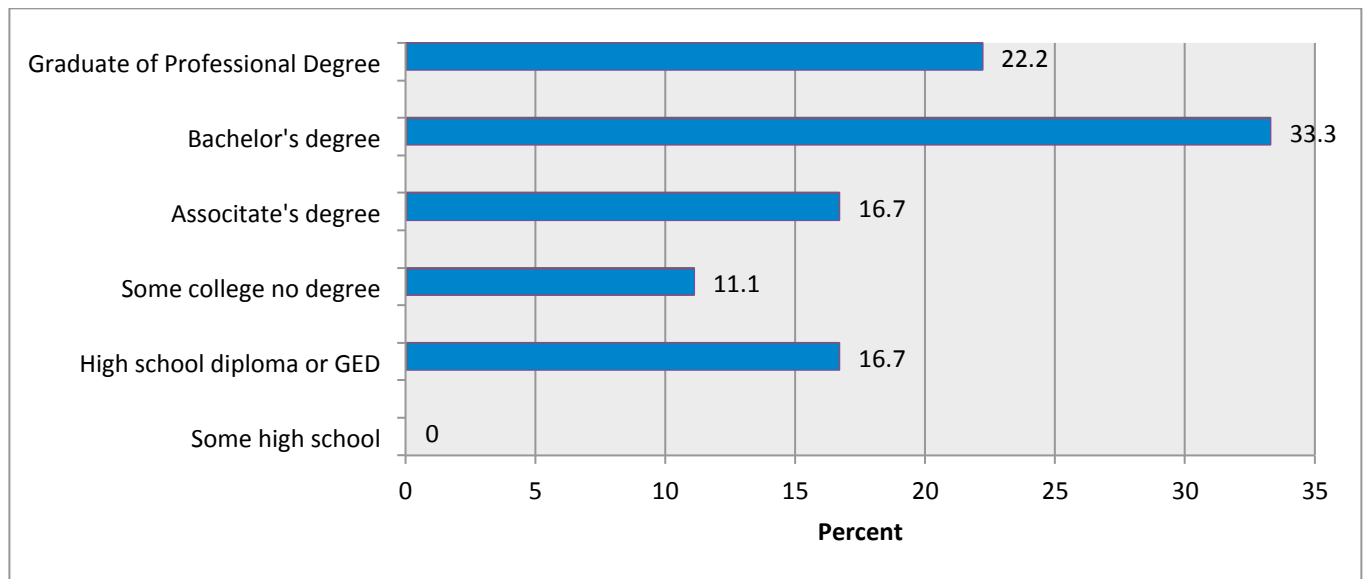
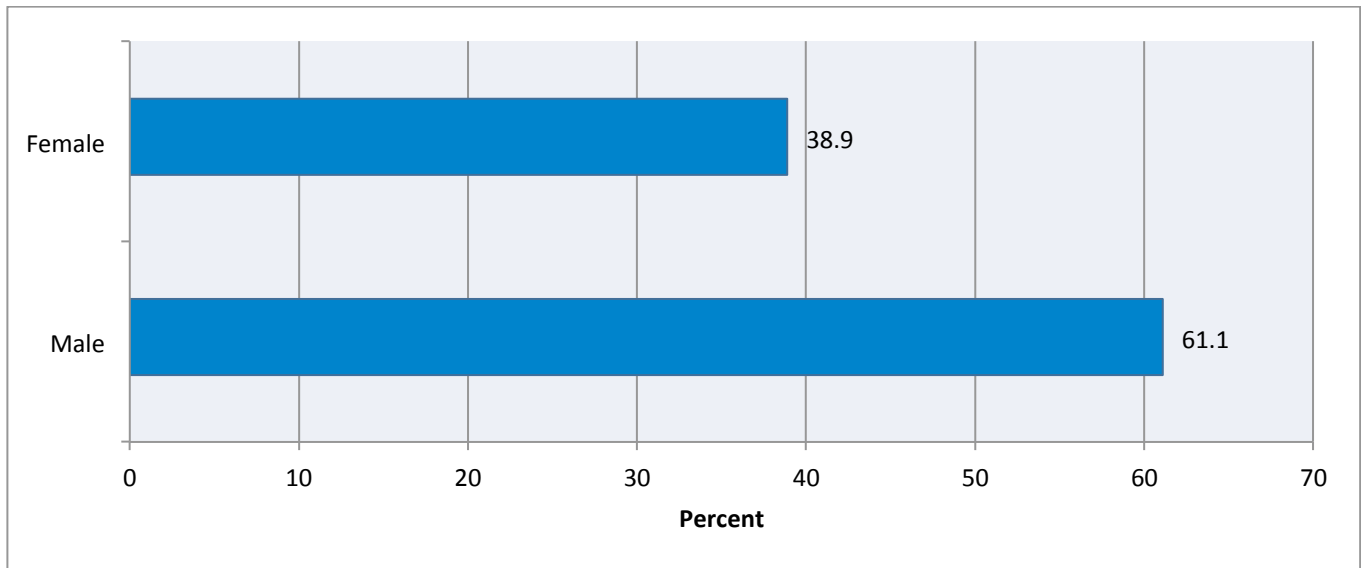


Figure 26. Respondents' gender distribution



Secondary Research

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

Health Outcomes

Mortality

The Mortality health outcomes indicate that the state of Minnesota and Clearwater County have fewer premature deaths than the national benchmark. Beltrami County, Minnesota has a much higher rate than the national benchmark.

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

		National Benchmark	MN	Beltrami County MN	Clearwater County MN
Premature death	Years of potential life lost before age 75 per 100,000 (age-adjusted), 2005-2007	5,564	5,272	8,741	5,016

Morbidity

The Morbidity health outcomes indicate that Minnesota and Beltrami County citizens report more days of poor health than the national benchmark; however, Clearwater County reports better health days. Minnesota, Beltrami County and Clearwater County report more physically unhealthy days than the national benchmark.

Minnesota, Beltrami County, and Clearwater County report more mentally unhealthy days than the national benchmark.

Minnesota has a higher percentage of low birth weight than the national benchmark; however Beltrami County has a lower percentage of low birth weight than the national benchmark. Clearwater County data was not available for birth weight.

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

		National Benchmark	MN	Beltrami County MN	Clearwater County MN
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	10%	11%	14%	8%
Poor physical health days	Average number of physical unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.6	3.1	2.9	1.8%
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.3	2.8	3.0	1.8
Low birth weight	Percent of live births with low birth weight (<2,500 grams), 2001-2007	6.0%	6.5%	5.7%	N/A

Health Factors

The Health Behaviors outcomes indicate that the state of Minnesota and Beltrami County have higher percentages of adult smokers than the national benchmark. Adult obesity is also higher in the state of Minnesota and in Beltrami and Clearwater counties. Beltrami County and the state of Minnesota have a lower percentage of physical inactivity than the national benchmark, while Clearwater County sits at the same level as the national benchmark.

Minnesota and Beltrami County have a substantially higher percentage (20% in MN and 22% in Beltrami County vs. the national rate at 8%) of binge drinking reports than the national benchmark. The state of Minnesota is near the national benchmark for motor vehicle deaths; however, Beltrami County has more than twice the national benchmark. There was no data available for Clearwater County regarding the motor vehicle crash death rate.

Sexually transmitted infections rank substantially higher than the national benchmark for Minnesota, Beltrami and Clearwater counties. The teen birth rate is also substantially higher in Minnesota, Beltrami County and Clearwater County than the national benchmark.

Health Behaviors

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

		National Benchmark	MN	Beltrami County MN	Clearwater County MN
Adult smoking	Percent of adults who currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	15%	19%	32%	N/A
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m ² , 2008	25%	26%	29%	28%
Physical inactivity	Percent of adults reporting no leisure physical activity, 2008	20%	17%	19%	20%
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%	22%	N/A
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	12.0	12.9	29.2	N/A
Sexually transmitted infections	Number of Chlamydia cases (new cases reported) per 100,000 population 2008	83.0	276.1	344.5	157.6
Teen birth rate	Number of teen births per 100,000 females ages 15-19, 2001-2007	22.0	27.5	51.0	46.1

Clinical Care

The Clinical Care outcomes indicate that Minnesota and Beltrami County have a lower percentage of uninsured adults while Clearwater has a slightly higher percentage. The percentage of uninsured youth is the same in Beltrami County as the national benchmark, but is higher in Clearwater County and lower in Minnesota as a whole.

The ratio of population to primary care physicians is near the same in Minnesota as the national benchmark. The ratio in Beltrami and Clearwater counties is substantially higher than the national benchmark. The ratio of population to mental health providers is much more favorable in Minnesota and in Beltrami County than the national benchmark; however, it is significantly less favorable in Clearwater County. The number of professionally active dentists is lower than the national benchmark in Minnesota and Beltrami County. There is no data available for Clearwater County. Preventable hospital stays are higher than the national benchmark in Minnesota, Beltrami and Clearwater counties.

Diabetes screening in Minnesota is slightly lower than the national benchmark and is significantly lower than the national benchmark in Beltrami and Clearwater counties. Clearwater County ranks higher than the national benchmark for mammography screenings, while Minnesota is slightly under the national benchmark and Beltrami County is significantly lower.

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

		National Benchmark	MN	Beltrami County MN	Clearwater County MN
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	13%	11%	12%	15%
Uninsured youth	Percent of youth ages 0-18 without health insurance.	7%	6%	7%	12%
Primary Care Physicians	Ratio of population to primary care physicians, 2008	631:1	636:1	742:1	1,178:1
Mental Health Providers	Ratio of total population to mental health providers, 2008	2,242:1	1,306:1	1,824:1	8,246:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	69.0	61.0	54.8	N/A
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	52.0	56.5	67.3	95.2
Diabetes screening	Percent of Medicare enrollees with diabetes that receive HbA1c screening, 2006-2007	89%	88%	71%	82%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	74%	73%	66%	76%

Social and Economic Factors

The Social and Economic Factors outcomes indicate that Minnesota and Beltrami and Clearwater counties all have a lower high school graduation benchmark than the national benchmark; however, Minnesota has a higher percentage of post-secondary education than the national benchmark. The unemployment rate was substantially higher in Minnesota than the national benchmark, and Beltrami and Clearwater counties have a much greater unemployment benchmark than the national benchmark. The unemployment rate in 2012 was substantially better than the national benchmark for Minnesota and Beltrami County; however, Clearwater County has a much greater amount of unemployment. The percentage of child poverty is much greater in Beltrami and Clearwater counties than the national benchmark; however, Minnesota is at the national benchmark.

Inadequate social support in the same in Minnesota as the national benchmark, and is only slightly higher in Beltrami County.

The percentage of children in single parent households is higher than the national benchmark in Minnesota, Beltrami and Clearwater counties.

The number of homicide deaths in Minnesota is higher than the national benchmark, and much higher in Beltrami County than the state and national benchmark.

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

		National Benchmark	MN	Beltrami County	Clearwater County
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years 2006-2007	92%	87%	70%	70%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	68%	72%	65%	57%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work 2009 November of 2012	5.3% 7.9%	8.0% 5.2%	8.9% 6.5%	15.1% 9.2%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	11%	11%	25%	23%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	14%	14%	15%	N/A
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%	41%	33%
Homicide rates	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	1.0	2.5	8.8	NA

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. In this rural area there can be a far distance to travel to grocery stores, and there are food deserts in some communities where only a gas station convenience store is close to home. Access to recreational facilities ranks lower than the national benchmark for Minnesota, Beltrami and Clearwater counties.

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

		National Benchmark	MN	Beltrami County MN	Clearwater County 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%	29%	33%
Access to recreational facilities	Number of recreational facilities per 100,000 population 2008	17.0	12.0	9.0	11.0

Youth account for 25% of the population in Beltrami County and 24% of the population in Clearwater County. Elderly account for 13% of the population in Beltrami County and for 19% of the population in Clearwater County.

Sixty-nine percent (69%) of Beltrami County is rural compared to 29% of Minnesota and 21% as the national benchmark. Clearwater County is 100% rural compared to 29% of Minnesota.

Only 4% of Minnesotans and 1% of the Beltrami and Clearwater County population is not proficient in English compared to the national benchmark, which is 9%. The illiteracy rate in Minnesota and Beltrami County is at 6% and Clearwater County is at 8%, compared to the national benchmark of 15%.

Demographics

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

		National Benchmark	MN	Beltrami County MN	Clearwater County MN
Youth	Percent of total population ages 0-17, 2009	24%	24%	25%	24%
Elderly	Percent of total population ages 65 and older, 2009	13%	13%	13%	19%
Rural	Percent of total population living in rural area, 2000	21%	29%	69%	100%
Not English Proficient	Percent of total population that speaks English less than “very well”. 2005-2009	9%	4%	1%	1%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	15%	6%	6%	8%

The population for this area is relatively young with only 2-3% older than 85 years of age and only 13-19 % older than 65 years of age.

The gender distribution is 50-50 in the area.

Population by Age

	National Benchmark	Beltrami County MN	Clearwater County MN
Total population	308,745,538	44,442	8,695
Percent ages 65 and older	13%	13%	19%
Percent 85 and older	2%	2%	3%
Percent male	49%	50%	50%
Percent female	51%	50%	50%

Based on 2010 Census data

Housing

The majority of individuals in this region own their homes with the largest percentage of home ownership in Clearwater County (80%).

	National Benchmark	Beltrami County MN	Clearwater County MN
Percent of occupied housing that is owner-occupied	65%	70%	80%
Percent of occupied housing that is renter-occupied	35%	30%	20%

Based on 2010 Census data

Economic Security

According to the 2010 Census Data, the population of working age in the labor force ranges from 64-66% in Beltrami and Clearwater counties. The percentage of those who are living at less than 100% of the poverty level ranges from 16-20%, and 41-42% are at less than the 200% of the poverty level.

The median household is lower than the national benchmark for both counties.

	National Benchmark	Beltrami County MN	Clearwater County MN
Percent of working age population in the labor force	65%	66%	64%
Percent of total population with income less than 100% of poverty	14%	20%	16%
Percent of total population with income less than 200% of poverty	32%	41%	42%
Median household income	\$51,914	\$43,384	\$39,310
Owner occupied housing units	76,089,650	12,175	2,871
Percent spending 30% or more income toward housing costs	30%	27%	28%
Renter occupied housing units	38,146,346	4,584	827
Percent renters spending 30% or more of income toward housing costs	47%	43%	41%

Diversity Profile

The population distribution from the 2010 U.S. Census Summary by race demonstrates that Minnesota is predominantly white followed by black alone. In Beltrami County the second leading group is the American Indian population followed by the Hispanic origin of any race.

Clearwater County, Minnesota is also mostly white. The second largest group is the American Indian and the Hispanic origin is the third leading population.

	Minnesota State Benchmark	Beltrami County MN	Clearwater County MN
Total population	5,303,925	44,442	8,695
White alone	4,524,062	33,359	7,579
Asian alone	214,234	309	21
Black alone	274,412	262	30
Hispanic origin – of any race	250,258	676	120
American Indian	60,916	9,004	782

Health Needs Identified

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

- Obesity
- Youth

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 4 in the Appendix displays the concerns and assessed needs that were determined by the assessment and includes the assets in the community that address the needs.

The priorities that remain include:

- Obesity specific to poor nutrition, inactivity and chronic disease and care coordination for these services
- Services for youth

Sanford Bagley will specifically address obesity and mental health and execute the implementation strategy.

Table 5 in the Appendix displays the unmet needs that were determined after the asset mapping exercise and the prioritized list of remaining needs.

IMPLEMENTATION STRATEGY

2013 Community Health Needs Assessment Sanford Bagley Implementation Strategy

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

- Obesity

Implementation Strategy: Obesity

- Participate and help develop a comprehensive weight management program within the Bagley and Bemidji regions using an interdisciplinary team inclusive of medical, nutrition, Behavioral Health and fitness professionals, as well as helping our appropriate patients gain access to weight loss surgery services.
- Continue promoting and increasing community members in the involvement of our Silver Sneakers program to promote and incentivize Medicare-eligible customers.
- Implement Sanford Frontiers weight management program within the Bagley Region.
- Actively participate with community wellness, fitness and healthy living entities to promote and support fitness and active living by sponsoring walking, screening and educational programs.

Implementation Strategy: Youth

- Discuss the need for youth services with community leaders.

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

Beltrami County

Minnesota

HEALTH OUTCOMES		Beltrami	*National Benchmark	Minnesota
<i>Mortality</i>				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	8,741	5,564	5,272
<i>Morbidity</i>				
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	14%	10%	11%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.9	2.6	3.1
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	3.0	2.3	2.8
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	5.7%	6.0%	6.5%
HEALTH FACTORS				
<i>Health Behaviors</i>				
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	32%	15%	19%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m ² , 2008	29%	25%	26%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	19%	20%	17%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking**, 2003-2009	22%	8%	20%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	29.2	12.0	12.9
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	344.5	83.0	276.1
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	51.0	22.0	27.5
<i>Clinical Care</i>				
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	12%	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	742:1	631:1	636:1
Mental health providers	Ratio of total population to mental health providers, 2008	1,824:1	2,242:1	1,306:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	54.8	69.0	61.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	67.3	52.0	56.5
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	71%	89%	88%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	66%	74%	73%

HEALTH FACTORS (continued)		Beltrami	*National Benchmark	Minnesota
<i>Social and Economic Factors</i>				
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007	70%	92%	87%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	65%	68%	72%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	8.9%	5.3%	8.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	25%	11%	11%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	15%	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	41%	20%	25%
Homicide rate	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	8.8	1.0	2.5

<i>Physical Environment</i>				
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	44%	92%	54%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	11.0	17.0	12.0

<i>Demographics</i>		Beltrami	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	13%	13%	13%
Rural	Percent of total population living in a rural area, 2000	69%	21%	29%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	1%	9%	4%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	6%	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>.

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2011 County Health Profile

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

Clearwater County

Minnesota

HEALTH OUTCOMES		Clearwater	*National Benchmark	Minnesota
<i>Mortality</i>				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	5,016	5,564	5,272
<i>Morbidity</i>				
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	8%	10%	11%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	1.8	2.6	3.1
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.9	2.3	2.8
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	-	6.0%	6.5%
HEALTH FACTORS				
<i>Health Behaviors</i>				
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/m ² , 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	-	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	157.6	83.0	276.1
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	46.1	22.0	27.5
<i>Clinical Care</i>				
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	15%	13%	11%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	12%	7%	6%
Primary care physicians	Ratio of total population to primary care physicians, 2008	1,178:1	631:1	636:1
Mental health providers	Ratio of total population to mental health providers, 2008	8,246:1	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	95.2	52.0	56.5
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	82%	89%	88%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	76%	74%	73%

HEALTH FACTORS (continued) *National
Clearwater 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	70%	92%	87%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	57%	68%	72%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	15.1%	5.3%	8.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	23%	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	33%	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	60%	92%	54%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	0.0	17.0	12.0

Demographics

		Clearwater	United States	Minnesota
Youth	Percent of total population ages 0-17, 2009	24%	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	100%	21%	29%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	1%	9%	4%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	8%	15%	6%

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

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

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Definitions of Health Variables

Definitions of Health Variables from the <i>County Health Rankings 2011 Report</i> 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

Beltrami County

Minnesota

AGE

CHARACTERISTICS

	Total	Less than 65 Years	Ages 65 and Older
<i>Population</i> ¹			
Total population	44,442	38,688	5,754
Percent ages 65 and older	13%	-	100%
Percent ages 85 and older	2%	-	16%
Percent male	50%	51%	45%
Percent female	50%	49%	55%
<i>Living Arrangements</i>			
Total households (by age of householder) ¹	16,846	13,013	3,833
Percent with family households (i.e., at least two people who are related)	64%	67%	52%
Percent with householder living alone	28%	23%	46%
Grandparents living with their grandchildren * ²	725	555	170
Percent who are responsible for their grandchildren	66%	68%	58%
<i>Housing</i> ¹			
Percent of occupied housing that is owner-occupied	70%	69%	75%
Percent of occupied housing that is renter-occupied	30%	31%	25%
<i>Economic Security</i> ²			
Percent of working-age population in labor force	66%	76%	14%
Percent of total population with income less than 100% of poverty	20%	22%	9%
Percent of total population with income less than 200% of poverty	41%	42%	38%
Median household income (by age of householder)	\$43,394	\$41,641	\$29,498
Owner-occupied housing units (by age of householder)	12,175	9,358	2,817
Percent spending 30% or more of income toward housing costs	27%	28%	25%
Renter-occupied housing units (by age of householder)	4,584	3,762	822
Percent spending 30% or more of income toward housing costs	44%	46%	34%

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

Source: U.S. Census Bureau, ¹2010 Census Summary File 1 and ²2006-2010 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.

