

Sanford Health Network

Community Health Needs Assessment

2012-2013

dba Sanford Tracy Medical Center EIN# 46-0388596

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Purpose

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

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

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

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

Acknowledgements

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

Sanford Enterprise Steering Group:

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

Sanford Sioux Falls Network Steering Group:

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

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

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

Our Guiding Principles:

- All health care is a community asset
- Care should be delivered as close to home as possible

- Access to health care must be provided regionally
- Integrated care delivers the best quality and efficiency
- Community involvement and support is essential to success
- Sanford Health is invited into the communities we serve

The following Sanford Tracy Steering Group members participated in this assessment work:

- Ardis Hendrickson, Executive Assistant, Southwest Health and Human Services
- Audrey Coopman, past City of Tracy Administrator, Tracy Hospital Board Member
- Jason Swanson, Executive Director, Prairie View Healthcare Center
- Stacy Barstad, MHA, CEO, Sanford Tracy and Westbrook Medical Centers
- Lori Hebig, Marketing/Community Relations Manager, Sanford Tracy and Westbrook Medical Centers
- Laurie Stenke, Director of Clinic Operations, Sanford Windom, Mt. Lake, Tracy, and Westbrook
- Angela Nelson, MSW, LGSW, Sanford Tracy and Westbrook Medical Centers
- Krista Kopperud, MPH, Marketing Coordinator, Sanford Tracy and Westbrook Medical Centers

The following key community stakeholders participated in this assessment work:

- Zehra Ali, Homemaker, Tracy, MN
- Roger Benson, Science Tacher, Tracy Area High School, Tracy, MN
- Darcy Carlson, Senior VP, Minnwest Bank South, Tracy, MN
- Linda Engelkes, Tracy, MN
- Derek L. Flann, Social Studies Teacher, Tracy Area High School, Tracy, MN
- Robert Gervais, City of Tracy EDA Director, Tracy, MN
- Kenneth Giles, Tracy, MN
- Roger Gorius, City Administator, Tracy, MN
- Rick Haberman, Phy Ed/Health Teacher, Tracy Public Schools, Tracy, MN
- Ziong Herr, Pastor, Tracy Hmong Alliance Church, Tracy, MN
- Kari Karbo, Balaton, MN
- Richard Karbo, I/E Planner, Balaton, MN
- Kerry Knakmuhs, Knakmuhs Insurance Agency, Walnut Grove, MN
- Lue Kue, Vice President, United Hmong International, Tracy, MN
- Ade Miller, Teacher, Tracy Public School, Tracy, MN
- Annette Miller, Director of Finance, SW/WC Service Cooperative, Balaton, MN
- Sue Nackerud, Administrative Assistant, Tracy Area Schools, Tracy, MN
- Tracey Olson, Principal, Tracy Area Schools, Tracy, MN
- Tony Peterson, Major & EDA Board Member, Tracy, MN
- Lisa Schaar, Teacher, Tracy Elementary School, Tracy, MN
- Carole Snyder, Retired, Sanford Tracy, Tracy, MN
- Charlie Snyder, City Council/EDA, Tracy, MN
- Nathan Stephens, Owner/Director, Tracy Area Funeral Home, Redwood Falls, MN
- Russ Stobb, Retired Teacher, City Council Member, Tracy, MN
- Tija Van Gelderen, Literacy Tutor, Tracy Area Elementary School, Tracy, MN
- Tamara Wee, Family & Consumer Science Teacher, Tracy Area Schools, Tracy, MN
- Willis Wendland, Hospital Board Member, Balaton, MN
- Loy Woelber, Supintendent of Schools, Dovray, MN
- Kah Yang, Walnut Grove, MN
- Terry Yang, Business Owner, Walnut Grove, MN

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Executive Summary

Purpose

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

Study Design and Methodology

The following qualitative data sets were studied:

- Community Health Needs Assessment of Community Leaders

The following quantitative data sets were studied:

- 2011 County Health Profiles for Lyon and Redwood Counties
- Aging Profiles for Lyon and Redwood Counties
- Diversity Profiles for Lyon and Redwood Counties

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

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

Key Findings – Primary Research

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.

Respondents believed that Tracy is a friendly community and that people feel connected. They also felt the current school system and health care facility are quality institutions within the community. Overall, respondents felt that Tracy is a safe, clean and healthy community to live in. They also felt that the community is "family-friendly" and that people tend to live a simple lifestyle. Surveyors also mentioned that they are happy that there are activities available for seniors and families including recreational sport activities.

Respondents listed health care and/or insurance and low wages as the top concerns in the community regarding economics. Poverty and availability of employment opportunities and affordable housing also topped the list. Respondents also showed concern about the cost and/or availability of elder care, availability of youth activities, changes in family composition, and physical health in Tracy.

Specific to community health and wellness, the cost of health insurance, prescription drugs, and health care were the top three concerns in the community. Availability of health insurance, access to health insurance coverage, availability and/or cost of dental and/or vision care also were major concerns. Cancer and chronic disease were the top concerns for illness in the community. Respondents cited obesity, lack of exercise and/or inactivity and poor nutrition/eating habits as their top concerns regarding physical health.

Surveyors felt that Sanford Tracy could improve in delivery of health care to the community through additional health services for obesity, improved costs of the delivery of health care, mental health services, and preventative services.

When choosing a primary care provider, the respondents said that location, availability of services, and quality of services were the top three reasons for their decision.

Sixty-eight percent (68%) of respondents utilize Sanford Tracy Medical Center for their primary health care facility. Marshall, Redwood Falls and Westbrook were the other locations of primary care.
A little under half of the survey respondents did not have a cancer screening in the past year. The top three reasons were: not medically necessary, no recommendation from physician, and unfamiliarity of cancer screening guidelines.

Key Findings – Secondary Research

Health Outcomes

- The Mortality health outcomes indicate that Minnesota as a state has fewer premature deaths than the national benchmark. Redwood County and Lyon County, however, has a much higher rate than the national and state benchmark.
- The Morbidity health outcomes indicate that Minnesota citizens (including Lyon and Redwood County residents) report more days of poor health than the national benchmark. They also report more physically unhealthy days than the national benchmark. Lyon County and Minnesota residents report a slightly increased number of poorer mental health days than the national benchmark. Redwood County has a significantly lower number of days that are considered "mentally unhealthy" than the national and Minnesota benchmark.

Health Factors

Health Behaviors

- Lyon County, Minnesota has a higher percentage of adults who currently smoke than the national benchmark.
- Adult obesity in Lyon and Redwood counties and across Minnesota is higher than the national benchmark. Physical inactivity in both counties is higher than the Minnesota benchmark. However, Minnesota's benchmark is lower than the national benchmark.
- Motor vehicle crash death rate is significantly higher in both Lyon and Redwood counties than the Minnesota and national benchmarks.

Clinical Care

- Redwood and Lyon counties have similar percentages of uninsured adults as the national benchmark, but higher than the state benchmark. The same is true for the percentage of uninsured youth.
- The ratios of total population in Lyon and Redwood counties to primary care physicians are higher than the national and Minnesota ratios. The ratio of total population to mental health providers is similar.
- The number of professionally active dentists per 100,000 population is lower than the national and Minnesota rates.
- Lyon County has a higher percentage of diabetes screening in the Medicare population than the national and state benchmarks. Redwood County has the same rate as the state - lower than the national benchmark. Mammography screening in Medicare enrollees shows Redwood County with a higher percentage than the state and national benchmarks; Lyon County is lower than both benchmarks.

Social and Economic Factors

- Lyon County has a higher percentage of high school graduates than the national and state benchmarks. Redwood County has a higher percentage than the Minnesota benchmark, but lower than the national benchmark. Lyon County has a higher percentage of adults with some post-secondary education than the Minnesota and national benchmarks; Redwood County has a lower percentage than the state and national benchmarks.
- 2008 data showed the percentage of children living in poverty in both counties were higher than the national and state percentages.
- The percentage of children in single parent households in both Lyon and Redwood counties was higher than the national benchmark, but lower than the state benchmark.

Physical Environment

- There is no air or ozone pollution in Lyon or Redwood counties.
- Access to recreational facilities in Lyon and Redwood counties is lower than the state and national benchmarks.

Demographics

- Redwood County has a higher percentage of youth living in the county than the state and national benchmarks. Elderly account for 15% and 20% of the population in Lyon and Redwood counties respectively, both of which are higher than the Minnesota and national benchmarks.
- Both counties are mostly rural as 50% and 66% of the population live in a "rural" area.
- Lyon and Redwood County residents have a higher rate of illiteracy than the Minnesota benchmark at 7 and 8%. However, they are lower than the national benchmark of 15%.

Implementation Strategy

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

- Urgent Care After Hours
- Mental Health Services

Implementation Strategy: Urgent Care After Hours

- Have full medical staff to be able to coordinate expanded hours
- Nursing staff coordination
- Receptionist staff coordination
- Market new Urgent Care hours to public
- Ancillary Staff Coordination (Lab/X-Ray, etc.)

Implementation Strategy: Mental Health Services

- Increase availability of medical health providers
- Obtain certification of Medical Home and implement health care coach to help with resources and guidance for patients
- Continue discussion on holding patients and resources to help with placing patients quickly
- Work with community partners to create new recovery program options for community members

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

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

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

Our Values:

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

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

Guiding Principles:

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

Description of the Hospital

Sanford Tracy Medical Center (Sanford Tracy) is a 25-bed Critical Access Hospital located in southwest Minnesota, Lyon County, in the city of Tracy. It is 90 miles from Sioux Falls, South Dakota and 150 miles southwest of Minneapolis/Saint Paul, Minnesota. Since 2001 Sanford Tracy has enjoyed a collaborative relationship with Sanford Westbrook Medical Center (Sanford Westbrook). As neighboring communities, these two health care facilities share administrative staff, CEO, CFO, DOO and managerial staffing in the areas of radiology, laboratory, human resources and marketing/community relations. The efficiency and cost effectiveness of these shared resources allows each facility to redirect valuable time, energy and financial assets into direct patient care. The two Critical Access Hospitals provide services for approximately 9,400 people.

Built by the City of Tracy in 1960 as a municipal hospital, the hospital became a leased member of the Sioux Valley (now Sanford Health Network) Health System in 1998 and is a Trauma 4 designated facility. Additional renovation and expansion was completed in 2010, which increased space in the primary clinic to accommodate additional primary care providers and place regularly scheduled specialized medicine clinics within close proximity. The hospital campus consists of a primary care clinic, medical specialty outpatient clinic, and a 30-apartment senior living facility. In addition, two satellite medical clinics are located in the neighboring communities of Balaton (12 miles to the west) and Walnut Grove (seven miles to the east. The service area of Sanford Tracy includes the communities of Tracy, Currie, Balaton, Amiret, Walnut Grove, Milroy and Revere. The population of this area is approximately 5,740 persons.

Description of the Community Served

Tracy is a city in Lyon County, Minnesota. As of the census of 2010, there were 2,163 people, 876 households, and 549 families residing in the city. The racial makeup of the city was 86.5% White, 0.1% African American, 0.3% Native American, 9.7% Asian, 0.1% Pacific Islander, 1.5% from other races, and 1.7% from two or more races. Hispanic or Latino of any race were 5.4% of the population.

Out of a total of 876 households, 29.3% had children under the age of 18 living with them, 48.5% were married couples living together, 9.9% had a female householder with no husband present, 4.2% had a male householder with no wife present, and 37.3% were non-families. Of all households, 34.7% were made up of individuals and 18.3% had someone living alone who was 65 years of age or older. The average household size was 2.39 and the average family size was 3.10.

The median age in the city was 38.7 years. Residents under the age of 18 were 26.4%, 7.9% were between the ages of 18 and 24, 22.5% were from 25 to 44, 23% were from 45 to 64, and 20.2% were 65 years of age or older. The gender makeup of the city was 48.2% male and 51.8% female.

Tracy is home to the Tracy-Milroy-Balaton High School and Elementary School, Sanford Tracy Medical Center, Tracy Food Pride, a public day care facility, retail shops, and a public library. In addition, numerous churches, city and county parks, an aquatic center, and recreation amenities are available. Active organizations in the community include Kiwanis, Lions Club, VFW, American Legion, Tracy Area Medical Foundation, Economic Development Authority, 4-H clubs, and Chamber of Commerce.

Study Design and Methodology

In May 2011 Sanford Health convened key health care leaders and other not-for-profit leaders in the Fargo Moorhead community to establish a Fargo Moorhead Community Health Needs Assessment Collaborative. A

primary goal of this collaborative is to craft standardized tools, indicators and methodology that can be used by all group members when conducting assessments and also be used by all of the Sanford medical centers across the enterprise. After much discussion it was determined that the Robert Wood Johnson Framework for county profiles would be our secondary data model.

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

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

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

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

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

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

The following qualitative data sets were studied:

- Survey of Key Stakeholders

The following quantitative data sets were studied:

- 2011 County Health Profiles for Lyon and Redwood counties
- Aging Profiles for Lyon and Redwood counties
- Diversity Profiles for Lyon and Redwood 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. Sanford Tracy key stakeholders performed the asset mapping and reviewed the findings. The group conducted an informal gap analysis to determine what needs remained after resources were thoroughly researched. Once gaps were determined the group proceeded to the prioritization process. The multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

Tracy Community Health Needs Assessment of Stakeholders

The purpose of the stakeholder survey was to explore the views of key leaders in the Tracy area (health professionals, social workers, educators, elected leadership, and nonprofit leaders, etc.) regarding the resident population's health and the prevalence of disease and health issues within the community.

The survey instrument was an Internet-based survey tool (i.e. Survey Monkey) designed by the Greater Fargo Moorhead Community Health Needs Assessment Collaborative with 30 questions focusing on community assets, general concerns about communities, community health and wellness concerns, and demographic information. This 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 Patient Protection and Affordable Care Act signed into law on March 23, 2010.

The survey was forwarded on to key contacts within the Tracy area and then disseminated throughout the community. Data was collected through late April. A total of 46 surveys were completed through the Internet link. The purpose of this survey was to learn about the perceptions of area key stakeholders and community members regarding the prevalence of disease and health issues in their community.

2011 County Health Profiles

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

Aging Profiles

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

Diversity Profiles

The Diversity Profiles are based on data from the U.S. Census Bureau, 2010 Census Summary File 1, and 2006-2010 American Community Survey Five-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across race and ethnic categories; however, because they are based on sample data, one should use caution when interpreting small numbers. Blank values reflect data that is missing

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

Limitations

Sanford Tracy gathered data from community stakeholders for the purposes of determining the needs of the community. There were 46 surveys completed. Because of the small sample size, it is important to note that this data may not represent all residents of the Tracy area. This data will serve as additional insight into prevalence of disease and health issues in the Tracy area as highlighted by statistics from the Minnesota Department of Health, The Centers for Disease Control and Prevention, and U.S. Census Bureau.

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

Primary Research

Summary of the Survey Results

Respondents believed that Tracy is a friendly community and that people feel connected. They also felt the current school system and health care facility are quality institutions within the community. Overall, respondents felt that Tracy is a safe, clean, and healthy community to live in. They also felt the community is "family-friendly" and people tend to live a simple lifestyle. Surveyors also mentioned they are happy that there are activities available for seniors and families including recreational sport activities.

Respondents of the survey listed health care and/or insurance and low wages as the top concerns in the community regarding economics. Availability of employment opportunities and affordable housing and poverty also topped the list. Respondents also showed concern about the cost and/or availability of elder care, availability of youth activities, changes in family composition, substance abuse, and physical health in Tracy.

Specific to community health and wellness, the cost of insurance, prescription drugs, and health care were the top three concerns in the community. Adequacy of health insurance, access to health insurance coverage, availability and/or cost of dental and/or vision care also were major concerns. Cancer and chronic disease were the top concerns for illness in the community. Respondents cited obesity, lack of exercise and/or inactivity and poor nutrition/eating habits as their top concerns regarding physical health.

Community Assets/Best Things about their Community

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

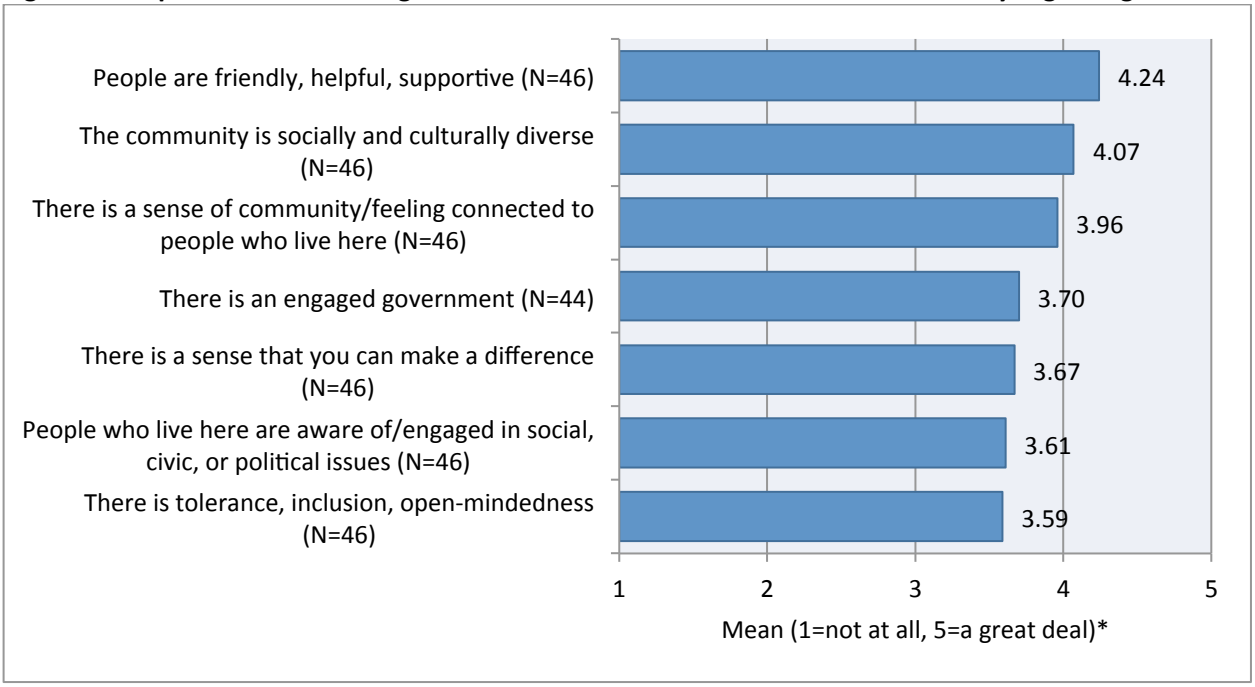
Respondents indicated the top five community assets of best things about the community were: people are friendly, helpful, and supportive, the community is socially and culturally diverse, there is a sense of community/feeling connected to people who live here, there is an engaged government, and there is a sense that you can make a difference.

Overall, respondents had moderately high levels of agreement regarding positive statements that reflect the people in their community (*Figure 2)*.

- The majority of respondents found that people in Tracy are friendly, helpful, and supportive. They also felt there is a sense of community/feeling connected to people who live here.

- Respondents also had a fairly high level of agreement that there is tolerance, inclusion, and open-mindedness in the community and they feel as those there is a sense that you can make a difference.

Figure 2. Respondents' level of agreement with statements about their community regarding PEOPLE

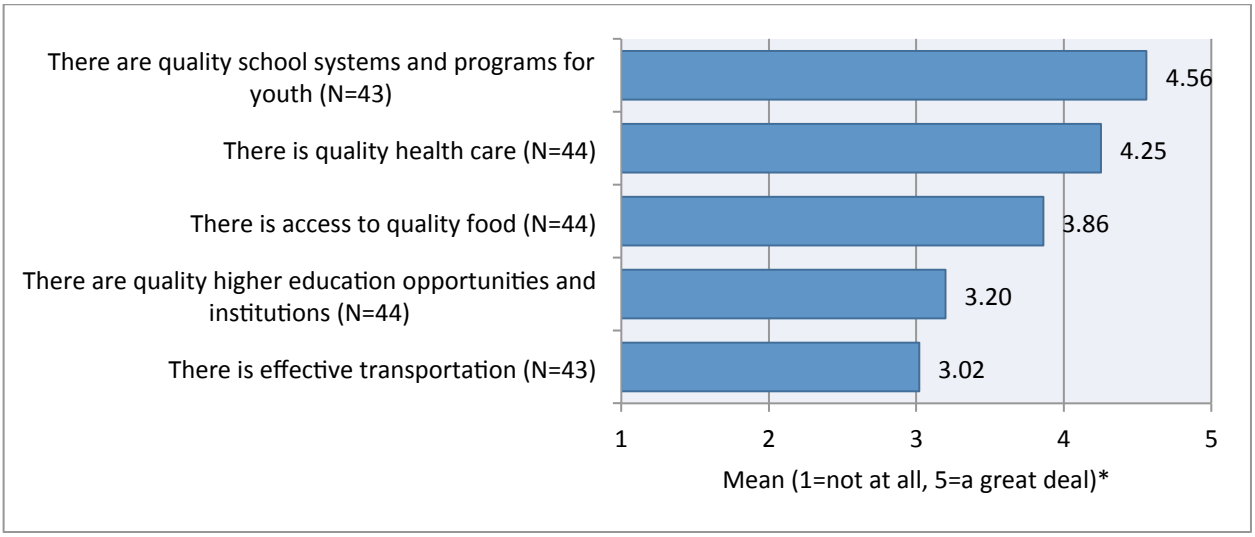


Services and Resources

Respondents had high levels of agreement that there are quality school systems and programs for youth in their community. They also agreed that there is quality health care and access to quality food in the community.

Although still a moderate level of agreement, respondents agreed the least there is effective transportation and quality higher education opportunities and institutions in the community *(Figure 3.).*

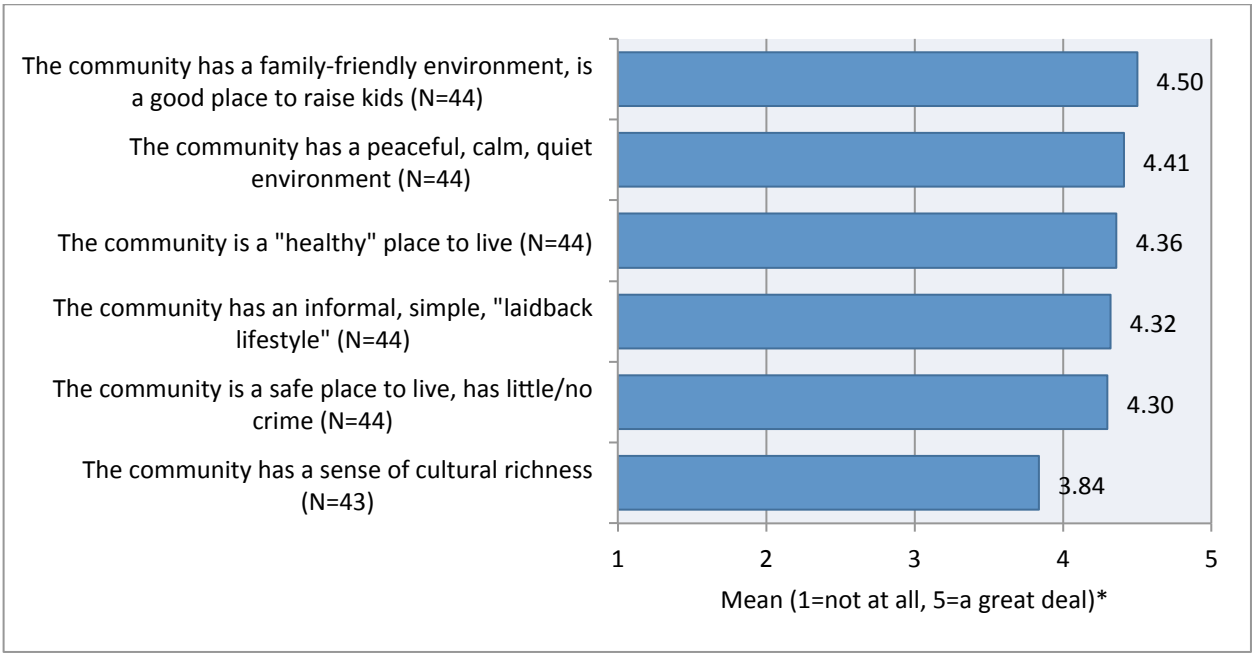
Figure 3. Respondents' level of agreement with statements about their community regards SERVICES and RESOURCES



Quality of Life

Overall, respondents had a very high level of agreement that their community is safe and a healthy place to live. Means ranged from 4.50 to 3.84, with the community having a sense of cultural richness ranked the lowest (*Figure 4).*

Figure 4. Quality of Life in Tracy



Respondents were asked to describe other best things about their community.

- Churches and school system
- People help each other out; the community is very caring and pulls together for families in need
- Cost of living is relatively low

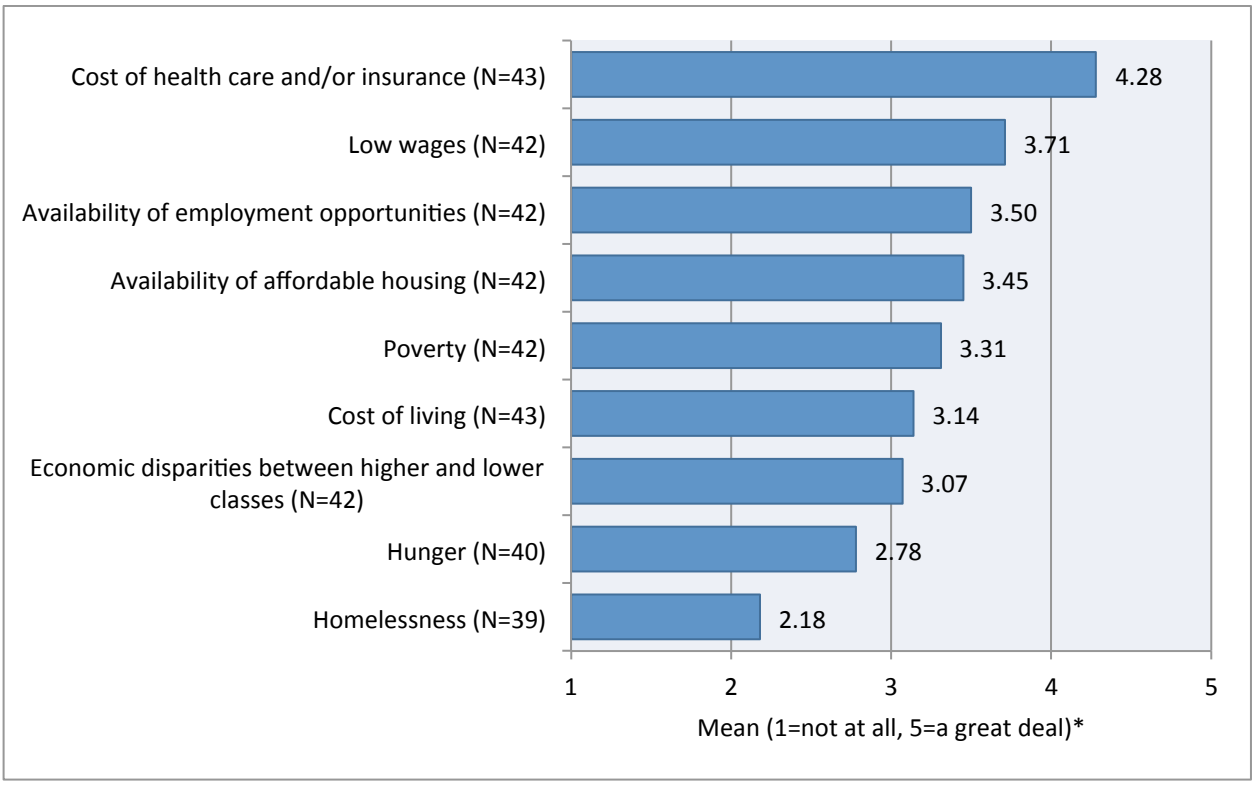
General Concerns about their Community

Using a 1 to 5 scale, with 1 being "not at all" and 5 being "a great deal," respondents were asked to rate their level of agreement with various statements regarding ECONOMIC ISSUES, SERVICES AND RESOURCES, YOUTH CONCERNS, and SAFETY CONCERNS in their community.

Economic Issues

Respondents had moderate levels of concern with respect to cost of health care and/or insurance, low wages, availability of employment opportunities, and affordable housing (Figure 5).