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Aging Profile

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

Clearwater County

Minnesota

CHARACTERISTICS	AGE		
	Total	Less than 65 Years	Ages 65 and Older
<i>Population</i> ¹			
Total population	8,695	7,074	1,621
Percent ages 65 and older	19%	-	100%
Percent ages 85 and older	3%	-	15%
Percent male	50%	51%	46%
Percent female	50%	49%	54%
<i>Living Arrangements</i>			
Total households (by age of householder) ¹	3,527	2,471	1,056
Percent with family households (i.e., at least two people who are related)	67%	73%	54%
Percent with householder living alone	29%	22%	44%
Grandparents living with their grandchildren * ²	71	34	37
Percent who are responsible for their grandchildren	59%	56%	62%
<i>Housing</i> ¹			
Percent of occupied housing that is owner-occupied	80%	82%	76%
Percent of occupied housing that is renter-occupied	20%	18%	24%
<i>Economic Security</i> ²			
Percent of working-age population in labor force	64%	79%	14%
Percent of total population with income less than 100% of poverty	16%	16%	14%
Percent of total population with income less than 200% of poverty	42%	41%	48%
Median household income (by age of householder)	\$39,310	\$39,730	\$22,703
Owner-occupied housing units (by age of householder)	2,871	2,154	717
Percent spending 30% or more of income toward housing costs	28%	29%	24%
Renter-occupied housing units (by age of householder)	827	607	220
Percent spending 30% or more of income toward housing costs	41%	43%	37%

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

Source: U.S. Census Bureau, ¹2010 Census Summary File 1 and ²2006-2010 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.

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Diversity Profile

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

Beltrami County

Minnesota

CHARACTERISTICS	Total	RACE				ETHNICITY
		White alone	Black alone	American Indian alone	Asian alone	Hispanic Origin - of any race
<i>Population</i> ¹						
Total population	44,442	33,359	262	9,004	309	676
Percent ages 0 to 17	25%	20%	34%	38%	20%	49%
Percent ages 18 to 44	37%	37%	53%	37%	66%	39%
Percent ages 45 to 64	25%	28%	10%	19%	12%	10%
Percent ages 65 and older	13%	15%	3%	6%	2%	2%
Median age (in years)	33.2	38.3	22.3	23.9	23.8	18.3
<i>Living Arrangements</i>						
Total households ¹	16,846	13,722	70	2,643	73	146
Percent with householder living alone	28%	29%	37%	24%	22%	17%
Percent with families with children ages 0 to 17	28%	25%	36%	38%	26%	51%
Grandparents living with their grandchildren ²	725	202	4	498	0	0
Percent who are responsible for grandchildren	66%	51%	100%	71%	-	-
<i>Housing</i> ¹						
Percent occupied housing that is owner-occupied	70%	74%	29%	56%	44%	43%
Percent occupied housing that is renter-occupied	30%	26%	71%	44%	56%	57%
<i>Educational Attainment</i> ²						
Percent of persons ages 25 and older with high school degree or higher	89%	91%	100%	76%	97%	90%
Percent of persons ages 25 and older with Bachelor's degree or higher	29%	32%	2%	11%	51%	23%
<i>Economic Security</i> ²						
Unemployment rate	9%	7%	2%	19%	7%	18%
Median household income	\$43,394	\$47,526	\$36,103	\$25,373	\$43,990	\$45,096
Percent of households with income <\$25,000	31%	27%	23%	49%	21%	37%
Percent of persons with income <100% poverty	20%	12%	26%	50%	15%	29%
Percent of children ages 0 to 17 in families with income <100% poverty	28%	13%	27%	59%	19%	30%
Percent of elderly ages 65 and older with income <100% poverty	10%	9%	-	31%	50%	0%

Source: U.S. Census Bureau, ¹2010 Census Summary File 1 and ²2006-2010 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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Diversity Profile

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

Clearwater County

Minnesota

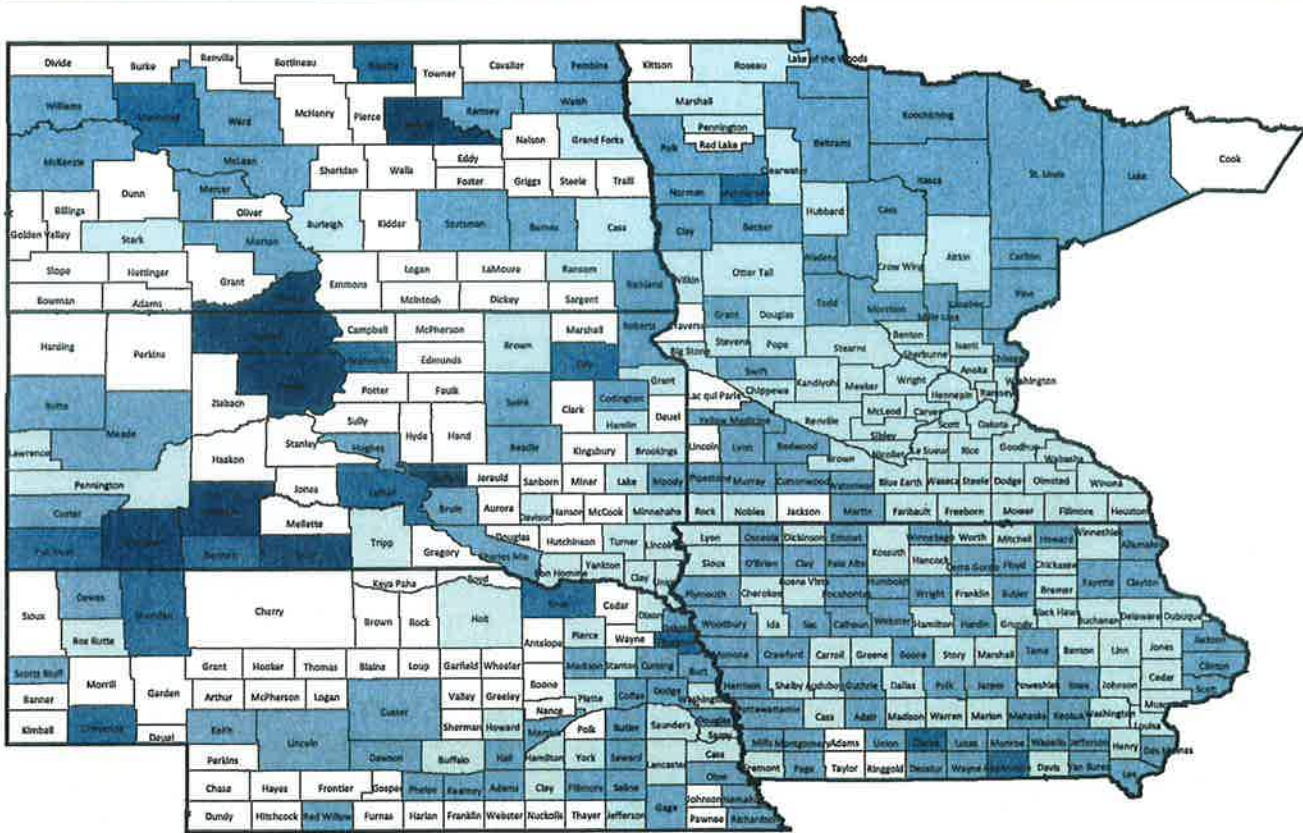
CHARACTERISTICS	Total	RACE				ETHNICITY
		White alone	Black alone	American Indian alone	Asian alone	Hispanic Origin - of any race
<i>Population</i> ¹						
Total population	8,695	7,579	30	782	21	120
Percent ages 0 to 17	25%	22%	70%	37%	57%	61%
Percent ages 18 to 44	28%	28%	23%	30%	38%	23%
Percent ages 45 to 64	28%	29%	0%	25%	5%	13%
Percent ages 65 and older	19%	20%	7%	8%	0%	3%
Median age (in years)	41.9	44.5	15.0	29.7	16.5	14.6
<i>Living Arrangements</i>						
Total households ¹	3,527	3,208	5	247	3	16
Percent with householder living alone	29%	29%	0%	27%	0%	13%
Percent with families with children ages 0 to 17	27%	26%	80%	40%	67%	38%
Grandparents living with their grandchildren ²	71	40	0	31	0	0
Percent who are responsible for grandchildren	59%	50%	-	71%	-	-
<i>Housing</i> ¹						
Percent occupied housing that is owner-occupied	80%	82%	20%	57%	33%	75%
Percent occupied housing that is renter-occupied	20%	18%	80%	43%	67%	25%
<i>Educational Attainment</i> ²						
Percent of persons ages 25 and older with high school degree or higher	84%	85%	100%	70%	60%	77%
Percent of persons ages 25 and older with Bachelor's degree or higher	15%	16%	9%	1%	0%	27%
<i>Economic Security</i> ²						
Unemployment rate	11%	10%	13%	29%	41%	0%
Median household income	\$39,310	\$42,118	\$35,268	\$23,583	\$71,042	\$23,250
Percent of households with income <\$25,000	31%	29%	46%	53%	33%	100%
Percent of persons with income <100% poverty	16%	13%	51%	38%	0%	0%
Percent of children ages 0 to 17 in families with income <100% poverty	21%	19%	0%	36%	0%	0%
Percent of elderly ages 65 and older with income <100% poverty	15%	14%	-	28%	0%	0%

Source: U.S. Census Bureau, ¹2010 Census Summary File 1 and ²2006-2010 American Community Survey (ACS) 5-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across race and ethnic categories; however, because they are based on sample data, one should use caution when interpreting small numbers. - Blank values reflect data that are missing or not applicable. Racial categories not represented include Native Hawaiian and Other Pacific Islander alone, Some Other Race alone, and Two or More races.

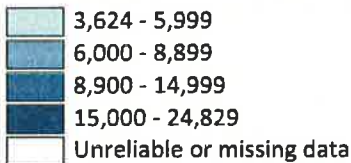
Disclaimer: The data displayed are from the source indicated; we do not vouch for the accuracy of the data or ensure they are the most recent available. The information is intended for personal, non-commercial use. It can be shared freely if it is not used for profit and appropriate acknowledgments are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

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



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.

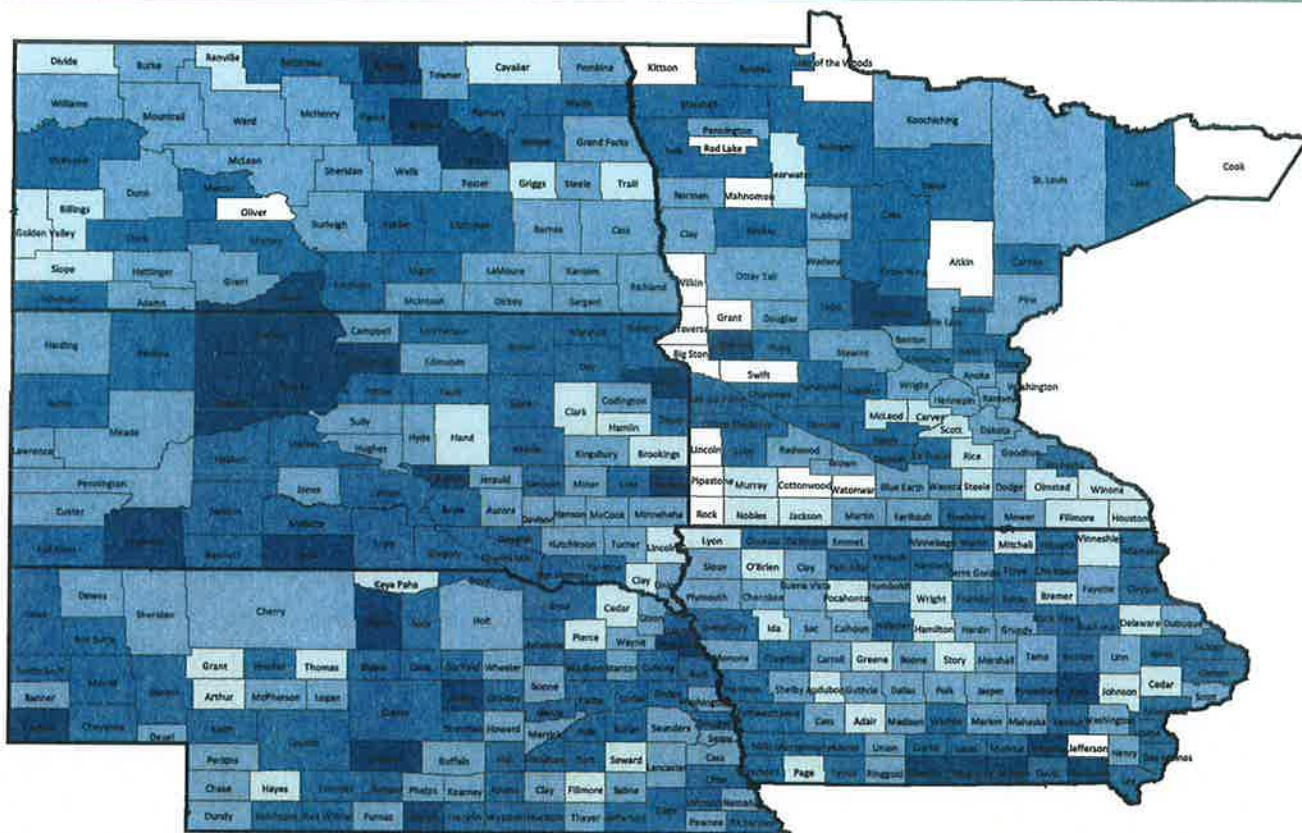
Importance: Age-adjusted YPLL-75 rates are commonly used to represent the frequency and distribution of premature deaths. Measuring YPLL allows communities to target resources to high-risk areas and further investigate the causes of death.

- 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/>.

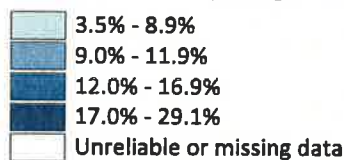
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Poor or Fair Health - A health outcome measure focusing on morbidity

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



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



CONTEXT

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

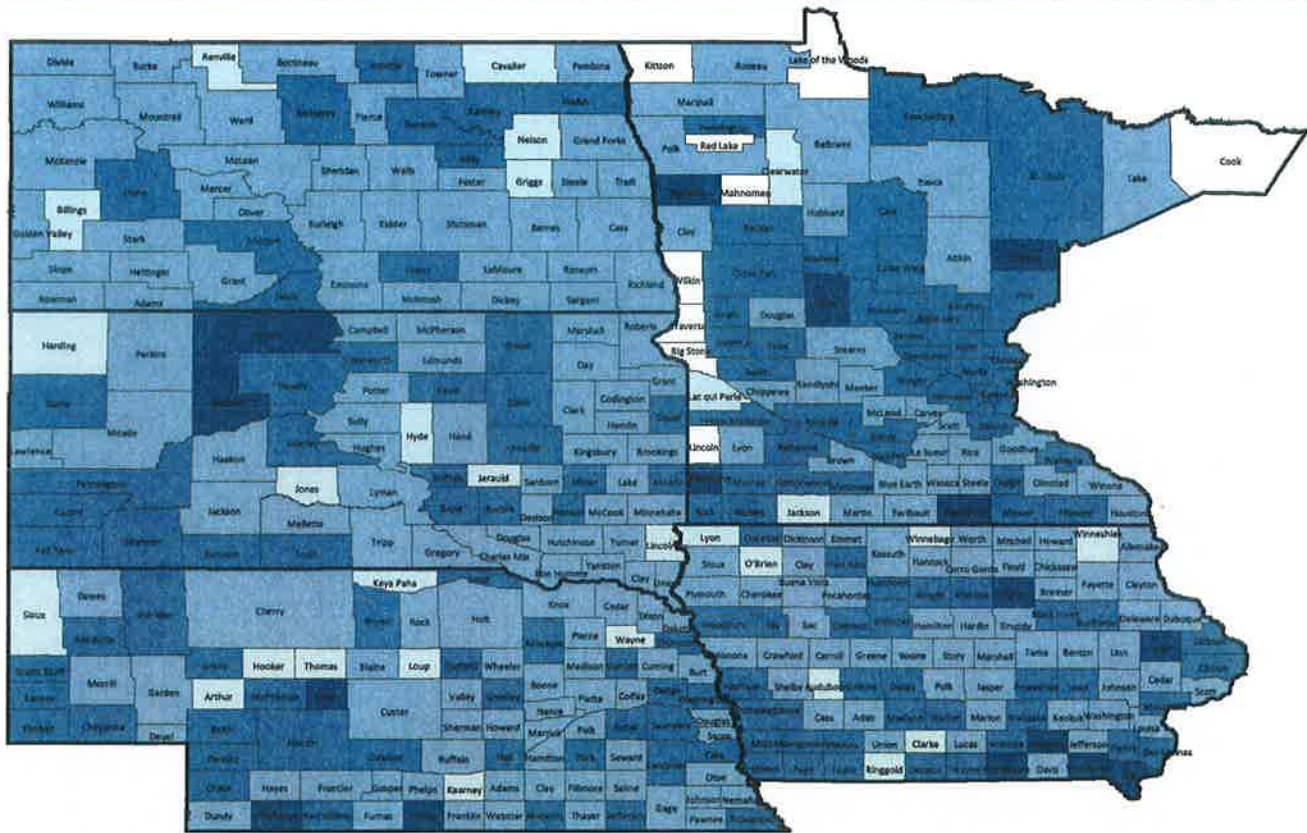
Where It Comes From: This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized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

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

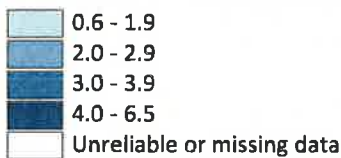
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

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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



CONTEXT

What It Is: The poor physical health days measure is based on responses to the question: “Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?” Presented is the average number of days a county’s adult respondents report that their physical health was not good. The measure is age-adjusted to the 2000 U.S. population.

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

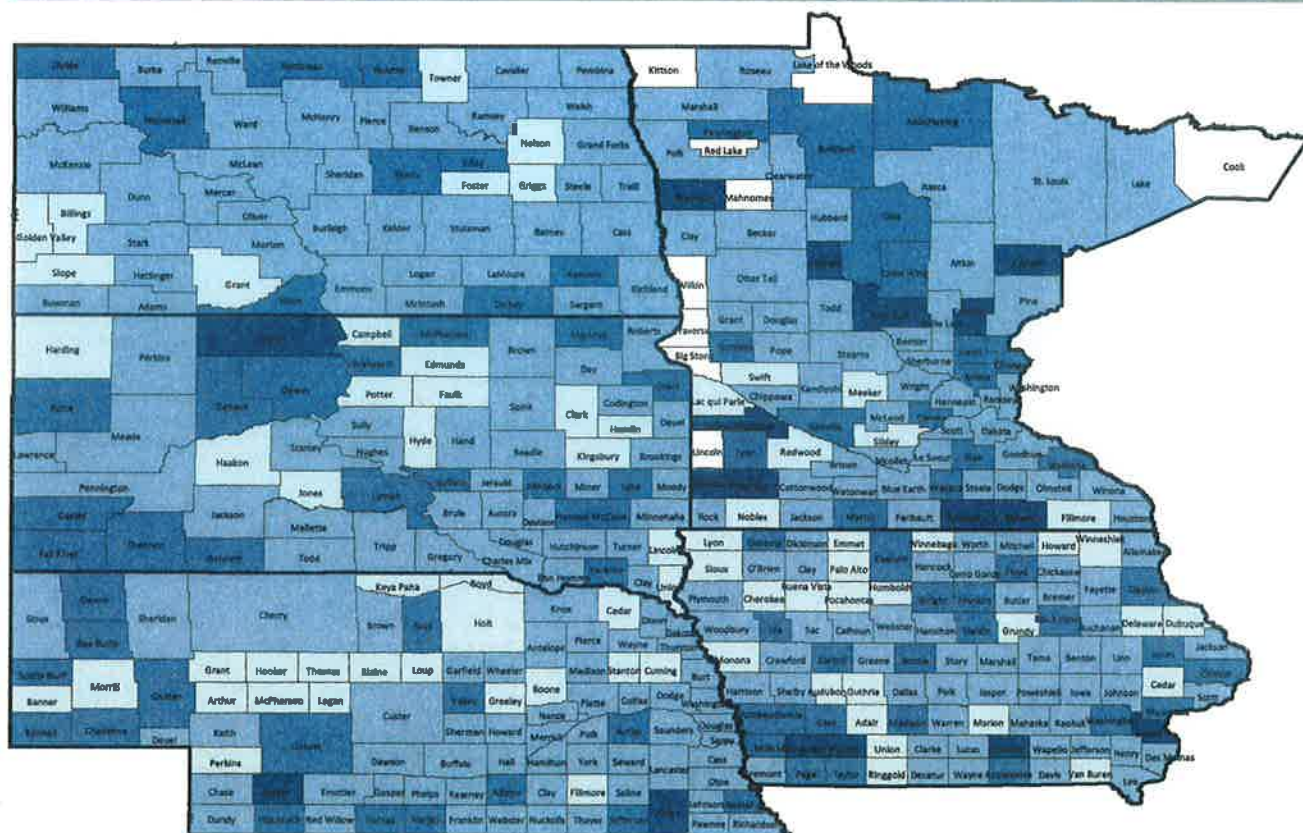
Importance: In addition to measuring how long people live, it is also important to include measures of how healthy people are while alive – people’s reports of days when their physical health was not good are a reliable estimate of their recent health.

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

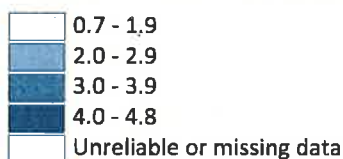
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Poor Mental Health Days - A health outcome measure focusing on morbidity

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



CONTEXT

What It Is: The poor mental health days measure is based on responses to the question: “Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?” Presented is the average number of days a county’s adult respondents report that their mental health was not good. The measure is age-adjusted to the 2000 U.S. population.

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

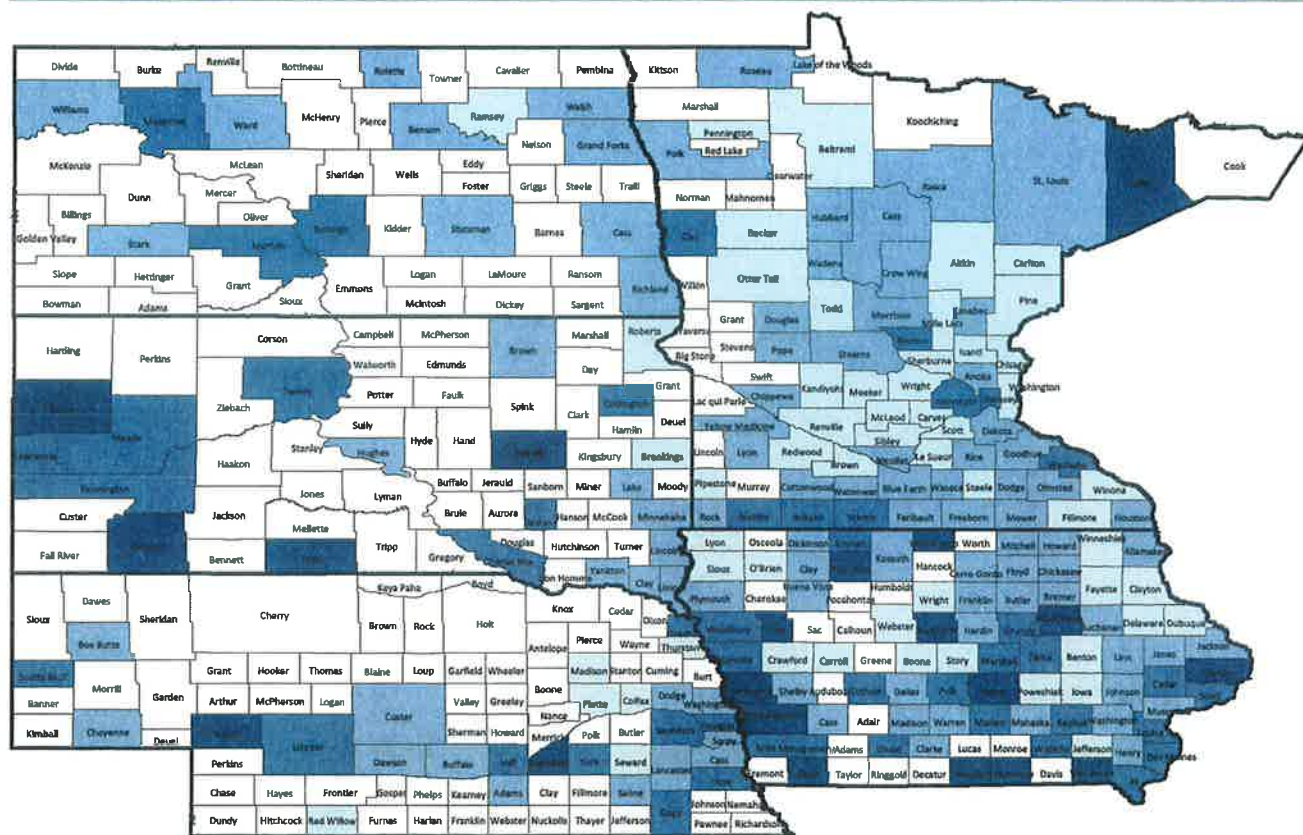
Importance: Overall health depends on both physical and mental well-being. Measuring the number of days when people report that their mental health was not good, i.e., poor mental health days, represent an important facet of health-related quality of life. The County Health Rankings considers health-related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

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

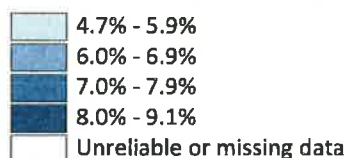
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Low Birthweight - A health outcome measure focusing on morbidity

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



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



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 of 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.

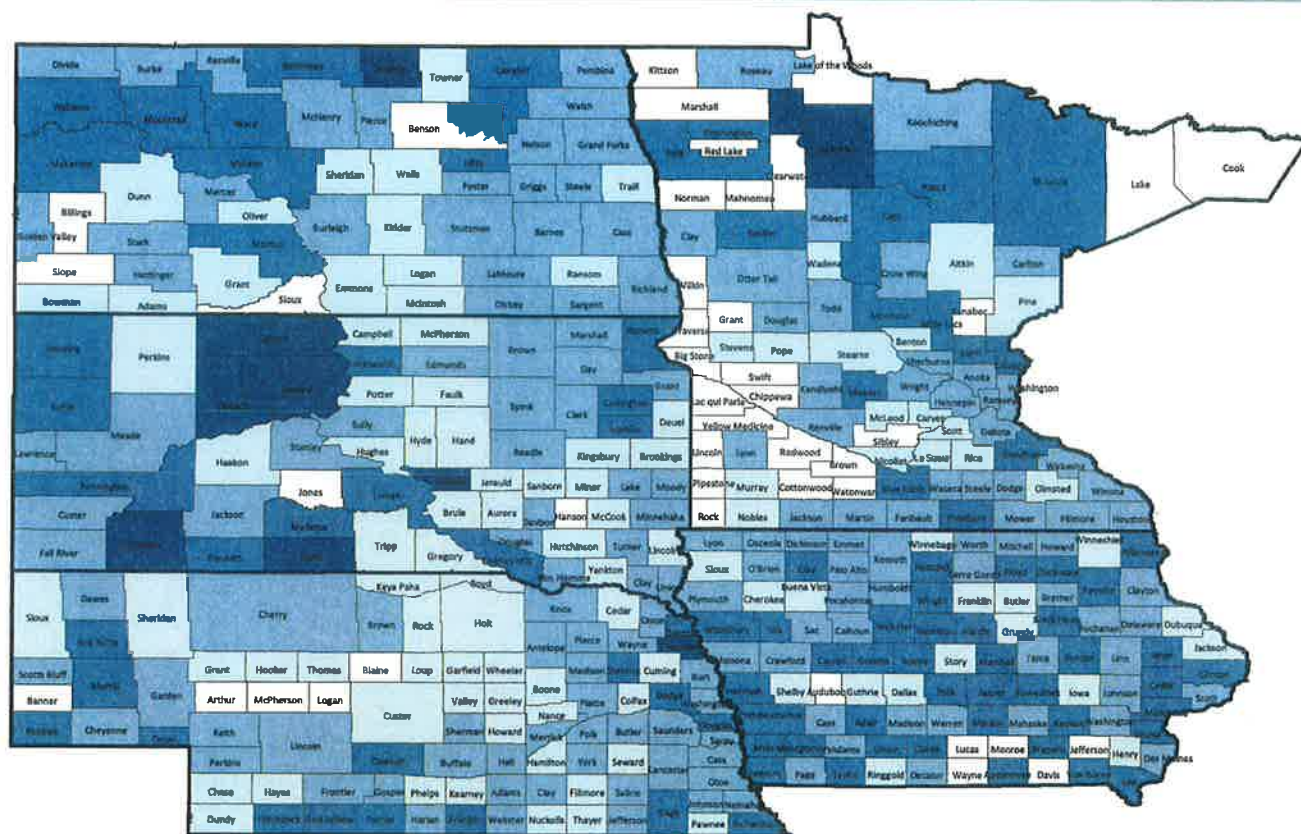
Importance: Low birthweight represents two factors: maternal exposure to health risks and an infant’s current and future morbidity, as well as premature mortality risk. The health consequences of low birthweight are numerous.

- 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



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.

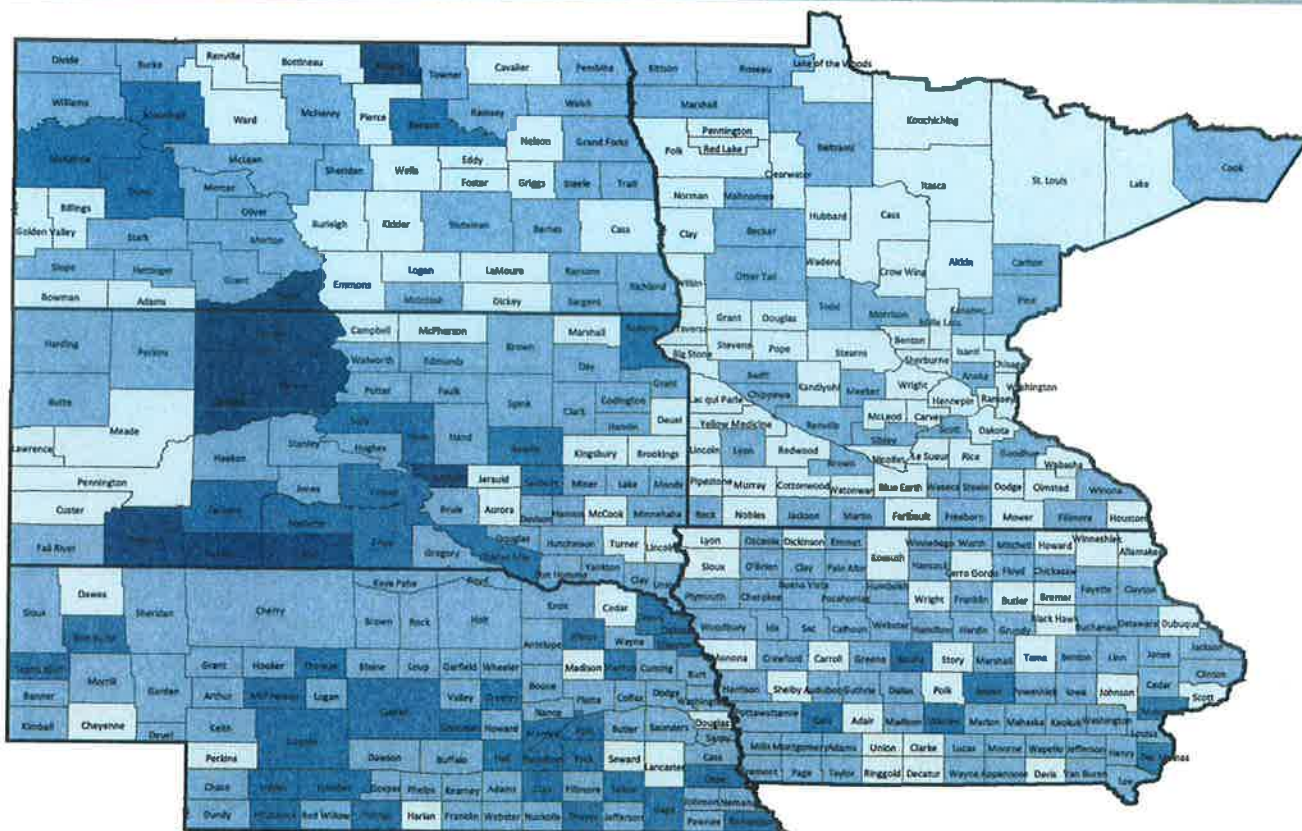
Importance: Each year approximately 443,000 premature deaths occur in the U.S. primarily due to smoking. Cigarette smoking is identified as a cause in multiple diseases including various cancers, cardiovascular disease, respiratory conditions, low birthweight, and other adverse health outcomes. Measuring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

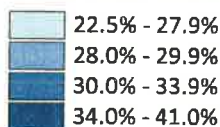
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Adult Obesity - A health factor measure focusing on health behaviors

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



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.

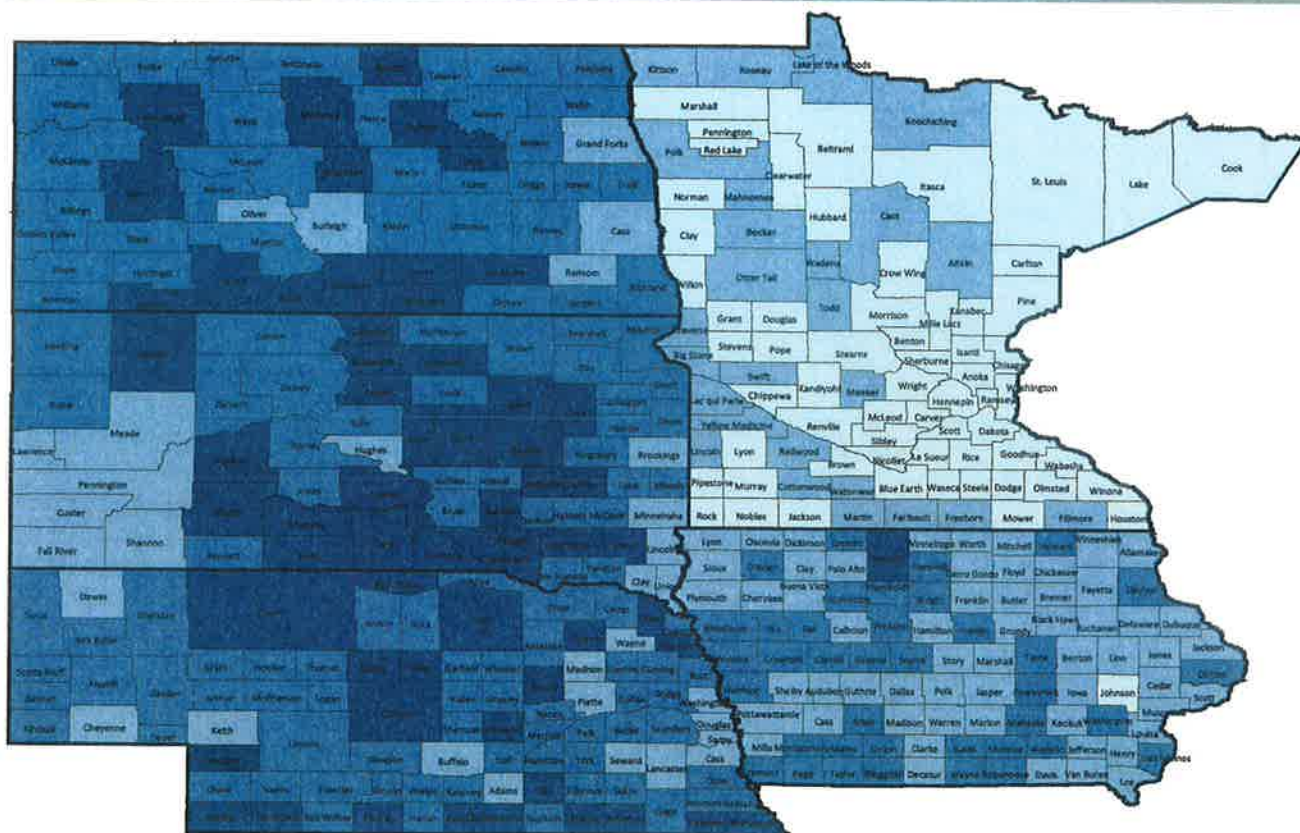
Importance: Obesity is often the end result of an overall energy imbalance due to poor diet and limited physical activity. Obesity increases the risk for health conditions such as coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep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

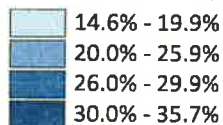
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Physical Inactivity - A health factor measure focusing on health behaviors

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



Percent of adults reporting no leisure time physical activity, 2008



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.

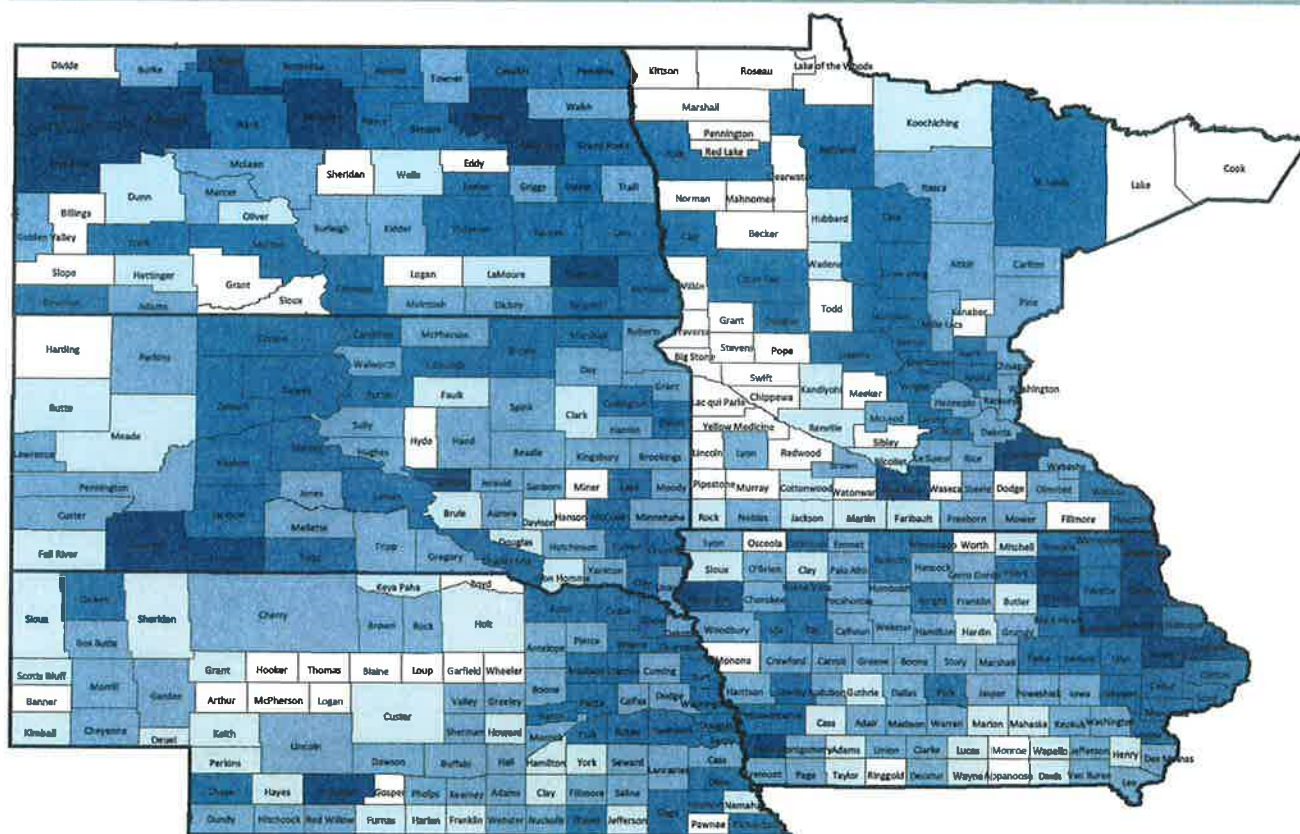
Importance: Regular physical activity is one of the most important things one can do for their health. It can help control weight, reduce risk of cardiovascular disease, reduce risk for type 2 diabetes and metabolic syndrome, reduce risk of some cancers, strengthen bones and muscles, improve mental health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

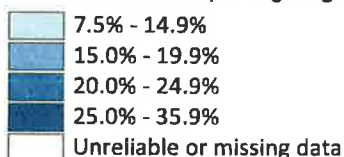
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Excessive Drinking - A health factor measure focusing on health behaviors

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



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



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.