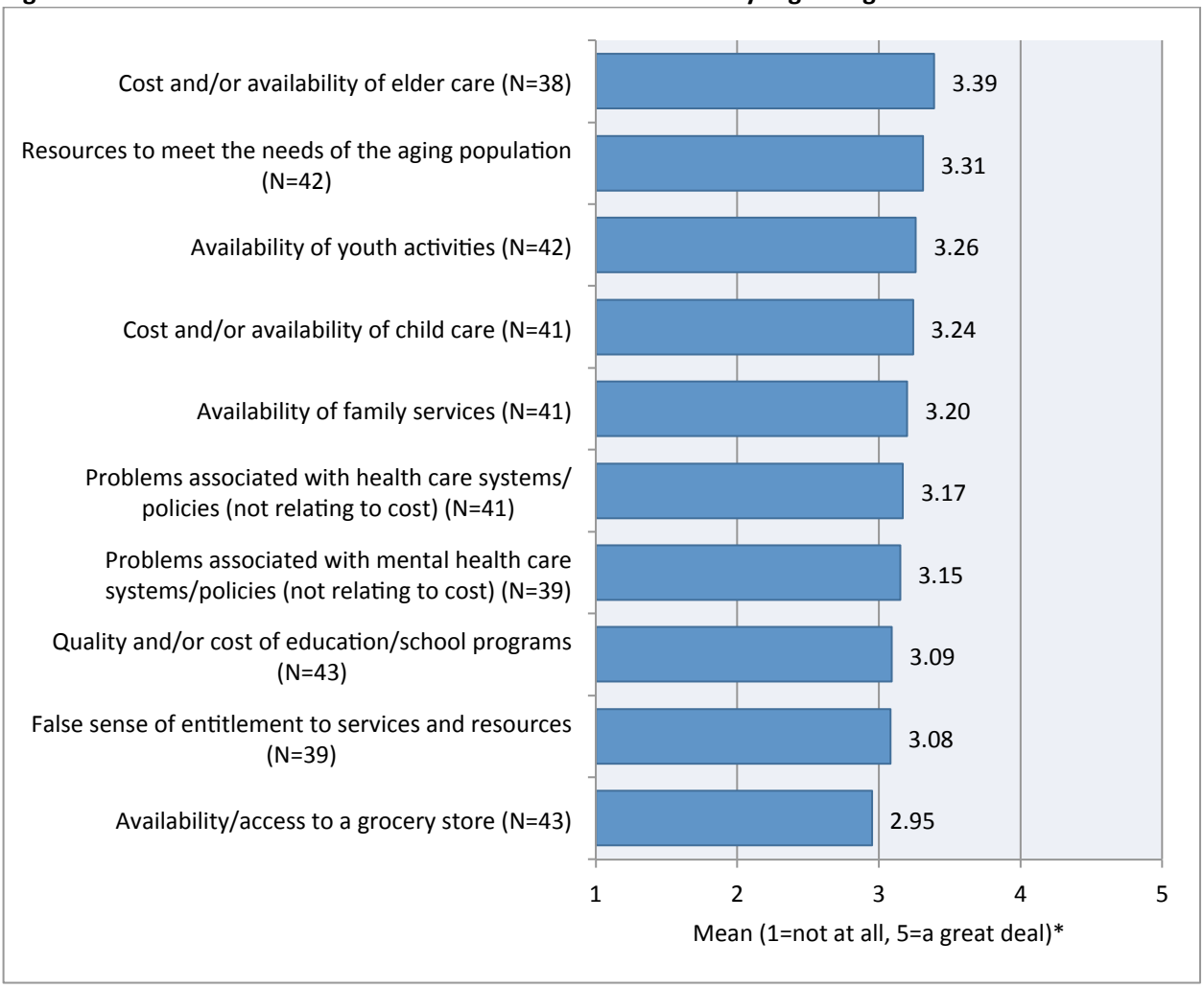
Figure 5. Respondents' level of concern with statements about their community regards ECONOMIC ISSUES



Services and Resources

Respondents were mostly concerned about the cost and/or availability of elder care, resources to meet the needs of the aging population, and the availability of youth activities *(Figure 6).*

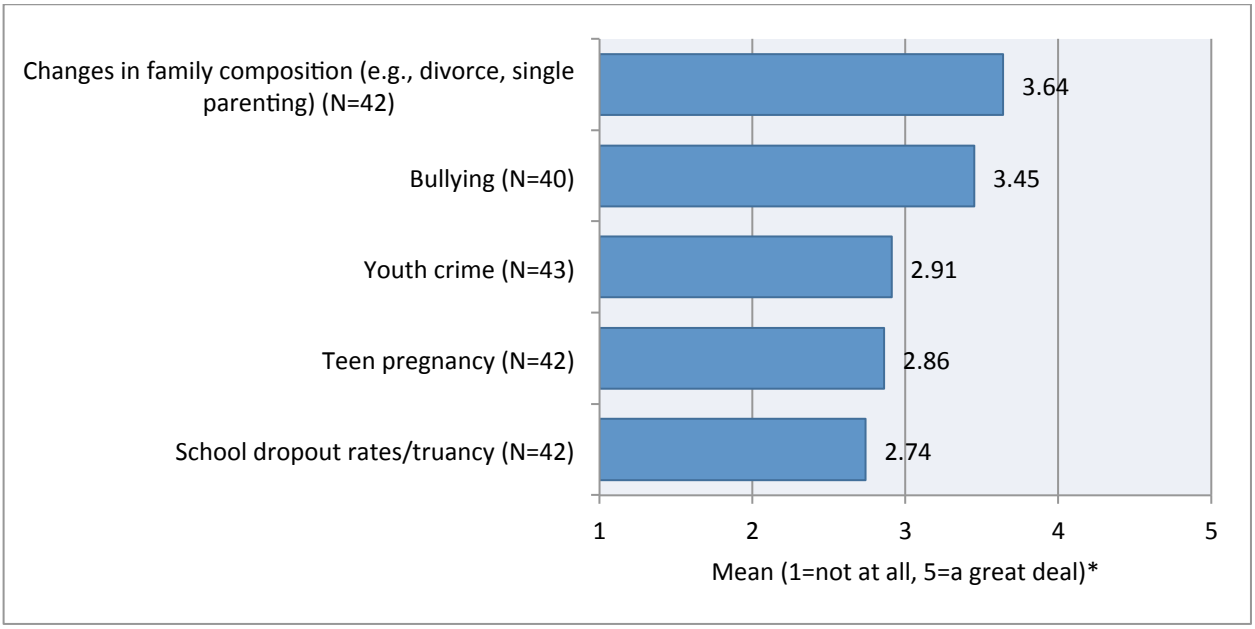
Figure 6. Level of concern with statements about the community regarding SERVICES AND RESOURCES



Children and Youth

Respondents showed moderate concern with changes in the family composition (e.g. divorce, single-parenting), bullying, and youth crime. Truancy was the area of least concern (*Figure 7).*

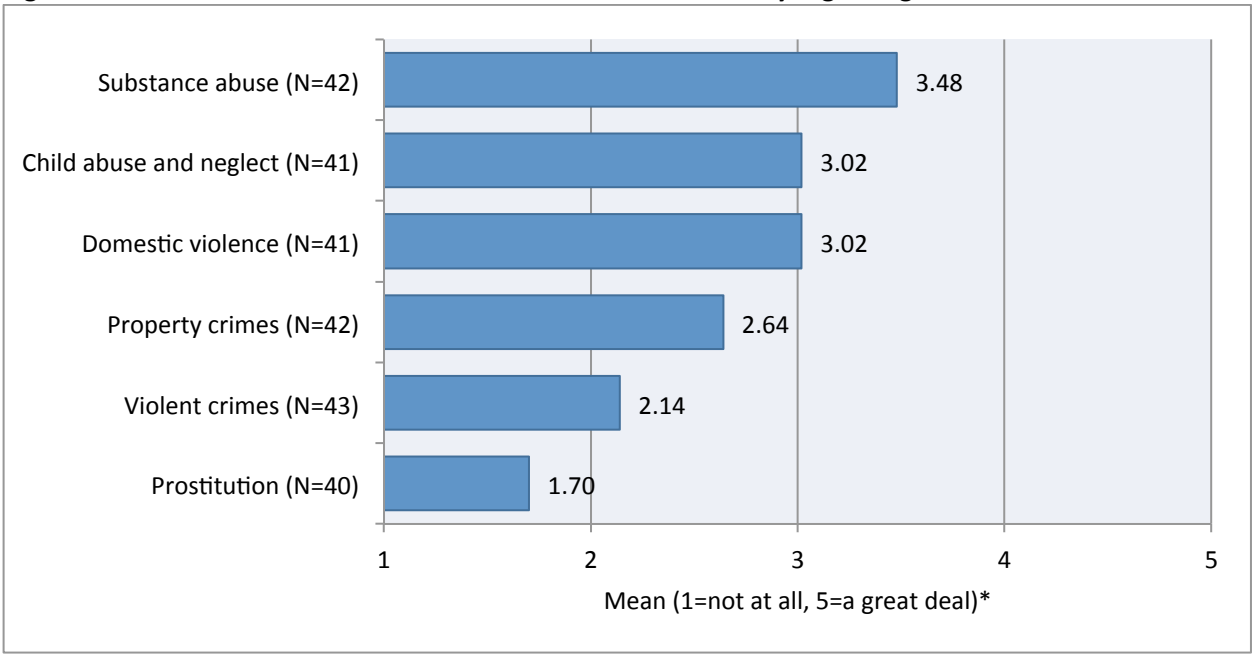
Figure 7. Level of concern with statements about the community regarding YOUTH CONCERNS



Safety Concerns

Respondents were moderately concerned with substance abuse in the community. They were least concerned with prostitution and violence crimes (*Figure 8).*

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



Health and Wellness Concerns about their Community

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

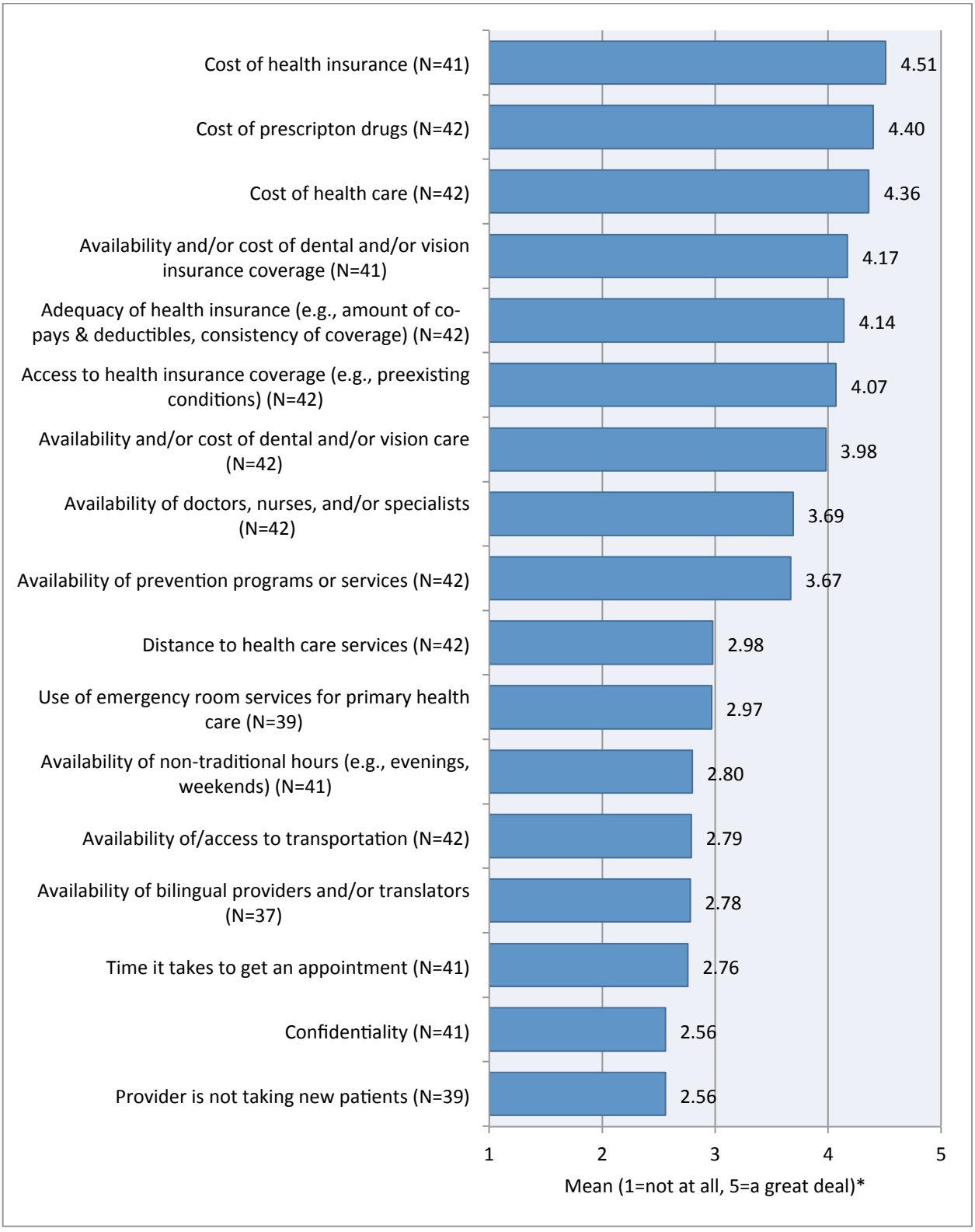
Access to Health Care

Respondents had concern with respect to costs associated with health and wellness in their community. Cost of insurance, prescription drugs, and health care were the top three concerns.

Availability and/or cost of dental and/or vision care, adequacy of health insurance, and access to health insurance coverage were also above average for level of concern.

Respondents were least likely to be concerned with a provider‘s availability of accepting new patients and patient confidentiality (Figure 9).

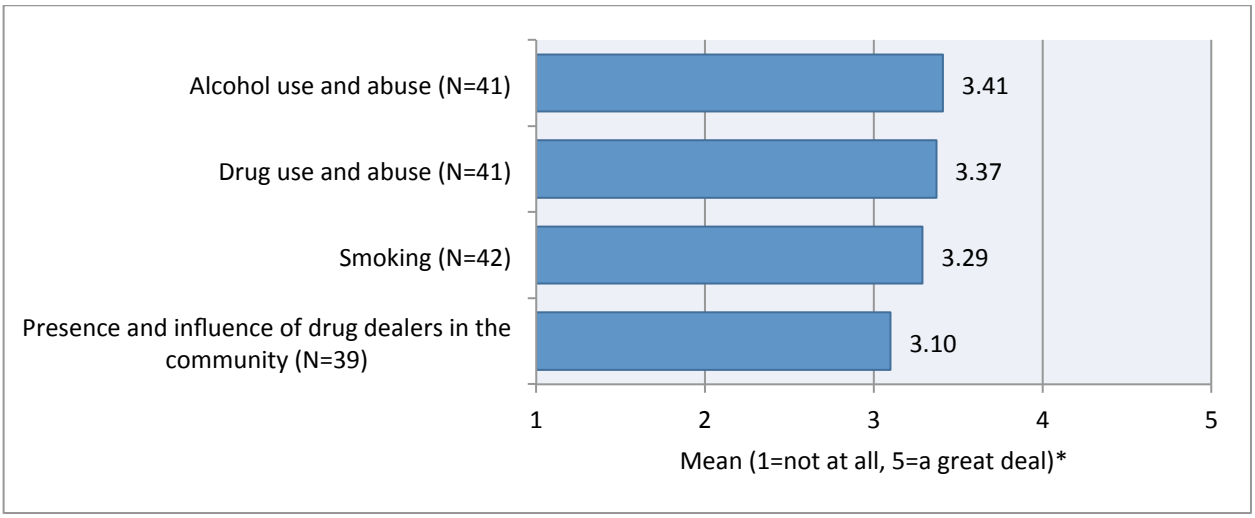
Figure 9. Level of concern with statements about the community regarding ACCESS TO HEALTH CARE



Substance Use and Abuse

Respondents were most concerned about alcohol use and abuse in the community followed by drug use and abuse. All areas were moderately concerning to the community members (*Figure 10).*

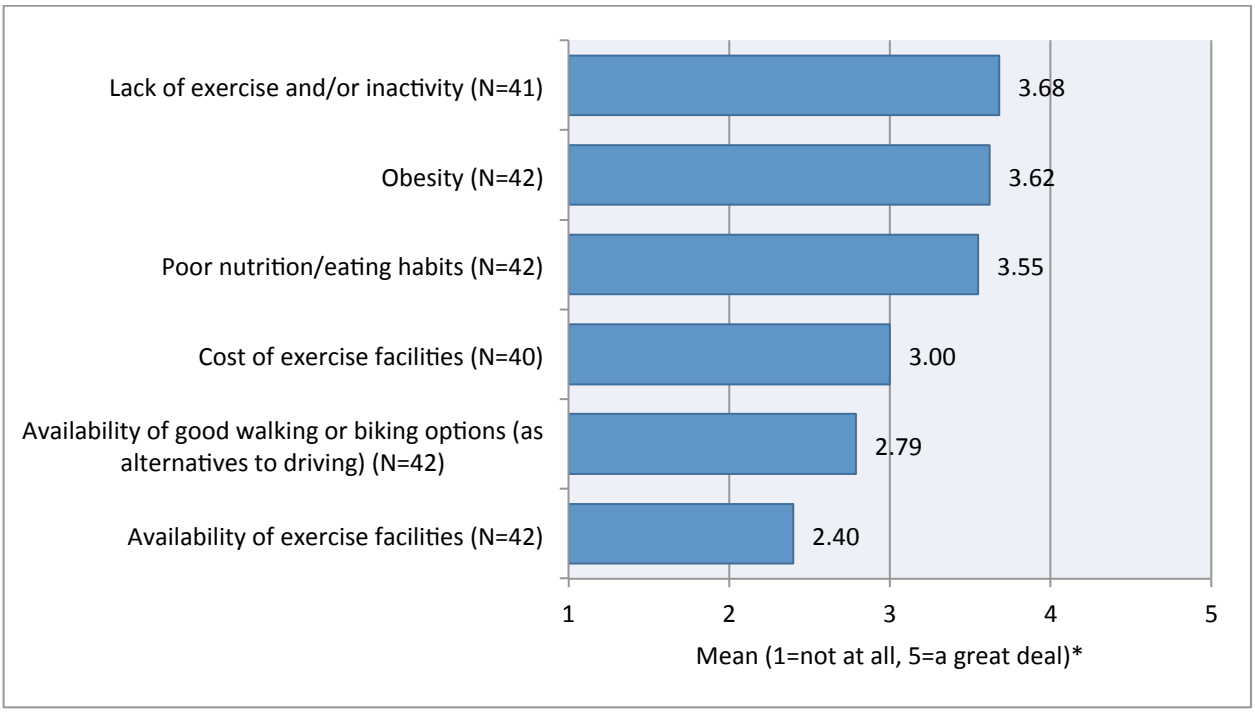
Figure 10. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE



Physical Health

The top three concerns respondents had in regards to physical health included lack of exercise and/or inactivity, obesity, and poor nutrition/eating habits (*Figure 11*).

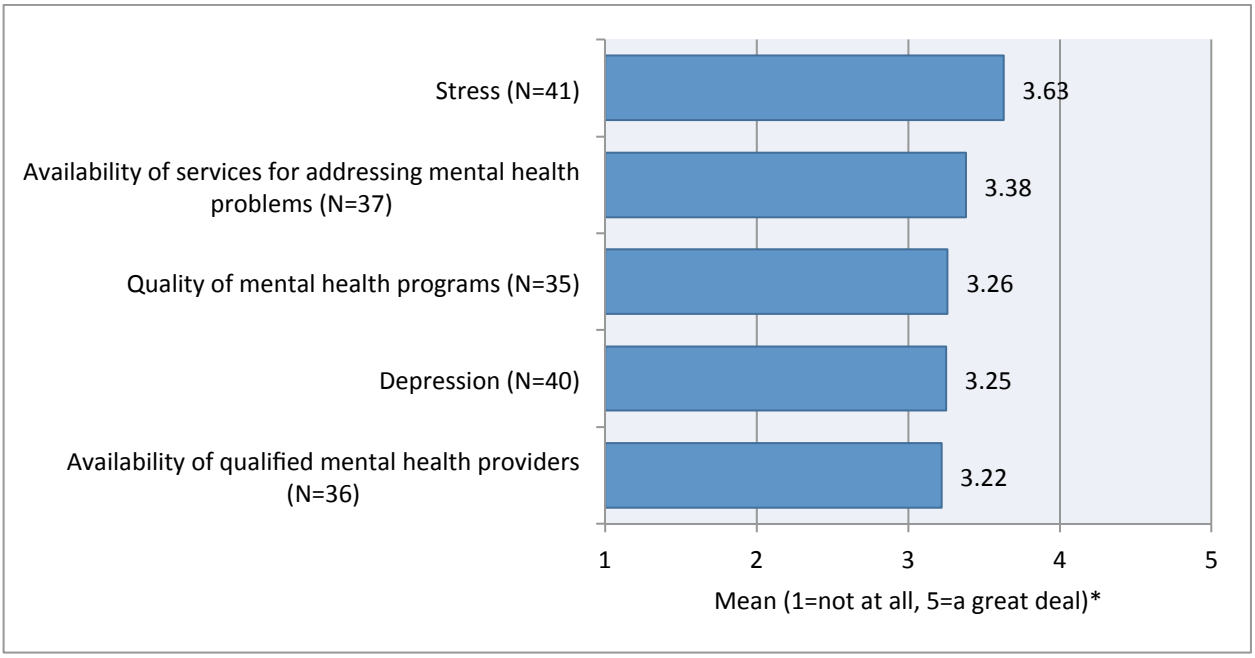
Figure 11. Level of concern with statements about the community regarding PHYSICAL HEALTH



Mental Health

Stress is highest mental health concern to the respondents followed by availability of services. All areas of mental health were moderately concerning to the community members *(Figure 12).*

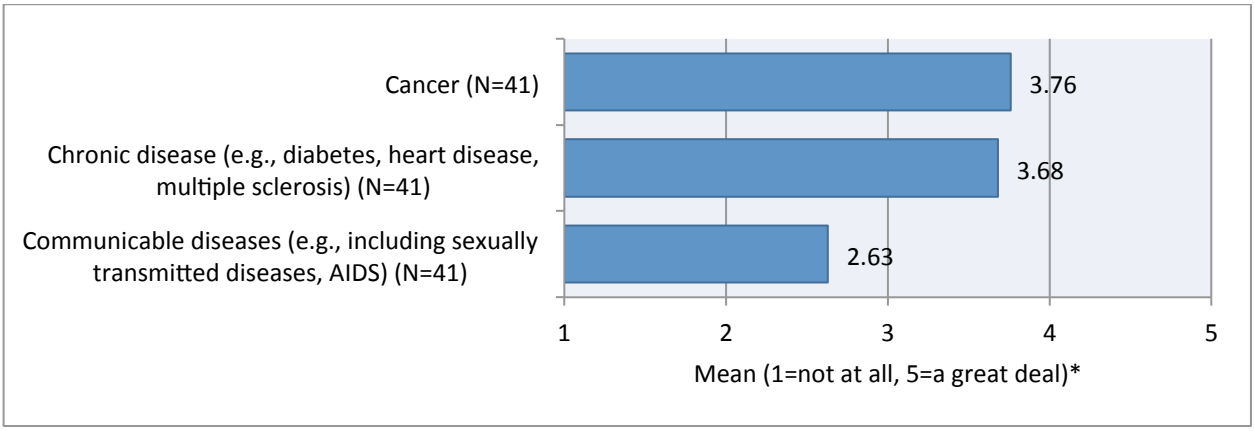
Figure 12. Level of concern with statements about the community regarding MENTAL HEALTH



Illness

Cancer was the number one concern of respondents regarding illness in the community. Chronic disease was second *(Figure 13).*

Figure 13. Level of concern with statements about the community regarding ILLNESS

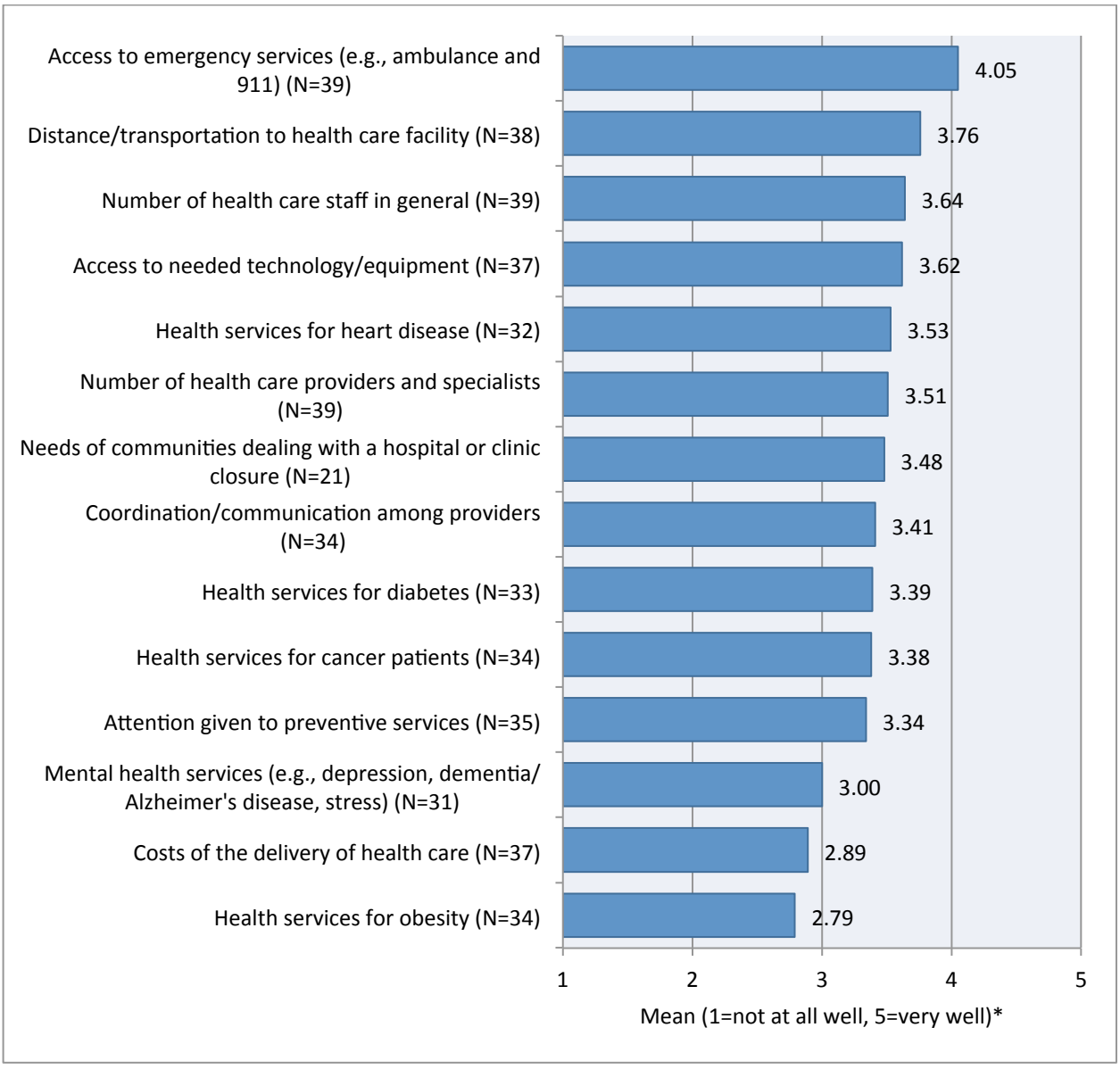


Delivery of Health Care

Respondents were asked how well the medical center is doing meeting the need of health and illness in the community. Access to emergency services, distance/transportation to health care facility, the number of health care staff in general, and access to needed technology/equipment were the top rated services.

Respondents felt that health services for obesity, mental health services, and costs for the delivery of health care could be improved upon (*Figure 14*).