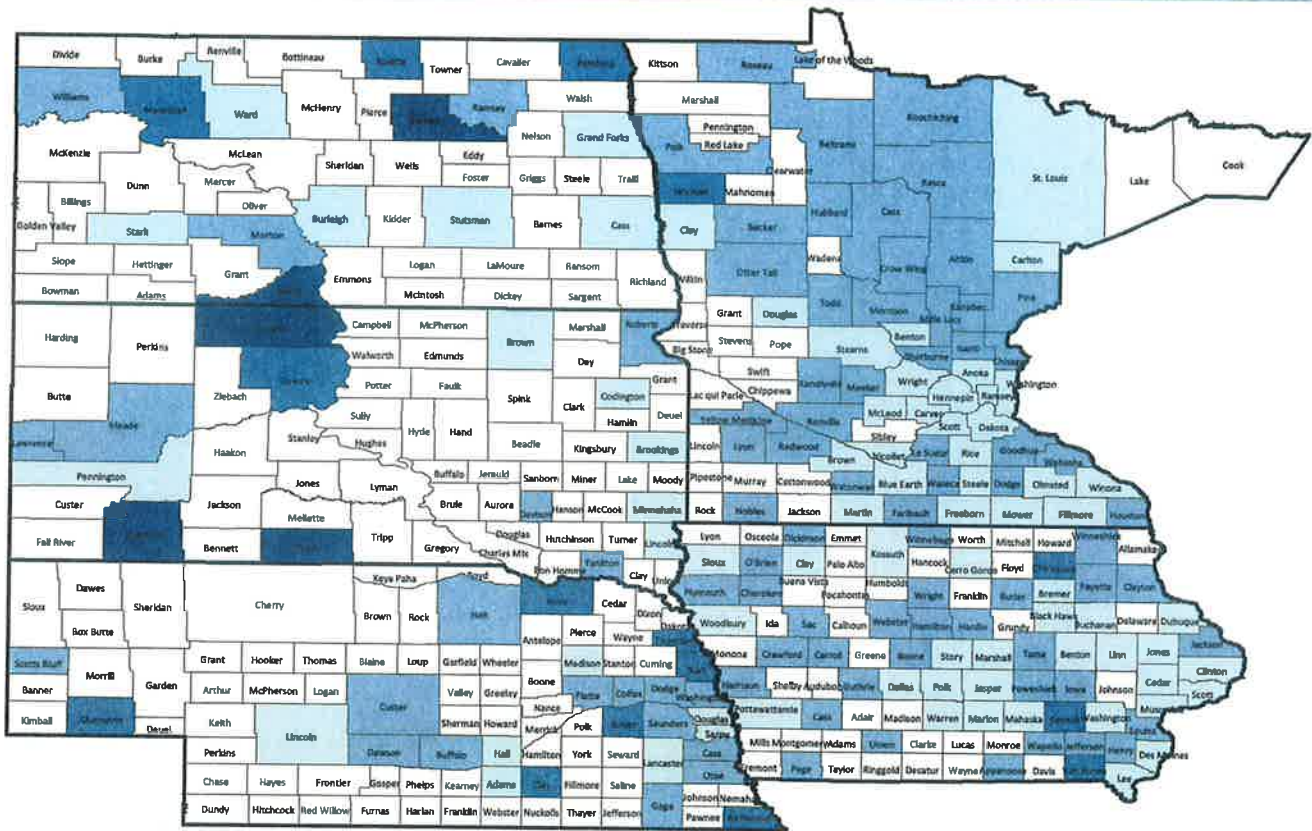
Importance: Excessive drinking is a risk factor for a number of adverse health outcomes such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and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

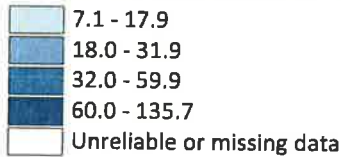
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Motor Vehicle Crash Death Rate - A health factor measure focusing on health behaviors

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



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



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.

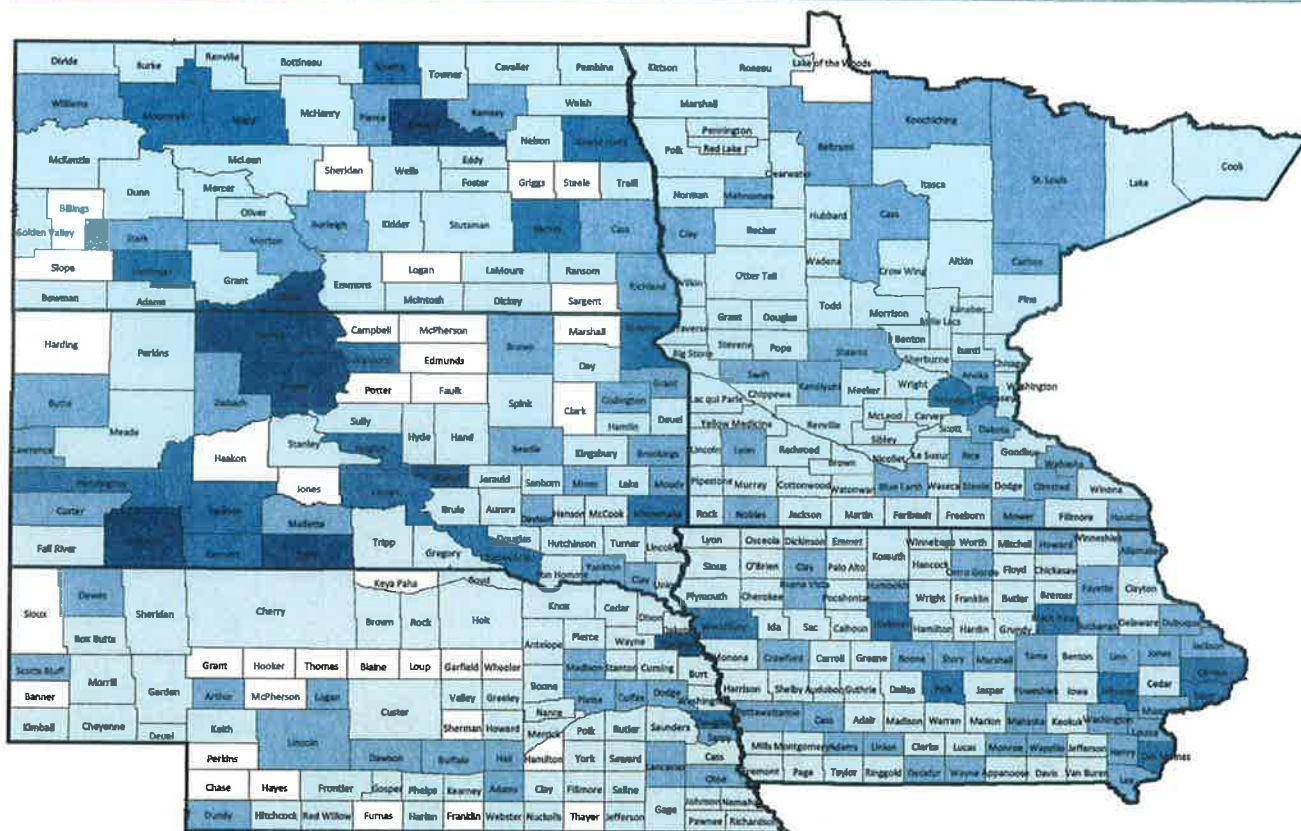
Importance: A strong association has been demonstrated between excessive drinking and alcohol-impaired driving, with approximately 17,000 Americans killed annually in alcohol-related motor vehicle crashes.

- 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/>.

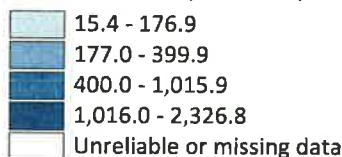
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Sexually Transmitted Infections - A health factor measure focusing on health behaviors

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



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



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.

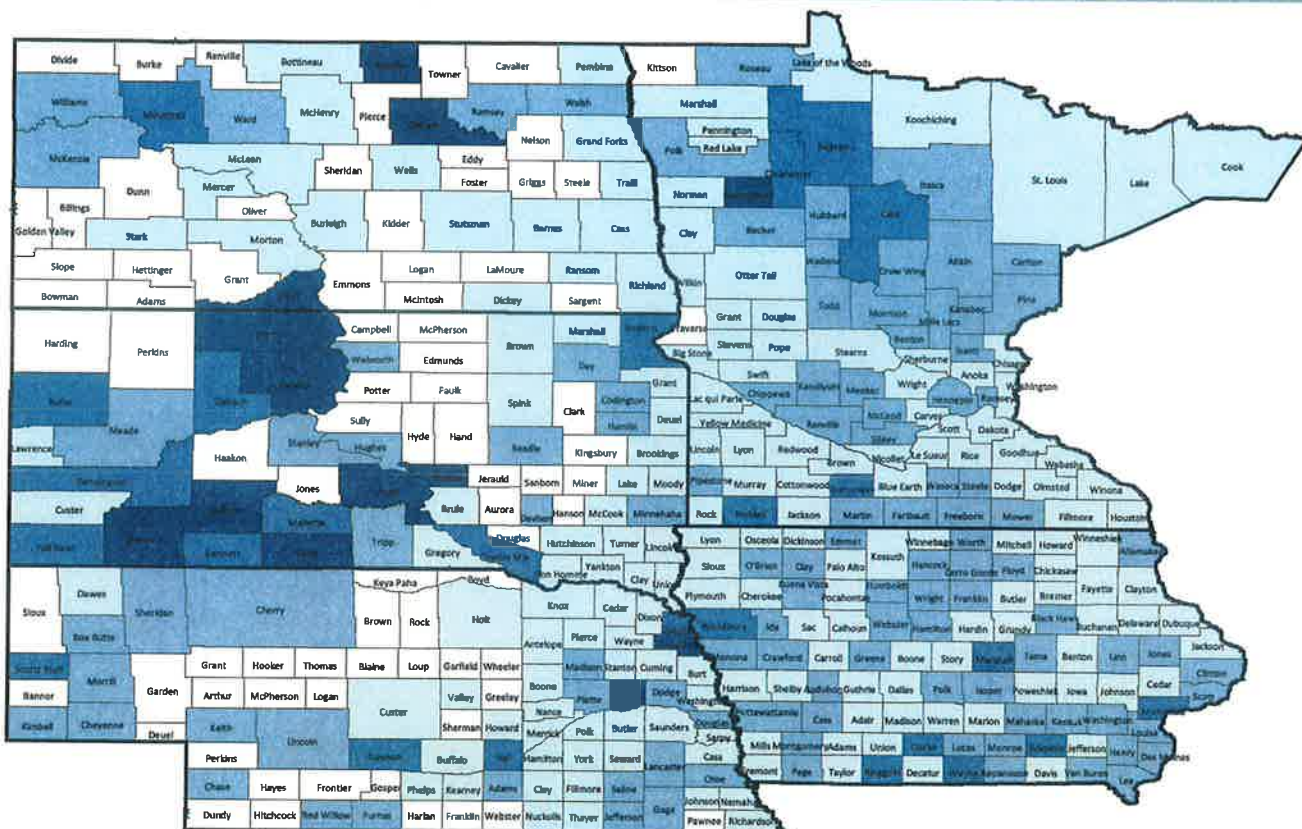
Importance: Chlamydia is the most common bacterial STI in North America and is one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain. STIs in general are associated with a significantly increased risk of morbidity and mortality, including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

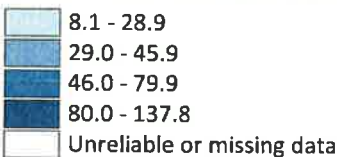
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Teen Birth Rate - A health factor measure focusing on health behaviors

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



Number of teen births per 1,000 females ages 15 through 19, 2001-2007



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).

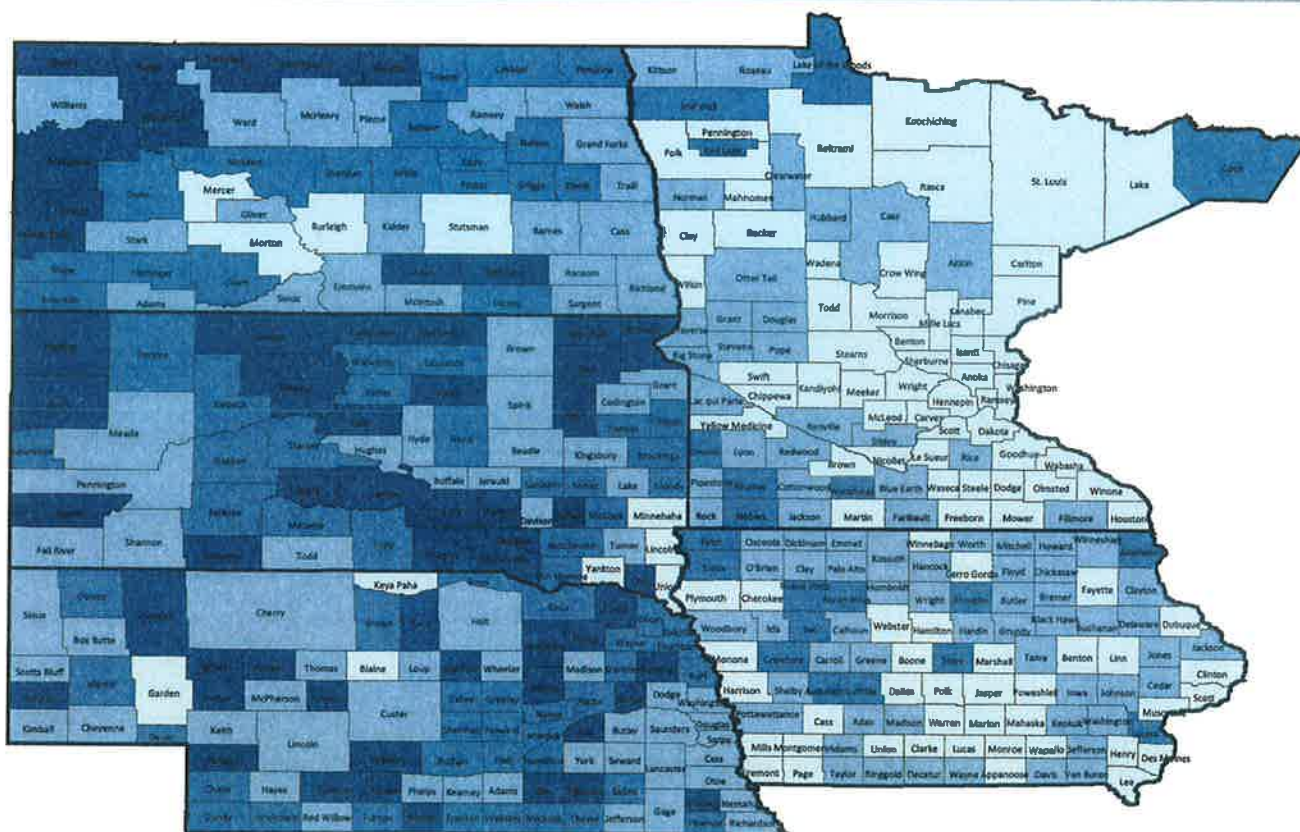
Importance: Teen pregnancy is associated with poor prenatal care and pre-term delivery. Pregnant teens are more likely than older women to receive late or no prenatal care, have gestational hypertension and anemia, and achieve poor maternal weight gain. They are also more likely to have a pre-term delivery 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/>.

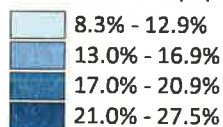
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Uninsured Adults - A health factor measure focusing on clinical care

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



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



CONTEXT

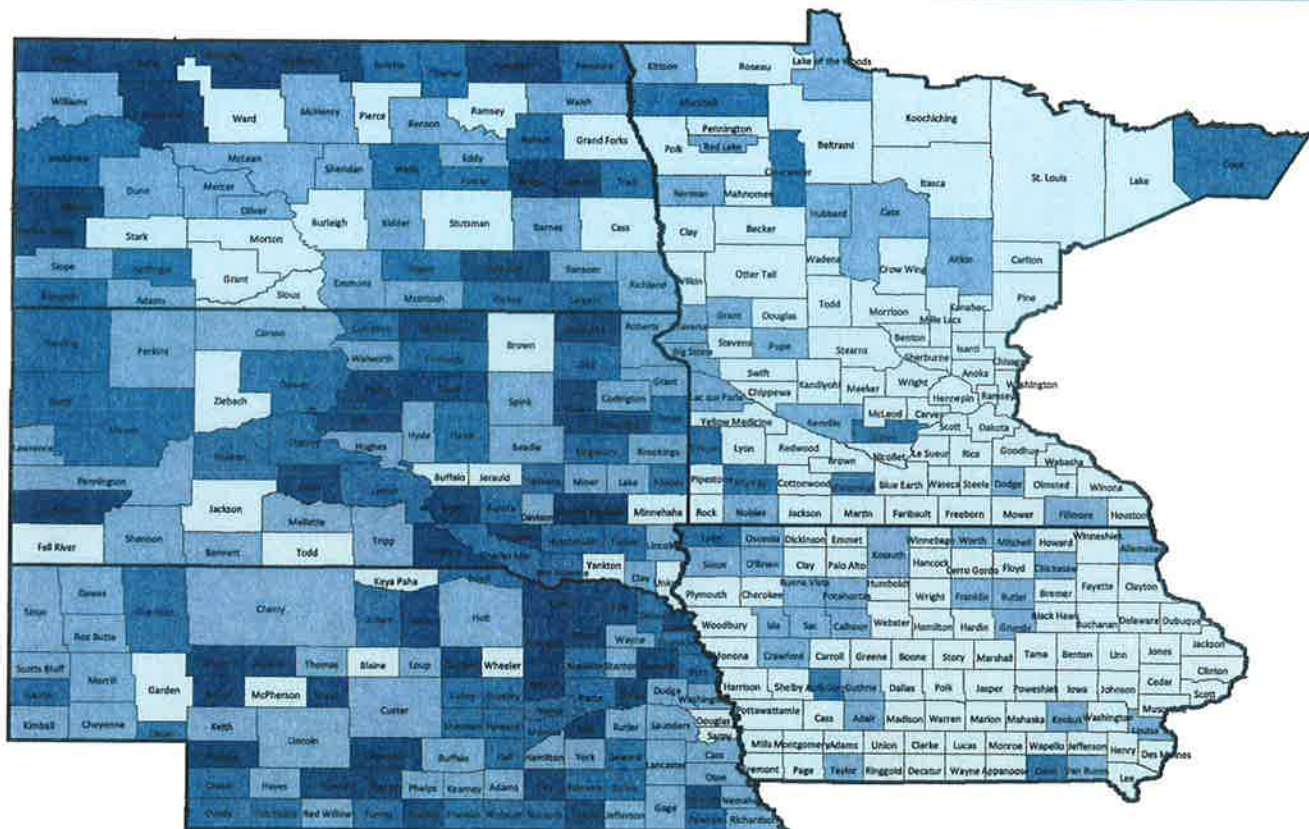
What It Is: The uninsured adults measure represents the estimated percent of the adult population under age 65 that has no health insurance coverage.

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.

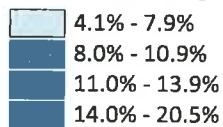
Importance: Lack of health insurance coverage is a significant barrier to accessing needed health care.

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



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.

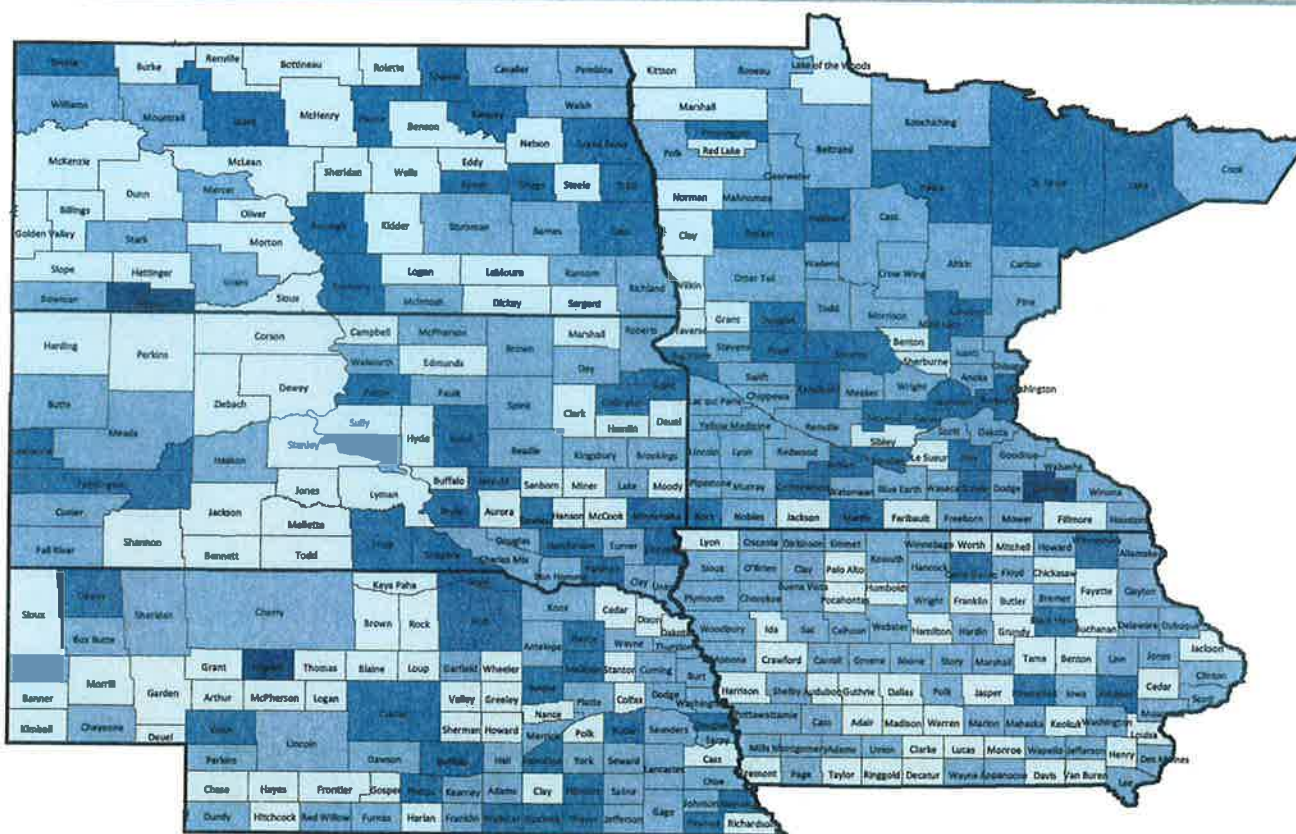
Importance: Children without health insurance are more likely than others to receive late or no care for health problems, putting them at greater risk for hospitalization. In addition to resulting in reduced access to health care, a lack of health insurance can also negatively influence children’s school 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/>.

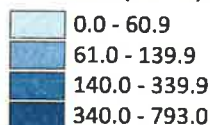
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Primary Care Physicians - A health factor measure focusing on clinical care

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



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



CONTEXT

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

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

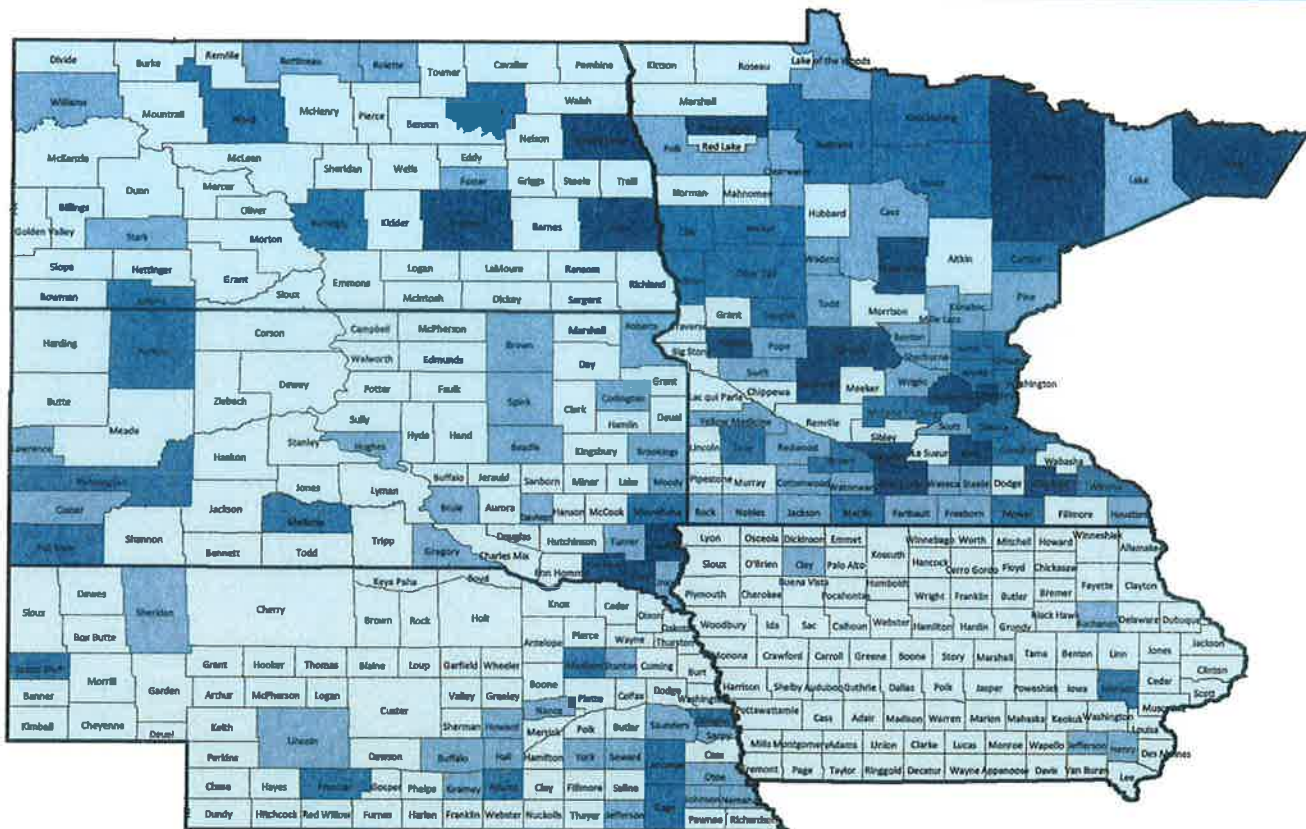
Importance: Having access to care requires not only having financial coverage but also access to providers. While high rates of specialist physicians has been shown to be associated with higher, and perhaps unnecessary, utilization, having sufficient availability of primary care physicians is essential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

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

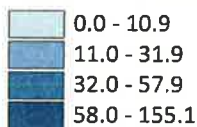
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Mental Health Providers - A health factor measure focusing on clinical care

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



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



CONTEXT

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

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

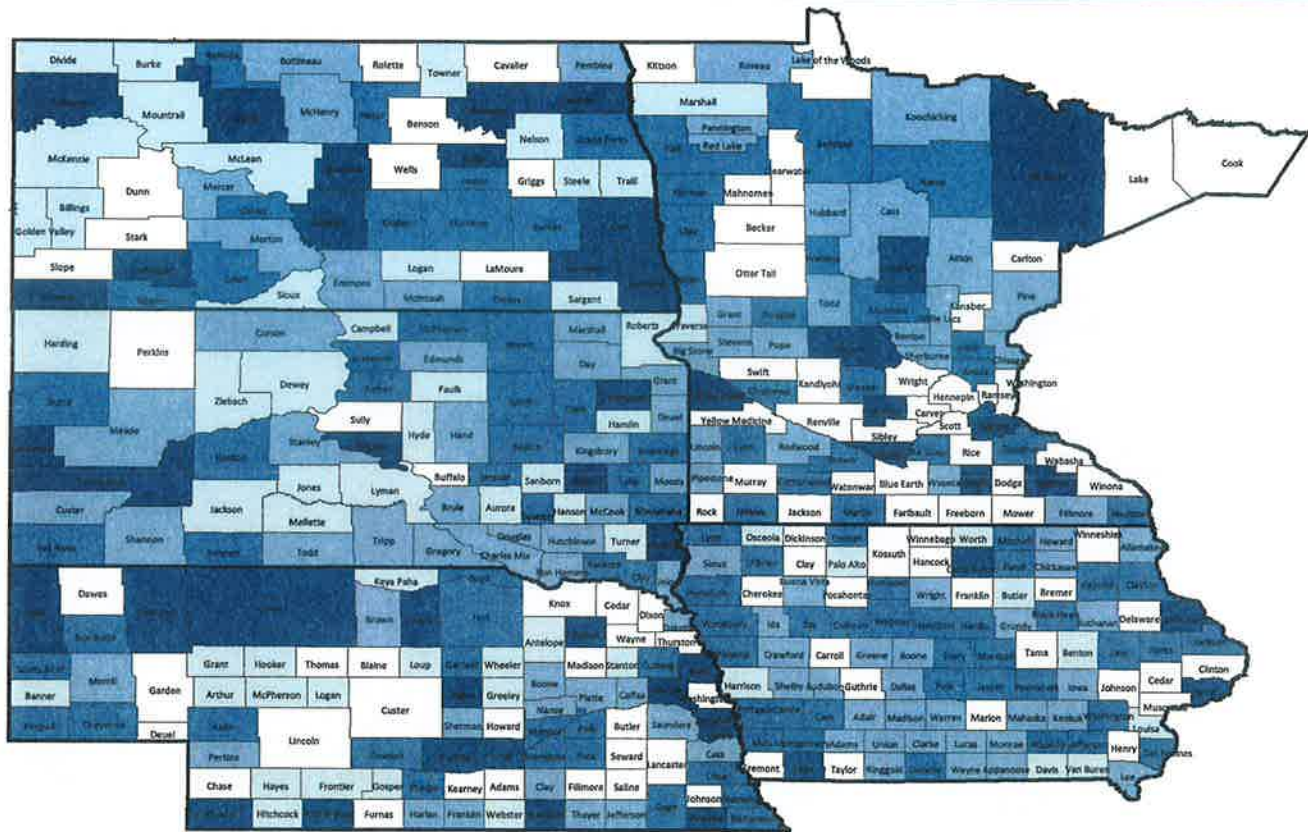
Importance: Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender. A key disparity often hinges on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

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

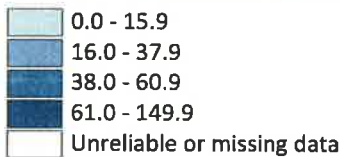
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Dentist Rate - A health factor measure focusing on clinical care

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



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



CONTEXT

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

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

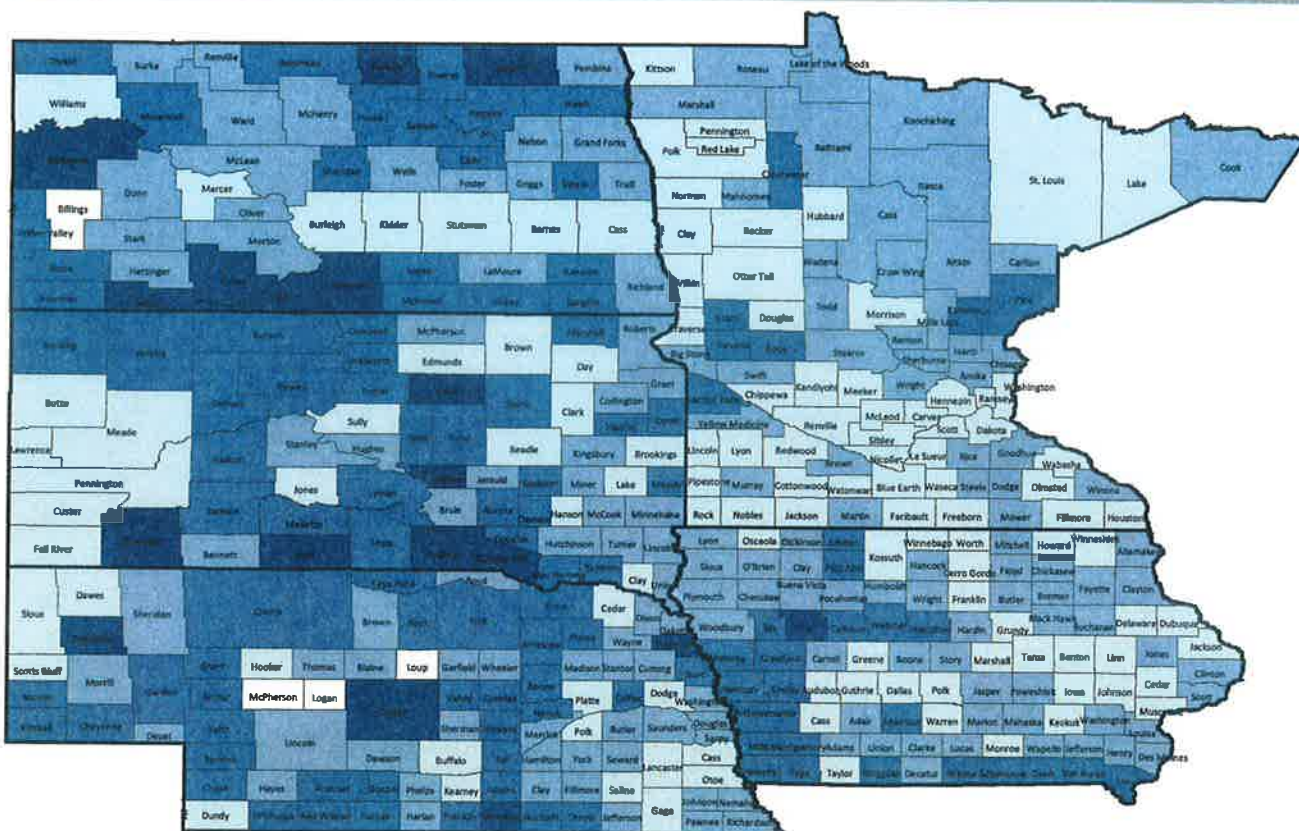
Importance: Today, thanks to fluoride, healthier lifestyles and quality dental care, more people than ever before are keeping their natural teeth throughout their lifetime. Yet for those who live in areas where a dentist is not available or those who cannot afford treatment, getting dental care can be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

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

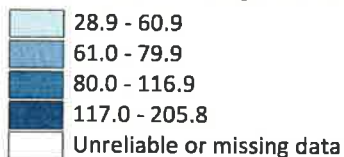
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Preventable Hospital Stays - A health factor measure focusing on clinical care

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



CONTEXT

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

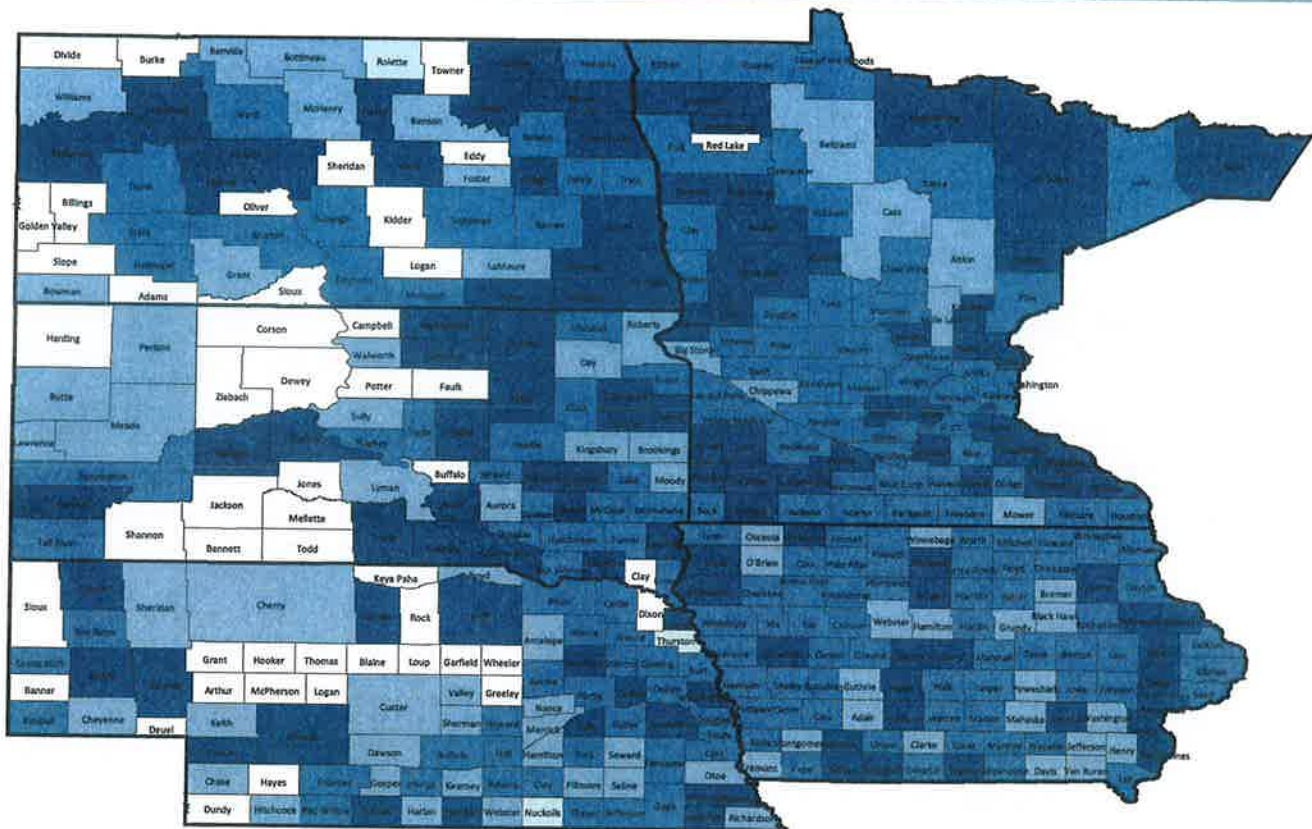
Where It Comes From: Estimates of preventable hospital stays were calculated by the authors of the Dartmouth Atlas of Health Care using Medicare claims data.

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.

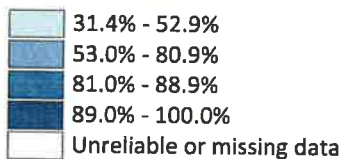
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

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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



CONTEXT

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

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

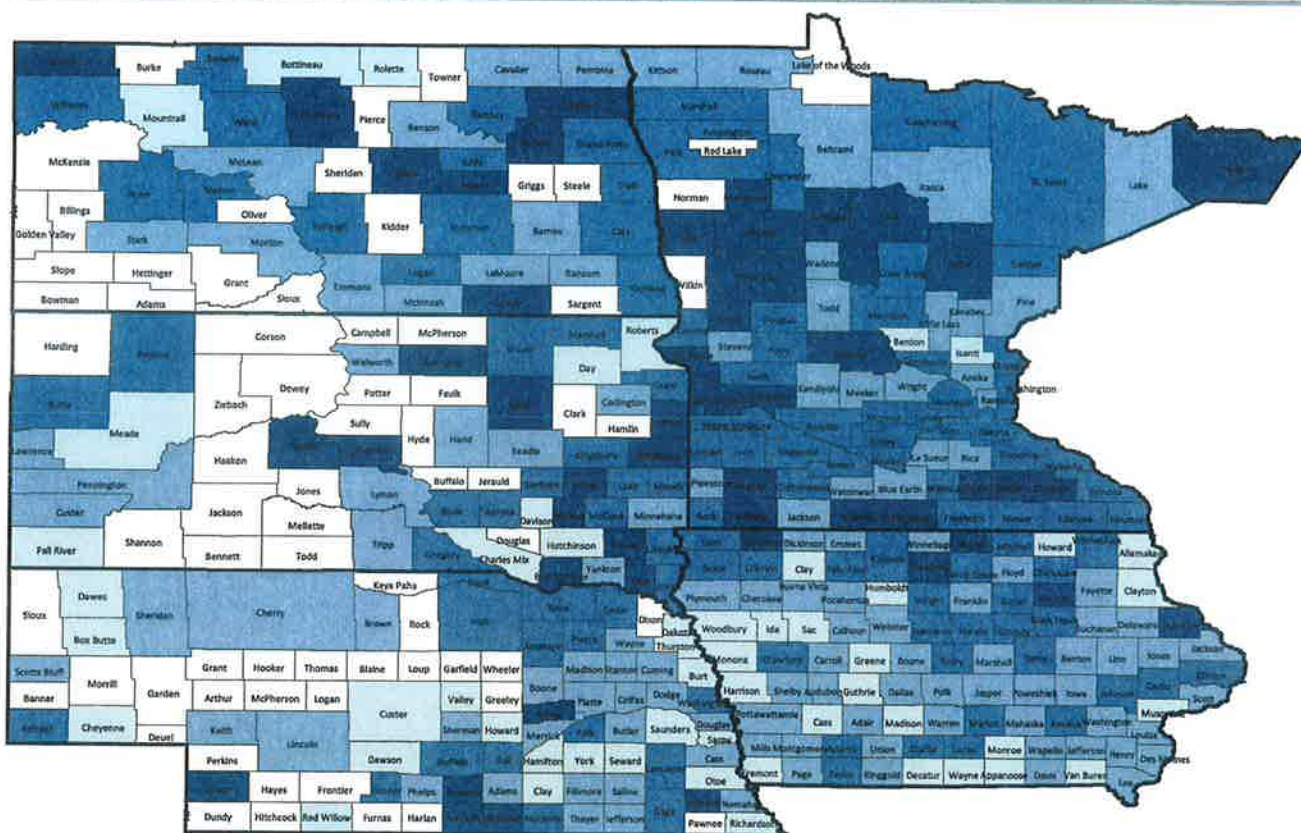
Importance: Regular HbA1c screening among diabetic patients is considered the standard of care. It helps assess the management of diabetes over the long term by providing an estimate of how well a patient has managed his or her diabetes over the past two to three months. When hyperglycemia is addressed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

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

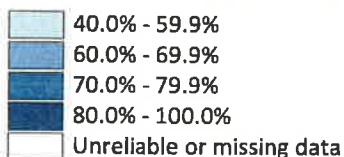
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Mammography Screening - A health factor measure focusing on clinical care

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



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



CONTEXT

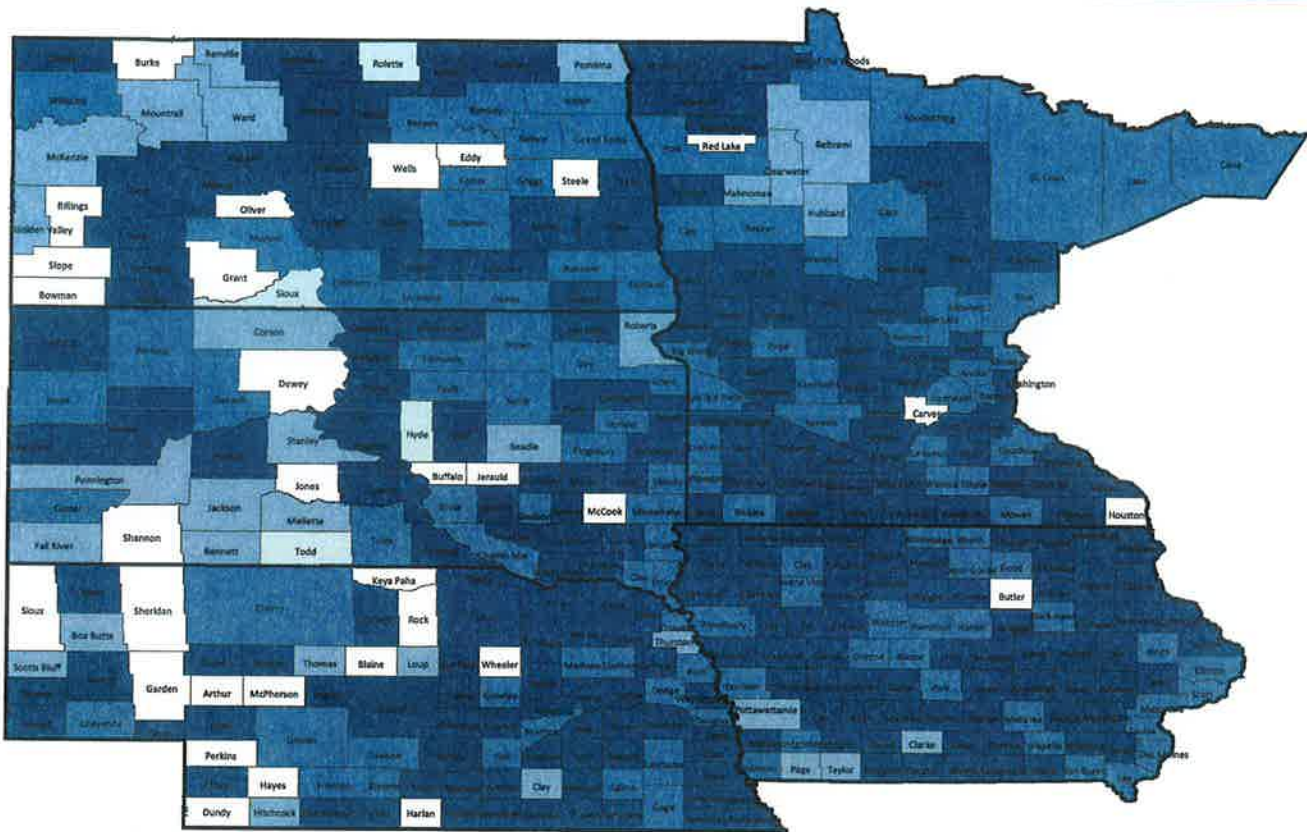
What It Is: This measure represents the percent of female Medicare enrollees ages 40 through 69 that had at least one mammogram over a two-year period.