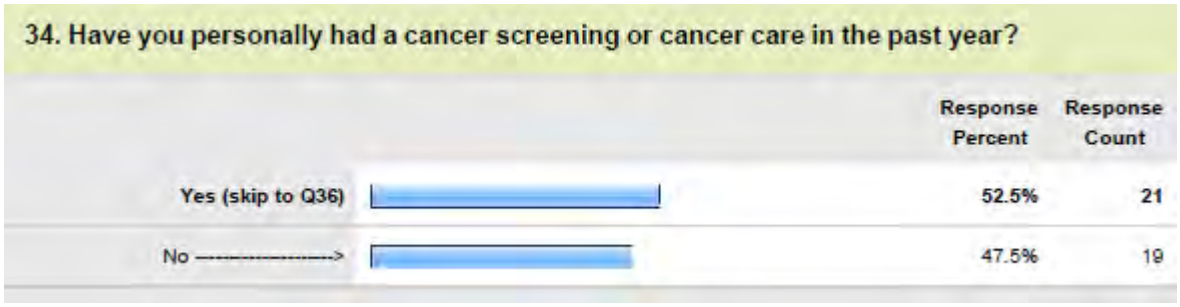
Figure 14. How well topics related to DELIVERY OF HEALTH CARE in the community are being addressed



Cancer Screening

47.5% of respondents did not have cancer screening or cancer care in the past year *(Figure 15).*

Figure 15. Cancer Screening or Cancer Care in the Past Year

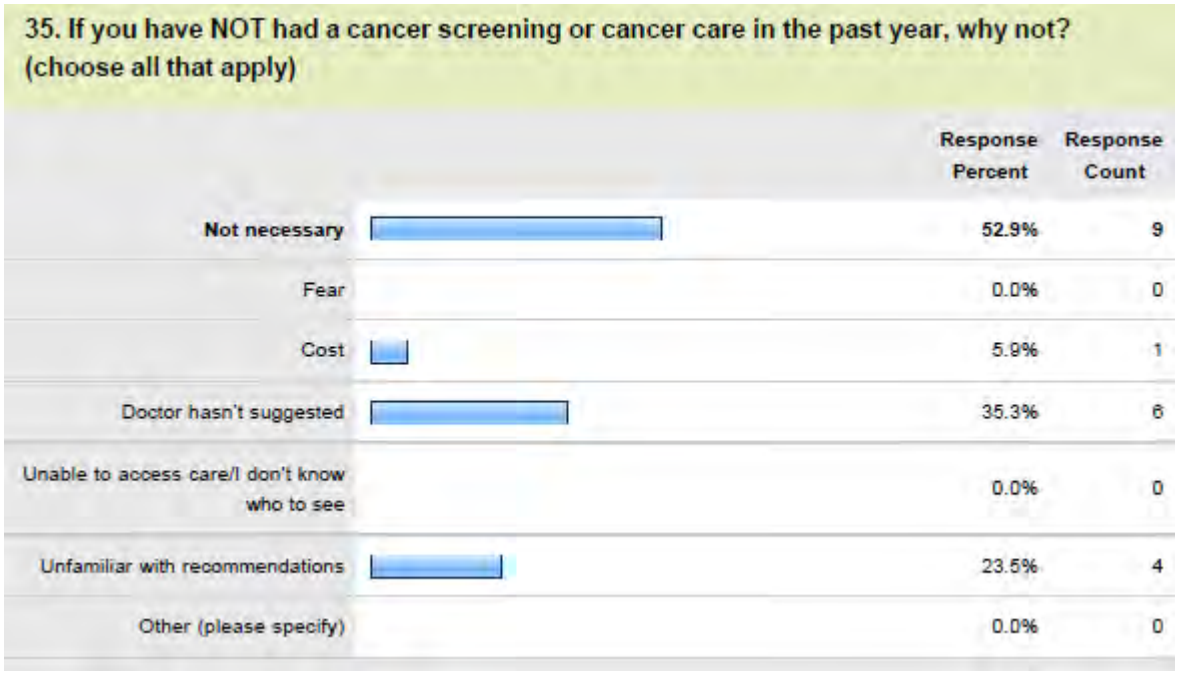


34. Have you personally had a cancer screening or cancer care in the past year?

	Response Percent	Response Count
Yes (skip to Q36)	52.5%	21
No ---------->	47.5%	19

Of those respondents who did not have a cancer screening or cancer care in the past year, the majority did not because it was not medically necessary. The second reason was based on the lack of provider recommendation/referral. 23.5% did not have a cancer screening due to lack of knowledge with screening guidelines and a smaller percentage did not have a screening because of the cost *(Figure 16).*

Figure 16. Reasons for Cancer Screening Decision



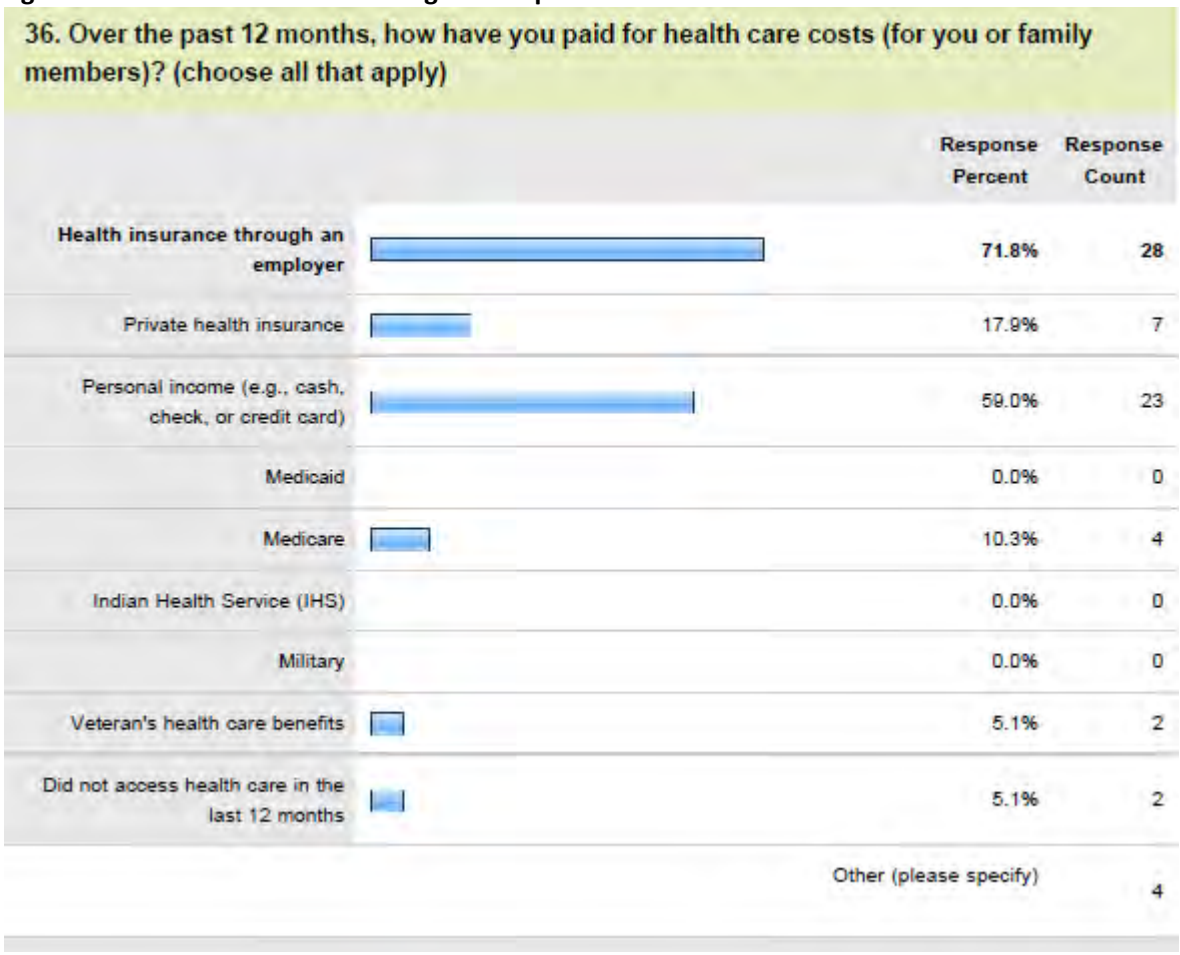
35. If you have NOT had a cancer screening or cancer care in the past year, why not? (choose all that apply)

	Response Percent	Response Count
Not necessary	52.9%	9
Fear	0.0%	0
Cost	5.9%	1
Doctor hasn't suggested	35.3%	6
Unable to access care/I don't know who to see	0.0%	0
Unfamiliar with recommendations	23.5%	4
Other (please specify)	0.0%	0

Health Care Coverage

Over 70% of respondents utilized employer-based health insurance to pay for medical costs. Personal income was second, followed by private health insurance *(Figure 17).*

Figure 17. Health Insurance Coverage of Respondents



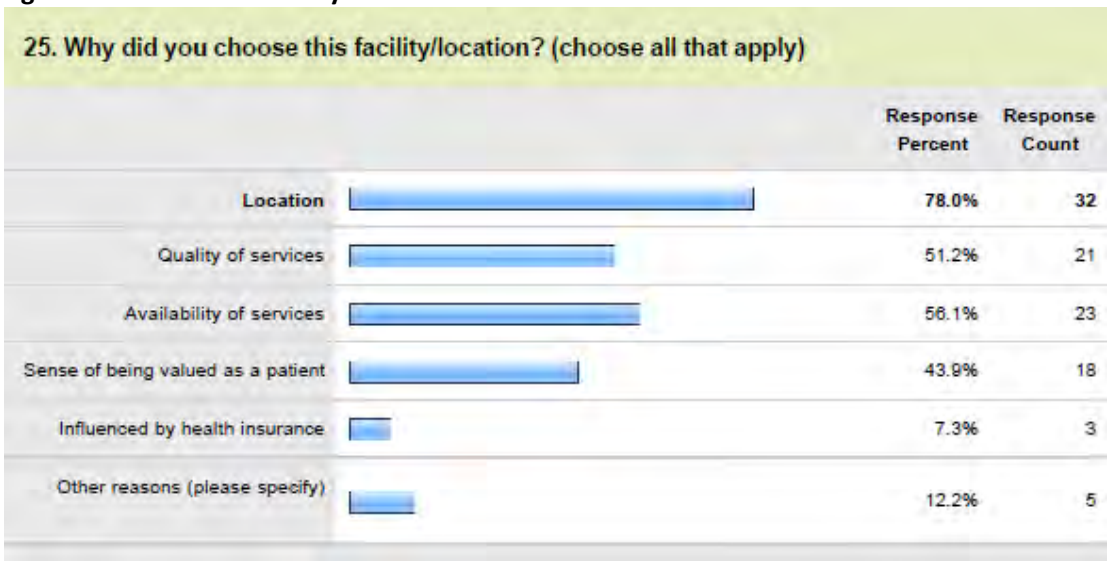
36. Over the past 12 months, how have you paid for health care costs (for you or family members)? (choose all that apply)

	Response Percent	Response Count
Health insurance through an employer	**71.8%**	**28**
Private health insurance	17.9%	7
Personal income (e.g., cash, check, or credit card)	59.0%	23
Medicaid	0.0%	0
Medicare	10.3%	4
Indian Health Service (IHS)	0.0%	0
Military	0.0%	0
Veteran's health care benefits	5.1%	2
Did not access health care in the last 12 months	5.1%	2
Other (please specify)		4

Primary Care Provider

68% of respondents utilize Sanford Tracy as their location for primary care services. They choose their primary care location based on location and availability of services. Health insurance did not seem to be a factor when picking a primary care location (*Figure 18).*

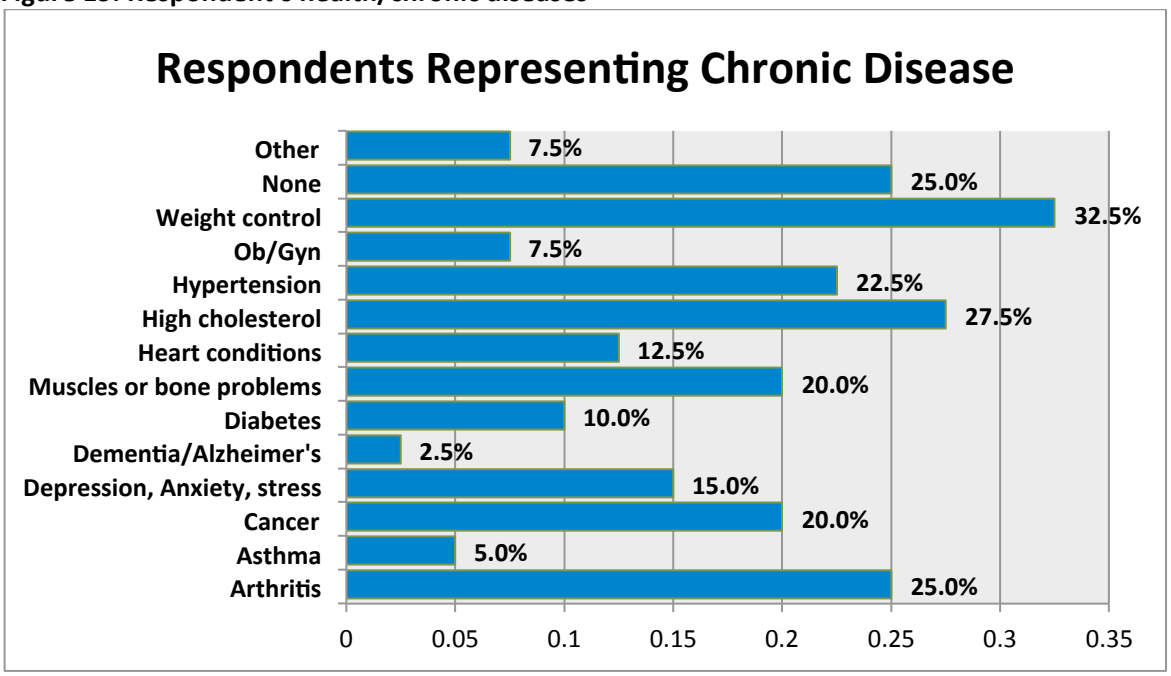
Figure 18. Choice of Primary Care Location



Respondents Representing Chronic Disease

Respondents were asked to select their personal general health conditions/diseases. High cholesterol received the most responses with 32.5 % of participants selecting this condition. The chronic diseases found in the highest percentage among respondents include, arthritis, cancer, muscles or bone problems, hypertension and hypercholesterolemia. (Figure 19)

Figure 19. Respondent's health/chronic diseases



Demographic Information

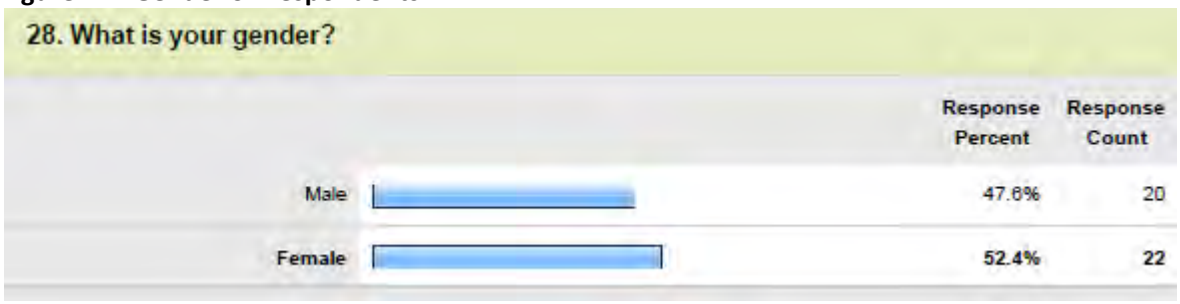
Respondents of the survey were more likely to be between the ages of 35 to 59 years of age (*Figure 20*). They were also more likely to be female (*Figure 21*) and have a Bachelor's degree (*Figure 22*).

Figure 20. Age of Respondents

27. What is your age?

	Response Percent	Response Count
18 to 24 years	0.0%	0
25 to 34 years	9.5%	4
35 to 44 years	21.4%	9
45 to 54 years	**35.7%**	**15**
55 to 59 years	16.7%	7
60 to 64 years	7.1%	3
65 years and older	9.5%	4

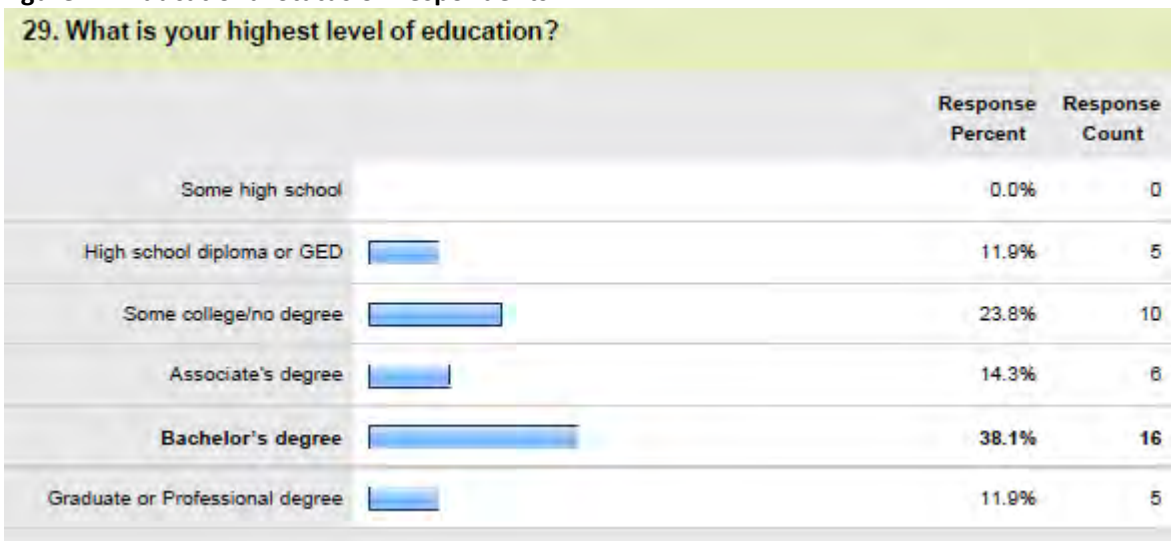
Figure 21. Gender of Respondents



28. What is your gender?

	Response Percent	Response Count
Male	47.6%	20
Female	**52.4%**	**22**

Figure 22. Educational Status of Respondents



29. What is your highest level of education?

	Response Percent	Response Count
Some high school	0.0%	0
High school diploma or GED	11.9%	5
Some college/no degree	23.8%	10
Associate's degree	14.3%	6
Bachelor's degree	**38.1%**	**16**
Graduate or Professional degree	11.9%	5

Secondary Research

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

Health Outcomes

Mortality

The Mortality health outcomes indicate that Minnesota as a state has fewer premature deaths than the national benchmark. Redwood County and Lyon County, however, have much higher rates than the national and state benchmark (*Figure 24*).

Figure 24. Mortality in Lyon and Redwood Counties

		Lyon County	Redwood County	National Benchmark	Minnesota
Premature Death	Years of potential life lost before 75 per 100,000 (age-adjusted), 2005-2007	6,014	7,196	5,564	5,272

Morbidity

The Morbidity health outcomes indicate that Minnesota citizens (including Lyon and Redwood County residents) report more days of poor health than the national benchmark. They also report more physically unhealthy days than the national benchmark. Both Lyon County and Minnesota residents report a slightly increased number of poorer mental health days than the national benchmark. Redwood County has a significantly lower number of days that are considered "mentally unhealthy" than the national and Minnesota benchmarks.

Lyon County and Redwood County residents have a lower percentage of low birth weight infants than the Minnesota benchmark. Redwood County is lower than the national benchmark (*Figure 24).*

Figure 25. Morbidity in Lyon and Redwood Counties

		Lyon County	Redwood County	National Benchmark	Minnesota
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	12%	12%	10%	11%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.7	3.0	2.6	3.1
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	3.2	1.1	2.3	2.8
Low birth weight	Percent of live births with low birth weight (<2,500 grams), 2001-2007	6.3%	5.7%	6.0%	6.5%

Health Factors

Health Behaviors

The Health Behavior outcomes indicate that Lyon County has a higher percentage of adults who currently smoke than the national benchmark.

Adult obesity rates in Lyon and Redwood counties and across Minnesota are higher than the national benchmark. Physical inactivity in both counties is higher than the Minnesota benchmark. However, Minnesota's benchmark is lower than the national benchmark.

Percentages of adults reporting binge drinking and heavy drinking in Lyon County is the same as the Minnesota benchmark, but higher than the national benchmark.

The motor vehicle crash death rate is significantly higher in both Lyon and Redwood County than the Minnesota and national benchmarks.

Sexually transmitted infections rank lower in both counties in comparison with the national and state benchmarks.

The teen birth rates in both counties are lower than the Minnesota rate, but higher than the national benchmark (*Figure 26*).

Figure 26. Health Behaviors Data in Lyon and Redwood Counties

		Lyon County	Redwood County	National Benchmark	Minnesota
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	17%	-	15%	19%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008	29%	28%	25%	26%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	19%	20%	20%	17%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking, 2003-2009	20%	-	8%	20%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	20.7	22.3	12.0	12.9
Sexually Transmitted infections	Number of Chlamydia cases (new cases reported) per 100,000 population, 2008	213.3	83.9	83.0	276.1
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	22.4	27.0	22.0	27.5

Clinical Care

The Clinical Care outcomes indicate that Redwood and Lyon counties have similar percentages of uninsured adults as the national benchmark, but higher than the state benchmark. The same is true for the percentage of uninsured youth.

The ratio of total population in Lyon and Redwood counties to primary care physicians is higher than the national and Minnesota ratios. The ratio of total population to mental health providers is similar.

The number of professionally active dentists is lower than the state and national data.

Preventable hospital stays in Lyon and Redwood counties are lower than the state benchmark. Lyon County is slightly higher than the national benchmark.

Lyon County has a higher percentage of diabetes screening in the Medicare population than the national and state benchmarks. Redwood County has the same rate as the state - lower than the national benchmark. Mammography screening in Medicare enrollees shows Redwood County with a higher percentage than the state and national benchmarks - Lyon County is lower than both benchmarks (*Figure 27*).

Figure 27. Clinical Care Data in Lyon and Redwood Counties

		Lyon County	Redwood County	National Benchmark	Minnesota
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	14%	13%	13%	11%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	7%	8%	7%	6%
Primary care physicians	Ratio of total population to primary care physicians, 2008	1,088:1	975:1	631:1	636:1
Mental health providers	Ratio of total population to mental health providers, 2008	2,276:1	5,199:1	2,242:1	1,306:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	40.3	32.3	69.0	61.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	52.7	50.7	52.0	56.5
Diabetes screening	Percent of Medicare enrollees with diabetes that receive HbA1c screening, 2006-2007	96%	88%	89%	88%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	71%	77%	74%	73%

Social and Economic Factors

The Social and Economic Factors outcomes indicate that Lyon County has a higher percentage of high school graduates than the national and state benchmarks. Redwood County has a higher percentage than the Minnesota benchmark, but lower than the national benchmark. Lyon County has a higher percentage of adults with some post-secondary education than the Minnesota and national benchmarks; Redwood County has a lower percentage than the state and national benchmarks.

The 2009 unemployment rates for Lyon and Redwood counties were higher than the national benchmark, but lower than the state benchmark.

2008 data also showed the percentage of children living in poverty in both counties was higher than the national and state percentages.

The percentage of children in single parent households in both Lyon and Redwood Counties was higher than the national benchmark but lower than the state benchmark.

The number of homicide deaths in Minnesota is higher than the national benchmark. (*Figure 28*)

Figure 28. Social and Economic Factors

		Lyon County	Redwood County	National Benchmark	Minnesota
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007	100%	90%	92%	87%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	74%	62%	68%	72%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	6.0%	7.0%	5.3%	8.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	12%	12%	11%	11%
Inadequate social support	Percent of adults that never, rarely, or sometimes et the social and emotional support they need, 2003-2009	12%	16%	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	21%	24%	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

The Physical Environment outcomes indicate that there is no air pollution or ozone pollution in this area.

Data shows that Lyon and Redwood counties have lower than average access to healthy foods than the state benchmark. However, all are lower than the national benchmark.

Access to recreational facilities in Lyon and Redwood counties rates lower than the state and national benchmarks. (*Figure 29*)

Figure 29. Physical Environment Data

		Lyon County	Redwood County	National Benchmark	Minnesota
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	0	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	50%	39%	92%	54%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	8.0	0.0	17.0	12.0

Demographics

Redwood County has a higher percentage of youth living in the county than the state and national benchmarks. Elderly account for 15% and 20% of the population in Lyon and Redwood counties respectively, both higher than the Minnesota and national benchmarks.

Both counties are mostly rural as 50% and 66% of its population live in a "rural" area.

Three percent (3%) of Lyon County residents are not considered "proficient" in English; Redwood 1%. Both counties have lower rates than the national and state benchmarks.

Lyon and Redwood County residents have a higher rate of illiteracy than the Minnesota benchmark at 7% and 8% respectively. However, they are lower than the national benchmark of 15%. (*Figure 30*)

Figure 30. Demographic Data for Lyon and Redwood Counties

		Lyon County	Redwood County	National Benchmark	Minnesota
Youth	Percent of total population ages 0-17, 2009	24%	25%	24%	24%
Elderly	Percent of total population ages 65 and older, 2009	15%	20%	13%	13%
Rural	Percent of total population living in a rural area, 2000	50%	69%	21%	29%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	3%	1%	9%	4%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy	8%	7%	15%	6%

Population Age

The population in Redwood County is relatively older than the rest of Minnesota and has a lower percentage of younger aged children than the state and national benchmarks. Lyon County, however, has a slightly higher percentage of older population than the state and national benchmark, but does have a higher percentage of youth than the state and national benchmark.

The gender distribution in the counties is similar to the Minnesota and national percentages: more female than male.

Figure 31. Population Breakdown of Lyon and Redwood Counties

	Lyon County	Redwood County	National Benchmark	Minnesota
Total population	25,891	15,972	311,591,917	5,344,861
Percent ages 65 and older	13.7%	19.7%	13.3%	13.1%
Percent 5 years and under	7.4%	6.4%	6.5%	6.6%
Percent male	49.7%	49.7%	49.2%	49.7%
Percent female	50.3%	50.3%	50.8%	50.3%

2011 Census data

Housing and Economy

Redwood County has a higher percentage of individuals who own their own home than the state and national benchmarks. Lyon County his lower percent of individuals who own their own home than the state benchmark, but higher than the national benchmark.

The average cost for a home in the county is $83,100, which is lower average than the rest of Minnesota and the nation.

The median household income in both counties is lower than the Minnesota and national benchmarks.

Lyon County sees a higher percent of persons living in poverty than the state benchmark, but lower than the national benchmark. Redwood County has a lower percent of people living in poverty than in comparison with the national and state benchmarks.

Figure 32. Housing and Economic Stats for Lyon and Redwood Counties

	Lyon County	Redwood County	National Benchmark	Minnesota
Housing Units	11,110	7,257	132,312,404	2,354,034
Homeownership rate, 2007-2011	67.8%	78%	66.1%	73.6%
Median value of owner-occupied housing units, 2007-2011	$137,600	$85,100	$186,200	$201,400
Median household income	$47,254	$45,177	$52,762	$58,476
Persons below poverty level, percent, 2007-2011	13.1%	10.5%	14.3%	11%

2011 Census data

Diversity Profile

The population distribution by race demonstrates that Minnesota and Lyon and Redwood counties are predominately white. The second largest populations in these two counties are Hispanic and Native American.

Figure 33. Diversity Profile for Lyon and Redwood Counties

	Lyon County	Redwood County	National Benchmark	Minnesota
Total population	25,891	15,972	311,591,917	5,344,861
White persons, percent, 2011	92.6%	89.3%	78.1%	86.9%
Black persons, percent, 2011	2.5%	0.6%	13.1%	5.4%
American Indian and Alaska Native	0.6%	5.0%	1.2%	1.3%
Asian persons, percent, 2011	2.7%	3.2%	5.0%	4.2%
Persons of Hispanic or Latino origin, percent, 2011	6.0%	2.2%	16.7%	4.9%

2011 US Census data

Health Needs Identified

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

- Access
- Cancer
- Chronic Disease
- Care Coordination
- City Infrastructure
- Dental Care
- Economy
- Elderly
- Emergency Care
- Health Factors
- Healthcare Cost/Insurance Cost
- Mental Health
- New Americans
- Obesity
- Physicians
- Pollution/Environment
- Prevention Safety
- Schools Substance Abuse
- Traffic
- Transportation
- Wellness
- Workforce
- Youth
- Sanford Specific

Community/Assets/Prioritization Process

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

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

The priorities that remain include:

- Urgent Care After Hours
- Mental Health Services

Sanford Tracy Medical Center is establishing key initiative strategies to address these three priority areas listed. The medical center has developed an implementation strategy and has begun to work to address these gaps.

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

Implementation Strategy

Urgent Care After Hours

Sanford Tracy Medical Center will be aiming to expand clinic hours to provide urgent care/after-hour services for the Tracy community. This will be accomplished by coordinating medical, nursing, receptionist and ancillary staff.

Mental Health Services

Sanford Tracy will be focusing on the expansion of Mental Health services currently available to patients. This will be done by recruiting additional mental health providers, expanding recovery programs available in the community, and assisting patients through the Medical Home program.

IMPLEMENTATION STRATEGY

2013 Community Health Needs Assessment
Sanford Tracy Implementation Strategy

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

- Urgent Care After Hours
- Mental Health Services

Implementation Strategy: Urgent Care After Hours

- Have full medical staff to be able to coordinate expanded hours
- Nursing staff coordination
- Receptionist staff coordination
- Market new Urgent Care hours to public
- Ancillary Staff Coordination (Lab/X-Ray, etc.)

Implementation Strategy: Mental Health Services

- Increase availability of medical health providers
- Obtain certification of Medical Home and implement health care coach to help with resources and guidance for patients
- Continue discussion on holding patients and resources to help with placing patients quickly
- Work with community partners to create new recovery program options for community members

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

Lyon County
Minnesota

		Lyon	*National Benchmark	Minnesota
HEALTH OUTCOMES				
Mortality				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	6,014	5,564	5,272
Morbidity				
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	12%	10%	11%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.7	2.6	3.1
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	3.2	2.3	2.8
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	6.3%	6.0%	6.5%
HEALTH FACTORS				
Health Behaviors				
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	17%	15%	19%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 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	20%	8%	20%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	20.7	12.0	12.9
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	213.3	83.0	276.1
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	22.4	22.0	27.5
Clinical Care				
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	14%	13%	11%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	7%	7%	6%
Primary care physicians	Ratio of total population to primary care physicians, 2008	1,088:1	631:1	636:1
Mental health providers	Ratio of total population to mental health providers, 2008	2,276:1	2,242:1	1,306:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	40.3	69.0	61.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	52.7	52.0	56.5
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	96%	89%	88%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	71%	74%	73%

2011 County Health Profile (Page 2)

Lyon County
Minnesota

HEALTH FACTORS (continued)		Lyon	*National Benchmark	Minnesota
Social and Economic Factors				
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007	100%	92%	87%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	74%	68%	72%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	6.0%	5.3%	8.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	12%	11%	11%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	12%	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	21%	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	50%	92%	54%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	8.0	17.0	12.0

Demographics		Lyon	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	15%	13%	13%
Rural	Percent of total population living in a rural area, 2000	50%	21%	29%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	3%	9%	4%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	8%	15%	6%

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

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

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

2011 County Health Profile

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

Redwood County
Minnesota

		Redwood	*National Benchmark	Minnesota
HEALTH OUTCOMES				
Mortality				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	7,196	5,564	5,272
Morbidity				
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	12%	10%	11%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	3.0	2.6	3.1
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	1.1	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				
Health Behaviors				
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	-	15%	19%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008	28%	25%	26%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	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	22.3	12.0	12.9
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	83.9	83.0	276.1
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	27.0	22.0	27.5
Clinical Care				
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	13%	13%	11%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	8%	7%	6%
Primary care physicians	Ratio of total population to primary care physicians, 2008	975:1	631:1	636:1
Mental health providers	Ratio of total population to mental health providers, 2008	5,199:1	2,242:1	1,306:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	32.3	69.0	61.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	50.7	52.0	56.5
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	88%	89%	88%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	77%	74%	73%

2011 County Health Profile (Page 2)

Redwood County
Minnesota

HEALTH FACTORS (continued)		Redwood	*National Benchmark	Minnesota
Social and Economic Factors				
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007	90%	92%	87%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	62%	68%	72%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	7.0%	5.3%	8.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	12%	11%	11%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	16%	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	24%	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	39%	92%	54%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	0.0	17.0	12.0

Demographics		Redwood	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	20%	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	7%	15%	6%

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

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

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

Definitions of Health Variables

Definitions of Health Variables from the *County Health Rankings 2011 Report* Variable	Definition
Poor or Fair Health	Self-reported health status based on survey responses to the question: "In general, would you say that your health is excellent, very good, good, fair, or poor?"
Poor Physical Health Days (in past 30 days)	Estimate based on responses to the question: "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?"
Poor Mental Health Days (in past 30 days)	Estimate based on responses to the question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"
Adult Smoking	Percent of adults that report smoking equal to, or greater than, 100 cigarettes and are currently a smoker
Adult Obesity	Percent of adults that report a BMI greater than, or equal to, 30
Excessive Drinking	Percent of as individuals that report binge drinking in the past 30 days (more than 4 drinks on one occasion for women, more than 5 for men) or heavy drinking (defined as more than 1 (women) or 2 (men) drinks per day on average
Sexually Transmitted Infections	Chlamydia rate per 100,000 population
Teen Birth Rate	Birth rate per 1,000 female population, ages 15-19
Uninsured Adults	Percent of population under age 65 without health insurance
Preventable Hospital Stays	Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees
Mammography Screening	Percent of female Medicare enrollees that receive mammography screening
Access to Healthy Foods	Healthy food outlets include grocery stores and produce stands/farmers' markets
Access to Recreational Facilities	Rate of recreational facilities per 100,000 population
Physical Inactivity	Percent of adults aged 20 and over that report no leisure time physical activity
Primary Care Provider Ratio	Ratio of population to primary care providers
Mental Health Care Provider Ratio	Ratio of population to mental health care providers
Diabetes Screening	Percent of Medicare enrollees with diabetes that receive HbA1c screening
Binge Drinking	Percent of adults that report binge drinking in the last 30 days. Binge drinking is consuming more than 4 (women) or 5 (men) alcoholic drinks on one occasion.

Aging Profile

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

Lyon County
Minnesota

CHARACTERISTICS	Total	AGE: Less than 65 Years	AGE: Ages 65 and Older
Population[1]			
Total population	25,857	22,338	3,519
Percent ages 65 and older	14%	-	100%
Percent ages 85 and older	3%	-	20%
Percent male	50%	51%	42%
Percent female	50%	49%	58%
Living Arrangements			
Total households (by age of householder)[1]	10,227	7,908	2,319
Percent with family households (i.e., at least two people who are related)	62%	66%	50%
Percent with householder living alone	30%	24%	49%
Grandparents living with their grandchildren*[2]	112	68	44
Percent who are responsible for their grandchildren	48%	41%	59%
Housing[1]			
Percent of occupied housing that is owner-occupied	66%	65%	72%
Percent of occupied housing that is renter-occupied	34%	35%	28%
Economic Security[2]			
Percent of working-age population in labor force	73%	85%	18%
Percent of total population with income less than 100% of poverty	12%	12%	11%
Percent of total population with income less than 200% of poverty	30%	29%	38%
Median household income (by age of householder)	$46,872	$47,333	$28,579
Owner-occupied housing units (by age of householder)	7,000	5,445	1,555
Percent spending 30% or more of income toward housing costs	19%	16%	29%
Renter-occupied housing units (by age of householder)	3,263	2,607	656
Percent spending 30% or more of income toward housing costs	42%	38%	58%

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

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

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

Diversity Profile

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

Lyon County
Minnesota

CHARACTERISTICS	Total	RACE: White alone	RACE: Black alone	RACE: American Indian alone	RACE: Asian alone	ETHNICITY: Hispanic Origin - of any race
Population [1]						
Total population	25,857	23,360	587	114	679	1,541
Percent ages 0 to 17	24%	23%	32%	27%	28%	41%
Percent ages 18 to 44	38%	36%	58%	46%	61%	47%
Percent ages 45 to 64	25%	26%	8%	22%	10%	10%
Percent ages 65 and older	14%	15%	1%	4%	1%	2%
Median age (in years)	34.1	37.0	23.3	23.8	23.0	22.1
Living Arrangements						
Total households [1]	10,227	9,576	198	29	178	381
Percent with householder living alone	30%	30%	29%	21%	19%	14%
Percent with families with children ages 0 to 17	29%	28%	36%	48%	38%	56%
Grandparents living with their grandchildren [2]	112	90	0	17	2	20
Percent who are responsible for grandchildren	48%	60%	-	0%	0%	85%
Housing [1]						
Percent occupied housing that is owner-occupied	66%	69%	8%	28%	36%	36%
Percent occupied housing that is renter-occupied	34%	31%	92%	72%	64%	64%
Educational Attainment [2]						
Percent of persons ages 25 and older with high school degree or higher	88%	90%	71%	78%	42%	57%
Percent of persons ages 25 and older with Bachelor's degree or higher	26%	27%	2%	0%	7%	7%
Economic Security [2]						
Unemployment rate	4%	3%	10%	7%	11%	14%
Median household income	$46,872	$49,065	-	$16,458	$43,576	$38,086
Percent of households with income <$25,000	26%	24%	92%	86%	8%	38%
Percent of persons with income <100% poverty	12%	9%	50%	85%	19%	42%
Percent of children ages 0 to 17 in families with income <100% poverty	11%	5%	0%	100%	12%	55%
Percent of elderly ages 65 and older with income <100% poverty	11%	11%	-	-	0%	78%

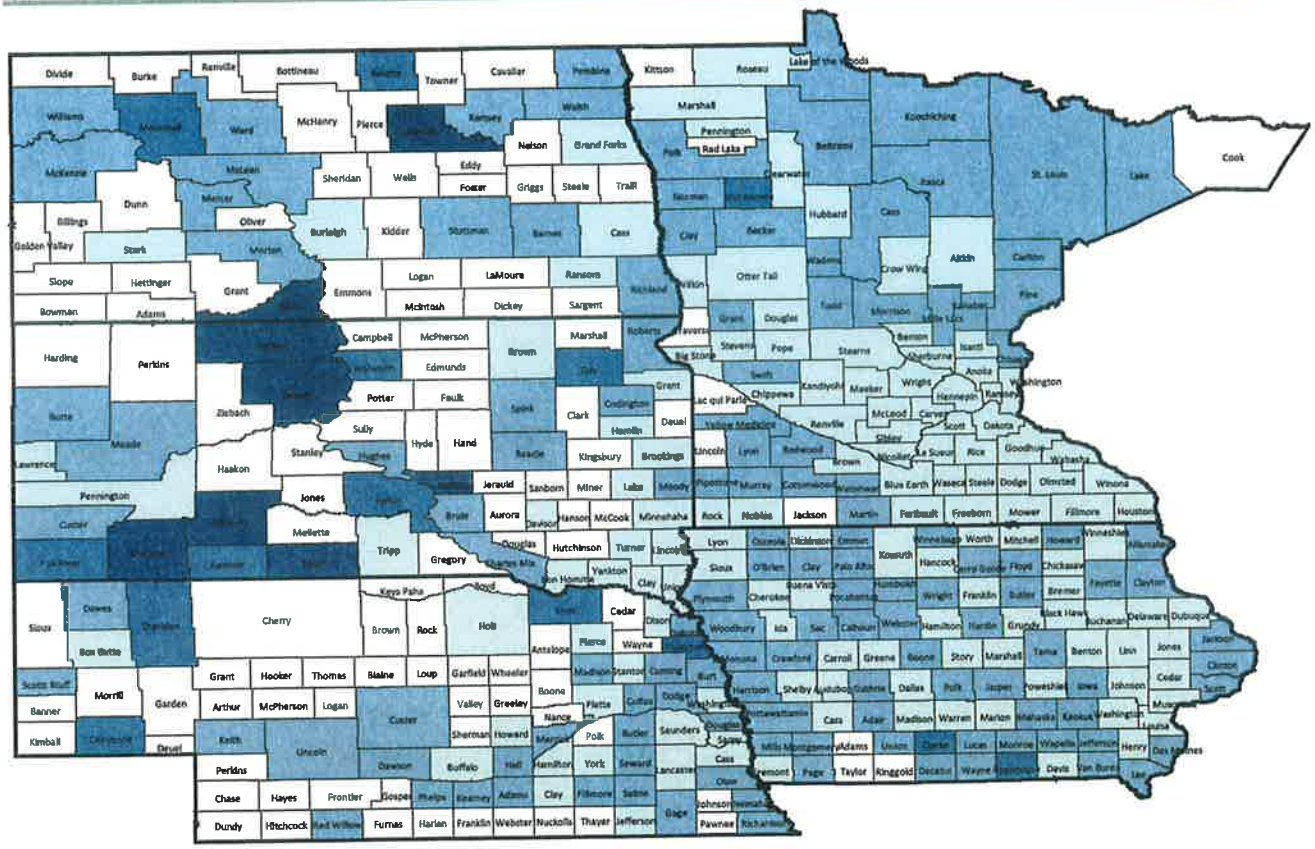
Source: U.S. Census Bureau, [1]2010 Census Summary File 1 and [2]2006-2010 American Community Survey (ACS) 5-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across race and ethnic categories; however, because they are based on sample data, one should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

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

Map 1

Premature Death - A health outcome measure focusing on mortality

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



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

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

CONTEXT

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

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

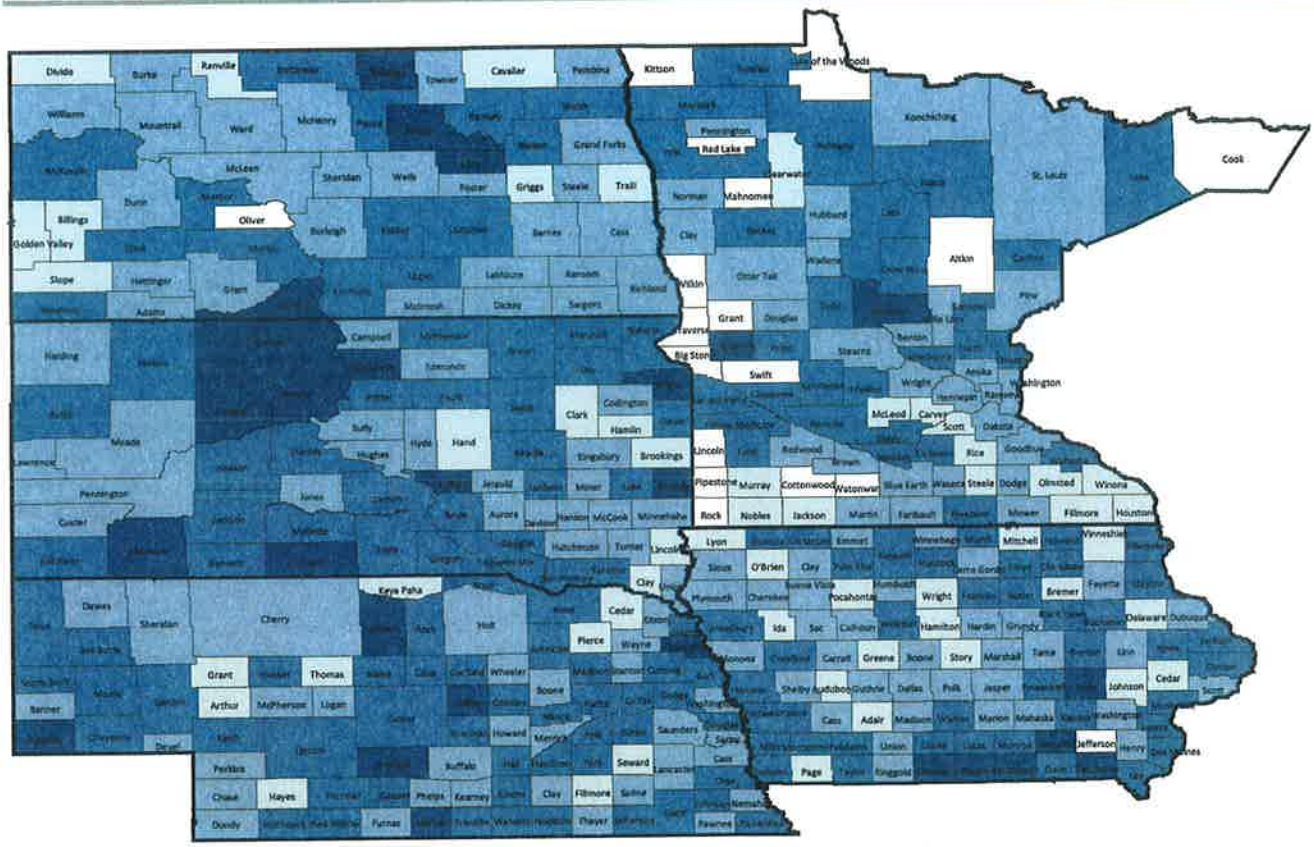
Importance: Age-adjusted YPLL-75 rates are commonly used to represent the frequency and distribution of premature deaths. Measuring YPLL allows communities to target resources to high-risk areas and further investigate the causes of death.

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

Map 2

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

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



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

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

CONTEXT

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

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

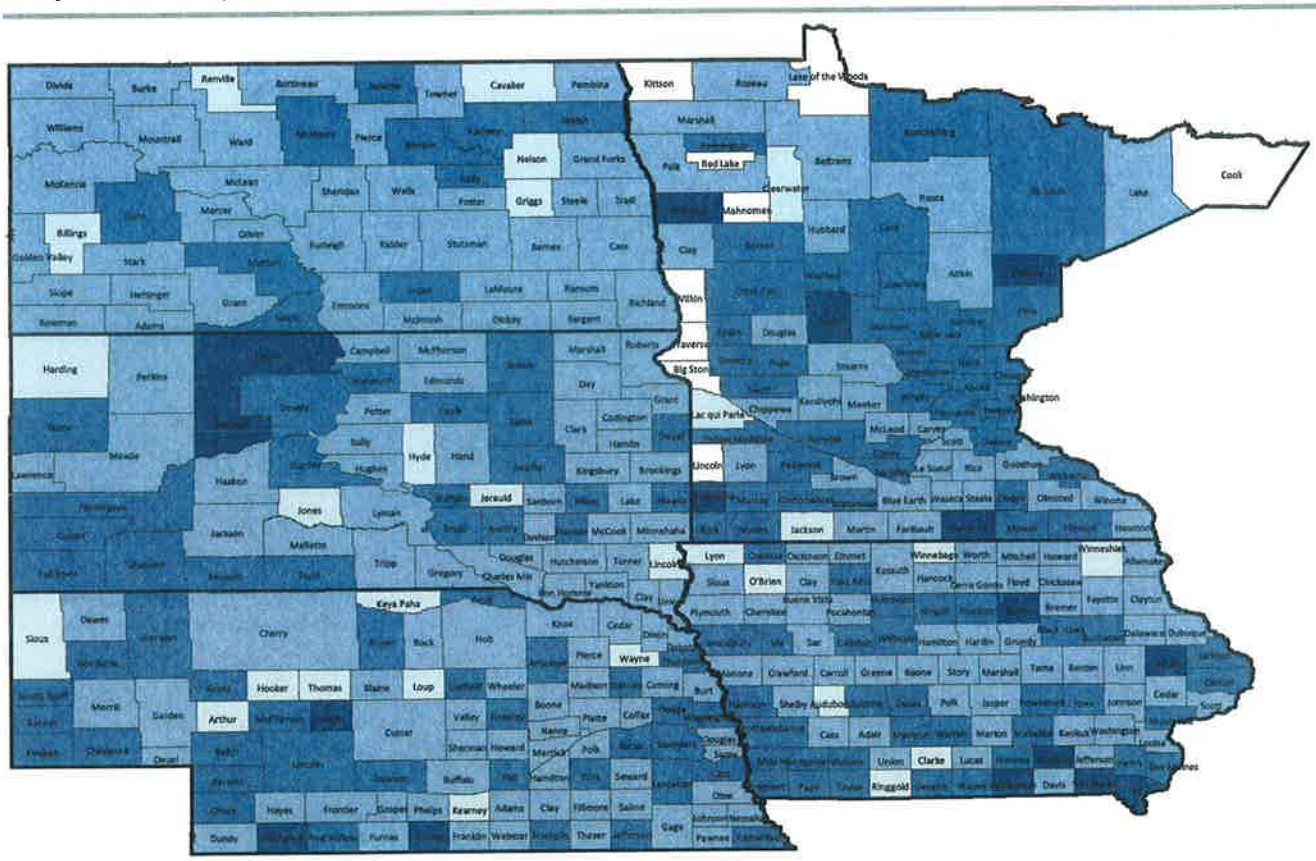
Importance: Self-reported health status is a widely used measure of people's health-related quality of life. In addition to measuring how long people live, it is important to also include measures of how healthy people are while alive – self-reported health status has been shown to be a very reliable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

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

Map 3

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

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



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

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

CONTEXT

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

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

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

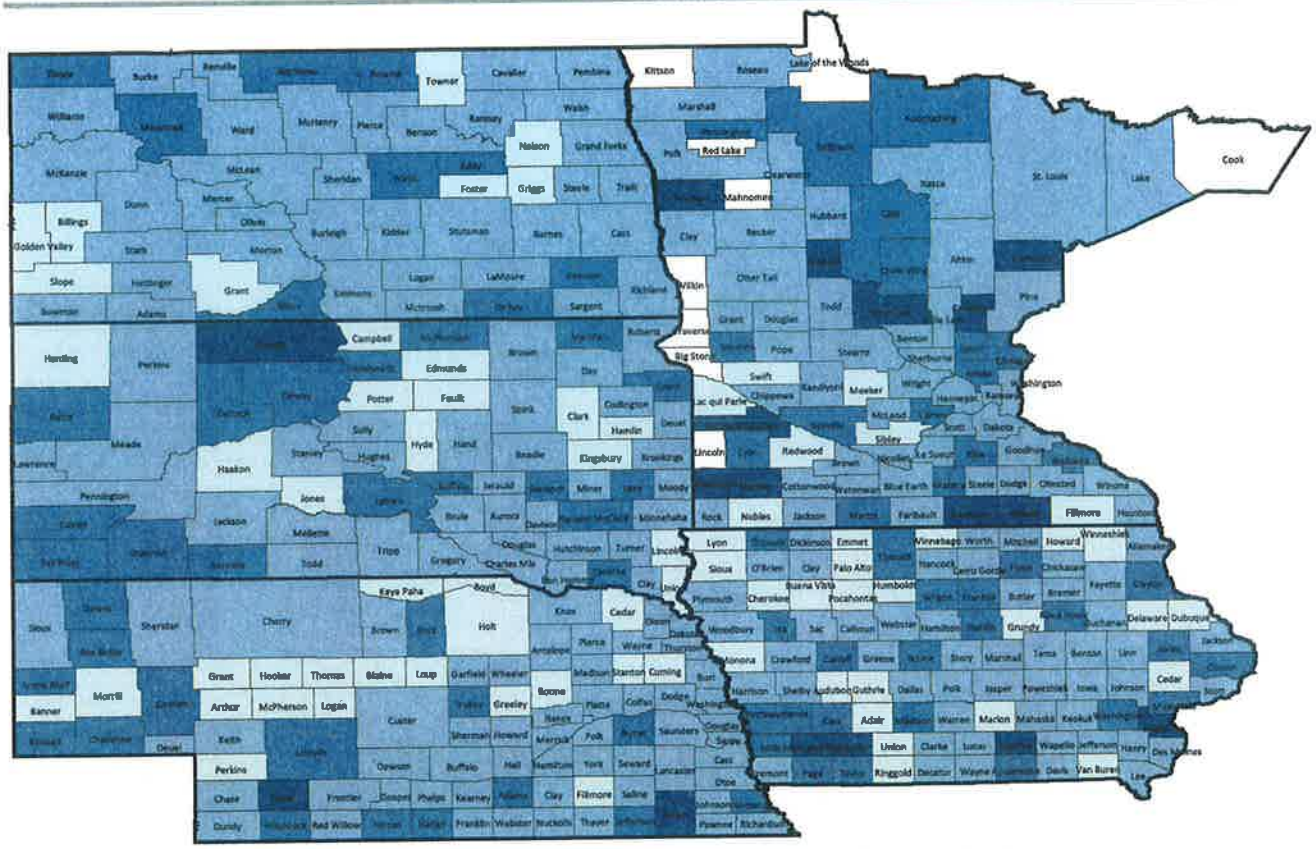
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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

Map 4

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

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



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

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

CONTEXT

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

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

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

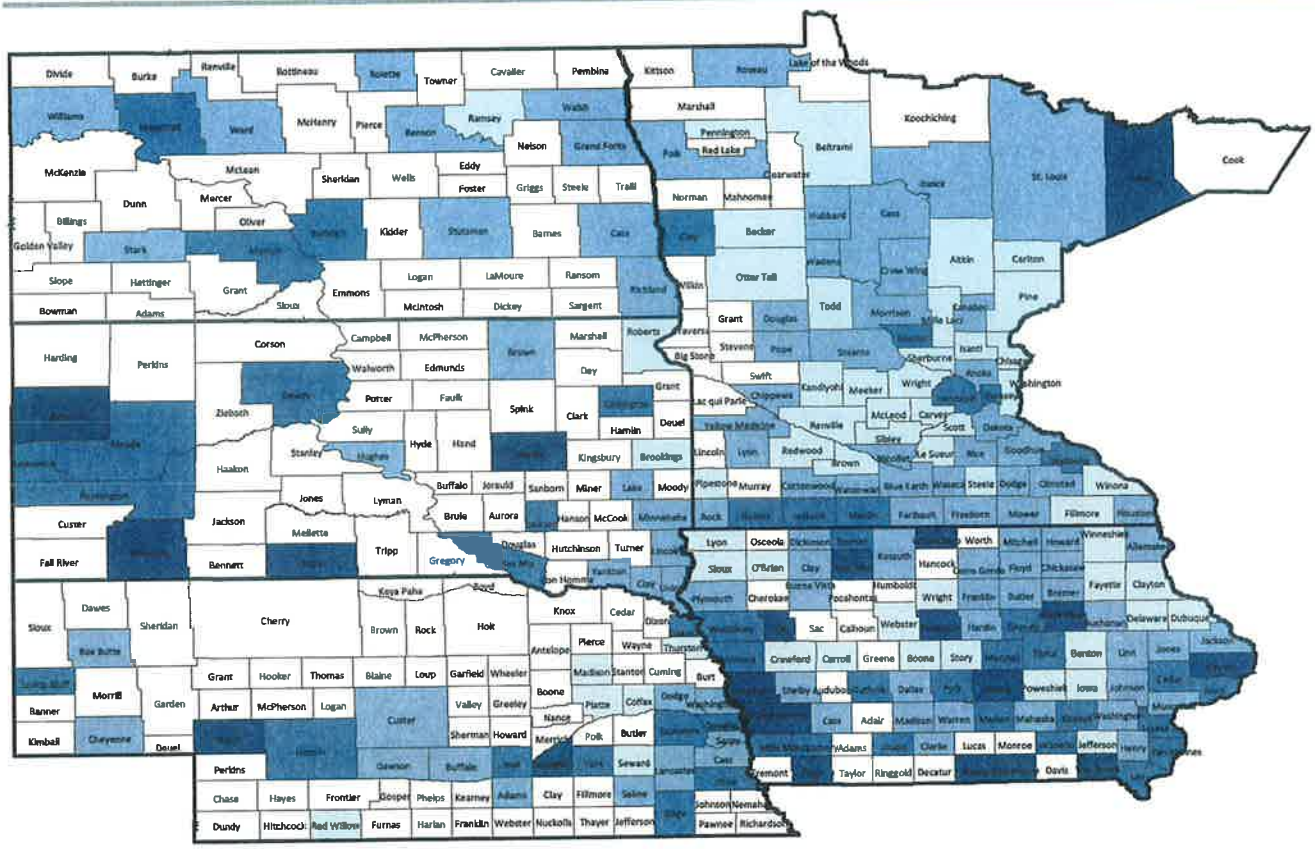
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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

Map 5

Low Birthweight - A health outcome measure focusing on morbidity

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



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

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

CONTEXT

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

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

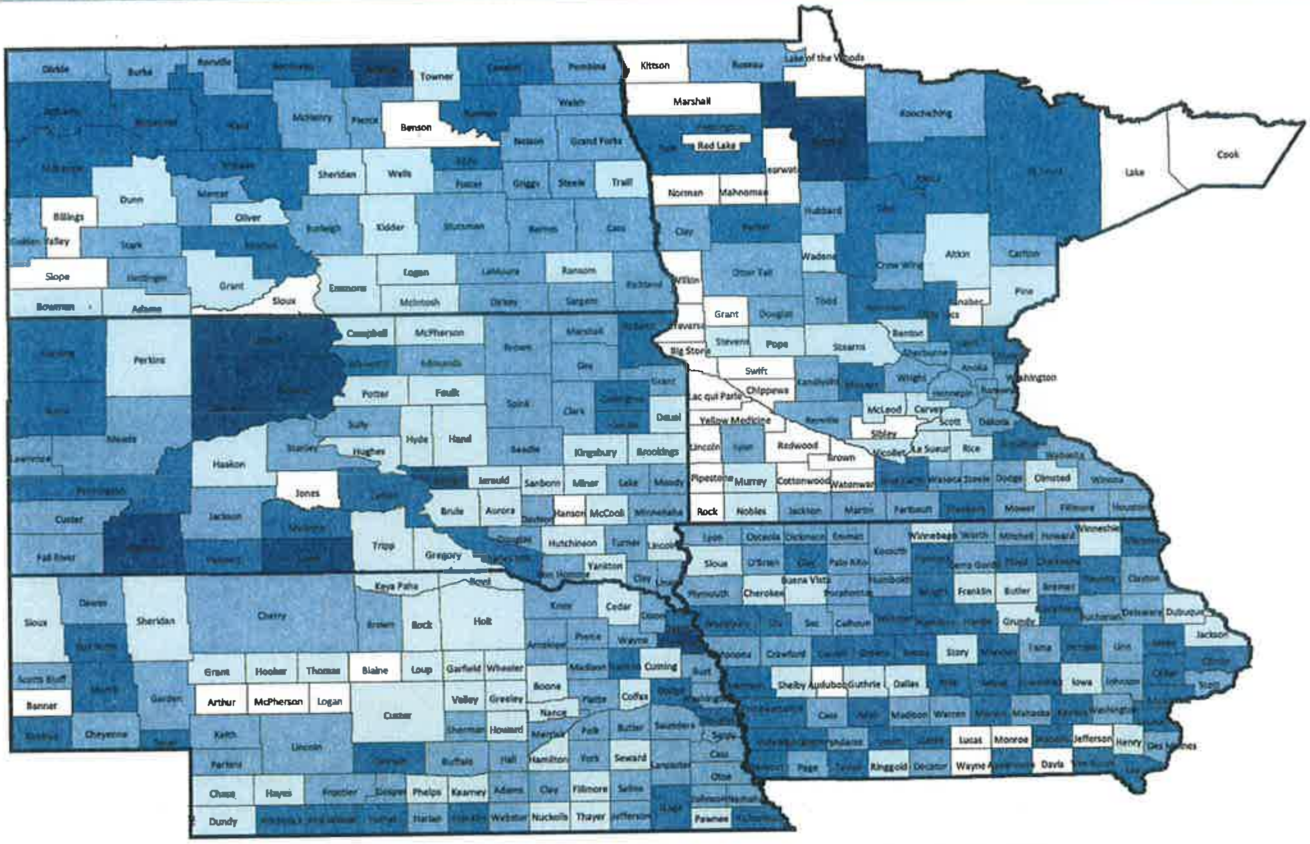
Importance: Low birthweight represents two factors: maternal exposure to health risks and an infant's current and future morbidity, as well as premature mortality risk. The health consequences of low birthweight are numerous.

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

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

Adult Smoking - A health factor measure focusing on health behaviors

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



Percent of adults that currently smoke and have smoked at least 100 cigarettes in lifetime, 2003-2009

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

CONTEXT

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

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

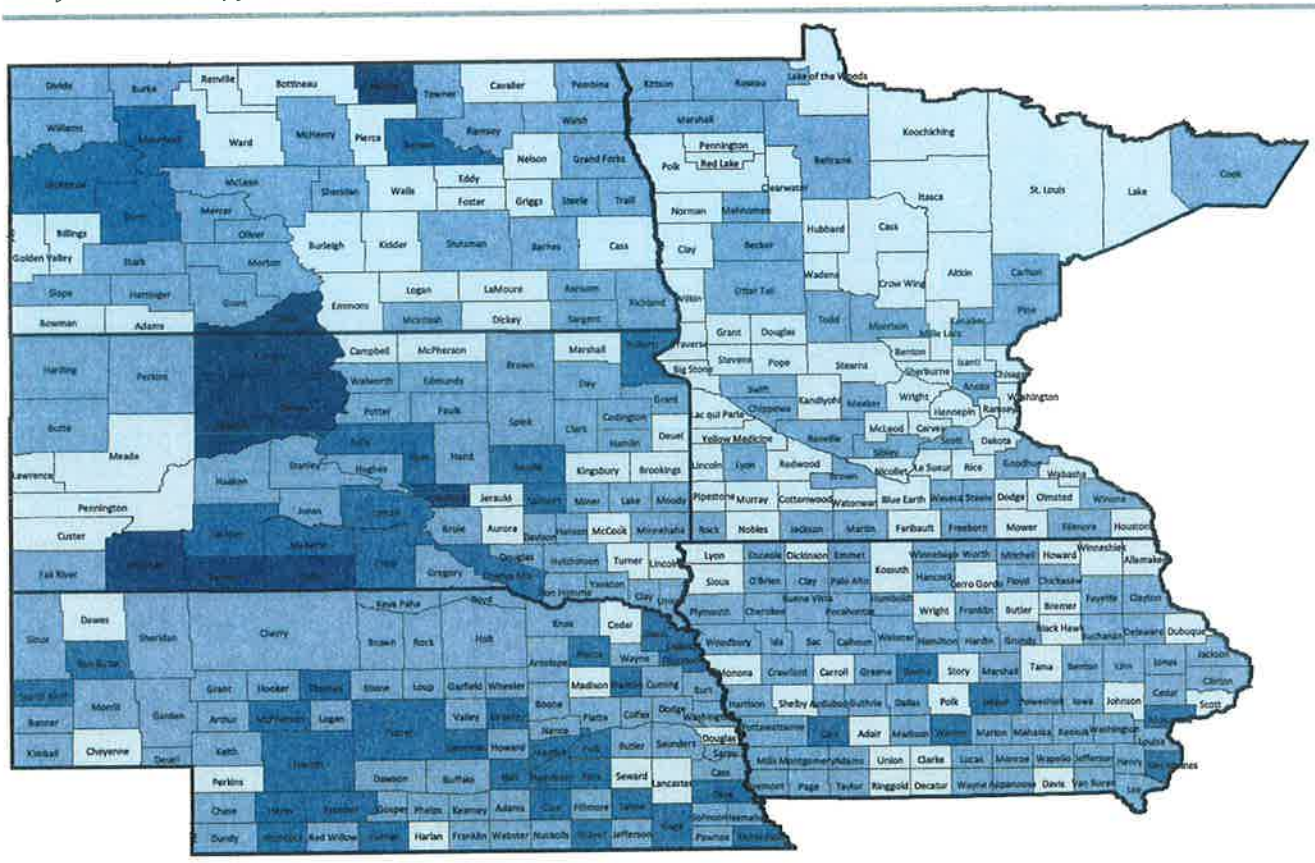
Importance: Each year approximately 443,000 premature deaths occur in the U.S. primarily due to smoking. Cigarette smoking is identified as a cause in multiple diseases including various cancers, cardiovascular disease, respiratory conditions, low birthweight, and other adverse health outcomes. Measuring the prevalence of tobacco use in the population can alert communities to potential adverse health outcomes and can be valuable for assessing the need for cessation programs or the effectiveness of existing programs.