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

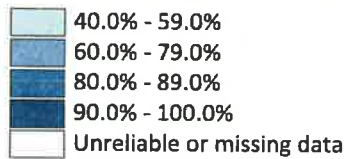
Importance: Evidence suggests that mammography screening reduces breast cancer mortality, especially among older women. A physician's recommendation or referral—and satisfaction with physicians—are major facilitating factors among women who obtain breast cancer screening. The percent of women ages 40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

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

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



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.

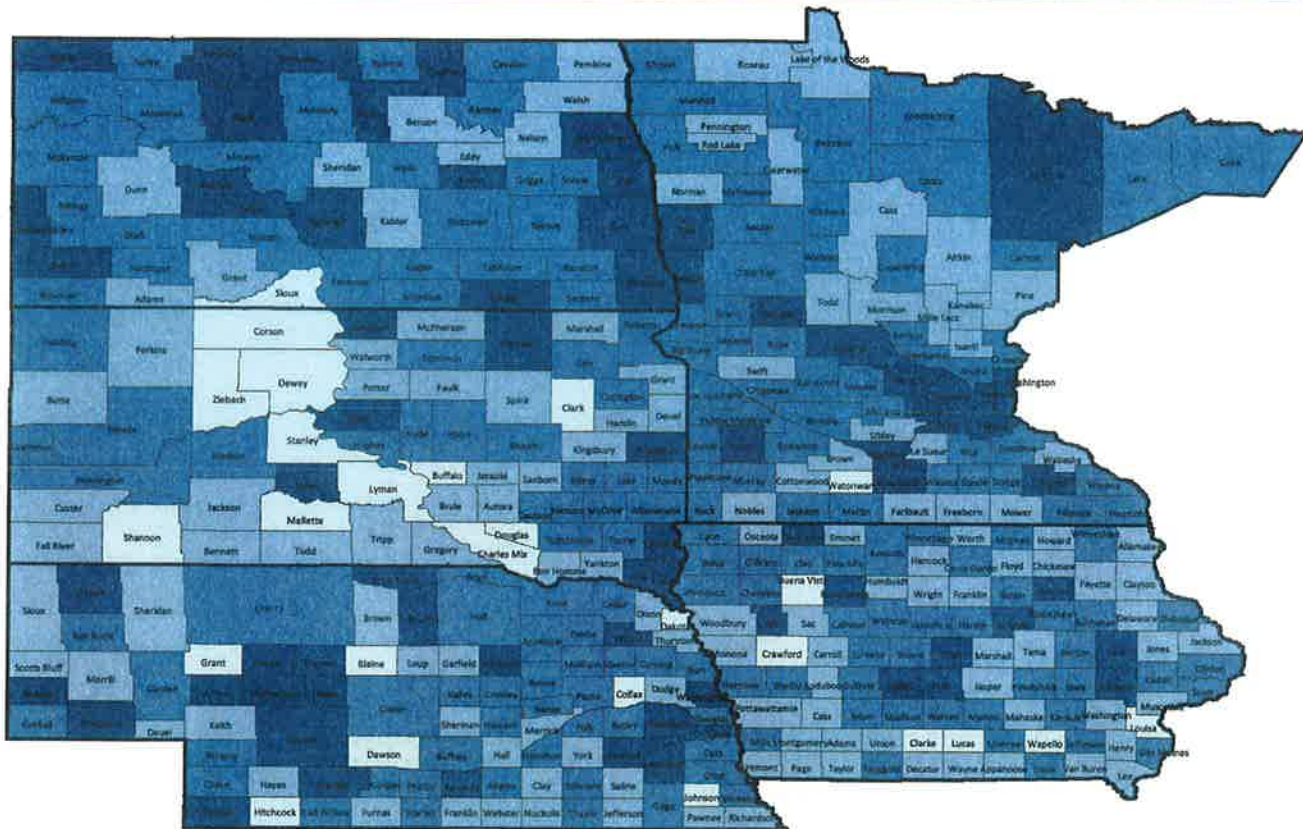
Where It Comes From: Estimates of high school graduation are based on the restricted-use versions of the LEA Universe Survey Dropout and Completion data and the Public Elementary/Secondary School Universe Survey data. These data were requested from NCES for the school year 2006-07.

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.

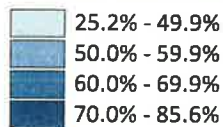
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Some College - A health factor measure focusing on education
 County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



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



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).

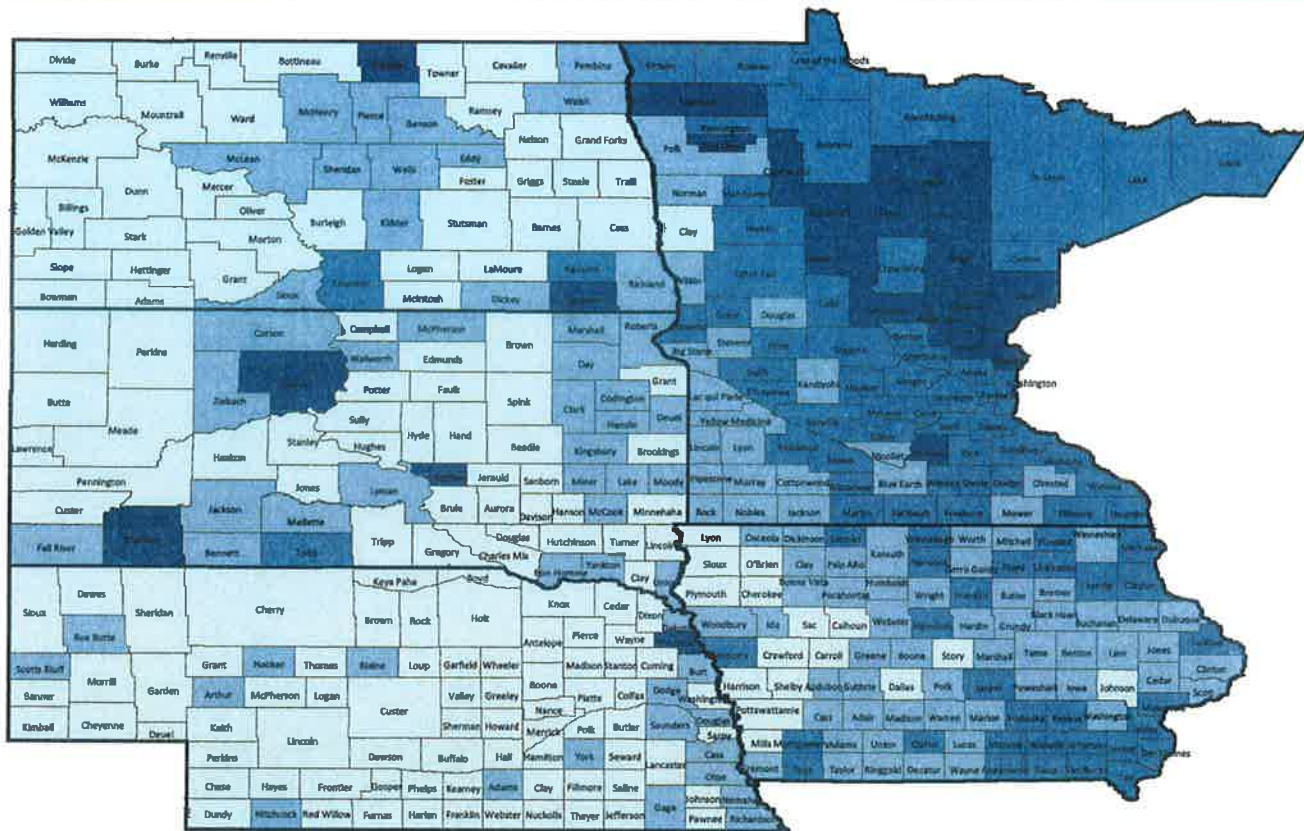
Importance: The relationship between higher education and improved health outcomes is well known, with years of formal education correlating strongly with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles.

- 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/>.

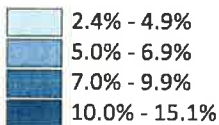
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Unemployment - A health factor measure focusing on labor

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



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).

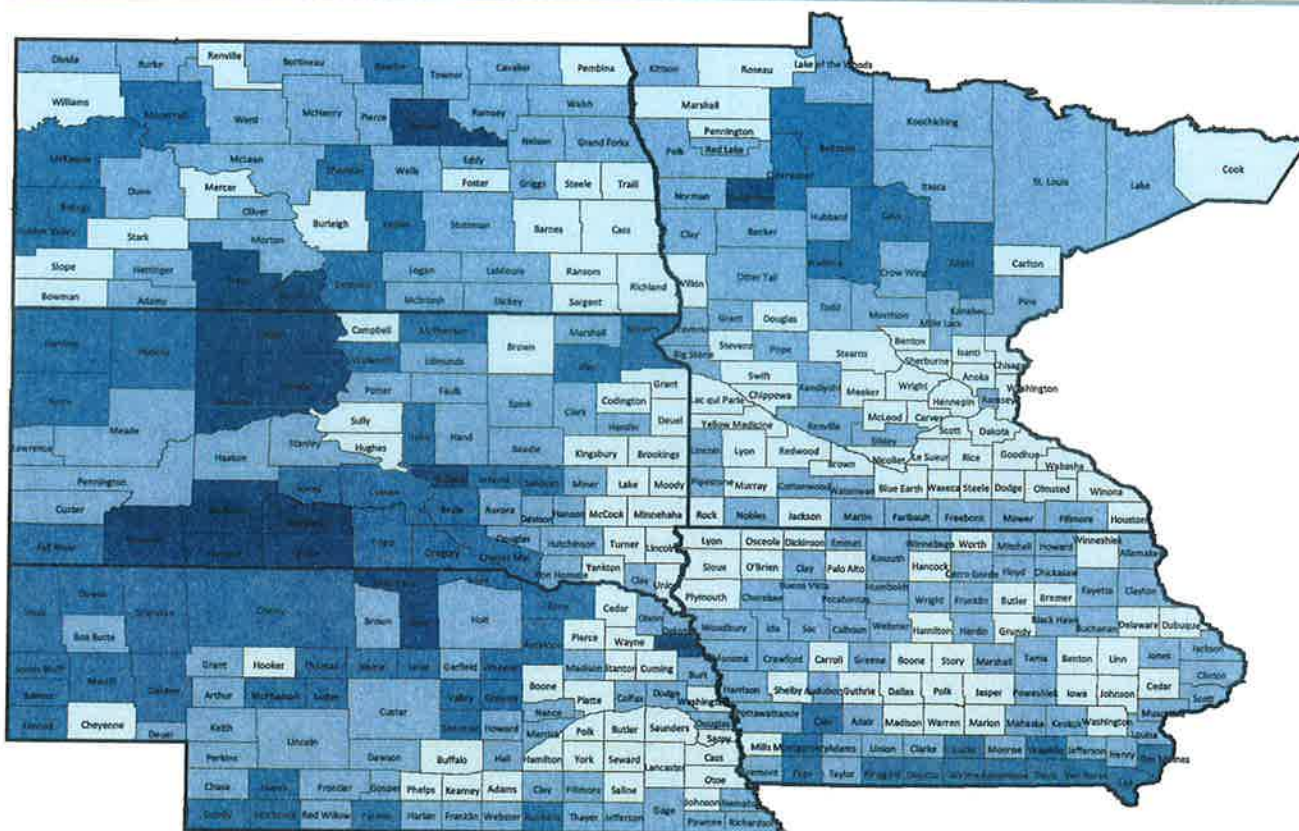
Importance: Unemployment may lead to physical health responses ranging from self-reported physical illness to mortality, especially suicide. It has also been shown to lead to an increase in unhealthy behaviors related to alcohol and tobacco consumption, diet, exercise, and other health-related behaviors,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

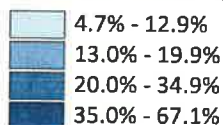
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Children in Poverty - A health factor measure focusing on income and poverty

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



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 achievement associated with poverty. The children in poverty measure is highly correlated with overall poverty rates.

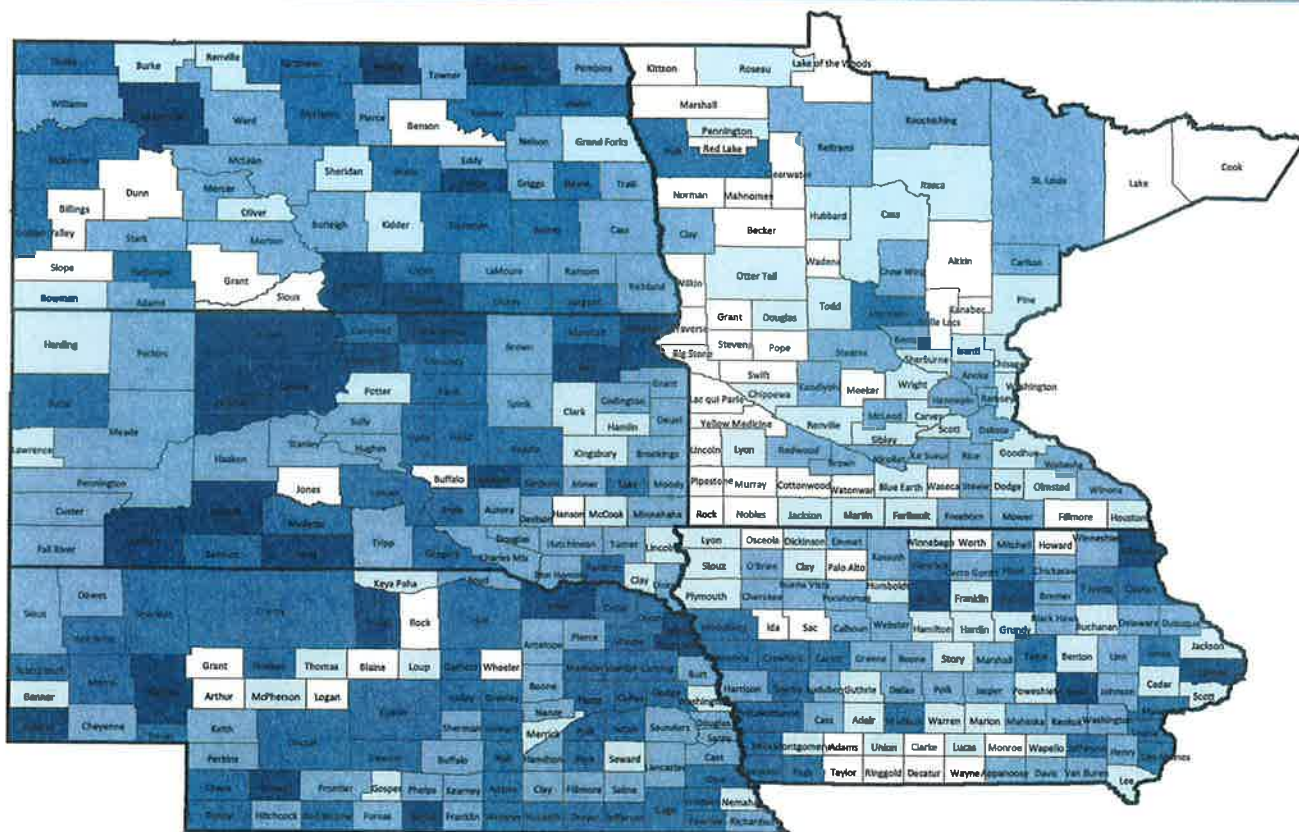
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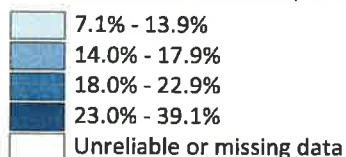
Inadequate Social Support - A health factor measure focusing on social networks

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

Map 25



Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009



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.

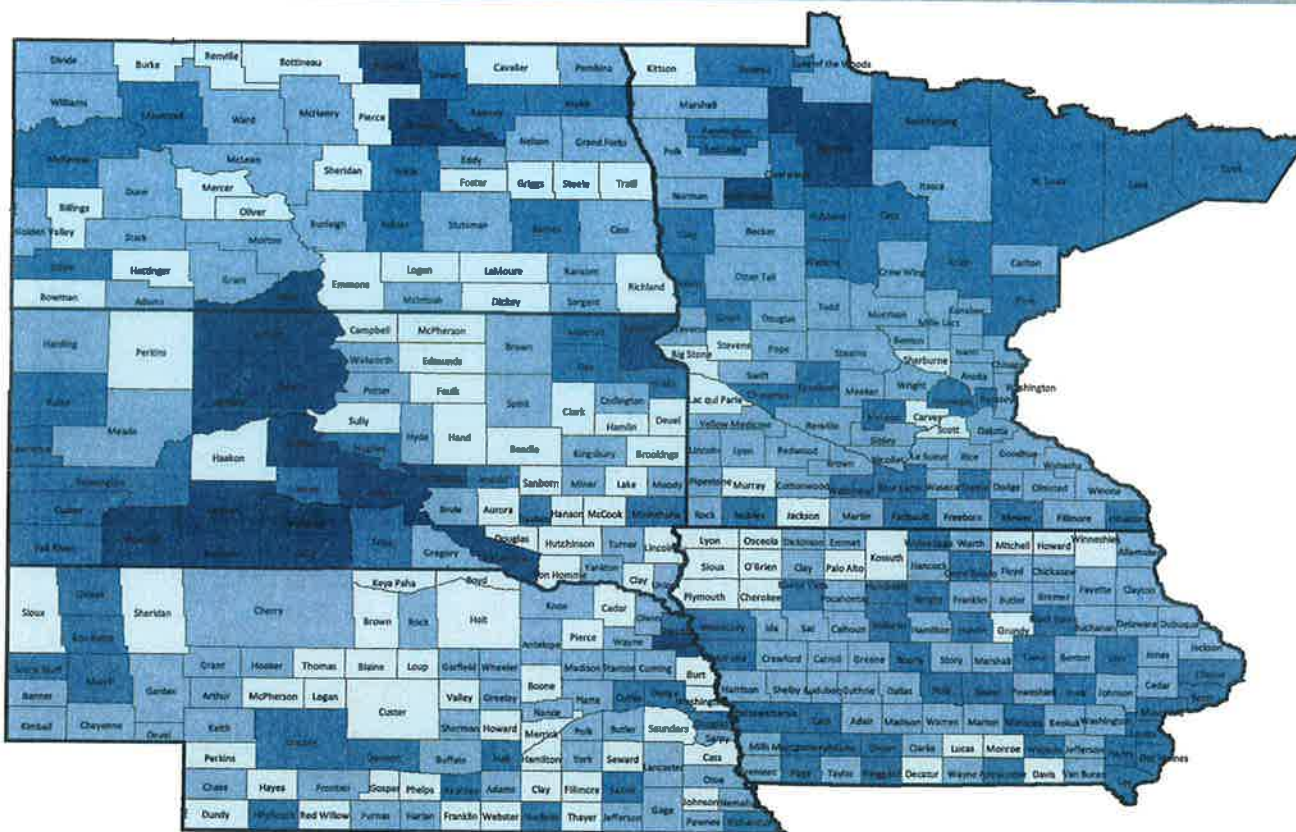
Importance: Poor family support, minimal contact with others, and limited involvement in community life are associated with increased morbidity and early mortality. Furthermore, social support networks have been identified as powerful predictors of health behaviors, suggesting that individuals without 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/>.