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

Map 7

Adult Obesity - A health factor measure focusing on health behaviors

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



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

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

CONTEXT

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

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

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

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

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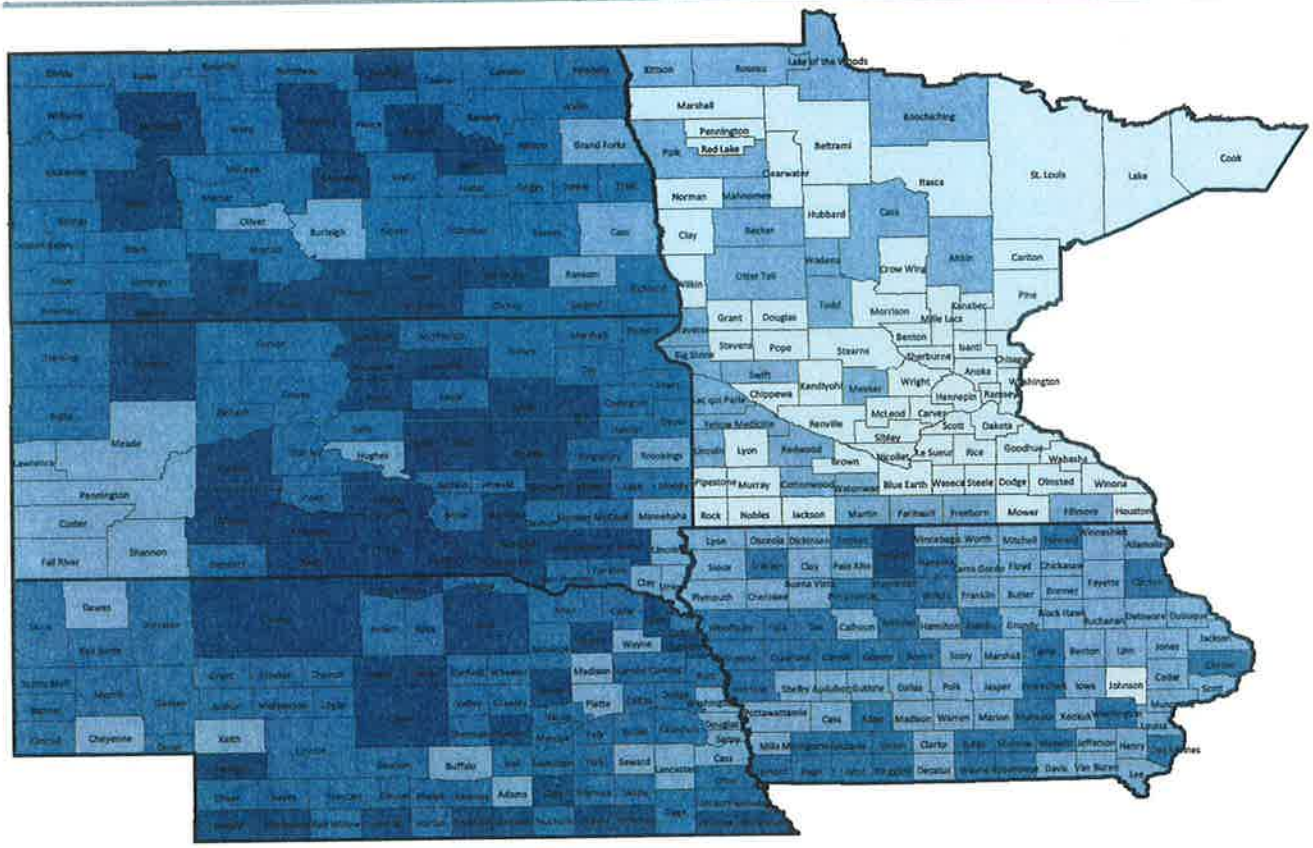
Map 8

Physical Inactivity - A health factor measure focusing on health behaviors

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



Percent of adults reporting no leisure time physical activity, 2008

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

CONTEXT

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

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

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

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

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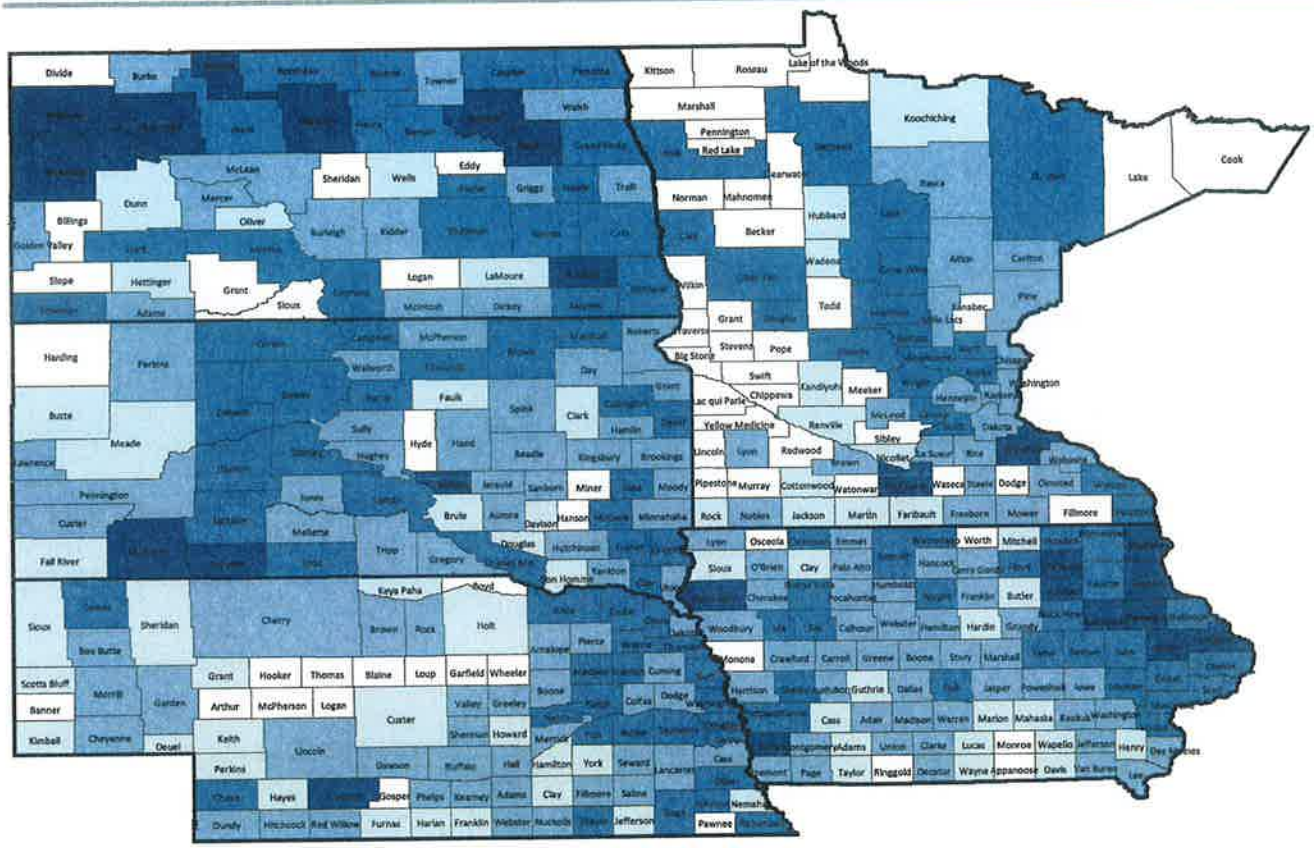
Map 9

Excessive Drinking - A health factor measure focusing on health behaviors

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



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

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

CONTEXT

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

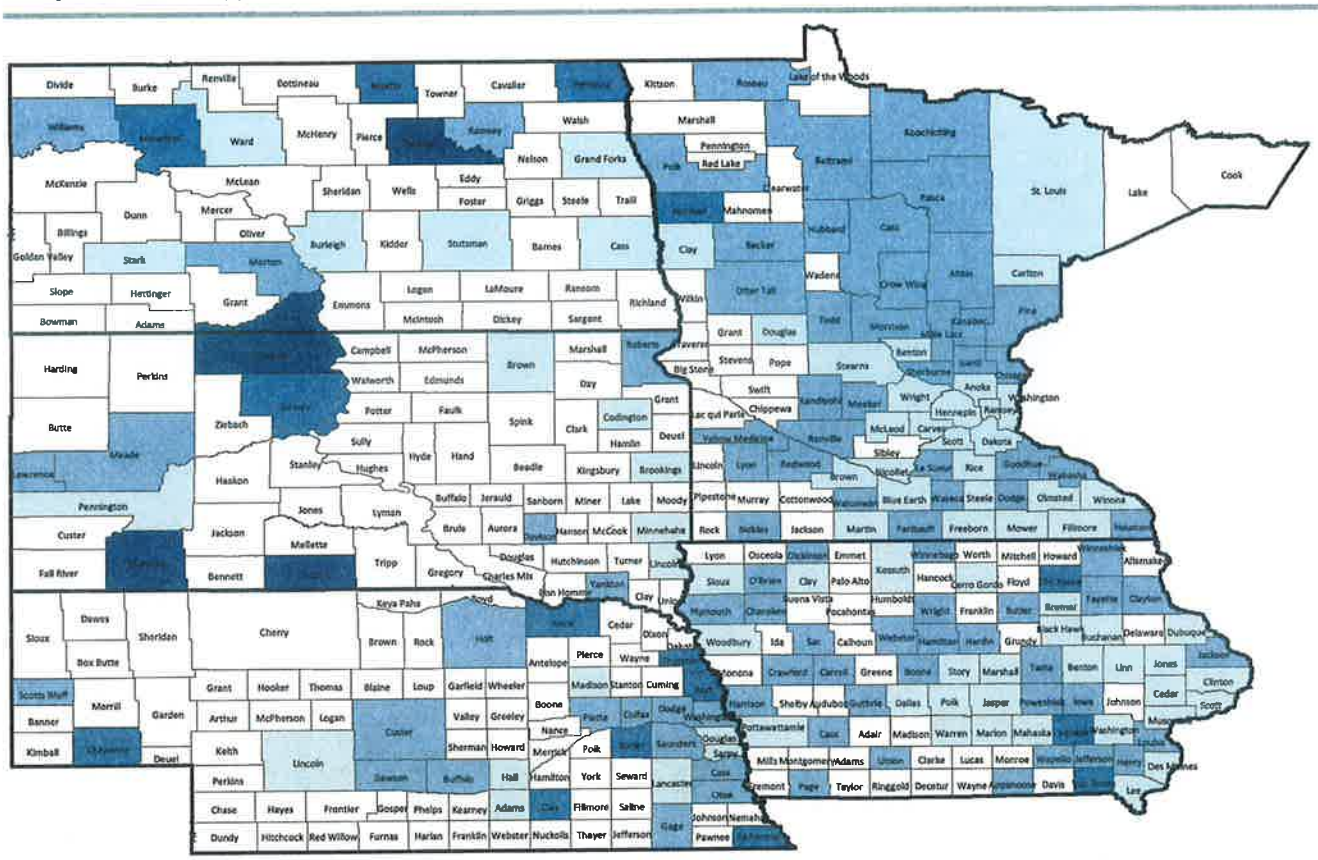
Where It Comes From: This measure was calculated by the National Center for Health Statistics using data obtained from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized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

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

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

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

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



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

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

CONTEXT

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

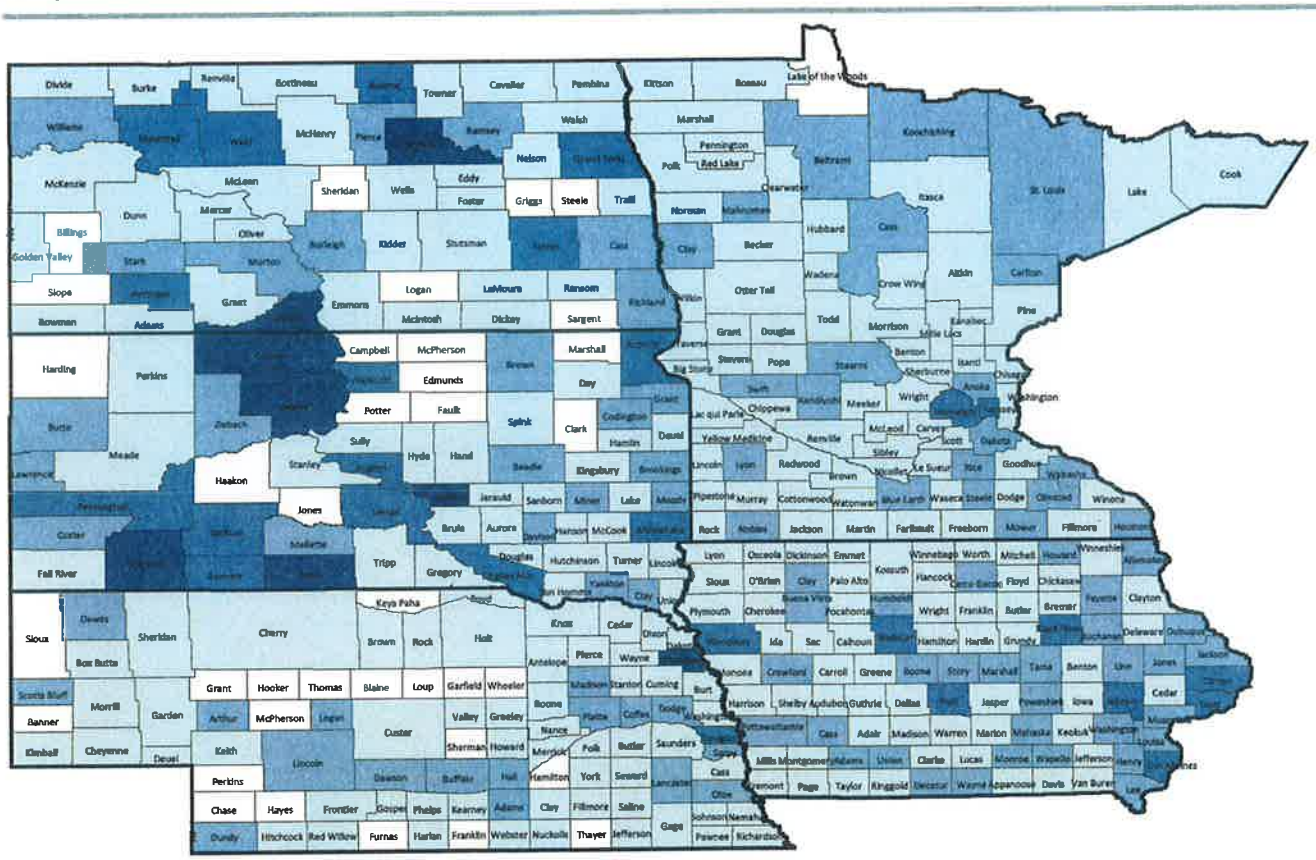
Where It Comes From: These data were calculated by National Center for Health Statistics (NCHS), part of the Centers for Disease Control and Prevention (CDC), based on data reported to the National Vital Statistics System (NVSS). NCHS used data for a seven-year period to create more robust estimates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

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

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

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

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



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

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

CONTEXT

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

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

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

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

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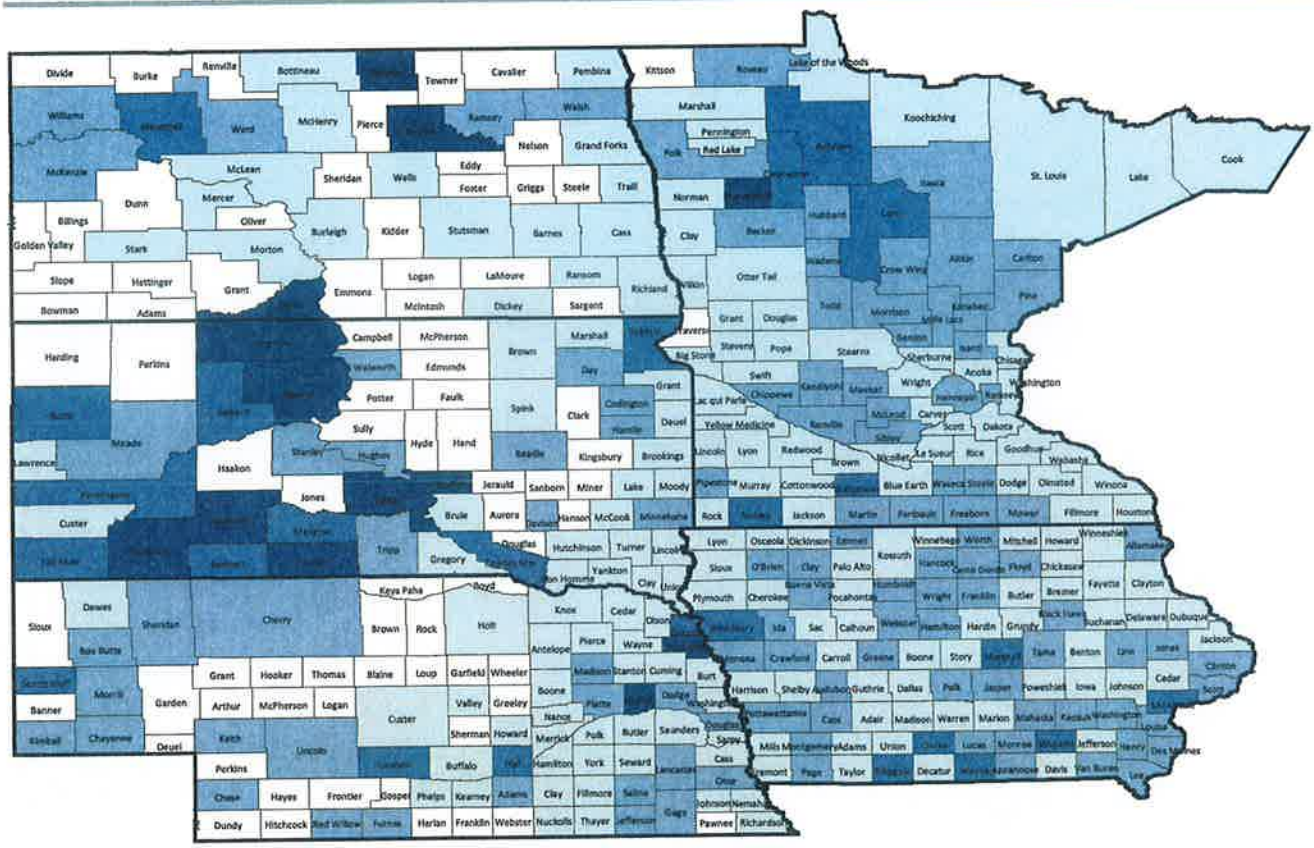
Map 12

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

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



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

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

CONTEXT

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

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

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

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

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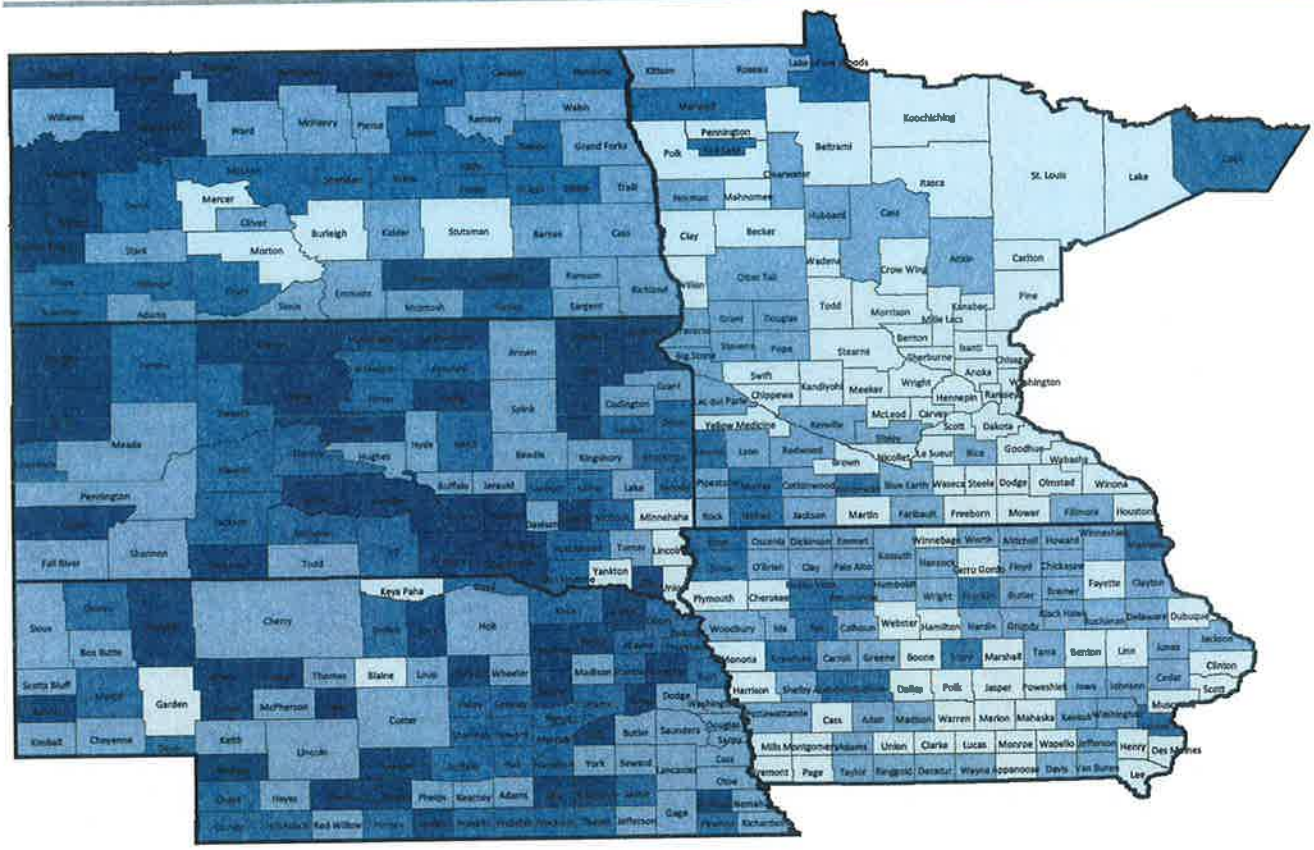
Uninsured Adults - A health factor measure focusing on clinical care

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



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

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

CONTEXT

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

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

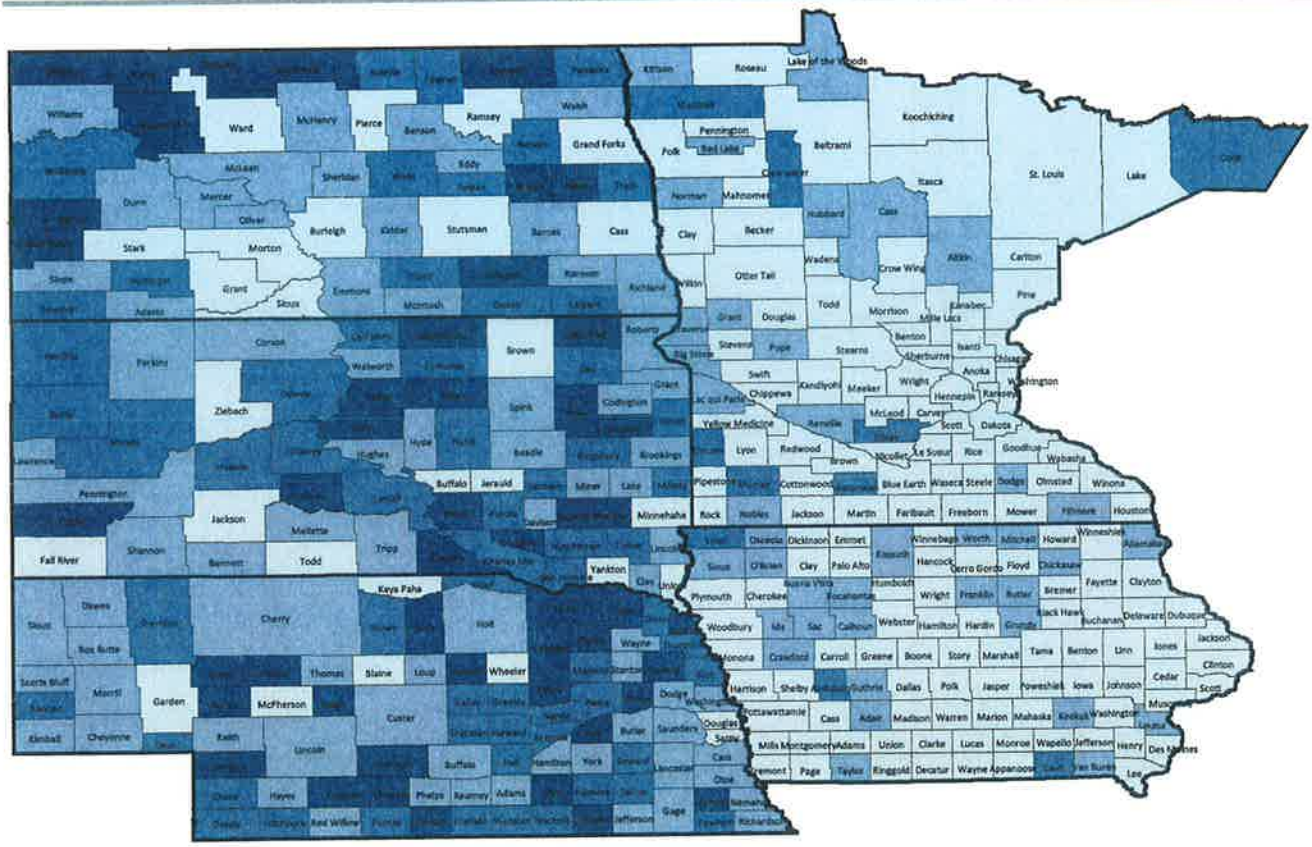
Importance: Lack of health insurance coverage is a significant barrier to accessing needed health care.

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

Uninsured Youth - A health factor measure focusing on clinical care

Map 14

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



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

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

CONTEXT

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

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

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

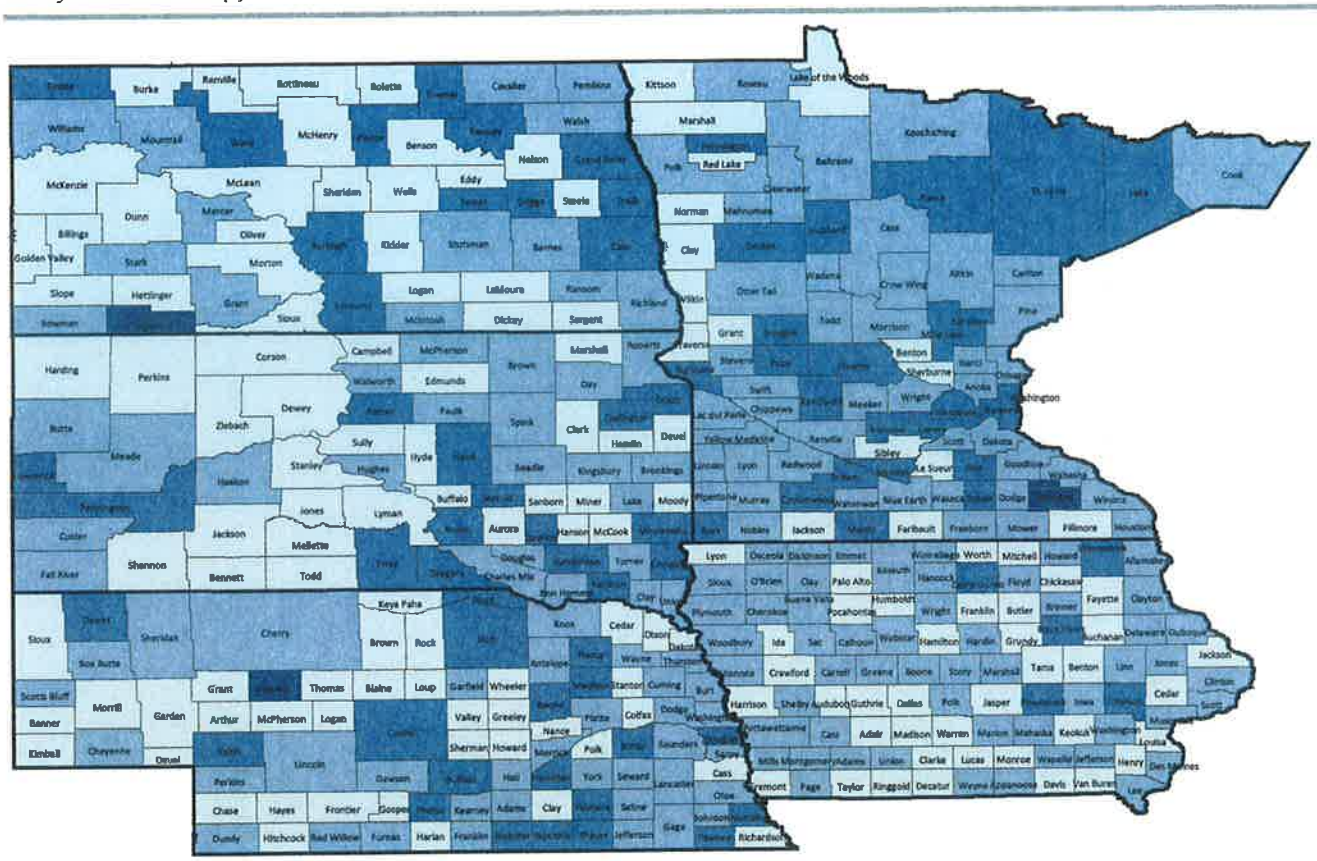
- Data were obtained from the Small Area Health Insurance Estimates (SAHIE), a program of the U.S. Census Bureau, http://www.census.gov/did/www/sahie/.

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

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

Map 15

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



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

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

CONTEXT

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

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

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

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

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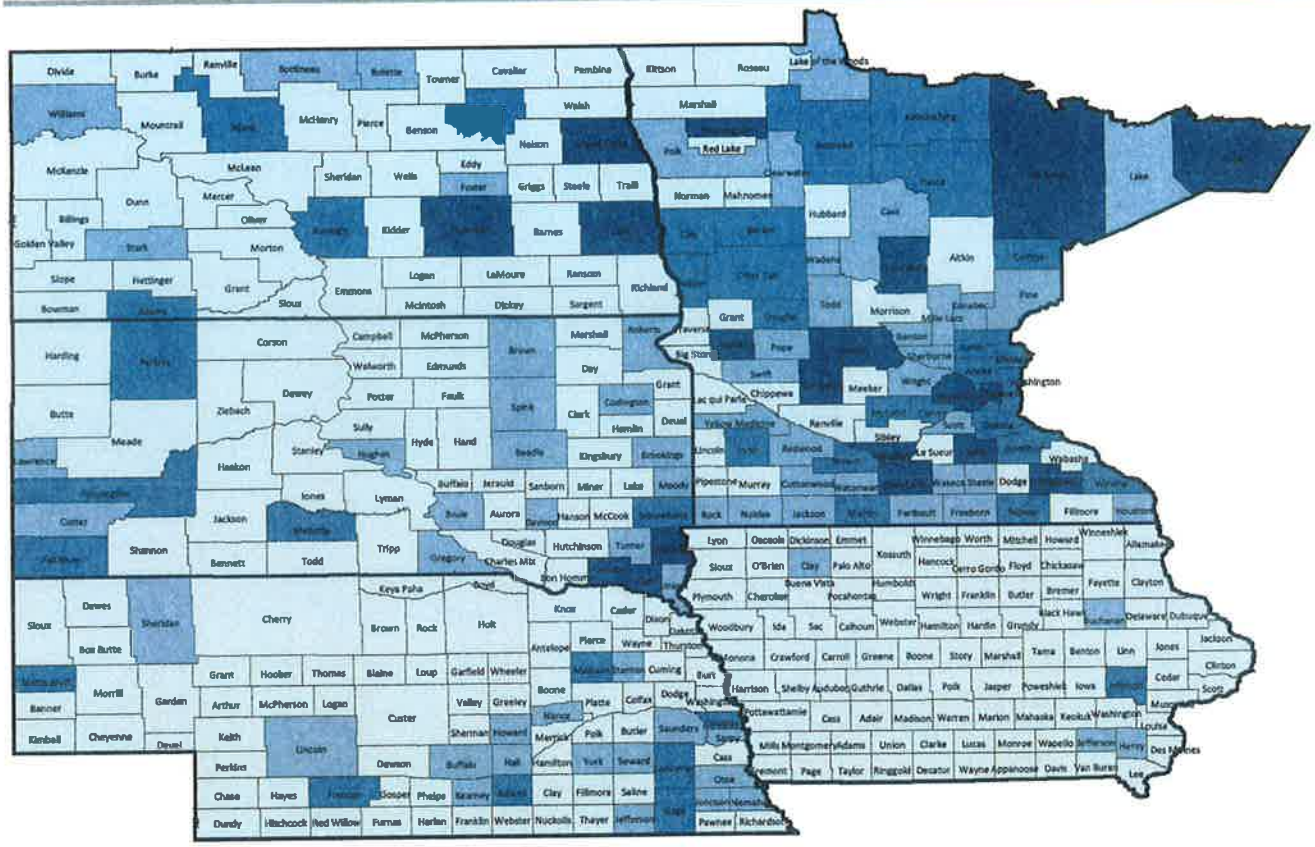
Map 16

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

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



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

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

CONTEXT

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

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

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

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

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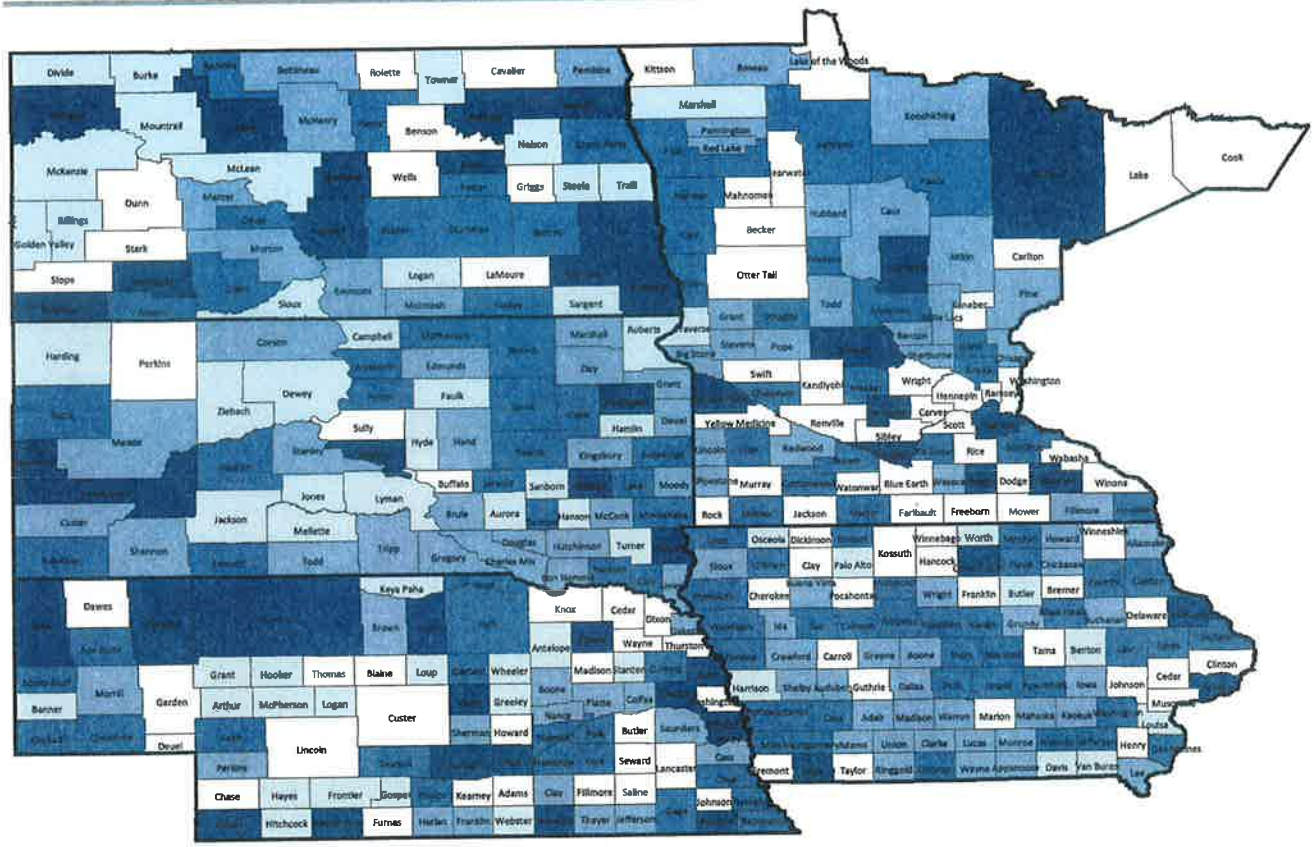
Map 17

Dentist Rate - A health factor measure focusing on clinical care

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



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

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

CONTEXT

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

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

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

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

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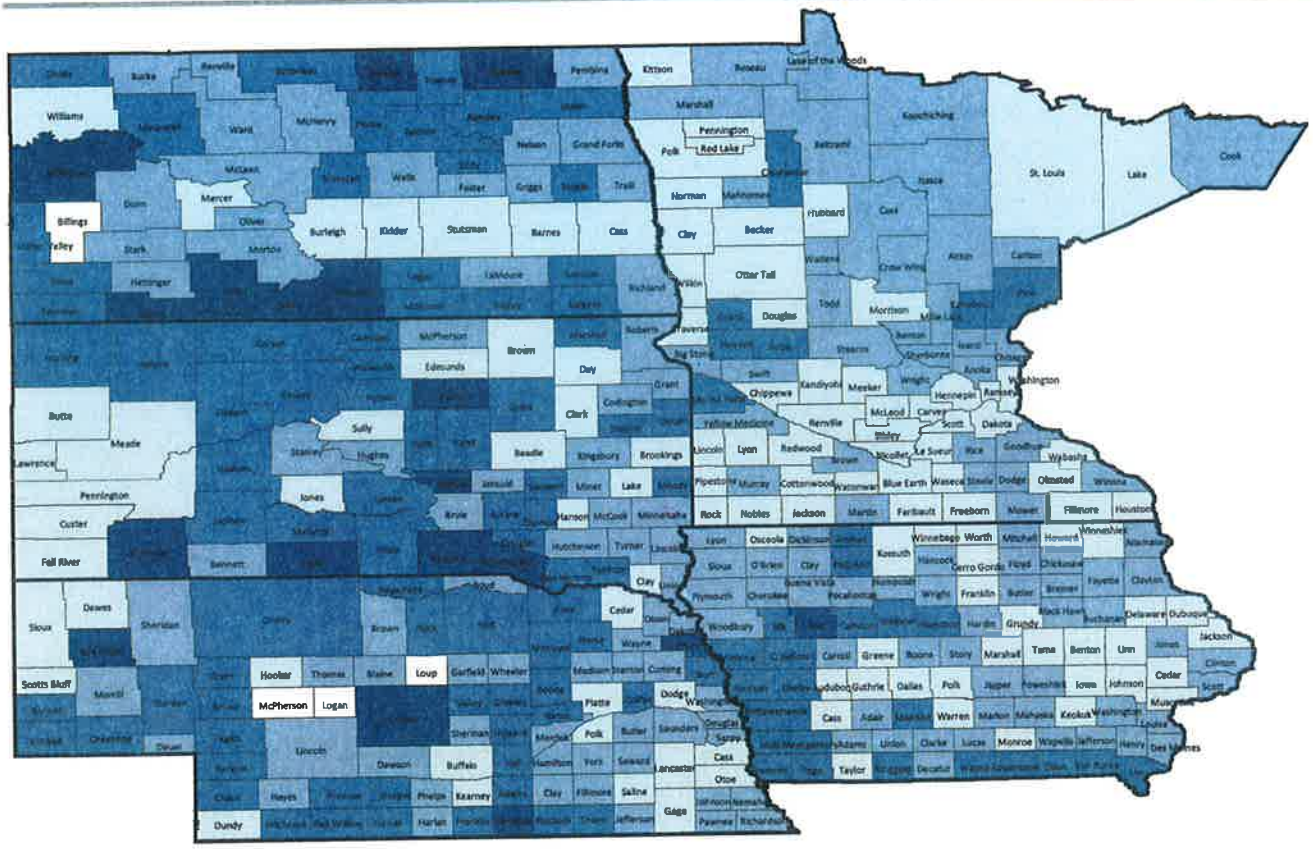
Map 18

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

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



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

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

CONTEXT

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

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

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

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

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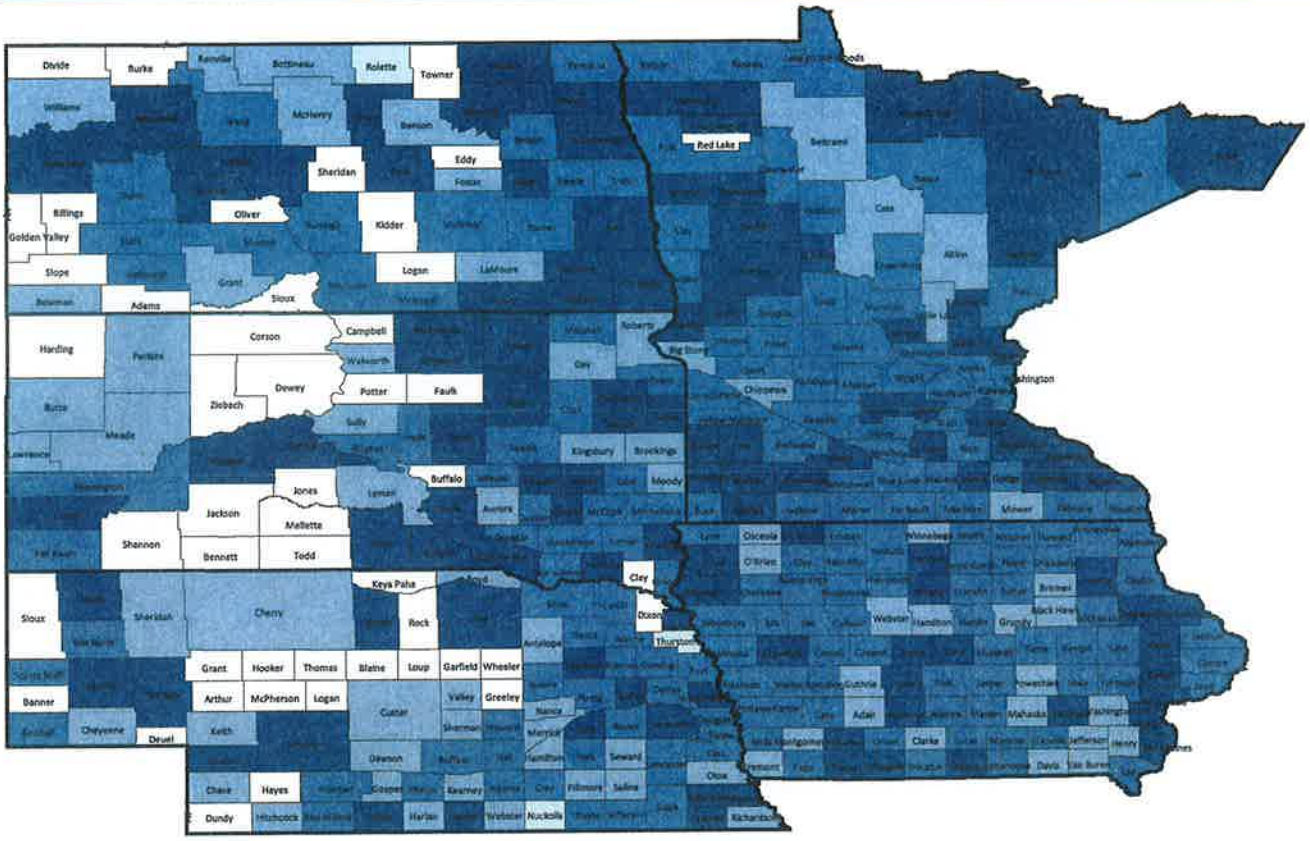
Map 19

Diabetic Screening - A health factor measure focusing on clinical care

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



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

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

CONTEXT

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

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

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

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

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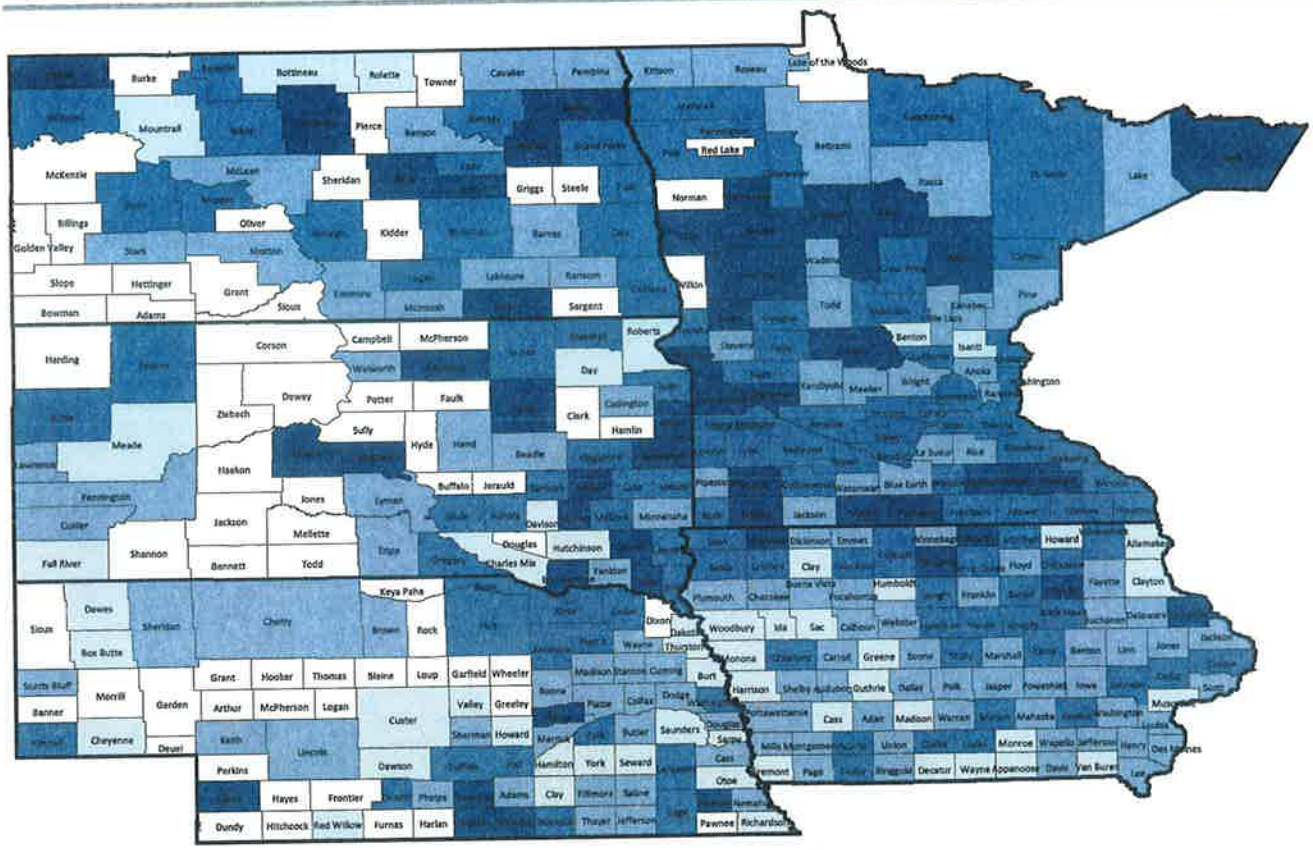
Mammography Screening - A health factor measure focusing on clinical care

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



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

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

CONTEXT

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

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

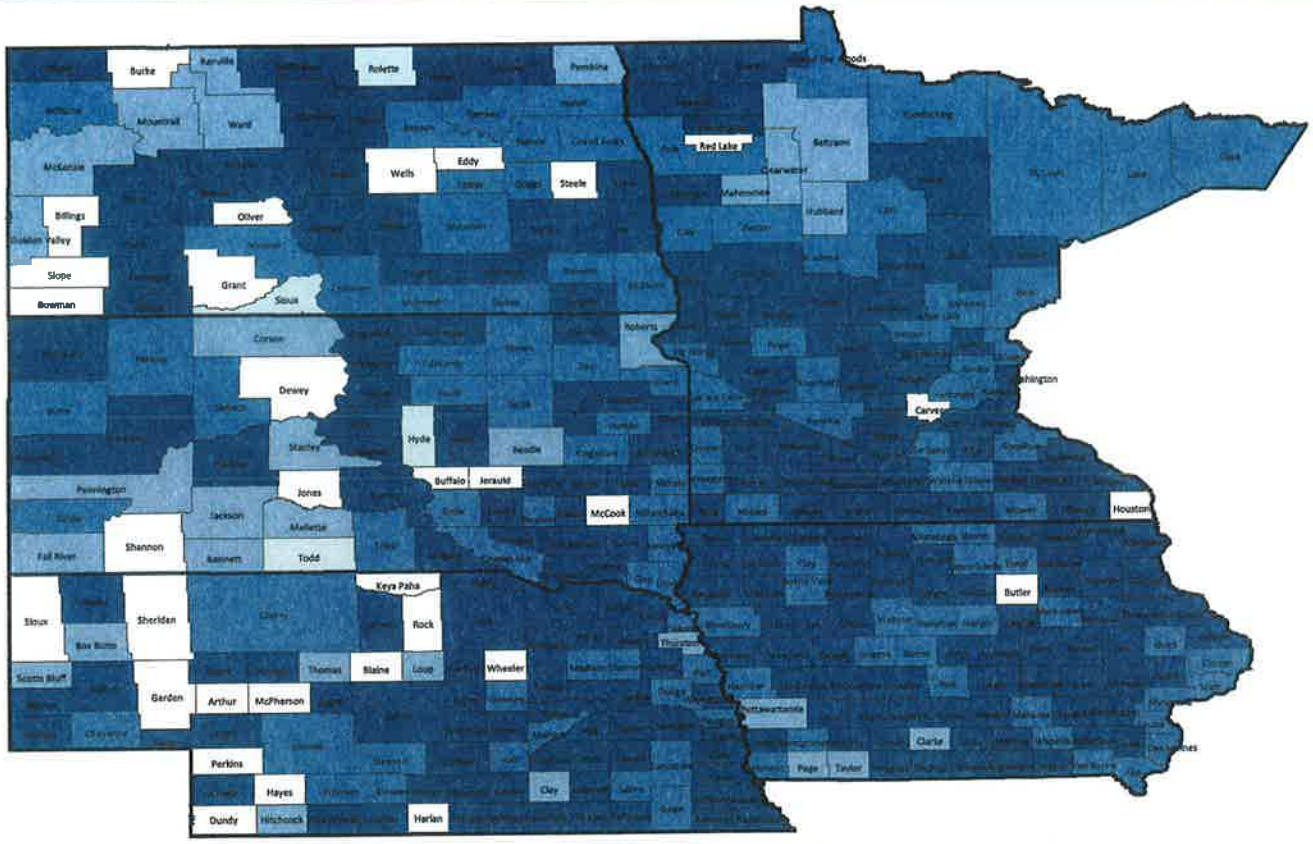
Importance: Evidence suggests that mammography screening reduces breast cancer mortality, especially among older women. A physician's recommendation or referral—and satisfaction with physicians—are major facilitating factors among women who obtain breast cancer screening. The percent of women ages 40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

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

High School Graduation - A health factor measure focusing on educaton

Map 21

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



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

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

CONTEXT

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

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

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

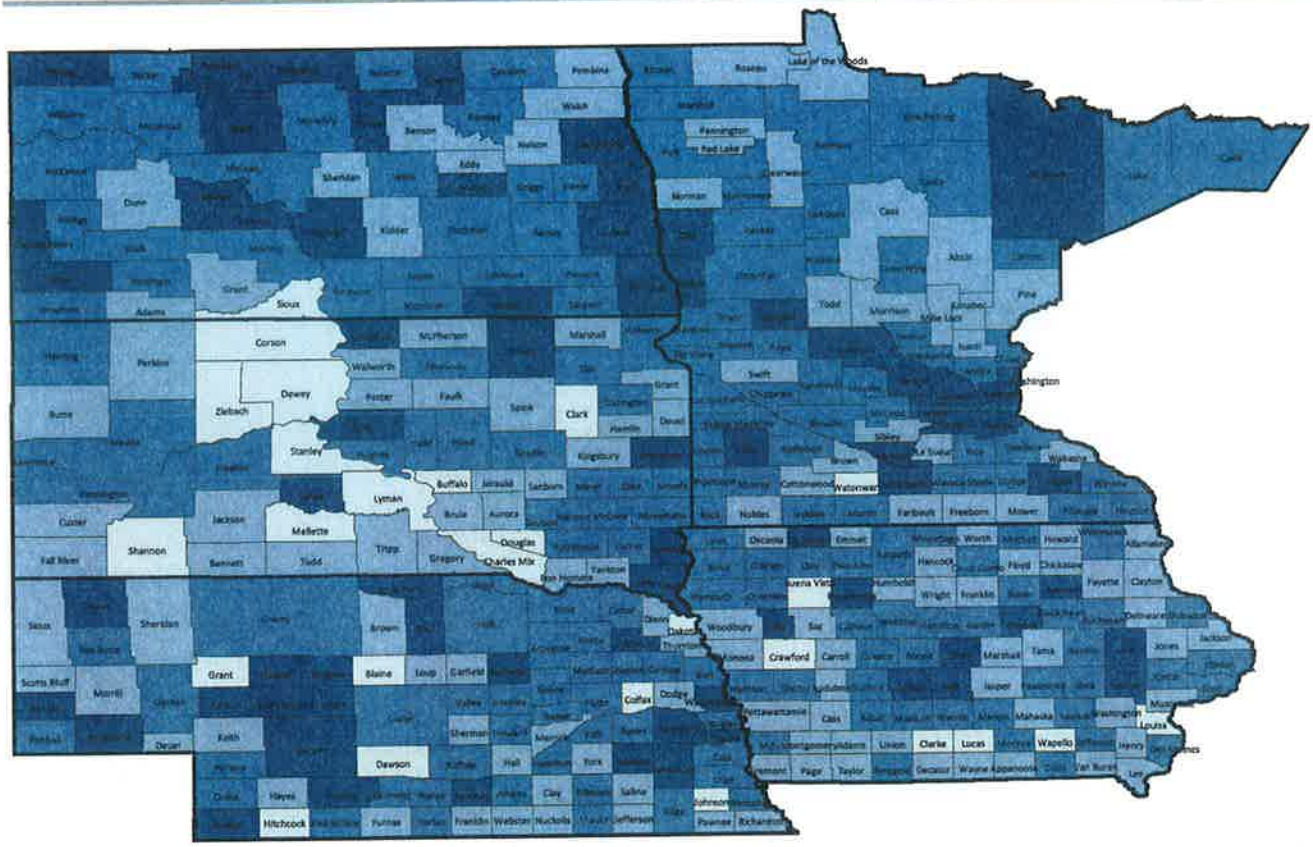
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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

Map 22

Some College - A health factor measure focusing on education

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



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

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

CONTEXT

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

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

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

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

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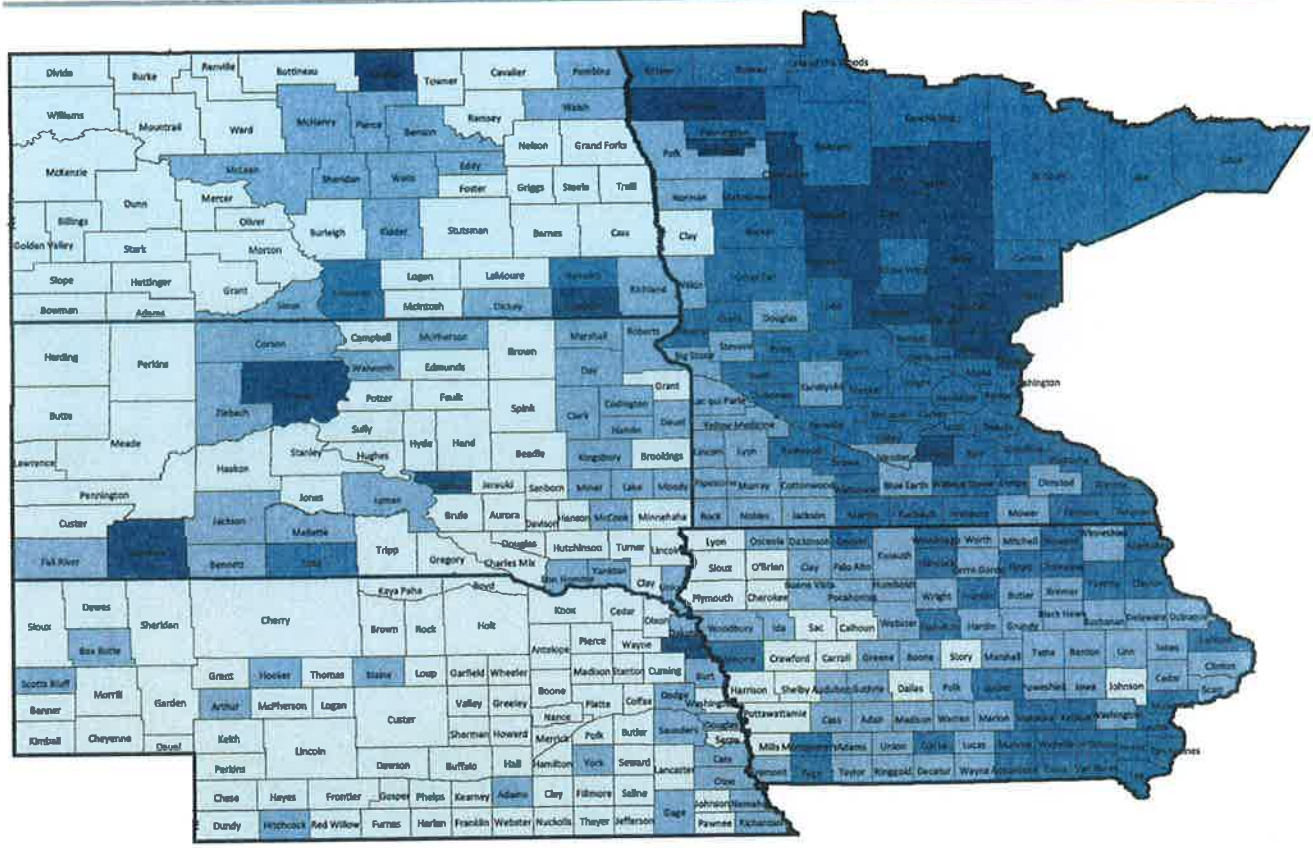
Map 23