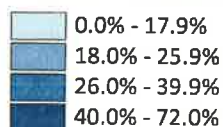
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Children in Single-Parent Households - A health factor measure focusing on families

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



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.

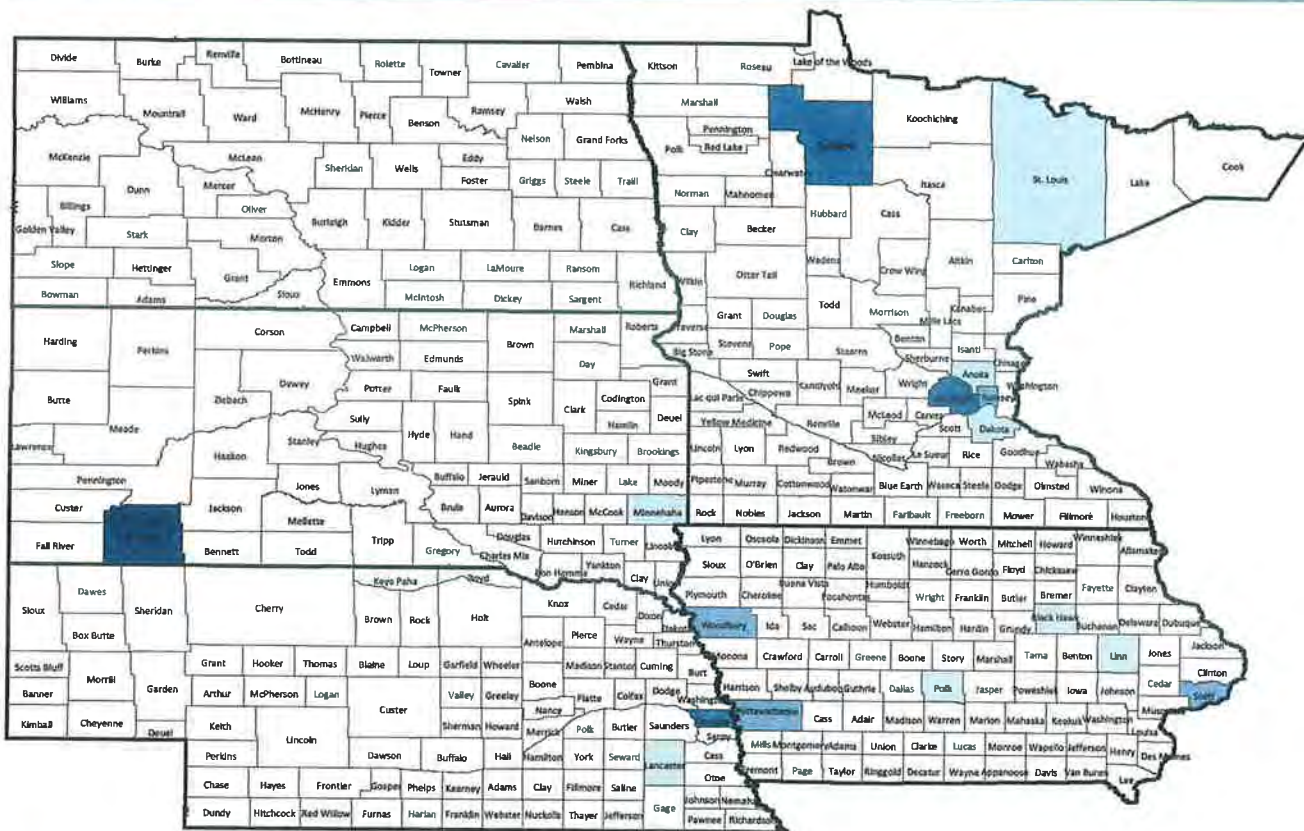
Importance: Adults and children in single-parent households are both at risk for adverse health outcomes such as mental health problems (including substance abuse, depression, and suicide) and unhealthy behaviors such as smoking and excessive alcohol use.

- 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/>.

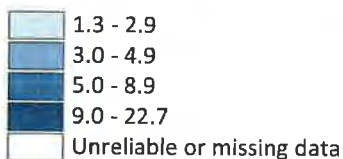
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Homicide Rate - A health factor measure focusing on violent crime

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



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.

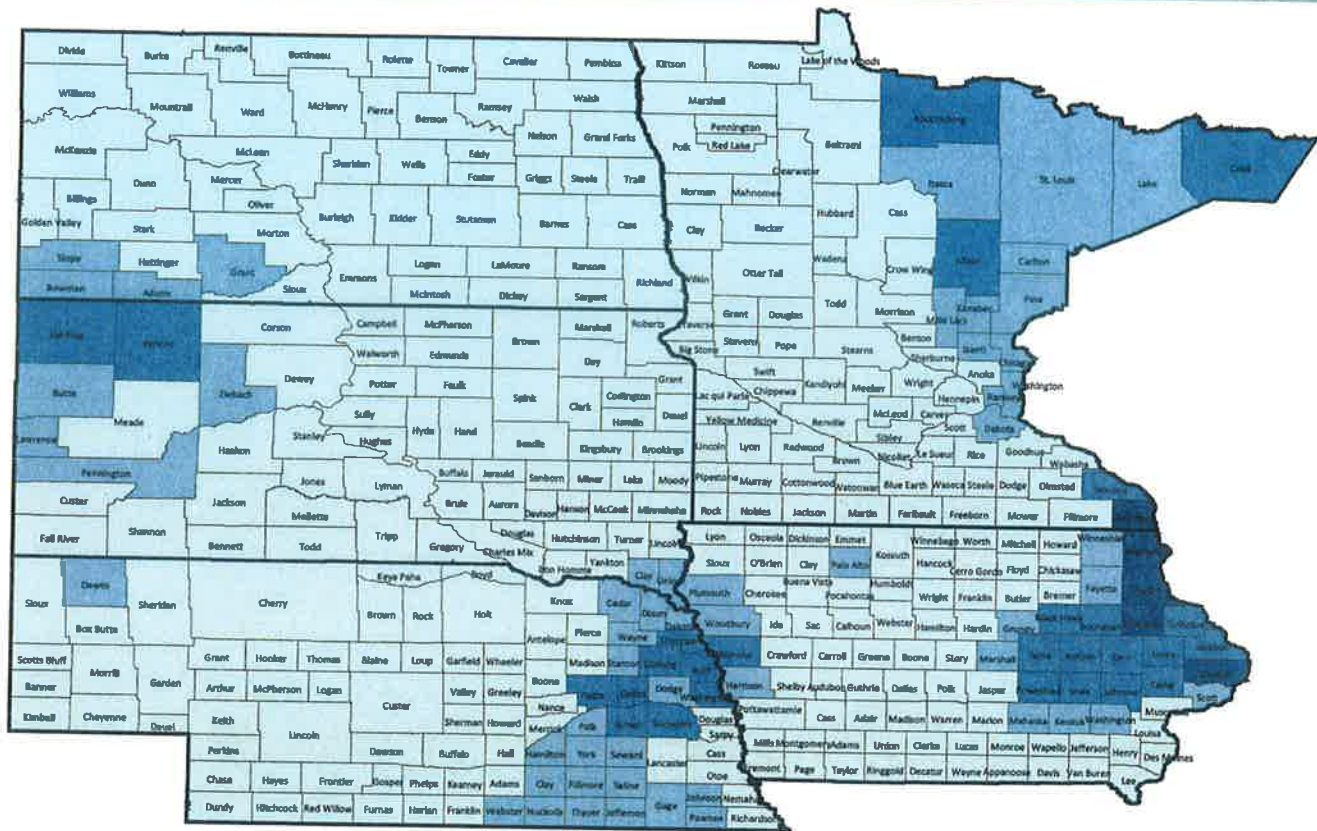
Importance: Because homicide is one of the five offenses that comprise violent crime, a homicide rate is used as a proxy when violent crime data are not available.

- 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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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



CONTEXT

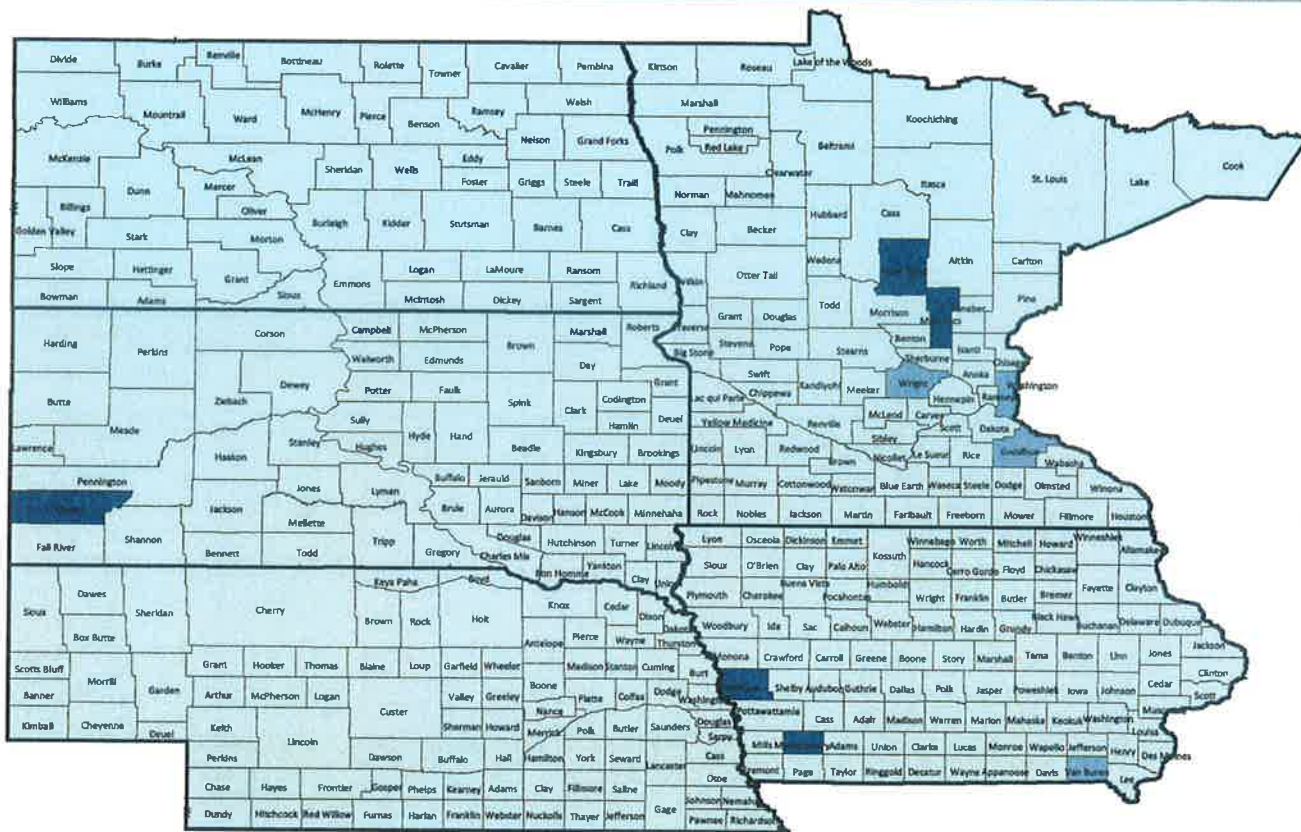
What It Is: The air pollution—particulate matter measure represents the annual number of days that air quality was unhealthy for sensitive populations due to fine particulate matter (FPM, < 2.5 µm in diameter).

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



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.

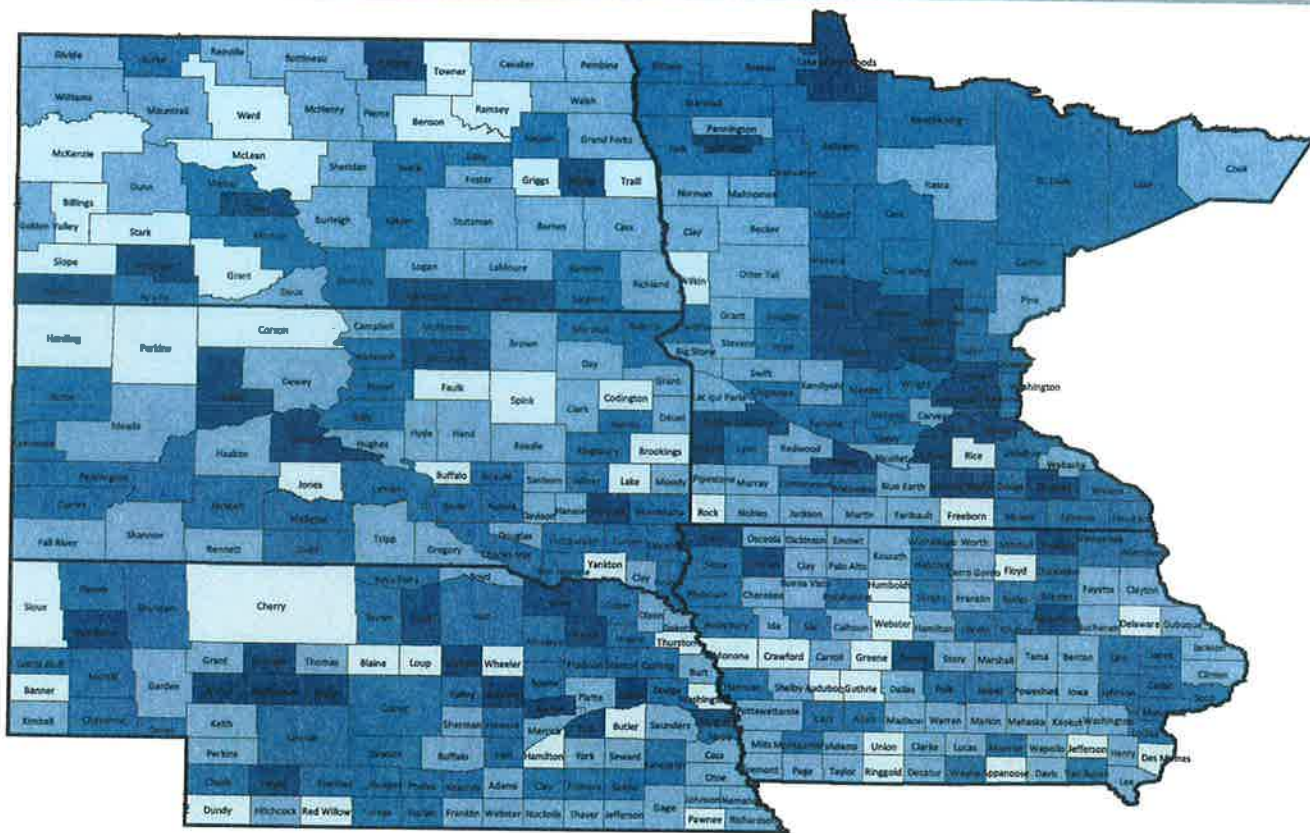
Importance: The relationship between elevated air pollution—particularly fine particulate matter and ozone—and compromised health has been well documented. The negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.

- 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/>.

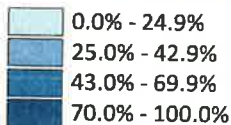
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Access to Healthy Foods - A health factor measure focusing on physical environment

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



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.

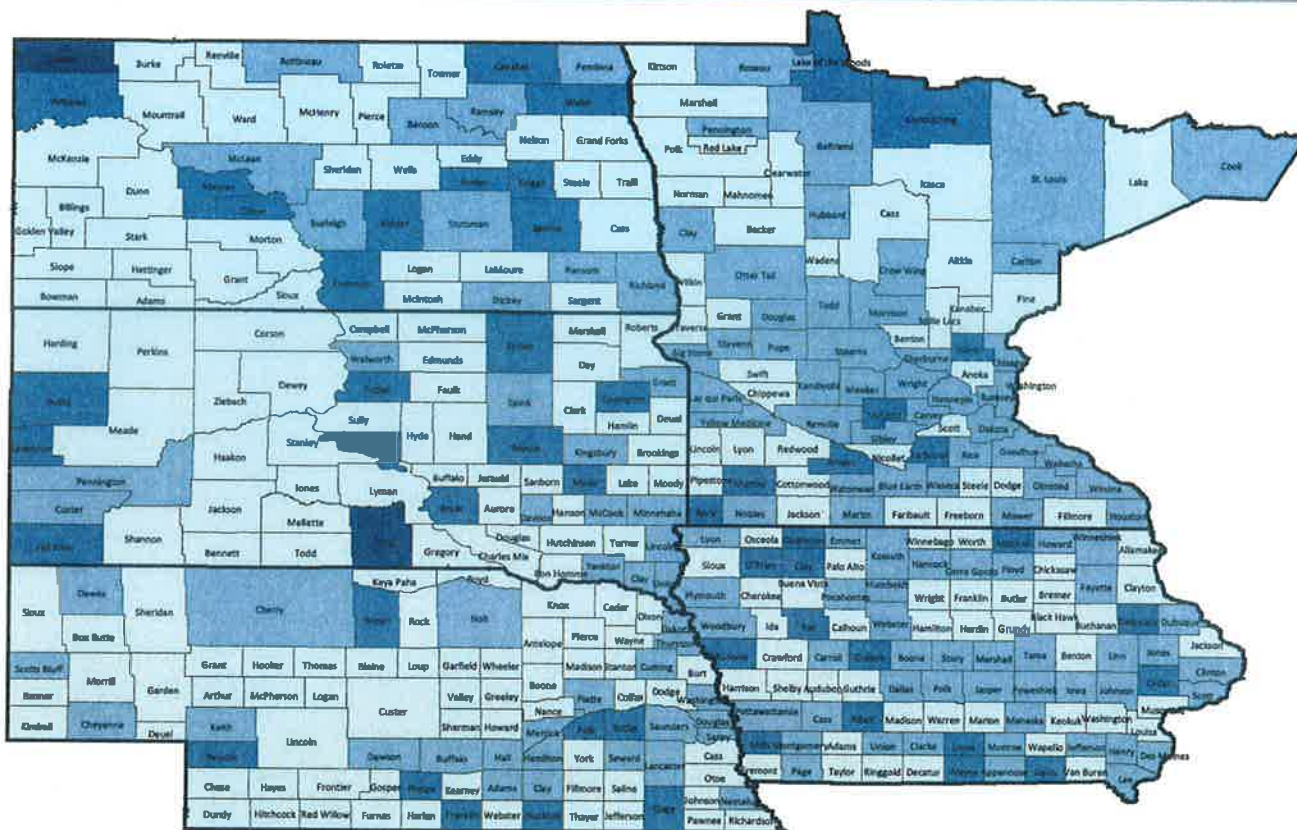
Importance: Studies have linked the food environment to consumption of healthy food and overall health outcomes.

- 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/>.