Unemployment - A health factor measure focusing on labor

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



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

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

CONTEXT

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

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

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

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

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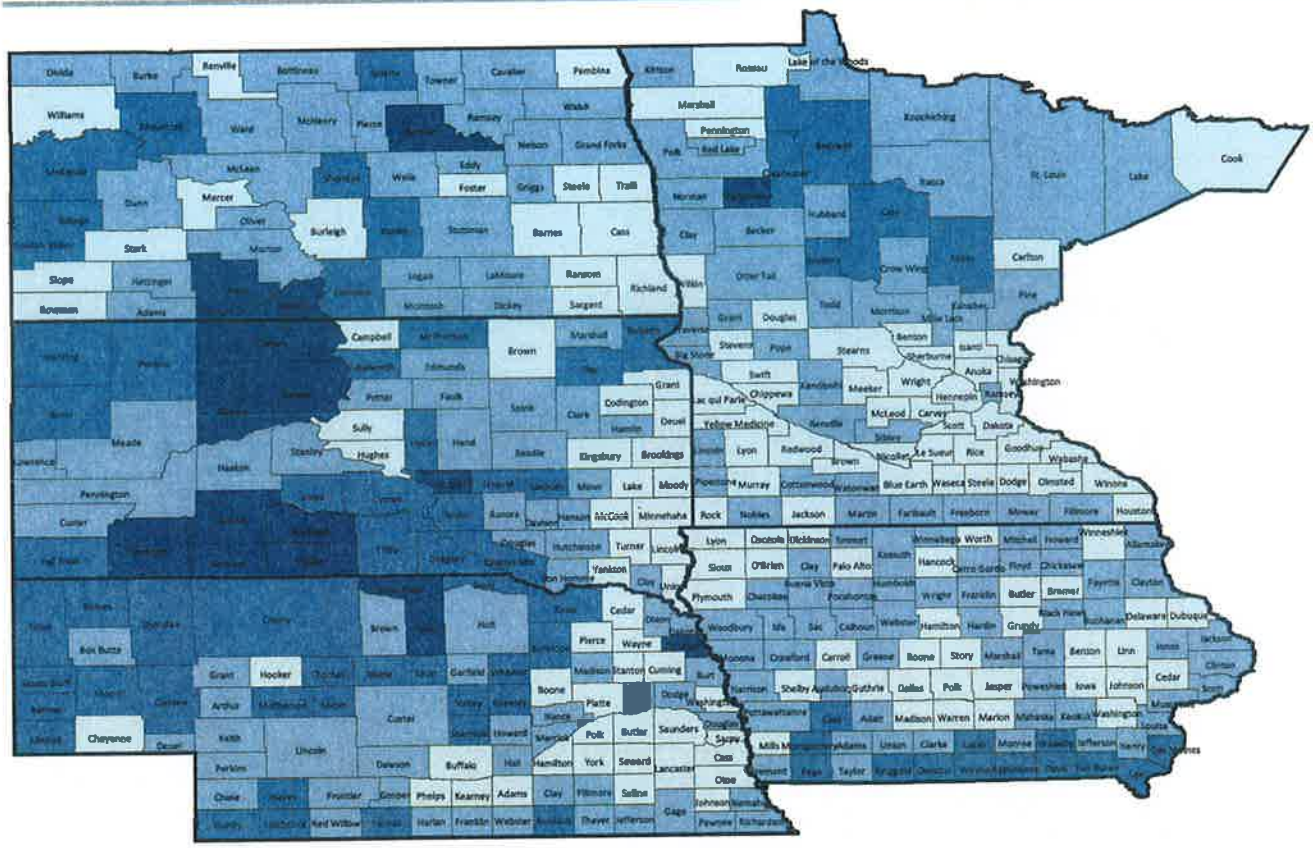
Children in Poverty - A health factor measure focusing on income and poverty

Map 24

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



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

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

CONTEXT

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

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

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

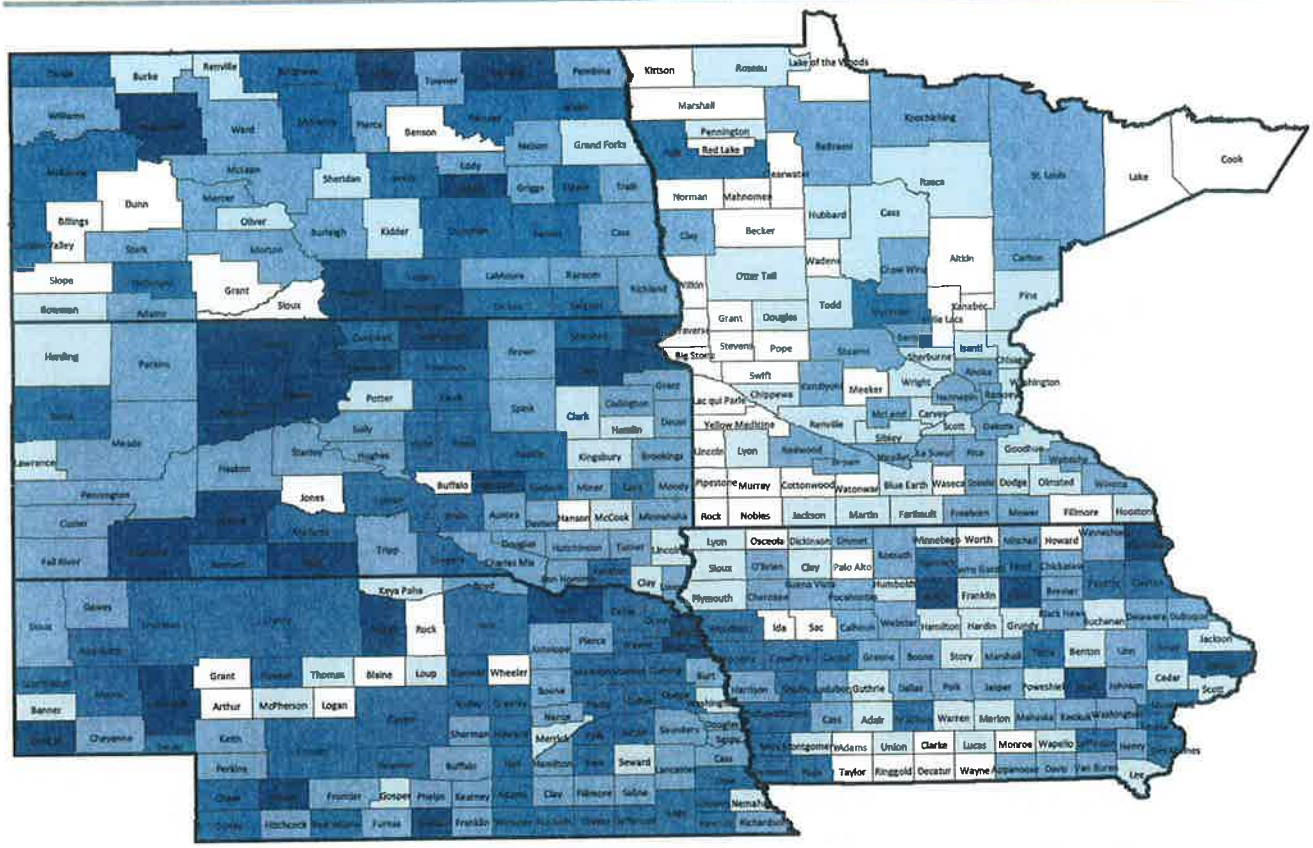
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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

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

Map 25

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



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

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

CONTEXT

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

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

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

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

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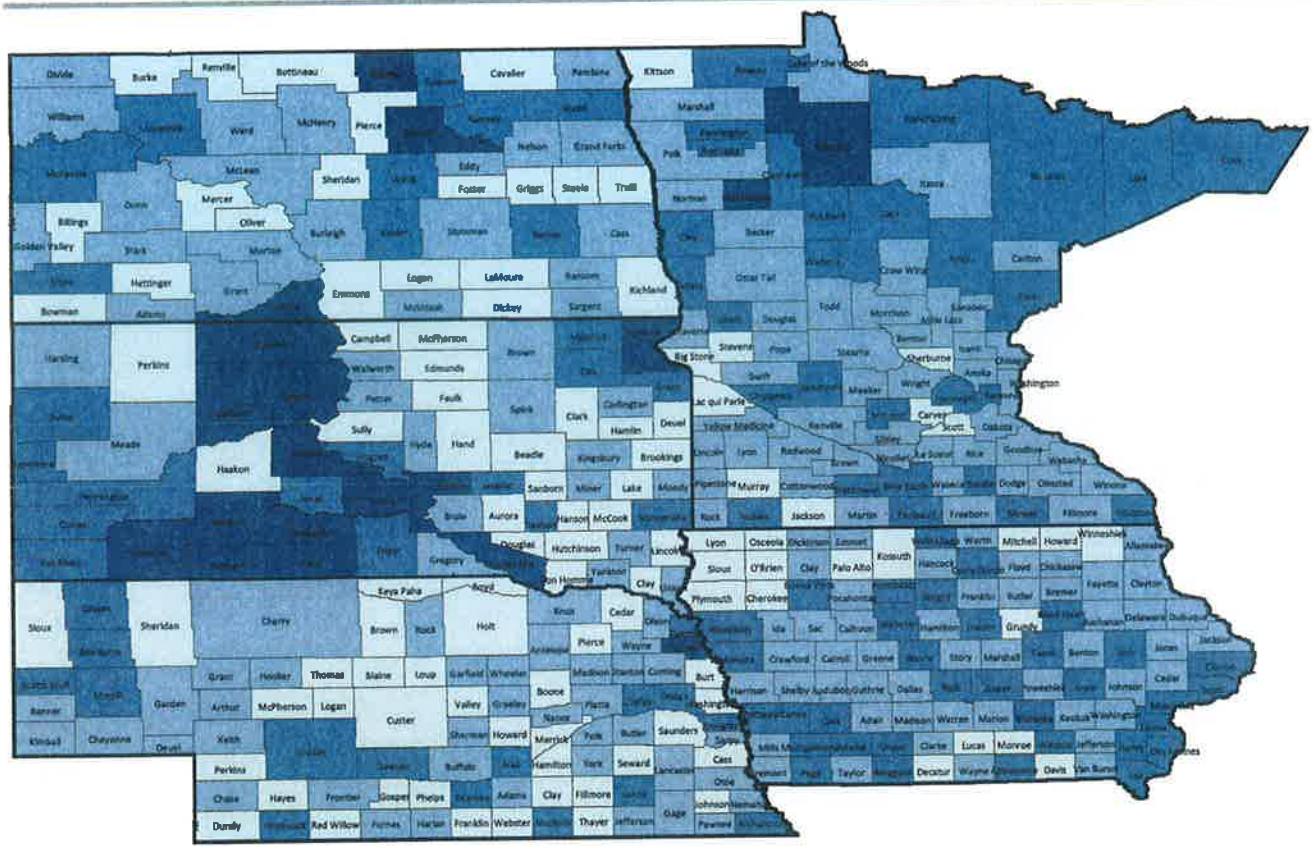
Children in Single-Parent Households - A health factor measure focusing on families

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



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

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

CONTEXT

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

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

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

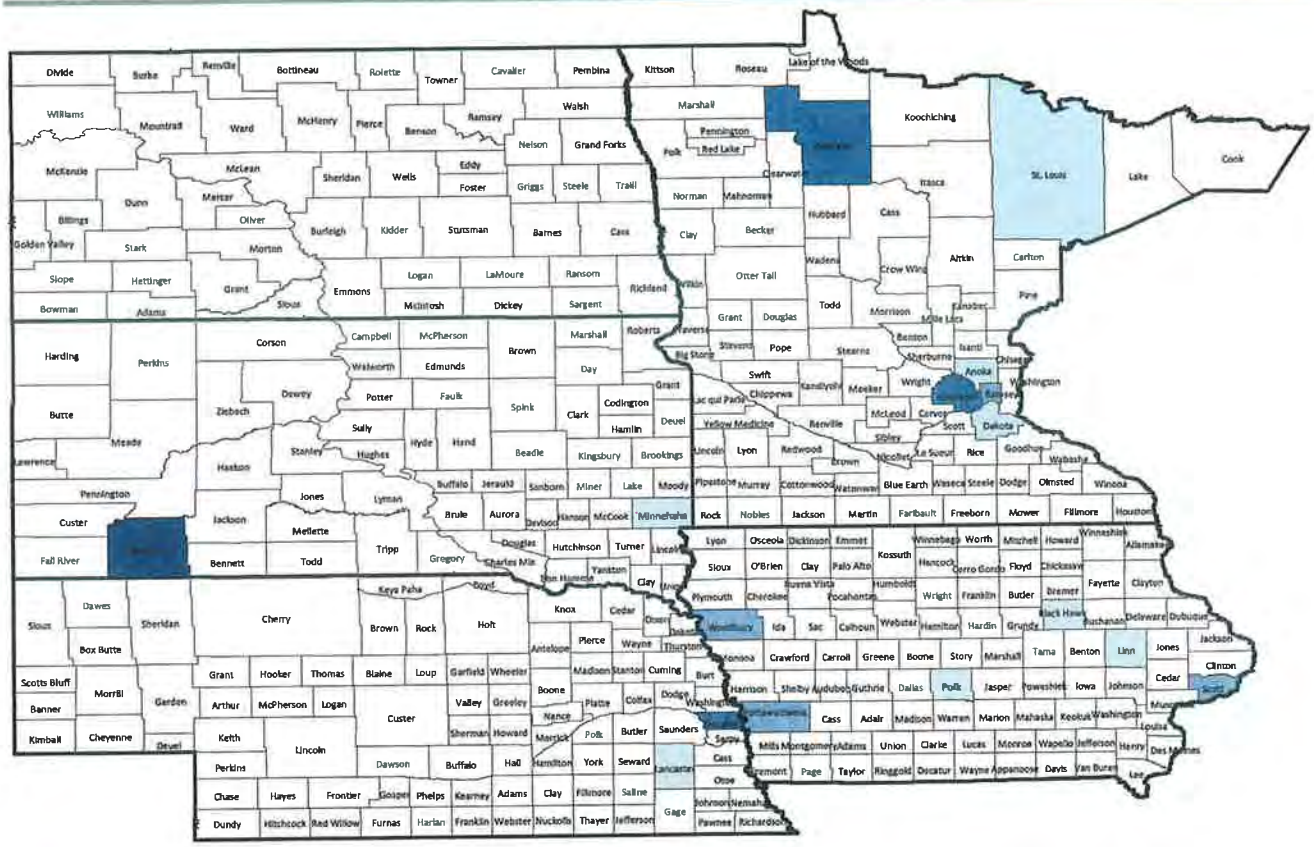
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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

Map 27

Homicide Rate - A health factor measure focusing on violent crime

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



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

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

CONTEXT

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

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

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

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

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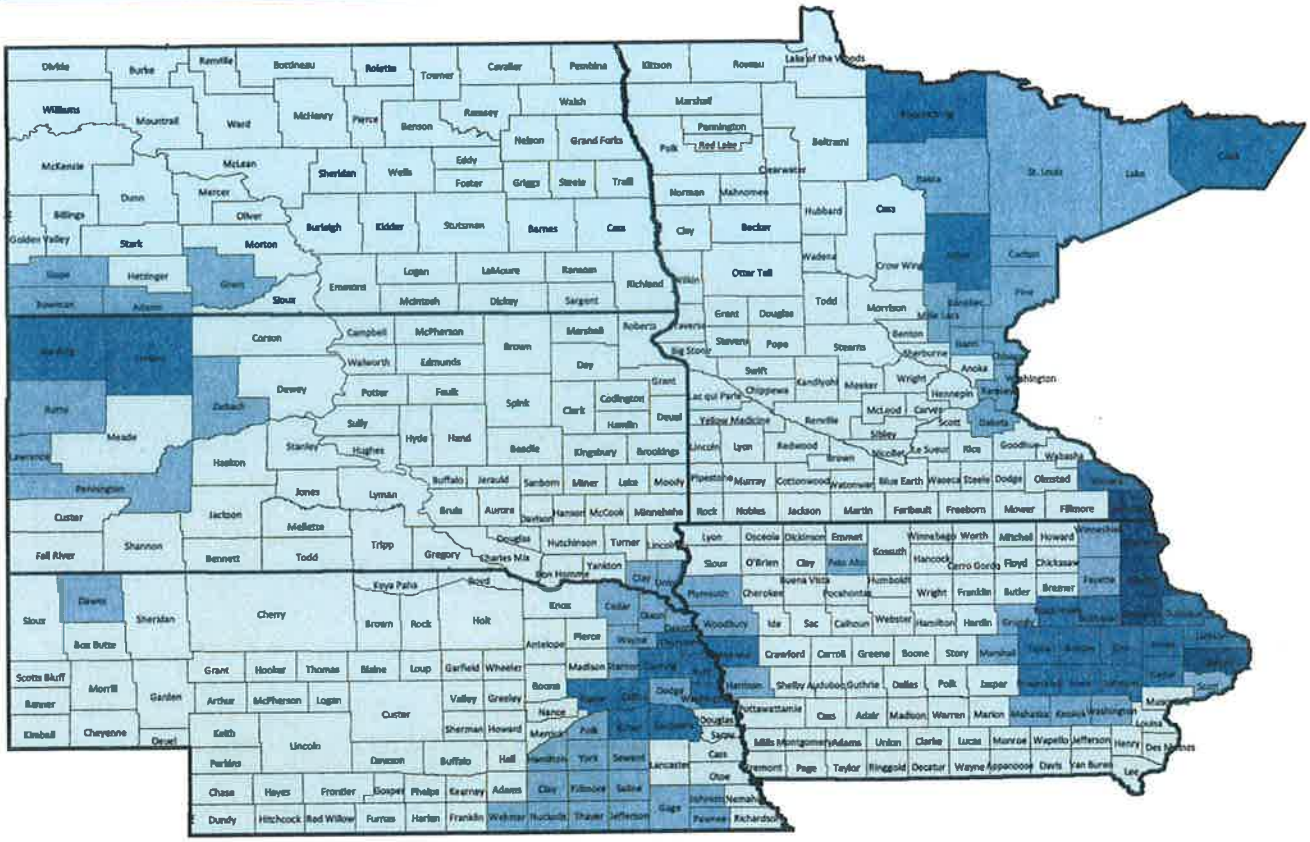
Map 28

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

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



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

- 0
- 1
- 2
- 3 - 4

CONTEXT

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

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

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

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

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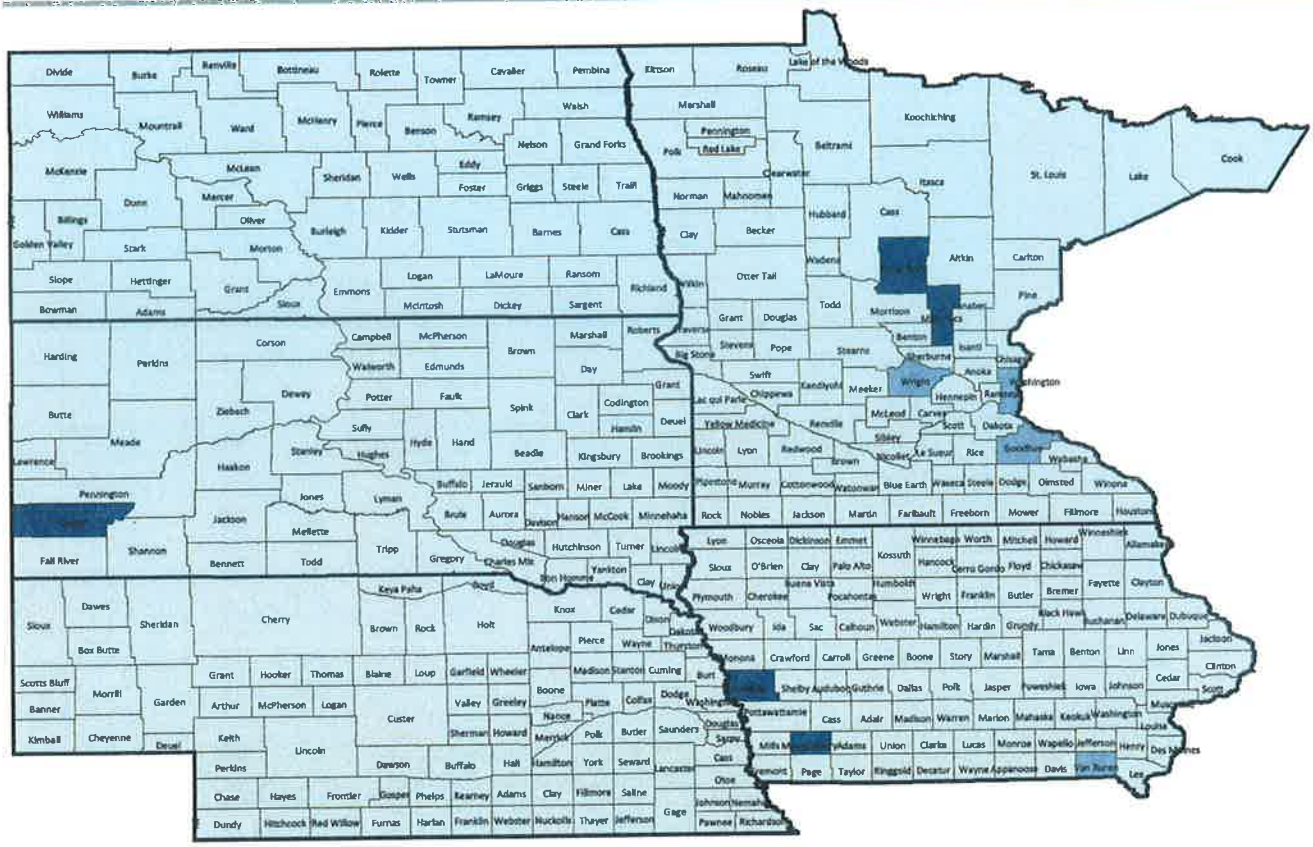
Air Pollution-OzoneDays - A health factor measure focusing on physical environment

Map 29

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



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

0
1
2

CONTEXT

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

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

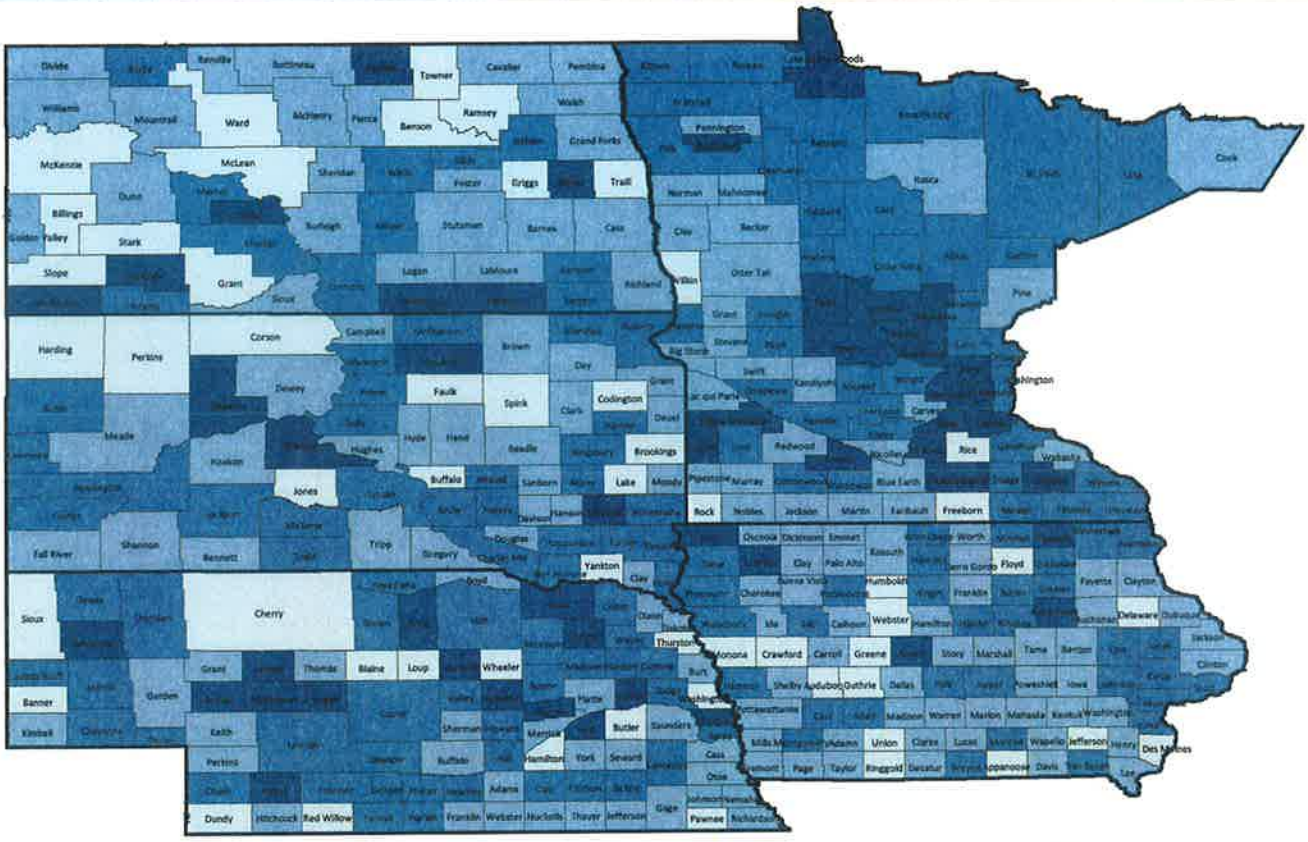
Importance: The relationship between elevated air pollution—particularly fine particulate matter and ozone—and compromised health has been well documented. The negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.

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

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

Map 30

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



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

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

CONTEXT

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

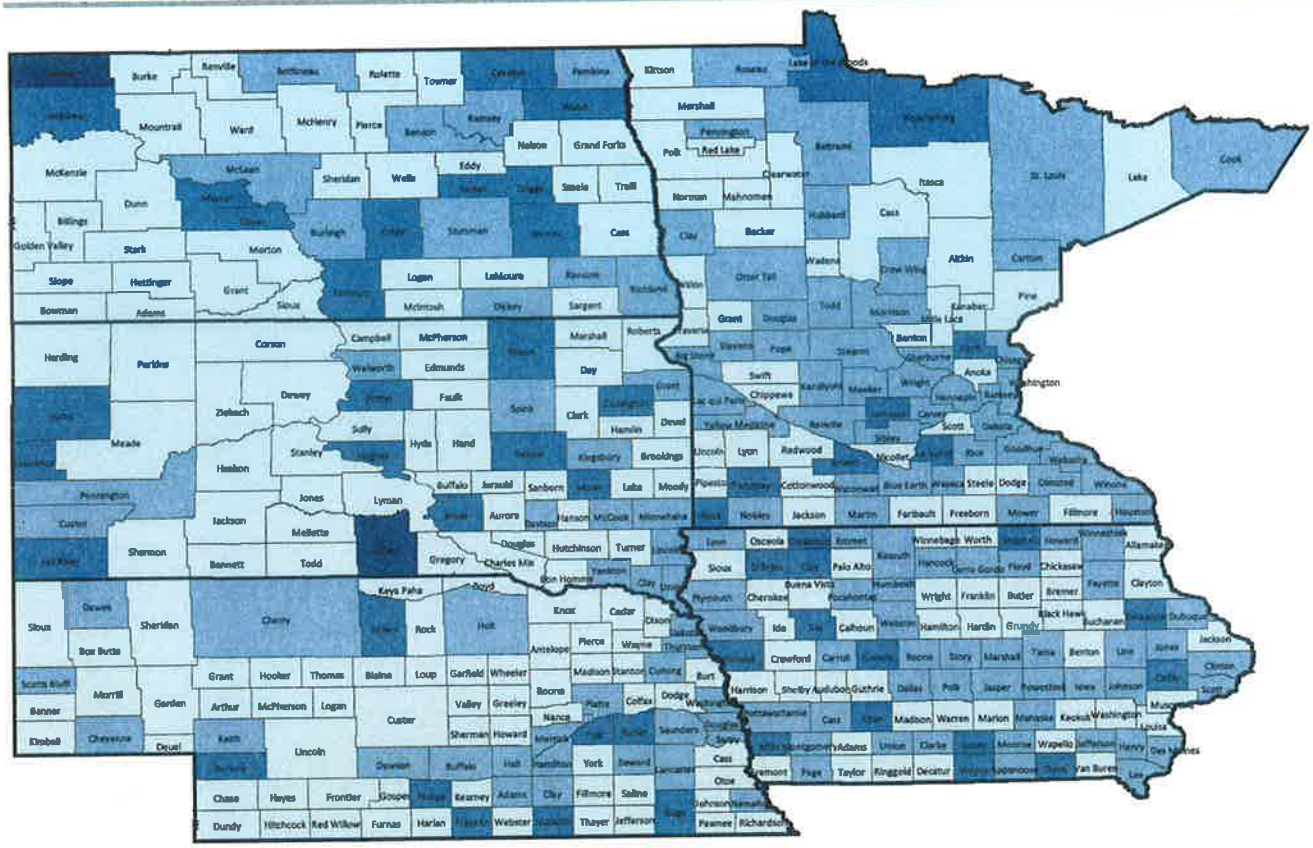
Where It Comes From: The measure is based on data from the U.S. Census Bureau's Zip Code Business Patterns. Healthy food outlets include grocery stores and produce/farmers' markets, as defined by their North American Industrial Classification System (NAICS) codes.