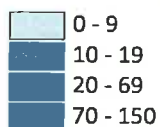
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Access to Recreational Facilities - A health factor measure focusing on physical environment

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



Number of recreational facilities per 100,000 population, 2008



CONTEXT

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

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

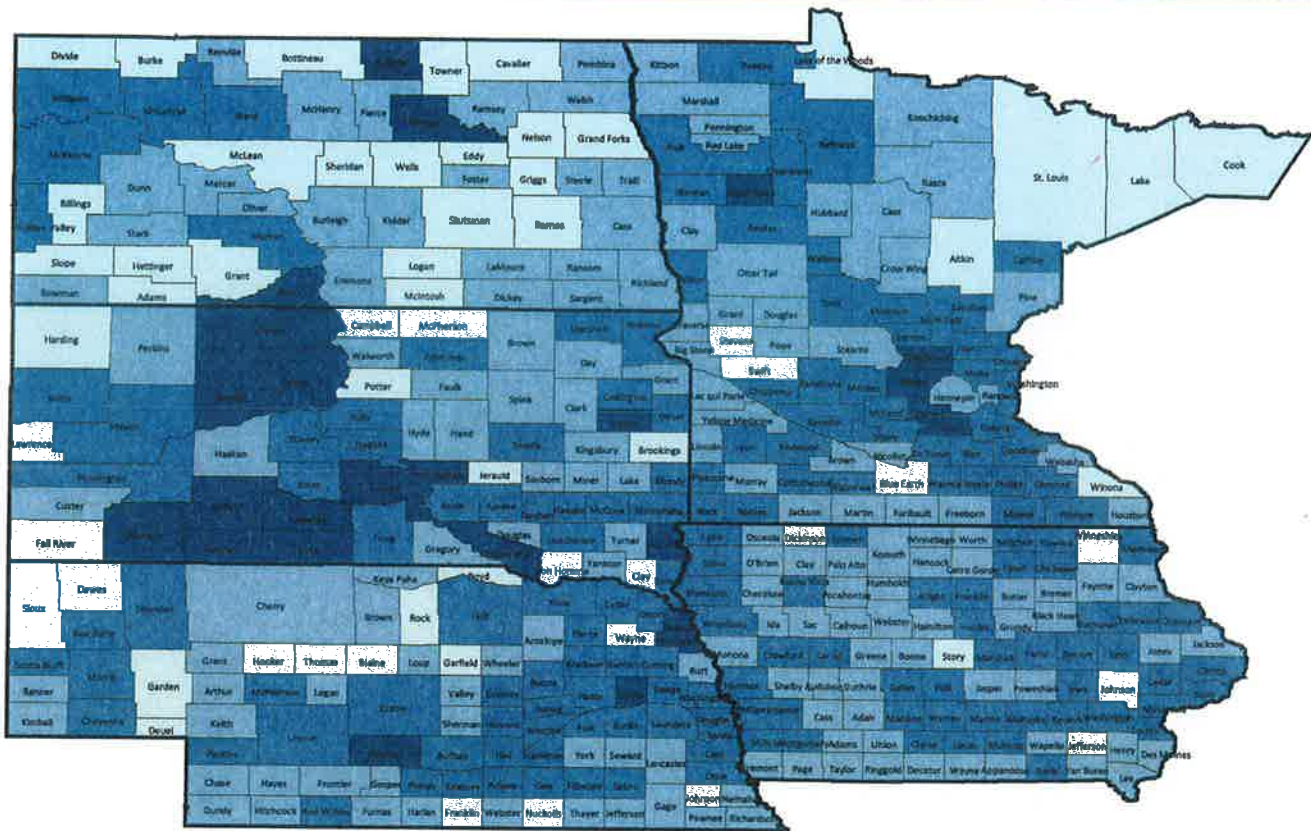
Importance: The availability of recreational facilities can influence individuals' and communities' choices to engage in physical activity. Proximity to places with recreational opportunities is associated with higher physical activity levels, which in turn is associated with lower rates of adverse health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

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

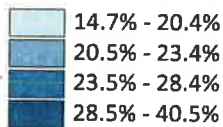
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Youth - A demographic measure

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



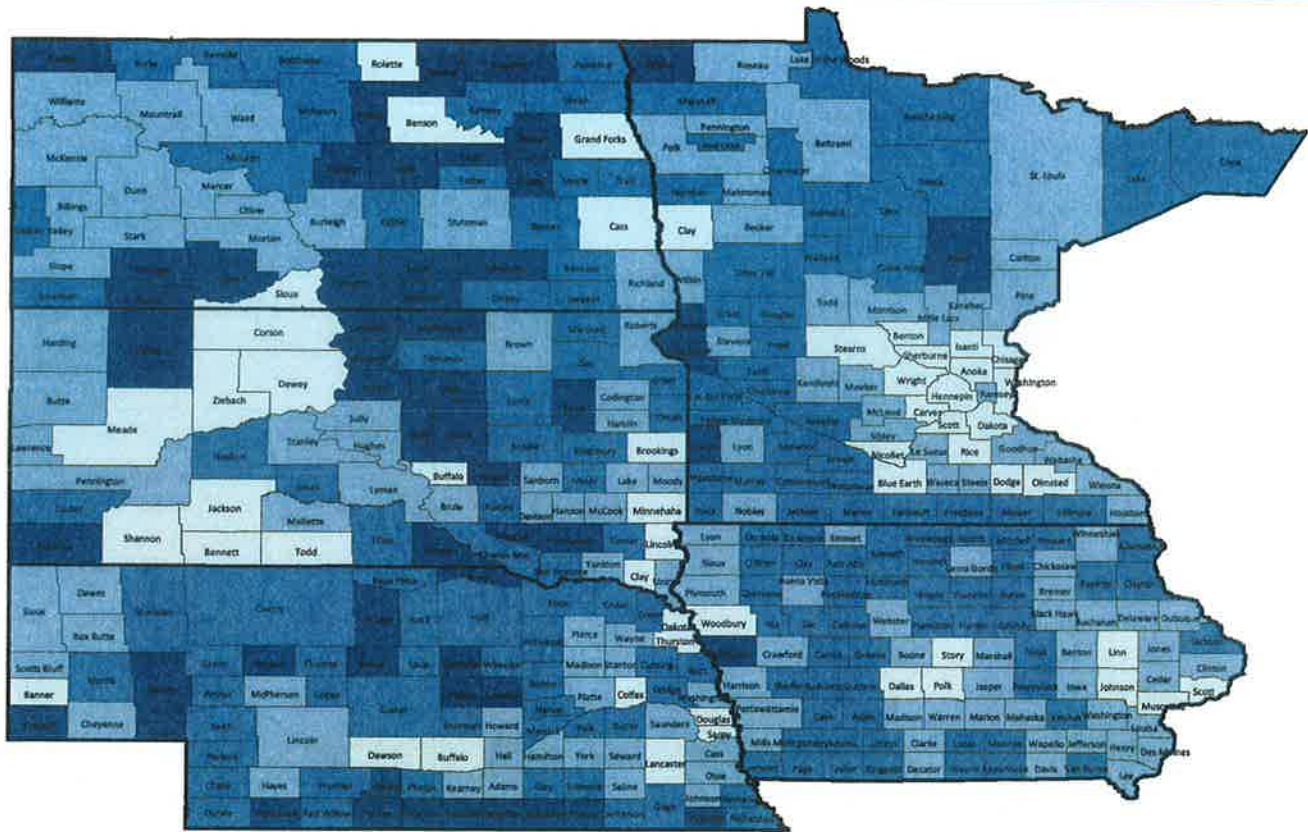
CONTEXT

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

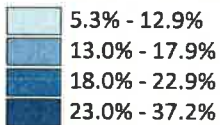
Where It Comes From: County demographic figures come from the U.S. Census Bureau's annual population estimates.

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



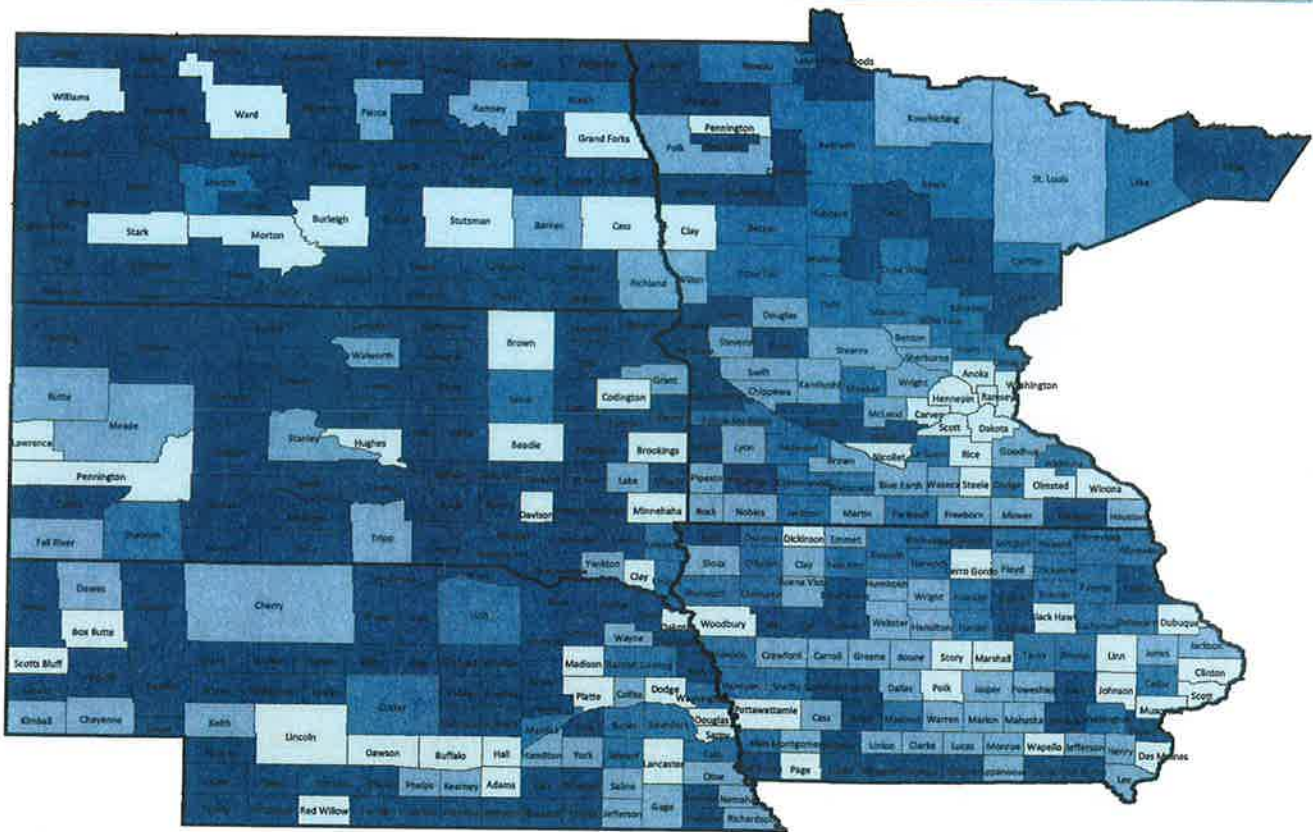
CONTEXT

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

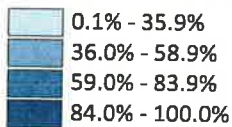
Where It Comes From: County demographic figures come from the U.S. Census Bureau’s annual population estimates.

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

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Percent of total population living in a rural area, 2000



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.

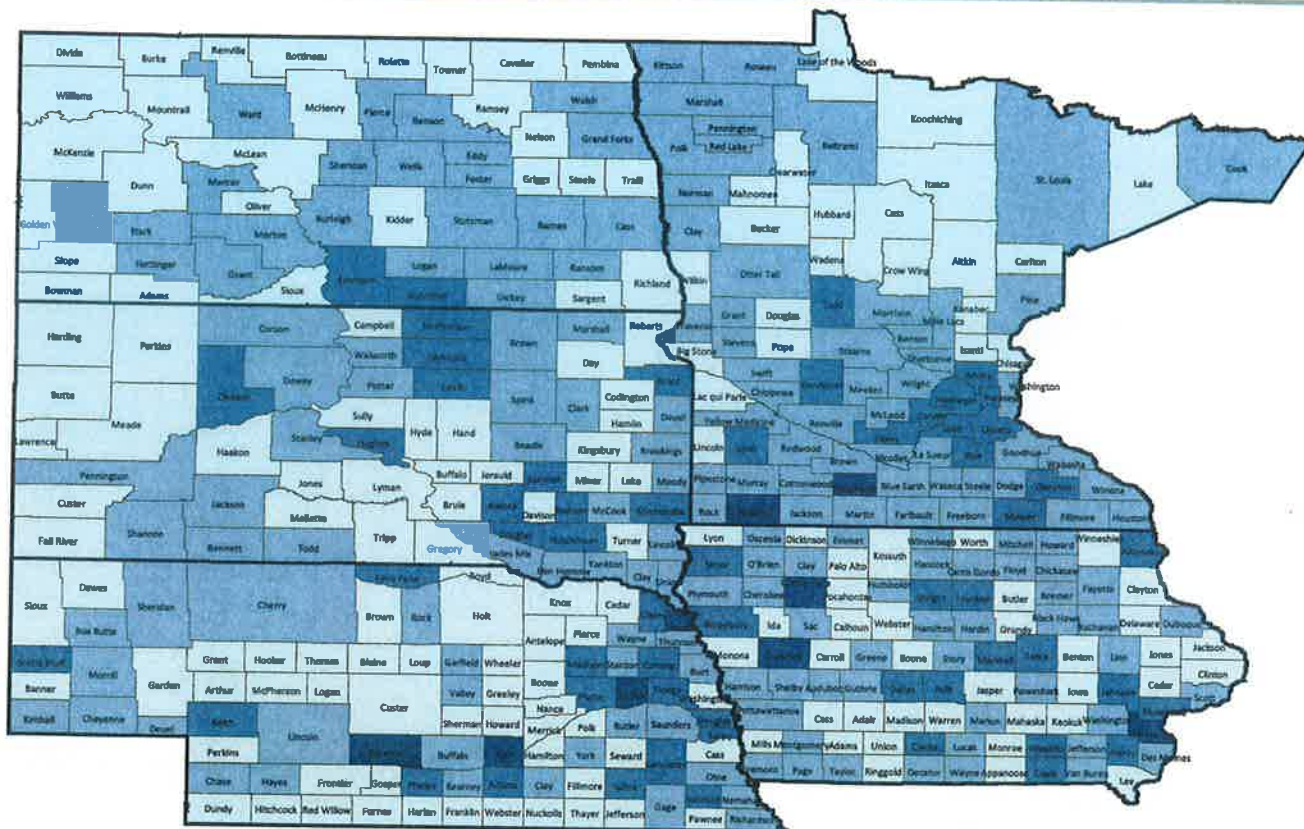
Where It Comes From: This measure is calculated by the U.S. Census Bureau using data from 2000.

- 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/>.

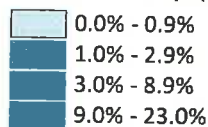
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Not English Proficient - A demographic measure

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



CONTEXT

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

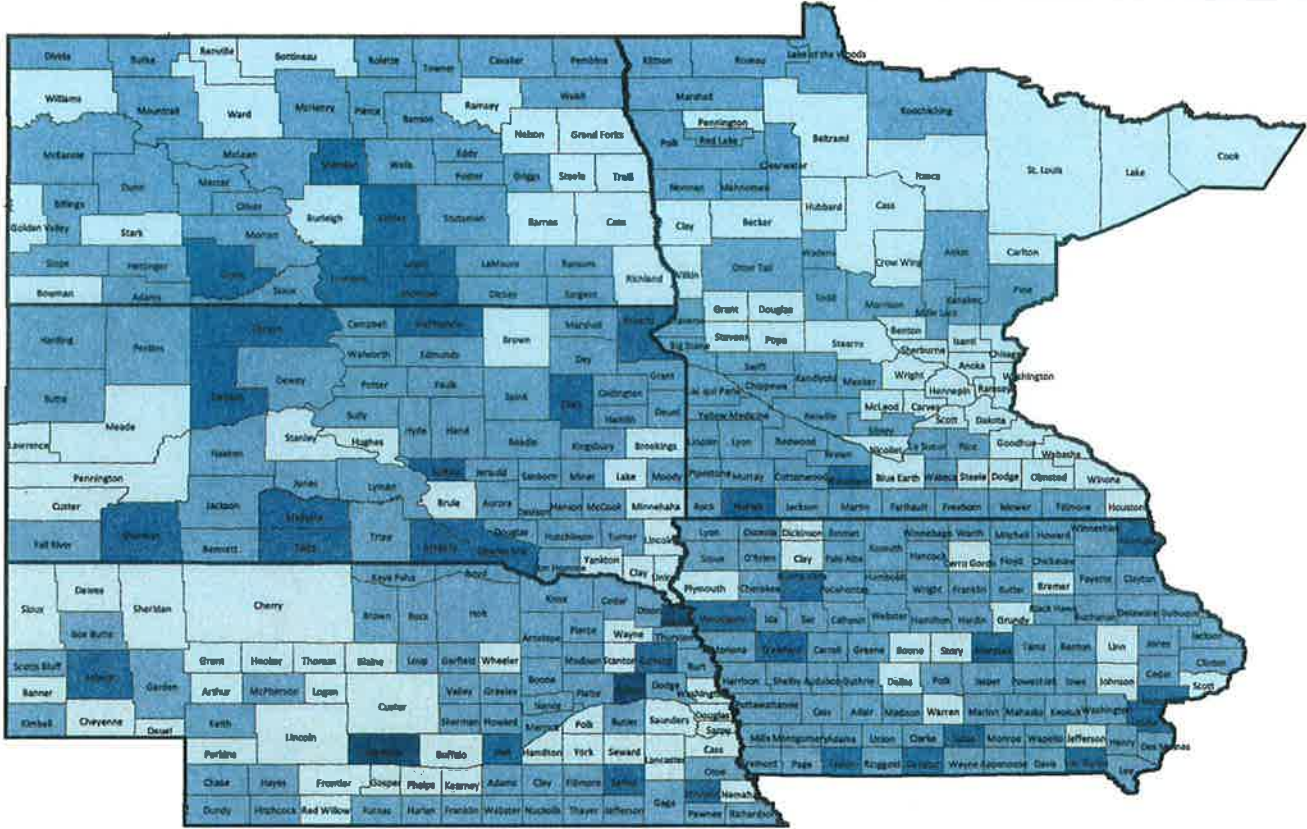
Where It Comes From: Data on spoken English proficiency come from the U.S. Census Bureau's American Community Survey 5-year estimates.

- 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/>.

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Table 1
Community Health Needs Assessment Asset Mapping
Bagley Stakeholders

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Care Coordination	<ul style="list-style-type: none"> Need better communication between the ER, clinics & dental office 	Sanford Medical Home	
Economic Situation/ Business community	<ul style="list-style-type: none"> Concern about local businesses being able to survive 		
Healthcare Cost/Ins. Cost	<ul style="list-style-type: none"> Concern about cost of healthcare 		
Judicial	<ul style="list-style-type: none"> Concern about misuse & sale of prescription drugs 		
Mental Health	<ul style="list-style-type: none"> Need options for mental health services for kids or adults 	Center for Psychiatric Care – 1-877-732-2411 Sanford One Care	
Obesity	<ul style="list-style-type: none"> Concern about the high levels of obesity & the fact that it leads to so many other conditions (heart disease, diabetes, etc.) 	Gwen’s Studio of Exercise & Dance – 218-694-2800 Change of Pace Fitness for Women – 218-694-3023 Smartfitt – 218-694-3001 Sanford WebMD Fit Kids	
Prevention	<ul style="list-style-type: none"> Lack of attention to preventive services (in all aspects of health & wellness) 		
Technology	<ul style="list-style-type: none"> Concern about access to medical technology & equipment 		

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Wellness	<ul style="list-style-type: none"> • Need a fitness center 	Gwen's Studio of Exercise & Dance – 218-694-2800 Change of Pace Fitness for Women – 218-694-3023 Smartfitt – 218-694-3001	
Youth	<ul style="list-style-type: none"> • Lack of role models for children • Lack of guidance for children to become productive members of society 	Clearwater Co. 4-H – 218-694-6151 Crisis Intervention (Child Abuse & Maltreatment – 1-800-422-0863 First Call for Help – 218-326-8565 Mahube Child Care Resource and Referral – 1-800-450-1385 Northwoods Coalition for Family Safety – 218-751-0211 Teen Line – 1-877-419-7233 Youth Employment Program – 218-751-8012	

**Table 2
Prioritization Worksheet**

Criteria to Identify Priority Problem

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

Criteria to Identify Intervention for Problem

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

Health Indicator/Concern <i>(from asset mapping and gaps analysis worksheet)</i>	Round 1 Vote	Round 2 Vote	Round 3 Vote
Care Coordination	vVVVV		
Economic Situation	vVVV	v	
Cost/Insurance	vVVV	vVV	v
Jud	vVVV		
Mental Health	vVV		
Obesity	vVVV	vVV	vVVVV
Prevention	vVVV	vVVV	
Teeth	vV		
Wellness	vVV		
Youth	vVVVV	vVVV	vVVV

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Community Health Needs Assessment Asset Mapping
Bagley Stakeholders

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Table 3
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 <i>(from asset mapping and gaps analysis worksheet)</i>	Round 1 Vote	Round 2 Vote	Round 3 Vote
Care Coordination	vvvvv		
Economic Situation	vvvv	v	
Cost/Insurance	vvvv	vvv	v
Jud	vvvv		
Mental Health	vvv		
Obesity	vvvv	vvv	vvvvv
Prevention	vvvv	vvvv	
Teeth	vv		
Wellness	vvv		
Youth	vvvvv	vvvv	vvvv