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

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

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

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



Number of recreational facilities per 100,000 population, 2008

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

CONTEXT

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

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

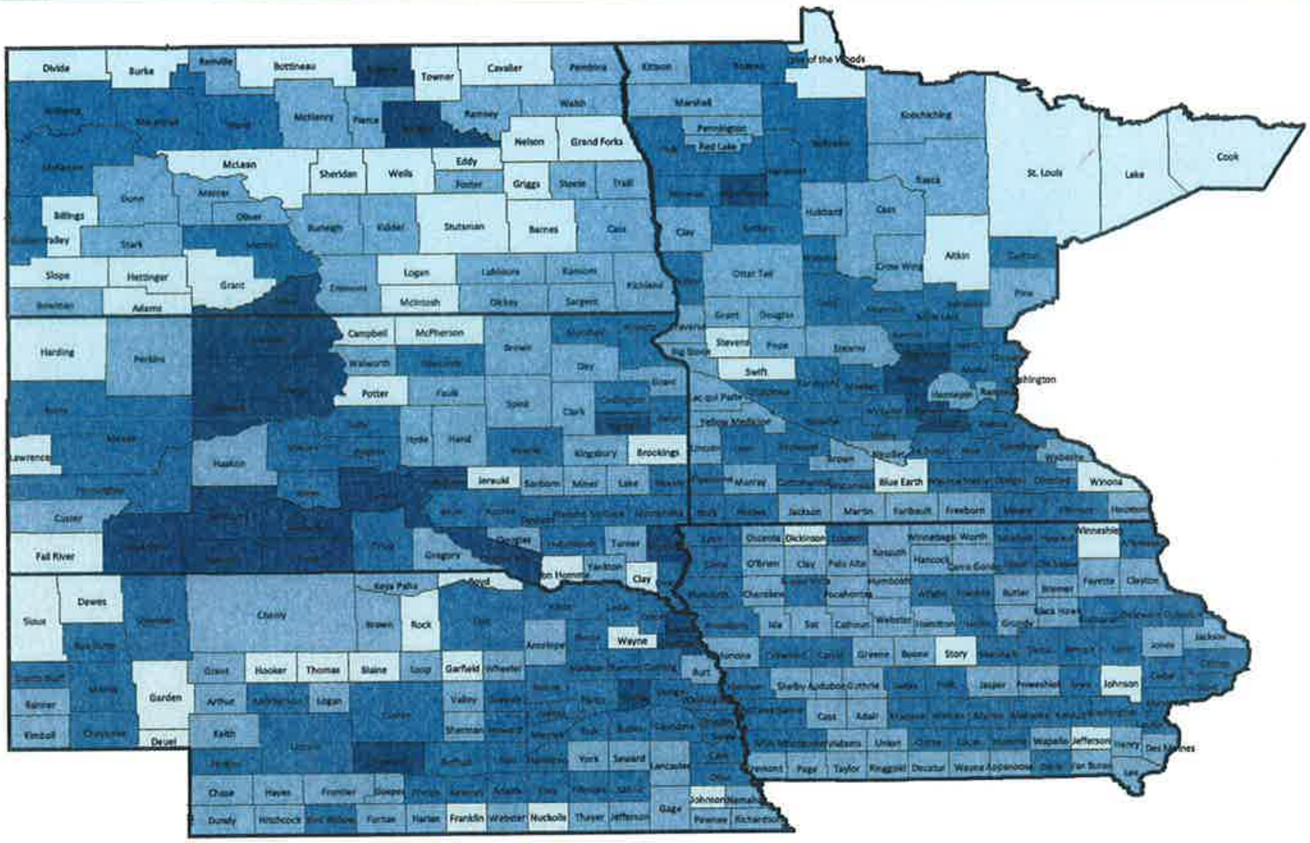
Importance: The availability of recreational facilities can influence individuals' and communities' choices to engage in physical activity. Proximity to places with recreational opportunities is associated with higher physical activity levels, which in turn is associated with lower rates of adverse health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

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

Map 32

Youth - A demographic measure

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



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

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

CONTEXT

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

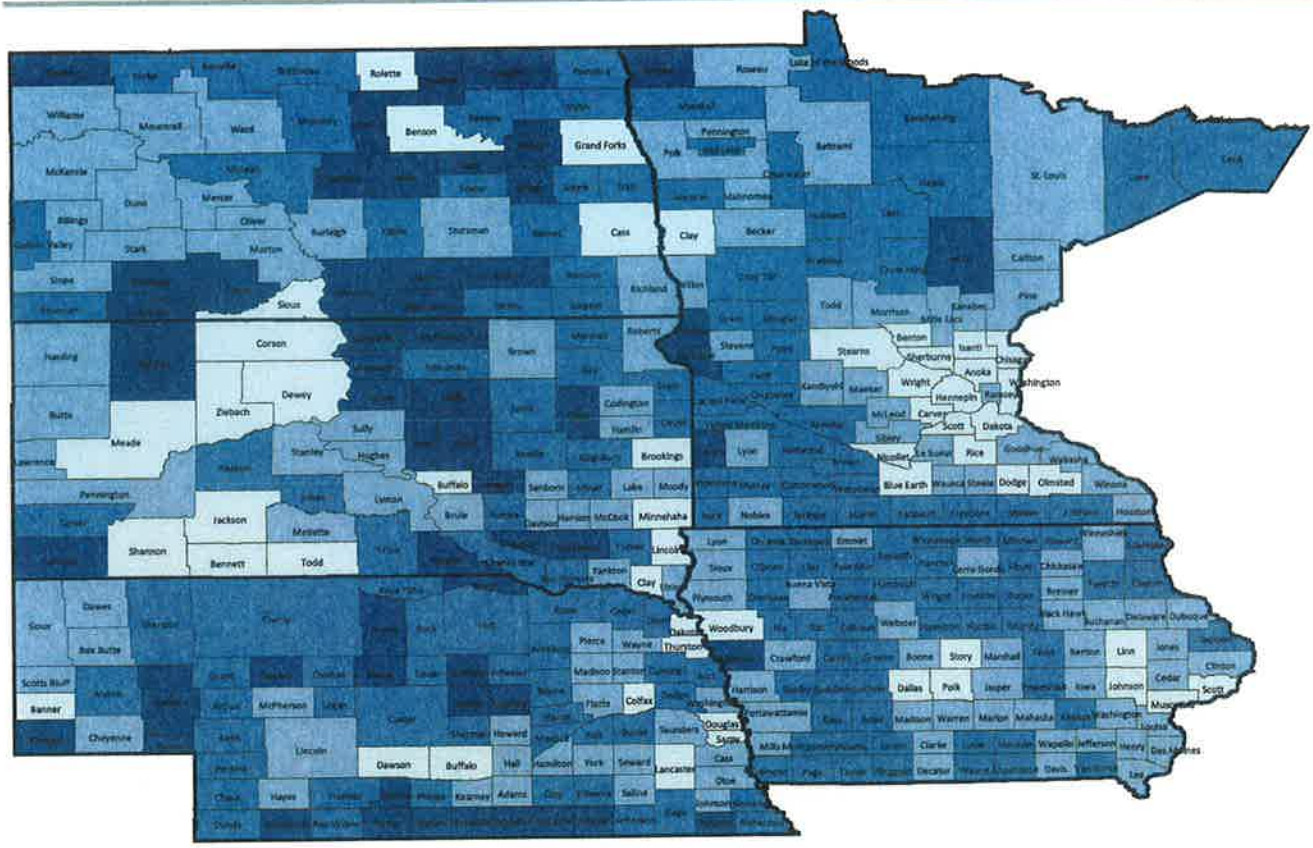
Where It Comes From: County demographic figures come from the U.S. Census Bureau's annual population estimates.

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

Elderly - A demographic measure

Map 33

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



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

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

CONTEXT

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

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

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

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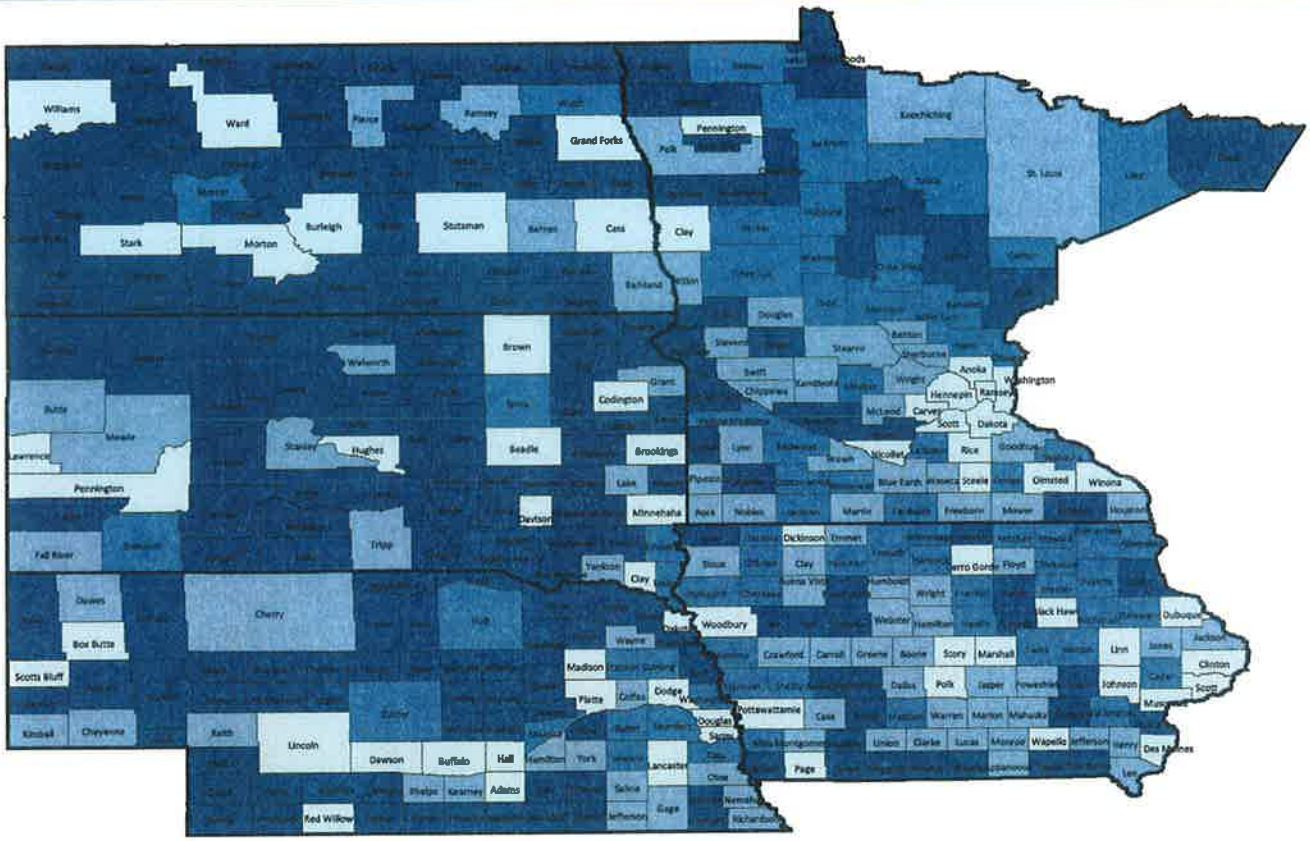
Rural - A demographic measure

Map 34

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



Percent of total population living in a rural area, 2000

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

CONTEXT

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

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

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

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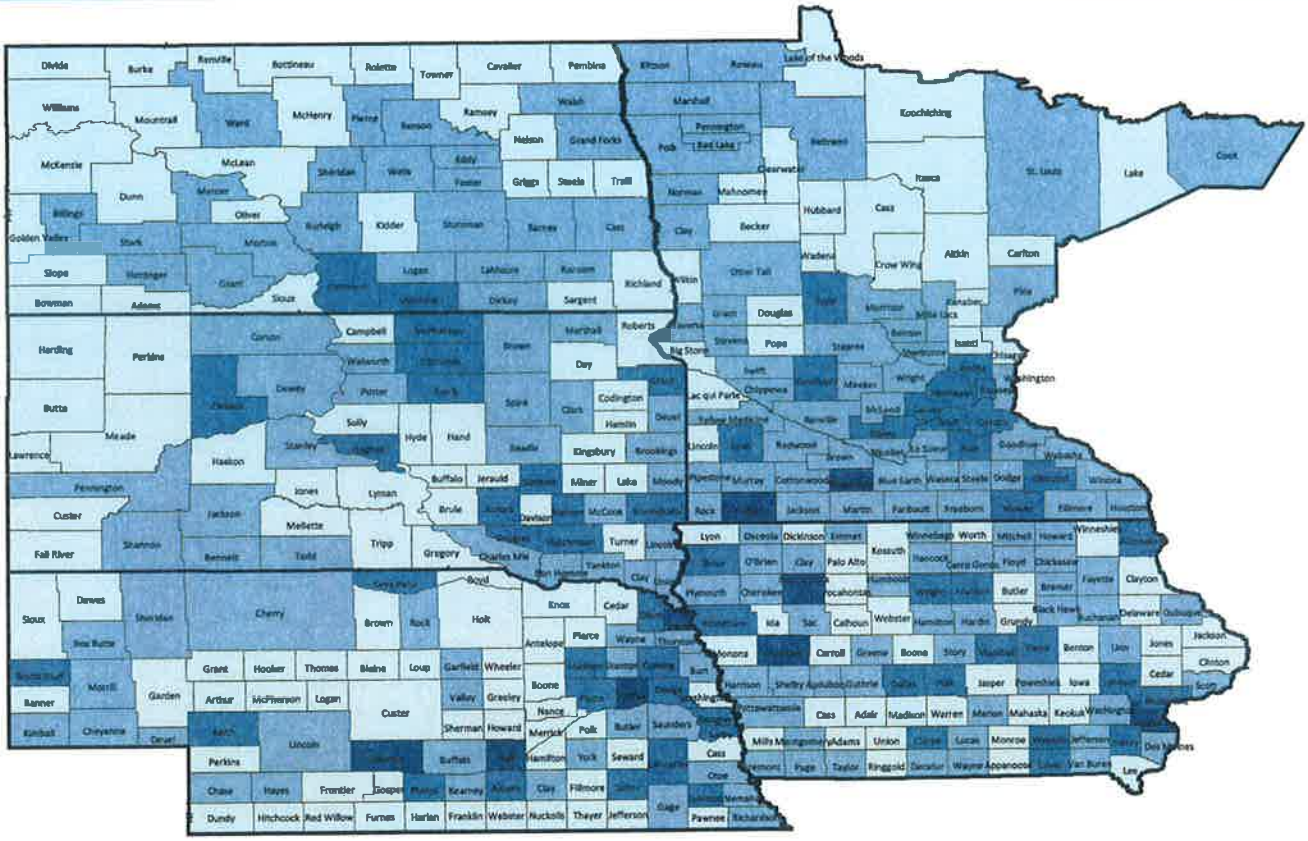
Not English Proficient - A demographic measure

Map 35

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



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

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

CONTEXT

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

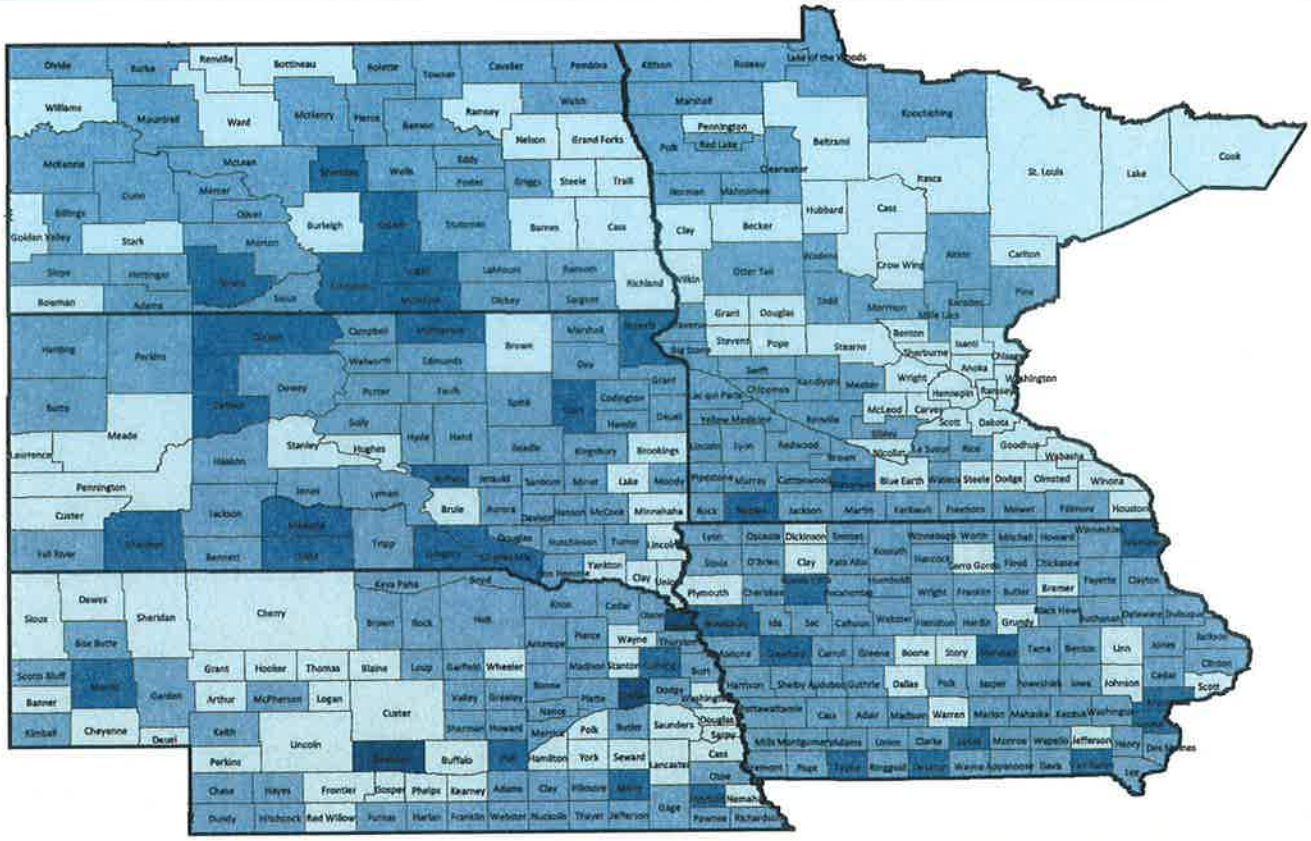
Where It Comes From: Data on spoken English proficiency come from the U.S. Census Bureau's American Community Survey 5-year estimates.

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

Map 36

Illiteracy - A demographic measure

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



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

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

CONTEXT

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

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

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

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

SANFORD™ HEALTH

Table 1
Community Health Needs Assessment Asset Mapping
Tracy Stakeholders

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Access	• Would like evening & weekend hours at the clinic • Would like an urgent care clinic/walk-in clinic that is reasonably priced • Concern about specialists who can only come once a month • High ratio of population for primary care physicians • High ratio of population for mental health providers	• Sanford Tracy currently offers Saturday morning clinic from 9-12; these are for walk-in's only. We do not offer evening hours. • Sanford Tracy offers endoscopy, cardiology, general surgery, ENT, nephrology, audiology, orthopedics, allergy, ob/gyn, urology, podiatry, ophthalmology, and psychiatry as outreach specialties. Because of physician schedules, having them once a month is positive. We are currently looking into oncology and dermatology through tele-medicine capabilities. • Sanford Tracy currently has 3 physicians and 3 mid-levels; our goal is to keep those positions filled as turnover occurs. • We have two new psychiatrists starting to come to Sanford Tracy once a month; we also have a new Mental Health practitioner starting in January 2013.	
Cancer	• High concern about cancer	• Sanford Cancer Biology Research Center • Outreach opportunities in oncology through tele-medicine	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
		• National organizations, such as the American Cancer Society, offer resources to cancer patients; need to be better about educating what is available and how to access them. • Sanford Tracy offers preventative screening for patients- mammography, colonoscopies, PSA, and the SAGE program.	
Chronic Disease	• High concern about chronic disease	• Sanford Medical Home • There are new provider performance measures for diabetes that will help improve the overall standard of care.	
Care Coordination	• Need more communication between providers – there is a disconnect between home care, NH, outreach, clinic	• Sanford Medical Home • Sanford Tracy has been working on this area by increasing communication between the nursing homes and the hospital/clinic. There has been an implementation of wristbands to help identify nursing home patients.	
City Infrastructure	• Concern about the condition of the streets • Concern about streets not being adequately plowed in the winter • Concern about ice & snow not being cleared from sidewalks • Curbs & gutters need to be adapted so the elderly & handicapped can walk safely • Need more street lighting in residential areas at night	• Though important for the community, Sanford Tracy does not have the capacity to meet the needs of these concerns. • It was recommended to bring the last concern to the city administration.	X
Dental Care	• Need a local dentist	• Dr. Heezen started a dentistry practice in July 2012 in Tracy. • Open Door of Mankato comes to Marshall once a month for medical and dental appointments.	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
		• UCare also offers a traveling dental care, but only takes UCare patients and is harder to schedule. • Dental varnishing is available for WIC patients through public health in their five-county service area. • The hospital did have a United Way grant to help coordinate local free dental care. Might be a good option to revisit in the future.	
Economy	• Unemployment rate is very high • Child poverty • Single parent households	• Though important for the community, Sanford Tracy does not have the capacity to meet the needs of these concerns. • Will bring these concerns to the City Administration	X
Elderly	• Need affordable help for the elderly so they can stay in their own homes • Need quality healthcare for the elderly	• Sanford Medical Home • There are grants available for those people who need help transitioning from higher levels of care to living at home. • There is need of education in the community.	
Emergency Care	• Want family members to be able to stay close to the patient during visit to emergency room	• Sanford Tracy works hard to work with the patient and their families when they arrive in the ER. Depending on the state of the patient, the family may (or may not) be able to stay close to them. • Continue having conversations with nursing staff to encourage ongoing communication with family during ER visits can help with this concern.	
Health Factors	• High rate of premature death • High rate of death by motor vehicle crash • High teen birth rate	• Education to patients can help reduce premature death. • "Toward Zero Death" is a program in Lincoln and	X

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
		Lyon counties that focuses on infrastructure changes to reduce motor vehicle crashes. • The group was not aware of any current programs for teenagers that may impact teen birth rate.	
Healthcare Cost/Insurance Cost	• Concern about overspending on healthcare facilities • Concern about prohibitive healthcare costs & high health insurance costs • Concern about those who do not pay so others have to make up for that • Concern about money spent on advertising & signage • Would like to get care in Tracy that is covered by Veteran's Benefits	• Though important for the community, Sanford Tracy does not have the capacity to meet the needs of these concerns. • Education to patients would help solve some of these concerns. • Will bring these concerns to the Minnesota Hospital Association.	X
Mental Health	• Lack of qualified mental health personnel • Need safe housing during mental health evaluation period	• Sanford One Care • Sanford Tracy is currently hiring a mental health professional. We are also having a child psychiatrist and adult psychiatrist come to Tracy once a month. • The medical center has discussed creating a space in the hospital where patients can stay after being admitted and transferred to different facility.	
New Americans	• Concern about young people (who are not 100% fluent in their own language) doing the translating for their parents • Concern with differences in culture in the community	• Sanford Tracy has recently updated their policy where a child under age of 18 cannot translate for their parent.	
Obesity	• Concern about obesity & all the health problems & costs associated with it • Need more education & follow-up with those who are overweight (exercise & diet education)	• Sanford WebMD Fit Kids • Sanford Medical Home • CHIP Grant has opportunities for schools to get involved with improving nutrition.	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need

Physicians	• Need providers who stay in the community long-term
	• Need a pediatrician available 27/7
	• Need specialists
	  ○ Cancer
	  ○ Obesity
	  ○ Dermatology
	  ○ Wound care (this is especially a concern for our aging population)
		• Sanford Tracy has similar challenges with provider retention as other medical facilities. Providers tend to stay 3-5 years (on average) and then move to new facilities.
		• Sanford Tracy has two pediatricians that offer clinic time once a week.
		• The medical center is looking into oncology, dermatology, and wound care as outreach through tele-medicine.	

Pollution/ Environment	• Concern about hard water, safe drinking water • Concern with smoke (fireplaces, fire pits, city dump)	• Though important for the community, Sanford Tracy does not have the capacity to meet the needs of these concerns. • Will bring these concerns to the City Administration.	X
Prevention	• Need more prevention services & education, especially for conditions like obesity & diabetes • Communicable disease	• Sanford WebMD Fit Kids. • Patient education from providers. • EMR/website print-offs with education material.	
Safety	• Police reports are vague - not sure how much crime is occurring in our community. Are we safe?	• Though important for the community, Sanford Tracy does not have the capacity to meet the needs of these concerns. • Will bring these concerns to the City Administration.	
Schools	• Need a truancy officer in the school. This would take the "policing" effort off the shoulders of those who should be teaching. • Concern about cutting PE in the schools	• Though important for the community, Sanford Tracy does not have the capacity to meet the needs of these concerns. • Will communicate concerns with Tracy schools.	X
Substance Abuse	• Lack of substance abuse programs for the community	• Sanford One Care • AA is available in Tracy • Need additional resources for Meth and narcotics	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
		• Not familiar with in-school programs for youth/teens; will bring this to the attention of the Tracy school district.	
Traffic	• More intersections need stop & yield signs • A stop sign is needed on the road on the south side of the hospital. There is a lot of traffic since the Fitness Depot opened & it is not safe for kids to cross to the pool in the summer.	• Though important for the community, Sanford Tracy does not have the capacity to meet the needs of these concerns. • Will communicate need for a stop sign/speed bump on the side of hospital to city administrator.	X
Transportation	• Need a system for commuting – buses, etc. • Need a taxi service	• Western Community Action has volunteer drivers in the Tracy area, but are dwindling down. We need additional volunteers. • No other transportation system in available.	X
Wellness	• Need for indoor exercise options for winter	• Sanford WebMD Fit Kids • Community Education sends out information on classes/indoor options for exercise during the winter months. • The Fitness Depot in Tracy is a exercise facility for community members; it does cost money to be a member.	X
Workforce	• Need more doctors, nurses & other healthcare staff	• Sanford Tracy continues to work on workforce retention; overall much lower than health care facility averages.	
Youth	• Concern about high number of youth using drugs • Concern about cutting PE in the schools • Bullying • Child abuse and neglect	• Sanford WebMD Fit Kids • Though important for the community, Sanford Tracy does not have the capacity to meet the needs of these concerns. • Need to communicate with the Tracy school district these specific concerns.	X

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Sanford Specific	• Concern about Sanford not supporting local businesses • Concern about constant staff change at the hospital	• Sanford Tracy has staff retention in their strategic plan; overall is much lower in regards to a 2-3% turnover rate. • Need for communication to the general public on events/activities/how $$ is spent, etc.	

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Table 2

Prioritization Worksheet

Criteria to Identify Priority Problem

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

Criteria to Identify Intervention for Problem

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

Health Indicator/Concern *(from asset mapping and gaps analysis worksheet)*	**Round 1 Vote**	**Round 2 Vote**	**Round 3 Vote**
Access	• Urgent Care/offer after hours • Specialists who come once a month • High Ratio for PCPs • High Ratio for Mental Health Providers	• Urgent Care/Offer After Hours • High Ratio for PCPs • High Ratio for Mental Health Providers	• Urgent Care/Offer After Hours • High Ratio for Mental Health Providers
Cancer	• Concern		
Chronic Disease	• Concern		
Care Coordination	• Communication between providers, etc.	• Communication between providers, etc.	
Dental Care	• Need a local dentist		

Health Indicator/Concern *(from asset mapping and gaps analysis worksheet)*	**Round 1 Vote**	**Round 2 Vote**	**Round 3 Vote**
Elderly	• Need affordable help for the elderly so they can stay in their own homes • Need quality healthcare for the elderly	• Need affordable help for the elderly so they can stay in their own homes	
Emergency Care	• Want family members to be able to stay close to the patient during visit to emergency room	• Want family members to be able to stay close to the patient during visit to emergency room	
Health Factors	• High rate of premature death • High rate of death by motor vehicle crash • High teen birth rate		
Mental Health	• Lack of qualified mental health personnel • Need safe housing during mental health evaluation period	• Lack of qualified mental health personnel • Need safe housing during mental health evaluation period	• Lack of qualified mental health personnel • Need safe housing during mental health evaluation period
New Americans	• Concern about young people (who are not 100% fluent in their own language) doing the translating for their parents • Concern with differences in culture in the community		

Health Indicator/Concern *(from asset mapping and gaps analysis worksheet)*	**Round 1 Vote**	**Round 2 Vote**	**Round 3 Vote**
Obesity	• Concern about obesity & all the health problems & costs associated with it • Need more education & follow-up with those who are overweight (exercise & diet education)	• Need more education & follow-up with those who are overweight (exercise & diet education)	
Physicians	• Need providers who stay in the community long-term • Need a pediatrician available 24/7 • Need specialists: Cancer Obesity Dermatology Wound Care	• Need providers who stay in the community long-term • Need specialists: Cancer Obesity Dermatology Wound Care	
Prevention	• Need more prevention services & Education, especially for conditions like obesity & diabetes • Communicable disease		
Substance Abuse	• Lack of substance abuse programs for the community	• Lack of substance abuse programs for the community	• Lack of substance abuse programs for the community
Wellness	• Need for indoor exercise options for winter		
Workforce	• Need more doctors, nurses, and other healthcare staff		

Health Indicator/Concern *(from asset mapping and gaps analysis worksheet)*	**Round 1 Vote**	**Round 2 Vote**	**Round 3 Vote**
Sanford Specific	• Concern about Sanford not supporting local businesses • Concern about constant staff change at the hospital	• Concern about Sanford not supporting local businesses • Concern about constant staff change at the hospital	• Concern about Sanford not supporting local businesses • Concern about constant staff change at the hospital

In attendance: Stacy Barstad, Lori Hebig, Laurie Stenke, Angela Nelson, Audrey Coopman, Jason Swanson, Ardis Hendrickson, and Krista Kopperud

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